NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
DAVE HEINEMAN, GOVERNOR

December 1, 2005

The Honorable Dave Heineman
Governor of Nebraska
State Capitol, 2nd Floor N.E.
Lincoln, NE 68509

Patrick O'Donnell
Clerk of the Legislature
2018 State Capitol
Lincoln, NE 68509

Gentlemen:

Enclosed with this letter is our report on the use of Long-Term Care Insurance Partnerships as a method for slowing the growth of Medicaid expenditures for nursing facility and home or community-based care for elderly Nebraskans. This report is submitted pursuant to Legislative Bill 709 (Laws 2005), section 12.

The report is a collaboration of the Nebraska Health and Human Services System and the Department of Insurance, with consultation from staff of the Governor's Policy Research Office and Senator Doug Cunningham's office. At the time of submission, federal legislation to lift the moratorium on establishment of future partnership programs is pending. If enacted, specific provisions of that legislation will determine the State's latitude in implementing a plan in Nebraska.

Please contact Ginger Goomis of HHSS at 471-9185 or Eric Dunning of DOI at 471-4650 with questions or comments regarding this report.

Sincerely,

Richard P. Nelson, Director
Department of Health and Human Services
Finance and Support

L. Tim Wagner, Director
Department of Insurance

Enclosure
CC: Senator Doug Cunningham, Nebraska Legislature
Lauren Hill, Governor's Policy Research Office

LONG-TERM CARE PARTNERSHIP PROGRAM DEVELOPMENT ACT PLAN

INTRODUCTION

LB 709 (Laws 2005), sections 9 to 13, created the Long Term Care Partnership Program Development Act. The act provided for the development of a plan by the Nebraska Health and Human Services System and the Department of Insurance, in consultation with the Health and Human Services Committee of the Legislature, for the establishment of a long-term care partnership program in the State of Nebraska. This report constitutes the plan as required to be submitted to the Governor and the Legislature no later than December 1, 2005.

In preparing the plan, the Nebraska Health and Human Services System and the Department of Insurance analyzed partnership programs. These programs were established by states prior to the enactment of federal restrictions on the establishment of such programs under the federal Omnibus Budget Reconciliation Act of 1993. Meetings were with held with representatives of the Health and Human Services System, Department of Insurance, Governor's Policy Research Office, long-term care insurance industry, and the Legislature.

Prior to the enactment of a federal moratorium on establishment of long-term care partnership programs, public-private partnerships linking the Medicaid program and the private sector insurance market were implemented in the states of California, Connecticut, Indiana, and New York. Basically, such programs provide that persons owning state approved long-term care policies may qualify for Medicaid without spending down to the normal Medicaid resource limits. There have been two partnership models utilized by these states. The first is the "dollar for dollar" model where beneficiaries are able to keep assets, when applying for Medicaid, equal to the benefits paid by the long term care insurance policy. The other model used is the "total asset" model where all assets are protected after a threshold of a certain number of years of coverage, usually three or four years, under the policy. Medicaid becomes responsible as the payer once partnership policy benefits have been exhausted.

Federal law has prohibited the expansion of these partnerships beyond those four states. In 1993, the federal Omnibus Budget Reconciliation Act amended Title XIX (Medicaid) of the Social Security Act to restrict such Medicaid partnership programs unless they had been federally approved as of May 14, 1993. Several states have passed legislation since that time allowing them to begin such a program if the federal law restriction is repealed. The potential benefit of these programs is to encourage people to purchase long term care partnership insurance policies to meet their long term care needs while saving Medicaid dollars for the payment that might have otherwise been expended for such care. This report will review and discuss the experiences and results of the long term care partnership programs in the four states that have operated programs; the issues for the insurance industry and their long-term care insurance products; the current federal legislation pending before Congress that might repeal the moratorium on long-term care partnerships; and the recommendations if the current moratorium is lifted.

LONG-TERM CARE PARTNERSHIP EXPERIENCE

Long-term Care Partnership plans, which were initiated in the early 1990's, have enrolled 211,972 policyholders[1] as reported by the United States Government Accountability Office[2]. The experiences of the four states can be instructive in terms of designing future programs and establishing realistic expectations about the short-range and long-range impact of such programs on Medicaid expenditures.

