# Table of Contents

## Chapter 1: Partnership Program Creation
- Defining Long-Term Care
- History of the Partnership for Long-Term Care
- Partnership Policies are Created
  - Chart: Partnership Program Overview
- Medicaid is the Largest Nursing Home Payor
  - Chart: Dollar-for-Dollar Partnership Protection
- Program Performance
- New Federal Legislation: The Deficit Reduction Act of 2005
- Questions that Remain Unanswered
- OBRA 1993 Provisions Pertaining to Partnership LTC
- Promoting Partnership Long-Term Care Plans
- Program Growth
- Partnership Participation
- Public Education
- Consumer and Agent Education
- Policy Benefits
- Inflation Protection
- Reciprocity Between States
- Looking into the Future
- State Funding

## Chapter 2: Program Benefits
- Making Benefit Choices
- Daily Benefit Options
- Expense-Incurred and Indemnity Methods of Payment
- Determining Benefit Length
- Asset Protection in Partnership Policies
- Policy Structure
- Home Care Options
- Inflation Protection
- Simple and Compound Interest
- Required Rejection Forms (in some states)
- Elimination Periods in LTC Policies
- Policy Type
- Restoration of Policy Benefits
- Preexisting Periods in Policies
- Prior Hospitalization Requirements for Skilled Care
- Deciding Between Federal Tax-Qualified & State Non-Tax Qualified (Non-Partnership) Policies
- Nonforfeiture Values
Partnership Long-Term Care Policies

Table of Contents

Waiver of Premium 49
Unintentional Lapse of Policy 50
Policy Renewal Features 50
Items Not Covered by the LTC Policy 51
Extension of Benefits 51
Affordability of Contracts 52
Standardized Definitions 52
Minimum Partnership Requirements 52
Benefit Duplication 53
Partnership Publication 53
Partnership Versus Traditional Policies 54
Abbreviations 56
The Cost of Long-Term Care in the US 57
Long-Term Care Partnership Program 58
Partnerships Save Assets from Medicaid Qualification 60
Accessing Policy Benefits 71
Medicaid 75
Protecting Partnership Policyholder Assets 78
Concluding GAO Observations 91
Impact of Asset Transfers on Medicaid 92
Methodology for Assessing Medicaid Savings 93

Chapter 3: Basic Policy Considerations for Traditional LTC Policies 95
What is a Traditional Long-Term Care Policy? 95
Policy Issue 96
Medicare Benefits 96
  Part A (Inpatient Care) 97
  Part B (Outpatient Care) 98
  Covered Under Either Medicare Part A or Part B 99
Medicare Supplemental Policies 101
  The Original Medicare Plan 102
  Medicare + Choice Plans 103
Protecting Assets 104
Medicaid Benefits 105
Relying on Insurance for LTC Payment 107
  State Requirements 107
  Age as a Policy Factor 108
A Younger Market Developing 109
Insurance Pricing 110
  Premium Mode 110
Reducing Benefits to Save Premium 111
Policy Renewal 112
Policy Review: 30 Day “Free Look” 112
Number One Best Selling Unread Document 113
“Notice to Buyer” 113
Policy Schedule 114
Policy Terminology 114
Elimination Periods in Policies 119
Policy Termination 120
Mental Impairments of Organic Origin 120
# Partnership Long-Term Care Policies

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization Requirements</td>
<td>120</td>
</tr>
<tr>
<td>Home and Community Based Benefits</td>
<td>121</td>
</tr>
<tr>
<td>Bed Reservation Benefit</td>
<td>122</td>
</tr>
<tr>
<td>Waiver of Premium</td>
<td>122</td>
</tr>
<tr>
<td>Selecting Other Types of Care</td>
<td>123</td>
</tr>
<tr>
<td>No Policy Covers Everything</td>
<td>124</td>
</tr>
<tr>
<td>Age Misstatement</td>
<td>125</td>
</tr>
<tr>
<td>Third Party Notification</td>
<td>126</td>
</tr>
<tr>
<td>Reinstatement of a Lapsed Policy</td>
<td>126</td>
</tr>
<tr>
<td>Section 6021: Expansion of State LTC Partnership Program</td>
<td>127</td>
</tr>
<tr>
<td>NAIC 2000 Model Act</td>
<td>129</td>
</tr>
<tr>
<td>&quot;Level Premium&quot; Does Not Mean Unchanging Rates</td>
<td>131</td>
</tr>
<tr>
<td>Financial Requirements for Rate Increases</td>
<td>131</td>
</tr>
<tr>
<td>Rate Certification from the Insurer’s Actuary</td>
<td>132</td>
</tr>
<tr>
<td>Consumer Disclosure</td>
<td>132</td>
</tr>
<tr>
<td>LTC Personal Worksheet</td>
<td>132</td>
</tr>
<tr>
<td>Is the Policy Suitable for the Buyer?</td>
<td>133</td>
</tr>
<tr>
<td>Consumer Publications</td>
<td>133</td>
</tr>
<tr>
<td>Post-Claim Underwriting</td>
<td>134</td>
</tr>
<tr>
<td>Tax-Qualified Policy Statement</td>
<td>134</td>
</tr>
<tr>
<td>Replacement Notices</td>
<td>135</td>
</tr>
<tr>
<td>Policy Conversion</td>
<td>135</td>
</tr>
<tr>
<td>An Overview</td>
<td>136</td>
</tr>
<tr>
<td>The Model Act Applies to All</td>
<td>136</td>
</tr>
<tr>
<td>Policy Renewable Provisions</td>
<td>137</td>
</tr>
<tr>
<td>Payment Standards Must be Defined</td>
<td>137</td>
</tr>
<tr>
<td>Preexisting Standards</td>
<td>138</td>
</tr>
<tr>
<td>ADLs</td>
<td>138</td>
</tr>
<tr>
<td>Life Insurance Policies with Accelerated Benefits</td>
<td>138</td>
</tr>
<tr>
<td>Nonforfeiture Provisions</td>
<td>139</td>
</tr>
<tr>
<td>Extension of Benefits</td>
<td>139</td>
</tr>
<tr>
<td>Home &amp; Community Care</td>
<td>139</td>
</tr>
<tr>
<td>Additional Provisions for Group Policies</td>
<td>140</td>
</tr>
<tr>
<td>Outline of Coverage</td>
<td>140</td>
</tr>
<tr>
<td>Policy Delivery</td>
<td>140</td>
</tr>
<tr>
<td>No Field Issued LTC Policies</td>
<td>140</td>
</tr>
<tr>
<td>Policy Advertising and Marketing</td>
<td>141</td>
</tr>
<tr>
<td>No Policy Covers Everything (Again)</td>
<td>141</td>
</tr>
<tr>
<td>Prior to the Sale</td>
<td>141</td>
</tr>
<tr>
<td>Shopper’s Guide</td>
<td>142</td>
</tr>
<tr>
<td>It’s Just Plain Illegal (twisting, high pressure, misrepresentations)</td>
<td>142</td>
</tr>
<tr>
<td>Association Marketing</td>
<td>142</td>
</tr>
<tr>
<td>Following the Sale</td>
<td>143</td>
</tr>
<tr>
<td>Failure to Pay Premiums</td>
<td>143</td>
</tr>
<tr>
<td>In Conclusion</td>
<td>143</td>
</tr>
<tr>
<td><strong>Chapter 4: Financial Planning for LTC</strong></td>
<td>145</td>
</tr>
<tr>
<td>The Importance of Planning</td>
<td>145</td>
</tr>
<tr>
<td>Chart</td>
<td>152</td>
</tr>
<tr>
<td><strong>Chapter 5: Terminology</strong></td>
<td>154-160</td>
</tr>
</tbody>
</table>

*Table of Contents*

Page 3
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Chapter 1

Partnership Program Creation

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

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

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

With the baby boom generation aging and the cost of services going up, paying for long-term care is an issue of pressing importance for policymakers who fear Medicaid applications will outpace the program’s financial ability. While some individuals can count on friends and family to assist with the activities of daily living, many others must determine how to pay for extended home-health services or a potential stay in a nursing facility.
The high costs of nursing home care make up the largest part of long-term care costs in the United States. Almost $122 billion was spent on services provided by free-standing nursing homes in 2005, with an additional $47.5 billion spent on home-health care. Medicaid accounted for the largest share at 43.9 percent of the total spent on nursing facilities. Consumers covered an additional 26.5 percent of nursing home costs out-of-pocket and private insurance covered another 7.5 percent.  

The likelihood of needing nursing home care is significant. A 65-year-old man has a 27 percent chance of entering a nursing home at some point in his life; a 65-year-old woman faces a 44 percent probability of doing so. While costs vary from state to state, and even from region to region within states, the average nursing home stay costs more than $70,000 per year (or nearly $6,000 per month). The financial stakes are high for both state and federal governments. On average, states spend 18 percent of their general fund budgets on Medicaid. Individuals must spend nearly all their non-housing assets before they qualify for Medicaid assistance, so financially it is devastating to everyone.

Defining Long-Term Care

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

Various laws will define long-term care based on their interpretation or intent. Partnership states will define long-term care based upon Partnership requirements. Federal law considers “long-term” to mean care provided for 90 days or more. Additionally, most long-term care

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1 Centers for Medicaid and Medicare Services (CMS), National Health Expenditures.
definitions relate to the inability to perform the general activities of living, called “activities of daily living” or ADLs. These activities include eating, toileting, transferring to and from beds and chairs, bathing, dressing, and continence. Non-tax qualified state plans may include ambulating as an ADL, the ability to move around independently. When ambulating was omitted from federal requirements, many long-term care professionals felt the omission reduced their client’s ability to collect insurance policy benefits.

A cognitive impairment is also used as a measure for collecting policy benefits. A cognitive impairment would be the inability to take care of oneself due to a cognitive impairment, such as Alzheimer’s disease or dementia.

A long-term care policy will cover multiple types of care: custodial or personal care, intermediate nursing care, and skilled nursing care. Medicare only covers skilled care, and only for a specified time period. No individual should rely on Medicare for their long-term care needs. Custodial or personal care is the least technical since it covers help with the daily activities of living. Skilled care is the highest level of technical care and can only be provided in the appropriate setting. The Medicare & You handbook, published by the Department of Health & Human Services, defines skilled nursing facility care as: “a semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (only after a 3-day minimum inpatient hospital stay for a related illness or injury) for up to 100 days in a benefit period. To get care in a skilled nursing facility, you must need skilled care like intravenous injections or physical therapy. Medicare doesn’t cover long-term care or custodial care in this setting.”

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

Statistically, the people most likely to end up in a nursing home are female, elderly, increasingly frail, who live alone, although any person
of any age can end up in a nursing home. Many would find it surprising that 40 percent of those in a nursing home are between the ages of 18 and 64.\textsuperscript{2}

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

A recent GAO report (May 2007) reports that it is unlikely that Medicaid will actually realize any savings since those that are buying Partnership policies tend to have sufficient assets to have funded a nursing home stay without applying to Medicaid. In two of the four initial Partnership states, more than half of Partnership policyholders over the age of 55 have a monthly income of at least $5,000 and more than half of all households have assets of at least $350,000 at the time they purchased their Partnership policy. In many cases, these individuals (80%) would have bought a traditional long-term care policy if Partnership plans had not been available, reports the Government Accountability Office (GAO).\textsuperscript{3}

Not everyone agrees with the GAO suggestion that Medicaid will not realize any real savings from Partnership plans. HHS commented that the study results should not be considered conclusive since it does not adequately account for the effect of estate planning efforts, such as asset transfers (although the period of time to do so has been increased to five years rather than the previous three years). It is the Health & Human Services’ (HHS) position that these individuals would have moved their assets, enabling them to qualify for Medicaid, had the Partnership Program not been available. Whether or not those who would have repositioned their assets would still have purchased a traditional long-term care policy is not known, of course, but one could theorize that high-income, high asset households often tend to be more aware of their options than those with less income and assets. Therefore, even if they did not reposition their assets, they may have

\textsuperscript{2} Health & Human Services
\textsuperscript{3} Long-Term Care Insurance, GAO Report to Congressional Requesters, May 2007
sought other measures to protect their assets (income cannot be shielded from nursing home contribution requirements).

The GAO report looked at:

1. The benefits and premium requirements of Partnership policies as compared with those of traditional policies;
2. The demographics of Partnership policyholders, traditional long-term care insurance policyholders, and people that had no long-term care insurance coverage; and
3. Whether the partnership programs are likely to result in savings for Medicaid.

Data from the four initial Partnership states was used from 2002 through 2005. The four initial Partnership states are California, Connecticut, Indiana, and New York.

History of the Partnership for Long-Term Care

In the late 1980s the Robert Wood Johnson Foundation (RWJF) supported the development of a new LTC insurance model, with 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...
Partnership Long-Term Care Policies

become impoverished to qualify for Medicaid, and states would avoid the entire burden of long-term-care costs.4

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 program states, which were 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 a need to seek ways to fund the care of those who were ending up on Medicaid. By the mid-1980s insurance companies were marketing private long-term care policies, although these early policies had several flaws in coverage.

