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"LONG-TERM CARE PARTNERSHIP INSURANCE REQUIRED TRAINING"

8 Hours of Continuing Education Credit

As required by the Deficit Reduction Act of 2005 and Illinois Insurance Regulation

ILLINOIS

COURSE NUMBER

25008

Dohrn Insurance Training, Inc.

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Table of Contents

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Table of Contents

Section 1) Partnership Long-Term Care

Definition

In an effort to enhance cooperation between a state government and private insurance companies a “Partnership Program” is offered to residents of a particular state who purchase a long-term care policy in that state. Under a federal law called the Deficit Reduction Act (DRA) of 2005, each state decides when or if it wishes to initiate a Long Term Care Partnership Program.

As part of DRA requirements a State must certify a partnership policy as meeting the requirements for inclusion to the Partnership Program. The DRA requirements for partnership policies include

- Inflation Protection
- Specified Consumer Protections
- Special Training to Producers Required by State Law

The key concept that sets a partnership policy apart from a traditional long term care policy is “asset disregard.” A consumer who purchases a qualifying partnership long term care policy is allowed to protect some assets after applying for Medicaid for additional long term care expenses. The amount of assets that may be disregarded (meaning the individual gets to keep them) equals the dollar amount of the benefits received under the long term care partnership policy that was purchased.

ASSET DISREGARD EXAMPLE:

Suppose Bob buys a qualifying partnership long term care policy that pays a total of $300,000 in lifetime benefits. If Bob actually requires long term care in the future and uses the entire $300,000 of policy benefits then he can apply for Medicaid and he would be entitled to keep $302,000 in assets. On the other hand, if Bob did not have a qualified partnership policy then he would only be entitled to keep $2,000 of assets in order to apply for Medicaid and the State would move to recover that $2,000 in the future from Bob's estate.

(NOTE: Just having a Partnership Policy does not entitled a person automatically for Medicaid benefits and the individual still must meet all the other qualifying criteria of the Medicaid program).

The case above is an example of the "dollar-for-dollar" asset disregard model and it is the model which is required under DRA for implementation by States who did not have a Partnership Program in place prior to 2005.

A consumer must be aware of the following:

> When purchasing a long term care policy make certain that It is Partnership qualified because a non-qualified plan may be identical in its coverage.

> Each State will have an effective date for the Partnership Program and therefore any policies of long term care issued prior to this State effective date will not qualify as a Partnership contract.

> A consumer must purchase a Partnership policy only from an insurance producer who is specially trained, according to the regulation in a specific State, to sell such a policy.

> Consumers must understand that eligibility for Medicaid still includes health, income and any other general requirements even if they own a Partnership Policy.

> Reciprocity between States that have a Partnership Program exists and the asset disregards will be honored by each Partnership State regardless of where the policy was purchased.

The next area explains the history of the Partnership concept and should aid in the understanding of where the concept is after DRA 2005 compared with the initial offerings from the 1980's.

History

By the late 1980's the Robert Wood Johnson Foundation supplied grant money to create a new Long Term Care model whose goal was to motivate more consumers to purchase individual long term care insurance policies. This initiative was called the "Partnership for Long-Term Care" and brought together States and private insurance carriers to invent a new insurance policy that moderate income level consumers could afford who were the most likely candidates for future Medicaid reliance to meet their long term care needs.

The goal of the design of the Partnership program was to make the policy attractive to consumers who would otherwise likely not purchase a long term care policy. By purchasing a qualifying partnership policy the State guarantees that if the benefits under the policy are not enough to meet long term care needs then the purchaser can qualify under Medicaid under special rules of eligibility while being allowed to keep a specified amount of assets. The thinking was to allow consumers of the partnership policy protection from becoming poverty stricken in order to qualify for Medicaid while rewarding the State with avoiding the financial burden of paying as much in long term care costs.

The Robert Wood Johnson Foundation provided start-up money for a program originally a handful of states: California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon and Wisconsin with the goal of shifting some of the financial cost relating to long term care away from Medicaid and toward private long term care insurance. Only four of the eight states that received this start-up funding actually created Partnership programs: California, Connecticut, Indiana and New York.

Two states, California and Connecticut opted to create a dollar-for-dollar approach. This means that the individual's assets are protected up to the benefit total of the private long term care insurance coverage paid. New York decided to utilize the "total asset protection" approach which means that all assets of the individual are protected when a state defined minimum benefit package partnership LTC policy is purchased. Lastly, Indiana decided to use the "Hybrid" concept that offers both dollar-for-dollar and asset protection. The exact type of asset protection is contingent upon the initial amount of coverage purchased. Therefore in Indiana total asset protection is available for policies with beginning coverage amounts which are greater or equal to a coverage level that is defined by the State.

The demographics and other trends of the program participants of these four pioneering partnership states, over a period of about the first ten years are highlighted as follows:

> Most partnership policyholders are married (about 2/3)

> Females outnumber males (about 6:4)

> Over 90% of partnership policy purchasers bought a LTC insurance policy for the very first time

> The average age of a purchaser was from 58 to 63 years of age

> Most policyholders (55% - 65%) had assets totaling more than $350,000

> At least half or more of policyholders in three states enjoyed household incomes that were greater than $5,000 monthly

> After ten years since purchase, over 95% of policyholders reported that they are in good to excellent health

> The vast majority of policies purchased were by individuals as opposed to through the group market

> Although there was medical underwriting about 7 of 8 applications were approved and only 1 in 8 was denied coverage.

> Most partnership policies remain active and very few policy owners have accessed long term care benefits.

> In the hybrid state of Indiana, later partnership sales have overwhelmingly been for total asset protection rather than opting for less coverage offered through dollar-for-dollar protection.

Shortly after the implementation of Partnership LTC in the four states cited, Congress began to have concerns over whether partnership policies were a good use of Medicaid tax dollars and placed into law restrictions on the concept by passing OBRA 1993. The four states with existing Partnership programs were granted permission to continue but OBRA prevented the spread of Partnership LTC to any other states until the Deficit Reduction Act of 2005 was passed and signed into law in early 2006.

GAO Report Analysis and Conclusion

In May of 2007 the Government Accounting Office (GAO) issued a lengthy study entitled "LONG-TERM CARE INSURANCE – Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings." The GAO analyzed the history of Partnership policies and offered its opinion as the result of a Congressional request to evaluate the concept. Specifically the report was designed to address these three areas:

1) Examine the benefits and premium requirements of partnership policies as compared with those of traditional long term care policies;

2) Examine the demographics of Partnership policyholders, traditional long term care insurance policyholders and people without long term care insurance; and

3) Whether the Partnership programs are likely to result in savings for Medicaid.

The data examined by the GAO for this report were from the four Partnership policy states during the period of 2002 through 2005. The goal of assessing how Partnership programs would impact Medicaid in the future was derived by:

1) Using data from surveys of Partnership policyholders to estimate how they would have financed their long-term care without the partnership program,

2) Constructing three scenarios, using the survey results mentioned in point 1, to compare how long it would take for an individual to spend his or her assets on long–term care before becoming eligible for Medicaid, and

3) Estimating the likelihood that Partnership policyholders would have become eligible for Medicaid based on their personal wealth and insurance benefits.

States informed the GAO that insurance companies were required to charge the premiums for comparable benefits for both Partnership and traditional long-term care policies and those carriers were not allowed to charge extra premium for the asset protection afforded by Partnership policies.

The GAO found that people who purchase long-term care insurance (whether Partnership or traditional) have higher incomes and greater assets than do people who do not purchase such coverage (around $5,000 or more monthly income and over $350,000 of assets at the time of contract purchase). The surveys revealed that about 80% of Partnership policyholders would have bought long-term care policies anyway even if Partnership contracts did not exist.

The remaining 20% indicated they would have self-financed their care without the availability of the Partnership program.

THE OVERALL CONCLUSION BY THE GAO:

Partnership programs are not likely to result in Medicaid savings and may actually increase Medicaid spending.

In general the study also concluded that an individual could self-finance for about as long as he or she would have if they had been using a Partnership policy. Therefore Medicaid spending would actually increase for these people because their Partnership policy allows them to protect assets while self-financing required them to spend assets down to $2,000. However, most policyholders are unlikely to exhaust their benefits and become eligible for Medicaid.

The GAO also indicated that in 2004 spending on Long-term care totaled $193 billion and half that amount was paid by Medicaid. In this same year only about 7% or $14 billion of this total tab was paid by private insurance and the rest of the bill was footed out of the personal wealth of individuals receiving the care. Therefore the concern of federal and state governments is that the growing demands for long-term care will strain the resources of all the governmental entities involved. With the aging of America in terms of not only significantly greater numbers but also greatly increasing lifespan, these are valid concerns for the near and long term future.

Deficit Reduction Act of 2005

President George W. Bush signed the Deficit Reduction Act (DRA) of 2005, also known as the budget reconciliation act, into law on February 8, 2006. Although the DRA was a broad based law affecting many financial areas, for purposes of this course the review is limited to elderly, Medicaid and Partnership LTC Program issues.

Asset Transfers

DRA lengthens the "look-back" period for asset transfer from thirty-six to sixty months (from three years to five years) and shifts the start of the penalty period for transferred assets from the date of transfer to when the individual who transferred the assets enters a nursing home and would otherwise be eligible for Medicaid coverage. Since this penalty does not begin until the nursing home resident is out of funds the nursing home may be put in the position of caring for the resident while waiting for the extended penalty period to end. The consequence may be that nursing homes will have large numbers of residents who cannot pay. States that have enacted legislation referred to as "filial responsibility laws" will allow nursing homes to seek reimbursement for resident's unpaid care from the residents' children.

Home Equity

Anyone who has more than $500,000 in home equity will be ineligible for Medicaid funded nursing home care. DRA also stipulates that states are allowed to raise this home equity threshold to as high as $750,000. Furthermore, these home equity thresholds will be indexed for inflation beginning in 2011 (for all items using the US Cities average, rounder to the nearest $1,000.

Additional DRA Highlights:

> Annuities are affected with new rules including one that requires that a state be named as the remainder beneficiary.

