LTC Partnership Plans

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In the previous chapters, we examined long-term care costs, long-term care insurance and learned about the advantages insurance offers. But what if a person does not buy an LTCI policy? If she needs long-term care, she must use her income, savings, and assets to pay for it, and if she needs care for a long time, she could exhaust these resources. Then she may have no other recourse than to apply for Medicaid. We have discussed the disadvantages to the individual of this situation, but it also presents a problem for the government -- the more people who rely on Medicaid, the greater the financial burden on this already strained program.

Thus, state governments have much to gain from encouraging individuals to provide for their long-term care needs by means of LTCI coverage. States have sought to do this in several ways, including offering tax incentives, targeting education and awareness programs toward consumers and employers, and sponsoring LTCI coverage for state employees and retirees. Another approach is long-term care partnership programs, and this is the focus of this chapter.

What Is a Partnership Program?

A long-term care partnership program is a program under which a state government modifies its Medicaid eligibility rules to give a financial incentive for the purchase of LTCI policies that meet certain requirements. These are called "Partnership LTCI" policies and their goal is to increase the number of people covered by private long-term care insurance and reduce Medicaid expenditures. The word "partnership" refers to the collaboration between the public sector (state government) and the private sector (insurance companies) in funding long-term care needs.

A partnership program works in this way: An individual purchases an LTCI policy that meets his state's requirements. If he needs eventually needs long-term care, the policy benefits pay for it, which relieves the state Medicaid program of that cost. If, however, he should need extended long-term care that exhausts his LTCI policy benefits and he is forced to apply to Medicaid, he is not obligated to spend all the assets he otherwise would under regular Medicaid rules. Under what is called the dollar-for-dollar approach, he may keep assets equal in amount to the benefits he received under his partnership policy (in addition to any other assets he would have been entitled to keep). Moreover, these assets are exempt from Medicaid estate recovery and so are preserved for his heirs.

Susan chooses to not purchase long-term care insurance. She develops a physical impairment and needs long-term care services. Before she can qualify for Medicaid, she must spend all her assets on care except for $2,000

(her state's asset eligibility limit) and a few noncountable assets. And when she does receive Medicaid benefits, she must enter a nursing facility instead of staying at home because her state provides only very limited benefits for home care. Furthermore, the nursing home of her choice does not have any Medicaid beds available, so she must go to a less desirable facility far from her family. Finally, after she dies any remaining assets are taken by Medicaid under the estate recovery rules.

John purchases an LTCI policy meeting the requirements of his state's long-term care partnership program. He becomes physically impaired and needs long-term care services., John uses his LTCI benefits to pay for most of his care. This is better for John, as he does not become impoverished, and he does not have to deal with the limitations of Medicaid coverage. (He can be cared for at home, and if he does eventually have to enter a nursing home, he has a wide choice of facilities.) This is also better for the state, as it does not have to pay for John's care.

Kevin also purchases a partnership LTCI policy, becomes impaired, and receives benefits from the policy. But he needs care for several years, and he eventually uses up his policy's $200,000 lifetime maximum benefit. He is now forced to apply for Medicaid. However, because he bought the partnership policy, he does not have to spend all the assets he otherwise would have. In addition to any noncountable assets and the $2,000 of countable assets his state allows him to keep, Kevin can retain $200,000, the amount he received in benefits from his partnership policy. Moreover, this $200,000 is protected from Medicaid estate recovery and preserved for Kevin's heirs.

Clearly, partnership policies offer significant advantages to consumers. They may be of particular value to those who are unable to afford a large amount of LTCI coverage but have significant assets they want to protect.

Emily has a limited income, but she has some assets she would like to pass on to her son Ted. She cannot afford an LTCI policy with a large lifetime maximum benefit that would cover all her likely long-term care needs, but for a fairly low premium she can buy a partnership policy with a $100,000 maximum. She might not need more than $100,000 in benefits, but if she does, she can apply for Medicaid, and $100,000 of her assets will be protected and preserved for Ted.

