DHS-4394-ENG

Appendices to Report on Public and Private Financing of Long-Term Care

A Report to the Minnesota Legislature

January 2005

APPENDIX A

APPENDIX A

RESULTS OF ELECTRONIC VOTING AT DECEMBER 3 CONFERENCE

Public and Private Financing of Long-Term Care

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Minnesota Department of Human Services
Continuing Care Administration

January 2005

Questions Asked of Attendees at December 3 Conference

TABLE 1: "Do you agree with the following statement: There is an adequate range of options to help people plan and pay for their own long-term care.

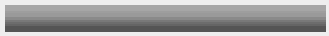
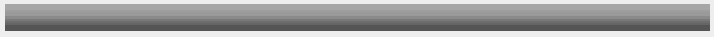
		Response Percent	Response Total
Strongly Agree		6.4%	6
Agree		20.2%	19
Undecided		14.9%	14
Disagree		**44.7%**	**42**
Strongly disagree		13.8%	13
		Total Respondents	**94**
		(skipped this question)	3

TABLE 2: "Please assign a value to each of the following LTC options in terms of its potential for use by individuals/families to pay for long-term care costs. (You can assign the same response to more than one option.)"

	Very Appealing	Appealing	Neutral	Unappealing	Very Unappealing	Response Average
Private long-term care insurance	28% (27)	**44% (42)**	15% (14)	9% (9)	4% (4)	**2.18**
Health insurance that includes long-term care benefits	23% (22)	**41% (39)**	12% (12)	14% (13)	10% (10)	**2.48**
Reverse mortgages	15% (14)	**44% (42)**	22% (21)	15% (14)	4% (4)	**2.49**
A loan program for families	4% (4)	27% (26)	28% (27)	**29% (28)**	11% (11)	**3.17**
Life insurance products that can help pay for long-term care	21% (20)	**60% (58)**	8% (8)	8% (8)	2% (2)	**2.10**
Hawaii's public savings plan (universal long-term care insurance)	**33% (32)**	27% (26)	23% (22)	12% (12)	5% (5)	**2.30**
Putting long-term care benefits into Medicare supplemental plans	11% (11)	**39% (37)**	15% (14)	19% (18)	17% (16)	**2.91**
Partnership for Long-Term Care program	28% (27)	**48% (47)**	22% (21)	2% (2)	0% (0)	**1.98**
					Total Respondents	**97**
					(skipped this question)	0

TABLE 3: "Thinking about the options you feel have the most potential, rank the following strategies from 1 to 5, from most effective to least effective, as ways the state can encourage greater use of private options?"

	Most Effective	Effective	Undecided	Not Effective	Least Effective	Response Average
tax credits or deductions to individuals	**46% (45)**	32% (31)	8% (8)	10% (10)	3% (3)	**1.92**
tax credits or deductions to employers	18% (17)	**43% (42)**	20% (19)	13% (13)	6% (6)	**2.47**
increasing consumer protections and safeguards for individuals who use these options	23% (22)	**41% (40)**	18% (17)	10% (10)	8% (8)	**2.40**
public information and education campaigns	**36% (35)**	**36% (35)**	15% (15)	8% (8)	4% (4)	**2.08**
rethinking and restructuring the public and private responsibility for long-term care payment (as in the Partnership program, for example)	**40% (39)**	34% (33)	16% (16)	5% (5)	4% (4)	**1.99**
					Total Respondents	**97**
					(skipped this question)	**0**

TABLE 4: "Do you agree with the following statements: The following programs should be supported in part (i.e., subsidized) with State funding:"

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Response Average
tax credits or deductions to employers that offer long-term care insurance or similar benefits	**40% (39)**	34% (33)	13% (13)	9% (9)	3% (3)	**2.01**
tax credits or deductions to individuals who purchase long-term care insurance or similar LTC program	**54% (51)**	33% (31)	8% (8)	4% (4)	1% (1)	**1.66**
loan program for families	3% (3)	26% (25)	**32% (31)**	20% (19)	20% (19)	**3.27**
increased consumer protections and safeguards for individuals using these products	29% (28)	**46% (45)**	16% (16)	6% (6)	2% (2)	**2.06**
public information and education campaigns	**43% (42)**	**43% (42)**	6% (6)	5% (5)	2% (2)	**1.79**
universal long-term care insurance (like the Hawaii plan)	**29% (28)**	**29% (28)**	25% (24)	9% (9)	7% (7)	**2.36**
reverse mortgages	10% (10)	25% (24)	23% (22)	**30% (29)**	11% (11)	**3.07**
Partnership for Long-Term Care program	29% (28)	**41% (39)**	21% (20)	6% (6)	2% (2)	**2.11**
					Total Respondents	**95**
					(skipped this question)	**0**

APPENDIX B

DETAILED DESCRIPTIONS OF FINANCING OPTIONS

Public and Private Financing of Long-Term Care

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January 2005

Public and Private Financing of Long-Term Care
Detailed Descriptions of Options
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1. Long-Term Care Insurance (LTCI)

Short Description:
Long-term care insurance ("LTCI") is private insurance that is purchased before long-term care is needed. If care is needed, the insurance policy pays benefits as stipulated in the policy purchased. Policies can be individual or group-based. Individual policies are sold directly to individuals, usually by insurance agents. Group LTCI is usually available through employers or associations that sponsor group plans as a benefit for their employees or members. Stand-alone, comprehensive coverage policies represent the bulk of the policies sold.

Since policies are private, their features or benefits will vary. Factors include:

- Services covered
- Facility covered (nursing home, assisted living, care or services at home, adult day care)
- Amount of coverage purchased in terms of time or dollars
- When benefits are paid
- What triggers eligibility for benefits
- How benefits are paid
- Whether the plan is inflation-protected
- Nonforfeiture of benefits (e.g., if the policyholder cannot continue paying premiums, is there some provision for partial benefits to be paid)

Background:
Focus groups held with representatives of the long-term care insurance industry in November 2003 identified some market trends in Minnesota. While the individual market continues to focus on older age groups with high incomes that are interested in asset protection, there is growing interest in the group market including employers of all sizes. There was also a request that the State continues to expand its role in providing materials similar to those generated through Project 2030 that lay out the demographic and financing issues that representatives use with potential buyers.

Studies have now suggested that employer sponsorship of long-term care insurance is a very important factor in the decision to purchase a policy. In 2003, a survey of Minnesota employers was completed to gauge their interest in offering LTCI to employees. About 165 employers responded to the survey, with the majority (69 percent) being mid-sized employers. Two-thirds of the employers indicated that it was somewhat or very likely that they would consider offering employee-paid LTCI in the future. Three-fourths of the employers said they would be more likely to consider offering LCI if the state provided educational materials for employees. The study concluded that a state educational campaign would likely increase employer interest in offering LTCI and the employers' willingness to offer information provided by the state for long-term care planning could be a significant benefit and provide an opportunity for broad public education on long-term care.[1]

[1] A copy of the complete report on "Employer Interest in Long-Term Care Insurance" can be found at http://www.mnaging.org/community/legislative.html

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In April of 2004, the Congressional Budget Office (CBO) projected only limited rise in the utilization of private insurance as a mechanism for financing long-term care. Factors contributing to the slow growth of the LTCI market include some that are unique to the characteristics of LTC, such as the interaction of private insurance and Medicaid and the inability to insure against certain kinds of risks. Other factors are common to most insurance markets, but particularly to "new ones," including issues related to administrative cost, premium stability and adverse selection.

Table 1: Basic Plan Elements

Tool	Long-Term Care Insurance
Who is Eligible?	Any individual may purchase a LTCI policy. However, some people are rejected for coverage due to certain medical conditions, or the need of needing long-term care services in the near future. The premium rate will be affected by the cost of providing services and the risk of needing long-term care. Policyholders usually become eligible for benefits when they reach a specific minimum level of impairment, such as being unable to perform certain activities of daily living (ADLs) or being cognitively impaired. Many plans also have a waiting period or deductible which requires the policyholder to pay for their own expenses for a specified number days or dollar amount before the insurer will pay benefits.
Who is Responsible for Payment?	Premiums for the policy are paid by the purchaser. Premiums for LTCI reflect the cost of services and the risk that a policyholder will require long-term care later in life. Fixed premiums are a key feature of policies; they are calculated to ensure that the total payments in premiums paid over the life of a policy, plus the interest accrued from investing premiums will be sufficient to cover the claims, the insurer's overhead and profit. Generally, the later in life the policy is purchased, the higher the premium. The cost of premiums also includes the marketing and selling the policies. Because most policies are sold to individuals rather than to groups, these costs tend to be high. The costs of selling group LTCI are lower. Each insurance company administers the products it sells.
Who Administers the option?	The option is administered by the private insurance company offering the policy.
What Services are Covered?	The services covered depend on the policy purchased. Older policies may have covered only nursing home care. Newer policies have recognized the broader range of long-term care needs and provide for broader coverage, including assisted living and care or services in the home.
Limits on Services or Length of Coverage	Typical LTCI insurance policies pay the cost of nursing home care and home and community-based care but specify a maximum daily benefit and may impose other limits on services. Some policies do offer coverage for an unlimited time period, but most offer services for a shorter set time, or until benefit payments reach a pre-set maximum lifetime benefit amount.
Portability or Flexibility of Plan	The portability or flexibility of the plan will depend greatly on the type of plan purchased. The most flexible policies will allow you to use your benefits to cover any necessary long-term care service in whatever setting that is needed.

