GA 4-HR LTC

Section 1 Introduction and Overview

Long-term care involves a variety of services designed to meet a person's health or personal care needs over a period of time. These services help people live as independently and safely as possible when they can no longer perform everyday activities on their own. Demography, dollars, and dependence on the help of others provide a compelling rationale for long-term care insurance. The public-private system of health care delivery in the United States has evolved over time as a patchwork of multiple programs that individuals find difficult to access. Despite billions of dollars in expenditures, the system often fails to meet the diverse needs of disabled individuals, and many believe that access to more appropriate services could be improved even at current funding levels.

Long-term care is provided in different places by different caregivers, depending on a person's needs. Most long-term care is provided at home by unpaid family members and friends. Care can also be provided by paid caregivers, usually at home, but also in a facility such as a nursing home.
The most common type of long-term care is personal care -- help with everyday activities, also called "activities of daily living." These activities include bathing, dressing, grooming, using the toilet, eating, and moving around -- for example, getting out of bed and into a chair.
Long-term care also includes community services such as meals, adult day care, and transportation services. These services may be provided free or for a fee.

Unprecedented growth in the elderly population is projected for the 21st century, and the population age 85 and over (those most in need of long-term care services) is expected to outpace the rate of growth for all aged. The population of younger disabled persons has been increasing and is expected to grow, although the exact size is difficult to predict.

Spending will escalate steeply whether or not reform occurs; every year, ominous headlines announce that expenditures for long-term care are projected to more than double in the following 25 years. Today family and friends provide the overwhelming majority of care for disabled persons informally on a nonpaid basis. The future demand for paid services may grow at an even faster rate because informal care giving will be difficult to sustain; some theoretical point of "care overload" will be reached and geographic dispersion of families will continue its attrition of those ready, able, and willing to care for those who cannot care for themselves.

Duration- How Long is Care Needed

Long-term care can last a long time (hence the name) or a lifetime. Short-term medical attention results from some sort of an acute condition such as a broken bone or a life-threatening condition. This care lasts several weeks or a few months while someone is recovering from a sudden illness or injury. For example, a person may get short-term rehabilitation therapy at a nursing facility after hip surgery, and then go home. Long-term care can be ongoing, as with someone who is severely disabled from a stroke or who has Alzheimer's disease. Many people can remain at home if they have help from family and friends or paid services. But some people move permanently to a nursing home or other type of facility if their needs can no longer be met at home.

Who Will Need Long-Term Care?

It is difficult to predict how much or what type of long-term care a person might need. Several things increase the risk of needing long-term care.

- Age -- The risk generally increases as people get older.
- Gender -- Women are at higher risk than men, primarily because they often live longer.
- Marital status -- Single people are more likely than married people to need care from a paid provider.
- Lifestyle -- Poor diet and exercise habits can increase a person's risk.
- Health and family history -- These factors also affect risk.

Despite the expense associated with the long-term care system, considerable dissatisfaction exists, especially among persons needing care. At the core of their frustration lies a belief that services are often difficult to access. Individuals seeking services often have to contend with a fragmented service delivery system that forces them to negotiate for services from a variety of federal and state agencies. Moreover, existing programs tend to deliver "one size fits all" services. The bulk of federal funding- -Medicare and Medicaid--pays for services that are often institutional and medical in nature and may not be appropriate for, nor preferred by, many individuals. Current government spending on long-term care is expected to rise, yet the long-term care system is fragmented, does not meet current demand, and is not well matched to the diverse needs of individuals. Insurance professionals must take into account two principles in long-term care insurance;

- greater tailoring of services to the needs of the individual
- greater flexibility in funding

Many view assisted living as a promising option for providing care and help to an increasing number of frail elderly persons in a less costly and more homelike setting than nursing homes. Assisted living facilities (ALF) are similar to other residential care settings, such as board and care facilities, that offer housing, meals, protective oversight, and personal assistance to persons with physical or cognitive disabilities. Unlike nursing homes or many board and care settings, however, assisted living attempts to provide consumers with greater autonomy and control over their living and service arrangements.

Consumer demand for assisted living appears to be high. However, media accounts have highlighted instances where assisted living residents have been harmed or died as a result of alleged inadequate care and supervision. Medicaid funds primarily go to nursing homes and other institutional settings of long-term care, but home and community-based services receive a growing share. Medicare primarily covers acute-care services and thus plays a lesser role in financing nursing home care; by paying only for short-term stays following a hospitalization. Medicaid, which is a jointly funded federal-state program, poses a large burden on states’ budgets, creating pressure on their capacity to absorb additional costs associated with the growing need for long-term care services over the coming decades. Private long-term care insurance is viewed as a possible way to reduce catastrophic financial risk for the elderly needing long-term care and to relieve some of the financing burden now shouldered by public long-term care programs. Yet private insurance, including both traditional health insurance and long-term care insurance represents only a small fraction of long-term care financing.

Relatively few older people have private insurance that covers the cost of long-term care. About 7.2 million Americans own traditional long-term care insurance policies (Forbes, 2016). Overall, the share of older adults who own long-term care insurance has barely changed since 2002, according to the Urban Institute. In 2002, about 10 percent of those 65 and older had coverage. By 2008 that share had ticked up to 12 percent, but in 2014, it dropped back to 11 percent. Among those aged 55-60, the share of policyholders slipped from 7 percent in 2002 and 2008 to just 5 percent in 2014. The wealthier an individual is the more likely he or she is to have coverage. About one in four of those 65 and older with assets of at least $1 million have this coverage. By contrast, just one in 25 of those with wealth between $50,000 and $99,999 have private long-term care insurance.

Of the surveyed policies, 95 per cent provided coverage for long-term care services in a range of settings, including nursing homes, assisted living facilities, and in the home. These are usually indemnity policies which reimburse the insured for long-term care expenses up to a fixed benefit amount, such as $100, $150, or $200 per day. In 2015, the typical purchaser was age 60 and had fairly substantial income and assets. Of the purchasers, 61 percent had incomes over $75,000 per year, and 82 percent had more than $100,000 in liquid assets. By comparison, only 43 percent of the general population age 50 and older had liquid assets in excess of $100,000. (AHIP, “Who Buys Long-Term Care Insurance in 2015-2016”).

Affordability and Coverage

Questions remain about the affordability of policies and the value of the coverage relative to the premiums charged, and while many states have adopted standards for long-term care policies, it is uncertain whether these fully assure consumer confidence in the reliability of long-term care insurance. If long-term care insurance is to have a more significant role in addressing the senior population's inevitable chronic health care needs, the policies offered must be viewed by consumers as reliable, affordable products with benefits and limitations that are easy to understand.

Long-term care includes many types of services needed when a person has a physical or mental disability. Individuals needing long-term care may have difficulty performing some activities of daily living (ADL) without assistance, such as bathing, dressing, toileting, eating, and moving from one location to another. They may have mental impairments, such as Alzheimer’s disease, that necessitate supervision to avoid harm to themselves or others or require assistance with tasks such as taking medications. Although a chronic physical or mental disability may occur at any age, the older an individual becomes, the more likely a disabling condition will develop or worsen. Nearly everyone knows (or knows of) a senior citizen who has limitations in the activities of daily living (ADL's) such as preparing food, doing housekeeping, and handling finances. Many of these people have limitations in two or more ADLs.

The increase in the use of home health services has been driven at least partly by increasing acceptance that most elderly consumers prefer to receive long-term care at home. As access to such services has been expanded, questions have arisen regarding how the states are assuring and measuring the quality of these services.

Quality, Performance, Outcomes

Quality, access, and cost have traditionally made up the three pillars of health care policy. This is so because attempts to improve a program’s performance on one

dimension, such as cost, may affect its performance on others, such as accessibility or quality. Thus, information on service quality should be interpreted in combination with data on access and cost, and optimal policy choices depend on monitoring all three aspects of service delivery. The term quality is used to refer to “the extent to which service increases the probability of desired outcomes and reduces them. Long-term care is basically custodial care; it is not intended to cure. It is chronic care that a person might need for the rest of his or her life. An individual can receive long term care in their own home, a nursing home or another long term care facility, such as an assisted living facility. People often confuse long term care with disability or short-term medical care. Long term care is **not:**

- care that is received in the hospital or at the doctor's office
- care needed to get well from a sickness or an injury
- short-term rehabilitation from an accident
- recuperation from surgery

Anyone can need long term care at any time in their life. Automobile and sporting accidents; disabling events such as strokes, brain tumors, and spinal cord injuries; and disabling illnesses such as multiple sclerosis and Parkinson's disease are examples of injuries and ailments that can happen to anyone at any age. Nearly 41% of long term care is provided to people under age 65 who need help taking care of themselves due to diseases, disabling chronic conditions, injury, developmental disabilities, and severe mental illness (Georgetown University Long-Term Care Financing Project. "Long-Term Care Financing Policy Options for the Future," June 2007).

LTC Misconceptions

Here are some common misconceptions about long-term care;

I am Too Young to Need Long Term Care- Long term care is not just for the elderly. Nearly 41% of long term care is provided to people under age 65 who need help taking care of themselves due to diseases, disabling chronic conditions, injury, developmental disabilities, and severe mental illness (Georgetown University Long-Term Care Financing Project).

My Family Will Take Care of Me- In today's society, adult children are more apt to live further away from their parents. In addition, many adult children are taking less vacation time and working longer hours. Taking care of a family member is a time-consuming commitment that often demands a significant number of hours from multiple family members. Even if family members can find the time to provide care to a family member, it often comes at a tremendous financial cost. Provision of care can cost the average caregiver in lost wages, pension benefits, and Social Security. While having a family tending care might be an option, it is generally difficult to do without additional assistance.

Medicare or Medicaid Will Cover My Bills- Medicare is generally available for people over age 65 and the disabled. It only pays limited amounts for skilled care following a hospital stay and it is not intended to cover care that assists people with activities of daily living for long periods of time. Specifically, Medicare covers the first 100 days of skilled care in a nursing home after a hospital stay of at least 3 days and as long as an individual enters a nursing home within 30 days of leaving the hospital. Medicare covers some home health care for the treatment of an illness or injury. Medicaid is a state-based program supplemented by Federal funds that provides health services to the poor and impoverished. Medicaid might cover costs if an individual meets the state poverty criteria. Many people attempt to "spend down" their assets to state required levels or try to transfer their assets to family members to

become eligible for Medicaid. States now have the authority to examine a Medicaid applicant's past five years of finances and impose penalties.

Health Insurance Will Cover My Bills- Health insurance rarely covers ongoing chronic care needs. Most health plans are intended to cover skilled, short term medical care as an individual recovers from an illness or injury.

I Can Save Enough on My Own- Paying from personal savings is one way to cover long term care expenses. However, consideration should be given to the cost of long term care services before relying on this method. The current national averages for long term care services (Genworth 2017 Cost of Care Survey):

- $135/day for a home health aide
- $70/day for care in an adult day care center
- $3,750/month for care in an assisted living facility
- $235/day for a semiprivate room in a nursing home
- $267/day for a private room in a nursing home

Home care (which most people prefer) is generally more affordable than nursing home care but still can be expensive. The Cost of Care Survey mentioned above observes that, when averaged nationally, the cost of a six-hour visit by a home health aide is $135. That comes to $35,100 per year for a home health aide visiting six hours per day, five days a week. Also in 2017, the national average cost of a semiprivate room in a nursing home was $85,775 annually. According to the U.S. Department of Health and Human Services, the average length of stay in a nursing home is 2.4 years. That is more than $205,000 per average stay. Paying for long term care out-of-pocket may be an option only if a person can afford these expenses. These figures are national averages and the cost of long term care services will vary by region. Also, each person's situation is unique and expenses will be more or less than others.

Long-Term Care Partnership Program

The Long-Term Care Partnership Program is a public-private partnership between states and private insurance companies, designed to reduce Medicaid expenditures by delaying or eliminating the need for some people to rely on Medicaid to pay for long-term care services. Individuals, who buy select private long-term care insurance policies that are designated by a state as partnership policies and eventually need long-term care services, first rely on benefits from their private long-term care insurance policy to cover long-term care costs before they access Medicaid. To qualify for Medicaid, applicants must meet certain eligibility requirements, including income and asset requirements. Traditionally, applicants cannot have assets that exceed certain thresholds and must “spend down” or deplete as much of their assets as is required to meet financial eligibility thresholds.

To encourage the purchase of private partnership policies, long-term care insurance policyholders are allowed to protect some or all of their assets from Medicaid spend-down requirements during the eligibility determination process, but they still must meet income requirements. The definition of assets differs between the Long-Term Care Partnership Program and Medicaid. The Long-Term Care Partnership Program uses the term ‘assets’ to denote savings and investments, and excludes income. For purposes of Medicaid eligibility, assets include both income, which is anything received during a calendar month that is used or could be used to meet food, clothing, or shelter needs, and resources, which are anything owned, such as savings accounts, stocks, or property.

Section 2 Alternatives to the Purchase of Long-Term Care Insurance

Planning Ahead

Some people plan for everything desired in retirement; travel, recreation, and an independent lifestyle. Money is put aside and assets grow in order to make it all possible. A serious accident or extended illness can change everything. By the year 2020, over 12 million older Americans will need long-term care. Most will receive care at home, and of those, 70% will be cared for by family members and friends. These figures are from the Health Insurance Association of America's "Guide to Long-Term Care Insurance." The same booklet points out those long-term care recipients and their families bear the costs of long-term care in most cases. About one-third of all nursing home costs are paid out-of-pocket by individuals and their families. Medicare only pays about 8% of the costs for short-term skilled nursing home care following hospitalization. Medicaid pays more than half of nursing home costs, but that funding begins only after the patient becomes eligible by depleting his or her own savings. The cost of long-term care is beyond the reach of most people.

Nursing home costs averaged around $97,455 per year in 2017, reaching as high as $140,416 in high-cost areas like New York City. Assuming costs increase by 5% annually, a nursing home stay could reach an average of $175,000 per year by 2030 (projection based on 2017 national average cost of $97,455 per year compounded annually at 5%). Paying for a home health care aide eight hours each day averaged more than $49,192 a year in 2017, and more than $62,348 in San Francisco, one of the higher-cost areas (Genworth, Cost of Care 2017).

Long-term care insurance should be seen as an asset protection plan, a mechanism used to keep an estate from disappearing while paying the costly bills of nursing homes. Money or assets will remain after death for charitable or inheritance plans. Insurance facilitates more options than Medicaid. The program has inflexible rules concerning what it covers and often cannot help the infirm elderly stay at home. The article echoes previous observations concerning the purchase of an LTC policy at younger ages, inflation protection and insurability being important considerations.

Reluctance to Buy- Long-term care coverage received a boost from the tax advantages offered under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Increasing press coverage about the impending demographic wave of an increasing frail and elderly population also encouraged sales. Data shows stand-alone individual long-term care insurance sales have declined in recent years. Declining sales are mainly due to cost concerns from the consumer perspective and profitability concerns from the carrier perspective. U.S. spending on long-term care was $246 billion in 2015. Only 3% of that total was from private long-term care insurance with 7 million insureds out of 89 million ages 55 and over.

- Long-term care insurance is associated with nursing home care. Less emphasis is placed on its ability to provide home-based care and other types of medical help.
- There is no consensus as to an optimum time to purchase long-term care insurance.

- There is a perception, rightly or wrongly held, that policyholders may pay premiums for years with little recompense in the long run.

Who Should Not Buy Long-Term Care Insurance?

Not everyone should buy a long-term care insurance policy. For some, a long-term care policy is an affordable and attractive form of insurance. For others, the cost is too great, or the benefits they can afford are insufficient. One should not buy a long-term care policy if it will cause a financial hardship and makes a person forego other more pressing financial needs. Each individual should carefully examine his or her needs and resources to decide whether long-term care insurance is appropriate. It is also a good idea to discuss such a purchase with his or her family. The need for long-term care can arise gradually as a person needs more and more assistance with activities of daily living, such as bathing and dressing, or the need can surface suddenly following a major illness, such as a stroke or a heart attack.

Some people who have acute illnesses may need nursing home or home health care for only short periods of time. Others may need these services for many months or years.

It is difficult to predict who will need long-term care, but there are studies that help shed some light on the probability of needing such care. Online searches project that from 43% to around 50% of those people who turn age 65 will enter a nursing home at some time during their life. One study reports that among all persons who live to age 65, 1 in 3 will spend three months or more in a nursing home. About 1 in 4 will spend one year or more in a nursing home, and only about 1 in 11 will spend five years or more in a nursing home[1.] Looking at these numbers from a different perspective, 2 out of 3 people who turn 65 will either never spend any time in a nursing home or will spend less than three months in one. So it would seem that the chances of needing home health care are substantially greater than needing nursing home care.

Once a person has assessed the probability of needing coverage, considerable thought should be given to the reasons why a policy is desired and the ability to pay for it. This depends on the age, health status, overall retirement objectives and income of the prospective purchaser. For instance, if the only source of income is Social Security benefits or Supplemental Security Income (SSI), one should probably not purchase long-term care insurance. Similarly, if there is trouble-stretching income to meet other financial obligations, such as paying for utilities, food or medicine, the purchase a long-term care insurance policy probably should not be made.

If someone already has existing health problems that are likely to result in the need for long-term care, he or she will probably not be able to buy a policy. For instance, a person with Alzheimer's disease or Parkinson's disease will not be accepted by a long-term care provider and will be barred from purchasing a policy. Insurance companies have medical underwriting standards in place to keep the cost of long-term care insurance relatively affordable. In the absence of such provisions, most people would not buy coverage until they needed long-term care services.

1 P. Kemper, C.M Murtaugh, "Lifetime Use of Nursing Home Care," *New England Journal of Medicine* 324, #9(Feb.28, 1991), pp595-600.

It is the age-old risk associated with any insurance. What are the chances that a person will have long-term care requirements? When, if long-term care requirements are needed, will they be needed? If needed, how extensive or minimal with the care be? Will one spouse of the aging couple need care or will both husband and wife be candidates?

Permitte divis cetera- 'leave the rest to the gods.' Horace gives us this line in the *Odes,* suggesting that there is just so much people can do to order their lives, make plans, and the like. "When you have done all you can in the interest of prudence, *permitte divis certa* and take the plunge."