Many were surprised to learn that it was not the so-called “poor” who were ending up dependent upon state and federal aid for their long term health care needs; the middle class were finding themselves

4 Issue Brief Long-Term Care Partnership Expansion: A New Opportunity for States
Partnership Long-Term Care Policies

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.\(^5\) 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. By 2010 the average cost is expected to be around $83,000 per year. 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.

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\(^5\) Program to Promote Long-Term Care Insurance for the Elderly, July 2007, Robert Wood Johnson Foundation
Partnership Long-Term Care Policies

• 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 more appropriate for the patient to receive professional care.

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

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

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

2. Providing access to quality long-term care that is appropriate for the individual’s medical situation;
3. Providing coverage for a full range of home and community-based services;

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

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

Partnership Policies are Created

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
Partnership Long-Term Care Policies

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.\(^6\) Currently not all 50 states are participating but they are being added gradually as the Department of Health & Human Services invites them to submit their applications. 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.

A quick overview of Partnership Programs:

<table>
<thead>
<tr>
<th>Year Implemented</th>
<th>California</th>
<th>Connecticut</th>
<th>Indiana</th>
<th>New York</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dollar-for-Dollar</td>
<td>1993</td>
<td>Hybrid</td>
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</tr>
<tr>
<td>Total Asset Protection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Number of participating insurers</td>
<td>5</td>
<td>8</td>
<td>13</td>
<td>8</td>
<td>17</td>
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<tr>
<td>Number of active partnership policies as of 2003</td>
<td>64,915</td>
<td>30,834</td>
<td>29,189</td>
<td>47,539</td>
<td>172,477</td>
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</tbody>
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GAO Analysis of Data from Robert Wood Johnson Foundation and state data of partnership plans

Some interesting initial Partnership facts:

- The average age of Partnership respondents was 58 and 59 years old (depending upon the state).
- Respondents listed their health as primarily excellent.
- The average age of Partnership policyholders ranged from 58 to 63, depending upon the state. California, for example, reported an average age of 60.
- Women have purchased more Partnership policies than have men.
- The majority of Partnership policy owners are married.

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\(^6\) Robert Wood Johnson Foundation’s Program to Promote Long-Term Care Insurance for the Elderly, July 2007
• For most, this is the first time they have bought a long-term care policy of any type.

• In California, Connecticut, and Indiana, the majority of policyholders have 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 Partnership policies written were comprehensive, covering both nursing home care and home and community-based care.

Medicaid is the Largest Nursing Home Payor

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

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

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

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

a. Freedom-of-choice waivers;

b. Home- and community-based-services waivers; and

c. Research waivers, which are typically used to test innovative ideas on a portion of those eligible for Medicaid.

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

Another approach, the one used for the Partnership program, is through a state amendment to its 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 controls legislation involving the Medicaid program, and John Dingell of Michigan, chair of the House Energy and Environment Committee. They had specific concerns, including the belief that:

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

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

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

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

Due to the delays caused by the Medicaid state plan amendment process and HCFA’s separate process needed to approve them, the Robert Wood Johnson Foundation (RWJF) awarded implementation grants to the states one at a time, from August 1987 through
Partnership Long-Term Care Policies

December 1988. Normally the national program procedure is to authorize all project sites at once.

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Partnership Policy Benefits Purchased:</th>
<th>Policyholder Assets Upon Medicaid Application:</th>
<th>Required Asset Spend Down for Medicaid Eligibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100,000</td>
<td>$100,000</td>
<td>None</td>
</tr>
<tr>
<td>$100,000</td>
<td>$150,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Traditional non-partnership policy purchased</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>No Policy Purchased of any type.</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

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.
Partnership Long-Term Care Policies

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.

Program Performance

In 1998, RWJF issued a grant to the Laguna Research Associates to coordinate the writing of a book on the implementation and future prospects of the Partnerships for Long-Term Care. Additionally the national program office convened yearly meetings for Partnership states. These results were published in 6 journal articles, various discussion papers and data reports.

The program did see growth:

• By 2000, 104,000 applications had been taken and more than 95,000 policies had been sold in the four program states of California, Connecticut, Indiana, and New York.
• Program redesigns were seen in Connecticut, Indiana, and California, which produced increases in applications ranging from 324 percent to 540 percent.

• New York experienced the highest sales, perhaps due in part to their generous asset protection benefits.

These sales came in spite of restrictive language embedded in the Omnibus Budget Reconciliation Act (OBRA) of 1993 that effectively curtailed one of the program’s primary goals: replicating the partnerships in other states. Although OBRA grandfathered the four initial program states, it also required states obtaining a state plan amendment after May 14, 1993, to recover assets from the estates of all persons receiving services under Medicaid. As a result of the restrictive language the Partnership asset protection component was only in effect while the insured was alive. Since one of the attractive aspects of Partnership policies was the possibility of passing assets on to heirs, OBRA removed a major selling attraction of Partnership plans, which then defeats the purpose of them – promoting insurance sales. Both the Illinois and Washington programs failed to protect purchasers from estate recovery since they were created after OBRA’s May 14, 1993 deadline.

Eight states, Colorado, Florida, Georgia, Michigan, Missouri, North Dakota, Ohio, and Rhode Island passed legislation that would facilitate Partnership policies but implementation had to wait for the overturn of the sections of OBRA pertaining to estate recovery.

Originally the state where the Partnership plan was purchased was the only place the policy could be used for asset protection; if the insured moved to another state the plan would still pay policy benefits, but no assets were protected from Medicaid’s spend-down requirements. Connecticut and Indiana sought to have that changed. These two states wanted reciprocal agreements by which qualified holders of Partnership policies could be eligible for care in either state.
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 Remain 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 in the future? 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

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7 Robert Wood Johnson Foundation • May 2007 • Long-Term Care Partnership Expansion
Partnership Long-Term Care Policies

have become so expensive that policyholders are allowing them to lapse even though premiums have already been paid for many years.

OBRA 1993 Provisions Pertaining to 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. The requirements in each section are as follows:

Sec 1917(b) paragraph 1 subparagraph C

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

Sec 1917(b) paragraph 3

This section prevents any state from waiving the estate recovery requirement for Partnership participants even if they want to in order to promote Partnership plan sales.
Sec 1917(b) paragraph 4 subparagraph B

This section requires a specific definition of "estate" for Partnership participants. Estates:

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

B. . . . any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), 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 a Partnership program may find themselves in the position of having to use a more encompassing definition for Partnership participants alone. These post OBRA Partnership states may even have to seek legislative approval to implement the required recovery process for Partnership participants.

Promoting Partnership Long-Term Care Plans

Several organizations are promoting Partnership plans, including the Center for Health Care Strategies, the National Association of State Medicaid Directors and George Mason University. The new long-term care options are made available through the Deficit Reduction Act of 2005.

There is no doubt that as the numbers of elderly Americans increase, long-term-care (LTC) needs and costs will grow. 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, and nursing home services. The hope is that greater use of individually purchased insurance policies will reduce the burden on Medicaid to some degree, although not all believe this is the case. 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 for encouraging consumers to invest in LTC insurance is the expansion of the Partnership for Long-Term Care, a unique insurance model developed in the 1980s with support from the Robert Wood Johnson Foundation (RWJF). Through the Partnership program states promote 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.

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 implemented Partnership programs in the early 1990s (California, Connecticut, Indiana and New York) and the assumption was that other states would follow. That is not what happened, however. Citing concerns about the appropriateness of using Medicaid funds for this purpose, Congress enacted restrictions on further development of the Partnership 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
Partnership Long-Term Care Policies

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. New York also recently added a dollar-for-dollar option for consumers.

As of 2005 more than 172,000 consumers in the four demonstration states had active Partnership policies. Because the program is fairly young and policies are generally purchased well before they are used, relatively few of the policyholders have actually needed long-term-care coverage. However, of those that have accessed their benefits, the Government Accountability Office reports that, “More policyholders have died while receiving long-term-care insurance (899 policyholders) than have exhausted their long-term-care insurance benefits (251 policyholders), which could suggest that the Partnership for Long-Term Care program may be succeeding in eliminating some participants’ need to access Medicaid.”

**Partnership Participation**

The successful implementation of Partnership programs has involved several parties, which includes state policymakers, private insurers and, of course, individuals to purchase the policies.
Partnership Long-Term Care Policies

The process always begins with the state who 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

Chapter 1 – Program Creation
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or purchase other private LTC insurance, then state savings will not be realized.

As states consider the best way to attract those individuals who would not otherwise purchase LTC insurance, the experience of the demonstration states play 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 notes 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 will 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.

**Consumer and Agent Education**

Given the complexity of the long-term care insurance industry, and the additional benefits of Partnership programs, many people felt it was necessary to include not only consumer education, but also 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.
Partnership Long-Term Care Policies

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

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

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

3. State insurance departments are responsible for ensuring that individuals who sell Partnership policies (insurance 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 want to 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.

Policy Benefits

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.

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.
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.

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.

**Looking into the Future**

Interest has remained steady in implementing Partnership programs. Before the passage of the DRA, 21 states had anticipated a change in the law and proposed or enacted authorizing legislation. A recent survey of state Medicaid directors found that out of a total of 40 states, 20 indicated that they planned to propose a Long-Term Care Partnership program within the year. As momentum behind the program grows, there will be many issues and concerns regarding the Partnership program. While a leading goal is to reduce the amount of Medicaid funds spent on nursing home and related care for the elderly, consumer advocates also hope to protect the assets of those who have saved their entire lives for retirement only to see those assets wiped out in a short period of time. All parties involved will be analyzing and examining this program to determine the ultimate outcome of this unique and innovative policy option.

**State Funding**

States already face huge financial stress as the baby boom generation ages. The **Center for Health Care Strategies** (CHCS) has launched an initiative designed to help states take advantage of new opportunities made available in the DRA. The Long-Term Care
Partnership Expansion project is being underwritten by the Robert Wood Johnson Foundation. Ten states will receive technical assistance to develop new Partnership programs.

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

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

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

2. **The length of time the policy will pay benefits:** this could range from one year to the insured’s lifetime. Of course, the longer the length of policy benefits, the more expensive the policy will be.

3. **Inclusion of an inflation guard:** Non-partnership plans will not require this, while Partnership plans have inflation protection guidelines that must be followed. An inflation protection guards against the rising costs of long-term care by providing an increasing benefit according to contract terms. Partnership plans have two types: an increase based on a predetermined percentage and an offer at specific intervals allowing the insured to increase benefits without proof of insurability.

4. **The waiting period, also called an elimination period,** must be selected. This is the period of time that must pass while receiving care before the policy will pay for anything. It is a deductible expressed as days not covered. The option can range from zero days to 100 days. A few policies may have a choice of a longer time period.

5. **Dollar-for-Dollar Partnership asset protection or Total Asset protection,** if both are available. A Hybrid model may
also be available. Not all states offer all options since DRA specifies 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.

As every field agent knows, clients often prefer to have the 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 periods, 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 the 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 will affect how the daily benefit works; for example a non-partnership policy may be purchased that covers home health care only (not institutionalized care). The daily benefit is based 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. By today’s standards, that would be extremely inadequate for nursing home care.

This daily benefit can have variations. Some policies will specify an amount (not to exceed 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 amounts paid will usually vary depending upon whether they are going towards a nursing home confinement, home health care, adult day care, and so forth. The "pool of money" type is gaining popularity.
Partnership Long-Term Care Policies

where offered, since consumers see it as a way to make health care choices more freely. Integrated policies are generally more expensive than indemnity contracts. As in all policy contacts, integrated plans have benefit qualification requirements, exclusions, and limitations; they do not simply hand the insured money to be used in any manner desired.

While sales can and do vary from state to state, California reported that the average daily amount purchased in Partnership plans was $150 (2003 GAO figure) with a lifetime benefit period. Indiana reported an average daily figure purchased as $130 per day, which may reflect the difference in state costs. Californians can expect to pay about $230 per day in a nursing home while Indianans will pay around $170. New Yorkers were buying an average of $200 per day benefit, but they also have some of the nation’s highest nursing home rates.

Expense-Incurred and Indemnity Methods of Payment

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

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

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

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

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

While statistics vary depending upon the source, most professionals feel a policy should provide benefits for no less than three years of continuous confinement. Some people will only be in a nursing home for three months while others may remain there for five years. While it does not make sense to over-insure, it is also important to have adequate coverage. Since the majority of consumers will not be willing to pay the price for a 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:

1. **Dollar-for-Dollar:** Assets are protected up to the amount of the private insurance benefit purchased. If policy benefits equal $100,000, then $100,000 of private assets are protected from the required Medicaid spend-down once policy benefits are exhausted and Medicaid assistance is requested.

2. **Total Asset Protection:** All assets are protected when a state-defined minimum benefit package is purchased by the consumer. In this case, as long as the individual buys the minimum required benefits under the state plan, all his or her assets are protected from Medicaid spend-down requirements even if the assets exceed the total policy benefits purchased. Only New
Partnership Long-Term Care Policies

York and Indiana have this option. Total asset protection will not be offered in any of the new Partnership plans.

3. **Hybrid**: This Partnership program offers both dollar-for-dollar and total asset protection. The type of asset protection depends on the initial amount of coverage purchased. Total asset protection is available for policies with initial coverage amounts greater than or equal to a coverage level defined by the state.

