2007 DRAFTING REQUEST

Bill

Received: **11/29/2006**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget**

By/Representing: **Milioto**

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

Drafter: **pkahler**

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Addl. Drafters:

Subject: **Insurance - other insurance**
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Extra Copies:

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Pre Topic:

DOA:.....Milioto, BB0197 -

Topic:

Deleting references to Federal Partnership Program

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 11/29/2006	jdyer 11/30/2006		_____ _____			State
/P1			pgreensl 11/30/2006	_____ _____	cduerst 11/30/2006		State
/1	pkahler 12/19/2006	jdyer 12/19/2006	sherritz 12/19/2006	_____ _____	sbasford 12/19/2006		State
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/1	pkahler 12/19/2006	jdyer 12/19/2006	sherritz 12/19/2006	1/8 pg 1/8	sbasford 12/19/2006		

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Long-Term Care Insurance - Federal Partnership Program

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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
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/?	pkahler	/P1 11/30 jld	11/30 P8	11/30 P8/P1			

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2007-09 Budget Bill Statutory Language Drafting Request

- Topic: Long-Term Care Insurance (Federal Partnership Program)
- Tracking Code: BB0197
- SBO team: Health
- SBO analyst: Steve Milioto
  - Phone: 266-8593
  - Email: Steve.Milioto@Wisconsin.gov
- Agency acronym: OCI/DHFS
- Agency number: 145/435
- Priority: High

1) Current law includes a provision calling for the Department of Health and Family Services to seek a federal waiver which would allow the department to implement the federal long-term care insurance Partnership Program. Please delete this provision.

2) Make any necessary modifications to the statutes so that Wisconsin can implement the provisions of the Deficit Reduction Act of 2005 as they pertain to the federal Partnership Program. Please see attached documents.

AARP Public Policy Institute

FACT SHEET

Long-Term Care Insurance Partnership Programs

Background – The long-term care insurance (LTCI) partnership program was developed in the 1980s to encourage people who might otherwise turn to Medicaid to finance their long-term care (LTC) to purchase LTCI. If people who purchase qualifying policies deplete their insurance benefits, they may then retain a specified amount of assets and still qualify for Medicaid, *provided they meet all other Medicaid eligibility criteria.* Currently, these programs operate in four states: California, Connecticut, Indiana, and New York. Table 1 illustrates the current number of policies in force and the number of people receiving partnership policy benefits in the participating states.

Table 1

State	Policies in Force	Number Receiving Partnership Benefits
California	64,915	343
Connecticut	30,834	141
Indiana	29,189	83
New York	47,539	642
4 State Total	**172,477**	**1,209**

Source: Government Accountability Office, 2005.

Demographics of Purchasers – Although the partnership program was intended to attract lower- to middle-income Americans (the cohort most likely to spend down to Medicaid), state policyholder surveys indicate that most purchasers have substantial assets. The majority of purchasers in California, Connecticut, and Indiana had assets in excess of $350,000.[1] In contrast, the average person age 55 or over has less than $50,000 in assets.[2] The New York program, unique in that it allows *unlimited* asset protection for purchasers, has primarily attracted higher-income purchasers, because of this feature and its resulting higher premium costs.

[1] California and Connecticut instructed respondents to exclude the value of their homes; Indiana instructed them to include home value.

[2] Excluding home value.

Expansion – The Deficit Reduction Act of 2005 (DRA 05) now allows *all* states the option to enact partnership policies. Policies in these *new* programs must meet specified criteria, including federal tax-qualification, identified consumer protections, and inflation protection provisions.

Compound annual inflation protection will be required for purchasers below age 61, although states can determine the percentage rate (e.g. 3 percent, 5 percent, etc.). "Some level of inflation protection" (not defined) will be required for purchasers between the ages of 61 and 75. Also, DRA 05 requires the U.S. Department of Health and Human Services to develop a reciprocity agreement, enabling purchasers to use their benefits in other partnership states; however, states may opt out of this reciprocity.

At least 21 states, anticipating a change in federal law, already have enacted authorizing legislation. These states are listed in Table 2.

Table 2

States with Partnership Legislation		
Arkansas	Iowa	North Dakota
Colorado	Maryland	Ohio
Florida	Massachusetts	Oklahoma
Georgia	Michigan	Pennsylvania
Hawaii	Missouri	Rhode Island
Idaho	Montana	Virginia
Illinois	Nebraska	Washington

Source: National Association of Health Underwriters Web site, 2006.

Impact of Partnership Programs on Medicaid Spending – Whether the partnership programs will help save the Medicaid program money is a major policy question. Proponents argue that, by deferring the use of Medicaid for those who otherwise would spend down their assets and qualify for benefits, people who purchase partnership policies will reduce Medicaid's spending on LTC.

Others argue that partnership programs will qualify people for Medicaid who otherwise would never have used the program: their own assets would have paid for their LTC costs. Moreover, some argue that, if Medicaid is intended to be a safety net for people with few assets and limited incomes, partnership programs could deplete Medicaid resources by qualifying people for benefits who can, and should, finance their own services. Partnership policies have the potential to save Medicaid dollars if they are purchased by people who would *not* have bought other (non-partnership) policies. If, instead, these policies *replace* LTCI policies that do not include Medicaid asset protection, then they may result in higher Medicaid spending. So far, the data are inconclusive because the programs are still relatively new and few purchasers have begun to use benefits.

Issues and Concerns – With the likely expansion of LTCI partnership programs into additional states, ***consumer education*** is critical. The addition of a partnership option in a growing number of states will add a layer of complexity to the already-difficult process of deciding whether to buy LTCI and, if so, which policy to purchase. While partnership programs allow purchasers to protect a certain level of assets if they deplete their insurance benefits and qualify for Medicaid, many consumers do not understand that Medicaid eligibility is not automatic. To qualify for Medicaid, individuals must meet the state's income and functional eligibility criteria, which may change by the time they apply for Medicaid.