The Medicaid Program, as payor of last resort, is intended to serve persons with low levels of income and resources who are financially unable to provide for their own health care needs. Persons with income and resources in excess of these levels are required to utilize or "spend down" these assets before Medicaid coverage begins. In contrast, Long-Term Care Insurance Partnership policies allow individuals to shelter certain assets and still be eligible for Medicaid, should these individuals eventually require long-term care services and meet Medicaid income requirements. Approved partnership policies must meet certain minimum coverage requirements established by the State (e.g., years of coverage, daily benefit amounts, covered services).

As a trade-off for relying on private insurance coverage for a period of time and deferring Medicaid long-term care coverage, policyholders are allowed to exempt certain assets when establishing Medicaid eligibility. Medicaid benefits by becoming the secondary rather than primary payor. The opportunity to maintain personal assets through the purchase of private insurance offers an appropriate alternative to "artificial impoverishment" where a person's assets are transferred to family members in order to qualify for Medicaid coverage of long-term care expenses.

Two basic approaches are used to determine the amount of protected assets: dollar-for-dollar protection and total asset protection. Under the dollar-for-dollar model, the value of assets that can be protected is equivalent to the value of the long-term care benefits paid by the private insurer prior to Medicaid coverage. Under the total asset model, once an established threshold of private insurance benefits is covered, the entire value of the policyholder's assets can be protected. California and Connecticut have adopted the dollar-for-dollar approach, Indiana uses a hybrid model (with dollar-for-dollar coverage up to a certain benefit level and total asset coverage for insurance benefits above this level), and New York allows total asset protection with minimum coverage of three years in a nursing facility and six years of home care. However, New York is considering adding a dollar-for-dollar provision because it offers more affordable premiums to the consumer.

The typical profile of an individual purchasing a long-term care insurance partnership policy in the four states is a married female, approximately 60 years of age, relatively healthy, and relatively wealthy, with assets of $350,000 or more and monthly income of at least $5,000, as documented in the GAO report cited previously.[3] Of the 211,972 policies purchased over the life of these programs, 172,477 (or 81%) of the policies are currently active. Less than 2% of overall policyholders have ever accessed long-term care benefits and less than 1% of current policyholders are now receiving long-term care benefits. Of the 251 policy holders who have exhausted the benefits of their long-term care insurance policies, 119 (or 47%) have accessed Medicaid.

Because of the limited number of persons utilizing long-term care benefits, it is difficult to draw conclusions about the potential impact of such programs on Medicaid expenditures. We do not know how many policyholders who utilized long-term care but did not access Medicaid would have done so if private insurance coverage had not been available. We also do not know how many policyholders who accessed Medicaid would have done so sooner without private insurance

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[1] Aggregate population of the four partnership states exceeds 64 million persons; active partnership policies represent less than one-half of one percent of population.

[2] "Overview of the Long-Term Care Partnership Program," United States Government Accountability Office report GAO-05-1021R to Senators Grassley, Baucus and Rockefeller dated September 9, 2005.

[3] Ibid.

coverage. Because of the time lag between purchase of a policy and the need for long-term care services, several decades of experience may be needed to fully evaluate the impact of partnership programs on long-term care financing. However, there are several reasons why partnership programs merit continued exploration.

Nebraska enjoys a relatively high market penetration at 17%[4] for long-term care insurance sales compared with other states, but the product is not widely utilized anywhere. Nebraska's population age 65 and over is projected to increase 75% by the year 2030. Longer life spans increase the likelihood of living with declining health and outlasting one's financial resources. Family members are less likely to be available to provide care. While the usual purchasers of private long-term care insurance do not share income and health characteristics with the Medicaid population, they have the potential to become Medicaid-eligible over time. They are also a likely focus for estate planners who encourage the use of various financial tools to dispose of assets in order to qualify for Medicaid long-term care services.

