CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

2020

Where we've Been, Where we are & Where we need to Go!

Course #85943

Senior Insurance Training Services

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Senior Insurance Training Services
8-hour CA Partnership CE Course #85943

SECTION I – INTRODUCTION TO LONG-TERM CARE INSURANCE

A. Why is the State Interested in Increasing Private LTC Coverage

- California's Medi-Cal System Bears 65% of all Nursing Facility Expenses
- Medi-Cal's exposure in California will significantly increase by the aging Baby-Boomers
- California's 65+ population is expected to double in the next 28 years
- Most Middle Income Californians don't have sufficient funds to cover their costs of Long-Term Care
- Partnership Certified policies are designed to be attractive to middle income Californians
- The policies must provide care coordination
- The policies home and community based care benefit is provided as a monthly pool of money
- The policies provide an exclusive "Medi-Cal Asset Protection" feature
- Starting January 1, 2011, the first wave of baby boomers began to turn 65; 10,000 every day for the next 20 consecutive years

B. The Purpose of This Course

- Assure a High Quality of Performance in Agents That Market These Policies
- The Importance of Understanding "Non-Exempt" from "Exempt" Assets for the purpose of Medi-Cal Eligibility
- The Difference between Partnership and Non-Partnership Policies
- Who Should Consider CA Partnership Policies and Who Should Not
- The difference between the CA Partnership and the Federal program
- Reciprocity
- And, Why The California Partnership for Long-term Care

C. What Is Long-term Care? Simply put:

1. **Long-Term Care Refers to a wide range of:**
   - Personal, Supportive, Medical and Social/Physiological Services for individuals who because of illness, disabilities and/or simply growing old, need special assistance with their normal daily activities for more than 90-days
2. **What every California needs to know**
   - If you require LTC because of a chronic physical condition or cognitive impairment who will pay for care? The answer is probably you, unless you protect yourself.

D. Establishing the Need for Long-term Care

1. **Key Findings (survey conducted in May, 1994):**
   - Californians Underestimate Their Risk of Needing Long-Term Care (45%)
   - Californians Underestimate the Cost of Long-term Care Services (43%)
2. **Cost of Long-term Care in California**
   - Nursing Home Care Cost: $140-$350 per day **(2020/ADR $320)**
   - Residential Care Facilities Cost: $125 to $150 or more per day
   - A Home Health Nurse approximately $180* per visit
   - A Home Visit by a Social Worker approximately $80* per visit
   - A Live-in Companion/Homemaker can cost up to $550* per day

   *** Through Lic. Agency**

E. Survey Says (in 1994):

1. **Californians mistakenly believe their insurance coverage includes LTC (35%)**
2. **Medicare (65+)**
   - Covers Skilled Care Only
   - Pays approximately 12% of NH Costs
   - Does Not Pay for Custodial Care
3. **Medigap/Medicare Supplements**
   - Covers some or all of Medicare's deductible, co-payments & co-insurance
   - Follows Medicare guidelines
   - Does Not Pay for Custodial Care
4. **Medi-cal**
   - California's name for Medicaid

F. 2010 LTC National Poll Findings

- **The bottom line:** Americans are not planning for possible long-term care needs but are concerned about how they will pay for it.
- **The vast majority of Americans are not prepared for the costs of long-term care**
- Nearly 6 in 10 Americans (59% of survey respondents) are worried about being able to pay for long-term care for themselves.
- 75% (3 out of 4) have made no preparations for their own or a loved one's long-term care needs in case it is needed.
- Even if it meant saving $25,000 a year, only 9% of respondents said they would place a loved one in a nursing home in another part of the state or in a neighboring state.
- **Consumers incorrectly believe the federal government or their health insurance will pay for their long-term care needs**
- Almost half of survey respondents (44%) incorrectly believe that Medicare or their private health insurance will pay for their long-term care needs. Actually, health insurance and the federal Medicare program do not generally cover long-term care.
- **People would prefer long-term care in their home**
- If given the choice between care in a facility such as a nursing home or an assisted living facility and care at home, 75% of respondents would prefer care at home.
- **However, 43% of respondents incorrectly believe Medicare or their health insurance will pay for home care.**

G. Who pays for Long-Term Care?

- In California, Medi-Cal is paying 65%;
- Medicare is paying 12% (Long-Term or Short-Term);
- Private Long-Term Care insurance is paying 2%;
- Other pay such as Veterans homes, et al., is 4%;
- The remainder of 17% is paid by the patients themselves or family members

SECTION II – THE WHAT, HOW, WHY AND WHEN OF THE PARTNERSHIP

A. What is the California Partnership?

1. **Simply put, it's a joint venture between the State of California and Private (Participating) Long-Term Care Insurance Carriers.**
2. **Current Participating Carriers are:**
   - Bankers Life and Casualty (*temporarily suspended itself*)
   - CalPERS Long-term Care Program (*launched December 2013*)
   - **Genworth is currently approved through Company Direct**
   - John Hancock Life Insurance Company *(withdrew September 2013)*
   - New York Life Insurance Company(suspended itself till 2020)
   - Transamerica anticipates re-entering CA Partnership in?
   - **Invited to apply: NGL, Thrivent, Mass Mutual, Mutual of Omaha in 2020**

B. How Did It Start, and Where Is It Now

1. **Robert Wood Johnson Foundation Planning Grant**
   - Formed in 1972 to provide funds for health care research and demonstration projects.
   - Included a program to promote LTCI in 1987
   - These programs were designed to encourage public/private partnerships linking insurance carriers with States Medicaid Programs and allowing purchasers to protect some or a majority of their assets from Medicaid "spend-down" rules
   - The intent was and is to encourage the purchase of private insurance for LTC and reduce the dependence on Medicaid
   - Governor makes it a permanent program on August 16, 2004

C. The Objectives of the California Partnership

- Increasing the Percentage of "At-Risk" Californians with Insurance that will protect against impoverishment for Long-term Care expenses.
- Constrain the growth of Public Expenditure for Long-term Care.
- Improve the Quality and Availability of Long-term Care Insurance Available to Consumers.

D. Concept of the California Partnership

- Relieve physical, financial and emotional burden on one's family and friends
- Maintain financial independence
- Protect one's assets from exorbitant expenses
- Ensure one's ability to secure quality care
- Ensure peace of mind for one's self and family ➡
  Why People Buy LTCI since 2010!
  Freedom>Choice>Independence>Control & Dignity

E. Why the California Partnership

- Intent was to ease the burden on Medi-Cal by creating a public/private partnership
- Medi-Cal expense in 1990 exceeded $3 billion
- Potential Medi-Cal expense in 2020 could exceed $28 billion
- **Current Medi-Cal Expenses for 2009 - $40.3 Billion**

F. Specially Trained Agents Only

- Policies will be marketed by specially-trained agents, Section 10234.93, Chapter 2.6 or Part 2 of the Insurance Code requires agents selling CA Partnership LTCI to complete 8 hours, classroom only of special education on the CA Partnership **prior to marketing any Partnership Policies**

G. The Target Market

- The Criteria in Determining Who Should Buy
  - Age
    - ✓ Pre-retirees 50-64
    - ✓ Recent retirees 65-75
  - Financials
    - ✓ Income: Equivalent to 1-years of a California Nursing Home stay **($115,000 in 2020)**
  - Assets*

    Equivalent to 2-year of a California Nursing Home Stay **($230,000 in 2020)** *Assets net of home