Regarding *income*, the GAO reported that about half or more of the purchasers in three states had average monthly incomes of $5,000 or more. To meet Medicaid's income eligibility, most states require that monthly income not exceed 300 percent of the federal Supplemental Security Income (SSI) amount (300 percent of SSI is $1,809 per month in 2006) or the monthly cost that Medicaid pays for nursing home care (which averaged $3,540 in 2002). While married individuals can protect additional income for a community spouse and qualify for Medicaid, only about 15 percent of nursing home residents are married. As a result, *many who have purchased partnership policies may never qualify for Medicaid because their incomes are too high.*

Another issue is *functional* eligibility. To receive LTCI benefits from a partnership policy, one generally must be cognitively impaired or need assistance with two or more activities of daily living (such as bathing or dressing). To meet Medicaid's functional eligibility criteria for LTC, most states have more restrictive disability criteria, often including medical needs. This may prove to be a problem for purchasers who deplete their partnership benefits and then cannot qualify for Medicaid.

Finally, the *ability to remain at home* is a potential issue for consumers. While consumers express an overwhelming preference to receive LTC services in their homes or in community-based settings, Medicaid beneficiaries have *no entitlement* to receive these benefits. A partnership purchaser who qualifies for Medicaid after depleting his or her insurance benefits may be able to receive services only in a nursing home, depending on the state's eligibility criteria for HCBS and whether there is a waiting list for services.

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Stone-Axelrad, Julie. *Long-Term Care Insurance Partnership Program.* CRS Report for Congress, Washington, D.C.: CRS, September 27, 2004.

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March 2006

FACT SHEET

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.

regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

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 Sec-

retary, 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."; 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 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.".

(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. 6032. 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:

"STATE FALSE CLAIMS ACT REQUIREMENTS FOR INCREASED STATE SHARE OF RECOVERIES

"SEC. 1909. (a) IN GENERAL.—Notwithstanding section 1905(b), if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

"(b) REQUIREMENTS.—For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

"(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to any expenditure described in section 1903(a).

"(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31, United States Code.

"(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

"(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31, United States Code.

"(c) DEEMED COMPLIANCE.—A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

"(d) NO PRECLUSION OF BROADER LAWS.—Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to programs in addition to the State program under this title, or with respect to expenditures in addition to expenditures described in section 1903(a), from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.".

(b) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2007.

Senate Bill

This provision would apply to payment made under the Medicaid program for calendar quarters beginning on or after the date of this Act's enactment, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. Amendments made by this provision would not apply to Medicaid assistance provided for services before the date of enactment, with respect to assets disposed of on or before the date of enactment, or with respect to trusts established on or before the date of enactment.

In the case of a state that the Secretary of Health and Human Services determines requires state legislation to meet the additional requirements of this provision, the state Medicaid plan would not be regarded as failing to comply with the requirements solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this Act. In the case of a state that has a two-year legislative. session, each year of the session would be considered to be a separate regular session of the state legislature. This amendment applies to provision under section 6011 of the Senate bill.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision with respect to amendments made by section 6016.

Subchapter B—Expanded Access to Certain Benefits

Expansion of State Long-Term Care Partnership Program (Section 6021 of the Conference Agreement, and Section 6012 of the Senate Bill, and Section 3133 of the House Bill)

Current Law

Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at: (1) the time of application to Medicaid; and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied.

In general, states allow individuals to retain no more than $2,000 in countable assets and exempt certain non-countable assets such as an individual's primary place of residence, one automobile, household goods and personal effects. Under section 1902 of the Social Security Act, a state may request the Secretary's permission to amend its Medicaid state plans to allow certain applicants to retain greater amounts of countable assets than other applicants and still qualify for Medicaid. Specifically, states that obtain the Secretary's approval may disregard some or all of the assets of persons apply-

ing for Medicaid who have purchased long-term care insurance policies.

Section 1917 of the Social Security Act (amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103–66) allows only those states with an approved state plan amendment as of May 14, 1993 to exempt individuals from Medicaid estate recovery who apply to Medicaid after exhausting their private long-term care insurance benefits. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. All of these states, except Iowa, have implemented partnership programs.

The four partnership states with active programs have different models for determining the amount of assets that an eligible participant may protect. Connecticut and California use a dollar-for-dollar model, in which the amount of the assets protected is equivalent to the value of the benefit package paid by the policy purchased (e.g., $100,000 of nursing-home or assisted living benefits paid enables that individual to retain up to $100,000 in assets and still qualify for Medicaid coverage in that state). New York uses a total asset protection model in which persons who purchase certain state-approved policies may qualify for Medicaid without having to meet any of Medicaid's asset criteria. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection (Indiana switched from the dollar-for-dollar model to the hybrid model in 1998).

Federal oversight of long-term care insurance is largely limited to provisions established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–191). HIPAA established new rules regarding the tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policy. LTC insurance products are largely regulated by states. Every state and the District of Columbia has some laws governing LTC insurance. Many of these laws reflect guidance provided by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators. This guidance, provided in the form of a Model Act and Model Regulations for LTC insurance, addresses a number of areas, including the following.

Model Regulations:

- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Requirements to deliver shopper's guide.

Model Act:

- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary;
- Accelerated death benefits; and
- Incontestability period.

HIPPA also includes requirements that tax-qualified policies comply with consumer protections regarding the delivery of policies, information on denials of claims, and disclosure. While many

state laws and regulations are based largely on the NAIC standards, others have adopted only some of these standards. As a result, there is significant variation in regulatory practices across states.