Income/Asset limits- Generally speaking, people with exempt assets below the current Medicaid threshold do not need long-term care insurance. These individuals will qualify for Medicaid insurance. Conversely, people with assets that exceed some dollar amount on the other end of the financial spectrum will not be candidates for long term insurance; they have enough in assets to cover the average nursing home stay. Anyone in the middle range, and there are many, should look at long-term care policies as a means of asset protection and financial protection for their heirs. As with any financial decision-making process, it is important that the applicant for long-term care insurance be encouraged to consult with tax and legal professionals to determine how best to employ his or her assets.

LTC Premium Expense

The National Association of Insurance Commissioners (NAIC) recommends that most people should not spend more than 7% of their annual income for long-term care annual premium. Seniors should exercise extreme caution when looking to purchase long-term care insurance. This is especially true when there is no premium guarantee offered and an insurer can increase the rates for a class of insured at any time. Retirees tend to be on fixed incomes or ones with modest cost-of-living adjustments (COLA). If premium increases outstrip COLA for the insured, they will soon find premiums exceeding the 7% of annual income cap. This could eventually force the policyholder to drop protection after investing money in premiums over a period of time.

A. Financial

Life Insurance Products Containing LTC Benefit Options-

Life policies can be sold with long-term care riders. This works like any other type of rider to a policy. An increase in premium accompanies the rider.

Life insurance companies that offer the option to accelerate the benefits of a policy limit such an option to individuals with life expectancies of less than 12 months. Such benefits, once received, may affect tax status and eligibility for state and federal means-based assistance programs. Basically, an accelerated death benefits rider allows insureds who are terminally ill or who suffer from certain catastrophic diseases to collect part or all of their life insurance benefits before they die, primarily to pay for the care they require. Benefits may also be payable if the insured is receiving long-term care. Accelerated death benefits riders are not uniform but they can be classified in the following ways;

1.) Terminal illness rider- This allows terminally ill insureds with a life expectancy of six months or a year to receive part or all of the policy proceeds. Many insurers allow the rider to be added without an extra premium, but any lump sums

advanced are discounted for interest to reflect the time value of money. The face amount of insurance, cash values if any, and premiums are reduced after the payment is made. For example Mr. Williams, terminally ill with cancer, asks for 50% of his $250,000 term insurance policy. The benefit is discounted for interest and Mr. Williams receives $116,000. This is a rounded figure. The actual amount will depend on the interest rate and discounting assumptions made by the insurer. Once the payment is made, premiums are reduced 50% and the face amount if the policy is reduced to $50,000.

2.) Catastrophic illness rider- Insured who have certain catastrophic diseases can collect part or all if the policy face amount with this type rider. Covered diseases normally include AIDS, life-threatening cancer, coronary artery disease, kidney failure, and similar devastating diseases.

3.) Long-term care rider-This type allows insureds that require long-term care to collect part of their life insurance prior to death. The rider may cover care in a skilled nursing facility, intermediate care facility, or custodial care facility. Some riders also cover certain types of home care. As an example, assume that a policy rider allows a monthly benefit to be paid equal to 2.5% of the face amount of insurance up to a maximum of 50% of the face amount. On a $250,000 policy, a maximum of $6,250 could be paid on a monthly basis for up to 20 months

Home Equity Conversions

The Federal National Mortgage Association, also known as Fannie Mae, buys mortgages and packages them into mortgage securities that are then resold to investors. The agency thus helps make considerable additional capital available for mortgage lending. The securities created by Fannie Mae are fully taxable, but they are backed by the government and so default is virtually impossible.

Fannie Mae believes that **Home Equity Conversion Mortgage HECMs** provide a valuable financing alternative for homeowners age 62 and older who wish to remain in their homes, but who need the equity tied up in those homes. In support of HUD's effort, Fannie Mae has agreed to purchase two types of adjustable-rate mortgages (ARMs) insured under this program -- one features monthly interest rate adjustments, and the other features annual rate adjustments. HECMs need not be repaid until the borrower moves, sells or refinances the property, or dies. FHA insures the lender against the risk that proceeds from the sale of the property may not be sufficient to pay off the mortgage balance. The following is a summary of the HECM program

Payment options

- Under the term option, borrowers may receive monthly payments for a fixed period they select.
- Under the tenure option, borrowers may receive monthly payments as long as they occupy the home as a principal residence.
- Under the modified term option, borrowers may set aside a portion of loan proceeds as a line of credit that can be drawn on at any time, and receive the rest of the principal limit in the form of equal monthly payments for a fixed period.
- Under the modified tenure option, borrowers may set aside a portion of loan proceeds as a line of credit that can be drawn on at any time and receive the rest of the principal limit in the form of equal monthly payments which will continue as long as they occupy their homes as a principal residence.

- Under the line-of-credit option, borrowers may draw up to a maximum amount of cash at times and in amounts of their choosing, as long as the borrowers continue to occupy the property as a principal residence and the borrowers' principal limit has not been reached.
- At the borrowers' request, and for a fee no greater than $20 at each request, borrowers may change from one payment option to another, as long as the mortgage balance is lower than the principal limit. There is no limit to the number of times that a borrower can change his or her payment plan.

Mortgage plans

Loan repayment requirement

Repayment of the loan is required only when the borrower no longer occupies the property as a principal residence (i.e., due to death, a move, or sale of property). The homeowner cannot be displaced and forced to sell the home, even if the unpaid principal balance (UPB) exceeds the property value, as long as the borrower remains a principal resident and adheres to the terms of the note. If the property is sold, the homeowner (or heir) receives any proceeds in excess of the amount needed to pay off the mortgage. A deficiency judgment is not allowed.

Eligible borrowers

Borrowers must be at least 62 years old and occupy as their principal residence a home that has little or no mortgage debt remaining. Borrowers also must undergo mortgage counseling by a HUD-approved counseling agency.

Eligible property types

Properties must be one-family principal residences or 2- to 4-unit properties occupied by eligible borrowers, and may include units in HUD-approved condominiums and planned-unit developments (PUDs). All properties must meet HUD's minimum property standards.

Principal limit

The HECM program limits the risk of loan loss by controlling the amount borrowers may receive. This is done by calculating a principal limit for each loan, which is based on the maximum claim amount, the expected average interest rate, and the age of the youngest borrower. The expected average mortgage interest rate for HECMs is the sum of the mortgage margin (which is determined by Fannie Mae) and the 10-year U.S. Treasury rate in effect at closing. This rate has nothing to do with the actual interest rate charged to the borrower.

Maximum claim amount

The maximum claim amount is the lesser of the appraised value or FHA's statutory mortgage limit for the geographic area. The statutory limit varies by geographic area.

Mortgage insurance

Mortgages will be insured by FHA up to the maximum claim amount. Borrowers will be charged an initial premium of 2 percent of the maximum claim amount and an annual premium of 1/2 percent of the outstanding mortgage balance. The mortgage insurance premium will be paid to HUD and added to the mortgage balance monthly.

Maximum terms

The tenure, modified tenure, and line-of-credit mortgages do not have maximum terms. The term and modified term mortgages have terms selected by the borrower. Borrowers may remain in the home even after payments stop, regardless of loan type, as long as they do not violate any covenants of the mortgage loan.

Calculating payments to borrowers

Scheduled monthly payments to borrowers are determined using principal limit factors provided by HUD. The payments will be based upon the age of the youngest borrower, the expected average mortgage interest rate, the type of payment plan chosen, and maximum mortgage claim amount.

Mortgage instruments

HUD does not provide standard documents, but requires HUD-drafted covenants to be incorporated into the documents. To be eligible for purchase by Fannie Mae, the documents must comply with Fannie Mae's guidelines, HUD regulations, and applicable laws.

Property insurance

Properties must be covered by hazard insurance (including flood insurance where applicable) that meets the general requirements for the type of property that secures the mortgage. However, the mortgage does not need to provide for the monthly deposit of escrow funds for the payment of hazard insurance premiums.

Savings/Private Investment

Savings- It is defined as income not spent. At the end of any period, saving is equal to income in that period minus consumption. It is negative if expenditures exceed income. In an economic sense, saving is a passive concept and does not imply any decision about the form savings may take, such as a savings account, purchasing annuities, buying stocks or bonds, etc. Savings is encouraged in a market economy, forced in a command economy. However it comes about, the image of an older couple, relaxed, trim, and fit with money in the bank carefully husbanded from years of work is a strong and powerful image. Advertisers often play on this image. It looms large in the middle-class psyche.

ad utrumque paratus

This Latin phrase means “prepared for the worst”. A mature person is ready to cope with any eventuality, including the final one. The Romans described such a person as *ad utrumque paratus,* literally “ready for either (eventuality).”

Private Investment- In common usage, “investment” is the expenditure on acquisition of financial or real assets. To the economist this is not investment, but the shifting of savings from one form (cash) to another. There are many types of private investment plans available, from savings and loan to the stock market. The fact that so many options exist may confuse and cow individuals into doing nothing at all with their potential savings. Add to this the scandals surrounding Wall Street, burst-bubble technology stocks, negative publicity about variable annuities, etc… and it’s a wonder there are so many people willing to invest. The median household income for 2015 was $56,277[2]. Many savings vehicles have a minimum amount needed to open or maintain an account. This is viewed by some as a disincentive to save, especially for those on a tight budget.

Annuities

The annuity contract which is sold by life insurers, allows the "scientific" liquidation of an estate, accompanied by the promise that the annuitant cannot outlive the stream of income produced by the liquidation. The insurer can make its guarantees based on the basic set of insurance principles; pooling of many similar exposures to loss, premiums paid in advance, and predictability based on the law of large numbers.

[2] U.S. Census Bureau, Household Income 2016, American Community Survey Briefs

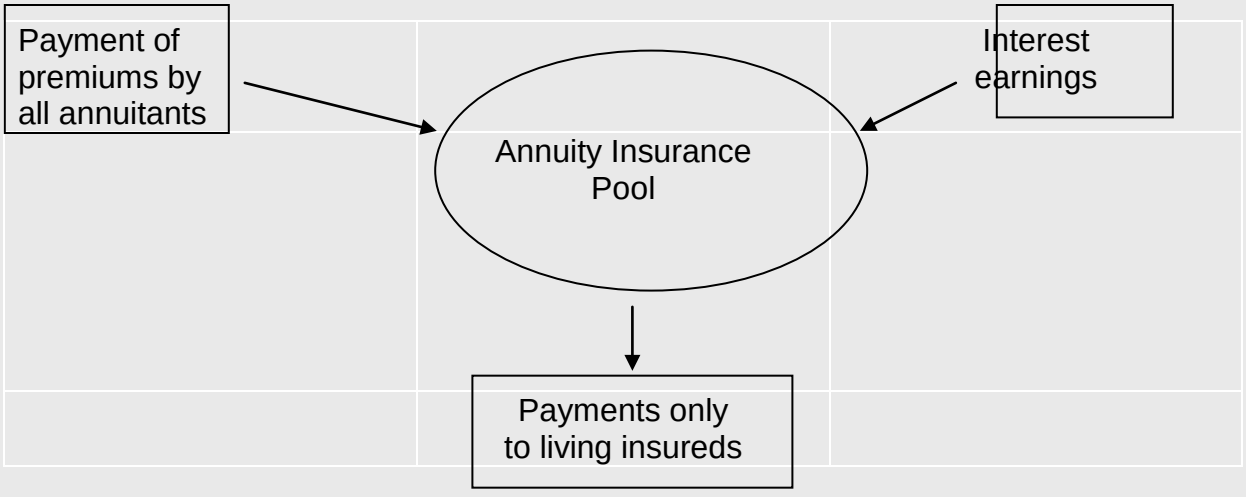
Many Americans acquire annuity protection from their employers as a result of participation in a pension plan. When the employer agrees to provide retirement income, the income represents an annuity promise to the retiree. In addition to pension plans, privately purchased annuities may be obtained from life insurers. Annuities have come and gone from the public's investing consciousness over the years. The LIMRA Secure Retirement Institute reports that in 2016 U.S. individual annuity sales totaled $202 billion. Contributions to group annuities, which are sold through employer-sponsored retirement plans, were $124 billion in 2016 (ACLI Fact Book 2017)

What an Annuity Does

An annuity is generally defined as a stream of regular payments. An annuity insurance policy is a contract in which the insurer promises the insured, called the annuitant, a regular series of payments, called rent. The basic insurance principles that underlie an annuity insurance operation are the same as those that underlie all insurance operations. That is, the insurance company combines many individuals exposed to the same peril. It uses the law of large numbers to predict in advance the payments it must make. Then it charges each insured a fair share of all losses. By charging a premium of all the individuals exposed to the peril, the insurance operation transfers money from all the people exposed to the peril to those who will experience the loss.

The "loss" insured against with an annuity is living a long time. This sounds like a loss that most people would not dislike. However, old age without money can be a tragedy. An annuity insurance operation transfers funds from those who die at a relatively early age to those who live to relatively old ages. That is, some annuitants will live to take out much more than they paid in as a premium. Other annuitants will not live long enough to take out as much as they paid in. Every annuitant pays a fair premium to enter the annuity insurance pool. In exchange for the premium, the annuitant obtains the right to receive regular payments from the insurance pool as long as he or she is alive. An insurance company earns interest on all the money in the pool. Therefore, the annuity payments received by an annuitant will come from three sources: (1) liquidation of the original premium payment, or principal, (2) interest earned on the principal, and (3) funds made available by the relatively early death of some annuitants. This concept is illustrated in the nearby illustration.

Figure 2-1. The Annuity Insurance Operation



It is interesting to note that the mortality table used by annuity insurers to predict the amount of payments they will make is not the same one used for life insurance calculations. People who purchase annuities live longer than do those who do not purchase annuities. While mortality tables used for life insurance calculations end at age 100, the 1983 individual annuity mortality table and Annuity 2000 mortality table continue to age 115. The reason for this is *adverse selection.*

Adverse selection in life insurance means that those people with a greater than average likelihood of premature death try to purchase life insurance at regular rates. Life insurers try to prevent adverse selection by requiring medical examinations in addition to other underwriting precautions. It is more difficult to prevent adverse selection by people purchasing annuities. Theoretically, an insurer could require a medical examination and then reject the "superhealthy" as "poor risks." However, this generally is not a sound approach to take with the public. Therefore, the insurer recognizes that people who purchase annuities are probably in above-average health. This explains why they use a mortality table that reflects this better than average mortality.

Viatical Settlements

Viatical settlements are basically a form of cashing out an insurance policy. It is the sale of an existing life insurance policy by a policyowner to a third party. The policyowner receives a discounted sum of cash, usually 55 to 85% of the face value, upon surrender of the life insurance to a third party. Policy assignment is as old as the insurance industry, the contract being considered personal property of the owner. The viatical settlement industry took its name from the Latin, *viaticum,* a noun that means “provisions for a journey.” So says one of the Internet sites touting this product. A group (found on the Internet) purporting to represent the viatical settlements industry has gone so far as to coin what appears to be their own transitive verb, “viaticate” (not found in the dictionary). However, the dictionary does contain the word “viatic”, *adj.*; “of or pertaining to traveling, a road, or way.” It is to be hoped the operators in this relatively new, unregulated industry do not end up taking people for a ride.

People want to sell policies for several reasons. Viatical settlements seem to be mostly associated with AIDS. They are catching on with people stricken with other terminal diseases and, with chronically ill people in need of long-term care. Any such illness is a heavy financial burden. Freeing up cash to help pay bills is one of the benefits of a viatical settlement. Or, it could be done in order to continue receiving quality health care, to afford the basic comforts of life and meet daily living expenses, to distribute gifts to family members or friends, to make a special trip or pilgrimage, or just to have financial independence.

In order to negotiate a policy, here are some requirements that will probably be considered by the viatical company;

- The policy must not be contestable by the insurance company; this usually means that the policy must have been in force for at least two years.
- The policy must be issued by a highly rated company (“A” or better, depending on the rating service).
- The named insured must be diagnosed as having a shortened life expectancy

◆There is a dollar value band of consideration. Some policies are too small, say below $10,000, to be worth the trouble to consider. Others may be too large a risk to cover by the companies operating in this fledgling industry.
◆All parties with ownership or interest in the policy are required to sign a release of interest in the policy.

The underwriting process for such a transaction involves obtaining and verifying medical and insurance information for review. This can take from two to four weeks. Requests for information are sent out and the primary physician completes a questionnaire. When all documents have been received and all questions answered, the file is reviewed, a projection of life expectancy made, and all other potential risks associated with the policy are weighed. Then an offer on the policy is made. In many cases, the processing time from receipt of a complete application to the date that funds are received is four to eight weeks. This seems a considerable time span for someone counting months to live. All types of individual policies and many group policies can be reviewed for purchase. Group policies must have an irrevocable beneficiary, absolute assignment, waiver of premium feature, or certain convertibility options. There are other alternatives available to a policyholder with a life threatening illness. The person may be able to borrow against the life insurance policy. If the policy has any cash surrender value, the owner may be able to cash out of his or her policy. A third alternative is the offer of an accelerated benefits option by the insurance company.

Taxation can be an issue. Under current Federal and some state tax laws, the sale of a life insurance policy may be taxable. Persons who are subject to taxation should be aware that, generally gross income does not include any amount received by a person owning a life insurance policy (whether in a single sum or otherwise) under contract supplemental thereto, if the amounts are paid pursuant to the sale of his or her life insurance policy with the sale of a life insurance policy on the life of a person with a life threatening illness. Anyone considering going the viatical settlement route should consult with a legal or financial professional before doing so to determine what, if any, taxes will be levied.

Viatical settlements are addressed under the Health Insurance Portability and Accountability Act (HIPAA). This Act states that any portion of the death benefit under a life insurance contract on the life of an insured that is sold or assigned to a viatical settlement provider shall be treated as an amount paid under the life insurance contract by reason of the death of the insured. A person meets the requirements for sale of the policy if he or she is terminally or chronically ill.

“Terminally ill individual” means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of certification.

“Chronically ill individual” has the meaning given by Section 7702B(c)(2) of the Internal Revenue Code.

The several states have enacted laws to protect viatical settlors. Several states have passed legislation allowing licensed insurance agents to act as viatical brokers. This could raise the possibility of a conflict of interest. An agent may be called upon to help acquire accelerated death benefits on an existing insurance contract. This pays little or no commission. The same agent may also advise the policyholder to look into a viatical settlement, a sale likely to generate a generous sales commission.

