

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Bassling</i>	DATE <i>7-28-06</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000119</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Deps, file</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
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4.			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

SMDL #06-019

JUL 27 2006

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171. The legislation made a number of changes in the Medicaid rules on eligibility and benefits. This letter provides information for States regarding implementation of section 6021 of the DRA. Section 6021 amends section 1917(b) of the Social Security Act (the Act) to provide for Qualified State Long-Term Care (LTC) Insurance Partnership programs, and permits an exception to estate recovery provisions with respect to individuals who receive benefits under LTC insurance policies sold in States that implement a Partnership program. These changes are described briefly below and are discussed in detail in the enclosure to this letter.

Qualified Partnerships

A Qualified State LTC Insurance Partnership (Qualified Partnership) means an approved State plan amendment (SPA) that provides an exemption from estate recovery in an amount equal to the benefits paid by certain LTC insurance policies, where those benefits were disregarded in determining an individual's Medicaid eligibility. Policies must meet specific conditions and the State Insurance Commissioner, or appropriate State official, must certify that a policy meets those conditions, in order for the State to apply the exemption from estate recovery. The term "Qualified Partnership" refers to Partnership SPAs, other than those approved as of May 14, 1993. However, those States that had approved Partnership SPAs as of May 14, 1993, continue to be "Partnership States," as long as they have not relaxed the consumer protection standards that were applied under their State plans as of December 31, 2005.

Effective Dates

A State plan amendment that provides for a Qualified Partnership under section 1917(b)(1)(C)(iii) of the Act can specify that policies issued after a certain date will be subject to the amendment, as long as that date is not earlier than the first day of the first calendar quarter in which the SPA is submitted for approval.

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Department of Health & Human Services
OFFICE OF THE DIRECTOR

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I am enclosing a more detailed explanation of the above DRA provisions. If you have any questions about this letter, or the enclosure, please feel free to contact Gale Arden, Director, Disabled & Elderly Health Programs Group at (410)786-6810, or by e-mail at Gale.Arden@cms.hhs.gov. We look forward to working with you as you implement this legislation.

Sincerely,

Dennis G. Smith

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roberly
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

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National Governors Association

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Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

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Lynne Flynn
Director for Health Policy
Council of State Governments

Enclosure

Qualified Long-Term Care Partnerships
Under the
Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6021

- I. Expansion of State Long-Term Care Insurance Partnerships
 - II. Definition of “Qualified State Long-Term Care Insurance Partnership” and Requirements
 - A. Definition
 - B. Requirements
 - III. Grandfather Clause
 - IV. Effective Date
- Appendix I Requirements for a Long-Term Care Insurance Policy under a Qualified Long-Term Care Insurance Partnership
- Appendix II National Association of Insurance Commissioners Model Regulations
- Appendix III National Association of Insurance Commissioners Model Act

Deficit Reduction Act of 2005

I. Expansion of State Long-Term Care (LTC) Partnership Program

Section 6021(a)(1)(A) of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, expands State LTC Partnership programs, which encourage individuals to purchase LTC insurance. Prior to enactment of the DRA, States could use the authority of section 1902(r)(2) of the Social Security Act (the Act) to disregard benefits paid under an LTC policy when calculating income and resources for purposes of determining Medicaid eligibility. However, under section 1917(b) of the Act, only States that had State plan amendments approved as of May 14, 1993, could exempt the LTC insurance benefits from estate recovery.

The DRA amends section 1917(b)(1)(C)(ii) of the Act to permit other States to exempt LTC benefits from estate recovery, if the State has a State plan amendment (SPA) that provides for a qualified State LTC insurance partnership (Qualified Partnership). The DRA then adds section 1917(b)(1)(C)(iii) in order to define a “Qualified Partnership.” States that had State plan amendments as of May 14, 1993, do not have to meet the new definition, but in order to continue to use an estate recovery exemption, those States must maintain consumer protections at least as stringent as those they had in effect as of December 31, 2005. We refer to both types of States as “Partnership States.”

