Chapter 1 Elder Care Needs

Elder Care Needs and Services
A quality elder care plan will be concerned with quality of life for the older client's remaining lifespan, which could be a few months or even three decades.

One task of the family members and professional advisors involved in the planning team is to make sure that the pension and other post-retirement funds are chosen and deployed wisely. But that is not the end of the story. People over 65 vary greatly in their physical and mental capacities and needs. Some need a few more nice days to perfect their golf swing, while others need constant hands-on care to perform even the most basic tasks of survival.

Health care is fairly peripheral to most financial plans, but it is crucial and central to elder care plans. With luck, very little medical care will be required and whatever care is necessary will be fully covered by Medicare and Medigap insurance. Yet, for many senior citizens, Alzheimer's disease or some other type of dementia will cause a gradual, but eventually severe, loss of cognitive power and ability for self-care. Or a chronic illness or a combination of several illnesses and conditions will call for home care assistance, a move to specialized housing, or a move to a nursing home.

Therefore, sound planning for the post-retirement years requires:

-A health care plan to ensure that quality care will be available when needed
-A way to pay for the care

Care mechanisms could include treatment by physicians, hospitalization, skilled or custodial nursing homes, care at home, or a move from the community to specialized housing. Payment sources might include the retiree's own funds, contributions by family members, an employer's health plan, Medicare, Medigap insurance, long-term care insurance, or Medicaid. More to the point, the plan will probably evolve over time, as the older person's needs change.

Deploying the Planning Tools
In many ways, sound planning remains the same no matter the age or medical condition of the client. Certainly, the planner will want to make sure that the client can achieve lifestyle objectives: having the appropriate income level, taking reasonable planning steps to minimize the tax burden, and drafting any documents needed for transactions or transfers including trust documents and a valid will.

In many instances, financial planners work with married couples, or are consulted by a married man who takes the lead in planning for the family. One type of typical client is a mid-life male executive or professional. But elder planning also involves many clients who are widowed or who never married. The typical client might be the elderly widow. Many planning devices are tailored for married couples: for instance, the gift and estate tax marital deduction and Medicaid protection for the community spouse. Of course, if the client is widowed or never married these devices are inapplicable.

Good planning requires an unprejudiced mind set. It is most common that in a married couple the husband will be older, earn more, have more assets, become sick first, and die first, leading to a prolonged period of widowhood for his spouse. This assumption does not necessarily pan out in a particular case. The younger spouse may die first, leaving a spouse suffering one or more serious physical or cognitive problems. This spouse may nevertheless survive for many years, requiring a large and ever-increasing amount of care in each year.

Not every senior citizen suffers from mental incapacity, and some will never suffer diminished capacity. Do not forget that senior citizens, just like their younger counterparts, are entitled to express generosity and romantic feelings. They are allowed to make mistakes about relationships or investments, as long as they are not the victims of illness, fraud, duress, undue influence, or financial elder abuse.

Alzheimer's Disease

In January, 1998, the GAO estimated that in 1995, at least 1.9 million, and probably closer to 2.1 million American senior citizens suffered from Alzheimer's disease at some level of severity. The prevalence increased greatly with age for those between 65 and 85, doubling every five years until leveling off at age 85.

The Alzheimer's Association estimates that the economic impact of this tragic disease is at least $33 billion a year. That is just the cost to business, as distinct from the Medicaid costs and out-of-pocket costs of caring for people with dementia. The Association's estimate is higher than GAO's. The Association believes that there are about four million Alzheimer's sufferers in the United States, that at least 19 million people have a family member with Alzheimer's, and that 90 percent of Alzheimer's patients have a family member who provides care giving assistance.

Although some caregivers are forced to quit their jobs or shift to a part-time schedule to meet their care giving obligations, about four-fifths of employed caregivers work full-time. About $26 billion of the cost to business comes from lost productivity among caregivers absent from work to cope with family needs. Replacing caregivers who are forced to quit their jobs costs the economy over $3.5 billion. An estimated $1.3 billion is allocated to keeping up health insurance for caregiver-employees who take leave under the Family and Medical Leave Act, to heavy usage of Employee Assistance Programs by caregivers, and to fees for temporary agencies. Industry also spends an estimated $7.14 billion on health insurance and taxes that are allocated to senior citizens' health care and federal Alzheimer's disease research.

It should be noted that Alzheimer's is not the only source of mental confusion among the aging. Problems can be caused by depression which often responds well to medication, hardening of the cerebral arteries, strokes, or adverse reactions or over-concentration of medications. There are an increasing number of programs for Alzheimer's patients, including day care centers and specialized housing and nursing units that provide stimulation and calm agitation. These programs make it possible for Alzheimer's patients to use energy safely without wandering and getting lost.

Care Needs

As it stands now, Baby Boomers are doing the bulk of the care giving, but eventually they will be

senior citizens and in need of care. In 1995, long-term care for the elderly cost over $90 billion. Medicare and Medicaid paid 60 percent of those costs, while most of the rest came out of the pockets of the elderly and their families. In 1995, long-term care insurance paid less than one percent of the total bill for long-term care. As the size of the senior population increases, and as health care continues to become more expensive, the overall bill for long-term care can only increase (as well as the productivity impact of younger relatives providing unpaid care). In 1998, close to one-quarter of the elderly population (at that time, more than 7 million people fell into this category) needed assistance with daily activities. The aging of the Baby Boomers could double or even quadruple the eventual number of disabled elderly people who need care.

It is hard to estimate exactly who will need nursing home care, and when they will need such care. In fact, it is hard even to find comprehensive data about actual nursing home utilization. However, once a decade, the federal Department of Health and Human Services performs a comprehensive nationwide survey. The latest survey was done in 1995, and it took until 1997 to compile and analyze the results.

In the decade between 1985 and 1995, the number of nursing homes actually declined due to the shift toward larger nursing homes (many of them owned by health-care chains). Between 1985 and 1995, the number of nursing home beds increased nine percent, but the number of nursing homes decreased 13 percent. In 1995, there were about 1.8 million beds in 16,700 nursing homes with 1.5 million beds occupied. Thus, nursing homes were full but not over-full (87 percent of capacity).

Close to 90 percent of nursing home residents were at least 65 years old with younger resident's victims of accidents or disease preventing their living independently. More than a third of nursing home residents were aged 85 or older. Close to three-quarters (72 percent) of residents were female. About one-sixth of residents were married. To look at it another way, Medicaid's provisions for the financial protection of the healthy spouses of nursing home residents are actually applicable to only about one-sixth of nursing home residents. Of the rest, 66 percent are widowed, 5.5 percent are divorced or separated, and 11.1 percent never married.

Caregiver Issues

The term "caregiver" is usually used to describe a family member or friend who provides informal, unpaid care. Caregivers differ in the amount of care they provide. Some live in the same home as the person receiving the care, and are responsible for significant amounts of hands-on care. Others, especially those who live far away, have a role that may include emotional and financial participation but not hands-on care.

The typical caregiver is a middle-aged woman caring for her aged mother. Caregivers are sometimes described as part of the Sandwich Generation because they are caught between the needs of their parents, their spouses, and their children. Care giving is emotionally stressful and often physically difficult. It limits the caregiver's productivity at work if the caregiver is employed. It may require the caregiver to quit a job or to cut back hours. For these reasons it imperils the caregiver's own financial security and ability to save for retirement.

Caregivers should be aware that a federal statute, the Family and Medical Leave Act (FMLA),

requires employers to grant up to 12 weeks unpaid leave per year (including full and partial days off) so that caregivers can deal with a parent's serious medical condition. It should be noted that the federal FMLA does not require employers to grant leave to care for a parent-in-law, although many caregivers are responsible for a mother-in-law or father-in-law. Many of the states have their own family leave acts, which may be more generous toward "caregivers-in-law."

In many cases, the caregiver will also serve as an agent under a Durable Power of Attorney, as trustee, or will be appointed as guardian for a mentally incapacitated senior citizen. The caregiver may also be named on the older person's joint accounts. Documents should set out exactly what powers the caregiver will have over the older person's finances, especially with regard to gifts. In some cases, "self-gifts" (gifts made by a caregiver to himself or to his spouse or children) are appropriate when they carry out the wishes of the older person and satisfy legitimate planning objectives, such as reducing the taxable estate. But in other instances they may be inappropriate, unfair to other family members, or possibly illegal as a violation of fiduciary responsibility.

End of Life Issues

It can confidently be predicted that all clients will die, sooner or later, as a result of one cause or another. Although nothing can alter this basic fact of existence, good planning can do a great deal to enhance the quality of life in the client's later years, including the time when the client is terminally ill or otherwise incapacitated.

The basic premise of our medical and legal systems is that health care is rendered based on a contract between the health care provider and the consenting patient. This model often breaks down at the end of life, because the patient is unconscious, suffers from Alzheimer's Disease or another illness that impairs cognition, or is otherwise unable to make care choices or give informed consent to care.

The legal system has responded in several ways, principally by making provisions for Advance Directives. That is, an adult who has mental capacity signs a document expressing his treatment wishes under various circumstances. The document can then be consulted if and when the patient is unable to express wishes directly. There are two main kinds of Advance Directives: the Living Will and the Durable Power of Attorney for Health Care. The Durable Power of Attorney for Health Care is also known as a health care proxy.

The Living Will is a written expression of the person's desire that treatment be either terminated or continued in the event the person ever becomes terminally ill and unconscious, or otherwise unable to express treatment preferences. States differ in the extent to which Living Wills can be used to refuse care or direct that nutrition and hydration be provided if the person is also unable to eat. Most states do allow Living Wills to be used for this purpose, as long as the person's wishes are clearly and unequivocally expressed. Also, an advance directive can be used to express a preference for maximum as well as minimum treatment.

The proxy works differently. It designates a person, such as a spouse, adult child, or family friend, to make treatment decisions if the patient cannot make the decisions personally. This is broader than the Living Will, because it can come into play when the person who granted the proxy is mentally incapacitated but not terminally ill. Once again, it is probably possible to give the proxy

decision-making power over nutrition and hydration decisions, but this is a matter of state law.

Certain health care providers that participate in Medicare, including hospitals and nursing homes, have an obligation under federal law to raise the subject of advance directives with their patients. The facility is not allowed to force patients to sign an advance directive. If a patient does sign an advance directive, the facility is required to make it a part of a patient's medical record. If a patient signs an advance directive, the health care provider is not required to provide care that conflicts with the advance directive. The health care provider is not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and state law allows any health care provider or any agent of such provider to conscientiously object. An increasing number of states have laws dealing with Do Not Resuscitate (DNR) orders. DNRs make it possible for an individual to say that he does not want CPR to be performed if he suffers a heart attack or respiratory arrest. Even in states that do not have specific statutes, it is worthwhile to discuss with the attending physician whether or not a "No Code" order should be placed in the medical record. If state law permits "out of hospital" DNR orders, and this is the client's wish, then local ambulance and EMS services should be notified and given a copy of the order so they will not perform an unwanted resuscitation.

Another trend in state law is the creation of "surrogate decision-making" laws. These laws set out a hierarchy of people (usually, the spouse first, then if there is no spouse, an adult child, and so forth) who have a legal right to make medical decisions for an incapacitated patient who has not created an advance directive. Since the vast majority of people do not create advance directives, these statutes solve many problems. Without such a statute, the health care facility must obtain a court order appointing a guardian and then approach the guardian for permission to carry out non-emergency health procedures, which is a cumbersome drain on both medical and legal resources.

The Planning Process and Team

The optimum elder plan reflects the wishes of the senior citizen and family to the extent that these wishes can realistically be carried out. It provides for quality care in the optimum setting. It can also provide for different settings, as needs change, since needs typically increase rather than decrease. The plan balances strictly financial issues such as investment and tax planning against medical, social, and psychological needs. It deploys financial products and services, as well as health care products and services, to meet these objectives.

You would not expect the average senior citizen to have access to a single person who combines the skills and perspectives of half-a-dozen professionals. The obvious solution is to create a planning team, each of whose members brings a set of skills and a professional perspective to the project of creating and monitoring the elder plan.

Depending on the facts of the situation, the preferences of the elder and family, and the size and complexity of the plan, the team might include:

-An attorney, preferably an attorney with current information about elder law. Certain states have a program that allows an attorney to become a Certified Elder Law Attorney

(CELA). Becoming a CELA is evidence of commitment to elder law, and of having achieved status within the field, although there are fine elder law attorneys who are not CELAs

-An insurance professional

-A Geriatric Care Manager (GCM), usually trained in nursing or social work, with practical expertise not only with services available to the elderly, how to coordinate a service plan, and how to apply for public benefits, but also day-to-day knowledge of, and contacts with, local service providers

-An accountant to deal with tax and financial matters (e.g., valuation of a closely held business when the founder retires)

-A financial planner, whether fee- or product-based

-A broker or investment advisor or both (the number and qualifications of people involved depending on the size and complexity of the portfolio).

Forming the Team

Professional ethical standards mandate that not only must a professional avoid practicing professions for which he is not licensed, but he should suggest the involvement of other professionals whenever the professional encounters a situation that he is not trained or equipped to deal with.

It should be made clear to the client that he can assemble the team personally, but that the professional initially consulted is willing and able to make referral suggestions. Consult the various codes of ethics for the extent to which fees can be shared, or if referral fees are appropriate.) In many instances, the client will not be aware of the full scope of services available, or of the division of labor among professionals. (For example: Few people outside the elder planning community even know that GCMs exist, and of those who are aware of GCMs, even less know how to work with them effectively.

The planner will want to develop a network of other elder planning professionals to work together on complex projects and to make referrals for simple tasks that fall into only one professional domain. An excellent way to do this is by attending multi-disciplinary continuing education programs. Not only will this hone the planner's skills, the planner will be able to observe local members of other professions.

In fact, it makes sense for a planner to offer his services as a speaker at single-profession or multi-disciplinary seminars. He can also offer his own seminars (e.g., to employee groups, at senior centers, or to a congregation), because individuals who have seen the planner offering useful professional advice are more likely to want to retain his services or purchase financial products from him.

Standards for making referrals, or adding a person to the team the planner recommends, include:

-Where and when did the person obtain basic education about elder planning?

-How does he stay current on elder planning issues? (E.g., from continuing education programs, committee activities, reading journals and newsletters, consulting Web sites that deal with planning issues)

-If professional specialty or certification programs are available, has the person obtained certification?

-Is elder planning central to the person's professional practice, or is it an afterthought?

-Is he aware of the functions of other professions in the team, and does he know when to refer the case or bring in another team member?

-Is he aware of potential legal pitfalls (so he will not give dubious advice) and sensitive to Medicaid and tax consequences of transactions?

-How much time will the person have to devote to this case?

-Will the person handle the case personally or delegate it to assistants? If it is delegated, how knowledgeable and skillful are the assistants?

-Does the person belong to important professional associations? Some professional associations are about as intellectually fruitful as a fraternity party, but others offer a year-round program of services, publications, and continuing education. On the other hand, some people just are not joiners, or they need to spend money that would otherwise go to dues on building a library or automating their practice

-Is the person easy to work with, and comfortable with older people and their families? How is his equivalent of a doctor's "bedside manner?"

Continuing Education and Certification in Elder planning

Late 1998 and early 1999 were marked by the development of several programs to train and certify elder planners. These programs merit investigation. One or more may offer a planner insights, planning tools, and enhanced credibility in the market. The Institute of Elder Planning Studies offers the Certified Elder Planning Specialists (CEPS) designation, covering many of the planning issues discussed in this course. The SRM (Senior Risk Manager) designation covers financial planning for individuals aged 60 to 85, but focuses on psychological factors rather than technical Medicare, Medicaid, and long-term care insurance issues. The Certified in Long-term Care Program (CLTC) deals with aging issues, Medicaid, long-term care insurance, and ethical issues, among others. An American Association of Long-term Care Insurance and National Forum on Long-term Care have both been formed, and may provide their own certifications.

Ethical Issues

Consider that when an eldercare planner takes on an elder planning case he is working for the whole family. The plan that is created may have implications that carry on for generations. The classic ethical issue for elder planners is "who is the client?" In the ideal case, everyone is "on the same page" and agrees what should be done. In the real world, it is far more likely that there will be disagreements and hard choices will need to be made. For example: It may cost more for a frail senior citizen to be cared for at home (with three shifts of attendants, plus professional care) than in a nursing home. If home care continues for years, and little or none of the cost is reimbursed by Medicare or insurance, there probably will be less for the senior citizen's heirs to inherit. Similarly, the decision of whether to discontinue life support may be colored by financial as well as religious and compassion-related motives.

Sometimes the older-generation member gets greater tax benefits from a lifetime gift, but the potential gift recipient prefers an inheritance. Sometimes the potential recipient wants a gift now, but the potential donor wants to hang on to the money. If a son or daughter is named as agent under a Durable Power of Attorney, the question becomes whether the agent is allowed to make gifts of the senior citizen's money to himself or to his family, and how this will affect the rest of the family.

As can be seen, there can be many interests and many opinions involved in creating a plan. The planner must decide who the client is and whose interests he must protect in case of conflict. Sometimes it is necessary for individuals with seriously conflicting interests to have separate representatives, or at least to sign a waiver indicating that they are aware of the potential conflict but choose to have the same attorney, accountant, or other adviser. It also matters who writes the check to pay the fee if the planner is a fee-based planner. That person may technically be the client, even if the planner was hired to make a plan for someone else. No matter who is technically the client, make sure that the planner receives the honest, unbiased, and uninfluenced opinion of the senior citizen who is the subject of the plan. It is often necessary to remove the children and in-laws from the room, and perhaps repeat the inquiries several times to find out what the senior citizen wants and not just what he thinks the children or in-laws want, or what an ideally unselfish parent would want.

Check with an experienced elder law attorney, or the local government agency that protects the elderly, for clues for how to spot physical or financial elder abuse and the scope of the legal duty to report suspected abuse. Most state laws provide that professionals have a legal duty to report suspected abuse that they observe as part of their professional practice. These laws provide that there is no penalty for making a good-faith report that turns out to be unfounded.

Another important ethical issue is how to handle a client who definitely would benefit by a particular transaction but perhaps lacks legal capacity to engage in the transaction. It is possible to reassure yourself, by taking extra time and trouble, that the older person finally understands the transaction and gives informed consent to engaging in it. See if the family or attending physician can suggest times when the older person is especially alert. But if capacity is permanently lacking, then it may be necessary to have a guardian appointed, to use a Durable Power of Attorney already in existence, or to have a guardian appointed for the specific and limited purpose of carrying out the necessary transaction.

Psychological Issues

The families the planner meets in his elder planning efforts will certainly be facing up to hard facts. Many of them will be going through a crisis. That means that sometimes the planner sees people at far from their best. Elder planning puts us in touch with some very frightening realities: chronic illness, debilitation, and loss of physical and mental capacity, loss of independence, confrontation with death, and the loneliness and anguish of survivors. To be an effective elder planner, a planner will have to understand how this work will affect him psychologically. On the good side, he may be "adopted" as a surrogate child by a really nice family who is grateful for the help he can give them. He may become caught in a swirling maelstrom of emotions in a family who is still angry and resentful about decades-old, half-forgotten events. He may be blamed for things that are not his fault and that he is not able to change: that he cannot bring back a lonely widow's beloved husband, that he cannot reverse a lifetime of bad financial choices by drafting a few documents, or that he cannot cure an inoperable cancer or restore capacities eroded by Alzheimer's disease.

The planner must be able to separate his professional skills from feelings about clients. He will also have to be able to sort out feelings about his own family from feelings about his clients and their families.

Income Tax Issues

Under our current system, where there are few tax brackets and the brackets are fairly close together, there is not much significance to the fact that many people drop into a lower tax bracket after retirement. For most purposes, senior citizens face the same income tax planning issues as any other taxpayer. See the various substantive chapters for income tax issues of, for instance, Social Security benefits, annuities, and retirement planning.

Persons over 65 are entitled to have approximately $1,000 more income than non-senior citizens before the need to file an income tax return at all is triggered. A senior citizen is entitled to a larger standard deduction than a non-senior citizen; an additional enhancement to the standard deduction is available to those who are legally blind. (These additional standard deductions are reduced if the senior citizen can be claimed as someone else's dependent.)

Low-income persons over 65 (and persons who have retired because of a permanent and total disability) may also qualify for a tax credit under Internal Revenue Code Section 22. The maximum amount of the credit is $1,125. The maximum credit may be reduced by non-taxable pension and Social Security benefits, and is phased out at higher income levels. For a married couple filing jointly, where both spouses qualify for the credit, the phase-out level starts at an Adjusted Gross Income (AGI) of $10,000 and completely phases out at an AGI of $25,000. See IRS Publication 524 for details. (A credit reduces the actual amount of tax due, while a deduction reduces the amount of taxable income that is used to calculate tax liability.)

In some instances, the senior citizen is considered, for tax purposes, as a dependent of a caregiver child, or of several children who have combined to provide a "multiple support agreement" covering the senior citizen. Five tests are used to determine whether a deduction may be taken:

-Whether the elderly person lives in the taxpayer's home for the entire year, or is a relative of the taxpayer.

-The elderly person is either a U.S. citizen or a legal resident of the U.S. or a country contiguous to the U.S.

-The senior citizen's gross income does not exceed $2,800 (in 2000 -- this amount is indexed for inflation); non-taxable Social Security benefits are not counted in gross income

-The senior citizen does not file a joint return

-The taxpayer provides at least half of the senior citizen's support (or at least half of the senior citizen's support is provided under a multiple support agreement).

If there is a multiple support agreement, it should be drafted to specify which contributor will take advantage of deductions arising out of the senior citizen's dependent status. The taxpayer claiming the deductions must personally provide at least 10 percent of the senior citizen's support. Unmarried caregiver whose dependent parent lives in his household can pay taxes at head-of-household rates, which are lower than rates for single persons. Head-of-household status may also be claimed by an unmarried person who pays more than one-half the cost of maintaining a separate household in which the parent lives. The child is deemed to maintain the household even during the parent's health-related absences (e.g., while hospitalized).

A caregiver child can claim a medical-expense deduction for expenses actually paid on behalf of a dependent parent. Even if the child is not able to take a dependency deduction (because the parent's income is too high, or because the parent files a joint return), the child can claim a medical expense deduction for amounts paid toward the parent's medical expenses. If there is a multiple support agreement, only the child who is entitled to claim the dependency deduction is allowed to deduct the parents' medical expenses. Other contributors to the multiple support agreement cannot, even if they actually paid the expenses.

Of course, the parents' medical expenses can be deducted only if they were not reimbursed by insurance or otherwise, if they are legitimate medical expense deductions, and only to the extent that, in conjunction with all other medical expense deductions, they exceed 7.5 percent of the taxpayer's adjusted gross income.

Not all health-related expenses are deductible. Unreimbursed costs of prescription drugs and insulin are deductible, but costs of over-the-counter medications are not. If an individual enters a nursing home primarily in order to receive medical care, all of the costs (including those that substitute for ordinary living expenses) are deductible. But if the primary motive is the convenience of the resident and the resident's family, then only the portion of the bill that can be allocated to medical and nursing care is deductible; the portion allocable to room and board is not.

Under appropriate circumstances, long-term care insurance premiums may give rise to a tax

deduction. Long-term care insurance benefits can be received tax-free, within statutory limits. The same limits apply to accelerated death benefits or viatical settlements that are received by a chronically (but not terminally) ill person who applies the benefits to the costs of health care. Tax advantages are not available to a healthy elderly person who chooses to enter into a viatical settlement for purely financial reasons.

