NYS PARTNERSHIP FOR LONGTERM CARE®

Affordable Financing for Long-Term Care

Consumer Booklet

www.nyspltc.org

Schedule of Minimum Daily Benefits for Partnership Policies

Effective Date	Nursing Home Daily Benefit Allowance*	Home and Community Based Care Daily Benefit Allowance**
January 1, 2006	$189	$95
January 1, 2007	$198	$99
January 1, 2008	$208	$104
January 1, 2009	$218	$109
January 1, 2010	$229	$115
January 1, 2011	$241	$121
January 1, 2012	$253	$127

*Nursing home daily benefit applies to the nursing home benefit of all policies. The minimum also applies to the residential care facility benefit and the home and community based care benefit of the Total Asset 100 and the Dollar for Dollar Asset 100 policies.

**Home and community based care daily benefit applies to the non-nursing home care of the Total Asset 50 and the Dollar for Dollar 50 policies.

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Introduction

This booklet has been prepared by the New York State Partnership for Long-Term Care, a partnership of the public and private sectors, to give you accurate and comprehensive information about long-term care insurance, and the Partnership program. The purpose of the booklet is to help you to prepare now for your future personal and financial independence.

In the past, little planning was done for long-term care needs because family members were usually available to provide care if a mother, father, spouse, or sibling needed it. However, changes in society and the family make this alternative less feasible today. Smaller families, separation of extended families by distance, higher divorce rates, and greater participation of women in the workforce are all factors that reduce the availability of long-term care assistance from family.

These factors make it vital to prepare for the prospect of needing long-term care with a sound financial plan. The following pages will help you evaluate the options you have for meeting your long-term care needs.

Planning for Long-Term Care Expenses

What is Long-Term Care?

Long-term care refers to a broad range of supportive medical, personal, and social services needed by people who are unable to meet their basic living needs for an extended period of time because of an accident, illness, or frailty. Long-term care involves receiving the assistance of another person(s) to perform the essential activities of daily living (ADL) when these tasks can no longer be performed independently. The ADLs include eating, toileting, transferring, bathing, dressing, and maintaining continence. Severe cognitive impairment may require long-term care services. ADL

assistance may be provided at home by formal (paid) caregivers, such as home health aides, or by informal (unpaid) caregivers, such as family members or friends. ADL assistance is offered in nursing homes, assisted living facilities, and adult day care centers.

How Likely Are You to Need Long-Term Care?

Americans live twice as long as they did a century ago. As we age, the greater become our chances of needing long-term care. In fact, 44 percent of persons reaching age 65 can expect to spend some time in a nursing home.[1] The average nursing home stay is 2.5 years, with one in five people staying more than five years.[2]

How Much Does Long -Term Care Cost in New York State?

The cost for long-term care depends on where you live, and on what kind and how much care you use. For example, in 2004, nursing home care statewide in New York averaged about $263 per day ($96,000 annually). In the New York City metropolitan area, the 2004 cost of nursing home care averaged about $308 per day ($112,000 annually).[3] The actual cost of care varies based on the choice of nursing home and locality.

Even at the lowest cost, you may find yourself spending more than $200 per day…

Home care services in 2004 ranged in cost from about $20 per hour for personal care to $100 per visit for RN nursing care.[4] Even at the lowest cost, you may find yourself spending more than $200 per day, depending on how much of your care is supplemented by family and friends.

Most people cannot afford to pay the cost of long-term care and keep their financial security intact. The result may be a reduction or even a loss of independence and personal control over their finances. However, by understanding and planning for the risks of needing long-term care, many people can retain their independence.

1 Brenda Spillman and James Lubitz, "New Estimates of Lifetime Nursing Home Use: Have Patterns of Use Changed?", Medical Care, 40 (10):971 (2002)

2 NYS Robert Wood Johnson Project, 1988 Nursing Home Discharge Survey (unpublished).

3 Bureau of Long-Term Care Reimbursement, NYS Department of Health.

4 Bureau of Long-Term Care Reimbursement, NYS Department of Health.

Who Pays for Long-Term Care?

Despite the lingering belief that Medicare covers long-term care, Medicare in fact paid only 14% of all long-term care costs in 2000.[5] Medicare and Medigap policies protect against acute care costs, such as hospital and physicians' charges. They were never meant to pay for services that address long-term care needs. Private and employer health and disability insurance programs typically do not pay for long-term care services either. With so little available from other sources, the bulk of long-term care costs are paid out of pocket by individual consumers and, increasingly, by the Medicaid program.

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For many people, the Medicaid program has become their long-term care "safety net" and the primary source of funding for these expenses. In fact, more than 80% of nursing home days in New York State are paid by Medicaid,[6] and Medicaid-financed long-term care costs New York taxpayers over $8.7 billion in 2002.[7] As the population continues to age and older New Yorkers require more care, funding of Medicaid becomes an urgent matter. The assumption of personal responsibility, mainly through the use of long-term care insurance, will help maintain Medicaid benefits for those in greatest need.

Are There Insurance Policies That Can Help With Long-Term Care Expenses?

Yes, there are good long-term care insurance policies available that can help protect you from the high cost of care. While some cover only nursing home stays, others are more comprehensive, paying benefits for home care, adult day care, and care provided in assisted living facilities.

Policies also offer various options for the benefit amounts they will pay for your care each day and over your lifetime, the length of the elimination or waiting (deductible) period, and the type of inflation protection provided. The elimination period is the number of days that the insured must pay for care before benefits are paid by the insurer. Premiums for long-term care insurance vary depending on your age, your health and the coverage you buy.

5 United States General Accounting Office, Long-Term Care: Aging Baby Boom Generation will Increase Demand and Burden on Federal and State Budgets (GAO-02-544T 2002).

6 Office of Medicaid Management, NYS Department of Health.

7 Office of Medicaid Management, NYS Department of Health.

Insuring a $200,000 home is more expensive than insuring a $100,000 home, and car insurance with a $500 deductible is less expensive than a policy with no deductible. It's the same with long-term care insurance. A policy that pays $300 per day for nursing home care will cost more than a policy that pays $200 per day. Similarly, a policy with a 90 day elimination period will cost less than a policy with no elimination period. The selections you make will affect your premiums. Your selections should be guided by the cost of nursing home care in your area balanced against your ability to pay the premiums (affordability).

In addition, premiums differ depending on your age when you buy the coverage. The younger you are at the time you buy the policy, the lower your premium will be. Therefore, it's a good idea to plan in advance and consider the purchase of long-term care insurance well before you are likely to need it, when premiums are more affordable.

Purchase in your younger years to obtain an affordable premium is not the only advantage. The ability to pass medical underwriting and become insurable is many times related to age. Medical issues that limit insurability may accumulate with age.

The younger you are, the more affordable your premium will be.

