

## *The Government and Long-Term Care Insurance*

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### **Learning Objectives**

*An understanding of the material in this chapter should enable you to*

- 18-1. Describe the NAIC model legislation that affects the policy provisions of long-term care insurance policies.
- 18-2. Describe the NAIC model legislation that affects the marketing of long-term care insurance.
- 18-3. Explain HIPAA's requirements for favorable tax-treatment of long-term care insurance policies.
- 18-4. Identify the ways that government acts as counselor regarding long-term care insurance.
- 18-5. Describe the implications of the Federal Long Term Care Insurance Program for long-term care insurance.
- 18-6. Explain the importance of partnership programs for long-term care and describe their features.

### **Chapter Outline**

NAIC MODEL LEGISLATION	18.2
Policy Provisions	18.5
Marketing	18.7
EFFECT OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	18.10
Requirements for Favorable Tax Treatment	18.11

GOVERNMENT AS ADVOCATE	18.13
Government as Counselor	18.13
The Federal Long Term Care Insurance Program	18.15
Partnership Programs For Long-Term Care	18.15
CHAPTER REVIEW	18.21

As stated in chapter 1, the evolution of long-term care insurance products has been dramatic with respect to the magnitude of the changes and the speed with which these changes have occurred. The development of this relatively new form of health insurance protection accelerated in large part due to the effect of the NAIC model legislation and HIPAA on the provisions of today's long-term care policies. This chapter examines the features and significance of these two forms of government regulation. When it comes to long-term insurance, however, government is more than just a regulator; it is an advocate. The chapter also reviews how government as a counselor, sponsor, and partner encourages the development of private-sector coverage of long-term care expenses.

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## **NAIC MODEL LEGISLATION**

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Because of its widespread adoption by the states, it is appropriate to discuss the NAIC model legislation regarding long-term care. The legislation consists of a model act that is designed to be incorporated into a state's insurance law and a model regulation that is designed to be adopted for use in implementing the law. This discussion is based on the latest version of the model legislation, which, as mentioned earlier, seems to be amended almost annually. Even though most states have adopted the NAIC legislation, some states may not have adopted the latest version. However, the importance of the model legislation should not be overlooked. Because most insurers write coverage in more than one state, it is likely that the latest provisions have been adopted by one or more states where an insurer's coverage is sold. Also, because most insurance companies sell essentially the same long-term care product everywhere they do business, the NAIC guidelines are often, in effect, being adhered to in states that have not adopted the legislation.

Before proceeding with a summary of the major provisions of the NAIC model legislation, it is important to make two points. First, although the model legislation establishes guidelines, insurance companies still have significant latitude in many aspects of product design. Second, many older policies that were written prior to the adoption of the model legislation or under one of its earlier versions are still in existence.

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The model legislation states that *long-term care insurance* is any insurance policy or rider that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person in a

setting other than an acute care unit of a hospital for one or more of the following: necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. This definition is broad enough to include policies or riders that provide coverage for long-term care in a single setting, such as the home, or a variety of alternative settings that range from the home to a skilled-nursing facility. The 12-month period has been the source of considerable controversy because, in effect, it allows policies to provide benefits for periods as short as 1 year. Many critics of long-term care insurance argue that coverage should not be allowed unless benefits are provided for at least 2 or 3 years. Statistics would seem to support their views. Approximately 55 percent of all persons currently in nursing homes have been there in excess of one year. This figure drops to about 30 percent for stays of 3 years or longer. On the average, the length of stay for persons currently in nursing homes has been about 2.5 years.<sup>1</sup> However, about 14 percent of stays exceed 5 years, and stays for such conditions as severe arthritis and Alzheimer's disease sometimes exceed 10 years.

The model act specifically states that the term "long-term care insurance" also includes group and individual annuities and life insurance policies or riders that directly provide or that supplement long-term care insurance. Long-term care insurance *does not* include an insurance policy that is offered primarily to provide any of the following:

- Medicare supplement coverage
- basic hospital expense coverage
- basic medical-surgical expense coverage
- hospital confinement indemnity coverage
- major medical expense coverage
- disability income or related asset-protection coverage
- accident-only coverage
- specified disease or specified accident coverage
- limited benefit coverage

In addition, long-term care insurance *does not* include life insurance policies (1) that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, a medical condition that requires extraordinary medical intervention, or permanent institutional confinement *and* (2) that provide the option of a lump-sum payment for the previous benefits if neither the benefits nor the eligibility for benefits is conditional upon the receipt of long-term care.

The act specifies, however, that any product advertised, marketed, or offered as long-term care insurance is subject to the act's provisions even if it is included in the previous list of policies or riders otherwise excluded from the definition of long-term care insurance.

The model legislation focuses on two major areas—policy provisions and marketing.

### **Policy Provisions**

Many of the criteria for policy provisions pertain to definitions, renewal provisions, limitations and exclusions, prior levels of care, incontestability, inflation protection, and nonforfeiture benefits.

