GA LTC Partnership Training

Long-Term Care Partnership Training

Introduction and Overview

What is Long-Term Care?

The phrase “long-term care” is subjective in nature. It can take on many meanings. Of course there are senior citizens that need assistance on a regular basis. A newborn is also going to need long-term care before the infant can take on the tasks of day-to-day living. Children and adolescents also need (what many parents may call) long-term care. There are many adults who, because of some unfortunate disability, need and will need someone to care for their physical needs. If you asked a sampling of people to document their visualization of long-term care, there would no doubt be a wide range of responses. This book limits its discussion on the matter to the long-term care needs of senior citizens. Because of the diverse perceptions that can be caused by the idea of “long-term care”, the state and federal governments have codified the concept of long-term care in order to standardize terminology, facilitate comparisons, and promote availability of products designed to ease the financial hardships brought on by the need for long-term care among today’s aging populations.

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.

Repeated Points

It was mentioned that many different ideas concerning the concept of long-term care exist. Most of the information and opinions expressed on long-term care come from representatives of citizen's groups known to have interest in long-term care, including but not limited to the League of Women Voters, the American Association of Retired Persons, the Friends of Residents in Long-Term Care, the Health Access Coalition, veteran's groups and many state and local domiciliary and nursing home advisory groups. Here is a listing of recurring themes for long-term care for the elderly and how it should be approached;

Emphasis on the desire for independence- A theme often voiced as the guiding premise for long-term care. In support of this idea, many health care advocates have made assessments of what is desired by older and mid-life consumers. These assessments leave no doubt that a chief desire of older consumers is to maximize their independence and remain in control of their personal environments and life decisions for as long as possible.

Long-term care as primarily a women's issue- Long-term care is not exclusively a women's issue, but women have a major personal interest in quality long-term care. Indicative of this theme is the percentage of caregiving performed by women, the economic disadvantages and often hidden poverty of older women living alone, and the high proportions of women who fill the beds in long-term care facilities.

Attitudes about aging and long-term care matter- The attitudes of both professionals and older adults affect how age-related problems are perceived and affect coordination of solutions to the problem of long-term care. Patronizing attitudes by professionals who feel they know what is good for older adults; denial by the "young-old" that they will ever need long-term care; and the "I've earned it" attitude among some affluent older adults when issues of taxation or cost sharing arise to help fund programs for low and moderate income older adults. Just such attitudes make effective long-term care programs difficult to administer and more difficult perhaps to wrap into a product and market by an insurance professional.

A comprehensive view of human needs- Groups representing seniors note that, while children's issues are an appropriate concern for society, any single focus on the needs of a specific age group for human services to the exclusion of all others is ill advised. The concern is that such advocacy will digress into an unfortunate pitting in policymaking process (as well as in individual economic decision-making) of the needs of children against the needs of older adults. Politicians as well as economic experts fear the political and social fallout from the issues of intergenerational equity. They reject the pitting of one generation against another.

The four "A's" in long-term care- The issue of access, availability, acceptability and affordability in long-term care are real. In addition to the unrealistic denial by some "young-old" adults that they would ever need services, experts on long-term care feel that many middle and upper income older adults with equal unrealism just assume that they can access available, acceptable, and affordable services when and if the need arises.

The states are the arenas where important initiatives for reform in health and social policy are occurring and will occur in the foreseeable future. In examining policy regarding long-term care, it is necessary to review the experiences of other states, regions, and nations. Citizen participation is necessary to initiate and sustain a comprehensive, workable long-term care program. This process begins with the

insurance professional. Locally, statewide, regionally, or nationally a program cannot be sustained without participation and understanding on the part of those most affected by the process. The interest in long-term care has increased in the past few years. The impact of such heightened awareness on public policy, especially the legislative process, will be borne out by the success of the products available to the public in the marketplace. This book probes highlights of the current trends and goals of long-term care. We will also try to note some of the obstacles to participation in long-term care insurance and discuss alternative methods for overcoming these barriers in order to develop avenues for participation and purchase of long-term care policies. Enlightened insurance professionals increasingly understand this and know that more realistic attitudes must be encouraged if consensus about long-term care is to be achieved.

(1) Long-Term Care Insurance

Defining Long-Term Care

Clinically- Long-term care is basically custodial care. It is important for people to realize that purely custodial care is the type of care most persons in nursing homes require. The only nursing home care that Medicare covers is skilled nursing care or skilled rehabilitation care provided in a certified skilled nursing facility.

"Long-term" vs. "short-term"- A health care practitioner certifies that the insured will need assistance with activities of daily living (ADLs) for at least a period of 90 days, while some non-tax qualified policies may provide benefits for serious illnesses of less than 90 days. The phrase "long-term" is not differentiated from "short-term" on a time line somewhere. Only for tax purposes is there an arbitrary cut-off point. A look at another vocation can illustrate the differences. In accounting terminology, the difference between "short-term" and "long-term" investments lies in the nature and purpose of the investment. Investments which are readily marketable and which can be sold without disrupting corporate policies or impairing the operating efficiency of the business should be classified as current assets. Investments that are made for the purpose of fostering operational relationships and which do not meet the test of ready marketability are long-term in nature.

To carry the analogy further, patients who will be ready within a reasonable period of time to return to the routines of work and family are given "short-term" care by medical providers. Those patients who are not expected to soon make the transition to this independent type of routine are given long-term care. We can apply the same concept to the difference between "long" and "short" term care. The nature and purpose of care is the controlling factor. So it is that the long-term can apply to those individuals with chronic rather than acute health conditions.

Traditionally, the public debate over containing the rate of growth in national health care expenditures is framed in terms of medical services. But treatment and care for people with chronic conditions require a host of non-medical services, from installing bathtub railings to finding supportive housing. The best ways to provide these services often are not by medical specialists or in medical institutions. In fact, the services that keep people with chronic conditions independent for as long as possible are frequently those that emphasize assistance and caring, not curing.

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.

This outline must be a stand-alone document in at least 10-point type

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.

Consumer Protection

Duties

All insurers and insurance professionals owe the policyholder, or a prospective policyholder, a duty of honesty, good faith and fair dealing. This applies to long-term care insurance as well as other forms of insurance transactions. The legal issues involving long-term care are challenging, the ethical issues can be seen as even more complex. Dealing with fiduciary matters involving the elderly is a formidable task. When it is someone the public perceives as frail, a grandparent/saint, and perhaps lacking cognitive skills, the agent maintains conduct above reproach. The best advice is the same as applies in other situations: document everything and don't make decisions for people.

Seniors have a right to self-determination, just like any other adult. This means that an adult has a right to make decisions regarding his or her own health care or living conditions. The principle implies that, in order to make such decisions, the adult has the right to sufficient information. The adult has the right to make an informed decision. Whether the situation is concerning an insurance policy or a housing situation, the insurance professional has the obligation to explain to the consumer the ramifications of his or her decision. Determining the competence of the individual to understand the explanation is somebody else's department. But who does make the decisions concerning legally determined competence? A person may be intermittently competent, that is, they may be somewhat confused but retain the capacity to understand an explanation sufficiently to make his or her own decision. The point is, such determinations are way beyond where most insurance agents want to go. Again, a policy of honest, good faith and fair dealing is the best defense in such a situation.

Unnecessary Replacement

Unnecessary replacement of long-term care insurance policies is not permissible, notably when replacement causes a decrease in benefits or an increase in premium. The test for unnecessary replacement often follows a state-mandated standard such as this;

The third or subsequent policy sold to a consumer in any 12-month period is defined as unnecessary. The assumption does not apply however, to policies used solely for the purpose of consolidating policies with a single insurer.

The application for long-term care insurance queries whether the offered policy is intended to replace existing LTC coverage. If replacement is involved in a sale, insurers are required to furnish a notice regarding replacement of long-term care insurance to the applicant.

Advertising

Like all insurance advertising, advertising for LTC products is provided to the department of insurance for review before publication. In addition to conformity with all applicable law, the advertising copy is retained by the insurer for a certain period of time, often three years. Ads designed to produce leads should contain a statement such as this prominently displayed;

"An insurance agent will contact you."

If some sort of cold lead device causes an insurance company representative to contact a consumer for the purpose of soliciting business, this fact is immediately disclosed to the consumer.

Marketing Standards

As an integral part of the concept of good faith, honesty and fair dealing, advertisements and other marketing may not be misleading. Consumers must be given fair and accurate comparisons of policies. No excessive insurance or inappropriate replacement policies may be sold. Here is a listing of other rules by which insurers abide;

1.) Marketing procedures must be set up to assure fair and accurate market comparisons (apples to apples).
2.) Maintain safeguards to assure that excessive insurance is not sold or issued.
3.) Report to the insurance department on a periodic basis a list of representatives authorized to sell long-term care insurance.
4.) Require agents selling LTC to complete training specific to long-term care. Agents must complete a course specific to LTC in order to market LTC or partnership policies. Some states maintain an eight-hour requirement as a part of, <u>not in addition to</u>, the existing training requirements for insurance license holders each renewal.
5.) Insurers must make certain that on the first page of any policy, certificate, or outline of coverage a statement similar to the following be displayed;
"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
6.) Make every reasonable effort to determine whether a prospective buyer of long-term care insurance already has long-term care or accident and sickness insurance and the amounts, if any.
7.) The insurer must establish audit procedures. Their purpose is to aid in verifying compliance with the requirements of the state insurance code.

Other acts or tactics prohibited by the insurance code include the following;
Twisting- This is the practice of knowingly making any misleading representation, incomplete or fraudulent comparison of insurance policies. The purpose would be to induce consumers to abandon their current policies under false pretenses.
High-pressure tactics- Inducing the purchase of insurance through force, fright, threat (implicit or implied), or undue pressure.
Cold lead advertising- The direct or indirect use of any type of marketing which fails to communicate in a conspicuous manner that the purpose of solicitation is a means of initiation of contact by an insurance agent or company.

Group Policies Issued Before 01/01/97

With regard to group policies issued before January 1, 1997- these policies can remain in force. A group policy or certificate may cease to be a federally qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury pursuant to Section 7702B(f)(2) of the Internal Revenue Code. In such a case, states require that the insurer must offer the policy and certificate holders the option to convert. The option to convert must be on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax qualified policies.

Preexisting Conditions Defined

Pre-existing conditions are exclusions to health insurance policies. They are conditions that existed for a stated time period before the policy was purchased which the insured knew or had reason to know existed. According to the Health Insurance Portability and Accountability Act (HIPAA), no policy can be sold as a long-term care insurance policy if it limits or excludes coverage by type of treatment, medical condition, or accident. However, there are several exceptions to this rule. For example, policies may limit or exclude coverage for preexisting conditions or diseases, mental or nervous disorders (but not Alzheimer's), or alcoholism or drug addiction. A policy cannot, however, exclude coverage for preexisting conditions for more than six months after the effective date of coverage.

The way preexisting conditions are defined does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant. Based on the application answers, the insurer can underwrite in accordance with that insurers established underwriting standards. Regardless of whether it is disclosed in the application, a preexisting condition does not have to be covered until the policy prescribed waiting period expires. Only if the policy specifically states otherwise does a preexisting condition have to be covered.

Minimum Standards for Home Care

Long-term care services are available that try to support older people in the most independent living situation possible- the home. Home care services assume that a person receiving these services has additional assistance from family or friends. When thinking about home care, prospective insureds need to realize that services and cost may vary depending on location. Here are six elements of home care;

Home health care- This is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

Adult day care- Refers to medical or nonmedical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal

services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.

Personal care- Concerns the assistance with activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. "Instrumental activities of daily living" include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

Homemaker services- Refers to assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

Hospice services- These are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

Respite care- Addresses the short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home. This is a separate benefit with its own conditions for eligibility and maximum benefit levels.