Medical underwriting is a requirement of essentially all long-term care insurance policies. The insurer may inquire or investigate your health and health history. Medical underwriting may result in denial of coverage. In the event of denial, you may want to consider another insurer, since the medical underwriting standards are not uniform. Also, some insurers may offer coverage for individuals with certain health conditions, but with a larger premium.

Remember, all insurance is based on the idea of risk sharing. By paying premiums, you are contributing your share to the risk pool, and if you need long-term care in the future, your policy will pay benefits that may exceed what you contributed in premiums. A 60 year old purchasing a policy with a benefit of $200 per day might have a premium of $2,000 per year. If our 60 year old didn't need care until age 75, he or she would spend $30,000 to pay the premiums. The cost of two years of care at that future time would be approximately $300,000, if health care costs continue to inflate as has been the experience. Pooling of risk makes the payment for your care possible, since some people will never need care or will need it for a relatively short period of time.

Long-term care insurance will help you plan a financial future that will provide you with the means to retain your independence, but just as importantly it will permit your immediate or extended family to continue on with a lifestyle that is not impeded by your long-term care needs.

The New York State Partnership for Long-Term Care

What Is the New York State Partnership for Long-Term Care?

The New York State Partnership for Long-Term Care program is designed to assist the residents of New York in planning for the cost of long-term care. The Partnership program combines private long-term care insurance with Medicaid Extended Coverage to provide New Yorkers a lifetime of long-term care benefits. Partnership policies can be identified by the distinctive logo that appears on the front of this booklet and on all materials related to the Partnership program. Both individual and group Partnership plans are available

in New York. Group plans, including the Partnership, may be offered to employees of organizations that make long-term care insurance one of their benefit choices.

The goal of the Partnership is financial independence for consumers through shared responsibility. This means that New York State will help you in planning for long-term care expenses. You can meet your responsibility by purchasing a Partnership long-term care insurance policy and keeping it in effect. The State will do its share by protecting you against the costs of extended-care situations through its Medicaid program.

The goal of the Partnership is financial independence for consumers through shared responsibility.

Almost all long-term care insurance policies that are sold today meet the tax qualification requirements of the federal Health Insurance Portability and Accountability Act of 1996. This legislation permits the exclusion of benefit payments for care from taxable income on the Federal income tax return. New York State does not treat the benefit payments as income either. Importantly, New York State allows a 20 percent tax credit for the payment of premiums on tax-qualified polices beginning in tax year 2004.

Tax-qualified policy premiums can be included with other medical expenses as a deduction on the Federal income tax return, but only to the extent that the total expenses exceed 7.5% of the adjusted gross income. The amount of premiums to be used as a deduction are subject to certain dollar limits that are indexed annually.

Partnership long-term care insurance policies contain unique features and must be approved by the Insurance Department of the State of New York. Under the New York State Partnership for Long-Term Care, many people will be able to provide for their own care without the need for impoverishment and total dependency on Medicaid.

How Can You Benefit by Purchasing a Partnership Policy?

As a Partnership participant you may obtain long-term care services beyond the benefit payments from the private insurance policy. When you satisfy the duration requirements of your program, you can then apply for a special Medicaid program called “Medicaid Extended Coverage.” Long-term care services in the Medicaid Extended Coverage program are obtained without a spend down of all or part of your assets, depending on your policy choice. Essentially, you have arranged for lifetime care. In the Medicaid program assets are referred to as resources, however, in this publication the

term assets will be used. Your income is contributed to the cost of your care when using Medicaid Extended Coverage.

There are two types of asset protection under the Partnership: Total Asset Protection and Dollar for Dollar Asset Protection.

The type of Partnership insurance plan you select determines how much of your assets will be protected when qualifying for Medicaid Extended Coverage. Total Asset Protection plans protect all of the insured's assets. There is no limit to the assets you may keep and still receive Medicaid Extended Coverage. Dollar for Dollar Asset Protection plans protect the insured's assets in an amount equal to the benefits paid out by the Partnership policy. Unprotected assets are subject to Medicaid rules. The asset protection of both plans extends to estate recovery actions. Total Asset Protection plans provide protection from all recovery. Dollar for Dollar Asset Protection plans provide protection for assets in an amount equal to the benefits paid by the Partnership policy. The protected amount is adjusted for asset transfers.

The benefits paid by the insurer of your Partnership policy may be used outside New York State, but Medicaid Extended coverage is available only when you apply for it in New York with an intention to reside.

Asset and income review at time of Medicaid application.

Total Asset Protection	Dollar for Dollar Protection
All assets are protected. Income is subject to Medicaid rules and will be used for care.	Assets equal to policy benefits received are protected. Unprotected assets and income are subject to Medicaid rules and will be used for care.

What Makes Partnership Policies Different from Other Long-Term Care Insurance Policies?

In addition to asset protection Partnership policies offer these advantages:

1 Lifetime Coverage

Use of Medicaid Extended Coverage when the private policy benefits are exhausted results in a lifetime of coverage for long-term care.

2 Required Minimum Standards

The minimum standards for Partnership policies are described in the next section. They are among the highest standards applied to long-term care insurance policies. All insurers participating in the program must offer policies that meet these minimum standards.

3 Monitoring

Policy sales and use of services are monitored by the Partnership to ensure that the program is meeting the needs of participants. Of course, any personal information that is collected and reviewed by the Partnership is strictly confidential and will not be disclosed without your permission.

4 Denied Benefit Authorization Requests (BAR)

You or your representative may request an independent review of a BAR denied by the insurer, if you feel your BAR has been denied incorrectly. The Partnership's denied BAR review process may occur concurrently with the insurance company's appeals process.

5 Arbitration

If the Partnership notifies you that your denied BAR is unresolved and continues to be disputed, you have the right to elect binding arbitration which is quicker and less expensive than litigation. Arbitration costs, except for the cost of an additional independent assessment, if needed, will be paid by your insurer. If you elect arbitration, the decision of the arbitrator will be binding on both you and the insurer.

The use of the court appeal process guaranteed under New York State Insurance Law is an alternative, as well as any appeals process offered by the insurance company, but these processes must be elected before the use of binding arbitration.

Highlights of Partnership Coverage

Four basic Partnership plans are available. Total Asset 50 and Total Asset 100 offer total asset protection. Dollar for Dollar 50 and Dollar for Dollar 100 offer partial asset protection based on the amount of benefit paid from the policy. The notations 50 and 100 represent the percentage of benefit paid for the home care or home and community based care compared to the nursing home benefit. In the case of the 50 designation the home care payment will be set at 50 percent of the nursing home daily benefit for the Partnership policy. In the case of the 100 designation the home care or the community based care payment will be set at 100 percent of the nursing home daily benefit. The amount of benefit for any policy can be increased beyond the minimum required benefit to provide a level of coverage that will meet the cost of care for your specific location.

