2007 DRAFTING REQUEST

Bill

Received: **09/07/2006**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

For: **Patricia Strachota (608) 264-8486**

By/Representing: **Sara Buschman**

This file may be shown to any legislator: **NO**

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Public Assistance - med. assist.**
Insurance - other insurance

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Strachota@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Long-term Care Partnerships

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 10/11/2006	jdyer 10/24/2006		_____ _____			State
/P1			nnatzke 10/25/2006	_____ _____	sbasford 10/25/2006		State
/1	pkahler 11/01/2006	jdyer 11/01/2006	pgreensl 11/01/2006	_____ _____	lparisi 11/01/2006		State
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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	03/08/2007	03/08/2007	03/08/2007	_____	03/08/2007	03/09/2007	

FE Sent For:

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/1	pkahler 11/01/2006	jdyer 11/01/2006	pgreensl 11/01/2006	_____ _____	lparisi 11/01/2006		

1/2 nwn 3/8 nwn/rs 3/8

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			11/1 pg	P8			

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Drafting History:

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/?	pkahler	pl 10/24 jld	nwn 10/24	nwn/rs 10/24			

FE Sent For: ****NOTE

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8/31/06 Mtg: Dick Sweet, Sara Buchman, DAK

Recommendations for drafting:

① Require OCI to certify policies that meet criteria

② Require DHFS to submit plan amdt – 3 mo.

③ Require DHFS to prepare training materials for insurance agents

④ Disregard, in eligib. determins., any assets received as benefits under policy; also exclude from estate recovery

⑤ RP; 49.45(31) (reqs. DHFS to seek waiver)

⑥ AM or RC; 49.47(9m) –) is not consistent w/ new Fed. stat.

Issue: (probably not draft) Issuing co. responsibility to cover benefits if co. is sold to another

Kennedy, Debora

From: Sweet, Richard
Sent: Wednesday, August 23, 2006 10:39 AM
To: Buschman, Sara
Cc: Kennedy, Debora
Subject: FW: CMS Rolls Out DRA Implementation Guidelines for Long Term Care Partnerships
Attachments: SMD-LTC.pdf; LTCEnclosure .pdf; Partnership Background Paper 0726069am.doc

Sara,

I'm not sure if you're on the NCSL mailing list, so I thought I would forward this information to you about the Partnership provisions of the Deficit Reduction Act. I'm also cc'ing Debora since this is the topic of our meeting next Thursday, 8/31.

Dick

From: healthpolicy-dist-request@ncsl.org [mailto:healthpolicy-dist-request@ncsl.org] **On Behalf Of** Joy Wilson
Sent: Thursday, July 27, 2006 1:11 PM
To: healthpolicy-dist@ncsl.org; humserv-l@ncsl.org; medicaid-dist@ncsl.org; NALFO-dist@ncsl.org
Subject: CMS Rolls Out DRA Implementation Guidelines for Long Term Care Partnerships

July 27, 2006

Friends:

Attached for your information and review are the following documents from the Centers for Medicare and Medicaid Services (CMS) regarding the implementation of key provisions of the Deficit Reduction Act related to long term care partnership programs:

- State Medicaid Director Letter - #06-019 – Long Term Care Partnerships (section 6021);
  - Backgrounder – Long Term Care Partnerships
  - Enclosure: Qualified Long Term Care Partnerships under the DRA

This information will be available on the CMS Website shortly, please visit http://www.cms.hhs.gov/DeficitReductionAct.

REMINDER:

Please join Dr. Mark McClellan, Administrator for the Centers for Medicare and Medicaid Services for an all States call, to discuss Deficit Reduction Act initiatives, including Money Follows the Person and other long term care initiatives. The call will be on Thursday, July 27, 2006 2:30 p.m. EST.

TOLL FREE #: 1-888-677-3119
PASSCODE: MFP
CALL LEADER: Ruth Miller

As always I hope this information is helpful to you. Please contact me if I can be of additional assistance to you.

Joy

Joy Johnson Wilson, Health Policy Director
444 North Capitol Street, NW, Suite 515
Washington, D.C. 20001
joy.wilson@ncsl.org
202-624-8689
202-737-1069 (fax)

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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.

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 Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
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

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 6J, relating to policy summary;
8. Section 6K, relating to monthly reports on accelerated death benefits; and
9. Section 7, relating to incontestability period.

DEHPG/DEEO 07/25/06 9:00am

Long-Term Care Partnerships

Background

Section 6021 of the DRA expands Long-Term Care (LTC) Partnerships. Previously, when determining eligibility for Medicaid, States were permitted, under the Social Security Act (the Act), to exclude from resources an amount equal to LTC benefits paid for by an LTC insurance policy. However, under another section of the Act, only States who submitted amendments to their State Medicaid plans as of May 14, 1993, (i.e., California, Connecticut, Indiana, Iowa, and New York) could exempt the excluded assets in the estate recovery process. This discouraged use of LTC insurance, because although it would allow individuals to qualify for Medicaid while retaining additional resources, those resources could not be protected for heirs, which is a critical concern for the elderly.