Prohibited Limitations

Policies generally cannot exclude certain conditions. Here is a listing of typical conditions that policies may not require, use as a limit, or exclusion;

▫Require a need for care in a nursing home if home care services are not provided

▫Require that skilled nursing or therapeutic services be used before or with unskilled services.

▫Require the existence of an acute condition.

▫Limit benefits to services provided by Medicare-certified providers or agencies.

▫ Limit benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law.

▫Define an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.

▫Require "medical necessity" or similar standard as criteria for benefits.

Expenses Incurred, Benefit Eligibility

In general, all expenses incurred by the insured in a residential care facility for long-term care services are to be covered. This means any diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, as well as maintenance or personal care services. Such services are to be paid, up to but not in excess of the maximum daily residential care facility benefit of the policy or certificate. No constraint is to be placed on who can provide the services, nor is it required that services be provided by the residential care facility, so long as the expenses are incurred while the insured is confined in the facility. Again, reimbursement for services will not exceed the maximum daily residential care facility benefit of the policy. The long-term care services mentioned must not conflict with federal law for the purpose of qualifying for favorable tax consideration provided by Public Law 104-191.

Nursing Facility Benefits

If a long-term care policy provides reimbursement for care in a nursing facility, it generally covers and reimburses for per diem expenses, as well as ancillary expenses, up to the policy's maximum lifetime daily facility benefit. When care in a nursing facility is offered in a long-term care policy, the minimum threshold for establishing eligibility is explained in the section of this text dealing with tax qualified vs. non-tax qualified policies. Insurance carriers can seek a third-party's opinion concerning the necessity of providing benefits to the named insured. The judgment concerning the necessity of services is a written statement from a physician, independent needs assessment agency, or any other source of independent judgment.

Benefits for LTC Contracts

As noted before, there are basically three different types of long-term care insurance policies;

1.) Nursing home/Institutional care only- For those requiring a high degree of care. The nursing facilities are licensed by the state and provide differing levels of care, facilities and professional assistance.
2.) Home care only- Intended for those people who want coverage only for home care. These individuals may have a desire not to leave their home environment or they may lack the financial resources to cover the cost of nursing home coverage
3.) Comprehensive long-term care- This pays for all or part of the cost of care whether received at home, an assisted living facility or residential care facility. Most people want to stay at home in their final years. They also want to avoid the risk of having no insurance benefits for nursing home services. Although more expensive, these policies are generally regarded as the best type of policy for most people.

The cost of LTC policies- Several factors influence the cost of a long-term care insurance policy. Most all of them involve shifting one or more types of risk of loss to the insurance company. This is the same with any insurance product. The end result is the more risk that is shifted to the insurance company, the higher the cost of the premium. The risk that a consumer chooses to retain by not purchasing insurance is a form of self-insurance. Potential purchasers differ with regard to their objectives for purchasing long-term care insurance. Some people tolerate a higher degree of risk than others do. The factors that affect risk and the cost of long-term care insurance are:

1.) Type of policy- The comprehensive policies are the most expensive. They cover, or neutralize the largest amount of risk related to long-term care. Home care and nursing facility policies are less expensive because they only take into account one component of the comprehensive policy.

2.) Age at which the policy is purchased- Purchase of insurance at lower ages allows the insurer to have the use of the premium dollar longer. A lower premium is charged at younger ages.

3.) The amount of economic protection purchased- Another term for the daily maximum benefit. It can run from $50 to $250 per day or more. Premiums usually are indexed to go up with each additional $10 of daily benefit purchased.

4.) The benefit period- This is the length of time during which the insurer will provide benefits. It is normally expressed in a number of days or years. There can also be a maximum lifetime dollar value.

5.) The existence of an elimination period- This is the required length of waiting time for the insured before he or she begins to receive benefits. Policies often require elimination periods of 30-90 days. During this time the insured pays all costs of long-term care out-of-pocket. The possibility exists that the insured will recover from whatever

illness ails him or her. If recovery occurs before the end of the elimination period, no insurance claim is made. The other side of that argument is the insured's concept of "long-term." If the goal is to insure against conditions lasting a year or more, short-term illness can be covered by a major medical policy or (for non-acute illnesses) with self-insurance funds and the help of family and friends.

At the time the contract is issued, the insured must weigh the three important variables; benefit period, elimination period, and daily maximum benefit. By carefully evaluating personal needs and preferences, the insured can arrive at an economically viable long-term care contract with which he or she can live Some individuals may want a shorter elimination period, or no elimination period at all. Others may comfortable with an extended benefit period as opposed to one or two years. One person is going to feel a low daily benefit amount is good enough while someone else wants a higher daily benefit amount. All of these factors have an effect on the premium charged for the long-term care insurance contract.

1.) Elimination period- the longer it is, the lower the premium will be
2.) Benefit Period- the longer it is, the higher the premium will be
3.) Daily maximum benefit amount- the higher this dollar amount is, the higher the premium will be

Determining the Right to Obtain Benefits

Assessment Process- Determining when the insured has the right to obtain benefits from a long-term care policy is a question to assess carefully. The criteria used in a policy are known as "benefit triggers." When satisfied, they enable the insured to access insurance coverage. The triggers work independently of each other. Generally the triggers are;

1.) Access to benefits if he or she has lost the ability to perform a certain number of recognized activities of daily living.
2.) Access to insurance benefits if the insured suffers from cognitive impairment.
3.) Access based on the concept of medical necessity.

The situation that is best for the consumer is to allow the insured's own physician to make the determination under all of the benefit eligibility triggers as to whether or not the insured meets the criteria set forth in the policy. This reassures the policyholder that, when the time comes, access to benefits will be achieved with a minimum amount of resistance from the insurance company. Some insurance companies allow this. Still, if benefits are held up, doctors are not in the business of tracking down insurance benefits for patients. No system is perfect.

Case Management and Care Advisory- Those insureds that fall victim to a chronic condition look for advice available on the subject of long-term care. This does not mean the insured wants a case manager to dictate the type of care and degree of care that will be paid for under the insurance policy. Care advisory services are important, especially for single individuals with no immediate family. He or she can receive assistance from someone who can coordinate the various types of care that might be available to them. As an example, care advisory services might help a person understand eligibility and access to the local "Meals on Wheels" program, help in lowering the cost of care at home. Care advisory is available from a variety of public agencies and senior advocacy groups. Although free of charge, this is a low level of care advisory.

Case management is defined as “the professional arrangement and coordination of health services through assessment, service plan development and monitoring.”1 It is a service that can be included as a benefit under the insurance policy, it can be structured as a prerequisite to receiving other benefits listed in the long-term care policy. Some consumer experts recommend that policies be selected that offer care advisory or case management services as options to the policy. The insured should reserve the right to request that the plan of care be established and maintained by his or her own physician. These consumer advocates observe that it is important not to agree to mandatory care management that can lead to restrictions on the type of care for which the insurance company is willing to pay. Mandatory case management can also increase the likelihood of disputes between the insurance company and the insured. If case management is mandatory under a policy, the insured’s best strategy is to be certain that the policy requires that the ultimate plan of care take into consideration the views of both the insured and the insured’s doctor.

It is important to remember that with qualified plans a licensed health care practitioner must develop a written plan of care after a personal examination of the insured. “Licensed health care practitioner” does not mean a doctor. No formal case management provisions are required for non-qualified long-term care benefits.

Contract Language and Administration- Insurance policies generally require that the insured give notice of any claim on the contract immediately upon its occurrence. The purpose is to enable the insurer to gather information while the condition is still fresh, and, in the case of property insurance, to take whatever steps are necessary to prevent further loss to the property. Long-term care insurance is not the same as insuring an automobile or the home. Regardless of the verbiage chosen by the insurer to express the concept of immediacy, delays are to be expected when loved ones, care givers, or other responsible parties to a chronically ill patient do not have actual possession of the policy and cannot be aware of policy details.

The definition of terms is bandied about repeatedly in this text. Again, the substance of the definitions and what they mean (or meant) to the policy owner at the time the policy was issued are the stuff of which lawsuits are made. It is important that all parties to the long-term care insurance contract understand how the policy is intended to perform. Because a lack of understanding seems inevitable on the part of at least some of the population of insureds, it cannot be stressed enough that agents document that every attempt was made to impart knowledge, information and enlightenment to the insured. This should be recorded to protect all parties; the insurer, its agents, and the insured.

The criteria used to determine eligibility for benefits is discussed throughout this book. Equally important is the question of who makes the decision as to whether or not the insured qualifies for benefits under the policy. Oftentimes, the policy provides that the determination is made by claims administrators within the insurance company. Other types of contracts provide that the decision is made by the insurer in conjunction with a case management agent, the insured, and the insured’s doctor. The case management agent can be an independent third party or someone paid by the insurance agency. The insurance consumer may reasonably question whether or not a case manager is truly independent if the insurance company ultimately pays them.

It is important to consider the differences between tax qualified and non-tax qualified policies in defining the insured’s right to receive benefits. Generally, access to insurance benefits is more difficult under a tax qualified policy than under a non-tax qualified. All

1 The Insurance Dictionary, Dearborn, 1990

other things being equal, it is assumed that the purchaser of insurance would benefit from the tax deduction and be economically better off with a tax qualified policy. This may or may not be the best choice.

Terms and Conditions of Long-Term Care Contracts

Several types of policies are available. Most are known as “indemnity” or “expense incurred” policies.

Indemnity and Integrated contracts

With an indemnity contract a daily maximum benefit is provided to the insured. For example, a maximum of $120/day might be paid for each day spent in a long-term care facility. Keep in mind that this is not an absolute amount to be paid. Rather, this is the highest dollar value that will be paid. If per diem expenditures amount to less than this figure, the expenses are paid and the patient retains the rest. Only those expenses incurred by the caregiver(s) are paid. The most common long-term care policies are the “indemnity” policies that pay a fixed dollar amount each day that the insured receives covered care. Much less common are policies that cover a certain percentage of the costs associated with various services. Another type of policy pays a specific dollar amount to cover the actual charges for services received.

Pooled Benefits

Today, many companies also offer “integrated policies” or policies with “pooled benefits.” This type of policy provides a total dollar amount that may be used for different types of long-term care services. There is usually a daily, weekly, or monthly dollar limit for covered long-term care expenses. For example, a policy with a maximum benefit amount of $150,000 of pooled benefits is purchased. Under this policy the beneficiary would have a daily benefit of $150 that would last for 1,000 days if the maximum daily amount is spent on care. If care costs less, the beneficiary would receive benefits for more than 1,000 days.

Benefit Period- The period of time during which the insurance policy pays costs on the insured’s behalf. This period can be from one year to the remaining lifetime of the insured. The benefits under a long-term care contract can be expressed in a time-dollar value combination. That is, a number of years (it can be shown as a number of days) of benefit payouts as well as an actual maximum dollar value to be paid. Purchasers are given a choice of benefits, such as a $50 daily and $100,000 lifetime maximum; $80 daily and $150,000 lifetime maximum; or $120 daily and $250,000 lifetime maximum.

> **Important-** Agents must make it very clear to current and prospective policyholders the significance of how the word “lifetime” is used in the context of a benefit period. A policyholder could easily assume that the “lifetime” refers to his or her lifetime and not that of the policy. Once the policy limits have been reached, the life of the policy is complete. No further payments will be made.

Dollar Amounts- The daily maximum benefit is a dollar amount chosen by the insured that can be affected by at least three things; daily cost of a nursing home stay, projected future ability of the insured to defray a portion of the expense, the amount of premium the insured is currently willing or able to pay.

