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Partnership Long Term Care Refresher Course

Mandated by the Deficit Reduction Act of 2005
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4 hours of continuing education credit

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Partnership Long Term Care Refresher Course

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Chapter 1: Long Term Care and Insurance

Section 1) Long Term Care Needs

Some of the reasons for needing long-term care insurance include a terminal illness, disability, illness, injury or the infirmity of old age. Some estimates made by experts indicate that as many as 50% to 60% of all individuals will need long term care help in during their lifetime. The need for long-term care may only last for a few weeks or months or it may exist indefinitely. The underlying reasons for needing care will determine the length of time, as well as the type, of required care.

Long term care may be based on one or more the following reasons:

- Rehabilitation from a hospital stay
- Recovery from illness, illness or surgery
- Terminal illness in the later stages
- Chronic medical conditions or severe pain
- Permanent disabilities
- Dementia
- Ongoing need for help with activities of daily living
- Need for supervision (keep individuals away from dangerous situation)

Long-term care services may be provided in any of the following settings:

- In the home of the recipient
- In the home of a family member or friend of the recipient
- At an adult day services location
- In an assisted living facility or board-and-care home
- In a hospice facility
- In a nursing home

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 Blacks. In 35 short years, this expectancy jumps to 60 and 50years, 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 aged 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 is amended to include Medicare, health insurance for the elderly aged 65 and older.

More cold numbers: as of 1990 12% or 31 million of the U.S. population was 65 or older. By the year 2025 the demographics show the number to be doubled at 62 million or 20% of the 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.

Activities of Daily Living

When a person needs someone else to help them with physical or emotional needs over an extended period of time, this requires some form of long-term care. This help may be required for many of the daily activities or needs that healthy and active people take for granted. The main activities of Daily living include:

- Walking
- Bathing
- Dressing
- Toileting (Using the bathroom)
- Preparing Meals or Food

Other common activities requiring the assistance of others can include:

- Helping with incontinence
- Managing Pain
- Preventing unsafe behavior
- Preventing wandering
- Answering the phone
- Providing meals
- Household Cleaning
- Shopping and Errands
- Transportation needs
- Paying bills
- Doing the laundry
- Writing letters or notes
- Making repairs to the home
- Maintaining a yard and snow removal

Thought (Cognitive) Impairment

Cognitive impairment is the general loss of mental or cognitive ability. Mental cognition refers to the various mental processes upon which our ability to engage in rational thinking are based. One major form of cognitive impairment are various forms of dementia.

Dementia is is significant loss of intellectual abilities such as memory capacity, severe enough to interfere with social or work functioning. Alzheimer's disease is a serious form and is the most commonly present in people older than age 70.

Section 2) Levels of Long Term Care

Skilled Care vs. Custodial Care

Custodial care and skilled care are terms used by the medical community as well as health insurance plans. These terms are primarily used to differentiate care provided by medical specialists versus care provided by aides, volunteers, family or friends. Skilled and custodial refer to the people who deliver the care not the actual care given.

Skilled care is the provision of services and supplies that can be given only by or under the supervision of skilled or licensed medical personnel. Skilled care is prescribed for settings that have the capability to deliver such services safely and effectively.

Custodial care is the provision of services and supplies that can be given safely and reasonably by individuals who are neither skilled nor licensed medical personnel. The medical necessity and desired results of skilled care must be clearly documented by a written treatment plan approved by a physician. A patient may have skilled and custodial needs at the same time. In these circumstances, only those services and supplies provided in connection with the skilled care are to be considered as such.

Section 3) Benefits and Features of LTC Policies

Daily or Monthly Benefits

Normally a daily benefit amount is selected by the purchaser in 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.

The amount of benefit selected by the insured should be based on current costs in the market area where the insured intends someday to receive long term care benefits, if necessary. By selecting a daily (or monthly) benefit amount that equals actual long term care costs today the insured can then select an appropriate inflation rider to assure adequate future benefits. Obviously any under funding of this insurance purchase will result in the shortfall requiring funding from some other source.

Lifetime Maximum

A long term care insurance policy contains a lifetime maximum benefit amount. If this maximum is exhausted then the insured has run out of benefits. The lifetime maximum is determined by multiplying the daily benefit amount times 365 and then multiplying that product by the total number of years covered under the contract.

Example

If the insured purchases a \$170 daily benefit amount payable for 5 years then the lifetime maximum can be calculated as follows:

Daily Benefit Amount: $\$170 \times 365 = \$62,050$ (Annual Benefit Amount)

$\$62,050 \times 5$ (Total Benefit years)
 = **\$310,250 (LIFETIME MAXIMUM)**

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.