National Clearinghouse for Long-Term Care. No provision in current law requires the establishment of a long-term care consumer clearinghouse.

In related activities, DHHS has funded some states to establish state-based consumer-friendly access to information about long-term care services. In FY2003 and FY2004, the Centers for Medicare and Medicaid (CMS) and AoA awarded approximately $19 million in grants to states for the purpose of assisting their efforts to create a single, coordinated system of information and access for all persons seeking long term care to minimize confusion, enhance individual choice, and support informed decision-making. In FY2005, $15 million was awarded. A total of 43 states have received grants for this purpose. Some of the common activities under this grants program include information and referral, outreach, counseling about public benefits and long-term care options, and case management. States' methods for implementing the grant may vary; some states have established an actual physical location, and other states have established a statewide clearinghouse through a toll-tree number or a web-based information site.

In addition, CMS has made available to the public, via its website, a comparison of Medicare and Medicaid-certified nursing homes and home health agencies. The information provides detailed facility and agency information and characteristics, and contains several measures of quality (e.g., improvement in mobility). This website does not cover assisted living facilities, group homes and other residential facilities that are not nursing facilities; nor does it cover non-medical, non-certified, home and community-based long-term care services.

Senate Bill

The Senate bill would exempt an additional group of persons with certain long-term care insurance plans from Medicaid estate recovery. This group would include individuals who received Medicaid under a Qualified State Long-Term Care Insurance Partnership plan meeting requirements A through G described below. The provision would also require that existing LTC insurance partnership programs satisfy requirements B through G below for LTC insurance policies sold on or after 2 years after enactment.

The Senate bill would define LTC insurance policies as including, but not be limited to, certificates issued under group insurance contracts [also would include individual and other LTC insurance contracts]. The term "Qualified State LTC Insurance Partnership," would mean a state with an approved Medicaid State plan amendment meeting the following requirements:

(A) the disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any LTC insurance policy sold under such plan amendment;

(B) a state would treat benefits paid under any LTC partnership insurance policy sold under another states' Qualified LTC In-

surance Partnership" or a long-term care insurance policy, the same as the state treats benefits paid under such a policy under the state's plan amendment;

(C) any long-term care insurance policy sold would be required to be a tax-qualified policy (Meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) and meet the consumer protection requirements described below;

(D) any policy would be required to provide for compound annual inflation protection of at least 5 percent and asset protection that does not exceed $250,000. This amount would be increased, beginning with 2007, from year-to-year based on the percentage increase in the medical care expenditure category of the Consumer Price Index for Urban Consumers (United States city average), published by the Bureau of Labor Statistics rounded to the nearest $100;

(E) an insurer would be allowed to rescind a LTC insurance policy in effect for at least 2 years or deny an otherwise valid LTC insurance claim only upon a showing (1) of misrepresentation that is material to the acceptance of coverage; (2) pertains to the claim made; and (3) could not have been known by the insurer at the time the policy was sold;

(F) any individual who sells these policies would be required to receive training and demonstrate evidence of an understanding of the policy and how it relates to other public and private LTC coverage; and

(G) the issuer would be required to report, to the Secretary required information, and to report to the state: (1) the information or data reported to the Secretary, (2) the information or data required under the minimum reporting requirements developed under section 103(c)(1)(B) of the Improving LTC Choices Act of 2005, and (3) such additional information or data as the state may require. If a LTC insurance policy is exchanged for another such policy, the effective date of coverage under the first policy would determine when coverage first becomes effective.

LTC insurance policies would be required to meet the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000). The requirements include the following topics described below.

Model Regulations:

- Guaranteed renewal or noncancellability;
- Prohibitions on limitations and exclusions;
- Extension of benefits;
- Continuation or conversion of coverage;
- Discontinuance and replacement of policies;
- Unintentional lapse;
- Disclosure;
- Required disclosure of rating practices to consumer;
- Prohibitions against post-claims underwriting;
- Minimum standards;
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;

• Standards for marketing, including inaccurate completion of medical histories;
• Suitability;
• Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
• Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
• Standard format outline of coverage; and
• Deliver shopper's guide.

Model Act:

• Preexisting conditions;
• Prior hospitalization;
• Contingent nonforfeiture benefits;
• Right of return;
• Outline of coverage;
• Requirements for certificates under group plans;
• Policy summary; and
• Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act would be treated as including any other provision the Regulation or Act necessary to implement the provision. The determination of whether any requirement under the Model Act or Regulation have been met would be made by the Secretary.

No later than one year after enactment, the Secretary, in consultation with the NAIC, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies would be required to develop uniform standards for:

• Reciprocity. These standards would ensure that LTC insurance policies issued under the state LTC partnership (described in this provision) would be portable to other states with such-LTC insurance partnerships;
• Minimum reporting requirements. These standards would be required to specify the data and information that each issuer of LTC insurance policies under State LTC insurance partnerships shall report to the state with which it has such a partnership. The requirements developed would be required to specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. States would be permitted to require an issuer of LTC insurance policy sold in the state (regardless of whether the policy is issued under a State LTC insurance partnership) to require the issuer to report information or data to the state that is in addition to the information or data required under these minimum reporting requirements;
• Suitability. These standards would be for determining whether a long-term care insurance policy is appropriate for the needs of an applicant (based on guidance of the NAIC regarding suitability).