Policy Feature and Benefit Table

	Total Asset 50	Total Asset 100	Dollar for Dollar 50	Dollar for Dollar 100
Asset Protection	Total asset protection.	Total asset protection.	Partial asset protection based on the amount of benefit paid.	Partial asset protection based on the amount of benefit paid.
Nursing Home Benefit shared by all plans	Nursing home minimum benefit is $189 per day for 2006*	Nursing home minimum benefit is $189 per day for 2006*	Nursing home minimum benefit is $189 per day for 2006*	Nursing home minimum benefit is $189 per day for 2006*
Home Care Payment	Set at 50% of nursing home benefits	Set at 100% of nursing home benefits	Set at 50% of nursing home benefits	Set at 100% of nursing home benefits
Duration	3 years of nursing home or 6 years of home care or a combination of the two	4 years of nursing home, residential care facility, or home and community based care, or a combination of the three	1.5 years of nursing home care or 3 years of home care or a combination of the two	2 years of nursing home, residential care facility, or home and community based care, or a combination of the three
Residential Care Facility Benefit	NA**	Residential care facility minimum benefit is $189 per day for 2006*	NA**	Residential care facility minimum benefit is $189 per day for 2006*
Home & Community Based Care Benefit	Home care minimum benefit is $95 per day for 2006*	Home and community based care minimum benefit is $189 per day for 2006*	Home care minimum benefit is $95 per day for 2006*	Home and community based care minimum benefit is $189 per day for 2006*
Elimination Period	No greater than 100 days. Policies with fewer days of elimination can be purchased for an increased premium.	No greater than 100 days. Policies with fewer days of elimination can be purchased for an increased premium.	No greater than 60 days. Policies with fewer days of elimination can be purchased for an increased premium.	No greater than 60 days. Policies with fewer days of elimination can be purchased for an increased premium.

*Higher than minimum coverage is available. Minimum daily benefit amounts for future years are found inside the front cover.

**Benefit for this care is available as a home care payment.

Policy Feature and Benefit Table (continued)

	Total Asset 50	Total Asset 100	Dollar for Dollar 50	Dollar for Dollar 100
Basic Benefits shared by all plans	• Nursing home care • Home care (home health care, personal care, assisted living care, skilled nursing care, adult day care • Respite care (14 nursing home equivalent days per year) • Care management (two days of long-term care planning services by a professional) • Alternate level of care (days spent in a hospital waiting for long-term care placement) • Nursing home bed reservation (20 days per year) • Hospice care			
Other Coverage Features shared by all plans	• 5% inflation protection, compounded annually (inflation protection is optional for persons 80 years of age or older at the time of purchase) • Level premiums* • Guaranteed renewable regardless of health changes • Extended grace period • Portability—coverage under the private insurance can be used outside New York State, however, Medicaid Extended Coverage is only available to persons who are residents of New York at the time of application. • Denied benefit authorization is monitored by the Partnership.			
Optional Benefits may be added to any plan, including but not limited to:	• Waiver of premium • Combined home care benefit • Independent provider benefit • Non-licensed/non-certified provider benefit (not offered in the Dollar for Dollar 50 and Total Asset 50 policies)			

*Individual policy premiums cannot be raised, but premium rates on a class basis may be raised with the approval of the New York State Insurance Department when the solvency of the class of policies is in question.

The more help you need from another person and the more tasks you need help performing, the more likely you are to meet the qualifying requirements.

Who is Eligible to Buy a Partnership Policy?

You are eligible to apply for a New York State Partnership policy if you live in New York State. To qualify for a policy, you also must successfully meet medical underwriting requirements of the insurer in most cases.

How Does an Insured Become Eligible for Benefits Under a Partnership Policy?

After a policy has been issued to you, you become eligible for benefits if you meet the qualifying requirements stated in your insurance policy. Generally, the qualifying requirements relate to a certain level of inability to perform particular everyday tasks called activities of daily living or ADLs, mentioned at the beginning of this booklet. The primary ADLs used for measuring your care needs are eating, toileting, transferring, bathing, dressing, and maintaining continence. The more help you need from another person and the more tasks you need help performing, the more likely you are to meet the qualifying requirements.

In addition, insurers may also establish benefit eligibility based on severe cognitive impairment. This condition refers to the loss or deterioration of intellectual capacity in people suffering from conditions, such as Alzheimer's disease or similar forms of irreversible dementia. Severe cognitive impairment must 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 deductive or abstract reasoning.

How Does an Insured Become Qualified for Medicaid Extended Coverage?

You may qualify for Medicaid Extended Coverage once you have satisfied the durational requirements of the policy you have purchased. Approximately 90 days in advance of satisfying the durational requirements you will receive a letter from the insurer advising you to make an application at your local Department of Social Services office. Your asset protection will be established and your current income determined, and if they satisfy Medicaid eligibility rules you will qualify for Medicaid Extended Coverage.

Choosing your Long-Term Care Policy

Should You Buy Partnership Long-Term Care Insurance?

This section will help you determine if a Partnership long-term care insurance policy is right for you, and, if so, what kind and level of protection you should consider. Because everyone's personal and financial circumstances are different, we urge you to consult with your financial and insurance advisors to assist you in making the most appropriate decision. There are, however, some general considerations that can give you some initial guidance.

Most people buy long-term care insurance to maintain independence.

Long-term care costs vary across New York State as well as around the country.

They wish to:

- Gain greater flexibility in selecting the type and location of the care they receive,
- Avoid total dependence on family or friends for help, and
- Protect their assets.

Before making your decision to purchase long-term care insurance, consider the following factors:

- The cost of care in your area,
- Help available to you from family members and friends, and
- Your financial situation.

The Cost of Care

In order to assure the greatest amount of flexibility in selecting the type and location of your care, should you need it, you need adequate financial resources. Insurance can help provide the means to assure your freedom of choice. Therefore, it is important for you to know how much care costs where you plan to live, before you consider how much insurance to buy. Long-term care costs vary across New York State as well as around the country. Getting an idea of the cost of nursing home and home care where you plan to live will help you identify the appropriate amount of coverage to purchase.

Help Available from Family Members

Care provided by your family and friends can postpone or perhaps eliminate the need for paid care. However, when planning for your long-term care needs, be realistic about how much care your family and friends could actually provide. It may not be feasible to rely on family members for support, or you may feel uncomfortable asking for assistance or moving in with family members. Unless you are certain you will be able to receive all of your care through unpaid support, you will probably need to pay for assistance. Depending on your financial situation, long-term care insurance may be an effective way of managing the potential cost of long-term care services. Consider the following questions to help guide your decision:

- For couples, would your partner be able/willing to care for your personal needs for an extended period of time?
- Are your children or other close family members within one hour's travel distance? Would they be able/willing to attend to your needs on a continuous and long-term basis?
- Are you willing to live with relatives or friends, if necessary?