#### ***Definitions***

Many words or terms cannot be used in a long-term care insurance policy unless they are specifically defined in the policy and are in conformity with the model legislation. Examples include activities of daily living (ADLs), adult day care, cognitive impairment, home health care services, mental or nervous disorder, personal care, and skilled-nursing care. These terms as defined are consistent with their use in other sections of this book.

#### ***Renewal Provisions***

No policy can contain renewal provisions other than guaranteed renewable or noncancelable. With either type of provision, the insurance company cannot make any unilateral changes in any coverage provision or refuse to renew the coverage.

Under a guaranteed renewable provision, coverage is also continued by the timely payment of set premiums, but the insurance company is allowed to revise premiums on a class basis.

Under a noncancelable provision (very rarely used with long-term care insurance), premiums are established in advance and the insured has the right to continue the coverage in force by the timely payment of premiums. The term *level premium* can be used only with a noncancelable policy.

#### ***Exclusions and Limitations***

Exclusions and limitations by type of illness, treatment, medical condition, or accident are prohibited, except in the following cases:

- preexisting conditions. The definition of preexisting conditions, however, can be no more restrictive than to exclude a condition for which treatment was recommended or received within 6 months prior to the effective date of coverage. In addition, coverage can be excluded for a confinement for this condition only if it begins within 6 months of the effective date of coverage.

- mental or nervous disorders (but this does not permit the exclusion of Alzheimer's disease)
- alcoholism and drug addiction
- illness, treatment, or medical condition arising out of war, participation in a felony, service in the armed forces, suicide, and aviation if a person is a non-fare-paying passenger
- treatment provided in a government facility, unless required by law
- services for which benefits are available under Medicare or other governmental programs, with the exception of Medicaid
- services for which benefits are available under any workers' compensation, employer's liability, or occupational disease law
- services available under any motor vehicle law
- services provided by a member of the covered person's immediate family
- services for which no charge is normally made in the absence of insurance
- expenses for services or items available or paid under another long-term care insurance or health policy

In addition, the model legislation permits exclusions and limitations for services provided outside the United States and for legitimate variations in benefit levels to reflect differences in provider rates.

#### ***Prior Levels of Care***

No policy can provide coverage for skilled-nursing care only or provide significantly more coverage for skilled care in a facility than for lower levels of care, such as custodial care.

Eligibility for benefits cannot be based on a prior hospitalization requirement, and eligibility for benefits provided in an institutional care setting cannot be based on the prior receipt of a higher level of institutional care.

A policy that conditions eligibility for noninstitutional benefits on a prior receipt of institutional care cannot require a prior institutional stay of more than 30 days.

#### ***Incontestability***

A policy must contain a provision that makes the policy incontestable after 2 years on the grounds of misrepresentation alone. The policy, however, can still be contested after 2 years on the basis that the applicant knowingly and intentionally misrepresented relevant facts pertaining to the insured's health.

If the policy has been in force for less than 6 months, an insurer can rescind the policy or deny an otherwise valid claim upon a showing of a

misrepresentation that was material to the insurer's acceptance of coverage. If the policy has been in force for at least 6 months but less than 2 years, the insurer can rescind the policy or deny an otherwise valid claim upon showing that the misrepresentation was both material to the insurer's acceptance of coverage and pertains to the condition for which benefits are sought.

The insurer cannot recover any benefits paid under a policy prior to the time the policy is rescinded.

### ***Inflation Protection***

Insurance companies must offer the applicant the right to purchase coverage that allows for an increase in the amount of benefits based on reasonable anticipated increases in the cost of services covered by the policy. The applicant must specifically reject this inflation protection if he or she does not want it. This provision does not apply to life insurance policies that provide accelerated benefits for long-term care. Chapter 19 discusses in detail the various types of inflation protection that long-term care policies may provide.

### ***Nonforfeiture Benefits***

Insurance companies must offer the applicant the right to purchase a nonforfeiture benefit. If the applicant declines the nonforfeiture benefit, the insurer must provide a contingent nonforfeiture benefit that is available for a specified period of time following a substantial increase in premium rates. This provision, like the inflation-protection requirement, does not apply to life insurance policies that provide accelerated benefits for long-term care. Chapter 19 also explains the types of nonforfeiture provisions that long-term care policies may contain.

## **Marketing**

Some of the provisions of the model legislation that pertain to marketing include outline of coverage, shopper's guide, 30-day free look, standards for appropriateness of coverage, limitations on post-claims underwriting, third-party notification of pending policy lapse, and policy replacement.

### ***Outline of Coverage***

An outline of coverage must be delivered to a prospective applicant at the time of the initial solicitation. Among the information it must contain is

- a description of the principal benefits and coverage provided in the policy
- a statement of the policy's principal exclusions, reductions, and limitations

- a statement of the terms under which the policy may be continued in force or discontinued
- a statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy contains governing contractual provisions
- a description of the terms under which the policy or certificate may be returned and premium refunded
- a brief description of the relationship of the cost of care and benefits
- a statement whether the policy is intended to be federally tax qualified

### ***Shopper's Guide***

A shopper's guide must be delivered to all prospective applicants. The guide must either be in the format developed by the NAIC or one developed by the state insurance commissioner. In the case of agent solicitations, the guide must be presented prior to the presentation of an application or enrollment form. Shopper's guides are discussed in more detail in chapter 20. A few states also require that information on Medicare supplement policies be provided to applicants aged 65 or older.