The Secretary, in consultation with those listed above, would also be required to submit recommendations to Congress with respect to the following:

• Incontestability. Recommendations regarding whether the requirements relating to incontestability for LTC insurance policies

sold under a state partnership program should be modified based on NAIC guidance;

• Nonforfeiture. Recommendations regarding whether requirements relating to nonforfeiture for issuers of LTC insurance policies under a state LTC insurance partnership program should be modified to reflect changes in an insured's financial circumstances;

• Independent certification for benefits assessment. Recommendations regarding whether uniform standards for requiring benefits assessment evaluations to be conducted by independent entities should be established for issuers of LTC insurance policies under such a state partnership program, and if so, what such standards should be;

• Rating requirements. Recommendations regarding whether uniform standards for the establishment of, and annual increases in, premiums for LTC insurance policies sold under such a state partnership program should be established and if so, what such standards should be; and

• Dispute Resolution. Recommendations regarding whether uniform standards are needed to ensure fair adjudication of coverage disputes under LTC insurance policies sold under such a state partnership program and the delivery of the benefits promised under such policies.

The DHHS Secretary would be required to annually report to Congress on the LTC insurance partnerships. Such reports would be required to include analyses of the extent to which such partnerships expand or limit access of individuals to LTC and the impact of such partnerships on Federal and State Medicaid expenditures and federal Medicare expenditures.

Effective Date. These amendments would become effective on October 1, 2007 and apply to long-term care insurance policies sold on or after that date.

House Bill

The House bill would amend section 1917(b)(1)(C)(ii) of the Social Security Act to allow additional groups of individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program. The term "Qualified State LTC Insurance Partnership," would mean a Medicaid State plan amendment that provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefit made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), 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. (In the case of a long-term care insurance policy exchanged for another such policy, this requirement would apply based on the coverage of the first such policy that was exchanged);

(II) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued on or after the first day of the first

calendar quarter in which the plan amendment was submitted to the Secretary;

(III) If the policy does not provide some level of inflation protection, the insured was offered, before the policy was sold, a long-term care insurance policy that provides some level of inflation protection;

(IV) The state Medicaid agency 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 or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(V) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (promulgated after consultation with the states), notification regarding when all benefits provided under the policy have been paid and the amount of such benefits paid, when the policy otherwise terminates, and such other information as the Secretary determines appropriate to the administration of such partnerships;

(VI) 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.

The Secretary, as appropriate, would provide copies of the state reports to the state involved and would promote the education of consumers regarding qualified state long-term care insurance partnerships. In addition, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, and the National Association of Insurance Commissioners, the Secretary would 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 State, the Secretary, and other Federal agencies can access.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary may develop, in consultation with the states and the National Association of Insurance Commissioners, uniform standards for reciprocal recognition of such policies among states with qualified state long-term care insurance partnerships.

Effective Date. A state plan amendment that provides for a qualified state long-term care insurance partnership would be 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.

Conference Agreement

The conference agreement amends section 1917(b)(1)(C)(ii) of the Social Security Act to: (1) require that existing partnership programs not allow consumer protection standards, as defined in a

Medicaid state plan amendment, to be less stringent (determined by the Secretary) than those applying under the state plan amendment as of December 31, 2005; and (2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), 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. In the case of a long-term care insurance policy exchanged for another such policy, this requirement applies based on the coverage of the first such policy that was exchanged;

(II) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the Medicaid state plan amendment;

(III) The policy meets the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000).

Model Regulations relating to:

- Guaranteed renewal or noncancellability (including some sections of the Model Act);
- Prohibitions on limitations and exclusions;
- Extension of benefits;
- Continuation or conversion of coverage;
- Discontinuance and replacement of policies;
- Unintentional lapse;
- Disclosure;
- Required disclosure of rating practices to consumer;
- Prohibitions against post-claims underwriting;
- Minimum standards;
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing, including inaccurate completion of medical histories;
- Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
- Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Delivery of shopper's guide.

Model Act relating to:

- Preexisting conditions;
- Prior hospitalization;
- Contingent nonforfeiture benefits;
- Right of return;
- Outline of coverage;
- Requirements for certificates under group plans;

- Policy summary; and
- Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act are treated as including any other provision of the Regulation or Act necessary to implement the provision. Long-term care insurance policies issued in a state shall be deemed as meeting the requirements of the model regulation or the Model Act if the state plan amendment provides that the State insurance commissioner for the state certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(IV) If at the date of purchase the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection.

(V) The state Medicaid agency 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 or 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 that include, in accordance with the Secretary's regulations (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) notification regarding when all benefits and their amounts under the policy have been paid, when the policy otherwise terminates, and other information that the Secretary determines is appropriate to the administration of the partnership programs. These regulations shall specify the data format and information to be reported, and the frequency with which such reports are to be made. The Secretary, as appropriate, provides copies of the reports to the state involved;

(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 consultation with other appropriate Federal agencies, issuers of long-term care insurance, and 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, the Secretary develops 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 mecha-

nism that State, the Secretary, and other Federal agencies can access.

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 listed above or substantially related those listed above, the Secretary reviews these changes, determines whether incorporating such changes into the corresponding provision would improve qualified state long-term care insurance partnerships, and, if so, incorporate the changes into the provision.

States may require issuers of long-term care insurance policies sold in that state (regardless of whether the policy is issued under a qualified state long-term care insurance partnership) to report additional information or data to the state.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary develops no later than January 1, 2007, in consultation with the National Association of Insurance Commissioners, states with experience with long-term care insurance partnership plans, other state, 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 which have benefits paid under such policies will be treated the same by all such states, and states with such partnerships shall be subject to such standards unless the state notifies the Secretary of the State's election to be exempt from such standards.

The Secretary annually reports to Congress on the long-term care insurance partnerships. Such reports would include analyses of the extent to which partnership programs expand or limit access of individuals to long-term care and the impact of such partnerships on federal and state expenditures under Medicare and Medicaid. Nothing in this provision shall require the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with a state partnership program.