II. Definition of “Qualified State LTC Partnership” and Requirements

A. Definition

Section 6021(a)(1)(A) of the DRA adds several new clauses to section 1917(b)(1)(C) of the Act. The new clause (iii) defines the term “Qualified State LTC Partnership” to mean an approved SPA that provides for the disregard of resources, when determining estate recovery obligations, in an amount equal to the LTC insurance benefits paid to, or on behalf of, an individual who has received medical assistance. A policy that meets all of the requirements specified in a Qualified State LTC Partnership SPA is referred to as a “Partnership policy.”

The insurance benefits upon which a disregard may be based include benefits paid as direct reimbursement of LTC expenses, as well as benefits paid on a per diem, or other periodic basis, for periods during which the individual received LTC services. The DRA does not require that benefits available under a Partnership policy be fully exhausted before the disregard of resources can be applied. Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the individual as of the month of application, even if additional benefits remain available under the terms of the policy. The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination.

It should be noted that while an approved Partnership SPA may enable an individual to become eligible for Medicaid by disregarding assets or resources under the authority of section 1902(r)(2) of the Act, the use of a qualified Partnership policy will not affect an individual's ineligibility for payment for nursing facility services, or other LTC services, when the individual's equity interest in home property exceeds the limits set forth in section 1917(f) of the Act, as amended by the DRA.

B. Requirements

The new clause (iii) also sets forth other requirements that must be met in order for a State plan amendment to meet the definition of a Qualified Partnership. These include the following:

1. The LTC insurance policy must meet several conditions, which are listed in Appendix I of this enclosure. These conditions include meeting the requirements of specific portions of the National Association of Insurance Commissioners' (NAIC) LTC Insurance Model Regulations and Model Act (see Appendices II and III).

The Qualified Partnership SPA must provide that the State Insurance Commissioner, or other appropriate State authority, certify to the State Medicaid agency that the policy meets the specified requirements of the NAIC Model Regulations and Model Act. The State Medicaid agency may also accept certification from the same authority that the policy meets the Internal Revenue Code definition of a qualified LTC insurance policy, and that it includes the requisite inflation protections specified in Appendix I. If the State Medicaid agency accepts the certification of the Commissioner or other authority, it is not required to independently verify that policies meet these requirements. Changes in a Partnership policy after it is issued will not affect the applicability of the disregard of resources as long as the policy continues to meet all of the requirements referenced above.

If an individual has an existing LTC insurance policy that does not qualify as a Partnership policy due to the issue date of the policy, and that policy is exchanged for another, the State Insurance Commissioner or other State authority must determine the issue date for the policy that is received in exchange. To be a qualified Partnership policy, the issue date must not be earlier than the effective date of the Qualified Partnership SPA.

2. The State Medicaid agency must provide information and technical assistance to the State insurance department regarding the Partnership and the relationship of LTC insurance policies to Medicaid. This information must be incorporated into the training of individuals who will sell LTC insurance policies in the State.
3. The State insurance department must provide assurance to the State Medicaid agency that anyone who sells a policy under the Partnership receives training and

demonstrates an understanding of Partnership policies and their relationship to public and private coverage of LTC.

4. The issuer of the policy must provide reports to the Secretary, in accordance with regulations to be developed by the Secretary, which include notice of when benefits are paid under the policy, the amount of those benefits, notice of termination of the policy, and any other information the Secretary determines is appropriate.

5. The State may not impose any requirement affecting the terms or benefits of a Partnership policy unless it imposes the same requirements on all LTC insurance policies.

III. “Grandfather” Clause

A State that had a LTC insurance Partnership SPA approved as of May 14, 1993, is considered to have satisfied the requirements in section II above if the Secretary determines that the SPA provides consumer protections no less stringent than those applied under its SPA as of December 31, 2005. Under this provision California, Connecticut, Indiana, Iowa, and New York would continue to be considered Partnership States.

