



Long-Term Care Insurance

Could Montana's New Partnership Plan Have Helped the Smiths?

by Jerry Furniss and Michael Harrington

Editor's Note: On July 1, 2009, Montana joined 29 other states by having regulations in place for insurers to offer long-term care insurance partnership plans. Authorized by the federal Deficit Reduction Act of 2005 and passed into law in Montana during the 2007 legislative session, partnership plans are designed to allow long-term care policy owners to protect assets from Medicaid recovery on a dollar-for-dollar basis. That is, to the extent that an insured who is covered by a long-term care partnership policy receives policy benefits (e.g., reimbursement for a nursing home stay), state Medicaid authorities will allow the insured to protect an equal amount of assets. This means that a partnership policyholder may be in a position to pass assets to heirs when the policyholder exhausts policy benefits and relies on Medicaid to provide for additional long-term care needs. The new partnership laws are designed to encourage more individuals to purchase long-term care insurance and thereby reduce the burden on Medicaid.

Mary and Bob Smith's Story

Mary, age 62, and Bob, age 65, have worked hard helping their only child through college and are now looking forward to living the life of empty nesters. They have tried to do everything right in funding their child's education, setting aside a \$10,000 emergency fund, prepaying funeral expenses, paying off both vehicles, accumulating \$200,000 in CDs from the sale of Bob's business, and purchasing a home that now has \$200,000 in equity and a small mortgage. Bob just retired and has an income of \$1,200 per month from his company retirement plan and receives Social Security retirement benefits of \$953 per month. At age 65, Bob became eligible for Medicare and also purchased a Medicare Supplement (Medigap) Policy. Mary is employed and earns \$1,500 per month and is covered by a group health insurance policy provided by her employer. The Smiths want to leave their home to their only child, Bob Jr., who plans someday to live in his childhood home and raise his own family. A month after retirement, Bob suffered a massive stroke, was hospitalized for a week, and then was moved to a skilled nursing facility for rehabilitation. After 60 days in the nursing facility, Bob's condition stabilized. Given the severity of his condition, he will need to remain in a nursing home for the remainder of his life. How will the Smiths survive this personal and financial crisis? What resources and insurance coverages do the Smiths have that cover these costs? How do the Smiths provide for themselves and still leave a legacy to their child?

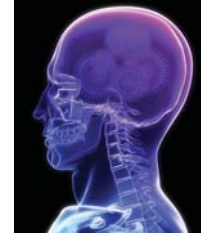
What Kind of Care Does Bob Need and Does Medicare Cover It?

Unfortunately, most Americans believe that they are adequately covered for the type of care that Bob needs. They believe that Medicare (the federal government health care program for individuals 65 or older), a Medicare Supplement (Medigap) Policy (a policy purchased from an insurer to supplement coverage under Medicare), and/or private individual or group medical expense insurance covers situations such as Bob's required long-term care. However, Bob needs substantial assistance with "activities of daily living (ADLs)," and most Americans (including Bob) are not adequately insured for those needs. ADLs include bathing, dressing, transferring (moving to and from a bed to a chair), toileting, remaining continent, and feeding oneself. This type of care (sometimes referred to as personal or custodial care) is not covered by Medicare, Bob's Medigap policy, or Bob's private health insurance.

Only A Small Portion of the Cost of Bob's Care Is Covered. Even though Bob's primary need is for long-term assistance with ADLs, Medicare does provide coverage for his initial six-day hospital stay, subject to a \$1,068 deductible and a \$135 deductible and 20 percent co-pay for physician's services. Since Bob's hospital stay was at least three days in length, and he was admitted into a skilled nursing facility within 30 days of his discharge, Medicare will pay for up to 100 days of his care as long as he needs some element of skilled care. Medicare pays for the first 20 days of care without a co-payment by Bob, but Bob must then pay a \$133.50 daily co-pay. However, because Bob's condition stabilized after 60 days in the skilled nursing facility, Medicare will no longer pay for his care since he now needs daily assistance with ADLs, and not acute medical care. (Acute care, which is covered by Medicare, Medigap policies, and private health insurance, is care which is needed to improve a patient's condition, including rehabilitative services, or to keep a patient's condition from deteriorating. Once the patient stabilizes and his or her main care need is assistance with ADLs, a long-term care policy is needed to provide coverage.) Even though Bob's policy that supplements his Medicare coverage (his Medigap policy) may cover the deductibles and co-pays required by Bob during his hospital stay, and a portion of his skilled nursing facility stay, his Medigap policy, like Medicare, will not cover his long-term care needs.

