

The New Long-Term Care Partnerships: Financial Protection for the Middle Class

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Abstract: Key elements in estate and financial planning include the preservation of assets for heirs, as well as the protection of assets from the escalating costs of long-term care. This article examines the role of the new long-term care Partnership policies in helping to achieve these goals. The article gives a brief history of Partnerships in our country and an overview of the new Partnerships that have recently been activated. It also includes a discussion of key elements affecting a financial professional's practice. A case study illustrates the importance of choosing proper design and structure elements in a Partnership policy, especially when working with middle-class clients.

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New State Long-Term Care Insurance Partnership Initiative Can Mean a Better Financial Future for Many Middle-Class Families

The average lifetime cost of long-term care for someone who has reached the age of 65 and needs care, in today's dollars, is \$155,000.¹ This includes the typical combination of paid care from nurses or home health aides, care in a nursing home or assisted-living facility, as well as the many hours of care provided by unpaid family members or friends. Approximately 20% of those who need long-term care can expect to need care for five years or more.²

Most people cannot afford to or simply do not have the time or discipline to save this amount of money. If they do decide to save on their own, it may be difficult to determine how much is enough. People wonder if they will be among the lucky 30% of all individuals reaching the age of 65 who will need no care.³ What they do not know is whether, if they do need care, they will require an average amount of care or if they will perhaps fall into the 20% who will need extensive care.⁴ The value of buying a Partnership-qualified (PQ) long-term care insurance policy to protect against this risk is that it eliminates the guesswork and avoids the need to take funds away from other healthy aging and retirement needs. The Savings Calculator⁵ at the federal government's National Clearinghouse for Long-Term Care Information Web site, www.longtermcare.gov, helps individuals determine how much they would need to save in order to cover the average long-term care risk. This exercise alone is often enough to convince someone of the need to find an alternative to self-funding for covering the rising costs of long-term care.

Long-term care insurance, while a relatively new insurance product, has evolved significantly and now offers many critical consumer protection features including greater assurance that rates are designed to remain stable over a person's lifetime. Since rates are based on the insured's age at application, it makes economic sense to purchase this coverage at younger ages.⁶ Also, younger individuals are usually healthier, making medical qualification easier. This insurance is more affordable than most people realize, and the New Partnership Initiative now makes it even more affordable and accessible to middle-income families who might have otherwise considered such coverage beyond their means.

The Deficit Reduction Act of 2005

Partnership programs began in 1988 with four states operating on a demonstration project basis with funding from the Robert Wood Johnson Foundation and permission from the federal Department of Health and Human Services to modify existing Medicaid asset eligibility rules for individuals who purchase a Partnership policy. The four original states, each with a slightly different approach to the concept, include California, Connecticut, Indiana, and New York. The Medicaid asset rules that were modified included both (1) the amount of assets one could retain and still qualify for Medicaid initially and (2) the exemption of those assets from estate recovery after the person's death. These four original state Partnership programs are still operational today and are no longer operating on a "demonstration project" basis.

Other states soon became interested in establishing programs of their own. But the federal Omnibus Budget Reconciliation Act of 1993 (OBRA 93) effectively halted the expansion of Partnership programs because it did not allow new Partnership states to provide all the same advantages provided in the four original states. Specifically, under OBRA 93 a state still had to recover from a person's estate any funds that its Medicaid program may have paid on that person's behalf. The original Partnership programs did not have this requirement. Without the ability to protect assets from estate recovery, participation in a Partnership program would certainly be much less attractive to consumers. Consequently, with the exception of Massachusetts (which established a Part-

nership-like program but without asset protection from estate recovery), no new state Partnership programs were established until very recently.

The Deficit Reduction Act (DRA) of 2005 lifted the estate recovery restriction, and as a result, many states already have or are establishing Partnership programs. The DRA was motivated largely by the generally positive experience of the original Partnership programs and the continuing and growing need to contain burgeoning Medicaid costs.

Through the DRA, the federal government and states have taken an important step to help Americans plan for their future. This new law allows each state to implement a long-term care insurance Partnership program. In doing so, the government is helping to make long-term care insurance more accessible and encouraging Americans to take personal responsibility for planning ahead for their potential long-term care needs.

What Is a Partnership Program?