Exclusions- This should receive as much attention as what is included in a contract. Such exclusions can be critical. Say the insured plans to permanently move to Canada or Mexico. A typical exclusion to contracts is a limit on benefits outside the U.S. Other

exclusions might be no reimbursement for services provided by members of the immediate family, or for injuries resulting from attempted suicide, as well as problems caused by alcoholism or drug addiction.

Elimination Period- After a contractually specified long-term care trigger event occurs, this is the period of time that must elapse before long-term care benefits are payable. This is not to be confused with “probationary period,” the waiting period after the issuance of an insurance policy when coverage is not provided for certain illnesses (used to protect insurers against preexisting conditions).

Policy Features Here is a listing of some of the features available in long-term care contracts that may be desirable to purchasers of long-term care coverage

Bed reservation benefit- Nursing homes can reserve facilities when a patient must leave the nursing home for hospital confinement. Due to the inherent uncertainty surrounding a nursing home resident’s return from the hospital, space may not be available when the patient checks out of the hospital. This policy feature assures the insured that a place will be made available for him or her at the nursing home after a hospital stay. The policy will probably limit this benefit to a maximum number of days per year.

Assisted living benefit- This feature can take different forms. It can be payment for a caregiver to help out the insured in the home. The help can be in the form of custodial care, therapy or actual daily health care. Or, it can be in the form of payment for living in an assisted living facility for seniors. Either way, the purpose of assisted living is to keep the person requiring care in the friendliest most healthful and cost effective environment available: the home.

Restoration of benefit- This rider to a contract allows the insured to have a portion of the maximum benefit available under a contract to be restored during subsequent calendar years in which the insured did not require services under the contract. This applies when the benefit period is less than lifetime. There are an ever-increasing number of people who recover from illnesses that used to quickly result in death. People who have heart attacks or strokes may need long-term care for a few months and then fully recover. Those policies containing a restoration of benefits clause eliminate the fear of all policy benefits being extinguished. The policyholder’s benefits will be fully restored as long as he or she does not need care for a certain period of time (often six months) after benefits are accessed.

Home modification- An alternative benefit paying for construction of facilities that make it easier for the insured to move about the home. This would include wheelchair ramps, handrails, and installation of monitoring systems and the like. The purpose here is again to make it easier for the patient to remain in the home environment.

Caregiver training- Changing bed linens, bedpans, applying dressing, and monitoring equipment are all parts of custodial care. Many of these duties can be assumed by those people already involved with the patient. A loved one, friend, or neighbor can assume these chores after a training period. This offers a cost advantage for all parties concerned when compared to hiring outside help from an agency, where wages, overhead and taxes must enter the equation.

Return of Premium- Unearned premium is returned to the policyholder if the policy is cancelled or lapses. This policy feature deals with the case where an insured stops making payments on the policy. In this case a partial return of the premium is made. This is especially useful if the policy is purchased at a younger age. Policies may return up to 80% of the premiums after a ten-year period of time.

Limited pay options
Limited pay options can be thought of as similar to a paid-up life insurance policy. The policy is paid for in full over a stated period of time. Two examples from the Internet; 1.) The 10-year payment option, an insured or his or her employer pays premiums over a 10-year period, after which the policy is considered paid-in-full. 2.) Pay-to-65 option, as the name indicates, the premiums are paid until the policyholder reaches age 65, at which time the policy is considered paid-in-full.

Waiver of Premium
This provision allows the insured to stop paying premiums once in a nursing home and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment. Others wait 60 to 90 days. Waiver of premium may not apply if a person is receiving care at home.

Nonforfeiture Benefit
This benefit returns some of the premiums paid on the policy if coverage is dropped. Without this type of benefit, a person would receive nothing if the policy were dropped 10 or 20 years later and no claim, or minimal claims, were made upon the policy. This benefit may be applicable if the purchaser is relatively healthy, has a good gene pool and anticipates no adverse health conditions, but still would like to protect family and assets against the unknown. A nonforfeiture benefit can add 10% to 100% to a policy's cost, depending on such things as age at the time of purchase, the type of nonforfeiture benefit offered and whether the policy provides for inflation protection.

Company Responsibilities
Long-term care policy owners can pay premiums for years before accessing benefits. Rate increases can derail the policy holder's ability to retain coverage when they get older.

Rate Stability
Rate stability is one of the most important regulatory issues in long-term care insurance. Unlike regular health insurance, long-term care insurance prefunds an event that, for the most part, occurs once and later in life. Policyholders typically pay premiums for 15 years or more before accessing benefits. Since many people are on fixed incomes when they need care, a large rate increase can often compromise their ability to retain coverage, laying waste to years of premium payments.

Certainly the expectations are that the initial rate is going to be adequate, and that it would include margins to avoid the need for rate increases. What companies tried to do within this model is to make an economic value change to the company so that the value of having an adequate initial premium is substantially greater than having a slightly more competitive premium and then trying to get profits through rate increases. The dual-loss ratio goes a long way to do that. One option is if a company never raises the rates, it never has to deal with the administrators or the regulators. The other option is if a company wants to be a little bit more competitive, it is more likely to file for rate increases if they are needed; and then the insurer runs into regulatory issues.

Policy Terms
Here are some terms that must be defined in an insurance policy so as to meet and satisfy the following requirements;
Medicare- It is defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended," or "Title I, Part I of

Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
Mental or Nervous Disorder- This term cannot be defined any more broadly than to include neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
Other services defined- Those such as "Skilled nursing care," "intermediate care," "home health care," shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is required to be delivered. All definitions that relate to the providers of these and other services must follow these guidelines: The providers of services shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Permitted Exclusions and Limitations

Long-term care policies can exclude from coverage the following conditions; Preexisting conditions or diseases, alcoholism and drug addiction, treatment provided in a government facility, services for which are available under Medicare or other governmental programs (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance. Also permitted to be excluded is illness, treatment, or a medical condition arising out of any of these situations; war or act of war, participation in a felony, riot, or insurrection, service in the armed forces, suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury, or aviation in the capacity of a non-fare-paying customer.

Claims Denial

State insurance codes are often found to require carriers to annually report the total number of claims denied by each class of business in the state. Other information required is the number of these claims denied for failure to meet the waiting period or because of a preexisting condition. The information provided will be through the end of the previous calendar year. Within a stipulated time frame of the date of denial, the insurer must provide to those insureds whose claims are denied a written notice explaining the denial. Insurers must annually report the number of denied claims and the insurance department makes available the denial rate of claims by insurer.

Consumer/Policy holder Right to Appeal

Every policy or certificate shall include a provision giving the policyholder or certificate holder the right to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursement payments.

No Termination During Claim

If an insurer terminates coverage of long-term care insurance while the insured is institutionalized, the termination will be without regard to (will not affect) benefits payable for the institutionalization under the policy. Benefits may continue beyond the period the long-term care insurance was in force. They can be limited to the duration of the benefit period, the payment of maximum benefits under the policy, or by other relevant conditions in the policy.

Individual Policy Renewal Provisions

On the first page of individual long-term care policies there must appear particulars addressing the term of coverage for which the policy is initially issued, the terms and conditions under which the policy may be renewed, and if the insurer can change the premium. If the premium can be changed, the policy must state the circumstances under which the premium may change. Written acknowledgement by the insured is required for any policy rider or endorsement that reduces or eliminates benefits. Likewise, any preexisting limitations in the policy must appear as a separate paragraph. The policy or certificate must be labeled “preexisting condition limitations.” In the same vein, any limitations or conditions for eligibility must also be in a separate paragraph of the policy.

Shortened Benefit Period- Nonforfeiture

Long-term care policies can offer at the time of application an option to purchase a shortened benefit period nonforfeiture benefit. Nonforfeiture refers to the non-surrender of the policy even though some act or omission has occurred on the part of the insured that, under normal circumstances, would cause the policy to terminate. These provisions do not apply to life insurance policies that accelerate benefits for long-term care. The shortened benefit period nonforfeiture benefit most often contain the following features:

- Eligibility begins no later than after 10 years of premium payments.
- The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater.
- The same benefits covered in the policy and any riders at the tome eligibility begins are payable for a qualifying claim.
- The lifetime maximum benefit may be reduced by the amount of any claims already paid.
- Cash back, extended term, and reduced paid-up forms of nonforfeiture benefits shall not be allowed.
- The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.

These conditions do not apply to life insurance policies that accelerate benefits for long-term care.

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

The insured has the right to change the designee at least every two years. If premiums are paid via a payroll or pension deduction plan, the written designee is not required. The application for long-term care must clearly indicate that some type of deduction/drafting plan is in effect. Within 60 days after the policyholder leaves any such arrangement, the requirements concerning written designee or waiver as outlined above must be met. At least 30 days before the lapse of a policy, the insurer must mail notice to the insured and the other parties designated to receive the information. As a further means of protecting the insured, long-term care policies will often provide a reinstatement period if evidence is presented that the insured suffers loss of functional capacity or cognitive impairment.

Post Claims Underwriting Prohibited

Although the purpose of medical underwriting is to assess an applicant's risk profile before coverage is issued. In some cases, an applicant may have an incentive to conceal information about his or her health or risk status from an insurer in order to obtain coverage or terms of coverage that might otherwise not be issued. Less frequently, an applicant might inadvertently fail to disclose information about past health history or about seemingly minor and unimportant. It is also possible that the insurer did not conduct sufficient medical underwriting at the time they issue a policy. If an insurance company determines through post-claims underwriting that a policyholder has not provided all health information (regardless of the applicant's intent), or that their medical condition was preexisting, it can result in serious financial and coverage consequences for the insured, up to coverage cancellation or policy rescission.

As a result of this coverage issue, long-term care insurance applications should feature clear, unambiguous, simple questions- those to which only "yes" or "no" are the anticipated answers. The questions must be designed to ascertain the health condition of the applicant and can contain only one health status inquiry per question. The application for insurance may also request the name of any prescription drugs and the prescribing physician's name. However, applicant's mistake concerning prescription information cannot be used for denial of a claim under the policy. In some states, a warning must be printed near the applicant signature block with the following or equivalent wording;
"Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or decrease your coverage."
Other considerations affecting the issuance of long-term care insurance include;

- Long-term care policies may not be field issued. Applications must be sent to the insurance company for underwriting purposes before a policy can be issued.

The contestability period for long-term care insurance is two years.

- At the time the policy or insurance certificate is delivered, a copy of the completed application must also be rendered to the insured.
- All insurers must maintain a record of rescissions, statewide and nationally, except for those initiated by the insured. This information must be reported on an annual basis to the department of insurance.

Prior Hospital Stay Requirement

Long-term care insurance contracts can be impacted by a requirement of prior hospitalization before making benefits available. Some states prohibit this requirement altogether. Likewise, eligibility for benefits for institutional care or home health care benefits may or may not be predicated on previous receipt of some other, previous form of institutional care.

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.

Examples of worksheets that are to be distributed to prospective purchasers of long-term care policies, note that worksheet language may be modified for individual, group, etc.

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Long-Term Care Personal Worksheet

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]

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.

Minimum Loss Ratio

The loss ratio measures the fundamental cost of underwriting operations. It expresses the relationship between losses and premiums. The pure loss ratio is found by dividing losses incurred during a reporting period by premiums earned in the same period.

$$\text{Pure Loss Ratio} = \frac{\text{Losses Incurred}}{\text{Premiums Earned}}$$

Another way of expressing the loss ratio is to include loss adjustment expenses so that all costs associated with the losses are contained in one figure.

$$\text{Net Loss Ratio} = \frac{\text{Incurred Losses + Loss Adjustment Expenses}}{\text{Premiums Earned}}$$

The larger the numerator, the larger the percentage. The loss ratio here seems to be the latter type. In assessing the expected loss ratio, the following items are to be considered;

a.) Statistical credibility of incurred claims experience and earned premiums
b.) The period for which rates are computed to provide coverage.
c.) Experienced and projected trends.
d.) Concentration of experience within early policy duration.
e.) Expected claim fluctuation.
f.) Experience refunds, adjustments, or dividends.
g.) Renewability features.
h.) All appropriate expense factors.
i.) Interest
j.) Experimental nature of the coverage
k.) Policy reserves
l.) Mix of business by risk classification
m.) Product features, such as long elimination periods, high deductibles, and high maximum limits.