How Do the Smiths Cover the Costs of Bob's Long-Term Care Needs?

Bob and Mary have three possible choices to cover Bob's long-term care needs: 1) cover the costs "out of pocket;"



ALZHEIMER'S

Every 72 seconds, someone in America develops Alzheimer's disease. Thirteen percent of people age 65 or older have Alzheimer's disease. Alzheimer's is the top claims producer for nursing home stays, followed by strokes. The average length of claim for those with Alzheimer's is 659 days (2007 Facts and Figures – Alzheimer's Association).

2) spend down assets and income to qualify for Medicaid; and/or 3) rely on coverage from a long-term care insurance policy.

Covering Long-Term Care Costs Out of Pocket. Since Medicare (and Bob's Medigap policy) will not cover Bob's long-term care nursing home costs, Bob and Mary could attempt to cover the costs through personal and/or family resources. However, Bob's needs are expected to be long-term and permanent. Since Mary hopes to remain in the family home, has limited income herself, and has no access to other family resources, Bob's and Mary's personal resources are somewhat limited. Assuming Bob's cost of care is about \$60,000 a year, and that Mary needs her \$1,500 monthly income to cover the small mortgage and her living expenses, the Smiths' emergency fund of \$10,000 will be depleted in a couple of months, and their \$200,000 will be depleted in a little over three years. The Smiths may consider a reverse mortgage to use the equity in their home to pay the required costs; however, they really want to leave their home to their son, who has always planned to raise his family there. A reverse mortgage would require the Smiths to give up ownership of the home once they die and would not provide them with the opportunity to leave the family home to their son. Bob's retirement annuity of \$1,200 per month and his Social Security retirement benefit of \$953 per month will fall short

of his anticipated nursing home costs by approximately \$3,000 per month. (According to state regulators, the average private pay rate at nursing homes in Montana was \$5,125.50 per month as of September 2008.) How do the Smiths cover the costs out of pocket? They don't, especially when Bob's stay turns out to be extended and when Bob needs institutional care.

Medicaid Coverage of Long-Term Care. Medicaid (the federal/state aid program for a number of groups, including those age 65 or older who meet asset and income guidelines) will cover Bob's long-term care needs once he expends his resources (assets) to the required levels.

On the asset side, both Mary's and Bob's assets (resources) are included, and Bob must exhaust the countable resources so they are at or below \$2,000. The couple's combined resources will be evaluated, and Mary will be allowed to retain half of their resources up to a maximum of \$109,560 (2009 level), and Bob will be allowed an additional and separate \$2,000. Once the couple's combined countable resources are below a total of Mary's half plus Bob's \$2,000, Bob will be resource-eligible for Medicaid. Fortunately, there are a number of resources that are excluded from the calculation. In Bob's case, the family home (and home furnishings), their vehicle with the highest equity value, and Bob's prepaid funeral arrangement are not counted as resources. In the Smiths' case, Bob will have to use over \$100,000 of his countable assets (which include his bank CD and emergency fund) for his care needs in order to qualify for Medicaid, and Mary will be able to retain the other half for her support. And, even though the \$200,000 of equity in the family home is not counted as a resource in order for Bob to qualify for benefits, Medicaid will seek to recover the costs of care expended on Bob's behalf from the home when Mary dies.

For Medicaid qualification on the income side, Mary's income is not counted for determining Bob's qualification for Medicaid. However, Bob would be expected each month to contribute his income to cover his long-term care costs to the



QUALIFYING FOR COVERAGE

According to AALTCi.org, 26,464 Montanans in 2007 were covered by long-term care policies. Insurers normally accept long-term care applications from applicants from ages 18 to 84. Thirty-six percent of long-term care policies sold in 2008 went to applicants ages 45-54, while 23 percent were sold to applicants in the 55-64 age range. Most insurers apply reasonably strict underwriting guidelines in the sale of long-term care insurance and thus don't cover all those who apply. Twenty-three percent of applicants in the 60-69 age category don't qualify for coverage, and the percentage of applicants rejected increases dramatically with age. Accordingly, 45 percent of applicants from ages 70-79 and 70 percent of applicants age 80 or older are rejected for coverage.

level of his monthly personal allowance of \$50. In arriving at that figure, Bob would be permitted to cover any health insurance premiums and make a contribution of a portion of his income to Mary. (The amount of Bob's income allowance that may go to Mary is a function of Mary's income level and minimums established by Medicaid.) After allowances, the balance of Bob's income each month must be used to cover his nursing home costs before Medicaid will cover any remaining costs incurred during the month. And, when Bob and Mary eventually die, state Medicaid authorities are required by federal law to recover from the Smiths' estates any costs expended by Medicaid for Bob's care.