### ***30-Day Free Look***

The policy must allow applicants to have a 30-day free look after the policy's delivery. During that time, an applicant may have the premium refunded if, after examining the policy, he or she is not satisfied for any reason. The policy is then void from its inception. A notice of this provision must be prominently displayed on or attached to the policy's first page.

### ***Standards for Appropriateness of Coverage***

Any entity that markets long-term care insurance, other than life insurance policies that accelerate benefits for long-term care, must develop and use suitability standards to determine whether the purchase or replacement of coverage is appropriate for the applicant's needs, and agents must be trained in the use of these standards. Chapter 20 discusses appropriateness of coverage and suitability in detail.

### ***Limitations on Post-Claims Underwriting***

An issue that has been of concern to regulators, consumers, and insurance professionals is *post-claims underwriting*. This practice occurs when an insurer does little underwriting at the time of the initial application for coverage. Then, after a claim is filed, the insurer obtains medical information that could have

post-claims  
underwriting

been obtained earlier and may rescind the policy or deny the claim based on this new information.

To control post-claims underwriting, applications for insurance must be clear and unambiguous so that an applicant's health condition can be properly ascertained. Except for policies that are guaranteed issue, the application must also contain a conspicuous statement near the place for the applicant's signature that states the following: "If your answers to this application are incorrect or untrue, the company has the right to deny benefits or rescind your policy."

If an application contains a question about whether an applicant has had medication prescribed by a physician, the application must also ask the applicant to list the medications that have been prescribed. If the policy is issued and the insurer knew or should have known at the time of application that the medications listed in the application were related to a condition for which coverage would normally be denied, it cannot rescind the policy for that condition.

The insurer is also required to obtain additional information on applicants aged 80 or older. This includes at least one of the following: a report of a physical examination, an assessment of functional capacity, an attending physician's statement, or copies of medical records.

Finally, a copy of the completed application must be delivered to the insured no later than the time of the delivery of the policy unless it was retained by the insured at time of application.

### ***Third-Party Notification of Pending Policy Lapse***

No policy can be issued until the applicant has been given the option of electing a third party to be notified of any pending policy lapse because of nonpayment of premium. The purpose of this provision is to eliminate the problem of policy lapse because a senile or otherwise mentally impaired person or a person with a loss of functional capacity fails to pay the premium.

### ***Policy Replacement***

If one long-term care insurance policy replaces another, the new insurer must waive any time periods pertaining to preexisting conditions and probationary periods for comparable benefits to the extent that the original policy had such provisions.

The model regulation also requires applications to contain questions as to whether the applicant has other long-term care insurance in force and whether a long-term care insurance policy is intended to replace any other medical expense policy or long-term care insurance policy in force. These questions include the following:

- Do you have another long-term care insurance policy?
- Did you have another long-term care insurance policy in force during the last 12 months? If so, with which insurer? If that policy lapsed, when did the lapse take place?
- Do you intend to replace any medical or other health insurance coverage with this policy?
- Are you covered by Medicaid?

Agents must also list any other health insurance policies they have sold to the applicant that are still in force as well as any policies sold to the applicant in the past 5 years that are not in force.

If it is determined that a sale will involve a policy replacement, an insurer or its agent must furnish an applicant with a notice regarding the replacement of long-term care coverage and its potential disadvantages. The applicant retains a copy of the notice; the insurer retains another copy, signed by the applicant. In addition, the insurer replacing coverage must notify the existing insurer of the proposed replacement within 5 days of the earlier of the date of application or the date the policy is issued.

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## **EFFECT OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

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The enactment of HIPAA in 1996 made the tax treatment of long-term care insurance more favorable. Chapter 6 discussed specifically the income tax-treatment of long-term care policies. Because favorable tax treatment is given only if long-term care insurance policies meet prescribed standards, the nature of most long-term care insurance coverage has changed. In many cases, the imposition of federal standards resulted in broader coverage for consumers. However, Congress seemed to have been concerned with the revenue loss associated with this tax legislation. As a result, policies that were modified to comply with the federal standards sometimes actually provide more limited access to benefits than had been previously required in several states. Moreover, the amount of long-term care insurance premiums that can be deducted for income tax purposes is subject to limitations.

It should be emphasized that the long-term care changes in the act are primarily changes in the federal income tax code. States still have the authority to regulate long-term care insurance contracts. They have no obligation to bring state rules and regulations into conformity with these tax changes. However, all states allow tax-qualified contracts so that consumers can obtain the favorable federal tax benefits.