Tool	Long-Term Care Insurance
	Policies with inflation protection increase the dollar value of their benefits by a contractually percentage each year (usually 5%).
Interaction with Medicaid	There is disagreement about the potential of LTCI to reduce Medicaid spending. This is because of the relatively slow rate of growth in the long-term care insurance market. CMS has provided the following statement, "Medicaid long-term care competes with private LTCI and makes the product more difficult to sell." In terms of asset requirements for Medicaid, private funds and LTCI benefits would need to be exhausted before one would be eligible for public funds.
Status of the option in Minnesota	**Market in Minnesota.** An estimated 114,000 LTCI policies were in force in Minnesota in 2004, representing 9% of the state's population between ages 50-84. This makes Minnesota the 13th highest state in sales penetration in the nation. The State of Minnesota sponsors a state employee-paid LTCI plan that was implemented in 2000 and 2001. The enrollment was done as a part of open enrollment during 2000 for employees and 2001 for retirees, and generated the highest participation rate of any public employee plan at that time in the nation with a 17% enrollment rate. The state offers a $100 tax credit for taxpayers who own a qualified policy, and the Department of Revenue estimates that fewer than half (about 42,000) of Minnesotans eligible for the $100 LTCI credit on their state tax return actually claim it. 67 companies were licensed to sell LTCI in the state in 2004. This number has declined in the past few years, as a number of companies once active in the market have either quit selling completely or are not selling new policies. The products sold are evolving significantly with new products becoming available. However, as new products enter the market, consumers are faced with increasing complexity. Additionally, small employers typically do not offer LTCI, and about 85% of Minnesota's workforce works for small employers with 1-19 employees.
Potential Market or Portion of Market this Option Occupies	In 1995, private insurance paid about $700 million nationwide for LTC services for seniors, or about .8% of all such expenditures. The Congressional Budget Office (CBO) estimates that in 2004, this spending was about $6 billion, or about 4% of total expenditures. However, "few" elderly people maintain private insurance. In 2001 William Scanlon, Director of Health Care Issues for the General Accounting Office estimated that less than 10% of seniors had coverage. There is therefore significant room for market growth to those seniors who would not be rejected for health reasons.
Characteristics of Current Users or Participants	It is estimated that LTCI purchasers in Minnesota have average annual income of $75,000, and purchase at age 58 on average. About 42,000 taxpayers took advantage of the LTCI tax credit in 2003, which is about 1%

Tool	Long-Term Care Insurance
	of the adult population in the state.
Research Findings	The study, *Private Information and its Effect on Market Equilibrium* suggests that although adverse selection exists in LTCI markets, it may not be producing higher overall claims costs. When several factors on the decision to purchase a long-term care policy were examined in, *The Importance of Employer-Sponsorship in the Long-Term Care Insurance Market,* interim results indicated that the factor most likely to affect the decision to purchase LTCI is access to employer-sponsorship. In *Financing Long-Term Care in the Twenty-First Century*, the claim that future demand for publicly financed services could be reduced is examined; the key factor is how many people could be persuaded to purchase LTCI. "Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance" published in *Elder Law Journal*, recognized that LTCI policies have been slow to enter the market, despite various strategies at both the federal and state levels designed to encourage their purchase. The authors conclude that these initiatives have achieved only modest success in penetrating the market for LTCI and their failure raises many policy issues, including whether government should intervene in the private market, and if so, what strategy is most efficient and effective. A 1990 study entitled, *Tax Deductibility of Long-Term Care Insurance Premiums: Implications for Market Growth and Public LTC Expenditures* found that a 100% above-the-line federal tax deduction for LTCI premiums would reduce net premium costs, increase LTC coverage, and bring about Medicaid savings. The tax expenditure would be offset by future reductions in Medicaid expenditures. *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy* concluded: "Older people are much less likely to be able to afford comprehensive (LTCI) coverage. The pared-down products that may be financially within the reach of the middle income households can provide only limited asset protection and at the same time may be suited to meet other goals, such as maximizing the likelihood of being able to remain at home or in a community setting. More research is needed to identify the variety of risks that individuals face and to develop alternative products that can better suit individual purchasers' circumstances, needs and objectives."

Table 2: Pros/Cons

Pros (advantages)	Cons (disadvantages)
Long-term care insurance provides asset protection, the ability to control long-term care decisions and choices.	Most financial experts suggest that long-term care insurance is not appropriate for someone with less than $35,000 in financial assets or if the monthly premium cost represents more than 7 percent of income. In other words, LTCI does not make financial sense for a person with little income or who already qualifies for Medicaid
Most policies available today are federally tax-qualified, meaning that in addition to certain tax benefits, they meet quality and consumer protection standards.	The tax benefits are currently relatively small. Plans purchased after HIPAA was enacted must conform to the law's requirements for the premiums to be tax-deductible.
Provides the ability to pass on an inheritance to family members (some purchasers also value not becoming a burden on their families).	Unless the most comprehensive care level is purchased, the amount of coverage selected may not cover needs, and purchasers may need to use additional resources.
Administrative costs for selling policies may fall as more employers offer LTCI as a benefit to their employees (since substantial costs are associated with marketing and enrolling).	In some cases, the premiums for group LTCI can actually be higher, since all members are covered, and those who would ordinarily be rejected or underwritten out need to be included.
The report "Can Aging Baby Boomers Avoid the Nursing Home? Long-Term Care Insurance for 'Aging In Place'" shows that increased purchases of comprehensive private insurance can reduce government expenditures for nursing home care and increase tax revenues by returning caregivers to the workplace.	Purchasing LTCI often means buying a product that will not be used for many years. It is difficult to predict what LTC will look like at the point when LTCI benefits are actually needed, or what role other entities, such as the government, will play.
Generally the premium is fixed for the life of the policy.	Some people will not qualify for insurance due to preexisting health conditions; additionally, the insurer may impose general rate increases applicable to an entire class of purchasers.
Some people value the protection from catastrophic events that could lead to bankruptcy or extensive use of income or assets.	If someone buys insurance and they never need LTC, they will not be able to recoup the funds paid into the insurance plan (although some policies now have pay-back features built-in).
In general, private products and private funds allow individuals to have greater choice when compared to strict public programs that may provide only limited benefits and options for coverage. Some purchasers are beginning to realize that current entitlement programs may become more limited in the future, curtailing their options and choice.	Purchasers need to be careful to buy from companies with proven "track records" and sound financial management
	Early LTCI policies have already been replaced with newer policies that cover more services, but

Pros (advantages)	Cons (disadvantages)
	people are limited to the benefits of the plan chosen.
	Buying younger often means getting a lower premium, but the value of the dollars could be greater through other types of investments. Additionally, younger people have many demands on income, often including caring for young children.
	The availability of Medicaid has been noted as a deterrent to the purchase of private long-term care insurance products.

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Moses, Stephen A. "Medicaid and LTCI: The CMS Perspective." Health Insurance Underwriter. February, 2004. Available at: http://nahu.timberlakepublishing.com/article.asp?article=847

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The Senior LinkAge Line® (SLL) is a telephone information and assistance service operated by the Minnesota Board on Aging that links callers to staff trained to answer questions about insurance, services and other aging programs. The SLL is receiving more calls about LTCI each year, a total of 1,600 calls in 2003.

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Web sites:
www.mape.org
www.doer.state.mn.us

2. Partnership for Long-Term Care Program

Short Description:
The Partnership for Long-Term Care (PLTC) was aimed at providing an alternative to spending down or transferring assets by forming a partnership between Medicaid and private long term care insurers. The Robert Wood Johnson Foundation awarded grants to four states--California, Connecticut, Indiana, and New York--to work with private insurers to create policies that were more affordable and provided better protection against impoverishment than those generally available. The touchstones for the policy goals were quality, affordability and coordination. The resulting PLTC combines private long-term care insurance with special Medicaid eligibility standards. Once private insurance benefits are exhausted, these rules are applied if additional coverage is necessary; those who purchase Partnership policies retain protection of some private assets.