A Partnership program is a collaboration or Partnership between a state government and the private insurance companies selling long-term care insurance in that state. A Partnership-qualified long-term care insurance policy (PQ policy) offers a special feature known as "Medicaid asset disregard," which allows the insured to retain additional assets if their care needs continue after they have used their private long-term care insurance coverage and need to rely on Medicaid for additional long-term care services.

With a PQ policy, if the insured applies for Medicaid, the program will let the insured retain assets in addition to those normally allowed under state Medicaid rules. This additional amount is equal to the amount of the benefits the insured receives under his or her PQ private long-term care insurance policy. This is over and above the asset amounts that the insured's state's Medicaid program normally allows him or her to keep. For a single person this is typically \$2,000.⁷ Moreover, these assets are exempt, after death, from Medicaid estate recovery and are preserved for the insured's heirs. (The amounts for married people when only one member of the couple needs care are greater, vary by state, and can range from \$20,880 to \$104,400 as of 2008.⁸)

Insureds are allowed to keep \$1 of additional assets for every \$1 they receive in benefits under their private PQ policy. For example, if an insured purchases and uses a PQ policy that pays \$100,000 in benefits, the insured could retain an additional \$100,000 of assets over and above the \$2,000 asset threshold Medicaid requires, if and when he or she applies and qualifies for Medicaid.

Keep in mind that the insured will still need to actually apply for Medicaid assistance and satisfy other Medicaid eligibility requirements pertaining to health status, income, home value, and possibly other criteria, so even with a PQ policy, eligibility for Medicaid is not automatic. Also, the services one receives under Medicaid may differ from the services covered under a PQ policy (e.g., many state Medicaid programs do not pay for assisted-living facilities and generally have specific guidelines and waiting lists for the receipt of in-home care) and may change over time.

A New Generation of Partnership Policies

The generally positive experience of the original Partnership programs and the rapidly growing need to hold down Medicaid expenditures has fostered a new expansion of Partnerships. The new Partnership program model is based on critical lessons learned from the four original state programs. The new programs have simplified administrative procedures, improved uniformity among states in terms of the requirements for product design and reporting, clarified the regulatory treatment of Partnership and non-Partnership (non-PQ) policies, and increased reciprocity among state programs.⁹

In states that provide reciprocity, the purchasers of PQ policies can be less concerned about moving to another state and potentially losing one of the main advantages of their policies—Medicaid asset disregard. Broad reciprocity makes Partnership policies more attractive to consumers, increasing the number of people who buy them. (States can elect not to provide reciprocity, but to date all new state Partnership programs are providing it.) The original four Partnership states may also opt in to the new Partnership reciprocity arrangement, though none have indicated whether they will do so or not at this time.

Each state determines if and when it wants to offer

a long-term care Partnership program. A PQ policy is a long-term care insurance policy that has been certified by a state as qualified for its Partnership program. Each state determines the requirements for its own Partnership program, following the broad DRA guidelines. States also specify the types of notices and disclosures they require insurers to send so that consumers know whether or not they have bought a PQ policy. The typical Partnership program has the following characteristics:

- For a policy to be PQ, it must meet specific requirements for inflation protection based on the insured's age at the time of purchase.
- All Partnership policies must also be federally tax-qualified (TQ) policies. Today, well over 95% of all policies sold are TQ.¹⁰
- Policies issued prior to a state's Partnership program effective date are not considered PQ. However, there are circumstances under which a client can exchange a previously purchased policy for one that is PQ. The rules and protocols for doing so will be defined by each state and/or by each insurer in which the state has left these decisions up to the discretion of the insurance carriers.¹¹

It is important to note that a state may not impose differing requirements on a PQ and non-PQ policy except with regard to inflation protection and disclosure and certification notices. Unlike the original four Partnership states, the new Partnership states cannot impose different or additional benefit mandates on a PQ policy.¹² For example, they do not require a separate application or policy forms for PQ and non-PQ policies nor mandate benefits specific only to Partnerships as do the original four states. These are important advantages both for consumer understanding and insurance company participation in the new Partnership program.

Partnership policies offer significant advantages to consumers. They may be of particular value to those who are unable to afford a large amount of long-term care insurance but who have assets they want to protect. Middle-income buyers can now obtain a smaller lifetime amount of coverage at less cost and still have the possibility of a Medicaid backstop that would allow them to preserve more assets than would otherwise be the case.