## Requirements for Favorable Tax Treatment

To understand whether a long-term care insurance policy will receive favorable tax treatment under HIPAA, it is necessary to understand the meaning of several terms. These include qualified long-term care insurance contract, qualified long-term care services, and chronically ill individual.

### *Qualified Long-Term Care Insurance Contract*

#### qualified long-term care insurance contract

The act provides favorable tax treatment to a *qualified long-term care insurance contract*. This is defined as any insurance contract that meets all the following requirements:

- The only insurance protection provided under the contract is for qualified long-term care services. The act does allow a contract to satisfy this requirement, however, if payments are made on a per diem or other periodic basis (such as \$150 per day) without regard to the expenses incurred during the period to which the payments relate.
- The contract cannot pay for expenses that are reimbursable under Medicare or would be reimbursable except for the application of a deductible or coinsurance amount. However, this requirement does not apply to expenses that are reimbursable if (1) Medicare is a secondary payer of benefits, or (2) benefits are paid on a per diem or other periodic basis without regard to the expenses incurred during the period to which the benefits relate.
- The contract must be guaranteed renewable.
- The contract does not provide for a cash surrender value or other money that can be (1) borrowed or (2) paid, assigned, or pledged as collateral for a loan.
- All refunds of premiums and all policyowner dividends must be applied as future reductions in premiums or to increase future benefits. A refund in the event of the insured's death or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.
- The policy must comply with various consumer protection provisions. For the most part, these are the same provisions in NAIC model legislation and already adopted by most states.

Under the act's provisions, a qualified long-term care insurance contract also includes the portion of a life insurance contract that provides long-term care insurance coverage by a rider or as part of the contract as long as the above criteria are satisfied.

Furthermore, the act allows any contract issued before January 1, 1997, that met the long-term care requirements in the state where the policy was

issued to be considered a qualified long-term care insurance contract even though the contract does not meet the above requirements. If such a “grandfathered policy” undergoes a material change, however, the policy must then conform to the HIPAA requirements to retain this status. An example of a material change is the addition of a new covered service for which an increased premium is charged.

Although the term “qualified long-term care insurance contract” is used in HIPAA and the Internal Revenue Code, different terminology is often used for the sake of brevity. Thus, it is common to see these contracts referred to just as qualified contracts (or policies), TQ contracts (or policies), or tax-qualified contracts (or policies). The latter terminology is used in this book. Similarly, contracts (or policies) that are not tax qualified are referred to as non-tax-qualified or NTQ.

To further complicate the issue of terminology, the terminology for qualified contract is sometimes preceded by the word *federally* to clarify that HIPAA provides favorable tax treatment with respect to federal tax laws, not state tax laws. It is left to the reader to determine the tax treatment of long-term care insurance in his or her own state. It should be noted, however, that most states do not tax long-term care insurance benefits, and about half the states that levy income taxes provide some type of tax deduction or tax credit for the purchase of long-term care insurance.

### ***Qualified Long-Term Care Services***

**qualified long-term  
care services**

The act defines *qualified long-term care services* as necessary diagnostic, preventive, therapeutic, curing, treating, and rehabilitative services, as well as maintenance or personal care services required by a chronically ill individual and provided by a plan of care prescribed by a licensed health care practitioner.

### ***Chronically Ill Individual***

**chronically ill  
individual**

A *chronically ill individual* is one who has been certified by a licensed health care practitioner as meeting one of the following requirements:

- The person is expected to be unable to perform, without substantial assistance from another person, at least two activities of daily living (ADLs) for a period of at least 90 days due to a loss of functional capacity. The act allows six ADLs: eating, bathing, dressing, using the toilet, maintaining continence, and transferring into or out of a bed, chair, or wheelchair. A tax-qualified long-term care insurance policy must contain at least five of the six. (The Secretary of the Treasury in consultation with the Secretary of Health and Human Services is permitted to prescribe regulations so that a person who has a level of disability similar to the level of disability of a person who cannot

perform two ADLs would also be considered chronically ill. However, no action has ever been taken in this regard.)

- Substantial supervision is required to protect the individual from threats to health and safety because of severe cognitive impairment.

For purposes of certifying an individual as chronically ill, a licensed health care practitioner is a physician, registered nurse, licensed social worker, or other person who meets any requirements prescribed by the Secretary of the Treasury. Recertification of an individual as chronically ill must occur at least every 12 months.

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## GOVERNMENT AS ADVOCATE

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Government typically assumes the role of an insurance regulator; a role that we have seen also extends to long-term care insurance. More recently, however, government has taken on a role that arguably can be described as an advocate of long-term care insurance. That role is evident as counselor, sponsor of the Federal Long-Term Care Insurance Program, and partner through Medicaid programs.

### Government as Counselor

The emerging role of government as counselor with regard to long-term care insurance is evident in the State Health Insurance Assistance Program and in the Long-Term Care Consumer Awareness Campaign.