H. Target Population/"At Risk" Population

Age Group	Total CA Population (regardless of income bracket) in the age group	Number of Married Persons	Incomes between the 25th & 75th percentile for Married Persons	Number of Single Persons	Incomes between the 25th & 75th percentile for Single Persons
55-59 (Pre-Retirees)	2,372,732	959,861	$49,156-$100,253	374,205	$49,057-$85,000
60-64 (Pre-Retirees)	2,093,918	823,028	$58,67 – $100,000	344,366	$58,671-$83,855
65-74 (Recent Retirees)	2,857,887	870,116	$78,243-$103,050	564,965,	$78,243-$137,090
Total at Risk ===➔		**2,653,005**		**1,283,536**	

***Numbers extracted from the U.S. Census Bureau, Current Population Survey, March 2018 Data.**

I. Introduction to Suitability

- Why is Suitability Important
- Financial Considerations

J. Unique Aspects of the CA Partnership

How the Partnership works

- Private Insurers Develop Policies
- Individuals Purchase Policies
- Private Policies are Back-Stopped by Public Benefits
- If the Insurance Runs Out, the Policyholder can apply for Public Benefits
- Each $1 of Insurance Payout protects an Equal Amount of the Insured's Assets
- Result: The Policyholder gets
  - Needed LTC care and lifetime protection of assets
  - Peace of Mind

K. Important Notice

- **State Endorsed (Good house keeping Seal of Approval)**
- **Provide Asset Protection**
- **Has a rate cap feature currently not required under traditional policies**
- **California pending for reciprocity**
- **Unique Care Management feature**

L. California Partnership for Long-term Care

	"Non-Exempt" Assets	LTC Insurance Payouts	Medi-Cal Spend Down Requirement
Person A	$50,000	$50,000	$0
Person B	$200,000	$200,000	$0
Person C	$1,000,000	$500,000	$500,000
Person D	$200,000	$0	$200,000

SECTION III – MEDI-CAL AS IT RELATES TO PARTNERSHIP FOR LTC

A. Understanding Medi-Cal: The Deficit Reduction Act of 2005

1. **What is it?**
   - Deficit Reduction Act (DRA) of 2005
2. **Eligibility**
   - Transfer of Assets
   - Look back and penalty period
3. **Estate Recovery**
4. **Medi-Cal Services**

B. Medi-Cal Overview

- **The Who, What, Where, Why, When and How of Medi-Cal as it relates to the CA Partnership – Important Notice:**
  - The following section on Medi-Cal is designed to give the agent a simple "overview" of Medi-Cal Eligibility Requirements, LTC Services and Recovery Provisions. Agents should refer to the "Before you Buy" Guide as their sales tool in presenting the CA Partnership for LTC and Medi-Cal eligibility rules.

C. What is Medi-Cal?

- Medi-Cal is California's Medicaid health care program. This program pays for a variety of medical services for children and adults with limited income and resources.
- Medi-Cal is supported by Federal and State taxes. You can apply for Medi-Cal benefits regardless of sex, race, religion, color, national origin, sexual orientation, marital status, age, disability, or veteran status. If you are found (or determined) eligible, you can get Medi-Cal as long as you continue to meet the eligibility requirements.

D. Deficit Reduction Act Changes *(will not be implemented in CA as 2020)*

- Made significant changes in Medi-Cal eligibility
- DRA cuts nearly $40 billion over five years from Medicare, Medicaid, and other programs
- Significant changes:
  - Look-back period (60 months being phased in over the next 2 years)
  - Transfer for penalty start date (date of application)
  - Undue hardship exception (harder to justify)
  - Treatment of annuities (considered in the 60-month "look back")
  - Community spouse income rules (income first rule)
  - Home equity limits ($858,000 plus, except for partnership policy holder: exempt)
  - Treatment of investments for CCRCS (now counted)
  - Promissory notes and life estates (now counted)
  - **State long-term care partnership programs**

E. **Understanding Medi-Cal as it Relates to Long-term Care**

1. **Medi-Cal is California's version of Medicaid, a federally supported but state administrated welfare program.**
2. **Roughly 50% by California general tax revenues and the other 50% is reimbursed by the federal government.**
3. **Medi-Cal Consists of 3 Parts:**
   - Eligibility (residency & assets)
   - Share of Cost (income)
   - Recovery
4. **Medi-Cal is the primary funder of public LTC services in California**

F. **Who Is Eligible for Medi-Cal? You Must Meet the Following Criteria:**

1. Be a Resident of the State of California
2. Be linked to the Program through any of the following:
   - be under the age of 21, or older than 65 or be a resident of a nursing facility
   - be receiving Supplemental Security Income (SSI)
   - be disabled, blind or pregnant
   - be the parent or caretaker of a needy minor, who parent is absent, deceased, unemployed, underemployed or incapacitated
   - Diagnosed with breast or cervical cancer
   - Have medically documented active tuberculosis
   - Have Property that does not exceed Medi-Cal limits

G. **The Application**

- Social Security Card
- Medicare Card
- Alien Registration Card
- Pregnancy Verification
- Income Verification
- Property Tax Statements
- Vehicle Registration
- Bank Information, etc.

H. What are the Resource Limits

1. **Exempt Property (Non-Exempt)**
   - A Home (**Home equity will not be counted/enforced**)
   - A Car
   - Household Goods
   - Business Property & Real Estate
   - Term Life Insurance
   - A Mortuary Trust & Cemetery Plot (up to $1,500)
2. **Non-Exempt Property (Countable Property*)**
   - Cash over $2,000 (CA)
   - Stocks/Bonds/IRA's/Keoghs
   - CD's/Single Premium Deferred Annuities/T-Bills
   - T-Note/Savings Bonds
   - Investment Property
   - Whole Life Insurance**
   - Vacation Homes
   - Second Vehicles

* Total non-exempt property can not exceed $2,000
** Face value greater than $1,500

I. Property Exemptions

- **One motor vehicle**
- **Personal property used in a trade or business**
- **Personal effects**: This includes clothing, heirlooms, wedding and engagement rings, and other jewelry with a net value of under $100
- **Household items**
- **IRA's, Keogh's, and other work-related pension plans.** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted.
- **Irrevocable burial trusts or irrevocable prepaid burial contract with a value of up to $1,500 plus accrued interest per person**
- **Burial space items**
- **Musical instruments**
- **Recreation items** including TVs, VCRs, computers, guns, collections, etc.
- **Livestock, poultry, or crops**
- **Countable property equal to the amount of benefits paid under a state-certified, long-term care insurance policy (Partnership Policies)**
- **Life insurance policies**. Each person may have life insurance policies with a combined face value of $1,500 or less plus accrued interest and dividends.