Long-Term Care Needs and Services

Long-term care is a very broad term that refers to a spectrum of services, support systems, and facilities that are designed to meet the ongoing medical, social, and personal needs of those who have functional disabilities. As such, it encompasses a wide range of demographics, services, and funding resources. The primary goals of long-term care are to help individuals maintain functionality and maximize independence.

Long-term care involves a variety of services that include medical and nonmedical care for people who have chronic illnesses, disabilities, or severe cognitive impairments that keep them from living independently. Long-term care helps meet both health and personal needs. Most long-term care provides assistance with support services—for example, the activities of daily living, like eating, dressing, and bathing. This type of care is provided at home, in the community, and in assisted living environments. Long-term care can also take the form of skilled care in nursing homes.

It is important to understand that the need for long-term care can surface at any age and that services can take the form of formal or informal arrangements. The adult long-term care population is diverse, much more encompassing than simply the elderly living in nursing homes. The non-elderly and persons living in the community also represent a large proportion of people requiring long-term care.

Defining the Need for LTC

Long-term care recipients may be of any age. Conditions that may lead to the need for long-term care include disability, mental decline or illness, AIDS, stroke, and simple frailty. The need for long-term care is primarily measured by assessing limitations in performing or managing tasks of daily living, including self-care and household tasks.

Obviously, the likelihood of receiving long-term care assistance increases with age. The aging of Americans will only increase the need for quality long-term care options. The growth in demand will be driven by increases in the numbers of elderly as a result of the aging of the baby boom generation and the trend toward increased longevity.

Projections from the U.S. Census Bureau indicate a rapid and extensive increase in the elderly population. In 2030, when all the baby boomers will be 65 and older, nearly one in five U.S. residents is expected to be 65 and older. This age group is projected to increase to 88.5 million in 2050, more than doubling the number in 2008 (38.7 million). Similarly, the 85 and older population is expected to more than triple, from 5.4 million to 19 million between 2008 and 2050. The number of people 85 years or older, nearly half of whom need assistance with everyday activities, will grow even faster.

Regardless of age, older people are more likely to receive long-term care at home or through community services rather than in nursing homes. Because the need for long-term care is expected to grow substantially in the future, this will place an ever-increasing strain on already burdened public and private financial resources.

Measuring Long-Term Care Needs

The need for long-term care services is measured in two ways. Activities of daily living (ADLs) are basic daily tasks. Instrumental activities of daily living (IADLs) are tasks necessary for independent living. Both serve as a measure of functional capacity. When a person's functional capacity is diminished because of physical or mental impairment and he or she requires help with daily tasks of living, the need for care may be in order.

Activities of daily living are the fundamentals of self-care and the very basic tasks of everyday life. These include:

-eating
-bathing
-dressing
-toileting
-continence maintenance
-transferring

Instrumental activities of daily livings are tasks necessary for independent community living. They reflect how an individual interacts with his or her environment. IADLs include such things as:

-using the telephone
-driving
-shopping
-preparing meals
-light housework
-taking medications
-managing money

Functional ability is the foremost indicator of the need for long-term care. The inability to perform ADLs and IADLs is the primary index of functional disability.

Who Needs Long-Term Care?

People may suddenly need long-term care after a crisis occurs, but for many, the need develops gradually. Older individuals are the primary users of long-term services, because functional disability increases with age. In 2008, about 9 million Americans over the age of 65 required LTC services. By 2020, that number will increase to 12 million. However, while most people who need long-term care are 65 or older, such services can be necessary at any age. Forty percent of people currently receiving long-term care are adults 18 to 64 years old.

According to the U.S. Department of Health and Human Services, the risk of needing LTC is fairly high. About 70 percent of individuals over age 65 will require some type of long-term care

services during their lifetimes. Over 40 percent will need care in a nursing home for some period.

Factors that influence the risk of needing long-term care services include the following:

-age—Risk generally increases with age.
-marital status—Single people are more likely to need care from a paid provider.
-gender—Women are more likely than men to need long-term care, because women tend to live longer.
-lifestyle—Poor diet and exercise habits can increase the long-term care risk.
-health and family history—A family history of poor health may increase the risk of needing long-term care.

From a medical standpoint and in absolute medical terms, long-term care is chronic care with the aim of management, control of symptoms, and maintenance of function. Chronic care differs from traditional acute care, which is medical care aimed at treating physical problems directly in an attempt to permanently cure or control them.

Long-term care may result to treat debilitating injuries (from a fall or other accident, for example), pulmonary and cardiovascular conditions, psychiatric disorders, kidney and liver malfunction, and similar problems. Degenerative conditions such as Parkinson's disease and rheumatoid arthritis can summon the need for long-term care services. Patients with prolonged illnesses—cancer or heart disease, for example—or who are recovering from a stroke or severe burns often require LTC.

Alzheimer's disease and other forms of dementia also contribute to the need for LTC and the growing population of LTC recipients. These conditions are characterized by the loss of or decline in memory and other cognitive abilities. Severe enough, they will interfere with daily life and one's ability to function independently. The number of Americans with Alzheimer's and other dementias is increasing every year because of the solid growth in the older population. This number will continue to increase as the baby boom generation ages. The Alzheimer's Association estimates that 10 million baby boomers will develop Alzheimer's disease in their lifetimes.

How and Where Long-Term Care Is Delivered

Long-term care needs encompass a wide range of medical and support services for individuals who lack some capacity for self-care and who are expected to need care for an extended period. The level of care required determines how and where the care is delivered.

Long-term care can be either "formal" or "informal." Unpaid care from friends and family is termed informal care. Formal care is furnished by nurses, home aides, homemakers and other paid providers.

The Long-Term Care Continuum

Long-term care can be thought of as a continuum of health and social services ranging from care at home via home health and homemaker services to services in the community, such as adult day care, to skilled care in nursing homes.

Necessary services may be either continuous or sporadic. Services are delivered for a certain period to those whose ability to function is limited. These functional disabilities may be temporary or permanent, mental or physical. Functional disabilities—that is, the inability to perform the activities of daily living—preclude a person from remaining independent. The inability to perform instrumental activities of daily living also prevents complete independence.

Home-Based Care

Most LTC recipients receive their care at home. The goal of home-based LTC services is to help individuals maintain their independence in familiar surroundings. Home-based services maximize all available resources—the home setting, available family members, volunteer and paid services, and financial resources.

Those receiving care generally prefer to remain in their homes for as long as possible. ADL needs can be met informally with the help of family members and friends, as well as formally through volunteers and homemaker services agencies.

Home-based services typically encompass the following:

-non-medical personal care services, such as help with ADLs
-homemaker services, which include help with tasks such as companion services, meal planning and preparation, shopping, light chores, bill-paying, transportation, and other IADLs
-home health care services which are provided by home health aides, registered nurses, licensed practical nurses, social workers, physical therapists, and hospice organizations, typically under a care plan prescribed by a physician.

Despite substantial public and private spending for long-term care, families continue to provide the majority of long-term care services. These caregivers provide informal or unpaid care to family members of all ages. Typically, adult children provide this care to elderly parents, and spouses provide it to one another.

Community-Based Care and Services

Community-based services take place outside the home in the community. These services meet the need for periodic care or supervision. They also serve the very important function of providing social contact for those who are frequently home-bound.

Community-based services include the following:

-adult day service (ADS) programs, also referred to as adult day care, which provide, for several hours at a time, structured health and social support services, such as meals, recreation, and rehabilitative therapy in a group setting

-senior centers, which furnish services such as nutritional counseling, meals, health screenings, and recreational, social, and educational programs without the level of supervision found in adult day service programs

-care giver support programs, which provide respite from the stress and demands of care giving in the form of substitute caregivers and caregiver support groups.

Facility-Based Care and Services

Facility-based services come into play when it is time to consider alternate living arrangements. Many LTC recipients need only assisted living types of arrangements. Perhaps they don't have the option of home-based care or have exhausted their home-based care resources. Others have health issues serious enough to require the level of care offered by a skilled nursing facility. For the range of services to meet these needs, the following facility-based services are available:

-Congregate housing, also called senior retirement communities, is merely a housing option for elderly residents who can take care of themselves. The community typically provides a variety of social and recreational activities.

-Adult foster care programs are composed of families who volunteer to take into their homes an older person who needs some help with ADLs or IADLs. They provide a room and services such as laundry and cooked meals.

-Board and care homes, sometimes called residential care homes, are group living arrangements offering a home-like environment. They typically provide help with the activities of daily living, but they encourage residents to act independently. They do not offer medical care.

-Assisted living facilities, similar to apartment-like settings, are an option for those who require a limited level of assistance. Residents are not able to live independently, but they also do not require skilled nursing care. These facilities encourage residents to bring their own furniture and keepsakes to make their units feel like home.

-Skilled nursing facilities (SNFs) represent a level of care that requires the daily involvement of physicians and a skilled nursing or rehabilitation staff. SNFs provide care to elderly or disabled patients who need substantial, long-term assistance. Personal care, recreation, and rehabilitation are also provided here.

-Continuing care retirement communities (CCRCs) can be thought of as large campuses consisting of many types of facilities. Some residents require no special assistance and live very independently in separate housing. Those requiring a slightly greater degree of support are housed in assisted living facilities on the same campus, and skilled nursing facilities are available for residents who need skilled care. CCRCs generally offer long-term contracts that guarantee care and shelter for life. Residents move from one facility to another as their health needs change. Because of the scope of services provided in CCRCs, they are very expensive and beyond the means of those with low to moderate income and assets.

Levels of Long-Term Care

In addition to the long-term care continuum which considers where care is provided, we must also examine the levels of care available to LTC recipients. Again, the level of needed care is a determining factor for how and where the care will be delivered. The three primary levels of care

are custodial, intermediate, and skilled.

Custodial care
Custodial care primarily provides assistance with ADLs. It is designed to meet the personal needs (as opposed to medical needs) of the recipient. Custodial care is not skilled medical care or therapy and does not require the ongoing supervision of trained medical personnel. It is intended to maintain and support an existing level of well-being and to preserve health and prevent its further decline. Custodial care may be delivered in the home or in a residence facility and may be performed in conjunction with an overall program of skilled treatment. In the home, custodial care is provided primarily by family members or friends but can also be provided by other unlicensed individuals or licensed health aides. By far, custodial care is the dominant form of long-term care.

Intermediate care
Intermediate care, delivered in an intermediate care facility (ICF), is provided under a doctor's supervision but is not considered to be continuously medically necessary. It includes nursing and rehabilitative care required only part-time or occasionally and is performed by skilled practitioners. Intermediate care may be provided at home or in a facility, depending on the particular condition and the patient's overall health.

Skilled care
Skilled care is provided in a skilled nursing facility (SNF). Skilled care is continuously medically necessary. That is, it is around-the-clock nursing delivered by RNs, LVNs, or LPNs, and at least one supervising RN is present at all times. Skilled care consists of nursing care, therapy, and rehabilitation. It is a comparatively high level of nursing and medical care for those whose conditions require ongoing and close monitoring.

Improvements in the Delivery of Long-Term Care Services and Providers
Historically, there has always been a need for health care specific to the elderly and other vulnerable populations. In tenth century Britain, almshouses funded by charity were established to provide a place of residence for the poor, old, and distressed. By the 1900s, the colonial almshouse became the first institution in this country to resemble institutionalized management of care for the poor, elderly, and disabled.

The Foundation for Long-Term Care in the U.S.
In 1935, President Roosevelt acknowledged the needs of the elderly citizens with the establishment of Title I of the Social Security Act, called the Old Age Assistance (OAA) program. This program gave cash payments to poor elderly people, regardless of their work record, by providing a federal match of state old-age assistance payments. The significance of OAA in the history of long-term care is that it created the foundation for the Medicaid program, which has become the primary funding source for long-term care today.

OAA provided elderly individuals with a steady source of income, allowing them to better care for themselves. However, OAA stipends were meager and insufficient to adequately meet recipients' needs. Though it abolished the need for almshouses and the shame associated with the poverty that accompanied these institutions, OAA did not address the need for a setting for chronic care for the elderly and disabled. As a result, the development of home care and nursing homes

emerged throughout the 1930s to the 1960s, forming the foundation for long-term care services and providers as we know them today.

Since the passage of the Social Security Act in 1935, several policies have played roles in the growth of the long-term care industry and its enduring efforts to cope with the complex issues of cost and quality. In 1950, amendments to the act established standards of care through nursing home licensing requirements and supported the growth of the LTC industry through the authorization of vendor payments. The Hill-Burton Act in 1946 and its many amendments influenced the growth of the nursing home industry by sponsoring the creation of a modern health care infrastructure.

In 1965, the Medicare and Medicaid programs were created through amendments to the original Social Security Act. Medicare and Medicaid became significant for the nursing home industry with the enactment of the 1967 Moss Amendments, which authorized nursing homes to utilize the Medicaid program. In 1972, Public Law 92-603 introduced Medicaid to those receiving supplemental security income (SSI) payments. In general, states rely on SSI eligibility rules, established at the national level, as the basis for Medicaid eligibility.

The Introduction of Long-Term Care Insurance

Long-term care insurance policies were introduced in the 1970s. However, the concept of taking responsibility for providing for one's own care in the event of a chronic disease or disability through insurance did not take hold until the late 1980s and early 1990s when the aging baby boomer generation began to accept this reality.

Until this time, extended care options were pretty much limited to care at home by family or through institutionalization. In the 1980s and 1990s, other LTC options gradually emerged. Assisted living facilities were pioneered to meet the need for those whose care requirements fell somewhere in between needing help with one or two ADLs and skilled nursing care. Assisted living facilities became very popular, and many found themselves on waiting lists to get in. Around the same time, the homemaker and home health service industries took off, and innovative concepts such as graduated care and adult day care were introduced.

Unfortunately, traditional health insurance did not cover the expenses associated with these growing care options. Many were forced to sell their homes and deplete their resources to receive state aid. Consequently, long-term care insurance was developed.

The Evolution of Long-Term Care Policies

The first LTCI policies were nursing home-only policies. Developed in the 1970s and covering care delivered only in nursing homes, these were not the full benefit policies we know today. The next generation of policies came about in the 1980s, which acknowledged the need for home health care benefits. Consequently, at this time, citizens could choose either nursing home-only policies or home health care-only policies. The early 1990s saw policies combining coverage for home health care, community-provided services, assisted living, and skilled nursing care. These were called comprehensive policies, and they allowed policy holder's to elect where and how to apply their policy benefits. The original nursing home-only and home care-only policies became known as non-comprehensive policies. Today, most insurers offer only comprehensive policies. In fact, in

some states, non-comprehensive policies are prohibited by law.

Another factor that has contributed to the evolution of long-term care policies is a better understanding by insurance company underwriters and actuaries of the risk assumed when an LTCI contract is issued. Some of the earlier generations of LTCI policies were not priced adequately, the result of poor underwriting, overly optimistic interest rate assumptions, inaccurate cost projections, and unanticipated lapse rates. When the time came for insurers to begin paying benefits under their original LTCI policies—some of which had been sold 20 years earlier—it became apparent that underwriters and actuaries did not know at the time the policies were issued how much health care costs would increase. Clearly, many insurers had underestimated their exposures. While some insurers made good on their claims, others were not able to do so. Policyholders who had been making their payments for years were not able to collect full benefits. Other policyholders who had yet to make any claims were faced with large premium increases. In addition to causing an enormous amount of litigation, the issue became political and spawned much of the citizen protection and other legislative efforts we know today.

As a result, today's LTC policies are more comprehensive and adequately priced. They are also backed by state and federal requirements that mandate specific benefits, and provisions that protect policy owners against large premium increases.

The Cost of Long-Term Care

Long-term care includes a broad range of medical, personal, and social support services that people need when they become disabled or as they age. The majority of these services are custodial: personal care services or assistance with activities of daily living that family members and friends are able to provide at no charge. However, as care and support needs increase, paid care is often necessary to supplement family support, to provide respite to caregivers, and often to render a level of care available only in a formal facility.

The High Cost of Care

The medical, personal, and social services required in the event of an accident, a chronic illness, a disability, or merely because of the aging experience are the most expensive of all health care expenses. Considering the great numbers of people affected by these events, it is easy to understand why long-term care costs are so high and continually on the rise.

The actual cost of long-term care depends on where the care is delivered, the level of care provided, how long the care is necessary, and the area of the country where care is provided. Some people require a minimal amount of assistance with only one or two ADLs or only for a short period. Others require skilled medical care over a long period. No one can foresee who will need long-term care, the type of care needed, or how long the care will be necessary.

Homemaker and home health services are typically provided in two- to four-hour blocks of time, referred to as "visits," and are generally more expensive in the evening and on weekends and holidays. The costs of services in some community programs, such as adult day service programs, are often calculated at a daily rate but vary based on programming costs and whether the services are privately funded or supported by government subsidies. Many care facilities charge extra for services provided beyond the basic room and board charge, although some may have all-inclusive

fees.

While the evolution of the nursing home and long-term care industries has experienced many improvements, it remains far from flawless. As a nation and as individuals, we are increasingly devoting higher levels of spending to health care. Health-care spending that is specific to long-term care is no exception to the trend of rising costs.

Long-Term Care Costs by Level of Care and Facility Type
The following are indicative of costs associated with various levels and types of long-term care services as of 2009. These are national average median rates; actual costs vary dramatically by state and by geographic location within each state.

Homemaker Services
Non-certified but licensed provider rate—Nationally, the average hourly rate charged by a non-Medicare-certified but licensed agency for homemaker services is $17.48.

Home Health Aide Services
Non-certified but licensed provider rate—Nationally, the average hourly rate charged by a non-Medicare-certified but licensed agency for home health aide services is $18.50.

Certified and licensed provider rate—Nationally, the average hourly rate charged by a Medicare-certified and licensed agency for home health aide services is $46.22.

Adult Day Health Care
The national average daily rate charged by adult day health care providers is $53.59.

Assisted Living Facility
Nationally, the average monthly rate for a private one-bedroom unit in an assisted living facility is $2,825 (implying an average annual cost of $33,900). These rates exclude one-time community or entrance fees, which are charged by approximately one-third of all assisted living facilities. These nonrefundable fees average $2,400.

Nursing Homes
Nationally, the average daily rate for a semi-private room in a nursing home is $183.25 (implying an annual rate of $66,886).

Nationally, the average daily rate for a private room in a nursing home is $203.31 (implying an annual rate of $74,208).

Currently, the average stay in a nursing home is about two and one-half years. At today's cost, that would amount to a total of about $167,200 to $185,520, depending on whether the accommodation is a semi-private or private room. In only ten years, assuming an annual increase in costs of 5 percent, a two and one-half year stay in a nursing home will cost between $272,000 and $302,000.

A Comparison of Long-Term Care Costs by Facility Type

The following chart compares the types of services and range of costs associated with the more common long-term care providers and facilities.

The Cost of Unpaid Care

While it may not be as apparent as the hard dollars spent on LTC services, there is also a significant cost associated with unpaid care provided by friends and family members who are the backbone of long-term care. Family and friends provide essential assistance with ADLs and IADLs to loved ones of all ages every day. The contributions of informal, unpaid caregivers are not only the foundation of the nation's LTC system but also an important component of the U.S. economy, with an estimated economic value of billions of dollars. In 2007, about 52 million people provided LTC services at some time during the year. The economic value of family care giving was at least three times as high nationwide as that provided by Medicaid home- and community-based services spending on similar services.

It is also important to understand that there is a significant cost of care giving to the caregivers themselves. The toll is more than a simple accounting for hours. Costs include direct out-of-pocket expenses, lost work time, lessened productivity, and fewer hours that can be devoted to other personal pursuits. There is also a very great emotional and psychological cost associated with care giving. All of these costs increase in intensity with the level of care provided.

Planning for Long-Term Care

While a frank and informed discussion about present and future medical and personal needs can secure the most suitable type of long-term care at the right time, many people find the topic discomforting. Others are in outright denial about the possibility of requiring long-term care. While the aging population, longer life spans, rising health care costs, and an ever-increasing strain on government services ought to compel all those over the age of 40 to prepare for the possibility of long-term care, that's not the case today. Most Americans have not seriously considered or planned for the emotional and financial consequences of aging. Many are not even familiar with the care options available and most, when the time comes, will be shocked by the associated costs.

Some people fail to plan simply because of misinformation or lack of information. Many believe that Medicare, Medicaid, or their health insurance will pay for long-term care. Medicare pays for LTC services only for short period, and only if the care is required following hospitalization. State Medicaid programs pay only for the financially needy and only when other qualifying criteria are met. Traditional health and medical expense insurance does not cover long-term care at all. Citizens need to be aware of these facts and be informed of the options they do have with respect to long-term care. Having reliable information helps ensure that appropriate options are considered if and when the need arises. An informed citizen is more likely to retain choice and control over where and how services are provided.

Fear of aging and its associated problems are clearly obstacles to planning for long-term care. Unfortunately, fear often leads to denial, and denial prevents people from aptly assessing their long-term care needs and taking the appropriate action to address those needs. The advantages of planning ahead are many:

-Planning ahead for long-term care is important; because there is a good chance an individual will need some level of long-term care if he or she lives beyond the age of 65.

-Planning ahead helps one understand the available LTC services, eligibility criteria, cost, and public and private payment options.

-Planning ahead allows assets and income to be preserved for uses other than long-term care, including preserving the quality of life for a spouse or other loved ones.

-Planning ahead means less emotional and financial stress on family members.

-Planning ahead helps ensure greater independence if and when the need occurs.

Summary
Long-term care takes into account a variety of services, including medical and nonmedical care for people who have chronic illnesses, disabilities, or cognitive impairments that keep them from living an independent life. Long-term care helps meet both health and personal needs. The need for long-term care can surface at any age. The medical, personal, and social services required in the event of an accident, a chronic illness, a disability, or merely because of the aging process are the most expensive of all health care expenses. Having reliable information on LTC services, options, and costs can help ensure the availability of care at the time it is needed.

Chapter 2 Financing for Long-Term Care

Public Financing for Long-Term Care
Estimations of present and future costs of long-term care vary. Regardless of the assumptions, only a limited number of sources exist to fund this care. Government programs and services supported by taxes are the most apparent source. Private resources, which include personal savings and investments, can be very limiting if not planned for in advance. Long-term care insurance, of course, is a very viable source for funding, but only when it is a suitable option for the potential policy holder.

The aging baby boom generation will lead to a sharp growth in federal entitlement spending. In the absence of significant reform, it will impose what may be an unsustainable burden on future generations. As the estimated 76 million baby boomers—those born between 1946 and 1964—continue to age, Medicare, Medicaid, and Social Security expenditures will nearly double as a share of the economy by 2035.7 Lacking any meaningful reform of these entitlement programs, an escalation of federal spending for Social Security, Medicare, and Medicaid may overwhelm the federal budget. A significant challenge for policymakers is to reconcile the concerns about the costs of long-term care with the public and private sectors.

Public and Private Payors of Long-Term Care
In the broadest of terms, there are essentially two sources available for the funding and payment of long-term care services: public and private.

Public financing for LTC services and support comes primarily from the Medicaid program. Although the federal and state governments jointly finance Medicaid, Medicaid is primarily a state-administered program. Of course, other public sources help provide payment for long-term care services. Each program is different and imposes specific rules for eligibility, the types of services it covers, how long it will pay for services, and in some cases, cost-sharing. Some programs focus on home and/or community-based services, while others—such as Medicare—only pay for some short-term nursing home stays or home health care. However, no public source of LTC funding compares to the magnitude of Medicaid and the dollars this program expends on long-term care.

Private funding for long-term care comes from individuals and their families and LTC insurance. In addition to insurance, private resources take the form of available savings and cash, investments, retirement accounts, and home equity. When the need arises, people tap into all available resources. (Private LTC funding options is the topic of the next unit.)