While long-term care insurance does not provide the complete answer, it may be one of several tools used in a comprehensive approach to lessen the pressure on Medicaid-financed long-term care. Suggestions gleaned from the four state operations include:

§ consumer education is vital to promote personal long-term care planning and to offset the prevailing notion that Medicare covers long-term care

§ the cost of long-term care insurance is a major deterrent, unless the policy is initiated at a relatively young age

§ inflation protection helps maintain benefit value between the date the policy is initiated and the date long-term care services are accessed but also increases the cost of the insurance product to the consumer

§ state-to-state reciprocity is useful so that the asset protection benefit can be accessed if the policyholder relocates to another state

§ insurance agent training is important to properly promote the sale of long-term care products

[4] Penetration rate is calculated by dividing the number of policies sold in a state by the number of residents age 50 or over. Source: America's Health Insurance Plans (AHIP) LTC Insurance Market Survey

PARTNERSHIP POLICY REQUIREMENTS

The long-term care partnership programs implemented to date had several stated goals, including increasing the regulatory standards for long-term care policies and increasing public awareness of the need for long-term care insurance policies. In view of the development of stronger regulatory standards for long-term care insurance products in both partnership and non-partnership states and the increased public awareness of the need to plan for long-term care, these goals appear to have been met.

The National Association of Insurance Commissioners has devoted significant attention to the appropriate regulatory standards and has adopted and amended long-term care model acts and regulations. In Nebraska, the Legislature adopted the first Nebraska Long-Term Care Insurance Act in 1987, amending and strengthening those standards in 1992 and 1999 as states gained regulatory experience with this product. The Department of Insurance adopted administrative regulations in 1988, with amendments in 1991, 1993, 1994, and 2000. These standards included such requirements as benefit triggers, mandated offerings of nonforfeiture benefits, and limitations on preexisting condition exclusions.

From a state public finance perspective, however, one of the pressing goals was to reduce dependence on Medicaid by encouraging citizens to buy long-term care insurance policies. In reviewing the rates of participation in the Long-term Care Partnership programs in the four existing states[5], the relatively limited number of insurers offering these plans[6], and the characteristics of the purchasers of these Partnership policies, the programs have not successfully created incentives for individuals to purchase long-term care insurance.

At the beginning of the partnership programs, significant attention was given to the development of a specific "partnership policy" which individuals would purchase to qualify for asset waiver. At the time the original partnership policies were designed, regulatory standards for long-term care insurance were less developed. While strict adherence to partnership plan-determined standards may have been viewed as necessary to protect purchasers, the development of regulatory standards tailored to long-term care insurance regulation over the last twelve years make those policy requirements less necessary. As insurers and regulators have developed more experience with long-term care insurance policies generally, the regulatory standards have been strengthened. These partnership specific policies, however, continue to make the policies more expensive and therefore less desirable. Any partnership plan developed in Nebraska should take these developments into consideration.

The partnership policies included policy terms that the partnership administrators believed would be desirable in a long-term care policy, most notably provisions that would provide protection from inflation by increasing the benefits over time. While these features and others like them may have been desirable for partnership administrators, they proved to be less desirable to actual purchasers of the policies. The increased costs necessary to support the added features priced the product out of the means of potential purchasers. These features represented significant deviations from products available in the non-partnership market, requiring not only increased premiums to support the benefit but increased costs for collection and analysis of actuarial data. These factors increased costs for purchasing partnership policies. Individuals didn't buy partnership policies, opting instead for less expensive basic coverage available in the states.

In addition, participation in the partnership program required extensive data reporting. While development of a Uniform Data Set was cited as an achievement of the program, the reporting

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[5] According to the Government Accountability Office, l72,000 policies are currently in effect. GAO-05-1021R Long-Term Care Partnership Program

[6] According to the Government Accountability Office, 17 insurers offer partnership policies in any one of the four states. Indiana has the highest number of insurers participating, with 8, and California the lowest, with 5. GAO-05-1021R Long-Term Care Partnership Program

requirements remained onerous. It is also unclear that the required data was actually necessary for the proper effective operation of the program. The data collection portions of the program appeared to be a disincentive to insurer participation in the partnership program.

To encourage participation in the program by actual individuals, it appears that rather than creating a specific "partnership policy", requiring only compliance with the current Nebraska requirements for long-term care insurance would be necessary. This will allow individuals to choose which policy provisions will be both desirable and affordable, and increase participation in any long-term care partnership program Nebraska would eventually adopt. Moreover, it would provide the necessary flexibility for insurers to offer a viable product that consumers would purchase. As Nebraska currently has forty-three companies authorized to market long-term care insurance in Nebraska, allowing each of these companies to develop viable products should improve the products offered to Nebraskans.