Long-Term Care Insurance.

Another option for the Smiths that may have helped them keep their home and their bank CDs and pass those assets to their son would have been long-term care insurance. First arriving on the scene in 1987, and with more than 9 million policies sold to date, long-term care insurance is

designed to cover the type of care (help with ADLs) that Bob needs. And, according to LIMRA International, 98.8 percent of all long-term care policies sold today are tax-qualified, which means that premiums are deductible and benefits are income tax-free, subject to IRS limits. A tax-qualified long-term care insurance policy may have been perfectly suited for Bob, who has suffered a massive stroke and needs assistance with several ADLs. One of the main benefit triggers for a tax-qualified long-term care policy is that the insured is expected to need "substantial" assistance with at least two of six ADLs for a period of at least 90 days. The other trigger found in these policies is "severe cognitive impairment which requires substantial supervision." The severe cognitive impairment trigger is well suited for advanced Alzheimer's patients, where, according to a Society of Actuaries November 2007 study, Alzheimer's was the number one claims producer, followed by strokes. Fortunately, Alzheimer's is required to be covered by long-term care policies under both Montana law and the federal Health Insurance Portability and Accountability Act (HIPAA).

Before Bob suffered his stroke, had he purchased a long-term care insurance policy with a daily benefit rate in the \$150- \$175 range, with a lifetime benefit, the issue of Medicaid qualification would not have arisen. Bob's income would have covered any of his out-of-pocket costs, and his long-term care policy with a lifetime benefit would have covered his needs. However, if Bob had chosen a less expensive policy (such as a four-year policy benefit period), Bob's long-term care costs for the first four years of nursing home stay (about

\$240,000) would have been covered by his long-term care policy; depending on how long Bob lived, he may or may not have exhausted his policy limits. If Bob did exhaust his policy limits (i.e., still needed care after his four-year policy terminated), he then would have needed to qualify for Medicaid in order to cover his long-term care needs.

What about the Smiths' desire to pass their family home and other assets to their son at their death? As previously addressed, Medicaid would recover its costs against the



WHICH LONG-TERM CARE POLICY IS RIGHT FOR YOU?

There is no such thing as a "standard" long-term care policy. And, many consumers assume that "long-term" care insurance covers them for life. Most insurers do offer a lifetime benefit option, but common coverage terms also include one year, three years, five years, and 10 years. The longer the coverage term, the higher the premium, all other things being equal. The issue of "how long" a policy period the Smiths can afford and what the odds are that the policy period will be exhausted due to Bob's condition are difficult questions. At the time of purchase, of course, no one knows the length of benefit period needed. Each purchaser must weigh policy affordability with the risks associated with purchasing a shorter benefit period. According to a recent Milliman Research Study, only 8 in 100 claimants exhausted their benefits under a long-term care policy with a three-year benefit period, and only 1.5 percent of claims exceed five years in duration. And, the cost savings of a lifetime benefit period versus a three-or

five-year period are substantial – insureds enjoy a 36 percent to 39 percent savings by buying the shorter three-year benefit period over the lifetime benefit option.

What benefit periods did buyers of long-term care in 2008 choose? According to AALTCi.org, 27 percent of long-term care insurance purchasers chose three years, 61 percent chose five years, and only 2 percent chose a lifetime benefit. Ten percent chose another category.

Most insurance advisors recommend that, with a limited budget, buyers of long-term care insurance first choose the benefit rate (the amount of daily benefit coverage reimbursed for covered expenses). Then, they choose the benefit period. And, with Montana's average nursing home rate hovering around \$157 per day, coupled with the fact that the average nursing home stay is around 2.04 years, the advice of choosing the benefit level first, then choosing the benefit period, seems to make sense.



PAYING FOR NURSING HOMES

According to the Montana Department of Public Health and Human Services, Medicaid funds 60 percent of the nursing home beds in Montana. Twelve percent of nursing home residents stay five years or more (The Lewin Group). The national average cost of a nursing home stay (semi-private room) is \$191/day (\$69,715/year) (MetLife Mature Market Institute) and, according to Montana regulators, the average private pay rate at nursing homes in Montana as of September, 2008, was \$168.50/day (\$61,506/year).