Indiana introduced a hybrid model in 1998. Consumers have purchased more long-term care insurance coverage to get total asset protection than they have the less expensive coverage for the dollar-to-dollar program. This would indicate that consumers are willing to pay a higher premium for the better asset protection offered by the Total Asset model. To trigger total asset protection in 2005 policyholders had to buy a policy benefit valued at $196,994 or greater. Prior to 1998, only 29 percent of the policies purchased had total coverage amounts large enough to trigger total asset protection. When compared with just the first quarter of 2005, 87 percent of policies purchased had total coverage amounts large enough to trigger total asset protection.

As you know, under the Partnership program the state will disregard the policyholder’s personal assets equal to amounts paid out under a qualifying dollar-for-dollar model insurance policy or it will disregard all assets under the Total Asset Model.

**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
Partnership Long-Term Care Policies

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 be produced.

The rising costs of institutional care surpass the increase in the Consumer Price Index. As of 2006 figures, a year of nursing home care in New York City costs approximately $146,000. While that is the high end of such care (Indiana residents pay around $62,000 per year) there is little doubt that costs are rising. 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
Partnership policies still give the applicant the choice of having or not having inflation protection, Partnership policies are structured differently.

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

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

Traditional long-term care plans continue to make inflation protection an option, which may be rejected by the applicant. Many in the health care field state that the amount of increase offered is not adequate, but it will help to offset the rising costs of long-term care. The inflation protection, usually a 5 percent compound yearly increase, may eventually become part of all policies, but currently it is most likely to be just an option that the consumer must accept or reject. Some states require the consumer to sign a rejection form as proof that the agent offered the option.

Simple and Compound Protection

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

simple interest earnings. The following graph more clearly illustrates how compounding works with the inflation protection riders:

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 5</th>
<th>Year 10</th>
<th>Year 15</th>
<th>Year 20</th>
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<td>$100</td>
<td>$121</td>
<td>$155</td>
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<td>$252</td>
</tr>
</tbody>
</table>

Required Rejection Forms

The individual state insurance departments generally recommend inflation protection riders to their citizens. Inflation protection plans must continue even if the insured is confined to a nursing home or similar institution. Many states are now requiring a signed rejection form if the insured does not accept the inflation protection option. Although this is intended to be consumer protection, it is also 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.

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 period has gained popularity.

As one might expect, the longer the elimination period, the less expensive the policy; the shorter the elimination period, the more expensive it is. Therefore:
Zero day elimination = higher cost.
100 day elimination = lower cost.

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

When considering which elimination period is appropriate, one should consider the consumer's ability to pay the initial confinement. For example, if a thirty-day elimination is being considered at $100 per day benefit, by multiplying $100 by 30 days, it is possible to see what the consumer would first pay: $3,000 before his or her policy began. 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

The specific type of policy to be purchased can be a harder question. 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.

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

Restoration of Policy Benefits

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

**Preexisting Periods in Policies**

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

A preexisting condition is one for which the policyholder received treatment or medical advice within a specified time period prior to policy issue. Under federal law, that period of time prior to application is six months. Failure to disclose conditions that were known to the applicant can result in claims being denied when benefits are applied for or result from that condition. Medication, it should be noted, constitutes treatment. In some cases, the insurance company will even rescind the policy due to failure to disclose all requested medical history. Some policies 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; other do 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 has to do with benefit triggers. Benefit triggers are the conditions that "trigger" benefit payment from the insurance company. If a person needs to enter a nursing home, but his or her policy will not pay because the policyholder has not met the criterion for collecting benefits, he or she will not be able to access their policy’s benefits. The difference directly relates to the activities of daily living (ADL). In the non-tax qualifies policy forms, ambulation tends to be the primary difference.
Ambulation is the ability to move around without help from another individual. This daily activity is often the first to deteriorate as we age.

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

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

2. The insured must be chronically ill by virtue of either one of the two following conditions:
   a. Being unable to perform two of the following activities of daily living (ADL): eating, toileting, transferring in and out of beds or chairs, bathing, dressing, and continence, or
   b. Having a severe impairment in cognitive ability.

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

Nonforfeiture Values

State regulators are giving nonforfeiture values a hard look. With rising premiums, many long term clients are finding they can no longer afford to keep their policy. When a consumer has held a long-term care policy for many years, never claiming any benefits, a lapse of the policy means wasted premium dollars, which have been paid out over several years. It obviously means that insurers have benefited while consumers have merely wasted premium dollars. If they are forced, through rising costs, to abandon their policies as they approach the age of needing the benefits insurers have benefited unfairly. Federal law requires that companies at least offer a nonforfeiture provision to the prospective policyholder in tax-qualified plans. Non-tax qualified
Partnership Long-Term Care Policies

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

Items Not Covered by the LTC Policy

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

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

Extension of Benefits

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

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

Standardized Definitions

As is so often the case, definitions need to be standardized to avoid misunderstandings. No policy may be advertised, solicited or issued for delivery as a long-term care Partnership contract which 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

It appears that those who buy Partnership plans are first-time long-term care insurance buyers. 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.

A report to Congressional Requesters by the United States Government Accountability Office (GAO) in May, 2007 came to many conclusions regarding the effectiveness of the Partnership plans and if and how they might save the states money by preventing use of Medicaid funds. According to their report, Partnership Programs include benefits that protect policyholders but are not likely to provide substantial Medicaid savings.

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. In response to a congressional request, GAO examined three things:

1. The benefits and premium requirements of Partnership policies as compared with those of traditional long-term care insurance policies;
2. The demographics of Partnership policyholders, traditional long-term care insurance policyholders, and people without long-term care insurance; and
3. Whether the Partnership programs are likely to result in savings for Medicaid.

To examine benefits, premiums, and demographics, GAO used 2002 through 2005 data from the four states with Partnership programs—California, Connecticut, Indiana, and New York—and other data sources. To assess the likely impact on Medicaid savings, GAO (1) used data from surveys of Partnership policyholders to estimate how they would have financed their long-term care without the Partnership program, (2) constructed three scenarios illustrative of the options for
financing long-term care to compare how long it would take for an individual to spend his or her assets on long-term care and become eligible for Medicaid, and (3) estimated the likelihood that Partnership policyholders would become eligible for Medicaid based on their wealth and insurance benefits.

California, Connecticut, Indiana, and New York require Partnership programs to include certain benefits, such as inflation protection and minimum daily benefit amounts. Traditional long-term care insurance policies are generally not required to include these benefits. From 2002 through 2005, Partnership policyholders purchased policies with more extensive coverage than traditional policyholders. According to state officials, insurance companies must charge traditional and Partnership policyholders the same premiums for comparable benefits, and they are not permitted to charge policyholders higher premiums for asset protection. Since it is the states rather than the insurers who provide this asset protection, there would be no reason for an insurer to charge higher rates for Partnership plans.

Partnership and traditional long-term care insurance policyholders tend to have higher incomes and more assets at the time they purchase their insurance, compared with those without insurance. In two of the four states, more than half of Partnership policyholders over 55 have a monthly income of at least $5,000 and more than half of all households have assets of at least $350,000 at the time they purchase a Partnership policy.

Available survey data and illustrative financing scenarios suggest that the Partnership programs are unlikely to result in savings for Medicaid, and may increase spending. The impact, however, is likely to be small. About 80 percent of surveyed Partnership policyholders would have purchased traditional long-term care insurance policies if Partnership policies were not available, representing a potential cost to Medicaid. About 20 percent of surveyed Partnership policyholders indicate they would have self-financed their care in the absence of the Partnership program, and data are not yet available to directly measure when or if those individuals will access Medicaid had they not purchased a Partnership policy. However, illustrative financing scenarios suggest that an individual could self-finance care, thus delaying Medicaid eligibility, for about the same amount of time as he or she would have using a Partnership policy, although the GAO identified some
circumstances that could delay or accelerate Medicaid eligibility. While
the majority of policyholders have the potential to increase spending,
the impact on Medicaid is likely to be small, reported the GOA,
because few policyholders are likely to exhaust their benefits and
become eligible for Medicaid due to their wealth and having policies
that will cover most of their long-term care needs.

Information from the four states may prove useful to other states
considering Partnership programs. States may want to consider the
benefits to policyholders, the likely impact on Medicaid expenditures,
and the income and assets of those likely to afford long-term care
insurance.

HHS disagreed with the Government Accountability Office’s (GAO)
report; they commented that the study results should not be
considered conclusive because they do not adequately account for the
effects of estate planning efforts, such as asset transfers with the goal
of Medicaid qualification. While some Medicaid savings could result
from people who purchased Partnership policies rather than
transferring their assets to others, they are unlikely to offset the costs
associated with those who would have otherwise purchased traditional
policies.

**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
The Cost of Long-Term Care in the United States

In 2004, national spending on long-term care, which includes care provided in nursing facilities, totaled $193 billion and nearly half of that was paid for by Medicaid, the joint federal-state program that finances medical services for certain low-income adults and children. In contrast, private insurance paid for about $14 billion worth of long-term care, which is about 7 percent of the total cost. The demand for this type of care is likely to increase as the proportion of those in the population age 65 and older (those most likely to need long-term care) increases. With Medicaid financing nearly half of the long-term care costs nationwide, policymakers are concerned that, without changes in how long-term care is financed, the growing demand for this type of care will continue to strain the resources of federal and state governments.

As we reported, in the late 1980s the Robert Wood Johnson Foundation (RWJF) provided start-up funds for programs in eight states. Those states included California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin. The goal was to encourage individuals to plan for their long term care needs and help shift some of the responsibility for financing long-term care to private sources.
Participation Long-Term Care Policies

care from Medicaid to private long-term care insurance. Four of the states that received funds, California, Connecticut, Indiana, and New York, established the programs. These four state-run long-term care programs, known as Partnership programs, encouraged individuals to purchase long-term care insurance by providing an incentive to purchase the Partnership LTC policies. Specifically, they allow those who purchase long-term care insurance policies through the program to exempt some or all of their personal assets from Medicaid eligibility requirements should the policyholders exhaust their long-term care insurance benefits and still need to continue receiving long-term care services (which obviously must continue to be paid for).

Without the Partnership plan exemption, before individuals could receive Medicaid benefits they would typically have to spend their assets on their long-term care until the assets met or fell below certain Medicaid thresholds. The Partnership plans do not exempt income, which must continue to be contributed towards the individual’s long-term care costs.

Long-Term Care Partnership Program

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

Medicaid does not grant asset protection for long-term care insurance policies purchased outside of the Partnership programs. 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
Partnership Long-Term Care Policies

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.

Since the early 1990s, the treatment of Partnership programs under federal law has changed. Although a number of states established, or were authorized to establish, programs prior to the enactment of the Omnibus Budget Reconciliation Act of 1993 (OBRA ’93), OBRA ’93 prohibited additional states from establishing similar programs. The legislation was enacted, in part, because of concerns about potential costs to Medicaid, but allowed California, Connecticut, Indiana, and New York to maintain their programs. More recently, the Deficit Reduction Act of 2005 (DRA) authorized all states to establish Partnership programs that meet certain criteria and required the original 4 participating states to maintain the existing consumer protections in their Medicaid plans. DRA provisions are intended, in part, to allow states to provide an incentive for individuals to take responsibility for their own long-term care needs rather than financially relying on the taxpayers.

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

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

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

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

While “assets” may be defined in various ways, this text uses the Partnership program’s definition of “assets.” Therefore, when referring to assets, we mean savings and investments, excluding income. For Medicaid eligibility purposes, the Medicaid program considers both income and assets.
Medicaid defines income as anything received during a calendar month that is used (or could be used) to meet food or shelter needs, including resources such as cash and anything owned, including but not necessarily limited to savings accounts, stocks, or property that can be converted to cash.

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

Prior to the enactment of OBRA ’93, California, Connecticut, Indiana, and New York established Partnership programs. Iowa and Massachusetts also received permission from the Health Care Financing Administration (now CMS) to establish a Partnership program, but had not implemented one as of October 2006.

Partnerships Save Assets from Medicaid Qualification

According to the National Association of Health Underwriters, prior to the enactment of DRA, there was legislative activity in 19 additional states to begin development of a Partnership program. As of October 2006, the only states with active Partnership programs were the original 4 states: California, Connecticut, Indiana, and New York.

However, HHS indicated that as of February 2007, CMS had approved Partnership program state plan amendments in 6 states: Florida, Georgia, Idaho, Minnesota, Nebraska, and Virginia. Although the program appears to be expanding beyond the original 4 states, concerns about the potential cost to Medicaid of expanding the program remain an issue. In 2005, the Congressional Budget Office (CBO) estimated that repealing the moratorium on new Partnership programs could increase Medicaid spending by $86 million between 2006 and 2015.

States are responsible for overseeing Partnership programs and regulating the Partnership programs as well as the traditional long-term care insurance policies sold in their states. As more states consider establishing Partnership programs, there is interest, on the part of Congress and others, in understanding how the four states with Partnership programs designed and regulate their Partnership programs, who purchases Partnership policies, and how these programs will impact Medicaid financially.

The GAO was asked to analyze the experience of the four states participating in the Partnership program. In August 2005, GAO provided a briefing, which summarized aspects of the design of these Partnership programs and included demographic information on Partnership policyholders.