Your financial situation

Assets

Asset protection is the key reason people include long-term care insurance in their financial plan. The Partnership's asset protection feature specifically addresses this matter.

If you own a home, the value of this asset may be appropriate for the protection provided by the purchase of Partnership long-term insurance. Depending on your age, you may have many years to accumulate additional assets before the need for long-term care arises. In this instance, the asset protection of long-term care insurance may be important to you even though your asset accumulation is modest now. If you have, or expect to have few assets at the time of needing long-term care, then long-term care insurance may not be an appropriate purchase for you. The National Association of Insurance Commissioners, in their most recently published guidebook, *The Shopper's Guide to Long-Term Care Insurance* (2003), suggest that you may wish to consider other options for financing your long-term care needs if your assets total less than $30,000.

...the asset protection of long-term care insurance may be important to you even though your asset accumulation is modest now.

The table below will help you determine your current and estimate your future asset value. Please keep in mind that the expected value of your assets at the time of needing long-term care is the value that should be considered for the asset protection provided by the Partnership insurance coverage.

Determine your assets:

Checking/savings accounts	$_____
Home value	_____
Real estate (other than your home)	_____
Business value	_____
CDs, stocks, bonds	_____
Mutual funds	_____
Money market funds	_____
Life insurance, cash value	_____
Other assets, IRAs, annuities ...	_____
Total value of your assets	$_____

Income

To determine your annual income, add the yearly totals of income from the following sources:

Wages and salary	$_____
Pensions (Social Security, veterans, private)	_____
Interest earnings	_____
Dividends	_____
Rental income	_____
Other income (include IRA & annuity distributions)	_____
Total annual income	$_____

Important Income Considerations

Generally, long-term care insurance premiums should consume no more than 7 percent of an individual's or couple's income according to The Shopper's Guide to Long-Term Care Insurance (National Association of Insurance Commissioners, Revised 2003). Be sure to consider present income and income in retirement. When premiums cause a relatively significant reduction in an individual's or couple's standard of living, long-term care insurance may not be an appropriate purchase, unless another strategy is created to support the premiums, for example, having premiums paid by family members.

Since you are responsible for paying your premiums to keep your insurance active, your income should be sufficient to pay your long-term care insurance premiums on a continuous basis. Using assets to support the premiums is not recommended unless the use meets the requirements of a special financial strategy. Such a strategy should be developed with the guidance of a financial advisor.

...your income should be sufficient to pay your long-term care insurance premiums on a continuous basis.

Your income should guide you in determining the amount of coverage to purchase. For example, if nursing home care costs are $250 per day in your area and you can afford to pay $50 per day from your income, then you might purchase a policy for $200 per day, for a lower premium than the cost of a $250 per day policy.

Under a Total Asset Protection plan your assets are fully protected when you apply for Medicaid Extended Coverage. However, you will be required to contribute your income to the cost of your care.

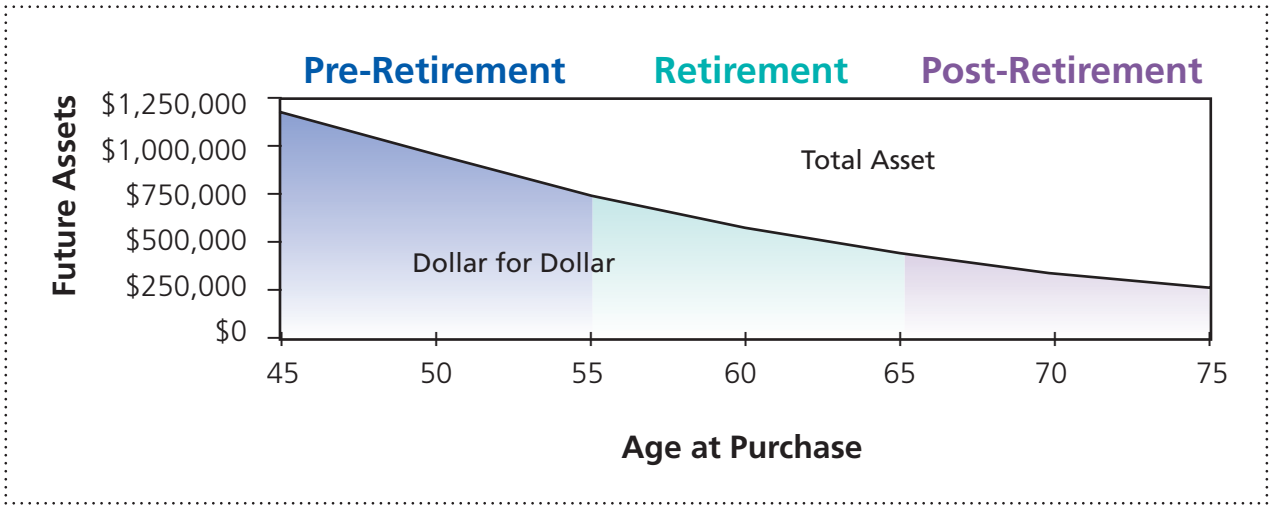
Under a Dollar for Dollar Asset Protection plan, your assets in excess of your asset protection and your income will be subject to Medicaid rules in determining your eligibility for Medicaid Extended Coverage. The asset protection in the dollar for dollar plans is determined by the total amount of the benefits paid from the policy.

Selection of Asset Protection Level

The amount of assets you own and wish to protect is a factor of selection between Total Asset and Dollar for Dollar Partnership plans. Your best estimate of the amount of assets you will own when you access the insurance benefits offers a clue to the selection among the four Partnership plans.

A chart based on the following assumptions is prepared to help with the choice between Total Asset and Dollar for Dollar Asset protection. The assumptions include: (1) insurance benefits will begin at age 80, (2) the nursing benefit will be used and it is $225 per day, (3) the benefit is subject to a 5% compounded annual adjustment, (4) benefit duration is 2.5 years, and (5) the assumptions describe a Dollar for Dollar policy.

The following chart can be used to guide you to a Partnership plan that will protect assets in the future based on your age at purchase.



Four steps to help you decide between Total Asset and Dollar for Dollar Protection.

1. Select the appropriate color for your situation, pre-retirement, retirement, or post-retirement.

2. Locate your present age on the horizontal axis.

3. Make as good an estimate as possible of the future value your assets at age 80.

4. Find this amount on the vertical axis.

Now, identify where lines exteded from these two points intersect in the field of the chart. If it lies somewhere within the Dollar for Dollar zone, then you may be properly insured with the Dollar for Dollar Asset Protection plans. If the intersection falls within Total Asset zone, then you are well advised to purchase one of the Total Asset Protection plans.