An individual in these circumstances can even tailor the lifetime maximum to the amount of assets he wants to protect -- if, for instance, he wants to protect $150,000, he buys a partnership policy with a $150,000 lifetime maximum. In this way partnership policies offer an incentive to those of modest means to buy at least a small amount of LTCI coverage -- and consequently lessen their potential burden on the state.

However, partnership policies have their limitations. To mention only two of the most important, if a person exhausts his insurance benefits, it is not guaranteed that he will qualify for Medicaid, and if he does qualify, although some assets are protected, he must generally spend his entire income on care. These and other disadvantages are discussed in detail later in this course.

The Original Partnership Programs

Partnership programs began in 1988, when the Robert Wood Johnson Foundation sponsored demonstration projects in four states, California, Connecticut, Indiana, and New York. Eventually, these projects became permanent, and other states expressed interest in establishing programs of

their own. But the federal Omnibus Budget Reconciliation Act of 1993 (OBRA 93) effectively halted the expansion of partnership programs. Under OBRA 93 any new programs would be required to apply estate recovery to protected assets -- that is, an individual with a partnership policy could retain assets as long as he remained living, but those assets would have to be taken by Medicaid after his death and could not be preserved for heirs. (The four state programs already in place at that time were exempted from OBRA and could continue to offer protection of assets after death.)

This rule, of course, made participation in a partnership program much less attractive for consumers, and consequently no new state programs were established for many years. However, the Deficit Reduction Act (DRA) of 2005 lifted this restriction, and as a result many states are currently establishing partnership programs. We will examine in detail the DRA and the new partnership programs, but first we will look at the original programs, which have continued to operate.

The Four Original State Programs

All four of the original states require that their partnership policies be federally tax-qualified, include an automatic 5% annual compound inflation protection feature, and provide comprehensive benefits (coverage of both facility care and home care). The four states also require partnership policies to provide at least a minimum daily benefit (this minimum varies by state and is adjusted annually). Each state also imposes other unique requirements.

All four state programs offer the dollar-for-dollar approach to asset protection, as described above. Indiana and New York also offer an alternative -- total asset approach -- which allows an individual with a partnership policy to keep all his assets, not just an amount equivalent to the LTCI benefits he receives. However, for a person to qualify for total asset protection in these two states, his policy must provide a certain minimum level of benefits.

Connecticut and Indiana have a reciprocity agreement, under which a resident may buy a partnership policy in one state, move to the other state and apply for Medicaid there, and receive dollar-for-dollar asset protection (but not total asset protection). Otherwise, an insured is entitled to Medicaid asset protection only in the state where he bought his policy.

The Experience in the Four Original States

One measure of the success of long-term partnership programs is how they have been received in the marketplace. This varies widely from state to state, but a significant number of partnership plans have been sold in all four states. In Connecticut and Indiana, they represent a substantial percentage of all LTCI policies in force. The administrative and reporting requirement imposed by the state appears to have a direct impact on the availability of partnership policies. If insurers find these requirements too burdensome, many may decide not to market partnership policies, and as a result fewer products are available, fewer agents are selling them, and fewer consumers buy them. Other factors include demographics, agent training, and the existence of programs for state employees and retirees, as well as competing non-partnership LTCI products sold in the state.

Another measure of the success is whether insureds are diverted from reliance on Medicaid for long-term care funding. A very small number of those holding partnership policies have exhausted their LTCI benefits and received Medicaid benefits, less than of 1 percent of the total. While it is difficult to know how many of these people would have gone on Medicaid if they had not bought a partnership policy, the experience so far is that partnership policies are keeping insureds off of Medicaid rolls.

A New Expansion of Partnership Programs

The generally positive experience of the four original partnership programs and the states' continuing need to hold down Medicaid expenditures have encouraged other states adopt state partnership programs. The newly adopted programs have learned from the original states and the new programs tend to promote simplified administrative procedures, greater uniformity among states in requirements for product design and reporting, less difference in the regulatory treatment of partnership and non-partnership policies, and reciprocity among state programs. It is hoped that simpler and more uniform state rules will make it easier for insurance companies to enter the partnership market. Broader reciprocity thus would make partnership policies much more attractive to consumers, increasing the number of people who buy them.