Reverse Annuity Mortgages

Here is general information on reverse mortgages;

Facts for Consumers from the Federal Trade Commission-

Produced in cooperation with the American Association of Retired Persons

If someone is age 62 or older and is "house-rich, cash-poor," a reverse mortgage (RM) may be an option to help increase their income. However, because the home is such a valuable asset, a person may want to consult with their family, attorney, or financial advisor before applying for an RM. Knowing rights and responsibilities as a borrower may help to minimize the financial risks and avoid any threat of foreclosure or loss of a senior's home. This section explains how RMs work. It describes similarities and differences among the three RM plans available today: FHA-insured; lender-insured; and uninsured. It also discusses the benefits and drawbacks of each plan. Each plan differs slightly, so care should be taken to choose the plan that best meets the homeowner's financial needs.

How Reverse Mortgages Work- A reverse mortgage is a type of home equity loan that allows individuals to convert some of the equity in their home into cash while retaining home ownership. RMs works much like traditional mortgages, only in reverse. Rather than making a payment to the lender each month, the lender pays the homeowner. Unlike conventional home equity loans, most RMs do not require any repayment of principal, interest, or servicing fees for as long as homeowner lives in his or her home. Funds obtained from an RM may be used for any purpose, including meeting housing expenses such as taxes, insurance, fuel, and maintenance costs.

Requirements and Responsibilities of the Borrower- To qualify for an RM, you must own your home. The RM funds may be paid to you in a lump sum, in monthly advances, through a line-of-credit, or in a combination of the three, depending on the type of RM and the lender. The amount you are eligible to borrow generally is based on your age, the equity in your home, and the interest rate the lender is charging. Because you retain title to your home with an RM, you also remain responsible for taxes, repairs, and maintenance. Depending on the plan you select, your RM becomes due with interest either when you permanently move, sell your home, die, or reach the end of the pre-selected loan term. The lender does not take title to your home when you die, but your heirs must pay off the loan. The debt is usually repaid by refinancing the loan into a forward mortgage (if the heirs are eligible) or by using the proceeds from the sale of your home.

Common Features of Reverse Mortgages- Listed below are some points to consider about RM's;

- RM's are rising-debt loans. This means that the interest is added to the principal loan balance each month, because it is not paid on a current basis. Therefore, the total amount of interest you owe increases significantly with time as the interest compounds.

All three plans (FHA-insured, lender-insured, and uninsured) charge origination fees and closing costs. Insured plans also charge insurance premiums, and some impose mortgage servicing charges. Your lender may permit you to finance these costs so you will not have to pay for them in cash. But remember these costs will be added to your loan amount.

- RM’s use up some or all of the equity in your home, leaving fewer assets for you and your heirs in the future.

- You generally can request a loan advance at closing that is substantially larger than the rest of your payments.
- Your legal obligation to pay back the loan is limited by the value of your home at the time the loan is repaid. This could include increases in the value (appreciation) of your home after your loan begins.
- RM loan advances are nontaxable. Further, they do not affect your Social Security or Medicare benefits. If you receive Supplemental Security Income, RM advances do not affect your benefits as long as you spend them within the month you receive them. This is true in most states for Medicaid benefits also. When in doubt, check with a benefits specialist at your local area agency on aging or legal services office.
- Some plans provide for fixed rate interest. Others involve adjustable rates that change over the loan term based upon market conditions.
- Interest on RM's is not deductible for income tax purposes until you pay off all or part of your total RM debt.

How Reverse Mortgages Differ- This section describes how the three types of RMs -- FHA-insured, lender-insured, and uninsured -- vary according to their costs and terms. Although the FHA and lender-insured plans appear similar, important differences exist. This section also discusses advantages and drawbacks of each loan type.

❶FHA-insured. This plan offers several RM payment options. You may receive monthly loan advances for a fixed term or for as long as you live in the home, a line of credit, or monthly loan advances plus a line of credit. This RM is not due as long as you live in your home. With the line of credit option, you may draw amounts as you need them over time. Closing costs, a mortgage insurance premium and sometimes a monthly servicing fee is required. Interest is charged at an adjustable rate on your loan balance; any interest rate changes do not affect the monthly payment, but rather how quickly the loan balance grows over time.

The FHA-insured RM permits changes in payment options at little cost. This plan also protects you by guaranteeing that loan advances will continue to be made to you if a lender defaults. However, FHA-insured RMs may provide smaller loan advances than lender-insured plans. Also, FHA loan costs may be greater than uninsured plans.

❷Lender-insured. These RM's offer monthly loan advances or monthly loan advances plus a line of credit for as long as you live in your home. Interest may be assessed at a fixed rate or an adjustable rate, and additional loan costs can include a mortgage insurance premium (which may be fixed or variable) and other loan fees. Loan advances from a lender-insured plan may be larger than those provided by FHA-insured plans. Lender-insured RMs also may allow you to mortgage less than the full value of your home, thus preserving home equity for later use by you or your heirs. However, these loans may involve greater loan costs than FHA-insured, or uninsured loans. Higher costs mean that your loan balance grows faster, leaving you with less equity over time. Some lender-insured plans include an annuity that continues making monthly payments to you even if you sell your home and move. The security of these payments depends on the financial strength of the company providing them, so be sure to check the financial ratings of that company. Annuity payments may be taxable and affect your eligibility for Supplemental Security Income and Medicaid. These "reverse

annuity mortgages" may also include additional charges based on increases in the value of your home during the term of your loan.

❸Uninsured. This RM is dramatically different from FHA and lender-insured RMs. An uninsured plan provides monthly loan advances for a fixed term only -- a definite number of years that you select when you first take out the loan. Your loan balance becomes due and payable when the loan advances stop. Interest is usually set at a fixed interest rate and no mortgage insurance premium is required.

If you consider an uninsured RM, carefully think about the amount of money you need monthly; how many years you may need the money; how you will repay the loan when it comes due; and how much remaining equity you will need after paying off the loan.

If you have short-term but substantial cash needs, the uninsured RM can provide a greater monthly advance than the other plans. However, because you must pay back the loan by a specific date, it is important for you to have a source of repayment. If you are unable to repay the loan, you may have to sell your home and move.
Reverse Mortgage Safeguards- One of the best protections you have with RMs is the Federal Truth in Lending Act, which requires lenders to inform you about the plan's terms and costs. Be sure you understand them before signing. Among other information, lenders must disclose the Annual Percentage Rate (APR) and payment terms. On plans with adjustable rates, lenders must provide specific information about the variable rate feature. On plans with credit lines, lenders also must inform you of any charges to open and use the account, such as an appraisal, a credit report, or attorney's fees.
For More Information- If you are interested in obtaining a current list of lenders participating in the FHA-insured program, sponsored by the Department of Housing and Urban Development (HUD), or additional information on reverse mortgages and other home equity conversion plans, write to:
AARP Home Equity Information Center American Association of Retired Persons 601 E Street, N.W. Washington, D.C. 20049

Informal Care by Family or Friends

Remaining at home for as long as possible is the goal for many in their golden years. Independent living with the appropriate amount of assistance is the ideal. However, a major issue for people to think about is the question of what to do with aging parents. As the population ages, the demand for nursing home care and home care programs will skyrocket. Home-based care, from meal preparation to nursing, costs far less and can be preferable for elders desiring to stay at home. Costs can soar when 24-hour care is required. Economic expense should not only be thought of as out-of-pocket expense, but also the opportunity costs when an adult son or daughter must devote time to the care of an aged parent. When to move a senior out of the home environment and into an assisted living facility is a delicate question.

Medicare

Most long-term care is furnished in nursing homes to people with chronic, long-term illnesses or disabilities. The care they receive is personal care, often called custodial care. Medicare does not pay for custodial care. Medicare pays less than 10% of all nursing home costs.

In 2015, Medicare provided health care coverage for 55 million Americans, making it the largest single health care payer in the nation. Enrollment is expected to reach 78 million by 2030.

Benefits

Medicare has four parts: Part A is Hospital Insurance. Part B is Medical Insurance. Medicare Part D covers prescription drugs. Medicare Advantage plans, also known as Medicare Part C, are another way for beneficiaries to receive their Part A, B and D benefits. All Medicare benefits are subject to medical necessity. The original program was only Parts A and B. Part D was new in January 2006; before that, Parts A and B covered prescription drugs in only a few special cases.

Part A: Hospital Insurance

Part A covers inpatient hospital stays (at least overnight), including semiprivate room, food, tests, and doctor's fees. Part A covers brief stays for convalescence in a skilled nursing facility if certain criteria are met:

1. A preceding hospital stay must be at least three days, three midnights, not counting the discharge date.
2. The nursing home stay must be for something diagnosed during the hospital stay or for the main cause of hospital stay.
3. If the patient is not receiving rehabilitation but has some other ailment that requires skilled nursing supervision then the nursing home stay would be covered.
4. The care being rendered by the nursing home must be skilled. Medicare part A does not pay for custodial, non-skilled, or long-term care activities, including activities of daily living (ADL) such as personal hygiene, cooking, cleaning, etc.

The maximum length of stay that Medicare Part A will cover in a skilled nursing facility per ailment is 100 days. The first 20 days would be paid for in full by Medicare with the remaining 80 days requiring a co-payment (as of 2017, $164.50 per day). Many insurance companies have a provision for skilled nursing care in the policies they sell. If a beneficiary uses some portion of their Part A benefit and then goes at least 60 days without receiving facility-based skilled services, the 100-day clock is reset and the person qualifies for a new 100-day benefit period.

Part B: Medical Insurance

Part B medical insurance helps pay for some services and products not covered by Part A, generally on an outpatient basis. Part B is optional and may be deferred if the beneficiary or their spouse is still working. There is a lifetime penalty (10% per year) imposed for not enrolling in Part B unless actively working. Part B coverage begins once a patient meets his or her deductible, then typically Medicare covers 80% of approved services, which the remaining 20% is paid by the patient.
Part B coverage includes physician and nursing services, x-rays, laboratory and diagnostic tests, influenza and pneumonia vaccinations, blood transfusions, renal dialysis, outpatient hospital procedures, limited ambulance transportation, immunosuppressive drugs for organ transplant recipients, chemotherapy, hormonal treatments, and other outpatient medical treatments administered in a doctor's office. Medication administration is covered under Part B only if it is administered by the physician during an office visit.

Part B also helps with durable medical equipment (DME), including canes, walkers, wheelchairs, and mobility scooters for those with mobility impairments. Prosthetic devices such as artificial limbs and breast prosthesis following mastectomy, as well as one pair of eyeglasses following cataract surgery, and oxygen for home use are also covered.

Complex rules are used to manage the benefit, and advisories are periodically issued which describe coverage criteria. On the national level these advisories are issued by CMS, and are known as National Coverage Determinations (NCD). Local Coverage Determinations (LCD) only apply within the multi-state area managed by a specific regional Medicare Part B contractor, and Local Medical Review Policies (LMRP) were superseded by LCDs in 2003.

Part C: Medicare Advantage Plans

With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These programs were known as “Medicare+Choice” or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, "Medicare+Choice" plans were made more attractive to Medicare beneficiaries by the addition of prescription drug coverage and became known as “Medicare Advantage” (MA) plans. Traditional or "fee-for-service" Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country. For people who choose to enroll in a Medicare Advantage health plan, Medicare pays the private health plan a capitated rate, or a set amount, every month for each member. Members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare (Parts A & B), such as prescription drugs, dental care, vision care and gym or health club memberships. In exchange for these extra benefits, enrollees may be limited in the providers they can receive services from without paying extra. Typically, the plans have a "network" of providers that patients can use. Going outside that network may require permission or extra fees.

Medicare Advantage plans are required to offer coverage that meets or exceeds the standards set by the original Medicare program, but they do not have to cover every benefit in the same way. If a plan chooses to pay less than Medicare for some benefits, like skilled nursing facility care, the savings may be passed along to consumers by offering lower copayments for doctor visits. Medicare Advantage plans use a portion of the payments they receive from the government for each enrollee to offer supplemental benefits. Some plans limit their members’ annual out-of-pocket spending on medical care, providing insurance against catastrophic costs over $5,000, for example. Many plans offer dental coverage, vision coverage and other services not covered by Medicare Parts A or B, which makes them a good value for the health care dollar, if you want to use the provider included in the plan's network or "panel" of providers.

Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan or a MA-PD. Since 2004, the number of beneficiaries enrolled in private plans has more than tripled from 5.3 million to 17.6 million in 2016. This represents 31% of Medicare beneficiaries. A third of beneficiaries with Part D coverage are enrolled in a Medicare Advantage plan.

Medicare Advantage enrollment is higher in urban areas; the enrollment rate in urban counties is twice that in rural counties (22% vs. 10%). Almost all Medicare beneficiaries have access to at least two Medicare Advantage plans; most have access to three or more. Medicare contracts with insurers to offer HMOs and Local PPOs. These entities contract with provider networks to deliver Medicare benefits. HMOs account for the majority (63%) of total Medicare Advantage enrollment in 2017; local PPOs, account for 26% of all Medicare Advantage enrollees..

Part D: Prescription Drug plans

Medicare Part D went into effect on January 1, 2006. Anyone with Part A or B is eligible for Part D. It was made possible by the passage of the Medicare Prescription Drug, Improvement, and Modernization Act. In order to receive this benefit, a person with Medicare must enroll in a stand-alone Prescription Drug Plan (PDP) or Medicare Advantage plan with prescription drug coverage (MA-PD). These plans are approved and regulated by the Medicare program, but are actually designed and administered by private health insurance companies. Unlike Original Medicare (Part A and B), Part D coverage is not standardized. Plans choose which drugs (or even classes of drugs) they wish to cover, at what level (or tier) they wish to cover it, and are free to choose not to cover some drugs at all. The exception to this is drugs that Medicare specifically excludes from coverage, including but not limited to benzodiazepines, cough suppressant and barbiturates. Plans that cover excluded drugs are not allowed to pass those costs on to Medicare, and plans are required to repay CMS if they are found to have billed Medicare in these cases. Note that for beneficiaries who are dual-eligible (Medicare and Medicaid eligible) Medicaid may pay for drugs not covered by part D of Medicare, such as benzodiazepines, and other restricted controlled substances.

Neither Part A nor Part B pays for all of a covered person's medical costs. The program contains premiums, deductibles and coinsurance, which the covered individual must pay out-of-pocket. Some people may qualify to have other governmental programs (such as Medicaid) pay premiums and some or all of the costs associated with Medicare.

Premiums

Most Medicare enrollees do not pay a monthly Part A premium, because they (or a spouse) have had 40 or more 3-month quarters in which they paid Federal Insurance Contributions Act taxes. Medicare-eligible persons who do not have 40 or more quarters of Medicare-covered employment may purchase Part A for a monthly premium of:

- $227.00 per month (2017) for those with 30-39 quarters of Medicare-covered employment, or
- $413.00 per month (in 2017) for those with fewer than 30 quarters of Medicare-covered employment and who are not otherwise eligible for premium-free Part A coverage.

All Medicare Part B enrollees pay an insurance premium for this coverage; the standard Part B premium for 2017 is $134.00 per month. A new income-based premium plan has been in effect since 2007, wherein Part B premiums are higher for beneficiaries with incomes exceeding $85,000 for individuals or $170,000 for married couples. Depending on the extent to which beneficiary earnings exceed the base income, these higher Part B premiums are $187.50, 267.90, or 348.30 for 2017, with

the highest premium paid by individuals earning more than $214,000, or married couples earning more than $428,000. Part C and D plans may or may not charge premiums, at the programs' discretion. Part C plans may also choose to rebate a portion of the Part B premium to the member.

Deductible and coinsurance

Part A - For each benefit period, a beneficiary will pay (in 2017):

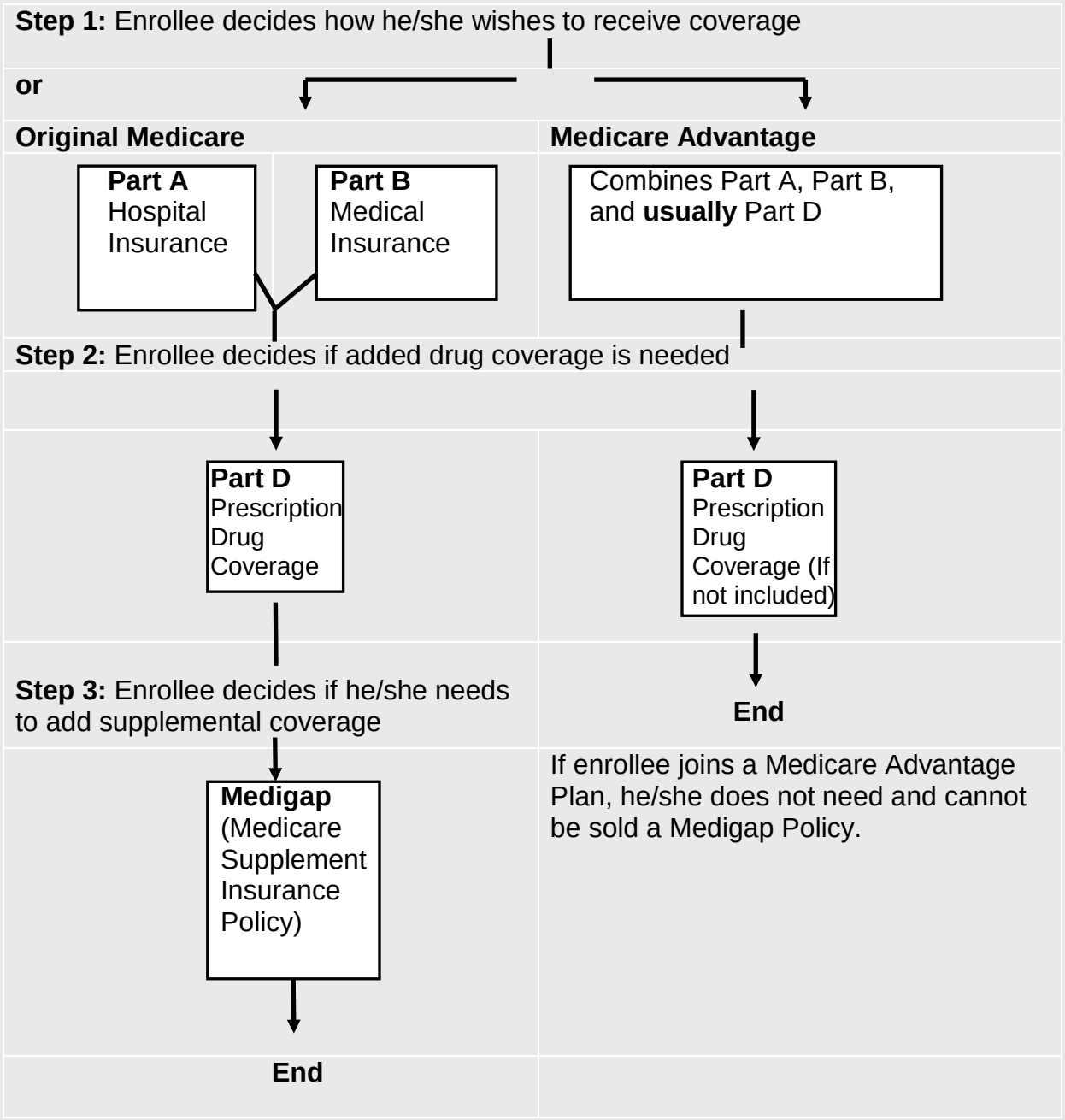
- A Part A deductible is $1,316.
- A $329 per day co-pay for days 61-90 of a hospital stay.
- A $658 per day co-pay for days 91-150 of a hospital stay, as part of their limited Lifetime Reserve Days.
- All costs for each day beyond 150 days.
- Coinsurance for a Skilled Nursing Facility is $164.50 per day for days 21 through 100 for each benefit period.
- A blood deductible of the first 3 pints of blood needed in a calendar year, unless replaced. There is a 3 pint blood deductible for both Part A and Part B, and these separate deductibles do not overlap.