Individuals can tailor the lifetime maximum bene-

fit of the insurance policy to the amount of assets they want to protect. For example, if individuals want to protect \$150,000, they can buy a Partnership policy with a \$150,000 lifetime maximum. In this way, Partnership policies offer an incentive to those of more modest means to buy at least a small lifetime amount of long-term care insurance and enhance their ability to do so. Some states may be reconsidering the minimum requirements for long-term care insurance, allowing one-year policies, whereas currently many states require a minimum of two years.

Status of State Activity on Partnership Programs (as of October 31, 2008)

States are moving rapidly toward implementation of the new long-term care insurance Partnership initiative. Insurers have received certification for PQ policies in Colorado, Florida, Idaho, Kansas, Minnesota, Missouri, Nebraska, New Jersey, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Rhode Island and Virginia (in addition to the original four Partnership states).

Additional states (Arkansas, Georgia, Iowa, Nevada, New Hampshire, Tennessee, Texas, and Wisconsin) have received approval of their State Plan Amendments (SPAs) to develop Partnership programs from the federal Center for Medicare and Medicaid Services (CMS); they are in various stages of program implementation. Arizona and Kentucky have recently filed their SPAs for approval to offer Partnership programs. Other states will follow, as many have filed enabling legislation to move forward with a state Partnership program (Figure 1).

Partnership Program Specifics

This section explains the key features of the new Partnership programs in more detail.

Inflation Protection

The DRA establishes requirements for inflation protection for PQ long-term care insurance policies. Specifically:

- Individuals age 60 or younger must have annual compound inflation protection.
- Individuals age 61 to 75 must have some type of inflation protection. This need not be automatic annual compound increases; it could be simple

inflation increases, a guaranteed purchase option (future purchase option), or some other form of inflation protection.

- Individuals age 76 or older must be offered an inflation-protection option but are not required to purchase that option.

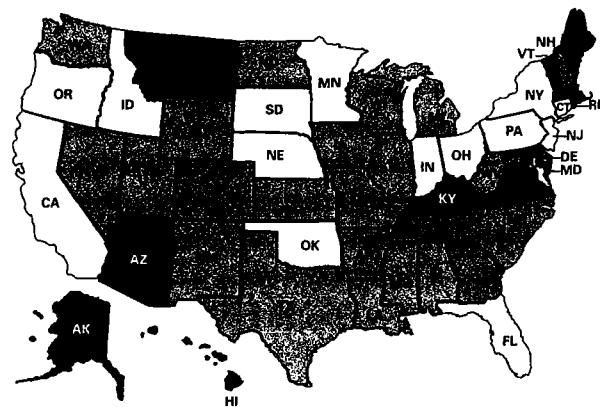
As noted above, all PQ policies must also be federally tax qualified, which means that those policies are required to offer 5% compound annual inflation protection to all purchasers. However, the individual has the right to decline this offer. Those who decline this offer are required to sign a statement indicating they received the offer and elected not to purchase it.

Some states have adopted the DRA language verbatim;¹³ others have adopted variations on that language that provide more specific guidance as to the various types of inflation protection that may be allowed. The major differences pertain to the requirements for individuals age 60 or younger since there are many variations that would satisfy the broad requirement to have “annual compound” inflation protection. Some states explicitly allowing some of these variations are described below:

- Idaho, Minnesota, Nebraska, Ohio, and South Dakota allow insurers to use an index for the

FIGURE 1

State Implementation Status as of November 2008



Policies for Sale ■ SPA Submitted
 Approved SPA ■ No SPA Submitted
 Source: <http://www.dehpg.net/LTCPartnership/map.aspx>

amount of the annual benefit increase based on some type of consumer price index, either a general one or one specific to long-term care.

- Idaho, Minnesota, Missouri, Nebraska, New Jersey, Ohio, South Dakota, and Virginia allow inflation protection annual increase amounts of less than 5% compounded annually (which is the prevailing level in the industry). Some of these states specify a minimum amount of 3%; others do not specify any minimum.

It is important to note that state requirements may change, so agents and insurers should continue to consult their state Department of Insurance for the most recent regulations regarding PQ policies.

Policy Exchanges

There are currently about 7 million long-term care policies in force. Many policies already in consumers' hands have all the required components that would make them PQ, but they were purchased before the Partnership program was in place in the owner's state. Many consumers with long-term care insurance policies only need to add inflation protection to have coverage that satisfies all the requirements of a PQ policy. Since PQ policies have the advantage of Medicaid asset disregard in the event that the consumer needs to apply for Medicaid benefits, there is an incentive to exchange the non-PQ policy for a PQ policy.

