



## **Laws Relating to Long Term Care**

### **Medicare**

#### **Skilled Nursing Care**

To be eligible for reimbursement for skilled care in a nursing home facility, the patient must meet four requirements:

1. A nursing home stay for skilled nursing care must follow a consecutive three-day hospital stay (not including day of discharge). This admission must occur within 30 days of hospital discharge, and must be for the same medical cause as the hospital stay.
2. The care required must be skilled nursing or skilled rehabilitation services as opposed to custodial care.
3. The facility must be certified by Medicare. About 50% of nursing home facilities offering skilled nursing care are certified, according to CMS.
4. A physician must certify the need for this care.

If all these conditions are met, Medicare will pay:

Day 1-20 – 100% of the Medicare approved amount

Day 21-100 – 100% of the Medicare approved amount after a copay of \$ **114.00** per day in the year 2005

Day 101 + - No coverage for skilled care.

#### **Home Health Care**

1. Part-time home health care is covered but 24-hour care is not covered. Part time care is defined as fewer than seven days a week or less than eight hours for 21 days or less.
2. The patient must be housebound, under a physician's care, and the physician must certify the need for the care.
3. The home health care agency must be certified by Medicare. About 50% of agencies are certified.
4. Medicare pays a pre-determined cost of eligible home health care for which you are approved.  
Covered services include:

- Part-time skilled nursing care or services of a home health aide
- Physical therapy
- Speech therapy
- Occupational therapy
- Medical social services under the direction of a physician
- Medical supplies
- Durable medical equipment

## **Medicaid**

Medicaid is a public assistance program for individuals with assets and income at or below the poverty level. The resource limits vary by state. The program is funded by state and federal funds. Two-thirds of all nursing home residents rely on Medicaid. While there are some federal guidelines concerning Medicaid, every state designs its own program. In addition to income requirements an individual must:

- Need long term care from a nursing home, at someone's home or in an assisted living facility.
- Must file for Medicare benefits first in the event Medicare will reimburse some of the cost.
- Must file for private insurance first if coverage exists.
- Must have exhausted personal resources.<sup>1</sup>
- Must file a claim for Medicaid benefits.

### **OBRA-93**

Many individuals try to transfer assets to other individuals to meet the qualifications for Medicaid. There are very stringent requirements for any asset transfers. OBRA-93 requires that regular transfers of assets must occur 36 months prior to applying for Medicaid and transfers out of a trust must occur 60 months prior to applying for Medicaid. The law also required that individual states enact legislation concerning estate recovery, which all states have done. If these time requirements are not met, Medicaid benefits will be reduced by the amount of the transfer. These circumstances include:

- Assets are transferred to someone other than a spouse.
- The transfer is done willingly and purposefully to qualify for Medicaid.
- The transfer triggers an "ineligibility" period (the 36 or 60 month period described above.)

## **The Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

**(Please note that NAHU does not provide tax advice. Consult your tax advisor on how these provisions may affect your own situation)**

HIPAA included one section on long-term care insurance. The new language says:

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<sup>1</sup> An individual may keep (his/her) home (while spouse is living) regardless of value, one automobile, household and personal belongings, wedding and engagement rings, life insurance, and burial plots and funeral expenses up to \$2,500. Most states set the poverty level for assets at \$2-3,000. For an at-home spouse, monthly income may be allowed as high as \$2,377 per month. The spouse may also retain one-half of the couple's assets up to about \$ 95,100.

- Long term care benefits under a qualified long-term care plan are not taxable. (Up to daily limits set annually)
- Employer premiums may be deductible without resulting in inclusion as compensation to the employee, and the policy benefits may not be nontaxable.
- Limited premium deductibility is available for individuals who itemize medical expenses on their tax returns.<sup>2</sup> If an individual does itemize these deductions, there are some limitations on the extent of deductibility based on age:

<b>Attained Age</b>	<b>Limitation*</b>
Less than 41	\$ 200
41-50	\$ 375
51-60	\$ 750
61-70	\$2,000
70 or older	\$2,500

\*Year 2005 limited premium deductibility is:

<b>Attained Age</b>	<b>Limitation</b>
Less than 41	\$ 270
41-50	\$ 510
51-60	\$1,020
61-70	\$2,720
70 or older	\$3,400

Self-employed individuals (sole proprietors, partners and more than 2% S-Corporation owners) were also allowed to deduct long-term care insurance premiums in accordance with the schedule detailed above. C Corporations may deduct premiums paid on behalf of employees and are not subject to the table limitations above.