CURRENT FEDERAL ENVIRONMENT/INTRODUCED BILLS

As of the date of this report, Congress has begun to reexamine its 1993 decision to prohibit states from waiving asset collection. Several bills have been introduced dealing with various aspects of long-term care insurance in this congress. In particular, two conference bills, S. 1932 and H.R. 4241, specifically include provisions allowing states to adopt new long-term care partnership plans.

The ultimate form of the legislation is undetermined. However, the two bills allow Nebraska to develop a long-term care partnership plan designed to avoid mistakes made in the original partnership states discussed in the preceding section. Even the more restrictive of the federal bills would require the state at a minimum to require adherence to the NAIC Model Long-term Care Insurance Regulation. States would be allowed to require more stringent policy terms, but would not be required to do so.

In view of the currently undetermined form of potential federal legislation, no specific legislation has been recommended for the Legislature's consideration during the 2006 legislative session, but a copy of the state of Maryland's contingency plan for Partnership policies has been included for your review. Sections of the federal bills have also been included in the appendix to this report. We will continue to monitor the progress of the federal legislation and update this report should federal law changes occur.

RECOMMENDATIONS

Taking into account that any Nebraska long-term care partnership legislation would have to comply with yet undetermined standards set by federal law, currently, HHSS and the NDOI believe that a Nebraska long-term care partnership plan should:

§ Allow participation in a Nebraska partnership plan by allowing Nebraskans to qualify on a dollar per dollar asset collection waiver, based on the amount of protection purchased by the individual.

§ Limit policy requirements to those required by future federal legislation and Nebraska minimum long-term care insurance policy standards to allow Nebraskans to purchase policies that are affordable to them.

§ Restrict data collection from insurers to those items that are useful to the HHS system, focusing on data needed to project future Medicaid expenditures and data necessary to comply with federal standards.

APPENDICES

State of Maryland Contingency Partnership Legislation

S. 1932, Section 6012
Long-term care partnership section of Senate Deficit Reduction Omnibus Reconciliation Act of 2005

H.R. 4241, Section 3133
Long-term care partnership section of House Deficit Reduction Act of 2005

Maryland LTC Act

§ 15-401.

CAUTION: READ FULL TEXT OF SECTION FOR SPECIAL NOTE

** SPECIAL NOTE: NOT IN EFFECT - CONTINGENCY - CHAPTER 442 - 1996 **

(a) In this subtitle the following words have the meanings indicated.

(b) "Commissioner" means the Insurance Commissioner.

(c) "Program" means the Maryland Partnership for Long-Term Care Program.

§ 15-402.

CAUTION: READ FULL TEXT OF SECTION FOR SPECIAL NOTE

** SPECIAL NOTE: NOT IN EFFECT - CONTINGENCY - CHAPTER 442 - 1996 **

(a) There is a Maryland Partnership for Long-Term Care Program.

(b) The purposes of the Program are to:

(1) Provide incentives for individuals to insure against the costs of providing for their long-term care needs;

(2) Provide mechanisms for individuals to qualify for coverage of the costs of their long-term care needs under the medical assistance program without first being required to substantially exhaust all their resources;

(3) Assist in developing methods for increasing access to and the affordability of a long-term care policy; and

(4) Alleviate the financial burden on the State's medical assistance program by encouraging pursuit of private initiatives.

(c) The Program shall:

(1) Be administered by:

(i) The Department; and

(ii) The Commissioner; and

(2) Provide for the financing of long-term care services by:

(i) Private insurance; and

(ii) State medical assistance.

§ 15-403.

CAUTION: READ FULL TEXT OF SECTION FOR SPECIAL NOTE

** SPECIAL NOTE: NOT IN EFFECT - CONTINGENCY - CHAPTER 442 - 1996 **

(a) To be eligible for the Program, an individual must:

(1) (i) Be covered by a long-term care policy that is approved for the Program by the Commissioner under § 15-404 of this subtitle; and

(ii) Have exhausted all benefits available under the policy that are available for services to treat or manage the insured's condition; and

(2) Satisfy any other requirement for eligibility established by the Department.