Some states require insurers to notify consumers of their right to exchange their existing long-term care insurance policy for a PQ one and specify how far back insurers must go in offering the exchange. Other states indicate they will allow insurers to offer or accept requests for a policy exchange but leave the details up to the insurer. As of February 2008, no state has prohibited insurers from offering exchanges.

Agent Training

States want to be sure that agents who are selling PQ policies have the necessary knowledge and training to fairly and accurately represent what those policies have to offer and to determine when it is suitable for an individual to buy such a policy. To that end, most states are following the NAIC model in requiring an initial eight

hours of training, with four additional hours every 24 months thereafter. A few states have adopted variations on the NAIC model requirements. These are discussed in greater detail later in this article.

Most of the states in the operational or implementation phase of a Partnership program have specified the topics to be included in agent training and set deadlines for the completion of the initial training. Most states are requiring resident agents to take either an eight-hour NAIC model course only, a version of this course with added material specific to the state's Medicaid and Partnership programs, or the eight-hour NAIC model course plus a shorter course or supplement on the state's Medicaid and Partnership programs.

Most states are actively reviewing Partnership training programs submitted by a variety of training vendors and insurance companies and are either providing lists of approved courses or providing other ways in which agents can identify qualifying courses. Some states are simply establishing requirements for training courses and leaving it up to the insurers to certify that their agents have taken a course that meets those requirements. And some states are requiring only that a course be CE approved; then it is up to the insurer to decide if it meets the state's published requirements for long-term care Partnership training.

How Will My Clients Know If They Have a Partnership Policy?

All states with Partnership programs require that a disclosure notice and certification statement be included along with the policy indicating that it is PQ where that is the case. A smaller number of states also require notification be provided to clients whose coverage choices on inflation protection are such that they do NOT have a PQ policy (or who have chosen to purchase a policy form that has not been certified as PQ). The certification/disclosure notice will be included in clients' issue kits at the time they receive their policies or, in the case of a policy exchange, may be sent to them directly from the insurance company. Unlike in the original four Partnership states, the PQ disclosure, for the most part, does not have to be in the policy or on the application form.

Is Partnership Asset Disregard Portable?

The U.S. Department of Health and Human Services has recently published recommendations for reciprocity standards.¹⁴ These will be the conditions under which states acknowledge the Medicaid asset disregard earned under a PQ policy sold in one state if the insured person moves to another state offering PQ policies and applies for Medicaid. The DRA provides that states may automatically offer reciprocity with other states unless they specifically opt out. To date, no state has indicated that it is likely to opt out of reciprocity once the regulations become final. (The original four Partnership states are not included in this reciprocity unless they specifically "opt in," which they may do under the proposed reciprocity standards.) States realize that a receiving state benefits when an individual who moves there has a PQ long-term care insurance policy, because the likelihood that the individual will need to rely on Medicaid is reduced given that he or she has long-term care insurance that satisfies certain consumer protection and coverage requirements.

Important Issues Affecting Financial Service Practices

There are several important issues that planners and insurance producers must address in regard to the new Partnerships. Some of these issues involve new requirements for substantial training and continuing education, and others involve the need for increased attention to necessary disclosures and the importance of enhanced record keeping.

The New Training Requirements

As the new Partnership programs are rolling out across the country, the states are issuing rules regarding new training requirements. In fact, some states have issued training requirements in advance of activating a Partnership program. In most states the new rules apply to all long-term care insurance agents in the state, but several states have issued rules that apply only to those selling Partnership policies.¹⁵ However, most of the major long-term care insurance carriers are requiring all their long-term care insurance agents to take the training in order to continue representing them in this market. Agents should

check with the insurance carriers they represent. Agents who do not represent a carrier participating in the Partnership programs and whose state requires the training only for those selling Partnership policies may still want to give serious consideration to taking the training. It will be time well spent if you are able to inform clients about the Partnership when asked and will leave you in a less competitively vulnerable position.