In this report, the GAO updated their information and provided a more detailed analysis of the Partnership programs. Specifically, they examined:

1. The benefits and premium requirements of Partnership policies as compared with those of traditional long-term care insurance policies, including information on benefits purchased by policyholders;
2. The extent to which states oversee Partnership policies as compared with their oversight of traditional long-term care insurance policies;
3. The demographics, including asset and income levels, of Partnership policyholders, traditional long-term care insurance policyholders, and people without long-term care insurance; and
4. Whether the Partnership programs are likely to result in savings for Medicaid.

When the GAO report refers to the four states with Partnership programs or the four states, it is referring to California, Connecticut, Indiana, and New York. According to CMS officials, as of October 2006, no other states had active Partnership programs; that is, no insurance companies were issuing Partnership policies in any other states.
Partnership Long-Term Care Policies

To compare the benefits and premium requirements of Partnership and traditional long-term care insurance policies, the GAO reviewed state regulations, and interviewed Partnership program officials and department of insurance (DOI) officials in each of the four states with Partnership programs. To compare the benefits purchased by Partnership policyholders and traditional long-term care insurance policyholders, the GAO obtained data from 2002 through 2005 from two sources. Their data source for benefits purchased by Partnership policyholders was the Uniform Data Set (UDS), a data set with information on Partnership policyholders compiled by officials in each of the four states with Partnership programs from data provided by participating insurers. The GAO data source for benefits purchased by traditional long-term care insurance policyholders was from a survey they conducted using five of the largest long-term care insurance companies in the individual long-term care insurance market.

To examine the extent to which states oversaw Partnership policies compared with state oversight of traditional long-term care insurance policies, the GAO reviewed state regulations and Partnership program documents, and interviewed officials from Partnership programs, long-term care insurance companies, and each Partnership state’s DOI, the entities that are responsible for regulating insurance policies, including long-term care insurance policies, that are sold in the states. The GAO also reviewed state regulations, Partnership program documents, and conducted interviews about how training requirements for insurance agents who sell Partnership policies compared with training requirements for agents who sell traditional long-term care insurance policies.

The UDS is a data set developed by the four states with Partnership programs, participating insurers, the National Program Office at the Center on Aging, University of Maryland, and the Program Evaluator, Laguna Research Associates. Data in the UDS are submitted by insurers to the Partnership program in the state in which they are participating and contain information on Partnership policyholders.

The GAO selected the five insurance companies on the basis of the total number of policies and amount of annualized premiums in effect in the individual market as of December 31, 2004.

To examine the demographics, including income and assets levels, of
Partnership policyholders, traditional long-term care insurance policyholders, and individuals without long-term care insurance, the GAO used data from three sources. First, to calculate the household income and assets of Partnership policyholders, they used available survey data from a sample of Partnership policyholders in California and Connecticut. The GAO restricted their analysis to the income and asset data from these two states because Indiana’s data was not sufficiently detailed to include in the analysis, and New York was not able to provide them with data from recent years. The GAO combined multiple years of such data in order to increase the sample size. To estimate the household income of individuals without insurance in California and Connecticut, the GAO used data from the American Community Survey (ACS) for 2004 published by the U.S. Census Bureau.²

Finally, GAO used national data from the Health and Retirement Study (HRS) for 2004, to compare household income and household assets for those individuals with traditional long-term care insurance and those without long-term care insurance.³ The HRS is a national survey sponsored by the National Institute on Aging and conducted by the University of Michigan of individuals over the age of 50. The Health and Retirement Study (HRS) is a longitudinal national panel survey that collects information over time on individuals over age 50. The first survey was conducted in 1992, and subsequent surveys were conducted every 2 years. The most recent survey for which data were available was 2004. The HRS collected information about retirement, health insurance, savings, and other issues confronting the elderly. To examine the age, marital status, and gender of Partnership policyholders, traditional long-term care insurance policyholders, and individuals without long-term care insurance, the GAO used data from the UDS and the HRS.

To examine whether the Partnership programs in the four states are likely to result in savings for Medicaid, the GAO assessed:

² For income and asset data in California the GAO combined data for 2003 and 2004, and for Connecticut, they combined data for 2002 through 2005.

³ To make the income analysis consistent across the different data sources, the GAO restricted their calculations of household income to individuals aged 55 and over.
1. Available state survey data of Partnership policyholders and
2. The options an individual has for financing long-term care and the time it would take for the individual to become eligible for Medicaid under three illustrative scenarios.

The GAO used illustrative scenarios since Partnership programs in the four states have only been operating since the early 1990s, and there is no available data describing when or if Partnership policyholders would have accessed Medicaid. As a result, there is insufficient data available to directly measure whether the Partnership programs have resulted in increased or decreased Medicaid spending. GAO used available survey data in California, Connecticut, and Indiana to determine what Partnership policyholders report they would have done to finance their long-term care needs if there had not been a Partnership program in their state. New York survey data was not available.

The GAO assessed three scenarios that represented the three main options an individual had for financing long-term care: financing using a Partnership policy, financing using a traditional long-term care policy, and self-financing without any long-term care insurance. The latter two scenarios described the financing options that a Partnership policyholder could use if the Partnership programs did not exist. The GAO used the three scenarios to explore how long it was likely to take before the individual depicted in their scenarios would have become eligible for Medicaid with a Partnership policy and, in the scenarios in which Partnership programs did not exist, with the other two financing options. In the scenarios if, in the absence of a Partnership program, an individual using a traditional long-term care insurance policy or relying on self-financing was likely to become eligible for Medicaid sooner than the same individual would have using a Partnership policy, they considered the Partnership programs to be a potential source of savings for Medicaid. In contrast, if the same individual delayed Medicaid eligibility using a traditional long-term care insurance policy or self-financing when compared with the time it would take the individual to become eligible for Medicaid using a Partnership policy, they considered the Partnership program to be a potential source of increased spending for Medicaid. To develop their scenarios, the GAO made several simplifying assumptions. These included the following:
• The individual depicted in the scenarios has $300,000 in assets, and in two of the scenarios a long-term care insurance policy worth $210,000—assets and benefits that are typical of many individuals with long-term care insurance—and the individual receives long-term care in a nursing facility with costs for a year of care of $70,000, about equal to average nursing facility costs nationwide in 2004.

• The individual has assets that are no less than the value of the individual’s Partnership policy—that is, the individual does not over-insure his or her assets.

• The individual is unmarried. While most Partnership policyholders are married at the time they purchase a Partnership policy, they are unlikely to require long-term care for many years, and their marital status can change. Most individuals who are admitted to a nursing facility are unmarried.

Where possible, the GAO used data from surveys of Partnership policyholders to support their assumptions. They also explored whether adjusting the assumptions changed the conclusions drawn. Although their scenarios represented the choices facing a single individual, the results of this analysis are applicable beyond one person. For example, the relative impact on Medicaid spending across the scenarios is independent of the amount of assets owned by the individual or the level of the individual’s insurance coverage.

As part of the GAO’s efforts to examine whether the Partnership programs were likely to result in savings for Medicaid, they also examined the likelihood that the population of Partnership policyholders might ever become eligible for Medicaid. To assess this likelihood, they examined the long-term care insurance benefits and income of Partnership policyholders. The GAO also assessed the number of people with Partnership policies who accessed Medicaid as of October 2006.

Based on discussions with state officials and reviewing documentation on uniformly collected insurer data and surveys of policyholders, the GAO determined that the information used was sufficiently reliable. They also examined reports on the Partnership
In the four states with Partnership programs, 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 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. 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. In comparing these two groups the GAO found that a higher percentage of Partnership policyholders purchased policies from 2002 through 2005 with more extensive coverage; for example, higher levels of inflation protection and coverage for care in both nursing facility and home and community-based care settings. Officials in states with Partnership programs do not allow companies selling long-term care insurance to charge Partnership policyholder’s higher premiums for the asset protection benefit. 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.
Partnership Long-Term Care Policies

Partnership policyholders in the four Partnership states 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. In addition, a higher percentage of Partnership and traditional long-term care insurance policyholders are married rather than unmarried, and female rather than male.

Available survey data from three Partnership states and the GAO’s three illustrative financing scenarios together suggest, according to the GAO, that the Partnership programs are unlikely to result in savings for Medicaid and may result in increased Medicaid spending. Based on surveys of Partnership policyholders in California, Connecticut, and Indiana, it was estimated that, in the absence of Partnership programs, 80 percent of Partnership policyholders would have purchased traditional long-term care insurance policies. The GAO’s long-term care financing scenarios suggested it would take longer for an individual with a traditional long-term care insurance policy to become eligible for Medicaid than it would the same individual with a Partnership policy. This makes sense since the Partnership policyholder would have protection for assets that the traditional policy owner would not have. Therefore, the 80 percent of surveyed Partnership policyholders may represent a potential source of increased spending for Medicaid, as Medicaid may begin paying for the long-term care of these policyholders sooner. 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. Data was not yet available to directly measure when or if these individuals would access Medicaid had they not purchased a Partnership policy. 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.

The GAO’s scenarios suggest that an individual who self-finances his or her long-term care without any long-term care insurance is likely to become eligible for Medicaid at about the same time as the individual would using a Partnership policy, though there were some circumstances that could accelerate or delay the individual’s time to Medicaid eligibility. While the majority of Partnership policyholders

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4 New York data was not available.
have the potential to increase spending, the GAO also anticipated that the impact of these programs was likely to be small since few policyholders would become eligible. Partnership policyholders tend to have incomes that exceed Medicaid eligibility thresholds and insurance benefits that cover most of their long-term care needs.

The states and HHS commented that the GAO report seemed flawed. In their opinion, important long-term care considerations were not included, such as asset relocation resulting in Medicaid qualification. The GAO felt evidence suggested the Partnership program was unlikely to result in savings for Medicaid, although the available data was limited since it is too soon to see how many people will deplete the policy benefits and seek access to Medicaid benefits. Some savings to Medicaid could be possible for reasons not currently recognized. However, the GAO felt Medicaid savings were unlikely to offset the potential costs associated with policyholders who would have purchased traditional long-term care insurance in the absence of the Partnership programs. If they purchased the traditional LTC policies they would not qualify for asset protection, resulting in self-funding once policy benefits were exhausted.

The GAO did not include a review of asset transfers because the evidence of such transfers is generally limited. It is not known how many people may have qualified for Medicaid benefits as a result of transfers, so it would be difficult for the GAO to include it in their study.\(^5\) However, in response to HHS’ comments, they did amend their report to make the discussion of asset transfers more prominent and to include reference to the 2007 GAO study. They also maintained that their methodology for estimating the financial impact of the program on Medicaid is sound and disagreed with California and Connecticut regarding the appropriateness of using the two survey questions. Specifically, by relying on the responses from these questions, the method California, Connecticut, and Indiana used to evaluate Medicaid costs underestimated, they said, the percentage of people who would have purchased traditional policies in the absence of the Partnership program. GAO felt their method of evaluating Medicaid savings is sound.

savings due to asset transfers overestimated the percentage of people who utilized this. Only time will tell the true story on asset transfers, but with the time period having been lengthened to five years, it may not be possible to know how accurate the GAO report was in respect to transfers.

Long-term care comprises 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.

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 is expensive, especially when provided in nursing facilities. In 2005, the average cost of a year of nursing facility care was about $70,000. In 1999, the most recent year for which data were available, the average length of stay in a nursing facility was between 2 and 3 years.
Partnership Long-Term Care Policies

Long-term care insurance is used to help cover the cost associated with long-term care. Individuals can purchase long-term care insurance policies directly from insurance companies, or through employers or other groups. The number of long-term care insurance policies sold has been small—about 9 million as of 2002, the most recent year for which data was available. About 80 percent of these policies were sold through the individual insurance market and the remaining 20 percent were sold through the group market.\(^6\)

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. Data from 2002 through 2005 show that the maximum daily benefit amounts can range from less than $100 to several hundred dollars per day, while benefit periods can range from one year to lifetime coverage.\(^7\)

- 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. According to data from 2002 through

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\(^7\) Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, The National Nursing Home Survey: 1999 Summary, Series 13, No. 152 (June 2002).
Partnership Long-Term Care Policies

2005, elimination periods can range from zero days to at least 730 days.⁸

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

Accessing Policy Benefits

There can be a substantial gap between the time a long-term care insurance policy is purchased and the time 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 in 2008 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 at an extra cost. Some future purchase options do not allow consumers to purchase extra coverage once they begin receiving their insurance benefit and the opportunity to purchase extra coverage may be withdrawn should the consumer decline a predetermined number of premium increases. A policy with a future purchase option may be less expensive initially than a policy with compound inflation protection. However, over time the policy with a future purchase option may become more expensive than a policy with compound inflation.