States that implemented LTC Partnerships more than 10 years ago continue to operate these successful programs. These States have found that while thousands of their residents have purchased LTC insurance policies, only a small fraction of these insured individuals ever find the need to apply for Medicaid. The continued success of these Partnerships for more than a decade encourages all States to consider the benefits of implementing a Partnership under the opportunity afforded by the DRA.

Summary of the LTC Partnership Program

Section 6021 of the DRA allows for Qualified State LTC Partnerships, which will permit States with approved State plan amendments (SPA) to exclude from estate recovery the amount of LTC benefits paid under a qualified LTC insurance policy. For States that elect this option, the State plan must provide that, in determining eligibility for Medicaid, an amount equal to the benefits paid under a qualified LTC policy is disregarded. The State must also allow, in the determination of the amount to be recovered from a beneficiary's estate, for the same amount to be disregarded.

A "Qualified Partnership Policy" is a policy that meets the following conditions:

1. the insured person is a **resident** of the Partnership State when coverage first became effective under the policy;
2. the policy meets the **IRS definition** of a "qualified LTC insurance policy;"
3. the policy **issue date** was not earlier than the effective date of the SPA;
4. the policy meets **specific rules of the** National Association of Insurance Commissioners (**NAIC**); and
5. the policy includes **inflation protection**. This requirement varies depending on the age of the insured at the time of purchase:
   - For purchasers under 61 years old, compound annual inflation protection;
   - For purchasers 61 to 76 years old, some level of inflation protection;
   - For purchasers over 76 years old, inflation protection is optional.

DHFS + OCI

Partnership States must ensure that the individuals who sell LTC policies in the State have been trained to explain to consumers the protections offered by LTC insurance, and how this insurance relates to private and public financing of LTC.

The DRA also requires that, no later than January 1, 2007, the Secretary will develop standards for reciprocal recognition of Partnership policies among Partnership States. This will enable individuals who purchase a Partnership policy in one State, and later move to another Partnership State, to enjoy the same protections in the new State. Also by January 1, 2007, the Secretary will specify data that must be collected regarding the purchases of LTC insurance policies, benefits paid under such policies and other related information. These standards will be developed in consultation with stakeholders including industry representatives, State Insurance Commissioners, and consumers.

In addition, the DRA requires that a National Clearinghouse be established. The purpose of the Clearinghouse will be to educate consumers about the availability and limitations of LTC coverage under Medicaid, and to provide State-specific contact information for State Medicaid programs and Partnerships. The Clearinghouse will also provide objective information to assist consumers with deciding whether or not to purchase LTC insurance and how to plan for LTC needs.

Next Steps for States

States that wish to implement a Qualified LTC Partnership can begin by taking the following steps:

- Submit a State plan amendment (SPA) that specifies that benefits paid under a qualified long-term care insurance policy will be disregarded in both the eligibility determination and in the estate recovery process. The SPA must also stipulate that the policies that serve as the basis for these disregards meet all of the requirements for a qualified long-term care policy as specified in the DRA, and that, where appropriate, the State Insurance Commissioner will attest that the policies meet those requirements. (1) (2) (3)
- States should work closely with their State Insurance Commissioners to establish efficient lines of communication regarding the Partnership and to assist the Commissioner in developing the training program that is required for individuals who will be permitted to sell qualified policies in the State. (4)
- Dialogue should be initiated with insurers, advocates, consumers and other interest groups to establish procedural and policy guidelines consistent with the DRA, State law and NAIC rules.

Subchapter B—Expanded Access to Certain Benefits

SEC. 6021. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM.

(a) EXPANSION AUTHORITY.—

(1) IN GENERAL.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(A) in paragraph (1)(C)—

(i) in clause (ii), by inserting "and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))" after "1993,"; and

(ii) by adding at the end the following new clauses:

"(iii) For purposes of this paragraph, the term 'qualified State long-term care insurance partnership' means an approved State plan amendment under this title that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

"(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

"(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

"(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

"(IV) If the policy is sold to an individual who—

"(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

"(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

"(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

"(V) The State Medicaid agency under section 1902(a)(5) provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

"(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

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"(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term 'long-term care insurance policy' includes a certificate issued under a group insurance contract.

"(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

"(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

"(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access."; and

(B) by adding at the end the following:

"(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

"(i) In the case of the model regulation, the following requirements:

"(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

"(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

"(III) Section 6C (relating to extension of benefits).

"(IV) Section 6D (relating to continuation or conversion of coverage).

"(V) Section 6E (relating to discontinuance and replacement of policies).