In most cases, the new Partnership states are basing their training requirements on the model the NAIC developed. Under this model, the initial training requirement is for eight hours and the ongoing training requirement is for four hours every 24 months thereafter. The subjects to be covered in the initial training cannot include marketing or selling techniques or training in an insurance company's own insurance products. The list of topics to be covered in most states includes the following: long-term care insurance, long-term care services, qualified Partnerships, and the relationship between qualified Partnerships and other public and private coverage of long-term care. About half the states have adopted this training model without alteration. Others require the addition of material covering the state's Medicaid and Partnership programs. Only one state has training requirements for resident agents that are different from this model. Colorado has a 16-hour initial and five-hour ongoing training rule and has an expanded content requirement. Iowa follows the content required but has shortened the time required in this education to four hours of initial training and three hours of ongoing training every three years (based on its CE cycle).

The good news for agents licensed in multiple states is that almost all states so far are facilitating reciprocity by accepting an NAIC model-type course taken in any state as fulfilling the requirements for nonresident agents in their state. Some are requiring an additional mini-course or supplementary training on their specific Partnership and Medicaid programs. Also, some states are considering nonresident agents to be Partnership certified as long as they meet the requirements of their resident state. Therefore, at this time there seems to be no reason for any agent to have to take multiple full-length state training courses to satisfy the initial requirements of multiple new Partnership states, with one possible exception. This exception might occur when an agent

took training in a nonresident state first because the agent's home state had no training requirements at the time, and he or she needed to qualify to sell in a nonresident state. Some states are requiring that their resident agents take a course that is unique to that particular state, and they will accept no other course (e.g., Colorado). The best course of action for any multistate licensed agent might be to fulfill resident state requirements first, whenever possible, and then complete any additional shorter courses or supplements needed for nonresident states. Check with your insurance carrier to see what training courses they will accept.

This rule of thumb does not hold, however, for the training requirements of the four original Partnership states. The California, Connecticut, Indiana, and New York Partnerships have specific training requirements for both resident and nonresident agents that are not based on the new NAIC model, and these states do not provide for training reciprocity with the new Partnership states or each other. However, it is possible that several of the new Partnership states might accept one of the four original Partnership states' training as qualification for nonresident agents, either with or without additional training required on their Medicaid and Partnership programs.

Evidence of successful completion of a qualified training course or courses must be obtained by the agent and a copy given to his or her carrier(s). According to the requirements of the DRA, the insurance carriers are charged with the responsibility of making sure the agents that represent them and sell Partnership policies have been trained. As noted above, most states require the Partnership training of all long-term care insurance producers, not just those planning to sell PQ policies. The carriers must keep records in accordance with the state's record-keeping requirements and provide verification of this training to a state's insurance commissioner if requested. Agents should set up and maintain their own files, keeping evidence of their required initial and ongoing training ready and available to produce.

The Suitability of the Product and the Importance of Design Factors

While there are state-mandated Partnership disclosure forms that must be given to clients, there are several

important facets of these new Partnerships that should be the focus of personal discussions during client planning meetings. These include disclosures such as:

- The services Medicaid covers may differ from those covered by private insurance (e.g., Medicaid offers more limited home and community care).
- Those services may change in the future.
- There are other eligibility criteria for Medicaid pertaining to income and functional status that one must also meet.

Also, Medicaid long-term care benefits, in comparison to those of a private PQ insurance policy, might prove totally unacceptable to the client. Another important possibility to be discussed is that a state may at any time in the future elect to discontinue its Partnership program. At present, only a few states promise to honor the Medicaid asset disregard of a PQ policy as long as you bought the policy while the state still had its Partnership program. Asset disregard also may not be available if you move to a state that opts out of reciprocity. Similarly, in order to have reciprocity if you move to another state, both the state in which you bought the Partnership policy and the state to which you have moved must have actively functioning Partnership programs in place. At any of these points, the planning done on the client's behalf would boil down to the long-term care insurance policy and its ability to stand on its own. The effectiveness of the planning then will be determined by the attention paid to the product selection and the design of its benefits and features.

A discussion of whether or not a long-term care Partnership policy is a suitable financial product for a particular client must begin with the underlying question: Is long-term care insurance an appropriate financial tool based on all the facts? For those who have little in the way of income and assets (e.g., less than \$30,000 in assets),¹⁶ a long-term care policy (PQ or not) may very clearly be an unsuitable purchase. There may not be enough income to maintain the policy premiums over the years, and the assets may be such that Medicaid qualification would come very quickly if long-term care were needed. Someone who had few assets to protect may not need or want the asset disregard that a PQ policy provides.