> States are now authorized to include home and community-based services as an optional Medicaid benefit (prior to this change, a state was obligated to receive waivers to offer these services).

> Long-Term Care Partnership Programs are available to any state.

> Continuing Care Retirement Communities (CCRC's) residents can now be required to spend down their declared resources prior to applying for medical assistance.

> Rules now exist whereby the entrance fee paid by an individual to a CCRC is considered an available resource (i.e. any remaining part which is still refundable can be claimed as a resource eligible for repayment).

> The purchase of a real property life estate is now included in the definition of an asset unless the life estate purchaser actually resides in the home for at least one year after the purchase date.

> Any resources used to purchase a promissory note, mortgage or loan is included as an asset unless the repayment terms meet the test of being actuarially sound, require equal payments and prohibit the cancellation of the balance upon the death of the lender.

> States may treat multiple transfers of assets as just one transfer and date the beginning of any penalty period as the earliest date that would apply to this type of transfer.

> States can no longer “round down” any fractional periods of ineligibility to determine ineligibility periods that are the result of any asset transfer.

Partnership Program Highlights

> When a consumer buys a long-term care policy they must make certain that the policy they purchase is actually a qualified Partnership policy (certified by the state in which they live) because a non-qualified policy may otherwise be identical to a qualified policy.

> A partnership policy must include inflation protection as indicated by state law.

> In Illinois anyone who is under the age of 61 must have an annually compounded rate of interest for inflation protection (DRA requires either a 3% or a 5% at this age annual rate in a Partnership Policy).

> In Illinois anyone who is at least 61 years old but less than 76 years of age must have annual compounded interest inflation protection in their Partnership policy.

> In Illinois anyone who is 76 years old or older, as of the purchase date, may not have inflation protection in their partnership policy but an insurance company may offer it if they wish to do so.

> LTC policies issued prior to the Partnership Program effective date are not Partnership qualified but there may be circumstances under which a non-qualified policy may be exchanged for a qualified Partnership LTC policy.

> In the event an individual owns a Partnership policy that does not mean they will automatically qualify for Medicaid; they must still meet the eligibility and asset requirements of their state. Also since Medicaid long-term care services vary by state they may not be the same as provided in a long term care policy.

> Partnership policies can only be sold in a state by a producer who is specially trained to sell partnership policies as the state has special training requirements for them.

> In Illinois, to be certified to sell Partnership policies a producer must:

1) Successfully complete course number 25008, an eight hour, once in a lifetime required continuing education course and

2) Complete an ongoing continuing education course of not less than four hours every 24 months.

Illinois Long-Term Care Partnership Program Act

Reproduced below is the entire text from the 2007 Public Act 095-0200 entitled "Illinois Long-Term Care Partnership Program Act":

AN ACT concerning long-term care.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Illinois Long-Term Care Partnership Program Act.

Section 5. Findings.

The General Assembly finds that our nation's current financing structure relies too heavily on individuals and families to bear the financial burden of long-term supportive services. The financial burden can be so large that for many individuals, particularly those with moderate income, the only alternative is Medicaid, which requires spending down all assets in order to qualify to receive long-term care benefits.

The General Assembly declares that Medicare is not intended to cover the majority of long-term care expenses. Medicaid is the largest source of funding for long-term care in the United States, making the financing of long-term care costs a significant issue for both State and federal budgets. The growth in spending by the federal government and states for long-term care services through Medicaid will continue to increase as the American population ages.

The General Assembly finds that one solution to help address the spiraling Medicaid growth and encourage individuals to plan for their long-term care is the Long Term Care Partnership Program, a public-private partnership between states and private insurance companies. It is the intent of this program to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid by providing incentives for individuals to insure against the cost of providing for their long-term care needs. The program, including the treatment of assets for Medicaid eligibility and estate recovery shall be structured and administered in accordance with federal law and applicable federal guidelines.

Section 10. Definitions.

As used in this Act

"Agency" means the Department of Healthcare and Family Services.

"Asset disregard" means, with respect to qualification for State Medicaid benefits, the disregard of any assets or resources in an amount equal to the insurance benefit payments beneficiary under a qualified long-term care insurance partnership policy.

"Department" means the Department of Financial and Professional Regulation.

"Medicaid" means the federal medical assistance program established under Title XIX of the Social Security Act.

"Qualified long-term care insurance partnership policy" means a policy that meets all of the following requirements:

(1) it covers an insured who was a resident of Illinois when coverage first became effective under the policy.

(2) it is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code as defined in Section 7702B(b) of the Internal Revenue Code of 1986 issued not earlier than the effective date of the State plan amendment;

(3) it meets the model regulations and requirements of the National Association of Insurance Commissioners modelspecified in paragraph (5) of Title VI, Section 6021 of the federal Deficit Reduction Act of 2005, and the Director of the Division of Insurance of the Department certifies it as meeting these requirements; and

(4) if the policy is sold to an individual who:

(A) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(B) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; or

(C) has attained age 76 as of such date, the policy may, but is not required to, provide some level of inflation protection

"State plan amendment" means a State Medicaid plan amendment made to the federal Department of Health and Human Services that provides for the disregard of any assets or that are made to or on the behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

Section 15. Illinois Long-term Care Partnership Program

(a) In accordance with Title VI, Section 6021 of the federal Deficit Reduction Act of 2005, there shall be established the Illinois Long-Term Care Partnership Program, to be administered by the Agency with the assistance of the Department to do the following:

(1) provide incentives for individuals to insure against the costs of providing for their long-term care needs;

(2) provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources;

(3) provide counseling services to individuals planning for their long-term care needs; and

(4) alleviate the financial burden on the State's medical assistance program by encouraging the pursuit of private initiatives

(b) The Agency shall

(1) Within 180 days of the effective date of this Act, or as soon thereafter as possible, make application to the federal Department of Health and Human Services for a State plan amendment to establish that, if an individual is a beneficiary of a long-term care partnership program certified policy, the total assets an individual owns and may retain under Medicaid and still qualify for benefits under Medicaid at the time the individual applies for long-term care benefits are increased by $1 for each $1 of benefit paid out under the individual's long-term care partnership program certified insurance policy

(2) Provide information and technical assistance to the Department on the Department's role in assuring that any individual who sells a qualified long-term care insurance partnership policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care

(c) The Department may not impose any requirement affecting the terms or benefits of qualified long-term care partnership policies unless the Department imposes the requirement on all long-term care policies sold in Illinois without regard to whether the policy is covered under the partnership or is offered in connection with the partnership.

(d) The issuers of qualified long-term care partnership policies in Illinois shall provide regular reports to the Secretary of the federal Department of Health and Human Services, in accordance with federal regulation. Issuers of qualified long-term care partnership policies in Illinois shall provide appropriate reports to the Agency and to the Department as determined by those entities.

Section 20. Administration

(a) The Agency and the Department are authorized to adopt regulations to implement the provisions of this Act and rules for its administration.
(b) The Agency and Department must comply with all federal rules developed in accordance with Title VI, Section 6021 of the federal Deficit Reduction Act of 2005, regarding data reporting, reciprocity with other states that develop long-term care insurance partnership programs, and any other matters, and shall have the authority to adopt regulations relative to the provisions of any federal rules and their administration.

(320 ILCS 35/Act rep.)

Section 25. The Partnership for Long-Term Care Act is repealed

Section 99. Effective date. This Act takes effect upon becoming law.

Effective Date: 8/16/2007
Public Act 095-0200

Insurance Carrier Product Implementation

Insurance Carriers who market qualified policies according to the Partnership Program must have them approved by any state in which they choose to market them and the qualified product must be certified as such by the state Director of Insurance. The policy approval process can vary from state to state taking only perhaps a few months in one state to more than a year in others.

It is entirely possible that while a state may have an existing effective date for the Partnership Program, there may actually be not one product that has been qualified under the program in that state. For instance in Illinois as of the July 1, 2008 date for required training there was not a single carrier that had a policy yet certified as qualifying under the Partnership Program. However, as of July 1, 2008 there were some such policies pending certification for sale in Illinois.

An insurance company is required to make certain that any producer selling a qualified Partnership Program policy has successfully completed the initial and ongoing training requirements as stipulated under state law.

Section 2) Traditional Long-Term Care Policies

Traditional Long Term Care policies refer to pre-HIPPA contracts that were not tax qualified. However, as qualified long term care policies flooded the market beginning in 1997 the name "traditional" stuck and this term is commonly used to refer to both qualified and nonqualified LTC plans. In no sense should the term "traditional long term care" ever be associated with a Partnership Program LTC policy.

Traditional long term care contracts were first offered for sale in the early part of the 1980's and they were radically different in coverage than what is available in the market today. These early policies were considered anti-consumer in many ways and this forced the first laws to be written by states to regulate this new policy type. Most early LTC coverage was offered as a rider to a life insurance contract (and this option is still available) but the first stand alone health LTC contracts caused state legislators to define what was and was not permissible for marketing to residents by the late 1980's and early 1990's.

The central idea of support by the federal and state governments for the sale of Long Term Care insurance by private companies has always been to try and shift the burden of cost away from the tax rolls and toward the individual. This has been, and will continue to be, an agonizingly slow transfer process from Medicaid to private insurance policies. With an unusually large segment of the US population about to pass through the elderly portal it is no wonder federal and state seem increasingly enthusiastic about the sale of private long term care insurance.

Qualified versus Non-qualified Long-Term Care Policies and Eligibility Requirements

Federal law allows individuals to deduct a portion of the premium of a tax-qualified long-term care policy from federal income taxes if taxes are itemized above 7.5% adjusted gross income. Also benefits received from a tax qualified long-term care policy are generally not treated as taxable income subject to a per diem (daily benefit payment) cap which is indexed for inflation.

Individual are required to meet eligibility requirements for a tax-qualified long term care policy to qualify for benefits under that policy, as follows

1) The policy must be in force (obviously)

2) The insured must be chronically ill, defined as:

    a) at least two activities of daily living (ADL's) need hands-on or stand-by help in order to be performed; and

    b) needing continual supervision because of a severe cognitive impairment; and

3) Certification by a licensed health care practitioner that the insured meets the definition of "chronically ill" and that the insured requires care for a minimum of 90 days because of the loss of functional capacity

Tax qualified long term care policies also have an advantage that the benefits received are not deemed to be income and therefore are not taxable. Since these contracts are treated like other heath insurance the benefits are a medical expense and the insured can also deduct some of the cost as mentioned earlier. This deduction is based on age: the older you are the more you can deduct if you qualify to itemize your federal tax return.