Part B - After a beneficiary meets the yearly deductible of $183.00 (in 2017), they will be required to pay a co-insurance of 20% of the Medicare-approved amount for all services covered by Part B with the exception of most lab services which are covered at 100%, The copay for outpatient mental health which started at 50% was gradually stepped down over several years until it matched the 20% required for other services. They are also required to pay an excess charge of 15% for services rendered by non-participating Medicare providers. The deductibles and coinsurance charges for Part C and D plans vary from plan to plan.

Medicare supplement (Medigap) policies

Some people elect to purchase a type of supplemental coverage, called a Medigap plan, to help fill in the holes in Original Medicare (Part A and B). These Medigap insurance policies are standardized by CMS, but are sold and administered by private companies. Some Medigap policies sold before 2006 may have included coverage for prescription drugs. Medigap policies sold after the introduction of Medicare Part D on January 1, 2006 are prohibited from covering drugs. Medicare regulations prohibit a Medicare beneficiary from having both a Medicare Advantage Plan and a Medigap Policy. Medigap Policies may only be purchased by beneficiaries that are receiving benefits from Original Medicare (Part A & Part B).

Chart 1 Medicare Basics



Payment for services

Medicare contracts with regional insurance companies who process over one billion fee-for-service claims per year. In 2015, Medicare accounted for 15% ($540 billion) of the federal budget. In 2017, Medicare benefit payments totaled $702 billion, up from $425 billion in 2007. For the decade 2015-2026 Medicare is projected to cost 9.1 trillion dollars.

Taking No Action

Doing Nothing- the *doppelganger* of a financially sound, money-saving senior citizen is conjured with the philosophy of doing nothing. People who did nothing to prepare for their old age, frittered money away and now, too old to work anymore, must scrape by on Social Security and whatever handouts their family, friends, or a philanthropic public happens to throw their way. This is the opposite end of the

spectrum from the saver. Anecdotes abound concerning people forced to stay in the workforce into their 70's because they had no money to retire.

Any discussion of what should be salted away for retirement invariably draws in subjective evaluations concerning an individual's ultimate goal in life. The vow of poverty of a nun or abbot by definition leaves them with no possessions in old age. The excesses of the gambler, drunkard or drug addict leaves them in a debilitated state and broke. There are many folks (some in our own families!) who, by chance or by choice, end up with nothing at the end of their working career. The reasons how or why people end up unable to support themselves in old age are as varied as the individuals who end up in that situation. Some are worthless scoundrels. Many are good people touched by bad fortune. Others can truly see no value in saving beyond their basic needs (however they perceive them).

Politicians make hay over the plight of these masses. Yet it often seems that the working and middle classes fund the politician's pipedreams. At any rate, consumers of limited financial means are in no condition to purchase long-term care insurance. A multitude of people does nothing. They need no instruction in how to do it. Their situation is beyond the scope of this text.

Agents should be Aware: Avoidance of Medicaid

The purchase of a long-term care policy will not necessarily ensure that someone will avoid Medicaid when they need long-term care. Whether that is to their advantage or not depends upon the individual's particular circumstances. People who are unlikely to be able to afford premiums, unable to absorb even a moderate increase are not appropriate purchasers, and the safety net of Medicaid may be their only option.

B. Alternative Living Settings/Arrangements

Retirement Homes

Such residential care facilities for the elderly provide assisted living arrangements. Residents are provided with a room, meals and activities. It is usually required that residents can act independently and be able to perform substantially all of the activities of daily living mentioned above. Such facilities are usually not required to have doctors or nurses on staff. These types of facilities are licensed and inspected by a state agency.

Life Care Communities

These operate with life care contracts, a combination of health care housing and insurance for seniors. The insured signs a contract, which remains in effect as long as that person lives. Such homes require an entrance fee and regular monthly charges. Additional charges may be required for higher levels of service. Various levels of long-term care are offered along with nursing home-type care. The senior may start out with an independent living arrangement, move to an intermediate care facility, and then the facility's skilled nursing facility.

Family Care

Unpaid family members and friends frequently provide informal long-term care. **Safety** is a number one concern of many caregivers, especially in care situations involving someone with a cognitive limitation. Four overlapping safety concerns usually top the list of caregiver worries:

1. Typically, an individual caring for a family member with a cognitive limitation, either from stroke or dementia, names the potential for *getting lost* as a high priority to address. This safety problem may occur as the result of wandering out of the house, walking away from the care-giver in public or becoming lost while driving.
2. The inability to avoid or respond correctly to an *emergency situation*, especially a fire, is a frightening prospect for caregivers. Fires are often started while attempting to cook or warm the house with a fireplace or space-heater. Smoking is also a major contributor to home fires. Individuals with mobility problems may not be able to respond quickly enough to a dangerous situation to avoid serious injury.
3. There are many ways to *injure* oneself in the home, but the most common by far are falls. Dementia is a major risk factor for falls due to lack of good judgment or distractions or preoccupation while walking. However, anyone can be distracted while walking and risk a fall.
4. Impaired vision or poor memory is often the culprits in *medication errors*. Individuals may take the wrong dosage, use the wrong medication, and forget to take medications or take them at the wrong time. Side effects of medication can include lack of concentration or short-term memory loss, adding further to the risk of taking the medication too often or not at all. Medication errors can also be made by caregivers who are rushed or distracted.

Besides safety concerns, caregivers involved in physically caring for a person with disabilities often name back strain and sprain as a disturbing risk. A third caregiving concern includes the exhaustion that often accompanies caring for another individual, especially if no respite is available. Four types of caregiver strain resulting from stress have been identified (Select Committee on Aging, 1987): emotional strain, physical strain, financial strain, and family strain. The issue of family care is discussed further in other parts of this book.

Fraternal, Religious and Other Organizations

Some organizations provide, sponsor, or give a stamp of approval to retirement living arrangements. Discretionary groups are groups that do not fit into the category of trade or professional groups. A large museum patrons group, a religious organization, or an environmental group might fit in this category. One can thumb through any denominational magazine and find several half-page or better advertisements for senior living arrangements. A check of the Internet turns up Catholic, Lutheran, Methodist as well as Masonic Lodges support retirement facilities for their members. The not-for-profit nature of these facilities requires two things; that they limit eligibility to the facility to members of the organization, and that they solicit donations for any operational funding shortfall.

Section 3 Qualified State Long-Term Care Insurance Programs

Long-Term Care Partnership Program

The Long-Term Care Partnership Program is a public-private partnership between states and private insurance companies, designed to reduce Medicaid expenditures by delaying or eliminating the need for some people to rely on Medicaid to pay for

long-term care services. Individuals, who buy select private long-term care insurance policies that are designated by a state as partnership policies and eventually need long-term care services, first rely on benefits from their private long-term care insurance policy to cover long-term care costs before they access Medicaid. To qualify for Medicaid, applicants must meet certain eligibility requirements, including income and asset requirements. Traditionally, applicants cannot have assets that exceed certain thresholds and must “spend down” or deplete as much of their assets as is required to meet financial eligibility thresholds.

To encourage the purchase of private partnership policies, long-term care insurance policyholders are allowed to protect some or all of their assets from Medicaid spend-down requirements during the eligibility determination process, but they still must meet income requirements. The definition of assets differs between the Long-Term Care Partnership Program and Medicaid. The Long-Term Care Partnership Program uses the term ‘assets’ to denote savings and investments, and excludes income. For purposes of Medicaid eligibility, assets include both income, which is anything received during a calendar month that is used or could be used to meet food, clothing, or shelter needs, and resources, which are anything owned, such as savings accounts, stocks, or property.

Background of LTC Partnership

Four original states adopted LTC Partnerships in 1997. Those states were New York, Indiana, Connecticut and California. Residents of those states were given the ability to purchase private long-term care policies, and when the policies' benefits are utilized, policyholders then can go onto Medicaid (if they meet all the other eligibility requirements) without spending down all of their personal assets. The Deficit Reduction Act of 2005 (DRA) which was signed into law in 2006 (P.L.109-171) allowed the other states to adopt LTC Partnerships.

The Georgia Department of Insurance (GADOI) proposed regulations for long-term insurance policies that will qualify as LTC Partnership policies and comply with the requirements in the DRA. Under the Partnership, special Health and Human Services Commission (HHSC) rules for determining Medicaid eligibility and estate recovery may be applicable to individuals who purchase qualified partnership policies and apply for Medicaid. These special rules allow the individual to protect assets equal to the amount of insurance benefits paid by a partnership policy so that such protected countable assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries. This feature of the Partnership is known as an "asset disregard" and the asset disregard applies to all insurance benefits received from a Partnership policy. The asset disregard applies to all insurance benefits paid on a reimbursement, cash benefit basis, indemnity insurance basis, or on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate. Similarly, the asset disregard applies to all insurance benefits received from a partnership policy regardless of whether such insurance benefits are for costs for long-term care that would be covered by Medicaid. The asset disregard may equal the amount of partnership policy benefits that have been paid out on the individual to date upon application and/or redetermination, even if additional benefits may be received in the future policy. The asset disregard does not include the return of premium payments made upon the termination of a partnership policy (due to cancellation or death) since such payments do not represent insurance benefits.

General Conditions for a Partnership Policy

The Long-Term Care Partnership Program was created as an incentive to help citizens plan for their long-term care needs. The partnership is a joint effort between private insurers and the state. Insurers must follow state and federal guidelines and agents must complete required training to sell partnership policies.

Partnership policies have an asset disregard benefit that is useful if the policyholder needs to apply for Medicaid. Partnership policies, however, do not guarantee acceptance into Medicaid. Policyholders still have to meet income, medical, and other eligibility criteria. Partnership policy requirements follow;

(a) A policy or certificate marketed or represented to qualify as an approved long-term care partnership program policy must comply with the following requirements:

(1) the insured individual was a resident of Georgia when coverage first became effective under the policy

(2) the policy is issued with and retains inflation coverage that meets the inflation standards based on the insured's then attained age (see following)

(3) the effective date of the coverage is on or after the GADOI rules adoption date

(b) Insurance benefit payments for purposes of the asset disregard when applying for Medicaid long-term care services are payments made for long-term care benefits and services and do not include such benefits as cash surrender values, return of premiums, premium waiver, or death benefits.

(c) A policy, certificate, or contract represented or marketed as a long-term care partnership policy shall provide a disclosure notice that explains the benefits associated with a partnership policy, that is issued in conjunction with the long-term care partnership policy or certificate, and that prominently discloses the following:

(1) that the policy, certificate, or contract meets the standards for the long-term care partnership program in Georgia;

(2) that the partnership status may be lost if the insured moves to a different state or modifies the coverage after issue;

(3) that the purchase of a partnership policy, certificate, or contract does not guarantee Medicaid eligibility nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility.

Dollar-for-Dollar

With the asset disregard benefit, every dollar of long-term care benefits a partnership policy pays will equal one dollar of countable assets that will be disregarded to determine eligibility for Medicaid. This means policyholders can retain assets above the normal limit and will not need to “spend down” their assets to qualify for Medicaid. In addition, the assets that were disregarded in the Medicaid eligibility process will not be subject to Medicaid liens and recoveries after the policyholder’s death.

In addition to asset disregard, long-term care partnership policies must also include the following benefits:

Inflation protection. Inflation protection helps the policy continue to pay long-term care benefits as costs rise. Partnership policies provide varying levels of inflation protection based on age of the insured:

- **Under 61 years old:** The insurer is required to offer the option to purchase five percent compound annual inflation protection. Individuals can choose to purchase protection at a lower rate, but then must retain some form of compound inflation protection. Upon attaining 61 years of age, policyholders

can amend the inflation protection provision to comply with requirements of the next age bracket.

- **Ages 61 to 76:** Insureds must purchase and retain some form of inflation protection until he or she is 76 years old.
- **After age 76:** Insurers must offer inflation protection, but insureds do not have to purchase or retain it.

Tax qualification

The insured may be able to deduct part of the premium from his or her taxes as a medical expense, and policy benefits are generally not taxable as income. If someone is considering a long-term care policy, he or she should ask an insurance professional if a partnership policy meets their needs. If a long-term care policy was purchased on or after February 8, 2006, the insured can explore the possibility of exchanging the policy for a partnership policy.

Note: Partnership policies will be accompanied by a disclosure statement identifying the policy as a long-term care partnership policy. Insureds must be made aware that if he or she makes any changes to the partnership policy, the insured could lose partnership policy status. An insurance professional can explain to the insured what changes will result in a status change.

Moving to another state

Georgia participates in a national reciprocity agreement with other states to honor the terms of partnership policies. If an insured moves to a state that participates in the reciprocity agreement, the policy purchased in Georgia will retain its partnership status. Care should be exercised in basing the decision to purchase a partnership policy on reciprocity with other states because states can opt in or out of the reciprocity agreement at any time. If a policyholder moves to another state, he or she will also need to meet all the Medicaid requirements for the new state of residence.

Tax-Qualified Long-Term Care Policies

Insureds may be able to deduct part of the premium for a tax qualified long-term care policy from taxes as a medical expense. However, in the case of an indemnity policy, there is an annual dollar cap. In addition, insureds are generally not required to claim qualified long-term care policy benefits as taxable income.

All policies sold before January 1, l997, are automatically tax qualified. Policies sold on or after January 1, 1997, may be either tax qualified or non-tax qualified. To determine whether a policy is tax qualified, insureds should look for a statement on the policy similar to this:

> "This policy is intended to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, Section 7702B(b)."

Consult with an attorney, accountant, or tax advisor about the tax implications of purchasing long-term care insurance.

Maximum Long-Term Care Premium Deductions, 2017*

Age	Maximum Allowable Deduction
40 or younger	$410
41 to 50	$770
51 to 60	$1,530
61 to 70	$4,090
71 or older	$5,110

* Note that maximum deduction amounts change annually.

To claim a tax deduction for long-term care premium payments, the insureds out-of-pocket medical expenses, including long-term care premiums, must be more than 7.5 percent of his or her adjusted gross income. The maximum amount of long-term care premium that can be deducted depends on an individual's age at the end of each tax year.

Comparing Tax Qualified and Non-Tax Qualified Policies

	Tax-Qualified Policies	Non-Tax Qualified Policies
Tax Deductions	Insured can deduct premiums with other annual uncompensated medical expenses.	Insured may or may not be able to deduct any part of the annual premiums.
Counting Benefits as Income	Benefits that are received and used to pay for long-term care services generally will not be counted as income. For policies that pay benefits using the expense incurred method, benefits that are received in excess of the costs of long-term care services may be taxable. For policies that pay benefits using the indemnity or disability methods, all benefit payments up to the federally approved daily rate are tax free even if they exceed expenses.	Benefits that you receive may or may not count as income.
Triggering Benefits	Federal law requires that the insured be unable to perform two ADLs without substantial assistance for at least 90 days before benefits are triggered. “Medical necessity” can’t be used as a trigger for benefits.	Policies can offer a different combination of benefit triggers. Benefit triggers are not restricted to two ADLs. Medical necessity” or other measures of disability can be offered as benefit triggers.
Covering Cognitive Impairment	A person must require “substantial supervision” for cognitive impairment to be covered.	Policies do not have to require “substantial supervision” to trigger benefits for cognitive impairments
Plan of care requirement	Plan of care from a health care practitioner required for payment of benefits	Not required for payment of benefits, but company may ask for it

Non-Tax Qualified Long-Term Care Policies

Premiums for non-tax qualified long-term care policies are not tax deductible. In addition, it may be that an insured has to pay taxes on any benefits the policy pays above expenses incurred.

To receive benefits from a non-tax qualified policy, the insured must have a cognitive impairment, such as Alzheimer's or a similar disease, or be unable to perform two of six activities of daily living (ADLs). However, some policies may offer more favorable benefit triggers. For example, a policy might require only a medical necessity and the inability to perform one of six or two of seven ADLs.

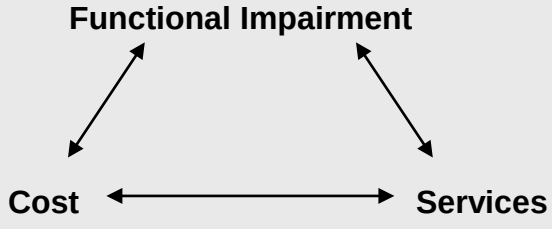
Section 4 Available Long-Term Care Services and Providers

The Availability of LTC Services and Facilities

People need long-term care if they are unable to take care of themselves because of a prolonged (chronic) illness or disability. Where does one go to find such care? Is it found in the yellow pages? The Internet? At church? Does the government help? When Uncle Carlos got to where he couldn't get around much anymore, Cousins Ray and Sandy seemed to deal with the situation pretty well. Do they have insight regarding the subject?