J. Property Exemptions - Real Property

- **Principal Residence**. Property used as a home is exempt (not counted in determining eligibility for Medi-Cal). When an applicant or beneficiary is absent from the home for any reason, including institutionalization, the home will remain exempt if the applicant or beneficiary intends to return home someday. The home also continues to be exempt if
- **Principal Residence** the applicant's or beneficiary's spouse or dependent relative continues to live in it. Money received from the sale of a home can be exempt for six months if the money is going to be used for the purchase of another home.
- **Other real property.** Up to $6,000 of the equity value in non-business real estate (excluding the home), mortgages, deeds of trust, or other promissory notes may be exempt. In order to receive this exemption, the property must produce an annual income of 6% of the net market value or current face value
- **Real Property.** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income

K. Your Home

- Transfer of Interest in Your Home (no look back)
- When Your Home is Exempt (intent to return)
- Transfer of the Home to a Spouse (at any time)
- **L. Special Agent Note**
- Pay "special attention" to "non-exempt" countable property: This is the amount that should be determined when reviewing a client's financial means towards his/her ability to self insure their long-term care risks. **It is this amount that should be the basis of how much Partnership protection one should purchase. And…**
- Purchasing an Annuity May NOT Make You Eligible for Medi-Cal
- Can You Spend Down Resources
- Can You Give Away Assets and Still Be Eligible for Medi-Cal
- How Is the Transfer Rule Triggered
- When to Apply for Medi-Cal Under the California Partnership

M. If Your Spouse Enters a Nursing Home

- What is the Law?
- What are the allowable Resources?
- What if you have Separate Property?
- What Resources Are Counted?
- Work Related Pensions and IRA's
- Physical Separation of Assets/Recordkeeping
- How is Your Income Divided?
- Fair Hearings
- Court Orders

N. Asset Limits

- **For 2020**, the at home spouse can keep up to $**128,640** of non-exempt assets and the institutionalized spouse can keep up to **$2,000** in a separate account total of **$130,640**
- Anything in excess of that must be "spent down" The $**128,640** is referred to as the "Community Spouse Resource Allowance" (CSRA)

O. Income Limits in the Community

- If living in the community:
- California Law has a fixed maintenance need standard,i.e.: the amount of monthly income that the state has determined you need for necessary monthly expenses, not including medical bills
- The need standard for a single elder (over 65) or disabled person is $600 per month; for an elder/disabled couple it is $934 per month as of 1/02
- If Single in a Nursing Home:
- residents with outside income may keep $**35 per month for personal needs**

P. Share of Cost in a Nursing Home

- Gavin enters a SNF. His income is still $800 per month from Social Security.

  $800 Unearned Income/SSI
  $ 35 Maintenance need for Long-Term Care
  $765

- Assuming no other deductions $765 is Gavin's share of cost
- The $35 is Gavin's "Personal Needs Allowance" Gavin's SOC is his cost to be paid each month, minus medical expenses not covered by Medi-Cal

Q. Income Limits in the Nursing Home

- If a Single is in a Nursing Home and has an at-home spouse:
  - Spouse at home can keep a **minimum monthly maintenance needs allowance, called the MMMNA.** The **2020** limit for the at-home spouse is **$3,217**
  - The institutionalized spouse may keep $**35 per month for personal needs**

R. **Agent Update – Senate Bill 2821**

- This bill would provide that, if permitted by Federal Law, a relative of a skilled nursing facility resident who is a Medi-Cal beneficiary may pay an additional amount to the facility to enable the resident to obtain requested non-covered (private-room) services, as described in the bill. The bill would prohibit the charge for these services from exceeding the charges to private pay residents for the same services.
- What percentage of nursing homes is Medi-Cal approved? Medicare approved?
  - Nearly 88 percent of the 1,450 nursing homes in California accept Medi-Cal:
    - ✓ Title 18 only (Medicare): 8.3%
    - ✓ Title 18/19 (Medicare/Medi-Cal): 80.4%
    - ✓ Title 19 only (Medi-Cal): 7.3%
    - ✓ No Participation 4.0%
- How does Medi-Cal treat domestic partnerships?
  - Medi-Cal does not consider someone in a "domestic partnership" as married. The applicant partner is simply considered a single individual. As such, he/she is allowed to keep $2,000 in resources and $35/month for personal needs if he/she is in a facility or $600/month of income if he/she resides in the community. The higher resource limits allowable under spousal impoverishment protection provisions **($128,640** for a couple in **2020**) and the spousal income allocation (up to **$3,217**/month in **2020)** permitted under those provisions will not apply to a domestic partnership.
  - Financial institution accounts held jointly with the partner are considered to be 100 percent available to the applicant partner unless there is clear evidence, beyond a statement or affidavit, that all or a portion of the funds in the account originate with the non-applicant partner.

S. **Agent Update**

- If the non-applicant partner refuses to liquidate, then real or personal property held jointly and requiring two signatures to liquidate is considered "unavailable" and is not counted. Additionally, transfers made to a partner are not protected transfers.
- For the purposes of estate recovery, the "domestic partnership" is not treated the same as marriage. There is no delay in the filing of a claim, as afforded a surviving spouse, upon the death of the Medi-Cal beneficiary. The State's claim, however, is limited to the decedent's interest in any assets held either solely or with their domestic partner (if no 'Declaration of Domestic Partnership' has been filed).
- **In a domestic partnership arrangement, if the Medi-Cal partner owns a house (just in his/her name) and then dies, will Estate Recovery collect if the surviving domestic partner is residing in the home?**
  - If the Domestic Partners have filed a "Declaration of Domestic Partnership" with the Secretary of State's office, the Estate Recovery Unit would treat this as a "Surviving Spouse" case and no claim would be presented until the death of the Surviving Partner. Without the "Declaration of Domestic Partnership" the Estate Recovery Unit would present a claim upon the death of the first partner. Heirs to the property would be given an opportunity for a Hardship Waiver. At the very least alternate payment arrangements, secured with a lien, may be negotiated with the heir(s) to the estate property so that the surviving partner is not displaced.

T. **New Law Extends Financial Protections for Medi-Cal's Long-term Care Benefit to Same Sex Spouses and Registered Domestic Partners**

- Sacramento - The Governor signed legislation authored by Assembly Member Mike Feuer (D-Los Angeles) that will provide same sex spouses and registered domestic partners of nursing home residents the same financial protections available to opposite sex married couples. Without these protections, Californians in same sex relationships risk losing access to joint financial resources, such as their home, bank accounts or stock, when their partner or spouse applies for the Medi-Cal long-term care benefit. The new law will take effect on January 1, 2012.
- Under current law, Medi-Cal's long-term care benefit helps to pay for medical care and services for people who have a chronic illness or disability, including the costs of placing an elderly person into a nursing home. To qualify for this benefit, some recipients are first required to contribute significant resources toward their medical costs. Existing law provides protections for opposite sex married couples that allow them to shield assets so that the spouse outside the nursing home retains a means of financial support and is not forced into poverty by these cost-sharing requirements.
- Unfortunately, these critical protections currently do not apply to same sex spouses or registered domestic partners. The federal government recently issued a memo clarifying that states have flexibility in administering the long-term care benefit. Assembly Bill 641 enables California to take the lead in ensuring that same sex couples are afforded the same financial protections provided to opposite sex couples. This bill extends critically needed protections to same sex couples who would otherwise be left impoverished by the costs of long-term care.

U. **Which Services are covered by Medi-Cal "For Long-Term Care"**

- Nursing Homes
- Home Health and Hospice
- Adult Day Health Care
- In-Home Supportive Services (Home Care)
- Related Services (Assisted Living Waiver Program)
  - Limited pay for RCF's in 15 counties
  - Does not cover R&B

V. **Medi-Cal and Home Care**

- Will Medi-Cal pay if I need Long-term Care Services in My Home?
- In-Home Support Services (IHSS)
- What are other Eligibility Criteria for IHSS
- How Does the Program Work?