But what about those who have little income but *some* assets that the family wishes to preserve, and so family members undertake the responsibility of funding the premium payments? Or what about the huge numbers of middle-class clients with some level of assets that they wish to pass on to heirs? They can perhaps afford *some* long-term care coverage but not lengthy or unlimited coverage. These scenarios are clearly suitable cases for a PQ policy. The choice of a PQ policy gives someone the hope of achieving an asset preservation goal by tailoring the policy to the amount of assets he or she wishes to protect while taking on a premium that is affordable. The insured can thus achieve potential asset protection, but he or she must also accept the possible drawbacks of any existing future Medicaid program or the possible dissolution of a state's Partnership program.

Special care must be taken in these cases when choosing an appropriate daily or monthly maximum benefit. In determining a policy structure to protect a desired asset level, the agent must be sure to give a high enough daily or monthly maximum with good inflation protection so that the insured is not copaying large amounts during the insurance coverage period. A substantial copayment might deplete the very assets one is trying to protect. These policies should be designed with the highest attention paid to the depth of coverage and inflation protection. Length of coverage should be looked at secondarily when trying to achieve a set level of asset protection.

A Case Study in the Importance of Proper Structure of the Policy

Loretta is a 62-year-old divorced woman with a strong desire to pass her modest savings on to her only child, a daughter, for the advanced education of her grandchildren, now one and three years old. Loretta hears of the Partnership program in her state and decides to purchase a policy that will accomplish several things, among them avoiding becoming a burden to her daughter should she become impaired and protecting her small nest egg for her grandchildren's education.

Loretta is planning on remaining in her two-bedroom apartment as long as possible but has not researched the cost of care in her area. Nursing homes there cost

about \$250/day, assisted living facilities around \$180/day, and home health aides around \$20/hour, with live-in aides at \$220/day. In order to protect her \$150,000 savings for her loved ones, and based on her current income, Loretta feels she can afford to spend between \$2,000 and \$3,000 per year on an insurance policy.

Loretta sits down with an insurance agent and tells him that since she took care of her own mother for almost four years, she wants coverage for at least four years. The insurance agent designs a policy with four years of benefits and, to cover the \$150,000 nest egg, a daily maximum benefit of \$110 with a 5% simple inflator and 60-day elimination. He does not do any financial fact-finding, but rather takes her statement of a need for \$150,000 in coverage, four years of benefit length, and a price range of \$2,000 to \$3,000 as all he needed to know. (Because Loretta is 62, all she needs to purchase to have PQ coverage is *any* kind of inflation protection which, in her state, includes the 5% simple inflation factor she is considering.)

Loretta also announces to the agent that she will be talking to another agent later that afternoon. With the competition in mind, her agent gives her a policy design at the low end of her desired price range. Since neither one of them really knows the cost of care in the area, and since \$110 per day sounds pretty good and a four-year benefit length covers the \$150,000, it was accepted as the "right policy" for her—according to Agent #1.

Later that day, Agent #2 sits down with Loretta. This agent actually gathers some information about the income Loretta expects to have after she retires, the ages and health issues of her parents and herself, the exact nature of her savings, and an idea of her daily living budget. Agent #2 comes up with a different design for her Partnership policy. He recommends \$190/day, a two-year benefit length, with 5% compounding automatic inflation and a 30-day elimination period. The premium is around \$3,000 annually, but he feels that this policy will better achieve her financial and lifestyle goals.

Loretta now faces a dilemma. Agent #1 is showing her a policy for \$2,000 that will protect her \$150,000 and give her the four years of coverage she wants. Agent #2 is showing her a policy that pays sooner and pays out more in daily benefits, but that costs more (\$3,000) and

is only going to last half the time of the other policy. The first policy would protect about \$160,000, and the second would protect up to just under \$139,000 in assets. How would these two policies perform in 20 years when we can forecast that Loretta might need some help?

Let's assume that the cost of care rose at a 5% annual rate over the years (close to the historic average). In 20 years, nursing homes would be costing \$660/day, assisted-living facilities \$470/day, and home health aides would be priced at \$53/hour or \$580/day for a live-in aide.