Where does one go for services? The answer is; to all of these resources. Information is the key to utilizing long-term care services in an efficient and economical manner. With long-term care, the critical thing to realize is the interrelationship between cost, services, and functional impairment.

That is, the less proficient an individual is at performing the six (or seven) activities of daily living (ADL's), the more intensive the services will be required. Remember that depending on how defined, ADL's include eating, dressing, bathing, toileting, ambulating, transferring, and continence. It will be seen in other sections of the text that what is included as an ADL is important.



The Long-Term Care Continuum

Long-term care services include an array of categorical programs offering medical, social, and other support services that are funded and administered by a variety of federal, state, and local agencies as well as through private sources. At times these services can be replete with gaps, duplication, and little or no emphasis on the

specific concerns of individual consumers. The need for a coordinated continuum of long-term care services is apparent. Numerous obstacles prevent its development, including inflexible and inconsistent funding sources, economic incentives that encourage the placement of consumers in the highest levels of care, lack of coordination between aging, health, and social service agencies at both state and local levels, and inflexible state and federal regulations.

Implementation of an effective program will help promote economic efficiency so that duplicative and confusing eligibility criteria, assessments, and service limitations will not inhibit consumer satisfaction, impede improvements in consumer health status, and result in the ineffective use of resources. It is in the interest of those in need of long-term care that a system be developed that provides dignity and maximum independence for seniors, creates home and community-based alternatives to unnecessary out-of-home placement, and is cost effective. A long-term care continuum should include the following goals;

- Provide a continuum of social and health services that foster independence and self-reliance, maintain individual dignity, and allow those in need of long-term care services to remain an integral part of their family and community life.
- If out-of-home placement is necessary, it should be at the appropriate level of care, and prevent unnecessary utilization of acute care hospitals.
- When family caregivers are involved in the long-term care of an individual, to support caregiving arrangements that maximize the family's ongoing relationship with, and care for, that person.
- Deliver long-term care services in the least restrictive environment appropriate for the individual.

Many times the striving for optimum conditions results in higher cost. For example, the average costs associated with impairment in one kind of ADL may differ from the average costs associated with impairments in other types. The nursing home residents with impairments in "late-loss" ADL's such as bed mobility or eating were associated with higher average nursing costs than nursing home residents with impairments in dressing or grooming.[3]

LTC Services Available

Many times, family members provide long-term care services to those with chronic illnesses. Long-term care is also provided by; home care agencies, senior centers, adult day care centers, traditional nursing homes, and continuing care retirement centers. As mentioned above, the complex and fragmented laws, regulations, and financing sources administered by multiple agencies of the federal and state governments result in equally complex, services in the community. To illustrate, county departments of health oversee nursing homes, while county departments of social services have jurisdiction over the in-home social services programs, and the city and county area agencies on aging coordinate other long-term care services. In addition, private, for-profit home-care programs proliferate in many of the more affluent areas.

3 Williams, B., Fries, B., et al., "Activities of Daily Living and Costs in Nursing Homes," Health *Care Financing Review,* Vol. 15, No. 5, Summer, 1994, pp. 117-135.

Chronic Conditions, Delivery Care and Services Provided

Long-term care is the kind of assistance a person needs when assistance is needed to help with personal care. A disabling or long-term (chronic) medical condition is what usually triggers the need for this type of assistance. Long-term care services can include in-home care, as well as nursing home or community-based care. The need for such services can happen to anybody. An accident or unexpected, severe illness can create the need for long-term care. So can the slow, steady onset of chronic diseases like arthritis, Alzheimer's disease or Parkinson's disease. Advancing age or feebleness can also contribute to the need for long-term care.

Coordinating the services and matching the unique needs of those requiring long-term care is, at best, difficult. Only recently did the state impose operations standards for board and care facilities that provide housing for individuals who might otherwise be institutionalized. An array of unconnected services heightens the critical importance of effective case management, information and referral services, and written understanding among state, county, and city agencies. In response to that need, Los Angeles County, for instance, has promoted cooperation across the city, county, and private sectors through long-term care task forces. Major expansions of long-term care services will impel fundamental reforms in service delivery and a major restructuring of existing programs. Like reforms in financing, those in service delivery are likely to be difficult. California legislation in the early 1980's proposing the coordination of services through a state long-term care corporation or through area agencies on aging generated significant and intense interagency disputes. Concurrent issues that affect local service delivery include the availability and specialized training of health and long-term care personnel.

Information on Services and Providers

The levels of care include; Acute, skilled nursing, intermediate, hospice, home, custodial, respite. Caregivers range in licensing and skill levels and include; therapists, registered nurse, certified nurse's aides, certified nurses' assistant, home health assistant and unskilled care. See the sub-heading below explaining "How and Where to Locate Services", for information on where to obtain information on LTC services.

Locations Where the Services are Provided- Formal Care

Nursing Homes

These are what generally come to mind when thinking of long-term care for the elderly. Residents in these facilities often cannot walk and generally need help in performing at least one activity of daily living. These activities include eating, dressing, toileting, bathing, continence, and transferring (getting from one place or position to another- more on that later). People in this situation may also have substantial memory loss. At a nursing home, the staff consists of registered nurses and certified nursing assistants. Nursing facilities must also have physicians readily available. In some nursing homes there are facilities provided strictly for the care of people with psychiatric problems. Others may address the needs of people with some form of dementia, perhaps an Alzheimer's disease wing. This is one of the things over which an individual has no control. Alzheimer's and similar diseases that affect the functioning of the brain and nervous system often lead to the need for extended long-term care. Over half of nursing home residents experience a cognitive impairment like Alzheimer's disease. All nursing facilities are licensed and inspected by the State's Department of Health Services (or its equivalent).

Retirement Homes

Such residential care facilities for the elderly provide assisted living arrangements. Residents are provided with a room, meals and activities. It is usually required that residents can act independently and be able to perform substantially all of the activities of daily living mentioned above. Such facilities are not required to have doctors or nurses on staff. These types of facilities are generally licensed and inspected by the State's Department of Social Services (or its equivalent).

Continuing Care Retirement Communities

Many senior citizens opt to move to continuing care retirement communities (CCRC's) such as senior apartments offering independent living in a large building where meals and weekly housekeeping are provided. Continuing care retirement communities can provide all levels of care and allow people to stay in the same facility throughout the senior years. There are large facilities offering assisted living services. This is licensed care. These services are offered under various cost structures, often on a per visit basis. An aide can come in to help with medications, dressing, etc. but they are not available for an extended period of time. Such living conditions are for fairly independent residents. An emergency call system is in place but is not intended for repeated use. People who cannot walk, dress, or generally get about without assistance need a caregiver within closer range. A board-and-care home or private caregiver would better suit them.

Life Care Homes

These typically operate with life care contracts, a combination of health care housing and insurance for seniors. The insured signs a contract, which remains in effect as long as that person lives. Such homes require an entrance fee and regular monthly charges. Additional charges may be required for higher levels of service. Various levels of long-term care are offered along with nursing home-type care. The senior may start out with an independent living arrangement, move to an intermediate care facility, and then the facility's skilled nursing facility.

Residential Care Facilities

Residential Care Homes are assisted living facilities providing various levels of care for those seniors who are semi-independent and those needing frequent assistance. State social welfare agencies are the regulating agency for such homes and the criteria vary by state. The home-like setting makes it much easier for seniors to leave the comfort of their own homes when they are no longer able to manage their total care. These homes offer meal service and basic care all the way to skilled nursing in some cases. Otherwise referred to as group homes, assisted living, personal care homes, or catered living, they provide routine services like health care monitoring, medication management, personal care assistance as needed, and limited health care services. Some homes have a resident nurse, while others have on-call staffing--depending on the level of care. Residential care homes are similar in concept to assisted living facilities where the main focus is on assistance with non-medical needs, such as meal preparation, grooming, and other daily activities.

The big difference in definition of residential care homes and assisted living facilities is the size. Residential care homes are designed on a smaller scale, offering a more intimate and personal atmosphere for seniors. State licensing is required for all residential care homes. These are not medical facilities and are not licensed as such.

Medicaid does not pay for care in these types of homes, but some homes may accept Supplemental Security Income as payment.

Adult Day Care

This type of care is outside the home and on a daily basis, as the name implies. These programs offer partial care programs. A good example of their use would be an older couple where the well spouse is the caregiver for the needy spouse. Such an arrangement allows the caregiving spouse some time away from what could otherwise be a 24-hour job of caring for the ailing family member. The same logic holds if family members need to work outside the home but want to keep the senior adult in the home. Utilization of these centers can forestall institutionalization of the loved one who has physical or mental functional impairments. There are two types of adult day care services;

- Social model- These centers offer supervised social and educational activities, including exercise, special events, nutrition guidance, family counseling and arts. The primary focus is recreation and social stimulation. Centers like this are for adults who need a protected environment and trained staff.
- Health care models- Many of the social model services are offered, along with additional comprehensive medical services, and rehabilitation. Also offered are physical, occupational and other special therapies. This type may also offer care for people with special needs.

Senior Community Centers

These facilities should not be confused with adult day care centers. Senior community centers have programs for active seniors, providing a social outlet for seniors not needing a protected environment or trained staff.

How Consumers can Locate Facilities

Long-term care services and facilities can be located through the network of information and assistance programs throughout the state as well as on the Internet. Through these programs, anyone can find out about the location of senior centers, senior nutrition sites, adult social day care and adult day health care centers, Alzheimer's resource centers, "Meals on Wheels" programs, transportation, care management programs, home health agencies, hospice programs, legal services and health insurance counseling. Specific questions about care or facilities can be directed to the state's department of health and/or social services.

Licensing Requirements- LTC

Requirements vary from state to state, often depending on the level of care involved. In most states, LTC facilities for adults divided between those for seniors in good health and those for residents who have physical or mental disabilities. Both types are different from nursing homes. Nursing homes are usually regulated separately. Any prospective resident should make sure that the LTC facility is properly licensed by the state. Logically, if a place has no license, no one can monitor the care provided.

An LTC facility does not provide medical care. Residents usually must be able to perform most of their activities of daily living. Sometimes, an LTC facility can admit residents who have substantial physical limitations. These facilities are not required to have either nurses or doctors on staff. Still an LTC facility can help residents with the self-administration of medications.

Nursing homes have unique licensing features regulated by the state. These facilities have nursing staff present around the clock. The staff of nursing homes includes registered nurses and certified nursing assistants. In addition, nursing homes must have easy access to doctors.

LTC Facilities		Nursing Home
Residential Care Facility for the Elderly	**Adult Residential Facility**	**Nursing Facility**
Generally for residents at least 60 years old.	Generally for residents less than 60 years old, but at least 18 years old. Residents often have physical or mental disabilities.	For residents of any age who need on-site nursing care
Non-medical care	Non-medical care	Medical care
Provides room and board, plus care and supervision	Provides room and board, plus care and supervision	Provides room and board, plus 24-hour nursing care

Section 5 Change in Long-Term Care Services and Providers

Changes in Covered Services Related to Definitions in Policies

From the consumer's point of view, the most desirable policy is one with flexible provisions. That is, policies likely to pay under many different circumstances and a variety of care settings. Policies offered eight to ten years ago cannot be offered today because of changes in insurance laws. For example, an older policy might require a hospital stay before paying benefits for a nursing home stay. This tends to trespass on benefits under Medicare. Such benefits are not offered today. Other policies may not have covered assisted living, offered inflation protection, favorable renewability provisions or comprehensive and understandable benefit triggers. State laws have done away with requirements for hospital stays before nursing home coverage. All tax qualified policies are guaranteed renewable.

Changes in Providers Related to Definitions in Policies

Agents need to understand the continuing evolution of long-term care services and providers in the context of relating those changes to both old and new policy language. Residential Care Facilities for the Elderly (RCFE) are good examples of types of places of care that insurers are increasingly willing to cover in policies, or willing to consider for the payment of benefits when it is not specifically covered. Adult Day Care is another. Earlier policies restricted benefit payment to only those

facilities that provided Adult Day Health Care, a much more restrictive definition. Another example is a policy covering home care with a concurrent requirement that specialized ancillary services must also be needed. The logic apparently being that the person would require institutional care without them.

Home Care Providers (Informal Care)

Long-term care (LTC) used to consist largely of nursing homes for the elderly, that is, custodial patients who were too dependent to live alone, but too healthy to stay in a hospital. But Medicare and managed care with a relentless focus, for good or for bad, on cost reduction are now bringing the custodial patient home. That patient is to be served by the blossoming home health industry as well as facilities designed especially for those needing “just a little” help.

Home v. Home Health Care

A popular alternative for seniors and their families is to remain in their own homes with hired assistance and services. This lets the individual make only small changes in routine and lifestyle. Occasional assistance through home nursing services supporting equipment permits safety at home while allowing the older adult to maintain independence. This is usually best when the senior is able to instruct the caregiver. Home care allows the flexibility of having assistance for a few hours a week or 24 hours a day. A full-time or live-in caregiver is appropriate when the senior may need minor assistance at various times around the clock. However, if the person needs help continually throughout the day and night, shift work of eight to twelve hours is more appropriate. In this case, it may be worth considering moving to a facility that can provide a higher level of care. Live-in care at home is an option for those with the wherewithal to pay, as a respite following an illness, or when the primary caregiver needs to be away. It is always advisable to hire a private caregiver through a bonded and insured agency. Agencies provide supervision of the employee, screening, insurance and taxes. If the caregiver becomes ill or needs time off, an agency can send a competent replacement.

Care from Family or Friends

Where to live after the onset of old age or after a spouse dies is a big issue. There is no easy answer, but families must plan for this. In order to avoid the expense of a nursing home, seniors can take one of two options: They often move in with their children. Family caregivers are often the best, and most economical, source of help. Or, they can stay in their own home and rely on visits and support from family and friends.

Adult children have an emotional stake in the well being of their parents, can oversee and anticipate needs as they arise, and can take over the finances of the aging relative when the situation warrants. Also, when outside help eventually is needed, the adult children can react to the situation quickly. Medicare or a basic health insurance policy often covers home health care. Some policies even offer benefits where a child or relative can care for the senior citizen with the insurance paying for it, the logic being that it is cheaper (and more desirable) than having an outside contractor do it. But not everyone is enamored with the idea of having a frail elderly person in his or her home.

Older Policies and Replacement

Older policies should be read and thoroughly understood. The object is to see that the services in such contracts may be more restrictive than those described in the newer policies. Agents should also be able to succinctly explain the change in services to the prospective insured when an older policy is replaced. The agent must point out the reason for replacement and whether it constitutes a material improvement, a fact that must be attested in the agent certification on the application. Other sections of this text discuss consumer protection and application specifics.

Definition of LTC Insurance

The purpose of long-term care insurance is to pay for some of the insured's expenses when assistance is needed with basic activities of living. Because of a chronic illness or disability, such things as bathing, eating, and toileting may require help. Long-term care insurance is any insurance that pays for the following;

- **Care in a facility that is NOT an acute care unit of a hospital-** such as a nursing home, a residential care facility, convalescent facility, extended care facility, custodial care facility, skilled nursing facility or personal care home
- **Home care-** including home health care, personal care, homemaker services, hospice or respite care
- **Community-based care-** such as adult day care or hospice

In general, three types of long-term care policies may be sold:

1.) **Nursing facility only.** These policies pay for skilled, intermediate or custodial care in a nursing home or similar facility. Some policies also cover care in a residential care facility for the elderly or a hospice.

2.) **Home care only.** These policies pay for care in the insured's own home. They are required to include home health care, adult day care, personal care, homemaker services, hospice and respite care. Some also include care management services and equipment prescribed for medical purposes.

3.) **Comprehensive long-term care.** These policies pay for long-term care provided at home or in the community as well as nursing facility care. All of the home and community services included in home care only policies must be included in a comprehensive policy as well.

Applicant defined

An "applicant" for long-term care insurance refers to:

- An individual who applies for long term-care insurance through an individual insurance policy
- A prospective holder of a certificate issued under a group long term care insurance policy

Certificate defined

Any credential or document issued under a group LTC policy which has been delivered or issued for delivery.

Group long-term care insurance defined

"Group insurance" is generally defined as an insurance contract made with an entity such as an employer, professional, or trade organization. It covers the people who have a relationship with the entity (employees, union members, etc.) purchasing the contract as well as their families/dependents. Premium payments may be split or paid by one side or the other. This type of insurance is typically written for life,

health/accident/ annuities, and disability. Typically, group long-term care is a policy delivered or issued for delivery in the state for;

- Employers or labor organizations, such as a steel mill, oil refinery or a local representing a group of workers. Or a trust can be established for the benefit of the members of such organizations. It can be any combination of current and former employees or members.
- Professional, trade, or occupational associations like a used car dealers association or the professional women in journalism guild. Membership could consist of any combination of current or former members if the association meets both of these requirements;

1.) It is made up of people who are or were actively engaged in the same trade, profession or occupation. That is, the endeavor indicated by the name of the umbrella group.
2.) The association has been perpetuated in good faith for purposes other than that of obtaining insurance.

- An "association" or group of associations that has come together for the purposes as outlined in the preceding section (not solely to acquire insurance). Also, must have at the outset a minimum of 100 persons as members, an active existence for at least one year. The association must also have a constitution and bylaws with the following requirements uniformly realized;

1.) The association holds meetings on a regular basis, at least once a year, to further the interests of members.
2.) Dues or contributions are required of the membership. This does not apply to credit unions.
3.) Members vote and are represented on governing councils of the group.

Before any advertising or policy marketing can take place, the association must file evidence with the insurance commissioner that the association consistently follows these requirements. Thirty days after filing these requirements, the organization is deemed to meet it unless the department of insurance determines that such is not the case. In other words, the department of insurance must investigate the group's relationship to the act of issuing insurance.

Other groups that do not meet the criteria as described above can issue or participate in a group insurance program if the following conditions apply;

a.) Group policy issuance by the organization does not conflict with the best interests of the public as a whole.
b.) The group policy's issuance will result in economies of scale as far as acquisition and administration are concerned. "Economies of scale" refer to factors that cause the average cost of producing a commodity to fall as output of the commodity rises. The commodity in this case is insurance. For instance, a firm or industry, which would less than double its costs, if it doubled its output, enjoys economies of scale.
c.) Benefits are reasonable in relation to the premiums charged.
d.) There is no deceptive or ulterior purpose in the name, true or fictitious, of the group or the policy for purposes of marketing.
e.) The marketing of insurance is not the group's principal source of revenue
f.) The group's marketing method to obtain new members is not connected to the solicitation of insurance.
g.) Benefits or services of significant value other than insurance are provided to members.