Many states require an individual long term care policy to be either guaranteed renewable or noncancellable.

Noncancellable

This contract right is considered to be the strongest renewability provision available to an insurance consumer and it means that except for nonpayment of premium the insurance company has no right to cancel the policy. Noncancellable also means the premium rate can never be increased and remain the same for the entire contract period.

Exclusions and Limitations

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.

Other limitations to a long term care policy are usually related to "Nonduplication" concepts which mean the insured is receiving benefits from some other source such as:

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.

Taxation of Benefits and Premiums

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.

Individuals 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 health 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.

Chapter 2) LTC Services and Providers

Long Term Care Alternatives

Are considerations of long term care for just 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 1
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 2
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 1 and 2 indicate that an unmarried and healthy male aged 85 or older would possibly have a busy social calendar among females their own age since there are more than twice as many and of those 6 of 7 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 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 but want 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.

There are two main purposes of adult day care. First, it can help the person needing care to improve in health and activity level. Secondly, it allows the normal home caregiver to get some much needed rest. Daycare services are typically offered from Monday through Friday and from morning through afternoon hours. Some daycare providers offer pick up and delivery service from and to the home for an additional charge. Families using day care can also have a working caregiver drop off the loved one in the morning and pick them up after work in the afternoon.

It is possible for adult day care providers who use a healthcare model to be eligible for Medicaid reimbursement. Medicaid views these services as a better alternative to nursing home care. Medicare is assessing to determine whether adult day care can be a viable alternative to home care in certain settings. Based on the assessment outcome Medicare may also become a principle payor of adult day services.

Long-term care insurance will also pay for adult day care. Since long-term care insurance is one of the few non-welfare, third-party sources of payment of adult day care, owning LTC insurance could be an important payment source to keeping adult day care as a viable future option.

Home Health Care

Home health care means that long term care is being provided in the home. These services can be very broad in scope 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.

Care in the home provided by a spouse or a child is the most common form of long-term care in this country. Over 70% of all long term care is provided at home is typically given by caregivers who receive no payment for their labor.

Lifting , bathing, dressing, diapering, toileting and helping with walking can be a challenge to family caregivers because they don't have the proper tools or are not trained in this area. The children of elderly care recipients may have difficulty dealing with cleaning or bathing their own parents. Other problems may stem from handling erratic behavior caused by patient dementia or depression.

Home care patients as a percent of all individuals in an age group goes up drastically with age. The age group of 85 and above represents only 4% of all the aged population yet it accounts for about 30% of all patients. Most of the aged population is between 65 to 75 years of age but they only accounts for about 27% of all home care patients.

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.

Assisted living is also referred to as residential care and it is a type of living arrangement in which personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available. The assisted living model is also designed to provide security, comfort and activities for residents. In contrast to nursing homes, residents in assisted living are independent and live on their own in a residential setting. Assistance with activities of daily living may include help with bathing, dressing, toileting, diapering, medicating, helping with daily living decisions and moving from one place to another.

One example is a residential board and care facility which is usually a converted home or small facility with three to ten beds where the caregiver is a homeowner or single proprietor with little or no support staff. This type of smaller facilities is not usually allowed to offer much care beyond bathing, dressing, providing meals or helping residents move around. They may contract with home health agencies, home visiting doctors or nurses to provide care for their residents.

The cost for board and care homes is typically much less than with large, new, apartment-style assisted living facilities. People who operate board and care homes have a love for the elderly and in essence are taking these people into their homes to care for them as if they were family members. Due to their small size these operations have little money to advertise and their residents usually come to them from referrals or word of mouth.

Assisted living fills a gap between home care and nursing homes. Prior to assisted living, a person needing professional care went to a nursing home even though the care didn't always merit the intensive supervision and control of a nursing home. This newer alternative of assisted living provides a more homelike environment for people needing or anticipating help with activities of daily living or incidental activities of daily living but for which 24-hour nursing care is not a necessity. Therefore assisted living decreases the cost from those associated with nursing homes.

Instead of the hospital environment of a nursing home, newer assisted living facilities look more like apartment buildings with private rooms or suites and locked doors. Contrary to an uninviting hospital lounge area or cafeteria, assisted living has gathering areas with couches, fireplaces, gardens, atriums, and plants. Central dining areas are appealing and often offer entertainment during or after mealtimes. Meaningful activities and chats with neighbors in pleasant surroundings, keep residents active and stimulated.