During the development phase of the program two program models emerged. California and Connecticut are using the Dollar for Dollar Model, while New York is using the Total Assets approach. Indiana uses a hybrid of the two models. Participating insurers must meet certain criteria before selling these special long-term care insurance policies. Key features of the product include inflation protection, consumer education and required uniform reporting for insurers, so results can easily be tracked.

Illustration
If a single person living in a Partnership state has assets totaling $125,000 and purchases a qualified LTCI policy with a coverage limit of $100,000, the following interaction between the LTCI policy and Medicaid occurs if a LTC need ensued. Following any elimination period or deductible contained in the LTCI policy, payment would be made according to the terms of the policy. (If during this time—approximately 2 years—the individual died, Medicaid would not be involved in any way, and the individual's estate would proceed as per his directives.) If, however, the full limit of the $100,000 policy were expended for care, the individual would next use $22,000 of their assets until reaching $103,000 in assets (the regular $3,000 Medicaid asset limit PLUS the disregarded $100,000 established under the Partnership Program's dollar-for-dollar model). At this point Medicaid would become the payer but only after the normal income contributions to cost of care that are required for everyone served by Medicaid. The $103,000 in assets is protected from Medicaid's eligibility calculation and is available to patient while they are alive with any unspent remainder going the policy holder's estate upon death.

Background:
The authority for instituting the PLTC program resides in state plan amendments rather than Centers for Medicare & Medicaid Services (CMS) waivers. There is a provision in Medicaid law allowing states to alter the asset eligibility criteria dependent on a state specified requirement. For the Partnership, it is the purchase of a state certified long term care insurance policy.

The Omnibus Reconciliation Act (OBRA) of 1993 contained language with direct impact on the expansion of the Partnership for Long-Term Care program. 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 were allowed to operate their partnerships as planned because their state plan amendments were approved by HHS before May 14, 1993. States seeking a state

plan amendment after May 14th must abide by the conditions outlined in OBRA'93. Three sections affect the program:

- **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.

Table 1: Current State Data	**California** (through 4Q 2003)	**Connecticut** (through 4Q 2003)	**Indiana** (through 2Q 2004)	**New York** (through 2-3Q 2003)	**Four State Total**
Total Applications Received:	**77,423**	**40,167**	**37,743**	**71,949**	**227,282**
Applications Denied:	13,439	4,817	5,445	11,701	35,402
Applications Pending & Withdrawn:	0	2,282	334	6,719	9,335
Total Policies Purchased:	**63,984**	**33,068**	**31,964**	**53,529**	**182,545**
Policies Dropped:*	6,000	3,256	3,434	5,286	17,976
Policies Not Taken Up:	3,316	2,496	2,434	5,359	13,605
Total Policies In Force (active):	**54,632**	**26,938**	**26,707**	**41,732**	**150,009**
Policyholders Who Received Service Payments:	624	244	210	896	1,974
* Does not include drops reported as deaths, rescissions or exhausted benefits.					

Table 2: Basic Plan Elements

Tool	Partnership Program for Long-Term Care
Who is Eligible?	Residents of one of the four states "grandfathered" in to the Program before the OBRA language took effect. Those purchasing also need to be eligible to purchase long-term care insurance.
Payment, Administration, Services, Limits on Services	These elements will generally be the same as when one purchases a long-term care insurance policy in any other state. The insurer must meet certain requirements before offering the product, and though aimed at being higher quality, the product may contain certain limits on services. In terms of administration, the difference lies in asset requirements for determining Medicaid eligibility.
Portability or Flexibility of Plan	In 2001 CMS approved legislation creating reciprocity between Connecticut's and Indiana's Medicaid programs for granting asset protection in the determination of Medicaid eligibility. The Connecticut and Indiana reciprocity agreement is the first of its kind in the country and represents the first step in portability of the Medicaid asset protection benefit. Under the agreement, Indiana Partnership policyholders who move to Connecticut will be able to receive dollar-for-dollar Medicaid asset protection if they apply to Connecticut's Medicaid program. The same is true for Connecticut policyholders who relocate to Indiana and apply to Indiana's Medicaid program. For the other states, policy holders could probably access care in states accepting their policy, but to retain asset protection, they would need to spend down in the state in which protection was purchased.
Status of the option in Minnesota or other states	21 states initiated legislative activity to establish a Partnership. The current OBRA language has prevented the programs from coming into effect. Ongoing efforts in other states include planning activities, statutory changes to facilitate development of Partnership programs and appeals to the US Congress to repeal restrictions enacted in 1993 that have stymied Partnership expansion. Minnesota has introduced legislation that would introduce the Partnership Program and to nationally repeal the federal statute. This legislation has not yet passed. The Partnership model continues to operate in the original four states: Connecticut, New York, Indiana and California.
	Connecticut: Began in March 1992 The Dollar for Dollar Partnership model allows consumers to purchase an amount of private coverage equal to the amount of assets that they wish to protect. Generally, the minimum policy must cover at least one year in a nursing home. If and when the private insurance benefits are utilized, the amount of private insurance benefits that was paid out for long-term care services is disregarded in determining eligibility for Medicaid. As with all Medicaid clients, policyholders who become eligible for Medicaid must contribute their income towards the cost of care under Medicaid

Tool	Partnership Program for Long-Term Care
	New York: Began in April 1993 The Total Assets model adopted by New York requires that consumers purchase three years of private coverage for the initial period of care, but then does not require any further contribution of the policyholder's assets once the private benefits have been exhausted. A minimum of three years of nursing home and six years of home care coverage, or a combination of the two, is required. After these private benefits are exhausted, none of the policyholder's assets will be considered in the determination of Medicaid eligibility, although the policyholder must contribute his/her income towards the cost of care.
	Indiana: Began in May 1993 Indiana initially adopted the Dollar for Dollar model, but in March 1998 changed to a combination of the Total Assets and Dollar for Dollar Models. Purchasers receive Total Asset protection if they purchase a policy having at least a state-defined amount of coverage ($140,000 in 1998, $147,000 in 1999, $154,350 in 2000 and increasing annually on January 1 for new policies purchased during that year) and Dollar for Dollar protection if the policy has less than that amount of coverage. Policies purchased prior to March 1998 were grandfathered into Total Asset protection if their original maximum policy amount was at least $140,000.
	California: Began in August 1994 The Dollar for Dollar Partnership model allows consumers to purchase an amount of private coverage equal to the amount of assets that they wish to protect. Generally, the minimum policy must cover at least one year in a nursing home. If and when the private insurance benefits are utilized, the amount of private insurance benefits that was paid out for long term care services is disregarded in determining eligibility for Medicaid. As with all Medicaid clients, policyholders who become eligible for Medicaid must contribute their income towards the cost of care under Medicaid
Potential Market or Portion of Market this Option Occupies	Currently the program operates in only four states. However, if the OBRA language were repealed, a potential market could exist in any state. The market would be similar to the current market for long-term care insurance, though may be larger due to the added incentive of protecting private assets. One statistic projects that the Partnership doubles the size of the potential market.
Research Findings	Those states participating in the Partnership have found the program must be simple, agents must be viewed as partners, the policies should be comparable to non-partnership policies and effective focus is on younger purchasers. One reviewer noted that as a product promoting the integration of the public and private sectors, Partnership has taken hits from both sides of the ideological perspective, yet retains bipartisan support in its communities. A review entitled, "Long-Term Care Partnership Program: Issues and Options" found that the program has not had a major impact on financing LTC in states with the program. The study calls the program's results to

Tool	Partnership Program for Long-Term Care
	date "modest." Another reviewer has noted that the Partnership's assumption that forgiveness of the Medicaid spend-down requirement would act as an incentive to buy long-term care insurance was wrong.
Characteristics of Current Users	The partnership was intended to attract users who would not otherwise buy LTC insurance because of the asset protection from spend-down.

Table 3: Pros/Cons

Pros (advantages)	Cons (disadvantages)
The Partnerships provide an incentive for insurers to offer high quality products and for consumers to protect themselves from the high cost of long-term care.	The 1993 OBRA language effectively removes incentives for states to offer a Partnership program.
The program helps to avoid Medicaid gaming as well as impoverishment.	Still involves an insurance product, therefore many people think they will never have a need for this product.
Improves the working relationship between the states and insurance providers.	So far, there are no clear savings to Medicaid. It may be too early to determine whether there are clear savings to Medicaid.
The program mitigates means testing concerns.	It is unclear whether the partnership attracts its target audience. So far, more people with middle class incomes have purchased, as opposed to those with modest means.
Improves consumer protection. Partnership policies are more likely to include inflation protection and offer coverage of home-based care.	Weak demand: despite the developments of products with improved consumer protection, overall demand for LTCI remains low.