Now let's look at Loretta's income and assets in 20 years. She receives \$1,800/month from Social Security, which is her only income source. (Income received from her ex-husband ceased the previous year upon his death.) Her savings are positioned in nonincome-producing investments and have grown to \$400,000, but so has the cost of college and graduate school for her grandchildren.¹⁷

Policy #1 would provide \$110/day with a 5% simple inflator after a 60-day elimination period for at least four years. The maximum payout of this policy is \$110 times four years times 365 days, which equals \$160,600. All these benefit amounts would increase by the 5% simple inflator. So in 20 years, Loretta's lifetime maximum and daily benefit would be \$321,200 at \$220/day. In contrast, after 20 years policy #2 would provide \$504/day (the initial \$190 benefits increased by the 5% compounding inflator) after a 30-day elimination period, for at least two years. The initial lifetime maximum of \$139,000 would have grown to just over \$368,000.

At 82 years of age, Loretta suffers a stroke, enters a hospital for a week, and then goes into a nursing home. Let's assume Medicare pays for the first 20 days of skilled rehabilitation care in the nursing home, at which point Loretta has recovered to the full extent that she ever will, and Medicare stops paying. She is in care in the nursing home for about two-and-a-half years.

Policy #1's Performance

Under policy #1 Loretta will pay for the next 40 days after Medicare ends (60-day elimination period minus the 20 days that Medicare paid)—over \$26,000. Then the policy will pay \$220/day, and Loretta will pay \$440/day (\$60 from income, assuming she gives up her apartment, and \$380/day from her assets). If Loretta

is in the nursing home for the average amount of time (2.5 years) and then dies, she would have spent almost \$372,000 of her \$400,000 nest egg copaying her care. Because of the impact of the lengthier elimination period and the high amount she must copay, she would have had to apply for Medicaid help, and qualified, very early on during the life of this policy in order to try to salvage a meaningful amount of her savings for her heirs, but in that case the additional asset protection afforded by the policy might have been lower. After the full four years of benefit payout, policy #1 would have protected about \$322,000. But unfortunately, because of these "coverage gaps," if Loretta had wanted to receive a type of care not provided by Medicaid and had relied completely on her policy, she would have spent all her savings long before the four-year benefit period was up. And if Loretta applied to Medicaid before exhaustion of the policy benefits, she might have even less asset disregard, as the amount of asset disregard in some states is based on the total benefits paid out up to the date of the Medicaid application.¹⁸

Policy #2's Performance

Under policy #2 Loretta will pay for the next 10 days (30-day elimination period minus the 20 days from Medicare)—\$6,600. At that point the policy will pay up to \$504/day for two years, and Loretta will pay \$156/day (\$60 from income and \$96 from savings). At the end of two years of insurance coverage Loretta will still have over \$323,000 in assets (assuming no further growth in the account) and can apply for and receive Medicaid assistance with additional asset protection of over \$367,000. If it is assumed that she lives for another six months after she has exhausted her two-year insurance policy, Medicaid will pay for this care and save her about \$108,000 in assets (\$660/day times 30 days times six months minus her income of approximately \$10,000 over six months). Comparing this to having a non-PQ policy and having to pay out of pocket, there can be significant asset protection. And if she continued to live for more than the case study's two-and-a-half years and receive care funded by Medicaid beyond this case study's six-month Medicaid-funded period, the entire nest egg would be protected for her heirs.

Product Suitability (continued)

To return to the product suitability discussion, aside from having a certain amount of inflation protection required based on the age of the applicant and certain disclosure and notification requirements, there is no difference between a PQ policy and a non-PQ product that is tax qualified. Furthermore, a strong argument could be made that for any long-term care insurance policy design to work well—PQ or non-PQ—it should have at *least* the inflation protection required by the DRA for a PQ policy. Assuming, then, that one has designed a policy and it would qualify as a Partnership policy, should a PQ policy be chosen over a non-PQ policy designed exactly the same? There would seem to be no practical reason to opt out of having PQ status. There will be no cost difference. And in many cases carriers are going to be issuing all new PQ-conforming policies with documentation stating that the policy is intended to be a Partnership policy. If a choice must be made, there is no reason not to choose a Partnership policy, assuming adequate inflation protection was going to be chosen anyway. There is no mandate that says that the insured **MUST** apply for Medicaid coverage if he or she runs out of insurance coverage. If Medicaid's care options are not acceptable to the insured when the insurance coverage that is paying for more desirable care runs out, he or she can just ignore Medicaid and start to pay privately for care. On the other hand, having a Partnership policy might provide another possible solution to having coverage for long-term care needs and gaining asset protection when and if the time comes that the insured finds himself or herself needing long-term care.