For example, a person in the retirement group buying a Partnership plan at age 55 and expecting to have an accumulation of assets of $1,000,000 or more at age 80 should consider a Total Asset Protection plan. Someone age 60 in the retirement group expecting to own assets in the $500,000 range at age 80 might consider a Dollar for Dollar Asset plan. When considering a Dollar for Dollar Asset plan, please note that the growth of the policy benefits by the time of access may not necessarily match the growth of your assets, and may cause a shortfall in asset protection.

If you foresee the possibility of substantial asset accumulation in your life by inheritance or unexpected growth of investments. Total Asset Protection may offer the coverage you need. The possibility of needing insurance benefits early in life is another reason to lean towards the purchase of a Total Asset Protection plan. As a general rule, Dollar for Dollar Asset Protection plans are best suited for situations where assets to be protected are limited and/or the premium expense is a matter of affordability. The chart is helpful, but generally not sufficient to determine the best policy selection for you. An insurance agent or a financial planner can help in this determination. Age at the time of purchase, amount of daily benefit purchased, and duration requirement are the determinants of the eventual amount of asset protection that is available from Dollar for Dollar Asset Protection plans.

Housing owned by individuals in the United States has a record of appreciation in most years and in most communities. Total Asset protection accords full protection of this asset. This protection is afforded even in the settlement of your estate. Dollar for Dollar Asset Protection also is extended to your home, but only to the amount of assets that are protected.

Home Care Decision

Before you make the decision about which policy is appropriate for you, it is necessary to consider how much coverage you wish to have for home care services. Partnership policies are available with a home care benefit equal to the nursing home benefit or at least one half the amount of the nursing home benefit. For most persons, the decision is based on a vision of their future requirement for care. If your vision includes greater use of home care including assisted living, then you may wish to consider a home care benefit equal to the nursing home benefit. Policies with the greater home care benefit are identified as the 100 series in both the Total Asset and Dollar for Dollar plans.

…the decision is based on a vision of their future requirement for care.

Daily Benefits

As described earlier in this booklet, nursing home costs in New York are quite high, and most people will not be able to pay the full cost for their care out of their income. If you are married, remember that if one spouse enters a nursing home, the spouse remaining in the community may still have the same fixed expenses for rent,

...most people will not be able to pay the full cost for their care out of their income.

utilities, etc. So, it may not be prudent to count on much more than your daily insurance benefit along with your discretionary income to pay for nursing home care.

If you are single and require care in a nursing home, some of your income will not be needed for food, rent, or other things that you would need if you lived at home. In this case, you might not need to insure for the full nursing home cost since much of your income will be available to help pay a part of the expense.

...the amount of your daily out-of-pocket expense may increase over time as the cost of care increases.

Discretionary Income

To determine your discretionary income, subtract the following yearly expenses from your total annual income:

Total annual income	**$_____**
Less these items:	
Mortgage/rent	_____
Insurance	_____
Taxes	_____
Food	_____
Clothing	_____
Utilities	_____
Transportation	_____
Other	_____
Total non-discretionary expenses	**$_____**
Total discretionary income	**$_____**

Your discretionary income should guide you in determining the amount of daily benefit coverage to purchase. For example, if nursing home care costs are $225 per day in your area and you can afford to pay $25 per day for your care from your discretionary income, you might purchase a policy for $200 per day, for a lower premium than insuring the cost at $225 per day. Keep in mind that the amount of your daily out-of-pocket expense may increase over

time as the cost of care increases. Current experience for inflation of nursing home care cost is approximately 5 percent per year. You may expect the same rate of increase to apply to your out-of-pocket expense. A handy rule to help you understand the effect of 5% annual compounding is that your expense doubles in about 14 years and triples in about 23 years. Looking 20 to 30 years into the future, the increase in the out-of-pocket expense could be significant.

Home care needs and costs are much more difficult to estimate. If no assistance from family and friends is available and care is needed 12 hours a day, for example, the expense may be $240 per day at the relatively low home care rate of $20 per hour. People whose primary goal is asset preservation and who have little or no family support may consider a policy with a higher nursing home daily benefit and a minimal home care benefit offered by both the Total Asset 50 and the Dollar for Dollar 50 plans. Persons with minimal support at home are likely to use nursing home care for their long-term care needs.

If no assistance from family and friends is available and care is needed 12 hours a day, for example, the expense may be $240 per day...

Inflation Protection

All New York State Partnership long-term care insurance policies issued to people age 79 and younger automatically include inflation protection that increases the daily benefit by 5% each year, compounded. Persons 80 years of age and older may elect to buy a policy without inflation protection. Inflation protection will help your benefits keep pace with the rising cost of long-term care services. Keeping up with inflation is important because you may not use your benefits for many years. When you do use them, you want to be sure that the daily benefits you purchased have increased along with the cost of care, and your growing assets will continue to be protected from paying for your care. For example, if a nursing home costing $91,250 annually ($250 per day) today were to increase its charges by 5% each year, its cost would nearly double in 14 years to $180,700.

Referring to the previous example, let's assume you decide to purchase a policy with a nursing home daily benefit of $200 per day, and you will cover the additional cost with a $50 per day co-pay yourself. At a 5% annual rate of increase, in 14 years, your out-of-pocket cost will nearly double to $99 per day. So, consider how much you are prepared to pay for out-of-pocket costs when you decide how much coverage to buy.

Elimination Period

The elimination or waiting period is the length of time you are expected to pay for long-term care costs once you have triggered your benefits, but before the insurance company begins to pay the benefits. The elimination period can be compared to the deductible amount on a car or homeowners insurance and, as with a deductible, the more you are willing to pay before the insurance policy pays benefits, the lower your premium will be.

Total Asset Protection policies have elimination periods of no greater than 100 days. Dollar for Dollar Asset Protection policies have elimination periods of no greater than 60 days. Many insurers offer shorter elimination periods with added premium cost.

While a longer elimination period will lower the premium you will pay, remember that you will be expected to pay for the cost of your care during that length of time. For example, if you choose a 100 day elimination period and your care costs $200 per day, you would have to pay $20,000 before the insurance company would begin to pay benefits. During this time you may also be eligible to receive Medicare* services, and this may help reduce your cost of care. Weigh the cost of paying for care during the elimination period against a higher premium for a shorter elimination period.

* For example, Medicare might pay some part of skilled nursing facility care for services up to 100 days for each benefit/care episode, if you are assessed as being in a rehabilitative or restorative condition, such as recovering from a stroke. (Search for *Medicare and You* 2006 at www.medicare.gov.)

While a longer elimination period will lower the premium you will pay, remember that you will be expected to pay for the cost of your care during that length of time.