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3. Adding nursing facility benefits to Medicare-related coverage
4. Health insurance options that combine health with long-term care

Short Description:
In the public sector--there is now over seven years experience of combining healthcare coverage and LTC within the Minnesota Senior Health Options program. Other states have upwards of twenty years experience working with the combined coverage under the Program of All-inclusive Care of the Elderly (PACE) program.

In the private sector--a Medicare Advantage HMO that now receives a risk-adjusted payment could operate with a care management component and limited--but important—extended care benefits similar to the two decade-old Social HMO program or the Evercare program. Advantages of this integration can include[2]:

- Support of medical care (e.g. arranging transportation to medical appointments, communicating information about medical problems that are observed by helpers in the home).
- Furthering a geriatrics approach by involving care management professionals and LTC staff along with the medical team.
- Enhancing management of transitions, by identifying new long-term care needs quickly after an acute exacerbation of a chronic illness, or assisting with creation of viable community support plans instead of nursing facility placement.
- Managing overlaps between skilled and long-term care.

Background:
Medicare Market in Minnesota Basic information about sources of supplemental insurance coverage for Minnesota Medicare beneficiaries was provided by the Minnesota Department of Health at both a videoconference briefing and at the December 3 conference.[3]

- 44% of Medicare beneficiaries in MN get their supplemental insurance coverage through Medigap insurance, 11% through a Medicare HMO, 9% through government programs, 22% through employer, and 14% have Medicare only.
- These patterns are different in the metro and rural portions of the state with far more rural Medicare beneficiaries using Medigap insurance for supplemental coverage than metro (55% vs. 37%) and more metro than rural getting coverage through employers (25% vs. 18%).
- Minnesota's coverage by Medigap at 44% is double the national average of 22%.

The strong reliance on Medigap policies as the supplementation of Medicare (especially in Greater Minnesota) makes combined products most likely to emerge in areas of the state where risk-based HMO products are used. However, the encouragement of combined products facilitates progress on several of this study's goals.

[2] W.N. Leutz, M.R. Greenlick, J.A. Capitman, "Integrating Acute and Long-Term Care," Health Affairs (Fall 1994):58-74.
[3] Julie Sonier, Assistant Director, Health Economics Program, Minnesota Department of Health on September 10, 2004 policy briefing and December 3, 2004 conference.

- The Minnesota study identified that having broadly recognized "trigger points" for purchase of LTC insurance protection could help broaden the base of individuals that have some source of private LTC coverage. One such trigger point could be upon Medicare eligibility. Actuarially sound combined products could offer limited LTC coverage for individuals who had not provided for their LTC through another vehicle.
- The incentives for the HMO to provide care coordination and supportive community supports are becoming clearer through the experience of "dual eligible" programs on the public side, and Social HMOs on the private side.
- The study found no compelling evidence that any specific program coordinating medical and LTC services would provide significant cost savings but valuable services are provided to consumers at basically equivalent cost to traditional Medicare, and long-term savings remain a possibility.
- The potential to affect the onset and progression of needs that require LTC (e.g. preventive health measures or moderation of disability through disease management) puts these options in an important position of being more than simply a financing vehicle.

Table 1: Basic Plan Elements

Tool	**Health Insurance: Adding Medicare Supplemental Policies to Bridge the Gap Between Medicare and Medicaid**
Who is Eligible?	A person purchasing a Medicare Advantage plan with supplemental benefits. (It is likely that only capitated plans would add care management and LTC benefit since they can realize any savings on the acute liability side that might be affected by better LTC supports.)
Who is Responsible for Payment?	The health plan pays for the care coordination and LTC services according to the contract.
Who Administers the option?	This option is administered by the health plan under the oversight of the federal Medicare program.
What Services are Covered?	A Medicare Advantage plan adds coverage for care coordination and a limited array of home and community-based services. When the consumer and their family receive assistance in learning about community-based LTC options and some coverage to use them, it is anticipated that they will be better private consumers of HCBS.
Limits on Services or Length of Coverage	Services would be on a year-by-year basis with enrollees responsible for payment of desired services that exceed the HMO contract.
Portability or Flexibility of Plan	The coverage would not likely be portable on the LTC side although medical benefit portability for a significant portion of a year (similar to current Medicare Advantage products) could continue. When in the service area, the plan would have an incentive to make enrollees familiar with informal or quasi-formal services which the enrollee might consider using beyond the HMO benefit. In addition, the flexible substitution of lower cost services that are not a formal part of the service benefit is encouraged by the financing, with consent of the enrollee.
Interaction with Medicaid or Medicare	If the health plan involved was also a MSHO participating plan, the smooth continuation of the enrollee's care under the richer Medicaid integration product could be accomplished if the enrollee becomes Medicaid eligible.

Tool	Health Insurance: Adding Medicare Supplemental Policies to Bridge the Gap Between Medicare and Medicaid
Status of the option in Minnesota or other states	No such products exist in Minnesota at this time. Four states; New York, California, Oregon and Nevada have Social HMO sites that function as described above.
Potential Market or Portion of Market this Option Occupies	The potential market is likely dependent on the growth of Medicare Advantage plans under the Medicare Modernization Act of 2003. This is a complex option to develop and to understand. It is also realistically limited to capitated plans that can realize the rewards of better coordination of care and reduction of unnecessary acute services.
Characteristics of Current Users or Participants	Social HMOs enroll over 100,000 Medicare beneficiaries in the four states where they are offered and reflect the general Medicare population in age, gender, income, and health status.
Research Findings	Research on current public and private integrated medical and LTC products is complex and controversial. Some studies have found little or no effect on long-term care utilization and consumer satisfaction, others have found reduced nursing home utilization and high consumer satisfaction. Studies of cost savings for Medicare and Medicaid are equally mixed.

Table 2: Pros/Cons

Pros (or advantages)	Cons (disadvantages)
The potential of positively affecting disability rates needs to be explored.	Evidence of cost saving is not clear
Minnesota health plans have experience with similar models on the public side	Complex programs to develop and administer
This option can be one of several "trigger points" (Medicare eligibility) to cause individuals to review and act on their lack of LTC financial coverage.	

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5. Life Insurance used to pay for long-term care

Short Description:
Generally, there are two types of life insurance. Permanent insurance has equity and cash value that can be utilized in a variety of ways. Term insurance, which may be thought of as "renting" temporary coverage involves a premium for a specific death benefit amount; the policy can also be converted into permanent insurance without penalty. Options for use of a permanent policy to finance long-term care include accelerated death benefits, life settlements, single premium/long-term care policies and viatical settlements.

Most insurance policies also have additional options called "riders." The newest products that can be used to finance long-term provide linked benefits: the policy becomes a life insurance policy that has a specific benefit for long-term care. There are two types of linked benefit policies. The first provides an accelerated death benefit rider, and the second provides a full-blown long-term care insurance rider; the latter has a monthly or daily payout and individuals usually must qualify for this option. Unlike freestanding long-term care insurance, this type of policy also pays a death benefit to one's heirs. The premium amount is selected establishes a death benefit equal to that amount.

Background:
As insurers continue to struggle with pricing for long-term care insurance, linked benefit policies (life insurance and long-term care insurance) can become a cost-effective alternative. This is additionally true as long-term care insurance premiums increase.

Table 1: Basic Plan Elements

Tool	Life Insurance That Pays for Long-Term Care
Who is Eligible?	Permanent Life Insurance: Holders of permanent life insurance policies can utilize the policies to fund LTC by withdrawing from the cash value, taking out a tax-free loan against the policy or by transferring the cash value into an annuity that pays out an income stream without creating a taxable event. Linked Benefits: A policy could be purchased that has a specific benefit for long-term care. Some provide benefits such as an accelerated death benefit or an actual long-term care benefit.
Who is Responsible for Payment and Administration?	If a permanent policy is used to finance costs, the owner of the policy would be responsible for payment. In the case of a linked benefits policy, the insurer may be responsible for payment or administration of the payment could be purchased as a specific benefit of the long-term care plan.
What Services are Covered?	What services are covered would depend on the type of linked benefit policy chosen. The policy could have a specific benefit for long-term care, or simply an accelerated death benefit which may be used toward long-term care costs.
Limits on Services or Length of Coverage	Limits on services or length of coverage would only be applicable under a linked benefit policy. If a long-term care benefit or long-term care insurance is included, there may be limits similar to limitations applied to long-term care insurance plans.
Portability or	The plan is fully portable and flexible since if it involves a direct payout.