Additional items related to long term care included in HIPAA:

- The IRS capped the amount of deductible benefits at \$240 per day for the year 2005
- Long-term care insurance may not be included in a Section 125 Cafeteria plan.
- Long term care insurance policies that pay on an expense-incurred basis will coordinate with Medicare.
- Qualified plans with deductible premiums and non-taxable benefits must offer a non-forfeiture benefit.
- In order for a plan to be deductible and the benefits to be non-taxable (qualified), the person on claim must be chronically ill. This means:
  - They must be unable to perform, without substantial assistance<sup>3</sup> from another individual, at least two of six activities of daily living, due to a functional activity loss that will last at least 90 days<sup>4</sup> in length; or

<sup>2</sup> According to Treasury less than 5 percent of the taxpaying public itemized medical expenses since they must first exceed 7.5% of adjusted gross income.

<sup>3</sup> Substantial assistance means either hands-on assistance or standby assistance. Hands on assistance means the physical assistance of another person without which the individual would be unable to perform the ADL. Standby assistance means the presence of another

- They must require substantial supervision to protect their health and safety due to a severe cognitive impairment<sup>5</sup>; or
- They must have a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services.

The six activities of daily living are eating, toileting, transferring, bathing, dressing, and continence.

### **Grandfathering**

Premium tax-deductibility was effective beginning in January of 1997. Any long term care insurance contract purchased and in force prior to January 1 of 1997 is considered qualified, regardless of whether or not it meets the provisions outlined above. Any material changes effectively remove the grandfathering status. Material changes include any change in the alternation of timing or amount of any item payable by the policyholder, the insured, or the insurance company.<sup>6</sup> Exceptions are premium mode changes; class-wide premium increases or decreases; after-issue of a spousal discount or the policyholder's exercise of any other right provided in the contract; benefit reductions if requested by the insured; continuation or conversion of coverage under a group contract; the addition, without an increase in premium, of alternate forms of benefits that may be selected by the insured; and purchase of a rider increasing benefits of a grandfathered policy if the rider alone would be considered a qualified long term care insurance contract.

### **Non-qualified plans**

Prior to HIPAA, most long-term care insurance policies provided a higher level of benefits than allowed under qualified plans. For example, the common "medical necessity" benefit trigger was not among the six allowed for qualified plans, and was replaced with an undefined trigger to be designed between Treasury and HHS. In addition, most policies did not have a 90-day requirement, effectively eliminating any short-term claims for long term care services. The biggest problem however, is the fact that HIPAA is silent about the tax status of benefits paid under non-qualified long term care plans, and Treasury has declined to provide a specific bright line on the issue, saying that it is Congress that was silent on the issue and that Congress should address the oversight. They did, however, create Form 1099-LTC as a potential answer, which must be issued by insurers for any long term care benefits paid. The form says that amounts paid under a qualified long term care insurance plan are excludable from income, and makes no reference to non-qualified long term care coverage.

### **State laws**

A number of states have passed legislation or have legislation pending either increasing deductibility or authorizing tax credits for the purchase of qualified long term care insurance.<sup>7</sup>

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person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the person is performing an ADL.

<sup>4</sup> The 90 day certification must be made at time of claim. Any licensed health care practitioner can make the certification.

<sup>5</sup> Severe cognitive impairment means a loss or deterioration in intellectual capacity that is comparable to and includes Alzheimer's disease and similar forms of irreversible dementia and can be measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short term or long term memory, orientation as to people, places, or time, and deductible or abstract reasoning. Substantial supervision means continual supervision by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety.

<sup>6</sup> IRS Notice 97-31.

<sup>7</sup> NAHU summary of state-level long-term care insurance tax incentive legislation.

## Long Term Care Partnerships

In 1988, a public/private alliance between state governments and insurance companies to further the development of long-term care insurance programs was created. With a goal of solving a portion of the long-term care financing problem, grants were awarded to four states--California, Connecticut, Indiana, and New York--to work with private insurers to create insurance policies that were more affordable and provided better protection against impoverishment than those generally available. The resulting Partnership for Long-Term Care combines private long-term care insurance with special Medicaid eligibility standards. Over the course of the development phase of the program two program models emerged. California, Connecticut are using the Dollar for Dollar Model<sup>8</sup>, while New York and Indiana are using the Total Assets approach and the dollar-for-dollar model.<sup>9</sup> Insurers participating in a partnership must meet a special set of criteria before selling these special long-term care insurance policies. To date, there are more than 20 insurers participating in the Partnership Programs in the four states. Following the implementation of the Connecticut Partnership program in 1992, a number of states initiated efforts to replicate the partnership program. However, due to the impact of the passage of the Omnibus Reconciliation Act of 1993 (OBRA '93), most of the states simply ceased their efforts at implementation.<sup>10</sup>

The Omnibus Reconciliation Act of 1993 contained language with direct impact on the expansion of partnerships for long-term care. The Act recognized the four initial states now operating partnership programs plus a future program in Iowa and a modified program in Massachusetts. These six states