#### *State Health Insurance Assistance Program*

#### **State Health Insurance Assistance Program (SHIP)**

Each state has a *State Health Insurance Assistance Program (SHIP)* that receives money from the federal government to give free local health insurance counseling to people with Medicare. Generally, SHIP counselors assist Medicare beneficiaries with their questions about benefits, claim denials and appeals, complaints about care or treatment, and selecting an appropriate Medicare plan. Significantly, among its other specific responsibilities, SHIPs offer guidance about the purchase of long-term care insurance. Medicare's Web site at [www.medicare.gov](http://www.medicare.gov) identifies and provides contact information for each state's SHIP by following the home page search tools under helpful phone numbers and Web sites. The home page also provides links to information on long-term care services and options to pay for them, including long-term care insurance.

**Long-Term Care  
Consumer Awareness  
Campaign*****Long-Term Care Consumer Awareness Campaign***

The *Long-Term Care Consumer Awareness Campaign* is a multistage project started in January 2005 as a cooperative effort between several participating states and agencies of the federal government to increase awareness among the public of the need to plan for long-term care.

The ultimate goal of the campaign, called “own your future,” is to measure the effect that increased awareness of long-term care needs among retirees and near-retirees will have on their increased planning and use of private-sector options, including long-term care insurance, to pay for long-term care. The campaign’s fundamental premise is that the burden of public financing of long-term care services under Medicaid will decline with the increased use of private-sector payment options.

The project’s immediate activities are state based direct mail campaigns supported by each participating state’s governor, and targeted to households with members between the ages of 45 to 70. Campaign materials include a Long-Term Care Planning Kit and state specific information and resources.

The results from a 2006 study of the responses generated by five initially participating states are encouraging.<sup>2</sup> On average, nearly 8 percent of the targeted population in these states requested the planning kit. While interest in planning is evident across all the socio-demographic groups within the target population, the typical responder across the five states is as follows:

- age 58 and married
- a household income of \$60,000–\$75,000
- a homeowner with a median home value of \$130,000
- some college education

Significantly, these respondents are individuals of more moderate income and assets who are potentially vulnerable to spend down to Medicaid if they do not learn about and adopt such planning options.

Another key finding from this study asserts that public sector sponsorship is critical to achieving good response rates on any campaign that promotes private responsibility for long-term care planning; it ensures consumer confidence in the objectivity of the information provided. Moreover, the study authors concluded that the campaign helped to renew collaboration between the public and private sectors with the unified objective of raising awareness and education on long-term care planning issues.

Fifteen states are currently participating in the campaign, which is now coordinated through the National Clearing House on Long-Term Care

Information. Further information on the campaign and a copy of the Long-Term Care Planning Kit is available at [www.longtermcare.gov](http://www.longtermcare.gov).

### **The Federal Long Term Care Insurance Program**

A major development in long-term care insurance was the group plan that the federal government established for its employees in 2001. Although the federal government is by far the largest employer to offer long-term care insurance, it is not the only government employer to do so; more than 30 states currently offer or are in the process of offering long-term care insurance to their employees and/or retirees.<sup>3</sup> Complete information on The Federal Long Term Care Insurance Program (FLTCIP), including eligibility, covered services, and benefits as well as a premium calculator, is available at [www.opm.gov/insure/ltc](http://www.opm.gov/insure/ltc).

Many in the insurance industry viewed the creation of the FLTCIP as a positive development that could serve to promote long-term care insurance.

First, the passage of the Long-Term Care Security Act addresses many long-standing sources of consumer reluctance to purchase long-term care insurance. In effect, the federal government is telling the members of its own federal family that the likelihood of needing long-term care is real, and they should consider a program to pay for it because current government and private medical insurance programs are insufficient. Enactment of the new law also implies that a government-sponsored and paid-for social insurance program to provide long-term care for all Americans is unlikely in the foreseeable future.

Second, the federal government, as the nation's largest employer, becomes a model for other employers and encourages them to establish employer-sponsored long-term care insurance programs. The significant education program during the open-enrollment period (referred to as the open season), with thousands of educational meetings, satellite broadcasts, and videos, also serves to raise the awareness of employees outside the federal program of their need for long-term care coverage and the possibility that their employers could offer it.

Finally, the action further validates the professional standing of insurance companies and their agents in their work to provide long-term care insurance to their clients.

### **Partnership Programs For Long-Term Care**

The partnership programs for long-term care are alliances between certain state governments and insurance companies to encourage the sale of approved long-term care policies. The goals of these programs are to protect people from being impoverished by long-term care expenses and to avoid their immediate

dependence on Medicaid. These programs also provide further evidence of government's advocacy of long-term care insurance. Indeed, the states that currently have partnership programs make a concerted effort to inform and counsel their residents about the value of purchasing long-term care insurance.

Partnership programs are summarized with respect to their impetus, program development, state requirements, program types, and limitations. The removal of a federal legislative impediment to widespread expansion beyond the original partnership states is also discussed.