Waiver of Premium

Waiver of premium is an option that may be offered in some Partnership policies. If you select this option, your premium will be waived when you have accessed the nursing home benefits of the insurance policy. Some insurers may waive the payment of premium when home care benefits of the policy have been accessed. You should evaluate whether your financial resources would allow you to continue to pay the premium when you use the benefits of your long-term policy. If it is doubtful you (or someone on your behalf) could continue to pay the premium when you are using the benefits of your long-term care policy, then paying the added amount for this waiver may be appropriate.

Nonforfeiture Benefit

The nonforfeiture benefit ensures that when an insurance policy is lapsed after a specific number of years, some of the benefits from the policy will be retained and available to the insured. A reduced benefit amount or a shortened benefit period is a common option for a nonforfeiture benefit. Partnership policies may have nonforfeiture benefits, but these reduced benefits may not be sufficient to meet the requirements for access to Medicaid Extended Coverage.

Making your choice

At this point you should understand the following factors to assist you in making your decision regarding long-term care insurance:

- whether your asset level is sufficient to protect with a Partnership policy,
- whether your present and after retirement income is sufficient to afford the premiums for a long-term care insurance policy and yet enable you to qualify for Medicaid Extended Coverage,
- the length of benefit duration for your care,
- the daily benefit amount required based on long-term care costs in the locality where you plan to live,
- whether the home care benefit should be equal to the nursing home benefit,
- whether Total Asset or Dollar for Dollar Asset protection is best for you based on your estimate of future assets,
- the amount of out-of-pocket expense you might be able to pay from your income,
- the length of the elimination period that is affordable,
- whether to include a waiver of premium benefit, and
- whether to include a nonforfeiture of benefit option.

This information is a guide to assist you in considering the purchase of New York State Partnership for Long-Term Care insurance. Discussing these concepts with a financial or insurance advisor is recommended.

Other Matters to Consider…

What If My Resources Are Limited?

Most of this booklet discusses the purchase of Partnership long-term care policies. These policies require that minimum benefits, such as inflation protection, be included. However, the cost of the policies may place them beyond the means of some people who desire and would be able to afford other, less expensive coverage. Although other policies will not qualify for Medicaid Extended Coverage because they are not part of the Partnership program, you may wish to consider the protection they offer. For general information about other long-term care insurance, you can call the New York State Insurance Department Consumer Hot-Line, toll free at 1-800-342-3736.

Medicaid Extended Coverage Is Not Portable

If you plan to relocate to another state after you purchase a Partnership policy, the insurance benefits are available for care in that state, but Medicaid Extended Coverage under the Partnership is available only if you are residing in New York State when you apply for Medicaid. A return to New York with the intention to reside is necessary to qualify for Medicaid Extended Coverage.

Medical Underwriting

If you decide to apply for a long-term care insurance policy, the insurer will usually request information about your medical history and functional status. Insurers may also contact your attending physician, and some conduct an independent assessment to confirm your current health and functional status depending on your age and information you provide on your application for coverage. If your health history includes certain illnesses or you are limited in your ability to perform routine daily tasks because of illness, accident or frailty, it is possible the insurer will not offer coverage to you. Specific questions about your insurability should be directed to your insurance advisor or directly to the insurance company with which you are dealing.

Age At Purchase

Purchase at a younger age results in a lower premium and greater affordability. Also, purchase at a younger age creates a greater likelihood of satisfying medical underwriting criteria. Increase of the premium is rapid as the senior years approach, and there may be an age when the premium is no longer affordable.

Purchase at a younger age results in a lower premium and greater affordability.

How Do I Apply for a Partnership Policy?

You must apply for a Partnership policy through a participating insurer or its representative, a licensed insurance agent or broker. In addition, the agent or broker must be certified for the sale of Partnership policies by the Partnership office. You determine the certification of an individual agent by access to the Partnership's web site or a call to the office. If you decide to participate in the Partnership program and are accepted for coverage, you will be asked to sign a Consumer Participation Agreement with the New York State Department of Health that describes how the Partnership program works, advises you what your responsibilities are, and requires your permission to collect information about you for program monitoring, evaluation and reporting purposes. In order to participate in the Partnership program, you must give your consent to permit your insurer to share information about you with the Partnership. Any information collected from policyholders is safeguarded for confidentiality by New York State and always reported as aggregate data; no individual information may ever be released without the individual's authorized consent.

The Consumer Participation Agreement is proof of your relationship with the New York State Department of Health. Please keep a copy of this agreement in your personal files.

Who Are the Insurers Participating in the Partnership?

The names, addresses, and telephone numbers of insurers offering Partnership long-term care insurance policies are available by calling the toll free number for the Partnership inside New York State, 1-888 NYSPLTC (1-888-697-7582), or (518) 473-8083 from anywhere, or you can visit the Partnership's home page on the Internet at www.nyspltc.org. Group policies are available to many employees in New York State. Check with your employer to determine if the New York State Partnership for Long-Term Care is a group benefit offering.

Is There a Way to Compare the Different Policies Available?

No matter what type of long-term care insurance policy you are considering, it is important that you compare the features and costs of products offered and the financial rating of the insurance companies whose products you are considering. The Policy Comparison Worksheet that follows will help you do this.

Long-Term Care Policy Comparison Worksheet

This worksheet is primarily intended to assist you in comparing Partnership long-term care insurance policies. However, the worksheet may also be used in comparing other long-term care insurance policies.

	Policy A	Policy B
Insurer name		
Agent name		
Rating Company_____	Rating:	Rating:
Rating Company_____	Rating:	Rating:
Rating Company _____	Rating:	Rating:

Insurance rating companies include: A.M. Best, Moody's, and Standard & Poors. These companies monitor the financial integrity and claims paying ability of insurance companies. Reports by these companies may be found in the reference section of public libraries and on the Internet.

Is the policy approved under the New York State Partnership for Long-Term Care?	☐ Yes	☐ No	☐ Yes	☐ No
Is the policy tax-qualified?	☐ Yes	☐ No	☐ Yes	☐ No

Does the policy cover the following levels and places where care is provided?

Nursing home care:	Skilled nursing care?	☐ Yes	☐ No	☐ Yes	☐ No
	Personal (custodial) care?	☐ Yes	☐ No	☐ Yes	☐ No
Residential care facility (Assisted living)?		☐ Yes	☐ No	☐ Yes	☐ No
Home Care:	Skilled nursing care?	☐ Yes	☐ No	☐ Yes	☐ No
	Personal (custodial) care?	☐ Yes	☐ No	☐ Yes	☐ No
	Adult day care?	☐ Yes	☐ No	☐ Yes	☐ No
Does the policy pay benefits for respite care?		☐ Yes	☐ No	☐ Yes	☐ No
		If yes: _____days/year		If yes: _____days/year	

How much will the policy pay for the following benefits:

	Policy A	Policy B
Home care?	$_____ day	$_____ day
Adult day care?	$_____ day	$_____ day
Assisted living facilities?	$_____ day	$_____ day
Nursing home care?	$_____ day	$_____ day
Respite care?	$_____ day	$_____ day
Does the policy pay for alternate level of care in a hospital?	☐ Yes ☐ No	☐ Yes ☐ No

How long will the policy pay benefits:

Nursing home?	_____ years	_____ years
Home care?	_____ years	_____ years
Lifetime benefit for nursing home care:	$_____	$_____
Lifetime benefit for home care:	$_____	$_____

How long is the elimination or waiting period?