Medicare and Long-Term Care

Many people believe that Medicare covers long-term care services. This is not the case. Medicare was never intended nor was it designed to support long-term care.

Medicare was implemented in 1965 as an amendment (Title XVIII) to the Social Security Act. Then and now, it is a federal health insurance program that provides hospital and medical expense coverage, primarily for those age 65 and older. At the time Medicare was enacted, the senior segment of the population was the most likely to be living in poverty, and only about half had insurance.8 since its introduction; many changes have been made to the Medicare program. Coverage now extends to include the legally blind, people with end stage kidney disease, and younger people who are disabled and who meet the criteria to collect Social Security disability benefits.

As wide-spread and encompassing as the program may be, however, Medicare does not contain a comprehensive long-term care component. It does not pay for ongoing assisted living or custodial care costs, which constitute the most common of long-term care services and needs. It does cover the cost of short-term services—physical and other therapies, for example—contracted through a home health care agency provided to the resident at home or at an assisted living facility. With regard to nursing home care, Medicare covers only those skilled nursing facility services rendered to help a patient recover from an acute illness or injury. Payment for skilled nursing care by Medicare requires that the patient must have first been hospitalized.

Medicare is administered by the federal government’s Centers for Medicare and Medicaid Services. Original Medicare consists of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Medicare Part C (Medicare Advantage) combines these two parts into a single program, typically available as and delivered through a managed care plan. Part D Prescription Drug Coverage provides for prescription drugs. Individuals who are covered by Original Medicare can enroll in a separate Part D plan; those who are covered by a Medicare Advantage plan may find that Part D is included in the plan, or its coverage may be available for purchase separately.

Broadly speaking, Medicare’s coverage for any ongoing care services is restricted to skilled nursing

care and home health care. However, this coverage is limited and cannot be considered (or relied on) for long-term needs.

Eligibility for Medicare Skilled Nursing Care

Nursing facility coverage under Medicare is very limited. If certain conditions are met, Medicare will fully cover the first 20 days of care in a skilled nursing facility (SNF) during each benefit period. (A Medicare benefit period starts when an individual enters the hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or SNF care was provided.)

For days 21 through 100 of each benefit period, the patient must share, or co-pay, the cost of SNF care by paying a daily coinsurance rate, which changes yearly. (In 2009, the coinsurance payment was $133.50 per day for each benefit period). After 100 days, all costs for each day in an SNF are borne by the patient.

Medicare pays for nursing facility care only when all of the following conditions have been met:

-The nursing home must be a Medicare-certified SNF providing 24-hour nursing care to convalescent patients.

-The patient must require daily continuous skilled nursing care or skilled rehabilitation services, as defined by the federal law.

-The patient must have spent at least three consecutive days in a hospital, and admission to the SNF must occur within 30 days after discharge from the hospital.

-A physician must certify that SNF services are needed for the same or related illness for which the person was hospitalized.

Skilled Nursing Services Covered by Medicare

Assuming the conditions just described have been met, the following nursing home services will be paid by Medicare:

-a semi-private room
-custodial care
-meals, including special diets
-regular physician and nursing services
-rehabilitation services
-laboratory tests
-drugs furnished by the facility
-medical supplies

Medicare does not cover personal convenience items, private duty nurses, or the additional cost for a private room.

Home Health Care Services Covered by Medicare
Medicare covers home health care, but services are limited to people with skilled care needs. To be eligible for home health services, beneficiaries must be homebound, require only intermittent skilled nursing or therapy services, and must be under the care of a physician who prescribes their plan of care. Home health aide services for assistance with ADLs can be provided during this time, but people who have no skilled care needs—that is, those who require assistance with ADLs only—are not eligible to receive home health care benefits.

Medicare's home health benefit is less restrictive than its SNF benefit. For example, eligibility for home health care is not linked to a recent hospitalization; there is no limit on the number of days of care or the number of home care visits a beneficiary may receive; and there is no required beneficiary cost-sharing. However, the condition that often gives rise to needing long-term care—ongoing assistance with ADLs—does not qualify for Medicare coverage.

Medicare Supplement Insurance
Citizens who elect to enroll in Original Medicare may augment their coverage with a private Medicare supplement (Medigap) policy. However, as the name implies, Medicare supplement policies are designed only to supplement Medicare benefits by covering the many and varied deductible, cost-sharing, and co-payment provisions that characterize the program. For example, a Medicare supplement may cover the coinsurance amount that applies to days 21 through 100 of skilled nursing facility care under Medicare Part A. However, Medicare supplement policies do not cover conditions that are not covered by Medicare; thus, Medicare supplement policies do not cover long-term care.

Medicaid and Long-Term Care
Serving a much more significant role than Medicare in the LTC arena is Medicaid. Medicaid is a cooperative program between the federal and state governments to pay for health care and medical services for certain needy, low-income individuals. The federal and the state governments share responsibilities in designing, administering, and funding the program. Although the federal government sets general guidelines for the program, the Medicaid program requirements are actually established by each state. At the federal level, the Centers for Medicare and Medicaid Services (CMS) is the agency charged with administering Medicaid. At the state level, the program is administered by the state's health and human services department or a family service agency.

Medicaid covers a range of services, including those needed by people to live independently in the community, such as home health care and personal care, as well as services provided in institutional settings. Most of these very essential services are not covered by Medicare or by traditional health insurance policies. As such, Medicaid has become the primary single payor of long-term care services, far surpassing any other public or private funding source.

The hard costs associated with long-term care are beyond the reach of most Americans, especially those who are retired or who, for health reasons, are no longer active in the workforce. Because Medicare does not cover extended long-term care services and despite the availability of LTC insurance policies, Medicaid remains the dominant payment resource for the millions who require long-term care services. In fact, Medicaid today pays for almost one-half of the costs associated with paid delivery of long-term care—approximately $100 billion. By 2017, Medicaid expenditures

for LTC services are expected to reach $225 billion.

Medicaid dollars are spent as follows for each service type for long-term care:

-4% Home Health Services
-10% Personal Care Services
-13% Intermediate Care Facilities
-26% Home & Community Based Waiver Services
-47% Nursing Facility Services

Eligibility for Medicaid Payment of LTC Costs
Medicaid was designed to provide health care to needy low-income individuals and their dependents. As such, it is not available to everyone who needs LTC services. Though the federal government establishes general program rules and guidelines, each individual state creates its own program within these guidelines; for this reason, eligibility and covered services vary from state to state. However, all states incorporate into their general eligibility criteria certain limits on income and personal assets. Coverage specifically for long-term care services requires that an individual also meet certain functional criteria in addition to financial criteria.

To qualify for the payment of long-term care expenses by Medicaid, an individual must meet three categories of requirements: general, functional, and financial.

Medicaid General Requirements
Medicaid's general eligibility requirements stipulate that an individual must be 65 or older, or permanently disabled or blind. He or she must also be a U.S. citizen (or hold qualified immigrant status) and be a resident of the state in which application for Medicaid is made.

Medicaid Functional Requirements
Medicaid applicants must undergo a functional assessment and, as a result, be determined to need long-term care. The assessment, performed by a medical specialist, is also used to determine where the care should be delivered: in a skilled nursing facility, or in the home or community. The functional assessment is generally based on whether an individual needs assistance with ADLs. Meeting Medicaid's functional eligibility requirements for home and community-based services may or may not be the same as the requirements for skilled nursing home care, depending on the state. In 2007, federal law changed to allow states to impose less stringent functional requirements for those who are able to receive care outside a nursing home.

Medicaid Financial Requirements
The individual must have levels of assets and income that are at or below certain levels. These levels are determined by the state in accordance with federal guidelines. Medicaid's financial requirements are explained in more detail later in this unit.

Medicaid Benefits
Medicaid does not pay benefits directly to beneficiaries. Instead, it makes payment to the providers furnishing services. The individual states establish eligibility standards, determine which benefits to cover, and establish provider payment rates. All state Medicaid programs must cover

the following basic services:

-inpatient and outpatient hospital services
-laboratory and X-ray services
-skilled nursing and home health services
-physician and certified nurse practitioner visits
-family planning
-periodic health check-ups
-diagnosis and treatment for children

Medicaid may also pay for things such as prescription drugs, clinic visits, prosthetic devices, hearing aids, some dental care, eye exams and glasses, transportation to and from treatment, and services not covered by Medicare.

All states provide long-term care services for people who are Medicaid-eligible and qualify for institutional care. Though the federal Medicare program does not cover the costs of assisted living facilities, Medicaid may pay for some level of the care component of assisted living. In 2007, states were granted the authority to pay for assisted living under Medicaid state plan amendments. Even so, benefits are limited.

Even when Medicaid does pay for long-term care, the conditions are not always the most favorable. Assisted living facilities, which allow residents some privacy and independence, often do not accept Medicaid patients, nor do all nursing homes. Most nursing facilities do accept Medicaid but limit the number of Medicaid beds they make available. Applicants can face long waits for the facility they prefer. Many times, they must settle for a facility far away from home and inconvenient for family. The placement process differs from state to state, but in some states, patients must take the first bed that becomes available no matter where in the state it is located. The available facility may not be as satisfactory as the patient's and family's first choice in terms of cleanliness, staffing, or quality standards.

Home and Community-Based Waivers

Though a few state Medicaid programs still require that long-term care be delivered only in nursing homes or skilled nursing facilities, most allow for covered care to be received in the home or in a community-based setting as well, under what is known as a waiver program. A waiver program enables a state to provide a variety of home and community-based services as alternatives to institutionalization for qualifying individuals or targeted groups. In this way, Medicaid waiver programs provide individualized support that helps people live in their homes or in community settings instead of institutional settings. Waiver programs essentially permit states to "waive" some of Medicaid's provisions and allow individuals to seek and receive Medicaid-covered care and services through means other than nursing homes.

Potential services that may be delivered under a waiver program include day services, respite care, home modifications, personal emergency response systems, non-medical transportation, and other services that keep beneficiaries at home and out of institutions for as long as possible. Waivers can also be used to provide Medicaid services for waiver participants that are not offered to other adult Medicaid beneficiaries, such as case management and personal assistance services.

Today the proliferation of community-based programs has captured a significant portion of the Medicaid funding that at one time went entirely to nursing home care.

Medicaid's Financial Requirements

Eligibility for payment by Medicaid for long-term care requires that a recipient have a low income and very few assets. In most states, LTC Medicaid recipients are limited to no more than $2,000 or $3,000 in assets. For many who need long-term care and who do not have any means other than Medicaid to cover the cost, this means that they will first have to "spend down" their assets to a level that qualifies them for benefits. Consequently, most private resources must be exhausted before Medicaid will pay for long-term care, essentially a process of self-impoverishment.

Unfortunately, those who must spend down their assets to qualify for Medicaid-paid long-term care lose not only their financial security but their independence and freedom of choice as well. Furthermore, once a person has been forced to deplete resources to qualify for LTC, he or she is so impoverished that returning to a pre-Medicaid financial position will never be an option.

Medicaid Treatment of Assets

Individual states establish their own eligibility rules and determine the level of assets that may be retained to receive long-term care under Medicaid. To this end, assets are deemed countable or non-countable. Countable assets are those whose values are counted in determining eligibility; non-countable assets are not considered.

Countable Assets

As a general rule, applicants for Medicaid-paid LTC may retain only about $2,000 to $3,000 in countable assets. Countable assets, also called non-exempt assets, include:

-cash
-checking and savings accounts
-certificates of deposit and money market accounts
-stocks, mutual funds, bonds, and other investment holdings
-IRAs and other retirement investments
-nonresident property

Generally, all money and property that can be valued and turned into cash are considered countable assets, unless it is specifically exempt. If the value of total countable assets exceeds the Medicaid eligibility limit, the applicant must then spend down these assets to the state-prescribed limit before qualifying. Certain allowances are made for married couples that enable the at-home, community spouse, to retain some countable assets and, therefore, remain living at home. (This is explained in the section "Avoiding Spousal Impoverishment.")

Non-countable Assets

Certain assets are not considered in the Medicaid eligibility determination. These are termed non-countable (or "exempt") assets and include:

-primary residence—A primary residence is not countable as long as the home's equity is less than $500,000 (up to $750,000 at state option). The exempt value is unlimited if a spouse, a child under the age of 21, or a blind or permanently disabled child is living in the home.

-automobile—One automobile of any value is exempt if one spouse is institutionalized. One auto of any value is exempt if the spouse needs the auto for employment or if the vehicle has been modified to be handicap accessible.

-household belongings—Household belongings, including furniture, appliances, and similar items, are not countable.

-personal possessions—Personal possessions such as jewelry, clothing, and similar items, are not countable.

-business property essential to self-support—A business property is exempt if it produces income sufficient to justify possession of the business assets (equipment and supplies, inventory, cash on hand).

-burial contracts—Burial contracts are exempt, though limits on the amount of the exemption may be imposed. The value of the burial contract must be reduced by the cash value of any life insurance policies

-burial plot—This exemption is for the applicant and his or her immediate family. It includes the purchase or prepayment of a gravesite, the opening and closing of a gravesite, a cremation urn, a casket, an outer burial container, and a headstone or marker.

-cash surrender value of life insurance—The cash value of any life insurance owned is exempt, up to a total of $1,500 for all such policies.

Medicaid Treatment of Income

States assess a Medicaid applicant's income level as well as the sources of his or her income. Like assets, income is deemed either countable or not countable. Most states define countable income as income from:

-Salaries and wages
-Pensions
-Social Security
-Veterans' benefits
-Interest earnings and dividends

Non-countable income includes:

-Temporary Aid to Needy Families (TANF) payments
-Supplemental security income (SSI)
-Food stamps
-Low Income Home Energy Assistance Program (LIHEAP) benefits
-Ffoster care payments/certain housing subsidies

Some states impose a cap on the amount of income one can qualify for and receive from Medicaid; other states do not have an income limit. However, once individuals are deemed eligible for Medicaid long-term care, they will be required to contribute a substantial portion of their income to the cost of care. This amount varies from state to state; it also varies depending on whether the individual is in a nursing facility or is receiving care at home or in the community, and whether a spouse is living in the home.

Generally speaking, those who receive care in a nursing facility must contribute virtually all of their income toward the cost of their care; Medicaid picks up the remainder. (The income of an institutionalized person's spouse is not affected and does not have to be directed to paying for the institutionalized spouse's care.) An institutionalized beneficiary is permitted to retain only a nominal amount of monthly income, such as $30 or $50. Generally, Medicaid recipients that receive care in their homes or through a waiver program are allowed to retain a larger amount of their income then recipients living in a nursing facility.

All states provide that greater income amounts may be retained if the Medicaid recipient is married and his or her spouse remains in the community.

Transferring Assets
In years past, given the Medicaid eligibility rules, applicants were tempted to simply transfer their assets to family members to meet eligibility criteria. Not surprisingly, the law now imposes certain requirements to curb this practice.

If an asset is improperly transferred, a state can consider the asset countable. States can "look back" for 60 months, called the look-back period, to find improper transfers of assets. If a transfer of assets for less than fair market value is found to have been made during the look-back period, the state will withhold payment for nursing facility care and other long-term care services for a specific period. This period is called the penalty period.

The penalty period begins when the individual enters a nursing home and otherwise meets Medicaid's eligibility requirements. The length of the penalty period is based on two factors:

-The market value of the property transferred.
-The average monthly rate for nursing facility care in the applicant's area.

The value of the transferred property is divided by the average monthly nursing facility rate in the applicant's area. The result is the penalty period: the number of months that Medicaid will not pay for care.

For example, suppose Gene transferred his $30,000 investment holdings to his son, Jake, on

March 1, 2010. On August 1 of that year, Gene enters a nursing home and applies for Medicaid. The state will look back 60 months from the date Gene entered the nursing home and applied for Medicaid and bring into its asset assessment all transfers Gene made during this time—from July 31, 2005, through August 1, 2010. The $30,000 transfer to his son will be included in Gene's asset assessment. If the average monthly rate for nursing facility care in Gene's area is $4,000, Medicaid payments for Gene's care will be withheld for seven and a half months ($30,000 ÷ $4,000). The effect is that Gene will have to pay out-of-pocket toward the cost of his care an amount equal to the value of the asset he transferred.

Allowable Transfers

Certain transfers are permitted. For example, a transfer to a spouse, a transfer to a third party for the benefit of a spouse, a transfer to a child over age 21 living in the home for at least two years before the applicant's institutionalization and who provided care to delay institutionalization, and transfers to disabled children are allowed and will not result in a Medicaid penalty period, even if made during the look-back period.

Avoiding Spousal Impoverishment

Before 1997, requiring applicants for Medicaid LTC benefits to spend themselves into near poverty had the unintended consequence of also impoverishing the community spouse. Today, spouses of nursing facility residents are protected from what is termed spousal impoverishment. States are required to permit the community spouse to retain income sufficient for support. This is termed a minimum monthly maintenance needs allowance (MMMNA).

The allowable income amount that may be kept to support a community spouse varies from state to state, but it is generally in the range of 200 to 300 percent of the federal poverty level. If the community spouse's own income is below the allowed MMMNA, the shortfall is made up from the nursing home spouse's income.

Any income the community spouse receives in his or her own name may be retained fully by the community spouse. In all circumstances, the income of the community spouse will continue undisturbed. That is, no portion of the community spouse's personal income may be used to cover the cost of care for the institutionalized spouse. In addition, a community spouse is allowed to retain without modification his or her share of income that is payable to the couple jointly.

With respect to assets, a community spouse may retain half or more of the couple's combined countable assets, subject to state and federal minimum and maximum limits. All states must allow the community spouse to keep all countable assets up to a certain minimum ($21,912 in 2009) and up to half of assets above this amount, up to a maximum amount ($109,560 in 2009). A state may impose a limit less than the maximum, but not more. (Minimum and maximum amounts are subject to change every year.)

The following simplified example illustrates how the asset rules for spouses work. It assumes a couple has combined countable assets of $78,000. The state in which the couple resides has set the asset limit for an institutionalized spouse at $2,000, and the community spouse is allowed to retain one-half of the couple's assets, up to a maximum of $100,000. This year, the husband enters a nursing home and applies for Medicaid.

Total countable assets: $78,000
Maximum allowance for nursing home spouse: – 2,000
Maximum allowance for community spouse (half of assets): –39,000
Amount exceeding maximum asset allowance: $37,000

The maximum allowance for the nursing home spouse ($2,000) plus the maximum allowance for the community spouse ($39,000) results in a total asset allowance for the couple of $41,000. To qualify for Medicaid assistance, this couple must spend down $37,000 of their joint countable assets.

Estate Recovery
Federal laws require states to recover Medicaid-paid expenses for long-term care from the estates of individuals who were institutionalized. This is known as estate recovery and occurs after the individual's death. If the decedent, as the Medicaid recipient, was 55 years old or older at the time of death and received Medicaid benefits on or after October 1, 1993, the state must initiate a recovery claim for expenses it paid for nursing facility services and home and community-based services. States also have the option of seeking recovery for payments for other Medicaid services. Estate recovery cannot be initiated if the Medicaid recipient leaves a surviving spouse or a child under the age of 21 (or a child of any age who is blind or disabled).

Estate Recovery Rules
Assets subject to recovery include both real and personal property. Real property includes homes and land. Personal property includes vehicles, furniture, bank accounts, and similar assets. The state may claim a portion of personal property owned jointly with another person. Property that was deemed not countable for purposes of qualifying for Medicaid can be subject to estate recovery upon the Medicaid recipient's death.

Recovery of assets from an estate may be made:

-After the death of an unmarried Medicaid recipient.
-After the death of a surviving spouse.
-When the Medicaid recipient has no surviving child under age 21.
-When the Medicaid recipient has no surviving child of any age who is blind or totally disabled.

In cases where estate recovery would create an undue hardship for surviving family members, the right to immediate recovery may be waived by the state. The administrator of a Medicaid recipient's estate must apply for a hardship waiver within six months of the decedent's death or within 30 days of receiving notice of a claim against the estate, whichever is later. The request for a hardship waiver must be in writing.

Medicaid and Long-Term Care Insurance
In recognition of the growing need for long-term care and the additional burden that will inevitably fall on hard-pressed state Medicaid programs as the ranks of the elderly continue to expand, the federal government affected a number of far-reaching reforms with the passage of the Deficit Reduction Act (DRA) in 2005. Among the many provisions of this act were changes to

Medicaid rules that now allow for the expansion of state long-term care partnership plans—plans that link state Medicaid programs with private long-term care insurance policies. Partnership plans are intended to encourage citizens to purchase affordable long-term care insurance policies and thus reduce the burden on state Medicaid programs. Partnership plans and the types of LTC policies that may be used for such plans are the topics of later chapters.

Private Funding for Long-Term Care

In the last unit, we examined the major sources of public funding for long-term care. The most significant government programs—Medicare and Medicaid—are, at best, very limited. Private funding for this need entails the use of personal resources: savings and investments, annuities and life insurance, and the equity in one's home. Also included in the scope of private funding resources is long-term care insurance, a product that is specifically designed for this need. For some, self-funding the long-term care risk can be accomplished without an LTC policy; however, for many, it represents the best way to address a risk that is very likely to materialize.

Self-Funding for Long-Term Care

As the term is used here, self-funding refers to paying for long-term care costs out-of-pocket with personal or family income, savings, pension benefits, stocks, bonds, and other investments. Contributions from children or other relatives may also come into play. Any financial product designed to grow and accumulate funds can be used as a way to save for future long-term care needs. However, most people find that, even when done in advance, saving a sufficient amount every month or every year for long-term care expenses is extremely difficult. Those who are older may not have enough time to ensure funding is complete.

When considering the best options to fund the costs of long-term care, the focus should be on what the cost of care will likely be in the future. The cost of all aspects of health care continues to increase; long-term care is no exception. The following chart projects today's costs into the future, using an assumed annual increase of 5 percent. The significant sums that will likely be needed are considerable; for many citizens, they may be unattainable.

The risks of self-funding long-term care costs for even the most prosperous individuals are significant. They include:

-Not being able to define future long-term health-care needs.

-Not knowing when long-term care may be needed.

-Not wanting to "sacrifice" money toward care that is intended to be passed on to family members and dependents.-Losing the ability, through dementia or similar cognitive failure, to understand on what type of care the money should be spent.

Generally, self-funding is possible only for individuals with above-average wealth. Those whose disposable incomes exceed the cost of care are the best candidates for self-funding. For most others, attempts at self-funding could exhaust assets, eventually leading to reliance on Medicaid or other public resources. Self-funding can also take the form of relying on or expecting family

members or loved ones to provide needed care. Depending on family and loved ones is certainly possible, but it ignores the realities of long-term care: that it can affect the quality of life of the caregiver, that the need for care will likely be ongoing and sustained, and that the caregiver may not be able to deliver the level or kind of care needed.

Long-Term Care Insurance

Though the means to self-fund the cost of long-term care are many and virtually any financial instrument or personal asset can be used for this purpose, the reality of long-term care presents significant challenges:

-The cost of the care is extremely high. Funding the need adequately requires thousands upon thousands of dollars. For high levels of care necessary over an extended period, the cost can be measured in hundreds of thousands of dollars.

-The likelihood of needing care is fairly high. It is estimated that about 70 percent of individuals over age 65 will require at least some type of long-term care services during their lifetimes.

-It is very difficult to predict when the need for care—and thus, the need for the funds—will materialize. It could be years into the future or it could be next month. Likewise, it is difficult to predict the level of care that may be required.