The Deficit Reduction Act

The federal Deficit Reduction Act (DRA) of 2005 (effective February 8, 2006) includes provisions intended to facilitate the nationwide expansion of state partnership programs and meet some of the other goals cited above.

As mentioned earlier, the DRA repealed the OBRA requirement that states must apply Medicaid estate recovery rules to assets protected under partnership programs. All states may now establish new programs that allow participants to preserve assets after death.

The DRA impose a degree of uniformity across states by setting minimum requirements for any new state partnership programs and for new partnership policies. The DRA promotes -- but does not require -- reciprocity among the new state programs. Specifically, reciprocity applies unless a state explicitly opts out. In addition, more uniform programs and policies from state to state should facilitate reciprocity. Under the DRA, new programs can protect assets on a dollar-for-dollar basis only. Total asset protection is not permitted. (The DRA exempts the four existing partnership program from these new rules and may continue to operate as before.)

Federal Requirements for Partnership Policies

The Deficit Reduction Act established requirements that an LTCI policy must meet to qualify for a qualified state long-term care insurance partnership (QSLTCIP) program – sometimes called partnership-qualified (PQ) policies or qualified partnership (QP) policies. (We'll use the term PQ when discussing partnership policies).

All PQ policies nationwide must meet the requirements of the DRA. In addition, individual states may impose on PQ policies benefit mandates or other requirements beyond those of the DRA. However, if a state imposes such requirements on PQ policies, it must impose them on non-PQ policies too. This provision is intended to minimize the differences between the two types of policies, making partnership policies easier to understand and market. (However, differences are not completely eliminated -- non-PQ policies might not meet all the DRA requirements imposed on PQ policies.)

General Requirements

To be a partnership-qualified policy, an LTCI policy must meet these general requirements:

A PQ policy must be a federally tax-qualified LTCI policy. This means that, in addition to the requirements outlined in this chapter, a PQ policy must also adhere to the requirements of HIPAA. As noted, the large majority of LTCI policies today are tax-qualified.

To have PQ status, a policy must be issued after the date on which the state partnership program goes into effect. Unlike HIPAA, which extended grandfathered status to LTCI policies already in force when that law went into effect, the DRA does not extend PQ status to policies already in force when a partnership program is established.

The insured must be a resident of the state sponsoring the partnership program when coverage first becomes effective. It is possible that an insured could later move to another state with a partnership program and enjoy Medicaid asset protection – but that depends on the state's reciprocity rules.

In addition, the DRA requires PQ policies to include certain consumer protection provisions, and they must meet certain age-based requirements for inflation protection.

Consumer Protection

Although the list of consumer protection provisions that a PQ policy must contain is long, it should be understood that these provisions are in fact included in most LTCI policies today. The DRA requirements are based on the NAIC's LTCI Model Act and Model Regulation that most states have adopted (in whole or in part). Even in states where they are not required, many insurance companies include these provisions to maintain product uniformity across the various states where they operate.

Documentation and Disclosure

- Outline of coverage and guide to LTCI. An outline of coverage is a description of the benefits, exclusions, and provisions of a policy. It must be provided to each prospective insured at the time of application. The insurance laws of most states specify the format and content of the outline of coverage. Prospective applicants must also receive a copy of *A Shopper's Guide to Long-Term Care Insurance*, published by the NAIC, or the state's own LTCI guide if it has one.

- Certificates for group coverage. Insurance certificates issued to individual insureds covered by a group policy must include a description of the principal benefits, the principal exclusions; and a statement that the group master policy determines the governing contractual provisions.
- General disclosure. The policy must include disclosure provisions regarding renewability, the payment of benefits, limitations, conditions on eligibility for benefits, tax consequences, and benefit triggers.
- Disclosure of past rate increases. The policy must disclose whether the insurer has ever had any premium rate increases on this or other related policy forms.
- Replacement coverage. The application must ask whether the applicant has any other long-term care insurance in force and whether the policy being applied for is intended to replace other coverage.