W. **Medi-Cal Recovery - Liens and Estate Claims**

- Dept of Health Services DHS, implemented an ER Program in June 1981
- Estate Recovery is different from Estate Taxation

X. Estate Recovery

- ER is barred from claiming:
  - during the lifetime of a surviving spouse; or,
  - when there is a surviving child who is under the age of 21;or,
  - when there is a surviving child who is blind or disabled
- Upon the death of the surviving spouse, ER may present a claim against the surviving spouse's estate to collect the amount of Medi-Cal paid services provided to the pre-deceased spouse or the value of the assets received by the surviving spouse, whichever is less.
- In 1993, federal and State law was amended, in part to expand the definition of the term "estate." This change revised the definition of an estate to include all real and personal property and other assets in which the individual had legal title or interest at the time of death (to the extent of such interest), including assets conveyed to a dependent, survivor, heir, or assignee of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. This includes assets received by a surviving spouse, whether through distribution or survival. In accordance with Title 22, Section 50961 and 50453.7(b), ER will reduce its claim for insurance benefits received under the California Partnership for Long-Term Care (LTC). These regulations provide a dollar for dollar asset exemption, based on the dollar amount of the payments made under the Partnership-approved LTC insurance policy. The Department will review the service summary when determining the balance owing on the Department's claim. The following examples will illustrate how this exemption is applied towards a Medi-Cal estate recovery claim.
- **Example #1:** Single man, in need of LTC, purchases a non-Partnership LTC insurance policy with a maximum pay-out of $100,000. He owns a home worth $100,000 and has a bank account with $2,000. He enters LTC and after exhausting the benefits of the LTC insurance policy, he applies for and is granted Medi-Cal benefits. Medi-Cal paid an additional $100,000 for his care.
  - **When he dies, what action would ER take?**
    - ✓ Since Medi-Cal paid a total of $100,000 for his care, ER would present a claim for $100,000 against his estate. While he was still able to qualify for Medi-Cal benefits, based on his exempt residence and $2,000 in the bank account, there is no asset protection provided by the policy because this was not a Partnership-approved policy. The ER, therefore, would pursue collection for $100,000.
- **Example #2:** Husband and wife apply for Medi-Cal for the husband, who is in a LTC facility. The couple has the following assets:
  - a home, held in joint tenancy, appraised for $141,500;
  - a joint savings account with $83,500;
  - other joint real property appraised for $100,000; and,
  - stock certificates, held jointly, worth $125,000;
  - a total of $450,000 in joint assets.

  The husband owned a Partnership-approved LTC insurance policy and ER was provided with a service summary, which verified $225,000 in benefits has been paid under the policy. Medi-Cal paid an additional $300,000 in benefits. The wife did not utilize Medi-Cal.

- **When the husband dies, what action does ER take?**
  - ✓ ER would take no collection action during the lifetime of the wife. When the wife dies, however, ER will present a claim, against her estate, for the husband's Medi-Cal usage.
  - ✓ At the time of his death, the husband's interest in the joint assets totaled $225,000 (or one half of their value) which passed to his wife upon his death. There were no statutory exemptions to the claim. Since the provided service summary indicated $225,000 in benefits, the dollar for dollar exemption will bar ER from collecting on its claim.

Y. Asset Protection and Medi-Cal

- Specially approved long-term care insurance policies allow California residents to protect specified amounts of assets from consideration, at the time of Medi-Cal eligibility. This method of converting a potentially countable asset is called asset-protection. This protection is in addition to exemptions and property limits already available under Medi-Cal eligibility and spousal impoverishment rules. Only the specific amount of asset protection purchased and used under a state certified long-term care insurance policy is exempted from consideration by the County Welfare Department at the time of application for Medi-Cal.
- All Medi-Cal eligibility rules in force at the time of application will apply with regard to the individual and his/her countable assets. The Partnership makes no changes in the Medi-Cal program; it only adds this Medi-Cal property exemption. Any existing estate recovery rights of the State of California are unchanged by the Partnership, except that an additional amount of assets will be exempt from recovery.

SECTION IV – UNDERSTANDING THE PARTNERSHIP PRODUCT

A. Additional Unique Aspects of the California Partnership

- Enhanced Standards
- Home and Community Based Services
- **Mandatory Inflation Protection (In 2019: 3% ,4%, 5% Compounded or 5% Simple at age 70 plus)**
- **Agent Training (8hr Classroom or Webinar every two years)**
- Insurer Reporting
- **Limits on Future Rate Increases**
- Step Down in Coverage
- Premium Credits
- Critical Review of Policies
- Critical Review of Marketing Material
- **Care Management**
- Integrated Benefits
- Monthly Pool for Home Care
- **Separate Risk Pools**
- RCF Feature in All Policies

B. Why <u>California Partnership Re-Design in 2018</u>

- Original Design required all partnership-approved policies to include a uniform benefits
- Sought to enable consumers to compare prices knowing that the essential benefits and protections were included in all Partnership endorsed policies
- Results in sales were disappointing
- Sales suffered for 3 reasons:
  - Missed some popular non-Partnership benefits
  - Uniform Design restricted agents/consumer flexibility & affordability
  - Policies were too costly (due to mandatory 5%compounded Inflation!)

C. <u>Major Changes in Partnership Policies Designed to Produce Increase in Sales</u>

- **Partnership Costs (Try to keep premiums at 2 -3% of one's income)**
- **Minimum Daily $ dropped to $100.00 times 30 days= monthly pool ($3000 minimum monthly pool)**
- **Benefits can now be reflected as pools of money $80,000, $100,000, $150,000, $200,000, $250,000, $300,000 etc…..)**
- Elimination Period (0-90 days)
- **Four Types of TQ Policies**
  - NH & RCF Policies
  - Integrated/Comprehensive Policies
  - Home Care Only
  - Home, Community & RCF Only

D. <u>Policy Stacking</u>

- **Policy Stacking Defined** – In general, "policy stacking" refers to the selling of a Partnership policy to supplement the coverage of an existing Non-Partnership policy. As an example, a consumer may have an existing Non-Partnership policy with a daily benefit that is significantly lower than the current Average Daily Private Pay Rate* (ADPPR) for nursing facility care. Often-times the existing Non-Partnership policy may not have inflation protection and may have greater than 90-day elimination period and may have a benefit trigger of more than 2 ADLs. These deficiencies, singularly or collectively, may cause a consumer to want to purchase a Partnership policy in order to bring coverage up to or closer to the present day cost of care.
- **Policy Stacking Prohibitions -** Policy stacking is NOT allowed. California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 8, Article 2, Section 58051(j) states the following:
  " Issuers shall not issue or deliver a Partnership Long-Term Care Insurance Policy or Certificate with knowledge that the individual is entitled to benefits under another long-term care insurance policy or certificate, unless:
  (1) the existing policy is in force under a non-forfeiture benefit provision; or
  (2) the existing policy or certificate is being replaced by issuance or delivery of the new Partnership Policy or Certificate."

* The ADPPR is the benchmark used by the California Partnership for Long-Term Care to determine the cost of long-term care in California. The rate is extracted from the California Office of Statewide Health Planning and Development's LTC Annual Financial Data Profile report

E. **What and Why**

- How can Long-Term Care Insurance be of benefit?
  - Asset Protection, Peace of mind, Freedom, Choice, Independence, Control
- How much insurance is enough?
  - How much "Non-Exempt" Assets do you want to Protect?
- What should middle income Californians do?
  - Either be Rich, Be Poor or Be Insured!