For these reasons, and for individuals other than the very wealthy, none of the private resources described so far in this unit can be relied on to fully meet the LTC funding need. None can ensure that necessary money will be available in adequate amounts when it is needed. Fortunately, there is another private resource available for LTC funding—one that is designed specifically to meet the risk and cover the need: long-term care insurance.

Long-term care insurance covers the risk of long-term care and pays benefits for policy holders that need care services and support. Though it will be discussed in detail in the next units, an overview is appropriate here. There are many types and forms of long-term care insurance, with many combinations of benefits and coverage. For example:

-A policy may cover the cost of care in all kinds of settings (a comprehensive policy) or only care that is delivered in the home or in a nursing facility a non-comprehensive policy).

-The policy holder may select from a range of daily benefit amounts the benefit the policy will provide (such as $100, $150, or $250) and the period that the policy will cover (such as one year, three years, five years, or a lifetime).

-A policy may provide benefits on an indemnity (specified amount) basis or on a reimbursement basis (actual costs incurred), up to the daily amount.

-A policy may be tax-qualified (in which case the premiums are deductible) or non-tax-qualified (in which case the premiums are not deductible).

-If it conforms to certain state and federal guidelines, a policy may be a partnership policy, which

would make the policy holder eligible to participate in the state's long-term care partnership program and allow him or her to retain a greater level of assets than otherwise allowed should he or she ever need to apply for Medicaid assistance.

Both individual and group LTC policies are available. Coverage considerations include the benefit amount, the elimination period, inflation protection, non-forfeiture protection, and other features. Underwriting requirements vary depending on the insurance company. Most insurers are unwilling to accept applicants who already have serious medical problems or who are already receiving care. The younger the applicant, the more likely coverage will be granted and the lower the premium. Like all insurance products, cost is also determined based on the features and options chosen.

Summary

Private funding for long-term care makes use of the income, assets, and personal resources an individual may have. Virtually any type of savings or investment product can be used for this purpose, as can the equity in a home. However, the cost of long-term care can be extraordinarily high; for other than the very wealthy, relying on personal income and assets may fall short of adequately covering the need. For many, long-term care insurance may be the best option. The many different types and forms of LTCI enable citizens to customize the type and level of coverage that is best for them and, to some degree, to control the premium.

The Basics of Long-Term Care Insurance

Most long-term care services begin at home with the help of family or friends until the burden of care giving becomes too much of an emotional and financial hardship. The next step is generally to hire a paid caregiver to help with ADLs and IADLs. Unfortunately, many people cannot afford to pay for such care even when it is delivered by the unskilled, unlicensed, or unsupervised, and more costly care by paid professionals is simply out of the question for most. Given the extraordinarily high cost of long-term care services, it is not surprising that few people are able to amass these sums. Fortunately, there is an option: long-term care insurance.

In exchange for the payment of premiums, long-term care insurance (LTCI) policies promise to pay benefits for custodial, intermediate, and/or skilled care. Like other types of insurance coverage's, LTCI contracts can be very complex. Even though policies have become more standardized in recent years, options, riders, elimination periods, benefit amounts, and other aspects of coverage can make the long-term care insurance picture difficult to fully comprehend.

Today's Long-Term Care Policies

Today's LTCI policies present many options to fulfill the care needs of seniors as well as those of any age with a chronic condition, disease, and/or disability. Choosing a benefit amount, benefit period, and the length of the elimination period are straightforward considerations, but today's policies contain a myriad of inflation protection, non-forfeiture benefits, elimination periods, pre-existing condition exclusions, premium payment options, and other provisions that make the selection of a suitable, appropriate policy a challenging task.

While today's LTCI policies may be complicated, it is important to recognize that they are a relatively new form of insurance. They are still in their early stages of development and are still

evolving. New systems or delivery methods for care available in the future might not be covered by today's policies. For example, LTCI policies offered in the mid-1980s did not pay for care in assisted living facilities, because these types of facilities were not common at that time. Those who purchased early generations of LTC policies may not have the coverage they need as the evolution continues.

Standardizing various elements of LTCI policies would significantly reduce citizen uncertainty about the product and make regulation easier for the states and the federal government. Although some standardization of policies has occurred, especially with respect to LTC partnership policies (discussed in the next chapter), policies still vary among insurers.

In an attempt to define minimum standards for long-term care insurance and to provide a measure of citizen protection for those who purchase these policies, the National Association of Insurance Commissioners (NAIC) created the Long-Term Care Insurance Model Act and Regulations. Many states have adopted this model as the foundation for the design and regulation of policies issued in their jurisdictions, another factor that is helping to standardize policies. However, currently, states can pick and choose the provisions of the model they incorporate into their state law and the extent to which they apply them.

The following describes the major forms of LTCI policies and the common features that most contain or offer.

Tax-Qualified and Non-Tax-Qualified Policies

Today's long-term care policies may be issued as either tax-qualified or non-tax-qualified. These two classes of LTC policies came about with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with the addition of Section 7702B to the Internal Revenue Code.

Before HIPAA, LTC insurance was not given the same tax treatment as other forms of health insurance. For example, some LTC services did not qualify as "medical care"; consequently, benefits an LTC policy paid for such services were potentially outside the scope of the income tax exclusion for reimbursements from accident and health insurance and were potentially taxable. Premiums employers pay for health and accident insurance for their employees are generally deductible by the employer and are not taxable to the employee; however, whether this treatment also applied to long-term care insurance was not clear. HIPAA clarified these questions by declaring that "qualified" long-term care contracts would be treated for tax purposes as accident and health insurance, and added Section 7702B to the Internal Revenue Code. Among other things, Section 7702B establishes standard requirements for qualified LTC contracts, subject to certain rules and restrictions. Policies that meet these requirements are known as tax-qualified policies. Policies that do not meet these requirements are non-tax-qualified policies.

Required Provisions for Tax-Qualified Policies

The defining standards HIPAA established for a LTC policy to be considered "tax-qualified" address the services such a policy must cover, the features it must contain, and the conditions that trigger the payment of benefits. These include the following:

-The policy must provide insurance only for long-term care services. These services are diagnostic,

preventive, therapeutic, or rehabilitative treatments relating to curing, treating, or mitigating a chronic condition or disease, or services related to maintenance and personal care.

-The policy cannot provide for a cash surrender value.

-The policy must be guaranteed renewable.

-The policy must use standard benefit triggers and pay its benefits if the policy holder is certified as chronically ill due to:

-The inability to perform two of six activities of daily living (eating, bathing, dressing, continence, toileting, and transferring) and the need for assistance is expected to last at least 90 days; or
-A severe cognitive impairment.

-The policy must specify that once the policy holder qualifies for benefits—under either the ADL trigger or the cognitive impairment trigger—an approved plan of care developed by a licensed health care practitioner must be in place.

By meeting the definition of tax-qualified, a long-term care policy is given advantageous tax treatment with respect to premiums and benefits.

Treatment of Premiums
Premiums an individual pays for qualified LTC insurance policies are tax deductible as an itemized deduction on Schedule A of Form 1040. When these amounts, added to other non-reimbursed qualifying medical expenses (including those for long-term care), exceed 7.5 percent of the individual's adjusted gross income (AGI), the excess may be deducted. However, a cap is placed on the deductible amount of these premiums, which varies by age and is subject to change every year.

Treatment of Benefits
Benefit dollars paid out from qualified LTC policies, subject to certain limitations, are not considered taxable income. If the contract is a reimbursement contract and pays for the actual costs incurred as a reimbursement for the cost of care, no portion of the benefit is taxable. If the benefit is paid as a flat indemnity amount regardless of the cost of care, there is a per day limitation on the amount that may be received tax-free. (In 2009, this daily limit was $280. It is subject to change every year.)

It should be noted that the tax treatment of benefits paid under a non-tax-qualified long-term care policy is not clear. The IRS has not definitely stated whether these benefits are taxable or not taxable.

Contracts Issued Before and After 1997
A contract issued after 1996 is a qualified long-term care insurance contract if it meets the requirements of IRC Section 7702B(b). A contract issued before 1997 is generally treated as a qualified LTCI contract if it met state law requirements for long-term care insurance contracts at the time and it has not been materially changed.

Any rider providing long-term care coverage that is attached to a life insurance policy or, with some exceptions, to an annuity (after 2009) will be treated as a separate contract.

Most LTCI policies sold today are tax-qualified contracts. Though some companies continue to issue non-tax-qualified policies, and some of these policies impose fewer restrictions on how an policy holder can qualify for benefits, non-tax-qualified policy forms are becoming less and less common. Furthermore, as noted, the IRS has not yet issued a definitive decision as to the tax treatment of benefits paid under non-tax-qualified policies, which also lessens their appeal. The following chart compares the features and treatment of tax-qualified and non-tax-qualified policies.

Comprehensive and Non-comprehensive Policies
As discussed previously, LTC policies are either comprehensive or non-comprehensive. The more common comprehensive policies cover care at all levels, home health care and nursing home care, as well as care in community-based settings such as assisted living. These are the most expensive policies, but they provide the greatest coverage.

Non-comprehensive policies are those that cover either home health care or nursing home care. Home health-care-only policies cover care provided in the home by nurses and therapists as well as personal care from home health aides and housekeepers. Nursing home-only policies pay for only the cost of a stay in a skilled nursing facility.

Reimbursement, Indemnity, and Disability Policies
Today's long-term care policies can pay benefits on a reimbursement (expense incurred) or a set-dollar (indemnity) basis. Under a reimbursement, or expense incurred policy, the insurer will pay no more than the actual charge for LTC services, covering all or a portion of the actual expenses incurred daily or monthly up to the daily or monthly maximum stated in the policy. Benefits may be paid to the provider or directly to the policy holder.

Unlike a reimbursement policy, benefits paid by an indemnity policy are a set dollar amount. Under this type of policy, the insurer will pay the amount specified in the policy, regardless of the cost of service. Provider bills are not necessary, and the insurer will often pay out monthly the fixed amount selected, regardless of whether services have been received that month, to the provider of those services.

A third type of LTC contract is the disability (cash) policy. Under these policies, benefits are paid when the policy holder qualifies for benefits (i.e., meets the policy's benefit trigger), regardless of whether the policy holder is actually receiving care or incurring expenses.

Chapter 3 Individual and Group Policies

Individual and Group Policies
In the long-term care market, coverage is available on both an individual and group basis. Though individual policies dominate, some employers offer this coverage to their employees. Of those that

do, most provide the benefit only on an "employee-pay-all" basis. This means that the employer does not contribute to the cost of the premium; it is paid entirely by the individual employee. However, the employee has the advantage of a group premium rate, which usually is lower than the rate that would apply to individual policies.

Most states require that group LTC participants be granted certain rights to continue or convert their coverage in the event coverage is terminated under the group plan. These rights are explained in detail in Later Lessons.

As a point of reference, the deductible limits in 2009 were $320 for those age 40 and under; $1,190 for those age 51 to 60; and $3,980 for those age 71 and over. Other amounts apply to those between these age brackets.

Common LTC Policy Characteristics and Features

The long-term care insurance market is characterized by a variety of policies and policy forms: tax-qualified and non-tax-qualified, comprehensive and non-comprehensive, reimbursement and indemnity, individual and group. As mentioned, some standardization is beginning to emerge, due in large part to the requirements that have been set for tax-qualified policies and those that are defined in the NAIC's model act. Still, even within these parameters, there exists a broad array of LTCI features, options, and limitations. Here we will cover the more common policy provisions and features. Unit 6 is devoted to the requirements for long-term care policies that are sold in states that have adopted the NAIC model and that are used in conjunction with state LTC partnership plans.

Covered Care

As noted earlier, an LTC policy may be either comprehensive or non-comprehensive. Most policies sold today are comprehensive policies, which cover care and services in a wide range of settings, for a multitude of needs. Comprehensive coverage typically includes:

-Skilled nursing facility care
-The cost of care delivered in the home, including skilled care and personal care (Many policies also cover some level of homemaker services as well as personal services.)
-Adult day care health centers
-Respite care for caregivers
-Hospice care
-Assisted living facility care
-Memory care centers
-Skilled nursing facility care

Comprehensive policies also cover care at all levels: custodial, intermediate, and skilled.

Eligibility for Benefits

Once a person has applied for LTCI coverage and has been approved, he or she will be eligible for benefits after coverage becomes effective and when he or she meets the policy's benefit triggers. As we've discussed, policy triggers may vary depending on whether the policy is tax-qualified or non-tax-qualified, but because most policies are tax-qualified, the triggering events for most

policy holders are cognitive impairment or the inability to perform at least two of six ADLs.

Benefits can begin after the elimination period (discussed in an upcoming section), as long as the covered services are part of an approved plan of care developed by a licensed health care practitioner of the policy holder's choice and approved by the insurer. Some policies require a doctor to verify that the ADL or cognitive impairment trigger has been met before benefit payments can begin. Some newer policies, however, pay benefits if a social worker, physical therapist, or other health care professional can show that the policy holder has experienced a qualifying event. The person who verifies that coverage has been triggered is called the gatekeeper.

Benefit Amount

The policy's benefit amount is the amount that the policy will pay, usually expressed as a dollar-per-day amount. The policy holder selects the daily benefit amount, typically ranging from $50 a day to $500 a day. Policy holders may be given the choice of having the same daily benefit apply regardless of where the care is delivered, or choosing a lesser amount for care delivered in the home. For example, the policy holder may elect a daily benefit of $250 for care delivered in a nursing facility and a home care benefit equal to 50 percent of the nursing facility rate for care delivered in the home.

The daily benefit is then multiplied by the number of days in the benefit period (discussed in the next section) to determine the total benefit payable under the policy. For example, assume an policy holder selects a daily benefit of $100 and a five-year benefit period. The policy will provide for a total of $182,500 in benefits:

-$100 x (365 x 5) = $182,500

LTCI policy benefits may also be expressed in terms of a lifetime maximum policy benefit. Under this scenario, the policy holder chooses a lifetime maximum benefit, for example, $100,000, $250,000, or $500,000. This is the pool of money from which benefits are paid. The daily benefit can be used in any way—for example; it can cover a combination of services, such as for home care and community-based care. When the policy's lifetime maximum has been exhausted, regardless of how paid, no further benefits are available. In addition, as benefits are paid, the policy holder is responsible for costs that exceed the benefit amount purchased.

Benefit Period

The benefit period is the length of time the policy will pay for covered services. It is usually defined in years. Common benefit periods are two years, three years, five years, and ten years. Many states specify that an LTC policy's benefit period can be no less than 12 months.

The benefit period begins on the date that the policy holder first makes a claim against the policy to pay for care. Payments continue for the duration of the period chosen. Some insurers allow policy holders to elect an unlimited benefit period under which payments are not limited to a specified number of years but continue for life.

A policy's premium is obviously influenced by the benefit period, as well as the benefit amount.

For example, a policy that pays $100 a day for five years of long-term care will cost more than a policy that pays $50 a day for three years.

Elimination Period

Common to long-term care policies are elimination periods. The elimination period, sometimes called the deductible period or waiting period, is the number of days after which the policy holder qualifies for benefits but before benefits are payable. It is defined in terms of a certain number of days the policy holder must be in residence in a nursing home or the number of home care visits received before policy benefits begin.

A policy may define the elimination period in terms of service days or calendar days. Service day elimination periods count days in which the policy holder actually receives care, such as in the home or in a skilled nursing facility. Calendar day elimination periods simply count the number of days from the point that the policy holder first needed care, regardless of whether that care is actually delivered.

Common elimination periods are 30, 60, 90, 120, and 180 days. Under a 30-calendar-day elimination period, for example, the policy will begin paying benefits on the thirty-first day after the policy holder began to receive care. Under a 30-service-day elimination period, the policy will begin paying benefits on the thirty-first day of care delivered to the policy holder.

Typically, it is up to the policy holder to choose the length of the elimination period. The appropriate period should be matched to the policy holder's ability to cover the cost of his or her care out-of-pocket. The longer policy's elimination period result in a lower premium. Obviously, longer elimination periods mean higher out-of-pocket costs.

Inflation Protection

Also common to today's LTC policies are inflation protection features. Because the cost of care in the future is likely to be much more than it is today, and because a benefit amount purchased today may not be enough to cover higher costs years from now when care is needed, inflation protection is usually advisable. Under policies with inflation protection, the initial benefit amount will increase automatically each year at some specified rate over the life of the policy.

Most policies offer inflation protection as an option that the policy holder can elect or reject. Protection is typically defined as a set percentage of the initial benefit amount, which increases at either a simple or compounded rate over the life of the policy. Simple inflation protection increases a policy's daily benefit amount every year by a certain percentage (usually 5 percent) of the original daily benefit amount; compounded inflation protection increases the daily benefit amount annually by a certain percentage (usually 5 percent) of the current daily benefit amount of the policy. For example, assume that Bill and Jill each purchase an LTC policy that provides a daily benefit of $100. Bill elects a simple 5 percent annual inflation protection; Jill elects a compounded 5 percent annual inflation protection. Every year, the daily benefit under Bill's policy will increase by $5 (5 percent of the original $100 daily benefit); the daily benefit under Jill's policy will compound the current daily benefit amount at 5 percent each year. The following shows the difference in daily benefits each will be able to count on in the future.

An inflation-protected policy provision can add a significant amount to the premium. However, without it, coverage may fall critically short of paying for services when they are needed. A policy that today would cover 100 percent of one's long-term care costs may, in a matter of only a few years, cover half or less of the cost if it does not include inflation protection.

Pre-Existing Condition Limitations

A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a licensed health care provider typically within six months before a policy's effective date. Some LTC policies contain a pre-existing condition limitation. This limitation is the period after purchasing the policy that benefits will not be payable for care related to that condition. Some policies apply pre-existing condition limitations only for medical conditions that are not disclosed on the application.

Most states require that policies covering long-term care services cannot contain a pre-existing condition limitation of more than six months after the effective date of coverage.

Non-forfeiture Benefits

A non-forfeiture provision is a clause in an insurance policy that allows the policy holder to receive all or a portion of the benefits or a partial refund on the premiums paid if the policy lapses due to nonpayment of premium. Essentially, it allows the policy holder to receive some value from the policy for premiums he or she had already paid. Common non-forfeiture provisions for LTC policies include:

-cash surrender option—This option allows the policy holder to surrender the policy for some cash amount if the policy lapses.

-return of premium option—This option allows the policy holder to receive some return of premiums paid if the policy lapses.

-shortened benefit period option—This option allows the policy holder to decrease the benefit period should the policy lapse. In other words, the policy holder retains the right to receive benefits under the policy equal in duration to premiums paid.

The non-forfeiture provision may be in effect only for a limited time and only after the policy has been in force for several years. Of course, no one should plan on letting an LTCI policy lapse, but a non-forfeiture clause can rescue some measure of benefits from the policy if it lapses.

Policy Renewability

Almost all individual long-term care policies are issued as guaranteed renewable (and those that are tax-qualified must be). This means that the insurer cannot terminate the policy for any reason —not for the policy holder's advancing age, not for declining health, not for claims made against the policy, not for any other underwriting consideration. The policy must be renewed, and the policy holder has the right to keep the policy in force as long as the premiums are paid on time. The insurer also cannot make any changes in any provisions of the policy while the insurance is in force without the agreement of the policy holder.

Guaranteed renewable policies also provide some level of protection against premium increases. The insurer cannot increase the premium charged for an individual policy; it can only increase premiums for an entire class of policies or an entire class of policy holder. Insurers must submit premium increases to state insurance departments. States have only limited authority to deny increases, especially when claims experience supports requests for higher rates.

Restoration of Benefits

The restoration of benefits feature is used when the policy holder receives benefits under the policy, and then a stated time (typically six months) passes with no further benefits being paid. The maximum amount of the original benefit purchased under the policy is then restored.

To illustrate, assume Mary owns an LTCI policy with a lifetime maximum benefit of $300,000. Mary uses $20,000 of her benefit amount, but then recovers and does not require additional LTC services. After six months pass without Mary using any more of the policy's benefits, the insurer will restore the policy to the full $300,000.

Most policies provide a restoration of benefits feature at no or very low cost. This is due to the nature of long-term care and the fact that most who meet a policy's benefit trigger do not typically recover to the extent that they stop making claims against their policy for the specified period. If an additional premium is required for this feature, it is most useful for younger policy holder's who are more likely to recover from a disabling condition.

Return of Premium

Sometimes the benefits under an LTCI policy are never used. Perhaps the policy holder dies before becoming eligible for benefits, or the policy holder simply never requires long-term care. Traditional LTCI policies have no cash value, and some insurance citizens have avoided the product for this reason. Return of premium rider's address this issue.

When a return of premium rider is attached to an LTCI policy, and policy benefits are not used, the insurer returns a portion of the premiums paid to the policy holder or, if the policy holder is no longer living, to a named beneficiary. This option, of course, can be very expensive. It may also require the policy to have been in force for an extended period (ten years, for example).

Waiver of Premium & Free-Look Period

A waiver of premium provision under an LTCI policy waives the requirement of paying the policy's premium while the policy holder is receiving benefits under the policy. This provision may vary depending on the insurer and the type of policy. For example, the waiver may apply only when the benefits are payable for skilled nursing home care, not for home health care. Other insurers apply the waiver for home health care benefits as well. Some insurers allow the waiver to become effective when the elimination period has been satisfied; others stipulate that the waiver becomes effective at some point after the elimination period is satisfied.

Long-term care policies, like all insurance policies, must provide policy holders with a free-look period. The free-look period is the time following policy purchase during which the policy holder may return the policy for any reason and receive a full refund. The free-look period is typically 30 days.

Grace Period and Third-Party Notification
Like most insurance policies, LTCI contracts include a grace period of at least 30 or 31 days before the policy lapses for nonpayment of premium. In other words, the insurer will accept a premium payment up to 30 or 31 days after it is due and not cancel the coverage.

Working in conjunction with the grace period is the third-party notification provision, which is unique to LTCI policies. This provision allows the policy holder to name a third party whom the insurer will notify in the event the policy is set to lapse because of nonpayment of the premium. The third party may be a relative, friend, or other advisor. With this option, the policy cannot be unintentionally terminated.

After notice is sent to the third party, the premium payment period is extended by an additional 30 or 31 days. During this time, the third party can see to it that the policy holder pays the premium or the third party can pay the overdue premium on behalf of the policy holder. This provision is particularly valuable for those with cognitive impairments.

Bed Reservation Benefit
If an LTC policy holder should require hospitalization during a stay in a nursing home or assisted care facility, some policies will pay to cover charges, up to the daily facility care benefit, to reserve the policy holder's bed in the nursing facility, typically for 7 to 21 days. Without this benefit, the family would have to pay to keep the bed open, or the nursing home could give the bed to someone else. Most nursing homes have waiting lists. Without a payment to hold a bed open, the policy holder would be forced to move if the home were full on his or her return.

Premium Payment Options
Most LTCI policies are issued on a level premium basis: that is, the same premium is due and payable as long as the policy is in force. For the payment of those premiums, the policy holder has a few options. These include:

Continuous payment option—With a continuous payment premium option, the policy holder pays premiums regularly—monthly, quarterly, semi-annually, or annually—as long as the policy is to remain in effect.

Guaranteed limited payment option—Under a guaranteed limited payment option, once the policy holder has made a certain number of annual payments, typically ten, the policy is paid up and no further premium payments are due. Of course, if rates increase during the premium payment period, the higher rate would apply. However, once the specified number of annual payments has been made, rate increases cannot affect the policy. The policy is fully paid up. Limited payment options include 5-year pay, 10-year pay, 20-year pay, and paid-up-at-age 65.

Single premium payment—With the single premium payment option, the policy holder pays the full premium in advance. Even if rates increase, the policy holder will owe no additional amount.