Many assisted living facilities allow home health agencies to come in and offer services for residents. Some states may allow facilities to have a resident nurse or therapist to help with minor medical problems. And some states even allow variances for assisted living to offer limited nursing home services. Some assisted living facilities specialize in the care of Alzheimer's patients. An Alzheimer's patient typically does not require a lot of medical attention but often requires supervision and confinement. Alzheimer's facilities have locked entrance doors to prevent residents from wandering.

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 by someone without medical skills like a nurses' aides.

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 performed 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-Care 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 of 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.

Hospice is a range of health and comfort care services that are delivered to patients who are nearing the end of life. In most cases, these patients have refused or otherwise are ineligible for receiving medical treatments. They are expected to live for 6 months or less after their admission to hospice care. The greatest consideration in hospice care delivery is providing comfort care services.

These services include medication delivery, particularly measures for pain relief; assistance with bathing and activities of daily living (ADLs); and spiritual counseling. The types and frequency of all hospice services are targeted based upon individual needs. Hospice services are delivered most often in the patients' homes (estimated at 90%)

Hospice care services are delivered by a team comprised of physicians, nurses, social workers, therapists, aides, pastors, and volunteers, all of whom address comfort care issues. Therefore these services attend to physical, spiritual, and other human needs that matter the most to end of life patients.

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 pro rata 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 will be provided but the price of this guarantee is the 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 whereby residents 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 on 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 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.

- 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 cosmetology bag.

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 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.

Chapter 3) Long Term Care Insurance Alternatives

Reverse Annuity Mortgage (RAM)

As the name hints, reverse annuity mortgages allow persons over the age of 62 to release equity in their primary residences without having to sell and move from their homes. Instead, of making payments immediately after taking out the mortgage, the flow of payments is reversed to the borrower in flat sum amounts, a credit line account, monthly cash advance, or any combination thereof.

The RAM was designed to help house-rich and cash-poor seniors tap equity from their homes without having to move or repay mortgages while they lived in their homes. The mortgagors must occupy the home as a principal residence (where they spend the majority of the year). All programs lend on single-family one-unit dwellings, and some programs also include 2 to 4 unit owner-occupied dwellings, condominiums, and manufactured homes. The holder of a RAM could use some or all of the funds to pay for long term care costs as an alternative to purchasing a long term care insurance policy

Because the borrower makes no monthly payment, the loan amount grows larger over time (thus your equity decreases). But federal guidelines on reverse annuity mortgages will not permit the loan value to ever exceed the value of your home at the time the loan is repaid. The loan size depends on several factors including the borrower's age, the value of the home, its location, and the cost of the loan (many of the fees can be financed into the loan to limit the out-of-pocket cash required). The maximum-size loan also depends on the loan program chosen. (The most well-known in the marketplace are the FHA-insured program Home Equity Conversion Mortgage and Fannie Mae's Home-Keeper mortgage.) Additionally, you can obtain a personalized quote as to the size RAM you could qualify for at the Web site of the National Center for Home Equity Conversion at www.reverse.org.

The RAM loan doesn't have to be paid back as long as the borrower lives in the home. But it must be repaid in full (including all interest and any other charges) when the last living borrower dies, sells the home, or permanently moves away.

Most RAMs are adjustable rate mortgages that adjust monthly and have maximum lifetime caps (i.e., loans that can't increase more than a predetermined percent over their lifetime). The lender is at risk because the total amount of interest accrued would be capped (should the borrower outlive the estimated life of the loan), so rates are considerably higher for the RAM than they are for the standard ARM programs.

Home Equity Lines Of Credit

The home equity line of credit is like a second mortgage loan, but the borrower does not have to take possession of all the money at one time. This type of loan is well suited for borrowers who anticipate that they will need more money in the near future, but do not need it immediately.

Setting up a home equity line can be like applying for a credit card. However, because a second mortgage is involved, there is processing, including an appraisal of the property. The application fee may be up to 2 percent of the line of credit, though some lenders may reduce or even waive this fee. Some plans also charge an annual fee to encourage the borrower to use the line once it has been granted. In addition, many plans require the borrower to take out a minimum amount when the loan is granted.

Home equity lines of credit offer a flexible way to access home equity, thereby financing periodic needs with tax-deductible interest. Borrowers may tailor the plan to the way they want to handle payments and can draw upon the line with checks (good for infrequent, large withdrawals) or credit cards (for frequent, smaller withdrawals).

While this borrowed money can also be used to pay for long term care expenses obtaining the line at favorable rates it will require the borrower to have a very good to excellent credit rating. An unfavorable credit score would force the borrower to pay much higher fees and interest rates and under that scenario, it likely would be inadvisable to use borrowed equity in lieu of a long term care policy.