"(VI) Section 7 (relating to unintentional lapse).

"(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

"(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

"(IX) Section 11 (relating to prohibitions against post-claims underwriting).

"(X) Section 12 (relating to minimum standards).

"(XI) Section 14 (relating to application forms and replacement coverage).

"(XII) Section 15 (relating to reporting requirements).

"(XIII) Section 22 (relating to filing requirements for marketing).

"(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

"(XV) Section 24 (relating to suitability).

"(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

"(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

"(XVIII) Section 29 (relating to standard format outline of coverage).

"(XIX) Section 30 (relating to requirement to deliver shopper's guide).

"(ii) In the case of the model Act, the following:

"(I) Section 6C (relating to preexisting conditions).

"(II) Section 6D (relating to prior hospitalization).

"(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

"(IV) Section 6F (relating to right to return).

"(V) Section 6G (relating to outline of coverage).

"(VI) Section 6H (relating to requirements for certificates under group plans).

"(VII) Section 6J (relating to policy summary).

"(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

"(IX) Section 7 (relating to incontestability period).

"(B) For purposes of this paragraph and paragraph (1)(C)—

"(i) the terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

"(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

"(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that

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"(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.".

(2) STATE REPORTING REQUIREMENTS.—Nothing in clauses (iii)(VI) and (v) of section 1917(b)(1)(C) of the Social Security Act (as added by paragraph (1)) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act) to require the issuer to report information or data to the State that is in addition to the information or data required under such clauses.

(3) EFFECTIVE DATE.—A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.

(b) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES.—In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which—

(1) benefits paid under such policies will be treated the same by all such States; and

(2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.

(c) ANNUAL REPORTS TO CONGRESS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)). Such reports shall include analyses of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal

and State expenditures under the Medicare and Medicaid programs. Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.

(2) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out paragraph (1).

(d) NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a National Clearinghouse for Long-Term Care Information. The Clearinghouse may be established through a contract or interagency agreement.

(2) DUTIES.—

(A) IN GENERAL.—The National Clearinghouse for Long-Term Care Information shall—

(i) educate consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program and provide contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;

(ii) provide objective information to assist consumers with the decisionmaking process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care and provide contact information for additional objective resources on planning for long-term care needs; and

(iii) maintain a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

(B) REQUIREMENT.—In providing information to consumers on long-term care in accordance with this subsection, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $3,000,000 for each of fiscal years 2006 through 2010.

CHAPTER 3—ELIMINATING FRAUD, WASTE, AND ABUSE IN MEDICAID

SEC. 6031. ENCOURAGING THE ENACTMENT OF STATE FALSE CLAIMS ACTS.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1908A the following:

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ed, which is classified to part B of subchapter IV of this chapter, 42 U.S.C.A. § 620 et seq.

Part E of subchapter IV of this chapter, referred to in subsec. (b)(3)(A)(i), (B)(i), is Social Security Act, Aug. 14, 1935, c. 531, Title IV, Part E, as added June 17, 1980, Pub.L. 96–272, Title I, § 101(a)(1), 94 Stat. 501, as amended, which is classified to part E of subchapter IV of this chapter, 42 U.S.C.A. § 670 et seq.

This subchapter, referred to in subsec. (e)(1) and (3)(B), originally read "this title", meaning Social Security Act, Aug. 14, 1935, c. 531, Title XIX, as added July 30, 1965, Pub.L. 89–97, Title I, § 121(a), 79 Stat. 343, as amended, which is classified to this subchapter.

Amendments

2006 Amendments. Subsec. (c). Pub.L. 109–171, § 6042(a), added subsec. (c).

Subsec. (e). Pub.L. 109–171, § 6043(a), added subsec. (e).

Effective and Applicability Provisions

2006 Acts. Subsecs. (a), (b), and (d) of this section applicable to cost sharing imposed for items and services furnished on or after Mar. 31, 2006, see Pub.L. 109–171, § 6041(c), set out as a note under 42 U.S.C.A. § 1396o.

Pub.L. 109–171, Title VI, § 6042(b), Feb. 8, 2006, 120 Stat. 86, provided that: "The amendment made by subsection (a) [enacting subsec. (c) of this section] shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006."

Amendment by Pub.L. 109–171, § 6043 (in part enacting subsec. (e) of this section) applicable to non-emergency services furnished on or after Jan. 1, 2007, see Pub.L. 109–171, § 6043(c), set out as a note under 42 U.S.C.A. § 1396b.

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan.

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of Title 26) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(c)—

(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless—

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of section 408 of Title 26; or

(II) purchased with proceeds from—

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such title;

(bb) a simplified employee pension (within the meaning of section 408(k) of such title); or

(cc) a Roth IRA described in section 408A of such title; or

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(ii) the annuity—

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (b), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual.