### ***Impetus***

Many middle-class people in nursing homes qualify for Medicaid by spending virtually all of their assets on long-term care or by transferring the assets to put themselves in a state of poverty. The result has been a staggering financial burden on Medicaid that endangers its mission to care for the poor in many states. The cycle of spending down to Medicaid dependence can be broken if more middle-class Americans—especially those of more modest means who are likely to spend down to qualify for Medicaid—could be broadly encouraged to purchase long-term care insurance.

The potential savings to the Medicaid program are obvious. If the policy's benefits prove sufficient to meet the cost of care, a person with long-term care insurance may not have to rely on Medicaid at all. Moreover, a comprehensive policy provides resources to care for someone at a much lower cost at home. If the person was on Medicaid, higher nursing home costs might be incurred.

In return for the potential cost savings generated by reducing Medicaid dependence, states are willing to offer an incentive for the purchase of long-term care insurance. Policymakers agreed that an effective incentive from the state is to allow people who purchase long-term care insurance to qualify for Medicaid while maintaining a higher-than-usual personal asset level. As a result, purchasers of long-term care insurance with significant assets could still qualify for Medicaid without having to spend down all their assets to meet the state's otherwise required level.

### ***Program Development***

In 1987, the Robert Wood Johnson Foundation funded a study by the state of Connecticut. The study concluded that collaboration between insurers and the state could help reduce the burden on the Medicaid program through the use of private long-term care insurance. The foundation subsequently awarded program development grants to four states: California, Connecticut, Indiana, and New York. The resulting and continuing programs in these four states, known as the partnership programs,<sup>4</sup> became operational in the early 1990s. The Department of Health and Human Services granted the required approval or waivers that permitted these states to change the Medicaid asset spend-down

requirements. Purchasers of long-term care insurance policies under these programs could then maintain some or all of their assets and still qualify for Medicaid without having to spend down their assets to levels typically required for Medicaid eligibility.

### ***State Requirements***

Insurers participating in the partnership programs are required to meet the state's requirements for qualified policies and reporting.

***Requirements for Qualified Policies.*** Insurance companies that participate in partnership programs must develop special products to qualify for approval in each state. The plans, which may be individual or employer sponsored, must meet HIPAA standards for tax-qualified policies. The state's approval further boosts consumer confidence in purchasing the plan. Policy requirements of most partnership programs, which were considered innovative a decade ago when they were first introduced, include the following:

- availability of both facility-only and comprehensive policies
- minimum and maximum benefit amounts and durations
- inflation protection
- single lifetime elimination period
- a care coordinator or consultant, often from a state-approved or state-required agency, to assist in planning for care and obtaining appropriate services
- protection against policy lapse due to nonpayment of premium through waiver of premium and notification of a specially identified third party in the event of the insured's failure to pay the premium
- state role in the claims process to ensure prompt payment and review of denials
- agent training in partnership policies

Some states require insurers to offer upgraded partnership products when new products are issued in the nonpartnership market. At least one state (California) requires any new policy enhancements also to be offered to current partnership policyowners.

An important objective of partnership programs is to encourage individuals of modest means to purchase coverage. To keep the cost of partnership policies affordable, the state programs may allow shorter benefit durations than otherwise allowed by state regulations. For example, California and Indiana allow the sales of policies with benefit durations of 1 year, and Connecticut allows sales of policies with a 2-year benefit

duration. Purchase of policies with shorter duration periods has ranged from 30 percent to more than 50 percent of partnership policies sold in some years.

**Reporting Requirements.** Partnership states require insurers to report activity on program-approved policies regularly. The reporting requirements encompass the following:

- new insureds, both individual and employer sponsored
- insureds who have changed or dropped coverage
- claimants, including those assessed for benefit eligibility and those meeting elimination periods
- applicants denied coverage

The partnership states have developed a single uniform data set and streamlined their requirements to ease reporting by insurers that participate in more than one state. In addition, the states themselves can more easily track partnership program progress.

### ***Program Types***

Two basic partnership models were developed—the total-assets model and the dollar-for-dollar model.<sup>5</sup> Both models have minimum requirements on the amount of coverage that a consumer is required to purchase. As with all Medicaid recipients, insureds who become eligible for Medicaid must contribute their income toward the cost of care.

**Total-Assets Model.** The total-assets model initially adopted by New York requires that participants select a minimum daily benefit amount for 3 years of nursing home care and 6 years of home health care, or a combination of the two. When total minimum benefits are exhausted (even if policy benefits are greater), the insured's income, which must be dedicated to paying for care, determines Medicaid eligibility, regardless of assets. However, New York's minimum coverage requirements, which are high compared to other partnership states, tend to discourage enrollment of middle- and lower-income persons. As a result, the state has added several versions of the dollar-for-dollar model as new consumer options.

**Dollar-for-Dollar Model.** The dollar-for-dollar model also allows consumers to protect their assets through the purchase of a partnership policy that has a state-approved level of coverage and benefits. When policy benefits are utilized, an amount of assets equal to the benefits that were paid for long-term care services is disregarded in determining financial eligibility for Medicaid. In general, the minimum policy must cover at least 1 year in a

nursing home at a minimum daily benefit amount. Three states—California, Connecticut, and Indiana—initially adopted this model.