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<sup>8</sup> The Dollar for Dollar Model is being used in California, Connecticut and Indiana. After meeting a stringent set of criteria, long-term insurance policies of varying length and scope are certified by the state insurance division. Policies must cover at least one year at issue and pay a minimum per day indemnity amount (different in each state). Once the benefits of a certified policy are exhausted, an application for Medicaid can be made using special eligibility rules. Every dollar paid out by an insurer through a certified policy will be deducted from the resources counted toward Medicaid eligibility. For example if a person receives \$50,000 of insurance benefits and exhausts their policy, \$50,000 of assets will be disregarded and therefore protected in the Medicaid eligibility process. Insurance payments must be for long-term care services, and must use benefit determination criteria similar to, if not exactly the same as, the state's. Once on Medicaid, an individual's income is devoted to the cost of care.

<sup>9</sup> The Total Assets Model, used in New York, requires long-term insurers to meet a somewhat different set of criteria before the policies are certified by the state insurance department. Certified policies must cover three years in a nursing home or six years of home health care. The minimum daily benefit for 1997 is \$122. Once the benefits of a certified policy are exhausted, the Medicaid eligibility process will not consider assets at all. Protection will be granted for all assets, but an individual's income must be devoted to the cost of care. New York began allowing the dollar-for-dollar model in 2005.

<sup>10</sup> The following states passed state legislation directing the state to create a partnership program. Most of these states (i.e., Missouri, North Dakota, Ohio and Rhode Island) simply stopped all efforts at implementation in the face of OBRA '93. Colorado and Michigan made their state language conditional upon the overturn of sections of OBRA '93 language that pertain to partnership programs. Maryland took several steps toward creating a partnership program. Program regulations were drafted, and part of their state plan amendment was approved. During the 1996 legislative session, further implementation of the program was made conditional upon the overturn of sections of OBRA '93 language that pertain to partnership programs. The following states have **active** partnership programs. Some are operating under the conditions outlined in OBRA '93 and others were exempted from this language. Illinois received an approved state plan amendment after the May 14, 1993, date specified in OBRA '93 and therefore all protected assets are subject to estate recovery. Illinois began offering partnership policies in December 1995, and to date two insurers have approved products and approximately 10 partnership policies have been sold. Recently, Illinois **modified** their program to combine the Dollar for Dollar Model and the Total Assets Model. Iowa created a partnership using the Dollar for Dollar Model in 1996. Their state plan amendment was approved before the May 14 deadline and, therefore, they can offer asset protection with no estate recovery. To date no insurers have chosen to participate in the program. Massachusetts offers a variation on the partnership program. There is no up-front asset protection. Clients must meet all of the Medicaid financial eligibility requirements; however, assets that are not counted as a part of the initial eligibility process may be protected from the state's estate recovery program. The state plan amendment for the Massachusetts program was obtained before the May 14th deadline and therefore is not subject to the estate recovery conditions of OBRA '93. Washington State replicated the Dollar for Dollar Model. Their state plan amendment was approved after the May 14th deadline and therefore protected assets under the partnership program are subject to estate recovery. To date no insurers have come forward to participate in the program. The state is ready to work with insurers should any decide to participate.

were allowed to operate their partnerships as planned because HHS approved their state plan amendments before May 14, 1993. States seeking a state plan amendment after May 14th must abide by the conditions outlined in OBRA'93. There are three sections with specific language pertaining to partnership programs. The following outlines the requirements in each section.

- **Sec 1917(b) paragraph 1 subparagraph C**  
This section requires any state operating a partnership program to recover from the estates of all persons receiving services under Medicaid. The result of this language is that the asset protection component of the partnership is in effect only while the insured is alive. After the participant dies, states must recover what Medicaid spent from the estate, including protected assets.
- **Sec 1917(b) paragraph 3**  
This section prevents a state from waiving the estate recovery requirement for partnership participants.
- **Sec 1917(b) paragraph 4 subparagraph B**  
This section requires a specific definition of "estate" for partnership participants. Estates:
  - A. shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and
  - B. . . . any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other assignment.

#### **Success in the four initial states**

Since California streamlined its partnership regulations in 1998 to allow the same benefits and options on both their Partnership and non-Partnership policy offerings, sales have exploded. As of March 31, 2005, 64,915 policies are in-force.

During the first six months of 1997, the Connecticut Partnership Program has experienced considerable growth with policy sales more than doubling over the previous six-month period since undertaking the process of working with insurers to offer similar benefits and similar costs in partnership and non-Partnership policies. In the first quarter of 2005, first-time purchasers represent 92% of the sales. Of the over 30,000 total policies in-force in 2005, only 23 have qualified for Medicaid as of March 31, 2005 and private insurance is paying for some of those now on Medicaid.