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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 in 2006 would cost about $400 per day 20 years later in 2028. A policy purchased in 2008 with a daily benefit of $150 without inflation protection would pay $150 per day—or 38 percent—of the daily cost of about $400 in 2028. The remaining $250 of the daily cost of the nursing facility care 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. For example, in Connecticut, if a 55-year-old man decided to buy a 1-year, $200 per day comprehensive coverage policy, in 2005 it would have cost him about $1,000 less per year than a comparable 3-year policy. Similarly, the age of an applicant also impacts the premium, as premiums typically are more expensive the older the policyholder at the time of purchase. For example, in Connecticut, a 55-year-old purchasing a 3-year, $200 per day comprehensive coverage policy in 2005 would pay about $2,500 per year, whereas a 70-year-old purchasing the same policy would pay about $5,900 per year. Health status may also affect premiums. Insurance companies take into account the health status of an
applicant to evaluate their risk. If an applicant has a medical condition that increases the likelihood of the applicant using long-term care services, but does not automatically disqualify the applicant from purchasing insurance, the applicant may receive a substandard rating from an insurance company, if allowed by state statutes, which may 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 and is insurable is known as underwriting. Examples of medical conditions that may not disqualify an individual from obtaining insurance but that can result in a substandard rating during the underwriting process include osteoporosis, emphysema, and diabetes. However, the severity and the ability to control and treat the medical condition are all factors that can also impact how a non-disqualifying medical condition impacts an underwriting rating.

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

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

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

• Requiring substantial supervision because of a severe cognitive impairment.

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

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

2. Increasing the premium of an existing policy because of a policyholder’s age or claims history. In addition, in order for a long-term care insurance policy to be tax-qualified, HIPAA requires that a policy offer inflation protection. The NAIC, who represents insurance regulators from all states, reported in 2005 that 41 states based their long-term care insurance regulations on the NAIC model, 7 based their regulations partially on the model, and 3 did not follow the model.

Medicaid supplies health care financing for poor individuals of all ages, not just the elderly. Medicaid is the primary source of financing for long-term care services in the United States. In 2004, almost one-third of the total $296 billion in Medicaid spending was for long-term care. 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 to 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. In all four states with 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, certain individuals with an equity interest in their home of greater than $500,000 are not eligible for Medicaid coverage for nursing facility services or other long-term care services. However, states have the option to increase the home equity interest level to an amount that does not exceed $750,000. 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.

**Medicaid**

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
Partnership Long-Term Care Policies

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 suggests that the incidence of asset transfers is low among nursing home residents covered by Medicaid.\(^9\) 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 3-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 3 to 5 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

\(^9\) GAO-07-280
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. In the four states with Partnership programs, those who purchase long-term care insurance Partnership policies generally must first use those 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. In 2006 there were about 190,000 active Partnership policies, out of the approximately 218,000 Partnership policies that had been sold. Between September 2005 and August 2006, the number of Partnership policies in the four states combined increased by about 10 percent since the inception of the Partnership programs.

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 states with Partnership programs give Partnership policy purchasers a 30-day “free look” period during which they can decide whether to keep their policy or drop it and receive a full refund.

By state, the number of Partnership policies, excluding those that were dropped, was 73,811 in California and 33,040 in Connecticut, through March 2006; 31,750 in Indiana through June 2006; and 51,262 in New York through December 2005.
This rate of increase varied across the states: the sales of Partnership policies in California increased by 14 percent. That was the largest percentage increase among the Partnership states. It compared with increases of 7, 9, and 8 percent in Connecticut, Indiana, and New York, respectively.

Protecting Partnership Policyholder Assets

The four states with Partnership programs vary in how they protect policyholders’ assets. The Partnership programs in California, Connecticut, Indiana, and New York have dollar-for-dollar models, in which the dollar amount of protected assets is 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 would have $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 offers total protection. That is, those who purchase 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, can protect all their assets at the time of Medicaid eligibility determination. In Indiana, in addition to the dollar-for-dollar models, the Partnership program offers a hybrid model that allows purchasers to obtain dollar-for-dollar protection up to a certain benefit level as defined by the state; all policies with benefits above that threshold provide total asset protection for the purchaser.

Under DRA, any state that implements a Partnership program must ensure that the policies sold through that program contain 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, while inflation protection is an optional feature for Partnership policyholders aged 76 or older.10

Some of the states that passed legislation prior to the passage of DRA to enable the creation of a Partnership program may need to make additional changes to meet DRA requirements.

DRA also requires that Partnership policies 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.

The four states with Partnership programs require Partnership policies 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. Compared with policyholders of traditional long-term care insurance policies, a higher percentage of Partnership policyholders purchased policies with more extensive coverage. In the four states, insurance companies are not allowed to charge policyholders higher premiums for policies with asset protection, and Partnership and traditional long-term care insurance policies with comparable benefits are required to have equivalent premiums.

In general, the four states with Partnership programs require that Partnership policies sold in their states include certain benefits that are not required for those states’ 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, all four states require Partnership policies to include inflation protection. There are some exceptions to the inflation protection requirement. For example in New York insurance companies are allowed to sell Partnership policies to policyholders 80 years of age or older without inflation protection.

Three of the four original Partnership states - California, Connecticut, and New York - require that Partnership policies include inflation protection that automatically increases benefit amounts by 5 percent annually on a compounded basis. In Indiana, Partnership policies are required to include either automatic compound inflation protection at 5 percent annually or in accordance with the consumer price index, or an inflation protection option that covers at least 75 percent of the average daily private pay rate.

The four states do not require traditional long-term care insurance policies to include inflation protection, though insurance companies in these states are required to offer inflation protection as an optional benefit. 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. For example, in 2005 a long-term care insurance policy with a $200 daily benefit, a 3-year benefit period, and inflation protection cost about $3,000 per year for a 60-year-old male; the same policy cost about $1,350 per year without inflation protection. An insurance company official told the GAO that the additional cost of inflation protection is the primary reason individuals do not buy a Partnership policy.

The four partnership states also require minimum daily benefit amounts for all Partnership policies, while in three of the Partnership states, traditional long-term care insurance policies are not subject to this requirement. New York does have minimum daily benefit
Partnership Long-Term Care Policies

requirements for that state’s traditional long-term care insurance policies.

According to Partnership and DOI officials in California and Connecticut, 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. According to Partnership program materials from New York, for example, the average daily cost of long-term care in a nursing facility in New York was about $263 per day in 2004. Anything less than New York’s 2004 minimum daily benefit amount of $171 for nursing facility care would therefore have required out-of-pocket payments for policyholders of more than one-third of the cost of their nursing facility care. In 2006, the required minimum daily benefit amounts for nursing facility care in Partnership policies ranged from $110 per day in Indiana to $189 per day in New York.

In the four states with Partnership programs, Partnership policies are subject to minimum nursing facility benefit period requirements established by the states, but some traditional long-term care insurance policies are not subject to these same requirements. In California and Indiana, Partnership policies are required to have dollar coverage that provides for at least 1 year of care in a nursing facility, while traditional long-term care insurance policies are not subject to a minimum benefit period requirement. The minimum amount paid under a Partnership policy for this dollar coverage can be no less than 70 and 75 percent of the average daily private pay rate for nursing facilities in California and Indiana, respectively.

In New York, Partnership policies are required to have minimum nursing facility benefit periods ranging from 18 months to four years, depending on the type of coverage an individual purchases, while certain traditional long-term care insurance policies are required to have one-year minimum nursing facility benefit periods. In Connecticut, Partnership and traditional long-term care insurance policies are both required to have one-year minimum benefit periods for care provided in nursing facilities.

Partnership and traditional long-term care insurance policies both typically include elimination periods, which establish the length of time a policyholder who has begun to receive long-term care has to wait
before receiving long-term care insurance benefits. The four states with Partnership programs limit the length of the elimination periods that can be included in Partnership policies. Two of the four states, Connecticut and New York, also generally limit the elimination period included in traditional long-term care insurance policies. In 2006, the elimination period for Partnership policies in California was no more than 90 days, while New York had a 100-day limit for their total asset protection policies. The maximum elimination period for New York’s dollar-for-dollar policies was 60 days. Indiana had a 180-day limit.

In Connecticut, the elimination period limit for both Partnership and traditional long-term care insurance policies was 100 days. According to a New York Partnership program staff member, in New York the elimination period for traditional policies was generally no more than 180 days. The effect of increasing the elimination period is to increase the out-of-pocket costs policyholders incur in paying for their long-term care. 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.

Unlike traditional long-term care insurance policies, Partnership policies in the four states must cover or offer case management services. In Connecticut and Indiana, the case management provision for Partnership policies is specific to home and community-based services.

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. Partnership program officials in California, Connecticut, and Indiana explained that their states require Partnership policies to cover case management services 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
Partnership Long-Term Care Policies

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.

Insurance companies in the four states with Partnership programs are subject to restrictions on the types of coverage they can offer in Partnership policies, while they are allowed to offer traditional long-term care insurance policies with more coverage options. In California, Connecticut, and Indiana, insurance companies can only offer Partnership policies with two types of coverage: an option that covers only nursing facility care, and a comprehensive option that covers nursing facility care as well as care provided in the home and in community-based facilities. In California, Indiana, and New York, nursing facility coverage also includes other settings that are similar to nursing facilities.

In New York, insurance companies may only offer Partnership policies that cover comprehensive care. The four states do not allow insurance companies to offer Partnership policies in their state that exclusively cover care provided in the home and in community-based facilities. However, in the four states, insurance companies can offer traditional long-term care insurance policies with nursing facility care only, home and community-based facility only, and comprehensive coverage options.

In the four states with Partnership programs, traditional long-term care insurance policies can include (and individuals can therefore choose to purchase) generally the same benefits found in Partnership policies. Traditional long-term care insurance policyholders cannot obtain asset protection through their policies.

However, Partnership policyholders tended to purchase benefits that are more extensive than those purchased by traditional long-term care insurance policyholders. The GAO found that from 2002 through 2005, a higher percentage of Partnership policyholders purchased policies with more extensive coverage compared with policyholders who purchased traditional long-term care insurance nationally. Specifically, more Partnership policyholders purchased policies with higher levels of inflation protection and coverage that includes care in both nursing
facility and home and community-based care settings. See table 1 for a summary of the benefits purchased by Partnership and traditional long-term care insurance policyholders. For example, while all Partnership policyholders had policies from 2002 through 2005 with the required inflation protection that generally increases daily benefit amounts by 5 percent annually, about 76 percent of traditional long-term care insurance policyholders had policies with some form of inflation protection. Similarly, during this period, 64 percent of all Partnership policyholders had policies that included daily benefit amounts of $150 or greater, while 36 percent of traditional long-term care insurance policyholders nationwide had policies that provided daily benefit amounts at this level or greater. While these differences may reflect the benefit requirements found in Partnership policies, they may also reflect the incentive offered by the asset protection benefit of Partnership policies, which may influence consumers deciding whether to buy a Partnership or traditional long-term care insurance policy. The differences may also reflect the demographic and financial characteristics of the people living in the four states with Partnership programs relative to other states.

According to state officials, the four states with Partnership programs require Partnership and traditional long-term care insurance policies to have equivalent premiums if the benefits offered (except for asset protection) are otherwise comparable. According to information from one state’s Partnership program, one reason for this requirement is that, unlike other insurance company benefits, insurance companies do not provide asset protection to Partnership policyholders. Instead, the four states with Partnership programs provide the asset protection benefit by allowing Partnership policyholders to protect some or all of their assets from Medicaid spend-down requirements. 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 are likely to have higher premiums. According to a Connecticut state official, in 1996, before the state required that Partnership and traditional long-term care insurance policies have equivalent premiums for the same benefits, Partnership policies were 25 to 30 percent more expensive than traditional long-term care insurance policies with comparable benefits. The official further explained that after the requirement was established, sales of Partnership policies in Connecticut more than tripled.
State officials reported that, while both Partnership and traditional long-term care insurance policies undergo reviews by the DOI in each of the four states with Partnership programs, Partnership policies in California and Connecticut also undergo another review by state Partnership program officials. The New York Partnership program does not conduct a review of Partnership policies. The New York DOI reviews all Partnership and traditional long-term care insurance policies.

Until recently, the Indiana Partnership program was housed in the Medicaid office and conducted an initial review of Partnership policies prior to the DOI review. As of September 2006, the Indiana Partnership program was housed in, and administered by, the DOI and there was only one review of Partnership policies, which was conducted by the DOI.

California and Connecticut Partnership program staff review Partnership policies to determine whether the policies include the benefits mandated by Partnership regulations, and whether the insurance companies can meet additional data reporting and other administrative requirements. The programs’ staff also tries to ensure that the policies can be easily understood and contain all of the required language. The Partnership program offices in California and Connecticut perform their review of policies first, and then pass the application on to the DOI for further review.

DOI officials in California and Connecticut reported that the Partnership office review of Partnership policies tends to be lengthier for insurance companies than the DOI review. A DOI official explained that when insurance companies add new benefit options to policies, the Partnership review can take longer. Other factors that may slow the Partnership review process include the time spent coordinating between the Partnership program and the state DOI, and the time it takes for insurance companies to learn how to complete the Partnership review process for the first time. State officials in Indiana and New York, where reviews of new Partnership policies are conducted by the DOI and not a separate Partnership program office, said it generally takes the same amount of time for Partnership and traditional long-term care insurance policies to pass through the review process.
Before they can sell Partnership policies, insurance agents must complete additional state training requirements compared with agents who sell only traditional long-term care insurance policies. Although each of the four states with Partnership programs has somewhat different requirements, in general the states require Partnership agents to undergo about a 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 to sell long-term care insurance in the four Partnership states, insurance agents must receive several hours of continuing education every 2 years. The required hours range from 5 hours every 2 years in Indiana to 24 hours every 2 years in Connecticut.¹¹

In New York the continuing education credits from the required Partnership policy training can be used to meet the DOI requirements for agent recertification for traditional long-term care policies.

