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.