(b) Program eligibility may not be denied under this section for policy benefits that are not available or appropriate for treating the insured's condition.

§ 15-404.

CAUTION: READ FULL TEXT OF SECTION FOR SPECIAL NOTE

** SPECIAL NOTE: NOT IN EFFECT - CONTINGENCY - CHAPTER 442 - 1996 **

(a) To qualify under the Program, a long-term care policy shall:

(1) Satisfy the requirements of Title 18 of the Insurance Article;

(2) Alert the purchaser to the availability of consumer information and public education provided by the Commissioner under § 15-406 of this subtitle;

(3) Provide for the keeping of records and an explanation of benefit reports on insurance payments which count toward Medicaid resource exclusion; and

(4) Provide the management information and reports necessary to document the extent of resource protection offered and to evaluate the Program.

(b) The Department may not approve a long-term care policy if the policy requires prior hospitalization or a prior stay in a nursing home as a condition of providing benefits.

§ 15-405.

CAUTION: READ FULL TEXT OF SECTION FOR SPECIAL NOTE

** SPECIAL NOTE: NOT IN EFFECT - CONTINGENCY - CHAPTER 442 - 1996 **

(a) When the benefits payable under the long-term care policy approved under § 15-404 of this subtitle are exhausted, determination of eligibility for medical assistance shall be made in accordance with subsection (b) of this section.

(b) In determining eligibility for medical assistance, an amount of resources equal to the amount of benefits paid under the long-term care policy shall be excluded from the Department's calculation of the individual's resources, to the extent the payments:

(1) Are for services that medical assistance approves or covers for recipients;

(2) Are for the lower of the actual charge and the amount paid by the insurance company; and

(3) Are for nursing home care or approved home care and community-based services.

§ 15-406.

CAUTION: READ FULL TEXT OF SECTION FOR SPECIAL NOTE

** SPECIAL NOTE: NOT IN EFFECT - CONTINGENCY - CHAPTER 442 - 1996 **

The Commissioner, through the Consumer Education and Advocacy Program, shall undertake measures to educate the public as to:

(1) The need for long-term care;

(2) Mechanisms for financing long-term care;

(3) The availability of long-term care insurance; and

(4) The asset protection provided under this subtitle.

§ 15-407.

CAUTION: READ FULL TEXT OF SECTION FOR SPECIAL NOTE

** SPECIAL NOTE: NOT IN EFFECT - CONTINGENCY - CHAPTER 442 - 1996 **

The Department and the Commissioner shall jointly:

(1) Adopt regulations necessary to carry out the provisions of this subtitle; and

(2) On or before October 1 of each year, report to the General Assembly, in accordance with § 2-1246 of the State Government Article on:

(i) The effectiveness of the Program;

(ii) The impact of the Program on State expenditures for medical assistance;

(iii) The number of enrollees in the Program; and

(iv) The number of long-term care policies offered in the State.

S.1932

Deficit Reduction Omnibus Reconciliation Act of 2005 (Engrossed as Agreed to or Passed by Senate)

SEC. 6012. STATE LONG-TERM CARE PARTNERSHIPS.

(a) EXPANSION OF STATE LONG-TERM CARE PARTNERSHIPS-

(1) IN GENERAL- Section 1917(b)(1)(C)(ii) (42 U.S.C. 1396p(b)(1)(C)(ii)) is amended to read as follows:

`(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under--

`(I) a Qualified State Long-Term Care Insurance Partnership (as defined in paragraph (5)); or

`(II) under a State plan of a State which--

`(aa) had a State plan amendment approved as of May 14, 1993, which provided for the disregard of any assets or resources to the extent that payments are made under a long-term care insurance policy or because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy; and

`(bb) has a State plan amendment which satisfies the requirements of subparagraphs (B) through (G) of paragraph (5) in the case of any long-term care insurance policy sold under such plan amendment on or after the date that is 2 years after the date of enactment of such paragraph.

For purposes of this clause and paragraphs (5) and (6), the term `long-term care insurance policy' includes a certificate issued under a group insurance contract.'.