Non-tax qualified policies (again those formerly referred to as “traditional long term care” insurance) also includes the "trigger" of calling the insured condition a "medical necessity" This means that the patient's own doctor, or that doctor in conjunction with someone from the insurance company, can state that the patient needs care for any medical reason that is covered under the terms of the policy. All LTC policies issued prior to January 1, 1997 are deemed to be tax qualified as long as they complied with state standards.

Non qualified LTC policies also allow the additional ADL of being ambulatory (able to walk on your own) and if you have trouble walking this can be a trigger for policy benefits to be paid. The other advantage is that the insured does not have to wait 90 days for the benefits to kick in.

Since the United States Treasury Department never clarified the status of benefits received under a non-qualified long-term care insurance plan, the taxability of these benefits is open to further interpretation. This means that it is possible that individuals who receive benefits under a non-qualified long-term care insurance policy risk facing a large tax bill for these benefits. Although this has not yet happened, the possibility can not be ruled out until or unless the tax code specifically addresses this issue.

Typical Benefits

Continued Care

In this context “continued care” means confined care services that are normally available with a traditional long term care policy. Coverages will include nursing home benefits, assisted living benefits, bed reservation and nursing home ambulance benefits.

The nursing home coverage pays up to a maximum daily benefit amount that was purchased by the insured for services like room and board, therapy, medication management and help with activities of daily living plus any supplies used by the nursing home for the care of the insured.

The plans also pay for care given in assisted living facilities. Room and board (usually for a single room unit) defined ancillary services and patient supplies used by the facility are covered.

A bed reservation benefit is very useful as it pays for a reserved bed up to a stated maximum number of days (usually 31) while the insured is absent (unless discharged) from the facility. This 31 day period is normally on a calendar year basis and often is additionally available for nursing home care in the same calendar year.

Finally a plan may pay for ambulance charges incurred by the insured to and from the nursing home and hospital.

Home Health Services

Studies show that most chronically ill people would prefer to stay in their own home, whenever possible. This segment of the market has seen explosive growth over the past twenty years. For example, spending for home health care has risen from $3.5 billion in 1990 to $41.3 billion in 2004 and the trend continues with a rapid growth level.

LTC policies will pay for covered services received by an insured at home when benefit eligibility has been established. People who assist the insured are referred to as personal and home care aides, homemakers, caregivers, companions or personal attendants. There is restriction as to who may be paid for these home health care services and close family members are usually not eligible to be paid for providing them. However, policies will pay for training a home health care giver who meets the contract definition.

These individuals can provide housekeeping as well as routine care services. Caregivers can clean client's homes, change bed linens and do laundry. They may also plan meals (including special diets), shop for food, and do cooking. Aides may also help clients get out of bed, bathe, groom and dress. Some accompany clients to doctors' appointments or on other errands.

Personal caregivers can be recruited and hired as independent contractors or they are often sought from reputable companies who do all the screening, recruiting and hiring for the insured and his or her family. These companies should do background checks and be bonded and insured and the caregivers they hire and send to clients should also be bonded and insured. Some states require specific licensing for providing this type of employment service.

Other Optional Features

There are many other alternative forms of care that are available to people who need assistance that will be paid as covered benefits under the LTC contract. These alternatives will be defined more thoroughly in Section 6 of this manual but these services include

1) Adult Date Care
2) Respite Care
3) Hospice
4) Continuing Care Retirement Communities (CCRC's)

Role of Care Coordinator

A "Care Coordinator" must be a licensed heath care practitioner who meets the qualifications as set forth under the terms of the LTC contract. It is their role, by training and experience, to coordinate all the needs of an insured who is chronically ill. A plan usually pays for the services of the care coordinator without reducing any other benefits of coverage provided under the policy. The concept is that the care coordinator will be available for ongoing assisting and managing of the insured's long term care needs on an efficient basis that will reduce the cost, yet maximize the care provided.

Care coordinators are trained to evaluate and identify a person's cognitive, functional, personal and social needs for care and services. These professionals will help put people together with a full and wide range of needed care and services including:

1) Assessing and reassessing, as necessary, an individual's health care needs status,

2) Creating a plan of care and services initially and ongoing monitoring for changes as required and

3) Helping to assist the insured and family to access any care and services changes as they may occur in the future.

Without the assistance of a qualified care coordinator, an individual with long term or assisted living needs would face a very difficult and time consuming task in trying to obtain the correct care and services needed by those caregivers properly trained to provide them. Undoubtedly the importance of the role of care coordinator cannot be over-emphasized.

Plan Features

The following features explain in general the terms THAT MAY BE offered in a traditional long term care policy. Reviewed are the typical provisions, exclusions and additional features that usually appear in such a LTC policy.

Grace Period

While graces periods normally are at least 31 days some contracts will extend beyond this time and offer an additional month or more. After the first month passes without payment a company may send out notification and give the policyowner more time as specified in the policy during which they may pay the premium owed without incurring a lapse.

Reinstatement

This clause will offer conditions under which a company may reinstate their lapsed contract when premium was not received during the stated grace period. These conditions will vary from company to company but can be no less generous than those proscribed by insurance regulation. This means a carrier may be more generous than the law allows in this regard.

Incontestability

Most states require that an individual long term care policy must be offered as no less than with a guaranteed renewability clause. This means that material misstatements cannot be used against the insured after a two year period from the date of policy issue. Some companies may be a bit more generous in this area as well. For instance a clause might read that any material misstatements discovered in the first six months or first year will cause a contract rescission but thereafter and until the two year period is reached the only misstatements that can be used for a rescission are those relating directly to the claim for benefits being made.

TYPICAL EXCLUSIONS

Care provided by a close family member (i.e. spouse, child, niece or nephew) is excluded. Some contracts will allow a family member to provide the care and receive benefits if the person is an employee of firm that regularly provides such care. The organization would have to be the entity receiving payment rather than family member.

If the care being given would normally be free without the presence of insurance.

Services received when the policy is not in force.

Treatment in a government facility, except a Veteran's Administration facility, or services which are eligible for payment under Medicare, any federal or state worker's compensation, employer's liability or occupational disease law or any motor vehicle no-fault law.

Care as the result of alcohol or drug addiction unless the addiction was to medication lawfully administered by a licensed physician.

Care resultant from suicide or a suicide attempt or self-inflicted injury.

Care or services provided outside of a geographic area (i.e. USA, Canada or the United Kingdom) except as provided under an international travel benefit clause.

Care or services that result from war or an act of war either declared or undeclared.

NONDUPLICATION CONCEPTS

Veteran's Administration Benefits – the policy may pay the difference between the insured's actual incurred expenses in a VA facility and those provided by or for the VA facility. However, the policy will not pay more than the benefit payable in the absence of any VA benefits.

Medicare

Any expenses reimbursable under Title XVIII of the Social Security Act (Medicare) will not be paid as a benefit by the insurance carrier.

MISCELLANEOUS POLICY FEATURES

Benefit Restoration

A contract may provide that a lifetime benefit maximum may be restored if a portion is utilized but the insured recovers for a minimum number of days before again requiring care covered under the policy.

30 Day Examination Right

Also known as the “free look provision” this allows the policy owner the right to return the policy within 30 days of delivery to the carrier for a full refund of any premium paid. Normally this 30 day requirement is mandated under state law. If a state was to require an even longer free look period then state law would prevail over the insurance company contract provision.

Guaranteed Renewability

This very important contract right means that as long as the policyowner pays the premium due in a timely fashion the carrier cannot cancel coverage. Most states require the inclusion of this renewability clause in an individual policy but may not require its inclusion in a group LTC contract. The clause also gives the carrier the right to increase premiums in the future to an entire “class of insureds” meaning the company cannot single out a policyowner for a rate hike but must apply a premium increase to everyone owning the same type of contract in a state.

Waiver of Premium

In the event the insured meets the eligibility requirement for the payment of benefits under the LTC policy then as of that date all premiums are waived. Usually to qualify an insured must be receiving a benefit relating to care or services in a nursing home, for assisted living or a minimum number of days of home health care. A waiver may end when either care benefits are no longer paid or the maximum payment time has been met.

Premium Refund

An optional rider offered by many companies is for the refund of premiums paid after death of the insureds based on a pro rata formula tied to any benefits for care or services that was paid by the policy as long as the contract was in force.

Premium Discounting

A contract may discount premium cost for one or more of the following reasons: spouse discount, two-person discount, employer or employee paid plans, membership in an affinity group.

Section 3) Partnership LTC versus Traditional LTC

This section explains the key differences between Partnership and Traditional LTC policies. Since Partnership policies offer asset protection for Medicaid eligibility, this role of coverage is highlighted. The element of LTC benefit inflation is analyzed to stress its critical role in the long term care planning process. Finally, this section offers the study comparison between the benefits typically purchased by Partnership and traditional LTC policyowners from a Government Accounting Office report of 2007.

Mandatory versus Optional Benefits

Long term care insurance can be purchased by people directly from an insurance company or through groups such as employer sponsored programs or association groups. Through the year 2002 there were approximately nine million LTC policies purchased and of those the individual versus group purchase was roughly an 80%-20% split. In an effort to set forth the partnership vs. traditional contract requirement differences, a review of possible benefits is necessary.

A Comprehensive Long Term Care policy means coverage includes benefits paid for care in a nursing facility and for care in home and community environments. Less than comprehensive offerings in the traditional LTC marketplace are available to cover only home and community based settings without nursing facility benefits. Obviously there are substantial premium savings when nursing home care is excluded from coverage. A partnership Program policy requires comprehensive long term care coverage and therefore this will increase the cost of coverage as opposed to buying a home and community only traditional LTC contract.