A state plan amendment that provides for a qualified state long-term care insurance partnership may provide that the amendment be effective for long-term care insurance policies issued on or after a date that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

With respect to policy exchanges, Conferees expect existing policy holders will be able to exchange existing policies for Partnership policies in accordance with policy provisions and state law after a State's plan amendment is effective.

National Clearinghouse for Long-Term Care. The Secretary establishes a National Clearinghouse for Long-Term Care Information (this may be done through a contract or interagency agreement). The National Clearinghouse for Long-Term Care: (1) educates consumers with respect to the availability and limitations of Medicaid long-term care coverage, including state Medicaid eligibility and estate recovery requirements; (2) provides objective information to assist consumers with the decision-making process for determining whether to purchase long-term care insurance or to

pursue other private market alternatives for purchasing long-term care; (3) provide contact information for additional objective sources on planning for long-term care services needs; and (4) maintain a list of states with state long-term care insurance partnerships.

In providing information to consumers on long-term care, 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.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out for the National Clearinghouse for Long-Term Care $3 million for each of fiscal years 2006 through 2010.

Expanded Access to Home and Community-based Services for the Elderly and Disabled (Section 6022 of the Conference Agreement, no provision in the Senate Bill, and Section 3131 of the House Bill)

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allow states to provide home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF–MR) or hospital. HCBS waiver services can include case management, homemaker/home health aide services, personal care, psychosocial rehabilitation, home health, private duty nursing, adult day care, habilitation, respite care, day treatment, and any other service requested by the state and approved by the Secretary. As part of the waiver, states may define the services that will be offered, target a specific population (e.g., individuals with developmental disabilities) or a specific geographic region, and limit the number of waiver participants (resulting in a waiting list for services in many states).

Approval for a HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if, on average, the per person cost under the HCBS waiver is no higher than the cost if the person were residing in one of the three types of institutions identified in Medicaid law, (hospital, nursing facility or ICF–MR). The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

A HCBS waiver is generally approved for a 3- or 5-year time period and is subject to additional oversight from the Centers for Medicare and Medicaid Services (CMS). In July 2003, there were 275 HCBS waivers nationwide in all states (except Arizona which offers HCBS services under a Section 1115 waiver).

Senate Bill

No provision.

House Bill

The House bill would allow states to cover a broad range of home and community-based services (HCBS) as an optional benefit under the state Medicaid plan without requiring a waiver. States

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-0930/

DOA:.....Milioto, BB0197 - Long-Term Care Insurance - Federal Partnership Program

FOR 2007-09 BUDGET -- NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** ???

Analysis by the Legislative Reference Bureau

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

(END)

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-0156/1
PJK:jld:nwn

2007 BILL

AN ACT ***to repeal*** 49.47 (9m); ***to repeal and recreate*** 49.45 (31); and ***to create*** 601.415 (8) of the statutes; **relating to:** a Long-Term Care Partnership Program.

Analysis by the Legislative Reference Bureau

Under current law, ~~the Department of Health and Family Services~~ (DHFS) administers the Medical Assistance (MA) program, which provides federal and state moneys to pay for health care and long-term care services provided to MA recipients. MA recipients are, generally, low-income, elderly, or disabled persons who meet other specific eligibility requirements. To be eligible for long-term care services under MA, an individual must meet certain very low income and resource requirements, and may have to "spend down" liquid assets by paying for his or her own long-term care until those income and resource requirements are met. In addition, DHFS may recover from a decedent's estate the amount of MA paid on behalf of the decedent for long-term care.

Under the State Long-Term Care Partnership Program under federal law, a state may seek approval of an amendment to its state MA plan that would allow it to disregard an amount equal to the amount of qualifying long-term care insurance payments received by an individual when the state is calculating the individual's income and resources for purposes of determining MA eligibility, and when the state is determining the amount that may be recovered from the deceased individual's estate for long-term care services under MA. For the long-term care insurance to qualify: 1) the individual must have been a state resident when coverage first

HEALTH AND HUMAN SERVICES ← head
MEDICAL ASSISTANCE ← subhead

became effective; 2) the coverage must not have been effective before the date of the state MA plan amendment; 3) the long-term care insurance policy must meet the definition under federal law, must meet the long-term care insurance model regulations and the requirements of the long-term care insurance model act promulgated by the National Association of Insurance Commissioners, and must provide specified inflation protection depending upon the age of the insured individual when coverage first began; and 4) the Commissioner of Insurance must certify that the policy meets all of those requirements. DHFS and ~~the Office of the Commissioner of Insurance~~ must work together to develop a training program for insurance agents who sell long-term care insurance to ensure that the agents understand long-term care insurance and how it relates to other public and private coverage of long-term care, including MA. In addition, an insurer that issues a qualifying long-term care insurance policy must report to the secretary of the federal Department of Health and Human Services (DHHS) regarding when benefits are paid, the amount of the benefits paid, termination of the policy, and any other information required by the secretary.

This bill requires DHFS to submit to the secretary of DHHS an amendment to the state's MA plan that satisfies the requirements of the State Long-Term Care Partnership Program under federal law. If the amendment is approved, DHFS must disregard, for purposes of MA eligibility and estate recovery, the amount of qualifying long-term care insurance payments made to an individual who receives MA for long-term care.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.45 (31) of the statutes is repealed and recreated to read:

49.45 **(31)** LONG-TERM CARE PARTNERSHIP PROGRAM. (a) The department shall submit to the federal department of health and human services, not later than 3 months after the effective date of this paragraph .... [revisor inserts date], an amendment to the state medical assistance plan that establishes in this state a Long-Term Care Partnership Program, as described in this subsection, and shall implement the program if the amendment to the state plan is approved. Under the program, the department shall ~~exclude~~ disregard an amount equal to the amount of benefits

that an individual receives under a qualifying long-term care insurance policy, as described in par. (b), when determining any of the following:

1. The individual's income and resources for purposes of determining the individual's eligibility for medical assistance.