Connecticut also offers a partnership long-term care insurance policy to state employees. Information on the Connecticut Partnership can now be obtained from its web site at <http://www.opm.state.ct.us/pdp4/ltc/home.htm>.

The Indiana Partnership Program, which has been marketing its program since 1993, has hit several milestones. Of the more than 34,000 policies sold, more than 29,000 are in-force. The new Total Asset Protection policy has spurred sales in the state. Marketing tools have been put in place to assist the partnership insurance agents in Indiana. <http://www.in.gov/fssa/iltcp/>

The New York Partnership Program is using the Total Assets Model, which requires insurers to meet a somewhat different set of criteria before they are certified to issue policies by the state insurance department. New York's Governor Pataki signed into law Chapter 42 of the Laws of 1997 which provides a first dollar state tax deduction for LTC insurance premiums in accordance with the

limitations set forth in HIPAA. New York alone now has nearly 48,000 policies in-force. The Partnership Program is now under the administration of the New York State Department of Health, Office of Medicaid Management. Information about the Partnership can be accessed on the Internet at: [www.nyspltc.org](http://www.nyspltc.org). Product improvements have steadily improved participation levels, adapting to the rapid changes that have occurred in the marketplace, the regulatory environments and the political arenas.

In early 2005, Governor Pataki recently signed legislation to allow the sale of dollar-for-dollar LTCi products in the state becoming the second hybrid state after Indiana.

### **Summary of Partnership Policy Sales**

Policy sales to date indicate steadily growing interest in public/private long-term care insurance policies. Sales also indicate that, when given the opportunity, consumers are willing to protect themselves against the costs of long-term care. Overall, the average policyholder's age is also dropping and is around 59 years. The following are highlights from Partnership policy sales in the four funded states.

Of the more than 264,609 applications received for the purchase of partnership long-term care insurance policies in the four participating states, there are currently more than 172,477<sup>1</sup> policies in force. This represents an increase of 46% in applications received and a 48% increase in policies in-force since 2001. Three states allow the sale of one- and two-year partnership policies. Policies with comprehensive coverage comprise the majority (91%) of all purchases and only 9% of policies provide facility coverage only<sup>2</sup>. The number of first time purchasers remains high at 93% with female purchasers out numbering male purchasers by 59% to 41% respectively<sup>3</sup>. Married purchasers vastly outnumber single purchasers approximately 71% to 29%<sup>4</sup>. The average age of the purchaser was 60 in 2005.

The number of policyholders who qualified for benefits as of March 2005 in the four states was 2,996 and 117 policyholders exhausted their policy benefits since the program began<sup>5</sup>.

### **Pending Federal Legislation**

There have been a number of efforts to improve deductibility of long term care insurance during the 109<sup>th</sup> Congress. The most promising is an effort by Senators Charles Grassley of Iowa and Blanche Lincoln of Arkansas, along with representatives Nancy Johnson of Connecticut and Earl Pomeroy of North Dakota. These legislators have come together on a bipartisan basis to provide a real incentive for Americans to purchase private long term care insurance coverage. Their legislation, **S. 1244** and **H.R. 2682**, would greatly improve affordability and accessibility of long term care and long term care insurance through the following important objectives:

- Change the current long-term care insurance deduction to an above the line deduction (meaning that people can take the deduction without itemizing).

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<sup>1</sup> Number of in force policies as of March 31, 2005 except NY which last reported December 31, 2004

<sup>2</sup> New York has only comprehensive policies only.

<sup>3</sup> Data reported as of March 2005.

<sup>4</sup> Data reported as of December 2005.

<sup>5</sup> New York reports 24 of those died as of April 18, 2005.

- Allows long term care insurance policies to be offered in employer cafeteria plans and flexible spending accounts.
- Provides financial assistance for those who are already ill (or their caregivers) with a tax credit of up to \$3,000 for people who need long-term care services.

In addition to the efforts to improve long term care insurance deductibility, Rep. John Peterson of Pennsylvania has introduced **H.R. 3511** to increase availability of long term care partnership programs beyond the current four states. The bill would remove the state amendment approval deadline put in place by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Removing the deadline would allow every state to implement a program and give their citizens the choice to participate.

If H.R. 3511 becomes law, it would permit states to achieve several objectives:

- Save Medicaid dollars because long-term care needs will be met by the private sector rather than through public expenditure
- Begin to address the future budget busting and expense bleeding costs that full reliance on public programs would saddle on future generations.
- Promote greater self-reliance in people meeting their own care needs rather than relying on a government entitlement
- Assist in the expansion of the long-term care insurance market, something badly needed in anticipation of a dramatic increase in the numbers of elderly requiring such care
- Allow the elderly to bequeath a portion of their assets to their loved ones instead of leaving them a burden