FAQ for Active Policyholders

The purpose of this document is to provide helpful information pertaining to commonly asked questions on the Partnership for Long-Term Care program.

Q1. How do I know if I have a NYS Partnership for Long-Term Care policy?

Make sure the New York State Partnership logo appears on your policy. All New York State Partnership policies should have the Partnership logo on the front page of the insurance policy and other materials related to it.

Q2. I need long term care services. How do I access my benefits?

To access benefits from your policy, the first step is to contact your insurance company directly to initiate the claims process. The name and contact information for your insurance company can be found in your policy. The insurance company will instruct you on various items related to the claims process, such as what information will need to be submitted and how the benefit payment process will work if you are approved for benefits. To access benefits for long term care services, you will need to satisfy your policy's "benefit trigger" requirement.

Q3. What is a policy "benefit trigger"?

Benefit triggers are the criteria that an insurance company will use to determine if you are eligible for benefits. Most companies use a specific assessment form that will be filled out by a nurse/social worker team or other medical professional. Benefit triggers*:

- Are the criteria insurance policies use to determine if you are eligible for long term care benefits.
- Are determined through a company sponsored nurse/social worker assessment of your condition.
- Usually are defined in terms of Activities of Daily Living (ADLs) or cognitive impairment(s).
- Most policies pay benefits when you need help with two or more of six ADLs or when you have a cognitive impairment.
- Once you have been assessed, your care manager from the insurance company will approve a Plan of Care that outlines the benefits for which you are eligible.

**These are guidelines only. Policyholders should always refer to their policy for specific instructions relating to benefit triggers.*

Q4. What is the difference between a Total Asset Protection plan and a Dollar-for-Dollar Asset Protection plan?

The type of asset protection afforded to you when you exhaust your minimum duration requirement on your long term care policy will depend on the type of policy you purchased. If you purchased a Total Asset Protection (TAP) policy, all of your assets (resources) will be protected at the time you are eligible to receive Medicaid Extended Coverage. If you purchased a Dollar-for-Dollar (DFD) asset protection plan, the amount of assets you will be able to protect from Medicaid will be equivalent to the amount of benefits paid out by your long term care insurance policy. For example, if your insurance company paid out $250,000 in benefits for your long term care services, the amount of asset protection awarded to you beneath a Dollar-for-Dollar policy would be equivalent to $250,000.

Q5. What is Medicaid Extended Coverage (MEC)?

Medicaid that is available to a Qualified Partnership Policyholder who has met the minimum duration requirement under his/her Partnership policy is called Medicaid Extended Coverage. The *Total Asset Protection* plans allow for the disregard of all of the policyholder's resources (assets) in determinizing eligibility for Medicaid Extended Coverage. *The Dollar-for-Dollar Asset Protection* plans allow for the disregard of the policyholder's assets (resources) under Medicaid Extended Coverage up to the total amount of benefits paid out by the participating insurer on behalf of the policyholder. Although assets (resources) will be protected (determined by the type of Partnership policy purchased by the applicant), income rules that are in effect at the time of application for Medicaid Extended Coverage apply in determining one's eligibility for Medicaid Extended Coverage.

Q6. I have a long term care policy that is <u>not</u> a Partnership policy. Can I access Medicaid without spending down my resources after my policy benefits are exhausted?

No. The only policies which qualify for Medicaid Extended Coverage and asset protection under the Medicaid program are Partnership policies. Every Partnership policy carries the Partnership logo.

Q7. I've received a 90-day notice letter from my insurance company – what does this mean?

At least 90 days prior to meeting the durational requirement for receiving Medicaid Extended Coverage, the participating insurance company is required to notify a Partnership policyholder via a 90-day notice letter. This notice shall inform the policyholder of their eligibility to apply for Medicaid Extended Coverage. The letter should also identify the approximate date of satisfying the durational requirement for Medicaid Extended Coverage. Lastly, the letter should also offer an approximate number of benefit days available before the policy benefits are exhausted. For example, an individual who purchased a Total Asset "3/6/50" policy will need to exhaust 3 years of nursing home coverage (i.e., 36 months of nursing home coverage or its equivalent) before they are eligible to receive Medicaid Extended Coverage.