2. The amount to be recovered from the individual's estate if the individual receives medical assistance.

(b) A long-term care insurance policy qualifies under par. (a) if all of the following criteria are met:

1. The insured individual was a resident of this state when coverage first became effective.

2. The policy was not issued before the effective date of the amendment to the state plan.

3. The policy meets the definition of a qualified long-term care insurance policy under 26 USC 7702B (b).

4. The policy meets the long-term care insurance model regulations and the requirements of the long-term care insurance model act promulgated by the National Association of Insurance Commissioners that are specified in 42 USC 1396p (b) (5).

5. The policy includes the applicable inflation protection specified in 42 USC 1396p (b) (1) (C) (iii) (IV).

6. The commissioner of insurance certifies to the department that the policy meets the criteria under subds. 3. to 5.

(c) The department and the office of the commissioner of insurance shall work together to develop a training program for individuals who sell long-term care insurance policies in the state to ensure that those individuals understand the

relation of long-term care insurance to the Medical Assistance program and are able to explain to consumers the protections offered by long-term care insurance and how this type of insurance relates to private and public financing of long-term care.

(d) An insurer that issues a long-term care insurance policy described in par. (b) shall be required to submit reports to the secretary of the federal department of health and human services, in accordance with regulations developed by the secretary, that include notice of when benefits are paid under the policy, the amount of the benefits, notice of the termination of the policy, and any other information required by the secretary.

SECTION 2. 49.47 (9m) of the statutes is repealed.

SECTION 3. 601.415 (8) of the statutes is created to read:

601.415 **(8)** LONG-TERM CARE PARTNERSHIP PROGRAM. The commissioner shall provide the certifications required under s. 49.45 (31) (b) 6. and shall cooperate with the department of health and family services in developing the training program under s. 49.45 (31) (c) for agents who sell long-term care insurance policies.

(END)

Insert 4-10 ✓

Insert 4-9 ✓

2007-2008 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

INSERT 4-9

SECTION 1. 49.47 (4) (b) (intro.) of the statutes is amended to read:

49.47 **(4)** (b) (intro.) Eligibility exists if the applicant's property, subject to the amounts disregarded under the Long-Term Care Partnership Program established under s. 49.45 (31), does not exceed the following:

History: 1971 c. 125; 1971 c. 213 s. 5; 1971 c. 215; 1973 c. 90, 147, 333; 1977 c. 29 ss. 593, 1656 (18); 1977 c. 105 s. 59; 1977 c. 273, 418; 1979 c. 34; 1981 c. 20, 93; 1981 c. 314 s. 144; 1983 a. 27, 245; 1985 a. 29; 1987 a. 27, 307, 399, 413; 1989 a. 9; 1989 a. 31 ss. 1462k to 1466d, 2909c to 2909i; 1989 a. 173, 336, 351; 1991 a. 39, 178, 269, 316; 1993 a. 16, 269, 277, 437; 1995 a. 27 ss. 3026 to 3028, 9126 (19); 1995 a. 225, 289, 295; 1997 a. 27; 1999 a. 9; 2001 a. 16; 2005 a. 25, 253.

SECTION 2. 49.47 (4) (c) 1. of the statutes is amended to read:

49.47 **(4)** (c) 1. Except as provided in par. (am) and as limited by subd. 3., eligibility exists if income, subject to the amounts disregarded under the Long-Term Care Partnership Program established under s. 49.45 (31), does not exceed 133 1/3% of the maximum aid to families with dependent children payment under s. 49.19 (11) for the applicant's family size or the combined benefit amount available under supplemental security income under 42 USC 1381 to 1383c and state supplemental aid under s. 49.77 whichever is higher. In this subdivision "income" includes earned or unearned income that would be included in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled under 42 USC 1381 to 1385. "Income" does not include earned or unearned income which would be excluded in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled individual under 42 USC 1381 to 1385.

History: 1971 c. 125; 1971 c. 213 s. 5; 1971 c. 215; 1973 c. 90, 147, 333; 1977 c. 29 ss. 593, 1656 (18); 1977 c. 105 s. 59; 1977 c. 273, 418; 1979 c. 34; 1981 c. 20, 93; 1981 c. 314 s. 144; 1983 a. 27, 245; 1985 a. 29; 1987 a. 27, 307, 399, 413; 1989 a. 9; 1989 a. 31 ss. 1462k to 1466d, 2909c to 2909i; 1989 a. 173, 336, 351; 1991 a. 39, 178, 269, 316; 1993 a. 16, 269, 277, 437; 1995 a. 27 ss. 3026 to 3028, 9126 (19); 1995 a. 225, 289, 295; 1997 a. 27; 1999 a. 9; 2001 a. 16; 2005 a. 25, 253.

(END OF INSERT 4-9)

INSERT 4-10

SECTION 3. 49.496 (3) (a) (intro.) of the statutes is amended to read:

49.496 **(3)** (a) (intro.) Except as provided in par. (b), the department shall file a claim against the estate of a recipient for all of the following, subject to the amounts disregarded under the Long-Term Care Partnership Program established under s. 49.45 (31), unless already recovered by the department under this section:

History: 1991 a. 39, 269; 1993 a. 301, 437, 491; 1995 a. 27; 1997 a. 27; 1999 a. 9; 2003 a. 33.