F. **Appropriateness of Long-Term Care Insurance**

- Age (at age in which they can afford and guarantee eligibility)
- Health (money pays for LTC insurance, health buys it)

F. **Appropriateness of Long-Term Care Insurance** *(continued)*

- Income (equivalent to 1yr. of nursing home care - CA in **2020 $115,000-$120,000**)
- Assets (equivalent to 2yrs. of nursing home care - CA in **2020 $115,000 X 2=$230,000)**
- Gender (women are at a greater risk)
- Marital Status (discounts, shared-care, underwriting considerations)

SECTION V – FEATURES, BENEFITS AND PLAN DESIGN

A. Nursing Facility/Residential Care Facility

1. Nursing Facility

- Provides 24-hr/day nursing service under a planned program of policies and procedures
- Has a Duly Licensed Physician available
- Has At Least One Nurse Employed Full Time
- Nurse on Duty or On Call
- Maintains Clinical Records

2. RCF

- A Facility Licensed as a RCF for the Elderly or RCD as defined in the CA Health and Safety Code
- Provide care on a 24 hour basis
- Have a Trained Employee at all times
- Three Meals a Day
- Have arrangements for an MD or RN in case of emergency
- Provide assistance with Meds

B. Integrated/Comprehensive Policies

- Integrated/Comprehensive Benefits
- Home Health Care Services
- Adult Day Health/Social Care
- Personal Care Services
- Homemaker Services
- Respite Care
- Hospice Care

C. Why the Partnership Will "NOW" Offer Home Care Only Policies

To Reflect Actual Claims Utilizations Numbers and more Affordable options

Policy Choices- Days of Care Covered	**Total Benefits Payable & Potential Asset Protection**	**2020 Minimum Daily Benefit - $230 70% of SPRR (Semi-Private Room Rate in 2020=$330)@3% Compounded**
	Year policy is purchased	20 Years after policy is purchased*
365 – 1 year of coverage	$80,300	$144,540
730 – 2 years of coverage	$150,600	$289,080
1095 – 3 years of coverage	$240,900	$433,620
1,460 – 4 years of coverage	$321,200	$578,160
1,825 – 5years of coverage	$401,500	$722,700

Special Note: To purchase LTCI policies approved by the CA Partnership, an individual must be a California Resident. *A Partnership insurance policy will pay for services even if the individual moves to another state and his/her insurance payments will count toward the Medi-Cal* property exemption. However, a Partnership policy holder must be a California Resident id he or she wishes to apply for Medi-Cal and receive the additional Partnership property exemption.

E. Path of Guided Self Discovery-Plan Design

NEED - (Statistics)	AGE	WANT - (Emotion)
Comprehensive	1. Type	Comprehensive
70% / $230.00	2. Dollar **($330.00**) **State Average 2020"ADPPR"**	100% / $330.00+
80% / 2-3 years	3. Duration	90% / 4-5 yrs
Longer / 90 days	4. Elimination	Shorter / 30
3% compounded	5. Inflation(3%,4%,5%)	3% compounded
No	6. NF	Yes
$_____		$

F. Coverage Limits for Partnership Policies Issued for Calendar Year 2020

	Nursing Home Care Payments DBA	RCF Payments DBA	Home/Community Payments MBA	Lifetime Maximum
	100% of 2020 APPDR @ $330	Allowable Range 70%-100%	Allowable Range 50%-100%	Allowable Range
Minimum Coverage Amounts	$230	$161	$3,450	$83,950
	$230	$161-$230	$3,450-$6,900	$83,950-Life
	$240	$168 - $340	$3,600 –$7,200	$87,600-Life
	$250	$175-$250	$3,750-$7,500	$91,250-Life
	$260	$182- $260	$3,900 - $7,800	$94,900-Life
	Maximum varies by insurer	Up to 100% of daily benefit amount	Up to 100% of daily benefit amount	No Maximum

G. How Can Shorter Be Better

- "When The Policies are too expensive."
- Where is the break even point
- Take a look at a couple of scenarios
- If there is a partnership policy, with inflation there is Medi-Cal spend-down protection then shorter may be better

H. Benefit Periods

$ Equivalent to "Pools of Money" (2020 Minimum is $230)
Assumes 20 years @ 3% Compound $ x 1.80 = $$

365 days (one yr)	730 days (two yrs)	1095 days (three yrs)
x230=$83,950	x230=$167,900	x230=$251,850
x240=$87,600	x240=$175,200	x240=$262,800
x250=$91,250	x250=$182,500	x250=$273,750

1,460 days (four yr)	1,825 days (five yr)
x230=$335,800	x230=$419,750
x240=$350,400	x240=$438,000
x250=$367,920	x250=$456,250

I. The Importance of the Home and Community Based Benefit as a Monthly Benefit

- The California Department of Health Services required all comprehensive Partnership Policies to Provide the Home and Community Based Care Benefit as a "monthly" benefit.
- Gives the consumer more flexibility
- Consumer may not "spend down" due to out of pocket expenses with less flexible benefit payment types (daily)

J. Other Provisions

Elimination Period

- **1 Year Policies: 0 or 30 days**
- **Two Year and Longer Policies: 0,30,60 and 90 days**

- **Built In Inflation Protection**
  - **3% , 4%,5% Compounded with no age based cap or**
  - **5% Simple at age 70 plus**
- When are you likely to Need Care?
- How much will costs rise in the Future?
- Shortened Benefit Period Non-forfeiture Benefit/Mandatory Offering
- Coordination of Benefits Feature
- Premium Waiver Begins on the First Day of Facility Care
- Long-term Care Services Countable toward Medi-Cal Property Exemption

SPECIAL NOTE in 2019
Partnership has approved:

- **3%, 4%, 5% compound (all ages)**

K. Which is the Best LTC Plan for You?

- Besides yourself, whom would you like to protect?
- How likely is it that you will need LTC someday?
- Who will be around to help you when you need care?
- How old are you?
- How substantial are your assets?
- How substantial is your income?

L. Consumer Protections

- Guaranteed Renewable
- Duty of Honesty, Good Faith, and Fair Dealing
- 30-Day Free Look
- Outline of Coverage
- Changing Your Benefits
- Shoppers Guide
- Checklist and Counseling Information - HICAP

M. What the Agent MUST Provide

- Outline of Coverage
- Personal Worksheet
- The Buyer's Guide "Taking Care of Tomorrow"
- The name, address and phone number of your local HICAP office
- **What Happens When Long-term Care costs Rise? A Comparison of Care Costs and Benefit Amounts (See Inflation illustration attachment 2019)**

Special Note: If the agent is discussing a Partnership-certified policy with a client, they should provide the client with a copy of "Before you Buy". This explains the Partnership's Unique Asset Protection provision discussed earlier. The client should receive these documents even if one does not agree to buy a policy that day.