A key component of purchasing LTC coverage is to assess the amount of benefit to purchase in terms of both dollar coverage and indemnity (the total length of time coverage exists once benefits begin) period selected. Normally a daily benefit amount is selected by the purchaser n conjunction with a total benefit period. Data from 2002 through 2005 show that average daily benefits purchased range from less than $100 per day to more than $300 and indemnity periods range from one year to lifetime coverage. Minimum daily benefits amounts are required by the Partnership Program but traditional LTC policies may offer this but are not required to do so.

Another factor affecting premium cost is the elimination period selected at purchase. This is a time deductible period during which benefits are not paid by the policy even though care has begun. During the elimination period the policyholder pays for costs out-of-pocket. Elimination periods typically run from zero days up to two years with many increments offered between these minimum and maximum extremes.

Once a person reaches the age of 65 it is estimated that about 70% will require long term care services of some type before death. The average age at which coverage is purchased is around sixty but the age at which benefits are normally used is when a person is between the ages 0f 75 to 85. This makes inflation a main concern when buying LTC coverage. While traditional LTC policies offer inflation protection, the purchase of it is optional. In a Partnership LTC policy inflation protection is required at specified purchase ages under 76 years of age. A more detailed discussion of inflation and the manner in which it can impact benefits is offered later in this section.

In states where both partnership and traditional LTC has been offered it has been observed that the primary reason people purchase traditional LTC is because of the greater cost of the partnership contract due to the requirements of inflation protection.

Another difference is that partnership LTC requires a minimum benefit period while traditional LTC coverage are not subject to a state mandated minimum benefit period. On the other hand, one similarity between the two is that both include an elimination period but a partnership policy will typically limit the elimination periods that can be included.

Yet one more requirement of a partnership policy is the inclusion of case management services (from an assigned care coordinator) which can include creating care plans, approving actual long term care services, monitoring the policyowners' medical needs as well as giving overall assessments of long term care needs. Traditional LTC contracts may offer a care coordinator benefit but are not required to do so.

A final requirement of partnership coverage is that the policies may only be sold by insurance producers that are specially trained to sell the product. Each state must define and certify course programs mandating that any producer who will sell a partnership policy has met the training obligation set forth by the state decision of insurance. In Illinois the requirement is to complete this one time course number 25008 and then subsequently a four hour continuing education course specific to maintaining this long term care sales authority during each subsequent two year producer license renewal period.

Role of Asset Protection

As detailed in an earlier section, Partnership Policies try to entice consumers to make the purchase because some or all of their assets can be exempted from Medicaid spend-down requirements. Traditional long term care policies cannot offer this asset protection possibility to prospective purchasers. Because the state's goal is to allow Partnership policies in order to protect the future of the Medicaid program, these contracts have greater benefit requirements than do traditional LTC policies. The thinking is that the Partnership Policy helps to assure that more significant portions of anticipated long term care costs will be covered by the contract benefits.

Historically people who have bought partnership policies receive more extensive coverage than those who opt for traditional LTC. This more extensive coverage naturally comes at a greater cost because a partnership contract requires the inclusion of both inflation protection, for most purchase ages, and comprehensive benefits. However, the valuable asset protection feature exclusively available through the purchase of a partnership policy makes a strong argument to pay the extra premium over the purchase of a traditional LTC policy.

Inflation

Baby Boomers, an estimated 70 million strong, started turning 60 in 2006. Many in this group with first witness their parents and then themselves needing long term care services. By 2030 about 8 million Americans will be over 85 years of age and by 2050 this total swells to 18 million people. Since people over the age of 80 are most likely to need long term care and services and the average age at which people purchase a LTC policy is about age 63, it is clear that the single greatest danger to the LTC policyowner is the threat of inflation.

Benefit Impact

What is the value of buying a long term care benefit based on long term care costs today if the benefit purchased does not increase to adjust for future inflation? The main reason traditional LTC policies have been more popular than the purchase of a partnership policy is due to the fact the buyer of a traditional LTC contract can enjoy cost savings due to either not purchasing inflation protection at all or adding a minimal rider to increase future benefits.

At average LTC purchaser ages, the cost of a 5% annual compound interest rider makes the policy cost about double that of a policy without inflation protection, other factors being approximately equal.

As of 2008, the average annual nursing home cost is pegged at around $70,000 which translates to about $190 per day. This average will vary depending upon geographic location. People who seek a nursing facility in or near a major urban area will pay significantly more for care than will people who populate rural areas. Likewise the cost in some states (for instance New York and Connecticut averaged about $250 daily as of 2008) will cost much more than other states (as low as $100 in several states).

Protection

If a buyer of LTC takes out a $150 daily benefit in the present and owns 5% annual and automatic compound inflation protection, then the daily benefit in 20 years will be about $400 a day. If the inflation protection purchased is only at a 3% annual compounded rate, then the daily benefit in 20 years will only be about $300 per day.

Traditional LTC policies may offer compound inflation ranging from 2% to 5% or they may offer simple interest annual increase. However, the purchaser of a traditional LTC policy may add inflation protection or they can choose not to have any inflation coverage at all as a way to keep premium cost down. Partnership policies require that purchasers under the age of 76 must have inflation protection in their policy. Furthermore, purchasers of a partnership LTC policy who are under the age of 61 must have a contract that automatically includes 5% annual compound inflation protection.

GAO Study Comparison

When the GAO released a May 2007 publication number 07-231 one of the points analyzed was to compare what benefits policyholders purchased during the period of 2002 through 2005. First, of all Long Term Care policy sold in the United State during this period, 98% were traditional and only 2% of the purchases was a Partnership Policy.

TABLE 1, entitled "2002 THROUGH 2005 BENEFITS PURCHASED BY TRADITIONAL AND PARTNERSHIP POLICYOWNERS" illustrates the differences in coverage between the two policy types and the table appears on the next page. In interpreting the data three points seem clear:

1) Partnership policyowners purchased significantly greater amounts of higher daily benefit amounts;

2) Traditional LTC buyers selected greater than 3 year and lifetime coverage more often than did partnership owners and

3) Partnership purchasers preferred greater than 90 day elimination periods over traditional LTC buyers by a ratio of about 2.5:1

TABLE 1

2002 THROUGH 2005 BENEFITS PURCHASED BY TRADITIONAL AND PARTNERSHIP POLICYOWNERS

	PARTNERSHIP	TRADITIONAL
Inflation Protection	100%	76%
Daily Benefit Amt.	35% bought $100 to $149; 40 % bought $150 to $199; and 24% bought $200 or more	53% bought $100 to $149; 25 % bought $150 to $199; and 11% bought $200 or more
Benefit Period	3 years > 37% Greater than 3 years but not unlimited> 30% Lifetime> 19%	3 years > 23% Greater than 3 years but not unlimited> 37% Lifetime> 26%
Elimination Period	30 -89 Days > 23% 90 Days > 47 More than 90 Days> 27%	30 -89 Days > 21% 90 Days > 60 More than 90 Days> 11%
Coverage Type	Comprehensive> All	Comprehensive> 91%

Section 4) Medicare and Medicaid

Roles

It is easy to confuse “Medicare” and “Medicaid.” While these two federal creations sound similar, their roles are very much different and separate when it comes to serving society as a social safety net. Medicare is administered by the federal government, funding is provided by the Social Security Program and financial need is not a criterion for eligibility because it is an “entitlement.” Medicare has many coverage elements but the main one for paying for elderly nursing home, home care and hospice services comes from “Part B” which was added to the program in 1972 and was designed to pay for supplemental charges including "outpatient" care: office visits to medical specialists, ambulance transportation, diagnostic tests performed in a doctor's office or in a hospital on an outpatient basis, physician visits while the patient is in the hospital, and other outpatient therapies that are prescribed by a licensed physician.

Currently about 14% of nursing home costs are paid by Medicare for short-term skilled nursing home care following hospitalization. Medicare also pays for some skilled at-home care but only for short-term basis for limited conditions and not for the long term help that many elderly people need.

Nursing Home Care

The following requirements must be met in order to qualify for nursing home confinement

1) The facility must offered a skilled level of care

2) The facility must be Medicare certified and only less than one half of nursing home facilities are Medicare certified

3) There is a prior hospitalization requirement of at least three days but no more than 30 days

4) The patient must require a skilled level of care

5) The care provided in the nursing home must be for the same condition that caused the hospitalization (or a condition medically related to it)

Once a person is qualified as outlined above, benefits for a stay in a skilled nursing facility are paid as follows:

1) For the first 20 days the patient pays nothing and Medicare pays the full cost.

2) Beginning on the 21st day the patient pays up to $128 a day (in 2008 and this amount is indexed each and rises with inflation) and then Medicare pays the full cost of remaining charges.

3) After 100 days the patient pays the full cost and Medicare pays nothing.

Many times nursing homes will end Medicare coverage for Skilled Nursing Facilities (SNF) care before they should. There are two common instance of this occurrence that leads to the wrongful denial of Medicare coverage to SNF patients. First, some nursing homes falsely assume that if a patient has stopped making recovery progress then Medicare coverage will stop. The fact is that if the patient requires continued skilled care simply to maintain his or her status (or to slow deterioration) then the care should continue and it is covered by Medicare.

The second common nursing home mistake is that they can incorrectly believe that care that requires supervision only as opposed to “direct” administration by a skilled nurse is excluded from Medicare's SNF benefit. Again the fact is that patients often receive a various treatments that don't need to be carried out by a skilled nurse but which may, when combined do require skilled supervision. If this situation occurs there is likely a potential for adverse interactions due to multiple treatments and this will require that a skilled nurse monitor the patient's care and status. This scenario means that Medicare will continue to provide coverage.

When a patient leaves a hospital and moves to a qualifying nursing home, the nursing home is required to provide written notice of whether the nursing home believes that the patient requires a skilled level of care and therefore is eligible for Medicare coverage. If a SNF treats a patient as being Medicare covered then often after just a couple of weeks SNF will decides that the patient no longer needs a skilled level of care and will issue a "Notice of Non-Coverage" to stop the Medicare coverage.