Policy Benefits

- Home and community care benefits. If a policy provides benefits for home and community care, these benefits must be at least equivalent to one half of one year's nursing home coverage. For instance, if a comprehensive policy contains a nursing home daily benefit of $180, the total benefits available for home and community care must be at least $32,850 ($180 times 365, divided by half, equals $32,850).
- Extension of benefits. The policy must include an extension of benefits provision that requires that nursing home benefits be paid even if the policy lapses provided the insured began receiving benefits prior to lapse and the nursing home stay continues. (In other words, if an insured enters a nursing home and begins receiving benefits, she must continue to receive benefits as long as they last, even if she lets her policy lapse, unless she leaves the nursing home.) Note that since most policies today have a waiver of premium provision and so do not require an insured who is receiving nursing home benefits to pay premiums, this consumer protection provision is rarely necessary, but it is required nonetheless.

Exclusions and Limitations

- Permitted exclusions and limitations. The policy may include only certain exclusions and limitations, as specified in the NAIC Model Regulation.
- Preexisting condition exclusions. If the policy contains a preexisting condition exclusion, this must be clearly indicated. The insurer may exclude only conditions existing six months or less before the policy's effective date, and it may not deny benefits for the condition for more than six months after the effective date.

Renewal, Replacement, and Termination of Coverage

- Renewability. The policy must be guaranteed renewable or noncancellable.
- Replacement of group coverage. If an employer replaces one group policy with another, the new coverage must be offered on a guaranteed issue basis (without underwriting) to everyone covered by the old coverage.
- Continuation or conversion of group coverage. An employee covered by an employer's group policy whose employment status changes has the right to either continue his group coverage or convert it to an individual policy providing the same coverage.

- Unintentional lapse. The policy must include a provision (such as impairment reinstatement) protecting the consumer against the lapse of her policy if she unintentionally neglects to pay premiums.
- Non-forfeiture. The purchaser must be offered the shortened benefit period non-forfeiture option. If the purchaser declines this option, the policy must provide contingent non-forfeiture benefits.

Incontestability

Incontestability. An insurer has the right to rescind (annul) coverage or deny a claim by contesting the validity of the policy if the insured made misrepresentations in the insurance application. (For instance, if a person did not disclose in her application that she already suffered from Parkinson's disease, and a year after coverage began filed a claim, the insurer might be able to contest the policy.) However, an incontestability clause must be included in a PQ policy. This clause places restrictions on the insurer's right to contest, and these restrictions become more stringent over time:

- If a policy has been in force for less than six months, the insurer must show that the insured made a misrepresentation that was material to her acceptance for coverage. (That is, if the correct information had been supplied, the insurer would have declined the application or offered coverage on a different basis.)

- If a policy has been in force for at least six months but less than two years, the insurer must show that the insured made a misrepresentation that was both material to her acceptance for coverage and pertains to the condition for which benefits are sought. (If the insured files a claim based on arthritis, the misrepresentation must pertain to arthritis.)

- If a policy has been in force for two years or longer, the insurer must show that the individual knowingly and intentionally misrepresented facts relating to her health. (This can be very hard to prove.)

The purpose of the incontestability clause is to give consumers confidence that a policy that they have been paying premiums on for some time will not be contested by the insurer when they apply for benefits. Similarly, the DRA prohibits post-claims underwriting. This is the practice of accepting an applicant for insurance without obtaining adequate information about her health status and health history, and later, when she files a claim, finding a reason to rescind her coverage based on information she neglected to provide in the application.

Sales and Marketing

- Sales practices. The insurer and its agents must comply with training requirements and other safeguards designed to prevent abusive practices that could harm consumers, such as making unfair policy comparisons, selling excessive insurance, misleading consumers, and using high-pressure tactics.
- Advertising. The insurer must submit any advertisement (written, radio, or television) to the state insurance commissioner for review or approval, as required by state law.
- Suitability. The insurer must assist the applicant in determining whether the purchase of long-term care insurance is appropriate for her, based on her financial situation and preferences. The

applicant must sign certain forms attesting that this has occurred and return them to the insurer.
- Thirty-day free look. The policy must include the 30-day free-look period.