N. Safeguard Aimed at Keeping Policies In-Force

- Step-Down Provisions for Lower Premium (not subject to underwriting)
- Step-Down Premium Credit
- Step Up in Coverage
- Limits on Future Premium Increases
- Provisions Governing Rate Increases
- Protection Against Unintended Lapse
- Selection of Designee/Waiver of Right
- Reinstatement of Coverage
- Materials to be Distributed by Agents Prior to Taking Application
- Marketing and Disclosure
- Requirements

Rights of current policyholders and options to: 1) lower premium and reduce coverage, 2) elect to increase coverage 3) new benefits or policies	**Step Down** Anniversary date of policy to lower premiums or in event of lapse or premium increase	**Step Up** No less frequently than on each anniversary date of policy issue, pay the premium based on attained age	**New Benefits/ Policies** When insurer develops new benefits or benefit eligibility or new policies with both
Length or Duration of Coverage	Reducing the maximum lifetime benefit The premium for the policy or certificate that is reduced in coverage will be based on the age of the insured at issue age and the premium rate applicable to the amount of reduced coverage at the original issue date	Increase lifetime maximum benefits	The insurer shall notify the policyholder of the availability of the new benefits or benefit eligibility or new policy within 12 months of the date that the new policy series is made available for sale in this State. The insurer shall offer the policyholder new benefits or benefit eligibility in one of the following ways: - By adding a rider to the existing policy and paying a separate premium for the new benefits or benefit eligibility at the insured's attained age. The premium for the existing policy shall be unchanged based on the insured's age at issuance. - The insured may be required to undergo new underwriting, but the underwriting shall not result in lower benefits than the policyholder or certificate holder were applying for the new policy or certificate. - For the purpose of this section, new benefits means coverage for new long-term care services or providers that are material in nature. New benefits do not include changes that are minor in nature. Changes that are minor in nature include, but are not limited to, changes in the elimination period, benefit periods and benefit amounts.
Daily $/per Diem Benefit	Reducing the nursing facility per diem and reducing the home and community-based service benefits of a home care only policy and of a comprehensive long-term care policy	Increase the amount of per diem benefits Increase the amount of both the nursing facility per diem benefit and the home and community-based benefits of a comprehensive long-term care insurance policy or certificate	
Types of Coverage *Converting Comprehensive to Facility or Home Care only, if offered by Insurance Carrier*	If the contract in force at the time a reduction in coverage is made provides for benefit adjustments for anticipated increases in the costs of long-term care services covered by the policy, those benefit adjustments in the benefit and daily, weekly or monthly home care benefits shall be adjusted in the same manner and same amount as the contract in force prior to the reduction in coverage. The insurer may include in a notice to those required in this subdivision providing the insured at least 30 days to elect to reduce coverage and the policy shall be reinstated without underwriting if the insured elects to reduce coverage.	The premiums for the riders to increase coverage may be based on the attained age of the insured. The premium for the original policy or certificate will not be changed and will continue to be based on the Insured's age when the original policy or certificate was issued. The insurer may require the insured to undergo new underwriting, in addition to the payment of an additional premium, to qualify for additional coverage. The insurer may restrict the age for issuance of additional coverage and restrict the aggregate coverage to the maximum amount that the insurer allows when issuing a new policy or certificate.	
Inflation Protection *Partnership or Non-Partnership*	If a policyholder chooses to reduce or eliminate the benefit adjustments provided by an inflation protection provision, then they shall be given the option to continue the daily, weekly, monthly and lifetime benefit amounts in effect at the time of the reduction. The policyholder or certificate holder of a policy or certificate offered under the California Partnership for Long-Term Care Program shall be offered options to reduce coverage that would maintain certification under the program. The insurer may also offer other reduction options that may result in a loss of partnership status, but the offer shall include a disclosure that identifies the benefit reduction options that may result in a loss of partnership status and explains that loss of partnership status may reduce or eliminate policy protections. This subdivision may apply to any premium rate increase, regardless of the original policy issue date.	Not addressed	
Elimination/Deductible Period	At Insurance Carriers discretion, the insured can ask for a higher deductibles, if available	At Insurance Carriers discretion, the insurer may ask the insured to decrease the elimination or deductible	
Conversion to New Benefits/Policy	Not Addressed	Can be offered	By replacing the existing coverage or certificate in accordance with Section 10234.87 (Premium Credits)
Premium Credits	Only applies if insured opts to convert to new policy	Only applies if insured opts to convert to new policy	By replacing the existing policy or certificate with a new policy or certificate in which case consideration for past insured status shall be recognized by setting the premium for the replacement policy or certificate at the issue age of the policy or certificate being replaced.

O. **Selected Administrative Protections**

- Policies Approved by Two State Agencies
- Marketing Materials Reviewed and Approved
- Higher Additional Standards for Insurers
- Additional Standards for Agents
- Who May Not Be Appropriate for This Program
- Should Individuals with Traditional LTCI be Encouraged to Convert to Partnership Policies?

P. **Conversion of Policies**

- Premium Credits
- Should I replace my existing Policy with a newer one?
- When is Replacement Appropriate

Q. **Premium Credits for Replacement/Conversion Policies**

- **Example:**
  - Old Policy - Premium of $1,000 annually
  - New Policy - Premium of $1,500 annually
  - Credit - 5% for each full year of premiums paid
  - Had old policy for six years -
  - How it Works: 6 years x .05 =.30
    $1,000 (old premium) x .30 = $300
    $1500 (new premium)
    -300 (credit)
    $1,200 (new annual premium)

R. **It's Just Too Expensive - The 2020 CA Premium (age of purchase 55) 3% Inflation/**

- $330 Per Day
- $9,900 Per Month
- $118,800 Per Year

-OR-

- $10 Per Day
- $300 Per Month
- $3,600 Per Year (3yrs of coverage)

2038 $244,404 Age 75

2043 $296,856 Age 80

2048 $373,744 Age 85

OR IS IT DIRT CHEAP?

SECTION VI – UNDERWRITING AND CARE MANAGEMENT

A. Pre-Health Underwriting

- An insurer MUST complete medical underwriting and resolve ALL reasonable questions ***prior*** to issuing a policy
- The agent MUST act as a field underwriter
- It is the AGENTS responsibility to understand the underwriting guidelines of the issuing insurance company
- **This is one of the MOST important components to ensuring the health of the insurance companies risk pool**
- **Special Partnership Note:** Remember, under the California Partnership for LTC, the individual has long-term care insurance and is in claim. However, if benefits are about to be exhausted and the insured still needs care, then the care management component will kick in and help develop a transitional plan of care. **A feature available only under the CA Partnership for LTC.**

B. When Will the Partnership-Certified Long-Term Care Insurance Begin Paying Benefits?

- All long-term care policies require that your physical or mental conditions meet certain standards before benefits will be paid. These standards are often called Benefit Triggers. The two Benefit Triggers allowed in Partnership-Certified long-term care insurance policies in California are:
  1. **Impairment in Activities of Daily Living (ADLs)**
     "Activities of Daily Living" (ADLs) are used to measure your physical abilities to determine if you qualify for benefits. The law requires tax-qualified policies to pay benefits if you are impaired in two out of the following six ADLs: bathing, dressing, transferring, eating, toileting and continence. Only two ADLs can be required before benefits will be paid for nursing home care, RCFE care, or home care. "Impairment" means that you need human assistance or continual supervision to perform an Activity of Daily Living.
  2. **Impairment in Cognitive Ability (or Cognitive Impairment)**
     "Impairment in Cognitive Ability" means that you need supervision or assistance to protect yourself or others because of mental deterioration caused by a mental disease such as Alzheimer's disease or a mental illness. A diagnosis of cognitive impairment is based on clinical evidence and by the use of standardized tests.
- **§58003 Benefit Eligibility**
  "Benefit Eligibility" in each policy or Certificate is defined as follows:
  (a) "How to qualify for Benefits: We will pay for the Qualified Long-Term Care Services covered by this policy if:
  (1) The insured becomes a chronically ill individual, and
  (2) The services are prescribed for the insured in a written Plan of Care.
  (b) The insured will be considered a chronically ill individual when one of the following criteria is met:
  (1) **The insured is unable to perform, without standby assistance or hands-on Assistance from another individual, [2 Activities of Daily Living] due to a loss of functional capacity and the loss of functional capacity is expected to last at least 90 days; OR**

(2) T**he insured has a Severe Cognitive Impairment requiring Substantial Supervision to protect the insured from threats to health and safety,**

(c) The certification that the insured is a Chronically Ill Individual must be made by a Licensed Health Care Practitioner, with the preceding 12 months and must be renewed at least every 12 months. The services to be paid by the Policy [Certificate] must be prescribed in a written Plan of Care prepared by a licensed health care practitioner.