IV. Effective Dates

A SPA that provides for a Qualified State LTC Insurance Partnership under the amended section 1917(b)(1)(C) of the Act may be effective for policies issued on or after a date specified in the SPA, but not earlier than the first day of the first calendar quarter in which the SPA is submitted.

The DRA requires the Secretary to develop standards regarding the portability of Partnership policies by January 1, 2007. These standards will address reciprocal treatment of policies among Partnership States. The Secretary is also required to develop regulations regarding reporting requirements for issuers of Partnership policies and related data sets. It is not necessary for States to wait for these standards and rules to be promulgated before submitting a Partnership SPA. A State may submit a Partnership SPA at any time after the effective date of the DRA.

Appendix I

Requirements for a Long-Term Care Insurance Policy under a Qualified Long-Term Care Insurance Partnership

In order for a State Plan Amendment to meet the definition of a “Qualified Partnership,” allowing the State to disregard assets or resources equal to the amount paid on behalf of an individual, the long-term care insurance policy, including a group policy, must meet the following conditions:

1. The policy must cover a person who was a resident of the Qualified Partnership State when coverage first became effective. If a policy is exchanged for another, the residency rule applies to the issuance of the original policy.
2. The policy must meet the definition of a “qualified long-term care insurance policy” that is found in section 7702B(b) of the Internal Revenue Code of 1986.
3. The policy must not have been issued earlier than the effective date of the SPA.
4. The policy must meet specific requirements of the National Association of Insurance Commissioners (NAIC) Long Term Care Insurance Model Regulations and Model Act. These are listed in Appendices II and III.
5. The policy must include inflation protection as follows:
 - For purchasers under 61 years old, compound annual inflation protection;
 - For purchasers 61 to 76 years old, some level of inflation protection; or
 - For purchasers 76 years or older, inflation protection may be offered but is not required.

Appendix II

NAIC Model Regulations

The following is a list of the NAIC Model regulations that are referenced in Appendix I, item 4:

Model Regulations

1. Section 6A, with a certain exception, relating to guaranteed renewal or non-cancellability;
2. Section 6B of the Model Act, as it relates to 6A;
3. Section 6B, with certain exceptions, relating to prohibitions on limitations and exclusions;
4. Section 6C, relating to extension of benefits;
5. Section 6D, relating to continuation or conversion of coverage;
6. Section 6E, relating to discontinuance and replacement of policies;
7. Section 7, relating to unintentional lapse;
8. Section 8, with certain exceptions, relating to disclosure;
9. Section 9, relating to disclosure of rating practices to the consumer;
10. Section 11, relating to prohibitions against post-claims underwriting;
11. Section 12, relating to minimum standards;
12. Section 14, relating to application forms and replacement coverage;
13. Section 15, relating to reporting requirements;
14. Section 22, relating to filing requirements for marketing;
15. Section 23, with certain exceptions, relating to standards for marketing, with the exception of specific paragraphs;
16. Section 24, relating to suitability;
17. Section 25, relating to prohibition against pre-existing conditions and probationary periods in replacement policies or certificates;
18. Section 26, relating to contingent non-forfeiture benefits;
19. Section 29, relating to standard format outline of coverage; and
20. Section 30, relating to the requirement to deliver the NAIC publication “*A Shopper’s Guide to Long-Term Care Insurance*”.

Appendix III

NAIC Model Act

The following is a list of the requirements of the NAIC Model Act that are referenced in Appendix I, item 4:

1. Section 6C, relating to pre-existing conditions;
2. Section 6D, relating to prior hospitalization;
3. Section 8, the provisions relating to contingent non-forfeiture benefits;
4. Section 6F, relating to right to return;
5. Section 6G, relating to outline of coverage;
6. Section 6H, relating to requirements for certificates under group plans;
7. Section 6I, relating to policy summary;
8. Section 6K, relating to monthly reports on accelerated death benefits; and
9. Section 7, relating to incontestability period.