The notice typically asks whether the patient would like the nursing home bill to be submitted to Medicare even though the nursing home's assessment of his or her care needs do not qualify. It does not matter if the SNF provides this non-coverage determination upon entering the SNF or after a period of treatment, the patient (or representative) should always ask for the bill to be submitted. By asking the SNF to submit the bill anyway to Medicare it force the nursing home to submit the patient's medical records for review to an intermediary which is an insurance company hired by Medicare to which review the SNF's determination.

Another reason the patient should insist on bill submission to Medicare is that this review is free and the patient may be eligible for additional Medicare coverage. Furthermore, while the review is being conducted, the patient does not have to pay the nursing home. If the appeal is denied, the patient will owe the facility retroactively for the period under review. Also, if the Medicare intermediary agrees with the nursing home that the patient no longer requires a skilled level of care, the next level of appeal is to an Administrative Law Judge. Such an appeal can take a year and normally involves hiring a lawyer. This avenue should only be taken if an experienced attorney firmly believes that Medicare made an incorrect coverage determination because appeals can be quite costly.

Home Health Care

If the recipient qualifies, Medicare will completely cover home health benefits. Although there is no limit on the length of time of coverage, in practice it is limited. Medicare home health benefits can mean the difference between a person continuing to stay at home, or having their health deteriorating until hospital care or nursing home placement become necessary.

Entitlement to Medicare coverage of home health care exists when the following requirements are met:

1) Home confinement (meaning that leaving home to receive services would be a "considerable and taxing effort"):

2) A licensed doctor has ordered home health services for you; and at least some element of the services you receive are defined as "skilled" which equals intermittent skilled nursing care, physical therapy or speech therapy.

3) The home health care agency must be Medicaid certified (again less than half are).

If the person meets the test of having an element of "skilled" care, then they are also entitled to Medicare coverage of

1) social services,
2) part-time or intermittent home health aide services, and
3) necessary medical supplies and durable medical equipment.

There is nothing for the Medicare patient to pay for home health care with the exception of 20 percent of the cost of medical supplies and equipment (such as durable equipment) and this can be paid by some Medicare Supplement policies. Although the government has not changed the terms of service in this area sometimes providers try to save in areas to balance their own business costs. Therefore Medicare recipients must advocate for the services they need.

The good news is that appeals for termination of home care services enjoy an initial success rate of about 40% at the first review level and that rate climbs to about 80% on appeal to the administrative law judge level. The bad news is that you have to pay privately for the care in order to have an appeal able issue because the issue on appeal is not the termination of a service, but the denial of Medicare payment for the service. This leads to most people settling for what they are given or they try to make do without the care or they hire help on their own who do not have the training necessary or the supervision normally provided by home health agencies.

Sadly, the majority of Medicare beneficiaries have not been informed of their appeal rights when given notice that their home health care benefits will be terminated. There are movements in place to try and rectify this failure to notify a recipient of their rights in this area.

Hospice Care

Medicare recipients who have no more than six months to live enjoy unlimited hospice care paid for entirely by Medicare. The care may be delivered either at home or in a hospice facility. Hospice care services include

1) home health aide and homemaker services,

2) physical therapy,

3) counseling,

4) physician and nursing services.

5) "respite care" - a maximum of five consecutive days of inpatient care designed to give the patient's primary at-home caregiver relief. The patient must pay a very tiny percentage of the cost of respite care; in 2008 it was only a 5% charge.

Other than being responsible for up to a small co-payment for each prescription drug hospice benefit, recipients have no deductibles or other co-payments for which they are responsible. By electing hospice care, the recipient has decided to receive non-curative medical and support services rather than to get treatment with the goal of trying to delay or cure the terminal illness.

Medicare's hospice home care benefit does not cover full-time care therefore it is only a viable option when there is a full-time caretaker in the home with the terminally ill person.

Medicaid

Medicaid is a joint federal and state program that has historically financed from between 40% to 50% of long-term care costs in the United State. Medicaid is not an entitlement because it only provides benefits to low-income individuals who must qualify for welfare before being eligible for benefits.

When a Medicaid qualified applicant seeks a nursing home facility they must accept entrance to a facility which accepts Medicaid benefits. Nursing homes are more reluctant to accept Medicaid patients because the reimbursement amount is lower than that normally received by private pay patients.

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eligible for *full* Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their State's Medicaid program, according to eligibility category. These additional services may include--for example--nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids.

For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort." Eligibility to receive Medicaid is not based on age but rather on financial need as determined by family income as related to state rules for eligibility through comparisons with national statistics which determines the “poverty level” from year to year. Table 2, 2007 U.S. Department of Health and Human Services (HHS) Poverty Guidelines, provides the most recent figures at the time this manual was written and it will adjust annually. Table 2 is shown in the next topic area under Asset and Income Tests.

Asset and Income Tests

Medicaid eligibility varies from state to state. The basic idea is that the federal government funds part of the program to state with annual block grants. These grants are designed to pay from 50% to 83% of an individual state’s Medicare funding. The actual funding a state receives is based on various economic factors the federal government weighs when allocating the block grants. Essentially, the poorer the state’s population then the greater the percentage the block grant will be of that state’s Medicare spending. States are responsible for funding the difference between the federal block grant received and the total Medicaid assistance the state pays to its eligible residents in a given year.
Whether or not a resident is eligible for Medicaid depends on that person’s state requirements.

Generally a resident must meet some proscribed needs test relating to income and assets and perhaps additional requirements depending on what services were received by the resident. When it comes to Medicare assistance for payments made by Medicaid for the resident, total allowed assets range from $2,000 to $5,000 for most states. After that income test varies by state but typically for Medicare recipients who wish to qualify for Medicare they must have a sufficiently low "Supplemental Security Income" (SSI) when compared with other seniors according to the published Federal Poverty Level (FPL). The 2007 FPL is shown in Table 2, below.

TABLE 2

2007 U.S. Department of Health and Human Services (HHS) Poverty Guidelines

Size of Family Unit	**48 Contiguous States and D.C.**	**Alaska**	**Hawaii**
1	$10,210	$12,770	$11,750
2	13,690	17,120	15,750
3	17,170	21,470	19,750
4	20,650	25,820	23,750
5	24,130	30,170	27,750
6	27,610	34,520	31,750
7	31,090	38,870	35,750
8	34,570	43,220	39,750
For each additional person, add	3,480	4,350	4,000

In Illinois a person must apply for Medicaid to become eligible and the 2008 SSI levels were

$564 single
$846 couple

Eligibility for SSI is determined by the Social Security Administration and is indexed for inflation.

Furthermore Illinois is what as known as a "209(b) state" when it comes to residents qualifying for Medicaid eligibility. A 209(b) state is a state that opted to continue to use the Medicaid eligibility standards it had in place when SSI was enacted in 1972. Those policies are generally more restrictive than the SSI eligibility rules. Therefore Illinois is one of the eleven hardest states for an aged, blind or disabled resident to qualify.

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid program. Qualified Medicare Beneficiaries (QMBs) generally must meet the following test to qualify for state Medicaid premium and cost-sharing:

Have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100% of the Federal Poverty Level (FPL).

Qualifying for Medicaid is a complex and challenging endeavor but it should be clear that Medicaid serves only Medicare recipients who have virtually no assets and whose income is among the lowest of the entire United State population.

Role of Partnership LTC and Federal and State Spending

As we consider our previous analysis of Traditional Long Term Care insurance policies, the services offered through Medicare and the eligibility concepts and spending of Medicaid it becomes clear that the federal and state LTC Partnership Program is hoping to reduce long term Medicaid costs. Each of these government “partners” have a lot to gain if the perceived shift to the private insurance sector of long term care costs does, in fact, reduce Medicaid spending.

The US elderly population will increase significantly through the year 2040. This aging factor will only be compounded by the fact that people are living significantly longer in this and future generations. There is a lot riding on the success of the LTC Partnership Program as well as any other combined efforts federal and state government can envision that will reduce Medicaid spending.

Section 5) Evaluating Client Long-Term Care Needs

General Reasons for Need for LTC Insurance

The fact that Americans are achieving greater and greater longevity is not a surprise as our medical technology combines with information promoting better health through diet and exercise. What is surprising is the actual number of Americans who reached age 65 and beyond as of the 1990's. The shock begins to seep in when we analyze the sheer multitude of elderly expected to be alive in America by the middle of the 21st century.

The reason we can predict sweeping shifts in the population is the science of "demographics". Demographics is the study of population with respect to any number of variables including sub sets based on age or economics. When the use of demographics encompasses the elderly, the actual impact of geriatric numbers can be astounding.

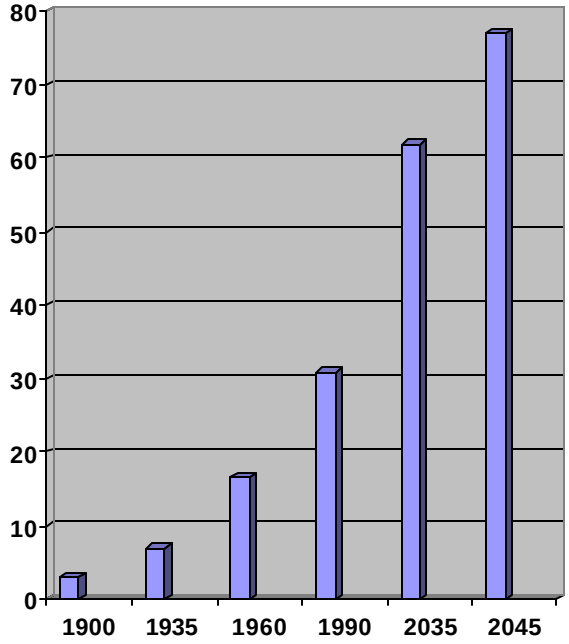
Consider the year 1900 when, in America, the total population was 77 million of whom about 3.1 million were aged 65 or older. This represented an elderly population which constituted about 4% of the entire population of the United States. In 1900 the average life expectancy by race was age 50 for Caucasians and 35 for African Americans. In 35 short years, this expectancy jumps to 60 and 50 years, respectively, by race.

Such a startling development put the federal government on notice that the issue of retirement and economics of the elderly class would loom much larger. Combined with the great depression, the sight of more and more poor elderly scared an entire generation into action. The Social Security Act is borne from the elderly demographics of the first part of this century.