The expected loss ratio for long-term care insurance varies by state. It should provide for adequate reserving of the long-term care risk.

Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). The legislation was designed partly to provide favorable tax treatment to "federally qualified" long-term care insurance policies. Policies sold before Jan. 1, 1997, are generally considered to be tax qualified. Policies sold after Dec. 31, 1996, were required to meet new standards to be considered qualified. While these standards include a number of consumer protections, they also specify the criteria that a covered individual must meet before any benefits can be paid. In some instances, tax qualified policies may require an individual to meet disability criteria that are more restrictive than many non-tax qualified policies.

As they relate to U.S. income tax, two types of long-term care policies offered are;

- Tax qualified (TQ) policies are the most common policies offered. A TQ policy requires that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more activities of daily living (eating, dressing, bathing, transferring, toileting, continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a doctor must provide a plan of care. Benefits from a TQ policy are non-taxable.
- Non-tax qualified (NTQ) was formerly called traditional long-term care insurance. It often includes a "trigger" called a "medical necessity" trigger. This means that the patient's own doctor, or that doctor in conjunction with someone from the insurance company, can state that the patient needs care for any medical reason and the policy will pay. NTQ policies include walking as an activity of daily living and usually only require the inability to perform 1 or more activity of daily living. The Treasury Department has not clarified the status of benefits received under a non-qualified long-term care insurance plan. Therefore, the taxability of these benefits is open to further interpretation. This means that it is possible that individuals who receive benefits under a non-qualified long-term care insurance policy risk facing a large tax bill for these benefits.

Fewer non-tax qualified policies are available for sale. One reason is that consumers want to be eligible for the tax deductions available when buying a tax qualified policy. The tax issues can be more complex than the issue of deductions alone, and it is advisable to seek good counsel on all the pros and cons of a tax qualified policy versus a non-tax qualified policy, since the benefit triggers on a good non-tax qualified policy are better. By law, tax qualified policies carry restrictions on when the policy holder can receive benefits. One survey found that sixty-five percent of purchasers did not know whether or not the policy they bought was tax qualified.

TQ or NonTQ

Advantages of TQ Policies

As the name suggests, the benefits revolve around tax issues:

- For your federal tax purposes, tax qualified Long-Term Care (TQ) long-term care insurance is treated like accident and health insurance. TQ long-term care insurance premiums are considered to be a medical expense and qualify as an itemized deduction up to a defined limit, based on the age of the policyholder and inflation. The younger you are, the less you can deduct.
- No benefits you receive will be taxed. In general, if a person receives benefits under a TQ LTCI policy (other than dividends or premium refunds), the benefits are excluded from income.
- Non-reimbursed long-term care services are also considered a medical expense and can be claimed as itemized deductions to the extent they exceed 7.5 percent of adjusted gross annual income. A tax advisor should be consulted.

Disadvantages of TQ Policies

Tax Qualified (TQ) policies do not have a Medical Necessity trigger, therefore you must:

- Need care for at least 90 days
- Be unable to perform at least 2 out of a list of 6 Activities of Daily Living, without substantial supervision. Activities of Daily Living (ADLs) are usually bathing, transferring, eating, dressing, continence or toileting. Substantial supervision may require "hands on" assistance or, if the policy wording is more lenient, it could simply require "standby" supervision, which means that someone watches you and

helps you, if the need arises. (People usually need assistance with Bathing before any other ADL.)
- Need substantial assistance due to a severe cognitive impairment.
- Have a Licensed Health Care Professional provide a Plan of Care.

Non-Tax Qualified (NTQ) Long-Term Care policies were the only policies available before 1997. They are still sold but, like Tax qualified polices, NTQs have their pros and cons.

Advantages of Non-TQ

- Non-Tax Qualified long-term care insurance policies can include a "Medical Necessity" trigger, although some LTC carriers are eliminating it. The Medical Necessity trigger will start your benefits if your doctor, or a doctor approved by your LTC insurance carrier, states that you need long-term care. This can be helpful if you cannot do certain things for yourself, like a administering a daily injection or changing your catheter, but you are able to perform all other ADLs.
- Does not require 90 days of care in order for Non-taxable LTC policy benefits to kick in. This means that NTQs can be used for short term care. For example, after a minor stroke, heart attack or accident.
- NTQs allow one more ADL as a trigger - Ambulating. Ambulation is walking and people usually need help with walking before Transferring.
- In the case of Cognitive impairment, NTQ policies may not require the same "substantial" supervision in order to trigger benefits.

Disadvantages of NonTQ

- Many Long-Term Care insurance carriers are no longer selling NTQs, probably because NTQ's are falling out of favor, even though they have less restrictive wording. Due to the higher risk, some of the Long-Term Care insurance companies who still offer NTQs are tightening up their policy wording, making it more difficult to receive benefits.
- Due to higher risk for the LTCi company, Non-Tax Qualified policies are usually more expensive.
- NTQs may require a person to need assistance with 3 ADLs, instead of the 2 that TQs require.
- NTQ policies benefits may be taxed in the future. If a policyholder receives LTCi benefits they are issued a 1099 - LTC at the end of the year. This includes Tax Qualified and Non-Tax Qualified policies. However, Tax Qualified policies are exempt. Per Diem benefits received on a TQ policy are tax free up to a certain amount for the tax year. Per Diem benefits above the IRS-imposed limit will be taxed as income, unless the taxpayer can provide proof that actual long-term care expenses were also above the limit.

Advertising Guidelines and Marketing Practices

A. Advertisements Must be Filed

Advertising

Advertising for LTC products must be provided to the insurance department for review before publication. In addition to conformity with all applicable law, the advertising copy must be retained by the insurer, generally for three years. Ads designed to produce leads must contain the following statement prominently displayed;

“An insurance agent will contact you.”

If some sort of cold lead device causes an insurance company representative to contact a consumer for the purpose of soliciting business, this fact must be immediately disclosed to the consumer.

B. Marketing Guidelines

Agents- When an agent markets long-term care insurance, he or she is making the product known to the public at large. There are several different ways to market LTC. No matter how it is handled, the agent has some basic responsibilities. Consumers must be given fair and accurate comparisons of policies (apples to apples). No excessive insurance or inappropriate replacement policies may be sold. Agents must seek to determine an applicant's existing coverage. Agents also must establish auditable procedures, that is, create a paper trail- document the client files. A properly documented file should contain complete and accurate answers to all pertinent questions. This allows the agent to properly assess the need for insurance and substantiates the reason for the sale.

Insurer Responsibilities- Insurers are generally required to report to the department of insurance on a periodic basis a list of representatives authorized to sell long-term care insurance. The list must be updated every six months. Insurers must require agents selling LTC to complete training specific to long-term care. Agents in the first four years of licensure must complete eight hours per year. After that, agents selling long-term care must complete eight hours of training specific to LTC every two years. This eight-hour requirement is a part of, not in addition to, the existing training requirements for insurance license holders.

Other acts or tactics prohibited by state insurance codes include the following;
Twisting- This is the practice of knowingly making any misleading representation, incomplete or fraudulent comparison of insurance policies. The purpose would be to induce consumers to abandon their current policies under false pretenses.
High-pressure tactics- Inducing the purchase of insurance through force, fright, threat (implicit or implied), or undue pressure.
Cold lead advertising- The direct or indirect use of any type of marketing which fails to communicate in a conspicuous manner that the purpose of solicitation is a means of initiation of contact by an insurance agent or company.

(2) Long-Term Care Services and Providers

State Insurance Codes generally see long-term care like this;

> Long-Term care can be defined as diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, which are provided in a setting other than an acute care unit of a hospital. This would include institutional care including care in a nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility, or personal care home. Home care would include home health care, personal care, homemaker services, hospice, or respite care. Community-based care includes adult day care, hospice, or respite care.

Facts About the Senior Population

The older population (65+) numbered 37.9 million in 2007, an increase of 3.8 million or 11.2% since 1997*.

• The number of Americans aged 45-64 - who will reach 65 over the next two decades - increased by 38% during this decade.

• Over one in every eight, or 12.6 percent, of the population is an older American.

• Persons reaching age 65 have an average life expectancy of an additional 19.0 years (20.3 years for females and 17.4 years for males).

• Older women outnumber older men at 21.9 million older women to 16.0 million older men.

• In 2007, 19.3% of persons 65+ were minorities--8.3% were African-Americans. Persons of Hispanic origin (who may be of any race) represented 6.6% of the older population. About 3.2% were Asian or Pacific Islander, and less than 1% were American Indian or Native Alaskan. In addition, 0.6% of persons 65+ identified themselves as being of two or more races.

• Older men were much more likely to be married than older women--73% of men vs. 42% of women. 42% older women in 2007 were widows.

• About 30 percent (10.9 million) of noninstitutionalized older persons live alone (7.9 million women, 2.9 million men).

• Half of older women (49%) age 75+ live alone.

• About 450,000 grandparents aged 65 or more had the primary responsibility for their grandchildren who lived with them.

• The population 65 and over will increase from 35 million in 2000 to 40 million in 2010 (a 15% increase) and then to 55 million in 2020 (a 36% increase for that decade).

• The 85+ population is projected to increase from 4.2 million in 2000 to 5.7 million in 2010 (a 36% increase) and then to 6.6 million in 2020 (a 15% increase for that decade).

• Minority populations are projected to increase from 5.7 million in 2000 (16.3% of the elderly population) to 8.0 million in 2010 (20.1% of the elderly) and then to 12.9 million in 2020 (23.6% of the elderly).

• The median income of older persons in 2007 was $24,323 for males and $14,021 for females. Median money income (after adjusting for inflation) of all households headed by older people did not change in a statistically different amount from 2006 to 2007. Households containing families headed by persons 65+ reported a median income in 2007 of $41,851.

• Major sources of income for older people in 2006 were: Social Security (reported by 89 percent of older persons), income from assets (reported by 55 percent), private pensions (reported by 29 percent), government employee pensions (reported by 14 percent), and earnings (reported by 25 percent).

• Social Security constituted 90% or more of the income received by 32% of all Social Security beneficiaries (20% of married couples and 41% of non-married beneficiaries).
• About 3.6 million elderly persons (9.7%) were below the poverty level in 2007 which is a statistically significant increase from the poverty rate in 2006 (9.4%).

Principal sources for this data are the U.S. Bureau of the Census, the National Center on Health Statistics, and the Bureau of Labor Statistics.