Sales conduct is discussed in the following Chapter.

Inflation Protection

As mentioned, the consumer protection provisions listed in the preceding section are already required by most states and included in most LTCI policies. And the great majority of LTCI policies today are federally tax-qualified. In these respects, partnership LTCI policies do not differ markedly from most other LTCI policies.

But in the area of inflation protection, PQ policies can differ significantly, as the DRA requires far more than HIPAA or the NAIC models. These requirements vary according to age at purchase (defined as the insured's age when the policy becomes effective).

- Individuals age 60 or younger must have "annual compound inflation protection."
- Individuals at least 61 but younger than 76 must have some type of inflation protection. This need not be automatic annual compounded increases; it could be simple rate increases, a guaranteed purchase option, or some other form of inflation protection.
- Individuals age 76 or older must be offered an inflation protection option, but they are not required to purchase that option.

Failure to have adequate inflation protection for insureds who will likely need benefits years after they buy their policy defeats the purpose of the partnership program. From the point of view of the state, if an insured's benefit amounts are not increased to cover increases in the cost of care, he is more likely to use up his benefits and qualify for Medicaid. And from the point of view of the insured, if his benefit amounts fall behind rising costs, he will pay more out of his own pocket even while he is insured, depleting the assets that he is trying to protect by participating in the program.

While inflation protection requirements are the main difference between PQ and non-PQ policies, this difference should not be exaggerated. Most LTCI policies today offer an automatic compound option or other type of inflation protection, and PQ policies are no different from non-PQ policies that include these features.

State Implementation

As we have seen, the Deficit Reduction Act establishes the framework for new state partnership programs, setting requirements that partnership-qualified policies must meet in all states. Many, but not all states, allow some form of Partnership LTC polices – and more states have applied for permission to offer Partnership policies. The DRA does promote uniformity, but it does not dictate all aspects of PQ programs -- states have a good deal of leeway to develop their own programs as they see fit. States may impose requirements on PQ policies in addition to those of the DRA, as long as they apply the same requirements to non-PQ policies. And some of the provisions of the DRA leave room for interpretation and variation in how they are implemented. No doubt, partnership programs will continue to evolve.

Inflation Protection

A PQ policy must provide "annual compound inflation protection" to insureds who are 60 years old or younger when they buy the policy. But the DRA does not clarify what is meant by this term or stipulate what types of inflation protection qualify, so the states are setting their own standards that they believe comply with this provision.

The DRA does not specifically mandate the 5 percent compound rate that is required by the original partnership programs. Therefore, some states are likely to accept other compound rates (such as 3 percent) as well as inflation protection based on a consumer price index that increases annually on a compound basis.

Some states may accept a guaranteed purchase option (GPO). However, for a GPO to qualify as "annual compound inflation protection," the offers of additional coverage would have to be made annually, and the amounts would have to be based on compounded increases in the benefit amounts.

Furthermore, states that allow GPOs may need to set rules for them. For instance, must increase offers continue for the life of the policy? (Under most but not all GPOs today, offers generally end if the insured becomes eligible for benefits or if he declines a certain number of offers.) And will a state require an insured to accept every increase offer that is made to maintain the PQ status of his policy? Or can he decline some offers as long as he does not decline so many that he forfeits his right to future offers?

States will also have to decide if they will require an insured to maintain the level of inflation protection required at the time of purchase through the life of the policy, or if they will allow him to downgrade inflation protection when he moves into an older age group, based on the purchase requirements for that age.

Jim buys a PQ policy at age 55, and to fulfill the requirement for annual compound inflation protection that applies at his age, he chooses an automatic 5 percent compound option. After he turns 61, can he switch to a less costly form of inflation protection, such as a 5 percent simple rate, as is permitted for those who purchase after 60? And when he turns 76, can he drop inflation protection altogether, since those who buy at that age are not required to have any?