(END OF INSERT 4-10)

12-19 Steve Miloto

remove references to partnership program but do not provide for DHFS to establish one

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-0930/P1
PJK:jld:pg

LRS-check request sheet
Deleting references to Long-Term Care Insurance

DOA:.....Milioto, BB0197 - Long-Term Care Insurance – Federal Partnership Program

FOR 2007-09 BUDGET -- NOT READY FOR INTRODUCTION

Don't gen

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program, which provides federal and state moneys to pay for health care and long-term care services provided to MA recipients. MA recipients are, generally, low-income, elderly, or disabled persons who meet other specific eligibility requirements. To be eligible for long-term care services under MA, an individual must meet certain very low income and resource requirements, and may have to "spend down" liquid assets by paying for his or her own long-term care until those income and resource requirements are met. In addition, DHFS may recover from a decedent's estate the amount of MA paid on behalf of the decedent for long-term care.

Under the State Long-Term Care Partnership Program under federal law, a state may seek approval of an amendment to its state MA plan that would allow it to disregard an amount equal to the amount of qualifying long-term care insurance payments received by an individual when the state is calculating the individual's income and resources for purposes of determining MA eligibility, and when the state is determining the amount that may be recovered from the deceased individual's estate for long-term care services provided under MA. For the long-term care

insurance to qualify: 1) the individual must have been a state resident when coverage first became effective; 2) the coverage must not have been effective before the date of the state MA plan amendment; 3) the long-term care insurance policy must meet the definition under federal law, must meet the long-term care insurance model regulations and the requirements of the long-term care insurance model act promulgated by the National Association of Insurance Commissioners, and must provide specified inflation protection depending upon the age of the insured individual when coverage first began; and 4) the Commissioner of Insurance must certify that the policy meets all of those requirements. DHFS and OCI must work together to develop a training program for insurance agents who sell long-term care insurance to ensure that the agents understand long-term care insurance and how it relates to other public and private coverage of long-term care, including MA. In addition, an insurer that issues a qualifying long-term care insurance policy must report to the secretary of the federal Department of Health and Human Services (DHHS) regarding when benefits are paid, the amount of the benefits paid, termination of the policy, and any other information required by the secretary.

This bill requires DHFS to submit to the secretary of DHHS an amendment to the state's MA plan that satisfies the requirements of the State Long-Term Care Partnership Program under federal law. If the amendment is approved, DHFS must disregard, for purposes of MA eligibility and estate recovery, the amount of qualifying long-term care insurance payments made to an individual who receives MA for long-term care.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.45 (31) of the statutes is repealed and recreated to read:

49.45 **(31)** LONG-TERM CARE PARTNERSHIP PROGRAM. (a) The department shall submit to the federal department of health and human services an amendment to the state medical assistance plan that establishes in this state a Long-Term Care Partnership Program, as described in this subsection, and shall implement the program if the amendment to the state plan is approved. Under the program, the department shall disregard an amount equal to the amount of benefits that an individual receives under a qualifying long-term care insurance policy, as described in par. (b), when determining any of the following:

1. The individual's income and resources for purposes of determining the individual's eligibility for medical assistance.

2. The amount to be recovered from the individual's estate if the individual receives medical assistance.

(b) A long-term care insurance policy qualifies under par. (a) if all of the following criteria are met:

1. The insured individual was a resident of this state when coverage first became effective.

2. The policy was not issued before the effective date of the amendment to the state plan.

3. The policy meets the definition of a qualified long-term care insurance policy under 26 USC 7702B (b).

4. The policy meets the long-term care insurance model regulations and the requirements of the long-term care insurance model act promulgated by the National Association of Insurance Commissioners that are specified in 42 USC 1396p (b) (5).

5. The policy includes the applicable inflation protection specified in 42 USC 1396p (b) (1) (C) (iii) (IV).

6. The commissioner of insurance certifies to the department that the policy meets the criteria under subds. 3. to 5.

(c) The department and the office of the commissioner of insurance shall work together to develop a training program for individuals who sell long-term care insurance policies in the state to ensure that those individuals understand the relation of long-term care insurance to the Medical Assistance program and are able

to explain to consumers the protections offered by long-term care insurance and how this type of insurance relates to private and public financing of long-term care.

(d) An insurer that issues a long-term care insurance policy described in par. (b) shall be required to submit reports to the secretary of the federal department of health and human services, in accordance with regulations developed by the secretary, that include notice of when benefits are paid under the policy, the amount of the benefits, notice of the termination of the policy, and any other information required by the secretary.

SECTION 2. 49.47 (4) (b) (intro.) of the statutes is amended to read:

49.47 **(4)** (b) (intro.) Eligibility exists if the applicant's property, subject to the amounts disregarded under the Long-Term Care Partnership Program established under s. 49.45 (31), does not exceed the following:

SECTION 3. 49.47 (4) (c) 1. of the statutes is amended to read:

49.47 **(4)** (c) 1. Except as provided in par. (am) and as limited by subd. 3., eligibility exists if income, subject to the amounts disregarded under the Long-Term Care Partnership Program established under s. 49.45 (31), does not exceed 133 1/3% of the maximum aid to families with dependent children payment under s. 49.19 (11) for the applicant's family size or the combined benefit amount available under supplemental security income under 42 USC 1381 to 1383c and state supplemental aid under s. 49.77 whichever is higher. In this subdivision "income" includes earned or unearned income that would be included in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled under 42 USC 1381 to 1385. "Income" does not include earned or unearned income which would be excluded in determining eligibility for the individual or family under s.

49.19 or 49.77, or for the aged, blind or disabled individual under 42 USC 1381 to 1385.