Upgrading/Downgrading Coverage
Some insurers allow policy holders to upgrade their LTCI policies after purchase. However, a new medical questionnaire may have to be submitted. Some policies allow the option of upgrading

coverage in the future without having to again prove insurability. An upgrade in coverage will require the payment of increased premiums.

Similarly, some insurers allow policy owners to downgrade their coverage, reduce their benefits, and thereby and reduce their premiums. This option is often called a step-down provision.

Joint-Long-Term Care Policies

Most long-term care insurance companies offer joint long-term care policies, sometimes called share care policies, for married couples. Joint policies are not a single policy; they are separate policies. However, with these policies, the total amount of coverage is pooled between the two. If one policy holder dies without having used all of his or her policy benefits, the surviving spouse has the unused benefits added to the remaining policy. Share care policies are typically more expensive than the purchase of two individual policies.

Policy Exclusions

LTCI policies, like all insurance, contain coverage limitations and exclusions. Generally, long-term care services are not covered when they result from the following conditions:

-Alcohol and drug addiction.
-Illnesses and/or injuries caused by acts of war.
-Wounds resulting from intentionally self-inflicted injury, such as attempted suicide.
-Treatment covered by Medicare.
-Services delivered by family members or friends.
-Some mental and nervous disorders.

It should be noted that under most state laws, long-term care policies cannot exclude Alzheimer's disease and other similar age-related dementias. Whereas Alzheimer's may be a condition for which an applicant is declined issue of a policy, it must be covered if a policy is issued. Thus, if a policy is issued and the policy holder subsequently develops this disease, coverage for its treatment cannot be excluded.

Underwriting Long-Term Care Insurance

When underwriting LTC policies, the focus is on the risks associated with long-term care, not acute care. For this reason, an applicant's functional and cognitive abilities are usually as or more important than medical conditions. An insurer will take into consideration a combination of factors: the applicant's age, gender, medical history, family history, current physical health, lifestyle habits, occupation, cognitive health, and similar factors. Because the LTC underwriter's job is to filter out applicants who pose a high risk of requiring care, and because cognitive disorders such as memory loss and dementia are major contributors to long-term care claims and nursing home admissions, these conditions (or the potential for them) are closely examined and may be cause for denial. Common conditions that result in denial of LTC policy applications include

-Current or recent use of long-term care services.
-Needing help with activities of daily living.
-Having Alzheimer's or other dementia.
-Having AIDS or AIDS-related complex.

Other conditions may not preclude the issue of a policy; instead, the insurer may rate the policy and set premiums at a higher level or may impose a pre-existing condition limitation.

Long-Term Care Insurance Premiums

The premium for a long-term care policy is established when the policy is issued and will remain at that level (as long as the policy holder does not increase rates for the entire class of policies). This is in keeping with the concept that LTCI is designed to be maintained for the long-term. Unlike other forms of health insurance, it is not priced or subject to renewal annually. As a general rule, the younger the policy holder is at the time of application, the lower the policy's premium.

In addition to the policy holder's age and his or her personal traits, other factors affect the premiums for an individual LTC insurance policy. These include:

-Whether the policy is a comprehensive or non-comprehensive policy—Comprehensive policies cover a wider range of risks and thus are typically more expensive.

-The amount of the policy's daily benefit and the length of the policy's benefit period—The higher the benefit amount and the longer the benefit period, the greater will be the policy's premium.

-The length of the elimination period—The longer the elimination period during which the policy holder will be responsible for paying the full cost of his or her care, the lower the premium.

-Whether the policy provides for inflation protection—Policies that provide some measure to increase the level of benefits over the life of the policy are more expensive than those that do not provide this protection. Policies that use an annually compounded rate of return to increase benefits are more expensive than policies that use a simple rate of return.

-Whether the policy provides a non-forfeiture benefit—A non-forfeiture benefit allows an policy holder to receive some value from the policy for premiums paid in the event the policy is lapsed or terminated. Adding a non-forfeiture benefit to an LTC policy can significantly increase the policy's premiums.

These factors can be modified or customized to make the premiums more affordable. For example, by electing an elimination period of 180 days instead of 30 or 90 days, the policy holder can lower the policy's premium. By electing a benefit for home health care at a rate equal to 50 percent of the daily benefit for skilled nursing care instead of 75 percent, the premiums for a comprehensive policy will be less.

Long-Term Care Claims

Benefits under an LTCI policy are paid when the policy holder provides proof of loss—documentation that the policy holder meets one of the policy's benefit triggers. The process of claiming benefits under a long-term care policy usually begins with a call to the insurer's claims department and the submission of the necessary claims forms. As part of the process, the policy holder may be required to authorize the insurer access to the policy holder's medical records and to submit a plan of care as prescribed by a physician or other health-care practitioner. The insurer will gather the necessary information to verify that the policy holder has met the policy's benefit

trigger. The review and evaluation process may take a number of weeks, but if the claim is approved, benefits are usually paid retroactively to the date the policy holder became eligible. In most cases, the policy holder is usually given the option of receiving benefits directly or having them assigned and paid to the care provider.

Long-Term Care Partnership Programs

As the need for long-term care grows and as greater and greater demand is made of state and federal health care programs, alternatives to the funding and delivery of such care have become necessary. One fairly new alternative comes in the form of state long-term care insurance partnership programs. Partnership programs represent something seldom seen: a genuine cooperation between business and government to address—and hopefully resolve—a major social issue before it becomes unmanageable.

What Is an LTC Partnership Program?

As we have learned, the cost of providing long-term care is largely borne by three parties:

-The government (primarily through Medicaid and, to a limited extent, through Medicare).
-Care recipients and their families (out-of-pocket through personal resources, assets and income, and through unpaid support delivered by family and friends).
-Insurance companies (primarily through LTCI policies).

Currently, the government carries the largest share of long-term care costs—approximately 66 percent. Citizens carry the next largest cost-share—about 22 percent—out-of-pocket. The smallest share—about 9 percent —is paid through private long-term care insurance.11 Intuitively, this seems backwards: an industry that is in the business of managing financial risk currently plays the least significant role in covering the cost of long-term care. Shifting this financial responsibility made so much fiscal sense that it became the basis for the "Partnership for Long-Term Care" initiative, a unique insurance program introduced in 1988 under the sponsorship of the Robert Wood Johnson Foundation (RWJF). The program's goal is simple: to encourage citizens to purchase affordable long-term care insurance policies and to reduce the burden on state Medicaid programs.

The partnership concept benefits all three parties to the long-term care financing issue:

-Citizen's benefit through the assurance of long-term care protection that can help them preserve personal assets (even if it becomes necessary to apply for Medicaid) while enjoying the greater choice of care options that insurance offers.

-States (specifically, their Medicaid programs) benefit by potentially reducing demand for Medicaid financing.

-Insurance companies benefit through increased ownership of their long-term care insurance products, which reinforces the insurance principle of spreading risk among a wider pool of individuals.

Originally modeled in four demonstration states (California, Connecticut, Indiana, and New York) and supported with funds and technical advice provided through the Robert Wood Johnson

Foundation, the initial partnership programs were designed for the express purpose of giving seniors a way to ensure they had long-term care funding when needed and, perhaps more important, to retain more of their assets while potentially qualifying for Medicaid benefits. The defining element in these programs is a partnership-qualified long-term care insurance policy.

Purpose: Shift Financial Responsibility to Insurers

States have always relied on a simple approach to Medicaid cost recovery: shift a portion of the financial responsibility to another payor. Traditionally the "other payor" has been the Medicaid recipient, via Medicaid's financial eligibility rules. These rules require recipients to exhaust virtually all personal income and assets (or assign them to the state) in return for Medicaid payment of long-term care needs. Only a nominal amount of about $2,000 or $3,000 in assets may be retained by a Medicaid recipient. In addition, amounts Medicaid pays may be recovered at the Medicaid beneficiary's death through the process of estate recovery.

Partnership programs redefine Medicaid's "other payor" to include the LTCI industry. For individuals who own a partnership-qualified long-term care insurance policy, the insurance will pay their initial costs. If care is needed beyond the level or duration of that which the policy provides, the policy holder may apply for Medicaid coverage. Qualification for Medicaid eligibility by those who own a partnership policy allows the policy holders to retain assets equal to the amount of benefits their policies pay. In addition, the assets that were disregarded for Medicaid eligibility are not subject to estate recovery at the partnership recipient's death.

Long-term care partnership programs are aimed primarily at those who have assets they want to protect but who may not have the means to fully cover their own long-term health care out-of-pocket (or who do not have the ability to pay for an amount of LTCI that would completely finance their future health care needs). By participating in a partnership program and purchasing a qualifying LTCI partnership policy, these individuals can be assured that some amount of their assets will be protected, for themselves and their heirs, if ever they do have to turn to Medicaid for assistance.

Minimum Standards for Group LTC Insurance Policies

Though individual policies dominate the LTC market, coverage is also available on a group basis. Group policies may be partnership-qualifying.

With group policies, an employer is typically the policyholder; the employees are the policy holders. All group policy holders must be given a certificate of coverage describing principal benefits and coverages, exclusions, reductions, and limitations. The NAIC Model Act and Regulations provides minimum standards for the continuation or conversion of such coverage in the event coverage terminates or is replaced.

Continuation or Conversion of Group LTC Policies

Continuation and conversion provisions give covered employees the right to either continue their group coverage or convert it to an individual policy providing essentially similar coverage. Either way, the terminated individual is fully responsible for paying premiums (even if the group plan was noncontributory). The DRA and the NAIC's Model Act and Regulations make continuation or

conversation provisions mandatory in partnership policies, thus ensuring a terminating employee of some important rights:

-conversion—the right to convert from group coverage under the employer's policy to an individual policy without having to furnish evidence of insurability;

-continuation—the right to continue one's coverage under the employer-sponsored plan at one's own expense. The continuation of coverage may be limited in duration (for example, 18 or 36 months).

Continuation or conversion privileges apply when the employee leaves the employer, either voluntarily or involuntarily for other than gross misconduct.

Discontinuance and Replacement of Group LTC Policies

If a group long-term care partnership policy is replaced by another group partnership policy issued to the same policyholder, the replacing insurer must offer coverage to all persons who were covered under the previous policy on its date of termination. This coverage cannot result in an exclusion for pre-existing conditions that would have been covered under the previous policy and cannot vary or otherwise depend on the individual's health or disability status, claim experience, or use of LTC services. In addition, to the extent that an policy holder satisfied any pre-existing condition exclusion period, that time must be "credited" to any exclusion period required under the new policy.

The premium charged under the new policy cannot increase because of either the increasing age of the policy holder at ages beyond 65 or because of the duration for which the policy holder was covered under the policy.

Minimum Standards for Marketing Partnership-Qualified LTC Insurance

The DRA specifically cites certain provisions of the NAIC model pertaining to marketing and policy issue that insurers and producers must follow when selling LTC partnership policies. Again, it is likely that a state that has adopted the model will impose these standards on all LTC carriers and producers, regardless of whether the policies are sold in conjunction with a partnership program.

Application Forms and Replacement Coverage

All LTC application forms must be designed to elicit information as to whether, as of the date of the application, the applicant has another LTCI policy in force or whether a policy is intended to replace any other accident and sickness or LTCI policy. The NAIC Model Act and Regulations sets forth specific questions to obtain this information. If it is determined that a sale will involve a replacement, the applicant must be given a copy of the "Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance."

In addition, the application must clearly provide notice that the company may have the right to deny benefits or rescind a policy if any answers on the application are incorrect or untrue. Producers must counsel their prospects and clients to provide full and truthful answers to all application questions.

Prohibition on Post-Claims Underwriting
Post-claims underwriting occurs when a policy is automatically issued upon application and a claim is subject to underwriting at the time the claim is filed. The usual consequence of post-claims underwriting is that coverage is denied and benefits will not be paid. This practice is specifically prohibited by the LTCI model act.

Free Look
Under the NAIC model, all LTC policies must provide for a free-look period of no less than 30 days and the right by the owner to return the policy for a full refund within that time for any reason.

Treatment of Pre-Existing Conditions and Probationary Periods for Replacements
If an LTCI policy (or, as noted, a group certificate) replaces another policy, the replacing insurer cannot apply any time periods for pre-existing conditions or probationary periods under the new contract to the extent that similar exclusions were satisfied under the original policy.

Insurer Reporting Requirements
For each LTCI producer, insurers must maintain records for replacement sales as a percentage of the producer's total annual sales, and the number of lapsed policies as a percentage of annual sales. Insurers must also report annually on its agents with the highest lapse and replacement rates. Replacements and lapses do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

As to qualified LTC contracts, insurers must report the number of claims denied for each class of business, expressed as a percentage of claims denied. It is likely that future versions of the NAIC model act will contain new and revised provisions for LTCI claims reviews and appeals processes for policy holders when claims are denied.

Requirements for Marketing
Every insurer marketing long-term care insurance, directly or through its producers, must conform to certain requirements with respect to marketing and selling LTCI policies, and establish auditable procedures for verifying compliance with these requirements. These requirements include the following:

-Establish marketing procedures and agent training requirements to ensure that marketing activities are fair and accurate and that excessive insurance is not sold or issued.

-Make every reasonable effort to identify whether a prospective LTCI applicant already has accident and sickness or LTCI and, if so, the types and amounts of any such insurance. However, in the case of qualified LTCI contracts, an inquiry into whether the applicant has accident and sickness insurance is not required.

-Make all required disclosures and provide copies of all required disclosures documents to applicants.

Required Consumer Disclosures
Required disclosures refer to the notices and information that an insurer must give to applicants and policy owners regarding their policies. They include policy language that clearly describes the policy's renewability, eligibility for benefits, and limitations. A partnership policy must clearly be labeled as "tax qualified." The insurer must also disclose whether and to what extent any premium rate increases have ever been imposed on the policy form.

In addition, all prospective applicants for LTC contracts must be given an outline of coverage and a copy of the NAIC's Long-Term Care Insurance Shopper's Guide(or a similar buyer's guide approved the state). The outline is intended to explain the significant features of the policy form, including its coverage and benefits, limitations and exclusions, the terms under which coverage may be continued, and the conditions under which premiums may be increased. The shopper's guide or buyer's guide helps citizens understand long-term care and the options that can help pay for long-term care services. The guide acts as a source to answer most of the questions posed by consumers and provides many tips to aid in the often complicated decision of whether to purchase LTC insurance.

Producer Training Requirements
Among the recent revisions to the NAIC LTCI Model Act and Regulation were those that established standards for producer training. These efforts were put on a fast track after DRA 2005 to coincide with state implementation of partnership programs. Recall that under the partnership provisions of the DRA, states must provide assurance to the CMS that producers who sell partnership policies can demonstrate an understanding of these policies and their relationship to public and private coverage of long-term care services.

The current NAIC model specifies that producers who sell LTC insurance must complete a one-time, eight-hour training course and, thereafter, ongoing four-hour continuing education every two years. The NAIC model applies the training requirements to all who sell long-term care insurance; however, a few states have limited the required training to only those who sell partnership policies.

Suitability
All insurers marketing long-term care must develop and use suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate for the needs of an applicant. In addition, all insurers must train their agents in the use of their suitability standards and must maintain and make available a copy of its suitability standards for inspection by the state insurance commissioner. Because it is so important to the sale of LTC insurance, suitability will be addressed in detail in the final lesson of this course.

Chapter 4 The Basics of a Partnership Program

The Basics of a Partnership Program
The basic concept behind an LTC partnership program is easy to understand. A partnership program joins a state's Medicaid program with ownership of private LTC insurance in such a way

that the state's Medicaid eligibility requirements are modified to provide financial incentives for residents to purchase private LTCI coverage. If the policy holder requires long-term care services, the LTC policy pays out its benefits. Then, in the event the policy holder continues to need care after the policy's benefits are exhausted, or the policy does not fully cover the cost of needed care, the policy holder can apply for Medicaid. However, the standard asset limit that the state Medicaid program would otherwise impose does not apply to the owner of an LTC partnership policy. He or she will be able to keep assets equal in amount to the benefits the policy provided. In addition, these assets are exempt from Medicaid estate recovery upon the policy holder's death.

To illustrate, suppose 63-year-old Jean purchases a qualified LTCI partnership policy. The policy provides a maximum benefit of $75,000. After three years of needing various levels of long-term care, Jean has exhausted her policy's benefits. At that point, Jean could apply for Medicaid. Whereas the Medicaid program in Jean's state would normally require that she have no more than $2,000 in assets to be eligible for Medicaid payment of her LTC costs, her qualified partnership policy enables her to disregard an additional $75,000—the amount the policy paid. Thus, Jean would be able to retain a total of $77,000 in assets and still be eligible for Medicaid. In addition, at Jean's death, the disregarded assets are not subject to estate recovery.

The goal of the long-term care partnership model is to use Medicaid's payment system for LTC services as an incentive for lower- to middle-income individuals to purchase qualified—and affordable—long-term care insurance, thus encouraging them to prepare for the possibility of needing long-term care. In turn, this may prolong or even preclude the need for Medicaid to pay for their long-term care services.

The Pilot Partnership Programs

As mentioned, four states—California, Connecticut, Indiana, and New York—were the four pilot partnership states. These programs began in the mid- and late-1990s. Each of these states designed its own program, working with the Centers for Medicare and Medicaid Services. As a result, two models emerged as a means of defining the partnership benefit:

-dollar-for-dollar method
-total asset protection method

Dollar-for-Dollar Model

California, Indiana, and Connecticut use the dollar-for-dollar method. Under this model, asset protection is equal to the amount of benefits paid from the partnership policy. For example, if Tom buys a partnership policy with a maximum lifetime benefit of $100,000, he would be entitled to up to $100,000 worth of LTC benefits paid by his policy. If additional care should become necessary, he could apply for Medicaid coverage while still retaining $100,000 worth of assets above what the Medicaid program otherwise allows.

The Total Asset Protection Model

New York uses the total asset protection method. Under this model, all assets are protected. This model is generally recommended for those with substantial wealth accumulation. New York policy holders were required to purchase more comprehensive coverage as defined by the state. Policy holders purchasing this type of policy could protect all of their assets when applying for Medicaid

once their policy benefits had been exhausted. Those who purchased the state-approved policies qualified for Medicaid without having to meet any of Medicaid's asset criteria. That is, policy holders could protect all of their assets at the time they were deemed eligible for Medicaid.

In 1998, Indiana switched to a hybrid model, whereby insurance citizens can choose between dollar-for-dollar or total asset protection. New York has added a dollar-for-dollar option for LTC citizens. By offering different models, these states give their insurance citizens the option of a lower premium in exchange for less asset protection, or greater asset protection for a higher premium.

It is important to note that in both the dollar-for-dollar and total asset protection models, individuals must still pass Medicaid's other eligibility tests after exhausting partnership policy benefits. In other words, whereas a partnership policy will allow participants to retain a greater level of assets, a participant must still meet Medicaid's general and functional requirements.

Concern over the Original Partnership Program

A few years after the original four state's partnership programs were enacted, Congress began to express concerns. One criticism was that Medicaid would wind up endorsing private insurance products. Another issue was the potential for increased Medicaid spending rather than an intended decline in it—that wealthy individuals or those of above-average means (who were considered likely to purchase LTCI anyway) would participate in the program, retain their assets, and have unintended access to Medicaid services.

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

As a result of these concerns, Congress enacted new laws that restrained expansion of partnership programs beyond the original four states. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) effectively prevented other states from developing partnership programs by changing the conditions under which states could amend the Medicaid asset disregard. Though the original four programs were grandfathered, OBRA required any new partnership program to provide asset disregard only for initial Medicaid eligibility; thus, disregarded assets would be deemed subject to estate recovery at the participant's death. OBRA specified that states were required to recover from a partnership participant's estate an amount equivalent to what Medicaid spent on his or her behalf, including any protected assets under the partnership program. In addition, any state that established an LTC partnership program after OBRA was required to use an expanded definition of "estate" than what was previously the norm.

Therefore, while OBRA did not ban the creation of new state partnership programs, the restrictions it imposed virtually had the same effect. It wasn't until a decade later that state partnership programs began to expand.

The Deficit Reduction Act of 2005 (DRA '05)

The Deficit Reduction Act (DRA) of 2005 ended the barrier OBRA '93 had imposed on partnership programs and opened the door for their expansion across the country. DRA authorized all states to establish partnership programs, defined certain criteria these programs must meet, and removed the requirement that subjected disregarded assets to estate recovery.

The following is the definition of a "qualified state long-term care insurance partnership" program as defined by the DRA:

. . . an approved State plan amendment [to the state's Medicaid laws] . . . that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy. . . .

In other words, if an policy holder under a qualified LTCI partnership policy requires Medicaid assistance after the policy's benefits have been paid, and he or she meets Medicaid's other eligibility requirements, the participant may retain assets equal to the benefits paid by the policy—assets that, without a partnership policy, might have been forced to be spent down. (This is the dollar-for-dollar model.) These assets remain available to the policy holder while receiving Medicaid payment for long-term care services and may be passed on to heirs and beneficiaries after the policy holder's death. They are not subject to estate recovery.

LTC Partnership Policy Standards

Along with creating partnership programs in all states, DRA also outlined specific requirements for all LTC policies sold in conjunction with such programs. All such policies must be tax-qualified and must conform to certain minimum standards set forth in the NAIC's Long-Term Care Model Act and Regulations. Additionally, no state may impose requirements on partnership policies that are not imposed on non-partnership LTCI policies. These requirements and standards will be discussed in detail in a later lesson.

Changes in the Look-Back and Penalty Periods

At the same time it expanded the opportunity for state partnership programs, the DRA tightened the requirements on Medicaid rules for the transfer of assets. Before this act, the look-back period was 36 months. DRA extended this period to 60 months (five years). In addition, DRA changed the beginning date of the penalty period. Before the enactment of the DRA, the penalty period began on the first day of the month during or after which assets were transferred. The penalty period now begins on the later of:

-the first day of the month when the assets are transferred
-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 penalty period.

It is anticipated that the extension of the look-back period and its redefinition may reduce the improper transfers of assets.

Reciprocity between States

Reciprocity between states is an attractive element of partnerships for citizens, because many do not know where they will reside in future years. The DRA requires standards of reciprocal recognition under which benefits paid under a partnership policy are treated the same by all partnership states. Policy holders in all participating partnership states are able to use their benefits in other partnership states.

To be eligible to participate in another state's partnership program, the policy holder at the time of policy purchase must be a resident of a state sponsoring a partnership program. Also, at the time the Medicaid application is made, the policy holder must be a resident of a partnership state. The policy holder may move to another state after purchasing a partnership policy and insurance coverage would remain in effect. However, only if reciprocity exists between the two states can the policy holder be certain of Medicaid asset protection in the new state.

In the absence of reciprocity, policy holders who move from one partnership state to another could find that, just as when moving from a partnership state to a non-partnership state, their asset protection does not apply in the new state.

Implementing a State Partnership Program

Any state can implement a partnership program. The LTC partnership model generally does not call for alterations in how a state's Medicaid program is administered. It simply requires that the state's Medicaid rules allow for increased asset disregard for those who own a partnership policy. This adjustment is addressed by the filing of a state plan amendment (SPA) with CMS, specifying that benefits paid under a qualified long-term care insurance policy will be disregarded in the state's Medicaid eligibility determination and the estate recovery process. The SPA must also stipulate that the policies serving as the basis for these disregards meet all of the requirements for a qualified LTC policy as specified by the DRA. Policies used in conjunction with a state's partnership program cannot be issued any earlier than the effective date of the SPA. As the partnership program has evolved nationally, many complex issues have surfaced, and others are sure to arise in the future. Some of these are examined in the following sections.