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. According to some state officials, agents need training on the Partnership program and Medicaid in order to understand the program and provide appropriate advice to their clients. In 2006, in three of the four states all Partnership program training was conducted in person, rather than via correspondence or on the internet. In New York agents completed an online internet-based course as well as classroom training as part of the Partnership program training. According to state officials, all four Partnership states require that the provider of this specialized Partnership training be approved by the state DOI, and in Connecticut, the training is provided exclusively by Partnership program staff.

Despite the complexity of long-term care insurance products, DOI officials in three states with Partnership programs reported that long-term care insurance policies, including Partnership policies, garner few complaints from policyholders. For example, from 1998 to 2005 the New York Insurance Department received an average of two to three

¹¹ GAO Report to Congressional Requesters
complaints about Partnership policies each year (there were 51,262 active Partnership policies in the fourth quarter of 2005 in New York). During this time period, according to data from the New York state DOI, complaints about all long-term care insurance policies in New York related to issues such as the interpretation of policy provisions, premium amounts, and refusals to issue policies.

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.

In examining Partnership policyholders in two states, traditional long-term care insurance policyholders nationwide, and those without long-term care insurance nationwide, the GAO found that Partnership and traditional long-term care policyholders are more likely to have higher incomes than those without such insurance, with 55 percent of them having monthly incomes of $5,000 or more. This compares to 43 percent for all households. Data from Indiana and New York are excluded from the GAO income and asset comparisons. New York did not collect income or asset data for its Partnership program, while Indiana income and asset data were not detailed enough to make comparisons with other states.

Income data for Partnership policyholders in Connecticut were from 2002 through 2005. Income data for Partnership policyholders in California were from 2003 to 2004. Data for all households in those two states were from 2004. The GAO combined multiple years of these data in order to increase the sample size.

Because the GAO did not have a direct measure of the population without long-term care insurance, they used the general population of all households as a proxy. Nationally, about 12 percent of the population over age 55 has long-term care insurance. Therefore they assumed that the income information from all households in two states with Partnership programs (California and Connecticut) largely reflected the income and asset patterns of people without long-term care insurance.
Partnership Long-Term Care Policies

Similarly, at the national level, when surveyed, 46 percent of traditional long-term care policyholders over age 55 had monthly household income of $5000 or greater, whereas 29 percent of those individuals over age 55 without long-term care insurance had such incomes. The GAO also found that more than half (53 percent) of Partnership policyholders had household assets of $350,000 or more in California and Connecticut. Data on the asset levels of all households in those states were not available for comparison. Nationwide, 36 percent of traditional long-term care insurance policyholders and 17 percent of people without long-term care insurance had household assets exceeding $350,000.

Approximately 12 percent of people nationwide over 55 have long-term care insurance so the report’s measure is likely to contain approximately 88 percent without long-term care insurance.

Approximately 2 percent of people nationwide with long-term care policies have Partnership policies. Thus, although the HRS data may include a small number of Partnership policyholders, about 98 percent of these people likely have traditional long-term care insurance.

In the GAO analyses, they found that Partnership policyholders in California, Connecticut, Indiana, and New York are younger on average than traditional long-term care insurance policyholders nationally and those without long-term care insurance nationally. They also found that those who purchase long-term insurance policies, whether traditional or Partnership, were more likely to be women than men, and married than unmarried.

Overall, the GAO’s scenarios suggested that in the aggregate the savings potential from the Partnership programs of the 20 percent of individuals who would have self-financed their care is outweighed by the 80 percent of individuals who will likely result in increased Medicaid spending. Few partnership policyholders are likely to become eligible for Medicaid, limiting the impact on Medicaid expenditures.

Although survey data and scenarios indicated that about 80 percent of Partnership policyholders who become eligible for Medicaid are likely to do so sooner than they otherwise would have without a Partnership

12 The national-level data are from 2004.
Partnership Long-Term Care Policies

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 purchase policies that are likely to cover all or most of their long-term care expenses during their lifetimes, thereby reducing the likelihood that the policyholders 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 between two and three years. 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, and fewer than 5 percent of all policyholders used their benefits for more than five years. Such data suggests Partnership policyholders will continue to purchase policies with benefit periods that cover their long-term care needs, with the percentage of Partnership policyholders who exhaust their benefits and then become eligible for Medicaid is likely to be limited. While some experts have reported that there is a recent trend for traditional long-term care insurance policies to be sold with shorter benefit periods, the minimum benefit requirements that applied to Partnership policies could result in Partnership benefits remaining more stable over time.

Secondly, it was 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. 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. In 2006, all states had a Medicaid monthly income eligibility threshold based upon the time they were admitted to the nursing facility. GAO’s study suggests that many Partnership policyholders will continue to be relatively wealthy and unlikely to meet these thresholds, even at the time they enter a nursing facility. For example, of all people who entered a nursing facility in 2004, the average asset value for the 25 percent of people with the highest assets was over $334,000 in 1992, and by 2004, 12 years later, their assets had grown to almost $430,000. Similarly, the average monthly income for the 25 percent of people with the highest incomes who were admitted to a nursing facility in 2004 was about
$5,600 in 1992 and about $3,700 in 2004—more than double the threshold for Medicaid eligibility in any of the four states with Partnership programs. Medicaid eligibility standards require income to be no higher than 300 percent of the Supplemental Security Income standard, which was $1,809 in 2006. However, only 1 percent of the Partnership policyholders in California and Connecticut had household incomes less than $1,000 per month at the time they purchased their long-term care insurance policies. The GAO analysis of HRS data also indicated that wealthy individuals continue to have a high level of assets. In 2006, the Medicaid eligibility thresholds in the four states with Partnership programs were $600 in California, $619 in Indiana, $1,809 in Connecticut, and $692 in New York. If individuals were in a nursing facility, they were permitted to keep a personal allowance amount to cover incidental purchases in the nursing facility. The personal allowances for individuals in nursing facilities in 2006 were $35 in California, $52 in Indiana, $61 in Connecticut, and $50 in New York.

The income levels of Partnership policyholders may reflect the fact that the cost of purchasing a long-term care insurance policy—including a Partnership policy—may exceed what most elderly households can afford. 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. A traditional long-term care insurance policy covering 3 years of care, with inflation protection, a $200 daily benefit allowance, and comprehensive coverage, costs about $3,000. In order to afford such a policy, an individual would need an annual income of about $43,000. However, data from the 2004 HRS show that about half of elderly households nationwide had annual incomes below $43,000. A survey of Connecticut Partnership policyholders suggested that cost was the most important factor in policyholders’ decision to let their policies lapse. Sixty-two percent of surveyed individuals in Connecticut who let their Partnership policy lapse said that they dropped their Partnership policy because it was too costly.

It is possible that Partnership policyholders with higher incomes could meet Medicaid income thresholds because the four states with

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13 In this particular example, GAO criterion for being among the wealthiest people was those people whose assets were in the highest 25 percent.
Partnership programs allow individuals to deduct medical expenses from their income when determining Medicaid eligibility. However, the individuals would still need to contribute their income toward the cost of care. Therefore, this limits Medicaid’s liability for individuals with higher incomes.

As of 2006, few Partnership policyholders in the four Partnership states had accessed Medicaid to finance their long-term care. Of the approximately 218,000 Partnership policies sold since the program was first introduced in the late 1980s, approximately 190,000 were still active as of August 2006. In addition, as of that same date, a total of 3,454 Partnership policyholders - less than 2 percent of all Partnership policyholders - had accessed long-term care benefits since the Partnership programs began. Of that group, 292 Partnership policyholders exhausted their long-term care insurance benefits, and 159 policyholders, approximately 54 percent of those who exhausted their benefits, subsequently went on to access Medicaid benefits. The number of Partnership policyholders who access benefits and also access Medicaid is likely to grow since people typically use long-term care services 15 to 20 years after they purchase their policy. The first Partnership policies were established less than 20 years ago so future data will yield greater understanding of whether or not Partnership plans actually save Medicaid (and the taxpayers) money. We do not know why some of the 292 individuals who exhausted their long-term care insurance benefits did not access Medicaid. It is possible that their income was higher than Medicaid eligibility thresholds, or they may have had unprotected assets that they had to spend down. Alternatively, they may have preferred to self-finance their care, they may have died, or they may have stopped using long-term care services.

**Concluding GAO Observations**

With DRA authorizing all states to implement Partnership programs, information on existing Partnership policies and policyholders from the four Partnership states may prove useful to other states considering such programs. In particular, states may want to consider the trade-offs that come with implementing a Partnership program. First, a Partnership program’s potential impact on Medicaid expenditures...
Partnership Long-Term Care Policies

should be considered. Based on their scenario comparison and survey data, the GAO anticipated that Partnership programs in California, Connecticut, Indiana, and New York are unlikely to result in savings for their state Medicaid programs and could result in increased Medicaid expenditures. This is largely due to the modifications of state Medicaid eligibility requirements states have to make in order to offer asset protection to Partnership policyholders and survey data showing that the majority of Partnership policyholders would have purchased traditional long-term care insurance had the Partnership program not existed. However, given the amount of long-term care insurance benefits and income and asset levels of current Partnership policyholders, the GAO also anticipated that relatively few policyholders will access Medicaid in the four Partnership states. Therefore, the impact of Partnership programs on state Medicaid programs will likely be small.

While Partnership programs are not likely to reduce states’ Medicaid expenditures, the programs do offer consumer benefits. The asset protection feature can benefit policyholders who exhaust their Partnership benefits and then access Medicaid. Even if individuals do not end up using their Partnership insurance or Medicaid, the availability of asset protection may provide peace of mind for those who fear the risk of having to spend their assets on their long-term care. However, states that implement Partnership programs should recognize that, because of their cost, Partnership policies generally do not benefit all consumers. The cost of annual premiums for long-term care insurance may not be affordable to individuals with moderate incomes, and as a result long-term care insurance policyholders, including Partnership policyholders, tend to be wealthier than those without such insurance.

Impact of Asset Transfers on Medicaid

The GAO acknowledged that some savings could result for Medicaid if, in the absence of a Partnership program, an individual would have self-financed his or her long-term care and transferred assets. They also acknowledged how a Partnership program could result in Medicaid savings if, in the absence of the Partnership program, an individual would have purchased a traditional long-term care insurance policy
and transferred assets that were at least equal to the value of the traditional long-term care insurance policy. However, their analysis suggested that these savings would be limited to those individuals who, prior to requiring long-term care, would have transferred assets to become eligible for Medicaid in the absence of the Partnership program. Further, the larger percentages of policyholders who represent a potential cost to Medicaid are likely to offset savings attributable to asset transfers.

It is very difficult to know the number of people who have transferred assets in order to qualify for Medicaid benefits. Obviously, these individuals would want to keep a low profile. In March 2007, the GAO published a report that included an analysis of asset transfers by nursing home residents using HRS data. They complemented that analysis by examining a sample of Medicaid applications in three states to identify the extent of asset transfer activity.

Both of these analyses suggested that about 10 to 12 percent of individuals transferred assets prior to applying for Medicaid, and the median amount transferred based on analysis of the HRS data and state Medicaid applications was $1,239 and $15,152, respectively. Many industry professionals feel much higher amounts are transferred, but that it fails to show up in available data.

Methodology for Assessing Medicaid Savings

California, Connecticut, and New York raised concerns about GAO’s methodology for estimating the financial impact of the Partnership program on Medicaid. California and Connecticut noted that they had excluded two Partnership policyholder survey questions from their analysis that they considered in their own analysis of the Partnership program. These questions asked Partnership policyholders whether they would have transferred assets to become eligible for Medicaid in the absence of the program and whether the Partnership program influenced their decision to buy long-term care insurance. In many cases, the questions seem to center on the quantity of assets actually transferred (for which little data exists).
Partnership Long-Term Care Policies

In the GAO analysis, they estimated that about 80 percent of Partnership policyholders would have purchased traditional long-term care insurance in the absence of the program, and they estimated that these individuals generally represented a potential cost to Medicaid. Their 80 percent estimate was based on analysis of the survey question about how Partnership policyholders would have financed their long-term care in the absence of the Partnership program.

It seems that there will continue to be differing views on the effectiveness of the Partnership policies until sufficient data becomes available. Will the program grow? Can those who need it most even afford the policies? Only time will tell, but with the passing of the DRA at least more states will be participating lending to new data that will hopefully reveal the full story.
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.

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

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 a nursing home stay 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:

There are basic benefits included in all the federally standardized Medicare supplemental plans. Under the basic benefits the recipient receives hospitalization under Part A, which means that Medicare will pay the hospital costs in the following manner:

**Part A (Inpatient Care):**

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

Part A will also cover skilled nursing facility care under very specific circumstances. When it is covered, a semiprivate room, meals, skilled nursing and rehabilitative services and other supplies associated with it will be covered. There is a three day related inpatient hospital stay required to qualify for skilled nursing facility care.
Partnership Long-Term Care Policies

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 would include 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 for those with a terminal illness is also covered under Part A of Medicare. It would include 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.

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

Part B (Outpatient Care)

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.

Each Medicare recipient should receive a copy of the current Medicare handbook from the federal government to learn precisely the benefits that will be received. Any person can request and receive this booklet by calling 1-800-633-4227.
Partnership Long-Term Care Policies

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.