Continuation of coverage or conversion of policies
In general group policies of long-term care insurance provide covered individuals with a basis for continuation of coverage or conversion to an individual policy of long-term care insurance. Group LTC policies are usually issued with either a continuation or conversion of coverage provision. The term "continuation of coverage" means a policy provision which will allow the certificate holder to maintain coverage under the existing group policy when the certificate holder is no longer a member under the group. The term "conversion of coverage" means a policy provision that allows an individual whose coverage under the group policy has terminated, including discontinuance of the group policy in its entirety, to convert to another policy with substantially equivalent benefits.

Policy defined
"Policy" means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit hospital service plan, or any similar organization, regulated by the insurance department.

General Provisions
State law charges state insurance departments with the regulation of insurers. The responsibilities include certifying that newly formed insurers comply with the law, monitoring out-of-state insurers to make certain they comply with in-state laws, and overseeing the general conduct of all insurers.

Products of Out of State Groups
Group policies issued by an out of state entity must essentially meet the requirements of an in-state entity offering group insurance to in-state residents. They are;

1.) Discretionary groups- These are groups that do not fit into the category of trade or professional groups. A large museum patrons group, a religious organization, or an environmental group might fit in this category. Such groups can issue insurance if doing so does not run athwart of public policy, benefits are reasonable, and there is no connection between the group and the business of selling insurance (it is not their principal source of revenue).
2.) Association groups- Employers, labor, professional or trade organizations, made up of current or former members, acting to promote the interests of the group, not in the interest of insurance, are groups included here. Such groups must hold regular meetings, have a statutorily defined organization or minimum number of members, and be in existence for a certain period of time.

As with in-state groups, the primary purpose of the group must be to promote some other interest than selling insurance contracts. In most states, an insurer issuing a policy must submit an informational filing to the department of insurance a prescribed time limit before marketing the product. The materials required to be filed are for informational purposes, not for approval purposes.

Section 6 Qualified State LTC Partnership Programs; State and Federal Requirements

Long-term care is one of the leading cost drivers in the Medicaid program. Medicaid pays for two-thirds of all nursing facility days in each state, and less than five percent of the population has private long-term care insurance. As the population in Georgia ages, the fiscal impact of publicly financing long-term care may grow exponentially. This impact may lessen if more citizens are encouraged to purchase long-term care insurance. However, current law does not provide any impetus for Georgians who can afford the cost to purchase that insurance due to strict asset limits for Medicaid eligibility and required estate recovery of assets. HB 1451 creates a long-term care partnership program in Georgia. Georgians who purchase long-term care policies under this program will be eligible for asset disregard up to the value covered by the private policy should they ever apply for Medicaid long-term care coverage.

Requirements to Sell LTC

Each individual who sells a long-term care benefit plan under the partnership for long-term care program must complete training and demonstrate evidence of an understanding of these plans and how they relate to other public and private coverage of long-term care.

Many middle-income people have too many assets to qualify for Medicaid but can't afford a pricey long-term care insurance policy. In an effort to encourage more people to purchase long-term care insurance, the Deficit Reduction Act of 2005 (DRA) created the Qualified State Long Term Care Partnership program.

The DRA allows the creation of a partnership program offers special long-term care policies that allow buyers to protect assets and qualify for Medicaid when the long-term care policy runs out. Private companies sell long-term care insurance policies that have been approved by the state and meet certain standards, such as having inflation protection. The program is intended to provide incentives for people to purchase long-term care insurance policies that will cover at least some of their long-term care needs. An internet search shows almost every state has a partnership program and Georgia is one of them.

The long-term care partnership program will open new long-term care markets with incentives for individuals to buy long-term care coverage. After Congress passed the DRA, the Georgia Statehouse responded with HB 1451 which made significant changes to comply with federal definitions and anticipate regulations that were to be promulgated by the U.S. Department of Health and Human Services.

NAIC Model Act

The majority of the requirements of the NAIC Model Act pertaining to long-term care insurance have been incorporated into the adopted sections with only a few necessary modifications.

HB 1451

HB 1451 – Presented by Reps. Sheldon, Knox, Walker, Byrd, Channell, and others, this bill amends Article 7A of Chapter 4 of Title 49, relating to the Long-term Care Partnership Program. The bill accomplished the following;

- Revises the definition of “asset disregard;”
- Alters “Long-Term” to “Qualified Long-Term” Care Partnership Program, and requires it to “meet the model regulations and requirements of the National Association of Insurance Commissioners’ long-term care insurance model regulation and long-term care insurance model act as specified in 42 U.S.C. 1917 (b) and Section 6021of the Federal Deficit Reduction Act of 2005 and the Commissioner certifies such policy as meeting these requirements;”
- Defines “State plan amendment;”
- Requires that within 180 days of the effective date of this Code section, the Department of Community Health “make application to the federal Department of Health and Human Services for a state plan amendment to establish that the assets an individual owns and may retain under Medicaid and still qualify for benefits under Medicaid at the time the individual applies for benefits is increased dollar for dollar for each dollar paid out under the individual’s long-term care insurance policy if the individual is the beneficiary of a qualified long-term care insurance partnership policy purchased through the Georgia Qualified Long-term Care Partnership Program; and the individual has exhausted the benefits of such policy;”
- Requires that the Department “provide information and technical assistance to the Commissioner to assure that any individual who sells a qualified long-term care insurance partnership policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;”
- Sets forth other duties for the Commissioner of Insurance, such as developing requirements to uphold this code section; and
- Requires issuers of long-term care partnership policies to report to both the Secretary of the Department of Health and Human Services and the Department of Community Health and the Commissioner of Insurance.

DRA Requirements

Section 6021(a)(1)(A)(iii)(III) of the DRA requires a qualified state long-term care partnership policy to meet several of the requirements of the Long-Term Care Insurance Model Act (Model Act) and the Long-Term Care Insurance Model Regulation (Model Regulation) promulgated by the National Association of Insurance Commissioners (NAIC). While the NAIC Model Act and the NAIC Model Regulation both prescribe requirements related to long-term care insurance policies, **only the NAIC Model Act contains specific licensee training requirements related to the sale,** solicitation, and negotiation of long-term care insurance. Neither the DRA nor HB 1451 specifically requires the Department to consider the NAIC Model Act in adopting long-term care partnership training requirements.

HB 1451 Requirements

As required by the DRA and HB 1451, the Georgia Long-Term Care Partnership (Partnership) program is a public-private initiative administered by the Department of Community Health, with the assistance of the Office of the Commissioner of Insurance, the Department of Human Services, and Division of Aging Services (DAS). Each agency is responsible for different parts of the program. The Division of

Medical Assistance is responsible for administering the Partnership program. The Office of the Commissioner of Insurance is primarily responsible for ensuring that insurers follow the federal regulations. The Division of Aging Services is responsible for counseling services to individuals in planning their long-term care needs, as well as marketing and outreach for the Partnership program. The Department of Human Resources is responsible for determining a Medicaid eligible person has the correct amount of resource dollars disregarded based on the payout of their Long Term Care Partnership policy.

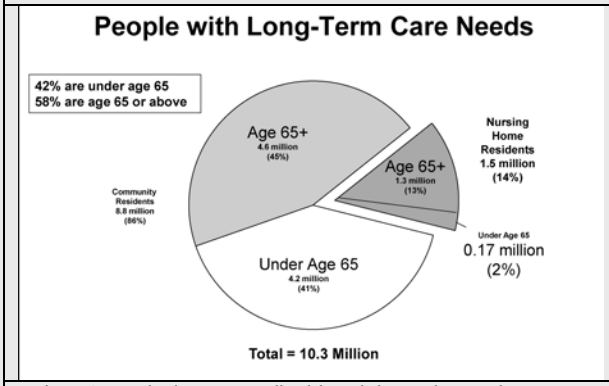
Section 7 Relationship Between Qualified State LTC Partnership and Other Coverages of LTC Services

Medicaid is the nation's major public health coverage program designed to address the acute and long-term care needs of millions of low-income Americans of all ages. Medicaid is the primary payer for long-term care. It covers a range of services including those needed by people to live independently in the community such as home health and personal care. Medicare also provides services in institutional settings such as nursing homes. Many of these critical services are not covered by Medicare or private insurance.

LTC Services and Supports

Over 10 million Americans need long-term services and supports to assist them in life's daily activities. The majority of individuals who receive long-term services are age 65 and above while 42 percent are under age 65.

Chart 7-1



Kaiser Commission on Medicaid and the Uninsured
Sources: Health Policy Institute, Georgetown University, analysis of data

People with long-term services needs span all ages and often have substantial acute care needs also. Children with intellectual disabilities such as mental retardation and developmental disabilities such as autism often need care throughout their lifetimes. Young adults with spinal cord and traumatic brain injuries and serious mental illness may need services for decades. Older people often need some long-term services due to decreasing mobility and cognitive functioning that comes with aging, and those with severely disabling chronic diseases such as diabetes and pulmonary disease need more extensive acute and long-term services as they age.

Paying for LTC

If someone has sufficient income and assets, they are likely to pay for long-term care needs on their own, out of those private resources. If an individual meets functional eligibility criteria and has limited financial resources, or depletes them paying for care, Medicaid may pay for that care. If a person requires primarily skilled or recuperative care for a short time, Medicare may pay. 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.

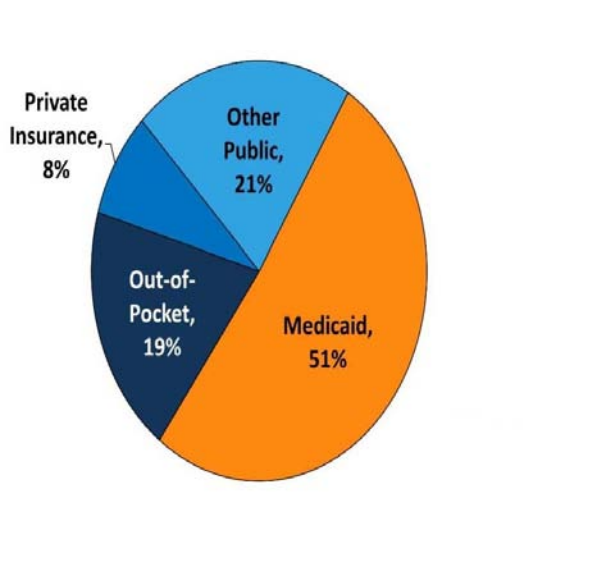
Long-Term Care Service	Medicare	Private Medigap Insurance	Medicaid	You Pay on Your Own
Nursing Home Care	Pays in full for days 0-20 if you are in a Skilled Nursing Facility following a recent hospital stay. If your need for skilled care continues, may pay for the difference between the totals daily cost and your co-payment for days 21-100. After day 100 does not pay.	May cover the co-payment if your nursing home stay meets all other Medicare requirements.	May pay for care in a Medicaid-certified nursing home if you meet functional and financial eligibility criteria.	If you need only personal or supervisory care in a nursing home and/or have not had a prior hospital stay, or if you choose a nursing home that does not participate in Medicaid or is not Medicare-certified.
Assisted Living Facility (and similar facility options)	Does not pay	Does not pay	In some states, may pay care-related costs, but not room and board	You pay on your own except as noted under Medicaid if eligible.
Continuing Care Retirement Community	Does not pay	Does not pay	Does not pay	You pay on your own
Adult Day Services	Not covered	Not Covered	Varies by state, financial and functional eligibility required	You pay on your own [except as noted under Medicaid if eligible.]
Home Health Care	Limited to reasonable, necessary part-time or intermittent skilled nursing care and home health aide services, and some therapies that are ordered by your doctor and provided by Medicare-certified home health agency. Does not pay for on-going personal care or custodial care needs only (help with activities of daily living).	Not covered	Pay for, but states have option to limit some services, such as therapy	You pay on your own for personal or custodial care, except as noted under Medicaid, if you are eligible.

Paying for long-term services is expensive and can quickly exhaust lifetime savings. The Genworth 2017 Cost of Care Survey informs that nursing home care averages

$97,000 per year, assisted living facilities average $45,000 per year, and home health services average $135 per day. In 2017, nearly $178 billion was spent on long-term services. Medicaid accounts for 51 percent of total long-term care spending. Medicare provides limited post-acute care accounting for slightly less than one-quarter of spending. Direct out-of-pocket care spending accounts for 19 percent of spending

Chart 7-2

LTC Spending Percentages



Note: Total LTC expenditures include only spending on nursing home and home health services. Some community-based services financed primarily through Medicaid home and community-based waivers and delivered in other settings are not represented here.
Source: Kaiser Commission on Medicaid and the Uninsured estimates based on CMS National Health Accounts data, 2015.

Qualifying for Medicaid LTC

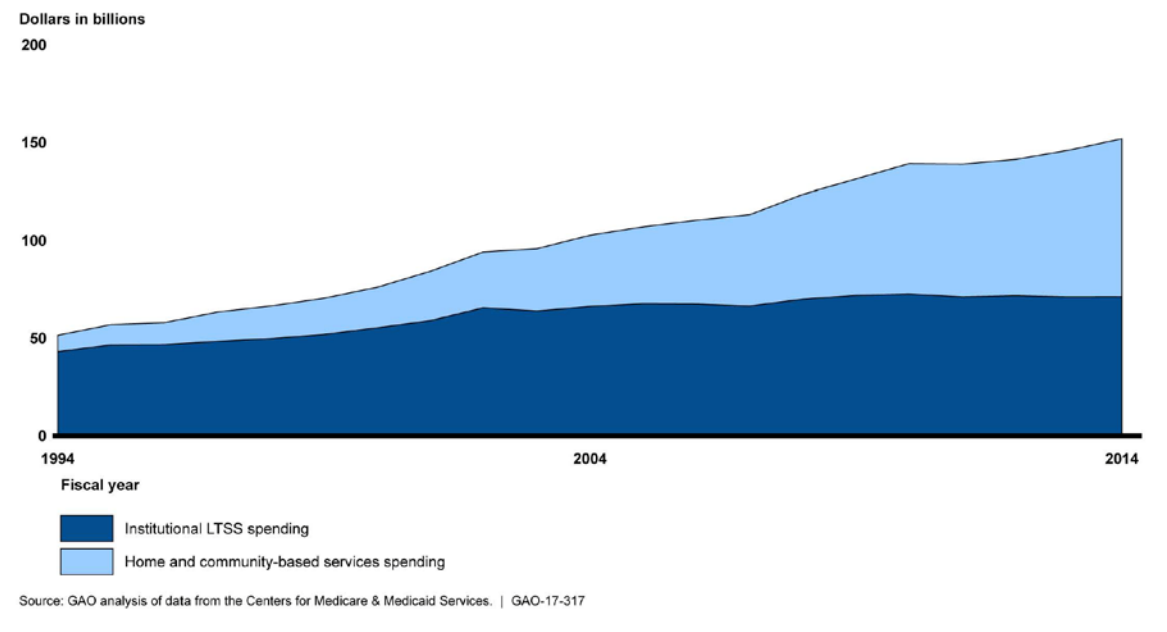
Medicaid is intended to assist low-income individuals and is not available to everyone who needs long-term services. Individuals must first meet financial qualifications for Medicaid coverage of long-term services and supports, in addition to meeting need criteria. For the elderly and people with disabilities with long-term services needs, these limits are often tied to the Supplemental Security Income (SSI) program - $750 per month in 2017 - but states can, and often do set higher limits. Additionally, elderly and disabled individuals who qualify for Medicaid must have very few assets ($2,000 for an individual and $3,000 for a couple, in 30 states). Medicaid is also the safety net for long-term care services for those who become impoverished as a result of disabling illness or injury. Thirty-four states, including DC, allow the medically needy - those with high medical bills - to spend down to a state-set eligibility standard, and because few people can afford the high cost of nursing home care, 38 states allow people needing nursing home care to qualify with income up to 300 percent of SSI ($2,250 per month in 2017). However, individuals who apply for Medicaid assistance with nursing home care are subject to a ‘look back’ period of five years for asset transfers during which eligibility may be denied. This is intended to prevent those above the eligibility levels for Medicaid from giving away their resources in order to qualify for Medicaid. Persons with substantial home equity are ineligible for Medicaid. To address the gaps in private coverage, many states provide a means for higher income individuals to buy-into Medicaid, such as the Ticket-to-Work option, which

allows individuals with disabilities to work and retain their health coverage, and the Family Opportunity Act for disabled children with family income up to 300 percent of poverty.

LTC Services Provided by Medicaid

Medicaid spending (federal and state) on LTSS is significant. LTSS spending was an estimated $152 billion in fiscal year 2014, or about one-quarter of the program's total expenditures annually. The demand for LTSS is expected to increase as the nation' s population ages and life expectancy increases, including individuals with disabilities and complex health needs who require long-term services and supports.

Chart 7-3
Medicaid Long-Term Services and Supports, Fiscal Years 1994-2014



The Medicaid HCBS (Home and Community-Based Services) programs are restricted as to how many persons can be served on the program in a given year. There were 35 states which had a wait list for waiver services in 2015. Texas has the largest number of persons on such lists (232,068) while among states with wait lists; North Dakota has the fewest (3). Delaware, D.C., Hawaii, Idaho, Massachusetts, Missouri, New Jersey, New York, South Dakota, and Washington have no wait lists.

Georgia Resources for LTC

Eligibility

To qualify for Medicaid, an individual must meet certain eligibility criteria. In Georgia, there are over twenty different coverage categories of Medicaid, known as classes of assistance, and each one has its own set of eligibility criteria. The classes of assistance are determined by a person's living arrangement, types and amounts of income, marital status, and prior Medicaid coverage, among other factors. For every class, an individual must meet the following criteria:

- Be age 65 or older, or be totally disabled, or be blind
- Be a U.S. citizen or a lawfully admitted alien who was lawfully admitted prior to August 22, 1996.

- Be a resident of Georgia (there is no time limit to establish residency, only the intention to permanently live in Georgia)
- Agree to assign all health insurance benefits to the Georgia Department of Community Health
- Apply for and accept any other benefits which may help to pay for medical expenses
- Meet financial eligibility guidelines for both income and assets. The financial criteria are different for every class of assistance.

An abridged version of the financial limits chart is presented here.