Conditions Resulting in the Need for Care

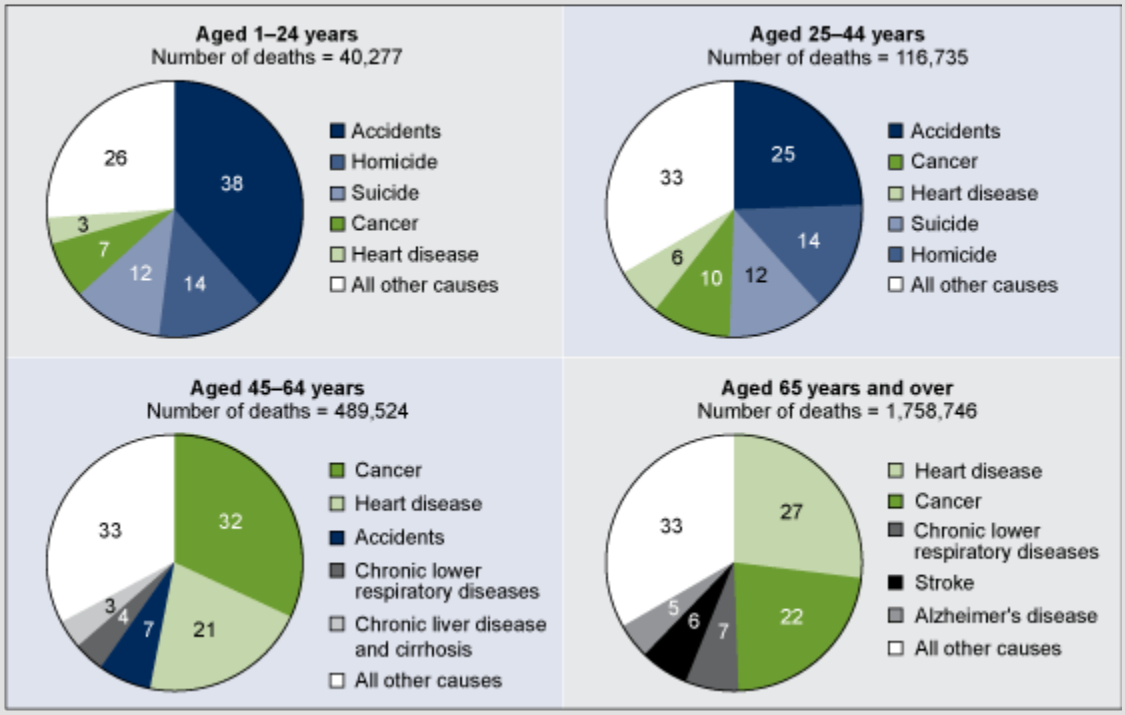
Chronic conditions are the major cause of illness, disability, and death in the United States today. In fact, in spite of broad public awareness of specific life-threatening diseases such as cancer and heart disease, most people are not aware that, collectively, chronic conditions account for three out of every four deaths today. The prevalence of chronic conditions in the early 21st Century is due to several factors, notably the changing nature of illness and increasing longevity. People are no longer dying from the same diseases as they did in previous generations. Infectious diseases were common causes of death until the 20th Century. With the important exceptions of AIDS, tuberculosis, and pneumonia, fatalities today rarely come from infectious diseases. (See Figure 2-1)

Advancing medical knowledge, including screening, treatment, surgical interventions, and pharmaceuticals, has prolonged the lives of many people with disabling chronic conditions, and increased the number of survivors of traumatic injury. Similarly, improvements in diet, sanitation, and medical care have resulted in significantly extended life expectancy. The fastest growing group of elderly people in the U.S. consists of those over 85 years of age. This is also the population that is most vulnerable to chronic conditions. In addition, the “baby boom” generation, now entering its fifties, will soon swell the over-65 population to record levels, with a corresponding increase in the prevalence of chronic conditions.

It is often said that people are living longer and healthier lives. Does this mean that chronic disability might become less of a problem in the future? Unfortunately, the answer is no.
Chronic conditions increase in both number and severity as people age. The high prevalence of chronic conditions among the elderly, combined with a rapidly growing population of elderly people, is expected to dramatically increase the absolute numbers of people with chronic care needs in the 21st Century. Even if disability rates decline or disability becomes less severe, this will not completely compensate for the continued growth in absolute numbers of the elderly. In an absolute sense, greater numbers of the elderly are likely to require greater resources expended on health services for chronic conditions.

Figure 2-1

Figure 5. Percent distribution of five leading causes of death, by age group: United States, preliminary 2009



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

Acute v. Chronic Conditions

Chronic care differs substantially from what most people associate with medical care. Acute care uses intensive, hospital-based, and often high technology medical services to cure acute manifestations of a disease or injury. Chronic care seeks to enable people with functional limitations to regain or maintain the highest level of independence and functioning possible. Chronic care typically provides both medical care and non-medical assistance from a wide range of caregivers in a variety of settings. Because chronic conditions by definition cannot be fully cured, chronic care also emphasizes long-term assistance and compassionate care.

Chronic care consists of several different types of care, predominantly:

♦**Medical Care:** A wide range of medical services provided in a hospital (such as surgery) or on an outpatient basis (such as chemotherapy treatments), or in the home. It may be in response to an acute phase of a chronic condition (for instance, severe pneumonia resulting from AIDS), complications resulting from one or more chronic conditions, or as part of the ongoing management of a long-term condition.

♦**Rehabilitative Care:** Usually prescribed following hospitalization, rehabilitative care includes physical, occupational, and speech therapies. It uses various social, educational, vocational, and sometimes medical services to train or retrain individuals disabled by disease or injury. It is administered in a variety of settings, including hospitals, skilled nursing and other subacute facilities and in the home.

♦**Personal Assistance:** This care is generally not medical in nature. Instead it focuses on helping people perform basic activities of daily living (ADL's), such as getting out of bed, using the bathroom, dressing, and eating, and can involve friendly visiting, or help

with work or leisure activities. It is typically provided in a home or community setting by relatively low-skilled workers. Personal assistance is required by both those who most likely will not regain former levels of independence and functioning, and those who temporarily have less function. The amount of personal assistance services provided in the community is growing at a very fast rate, largely funded by the chronically ill themselves (out-of-pocket) or by Medicaid. Personal assistance also is provided in nursing homes or other residential settings.

Chronic Care Services
- inpatient and outpatient medical and nursing care home health care
- homemaker services
- adult day care nursing home care
- help with activities of daily living such as dressing, bathing, and eating
- rehabilitative therapies housing with supportive services

Chronic Care Is Different from Acute Care

Goals of Care
acute: To restore a person to previous level of functioning, if possible.
chronic: To maintain independent living, if possible, facilitate successful personal and social adjustment, and minimize further deterioration of physical and mental health. By definition, does not aim to “fix" or "cure."

Providers of Care
acute: Specially trained providers in institutions set up precisely for acute care purposes.
chronic: Multiple sources, including an often-unorganized network of relatives, friends, and community services along with hospitals, home health care, and social service agencies. Chronically ill people and caregivers find that few experts know how to organize a full regimen of chronic care.

Scope of Care
acute: Medical care primarily.
chronic: Broad scope of social, community, and personal services, as well as medical and rehabilitative care.

Quality of Care
acute: Significant government investment in outcome measures and quality of care standards for most hospital-based acute conditions.
chronic: Relatively few measures to date to assess the quality of care provided by home health agencies, community-based agencies, ambulatory care clinics.

Organizations Involved in Care
acute: Typically occurs within one institution.
chronic: Requires inter-organizational collaboration. At its most complex, integrates person's primary care, acute care, and long-term care needs. Might involve local health centers, hospitals, and community service agencies. Caregiver "team" might include primary care physician, specialists, social workers, nurse practitioners, home aides, and family members.

The Services and Providers of Care

Long-term care for senior citizens can be handled by family members under ideal conditions. In the real world however, third parties will have to be engaged to do the job. Paid long-term care comes under two broad categories; home care and institutional care. With home care, the elderly person remains in the home. A paid provider comes in to the home during the day or actually lives in the house. Such third-party caregivers are reimbursed accordingly for their services. If home care for the chronically ill individual is not feasible, they must move into a nursing home where around the clock attention is available. The older a person gets, the more likely they will live in a nursing home

Informal caregivers-unpaid family, friends, and community volunteers-provide the vast majority of care and assistance to chronically ill and disabled people. Although hospitals have traditionally provided the medical care needed by people with chronic conditions, technological advances increasingly allow medical care to be delivered in non-hospital settings as well. However, because chronic care includes many types of assistance, not only medical care. The "system" of chronic care includes many institutions and sources of care. Some major sources of chronic care other than hospital care are outlined below.

Home Care Home care today includes a variety of services, based on the level of assistance required by the person with a disability or chronic illness. Home care services range from high-intensity home health care to lower intensity, lower-skilled personal assistance services (such as assistance in bathing, eating, shopping, or housecleaning). Services may be delivered in a variety of settings, ranging from an individual's freestanding home to an assisted living apartment or board-and-care home. Since some disabled individuals require help but are not homebound, personal assistance services also may be provided in a work or recreational setting, while the person is carrying out his or her daily activities. In every state there are thousands of home care agencies, many of which are Medicare-certified. Each of these may offer any number of the services described above. The staff that provides home health care and personal assistance services ranges from registered nurses, to licensed practical nurses, to lesser-trained home health aides. Services are also provided by voluntary community agencies that provide meals, transportation, respite care, and other assistance.

Supportive Housing Supportive housing includes housing units that have been modified (via handrails, ramps, or emergency call buttons) or service-enriched (such as on-site case management or homemaking help) to enable persons with disabilities (especially the frail elderly) to remain as independent as possible. Examples of supportive housing include assisted living facilities, continuing care retirement communities (CCRC's), and board-and-care homes. The services provided range from housing modifications, to case management, to the linking of housing facilities with outside providers of the services residents require. Board-and-care homes and assisted living facilities typically provide room, board, and some degree of supervision or 24-hour protection and oversight.

Other Services Among the other supportive services currently available in some areas are respite care, adult day care, and hospice care. These services are provided by various agencies, in settings ranging from the individual's home to facilities built especially for providing the service. Respite care involves short-term care that attends to the needs of the person with a disability, allowing his or her informal caregiver (e.g., a family member) to attend to other matters, or to rest. Adult day care programs provide a mix of health, social, and related support services to persons with functional impairments. This care is delivered within a designated facility, for periods less than 24 hours in duration. Hospice

care is delivered in a person's home, or in a homelike setting, and is designed to meet the physical, emotional, and spiritual needs of those who are nearing death. Hospice care includes pain management, and focuses on working with the dying person's immediate family, the clergy, and the person's medical care providers.

Nursing Homes Nursing homes today vary widely in size, ownership, and mission. In general, nursing homes are defined as institutional, convalescent settings providing care for people with chronic illness, and for those recovering from an acute illness. As of this writing, the Center for Disease Control website estimates the number of nursing homes at 16,100 facilities, housing approximately 1.5 million people at any given time. Beyond room and board, nursing homes provide services ranging from care and supervision for persons with Alzheimer's disease to sophisticated medical care such as ventilator care or infusion therapy. In addition, some nursing homes offer rehabilitative care, dietary guidance, and social services, among other services.

Who Needs Care and Why

The answer to that query is simple; old people and those who are chronically ill. Beyond that, the lines of distinction become fewer and less readily discernible. A simple one-dimensional statement disguises a multiplicity of demographic phenomena, which are all part of a society's aging process. Who is "old" in today's society? Both falling birth rates and death rates alter the age distribution of the population, but at opposite ends of the population's age spectrum. Also important are changes in age-specific rates of sickness and disability: any improvements in health and functional ability of the aged tend to mitigate the increasing dependency that otherwise results when mortality rates decline. A recurrent theme in the literature on the growing population of the oldest old is their high degree of heterogeneity. Researchers found a great variability in physiological rates of aging, the variability of disease is greater the older the population.[2] An implication here is that older persons who are ill have a greater need for costly individualized care and attention than younger patients. Another implication is that aging may actually change the character of an age cohort. An age cohort is a grouping of people according to age. The U.S. Census Bureau uses five-year increments (60 to 64, 65 to 69, 70 to 74, etc.), so researchers use the same format.

Licensed Health Care Practitioner

The conditions outlined above must be met by a "chronically ill individual". A chronic illness is characterized by persistent and recurring health consequences lasting for periods of years. A licensed health care practitioner independent of the insurer must make this call. The health care practitioner must develop a plan of care for the insured and the condition of the insured must be re-evaluated and re-certified every 12 months.

Whatever the cost of the certification or promulgation of plans to meet the needs of the chronically ill insured, it cannot be deducted from the total lifetime maximum benefit value of the insurance policy. This requirement only applies to a policy intended to be a tax qualified long-term care insurance contract.