Q8. Once I receive the 90-day notice letter, do I have to apply for Medicaid Extended Coverage right away?

No. Qualified Partnership Policyholders who have exhausted their durational requirement for receiving Medicaid Extended Coverage (i.e., utilizing 36 months of nursing home benefits or its equivalent under the policy/certificate for a Total Asset "3/6/50" policy) are eligible to receive Medicaid Extended Coverage. However, if there are residual monies remaining on the policy/certificate, it may be in the best interest of the policyholder to wait until the policy has been exhausted completely before applying for Medicaid Extended Coverage. If a policyholder chooses to apply right away and there are residual monies remaining on the policy, Medicaid will treat these monies as a 'third party payer' and allow the individual to receive Medicaid Extended Coverage (if they qualify).

After private benefits have been exhausted, Qualified Partnership Policyholders may elect to pay privately for care and services. As long as the minimum duration requirement has been met, a Policyholder can apply for Medicaid Extended Coverage at any time in the future.

Q9. How do I qualify for Medicaid Extended Coverage?

Eligibility for Medicaid Extended Coverage is based upon time and financial resources, i.e., income and assets, if applicable, according to the type of Partnership plan selected. Individuals who purchase Partnership policies and subsequently use policy benefits according to the Partnership minimum requirements of the plan they selected, may apply for Medicaid Extended Coverage. Even if there are residual monies remaining under a Partnership policy, individuals may still apply for Medicaid Extended Coverage so long as they have exhausted the duration of nursing home equivalent benefits for the policy they purchased.

Q10. How do I apply for Medicaid Extended Coverage? Is it automatic?

Medicaid Extended Coverage is NOT automatic. It is the responsibility of the policyholder and/or their representative to apply for Medicaid Extended Coverage. Whether you have a Total Asset Protection policy or a Dollar-for-Dollar Asset Protection policy, to apply for Medicaid Extended Coverage you must contact the Local Department of Social Services (LDSS) in the county where you reside. If you are residing in a nursing home or an adult residential care facility, your county of residence for Medicaid purposes should, in most instances, be the county where you were residing prior to your admission. The LDSS is responsible for conducting the Medicaid Extended Coverage eligibility process.

For a complete list of NYS Local Departments of Social Services, please follow this link: http://www.health.ny.gov/health_care/medicaid/ldss.htm

If the policyholder is residing in New York City (within the five boroughs of New York City), they may contact the Human Resources Administration by calling (718) 557-1399.

Q11. I understand that my assets (resources) will be protected – but what about my income?

All income rules in effect at the time of application for Medicaid Extended Coverage will apply in determining one's eligibility for Medicaid Extended Coverage. This is not to be confused with assets (resources) that a policyholder may have, which remain protected depending on the type of the Partnership policy that was purchased; i.e., Total Asset Protection policy or Dollar-for-Dollar.

For more information on this topic, please visit the following document: https://nyspltc.health.ny.gov/docs/medelg.pdf.

Q12. What is considered an asset (resource)?

All or a portion (depending on the policy purchased) of a qualified New York State Partnership for Long-Term Care policyholder's resources are exempt from consideration in determining Medicaid Extended Coverage eligibility. Additionally, since resources are exempt from consideration in determining a qualified policyholder's Medicaid eligibility, the transfer of resources provision (i.e., look-back period and penalty period) does not apply. Income produced from an asset (resource) can be considered in determining eligibility for Medicaid Extended Coverage. Although not an exhaustive list, the most common types of assets (resources) that are protected include the following:

- Cash
- Checking Accounts
- Savings Accounts
- Real Estate
- Mutual Funds
- CDs
- Stocks and Bonds
- IRA*

**A Roth IRA, which would be treated the same as a traditional IRA, would be considered a protected asset (resource). Required Minimum Distribution (RMD) is counted as 'income'.*

Q13. How much money am I allowed to keep per month once I'm on Medicaid?