C. Care Management

- The Unknown Benefit

D. CPLTC Statute

- In order for services received to be counted toward the asset disregard for the purposes of Medi-Cal eligibility and estate recovery, services must be part of a Plan of Care completed by the CMPA approved by DHS
- Care Management is a REQUIRED benefit in all Partnership policies

E. Definition of Care Management

- Care management/care coordination takes an all-inclusive look at a person's total needs and resources and links that person to a full range of appropriate services, using all available funding (and informal) sources.

F. Care Management Provider Agencies (CMPA's)

- CMPA is staffed by Nurses and Licensed Social Workers
- All CMPA's are approved by the Partnership
- Includes tools, protocols, training, etc.
- Quality Assurance Program required
- Submit Annual Report for review

G. What Else?

- Develop and maintain provider network
- Extensively contract with community-based organizations throughout California, including HHA's, HCAO and/or private registered nurses/social workers
- Coordinate between provider network and insurance companies

H. Who are the CMPA's?

- **The four CMPA's currently approved:**
  - Capitated Health Care Services
  - Family Caring Network, Life Plans, Inc.
  - Long-term Solutions
  - Evercare Connections

I. Care Management Components

- A comprehensive face to face assessment;
- **Development of a plan of care;**
- **A comprehensive face to face reassessment at least every six months;**
- **Coordination and monitoring of services;**
- **Development of a discharge plan.**
- **Development of a transition plan if immediately eligible for Medi-Cal.**

J. Face to Face Assessment

- How claimant performs ADLs
- Is there cognitive impairment (Uses tests prescribed by Partnership)
- How claimant performs IADLs
- What was original injury
- Talk to physicians and care givers
- Assess informal care available and whether relief to care giver is required (respite)
- List of medications
- What psycho-social issues may be impacting ADL's
- What are the family relationships
- Any safety issues in house
- Explain the coordination and monitoring and determine need and claimants desire

K. Plan of Care

- Identifies the type, frequency and the cost of necessary services for formal and informal care
- Any changes to the plan of care must be documented
- Developed with client, family and doctor input

L. Reassessments

- Ongoing face to face reassessment at least every six months
- Periodic telephone contact in interim
- Assess change in needs and adjusts Plan of Care

M. Coordination and Monitoring

- If desired by client, and deemed necessary by Care Manager, services also include:
- Coordination (Implementation)
- Ongoing monitoring

N. Discharge Planning

- When benefits are set to exhaust, the CMPA will:
- Assure future needs are met
- If applicable, prepare a transition plan for Medi-Cal

O. Clients Transitioning to Medi-Cal

- People in Benefit: 7,390
- Exhausted Benefits: 847
- Transitioned to Medi-Cal: NA

*As of 2nd Quarter 2017

SECTION VII – CASE STUDY

A. Case Study

- 83 female policyholder
- Suffers a fall and fractures hip, and elbow
- Prior to fall lived alone and depended on family/friends for transportation to doctors, shopping, etc.

B. Agent Role

- If contacted by client, what should the agent do?
- Advise them to wait until deductible met?
- Call the insurer or CMPA?
- Be prepared to provide the necessary phone numbers to access policy benefits
- Be prepared to reassure your client by telling them what to expect when they call the company
- Be prepared to educate them on how care management works

C. Insurance Company Role

- Claimant contacts her company the following day as advised by her agent
- Intake nurse gathers basic information, assigns a claim number, and a letter is sent to client indicating file is opened.
- Insurance company made referral to CMPA the same day
- Client has a policy that provides $3,900 for N/H, RCFE and home and community based benefits
- 30-Day elimination period

D. CMPA Role

- Care Manager called and performed initial telephone assessment. Determined client needed services put into place, even though they still had to meet a 30 day EP.
- Scheduled appointment for the face to face assessment.
- Face to Face Assessment completed in clients home. Determined deficit in 4 ADL's.
- Based on assessment, care manager developed plan of care that included, in part, the following recommendations :
  - Care with a home health agency for 8-hours a day, paid by client for 1st 30 days.
  - Care Manager identified need for walker/cane and contacted physical therapist to advise of need. (All Inclusive Assessment)

E. Insurance Company Role

- Reviewed documentation from CMPA against contract provisions. Determined client qualified. Notified CMPA of outcome
- Sent approval of benefits letter to client
- Also discussed Plan of Care with client
- Provided client and son with copy of Plan of Care
- Reminder: It is the final decision of the CMPA what covered services are included in the Plan of Care.

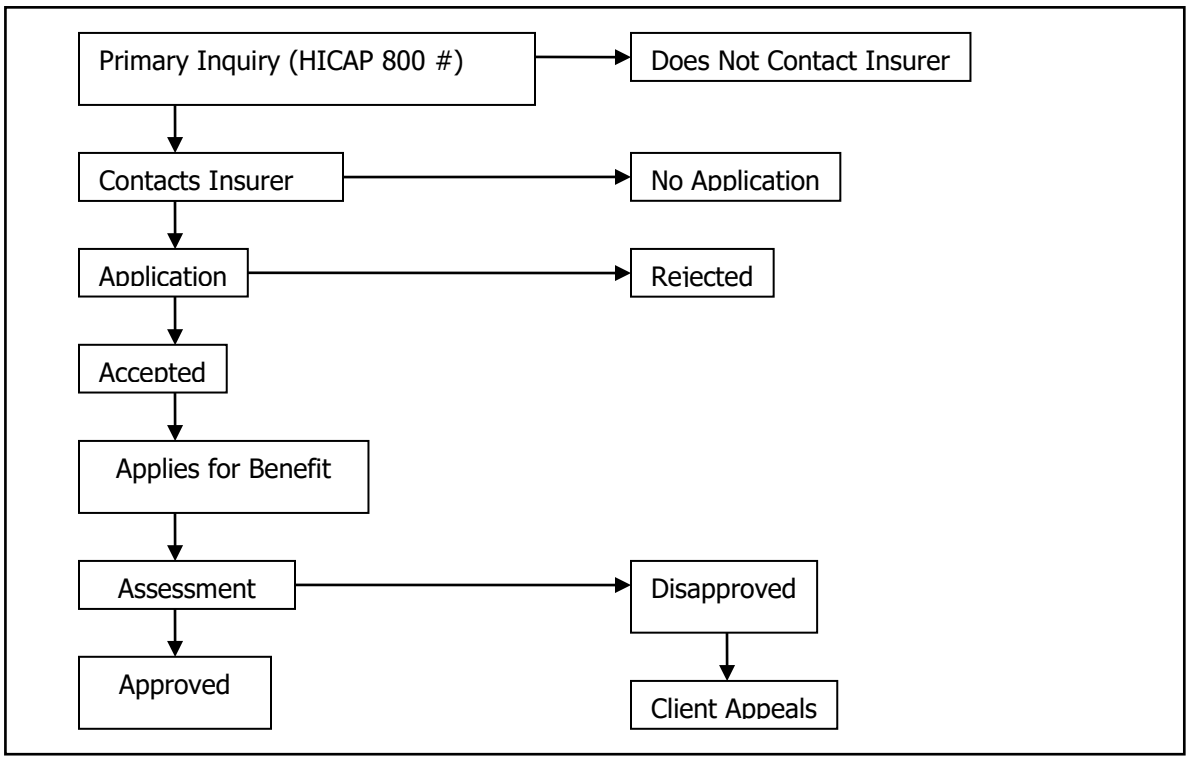
F. Care Coordination and Monitoring

- Care coordination and monitoring was requested by client and deemed necessary by care manager for first 3 months of care. Cost was covered as an administrative expense (Insurer choice)