Licensed health care practitioner- Under a tax qualified long-term care insurance contract, this phrase refers to a physician, registered nurse, licensed social worker, or other individual prescribed by regulation. . Since this is federally tax qualified, such a "practitioner" must be titled as such under U.S. Treasury regulations.

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2 Riley, M.W. and Bond, K. 1983. "Beyond Ageism: Postponing the Onset of Disability." PP 243-252 in A*ging in Society: Selected Reviews of Recent Research"*

Plan of Care- This means a written description of the insured individual's needs and a specification of the type, frequency, and providers of all formal and informal long-term care services required by the insured, along with costs associated with the plan.

Demographic Features

The subjection of a heterogeneous population to survival hazards leads to a highly selected cohort of survivors. As an example, cancer and diabetes death rates decline with age at the oldest ages; this suggests selection at younger ages of the most susceptible to those ailments. Similarly, the rate of disability among the non-institutionalized population declines between ages 65 and 85; this suggests that nursing home admissions and death at younger ages select out those most prone to disablement. As the relative size of the elderly population increases, so does the prevalence in the population of conditions associated with old age. In addition to killer diseases such as cancer, and chronic nonfatal ailments such as cataracts, these include geriatric syndromes like memory loss and urinary incontinence. By making family or institutional care necessary, the latter conditions can be as costly of resources as fatal illnesses. Urinary incontinence, for example, has been estimated to account for as much as 20% of the total cost of nursing home care.[3]

Women have a lower and more rapidly improving mortality rate at older ages, so the elderly population is predominately female and has been increasingly so. For example, in the population aged 85 and older, where the ratio of men to women has declined from 0.75 in 1940 to 0.44 in 1980. As a result, widowhood is by far the most common situation of women who have survived beyond age 85. In 1980, only 33% of women aged 65-69, but 82% of those 85 and older, were widowed. In contrast, almost half of men over 85 remained married, while only 44% were widowed. [4]

Oldest Old

Because the oldest old are the most intensive users of medical and long-term care, their numbers are a most critical element of any forecast of future costs. Their projected population is extremely sensitive to mortality assumptions. A discussion of the statistical methodology used to determine how old people can get is beyond the scope of this book. One researcher, James Fries, postulated in the 1980's that age 85 was an appropriate upper limit for average longevity ("Aging, Natural Death, and the Compression of Morbidity.") More recent models of aging and death take issue with these findings. The important point is that life expectancy will increase and somebody is going to end up on or beyond the upper limits of the bell curve.

Provision of and Payment for Services

Medicare probably won't pay your nursing-home bill. Medicare, as mentioned, is a federal *health insurance* program. Its focus, therefore, is on medical care. If you're discharged from a hospital and need acute care in a skilled-nursing home or if you need intensive rehabilitation, Medicare may pay most or the entire bill. However, such stays are relatively rare. Medicare actually pays for less than 2% of total nursing-home costs.

What about private health-care insurance, inducing Medigap policies? What about employer-sponsored retiree benefits? Again, the emphasis is on reimbursement of medical expenses. Money spent for custodial care-keeping nursing-home residents clean

3 Minaker, K., and Rowe, J. 1985. "Health and Disease among the Oldest Old" *Milbank Memorial Fund Quarterly/Health an Society 63, no. 2: 324-349*

4 Rosenwaike, I. 1985. "A Demographic Portrait of the Oldest Old." Ibid. PP 187-205

and fed-won't come from Medicare, from Medicare supplemental, from a health insurance policy, or from a health maintenance organization (HMO).

So where will the money come from? It will come from the nursing-home residents themselves. Or from their middle-aged children, who want to take care of their aging parents, from long-term care insurance or from Medicaid. Medicaid is the primary source of financing for long-term care and accounts for the large majority of public spending on long-term care.

Below the poverty line, Medicaid will pay for nursing-home care. Nursing homes usually receive lower fees from Medicaid than they get from "private pay" patients. Though this isn't always the case, Medicaid patients may become second-class citizens, with lower levels of service. In fact, some nursing homes are reluctant to accept Medicaid patients. Even if an individual does not deplete all of their assets, nursing-home costs may deplete resources so that there is less for children to inherit. To avoid this situation, the middle-aged children contribute to nursing-home care. The financial squeeze can be excruciating for people who are trying to put their own children through college while they support their aging parents.

Pay-as-You-Go

So, what seems to be the problem with jettisoning your assets and letting Uncle Sam pay for nursing home care? Despite the rhetoric of “too proud” to do so, many people end up on the Medicaid dole. We have entered the 21st century with a demographic environment that appears to favor saving and with a system of social insurance heavily dependent on intergenerational transfers. This conflict threatens the very existence of the public programs which today finance health and long-term care for the aged. The Social Security program was established in 1935, during the administration of President Franklin D. Roosevelt. Succeeding administrations have continued to expand this system of social insurance. Benefits for the unemployed, the disabled, the retired, survivors of deceased workers, and the aged in ill health are financed by payroll taxes and available to workers regardless of demonstrated need. These programs are financed on a “pay-as-you-go” basis. Current tax revenues are used to pay current benefits, instead of being saved to fund future benefits. The programs’ trust funds have at most times been only large enough to weather unexpected temporary revenue shortfalls. The advantages of choosing pay-as-you-go financing over full funding were evident in the 1930’s and the next three decades;

- It allowed a new program to pay immediate benefits, such as retirement benefits, to those in need, without prior contributions. The program incurs a debt to workers, repaid through benefit payments to them at a later date, and financed by taxing the next cohort of workers. A new debt is thereby incurred to those workers, which is paid back by taxing the next cohort, and so on indefinitely. A pay-as-you-go system borrows from the distant future to pay benefits to an initial cohort of beneficiaries who have made little contribution of their own. Besides making great politics, pay-as-you-go Social Security was an attractive way to make retirement (or the thought of it) possible in the Great Depression when jobs and money were scarce. This also increased the chance of employment for younger workers.
- Population and economic growth in the mid-twentieth century enabled subsequent generations of workers to prosper under pay-as-you-go. Intergenerational transfers provide even those who are currently retiring with greater lifetime income than would have been provided by a funded system. For example, a male worker aged 65 in 1984 and earning 50% of the maximum covered earnings since 1937 would receive

> OASDI benefits equal to 2.79 times the accumulated value (with interest) of his employee OASDI payroll taxes. Pay-as-you-go programs outperform saving or fully funded programs as long as the payroll tax base grows sufficiently. Payroll tax contributions earn a positive return if each successive generation is able to make larger and larger transfers to its elders, for then each generation's benefits exceed its contributions.

Here is a simple model; Assume the employed labor force grows at a constant rate *n* per generation, that real wages per worker grow at a steady rate *w* per generation, and that financial assets earn real interest at a constant rate *r* per generation. Also assume that the payroll tax rate, the percentage of earnings paid to finance social insurance, is held constant from generation to generation. Because the payroll tax base benefits from both wage and employment growth, it grows at a rate of ($w + n$) per generation, so that revenues are always sufficient to provide each retired person with transfers equal to ($1 + w + n$) times the tax paid a generation before. In contrast, a dollar committed by a worker to personal savings is transformed into ($1 + r$) dollars, a generation later, regardless of changes in employment and wage growth rates. If *n* and *w* were sufficiently large, then ($1 + r$) dollars are less than the ($1 + w + n$) dollars which can be earned by committing the dollar to a tax-and-transfer scheme.[5]

The result is that not only the first generation but all generations for all time are made financially better off by instituting a system of intergenerational transfers. But this result only holds true in a world with sufficiently high population growth. The opposite happens if population and wage growth are too small. Aside from the first (non-contributing) generation, which is made better off in any case, the transfers will impoverish each subsequent generation, relative to the saving of the same funds.

Labor force entrants today may ultimately receive less from transfers than from a funded system for this reason. Starting in the late '80's a projected low rate of growth of the working-age population was documented by the U.S. Census Bureau and such journals as *National Demographics* magazine. Even if these projections are only partially true, the aftermath of birthrate fluctuations will profoundly affect our demographic future. Analyses have been made on the difference between the largest intergenerational transfer, Social Security, and private saving, commonly comparing the average worker's lifetime treatment by Social Security with that of private saving. As explained above, the results hinge on the underlying assumptions about wages, population growth, and interest rates. Long-time Social Security chief actuary Robert Myers concluded that Social Security might be "a poor bargain for young new entrants when the combined employer-employee tax is considered." (Employers must match their employees' payroll tax payments). His estimates show that the combined taxes paid over the lifetime of a young mid-1980's career entrant, accumulated with interest, will equal about 1.5 times the lifetime benefits that will be paid to that worker, and may ultimately be close to two times lifetime benefits for later birth cohorts.[6] Others have produced similar results, all comparisons being unfavorable to Social Security.[7] Future real interest rates cannot be known for sure, but the real interest rate can safely be assumed to remain in the historical range of 2%-3%.

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5 Aaron, H. 1966. "The Social Insurance Paradox" *Canadian Journal of Economics and Political Science* 32, no. 3 and Solow, R. 1970. *Growth Theory: An Exposition.*

6 Myers, R. 1985. *Social Security*

7 Boskin, M.J. et al.1983. "Modeling Alternative Solutions to the Long-Run Social Security Funding Problem." *Behavioral Simulation Models in Tax Analysis* and Boskin, M., Kotlikoff, L. et al. 1987. "Social Seriate: A Financial Appraisal across and within Generations." *National Tax Journal* 40, No. 1 (March): 19-34.

When economists speak of the real interest rate, they mean the current prevailing interest rate less the current rate of inflation.

An outcome of this discussion is that slow growth in the payroll tax base has turned against the rate of return advantage of pay-as-you-go programs. This conclusion would seem to cast the early 21st Century as an inopportune time to expand, or perhaps even rely on, pay-as-you-go programs. This discussion has focused on the Social Security system. The analysis also applies, it would seem, to Medicare and Medicaid, the other two large pay-as-you-go programs.

(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 by President Bush on February 8, 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 your 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.

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.

Maximum Long-Term Care Premium Deductions, 2010*

Age	Maximum Allowable Deduction
40 or younger	$330
41 to 50	$620
51 to 60	$1,230
61 to 70	$3,290
71 or older	$4,110

* Note that maximum deduction amounts change annually.

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.

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

(3)(A) 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. As of June 1, 2009, 29 states had implemented partnership programs 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.

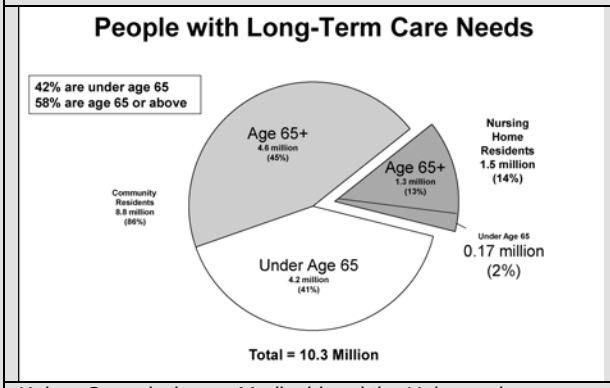
(3)(B) Relationship Between Qualified State LTC Partnership and Other Coverages of LTC Services

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 3-1



Kaiser Commission on Medicaid and the Uninsured
Sources: Health Policy Institute, Georgetown University, analysis of data from 2005 Natl Health Interview Survey and 2004 National Nursing Home Survey

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 extensve acute and long-term services as they age.