For nursing home care:	_____ days	_____ days
Counted as calendar days?	☐ Yes ☐ No	☐ Yes ☐ No
Counted as service days?	☐ Yes ☐ No	☐ Yes ☐ No
For home care:	_____ days	_____ days
Counted as calendar days?	☐ Yes ☐ No	☐ Yes ☐ No
Counted as service days?	☐ Yes ☐ No	☐ Yes ☐ No

How often do you need to satisfy the elimination period?

Once per episode?	☐ Yes ☐ No	☐ Yes ☐ No
Once for the life of the policy?	☐ Yes ☐ No	☐ Yes ☐ No

How does the policy treat pre-existing conditions?

	Policy A	Policy B
Is there a pre-existing condition exclusion?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, how far back does it apply?	_____ months	_____ months
And how long must the policy be in effect before the pre-existing condition is covered?	_____ months	_____ months

Are premiums waived for:

Nursing home care?	☐ Yes ☐ No	☐ Yes ☐ No
Home care?	☐ Yes ☐ No	☐ Yes ☐ No
Residential care facilities (including assisted living)?	☐ Yes ☐ No	☐ Yes ☐ No

What type of inflation protection is available under the policy:

Automatic annual increases (compounded)?	☐ Yes ☐ No If yes, _____%	☐ Yes ☐ No If yes, _____%
Automatic annual increases (simple)?	☐ Yes ☐ No If yes, _____%	☐ Yes ☐ No If yes, _____%
Periodic offer to increase?	☐ Yes ☐ No If yes, _____%	☐ Yes ☐ No If yes, _____%

Does the policy provide the following:

Information and referral services?	☐ Yes ☐ No	☐ Yes ☐ No
Consultation services (care management)?	☐ Yes ☐ No	☐ Yes ☐ No
Other care management services?	☐ Yes ☐ No	☐ Yes ☐ No

Cost of coverage

How much does the policy cost?	$_____ month	$_____ month

Other policy options and riders:

	Policy A	Policy B
	$_____ month	$_____ month
	$_____ month	$_____ month
	$_____ month	$_____ month
	$_____ month	$_____ month
	$_____ month	$_____ month
	$_____ month	$_____ month

Total policy premium cost:

$_____ month	$_____ month

Glossary

Activities of Daily Living (ADLs) are every day actions that people do independently –such as eating, toileting, transferring, bathing, dressing, and maintaining continence.

Acute Care is medical care that is required for a short period of time to cure a certain illness and/or condition.

Adult Day Care refers to health support and rehabilitation services provided in the community to people who are unable to care for themselves independently during the day, but are able to live at home at night.

Alternate Level of Care is care received in a hospital inpatient setting for those persons waiting to be placed in a nursing home or while arrangements are being made for home care.

Asset Protection refers to total or dollar for dollar asset protection from Medicaid's "spend down" requirements and is available with the Medicaid Extended Coverage feature of New York State Partnership for Long-Term Care plans.

Assisted Living includes services provided to support an individual in the performance of activities of daily living (ADLs) or severe cognitive impairment, usually in a community-based residence. Assisted living in the Total Asset 50 and Dollar for Dollar Asset 50 is paid as a home care benefit. Assisted living facilities are now licensed in New York State and are identified as an Adult Care Facility or an Assisted Living Residence.

Bed Reservation is the length of time that a nursing home will hold a bed for resident's return from an absence, for example a hospital visit. The Total Asset 100 and the Dollar for Dollar 100 include a bed reservation provision for residential care facilities. Partnership policies provide for 20 days of bed reservation annually.

Benefit Authorization Request (BAR) is the request for access to the benefits of the Partnership insurance policy. The determination is made on the basis of inability to perform activities of daily living (ADLs) or severe cognitive impairment.

Care Management refers to the consultative and planning services provided by a professional, typically a licensed nurse or social worker, to assess, coordinate and monitor the overall medical, personal and social services needed by an individual requiring long-term care.

Chronically Ill Individual describes a person who is unable to perform without substantial assistance from another individual at least 2 ADLs for a period of at least 90 days due to a loss of functional capacity, or a person requiring substantial supervision to protect the person from threats to health and safety due to severe cognitive impairment.

Cognitive Impairment -See Severe Cognitive Impairment.

Combined Home Care Benefit may be offered by an insurer, and it permits combining of home and community based care benefit days to pay an amount in excess of the daily benefit amount for home and com-

munity based care benefits set forth in the policy. When this benefit is provided in the policy, the combination of benefit days shall result in no more than the equivalent of 31 days of home and community based care benefits being paid at the home and community based care daily benefit amount in any one month period.

Community Based Services are long-term care services that generally are provided at the insured's home, but include services rendered in a group setting, such as an adult day care center, or where human assistance is required by the insured to aid in necessary travel, such as to a physician's office.

Custodial Care is non-medical care that addresses personal needs and is available to a chronically ill individual.

Dollar for Dollar Asset Protection refers to the amount of assets that are disregarded under Medicaid resource spend down rules, and is equal to the amount of benefits paid from the Dollar for Dollar 50 or Dollar for Dollar 100 plans.

Elimination Period is the number of days of out-of-pocket expense paid by the insured for long-term care services after the insurance benefits are triggered but before the benefits are paid under the policy. Sometimes this period is defined as the waiting or deductible period. It can be no greater than 100 days in a Total Asset Protection plan and no greater than 60 days in a Dollar for Dollar Asset Protection plan. Policies are available with shorter elimination periods at higher premium cost.

Extended Grace Period is at least an additional 30 day period of time in which an overdue premium may be paid without penalty, resulting from designation of a person to receive notice when the policy is about to lapse. This time is in addition to the normal grace period provided by the insurer.

Free Look Period a time period after receipt of the policy during which a policyholder can cancel and get a full refund. In New York State this period is 30 days for long-term care insurance policies.

Guaranteed Renewable means the individual policy must be continued in force by the insured through the timely payment of premiums, and the insurer has no unilateral right to make any change in any provision of the individual policy while the insurance is in force. The exception is that premium rates may be revised by the insurer on a class basis. The insurer cannot decline to renew the individual policy as long as the insured makes timely payment of premiums, and, as long as the individual policy was delivered or issued for delivery in New York State, the insurer cannot change the premium rates on a class basis without the approval of the New York State Insurance Department.