Tool	Life Insurance That Pays for Long-Term Care
Flexibility of Plan	For linked benefits plans, the portability or flexibility may be limited by long-term care insurance benefits.
Interaction with Medicaid	Life insurance can affect Medicaid eligibility in several ways. Face and cash surrender value of permanent life insurance policies as well as dividends all have potential to affect eligibility. Life insurance policies are considered when calculating burial fund exclusions, determining available assets, and may, in certain circumstances, be looked at when determining if uncompensated asset transfers have occurred.
Status of the option in Minnesota or other states	All these options are currently available in Minnesota. In Wisconsin, some state employees are able to convert group life insurance coverage to pay premiums for health insurance or long-term care insurance.
Potential Market or Portion of Market this Option Occupies	About 40% of the adult population has some type of life insurance. Therefore any of these policy holders could potentially use the life insurance policy to help cover LTC costs. One firm's 2001 estimate stated that women account for 70% of insurance purchases for LTC.
Characteristics of Current Users or Participants	For the single-premium life/long-term care policy, purchasers have a "chunk" of money available for purchase. Many consumers think the need for long-term care is not realistic and prefer an option that allows for self-funding. For those whom a death benefit for their heirs is important, a linked-benefit plan may not be ideal, since long-term care costs can decrease the death benefit. Finally, those choosing the accelerated death benefit are usually facing some type of terminal illness.

Table 2: Pros/Cons

Pros (advantages)	Cons (disadvantages)
Cash, CDs, annuities, or other relatively liquid resources can be used to purchase a single premium policy.	A substantial deposit is needed to have a meaningful long-term care benefit because funding is done on a single premium basis.
A person may be able to move the cash value from one life insurance policy into this type of combined product without tax consequences. If someone is 59 ½ + they can transfer funds from an IRA, Keogh or qualified annuity into this policy.	The longer a person holds the policy without needing care, the more benefit can be provided. If care is needed earlier, they may not have accumulated enough benefit to cover the cost of care.
This option may be good for people who would like to self-insure against the risk of needing long-term care coverage	It is difficult to plan for inflation, and a rider may be required to receive inflation upgrades.
The premium is guaranteed, or "locked in."	The death benefit can be reduced by long-term care costs (this is applicable in the case of linked benefits policies).
Coverage can provide for both long-term care	Underwriting can be difficult if the policy

Pros (advantages)	Cons (disadvantages)
needs as well as provide a death benefit for heirs the cash value can also be accessed if needed.	considers both morbidity and mortality.
The longer someone has the policy without filing a claim, the more accumulation is available for long-term care needs.	

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6. Reverse Mortgages

Short Description:
A reverse mortgage is a mortgage that allows homeowners age 62 and older to use the equity in their home to receive cash while continuing to own and live in their home. It is used by older Americans to convert the equity in their homes into cash. They are different from conventional home equity loans because there are no income or credit qualifications, no monthly or immediate repayments, and the mortgage is paid off when the home is no longer the primary residence of the borrower. The name stems from the fact that the payment stream is "reversed." Instead of the borrower making monthly payments to a lender, as with a regular mortgage or home equity loan, a lender makes payments to a borrower. The types of reverse mortgages are single purpose, Federal Housing Administration insured Housing Equity Conversion Mortgage, ("HECM"), and Fannie Mae's proprietary program, Home Keeper.

The amount that can be borrowed is based on the value of the home or FHA or Fannie Mae's lending limit, the age of the youngest borrower (or joint life expectancy of all borrowers), and the current interest rate. The loan fees and any current liens must be paid at the time of closing (and may be paid with the reverse mortgage proceeds). Note that one can do a reverse mortgage with a higher valued home, but the maximum borrowed is based on the lending limit of the program chosen. Any equity above the limit is retained equity of the borrower or the heirs.

The borrower can receive their cash in monthly payments, a line of credit, a lump sum, or a combination of these. The monthly payments may be received as a "tenure plan," receiving a monthly check as long as they live in their home, or they may be based on a period of time.

The initial FHA interest rate is determined at the time of closing and is based on the 1-year U.S. Treasury Index and the expected interest rate for projection purposes is based on the 10-year U.S. Treasury. Then it adjusts monthly or annually. The Fannie Mae rate is a monthly adjustable rate based on the one-month CD rate. The adjustable rate does not affect the amount of money received, but the amount that is required to be paid back. Interest is only charged on money withdrawn. Any money left in the line of credit earns a growth rate.

Background:
Shortly before leaving office, President Clinton signed legislation that would reduce the cost of getting an FHA HECM in cases where the loan proceeds are used to purchase qualified long-term care insurance. HUD would agree to waive the up-front mortgage insurance premium charged to borrowers, which could save several thousand dollars. Before implementing the policy, Congress asked HUD to conduct an actuarial analysis. Consequently, an Interim Rule was issued by HUD in 2004 that reduces the upfront mortgage insurance premium (MIP) charged to seniors who refinance a HECM. The MIP will now be paid on the difference between the home value at the time the original HECM was made and the newly appraised value at the time of refinancing.
Also in 2004, a study by the National Council on Aging (NCOA) showed that using reverse mortgages to pay for long-term care at home has potential in addressing long-term care financing needs. The NCOA with the support of both the Centers for Medicare & Medicaid Services (CMS) and the Robert Wood Johnson Foundation is laying the groundwork for a public-private partnership aimed at increasing the use of reverse mortgages to help pay for long-term care. The goal of the Use

Your Home to Stay at Home™ program is to increase appropriate use of reverse mortgages so that homeowners can utilize home equity to pay for long-term care services or insurance.

Financing Strategies for Supporting Aging in Place

Source of Funds	Money for mortgages, taxes, repairs, etc.	Money for safety, accessibility modifications	Money for short-term services	Money for long-term services
Self-fund, e.g., savings, investments, trusts	X	X	X	X
Family contributions	X	X	X	Depends on how long money is needed
Volunteers, donations	X	X	X	Depends on how long money is needed
Coverage for services, e.g., MA waivers		X	X	X
Repair grant or "deferred" loan	X	X		
Take in a renter, "homeshare"	X	X	X	X
Refinance existing primary mortgages	X	X	X	Depends on value involved
New primary mortgages	X	X	X	Depends on value involved
Home improvement loan (installment lending – 2nd mortgage)	X	X		
Personal loan (installment lending – unsecured)	X	X	X	
Equity line of credit	X	X	X	Depends on value involved
Federal income tax deduction – accessibility modifications		X		
Property tax deferral, e.g., "This Old House"	X	Depends on impact on value		
Property sale/leaseback		X	X	Depends on value involved
Life estate				
Reverse mortgages	X	X	X	Depends on value involved
Others?				

Source: "Using Home Equity for Long-Term Care." by Diane Sprague, MHFA, Policy Briefing, August 6, 2004

An Example of
Reverse Mortgage Processing Costs
For a $200,000 Home

Costs	$50,000 loan	$100,000 loan	$150,000 loan
Origination fee -- greater of 2% of loan or $2,000*	$2,000	$2,000	$3,000
FHA mortgage insurance premium -- lesser of 2% of home value or area FHA loan limit	$1,000	$2,000	$3,000
Appraisal -- $350 - $500	$500	$500	$500
Credit report -- $50	$50	$50	$50
Flood certification -- $18 - $20	$20	$20	$20
Courier fee -- $30 each	$30	$30	$30
Escrow, settlement fee -- $250 - $300	$300	$300	$300
Abstract or title search -- $125 - $150	$150	$150	$150
Title examination -- $125 - $130	$130	$130	$130
Document preparation fee -- $125	$125	$125	$125
Title insurance** Lender's - $250 - $300 Borrower's - $150 - $200	$500	$500	$500
Endorsements -- two at $50 each	$100	$100	$100
Recording fees -- $25 - $30 each mortgage + $5 conservation fee	$35	$35	$35
Mortgage registration tax -- $.23/$100 loan***	$115	$230	$345
Plat drawing -- $60	$60	$60	$60
Name search -- $30	$30	$30	$30
Assessment search - $30	$30	$30	$30
TOTAL****	$5,175	$6,290	$8,405

*May also be a monthly servicing fee
** Figures here are a rough average - based on complexity of title/areas of concern, may vary by neighborhood/community
***State law allows larger counties to charge a $.24/$100 rate.
****Lenders may add other charges to bring in more revenue, e.g. an "underwriting fee" of $250-300.
Source: Minnesota Housing Finance Agency