LTCI Partnership Program in Florida

The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Families, is directed to establish a qualified state Long-Term Care Insurance Partnership Program in Florida, in compliance with the requirements of s. 1917(b) of the Social Security Act, as amended.

(1) The program shall:

(a) Provide incentives for an individual to obtain or maintain insurance to cover the cost of long-term care.

(b) Provide a mechanism to qualify for coverage of the costs of long-term care needs under Medicaid without first being required to substantially exhaust his or her assets, including a provision for the disregard of any assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under the program.

(c) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(2) The Agency for Health Care Administration, in consultation with the Office of Insurance

Regulation and the Department of Children and Families, and in accordance with federal guidelines, shall create standards for long-term care partnership program information distributed to individuals through insurance companies offering approved long-term care partnership program policies.

(3) The Department of Children and Families, when determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long-term care partnership program policy, shall reduce the total countable assets of the individual by an amount equal to the insurance benefit payments that are made to or on behalf of the individual.

Home Equity Value and Asset Protection

As noted earlier, Medicaid eligibility requirements impose a $500,000 cap on the equity interest a Medicaid applicant can have in his or her home ($750,000 at a state's option). This requirement was added by DRA 2005. (Previously, the value of a home was not included when determining Medicaid eligibility.) The requirement raises a question with respect to a partnership program: can asset protection be used to increase the home equity value allowance? For example, could someone with a partnership policy providing $100,000 in asset protection (assuming the person does not have $100,000 in assets other than home equity) use that to increase the protected value of his or her home and still qualify for Medicaid? The answer is no.

Exhaustion of Policy Benefits

In some cases, it is possible for a person to require Medicaid assistance before exhausting his or her partnership policy benefits. For example, an individual's cost of care may exceed the daily benefit amount the policy provides. This presents some further complexities to LTCI partnership policies. Medicaid has resolved this issue by allowing individuals' access to Medicaid while the insurance is still paying benefits. In such a situation, policy holders are permitted to protect assets equal to what their policy has paid out to-date. Medicaid pays for care in conjunction with the remaining insurance benefits. Over time, the asset protection amount increases as the insurance continues to pay benefits.

In July 2006, the Centers for Medicare and Medicaid Services supported this position by noting the following:

The DRA does not require that benefits available under a partnership policy be fully exhausted before the disregard of resources can be applied. Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the individual as of the month of [Medicaid] application, even if additional benefits remain available under the terms of the policy.

However, additional questions were triggered by what the CMS also stated: "The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination." Though this statement seems to suggest that the policy holder must make a choice between the earlier but reduced protection and the later full protection, it is open to interpretation.

It is up to the individual states to determine how they will handle this situation. Some states

require partnership participants to exhaust their policy benefits before asset protection will be granted. Other states construe the CMS position to mean that the eligibility process is ongoing, not a one-time determination. The initial Medicaid application and the ongoing re-determination of eligibility are seen as part of an entire eligibility determination process. Consequently, it is possible for an policy holder, while on Medicaid, to continue to accrue a level of asset protection equal to what is eventually paid out over the life of the policy. The asset protection amount is not capped at application. Rather, it has the potential to grow as benefits under the policy are paid out. In this case, the meaning of "[t]he amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination" is the most recent eligibility determination, as many states look upon eligibility as an ongoing process with eligibility reevaluated at certain intervals.

Though an individual may qualify for Medicaid before exhausting the benefits from a partnership policy, Medicaid remains the "payor of last resort." This means that long-term care claims are paid first by the policy (or any other insurance the participant may have) before Medicaid will pay claims.

Types of Services and Asset Disregard

Another issue is whether special limits should be placed on the types of services the LTCI policy pays for. For example, Mike's policy pays for assisted living, but he lives in a state that does not cover assisted living as a Medicaid benefit. Should Mike gain asset protection for the money spent during his time in the assisted living facility?

It was determined yes. This situation is no different from one in which Mike might have used his own money to pay for care in the assisted living facility, which might have impoverished him and qualified him for Medicaid anyway.

However, using benefits under a partnership policy for services not covered by Medicaid does not mean that Medicaid will cover those services once it begins payment on the policy holder's behalf. In our example, Mike would not receive Medicaid payment for assisted living, because assisted living is not a Medicaid-covered benefit in his state. Upon Medicaid eligibility, Mike would have to choose between using his protected assets to continue to pay for assisted living himself, or agree to receive care as allowed by Medicaid in his state.

Tracking Protected Assets

As with all applicants for Medicaid, asset identification for partnership participants is part of the eligibility process. The total amount of assets that must be spent down before a partnership participant is eligible for Medicaid must be determined in conjunction with:

-the assets that are non-countable under Medicaid (household belongings, burial plots, one automobile, etc.);

-the standard asset allowance normally allowed by Medicaid (typically $2,000 to $3,000 for single applicants);

-the asset allowance that is available to a community spouse, if the applicant is married; and

-the amount of protected assets as per the dollar-for-dollar partnership policy payout allowance.

Tracking protected assets for Medicaid eligibility when the policy holder has a partnership policy can be a difficult task. Some states require that Medicaid recipients actually designate the specific assets that are to be protected. Once the initial amount of protected assets is identified and Medicaid eligibility is established, states can use periodic eligibility re-determination tests to assess the beneficiary's financial transactions during the current interval. Typically, if a protected asset is sold or transferred, then the original protected amount is reduced for both asset disregard and estate recovery.

Insurers that sell LTCI partnership policies must assist in this tracking process. So that an policy holder's partnership participation is recorded and his or her assets protected, the insurer must report to the state Medicaid agency when a partnership policy is sold, when the policy pays benefits, the amount paid, and when such policies terminate.

Realities of State Partnership Programs

It is anticipated that LTC partnership programs will provide at least a partial solution to the critical problem of funding long-term care costs. However, these programs have their limits. Citizens who are considering these plans and producers who sell policies for these plans must understand the following:

-Partnership participation does not automatically guarantee enrollment in Medicaid or the payment of Medicaid funds once a policy's benefits are exhausted. The policy holder individual must still meet Medicaid requirements for eligibility—medically, functionally, and financially

-Partnership protection does not alter the fact that Medicaid remains the payor of last resort. Even if an policy holder qualifies for long-term care Medicaid payments while receiving policy benefits, benefits payable from the policy must be applied before Medicaid assumes any payments.

-Partnership participation protects assets, not income. Once a partnership participant qualifies for Medicaid, a large part of his or her income must be directed to paying for the costs of his or her care.

-Partnership participation may not protect all of an individual's assets. Because protection is limited to the amount of benefits paid under the policy, any assets the participant has above this amount may have to be spent down for the participant to qualify for Medicaid. (Total asset protection is limited to partnership programs in New York and Indiana.)

-Partnership participation does not guarantee that the policy holder will be able to receive care in his or her home or in a facility of his or her choosing. If and when a partnership participant turns to Medicaid, he or she may be forced into another facility or be required to forego home care.

-Partnership participation does not guarantee that future Medicaid eligibility requirements will be the same. Income and asset requirements could be more stringent in years to come, making it more difficult to qualify for Medicaid benefits.

-Partnership participation does not ensure that asset protection will be available if the participant moves to another state that does not have a partnership program or does not have a reciprocity agreement with the original state. Furthermore, reciprocity between states for partnership protection of assets does not ensure that the requirements for Medicaid eligibility will be the same in each state.

Summary
The long-term care partnership model presents insurance citizens with a means of preparing for their long-term care needs while still having the assurance that Medicaid will be there for them if necessary. The risk of impoverishment is significantly reduced for partnership policy holders; because they can trust that their assets will not be totally depleted before Medicaid assistance is available. Any state may implement a partnership program. Insurers must follow state and federal guidelines to sell partnership policies.

Chapter 5 Program History

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

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

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

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

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

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

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

The situation is not expected to improve unless the general population accepts their responsibility by purchasing insurance or providing some financial avenue to pay for long-term care needs. Concern about the financing of long-term care is based on set predictions: the population of chronically ill elderly will inevitably increase with the population of those older than age 80 and with medical advances that enable those with chronic diseases to survive longer. According to a study published by the New England Journal of Medicine, 43 percent of all Americans will enter a nursing home at some time before they die. Of these, 55 percent will stay at least one year and 21 percent will stay at least 5 years. The average stay will last two and a half years. Medicare will pay less than 9.4 percent of the long-term care costs since that program was never designed to cover care in a nursing home beyond a very short period of time.

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

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

-Delaying the moment at which patients qualify for Medicaid could avoid financial disaster for the patient and their families.

-Preventing financial spend-down, and subsequent qualification for Medicaid benefits, would save public funds.

-Elderly consumers would benefit if risk pooling could be implemented by state legislatures specifically designed to provide a safety net for medically uninsurable people.

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

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

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

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

-Avoiding impoverishment for elderly individuals by guaranteeing some measure of asset protection.

-Providing access to quality long-term care that is appropriate for the individual's medical situation.

-Providing coverage for a full range of home and community-based services.

-Development of a case management infrastructure in which the gatekeeper bears some financial risk in order to prevent excessive or inappropriate utilization (they did not want family members to be able to use this program inappropriately for their ill or frail member).

-Assurance of equity and affordability in the long-term-care-insurance program for lower-income individuals.

Partnership Policy Creation

The national program office is located at the University of Maryland Center on Aging. Their primary responsibilities were to provide leadership and technical assistance for grantee institutions during the planning and implementation stages. They would also offer information to other states that were interested in replicating the public-private partnership programs, or even pursue

alternative programs that might appropriately address the situation. Additionally, they wanted to develop and implement some type of media relations strategy that would increase policy sales. Obviously, if consumers did not buy the partnership policies, they would not solve the problem.

The planning phase of Partnership long-term care policies was authorized in 1987 with funding of $3.2 million. The national program office contacted states that had demonstrated a commitment to reforming long-term care financing. Grants were awarded to California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin. These eight states collected and analyzed data from nursing homes, the elderly population, state Medicaid files, and insurers to help them design and price their products and to assess products' impact on costs.

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

Partnership facts:

-The average age of early Partnership respondents was 58 or 59 years old (depending upon the state).

-Respondents listed their health as primarily excellent.

-The average age of Partnership policyholders ranged from 58 to 63, depending upon the state. California, for example, reported an average age of 60.

-Women purchased more Partnership policies than men.

-The majority of Partnership policy owners were married.

-For most, this was the first time they had bought a long-term care policy of any type.

-In California, Connecticut, and Indiana the majority of policy holders had income greater than $5,000 per month and total non-housing assets of more than $350,000.

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

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

State Amendments and Waivers

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

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

-Federal legislation: a federal legislative waiver is essentially a congressional mandate that gets written into public law.

-Administrative approval: Health Care Financing Administration (HCFA) of the U.S. Department of Health & Human Services administers Medicaid and can grant an administrative waiver of Medicaid requirements. Administrative waivers come in three types:

-Freedom-of-choice waivers
-Home- and community-based-services waivers
-Research waivers, which are typically used to test innovative ideas on a portion of those eligible for Medicaid

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

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

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

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

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

-The standards implicit in the waiver request were too lenient

-Private insurers needed to improve consumer protections substantially before playing a major role in public-private partnerships

-Medicaid dollars should go to help only the poor and nearly-poor rather than those with enough assets to purchase long-term care policies

-The direct link between the public and private sectors should be made only with great caution, since direct links might imply extensive public responsibility to ensure the fairness, viability, and quality of the private insurance product

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

-Insurance regulations governing partnerships in several of the states had to be modified to reflect the Medicaid state plan amendments

-State legislatures usually had to approve the regulation changes and then HCFA had to approve the state plan amendments

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

Due to the delays caused by the Medicaid state plan amendment process and HCFA's separate process needed to approve them, the Robert Wood Johnson Foundation (RWJF) awarded implementation grants to the states one at a time, from August 1987 through December 1988. Normally the national program procedure is to authorize all project sites at once.

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

California, Connecticut, and Indiana based their Partnership plans on a dollar-for-dollar model, although Indiana changed its model in 1998. Under the dollar-for-dollar model, for each dollar of long-term care coverage purchased by the insured from a private insurance carrier participating in the partnership, a dollar of assets was protected from the spend-down requirements for Medicaid eligibility. Therefore, if Joe buys a policy that provides $50,000 in benefits, he is protecting the

same amount ($50,000) of his personal assets from the spend-down requirement. Partnerships do not protect Joe's income, just the assets he has acquired.

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

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

Whatever non-housing assets the insured has, he or she will be allowed to keep an amount of assets equal to the amount of long-term care coverage that was purchased through the Partnership program (plus the $2,000 in assets that everyone is allowed to keep). Any income, including Social Security income, pension income, or any non-housing income that is received must be contributed to the policyholder's medical care expenses.

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

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

States participating in Partnership plans all conducted extensive promotional and educational campaigns designed to inform the public about the availability of these insurance policies with the goal of increasing sales (which would ultimately relieve the state of some portion of their Medicaid expenditures). RWJF contributed to some of the promotional campaigns by providing contracts with public relation firms. Participating states collected and analyzed sales and marketing data and used the information to evaluate the Partnership programs, making any changes they felt necessary.

Informal versus Formal Care

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

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

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

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

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

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

New Federal Legislation: The Deficit Reduction Act of 2005

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

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

Questions that Remained Unanswered

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

Health Insurance Portability and Accountability Act (HIPAA)

The federal government has recognized the urgency for long-term care insurance. Although funding the cost of institutionalization can be achieved through other means besides long-term care insurance, it is the most logical avenue for most people. As a result of this recognition, in 1996, the U.S. Congress enacted the Health Insurance Portability and Accountability Act, generally referred to as HIPAA. It may also be known as the Kennedy-Kassebaum Bill. President Bill Clinton signed this act into law in August of 1996. It may also be referred to as Public Law 104-191. The entire law is very complex, but for our purposes only the long-term care portion will be relevant.

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

-Classification of long-term care costs as a medical expense thus providing taxpayers some economic relief, but only if they met specific criteria, including the type of policy they purchased.

-Categorized long-term care insurance as accident & health insurance thereby providing clarity as to the tax treatment of premium and benefits.

-Provided the general public with an incentive to purchase this type of product.

Specifically, the IRS defines "qualified long-term care services" as necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.

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

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

-The insured is unable, for at least 90 days, to perform at least two activities of daily living, called ADLs, without substantial assistance from another individual, due to the loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence.

-The insured requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

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

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

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

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

the policy has been met.

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

OBRA 1993 Provisions and the Partnership for Long-Term Care
The Omnibus Reconciliation Act of 1993 contained language with direct impact on the expansion of Partnerships for long-term care. The Act recognized the initial four states operating Partnership programs as well as the future program in Iowa and the modified program in Massachusetts. These six states were allowed to operate their Partnership programs as planned since their state plan amendments were approved by HHS prior to May 14, 1993.

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

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

Sec 1917(b) paragraph 3
This section prevents any state from waiving the estate recovery requirement for Partnership participants even if they want to in order to promote Partnership plan sales.

Sec 1917(b) paragraph 4 subparagraph B
A specific definition of "estate" was necessary for Partnership participants. Estates:

> -shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law
>
> -any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other assignment.

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

Promoting Partnership Long-Term Care Plans

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

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

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

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

Program Growth

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

There were two different models used for asset protection: dollar-for dollar and asset protection. California, Indiana and Connecticut chose the dollar-for-dollar model. Under dollar-for-dollar, the amount of insurance coverage purchased equals the amount of assets protected from consideration if and when the consumer needs to apply for Medicaid benefits. For example, a

consumer who bought a policy with $100,000 in benefits would receive up to $100,000 worth of qualified long-term care insurance benefits. Once the insurance benefits were exhausted, if further care was necessary, the individual would be able to apply for Medicaid coverage, while still retaining $100,000 worth of assets.

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

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

Partnership Participation

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

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

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

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

Public Education

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

LTC insurance, then state savings will not be realized.

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

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

DRA Requirements

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

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

-The secretary of Health and Human Services (HHS) is required to establish a National Clearinghouse for Long-Term Care Information that will educate consumers about the need for long-term care and the costs associated with these services. HHS will provide objective information to help consumers plan for the future. The website www.longtermcare.gov was established to aid in consumer education.

-Partnership programs must include specific consumer protection requirements of the 2000 National Association of Insurance Commissioners (NAIC) LTC Insurance Model Act and Regulation. If the NAIC changes the specified requirements, the HHS secretary has 12 months to determine whether state Partnership programs must incorporate the changes as well.

-State insurance departments are responsible for ensuring that individuals who sell Partnership policies (insurance agents) are adequately trained and can demonstrate understanding of how such policies relate to other public and private options for long-term-care coverage.

Education for both consumers and insurance agents are closely aligned. Insurance agents play a

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

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

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

Unfair Claim Practices Defined Under the NAIC

NAIC unfair acts:

-Knowingly misrepresenting to claimants or insureds relevant facts or policy provisions that relate to the coverages at issue

-Failing to acknowledge with reasonable promptness the receipt of communications that are pertinent to claims

-Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims

-Not attempting in good faith to settle claims promptly, fairly, and equitably when it is reasonably clear the insurer is liable to pay such claims

-Compelling claimants to institute lawsuits to recover amounts due under policies by offering substantially less than the amounts that claimants ultimately recovered in lawsuits

-Refusing to pay claims without conducting a reasonable investigation of those claims

-Failing to affirm or deny coverage of claims within a reasonable time after completion of the claim investigation

-Settling or attempting to settle claims for less than the amount that a reasonable person would believe the claimant was entitled to receive according to the terms of advertising material that accompanied or was part of an application

-Settling or attempting to settle claims based on an application that was materially altered without notice to, or the knowledge or consent of, the policyowner

-Making claim payments without indicating the coverage under which each payment is being made

-Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form

-In the case of claim denials or offers of compromise settlement, failing to promptly provide a reasonable, accurate explanation of the reason for such actions

-Failing to provide forms necessary to present claims within 15 calendar days of a request for such forms

Unfair Claim Distributions

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

-Attempting to settle a claim based on an application which the company has changed without the insured's knowledge or permission;

-Delaying a claim investigation by requiring unnecessary reports or documents;

-Failing to act promptly after receiving information concerning an insurance claim;

-Failing to comply with prompt claims investigation standards;

-When applicable, failing to pay a claim quickly, fairly and equitably;

-Failing to promptly settle claims where liability is reasonably clear under one portion of the policy to influence settlement under any other portion of the insurance policy coverage;

-Failing to promptly and clearly explain the basis in the policy or the law for either denying a claim or offering a compromise settlement;

-Discouraging a policyholder from using arbitration;

-Misrepresenting significant facts or insurance policy provisions;

-Refusing to keep an insured informed of claim developments within a reasonable time after receiving a completed proof of loss statement;

-Denying claims without a reasonable loss investigation;

-Offering very low settlements to encourage insureds to sue; and

-Settling claims for amounts that are lower than a reasonable person would expect.

Policy Benefits are Chosen at the time of Application

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

Mandatory Protection in Partnership LTC Policies

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

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

FPO and ABI

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

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

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

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

Suitability Form Requirements:

Long-Term Care Insurance Personal Worksheet:

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

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

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

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

Reciprocity between States
In 2001 Indiana and Connecticut implemented a reciprocity agreement between them allowing Partnership beneficiaries who have purchased a policy in one state (but move to the other) to receive asset protection if they qualify for Medicaid in their new locale. Prior to this agreement asset protection did not transfer outside of the state where the policy was purchased, although the Partnership insurance benefits were portable. The asset protection specified in the agreement are limited to dollar-for-dollar, so Indiana residents who purchase total asset protection policies would only receive protection for the amount of LTC services their policy covered if they moved to Connecticut.

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

State Funding

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

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

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

Chapter 6 Partnership Program Requirements

Requirements for LTC Partnership Policies

Federal law authorizes state insurance commissioners, upon implementing a qualified state long-term care insurance partnership program, to certify that its associated policies meet certain standards and requirements. These standards and requirements are set forth in the partnership provisions of DRA 2005 as well as specific provisions of the Long-Term Care Insurance Model Act and Regulations promulgated by the NAIC. To be an LTC partnership state and offer partnership benefits to its citizens, a state must adopt certain provisions of the NAIC model. The focus of this unit is on the requirements for policies that are used in conjunction with state partnership programs.

A qualified long-term care partnership policy is one that is approved for use in conjunction with a state's partnership program. The amount of benefits paid under a partnership policy will provide an equivalent asset disregard in the event the policy holder turns to and qualifies for Medicaid payment for long-term care services and will protect those assets from recovery by the state upon the participant's death.

The insurance benefits upon which a disregard may be based include benefits paid as direct reimbursement of LTC expenses as well as indemnity benefits paid on a per diem or other periodic basis. In most states, benefits available under a partnership policy do not have to be fully exhausted before the disregard of resources can be applied; Medicaid eligibility may be determined by applying the disregard based on the amount of policy benefits paid as of the month

of application, even if additional benefits remain available under the policy. The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination.

DRA 2005 set forth minimum standards that must be met for an LTC policy to qualify for use in a state partnership program. Among these requirements are:

-The policy holder must be a resident of the partnership state when the policy is issued, and the policy must be issued after the state's partnership program goes into effect.

-The policy must meet the definition of a tax-qualified LTCI policy found in section 7702B of the Internal Revenue Code.

-The policy must meet specific requirements of the NAIC's Long-Term Care Insurance Model Regulations and Model Act.

-The policy must include some measure of inflation protection for purchasers younger than 76 and the offer to purchase inflation protection for those who are 76 and older.

-Issuers of partnership policies must conform to certain reporting requirements and must make this information available to the agency that administers the state's partnership program. Such reports include notice of when benefits are paid under such policies, the amount of those benefits, and notice of termination of the policy. Insurers must also report on the activities of their producers who sell these policies.

-The state may not impose any requirement affecting the terms or benefits of a partnership policy unless it imposes the same requirements on all LTC insurance policies.

Tax-Qualified LTC Policies

Long-term care partnership policies must be tax-qualified policies as set forth in IRC Section 7702B(b). As has been discussed, the defining aspects of tax-qualified policies include these:

-The policy provides coverage only for qualified LTC services.
-The policy's benefits are triggered when the policy holder is diagnosed as chronically ill and:
- is unable to perform without substantial assistance at least two activities of daily living for at least 90 days or
-requires substantial assistance due to severe cognitive impairment.

A tax-qualified policy—and by extension, a partnership policy—must define activities of daily living as eating, toileting, transferring, bathing, dressing, and continence and must include at least five of these ADLs in the contract's language. Premiums paid for a qualified LTC policy are eligible for the medical expense tax deduction (subject to dollar amount limits that increase with the age of the individual), and benefits are not taxable.

NAIC LTC Model Act and Regulations

In addition to requiring that only tax-qualified policies may be used in a partnership program, the DRA also specified that policies must meet certain provisions of the NAIC Long-Term Care Model Act and Regulations. The act and regulations present a basic scheme of policy provisions and market conduct standards that encourage uniform development of state regulations governing long-term care insurance. Yet provisions can be flexible enough to accommodate a state's special requirements.

The Long-Term Care Insurance Model Act and Regulations has many goals:

-to promote the public interest.
-to promote the availability of long-term care insurance coverage.
-to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices.
-to facilitate public understanding and comparison of long-term care insurance coverages.
-to facilitate flexibility and innovation in the development of long-term care insurance.

The NAIC model was first set forth in the 1980s and has undergone several revisions since, a practice that will likely continue. DRA requires that states enacting partnership programs must adopt certain provisions of this model or those that are more stringent (i.e., more favorable to the policy holder). It also specifies that any future changes to the model must be reviewed at the federal level to determine whether they would improve partnership programs.