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.

Covered Under Either Part A or Part B

Either Part A or Part B of Medicare may cover the first three pints of blood each year.

Beyond these basic benefits, some plans offer additional coverage. Plans A through L (plans K and L were added with the adoption of the Medicare drug benefit plan) have been mandated by federal legislation. Medicare plans I and J are no longer sold since they included a drug benefit that is now available through Medicare’s prescription coverage. All companies marketing Medigap policies must offer exactly the same benefits. In other words, all companies offering
Plan C will have identical benefits, except for price, which may legally vary.

Plan A has only the basic benefits, with no additional coverage offered beyond that. It is rare for consumers to buy plan A. If any other plan is offered, however, the insurance company must also offer Plan A.

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. From the hospital, 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 is the type most commonly received. When the level of care received is skilled (not intermediate or custodial) Medicare will pay for the first 20 days entirely. Neither the patient nor their supplemental policy will have to cover anything, as long as the charges are **approved**. Approval is the key point. Anything **not approved by Medicare** will not be covered.

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

Obviously 100 days of coverage is not sufficient and cannot be considered “long-term.” Even the federal definition of long-term care defines a care period of no less than 90 days. The consumer cannot and should not rely on Medicare or their supplemental Medigap policy for long-term medical needs in a nursing home facility.
Some Medicare recipients do receive skilled care benefits. To qualify for the nursing home care that is available under Medicare, the patient must meet certain qualifications, including:

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

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

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

**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.
The traditional fee-for-service plans still exist, but now there are other plans available as well.

**The Original Medicare Plan**

The Original Medicare Plan covers most health care services and supplies, but it doesn’t cover everything. Most people choose to get some type of additional coverage (supplemental insurance). This is a fee-for-service plan, which means the individual is charged a fee for each service. 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 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 (Part C)

A Medicare Advantage Plan is a health coverage choice that is part of Medicare, namely Part C. Private companies offer Medicare Advantage Plans, which are sometimes referred to as Part C or simply MA plans. The private company provides both Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Of course emergency and urgent care will always be covered as well.

Medicare Advantage Plans or Part C of Medicare must cover all of the services that the Original Medicare covers except hospice care. Hospice care continues to be covered under the Original Medicare coverage even if Part C is selected. Medicare Advantage Plans are not considered Medicare supplement insurance.

Many consumers select coverage under Part C because they receive extra benefits, such as vision, hearing, dental and wellness programs. Advantage plans often include prescription coverage. Those who select Advantage plans must still purchase Part B coverage and pay the appropriate premium that requires. Subscribers to Part C plans also typically pay a monthly premium for the Medicare Advantage Plan coverage. Medicare pays the private company a fixed amount each month rather than paying on individual claims as they arise. Although all Advantage Plans must follow Medicare’s rules, they can charge different out-of-pocket costs and have different rules for the services they receive.

Medicare Advantage plans offer subscribers a variety of plan choices, which include health maintenance organizations (HMO), preferred provider organizations (PPO), private fee-for-service plans (PFFS), medical savings account plans (MSA), and even special needs plans (SNP). The subscriber is still in the Medicare program under all of these choices, which means all individual Medicare rights and protections continue. The regular Medicare services are still available but some plans may provide additional benefits. Regardless of which plan is chosen, however, there are no long-term care services in a nursing home beyond that supplied by Medicare for skilled nursing care.

Decisions on which type of plan to join are usually made on the basis of cost and benefits. Choice of coverage might even be based upon...
Partnership Long-Term Care Policies

which insurer is operating locally. Since types of coverage can vary it is important for subscribers to be aware of limitations as well as benefits.

The ability to join a Part C Advantage Plans is not difficult. Typically the following is required:
• The applicant must have both Parts A and B of Medicare;
• The applicant must live in the plan’s service area;
• The applicant may not have End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant. However, once a successful transplant has been performed it may then be possible to join an Advantage Plan.

If the individual is already enrolled in a Medicare Advantage Plan when ESRD or kidney failure occurs, he or she would be covered under that plan.

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 fifteen 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
Partnership Long-Term Care Policies

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 Oklahoma.

There is one aspect of Medicaid that is uniform to all states: the fact that qualification depends upon “spending-down” assets. 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 to 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 the 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 development, 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 that 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 cost 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.
Relying on Insurance for LTC Payment

In the past ten years, insurance policies for long-term care needs have become popular. 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 Policy, Comprehensive LTC Policy, 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.

State Requirements

The contracts offered will vary with the state, since each state will require 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 will have 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 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.

**Age as a Policy Factor**

The age of the applicant will have an impact on the cost of the LTC policy, the older the applicant the more expensive the policy. Age matters because the less time the insurance company has to collect premiums, the greater the company's risk exposure is. Therefore, the price for the policy is higher. 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. When each birthday determines the rate, the policy rate book will show it as such:

<table>
<thead>
<tr>
<th>Age:</th>
<th>Price:</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>$</td>
</tr>
<tr>
<td>66</td>
<td>$</td>
</tr>
<tr>
<td>67</td>
<td>$</td>
</tr>
<tr>
<td>68</td>
<td>$</td>
</tr>
<tr>
<td>69</td>
<td>$</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Age:</th>
<th>Price:</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>$</td>
</tr>
<tr>
<td>70-74</td>
<td>$</td>
</tr>
<tr>
<td>75-79</td>
<td>$</td>
</tr>
<tr>
<td>80-84</td>
<td>$</td>
</tr>
</tbody>
</table>

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 the forties and fifties are expressing interest. The average Partnership policyholder is between 50 and 60 years old. Surprisingly most companies do not sell, or even offer to sell, to the younger ages. Many policies are not available to anyone under the age of 40 or even 50. 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.

The possibilities 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 widespread 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.
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.
Reducing Benefits to Save Premium

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

There are several ways that benefits may be reduced:

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

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

Example:

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

If there is not a state requirement requiring Bert’s issuing company to allow benefit reduction in order to save premium then a new application must accomplish this. A new application will be based on Bert’s current age of 70. Even though he is only two years older, the extra premium caused by this additional age saves little, if any, premium even with fewer benefits. As a result, Bert still cannot afford a long-term care policy. Bert may eventually have to rely on Medicaid to pick up any long-term care expenses. Because this is often the case, it is in the state's best interest to mandate that a consumer can lower benefits on an *existing* policy. Such a requirement is likely to save the state Medicaid dollars.

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

Policy Renewal

It is not likely that a long-term care policy would be written with premiums guaranteed to remain the same. Most long-term care policies are now *guaranteed renewable*, meaning the premiums are subject to change. In a guaranteed renewable policy the insured's contract will remain in effect during 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 recognize 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.
Partnership Long-Term Care Policies

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.

Number One Best Selling Unread Document

Insurance policies have been called the number one best selling unread document. Every insurance contract advises the consumer to completely review their issued policy, but few probably do so. Although the wording may vary, the contract will state that issuance was based upon the answers given by the applicant to the questions in the original application. A copy of the original application will be included in the issued policy. If the answers given by the applicant were incorrect or untrue, the company has the right to deny benefits or rescind the policy within the first two years after it was issued. Policyholders should take the time to review their newly issued policy. If they discover the writing agent incorrectly listed any item, the insured should immediately contact the insurance company and get the item corrected.

“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:

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

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

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

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

Policy Terminology

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

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

The following is a list of commonly used definitions:
Home & Community Based Care
Home and community-based care is required and provided in a home convalescent unit under a plan of treatment, in an alternate care facility, or in adult day health care.

Home Convalescent Unit
Home convalescent units are NOT a hospital. It may be one of the following:
- the insured's home
- a private home
- a home for the retired
- a home for the aged
- a place which provides residential care; or
- a section of a nursing facility providing only residential care.

Plan of Treatment
A plan of treatment is a program of care and treatment provided by a home health care agency. Each company may include additional information that may include:
  a) A requirement that it must be initiated by and approved in writing by your physician before the start of home and community based care; and
  b) A requirement that it must be confirmed in writing at least once every 60 days.

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

Adult Day Health Care
Adult day health care is 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:
Partnership Long-Term Care Policies

a) 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;

b) Has a trained and ready to respond employee on duty at all times to provide that care;

c) Provides 3 meals a day and accommodates special dietary needs;

d) Licensed or accredited by the appropriate agency, where required, to provide such care;

e) Provides formal arrangements for the services of a physician or nurse to furnish medical care in case of emergency; and

f) Provides appropriate methods and procedures for handling and administering drugs and biologicals.

Many types of facilities would meet these criteria.

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

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

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

Caregiver Training
Caregiver training is training provided by a home health care agency, long-term care facility, or a hospital and received by the informal caregiver to care for the insured in his or her home.
Respite Care
Respite Care is provided as a service for those who perform the primary care services for an individual. It includes companion care or live-in care provided by or through a home health care agency, to temporarily relieve the informal caregiver in the home convalescent unit.

Long-Term Care Facility
A long-term care facility is a place which:

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

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

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

- Provided for acute or chronic conditions;
- Consistent with accepted medical standards for the insured's condition;
- Not designed primarily for the convenience of the insured or the insured's family; and
- Recommended by a physician who has no ownership in the long-term care facility or alternate care facility in which the insured is receiving care.
Inability to Perform Activities of Daily Living
An inability to perform the activities of daily living means the insured is dependent on another person to help them function on a daily basis. This may be the result of injury, sickness or simple frailty due to age.

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

1. eating
2. dressing
3. bathing
4. toileting & associated functions
5. transferring to and from beds, wheelchairs, or chairs.

Cognitive Impairment
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.

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.

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

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

Maximum Lifetime Benefit

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

Elimination Periods in Policies

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

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

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

**Mental Impairments of Organic Origin**

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

**Hospitalization Requirements**

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

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

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

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

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

**Home and Community Based Benefits**

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

1. The care must be medically necessary.
2. The policyholder must be unable to perform one or more of the activities of daily living stated within the policy.
3. There must be some type of cognitive impairment.
Benefits payable under the policy will depend upon the options selected at the time of policy purchase. If home care is included in the contract, it will typically be paid at 50% of the institutional benefit. In other words, if $100 per day is paid for the nursing home, then $50 per day will be paid for home care. Many of the integrated plans pay the same daily amount for home and community based care as they pay for nursing home care. That’s because an integrated plan uses a “pool of money” that may be applied, as the insured desires. An agent should never take this for granted; he or she should always check the policy or call the benefit department of the insurance company for details.

Bed Reservation Benefit

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

The bed reservation benefit is for a temporary hospitalization. It would not continue indefinitely. Commonly, bed reservation benefits are limited to 21 days per calendar year. Unused days from one year can seldom be carried over into the next calendar year. It may be possible, however, to use bed reservation days to satisfy the elimination period in the policy. Again, the agent will want to check with the issuing company to make sure they allow this.

Waiver of Premium

It is now common for long-term care policies to contain a waiver of premium. A waiver of premium has to do with renewal premiums during an institutionalization or while receiving benefits under the terms of the policy. When the policyholder has received benefits under the policy for the number of days specified, their renewal...
Partnership Long-Term Care Policies

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:

\[
30 \text{ days} + 90 \text{ Days} = \text{waiver satisfaction (120 days total time for waiver qualification).}
\]

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.

**Selecting Other Types of Care**

Many insurers now offer an alternative plan of care, which is covered under the policy provisions. If the policyholder would otherwise need a long-term care facility confinement, the company will pay for an alternative service, devices or benefits. The alternative
plan of care must be medically appropriate and medically acceptable. This is determined by specific requirements, including:

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

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

No Policy Covers Everything

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

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

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

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

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

Agents who routinely do not disclose obvious or stated medical conditions risk being “red tagged” by the insurers. This means they underwrite all applications to a greater degree because the insurer is not confident that the agent is truthfully listing all medical conditions. In some cases the insurer may even refuse applications from a seemingly dishonest agent. Agents who knowingly fail to list all stated or obvious medical conditions are “clean-sheeting” the application.

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

**Age Misstatement**

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

Few companies rescind (void) a policy due to age misstatement. It may happen, however, if the age misstatement puts the applicant in an age bracket that is not acceptable for underwriting (an 80-year old who is listed as 79 might fall into this category). The company would, however, require that the additional premium be paid. If the correct
Partnership Long-Term Care Policies

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.

**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:

<table>
<thead>
<tr>
<th>Dollar-for-Dollar Asset Protection</th>
<th>In order to provide asset protection, states must make necessary statute amendments that provide for the disregard of assets when applying for Medicaid benefits.</th>
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<tbody>
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<td></td>
<td>An individual applying for benefits must be a resident of the state when the coverage first became effective</td>
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### 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

Policies are deemed to meet required standards of the model regulation or the model Act if the state plan...
Where Required | 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
Partnership Long-Term Care Policies

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,

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1 Georgetown University March 2004 Issue Brief
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:
Partnership Long-Term Care Policies

(a) 58 percent of the revenues that would be generated by the existing premium, and
(b) 85 percent of the revenue generated by the premium increase.

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

Rate Certification from the Insurer’s Actuary

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

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?

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 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?