(2) SATISFACTION OF MINIMUM FEDERAL STANDARDS, TAX

QUALIFICATIONS, INFLATION PROTECTION, AND OTHER REQUIREMENTS FOR LONG-TERM CARE INSURANCE PARTNERSHIPS- Section 1917(b) (42 U.S.C. 1396p(b)) is amended by inserting at the end the following:

`(5) The term `Qualified State Long-Term Care Insurance Partnership' means a program offered in a State with an approved State plan amendment that provides for the following:

`(A) Subject to the limit specified in subparagraph (D), 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 long-term care insurance policy sold under such plan amendment.

`(B) A requirement that the State will treat benefits paid under any long-term care insurance policy sold under a plan amendment of another State that maintains a Qualified Long-Term Care Insurance Partnership or is described in subsection (b)(1)(C)(ii)(II) the same as the State treats benefits paid under such a policy sold under the State's plan amendment.

`(C) A requirement that any long-term care insurance policy sold under such plan amendment--

`(i) be a qualified long-term care insurance contract within the meaning of section 7702B(b) of the Internal Revenue Code of 1986; and

`(ii) meet the requirements described in paragraph (6).

`(D) A requirement that any such policy sold under the State plan amendment shall provide for--

`(i) compound annual inflation protection of at least 5 percent; and

`(ii) asset protection that does not exceed $250,000.

The dollar amount specified in the preceding sentence shall 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 All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, rounded to the nearest $100.

`(E) A requirement that an insurer may rescind a long-term care insurance policy sold under such State plan amendment that has been in effect for at least 2 years or deny an otherwise valid long-term care insurance claim under such a policy only upon a showing of misrepresentation that is material to the acceptance of coverage, pertains to the claim made, and could not have been known by the insurer at the time the policy was sold.

`(F) A requirement that any individual who sells such a policy receive training, and demonstrate evidence of an understanding of, the policy and how the policy relates to other public and private coverage of long-term care.

`(G) A requirement that the issuer of any such policy report--

`(i) to the Secretary, such information or data as the Secretary may require; and

`(ii) to the State, the information or data reported to the Secretary (if any), the information or data required under the minimum reporting requirements developed under section 6012(b)(2)(B) of the Deficit Reduction Omnibus Reconciliation Act of 2005, and such additional information or data as the State may require.

For purposes of applying this paragraph, if a long-term care insurance policy is exchanged for another such policy, the date coverage became effective under the first policy shall determine when coverage first becomes effective.

`(6)(A) For purposes of subparagraph (C)(ii) of paragraph (5), the requirements of this paragraph are met if a long-term care insurance policy sold under a plan amendment described in that paragraph meets--

`(i) MODEL REGULATION- The following requirements of the model regulation:

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

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

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

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

`(ii) MODEL ACT- The following requirements of the model Act:

`(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).

`(B) DEFINITIONS- For purposes of this paragraph--

`(i) MODEL PROVISIONS- 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) COORDINATION- Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

`(iii) DETERMINATION- For purposes of this paragraph, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.'.

(3) EFFECTIVE DATE- The amendments made by this subsection take effect on October 1, 2007, and apply to long-term care insurance policies sold on or after that date.

(b) DEVELOPMENT OF UNIFORM STANDARDS AND RECOMMENDATIONS-

(1) IN GENERAL- Not later than 1 year after the date of enactment of this Act, the Secretary, 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 shall develop the uniform standards described in paragraph (2) and submit recommendations to Congress with respect to the issues identified in paragraph (3).

(2) UNIFORM STANDARDS- The uniform standards described in this paragraph are the following:

(A) RECIPROCITY- Standards for ensuring that long-term care insurance policies issued under a State long-term care insurance partnership under 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)) are portable to other States with such a partnership.

(B) MINIMUM REPORTING REQUIREMENTS- Standards for minimum reporting requirements for issuers of long-term care insurance policies under such State long-term care insurance partnerships that shall specify the data and information that each such issuer shall report to the State with which it has such a partnership. The requirements developed in accordance with this subparagraph 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.

(C) SUITABILITY- Suitability standards for determining whether a long-

term care insurance policy is appropriate for the needs of an applicant, based on guidance of the National Association of Insurance Commissioners regarding suitability.