Medicaid rules and income allowance may change from year to year. Therefore, it is always best to direct income-specific questions directly to the Local Department of Social Services where the Medicaid application will be processed. For a broad overview of Medicaid income allowances, please visit the following link on our website: https://nyspltc.health.ny.gov/medicaid/index.htm.

Q14. Am I able to transfer assets once I'm eligible for Medicaid Extended Coverage?

Yes*. Qualified Partnership Policyholders are exempt from any transfer of resource provisions (i.e., look-back period and penalty period).

**This exemption rule applies to Total Asset Protection policyholders, or for Dollar-for-Dollar policyholders only up to the amount that is protected.*

Q15. Am I subject to the five-year look-back period when applying for Medicaid Extended Coverage?

Qualified Partnership Policyholders with Total Asset Protection policies are exempt from the look-back period. Dollar-for-Dollar policyholders will be subject to a five-year look-back period.

Q16. Once I'm on Medicaid Extended Coverage, where can I receive long term care services?

Long term care services and supports are determined on an individual basis by the Local Department of Social Services (LDSS). In general, Medicaid Extended Coverage will become the primary payer of services either received in the home or at the nursing home level. Other care options may also be available, such as adult day care. It is best to check with your Local Department of Social Services (LDSS) for a full description of the services available to you once you're on Medicaid Extended Coverage.

Q17. When I become Medicaid eligible after my policy's minimum benefit duration period is exhausted, will Medicaid provide the same home care services I have been receiving under my private insurance portion of my Partnership coverage?

When you apply for Medicaid Extended Coverage under the Partnership program, you will be assessed for your home care needs by your Local Department of Social Services (LDSS) based on a number of factors. While there are no guarantees regarding the precise array and quantity of services you may be determined eligible to receive under Medicaid for your continuing long term care needs, the LDSS assessment process will take into account your level of disability, any available support systems present (or absent) in your situation, and the services you are or have been receiving under your private insurance coverage.

Q18. Can I use Medicaid Extended Coverage while residing in an Assisted Living Residence?

Sometimes. It is important for Policyholders to ask the Assisted Living Residence what kind of payment it accepts, ideally prior to moving in. Many Assisted Living Residences accept private payment or long term care insurance and some accept Supplemental Security Income (SSI). Currently, Medicaid and Medicare will not pay for residing in an Assisted Living Residence, although they may pay for certain medical services received

while living in the Assisted Living Residence, such as in the case of the New York State Assisted Living Program (ALP).

Assisted Living Program (ALP) availability is limited, as there are a limited number of Assisted Living Residences throughout the state of New York that participate in this program. It is best to check with the Assisted Living Residence of which you plan to reside in/currently are residing to inquire about their ALP availability.

Q19. My Partnership policy is "portable" – what does this mean?

The long term care benefits (insurance benefits) on an individual's Partnership policy can be used in all 50 States.

Q20. What if I am residing outside of New York State at the time that I need Medicaid Extended Coverage?

If you are residing in a state that participates in reciprocity, you may be eligible to receive Medicaid Extended Coverage beneath that state's Medicaid rules. The assets protected in a reciprocal state will be on a Dollar-for-Dollar* basis. You may return to New York at any time to receive Total Asset protection. Visit the following Reciprocity Map link for a full list of currently participating reciprocal states**:

https://nyspltc.health.ny.gov/reciprocitymap.htm.

**See Question #4 for an explanation of Dollar-for-Dollar asset protection.*
***Please note that states may opt in and/or out of reciprocity at any time.*

Q21. What is the New York State tax credit that pertains to my long term care policy?

The allowable credit is 20% of the premiums paid during the tax year for purchase of, or for continuing coverage under a qualifying long-term care insurance policy. As of 2020, the credit amount cannot exceed $1,500. This credit is available to anyone paying premiums, including children who pay for coverage on behalf of their parents when they file a New York State income tax return.

Q22. I recently experienced an increase in my premium – who can I contact regarding this?

Policyholders may reach out directly to the New York State Department of Financial Services (formerly, the New York State Insurance Department) for queries and/or complaints regarding rate increases.

Please note: The New York State Partnership for Long-Term Care is housed within the New York State Department of Health and has no regulatory oversight of insurance companies.