Indiana later changed to a hybrid arrangement that allows a total-assets model for coverage amounts above an annually increasing threshold level (\$228,045 for 2008) with a dollar-for-dollar model for coverage levels below the threshold amount. Policies purchased prior to March 1998 are grandfathered into total asset protection if their original maximum policy amount was at least \$140,000.

### ***Limitations***

A person with a partnership policy has all the advantages of long-term care insurance discussed throughout this book. The limitations of the program occur if those with approved policies qualify for Medicaid under the partnership program. Although assets are protected as enrollees turn to Medicaid to pay for their care, they must keep in mind the Medicaid shortcomings discussed in chapter 17.

In addition, as mentioned previously, although assets are protected, income is not. Program beneficiaries must therefore spend essentially all their income, allowing certain limited amounts for the support of a spouse who continues to live at home. This standard Medicaid requirement effectively eliminates participation in partnership plans by high-income persons.

Although insureds under this program may receive their insurance benefits in any state, their assets are protected only in the state where they purchased their partnership-program-eligible policy. This is currently a major drawback as many people relocate at or during retirement for leisure living or to be near family. However, with the approval of the Department of Health and Human Services, Connecticut and Indiana have established reciprocity of program benefits between them, whereby residents with partnership policies in one state who relocate to the other are eligible for asset protection in the determination of Medicaid eligibility. If many states implement partnership programs, reciprocity among them would be a significant advantage, creating a further incentive to purchase coverage under the program.

### ***Program Experience***

More than 15 insurance companies participate in partnership programs in one or more of the original four partnership states.<sup>6</sup> Since the inception of the programs through 2005, a study reported that combined sales of partnership-approved policies in these states exceeded 211,000. Although the number of policies increased significantly since the programs began, a decline in sales in recent years is regarded as reflecting general market trends.

Approximately 172,000 policies were in force at the end of the study

period. At that time, 1,209 active policyowners were currently receiving long-term care insurance benefits, with over 899 having died while receiving benefits. An additional 251 insureds had exhausted their benefits, with only 119 of this number accessing Medicaid. State officials believe that the remaining 132 persons are not accessing Medicaid because they are spending down income or unprotected assets, their health has improved, or their families are providing informal care.

In some ways, the available data may be encouraging regarding success of partnership programs to reduce Medicaid spending. For example, the number of persons with partnership policies who died while accessing their benefits is more than three times the number of those who exhausted their benefits. Available data, however, remain insufficient to confirm the effectiveness of partnership programs in relieving the long-term care cost burden on Medicaid. Current studies do not answer such key questions as whether the policies are purchased by people who otherwise would not buy insurance, whether the partnership policies are a substitute for other long-term care insurance policies, or if participants would have used Medicaid regardless of their long-term care insurance. The answers to these questions require continued evaluation.

Moreover, to be successful, partnership programs must encourage enrollment of persons at middle and lower-middle income levels because they are generally less likely to purchase long-term care insurance and more likely to become Medicaid eligible by spending down their assets. Thus far, available data from the partnership states indicate that the program encourages many upper-middle income persons to obtain long-term care insurance—but they are already the most common buyers of this type of insurance.

### ***Removal of a Federal Legislative Impediment***

The Deficit Reduction Act of 2005 (DRA) removed a long-standing impediment to the expansion of partnership programs beyond those implemented in the initial four states.

The Omnibus Budget Reconciliation Act of 1993 (OBRA) effectively eliminated an important feature of state partnership programs approved by the Department of Health and Human Services after May 14, 1993. Any partnership program approved after that date was no longer able to exempt amounts from Medicaid's estate recovery requirements for individuals who applied to Medicaid after exhausting their private long-term care insurance benefits. Even though a new partnership program could continue to allow a participant to retain greater asset amounts upon application for Medicaid, the state was required to recover Medicaid's long-term care expenditures from the participant's estate, including the previously protected assets. Thus, the asset-

protection component of any new partnership program would be in effect only while the participant was alive. This requirement effectively removed the asset-protection incentive essential to consumer interest in any long-term care insurance policy that a new state partnership program might offer.<sup>7</sup>

DRA restored the ability of states to obtain a Medicaid plan amendment that allows exemption from the estate recovery requirement for qualified partnership programs. However, these partnership programs may exempt only the amounts of the insurance benefits made to or on behalf of an individual under a long-term care policy that meets the requirements specified in the law. These standards are consistent with the practices of the four active programs and conform to NAIC and HIPAA provisions.

As a result, new state programs may qualify for partnership program status. However, while the act grandfathers programs approved prior to OBRA, new qualified partnership programs must use only the previously described dollar-for-dollar model (not the total-assets model) to determine the amount of assets exempt from estate recovery.