Paying for LTC

If you have sufficient income and assets, you are likely to pay for your long-term care needs on your own, out of those private resources. If you meet functional eligibility criteria

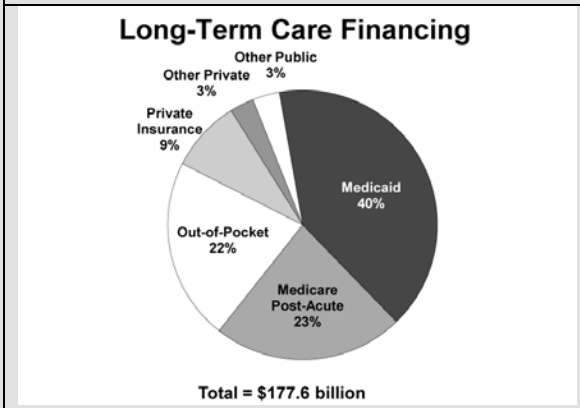
and have limited financial resources, or deplete them paying for care, Medicaid may pay for your care. If you require primarily skilled or recuperative care for a short time, Medicare may pay. The Older Americans Act is another Federal program that helps pay for long-term care services. Some people use 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 of $137.50/day for days 21-100. After day 100 does not pay.	May cover the $137.50/day 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. Nursing home care averages $72,000 per year, assisted living facilities average $38,000 per year, and home health services average $21 per hour. In 2006, nearly $178 billion was spent on long-term services. Medicaid accounts for 40 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 22 percent of spending

Chart 3-2



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, 2010.

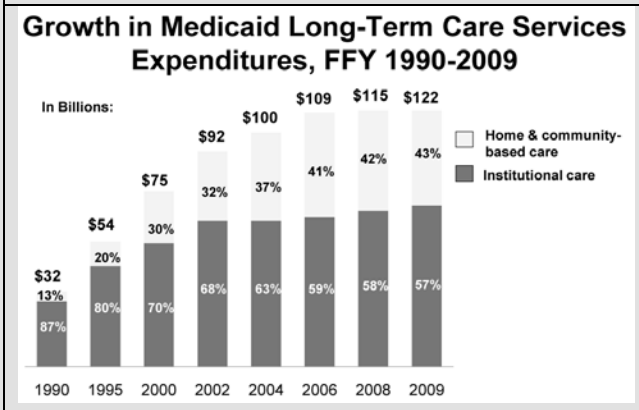
Qualifying for Medicaid LTC

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 $674 per month in 2010 - 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 ($2,022 per month in 2010). 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

Over 3 million individuals, or 7 percent of the Medicaid population, rely on Medicaid long-term care services for a range of physical and mental health care needs. Medicaid coverage of long-term care includes a range of services and supports that assist individuals with performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These range from providing assistance with eating, dressing, and toileting, to assisting with managing a home and medication management. Medicaid covers a continuum of long-term care service settings. While many prefer to remain in the community, some individuals with extensive needs require nursing home care. Spending on Medicaid HCBS has been growing. In 2009, spending on HCBS accounted for 43 percent ($52.8billion) of total Medicaid long-term care services spending, up from 13 percent in 1990.

Chart 3-3



Note: Home and community-based care includes home health, personal care services and home and community-based service waivers. Institutional care includes intermediate care facilities for the mentally retarded, nursing facilities, and mental health facilities.
Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of HCFA/CMS-64 data.

Spending patterns for Medicaid home and community-based services vary widely among states, with the percentage of long-term care expenditures going towards HCBS ranging from 13 percent in Mississippi to 73 percent in New Mexico. Demand for services in the community is growing. In 2009 there were 365,553 individuals in 39 states on waiting lists for Medicaid HCBS.

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.

Medicaid Financial Limits

FAMILY SIZE	Medically Needy ABD	SSI Payment Amount	NURSING HOME/CCSP HOSPICE	QMB (100% + $20)	SLMB (120% + $20)	QI-1 (135% + $20)	QDWI	Resource Limits
Individual GROSS MONTHLY	$317	$674	$2,022	$928	$1,109	$1,246	$3,715	SSI/NURSING HOME/ CCSP/HOSPICE $2000 (Individ) $3000 (Couple) QMB/SLMB/QI-1 $6,680 (Individ) $10,020 (Couple) ABD MN $2000(Individ) $4000 (Couple)
GROSS ANNUAL	N/A	$8,088	$24,264	$11,136	$13,308	$14,952	$44,580	
Couple GROSS MONTHLY	$375	$1,011	$4,044	$1,246	$1,491	$1,675	$4,989	
GROSS ANNUAL	N/A	$12,132	$48,528	$14,952	$17,892	$20,100	$59,868	

COMMUNITY SPOUSE $2,739.00
DEPEND. FAMILY MEMBER $1,839 (Effective 4/1/11)

Aged, Blind and Disabled (ABD) - ABD Medicaid provides long-term care services in nursing and intensive care facilities
Medical Treatment Facility (MTF) - This includes nursing homes, hospice care, hospital stays of 30 days or more, and Community Care Services.
Supplemental Security Income (SSI) - If an individual is eligible for SSI, he or she qualifies for Medicaid automatically. Any person who may be potentially eligible for SSI will be referred to Social Security before a Medicaid application will be taken.
Community Care Services Program (CCSP) – This helps people who are elderly and/or functionally impaired to live in their homes and communities. For elderly and/or functionally impaired people, CCSP offers community-based care as an alternative to nursing home placement.
Qualified Medicare Beneficiaries (QMB) - This coverage pays an individual's Medicare premium, Medicare coinsurance and deductibles. It does not pay for any prescription drugs.
Specified Low-Income Medicare Beneficiaries (SLMB) - Program is for people who receive Part A Medicare and whose income is between 100% and 120% of the Federal Poverty Level. The Federal Poverty Level is available on the Internet at http://aspe.hhs.gov/poverty
Qualified Individual 1 (QI 1) – It pays only the Medicare Part B premium for Medicare beneficiaries who are not eligible for Medicaid.
Qualified Disabled Working Individual (QDWI) - The QDWI program will pay Medicare Part A premiums. If under age 65, disabled and no longer entitled to free Medicare Hospital Insurance Part A because of successful return to work, individuals may be eligible for a state program that helps pay Medicare Part A monthly premium.

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 will increase by one month each month through January 2011 at which time 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.

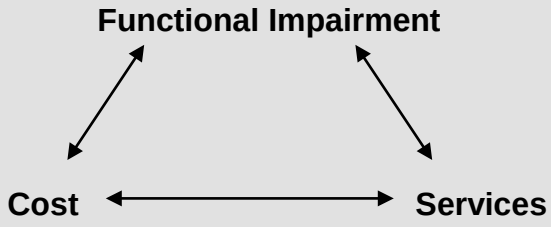
(3)(C) Available Long-Term Care Services and Providers

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? Do you find it 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. We will see 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.[8]

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.

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.

8 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.

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 on 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

(3)(D) 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 specially 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.

(4) 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 that 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 $72,000 per year in 2009, reaching as high as $138,000 in high-cost areas like New York City (U.S. Department of Health and Human Services, 2009, based on average daily rates for a semiprivate room). Assuming costs increase by 5% annually, a nursing home stay could reach an average of $191,000 per year by 2030 (projection based on 2009 national average cost of $72,000 per year compounded annually at 5%). Paying for a home health care aide eight hours each day averaged more than $61,000 a year in 2009, and more than $99,000 in San Francisco, one of the higher-cost areas (U.S. Department of Health and Human Services, 2009. Based on San Francisco home health aide average hourly rate).

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 has also encouraged sales. A recent report by HIAA shows that between 1987 and 1995, insurers sold 4.35 million policies. Sales have been growing

20% per year. In the marketplace there are around 100 million potential buyers, but sales may not continue to expand because of theses major obstacles;

- 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. You should not buy a long-term care policy if it will cause a financial hardship and make you 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 your 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[9]. 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

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

affordable. In the absence of such provisions, most people would not buy coverage until they needed long-term care services.

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 we can do to order our lives, make our 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 our 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. It must also be noted that 29.4% of all U.S. households had income below $25,000 in 2003[10]. 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.

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,

[10] U.S. Census Bureau, Statistical Abstract of the U.S., Sec. 13, ‘Income, Expenditures, and Wealth’

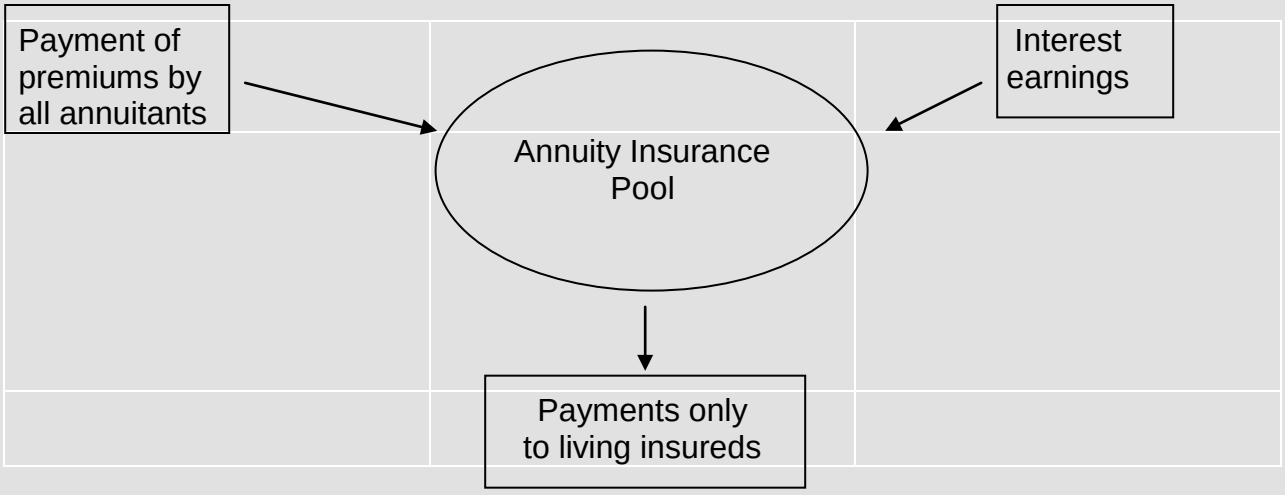
privately purchased annuities may be obtained from life insurers. Annuities have come and gone from the public's investing consciousness over the years, between 1989 and 1999, the American Council of Life Insurers reported that premiums on annuities more than doubled from $49.4 billion to $115.6 billion.

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 4-1. 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 you are age 62 or older and are "house-rich, cash-poor," a reverse mortgage (RM) may be an option to help increase your income. However, because your home is such a valuable asset, you may want to consult with your family, attorney, or financial advisor before applying for an RM. Knowing your rights and responsibilities as a borrower may help to minimize your financial risks and avoid any threat of foreclosure or loss of your

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 be careful to choose the plan that best meets your financial needs.

How Reverse Mortgages Work- A reverse mortgage is a type of home equity loan that allows you to convert some of the equity in your home into cash while you retain home ownership. RMs works much like traditional mortgages, only in reverse. Rather than making a payment to your lender each month, the lender pays you. Unlike conventional home equity loans, most RMs do not require any repayment of principal, interest, or servicing fees for as long as you live in your 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.

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 2010, $137.50 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.

Medigap

Medicare Supplement or Medigap refers to various private supplemental health insurance plans sold to Medicare beneficiaries in the United States that provide coverage for medical expenses not or only partially covered by Medicare. Medigap's name is derived from the notion that it exists to cover the difference or "gap" between the expenses reimbursed by Medicare and the total amount charged.