Table 1: Basic Plan Elements

Tool	Reverse Mortgages
Who is Eligible?	• Persons age 62 and older • Own their home free and clear, or nearly so • Single-family residence or condo (for Home Keeper) or two- to four-unit residence or condo (for HECM) • Home is the primary residence • Expect to remain in the primary residence as long as participating in the Home Keeper or HECM program • Attend free counseling session o NOTE: There is no income or medical requirement to qualify for a reverse mortgage.
What are Payment Options?	5 payment options are available: • Term: Equal monthly advances for a fixed number of years • Tenure: Equal monthly advances for as long as the borrower remains in the home • Line of Credit: Cash dollar amount available on demand • Modified Tenure: Set aside part of the proceeds as a line of credit, in addition to monthly payments • Lump Sum Cash Advance: Receive all money in a lump sum at the closing of the reverse mortgage
Who is Responsible for Payment (repayment of the loan)?	Payment of the reverse mortgage is not due until the borrower permanently leaves the home. As a non-recourse loan, the repayment amount cannot exceed the value of the home. The loan is generally paid through the sale of the home. If the heirs want to maintain ownership, they may liquidate assets or obtain a conventional mortgage. In the case of joint borrowers, when one of them dies, the mortgage stays in place as long as the other borrower has the home as their primary residence. The repayment amount includes the closing costs, cash advanced to the borrower over the length of the loan, and the accrued interest. Any remaining equity is retained by the borrower or the heirs. Payments can also be made during the time of the loan. The amount paid reduces the balance of the loan and increases the amount available in the line of credit. It can be repaid at any time without prepayment penalties.
Who Administers the option?	Lenders must be qualified to process for HUD, Fannie Mae or have one of the private products available. The Federal Housing Administration (FHA) requires that homeowners receive counseling from a Housing and Urban Development (HUD) certified counseling agency before they apply for the loan. Counseling is a free service, provided by a trained third-party housing counselor.
What Services are Covered?	The cash received from a reverse mortgage may be used for any purpose. There is not currently a requirement that proceeds from a reverse mortgage

Tool	Reverse Mortgages
	be used to finance long-term care. If the home needs physical repairs (mandatory repairs) a portion of the proceeds will be set aside for this purpose.
Length of Coverage	A borrower can stay in the home as long as it is the primary residence. The loan does not need to be repaid until the borrower chooses to move, sell, dies or turns 150 years old. If the tenure payment plan is chosen, as long as the home is the primary residence, monthly payments will continue. If a term payment plan (available through HECM only) is chosen, when the term has ended, payments cease. Although the borrower may stay in the home until it is no longer the primary residence.
What are the Costs?	Costs include appraisal, origination fee, title insurance, escrow and recording fee (most of these costs are described as closing fees). A monthly service fee is another cost. The FHA plan also includes a 2% initial mortgage insurance premium. It protects the borrower from ever paying more than the value of the home. FHA also guarantees the funds are available to the buyer.
Portability or Flexibility of Plan	A borrower can stay in the home as long as it is the primary residence. The loan does not need to be repaid until the borrower chooses to move, sell, dies or turns 150 years old.
Interaction with Medicaid or Medicare	Distributions from a reverse mortgage are excluded assets in the month of distribution. Distributions are not considered to be income. If retained past the month of distribution, the amount retained is added to other available assets and, if over the limit, subject to reduction. Because these distributions are not considered income, they are not included when calculating the amount of a person's income that must be contributed toward the cost of long term care. The money received from a reverse mortgage is considered a loan, not income so the money is also tax free. Public benefits, such as Medicaid, are not affected if the cash received from the reverse mortgage is spent in the month it is received.
Status of the option in Minnesota or other states	<u>Lending Limits</u>: • FHA's lending limit or maximum claim amount varies by the county in which one lives ranging from $160,176 to $290,319 for 2004. Currently FHA will calculate payouts available on up to $218,405 of home value. For most of greater Minnesota the payouts are available on up to $154,896 of home value in the Twin City Metro Area. Both of these limits are large increases since 2003. • The Fannie Mae (FNMA) Reverse Mortgage will consider higher home equities when calculating payments. The national limit is $333,700. The current FNMA limit is $300,700 in Minnesota, and ranges by county.

Tool	Reverse Mortgages
	Counseling Requirement: In establishing reverse mortgages the Federal Housing Administration (FHA) required that homeowners receive counseling from a Housing and Urban Development (HUD) certified counseling agency before they apply for the loan, Minnesota statue also requires counseling for any reverse mortgage. A final option is the "jumbo" reverse mortgage which is a Cash Account High Benefit available from the company Financial Freedom. It is marketed to high valued homes ($600,000+) and is available in most states.
Potential Market or Portion of Market this Option Occupies	**Nationally**: about $2 trillion is available in equity among 62+ households. Additionally, 85% of older homeowners want to stay in their homes and never move. Of the nearly 28 million households age 62+, NCOA states that nearly half, or about 13.2 million are good candidates for a reverse mortgage. Of the 13.2 million, 5.2 million are either already receiving Medicaid or are at financial risk of needing it if they were faced with paying the cost of long-term care at home. This economically vulnerable segment could access $309 billion through reverse mortgages; the average mortgage amount is $72,128. **Minnesota**: 400,000 homeowners are eligible; 80% own their living unit and 72% of those owners have no mortgages. In MN, there have been 2,618 reverse mortgage loans made; 531 were insured by HUD. There was a 50% increase in closings last year. However, HUD or Fannie Mae - qualified lenders, or lenders offering private products are not available in much of the state.
Characteristics of Current Users or Participants	Reasons for doing a reverse mortgage include: -One has substantial equity in their home and wants to use the cash now -An immediate need for cash exists -One has lived in their home for years and wants to stay there -One wants to move but cannot afford or does not want to make mortgage payments -To eliminate a current mortgage payment
Research Findings	The NCOA study shows that reverse mortgages can offset long-term care expenses. Barbara Stucki is the NCOA project manager. Her work suggests that liquidating housing wealth through reverse mortgages "can play an important role in improving the way we pay for long-term care in this country." As for linking reverse mortgages and long term care insurance, potential for savings is noted in the report, "Primer: Linking Reverse Mortgages and Long-Term Care Insurance." However, there is mismatch in the timing of purchase. Research also indicates that these loans can be costly. Implications are further discussed in the pros and cons table below.

Table 2: Pros/Cons

Pros (advantages)	Cons (disadvantages)
Provides financial resources, that can be accessed on relatively short notice and without regard for the health status of the borrower. This makes it an option for those who would not qualify for an insurance policy.	It can be difficult to compare the true costs of different loans from different lenders. The best way is to compare each loan's "TALC" or total annual loan cost.
The funds can be used to purchase LTC insurance or to pay for LTC needs, depending on the loan amount.	There is a mismatch in the optimal time to buy LTCI and use of reverse mortgages. The optimal time to get a reverse mortgage is later in life, whereas the optimal time to purchase long-term care insurance is earlier in life.
Equity in the home that is under utilized could provide cash flow for someone who is "house rich" and "cash poor."	The funds generated may not be enough to pay for long-term care needs. The amounts may be enough to pay insurance premiums, but this is only an option if the homeowner is insurable.
The heirs can retain the home upon death by repaying the reverse mortgage, or they could sell the home and keep the balance, if any, between the sale price and any loan amount due.	The loan amounts are not adjusted for inflation, so the gap between long-term care expense costs and the loan amount will grow over time, especially if the need for care is in the future.
There are no restrictions on how the proceeds can be used.	If lifetime tenure is not chosen, the borrower may outlive the reverse mortgage proceeds. Then the loan becomes due if the home is no longer the primary residence of the borrower.
	Since the owner is still responsible for taxes, repairs and maintenance, the remaining income may be insufficient to fund long-term care needs.

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7. Family loan or line of credit program

Short Description:
Because we know of no other program set up to offer loans to families for elder care, this briefing paper uses the Family Elder Care Loan developed by ElderLife Financial, Inc. to describe and analyze this option.

The Family Elder Care Loan program allows for up to five adults to pool resources to acquire a loan to pay the costs of long-term care services for an older relative. The primary use of the program has been to allow greater flexibility for those who need to move an elder into an assisted living facility, but do not have the necessary down payment. The Family Payment Plan helps families pay for care by allowing them to make smaller monthly payments over time. Family members borrow what they need each month. Payments start at $100 for any amount borrowed under $5,000. If more than $5,000 is borrowed, payments increase by $20 for every additional $1,000 borrowed (example: $7,000 borrowed = a monthly payment of 7 x $20 or $140).

The senior pays what he or she can each month, and the Family Elder Care Loan Administrator pays the rest to the care provider. The child(ren) make smaller monthly payments over time in repayment of the amount borrowed.

This loan is a personal unsecured loan and the interest rate is a monthly variable with an "effective APR" of 4%-7% over prime. As of May 2004, Family Elder Care Loans are issued at an effective APR of roughly 11%. A transaction fee of 2% is provided to the care provider.

Background:
ElderLife Financial was initially known as Grannie Mae, though notice by Fannie Mae caused a name switch. The ElderLife Financial mission statement notes, "Until now, few payment options have existed for families seeking assisted living and other care services for their elders; that is why we created the Family Payment Plan." This product is aimed at persons entering assisted living facilities, although use to pay for long-term care and nursing home care is also occurring. One estimate notes that about 25% of all assisted living residents get some financing from other family members.