By 1960 the population age 65 and older climbed to 16.7 million people or more thereby doubling to 9% of the entire population over the levels of the year 1900. A few years later The Social Security Act was amended to include Medicare, health insurance for the elderly aged 65 and older.

More cold numbers: as of 1990 12% or 31million of the U.S. population was 65 or older. By the year 2025 the demographics show the number to be doubled at 62 million which will translate into 20% of the total population. In 2045 we will come full circle with respect to the year 1900 as the elderly population is expected to grow to 77million, or what the entire U.S. population was just a century and a half earlier. The growth of the US elderly population from 1900 and projected through 2045 is shown in Table 3, ELDERLY POPULATION OF UNITED STATES, below:

TABLE 3
ELDERLY POPULATION OF UNITED STATES
(Age 65 and older – In Millions)



If the current system is financially strained to accommodate the elderly, then how will the nation take care of an older population that doubles by 2045?

Another question comes to mind. In addition to greater numbers is there any other reason for the increasing popularity of nursing homes for the aged? The answer would be yes primarily due to lifestyle influences of what has often been called the "sandwich generation". Middle aged people having both needy children and aging parents who place increased strain on the primary nuclear family. The stress related to worrying about and caring for aged parents is enormous.

It is increasingly rare to find families on "Walton's Mountain" wherein the 1930's family depicted on the television series took care of Grandma and Grandpa after they experienced debilitating health problems. Today the solution is to find an appropriate geriatric community or care facility, if the financial details can be worked out.

The burden of an increasing elderly population has also been measured by the technique known as the **"Old Age dependency Ratio" (OADR). OADR measures the number of people aged 65+ in the population compared to every 100 working age Americans. Today's OADR of 20 is expected to climb to 32 by the year 2025.** That simply means that as time passes the older population becomes more dependent upon greater numbers of the younger population to sustain economic viability, especially when it involves funding government social and entitlement programs like Medicare and Medicaid. The OADR number was just one in the late 1930's shortly after Social Security was enacted in 1935 because they just a few active beneficiaries collecting benefits compared to the number of people who were paying into the program.

Statistics indicate older elderly age segments require greater help with activities of daily living**. Only 9% of seniors aged 65-69 require such help** while 45% of people 85 and older need personal care assistance. **Of this oldest age group, most are females living alone with little or no disposable income.**

Since the oldest category (age 85+) needs the most care and is expected to more than double in size by 2045, the strain to pay with welfare programs may stretch them past the breaking point. These demographic factors cannot be ignored by people currently under the age of 65 who may still be in a position to purchase long term care insurance. Despite all these demographics staring pre-65 year old consumers in the face, privately owned insurance is currently the method least used for paying for long term care costs.

Personal Factors

If a prospect for long term care insurance is suitable by age, income and other factors and is unsure of committing to the purchase he or she may find it useful to analyze their personal situation with respect to

1) Health Risks;
2) Family Considerations;
3) Asset Review; and
4) Self-Insuring Pros and Cons

as a logical prelude to making this important decision. Here is a general discussion of each point in more detail:

HEALTH RISKS

The first exercise is to consider your personal and family health history. If a prospect is in their early 50's and already suffers from a host of health problems, it may be difficult or impossible to purchase a suitable LTC policy at an acceptable cost. Obviously the best time to purchase LTC, or any insurance for the matter, is when you are younger and healthier as opposed to older and more decrepit.

Concerns should be pressing if there is a family history of conditions like Alzheimer's disease, Parkinson's disease, Heart problems, stroke or cancer. A history of any one or more of these conditions should sound an alarm of concern to consider the purchase of a suitable long term care policy.

FAMILY CONSIDERATIONS

This is a brief list of questions, relating to current family circumstances, which should be posed and answered:

1) Is accepting help from others something you are willing to do?

2) Do you have any children willing to assist you in your current residence who live within convenient driving distance of your home?

3) What is your plan if you family was not able to take care of you either now or in the future if you have a need for assistance?

4) What is the current status of the health of your spouse?

5) Are you comfortable with your current living arrangements?

This line of questioning and considered answers is designed to make people realize whether or not they have a long term care planning issue. If someone who should be analyzing the purchase of LTC has not been thinking about this need, posing and answering these questions will possibly prompt them to move forward to protect self and family with the proper coverage.

Asset Review

Needing Long Term Care insurance and being in a position to afford the premium cost are two different concepts. To determine financial position, an asset assessment is recommended. The assets to total will include certificates of deposit, stocks, bonds and other assets excluding home equity.

The second phase is to consider, once all assets are totaled, whether or not the individual is concerned about the prospect of losing them. If the answer is “yes” then the next step is assess which assets require protection as well as the total amount requiring protection, since one year of long term care nursing cost is about $70,000 in 2008.

Self-Insuring Pros and Cons

The term “self-insure” shall mean not transferring the long term care cost to a private insurance company while also being ineligible for Medicaid. Those who quality for Medicaid only do so because they meet all eligibility test including the asset requirement and therefore people in this category are utilizing the safety net of social welfare.

Individuals who use personal assets to pay for long term care expenses prior to qualifying for Medicaid are self-insuring the risk. The individual decision of whether or not to transfer the LTC risk to a policy will depend on two basic factors:

1) the amount of assets owned and

2) the amount of disposable income and whether or not it is sufficient income for the premium cost required.

Generally, if the amount of owned assets is equal to or exceeds the cost of one year of nursing facility care and the individual has enough disposable income to handle the long term care policy cost, then that individual may wish to consider an LTC policy purchase. On the other extreme, people who are wealthy enough and who could easily pay the monthly cost of nursing home care without threat to asset principal would have no need to purchase an LTC policy, thus self-insuring makes sense in this example. Between these extremes of the poorest and wealthiest older Americans lies the territory of those who must decide whether self-insurance makes sense to them.

The next topic explores the concept of “who buys long term care insurance.”

Demographics of Types of LTC Purchasers

There has been more than one detailed study done during the period of from 1990 through 2005 designed to see who buys LTC coverage and who does not, as well as the underlying attitudes behind the range of consumer behavior. Time and again these studies show that the main reasons people tend not to buy LTC coverage is because they are confused about what the government pays or does not pay or they mistakenly believe that the government will pay for their long term care services if, in fact, they ever need such services. Twice as many non-purchasers of LTC insurance believe that the government will take of the cost of their long term care service compared with those who bought an LTC policy.

On the other hand, for those people who do purchase long term care coverage there are many reasons for this action taken but the primary factor is to protect assets. In fact, younger buyers of LTC simply view the purchase as part of a broader financial and retirement planning process.

Other demographic highlights:

> In 1990 29% of those making less than $20,000 bought LTC but in 2005 it was only 3%;

> In 1990 33% of those making $20,000 - $34,999 bought LTC and in 2005 it was 13%;

> In 1990 17% of those making $35,000 - $49,999 bought LTC and in 2005 it was 13%;

> In 1990 21% of those making $50,000 or more annually bought LTC and in 2005 it was 71%;

> Long term Care policy purchasers believe they are at a greater risk for needing long term care services than those who are non-buyers (whether this is just an attitudinal belief or based on family health risk assessment is not clear);

> The 1990-2005 trends were that males are increasingly purchasers (37% up to 43%) and females' purchase rate is slightly decreased (63% down to 57%);

> The average purchase age has decreased from 68 in 1990 to 61 in 2005 and continues to trend lower;

> In 2005 77% of LTC policies were purchased by individuals who were aged 64 or less years a clear trend away from 1990 and 1995 when most policies were purchased by people aged greater than 64 years;

> LTC policies are overwhelmingly purchased by married people (73%) as opposed to those who are divorced (10%), widowed (9%) or were never married (6%);

> By 2005, 76% of LTC purchasers had assets of $100,000 or more versus 1990 and 1995 when only 40% of those with over $100,000 in assets were purchasers;

> The education level of buyers has increased significantly since 1990 when only 33% of buyers had been graduated from college 2005 when 61% of purchasers have a college degree;

> When it came to basic perceptions about the costs of long term care services between buyers and non-buyers of LTC policies, 61% of buyers overestimated the costs while 70% of the non-buyers underestimated the costs.

> Current purchasers are tending to buy comprehensive policies (90% in 2005 vs. 37%) , are opting for longer elimination periods, are increasingly adding inflation protection to polices and the average premium cost keeps increasing ($1,071 in 1990 vs. $1,918 in 2005).

> The primary reason new buyers purchased a policy in 2005 was from the fear that the cost of the insurance would increase in the future (70% felt this way.)

Suitability

There is increasing pressure on insurance companies and the agents who market long term care policies to make them accountable for marketing LTC to clients who meet suitability tests. It should be obvious that trying to sell LTC to a person who has few assets and a small income is not only a waste of time, it is simply wrong. Also increasingly clear is the concept that potential LTC consumers need information and education about not only policies and coverage options but also about how Medicare and Medicaid function in the long term care and services arena.

All studies mentioned illustrate the point that people who do not own LTC are not aware of the facts about nursing and home health costs tend to misunderstand what the roles of federal and state governments are when it comes to paying for these costs. They also show that people who have purchased a LTC policy seem content with their purchase and better understand how and why the coverage helps them.

Therefore beyond the simple idea that people with few assets and limited incomes are not candidates for a LTC policy is another: that people need to be educated and informed on the topic relating to long term care costs and services before any consideration of coverage begins.

Section 6) Long Term Care Alternatives of Care

Are considerations of long term care just for the elderly or for people of all ages? Strikingly 40% of all long term care recipients are under age 65 and of this forgotten group about only 10% are in nursing homes while the rest are cared for within their own community and mostly at home.

According to the US Census Bureau a study of "Older Adults in 2005" revealed the following trends in the US populations for people who were 55 and older

> The number of people aged 55 to 64 increased by the greatest percentage, 25%, and totaled 30.4 million.
> The second greatest increased segment was 85 and older which rose 20.2% for a total of 5.1 million people.
> The 65-74 and 75-84 year old group went up only 1.4% and 5.6%, and total 18.6 and 13.1 million respectively.