While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust—

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.

(B) In the case of an irrevocable trust—

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter, and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e)(1) In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) of this section (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F) of this section, the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f)(1)(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

(Aug. 14, 1935, c. 531, Title XIX, § 1917, as added Sept. 3, 1982, Pub.L. 97–248, Title I, § 132(b), 96 Stat. 370, and amended Jan. 12, 1983, Pub.L. 97–448, Title III, § 309(b)(21), (22), 96 Stat. 2410; Dec. 22, 1987, Pub.L. 100–203, Title IV, § 4211(h)(12)(A), 101 Stat. 1330–207; Dec. 22, 1987, Pub.L. 100–203, Title IV, § 4211(h)(12)(B), as amended July 1, 1988, Pub.L. 100–360, Title IV, § 411(*l*)(3)(I), 102 Stat. 803; July 1, 1988, Pub.L. 100–360, Title III, § 303(b), 102 Stat. 760; Oct. 13, 1988, Pub.L. 100–485, Title VI, § 608(d)(16)(B), 102 Stat. 2417; Dec. 19, 1989, Pub.L. 101–239, Title VI, § 6411(e)(1), 103 Stat. 2271; Aug. 10, 1993, Pub.L. 103–66, Title XIII, §§ 13611(a) to (c), 13612(a) to (c), 107 Stat. 622 to 628; Feb. 8, 2006, Pub.L. 109–171, Title VI, §§ 6011(a), (b), (e), 6012(a) to (c), 6014(a), 6015(b), 6016(a) to (d), 6021(a)(1), 120 Stat. 61 to 68.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

2006 Acts. House Conference Report No. 109–362, see 2006 U.S. Code Cong. and Adm. News, p. 3.

Statement by President, see 2006 U.S. Code Cong. and Adm. News, p. S3.

References in Text

This subchapter, referred to in text, originally read "this title", meaning Social Security Act, Aug. 14, 1935, c. 531, Title XIX, as added July 30, 1965, Pub.L. 89–97, Title I, § 121(a), 79 Stat. 343, as amended, which is classified to this subchapter.

Subchapter XVI of this chapter, referred to in text, originally read "title XVI", meaning Social Security Act, Aug. 14, 1935, c. 531, Title XVI, as added Oct. 30, 1972, Pub.L. 92–603, Title III, § 301, 86 Stat. 1465, as amended, which is classified to subchapter XVI of this chapter, 42 U.S.C.A. § 1381 et seq.

Amendments

2006 Amendments. Subsec. (b)(1)(C)(ii). Pub.L. 109–171, § 6021(a)(1)(A)(i), inserted "and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))" after "1993,".

Subsec. (b)(1)(C)(iii) to (vi). Pub.L. 109–171, § 6021(a)(1)(A)(ii), added cls. (iii) to (vi).

Subsec. (b)(5). Pub.L. 109–171, § 6021(a)(1)(B), added par. (5).

Subsec. (c)(1)(B)(i). Pub.L. 109–171, § 6011(a), inserted "or in the case of any other disposal of assets made on or after February 8, 2006" before ", 60 months".

Subsec. (c)(1)(D)(i). Pub.L. 109–171, § 6011(b)(1), struck out "(D) The date" and inserted "(D)(i) In the case of a transfer of asset made before February 8, 2006, the date".

Subsec. (c)(1)(D)(ii). Pub.L. 109–171, § 6011(b)(2), added cl. (ii).

Subsec. (c)(1)(E)(iv). Pub.L. 109–171, § 6016(a), added cl. (iv).

Subsec. (c)(1)(F). Pub.L. 109–171, § 6012(b), added subpar. (F).

Subsec. (c)(1)(G). Pub.L. 109–171, § 6012(c), added subpar. (G).

Subsec. (c)(1)(H). Pub.L. 109–171, § 6016(b), added subpar. (H).

Subsec. (c)(1)(I). Pub.L. 109–171, § 6016(c), added subpar. (I).

Subsec. (c)(1)(J). Pub.L. 109–171, § 6016(d), added subpar. (J).

Subsec. (c)(2). Pub.L. 109–171, § 6011(e)(1)(B), inserted after subpar. (D), the following: "The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual."

Pub.L. 109–171, § 6011(e)(2), inserted at the end of par. (2), the following: "While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days."

Subsec. (c)(2)(D). Pub.L. 109–171, § 6011(e)(1)(A), struck out the semicolon at the end and inserted a period.

Subsecs. (e), (f). Pub.L. 109–171, § 6012(a), redesignated former subsec. (e) as subsec. (f) and added a new subsec. (e).

Subsecs. (f), (g). Pub.L. 109–171, § 6014(a), redesignated former subsec. (f), as redesignated from subsec. (e) by § 6012(a), as subsec. (g) and added a new subsec. (f).