DRA also promotes the expansion of state partnership programs through new initiatives:

- a national clearinghouse of information to educate consumers on long-term care
- standards for uniform reciprocal recognition of long-term care policies offered through states with qualified partnership programs
- an annual report to Congress by the Secretary of Health and Human Services on qualified partnership programs

Anticipating a change in the federal law, over 20 states have already enacted legislation or approved regulations that allow the establishment of new partnership programs. However, at the time this book is being written, no new programs are in operation.

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## CHAPTER REVIEW

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### Key Terms

post-claims underwriting  
 qualified long-term care insurance  
 contract  
 qualified long-term care services  
 chronically ill individual

State Health Insurance Assistance  
 Program (SHIP)  
 Long-Term Care Consumer  
 Awareness Campaign

**Review Questions**

*Review questions are based on the learning objectives in this chapter. Thus, a [18-3] at the end of a question means that the question is based on learning objective 18-3. If there are multiple objectives, they are all listed.*

1. How does the NAIC model legislation affect long-term care insurance policies? [18-1]
2. What types of limitations and exclusions does the NAIC model legislation allow in long-term care insurance policies? [18-1]
3. How does the NAIC model legislation affect an applicant with respect to inflation protection and nonforfeiture benefits? [18-1]
4. What types of information are contained in the outline of coverage that must be given to an applicant for long-term care insurance? [18-2]
5. What provisions are contained in the NAIC model legislation with respect to each of the following?
  - a. shopper's guide [18-2]
  - b. free-look period [18-2]
  - c. standards for appropriateness of coverage [18-2]
6. How does the NAIC model legislation control post-claims underwriting? [18-2]
7. What is the purpose of a third-party notification of pending policy lapse? [18-2]
8. What regulations apply to the replacement of long-term care insurance policies? [18-2]
9. What is the general nature of the HIPAA provisions that apply to long-term care insurance? [18-3]
10.
  - a. How does HIPAA affect long-term care policies issued before January 1, 1997? [18-3]
  - b. What effect does HIPAA have on state tax laws for long-term care insurance? [18-3]
11.
  - a. What are the six activities of daily living (ADLs) that may be contained in a federally tax-qualified long-term care insurance policy? [18-3]
  - b. How many of these ADLs must be contained in such a policy? [18-3]
12. What two programs suggest that the federal and state governments are working cooperatively as counselors to the public on the need for protection against the expenses of long-term care? [18-4]

13. What are the implications of FLTCIP for the growth of long-term care insurance? [18-5]
14.
  - a. What is the nature of partnership programs for long-term care? [18-6]
  - b. What is the impetus for such programs? [18-6]
15. What is the nature of long-term care insurance policies sold under partnership programs? [18-6]
16. Describe each of the following types of partnership programs for long-term care:
  - a. total-assets model [18-6]
  - b. dollar-for-dollar model [18-6]

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## NOTES

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1. *The National Nursing Home Survey, 1999 Summary*, Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS), June 2002.
2. *Pilot Long-Term Care Awareness Campaign: Phase I Final Report, Executive Summary*, U.S. Department of Health and Human Services, February 24, 2006, pages 2–4.
3. The Minnesota Department of Employee Relations conducted a *Survey of States that Offer Long-Term Care Insurance to Employees and/or Retirees*. The survey, updated in August 2003, identified 31 states that offer such long-term care insurance programs. The California program, self-insured through a trust established by the California Public Employees Retirement System (CalPERS), is by far the largest of these programs with over 170,000 enrollees. With the exception of the program in Alaska, which like that in California is self funded, all other state programs are insured.
4. Detailed information on the specific partnership programs is available from each state's Web site as follows: California ([www.dhs.ca.gov/cpltc](http://www.dhs.ca.gov/cpltc)), Connecticut ([www.CTpartnership.org](http://www.CTpartnership.org)), Indiana ([www.IN.gov/fssa/iltcp](http://www.IN.gov/fssa/iltcp)), and New York ([www.nyspltc.org](http://www.nyspltc.org)).
5. Program descriptions are taken from the Center for Health Policy, Research, and Ethics, George Mason University, from its Web site at [www.gmu.edu/department/chpre/index.html](http://www.gmu.edu/department/chpre/index.html).
6. The discussion on program experience is based on *Overview of Long-Term Care Partnership Program*, a letter to Committee on Finance, United States Senate, from John E. Dicken, Director, Health Care, United States Government Accountability Office, September 9, 2005 and *The Long-Term Care Partnership Program: Issues and Options*, George Washington University School of Public Health and Health Services, December 2004.
7. At the time of OBRA's enactment, states other the original four states with active programs had shown interest in partnership programs.

Because its plan amendment was approved before the OBRA legislative deadline, the Iowa partnership program can offer asset protection with an exemption from estate recovery under Medicaid. Massachusetts is also not subject to the estate recovery conditions of the legislation, but its partnership program provides no up-front protection of assets upon application for Medicaid. Illinois and Washington also undertook partnership program initiatives, but both programs are subject to the estate recovery requirement. All these programs experienced little or no insurer interest.

With DRA's enactment, the above-mentioned states as well as other states enacting new enabling legislation may pursue active implementation and/or establishment of partnership programs for long-term care insurance.