(Editor's note: these numbers indicate that since the average age of a long term care policy purchaser has been about 63, from the year 2005 through about 2020 should prove to be the golden age for marketing long term care policies).

This 2005 Census report also show that as people age the number of males in the population steadily decreases from being about even at age 55 to:

TABLE 4
UNITED STATE CENSUS 2005
NUMBER OF MALES PER 100 FEMALES

Ages 55-64	93
Ages 65-74	84.4
Ages 75-84	67.9
Ages 85 +	45.9

In this same 2005 report here is a breakdown of marriage percentages by age and gender:

TABLE 5
UNITED STATE CENSUS 2005
PERCENTAGE MARRIED BY GENDER

	MEN	WOMEN
Ages 55-64	74.5	62.9
Ages 65-74	75.5	54.1
Ages 75-84	69.3	35.5
Ages 85 +	56.5	14.5

Tables 3 and 4 indicate that an unmarried and healthy male aged 85 or older would possibly have a busy social calendar among females his own age. There are more than more than twice as many females and about 6 of 7 of these older females are unmarried.

The actual risk of needing long-term care is based upon the manner in which it is defined but the general consensus places the figure at about the 50% level, meaning 1 in 2 people over the age of 65 will require some form of long term care services. This high percentage of projected need is based upon

> The aging US population
> Technological advances that promise to significantly increase life spans
> A mobile US population in which adult children of aging parents increasingly live more than 500 miles away
> Increasing difficulty of finding qualified caregivers to provide services in the home

The cultural changes in the United States will also affect how and where long term care services will be delivered. Historically, women have provided in home care to the chronically ill. Over the past generation the number of women working outside of the home has increased markedly leading to a shortage of females as traditional caregivers. The so called “sandwich generation” or people who have elderly parents that need attention while also tending to the needs of their own college aged children while simultaneously trying to plan and fund their own impending retirement. Another way family size and location has been affected is by the ever present high divorce rate.

Since we are a changing and aging society it is flexibility that will be required in the near term and future for delivering long term care solutions to those who require assistance. These services range from unskilled help at home all the way to custodial and highly skilled caregivers in institutional settings

Here is a synopsis of those who supply long term care services in various forms:

Adult Day Care

Adult day care offers daytime programs for usually older adults that may include a range of social, medical, and personal services. Providers of adult day care can be hospitals, religious or other civic groups, nursing homes or local governments. This is an ideal solution for a person who wants to give care to a loved one but who must work during the day yet wishes to keep a family member living at home with them. The recipient of adult day care is usually someone who should not be left alone for prolonged time periods.

Home Health Care

Health Home health care means that long term care is being provided in the home. These services can be very broad in scope and may include assistance with activities of daily living like personal care, or more advanced help like skilled nursing care or speech therapy. Other services could include those which are social in nature or the services of a home health aide. Home health care can be provided as often as several times a day or as infrequently as once a week or a couple of times per month. The idea is to provide the help that is needed at the times required.

Respite Care

Respite care is meant to help a caregiver by allowing them some time away from the person requiring the care, often a close family member like a spouse or son or daughter. Long term care policies will often have a benefit that pays for the temporary services of providing formal care services in an approved facility provides so the family caregivers can do errands, rest or take a much deserved and needed short vacation.

Assisted Living Facility Care

This level is viewed as a “halfway” type of care Assisted for individuals who require daily assistance, but don’t need full time nursing care in an actual facility or nursing home. Various levels of personal care is offered in a setting that is more like your own home than a nursing home and thus the name “assisted living facilities” is the reference used in the marketplace for this service.

Custodial Nursing Care

Custodial nursing care is at a level that meets the personal needs of an individual and usually helps with what are commonly termed "essential activities of daily living." Examples of these activities are help with bathing, dressing, eating, taking medicine and with using a toilet. The caregiver at this level may still be provided by someone without medical skills, like a nurses' aide.

Intermediate Nursing Care

For those who do not yet require a skilled level of care 24 hours a day and 7 days per week, intermediate nursing care should be selected. At this level of care the services are occasional or intermittent nursing and rehabilitative care that must be performed by and under the supervision of skilled medical personnel.

Skilled Nursing Care

Individuals requiring "around the clock" care must be placed in a skilled nursing facility. This level of care has to be preformed under the supervision of skilled medical personnel. Nursing and rehabilitative services administered by registered nurses, licensed practical nurses or by licensed physical therapists under the orders of a licensed physician and with his or her supervision. Furthermore a skilled nursing facility only qualifies for benefits under a long term care policies if:

> It is a facility that is licensed by the state to provide nursing care as its main function;

>Provides continuous room and board for a minimum number of people:

> provides supervised care by an on-duty RN or LPN, maintains daily medical records and

> Maintains records of medications given and controls the methods by which medications are administered.

Homemaker and Home Health Aide Services

Just as the name of the service implies, Homemaker and home-care aide services can include household chores, shopping, cooking, and various duties relating to personal assistance. Payment is normally on a fee-for-service basis for the activities provided. This can be an important and invaluable service allowing the elderly to remain in their own home.

Hospice Care

If an individual is diagnosed as being terminally ill hospice care is a specialized approach offering comprehensive medical assistance in combination with social, emotional, and spiritual support services. It is aimed at not only helping the patient but also helping family members to cope with the final months and days in the life if a loved one. Payment for hospice programs can be made through both private insurance and governmental insurance programs. Usually a hospice coordinates the efforts of a team that is composed of professionals and volunteers alike to care for each patient on an individual basis.

Continuing Care Retirement Communities (CCRC)

A continuing care retirement community (CCRC) is a residential care community designed for retirees who are able to initially take care of themselves upon entering the community. A key element of CCRCs' is that long-term retirement care is provided. Residents enter into a contractual relationship with the CCRC that can last a lifetime.

In a typical CCRC contract, the residents is furnished with an apartment, health-care services, social services, recreational activities and planned social activities. However, the amount of health-care services provided, including long-term care services, depends on the contractual agreement between the resident and the CCRC. There is often a large initial deposit required by the contract and a monthly rental amount is paid. Depending upon the contract, some prorated portion of this deposit amount may be returned upon the death of the resident and at this time, it may be claimed by Medicaid under certain situation and conditions.

CCRC's usually fall into three categories based upon the amount of nursing home care to be provided. The nursing home care is then included in the price of admission. The first and most expensive choice is unlimited nursing home care that will be provided but the price of this guarantee is one time and usually upfront payment of a special entry or endowment fee which can be many hundreds of thousands of dollars.

A different and lower cost CCRC agreement involves a smaller initial cost in exchange for a specified, rather than unlimited, period of nursing home care should it become necessary. The third cost option is a fee for service arrangement wherebyresidents agree to pay all nursing home cost on a per diem basis.

Entry to a CCRC is based on an admission process which delves heavily into the financial and physical health of an applicant and the emphasis is definitely placed on wealth. As long as the applicant suffers from no dementia and does not yet require daily assistance, they pass the health exam. The financial requirement routinely stresses monthly income of 150% to 200% of the CCRC monthly cost for eligibility.

Before a consumer selects a CCRC it is highly advisable that they obtain copies of recent financial statements and have them evaluated. The CCRC is a substantial investment and the CCRC should be financially sound. All other details are spelled out in the contract between the parties. The applicant needs an attorney to properly review all the elements of the agreement.

If a resident leaves a CCRC the contract can have a provision to return all or part of the entry or endowment fee. Other situations, such as a couple in a CCRC (one of whom used some nursing care while the other didn't), would result in a partial refund to the surviving spouse. In the event the resident dies without using nursing care, any refund can be payable to the estate, unless Medicaid has a claim for reimbursement as required by DRA 2005.

Lastly, since qualifying for various levels of home, assisted or nursing care depends upon having multiple difficulties with various activities of daily living defining terminology is important. “Activities of Daily Living” are the following basic activities required for the applicant to remain independent.

Definitions for standard Activities of Daily Living (ADL's):

1) "Eating": feeding oneself by getting food into the body from a receptacle such as a plate, cup or table or by a feeding tube or intravenously.

2) "Toileting": getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

3) "Transferring": moving into and out of a bed, chair, or wheelchair.

4) "Bathing": washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

5) "Dressing": putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

6) "Continence": the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.

Section 7) Partnership Long-Term Care Summary

To summarize the reason the Partnership Program exists encompasses many inter-related variables. The first main root is the aging of America and the sheer numbers of people who are, or who will be, accessing long term care services. The second variable has been the expansion of government entitlement and welfare programs since the 1960's and the increased numbers of people who utilize these programs. Third is a desire by those who run and manage government to take some of the burden from taxpayers as the source of paying for nursing care and to transfer more of it to the private insurance sector as the population base requiring this care stretches to all time highs.

Problems Due to Aging Population

One of the greatest challenges Social Security and Medicaid face with the elderly population is reflected in the previously mentioned OADR – Old Age Dependency Ratio. At the inception of Social Security in the 1930's it was never imagined that by the year 2025 there would only be two workers contributing into the program for every one person currently receiving benefits under the program.

How could the initial actuarial assumptions be so flawed to allow this impending nightmare to happen? Human nature played a key role. Since the actuaries of the day in 1930 America could only base assumptions of what they knew at the time, their projections used mortality figures into the future which were realistic for that time. Mortality rates in the first half of the twentieth century were significantly different just fifty years later.

When the first Social security recipients began receiving benefits if greater numbers, in the 1960's, it was normal for a person to retire at age 65 and then die within a few years of retirement. Today it is projected that one in four people who reach age 65 will live to at least 90 years of age. Therefore a program that started out as a safety net for older Americans has become a shaky proposition despite the repeated calming words from politicians who constantly affirm the soundness of the program.

In the 1960's and early 1970's and then again in 2006, Social Security created the greatest program expansions in history with the introduction of Medicare Part A, Part B and Part D, respectively. As Americans continue to age in not only the greatest numbers ever but simultaneously with increasing life spans, the Social Security program must try to accommodate numbers never envisioned when the program was created. Since Part B does pay significant amounts of money in nursing and home health care benefits, the continued viability of the program is essential for delivering such care services to the elderly population of America.