Home Care and **Home and Community Based Care Benefits** refer to a wide range of long-term health care services including skilled nursing care, home health care, personal care services, assisted living, and adult day care.

Hospice Care is a program of care and treatment for persons who are terminally ill and have a life expectancy of six months or less.

Independent Provider Benefit is a home care benefit under a plan of care paid to a provider who is: either officially trained or certified as a health care provider, or licensed as a health care practitioner. However, the provider need not be affiliated with an entity licensed or certified by the jurisdiction where the provider is rendering home care benefits.

Lapse refers to a policy that has been cancelled due to the non-payment of premiums.

Level Premium refers to a policy sold on the basis that the premium will remain the same throughout the life of the policy. An insurer may seek a premium increase for all policyholders in an insured class, and such an increase will apply to all policyholders within the class if granted. The New York State Insurance Department reviews such requests to determine whether they are justified on the basis of the insured class solvency.

Long-Term Care means necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services, required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner. These services are not limited to a facility. This definition is similarly identified as "qualified long-term care services" in the Internal Revenue Service code.

Long-Term Care Insurance is insurance available through private insurance companies as a means for individuals to pay for needed care and protect themselves against the high costs of long-term care. This is the most comprehensive level of coverage for long-term care services under insurance regulations in New York State.

Medicaid is a means-tested program supported by federal, state and local funds, and administered by each state to provide health care for eligible individuals.

Medicaid Extended Coverage is the Medicaid assistance that is available to Partnership participants who have met the duration requirements of their policies. For the Total Asset Protection plans only income is considered in the determination of the benefits. For the Dollar for Dollar Asset Protection plans income and unprotected assets are both considered in the determination of benefits. For both plans protection against liens or recovery from the assets of the estate of the participant is provided up to the level of asset protection that is established by use of the participant's insurance plan. In the case of Total Asset Protection no liens or recoveries will be pursued against assets.

Medical Underwriting is a process of examining the current health and health history of a prospect to be insured. The insurer may reject the application for insurance or offer an alternative premium schedule for a person who does not meet the insurer's standards for health or health history at the time of application. A waiver on coverage for existing health conditions, so that the existing conditions are not covered, is another alternative available and used by insurers.

Medicare is a federal government insurance program to assist those 65 and older and the disabled with medical and hospital expenses. Medicare covers only skilled care in a skilled nursing facility and limited nursing care at home. It does not usually provide benefits for personal or custodial care, and for this reason provides limited assistance in a program of long-term care. Medicare requires co-payments and deductibles.

Medicare Supplement or "Medigap" Policies are private insurance policies that supplement Medicare benefits by covering co-payments and deductibles for medical and hospital expenses. Similar to Medicare, these policies do not provide coverage for personal or custodial care, and for this reason provide limited assistance in long-term care situations.

Nonforfeiture Benefit is designed to ensure that if an insurance policy is lapsed after a specific period of time, some of the benefits from the policy will be retained and available to the insured. Partnership policies may have nonforfeiture benefits, but these reduced benefits may not be sufficient to meet the requirements for access to Medicaid Extended Coverage.

Non Licensed/Non Certified Provider some policies may provide for payments to individuals who are not licensed or certified for certain long-term care services, such as homemaker services. Payments are not available for immediate family members or persons who normally live in the policyholder's household. This coverage is only permitted in the Total Asset 100 and the Dollar for Dollar 100 policies, and the insurer is not required to offer the coverage.

Nursing Home is a facility that provides room and board and a planned, continuous medical treatment program, including 24-hour-per-day skilled nursing, personal and custodial care. All nursing homes that are licensed or certified and legally operating within the appropriate jurisdiction are deemed to be eligible for benefit payments.

Personal Care refers to assistance provided by another person to help with walking, bathing, eating and other routine activities of daily living. It is provided by aides who are not medical professionals but who are trained to help with these tasks. For tax-qualified coverage personal care must meet federal statutory/regulatory requirements to be eligible for benefit payment.

Pre-existing Condition is a condition for which medical advice was given or treatment was recommended by, or received from, a licensed health care provider within six months before the effective date of coverage. If the insurer uses a pre-existing condition limitation, then the pre-existing condition limitation cannot be excluded from coverage for more that six months after the effective date of coverage.

Residential Care Facility is a facility that provides 24-hour care and services sufficient to assist a minimum of three residents with personal needs that result from the inability to perform ADLs or from severe cognitive impairment. Additionally, the facility provides at least two meals per day, has formal arrangements for emergency medical care, and has appropriate procedures in place for the administration of prescribed drugs where allowed by law. All residential care facilities (also known as assisted living facilities, adult care facilities, assisted living residences, assisted living programs) that are licensed or certified and legally operating within the appropriate jurisdiction are deemed to be eligible for benefit payments.

Resources is the term used by Medicaid offices in New York to describe the assets of an applicant to the Medicaid program.

Respite Care is nursing home or home care that temporarily replaces the existing level of support received from an informal, non-paid caregiver for the purpose of providing care and supervision to the patient while relieving the caregiver.

Severe Cognitive Impairment refers to the loss or deterioration of intellectual capacity in people suffering from conditions, such as Alzheimer's disease or similar forms of irreversible dementia. Severe cognitive impairment must 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 deductive or abstract reasoning.

Skilled Nursing Care is nursing and rehabilitative care provided by, or under the direction of skilled medical personnel.

Spending down refers to depleting almost all income/assets to meet usual eligibility requirements for Medicaid. Medicaid offices use the term resources to identify assets.

Tax-Qualified Policy provides favorable tax treatment for premiums and benefits paid by the policy. These policies must conform to the requirements of the federal Health Insurance Portability and Accountability Act of 1996 and federal regulations/guidance in order to gain the favorable tax status. Long-term care insurance policies approved by the New York State Insurance Department (where the New York State Insurance Department has approval jurisdiction) as tax-qualifying, also are provided favorable tax treatment by the State of New York.

Third Party Notice is a policy feature that permits the insured to designate a person who will be notified when coverage is about to end because the premium has not been paid (See Lapse).

Total Asset Protection refers to the disregard of a Partnership participant's assets, after satisfying the duration requirements of the Total Asset 50 or Total Asset 100 plan, when determining his/her eligibility for Medicaid Extended Coverage.

Waiver of Premium is a policy benefit that may be offered by an insurer to waive the payment of premiums after care has begun. This benefit may be offered at an increased premium charge. The period, when waiver of premium begins, and for what specific type of care, nursing home care, residential care facility, home care, or community based services, are specified in the individual policy. The policy should be examined to determine the requirements.

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