The Family Payment Plan was modeled after the concept behind student loans. In the 1960s only wealthier families could afford to finance their child's education, and so, student loans were initiated. For school loans, parents made payments on behalf of children; for elder care loans, children make payments on behalf of parents. The ElderLife loan seeks to make funding available to middle class families. The student loan analogy is used because they became popular and widely used due to: promotion by states; availability; financial aid counselors; fast application; money up front; loan is paid back over time.

Table 1: Basic Plan Elements

Tool	Family Elder Care Loan
Who is Eligible?	Anyone who applies for the unsecured loan and is approved. Loans can be approved for up to $50,000 per applicant and up to five people may co-sign on the loan. Credit approval and credit rate will be based on FICO scores, debt to income ratios, comparison of most recent behavior to historical behavior, and the loan amount needed and value of collateral, if any.
Who is Responsible for Payment?	The children or others who sign on to the loan are responsible for its repayment. Generally the elder pays what he or she can out-of-pocket, and a loan is taken for the amount remaining. While borrowers are approved for a certain maximum amount, they can only draw down what they need each month to pay for that month's care. For every $1,000 borrowed, the family's monthly payment is roughly $20.00. Thus if a family borrowed $5,000 the monthly payment is $100 until the balance is paid back. (This example has been modified to include interest.)
Who Administers the Option?	The monthly disbursement of cash is processed by ElderLife Financial. Funds are wired directly to the provider and ElderLife bills the family for the minimum monthly payment.
What Services are Covered?	Generally, a family learns about ElderLife Financial through a participating nursing facility or assisted living facilities. The loan does not limit the way care is provided at the facility. However, the loan amount must be used for long-term care.
Limits on Services	None, only that the proceeds of the loan be used for long-term care services.
Portability or Flexibility of Plan	Since the loan originates through the care provider, it is not portable, unless the elder were transferring to another participating facility. Additionally, the monthly amount is wired directly to the long-term care provider to ensure the loan money is being used for the intended purpose.
Interaction with Medicaid or Medicare	ElderLife is similar to the reverse mortgage in its interaction with Medicaid, since both options may postpone use of Medicaid until the last moment. However, should Medicaid be utilized, a lien would attach to the home if available or any other financial asset. Therefore, if families were planning to use the proceeds from the sale of the home to repay the ElderLife loan, Medicaid would recover first.
Status of the option in Minnesota or other states	*Minnesota: The Family Elder Care Loan is not currently active in Minnesota, though ElderLife Financial has expressed interest in expanding the plan. The plan is currently available in the following states: New Jersey, Kansas, Maryland, Missouri, Tennessee, Virginia
Potential Market or Portion of Market this Option Occupies	The product could potentially be made available through any nursing or assisted living facility that ElderLife Financial approved to participate in the program.
Characteristics of Current Users or Participants	The ElderLife Family Elder Care Loan can be used in the following situations: a. Seniors need care (especially facility-based) but the family cannot sell the home immediately

Tool	Family Elder Care Loan
	b. Seniors need care but cannot liquidate Certificates of Deposit or other illiquid assets such as valuable life insurance policies c. Seniors need care but have spent down all assets d. Seniors have long-term care insurance but such insurance has up to a 100-Day elimination period which can run into the tens of thousands of dollars e. Seniors have long-term care insurance but (in a typical example) the insurance covers only a portion of the total cost, e.g. $90/day of the $120/day needed for care.

Table 2: Pros/Cons

Pros (advantages)	Cons (disadvantages)
Could be utilized if a senior had spent down everything and the family wanted to privately pay for options which Medicaid was not legally able to pay for.	If family members were planning to repay the loan through sale of the home and the elder has gone on Medicaid, Medicaid would trump the ElderLife loan.
Could be utilized if a senior has life insurance benefits which cannot be realized until after death.	There may be less incentive for private family financing if an elder has spent down and costs of care are higher than the value of the home.
The senior does not have to immediately liquidate assets, such as the home, to pay for long-term care.	This is only an option for middle class families who could qualify for an unsecured loan.
Can be used when a reverse mortgage is not an option: when a senior needs to move into an assisted living facility (and is therefore no longer in the home).	The interest rate is on average 11%. This compares to 30-year fixed mortgages at 6.05%, which is approximately the rate available on reverse mortgages.

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8. Universal long-term care savings plan (Hawaii's CarePlus)

Short Description:
In 2002 Hawaii became the first state to create a long-term care financing program that was intended to ensure universal coverage. CarePlus is a compulsory social insurance program designed to supplement long-term care funding. The program was to be funded through a $10 per month payment by every adult age 25 and older filing an income tax return. Participation would be vested at a rate of 10% per year to full benefits after 10 years. Participants may choose their services and providers. The program would cover one year of care with a maximum daily benefit of $70 per day after a 30-day waiting period for participants who become eligible for benefits. The program creates a trust fund, called the Hawaii Long-Term Care Benefits Funds.

Year	Initial tax = $10/month with incremental increases	Increase in Benefits over Time
2006	$12.00	
2007	$14.00	
2008	$16.00	$72.10
2009	$18.00	$74.26
2010	$20.00	$76.49
2011	$22.00	$78.79
2012	$23.00	$81.15
2013		$83.58

The Hawaii plan passed through the Hawaii Legislature in early May of 2003, but was vetoed by Governor Lingle during special session in July of 2003. The governor ran on a "no new taxes" campaign, and this plan "looked like a tax." During the 2004 session, a long-term care insurance tax credit was passed. The CarePlus proposal was also re-introduced as companion bills in both the House and Senate, but was deferred to a future, unspecified date.

Background:
The elements of the Hawaii plan include the following:

- Universal, long-term care insurance plan
- Publicly financed through a long-term care insurance tax
- Funds generated are reserved in a private Trust Fund
- The Trust Fund is managed by a Board of Trustees, consisting of business and community leaders, appointed by the governor
- A defined cash benefit that allows the beneficiary to select the service or product that best suits their needs

Social Insurance
Care Plus is a social insurance program. Historically, social insurance has had two uses: 1) To spread the risk of relatively infrequent but very costly events over the entire population that is subject to the event; and 2) to assure a floor of income protection upon retirement to meet a societal

need. The common goal of social insurance is that government undertakes to assure participants pay for at least a modest level of care while they are healthy and young. Care Plus was designed to relieve the pressure on an entitlement program for the poor (Medicaid), thereby reducing direct demands on the state to accommodate persons who lived their whole lives as middle class, only to become "poverty cases" in their old age because of the high use of long-term care.

Actuarial Analysis

An actuarial analysis of ten feasible options for plan design was developed to determine the plan's performance. The base case consisted of the status quo and then nine micro-economic model projections were developed. The Lewin ICF microsimulation model was purchased, and all 28,000 cells were reformatted to make it Hawaii-specific. Of the ten options analyzed, the social insurance model best met the criteria for affordability, universal coverage, offset of state costs for LTC and long-term viability of the program. John Wilkin and Gordon Trapnell conducted the actuarial analysis, and determined the program actuarially sound under all ten options.

Table 1: Basic Plan Elements

Tool	Hawaii Plan / Care Plus
Who is Eligible?	Anyone over age 25 with income above the minimum filing level established for the Hawaii Resident Tax Return. This includes retirees and homemakers. A $10 monthly tax would be imposed per person and deposited into a long-term care benefits fund administered by the tax department. The tax ceases once the person goes on claim. The tax was to increase to $23 in 2012. Participants are fully vested after ten years. "De-vesting" occurs at a rate of 10% per year after a one year grace period for participants who fail to contribute. An independent medical evaluation determines the eligibility for benefits. To become eligible, two deficiencies in ADLs or cognitive disabilities such as Alzheimer are required.
Who is Responsible for Payment?	The State Dept. of Taxation is responsible for collecting the tax. An appointed Board of Trustees is responsible for policy and for maintaining the trust fund. Payment to the providers is overseen by third party administrators (TPAs). TPAs contracted by the state are responsible for determining eligibility of the beneficiaries and for the pay out of benefits. They will also provide for care coordination and education.
Who Administers the option?	A Board of Trustees comprised of business members, community leaders and beneficiaries will govern CarePlus. The fund will have, as advisors to the board, an actuary and investment advisor.
What Services are Covered?	Any level of care and provider, including friends and family, may be chosen by participants. The program would cover 365 days of care with a maximum daily benefit of $70 per day (gauged to inflation) after a 30-day