Georgia Medicaid Long Term Care Eligibility for Seniors									
Type of Medicaid	**Single**			**Married (both spouses applying)**			**Married (one spouse applying)**		
	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required
Institutional / Nursing Home Medicaid	$2,250 / month	$2,000	Nursing Home	$3,375 / month	$3,000	Nursing Home	$2,250 / month for applicant	$2,000 for applicant & $123,600 for non-applicant	Nursing Home
Medicaid Waivers / Home and Community Based Services	$2,250 / month	$2,000	Help w/ 2 ADLs	$3,375 / month	$3,000	Help w/ 2 ADLs	$2,250 / month for applicant	$2,000 for applicant & $123,600 for non-applicant	Help w/ 2 ADLs
Regular Medicaid / Aged Blind and Disabled	$1,005 / month	$2,000	None	$1,103/ month	$3,000	None	$1,005 / month	$2,000	None

Public laws - Through the years, Congress has passed six public laws which provide for Medicaid coverage for people who have been terminated from SSI. Each public law has different financial criteria.
Adult Medically Needy - This is the one Medicaid program that has no income maximum. An individual can qualify for Medicaid if his or her medical bills exceed a certain dollar amount. The specific dollar amount for each individual is based on his or her monthly income (this is known as the spenddown). Medically needy is limited to three months at a time, and only pays for bills incurred after the spenddown is met.

Understanding Medicaid - A Handbook about Medicaid Services in Georgia is a publication that summarizes the various services and provides additional information about them. It is available online at:

http://www.communityhealth.state.ga.us/departments/dch/v4/top/shared/medicaid/publications/medfinal2.pdf

Eligibility Rules

The purpose of this section is to provide a general understanding of the rules relating to eligibility for Medicaid payment of long-term care services in Georgia and the interaction between Medicaid eligibility and the Long-Term Care Partnership.

Policy governing Medicaid for people who are elderly and people with disabilities is very complex and has many exceptions and special rules for various situations. For this reason Medicaid eligibility, including resource disregard, is determined on a case-by-case basis by staff with the Georgia Department of Community Health (DCH). Resource disregard for estate recovery purposes are determined by staff at the DCH.

Resources for LTC Insurance Professionals

Insurance agents are not to determine Medicaid eligibility or guarantee specific resource disregards. They should direct potential policyholders to DCH for questions on eligibility and for questions on the Medicaid Estate Recovery Program. If there are questions about a person's status in Medicaid, those questions must be asked by that person or that person's authorized representative. Questions about how Medicaid for people who are elderly or people with disabilities policy would be applied to a specific person's circumstances cannot be provided in advance of that person filing an application and providing the information necessary to determine eligibility. The DCH staff may explain policy relating to these issues but will not give advice.

Medicaid Eligibility and the Long-Term Care Partnership

Medicaid provides a full range of benefits to people who qualify. Medicaid services include but are not limited to some services in each of the following categories:

- Inpatient and outpatient hospital and clinic services.
- Emergency hospital services.
- Laboratory and x-ray services.
- Physician services.
- Prescription drugs.
- Long-term care services such as home health, hospice, adult daycare, assisted living or nursing facility care.

Medicaid programs are operated by each state but overseen by the federal government through the Centers for Medicare and Medicaid Services (CMS). The Long-Term Care Partnership is a joint effort between private long-term care insurers and state agencies. The partnership encourages people to plan for their long-term care needs. Specifically, the partnership involves collaboration among private long-term care insurers, agents authorized to sell long-term care policies, the Georgia Department of Insurance, and DCH. A qualified Long-Term Care Partnership policy must meet all the rules set out by the Georgia Department of Insurance and must include a specific amount of inflation protection based on the person's age at the time he or she purchases the policy.

Owning a qualified Long-Term Care Partnership policy does not guarantee access to Medicaid, even if the policyholder exhausts his or her policy benefits. A person must still meet all Medicaid eligibility requirements to be determined eligible for Medicaid.

In those situations, the value of a Long-Term Care Partnership policy emerges when a policyholder applies for Medicaid. In that process, the policyholder's countable resources may be "disregarded" in an amount equal to the value of benefits paid through the Long-Term Care Partnership policy.

If the policyholder then needs to rely on Medicaid for payment of long-term care services, the person may qualify for various Medicaid long-term care programs and still own countable resources in excess of the statutory resource limit. Additionally, when the policyholder dies, resources that were disregarded in the Medicaid eligibility process will not be subject to recovery by Medicaid for the policyholder's Medicaid costs.

This resource document will provide the reader with:

- A discussion of the general eligibility criteria for Medicaid payment of long-term care services.
- An explanation of the interaction between the Medicaid eligibility and the Long-Term Care Partnership.
- Information about how people can apply for Medicaid.

General Eligibility Criteria for Medicaid Payment for Long-Term Care Services

1. Georgia Residency

- Georgia Medicaid follows the federal Medicaid residency rules, which require that a person must be a Georgia resident at the time of application and must intend to remain in Georgia. There is no time requirement for living in Georgia to establish residency.

2. Citizenship and Immigration Status

- To be eligible for Medicaid a person must be either a U.S. citizen or a non-citizen with a qualified immigration status.

3. Medicaid Eligibility Group

- To be eligible for Medicaid a person must qualify under a group authorized for coverage under the federal Medicaid rules and covered by Georgia Medicaid.

4. Third Party Resource (TPR)

- Medicaid is typically the payer of last resort.

  A person with other health care coverage or who has another party liable for the medical expenses must have medical costs paid by those sources before Medicaid pays claims. A person is required to cooperate with providing information regarding other payment sources.

5. Specific Requirements for Medicaid Payment of Long-Term Care Services

A person must:

- Have a medical necessity designation requiring a level of care provided in a long-term care facility such as a nursing facility or an Intermediate Care Facility for Persons with Mental Retardation. The medical necessity designation also determines if the person qualifies to receive home and community-based services through a Medicaid home and community-based waiver program.
- Meet functional assessment criteria for personal care services.
- Be a resident of a long-term care facility or qualify to receive home and community-based services under one of the Medicaid waiver programs.
- Not have home equity in excess of $500,000.
- Not be in a penalty period for an uncompensated transfer of income or resources.

- Penalty periods are assessed when a person or the person's spouse make an uncompensated transfer during a specified period of time (called the look-back period) prior to a person requesting Medicaid payment of long-term care services or anytime while the person is receiving Medicaid payment of long-term care services.
- The look back period is currently 36 months but was increased to 60 months in the federal Deficit Reduction Act of 2005 (DRA). The 60 month look-back period was phased in. Beginning February 2009 the look-back period increased until it reached 60 months.
- The penalty period is calculated by dividing the value of the uncompensated transfer by the **Statewide Average Daily Rate for Nursing Care** in effect at the time a person requests Medicaid payment for long-term care services. This calculation results in a number of days during which the person is ineligible for Medicaid payment for long-term care services.

  For uncompensated transfers made prior to Oct. 1, 2006, the penalty period begins in the month in which the transfer occurred; for uncompensated transfers made on or after Oct. 1, 2006 the penalty period begins with the date the person applies for Medicaid and would otherwise be eligible for Medicaid payment for long-term care services.

- Disclose any annuity interest, and if married, annuity interest of a spouse and name the State of Georgia as a remainder beneficiary of any annuity owned by the person or person's spouse.

Note: Home equity in excess of $500,000 or a transfer penalty applied to long-term care services does not restrict payment for Medicaid services other than for long-term care services. This means an applicant with excess home equity or on whom a transfer penalty has been applied, may still qualify for Medicaid coverage of benefits other than long-term care.

Section 8 The Effect of Inflation on Benefits and the Importance of Inflation Protection

The term “inflation protection” is a term used by the industry although the nomenclature is misleading. Almost none are actually linked to the Consumer Price Index (CPI) (Weiss, 2002). The author recommends qualifying language be used when the term ‘inflation protection’ is introduced in this context.

Inflation Protection

Insurers must offer to policyholders the option to purchase a long-term care policy that provides for benefit levels to increase because of increases in the costs of long-term care. Such an inflation protection policy often includes at least one of these

1.) It increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5%.

2.) Guarantee that the policyholder has the right to increase benefit levels at least on each anniversary date of the policy. The additional coverage may cost more, and may be based on the attained age of the insured. An extra premium can be paid for riders that increase coverage in any of the following ways;

a.) Increase the amount of the per diem benefits.

b.) Increase the lifetime maximum benefit.

c.) Increase the amount of both the nursing facility per diem benefit and the home-and community-based care benefits of a comprehensive long-term care insurance policy or certificate.

Policies shall cover a specific percentage of actual or reasonable charges rather than a dollar amount. Insurers of group long-term care insurance policies are to offer the holder of the group policy the opportunity to have the inflation protection extended to existing certificate holders, but the insurer is relieved of the obligations imposed by this section if the holder of the group policy declines the insurer’s offer.

Unless the group is a continuing care retirement community, the offer is made to each proposed certificate holder. The offer is not required for life insurance policies or riders containing accelerated long-term care benefits or expense incurred long-term care insurance policies.* These inflation safeguards continue under the policy without regard to an insured’s age, claim status or history, or the length of time the person has been insured under the policy. If automatic benefit increases are offered as a feature of the inflation protection plan, the insurer must quote a premium that is expected to remain constant. Unless the premium is guaranteed to remain constant, any offer of this type must disclose that the premium may change in the future. It is mandatory that the 5% benefit increase feature be included in long-term care policies unless the insured specifically rejects it. The rejection of the inflation protection provision must be signed by the policyholder and must be worded in this form;

“I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject inflation protection.”

_____ _____

Signature of Applicant Date

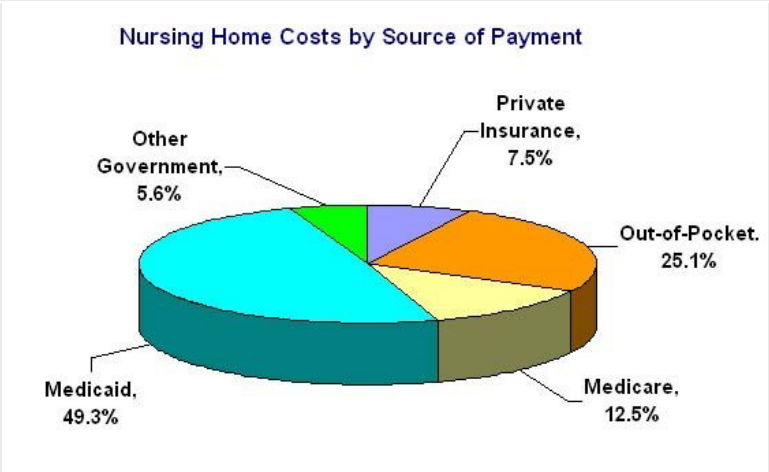
* This does not include ‘expense incurred’ policies paying a certain percentage of reasonable and customary charges up to a specified, indemnity-type maximum amount.

The outline of coverage must include the following information;

1.) A graphic comparison of the benefit levels of a policy that increases benefits at 5% per anum (minimum) and one with no increase in benefits.
2.) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.
3.) Reasonable pro forma or graphic illustrations may be used to further elucidate the benefits of inflation protection.

Inflation has a direct impact on the amount of coverage sought by insureds. When the contract is purchased, consumers choose a daily benefit, usually from $40-$250. With time, inflation pushes up the cost of care while the policy benefit levels remain constant. The inflation rider is offered by many companies as the solution to the problem. The consumer must decide at the time of purchase whether to take the inflation rider. It can double the annual premium when the policy is purchased from the 40-mid 50's age range. This may be a hard decision when weighing value and price, especially with other family demands pulling at the pocketbook. Still, many experts recommend that younger purchasers take the inflation rider. Some insurers address the problem with a guaranteed increase option. This allows the policyholder to periodically increase the daily benefit a certain amount with no new underwriting. Without such an option or the inflation rider, the only way a policyholder can increase long-term care coverage is to switch to a new policy with higher benefits. That can get expensive since it requires new underwriting and pricing.

Chart 8-1



Genworth Data 2015

Statutory Requirements

As noted in the previous section, policyholders and applicants for long-term care insurance must be offered at least 5% annual compounded inflation protection. If the applicant does not desire such protection, a statement must be signed refusing such protection before a policy can be issued.

Long-Term Care costs vary significantly depending on the level of care needed and where the individual is located. Here are median care costs of different services in Georgia, according to a 2015 study conducted by Genworth Financial;

Home Health Aide Hourly Rate (Medicare Certified) $18
Assisted Living Facility Monthly Rate (Private Room) $2,880
Nursing Home Daily Rate (Semi-private Room) $183
Nursing Home Daily Rate (Private Room) $195

Past Increases in Long-Term Care Costs

Shown below is a schedule of annual increases in California nursing home rates, as an example.

Year	Revenue per Day	Increase From Previous Year	CPI	% Change
1981	$ 42.92		90.9	
1982	47.06	9.6%	96.5	6.2%
1983	50.53	7.4%	99.6	3.2%
1984	53.97	6.8%	103.9	4.3%
1985	57.91	7.3%	107.6	3.6%
1986	62.10	7.2%	109.6	1.9%
1987	66.42	7.0%	113.6	3.6%
1988	71.23	7.2%	118.3	4.1%
1989	76.13	6.9%	124.0	4.8%
1990	81.52	7.1%	130.7	5.4%
1991	87.15	6.9%	136.2	4.2%
1992	92.43	6.1%	140.3	3.0%
1993	97.63	5.6%	144.5	3.0%
1994	101.91	4.4%	148.2	2.6%
1995	106.56	4.6%	152.4	2.8%
1996	110.78	4.0%	156.9	3.0%
1997	112.98	1.9%	160.5	2.3%
1998	123.81	9.6%	163.0	1.6%
1999	129.43	4.5%	166.6	2.2%
2000	137.23	6.0%	172.2	3.4%
2001	143.63	4.7%	177.1	2.5%
2002	153.37	6.8%	179.9	1.3%
2003	158.11	3.1%	184.0	2.3%
2004	168.71	6.7%	188.9	2.7%
2005	178.77	6.0%	195.3	3.4%
2006	189.39	5.9%	201.6	3.2%
2007	198.17	4.6%	207.3	2.8%
2008	205.34	3.6%	215.3	3.8%
2009	213.49	4.0%	214.5	(0.4)%
2010	221.14	3.6%	218.1	1.6%
2011	229.66	3.8%	224.9	3.1%
2012	233.53	1.7%	229.6	2.0%
2013	241.45	3.4%	232.9	1.4%
2014	244.75	1.4%	236.7	1.6%
2015	253.04	3.4%	237.0	0.1%
2016	265.76	5.0%	240.0	1.3%

The increase from 1981-2016 was $222.84 - an absolute increase of 519%. In the 35 years reported since 1981 that comes up to a compounded increase of about 5.35% yearly.

To determine the nominal rate when present value and future amount are known (using logarithms):

$$R = \left(\frac{S}{P} \right)^{\frac{1}{n}} - 1 \text{ -or- } \qquad (1+R)^n = \frac{S}{P}$$

where

R = Rate of Interest per Period

S + Future Amount

P = Present Value

N = Number of Conversion Periods

The hand-held financial calculator rendered the use of these equations obsolete. The Internet now provides present/future value calculators that render the use of a hand-held calculator for such purposes unnecessary. Such things used to be ciphered with pencil and paper, using a log table. These tables can be found in any accountant's handbook of formulas.

Most people prefer to receive care at home. According to the Genworth study, Georgia families can expect to pay an average of $41,184 for a year of assistance from a home health aide. A home health aide provides assistance to seniors, disabled or chronically-ill individuals so that they may be able to live in their own homes.

Paying for all these services has long been a burden to many families in Georgia. Many pay out-of-pocket and then apply for government assistance through Medicaid for their continued care needs once they have depleted their assets. However, the Georgia Medicaid program requires an **asset limit of not more than** $2,000 for individuals and $3,000 for couples in order to qualify.

Compare the annual percentage increases in nursing home costs with the changes in the CPI for the year in the rightmost column. The nursing home cost exceeds the CPI. The **Change in CPI** information is from the Bureau of Labor Statistics, CPI-All Urban Consumers, base period: 1982-84=100.

Future Nursing Home Costs

Here are some figures that illustrate the future costs of nursing home care; Assumptions- It is assumed that the individual going in for a nursing home stay is destined to reside there for 2¼ years. Assume for this example nursing home cost increases of 5% per year. The average cost for a nursing home stay for purposes of this example is assumed to be $103 per day. With this information the following can be determined.

Cost for the stay in today's dollars = (2.25 x 365 x 103)	$84,589
Cost for the nursing home stay in the future;	
In 14 years…….	$170,129
'20 years…….	229,650
'30 years…….	378,629

These figures are determined using the compound interest formula:

$$S = P(1+R)^n$$

where

S = Compound Amount or Future Value

P = Principal
R = Interest Rate per Period
n = Number of Conversion Periods

One can see from the price increases that inflation has a noticeable effect on the cost of a nursing home stay.

Policies without inflation protection- Policies can be purchased that offer benefits equal to the average nursing home cost in today's dollars. It is worth noting the out-of-pocket expenses that will be incurred by the insured with such a policy, using the same assumptions and time frames as above.

Cost of 2¼ yr. stay 14 years hence	$170,129
Benefits paid in today's dollars	84,589
Out-of-pocket (OOP) expense	$85,540
Daily OOP (85,540 ÷ 821.25 days)	$104.16
Cost of 2¼ yr. stay 20 years hence	$229,650
Benefits paid in today's dollars	84,589
Out-of-pocket (OOP) expense	$145,061
Daily OOP (145, 61 ÷ 821.25 days)	$176.63
Cost of 2¼ yr. stay 30 years hence	$378,629
Benefits paid in today's dollars	84,589
Out-of-pocket (OOP) expense	$294,040
Daily OOP (294,040 ÷ 821.25 days)	$358.04

Policies with partial protection- Policies may also be purchased whose benefits increase in value using simple rather than compound interest. The value of benefits paid in the future would be calculated using a simple interest formula;

$$M_v = P(1+RT)$$

Where
M_v= Maturity value (future value)
P = Principal amount
R = Rate of interest
T = Time frame

Here is a breakdown of the out-of-pocket expenses that will be incurred using just such a policy, again with the same set of assumptions. The benefits derived with simple interest are referred to as benefits derived from "simple increases."