Life Insurance

Another long term care financing method could be to use the cash value accumulation found in permanent life insurance. While old fashioned whole life policies require policy loans to access values while retaining insurance coverage, the interest charges for these policy loans can be substantial (7%-9% or greater) and compounded. The use of cash value from universal life, variable life or the newer equity indexed life contracts is usually more favorable since longer term policyholders normally pay only nominal or no interest charges. Also, these interest sensitive cash accumulation contracts may also allow for the withdrawal of cash value without interest, but such partial surrenders can lead to unfavorable tax consequences depending upon how long the policy has been in force.

Another possible strategy to use life insurance as an alternative to the purchase of a long term care policy is to purchase a life policy offering long term care payments as a rider option. Originally, long term care was offered as a rider to a life contract but then stand alone long term care products emerged and took over the market. Recently however, there has been a return to coupling long term care income to a life policy purchase.

Finally, a current life policy purchase without any long term care coverage is also a possibility especially to younger (age 50-60) purchasers who have two to three decades for cash value to grow prior to needing funds for long term care purposes. However, using this approach requires the current availability of long term funds from an alternative source in the event the need for such funds happens unexpectedly early, before cash value has had time to sufficiently grow.

Modern interest sensitive cash accumulating life insurance plans can be an effective and useful tool to not only protect ending career higher income production but to also fund the contracts cash policy account on a tax-deferred and favored basis. One strategy could be to pay more than required annual premium targets but to stay under the 7 Pay Life Test maximums, if the purchaser has the excess funds to maximize cash value in this manner. Maximum funds growing on a tax deferred basis over many years could result the ready availability of funds that may far exceed the limits otherwise found under the terms of a long term care policy.

Annuities

Does the client own an annuity or annuities with substantial cash value? If so, does the client need these funds for future retirement income purposes or could these values be used to pay for possible future long term care expenses? Annuities usually allow the owner to withdraw up to 10% of the cash value in any given year or even greater access cash value triggered when entering a nursing care facility.

Life Settlements

A life settlement means you can sell your life insurance for the present value of the policy. This is usually done when the original reason why you bought your life insurance policy no longer exists. For example, you have a life insurance policy and you get divorce. You might be able to sell the life insurance policy for present value. The money from the sale can be used to pay for your long-term care needs.

To be eligible for this, you can't be ill and must generally be over 70 years of age with a life expectancy of 12 years or less. A life settlement can be made at a younger age if the person qualifies as to reduced life expectancy.

The money received from a life settlement is taxable and a person should consult with a qualified tax expert prior to make such an arrangement. Furthermore, the amount obtain from a life settlement after taxes may not be enough to cover future long term care costs.

Savings and Income

An individual can, of course, use savings or other personal resources to pay for long-term care. This is referred to as "self-insuring". Such personal resources may include money in a checking or savings account, stocks, bonds, investments, life insurance policies, pensions, and income. Other family members may also offer to give you money towards your long-term care needs. If this option is selected then the individual should plan ahead before needing long-term care. It is wise to preplan all expected future health care needs and costs.

Paying long-term care costs out-of-pocket is very expensive. This option may only be practical for people with above average financial resources.

Here are some concepts to consider that relate to requirements and limits for self-insurance or a personal savings plan:

> If you don't need long-term care, you will still have your money that you set aside for long-term care needs. This money is yours. You might be able to leave something to your heirs (family or friends).

> The money you save (set aside) should only be used for your long-term care needs. You might not save enough money to pay for all of your long-term care costs. To be self-insured, you will have to start at a young age, save a lot of money, and stick with this plan for a long period of time.

> If you set aside enough money for your long-term care needs, you can choose where and how you receive your care.

> There may be rules about when you can use your investments for paying long-term care. In some cases, you may have to pay a penalty for withdrawing the money.

> You don't have to worry about qualifying for a long-term care insurance policy.

> If you need long-term care and use your money, you might not be able to leave anything to your heirs (family or friends).

Medicare

Nursing home or skilled nursing facility stays must be related to diagnosis during a hospital stay. For instance, your hospital stay was for a stroke. Then, a nursing home or skilled nursing facility stay for rehabilitation would be covered. A nursing home or skilled nursing facility stay includes a semi-private room, meals, and rehabilitative and skilled nursing services and care.

The coverage is limited to a maximum of 100 days in a benefit period. The first 20 days are paid in full, and the remaining 80 days will require a co-payment. Medicare Part A will not cover long-term care, non-skilled, daily living, or custodial activities.

Nationally, Medicare pays only about 2% of all long term care costs.