(3) RECOMMENDATIONS- The recommendations described in this paragraph are the following:

(A) INCONTESTABILITY- Recommendations regarding whether the requirements relating to incontestability for long-term care insurance policies sold under a State long-term care insurance partnership program under section 1917(b)(1)(C)(ii) of the Social Security Act should be modified based on guidance of the National Association of Insurance Commissioners regarding incontestability.

(B) NONFORFEITURE- Recommendations regarding whether requirements relating to nonforfeiture for issuers of long-term care insurance policies under a State long-term care insurance partnership program under section 1917(b)(1)(C)(ii) of such Act should be modified to reflect changes in an insured's financial circumstances.

(C) 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 long-term care insurance policies under such a State partnership program and, if so, what such standards should be.

(D) RATING REQUIREMENTS- Recommendations regarding whether uniform standards for the establishment of, and annual increases in, premiums for long-term care insurance policies sold under such a State partnership program should be established and, if so, what such standards should be.

(E) DISPUTE RESOLUTION- Recommendations regarding whether uniform standards are needed to ensure fair adjudication of coverage disputes under long-term care insurance policies sold under such a State partnership program and the delivery of the benefits promised under such policies.

(4) STATE REPORTING REQUIREMENTS- Nothing in paragraph (2)(B) 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 State long-term care insurance partnership under section 1917(b)(1)(C)(ii) of the Social Security Act) to require the issuer to report information or data to the State that is in addition to the information or data required under the minimum reporting requirements developed under that paragraph.

(c) ANNUAL REPORTS TO CONGRESS- 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.

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

SEC. 6021. ENHANCING THIRD PARTY RECOVERY.

(a) CLARIFICATION OF RIGHT OF RECOVERY AGAINST ANY THIRD PARTY LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE- Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended--

(1) in subparagraph (A), in the matter preceding clause (i)--

(A) by inserting `, including self-insured plans' after `health insurers'; and

(B) by striking `and health maintenance organizations' and inserting `health maintenance organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service'; and

(2) in subparagraph (G)--

(A) by inserting `a self-insured plan,' after `1974,'; and

(B) by striking `and a health maintenance organization' and inserting `a health maintenance organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service'.

(b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA- Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended--

(1) in subparagraph (G), by striking `and' at the end;

(2) in subparagraph (H), by adding `and' after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

`(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, health maintenance organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--

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SEC. 3133. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM.

(a) In General- Section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p (b)(1)(C)) is amended--

(1) in clause (ii), by inserting `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

(2) 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 (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.

`(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 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 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 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 regulations of the Secretary (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 may be 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.

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.

`(iv) The Secretary--

`(I) as appropriate, shall provide copies of the reports described in clause (iii)(V) to the State involved; and

`(II) shall promote the education of consumers regarding qualified State long-term care insurance partnerships.

`(v) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, and State insurance commissioners, 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.'.

(b) Construction- Nothing in the amendments made by subsection (a) shall be construed as affecting the treatment of long-term care insurance policies that will be, are, or were provided under a State plan amendment described in section 1917 (b)(1)(C)(ii) of the Social Security Act that was approved as of May 14, 1993.

(c) Effective Date- A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by subsection (a) 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.

(d) 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 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.

SEC. 3134. HEALTH OPPORTUNITY ACCOUNTS.

Title XIX of the Social Security Act, as amended by section 3124, is amended--

(1) by redesignating section 1937 as section 1938; and

(2) by inserting after section 1936 the following new section:

`HEALTH OPPORTUNITY ACCOUNTS

`SEC. 1937. (a) Authority-

`(1) IN GENERAL- Notwithstanding any other provision of this title, the Secretary shall establish a demonstration program under which States may provide under their State plans under this title (including such a plan operating under a statewide waiver under section 1115) in accordance with this section for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a `State demonstration program'.

`(2) INITIAL DEMONSTRATION- The demonstration program under this section shall begin on January 1, 2006. During the first 5 years of such program, the Secretary shall not approve more than 10 State demonstration programs, with each State demonstration program covering one or more geographic areas specified by the State. After such 5-year period--

`(A) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that a State demonstration program previously implemented has been unsuccessful, such a demonstration program may be extended or made permanent in the State; and

`(B) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration programs previously implemented were unsuccessful, other States may implement State demonstration programs.

`(3) APPROVAL- The Secretary shall not approve a State demonstration