Smiths' house and other assets upon their death. So, a long-term care policy may or may not have served the Smiths' wishes, depending on a number of factors, including the timing of Bob's death and the length of long-term care coverage purchased.

The Deficit Reduction Act (DRA) of 2005 and Long-Term Care Partnership Plans

In 1993, four states – California, Indiana, New York, and Connecticut – stepped up to the task of meeting the federal government's offer of modifying Medicaid rules in order to encourage the purchase of long-term care insurance. The idea was to give consumers incentives by promising that if they purchased a specific type of long-term care policy (known as a Partnership Policy), then Medicaid authorities would disregard a portion of policyholders' assets for both Medicaid qualification and estate recovery purposes. (This promise in Montana is known as Asset Protection.) The government reasoned that if consumers were allowed to protect assets in an amount equal to what their long-term care policies paid out, then more consumers would purchase more, and larger, long-term care insurance policies. Consequently, consumers would not need Medicaid, or would need Medicaid for shorter periods of time.

The "Asset Protection" Promise in Action. Under the asset protection promise, an insured with a long-term care partnership policy that pays out \$300,000 in long-term care benefits would result in the insured's ability to qualify for Medicaid without spending down as much in resources. (The Smiths' resources would be spent down to Bob's \$2,000 plus Mary's one-half of the family's resources not to exceed \$109,560, plus the \$300,000 protected by the long-term care partnership policy.) And the insured would be able to protect \$300,000 of assets from Medicaid asset recovery upon death. In other words, the Medicaid authorities would "protect" an amount of assets from estate recovery equal to the amount of benefits paid out by the insured's long-term care insurance policy.

To the extent that long-term care insurance pays for long-term care costs and obviates the need for Medicaid coverage, the burden on Medicaid is lessened. And, with the over age 65 crowd expected to double from 40 million in 2010 to 80 million in 2040, Medicaid can use all the help it can get. Additionally, according to the U.S. Census, the 85 and older segment of the U.S. population is estimated to grow from 5.3 million to 21 million by 2050 and will place an ever-increasing strain on state and federal budgets.



SAVING TAXPAYER DOLLARS?

Do Partnership Plans save taxpayer dollars? According to a 2005 Congressional Research Study of the original four partnership states, surveys indicate that purchasers are motivated by the asset disregard feature of partnership policies. Proponents of partnership plans claim the savings are real; for instance, the American Association for Long-term Care Insurance states that “each policyholder who buys LTC with age appropriate inflation has the potential to save the Medicaid program \$15,200 (2009).”

While various studies do indicate Medicaid savings as a result of implementing partnership plans, there remains uncertainty about the magnitude of such savings. However, for insureds able to protect and pass assets to heirs, the opportunity to purchase a partnership plan is very real and could help them realize their wishes. And, where Medicaid realizes savings as a result, taxpayers are also beneficiaries.

No other states were allowed to develop partnership plans after the 1993 deadline until Congress passed the Deficit Reduction Act (DRA) of 2005. Since the 2005 passage of the DRA, 26 states have joined the original four states by passing legislation authorizing the offering of long-term care partnership policies. Montana passed enabling legislation in 2007, and, as of July 1, 2009, Montana insurers may submit partnership plans for approval consideration. It seems, therefore, that partnership plans are now reasonably close to becoming a reality in Montana.

But What About Bob?

As previously discussed, one of the ways for Bob and Mary to cover Bob’s nursing home costs would have been through the purchase of long-term care insurance. Had the Smiths purchased a long-term care policy with a lifetime benefit plan, Medicaid benefits would not have been needed and Bob’s needs would have been addressed. However, if Bob had purchased a shorter plan (perhaps a three-year, four-year,

or five-year benefit plan), Bob would have needed Medicaid to cover his long-term care needs after his long-term care insurance policy benefits were exhausted.

Assuming that Bob purchased the four-year plan discussed earlier, the policy would have paid its maximum benefits of \$240,000 prior to Bob’s need for Medicaid coverage. And, had the policy been a partnership plan, Bob would not have had to use his \$100,000-plus in countable assets in order to qualify for Medicaid, because of the asset protection rules. The Smiths would then have been positioned to protect their family home and/or other assets up to \$240,000 in value (the amount paid out by Bob’s partnership policy). So, for the Smiths, the purchase of a long-term care partnership policy may have been just what the doctor ordered, with all major stakeholders – the Smiths, Bob Jr., and the Medicaid program – coming out winners. □

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