Medicaid

If your income and resources are limited, you may qualify for Medicaid. Most of your health care costs are covered if you have Medicare and Medicaid. Medicaid is a joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state.

Eligibility requirements and types of services covered vary from state to state. Most often, eligibility is based on your income and personal resources. The best sources for that information are the state Medicaid office or an attorney. In some states, people with Medicaid may get coverage for things like nursing home care, home care, and outpatient prescription drugs that aren't covered by Medicare.

Often there is a requirement for you to spend down your personal resources (assets) before you qualify. You may want to get more detailed information from your state Medicaid office or an attorney before spending down your resources. Some people think that giving their resources to a family member or friend will make them eligible for Medicaid. There are certain rules for spending down your resources.

States are required to find out if any resources were given away before you get Medicaid. If a state finds that resources were given away, the state must charge you a penalty. For example, this penalty may be to stop paying for your nursing home care. To avoid a penalty, you should talk with your state Medicaid office or an attorney about what you can and can't do with your resources.

Listed below are some opportunities and requirements/limits for Medicaid:

- > Medicaid pays for some long-term care services at home, in the community, and in a nursing home.

- > You must meet low income and limited asset tests in your State and limited to a Medicaid licensed facility with an available Medicaid bed.

- > You might be able to stay in your home and get your long-term care services.

- > You must meet the Medicaid eligibility requirements.

Chapter 4) Inflation Impact on Long Term Care Benefits

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.

Consider the average LTC purchaser age of about 60; 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).

Inflation Examples:

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.

Inflation and Reduced Purchasing Power

In 1967 the United States government decided to measure the change in the price of selected goods and services and compare them from year to year. This "urban" purchasing pattern became the statistical measurement for the U.S. economy inflation rate. The index was replaced in the 1990's after it was decided it was no longer a reflective measure of inflation. However the chart below demonstrates the devastating effect inflation has on prices.

INFLATION SINCE 1967

<u>YEAR</u>	<u>INFLATION RATE</u>	<u>COST VS 1967 DOLLAR</u>
1967	0	\$ 1.00
1970	16%	\$ 1.16
1975	61%	\$ 1.61
1980	146%	\$ 2.47
1985	222%	\$ 3.22
1990	291%	\$ 3.91
1995	356%	\$ 4.56
2000	415%	\$ 5.16
2005	487%	\$ 5.85
2010	553%	\$ 6.53

As the previous chart demonstrates through historical reference, the long term care purchaser needs to be fully aware that when a purchase is made in the present for a benefit that will be used from ten to twenty or more years in the future, the purchasing power cannot be ignored.

No Inflation Coverage

If the long term care insurance purchaser elects to ignore inflation they do so at their own folly. While the cost of inflation coverage significantly increases the cost of LTC coverage and there may be a temptation to forgo this extra expense, such impulses should be resisted. Logically, the only reason someone would not have inflation protection on their LTC policy is because it was not available due to age at the time of purchase.

If the main purpose to buying coverage is to have the money required at the time long term care may be required then it seems to make little sense for making such a purchase only to later find that the ravages of inflation have made the policy purchase ineffective.

Traditional LTC Policy Inflation Riders

Under the terms of a traditional long term care policy the purchase of inflation protection is entirely optional and the availability of such a rider varies from company to company. The best offerings compound the original daily benefit purchase amount at a five percent rate annually. Therefore approximately every fourteen years the original benefit will double in value. The election of such inflation protection effectively doubles the premium cost of the traditional long term care policy.

Unfortunately many consumers balk at such an increase of cost and either want to forgo the inflation protection altogether or to decrease the compound rate to lower, and more ineffective, levels. This is an area where the producer must be especially vigilant in explanation and resolve to try and convince the consumer that maximum inflation protection is in their best interest.

Partnership LTC Inflation Protection

A partnership policy must include inflation protection as indicated by state law as a result of the Deficit reduction Act of 2005.

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 included 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.

These federal and state inflation mandates on inflation protection when purchasing a Partnership LTC policy make it clear that purchasing such coverage is best done when younger (age 60 or earlier) rather than at older ages when cost goes up and inflation protection options erode.

Chapter 5) Partnership LTC vs. Traditional LTC Policies

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.

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.

Main Differences

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 in 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 of 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.

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.

Deficit Reduction Act Requirements

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 Caution

> 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.

Producer Training Requirements

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. Prior to July 1, 2008 a producer was required to complete a traditional long term care course which earned six hours of continuing education credit, one in a lifetime. This was replaced as of July 1, 2008 with the following:

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.

This four hour “refresher” course is required for the first time during the renewal period immediately following the renewal period in which the producer originally completed course number 25008.