Cost of 2¼ yr. stay 14 years hence	$170,129
Benefits paid with simple interest	143,801
Out-of-pocket (OOP) expense	$26,328
Daily OOP (26,328 ÷ 821.25 days)	$32.06
Cost of 2¼ yr. stay 20 years hence	$229,650

Benefits paid with simple interest	169,178
Out-of-pocket (OOP) expense	$60,472
Daily OOP (60,472 ÷ 821.25 days)	$73.63
Cost of 2¼ yr. stay 30 years hence	$378,629
Benefits paid with simple interest	217,472
Out-of-pocket (OOP) expense	$161,157
Daily OOP (161,157 ÷ 821.25 days)	$196.23

As the benefits increase, the premiums will also increase. It is a trade-off as to what the insured prefers (or can afford, for that matter). Spend more for premiums today or more on out-of-pocket expenses in the future.

Inflation Escalator and Benefit Increases

Inflation is a four-letter word to economists. It is the phenomenon of too much money chasing too few goods and services, manifested as a persistent increase in the general level of prices. It is normally associated with a devaluing of the worth of money. Inflation is a recurring but only intermittent historical occurrence. Its most serious recent appearance occurred in the 1970's in the wake of the quadrupling of oil prices in 1973, when annual inflation rates in the developed world rose as high as 25%. For the rest of the post-war period it has not been unusual for the inflation rate to be exceeded by the real growth rate. A crucial feature of inflation is that price rises are sustained.

Accounts of the causes of inflation are numerous. The most popular arguments are these;
1.) Demand-Pull Inflation- It is caused by excess demand in the economy.
2.) Cost-Push Inflation- It is caused by high costs.
3.) Monetarism- It results from excessive increases in the money supply.

These causes often amount to the same thing. All are beyond the scope of this book. All three of the causes amount to an attempt by a nation to live beyond its means, or to enjoy a living standard higher than that allowed by its output and borrowing. This implies that inflation can rarely be cured by a measure that does not suppress attempts at maintaining high living standards and explains why the reduction of inflation is associated with austerity measures. There are examples of economies borrowing and spending more that their economies produced. The rapidity with which the problems are attacked and the speed of the comeback of those economies indicates the degree to which governments understand the problems brought on by inflation and their willingness to accept the cure (not simply print more money) for what ails them.

Since the inflation phenomenon exists, policyholders and potential purchasers of long-term care insurance must be protected against the erosion in value of their purchasing power. Insurers must offer an inflation protection long-term care policy that provides for benefit levels to increase because of increases in the cost of long-term care.

Section 9 Consumer Suitability Standards and Guidelines

Insurers are required to develop and maintain suitability standards to determine whether the purchase or replacement of long-term care by the applicant is warranted. Agents must be trained in the use and employment of suitability standards. The suitability standards must be maintained and made available for review by the department of insurance. The suitability standards established by the insurer are to be used in determining whether or not to issue coverage and agents are required to employ the standards in marketing efforts. Factors to be taken into consideration when determining whether an applicant meets the standards include the following;

1.) The applicant's ability to pay for the coverage. Any other pertinent financial information concerning the applicant should also be taken into account
2.) The applicant's objective with respect to the long-term care insurance and the pros and cons of insurance as a means of meeting the objective.
3.) A comparison of the value, benefits, and costs of the applicant's existing insurance versus the proposed new insurance.

Reasonable efforts must be made to determine these goals. Among them must be included the presentation of the "Long-Term Care Insurance Personal Worksheet," as contained in the Long-Term Care Insurance Model Regulations of the National Association of Insurance Commissioners (NAIC). The worksheet must appear in at minimum 12-point type. This worksheet can be readily found in the back of the pamphlet entitled "*A Shoppers Guide to Long-Term Care Insurance*" published by the NAIC. The insurance department must approve a copy of the issuer's personal worksheet.

Before an insurer can consider an applicant for coverage, the applicant must complete and return a personal worksheet. Worksheet information must be kept confidential by the insurer. The worksheet requirement does not apply to group insurance certificates. In the event that an applicant does not meet the insurer's financial suitability standards or if the applicant declines to provide the information, the application may be rejected. A different approach is to send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the NAIC. A sample can be seen at Example III P 1. In the event the applicant declines to provide the requested financial information, some other means can be used to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification can be included in the applicant's file.

In general, insurers annually report the total number of applications received to the department of insurance. Additional information to be reported is the number of people who did not want to provide information on the personal worksheet, the number of applicants who did not meet suitability standards, and the number who chose to conform after receiving the suitability letter. The requirements listed here do not apply to accelerated benefits for long-term care under life insurance policies.

Replacement coverage- Older policies should be read and thoroughly understood. The object is to see that the services in such contracts may be more restrictive than those described in the newer policies. Agents should also be able to succinctly explain the change in services to the prospective insured when an older policy is replaced. The agent must point out the reason for replacement and whether it constitutes a material improvement, a fact that must be attested in the agent certification on the application. Other sections of this text discuss consumer protection and application specifics.

Section 10 Medicaid Eligibility Criteria and Requirements

Financial Eligibility Criteria for People Requesting Medicaid Payment for Long-Term Care Services

Medicaid was established as Title IX of the 1965 Amendment to the Social Security Act It is a health insurance program for certain low-income people. These include: certain low-income families with children; aged, blind, or disabled people on Supplemental Security Income; certain low-income pregnant women and children; and people who have very high medical bills. Medicaid is funded and administered through a state-federal partnership. Although there are broad federal requirements for Medicaid, states have a wide degree of flexibility to design their program. States have authority to establish eligibility standards, determine what benefits and services to cover, and set payment rates. All states, however, must cover these basic services: inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing and home health services, doctor's services, family planning, and periodic health checkups, diagnosis and treatment for children. Long-term care recipients of Medicaid come almost exclusively from the aged, blind and disabled group of eligible beneficiaries but very few of those are actually receiving SSI (Supplemental Security Income). SSI is a welfare payment for certain disabled or handicapped individuals who are unable to work, have no assets and have no extended family financial support. Certain provisions of the enabling Act, as well as congressional amendments since 1965 have allowed the aged, blind and disabled who don't qualify for SSI to receive Medicaid under an alternate set of eligibility rules.

1. Income

- General

Medicaid income eligibility is based on countable income. The rules for determining countable income vary by eligibility group. Policy rules for each group determine the specific types of income that are excluded, which family members' income is counted toward another family members' eligibility, and which deductions are subtracted from gross income.

People with countable income equal to or less than the income limit of the person's eligibility group are income eligible for Medicaid.

- Payment for the Cost of Long-Term Care

When a person is determined income eligible for Medicaid long-term care services, a separate income calculation is made to determine how much of the person's income

must be paid toward the cost of Medicaid long-term care services. The amount of the person's contribution (copayment) is the income left after allowable deductions. Deductions vary based on the type of long-term care and the person's circumstances. The copayment is generally made to the long-term care facility or to the waiver service provider.

2. Resources

- Resource limit

Georgia limits the amounts of resources people can own in order to be eligible for Medicaid coverage. The Medicaid eligibility specialist determines if the person has countable resources at or below the Medicaid resource limit. Currently the resource limit for a single person is $2,000 and $3,000 for couples applying for long-term care services.

- Resource treatment for certain married couples

A special set of rules, called spousal impoverishment rules, apply to a married person requesting Medicaid payment for long-term care services. Married couples may complete the resource assessment (Spousal Protected Resource Amount) as soon as possible when one spouse requires long-term care services that are anticipated to last for more than 30 days, even though they may not be requesting Medicaid payment. This allows the married couple to know when the spouse receiving long-term care services may be eligible to receive Medicaid payment for long-term care services. The actual amount of resources that can be kept by the spouse not receiving Medicaid services is determined by HHSC's Medicaid eligibility specialist.

Section 11 Asset Disregard Under Qualified State LTC Partnership Program

Interaction between the Long-Term Care Partnership and Medicaid Payment of Long-Term Care Services.

1. How Resource Protection works Under the Long-Term Care Partnership

A person with a qualified Long-Term Care Partnership policy may designate countable resources for a dollar-for-dollar disregard in an amount equal to the value of benefits paid out by the policy.

Once the countable resource is designated, Medicaid:

- Disregards the value of the designated countable resource in the resource limit calculation.
- Allows the person to transfer the designated countable resource without penalty.

However, Medicaid will not **pay for long-term care services until these same benefits paid under the person's Long-Term Care Partnership policy have been exhausted. This is consistent with federal law that Medicaid is the payer of last resort.**

The policyholder must provide a written resource designation and must verify the value of the designated resources.

- Once the countable resources are designated, the policyholder must:
    - Report any sale, transfer or conversion of designated resources and verify the value of the designated resources as of the date the reported transaction took place.
    - Document and verify any designated resources still owned by the person at the time of each Medicaid redetermination. (Special reviews may be performed periodically prior to each annual redetermination.)

Note: If a designated resource is expended, no additional resource designation is allowed, nor may any otherwise excluded resource be substituted in its place.
People receiving Medicaid payments for long-term care services that secure additional resources and have not designated resources up to the amount of benefits paid by the Long-Term Care Partnership policy may then designate additional countable resources up to the amount of benefits paid by the policy.

2. Policy Concepts for Resource Disregards
Under Medicaid long-term care policy, certain resources such as a person's home may not be included when determining a person's statutory countable resource limit. For this reason, only countable resources may be designated for the disregard when determining Medicaid eligibility for those with qualified Long-Term Care Partnership policies.
If a designated resource declines in value, additional countable resources may be designated up to the amount of benefit paid under the Long-Term Care Partnership policy.
A person may expend a designated countable resource, however no additional disregard is allowed in this circumstance.
Transferred countable resources may be designated for the disregard.
The countable resource disregard may not be applied to home equity value in excess of $572,000 for 2018. The value is adjusted annually for inflation.
The countable resource disregard is applicable only to the person who has received benefits under the Long-Term Care Partnership policy.
When a policyholder has fewer countable resources than the Long-Term Care Partnership policy has paid, the unused disregard balance will be protected after the policyholder dies and Medicaid Estate Recovery becomes applicable.
Georgia participates in reciprocal recognition with other states with Long-Term Care Partnerships.

How to Apply for Georgia Medicaid Programs
To apply for Medicaid, submit a completed application at any local DHS Division of Family and Children Services (DFCS) office, by mail, telephone, fax, e-mail, or at designated agencies. Here is a DFCS link;
https://dfcs.georgia.gov/medicaid

Medicaid Estate Recovery Program
Georgia's Medicaid Estate Recovery Program, as defined in the Rules of the Department of Community Health, Medical Assistance, Chapter 111-3-8, began in 2006.

Overview

Estate Recovery in the Medicaid program was made mandatory to the states by the federal government pursuant to the Omnibus Budget Reconciliation Act of 1993. Estate Recovery applies to Medicaid members:

- Who at the time of death were any age and an inpatient in a nursing facility, intermediate care facility for people with mental retardation or other mental institution.
- Who at the time of death were 55 years of age or older when the person received home and community-based services instead of care in an institution.

The Estate Recovery statute has existed in Georgia since 1981. Only estates that are valued less than $25,000 are excluded from Estate Recovery, in accordance with federal law.

Claims Against Estate

Under this program, the state may file to claim against the estate of to deceased Medicaid recipient, age 55 and older, who applied for certain long-term care services on or after March 1, 2005. Claims include the cost of services, hospital care, and prescription drugs supported by Medicaid under the following programs:

- Nursing facility;
- Intermediate care facility for persons with mental retardation (ICF/MR), which includes state schools;
- Medicaid waiver programs

What is an "estate" in estate recovery?

The definition of an estate is "all real and personal property under the probate code." The estate also includes real property passing by joint tenancy, right of survivorship, life estate, survivorship, trust, annuity, homestead or any other arrangement. The estate additionally includes excess funds from a burial trust or contract, promissory notes, cash and personal property.

When must DCH be notified of a qualified estate?

DCH must be notified:

- Within 30 days of the death of the Medicaid member
- If the personal representative of an estate makes a distribution either in whole or in part of the property of an estate without having reimbursed the Medicaid agency, the personal representative may be held personally liable

Delayed Recovery

Recovery is delayed if:

- The deceased recipient's spouse is still living
- The deceased recipient has a living child under the age of 21
- The deceased recipient has a living child of any age who is blind or permanently and totally disabled pursuant to Title XIX of the Social Security Act

A lien may be placed on the home, but the recovery will be delayed while the following persons are still living in the home:

- A sibling of the member who was residing in the member's home for at least one year on a continuous basis immediately before the date that the member was institutionalized
- A child of the member who was residing in the member's home for at least two years on a continuous basis before the date that the member was institutionalized

and who has established to the satisfaction of the department that he or she provided care that permitted the member to reside at home rather than to become institutionalized

Additional Information
For additional information, contact the Estate Recovery Office, **770-916-0328** or visit www.hms.com/ga/medicaidrecovery.
Questions on Medicaid Estate Recovery may submit them to: GAEstateRecovery@dch.ga.gov., or write to: The Georgia Department of Community Health, Estate Recovery Unit, 900 Circle 75 Parkway, Suite 650 Atlanta, GA 30339

Section 12 Statutory Policy Provisions, Requirements, and Terminology

Agent Responsibilities

Requirement for Replacement Notice

Application forms include a question addressing whether the proposed policy is intended to replace any other accident and sickness or long-term care policy already in force. This proviso is not applicable to insurers using direct response solicitation methods. If a sale requires replacement, the applicant is furnished a notice regarding replacement. A signed copy of the notice will be kept by the insured and one will be given to the applicant. An example of the form follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with long-term care insurance coverage to be issued by (company name) Insurance Company. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new coverage.

(1) Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.
(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
(3) If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may

provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

_____(Date)

_____(Applicant’s Signature)

Group Coverage- If not subject to the 30-day return provision the notice above is modified to reflect an appropriate time frame. Except when the group insurance is for an employer or labor organization, the replacement notice includes the following verbiage;

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long-term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons: ___Additional or different benefits (please specify) _____. _____ No change in benefits, but lower premiums. _____ Fewer benefits and lower premiums. _____Other (please specify) _____.

_____
(Signature of Agent and Name of Insurer)

_____
(Signature of Applicant)

_____
(Date)

Outline of Coverage

In order that the consumer may be better served, state insurance codes require that an outline of coverage accompany any presentation to a potential insurance purchaser. It is delivered at the initial solicitation of business. The attention of the buyer must be directed to the instrument in order to understand and recognize its purpose. It can contain no advertising material. If an agent calls, the agent will provide the prospective purchaser with the outline before any application or enrollment form. If by mail or other direct solicitation, the outline of coverage is presented in conjunction with the application or enrollment form.

Generally, the outline must follow the usage and sequence stipulated in the Code. Any exceptions to this mandate will be noted. The text which is capitalized or underscored in the outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.

The outline of coverage usually includes:

- A description of the principal benefits and coverage provided in the policy;
- A statement of the principal exclusions, reductions, and limitations contained in the policy;
- If the policy is not expected to cover 100 percent of the cost of services for which coverage is provided, a statement clearly describing any such limitation;
- A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;
- A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and
- A statement that the policy has been approved as a long-term care insurance policy meeting the requirements of state law.

Forgetfulness

Applicants for long-term care coverage must be given the right to designate at least one person other than the applicant to receive notice of policy lapse due to nonpayment. Applicants need to supply the insurer;

- A written designation listing the name, address, and telephone number of at least one individual other than the applicant who is to receive notice of lapse of policy
- A waiver is required from the applicant, electing not to designate additional persons to receive notice. Here is the notice form;

Protection Against Unintended Lapse.
I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

_____ _____
Signature of Applicant Date

.

Long-Term Care Personal Worksheet

Whether or not an individual should buy a long-term care insurance policy depends on his or her age, health status, overall retirement goals, income, and assets. The applicant's goals or needs with respect to long-term care along with advantages and disadvantages of insurance to meet these goals must be considered.

Reasonable efforts must be made to determine these goals. Among them must be included the presentation of the “Long-Term Care Insurance Personal Worksheet,” as contained in the Long-Term Care Insurance Model Regulations of the National Association of Insurance Commissioners (NAIC). The worksheet must appear in at minimum 12-point type. This worksheet can be readily found in the back of the pamphlet entitled “*A Shoppers Guide to Long-Term Care Insurance*” published by the NAIC. The insurance department must approve a copy of the issuer’s personal worksheet.

The personal worksheet is meant to help buyers and sellers determine product suitability. The worksheet is a quantitative approach to making decisions in the face of uncertainty, based both on considering the probabilities of different outcomes and the relative utility (or value or worth) of those outcomes to the prospective insured. Utility analysis estimates the value of benefits in relation to cost. It gives buyers a way to evaluate different outcomes. This decision aid helps prospective purchasers weigh the risks and benefits of purchasing insurance. Consumers complete a personal worksheet through which they can clarify their personal values and goals concerning the benefits and risks of the long-term care insurance purchase.

_____ ⋖⧫⋗ _____

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don’t want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don’t want their family to have to pay for care or don’t want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

The insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?
☐From my Income ☐From my Savings/Investments ☐My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)☐Under $10,000 ☐$[10-20,000] ☐$[20-30,000] ☐$[30-50,000] ☐Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
☐No change ☐Increase ☐Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐From my Income ☐From my Savings/Investments ☐My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
☐From my Income ☐From my Savings/Investments ☐My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐Under $20,000 ☐$20,000-$30,000 ☐$30,000-$50,000 ☐Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐Stay about the same ☐Increase ☐Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐	The answers to the questions above describe my financial situation. **Or** I choose not to complete this information. (Check one.)
☐	I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: _____ _____

(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____

(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____]

(Applicant) (Date)

[The insurer chooses the appropriate sentences depending on whether this is a direct mail or agent sale]

The company may contact you to verify your answers.

[When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed]

30-Day Free Look

Individual policy applicants (not group) have the option to return a policy by mail if not satisfied with the product. The policy can be mailed back within 30 days for a full refund of the premium. Such an action by the applicant voids the policy and puts both parties back in the position they were in before the policy was issued. Policies must have information regarding this return feature printed prominently on the first page of the policy.
Here is an example of the suitability letter to be distributed to prospective purchasers of long-term care policies, note that worksheet language may be modified for individual, group, etc.

Example l P 1 Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

Example I P 2 Things To Know Before Buying LTC Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.