Replacements

Can an existing LTCI policy be exchanged for a PQ policy? Under the DRA, if an individual owns an LTCI policy that does not qualify for PQ status, she may exchange it for a PQ policy. But only benefits received under the new policy, and not benefits that may have been received under the old policy, are counted toward Medicaid asset protection. (However, this rule will probably come into play only rarely, as an insured who is receiving or has received benefits is unlikely to be accepted for a new policy.)

Many existing policies meet all the requirements for PQ status except that they were issued before the effective date of the state partnership program. In such cases, an insured making an exchange is

simply switching his old policy for an identical new one. Many other existing policies meet the PQ requirements except for issue date and inflation protection, in which case the new policy is essentially the same with the addition of an inflation feature.

States will likely facilitate exchanges by allowing insurers to simply issue an endorsement or rider to an existing policy stating that it has PQ status. However, it is possible that some states may require insureds to lapse their existing policy and purchase a new one.

Coverage Changes

Insureds sometimes want to make a change in their policy after it has been in force for some time. Needs and circumstances can change over time. Some may want to decrease their benefits, perhaps to make their premium more affordable. They might, for instance, want to change comprehensive coverage to facility-only coverage because they believe they have sufficient family support to handle any home care needs. Alternatively, an insured may want to increase her benefits. Such changes are not unusual given that people generally buy LTCI coverage many years before they are likely to need benefits. But the question arises, if a person buys a PQ policy and later makes a change in her coverage, will the PQ status of the policy be affected?

The DRA states that changes in a policy after it is issued will not affect its PQ status as long as all PQ requirements continue to be met. As we have seen, the great majority of DRA PQ requirements pertain to consumer protection provisions, and these are unlikely to be affected by any coverage change requested by an insured. However, if an insured downgrades or eliminates an inflation protection feature, this could violate the DRA inflation protection requirements, depending on how the state interprets those requirements. It is also possible that a coverage change could violate a state-imposed PQ requirement.

Reciprocity

If a person buys a PQ policy in State A and later moves to State B and applies for Medicaid, will he be entitled to asset protection in State B? If State B has a partnership program and there is reciprocity between the two states, the answer is yes. Otherwise, the person will have to forgo asset protection, or move back to State A, or move to another state that does have a program and reciprocity with State A.

Under the DRA, reciprocity is the rule unless a state explicitly opts out, and the degree of uniformity the DRA imposes on PQ programs should foster reciprocity. Reciprocity is usually advantageous for a state. If a person with a PQ policy moves in, the state gains a resident with good LTCI coverage who is less likely to need Medicaid benefits than someone without such coverage. It is true that, under reciprocity, if the new resident does end up going on Medicaid, the state will not be able to take assets it otherwise would have been entitled to. But this is not a common occurrence, so the gains to the state would appear to outweigh the losses.

However, the DRA does not require reciprocity, and of course it does not require the states to establish a partnership program. So some states will probably not create programs, and the owners of PQ policies moving to those states will not be entitled to any asset protection there.

Application Date

Must an insured wait until his LTCI benefits are completely exhausted before applying for Medicaid? Or can he apply before he has received all benefits payable by his policy? Under the DRA, an insured does not have to wait until the exhaustion of benefits, but the amount of assets that will be protected is based on the amount of insurance benefits paid as of the time of application. In other words, an insured may apply for Medicaid before he has used up his LTCI benefits, but if he does so, he will receive credit only for the benefits paid up to that time, even if benefits continue to be paid afterwards. If, on the other hand, he waits until all benefits due under the policy have been paid, he will receive credit for the full lifetime maximum benefit of the policy.

Joanne has a PQ policy with a lifetime maximum benefit of $200,000. After she has received $150,000 in benefits, she applies for Medicaid. She may apply at this time, but she will be entitled to only $150,000 in asset protection, even if the remaining $50,000 of benefits is eventually paid out.

Sylvia also has a PQ policy with a lifetime maximum benefit of $200,000. She waits until she has received the entire $200,000 before she applies for Medicaid. She will be entitled to $200,000 in asset protection.

Thus, waiting is often advantageous, but not always. For instance, if a person has only $100,000 in assets to protect and has already received that amount in insurance benefits, there may be no reason to wait, even if he is entitled to additional benefits. Also, some individuals who are under a financial hardship as they near the end of their insurance benefits may want to apply early.