The balance of this lesson reviews the key provisions in the NAIC model and the requirements for partnership policies. Keep in mind that in most states, these requirements are likely to apply to both partnership policies and non-partnership policies, because any requirements that a state places on partnership policies must also be imposed on non-partnership policies. The scope of the NAIC model is actually aimed at all long-term care policies, not just partnership policies. A state may adopt the NAIC model without having a partnership program in place.

Minimum Standards for LTC Partnership Insurance Policies

Minimum Coverage Standards

All qualified LTC partnership policies must provide coverage for LTC services in a licensed care facility, such as a nursing home. They are not required to provide coverage for home and community-based care; however, they may (and many do). If a policy does provide coverage for home and community-based care, these benefits must be equal to no less than one-half of one year's coverage of the policy's nursing facility benefit.

For example, suppose that a policy holder owns a qualified LTC policy that provides a daily nursing facility benefit as well as coverage for home and community-based care. The nursing facility benefit is $150 a day. In this case, the policy's total home and community care benefit must be at least equal to $27,375:

($150 x 365) x .50 = $27,375

If coverage for care in the home or in a community-based setting is included under the policy, the insurer cannot limit the benefit by specifying that the policy holder must need care in a skilled nursing facility if home health care services were not provided, nor can the insurer require that only registered nurses or Medicare-certified agencies deliver the care. Adult day care services must be included in policies that cover home and community care.

Compared to other long-term care policies, partnership policies are generally issued with limited lifetime maximums ($100,000 to $250,000 is typical). This helps keep partnership policies affordable for the market they are intended to serve, which in turn supports a key objective of partnership programs.

Benefit Triggers

The benefit triggers under a partnership policy—needing help with at least two activities of daily living and cognitive impairment—must be described in the policy and labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers must also be explained here. If the policy requires that an attending physician or other person certify a certain level of functional dependency for the policy holder to be eligible for benefits, this too must be specified.

Basis for Policy Renewability

At a minimum, long-term care partnership policies must be issued as guaranteed renewable; they may be issued as non-cancelable. "Guaranteed renewable" means that the policy cannot be cancelled or altered by the insurance company as long as the policy holder continues to pay premiums on time. Guaranteed renewable policies also provide that premiums will not be increased on an individual basis. Thus, the policy holder may continue the policy regardless of advancing age or declining health conditions, and premium rates may only be raised on a class basis—that is, for a given class or group of policy holders—and only after the issuing insurer has received approval for the premium increase from the state's insurance commissioner.

Policies and certificates that are guaranteed renewable must contain the following statement:

RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

Guaranteed renewable policies must state clearly the conditions under which the company has a right to change the premium and the policy owner's options in the event of a premium increase.

The term non-cancelable may be used only when the policy holder has the right to continue the long-term care insurance in force by the timely payment of premiums, during which time the insurer cannot unilaterally make any change in any policy provision or in the premium rate. Policies and certificates that are non-cancelable must contain the following statement:

RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your

premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

Only non-cancelable policies may use the term "level premium." The policy must also describe any waiver of premium provisions or state that there are no such provisions.

Policy Limitations and Exclusions

With some exceptions, a qualified partnership policy cannot limit or exclude coverage by type of illness, treatment, medical condition, or accident. The conditions that may be excluded are:

-pre-existing conditions or diseases.
-mental or nervous disorders (except Alzheimer's disease, which cannot be excluded).
-alcoholism and drug addiction.
-illness, treatment, or medical condition arising out of
    -war or act of war, declared or undeclared
    -participation in a felony, riot, or insurrection
    -service in the armed forces or auxiliary units
    -suicide, attempted suicide, or intentionally self-inflicted injury
    -aviation relating only to non-fare-paying passengers
-treatment provided in a government facility or services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, or any motor vehicle no fault law
-services provided by a family member or those for which no charge is normally made in the absence of insurance
-expenses for services available or paid under another long-term care insurance or health insurance policy

Extension of Benefits

The policy must include a provision that continues benefit payments in the event the policy lapses after the policy holder begins to receive care in a nursing facility and benefit payments have begun.

Most policies today include a waiver of premium provision that basically accomplishes the same thing. A premium waiver permits the policy holder to stop making premium payments when coverage applies for benefits in a skilled nursing facility. No further premiums will be due until the policy holder leaves the SNF. The typical waiver of premium takes effect after benefits have been paid for 90 consecutive days in an SNF.

Offer of a Non-forfeiture Benefit

Under the NAIC model, partnership policies must offer citizens the option to purchase a non-forfeiture benefit. They must also provide some form of contingent benefit upon lapse if the non-forfeiture benefit offer is rejected.

As explained in Unit 4, a non-forfeiture provision in a long-term care policy provides for some level of benefit if the policy lapses or is cancelled. It usually takes the form of a return of premium (which returns to the policy owner a percentage of the sum of premiums paid at the time of cancellation) or a shortened benefit period (which extends coverage for a certain period following the policy lapse or cancellation). Insurers may offer the choice of both or one or the other. If elected, a non-forfeiture option will increase a policy's premium.

If a policy owner chooses not to purchase a non-forfeiture benefit, the policy must provide for a contingent non-forfeiture benefit, which applies in the event that premiums are increased beyond a specified level and the policy owner decides not to pay the higher premium and the policy lapses. This benefit does not require the payment of an additional premium.

The contingent benefit may take one of two forms:

-the offer to reduce benefits provided by the current coverage so that the required premium payment is not increased

the offer to convert the coverage to a paid-up status with a shortened benefit period. (This is the default option if the policyowner makes no election.)

The contingent benefit upon lapse takes effect when a policy's premium increases to a level that equals or exceeds a certain percentage of the initial premium, and the policy lapses within 120 days of the increased premium's due date. The following chart is a partial illustration of how this provision works. If a premium increase is equal to or greater than the percentage shown, the contingent benefit would apply if the owner chooses to discontinue his or her coverage.

Protection against Unintentional Lapse

Lapse protection must be included in partnership policies, giving the policy holder the opportunity to reinstate the policy without underwriting or premium increases in the event he or she unintentionally fails to make a premium payment. Lapse protection may be accomplished in one of two ways: an impairment reinstatement provision or a third-party notification provision.

An impairment reinstatement provision requires that the policy be reinstated if the policy holder provides proof that he or she was cognitively impaired or had a loss of functional capacity before the policy's grace period expired. This proof must be provided and outstanding premiums paid within a specified period, such as five or six months.

A third-party notification provision requires the insurer to send notification to a designated third party, such as a family member or an attorney, that the policy is about to lapse. The applicant has the right to designate at least one person who is to receive the notice of termination in addition to the policy holder. The intent is to allow the third party to intervene and help ensure that the premium is paid and the policy continues in force. The period for the payment of any past due premium is extended beyond a certain time past the grace period. In the event an applicant elects not to designate a third party for this purpose, a waiver of the election must be signed and submitted with the application.

Incontestability Clause
Under the NAIC's model, an insurer has only limited rights with respect to denying a claim or rescinding an LTC policy. An insurer may rescind an LTCI policy or deny an otherwise valid LTCI claim only upon showing misrepresentation that is material to the acceptance for coverage.

-If the policy has been in effect six months or less, the insurer need only show that the applicant misrepresented a fact that was material to the coverage's approval.

-If the policy has been in effect at least six months but less than two years, the insurer must show a misrepresentation that was both material to the policy being issued and is related to the medical condition creating the need for LTC.

-If the policy has been in effect for two years or more, the insurer has the difficult task of proving that the policy holder knowingly and willfully misrepresented material facts related to his or her health.

Inflation Protection
Inflation protection is recognized as a vital feature for long-term care policies. It is considered so important, in fact, that the DRA itself not only specifies that partnership policies must contain such a feature but also defines the provisions. LTC partnership policies must contain a level of inflation protection that is based on the age of the policy holder when the policy is issued.

under age 61—Compound annual inflation protection must be provided, and each state determines the rate it will use. (Commonly used rates are 3 and 5 percent.)

age 61 to age 76—Some level of annual protection must be provided; however, the protection need not be automatic and may be in a form other than compound interest (such as simple interest increases or guaranteed purchase options).

age 76 and older—The policy does not have to provide for inflation protection, but the buyer must be given an option to purchase it. The buyer may accept or decline the option.

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.

Chapter 8 Policy Considerations

What is a Traditional Long-Term Care Policy?

Since long-term care benefits cover multiple types of care, a long-term care policy might cover home care, assisted living, community-based services, adult day care (both medical and non-medical), or a nursing home. As time goes by, other forms of care may be developed. With these

various services in mind, a long-term care policy is a contract that provides benefits for an extended period of time in some location other than a hospital. The exact benefits will vary, but each contract will have a policy schedule that states precisely what is covered. It will include the elimination period, the maximum daily benefit for home and adult day care, the maximum nursing home benefit and the maximum lifetime benefit. Even life insurance policies may have a nursing home benefit provision.

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

Policy Issue

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

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

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

Comprehensive and Non-Comprehensive Options

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

Medicare Benefits

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

It should be noted that even if a person continues to work past Medicare's qualifying age of 65, he

or she can still apply for and receive Medicare benefits. In many cases, if the employer supplies medical coverage, Medicare will become the secondary payer.

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

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

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

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

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

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

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

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

Medicare Part A (Hospital Insurance)

Part A helps to pay for:

- -Inpatient care in hospitals
- -Inpatient skilled nursing facility care (never custodial or intermediate care)
- -Hospice care

-Home health care
-Blood
-Inpatient care in a religious nonmedical health care institution

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

Medicare will pay the hospital costs in the following manner:

-Semiprivate room and board (meals).

-General nursing and miscellaneous services and supplies.

-Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

-The first 60 days of confinement EXCEPT for the deductible. The deductible amount can change each January first.

-From the 61st day through the 90th day EXCEPT for the co-payment which must be covered by either the patient or their insurance company. Again, the amount of the co-payment can change each year, beginning on January first.

-From the 91st day and after:

-While using 60 lifetime reserve days. There is a co-payment that would not be covered by Medicare. The patient or their Medigap policy would cover this co-payment.

-Once lifetime reserve days are used, an additional 365 days will be covered by the Medigap insurance policy if there is one in place.

-Beyond the additional 365 days, there are no more hospital benefits under Medicare.

Skilled Nursing Care Covered Under Medicare

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

The Medicare beneficiary, upon entering the nursing home, will receive benefits for only skilled

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

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

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

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

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

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

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

Home Health Care

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

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

Medicare Part B (Medical Insurance)
Medicare Part B helps to cover:

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

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

There are now many preventive services available. Such as:

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

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

Medicare also covers comprehensive programs that include exercise, education and counseling for patients who meet specific conditions. They cover intensive cardiac rehabilitation programs that are usually more rigorous than regular cardiac rehabilitation programs. Services are covered in the doctor's office or hospital outpatient setting. There will be a 20 percent copayment and of course the service must meet Medicare's guidelines. Cardiovascular disease behavioral therapy with the beneficiary's primary doctor is a covered service too so that the beneficiary can have his or her blood pressure checked as well as discussions regarding aspirin therapy or other means of controlling symptoms.

There is limited coverage for chiropractic services to help correct subluxation using manipulation

of the spine. There will be a 20 percent copayment and again it must meet Medicare's guidelines for them to make a payment.

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

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

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

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

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

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

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

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

B Medicare benefits must specifically reject them by following the instructions that come with the Medicare card. Otherwise, enrollment will be automatic.

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Plans

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

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

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

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

Protecting Assets

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

Protecting one's assets is a valid concern. Many elderly people do eventually qualify for Medicaid, but only after they have depleted most of their personal non-housing resources. Medicaid is the joint federal-state program that pays for health care costs for needy low-income residents of all ages (not just the elderly). Benefits are typically available to the poor, to certain disabled citizens, and to persons over the age of 65 who meet the economic means test. To meet this economic means test, the person must be impoverished. Some items are exempt while still allowing qualification. One asset that would be exempt is the person's personal home, in which they have been residing. Also exempt are some personal items, one vehicle for transportation, and in a few cases, specific types of annuities. Income producing property may be exempt as long as the income goes towards the person's care. Since each state controls some aspects of Medicaid qualification, it is very important to understand your own state's guidelines. While each state pays approximately half of the cost (with the federal government paying the other half) the exact amount paid by the state varies depending on multiple factors. Each state also is allowed to administer many elements according to their own desires, as long as it does not clash with federal guidelines. As a result, what worked for Uncle Joe in California may not work for Aunt Mabel in New York.

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

Medicaid Benefits

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

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

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

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

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

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

The Patient Protection and Affordable Care Act

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

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

The Donut Hole

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

In General

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

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

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

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

State Requirements

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

Most states will have adopted tax-qualified LTC policies, so there will be two types available: tax qualified and non-tax qualified. In a few states, there will also be partnership policies available. Partnership policies are a special kind designed to allow enrollees to avoid impoverishment due to a nursing home confinement. They require special agent education to market them. They may not be marketed unless this education is completed.

Relying on Insurance for LTC Payment

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

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

Insurance Pricing

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

Premium Mode

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

Age as a Pricing Factor

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

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

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

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

A Younger Market Developing

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

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

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

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

Reducing Benefits to Save Premium

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

There are several ways that benefits may be reduced:

1.Reduce the length of benefit payments (from lifetime to 4 years, for example).

2.Reduce the daily benefit amount.

3.Discontinue some benefits, such as home health care options.

4.Convert from one policy form to another, if the state has provisions that allow this.

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

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

Guaranteed Renewable

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

Policy Review: 30-Day “Free Look”

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

them. The consumer need not say why they have changed their mind. The refund must be issued within 30 days of the consumer's notification to cancel the policy.

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

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

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

-Elimination period (deductible expressed as days not covered)
-Maximum daily home and adult day health care benefit
-Maximum daily nursing home facility benefit
-Maximum lifetime benefit
-Type of inflation benefit, if any.

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

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

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

Chapter 9 Long-Term Care Ethics

Long-Term Care Ethics
The concept of ethics and ethical sales practices applies to any insurance product, but it is especially important when the issue is long-term care. Ethical practices can be defined by laws and regulations in terms of required and prohibited activities, and they can be set forth in a company or professional association's code of conduct. However, perhaps the most compelling force that guides ethical conduct comes from the standards that individuals set for themselves as a reflection of their desire to do good. Insurance producers who serve the senior market and

represent late-life products such as long-term care insurance have the capacity to help citizens manage a very specific and very critical risk; however, they must act at all times in accordance with what is best for their prospects and clients.

Is Long-Term Care Insurance Right for Everyone?

Long-term care insurance presents a viable option to the risk of long-term care by ensuring that an individual retains control over where care is received and that funds will be available to cover the costs of care if and when it is needed. However, despite its many benefits, long-term care insurance is not right for everyone. Producers must consider carefully their clients' needs, objectives, and financial limitations when presenting these policies. Long-term care insurance is best for those who need the coverage and can afford the premium without sacrificing current standards of living.

Producers must keep in mind the long-term nature of LTCI and the ongoing premium commitment the product entails. Whereas an individual's income level may be adequate today, it could decline once he or she reaches retirement, or it may not keep pace with the cost of living over time. Clients must at all times be able to afford their premiums and still have a cushion for unexpected expenses or possible premium increases in the future.

Producers should also understand the significant role of Medicaid in meeting the long-term care need. The fact is Medicaid pays most LTC costs. People with low or moderately low incomes may not have much in the way of assets that need protection. They may already qualify for Medicaid LTC services. In addition, these people may not be able to afford LTCI premiums. For these reasons, long-term care insurance is probably not right for people with fixed or low incomes and may not be right for people with moderate incomes who could, without hardship to themselves or any dependents, spend down their assets to meet Medicaid eligibility.

At the other end of the spectrum are those who may not need an LTCI policy because they have significant assets and income and could afford to pay for a nursing home stay. Granted, assets would have to be considerable to meet the projected future costs of long-term care, but some fortunate people do fit into this category. Those with significant assets may be better off self-insuring or using a combination of funding strategies that includes self-insuring and private insurance.

Somewhere in the maze of people who are not appropriate candidates for LTCI is a viable market of those who need and can benefit from long-term care insurance. Generally speaking, these are individuals who:

-Have a fair amount of assets to protect
-Do not want (or cannot afford to) use savings or retirement income to pay for long-term care
-Are concerned about preserving assets for a spouse or heirs
-Have reason to believe they may require LTC because of a health factor or family history but who do not yet have a specific diagnosed condition that would later prevent them from obtaining insurance

-Want to retain control over how and where they will receive future care
-Prefer to spare their family the responsibility for care
-Have the financial resources to pay for the coverage without difficulty

Fortunately, producers have the benefit of specific standards and tools to guide their efforts when determining who is an appropriate candidate for long-term care insurance. These standards and tools are found in state laws and regulations, in company policy and procedure guidelines, and in the principles that define needs-based selling and suitable product placements.

Consumer Standards and Guidelines
The long-term care partnership provisions of the DRA cite certain consumer protection requirements of the NAIC LTC Model Act and Regulations that must be followed to market and sell partnership policies. As discussed in the previous unit, these include:

-establishing and implementing marketing procedures and producer training requirements to ensure that products are appropriately placed, policy comparisons are fair and accurate, and that excessive insurance is not sold or issued;

-providing copies of all required informational and disclosure documents to applicants, including shopper's guides and coverage outlines;

-reviewing and monitoring producer activity, including lapse and replacement rates;

-conforming to the prescribed language and format for outlines of coverage and policy forms, including a statement that informs the buyer that the policy may not cover all of the costs associated with long-term care during the period of coverage;

-making reasonable effort to identify whether prospective LTCI applicants already have accident and sickness or LTCI and the types and amounts of any such insurance; and

-establishing auditable procedures for verifying compliance with these rules.

In addition to these requirements—which many states impose on the sale of any long-term care insurance policy, regardless of whether it is used in conjunction with a partnership program—insurers and producers must comply with the provisions of a state's fair practices laws and regulations.

Unfair and Deceptive Trade Practices and Acts
Drafted in 1964, the Uniform Deceptive Trade Practices Act was designed to bring state law up to date by removing undue restrictions on common law action for deceptive trade practices. Every state has codified some form of consumer protection legislation modeled after the act. Although these statutes vary from state to state, they all target a common element—fraudulent and deceptive acts by businesses.

Most state deceptive trade practices statutes include broad restrictions of the terms "deceptive" or "unfair" trade practices. They often include prohibitions against fraudulent practices and unconscionable acts as well. Some examples of deceptive trade practices or acts are:

-disparaging the goods or services or business of another by a false or misleading representation of a material fact

-representing that consumer goods or services have a sponsorship, approval, use, or benefit that they do not have

-deception, fraud, false pretense, false premise, misrepresentation, or knowing concealment, suppression, or omission of any material fact with the intent that a consumer rely on it;

-the use of any plan or scheme in soliciting sales or services over the telephone that misrepresents the solicitor's true status or mission

-the use of a contract related to a consumer transaction containing a confessed judgment clause that waives the consumer's right to assert a legal defense to an action

To further citizen protection, states typically incorporate some form of deceptive trade practice legislation into their insurance codes. The prohibited acts just listed are insurance industry-specific and usually relate to the sale of policies and the payment of claims.

The NAIC's LTC model specifically addresses deceptive trade practices. In addition to the practices prohibited in a state's unfair trade practices act, the following acts and practices are also prohibited:

-**Twisting**
Twisting is knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policy or of any insurer to induce someone to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert a policy or to take out a policy with another insurer.

-**High-Pressure Tactics**
A high-pressure tactic is defined as using any method of marketing with the effect of inducing the purchase of insurance through force, fright, threat, or undue pressure. This applies whether the marketing method in question is explicit or merely implied.

-**Cold Lead Advertising**
Cold lead advertising is using, directly or indirectly, any method of marketing that fails to conspicuously disclose that a purpose of the marketing is to solicit insurance and that contact will be made by an insurance producer or insurance company.

-**Misrepresentation**
Misrepresentation involves misrepresenting a material fact in selling or offering to sell a long-term

care insurance policy. A material fact is a fact that would be important to a reasonable person in deciding whether to engage in a particular transaction. It is an important fact as distinguished from a trivial one.

Suitability

In the context of long-term care and long-term care insurance, the term "suitability" refers to the determination of whether a policy is appropriate for a particular consumer. As noted at the beginning of this unit, LTC insurance is not right for everyone. Some questions to be answered when determining suitability include:

-Does the policy address the applicant's need for LTC services?

-Does the recommendation to purchase a policy take into account the applicant's ability to pay?

-Does the recommended policy provide adequate, but not excessive, coverage?

-Does the applicant fully understand the policy offered and its benefit provisions?

-If the policy is a partnership policy, is the recommended amount of coverage in line with the value of the assets the applicant wants to protect—neither too much nor too little?

-What other resources may be available to the applicant that would cover his or her need for long-term care?

NAIC Suitability Standards

To promote suitable recommendations and sales of long-term care policies, the NAIC model imposes certain requirements on insurers. According to the model, all insurers marketing LTC policies must:

-develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

-train its agents in applying its suitability standards; and

-maintain a copy of its suitability standards and make them available for inspection upon request by the state's insurance commissioner.

To determine whether an applicant meets the standards developed by the issuer, the procedures must address the following:

-the applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage, such as the applicant's current income, any expected changes to income, and the amount of assets at risk;

-the applicant's goals or needs with respect to long-term care, such as to remain independent as long as possible, to preserve assets for heirs or charities, to have more control over the LTC services delivered, and the advantages and disadvantages of using insurance to meet these objectives; and

-the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

Determining suitability for LTCI should also consider the applicant's age and the appropriateness of inflation protection, the local cost of services, and diagnosed medical conditions, if any.

Personal Worksheet

Insurers and producers must make "reasonable efforts" to obtain the information necessary for a suitability analysis. Certainly, such efforts should be based on the principles prescribed by a needs-based sales model, where the focus is on determining the client's needs, goals, and objectives in light of his or her financial resources. Needs-based selling includes a thorough discovery or "fact-find" and an analysis of the information revealed in the fact-find. Then, only if a need is determined that can be met by an insurance policy, may a product recommendation be made. In this way, needs-based selling is distinct from product-based selling, which focuses on a product's features and benefits.

Supporting the principles of needs-based selling is the NAIC's model, which stipulates that "reasonable efforts" to information-gathering include having all potential LTCI buyers complete a "Long-Term Care Insurance Personal Worksheet" before application. The worksheet assists the insurer in assessing the suitability of a proposed policy and issuing long-term care insurance only to those who need the coverage and who can afford it. (A sample personal worksheet developed by the NAIC for this purpose is included at the end of the printable version of the course curriculum. Insurers may adopt this sample or develop a similar version of their own.)

The completed personal worksheet must be returned to the issuer and must be reviewed by the insurer before a policy is issued. (The worksheet does not have to be returned for sales of employer group LTCI to employees and their spouses.) The sale or dissemination outside the company of information obtained through the personal worksheet is prohibited.

Suitability Letter

Upon receipt of a worksheet in conjunction with an LTCI application, the insurer will assess the information in light of its established suitability standards to determine whether issuing a long-term care policy to the applicant is appropriate and can be supported by the facts and data. If the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the information, the issuer may reject the application.

Alternatively, the issuer may send the applicant a suitability letter. A suitability letter is sent if a review of the facts suggests that the policy being applied for is not suited for the applicant's needs or goals. It also explains the insurer's finding. It reads, in part, as follows:

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

The suitability letter includes a section for the insurer to briefly explain the reason for its determination and provides the applicant the choice of checking "yes" or "no" to proceed with the underwriting process. (A sample suitability letter, developed by the NAIC, is included at the end of the printable version of the course curriculum.)