Products available

Medigap offerings have been standardized by the CMS into twelve different plans, labeled A through L, sold and administered by private companies. Each Medigap plan offers a different combination of benefits. The coverage provided is roughly proportional to the premium paid. However, many older Medigap plans offering minimal benefits will cost more than current plans offering full benefits. The reason behind this is that older plans have an older average age per person enrolled in the plan, causing more claims within the group and raising the premium for all members within the group. Since Medigap is private insurance and not government sponsored, the rules governing the sale and offerings of a Medigap insurance policy can vary from state to state. Some states such as Massachusetts, Minnesota, and Wisconsin require Medigap insurance to provide additional coverage than what is defined in the standardized Medigap plans.

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 from whom they can receive services 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.

The 2003 Medicare payment formulas overpay plans by 12 percent or more compared to traditional Medicare (Medicare Payment Advisory Commission Annual Reports to Congress, 2006, 2007, and 2008). In 2006 enrollees in Medicare Advantage Private Fee-for-Service plans were offered a net extra benefit value (the value of the additional benefits minus any additional premium) of $55.92 a month more than the traditional Medicare benefit package; enrollees in other Medicare Advantage plans were offered a net extra benefit value of $71.22 a month more. However, Medicare Advantage members receive additional coverage and medical benefits not enjoyed by traditional Medicare members, and savings generated by Medicare Advantage plans may be passed on to beneficiaries to lower their overall health care costs. Other important distinctions between Medicare Advantage and traditional Medicare are that Medicare Advantage health plans encourage preventive care and wellness and closely coordinate patient care.

Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan or a MA-PD. Enrollment in Medicare Advantage plans grew from 5.4 million in 2005 to 8.2 million in 2007. Enrollment grew by an additional 800,000 during the first four months of 2008. This represents 19% 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. Because of the 2003 law's overpayments, the number of organizations offering Fee-for-Service plans has increased dramatically, from 11 in 2006 to almost 50 in 2008. Eight out of ten beneficiaries (82%) now have access to six or more Private Fee-for-Service plans.

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.

Eligibility and enrollment

Individuals are eligible for prescription drug coverage under a Part D plan if they are entitled to benefits under Medicare Part A and/or enrolled in Part B. Beneficiaries can obtain the Part D drug benefit through two types of private plans: they can join a Prescription Drug Plan (PDP) for drug coverage only or they can join a Medicare Advantage plan (MA) that covers both medical services and prescription drugs (MA-PD). The latter type of plan is actually part of Medicare Part C and has several other differences relative to original Medicare. About two-thirds of Part D beneficiaries are enrolled in a PDP option. Not all drugs will be covered at the same level, giving participants incentives to choose certain drugs over others. This is often implemented via a system of tiered formularies in which lower-cost drugs are assigned to lower tiers and thus are easier to prescribe or cheaper.

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:

- $254.00 per month (2010) for those with 30-39 quarters of Medicare-covered employment, or

- $461.00 per month (in 2010) for those with less 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 2009 is $96.40 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 $134.90, $192.70, $250.50, or $308.30 for 2009, with the highest premium paid by individuals earning more than $213,000, or married couples earning more than $426,000. In September 2008, CMS announced that Part B premiums would be unchanged ($96.40 per month) in 2009 for 95 percent of Medicare beneficiaries. This would be only the sixth year without a premium increase since Medicare was established in 1965. Medicare Part B premiums are commonly deducted automatically from beneficiaries' monthly Social Security checks. 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:

- A Part A deductible of $1,068 (in 2009) for a hospital stay of 1-60 days.
- A $267 per day co-pay (in 2009) for days 61-90 of a hospital stay.
- A $534 per day co-pay (in 2009) 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 $137.50 per day (in 2010) 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 $155.00 (in 2010), 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%, and outpatient mental health which is currently (2010-2011) covered at 55% (45% copay). The copay for outpatient mental health which started at 50% is gradually being stepped down over several years until it matches 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

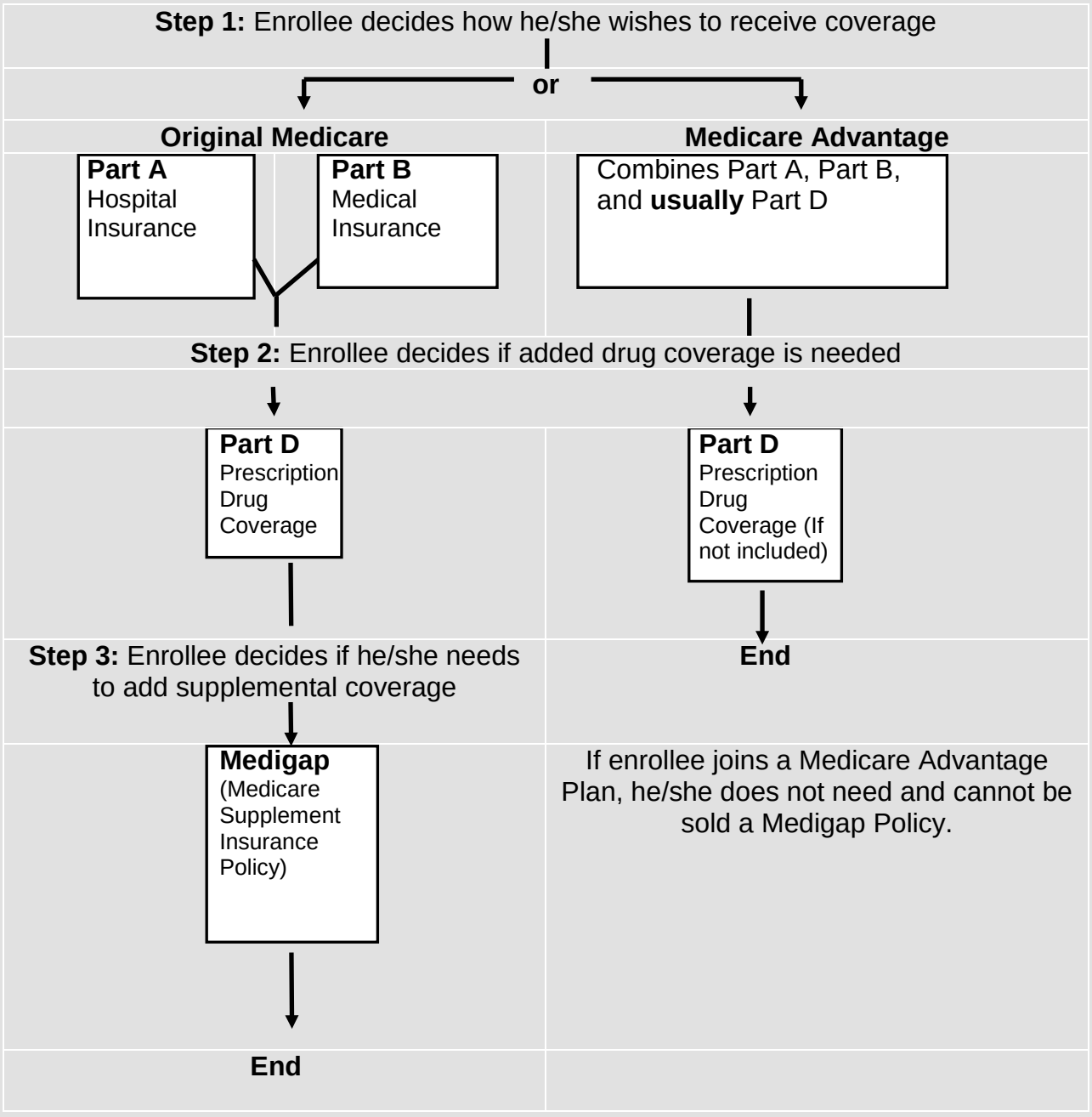
Some people elect to purchase a type of supplemental coverage, called a Medigap plan, to help fill in the holes in Original Medicare (Part A and B). These Medigap insurance policies are standardized by CMS, but are sold and administered by private companies. Some Medigap policies sold before 2006 may include 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).

Payment for services

Medicare contracts with regional insurance companies who process over one billion fee-for-service claims per year. In 2008, Medicare accounted for 13% ($386 billion) of the federal budget. In 2010 it is projected to account for 12.5% ($452 billion) of the total expenditures. For the decade 2010-2019 Medicare is projected to cost 6.4 trillion dollars or 14.8% of the federal budget for the period.

Chart 4-1 Medicare Basics



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 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 are often the culprits in *medication errors*. Individuals may take the wrong dosage, use the wrong medication, 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. For example the March, 2011 issue of *Presbyterians Today* magazine has several half-page or better advertisements for senior living arrangements. A check of the Internet shows the United Methodists 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.

(5) 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

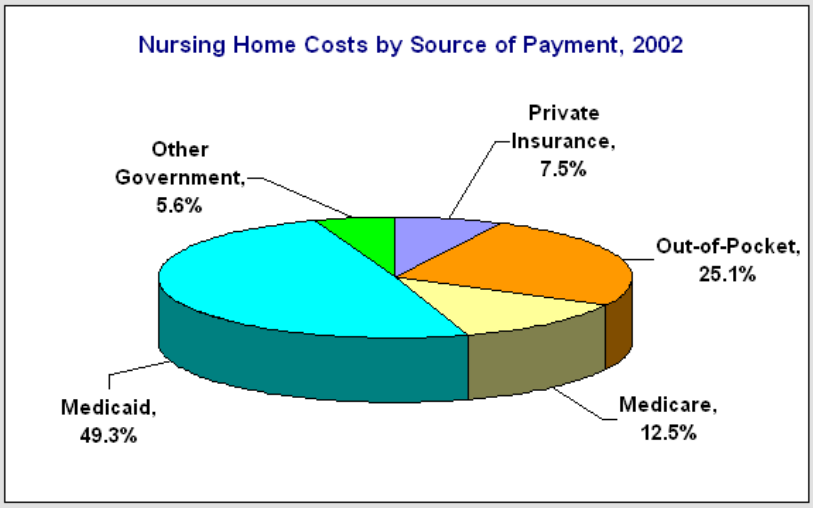
* This does not include ‘expense incurred’ policies paying a certain percentage of reasonable and customary charges up to a specified, indemnity-type maximum amount.

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 5-1



Statistical Abstract of the U.S. 2005

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 you are located. Here are median care costs of different services in Georgia, according to a 2010 study conducted by Genworth Financial;

Home Health Aide Hourly Rate (Medicare Certified) $17.50

Assisted Living Facility Monthly Rate (Private Room) $2,400
Nursing Home Daily Rate (Semi-private Room) $160
Nursing Home Daily Rate (Private Room) $175

Most people prefer to receive care at home. According to the Genworth study, Georgia families can expect to pay an average of $40,040 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.

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	226.09[11]	5.9%	218.1	1.6%

[11] Estimated; based on 5.9% annual increase

The increase from 1981-2009 was $170.57 - an absolute increase of 497%. In the 24 years reported since 1986 that comes up to a compounded increase of about 6.9% yearly.

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

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

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.

Compare the annual percentage increases in nursing home costs with the changes in the CPI for the year in the rightmost column. Except for the anomalous jumps in 1998, 1999 and 2001, the annual increases in recent years have trended downwards. They still exceed 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- We will assume 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. We refer to the benefits derived with simple interest 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. Mexico in the early 1990's and emerging Asian markets in 1997 are examples of economies borrowing and spending more that their economies produced. The rapidity with which the problems were attacked and the relatively quick comeback of those economies also indicates the degree to which governments now 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.

(6) 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.

(7) 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 Assessment (SPRA)) 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.

(8) 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 $536,000 for 2013. 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 to the application;
http://dfcs.dhr.georgia.gov/portal/site/DHS-DFCS/menuitem.8237042e9dbda3aa50c8798dd03036a0/?vgnextoid=4bf8b9a195b4ff00VgnVCM100000bf01010aRCRD

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 May 3, 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 our Web site **www.dch.georgia.gov**.
Members with 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, 6300 Powers Ferry Road, Suite 600-288, Atlanta, Georgia 30339.