The Importance of Keeping Good Records

In addition to maintaining evidence of the completion of any required training, there are components of an agent's client files that should receive some increased and devoted attention. If a fact finder is used, of course a copy belongs in the file. It is always an excellent idea to have notes about why a particular policy plan design was chosen. It might also be worth considering adding a Partnership checklist to serve as a reminder to discuss both the possible advantages of a Partnership policy and the potential future events that could alter or even erase the potential for Medicaid "backup." Clear evidence that these issues were personally discussed might be a wel-

come sight on opening a client file in 20 years or more if a Partnership ceases operation or Medicaid eligibility rules become ever more stringent.

If a client intentionally opts out of accepting a Partnership policy when he or she received a conforming policy design and was given the opportunity to have it endorsed as PQ, it would be good to have detailed notes on file as to the reason for the client's declining the Partnership endorsement. Some companies will not give a choice and will automatically send a Partnership endorsement attached to the policy; others will send an opt-out form that the client must sign and return to the company as proof that the client does **NOT** desire Partnership endorsement. A copy of this form in the producer's client file is highly recommended.

Remember that the client is never going to be forced into applying for Medicaid in the future. Also, keep in mind that the first call of complaint from an insured or, more probably, an insured's family member will almost certainly be to the office of the insurance producer—even before they contact the insurance carrier or the state insurance department. Have notes on file about all conversations in person, by e-mail, or by telephone. Include who was on the call, the date and time of the call, the topics covered, and any actions that were agreed upon.

It is also important to remind your client to make sure that family members are aware of the fact that the individual has a PQ policy so that, should the individual not be competent at the time care is needed, the family can assist with the process of applying for Medicaid and obtaining asset disregard.

For More Information and State-Specific Updates

The Partnership is a new initiative with many complex issues for states and insurance companies to address. Please consult your state's Partnership Web site or the following resources for up-to-the-minute information on how your state is implementing the Partnership program.

Consumers who want to learn more about Partnership programs should visit the Web site of the National Clearinghouse for Long-Term Care Information: http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Private_Programs/LTC_Insurance/index.aspx#SPLTCIP.

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(1) Alexcixh, personal communication and analysis, 2008, based on data from Kemper, Komisar, and Alexcixh, "Long-Term Care over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42 (Winter 2005/2006): 335-350.

(2) Kemper, Komisar and Alexcixh, "Long-Term Care over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42 (Winter 2005/2006): 335-350.

(3) *Ibid.*

(4) *Ibid.* page 342.

(5) http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Considerations/Savings_Calculator.aspx?rand=2.

(6) Most insurers no longer impose a minimum issue age, although some may limit the purchase to those age 18 and older. There may be a few insurers still limiting the purchase to those age 40 and older.

(7) www.longtermcare.gov.

(8) www.cms.hhs.gov/medicaideligibility/download/1998-2008ssifbr061908.pdf.

(9) *The New Long-Term Care Partnership Programs: Understanding Needs, Solutions and Ethical Considerations* (Washington, DC: America's Health Insurance Plans, 2007): 173-174.

(10) *Ibid.*, chapter 11.

(11) <http://www.dehpg.net/LTCTPartnership/map.aspx>.

(12) America's Health Insurance Plans, *The New Long-Term Care Partnership Programs*, chapter 11.

(13) <http://www.dehpg.net/LTCTPartnership/map.aspx>.

(14) *Federal Register*. 73, No.170 (September 2, 2008).

(15) America's Health Insurance Plans, "Long-Term Care Partnership Monthly Training Update" newsletter, <http://www.ahip.org/ciepd/LTCTUpdates/LTCTUpdateOct2008.pdf>.

(16) www.longtermcare.gov.

(17) For simplicity's sake, at the time of nursing home entry, the effect of inflation on the benefit levels of both policies and on the cost of care were dropped. In reality, the daily maximum payouts of the policies would continue to increase. The lifetime maximum benefit would also increase. But it is probable that the cost of care would increase over two-and-a-half years as well.

(18) Some states say they are going to continually reassess Medicaid eligibility as well as asset disregard, so that as the total amount an insured has received in benefits from his or her PQ policy grows, even after qualifying for Medicaid, some states will increase the insured's asset disregard amount by a corresponding amount. But should Loretta's savings be repositioned into an income-producing asset, it is also possible she could lose her Medicaid eligibility.