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

Consumer Publications

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

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

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

Tax-Qualified Policy Statement

If it is a Partnership 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. Having a tax qualified policy does not automatically mean it will reduce taxation since there are other
requirements when filing a federal tax return, such as the percentage that must exceed a percentage of income.

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

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

**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 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

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2 Act 2, Reg. 3
Partnership Long-Term Care Policies

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:

a) The only insurance protection provided under such contract is coverage of qualified long-term care services;

b) 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;

c) Such contract is guaranteed renewable;

d) 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.

e) All refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

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


These long-term care policies must have renewal 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?
Partnership Long-Term Care Policies

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:
   a. Reduced paid-up insurance.
   b. Extended term insurance.
   c. Shortened benefit period.
   d. Other similar offerings approved by the appropriate State regulatory agency.

**Extension of Benefits**

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

**Home Health & Community Care**

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

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

Outline of Coverage

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

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

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

Policy Delivery

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

No Field Issued LTC Policies

There was a time when long-term care policies could be field issued by the agent because underwriting was completed when a claim was filed rather than at policy issuance. Field issued policies are not allowed under the Model Act and Regulation since it is not good for the consumer. It lends to policy rescission because underwriting is not
performed until a claim is filed. 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.
Partnership Long-Term Care Policies

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

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

Shopper’s Guide

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

It’s Just Plain Illegal

Some practices are just plain illegal. This would include what is referred to as “twisting,” which means using the facts to suit one’s own needs (not the needs of the consumer). A person who uses twisting is either changing the facts to suit their own needs or providing some facts, but omitting others in order to complete the sale. It might be omitting information that should be disclosed, or it might be stating facts in a way that will allow the consumer to assume that which is not true. Often twisting is used to make an existing policy appear unfavorable, when in fact the policy is appropriate for the consumer.

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

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

Association Marketing

There are also requirements for those who market to association members. Marketers must provide objective information, 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 of delivery 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. In rare cases, gross misrepresentation with the intention to defraud may cause a policy rescission beyond 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.

In Conclusion

Long-term care insurance has been closely observed by the NAIC since the product’s introduction. The NAIC developed its Long-Term Care Insurance Model Act and Regulation in the 1980s with the intent of promoting the availability of coverage, protecting applicants from unfair or deceptive sales or enrollment practices, facilitating public understanding and comparison of coverages, and facilitating flexibility and innovation in the development of long-term care insurance. Generally, the NAIC Model Act and Regulation establish:

- Policy requirements: (a) requiring a standard format outline of coverage; (b) requiring specific elements for application forms and replacement coverage; (c) preventing cancellation of coverage upon 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.
The National Clearinghouse for Long-Term Care Information is a website developed by the U.S. Department of Health and Human Services to provide information and resources for consumers. Their goal is to provide sufficient information to encourage purchase of long-term care insurance products. This site is provided to help individuals and their families plan for future long-term care (LTC) needs. To access this website go to www.longtermcare.gov.

The Importance of Planning

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

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

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

Long-term care can include multiple types of services that are necessary to meet health or personal needs of daily living. The words, “long-term”, mean care for an extended period of time. Most long-term care is non-skilled personal care assistance, such as help performing everyday Activities of Daily Living (ADLs), which include:

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

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

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

Approximately 9 million Americans over the age of 65 will need long-term care services. By 2020, that number will increase to 12 million. Surprisingly, 40% of people receiving long-term care are adults between the ages of 18 and 64 years old. As some types of illnesses
Partnership Long-Term Care Policies

continue to spread, such as AIDS, this figure could rise. Even so, most people who need long-term care are those age 65 or older.¹

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

• Age – The older an individual is, the more likely that care will be needed in some form.

• Marital Status - Single people are more likely to need care from a paid provider.

• Gender – Because women live longer than men, they have a higher risk of requiring long-term care services. Additionally, they often hurt their own health caring for ill husbands at home.

• Lifestyle - Poor diet and exercise habits will increase the risk of needing long-term care services.

• Health and Family History – inheriting good genes are a plus.

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

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

• Services at your home from a nurse, home health/home care aide, therapist, or homemaker;

¹ National Clearinghouse for Long-Term Care Information, 5/25/2007
Partnership Long-Term Care Policies

- Care in the community; and/or
- Care in any of a variety of long-term facilities.

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

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

Some people will enter a nursing home for a relatively short period of time while they recover from a sudden illness, surgery, or injury; they may then be able to receive care at home. Others may need long-term care services continually. Some people may begin care at home, but eventually require a nursing home or other type of facility-based setting for more extensive care or supervision. Such things as assisted-living facilities have enabled many people to get the supervision and care they need without going to a nursing home.

An important part of planning for long-term care is deciding how to pay for services. Medical care in general is expensive and services dealing with long-term care needs are no exception. Current figures were not available as of this writing, but 2006 figures show the following:

- A daily average nursing home rate in Texas was $147.21.
Partnership Long-Term Care Policies

- A daily average nursing home rate in Mississippi was $151.05;
- A daily average nursing home rate in Idaho was $155.25;
- A daily average nursing home rate in Illinois was $161.44;
- A daily average nursing home rate in N. Carolina was $166.47;
- A daily average nursing home rate in Indiana was $169.48;
- A daily average nursing home rate in Michigan was $177.91;
- A daily average nursing home rate in Arizona was $187.40;
- A daily average nursing home rate in Oregon was $193.03;
- A daily average nursing home rate in Florida was $195.84;
- A daily average nursing home rate in Washington was $210.66;
- A daily average nursing home rate in California was $230.03
- A daily average nursing home rate in New Jersey was $236.00;
- A daily average nursing home rate in Hawaii was $270.92;
- A daily average nursing home rate in New York was $297.60;
- A daily average nursing home rate in Connecticut was $326.28.

Since we have not listed all states, this is only a general overview of nursing home costs. Since costs can also change rapidly it is always important to check local costs prior to needing a nursing home, especially if an individual is deciding upon the benefits of a nursing home policy being considered for purchase.

While some people may qualify for Medicaid, the major payer of long-term care services, many won't. There are other federal public programs, such as the Older American's Act, and state funded programs that pay some long-term care services. However, virtually all programs have some criterion that must first be met, such as poverty status. Like Medicaid they help those people with the most pressing financial need. Before Medicaid will pay a single dollar towards long term care expenses the applicant must have spent down all their personal assets. He or she will also be required to contribute at least a portion of any income they have access to. The amount of
income contributed will depend upon several factors, including a spouse that might be partly or wholly dependent upon that income.

Paying for long-term care from personal income and resources can be challenging. Even modest home care is expensive. Based on 2006 average costs, an individual requiring assistance with personal care at home three times a week would pay an average cost of about $16,000 per year.

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

Costs will always vary based on the extent of the services received. Home health and home care services, provided in two-to-four-hour blocks of time referred to as “visits,” are generally more expensive in the evening, or on weekends or holidays. The costs of services in some community programs, such as adult day service programs, are often provided at a per-day rate, but vary based on overhead and programming costs. Many care facilities charge extra for services provided beyond the basic room-and-board charge, although some may have “all inclusive” fees.

The average costs in the United States (in 2006) were:

- $171 per day for a semi-private room in a nursing home (based on all 50 states);
- $194 per day for a private room in a nursing home (based on all 50 states);
Partnership Long-Term Care Policies

• $2,691 per month for care in a one-bedroom unit in an assisted living facility (based on all 50 states);
• $25 per hour for a home health aide (based on all 50 states);
• $17 per hour for a homemaker services (based on all 50 states);
• $56 per day for care in an adult day health care center (based on all 50 states).

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

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

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

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

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

<table>
<thead>
<tr>
<th>Long-Term Care Service</th>
<th>Medicare</th>
<th>Private Medigap Insurance</th>
<th>Medicaid</th>
<th>You Pay on Your Own*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home Care</td>
<td>Pays in full for days 0-20 if care is in a Skilled Nursing Facility following a recent hospital stay. If the need for skilled care continues, may pay for days 21 through 100 after a daily co-payment is met by the patient.</td>
<td>May cover the daily co-payment if the nursing home stay meets all other Medicare requirements.</td>
<td>May pay for care in a Medicaid-certified nursing home if the patient meets functional and financial eligibility criteria.</td>
<td>If the patient needs only personal or supervisory care in a nursing home and/or has not had a prior hospital stay, or if the patient chooses a nursing home that does not participate in Medicaid or is not Medicaid-certified.</td>
</tr>
<tr>
<td>Assisted Living Facility (and similar facility options)</td>
<td>Does not pay</td>
<td>Does not pay</td>
<td>In some states, may pay care-related costs, but not room and board</td>
<td>Patient pays for this except as noted under Medicaid if eligible.</td>
</tr>
<tr>
<td>Continuing Care Retirement Community</td>
<td>Does not pay</td>
<td>Does not pay</td>
<td>Does not pay</td>
<td>Patient must pay for this type of care.</td>
</tr>
<tr>
<td>Adult Day Services</td>
<td>Not covered</td>
<td>Not Covered</td>
<td>Varies by state, financial and functional eligibility required</td>
<td>Patient pays for this (except as noted under Medicaid, if eligible).</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Limited to reasonable, necessary part-time or intermittent skilled nursing care and home health aide services, and some therapies that are ordered by the patient’s doctor and provided by Medicare-certified home health agency. Does not pay for only on-going personal care or custodial care needs (help with activities of daily living).</td>
<td>Not covered</td>
<td>Pays for home health care, but the individual states have the option of limiting some services, such as therapy.</td>
<td>Patient pays for personal or custodial care, except as noted under Medicaid, if eligibility standards are met.</td>
</tr>
</tbody>
</table>

On an aggregate basis, the largest share of nursing home expenses, 48 percent, are paid for by Medicaid following the patient’s asset depletion. On an individual basis, it may feel to the patient and his or her family as though they are paying the major portion. Even if Medicaid ends up paying $100,000 in comparison to the patient’s $50,000, when asset depletion occurs it may still feel unfair. Anyone
Partnership Long-Term Care Policies

with reasonable income and assets will pay at least a portion of their nursing home and other long-term care services.

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

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

The following shows spending for long-term care costs:
Chapter 5

Terminology

Insurance policies are legal contracts. As such, terminology is very important. Long-term care policies must follow state and federally mandated terms. In the case of Qualified Long-Term Care plans, the definitions must satisfy those as amended by the U.S. Treasury Department.

Activities of Daily Living: Qualified long-term care policies have six activities of daily living. They are: bathing, continence, dressing, eating, toileting, and transferring.

Acute Condition: The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the patient’s health status.

Adult Day Care: A program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside of the home.

Ambulation: In some policies, ambulation is considered an activity of daily living (ADL), but not in all contracts. Tax-qualified LTC policies have eliminated this as an ADL. Ambulation is the ability to move around independently, without help from others.

Assets: As it applies to the Partnership definition, assets mean savings and investments but exclude income. Medicaid qualification considers everything as assets, including income.

Automatic Benefit Increase Option (ABI): An inflation protection clause where the amount of LTC coverage increases automatically on an annual basis by a contractually specified amount. The increase
Partnership Long-Term Care Policies

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.
**Partnerhsip Long-Term Care Policies**

**Home Health Care Services:** Medical and non-medical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with the activities of daily living and respite care services.

**Hybrid Partnership Plans:** Hybrid plans offer both dollar-for-dollar and total asset protection. The type of asset protection depends on the initial amount of purchased coverage. Total asset protection is available for policies with initial coverage amounts equal to or greater than a level defined by the state.

**Income:** For Medicaid purposes, income is anything received during a calendar month that is used or could be used to meet food or shelter needs. It includes cash, savings accounts, stocks, or property that can be converted to cash.

**Indemnity Insurance Contracts:** Indemnity plans pay a set amount of money per day or per covered ailment, but will not exceed the actual cost. In LTC policies, this would be expressed as $100 per confinement day, for example.

**Inflation Protection:** There are two types of inflation protection used in LTC policies (1) future purchase options (FPO) and (2) automatic benefit increase options (ABI). Refer to FPO or ABI.

**Integrated Long-Term Care Policies:** Integrated policies offer a more relaxed benefit formula than other models since they offer a “pool” of benefits that allow the policy owner to make personal care choices, as long as those choices qualify under the terms of the policy contract. Once the pool of money is exhausted, the policy ends.

**Level Premium:** This term might be taken to imply that premiums will not increase, which is not necessarily true. Depending upon state language, level premium means that premium will not increase due to advancing age or increased claim submission, but 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
Partnership Long-Term Care Policies

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.
**Partnership Long-Term Care Policies**

**Traditional Long-Term Care Insurance:** A long-term care policy that was purchased on either a tax-qualified or non-tax qualified basis that does not offer asset protection for Medicaid qualification purposes.

**Transferring:** Moving into or out of a bed, chair, or wheelchair.

**Underwriting:** The process of reviewing the applicant’s medical and health-related information to determine if he or she presents an acceptable level of risk for insurance coverage.

**Waiting Period:** Also called an elimination period, it is a long-term care policy deductible expressed as time not covered. It is the first days of confinement or benefit qualification that must be covered by the insured prior to the policy paying benefits.

**Waiver of Premium:** Offered in many LTC contracts, a waiver of premium waives the premium requirement once the insured begins to collect qualified policy benefits. The waiver of premium clause is subject to the listed conditions in the policy.

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**United Insurance Educators, Inc.**