Finally, it should be kept in mind that the process of applying for Medicaid can take several months, so those who wait until their insurance benefits have completely run out before starting this process may have to pay for their care out of their own pocket for a time.

If an insured does qualify for Medicaid before he exhausts his LTCI benefits, the Medicaid program will generally require that the insurance remain the "first payer" -- that is, the LTCI policy must continue to pay benefits, with Medicaid providing additional benefits for any expenses not covered by the insurance but covered by Medicaid. This also must be weighed in determining whether it is advantageous to apply for Medicaid early.

Certification and Disclosure of PQ Status

If a product developed by an insurance company meets all the requirements of the DRA and of a state partnership program, how does it become a partnership-qualified policy?

- The state insurance department reviews the product and certifies that it meets all requirements. Alternatively, an insurance department could establish a process for self-certification, such as a checklist.
- The insurer must prominently disclose to consumers whether or not a policy is partnership-qualified. This disclosure will most likely be made in a form provided by the state or developed by the insurer and included with the policy when it is delivered. This approach will facilitate the proc-

ess for policies already in force that meet the PQ requirements -- instead of having to revise such policies simply to add the disclosure statement and re-file them, the insurer can simply issue the form to policyholders.

Reporting

Insurance companies will have to report certain data on their PQ policies. There are two reasons for this requirement:

- A state Medicaid program needs to know whether an individual is covered by a PQ policy, and if so, how much (if any) she has received in benefits, so that this information can be taken into account if she applies for Medicaid.
- The states and the federal government need data for use in evaluating partnership programs and setting policy for them. Government agencies will want to know whether the asset protection offered by PQ policies does in fact lead consumers to buy them, what type of PQ policies consumers are buying, and what impact the program is having on Medicaid finances.

Training

The DRA and CMS directives require each state insurance department to provide assurance to the state Medicaid program that any person who sells, solicits, or negotiates a PQ policy has received training in these policies and demonstrated an understanding of them and the part they play in the public and private financing of long-term care.

What will this mean in practice for insurance agents? In addition to the requirements they must meet to sell long-term care insurance in their states, there will be new training requirements for selling partnership LTCI policies. There may also be an examination to satisfy the requirement to demonstrate understanding.

States will of course vary in their exact requirements, but at its September 2006 meeting, the NAIC adopted a Model Bulletin that will likely be adopted (perhaps with some modifications) by many states. The requirements of the Model Bulletin are as follows:

- All LTCI agents in the state will receive training in PQ policies.
- There will be an initial training course of no less than eight hours. In addition, agents will be required to receive no less than four hours of ongoing training (continuing education) every 24 months thereafter.
- Topics covered in the training must include long-term care services, long-term care insurance, PQ policies, and the relationship between PQ policies and other public and private coverage of long-term care. All types of LTCI policies must be covered, with the advantages and disadvantages of PQ and non-PQ policies discussed. State or federal law may require the use of certain materials.
- The training cannot include any training that is specific to an insurance company or its products. It cannot include any sales or marketing information, materials, or training.
- The state's requirements for continuing education (such as those related to class attendance, the conduct and monitoring of examinations, self-study courses, and web-based training) must be adhered to.

- When a state establishes a partnership program, it will set a date at least one year after the effective date of the program, by which time all agents selling LTCI must have received the training. Until that date, any licensed and qualified LTCI agent may sell PQ policies.
- Insurance companies issuing PQ policies must require agents selling these policies to provide them with verification that they have received this training. The companies must maintain this verification on file and be able to provide it to the state insurance commissioner upon request.

Keep in mind that some states may not adopt this model, and their training requirements may differ. And of course the four original state partnership programs will continue to operate differently.

It is the intention of the NAIC Model Bulletin that satisfaction of the training requirement in any state will be deemed to satisfy it in any other state. However, agents are advised not to assume reciprocity with any state but to seek confirmation with the state insurance department. In particular, states that do not adopt the NAIC training model might not be granted reciprocity by states that do.