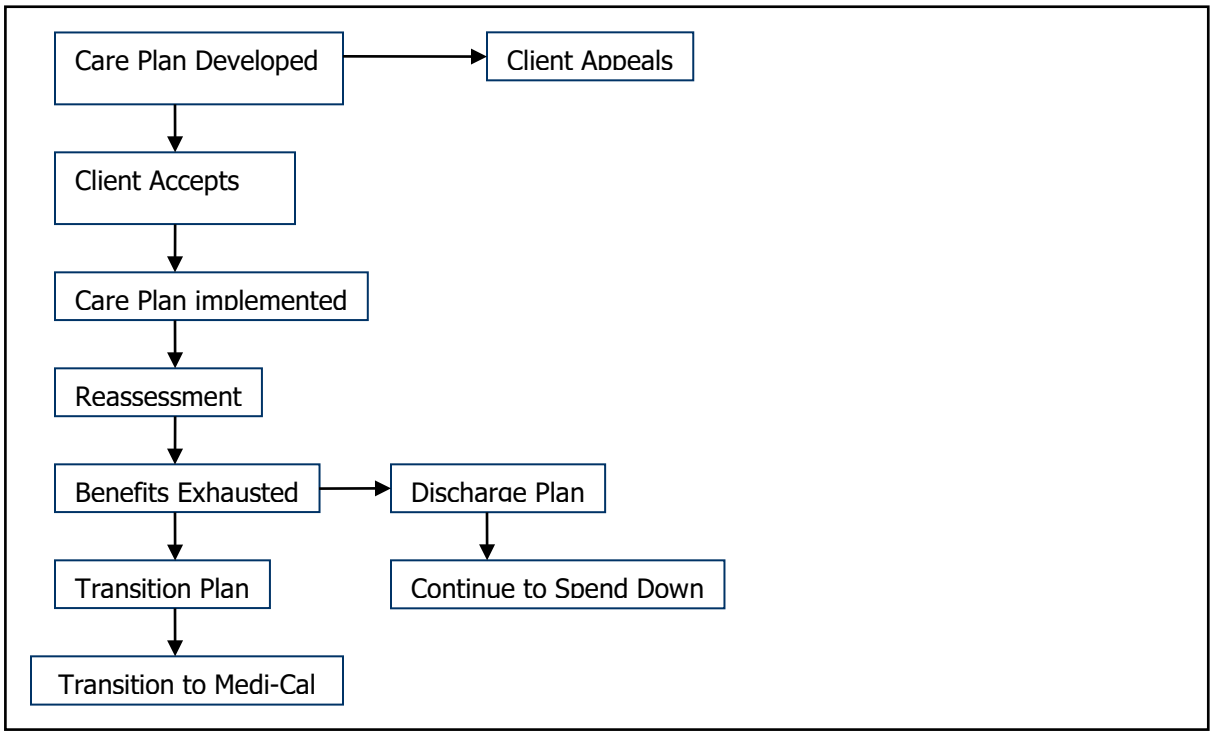
G. Care Management – Discharge Planning

- Client attained independence in 6 months.
- Lifeline system kept in home.
- Therapist recommended client keep cane to help with balance.
- Bathroom grab bars were installed.
- Care Manager provided client and son list of RCFE's in area to investigate for future care needs.

H. CA Partnership for LTC - Critical Path



I. CA Partnership for LTC - Critical Path

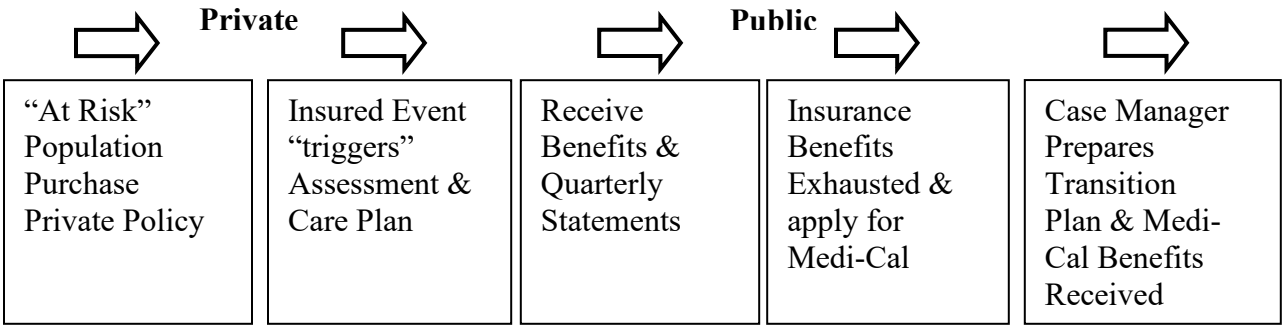


J. Take a Look at the Sample Documents

- *Sample* "Quarterly Medi-Cal Asset Protection Report"
- *Sample* "Service Summary Report"
- *Sample* "Notice of Projected Policy Benefits Exhaustion"
- *Sample* "Request for Discharge/Transition Plan"

SECTION VIII – OVERVIEW AND CONCLUSION

A. How the CA Partnership Works In Review



B. CA Nursing Homes and Medi-Cal

- Medi-Cal Eligibility
- Eviction and Transfer
- Bedhold
- Patient's Bill of Rights

C. In Conclusion – Goals of the California Partnership

- 1. make affordable insurance available to uninsured middle income Californians
- 2. include features to keep policies in force until benefits are needed
- 3. insure benefits are adequate to cover cost of care when care is needed
- 4. reduce the number of Californians who spend-down to public assistance levels

D. Websites of Interest

- www.planningforltc.org - California Partnership for Long-Term Care
- www.insurance.ca.gov – California Department of Insurance
- www.KFF.org – The Henry J. Kaiser Family Foundation
- www.RWJF.org – The Robert Wood Johnson Foundation
- www.CANHR.org – California Advocates for Nursing Home Reform
- www.cahealthadvocates.org – California Health Advocates
- www.ureadyca.org – Partnership Consumer Website

E. The California Partnership - A New Approach to Long-term Care Insurance

The significance of the Partnership goes beyond a quality product and consumer education. The Partnership provides a LTC Insurance program that is good for California because it will also help contain Medi-Cal expenditures. By purchasing insurance through the Partnership, policyholders will cover some, if not all, of their LTC costs before state funds are utilized. This alternative approach to dealing with LTC may deter people from transferring their assets and relying on the government to pay for all their care expenses. It represents a public and private partnership that works for everyone by helping to contain taxpayers' costs.

Independence You Want … Just When You Need It Most