If the applicant declines to provide financial information, the issuer may use some other method to verify the applicant's intent for purchasing LTC insurance. Either the suitability letter, signed and returned by the applicant, or a record of the alternative method of verification must be made part of the applicant's file.

Suitability Reporting Requirements
Insurers must report annually to their states' commissioners the following:

-the total number of long-term care applications received from residents of their states;
-the number of those who declined to provide information on the personal worksheet;
-the number of applicants who did not meet the suitability standards; and
-the number of those who chose to confirm their intent to purchase LTCI after receiving a suitability letter.

Policy Replacement
A problem that has surfaced with the growth of the LTCI industry is replacements. In many cases, new policies that are recommended and purchased are not significantly different from the coverage they replace. Unfortunately, some producers are encouraged to recommend inappropriate replacements, because commissions paid during the first year of a policy are often much higher than the commission for renewal years. Another factor motivating replacements by less-than-ethical producers is the fact that LTCI premiums are based on the purchaser's age at the time the policy is issued, and a buyer who replaces an older policy with a similar new policy will pay more for the same or similar benefits because of his or her current age. Thus, the producer's commission will be higher.

Industry regulators recognize that long-term care insurance is in an evolutionary stage. Product designs need to change to be responsive to the needs of citizens. For example, newer LTCI policies may have more favorable provisions than older policies or provide coverage for expanded care options. Also, newer policies generally do not require prior hospital stays or certain levels of care before benefits begin. Because long-term care insurance and long-term care insurance regulations are continually changing, it is important to keep in mind that not all replacements are improper. Replacement does serve a purpose when it is in the best interest of the citizen. The defining element is the consumer's interest—not that of the producer or company.

Nearly all states have adopted rules to discourage unjustified replacement of existing policies. Insurers or producers must identify applicants who are replacing an existing policy and notify the applicant of the implications of buying replacement coverage. LTCI application forms include questions designed to elicit information as to whether, as of the date of the application, the applicant has other long-term care insurance coverage in force or whether the policy applied for is intended to replace any other accident and sickness or LTCI policy presently in force. A supplementary application or other form to be signed by the applicant and the producer containing the questions may be used.

The questions designed to solicit this information are as follows:

-Do you have another long-term care insurance policy or certificate in force, including a health care service contract or a health maintenance organization contract?

-Did you have another long-term care insurance policy or certificate in force during the last 12 months?

-If so, with which company?

-What is the expiration or paid-to-date of that policy?

-If that policy lapsed, when did it lapse?

-Are you covered by Medicaid?

-Do you intend to replace any of your medical or health insurance coverage with this policy or certificate?

If the applicant chooses to move forward with the replacement, the existing insurer must be notified. In all cases, producers should counsel their clients to make sure that the replacing insurer accepts the application and issues the new policy before the original policy is cancelled.

The Producer's Role

The realities of today's market and the growing need for long-term care offer the insurance producer many opportunities. As more and more consumers recognize long-term care as a true risk, producers are well positioned to expand and enhance the real "product" they represent: financial security. Those who educate and prepare themselves to provide sound, objective, and informed advice on the need for long-term care and the options that are available to meet this need will find that they can, at once, deliver a valuable consumer service, further client trust, and build new client relationships

Summary

Ethical standards are found in statutory regulations, professional codes of ethics, company policies, and personal behavior. Producers with the highest standards will call upon all of these for

guidance when selling long-term care insurance. Long-term care insurance is not right for everyone, so producers must carefully consider client needs, objectives, and ability to pay when recommending policies. The NAIC's standards and guidelines set forth many consumer protection requirements aimed at saving insurance buyers from harm in the way of unfair or deceptive trade practices and acts. Following these guidelines and the NAIC's suitability measures will help producers achieve high standards of ethical fitness.

Chapter 10 Policy Definitions

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

The exact listing of the page heading may vary, but probably it will state "definitions" somewhere.

Whatever the page heading, it will state exactly what the policy terms mean or give the page number in the policy where the definition is listed.

The following is a list of commonly used definitions:

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

-Eating
-Dressing
-Bathing
-Toileting & associated functions
-Transferring to and from beds, wheelchairs, or chairs.

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

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

-Provides 24 hour a day care and services sufficient to support needs resulting from the inability to perform Activities of Daily Living or cognitive impairment;

-Has a trained and ready to respond employee on duty at all times to provide that care

-Provides 3 meals a day and accommodates special dietary needs

-Licensed or accredited by the appropriate agency, where required, to provide such care

-Provides formal arrangements for the services of a physician or nurse to furnish medical care in case of emergency

-Provides appropriate methods and procedures for handling and administering drugs and biologicals.

Many types of facilities would meet these criteria.

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

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

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

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

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

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

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

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

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

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

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

Long-Term Care Facility
A long-term care facility is a place which:

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

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

Maximum Lifetime Benefit
The maximum lifetime benefit is the total amount the insurance company will pay during the

insured's lifetime for all benefits covered by the policy. This will be shown on the Policy Schedule page.

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

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

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

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

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

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

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

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

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

30 days are not covered. Benefits begin to be payable on the 31st day for covered services. Of course, eligibility must also be established before benefits would be received.

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

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

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

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

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

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

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

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

Home and Community Based Benefits

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

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

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

Bed Reservation Benefit

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

The bed reservation benefit is for a temporary hospitalization. It would not continue indefinitely. Commonly, bed reservation benefits are limited to 21 days per calendar year. Unused days from one year can seldom be carried over into the next calendar year. It may be possible, however, to use bed reservation days to satisfy the elimination period in the policy. Again, the agent will want to check with the issuing company to make sure they allow this.

Waiver of Premium

It is now common for long-term care policies to contain a waiver of premium. A waiver of premium has to do with renewal premiums during an institutionalization or while receiving benefits under the terms of the policy. When the policyholder has received benefits under the

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

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

-Elimination Period + Benefit Days = waiver satisfaction.

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

-30 days + 90 Days = waiver satisfaction (120 days total time for waiver qualification).

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

Alternative Plan of Care

Policies may offer an alternative plan of care that is covered under the policy. If the insured would otherwise need care in a long-term care facility (nursing home), the company will pay for an alternative service, devices, or benefits. The alternative plan of care must be medically appropriate and medically acceptable. This is determined by specific requirements, including:

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

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

No Policy Covers Everything

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

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

1.Losses due to a condition for which the policyholder can receive benefits under Workers' Compensation or the Occupational Disease Act

2.Losses due to the result of war or any act of war

3.Losses payable under any federal, state, or other government health care plan or law, except Medicaid. The company will reduce their benefits in direct relationship to the amount covered by any government health care plan or law to the extent that the combination of payments exceed 100% of the actual charge for the covered service.

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

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

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

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

Age Misstatement

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

Few companies rescind (void) a policy due to age misstatement. It may happen, however, if the age misstatement puts the applicant in an age bracket that is not acceptable for underwriting (an

80-year old who is listed as 79 might fall into this category). The company would, however, require that the additional premium be paid. If the correct age would have meant that the policy would not have been issued at all, then the premium that was paid will be returned to the consumer and the policy voided.

Third-Party Notification

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

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

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

Reinstatement of a Lapsed Policy

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

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

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

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

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

Even when errors are discovered and the agent has left the insurance field, lawsuits may still be filed against the insurer. One of the reasons insurance companies have become so pro-active regarding agent education has to do with preventing lawsuits. Of course, if the policy is a Partnership contract there are also federal government regulations regarding suitability. Issuing insurance companies are required to adhere to these mandates and in fact there must be a specific person that makes sure all issued policies follow federal requirements.

Section 6021: Expansion of State LTC Partnership Program
The Deficit Reduction Act of 2005 (effective in 2006) provided some statutory Requirements that are important to the expansion of long-term care Partnership policies. This would include:

Dollar-for-Dollar Asset Protection
In order to provide asset protection, states must make necessary statute amendments that provide for the disregard of assets when applying for Medicaid benefits.

An individual applying for benefits must be a resident of the state when the coverage first became effective under the policy.

The Partnership policy will be a tax-qualified plan that was issued no earlier than the effective date of the state plan amendment allowing use of such LTC policies. They must meet the October 2000 NAIC model regulations and requirements for consumer protections.

Inflation Protection
Since most people will not use their long-term care benefits for many years after purchase, it is important to include inflation protection. Partnership plans have specific inflation protection requirements. The requirements were previously outlined in this course.

Plan Reporting Requirements
Partnership plan insurers must provide regular reports to the HHS Secretary and include specific information, including:

-Notification of when benefits have been paid and the amount of benefits paid.
-Notification of policy termination.
-Any other information requested by HHS.

The state may not impose any requirements affecting the terms or benefits on Partnership policies that were not also imposed on traditional non-partnership plans.

States may require issuers to report additional information beyond those listed and there may be differences among the states.

Consumer Education
It is the responsibility of each state to properly educate their consumers so they are aware of their asset-protection options.

Agent Education
Most states will be imposing some type of continuing education requirements for those agents wanting to market Partnership plans. While these agent requirements will vary, many states are adopting an initial requirement of 8 hours, with 4 hours required each license renewal period thereafter.

State Amendments Where Required
Policies are deemed to meet required standards of the model regulation or the model Act if the state plan amendment is certified by the state insurance commissioner in a manner satisfactory to the Secretary.

Reciprocity
States with Partnership contracts must develop standards for uniform reciprocal recognition of Partnership policies between participating states. This would include benefits paid under the policies (being treated equally by all states) and opt out provisions where states could notify the Secretary in writing if they do not want to participate in a reciprocity program.

State Effective Dates
Qualified state long-term care Partnership policies issued on the first calendar quarter in which the plan amendment was submitted to the Secretary.

NAIC 2000 Model Act
No one has argued against purchasing a long-term care policy to protect against the costs of receiving care for an extended period of time. However, like so many things, these early policies had many initial flaws that were not consumer friendly or, in some cases, even ethical.

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

The national Association of Insurance Commissioners is a non-profit organization made up of the insurance regulators from the 50 states, the District of Columbian and the four United States territories. They have worked with regulators, legislators, the insurance industry, and consumers

to create a comprehensive uniform model law, often referred to as the NAIC Act, and related regulations for long-term care insurance.

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

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

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

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

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

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

the policies since they pay in premiums for a policy they may have to lapse when premiums rise beyond their means.

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

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

-58 percent of the revenues that would be generated by the existing premium.
-85 percent of the revenue generated by the premium increase.

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

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

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

LTC Personal Worksheet
Insurers use a long-term care worksheet called the Long-Term Care Insurance Personal Worksheet. This is provided to applicants during the solicitation of a long-term care policy. The

worksheet and rate information are provided to the Insurance Department's Office for review in most cases.

Is the Policy Suitable for the Buyer?

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

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

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

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

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

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

If the potential applicant refuses to answer questions regarding income, assets, and other financial information necessary to make an appropriate determination, then neither the selling agent nor the issuing insurer bears any responsibility if the decision to buy turns out to be a poor choice. The insurer can reject the application if the buyer has refused to supply necessary

information, but is not required to do so. It can send out a letter outlining the need for the requested information and hope the applicant then provides the information. Either the applicant's returned letter or a record any alternative method of verification of information must be made part of the applicant's file.

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

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

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

Consumer Publications

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

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

Post Claim Underwriting

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

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

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

Tax-Qualified Policy Statement

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

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

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

Replacement Notices

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

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

Policy Conversion

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

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

An Overview

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

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

-Policies cannot increase premiums due to advancing age. In other words, premiums may not increase when a policyholder has a birthday. Premiums may increase simultaneously for all who hold similar policies.

-Policies cannot be cancelled because of advancing age or deteriorating health.

-Policies must offer a nonforfeiture benefit that, if purchased, ensures the consumer that a lapsed or cancelled policy means some benefits would still be available for a specified period of time.

-Policies must offer an inflation protection that, if purchased, ensures benefits keep pace with inflation. This is especially important for those purchasing their policies at younger ages.

The NAIC Model Act Applies to All

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

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

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

1.The only insurance protection provided under such contract is coverage of qualified long-term care services

2.Such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount

3.Such contract is guaranteed renewable

4.Such contract does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed

5.All refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits

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

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

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

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

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

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

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

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

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

How is one to know if the life policy has the option of accelerated benefits? Treatment of coverage provided as part of a life insurance contract, except as otherwise provided in state regulations,

generally apply if the portion of the contract providing such coverage is a separate contract. While it is always necessary to refer to the actual policy, the term "portion" means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

Nonforfeiture Provisions
Generally a nonforfeiture provision must meet specific requirements:

1.The nonforfeiture provision must be appropriately captioned.

2.The nonforfeiture provision must provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the appropriate State regulatory agency for the same contract form.

3.The nonforfeiture provision must provide at least one of the following:
- -Reduced paid-up insurance.
- -Extended term insurance.
- -Shortened benefit period.
- -Other similar offerings approved by the appropriate State regulatory agency.

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

Home Health & Community Care
Minimum standards and benefits must be established for home health and community care in long-term care insurance policies.

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

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

- -Benefits and coverage

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

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

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

No Field Issued LTC Policies
There was a time when long-term care policies could be field issued by the agent because underwriting was completed when a claim was filed rather than at policy issuance. Field issued policies are not allowed under the Model Act and Regulation since it is not good for the consumer. Policies must be underwritten prior to policy issuance.

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

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

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

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

Prior to the Sale
Agents and insurers have pre-sale responsibilities. They must provide the applicant with copies of personal worksheets and potential rate increase disclosure forms. They must also identify whether or not the applicant has long-term care insurance or coverage elsewhere. If there is

existing coverage, the agent must find out if the applicant intends to replace the existing LTC policy with the new coverage.

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

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

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

Illegal Practices
Some practices illegal. This would include what is referred to as "twisting," which means using the facts to suit one's own needs (not the needs of the consumer). A person who uses twisting is either changing the facts to suit their own needs or providing some facts, but omitting others in order to complete the sale. It might be omitting information that should be disclosed, or it might be stating facts in a way that will allow the consumer to assume that which is not true. Often twisting is used to make an existing policy appear unfavorable, when in fact the policy is appropriate for the consumer.

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

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

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

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

If the applicant failed to provide full information an incontestability provision exists. For material misrepresentation, the time period for rescinding the policy is six months. A misrepresentation pertaining to both material information and medical conditions the time period is two years for policy rescission. Information that was knowingly and intentionally misrepresented may cause a

policy rescission for more than two years. When a policy is rescinded, benefits may not be recovered.

Failure to Pay Premiums

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

Ethical Considerations

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

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

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

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

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

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

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

Full Disclosure

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

Conclusion

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

-Policy requirements: (a) requiring a standard format outline of coverage; (b) requiring specific elements for application forms and replacement coverage; (c) preventing cancellation of coverage upon unintentional lapse in paying premiums; (d) prohibiting post-claims underwriting; (e) prohibiting preexisting conditions and probationary periods in replacement policies or certificates; and (f) establishing minimum standards for home health and community care benefits in long-term care insurance policies.

-Benefit requirements: (a) requiring the offer of inflation protection; (b) requiring an offer of nonforfeiture benefits; (c) requiring contingent benefit upon lapse if the nonforfeiture benefit offer is rejected; and (d) establishing benefit triggers for nonqualified and qualified long-term care insurance contracts.

-Suitability requirements: (a) explaining and reviewing a personal worksheet with applicants; and (b) requiring that insurers deliver a shopper's guide to buying long-term care insurance to applicants.

-Insurer requirements: (a) reporting requirements; (b) licensing requirements; (c) reserve standards; (d) loss ratios standards where applicable; (e) filing and actuarial certification requirements; and (f) standards for marketing.

-Penalties and disclosure requirements.

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

Insurance policies are legal contracts. As such, terminology is very important. Long-term care policies must follow state and federally mandated terms. In the case of Qualified Long-Term Care plans, the definitions must satisfy those as amended by the U.S. Treasury Department.

Activities of Daily Living: Qualified long-term care policies have six activities of daily living. They are: bathing, continence, dressing, eating, toileting, and transferring.

Chapter 11 Terminology

Acute Condition: The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the patient's health status.

Adult Day Care: A program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside of the home.

Ambulation: In some policies, ambulation is considered an activity of daily living (ADL), but not in all contracts. Tax-qualified LTC policies have eliminated this as an ADL. Ambulation is the ability to move around independently, without help from others.

Assets: As it applies to the Partnership definition, assets mean savings and investments but exclude income. Medicaid qualification considers everything as assets, including income.

Automatic Benefit Increase Option (ABI): An inflation protection clause where the amount of LTC coverage increases automatically on an annual basis by a contractually specified amount. The increase may be on either a simple or compound basis, depending upon policy terms. The premium remains fixed since the increases were automatically built into the original premiums.

Bathing: Washing oneself by sponge bath or in either a tub or shower, including the task of getting into and out of the tub or shower.

Benefit Trigger: Also known as a Policy Benefit Trigger, it is the condition or circumstance that "triggers" policy payment or Medicare payment.

Cognitive Impairment: A deficiency in the person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

Copayment: An amount paid in some Medicare plans and Medicare prescription drug plans for each medical service, such as a doctor's visit or prescription.

Custodial Care: Non-skilled personal care, such as help with the daily activities of living. It may include care that most people do for themselves, like using simple medications or nonprescription products. Medicare does not pay for custodial care.

Deficit Reduction Act of 2005: Signed by President George W. Bush in 2006, DRA allowed long-term care insurance Partnership models to be used in all 50 states. It increases the incentives to purchase long-term care insurance. This act also changed the asset transfer time period from three to five years making asset transfer more difficult if done for the purpose of Medicaid qualification.

Dollar-for-Dollar Asset Protection: In Partnership LTC policies, the amount of protection (benefits) purchased by the consumer protects an equal amount of assets (never income) from Medicaid qualification requirements. Therefore, since it matches dollar-for-dollar, an individual who buys $50,000 of insurance is also protecting $50,000 of assets from Medicaid spend-down requirements.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Elimination Period: Also called a waiting period, it is a long-term care policy deductible expressed as time not covered. It is the first days of confinement or benefit qualification that must be covered by the insured prior to the policy paying benefits.

Exceptional Increase: Means only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified due to changes in laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products.

Extension of Benefits: When an insured is receiving qualified benefits under their policy at the time the policy cancels, most states require benefits to continue through the duration of the policy terms.

Future-Purchase Option (FPO): An inflation protection clause where the consumer agrees to a premium for a set amount of coverage. At specified time intervals the insurer offers to increase existing coverage for additional premium, but does not underwrite the increase.

Guaranteed Renewable Policy: A guaranteed renewable policy gives the insured the right to continue their coverage as long as they pay their premiums in a timely manner. The insurer may not unilaterally change the terms of the coverage or decline to renew. Premiums rates can (and often do) change.

Hands-On Assistance: Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

Home Health Care Services: Medical and non-medical services, provided to ill, disabled, or inform persons in their residences. Such services may include homemaker services, assistance with the activities of daily living and respite care services.

Hybrid Partnership Plans: Hybrid plans offer both dollar-for-dollar and total asset protection. The type of asset protection depends on the initial amount of purchased coverage. Total asset protection is available for policies with initial coverage amounts equal to or greater than a level defined by the state.

Income: For Medicaid purposes, income is anything received during a calendar month that is used or could be used to meet food or shelter needs. It includes cash, savings accounts, stocks, or property that can be converted to cash.

Indemnity Insurance Contracts: Indemnity plans pay a set amount of money per day or per covered ailment, but will not exceed the actual cost. In LTC policies, this would be expressed as $100 per confinement day, for example.

Inflation Protection: There are two types of inflation protection used in LTC policies (1) future purchase options (FPO) and (2) automatic benefit increase options (ABI). Refer to FPO or ABI.

Integrated Long-Term Care Policies: Integrated policies offer a more relaxed benefit formula than other models since they offer a "pool" of benefits that allow the policy owner to make personal care choices, as long as those choices qualify under the terms of the policy contract. Once the pool of money is exhausted, the policy ends.

Level Premium: This term might be taken to imply that premiums will not increase, which is not necessarily true. Depending upon state language, level premium means that premium will not increase due to advancing age or increased claim submission, but claims can increase if they do so for all policyholders.

Long-Term Care: A variety of services that help people with health or personal needs and activities of daily living for an extended period of time (federally defined as no less than 90 days).

Such care may be provided in a nursing home, but also in the patient's home, in an assisted living facility or some other community setting.

Look-Back Period: The period of time during which assets may be successfully transferred to another without affecting Medicaid eligibility. Previously set at three years, the Deficit Reduction Act of 2005 extended that time period to five years. If an individual transfers assets for less than their fair market value within this "look-back" period, he or she becomes ineligible for Medicaid benefits for the length of time those assets would have covered their medical care. The DRA also changed the beginning date of the penalty period.

Medicaid: A joint Federal and state program that helps with medical costs for those who have limited income and assets. Medicaid programs vary from state to state, but most health care costs are covered if the individual meets the criterion.

Medicare: "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended" or "Title I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

Mental or Nervous Disorder: A condition that includes more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Non-Cancelable Policies: Non-cancelable means the insured has the right to continue their coverage as long as they pay their premiums in a timely manner. The insurer may not unilaterally change the terms of the coverage, decline to renew, or change the premium rates. The fact that premiums do not increase is the outstanding point of non-cancelable policies and the reason that it would be rare to find an LTC policy with this contract clause.

Nonforfeiture Values: A policy feature that provides a specified paid-up benefit or returns at least part of the premiums to a consumer who cancels the policy or lets it lapse.

Partnership Long-Term Care Policies: A tax-qualified long-term care policy purchased through the Partnership program that provides asset protection on either a dollar-for-dollar method or a total asset protection method. There may also be hybrid models. The purpose of asset protection is to allow the specified amount of assets to be disregarded for the purpose of Medicaid qualification.

Personal Care: Hands-on assistance with the activities of daily living. This may also be called custodial care.

Pre-existing Condition: A preexisting condition is one for which the policyholder or applicant has received treatment or medical advice within a specified time period prior to policy issue or prior to receiving policy benefits.

Respite Care: care which gives families temporary relief from the responsibility of caring for family members who are unable to care for themselves. Respite care is provided in a variety of settings, including in the patient's home, at an adult day center, or in a nursing home.

Skilled Nursing Care: A level of care requiring the daily involvement of skilled nursing or rehabilitation staff, and provided under the instruction or supervision of a physician or skilled medical person. This type of care must be performed in an institution that is licensed to deliver such care.

Suitability Standards: Guidelines issued by an insurer that help consumers determine whether a long-term care insurance policy is appropriate for them.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing the associated personal hygiene.

Total Asset Protection: Available only in New York and Indiana, these Partnership LTC policies provide total protection of all personal assets as long as the insured has met the minimum policy requirements, such as three years of nursing home care, or six years of home health care.

Traditional Long-Term Care Insurance: A long-term care policy that was purchased on either a tax-qualified or non-tax qualified basis that does not offer asset protection for Medicaid qualification purposes.

Transferring: Moving into or out of a bed, chair, or wheelchair.

Underwriting: The process of reviewing the applicant's medical and health-related information to determine if he or she presents an acceptable level of risk for insurance coverage.

Waiting Period: Also called an elimination period, it is a long-term care policy deductible expressed as time not covered. It is the first days of confinement or benefit qualification that must be covered by the insured prior to the policy paying benefits.

Waiver of Premium: Offered in many LTC contracts, a waiver of premium waives the premium requirement once the insured begins to collect qualified policy benefits. The waiver of premium clause is subject to the listed conditions in the policy.