Tool	Hawaii Plan / Care Plus
	waiting period. Note: the benefits are for a defined dollar per day pay-out for a specified period of 365 days, but the days need not be continuous nor is this a post-service reimbursement plan.
Limits on Services or Length of Coverage	The period of benefits is only one year or 365 days with a maximum daily benefit of $70 per day (gauged to inflation) after a 30-day deductible. Otherwise, participants may choose any level of care and the provider freely, including friends and family members.
Portability or Flexibility of Plan	Fully portable for those who had accumulated any level of benefits. If an individual files a Hawaii Resident Tax Return, he or she will be enrolled (including part-time residents). Should a person move out of the state and continue to file and pay Hawaii state income taxes, he or she will continue in the program. However, pensioners who do not file Hawaii state taxes will be required to file a return because there is no other mechanism by which to enroll this population.
Interaction with Medicaid or Medicare	The program is primary to Medicaid (and private insurance) and secondary to Medicare, ie, the benefits act like part of a beneficiary's assets in considering Medicaid eligibility.
Status of the option in Minnesota or other states	*New York: Bill introduced to create a task force to find ways to make LTCI universal, possibly through a payroll tax. *Minnesota: Analyzing CarePlus among several possible options for private long-term care financing. Montana: The Aging Network in Montana is looking at the future needs of the elderly. Since the elderly population of Montana is expected to more than double in the next 15 to 20 years and the state needs to develop long-term care services in rural Montana, it is considering a $.05 per 12 ounces fee on soft drinks tax in addition to the current price; pop distributors will also get 2% of the fee back as a tax credit. This would raise about $20 million per year. About 50%-60% of the funds would go into a trust for the future and the remaining funds would go to maintaining current services while further developing respite care and Medicaid Home and Community Based services. The Aging Network believes this action will save taxes in the future
Potential Market or Portion of Market this Option Occupies	This is a state-specific plan, and therefore the potential market is all adults over the age of 25 who file income taxes. However, Vermont also considered the model in the early 1990's. Maine, Washington and Oregon have all shown interest. Montana is trying to build a LTC trust fund using tax revenues from the sale of soda pop. Other similar state proposals include use of sin taxes, property taxes and income taxes to fund a CarePlus program.
Characteristics of Current Users or Participants	The plan was vetoed by the new governor who ran on a "no new taxes" campaign. She supports a tax credit for the purchase of long-term care insurance rather than the CarePlus approach to long-term care financing.

Tool	Hawaii Plan / Care Plus
Research Findings	Traditional peer-reviewed research does not yet exist for CarePlus. However, many esteemed scholars participated in developing the program, and the actuarial analysis was conducted by a credible institute, which recommended that the program is actuarially sound (or in other words, the program design is sufficient to assure the full payment of benefits when due). Additional consultants include Josh Wiener of the Urban Institute, Kevin Mahoney of Cash and Counseling and Judith Feder of Georgetown University.

Table 2: Pros/Cons

Pros (advantages)	Cons (disadvantages)
Early intervention benefits	The program will not eliminate completely the reliance on Medicaid to pay for the care of the sickest elderly.
Social insurance program: Spreads the risk of relatively infrequent but very costly events over the entire population that is subject to the event	The program may look too much like an entitlement program, effectively discouraging the purchase of LTCI (The program was vetoed by the governor in favor of a tax credit for purchase of long-term care insurance).
Social insurance programs can change the benefits at any time by changing the law or regulations.	A statutory right to benefits is somewhat weaker than the contractual rights to benefits found in private insurance.
Because social insurance programs are assured of instant flow of new entrants and that the government will not "go out of business," they need not be fully funded.	Some in the LTCI business feel the product is not actuarially sound and is underpriced, despite the Report's documentation.
Provides the frail elderly and their families with some degree of control and choice in caring for their loved one.	All participants are charged the same "premium," regardless of the level of risk they bring into the pool. Therefore, though not a tax, this charge is regressive since there is no income gradient.
Allows people to stay at home longer than might otherwise be possible.	It may encourage financial or physical abuse of the elderly by allowing friends and relatives to be paid for services provided (although there is no evidence of this in Cash and Counseling and other programs that pay families).
Protects precious public dollars for truly needy people.	
It will motivate the private long-term care insurance industry to develop affordable plans supplementing or working around the state's basic plan.	

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9. Long-term care annuities

Short Description:
Long-term care annuities are an example of a combined savings and insurance product where an individual purchases an annuity as well as a long-term care policy. When the benefit is triggered, the long-term care policy increases the monthly cash amount received over and above the basic annuity, for use in paying long-term care costs.

Generally there are two types of annuities: deferred and immediate. A deferred annuity consists of two funds, one for long-term care needs that typically grows at a higher interest rate which can directly pay for long-term care services or long-term care insurance, and the other as a regular cash fund that grows at lower, but guaranteed, rate. It may be purchased up to age 85. Seven broad health requirements must be satisfied in order to qualify. Once benefit eligibility h as been determined, long-term care benefits can begin after a 7-day waiting period. The monthly long-term care benefit payout depends on the deferred annuity value. Most deferred annuities provide long-term care coverage for up to 36 months.

An immediate annuity is available to people with uninsurable health conditions or already receiving long-term care. If an individual qualifies, a single premium payment is converted into a monthly income guaranteed for the life of the policyholder. It is medically underwritten to determine the pay-out schedule and associated premiums. Because it is expected that someone with a disability or health condition requiring LTC will have a shorter life expectancy, a lower premium cost is required to obtain a given monthly payment (as compared with a regular annuity). The long-term care annuity (LTCA) is an immediate annuity.

Background:
Key to combining long-term care and income security is the potential to expand the number of people who would be eligible to purchase long-term care insurance by pooling the competing risks of long life versus short life with disability. Pooling the risks has the potential to reduce the need to exclude potential buyers of LTCI through medical underwriting. Currently, medical underwriting has been estimated to exclude 12% to 23% of the population from purchase of LTCI at the age of 65, and larger proportions at older ages. The initial lump sum premium outlay of the annuity would reflect the trade-off between the higher costs for those currently underwritten out (those with shorter lives, less likely to benefit from the annuity payout) and the lower income annuity costs (those with longer lives).

Table 1: Basic Plan Elements

Tool	Long-Term Care Annuity
Who is Eligible?	Those who meet the age and health requirements for either the deferred or immediate annuities. Under the long-term care (LTC) annuity model, those who are eligible would include members who are currently underwritten out, i.e. those with existing health conditions that preventing them from purchasing disability protection.
What are the specifics of the plan?	The LTC annuity product provides cash benefits. In the event of disability additional income is provided that is not tied to particular services or service mixes, as in long-term care insurance products. This "pool of money"

Tool	Long-Term Care Annuity
	approach uses a single maximum per diem benefit for all covered services, rather than a lower per diem for home care.
Interaction with Medicaid	The income from an annuity received by a Medicaid recipient residing in a LTCF would be counted as income in determining the person's contribution toward the cost of long term care services. In some circumstances, the cash value of an immediate annuity could be considered an available asset and could affect Medicaid eligibility. Additionally, the annuitization date would be considered in determining if there was an uncompensated transfer of assets and subsequently may result in a penalty for Medicaid payment of LTC services.
Status of the Option	In general, annuities are currently available and can be used in any state. The integrated LTC annuity model that combines income and disability marketed and carried by only a few companies.
Potential Market or Portion of Market this Option Occupies	The potential market includes all those persons who would normally be interested in a deferred annuity. For immediate annuities, those who are already in nursing homes can receive benefits. It may also be beneficial for couples where one partner is already receiving care while the other partner remains in the community. For the integrated LTCA model, 98% of 65-year olds could purchase under minimal underwriting, compared with only 77% under current underwriting practice.
Characteristics of Current Users or Participants	For individuals who have a long life expectancy or a lot of illness in their families, a LTCA offers protection on both fronts. Under LTCA, the life expectancy of the population purchasing the LTCA would be two years shorter on average and would have slightly lower disability years than purchasers under current underwriting.

Table 2: Pros/Cons

Pros (advantages)	Cons (disadvantages)
Individuals can cover both the risk of outliving their money and the risk of needing long-term care.	The amount of money needed to create this product may be prohibitive for many, especially the "tweeners."
People in poor health or already receiving long-term care can still utilize this option.	Few people are aware of the option because combined products have not gained popularity yet.
It may be easier to qualify for a deferred annuity rather than a long-term care insurance policy.	Immediate annuities are of less benefit for a single individual in a nursing home because he or she would have to pay the monthly income from the annuity to the nursing home.
If the entire long-term care annuity is not used, something can be left for the heirs.	Deferred annuities may be subject to certain tax liabilities.
For an integrated income and disability annuity, pooling disability and mortality risks can reduce the need for medical underwriting.	The annuity may not provide enough funds to cover expensive long-term care needs, especially if the annuity does not include inflation.

Pros (advantages)	Cons (disadvantages)
The LTCA is less expensive than the combined price of each product standing alone.	LTC may be subject to adverse selection of mortality risks.

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