SECTION 4. 49.47 (9m) of the statutes is repealed.

SECTION 5. 49.496 (3) (a) (intro.) of the statutes is amended to read:

49.496 **(3)** (a) (intro.) Except as provided in par. (b), the department shall file a claim against the estate of a recipient for all of the following, subject to the amounts disregarded under the Long–Term Care Partnership Program established under s. 49.45 (31), unless already recovered by the department under this section:

SECTION 6. 601.415 (8) of the statutes is created to read:

601.415 **(8)** LONG–TERM CARE PARTNERSHIP PROGRAM. The commissioner shall provide the certifications required under s. 49.45 (31) (b) 6. and shall cooperate with the department of health and family services in developing the training program under s. 49.45 (31) (c) for agents who sell long–term care insurance policies.

(END)

2007-2008 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0930/1ins
PJK:jld:pg

INSERT 2-A

Current law requires DHFS to seek federal approval of a pilot project under which a person receiving benefits under a long-term care insurance policy that satisfies criteria established by DHFS may be eligible for MA even though their income and resources exceed the limits for eligibility. This bill removes the requirement to seek approval of such a pilot project.

(END OF INSERT 2-A)

Kahler, Pam

From: Milioto, Steve - DOA
Sent: Sunday, January 07, 2007 9:46 AM
To: Kahler, Pam
Subject: RE: LRB-0930

Hi Pam --

I think you are right. Go ahead and delete those provisions from the draft. Best, Steve

---

From: Kahler, Pam [mailto:Pam.Kahler@legis.wisconsin.gov]
Sent: Friday, January 05, 2007 5:17 PM
To: Milioto, Steve - DOA
Subject: LRB-0930

Hi, Steve:

I just came across something that we might want to add to the draft that deletes references to the federal partnership program on long-term care insurance. Take a look at s. 146.91 (2) (c). I don't know if DHFS has actually designed such a program. If we get rid of that paragraph, sub. (5) can probably go, too. Let me know what you think. Thanks.

Pam

Pamela J. Kahler
Legislative Attorney
Legislative Reference Bureau
608-266-2682

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-0930/1
PJK:jld:sh

DOA:.....Milioto, BB0197 - Deleting references to Federal Partnership Program

FOR 2007-09 BUDGET -- NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program, which provides federal and state moneys to pay for health care and long-term care services provided to MA recipients. MA recipients are, generally, low-income, elderly, or disabled persons who meet other specific eligibility requirements. To be eligible for long-term care services under MA, an individual must meet certain very low income and resource requirements, and may have to "spend down" liquid assets by paying for his or her own long-term care until those income and resource requirements are met.

Current law requires DHFS to seek federal approval of a pilot project under which a person receiving benefits under a long-term care insurance policy that satisfies criteria established by DHFS may be eligible for MA even though the person's income and resources exceed the limits for eligibility. This bill removes ~~the requirement to seek approval of such a pilot project.~~ both of these requirements

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.45 (31) of the statutes is repealed.

SECTION 2. 49.47 (9m) of the statutes is repealed.

(END)

Insert 2-2 ✓

2007-2008 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0930/2ins
PJK:jld:sh

INSERT A-1

Current law also requires DHFS to include, as part of a program on long-term care insurance, allowing persons to retain excess assets for MA eligibility if they purchase long-term care insurance.

(END OF INSERT A-1)

INSERT A2

and removes the requirement that the program designed by DHFS allows persons to retain

(END OF INSERT A-2)

INSERT 2-2

SECTION 1. 146.91 (2) (c) of the statutes is repealed.

SECTION 2. 146.91 (5) of the statutes is repealed.

(END OF INSERT 2-2)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0930/2dn
PJK:jld:sh

date

I don't know how far you want to go with this, but

Steve:

I noticed that the council on long-term care insurance, referenced in s. 146.91, no longer exists. The last time it existed in the statutes was in the 1989-90 version, in s. 15.197 (20). Its sole duty was to advise DHFS under s. 146.91, and s. 15.197 (20) had an in-text termination of September 1, 1988. Perhaps all of s. 146.91 could be repealed.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0930/2dn
PJK:jld:pg

January 8, 2007

Steve:

I noticed that the council on long-term care insurance, referenced in s. 146.91, no longer exists. The last time it existed in the statutes was in the 1989-90 version, in s. 15.197 (20). Its sole duty was to advise DHFS under s. 146.91, and s. 15.197 (20) had an in-text termination of September 1, 1988. I don't know how far you want to go with this, but perhaps all of s. 146.91 could be repealed.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-0930/2
PJK:jld:pg

DOA:.....Milioto, BB0197 - Deleting references to Federal Partnership Program

FOR 2007-09 BUDGET -- NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program, which provides federal and state moneys to pay for health care and long-term care services provided to MA recipients. MA recipients are, generally, low-income, elderly, or disabled persons who meet other specific eligibility requirements. To be eligible for long-term care services under MA, an individual must meet certain very low income and resource requirements, and may have to "spend down" liquid assets by paying for his or her own long-term care until those income and resource requirements are met.

Current law requires DHFS to seek federal approval of a pilot project under which a person receiving benefits under a long-term care insurance policy that satisfies criteria established by DHFS may be eligible for MA even though the person's income and resources exceed the limits for eligibility. Current law also requires DHFS to include, as part of a program on long-term care insurance, allowing persons to retain excess assets for MA eligibility if they purchase long-term care insurance. This bill removes both of these requirements.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.45 (31) of the statutes is repealed.

SECTION 2. 49.47 (9m) of the statutes is repealed.

SECTION 3. 146.91 (2) (c) of the statutes is repealed.

SECTION 4. 146.91 (5) of the statutes is repealed.

(END)