As Social Security creaks and groans under the staggering economic pressures of the first fifty years of the twenty-first century it seems likely that the benefits being delivered will have to be redefined with respect to eligibility. While Social Security is an entitlement program it would appear likely that at some point it must means test and place other qualifications to eligibility in play in order to preserve the soundness of the system. Such actions would shift Social Security from being an entitlement to that of a social welfare program requiring eligibility before paying benefits, more similar in nature to Medicaid.

Decreasing Mortality

In a report released by the American Heart Association in January 2008 it was revealed that since 1999 the mortality rates for coronary heart disease and strokes, the first and third leading causes of death in America, each decreased by about 25%. These reductions were attributable to several sources included better preventive care, faster treatment at the onset of symptoms, smoking reduction rates, more effective medications and technology advances.

While there are many reasons a person will require long term care services in the future and heart disease and stroke are just two of them, this report poses many questions that directly impact on the costs of future long term care. The first question is whether the decreases in mortality rates for these two conditions have improved or are the just delayed? Since people are living longer due to the same reasons cited, perhaps the death rates of cancer and heart disease are simply delayed and not eliminated. If this supposition is accurate then the costs associated with long term care from these causes may only be pushed further into the future and possibly result in greater long term care costs instead of less expense.

There is no disputing that people are living significantly longer than ever before and, absent a medieval plague, they will likely continue to do so. Therefore as the population at older ages grows and bulges in numbers, the stress it could place on both entitlements and Medicaid could prove to be quite a challenge in the not so distant future.

All life insurance companies are bound to use the 2001 CSO Mortality Table beginning in 2009 and this difference between it and the older 1980 CSO table are startling. One need look no further than current universal life policies that place the death age at 115, 120 or even 125 as a result of current mortality rates as compared to the 1980 table which used age 95 as the universal life endowment point. Permanent life will follow as the endowment point will increase from 100 to 115 and 120 years of age.

In 2000, there were 50,454 centenarians (people age 100 or over), representing only 1 out of every 5,578 people. In 1990, centenarians numbered 37,306 people (1 out of every 6,667 people). There are expectations by some members of the medical research community that the centenarian population will explode within the next twenty years as advances in medicine and technology allow humans to extend life spans to unheard of ages. There is some evidence suggesting that reaching age 120 or even 130 may become as common by 2050 as reaching ago 80 is today.

What proportion of the older population lived in nursing homes in 2000? The percent of people 65 years and over living in nursing homes declined from 5.1 percent in 1990 to 4.5 percent in 2000 (see Table 8). This percent decline occurred for people 65 to 74 years, 75 to 84 years, and especially in the population 85 years and over, where only 18.2 percent lived in nursing homes in 2000, compared with 24.5 percent in 1990. Ninety-one percent of the nursing home population was 65 years and over in 2000, compared with 90 percent in 1990.

The nursing home data suggest that those needing long term care services are increasingly turning to at home care as opposed to utilizing a nursing facility. If this trend continues purchasers of long term care policies will seek benefits that stress home health care and insurance carriers will find it necessary to adapt to this demand. Will this shift result in slowdown of nursing care costs and allow the policyholder to enjoy longer periods of care for the benefits purchased? Whatever happens, it will be interesting to witness the free market economy mold and shape long term care services based on demand, especially as the baby boomers flood the age groups associated with requiring long term care services

Role of Federal and State Governments

As previously discussed, the Medicare and Medicaid programs are the two sources of federal tax dollars that are used for long term care services for the elderly. While Medicare "only" pays for about 14% of these costs it provides money for only short term periods of care. Medicaid, on the other hand, has historically paid for about one-half of the total long term care costs in the United States. Therefore the more long term care costs that can be shifted to private insurance and individuals; the greater the savings will be to Medicare and Medicaid.

The federal and state Medicaid program which takes the brunt of the long term care cost assault, is particularly concerned with the fast approaching expanding elderly population due to the aging of baby boomers. The clock is ticking and federal and state authorities are desperately searching for solutions to the long term care cost problem. Will the Partnership Program be the answer government is looking for? That question will be discussed in the next and final topic area.

As recently as the 1990's, various elderly special interest lobbyists like the American Association of Retired People (AARP), were advocating that the government should pay the long term care costs of all senior citizens out of tax dollars. Obviously this approach would only increase federal spending for long term care services and was not considered seriously.

Only half of poor women and children for whom Medicaid funding was originally intended, are able to obtain Medicaid coverage. This literally creates a competition for limited welfare dollars between three generations: the aged, the middle aged and the young. Since most of the government tax dollars that are used to pay for long term care costs come from Medicaid, it is imperative to shift this burden so the program can more efficiently try to perform it original and intended mission in society.

Much has recently been debated by state and federal governments about federal "unfunded mandates." This means States are ever more resentful of being ordered by the federal government to provide specified services while funding is then left to the state to determine. Although Medicaid is technically not an "unfunded mandate", its structure has resulted in turmoil to state governments who must figure out ways to balance spending while coping with an explosion of health care cost to the financially needy compounded by an aging population.

Medicare funding at the state level becomes an unwelcome football to politicians who are essentially placed in a "lose-lose" situation. If they cut back eligibility or spending politicians are accused of being uncaring toward the poor and elderly. If they chose to raise taxes to meet increased expenditures, the tax paying public becomes annoyed and may take away the job of the elected official.

As the future unfolds it is unlikely that the Federal government, with huge National debt and ongoing budget deficits will be of much help with meeting Medicaid's increasing financial requirements. It is state governments who are most likely to solve the dilemma one way or another. Either way, the decisions facing state officials are bound to be difficult and unpopular with someone.

The direction eligibility requirements take in the future is most likely related to voting power. It seems obvious that as long as welfare funding priorities are set by political mechanisms, whichever group flexing the greatest electorate muscle is most often the winner of public financing. In the case of Medicaid, since the poor have not historically been active voters and children are not allowed a vote at all, the expanding elderly population would appear to have victory by default.

The long term psychological and financial impact such a policy would have on America's young and poor population can only become more evident over time. As the population ages and grows to a larger percentage of the overall population, it is a political force to be reckoned with. The aged will not only be strong politically but also financially. The demands for better quality long term care will conflict with the current Medicaid format.

Since tax increases never seem to be popular, especially to people who pay them, a shift to private payment sources seems a reasonable alternative. The most logical private pay concept could center on the long term insurance policy. Perhaps an employer/employee pay plan similar to Social Security will be utilized to fund future long term care nursing needs. Such a program would make long term care available to not only the rich and middle class but to the low end socio-economic worker as well.

Perhaps federal law could be amended to extend the qualified funding concepts of corporate pension planning or Individual Retirement Arrangements to the long term care insurance policy. In any event, shifting the payment burden from welfare use of tax dollars to some sort of private initiative seems unavoidable if the needs of all age groups in America are to be adequately served.

The effect of a shift to private pay from Medicaid funding would be an enormous relief to an overburdened system. The funds could serve more of those to whom it was originally intended: children and parents on welfare. Deciding to maintain the status quo direction of Medicaid seemingly invites disaster. As the burgeoning elderly population places more demands on existing nursing care facilities, overcrowding becomes a villainous possibility. New facilities will not be erected with gusto if the Medicaid system cannot meet current payment demands. Waiting lists will be certain to grow longer and choice will become even more limited.

Although the elderly represent a strongly unified political group when it comes to obtaining federal tax dollars, allocating most or all of Medicaid's dollars to them in the future is simply not a viable option. The only direction for Medicaid, if it continues the current course, is to increase taxation on both state and federal levels to raise the additional billions of dollars needed to care for the extra millions of elderly expected from now until the year 2040.

The demographics dictate choices must be made and contingencies must be planned. Taking off blinders will result in more options for everyone. The great deficiency of Medicaid seems to be a lack of planning. Fifty Years ago, no one looked at the future of costly nursing care and growing populations as an economic threat. Fifty years ago most Americans were preoccupied with the possibility of nuclear war. Yesterday's fears from the "Cold War" may transfer to the impending realities of the "Age War".

Will Partnership LTC Policies Reduce The Use of Taxes?

This, as the old adage goes, is the million dollar question! Will the asset protection of the Partnership Program induce great numbers of the aging population to purchase LTC policies? If it does, will this result in desired Medicaid tax savings for federal and state governments?

As noted in Section 1, in its report to Congress in May 2007, the Government Accounting Office (GAO) came to the conclusion that the benefits offered in Partnership Program were not likely to result in Medicaid savings. In fact the study went so far as to predict that the Partnership Program may actually cost the Medicaid program more in taxes, at least until about 2020.

The GAO felt that the people most likely to buy adequate coverage under the Partnership Program would benefit more greatly if they were allowed to protect several hundred thousands of dollars worth of assets and then ran out of benefits thereby qualifying for Medicaid. Since the poor will not be able to afford coverage, the segment of the elderly most likely to buy the LTC coverage are the ones most likely to cost Medicaid more tax dollars in the future.

State governments, on the other hand, have a different take of this than does the GAO. State government officials feel that the availability of Partnership LTC coverage will reduce the total assets that some elderly seek to hide or transfer to "spend-down" wealth to qualify for Medicaid. The thinking is that this segment of the elderly population would rather protect assets through Partnership LTC and be less inclined to try and cheat the system. The response from the GAO to this argument by the states is that states are overestimating the numbers of elderly that were "spending-down" assets to qualify for Medicaid.

What of the prospective partnership purchaser, don't they have a lot to gain by retaining assets that might otherwise be lost to a nursing home someday? Or will people purchase partnership policies, retain assets and cost the federal and state partners even more in future Medicaid tax dollars? Obviously, if the government felt partnership policies would increase Medicaid spending they wouldn't seek to expand the concept through the Deficit Reduction Act of 2005. But is it possible that this partnership hope will never materialize but instead do the opposite of what it is intended to do? We can all guess or offer an opinion but only time and statistics will reveal the success or failure of the LTC partnership initiative

In the final analysis the only way it will be known whether or not Partnership LTC helps to reduce federal and state spending for long term care costs is to wait and see what happens.