DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

Qualified Long-Term Care Insurance Partnership Program

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Delaware Title XIX Medicaid State Plan and the Division of Social Services Manual regarding the *Qualified Long Term Care Insurance Partnership Program*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 Delaware Code Section 10115 in the November 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by November 30, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed amends the Delaware Title XIX Medicaid State Plan and the Division of Social Services Manual regarding implementation of a *Qualified State Long-Term Care Insurance Partnership Program.*

Statutory Authority

Deficit Reduction Act of 2005 (Public Law 109-171), enacted on February 8, 2006

Background

Section 6021 amends section 1917(b) of the Social Security Act (the Act) to provide for Qualified State Long-Term Care (LTC) Insurance Partnership programs, and permits an exception to estate recovery provisions with respect to individuals who receive benefits under LTC insurance policies sold in States that implement a Partnership program.

Section 6021(a)(1)(A)(iii) defines the term "Qualified State LTC Partnership" to mean an approved State plan amendment (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."

Summary of Proposal

The proposed amendment provides incentive to individuals who purchase a Qualified Long-Term Care Insurance Partnership Policy by allowing the policyholder a disregard of assets or resources in an amount equal to the insurance benefit payments paid for the beneficiary**[. ~~once the policy holder has exhausted their long-term care benefits.~~]** The dollar amount paid by the policy for their care is also exempt from the recovery of medical assistance received by the participant (Estate Recovery).

[Individuals will not be eligible for Medicaid to meet their long-term care needs until the policyholder has exhausted the long-term care benefits provided by their Qualified LTC Partnership Policy.]

Delaware's Department of Insurance would approve long-term care insurance policies and ensure that insurance agents are trained and certified. Insurers authorized to offer long-term care insurance will be obligated to disclose the existence of the *Qualified Long-Term Care Insurance Partnership Program*.

This amendment provides for the disregard of resources in an amount equal to the insurance benefit payments made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy, in accordance with the provisions of Section 6021 of the Deficit Reduction Act of 2005. The disregard will be in the form of one dollar of assets retainable for every dollar in benefits paid under a long-term care insurance policy if the policyholder received Medicaid benefits while or after accessing the long-term care insurance benefits.

The provisions of these amendments are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Fiscal Impact Statement

The intent of a *Qualified Long-Term Care Insurance Partnership Program (QLTCIP)* is to reduce the burden of long-term expenses on Medicaid by providing incentives to purchase long-term care insurance. The fiscal impact of implementation is an indeterminable decrease in expenditures. There may be costs associated with the establishment of the QLTCIP program, such as: developing training programs; preparation of annual reports; and, potential reduction in Medicaid estate recovery proceeds. However, these costs are expected to be more than offset by the fact that long-term care insurance policies will initially be paying for services rather than Medicaid. Exact dollar amounts are indeterminable because the number of people who will participate in the Program is unknown.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP), the Delaware Developmental Disabilities Council (DDDC), the Governor's Advisory Council for Exceptional Citizens (GACEC) and, the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

ACLI and AHIP

As we understand it, the Delaware Division of Medicaid and Medical Services is proposing to prohibit policyholders of a Qualified Long-Term Care Partnership Policy from being eligible for asset disregard or eligible for Medicaid until the policyholder has exhausted the long term care benefits provided by the qualified LTC partnership policy.

The Deficit Reduction Act of 2005 (Pub.L 109-171) did not require exhaustion of private long term care coverage before one can apply for Medicaid. The reason that an exhaustion of benefits requirement is not a sensible approach is because the person with private insurance would only be allowed to apply after he has exhausted his private coverage. Since the Medicaid application process may take several days/months, the person would be liable to pay his own expenses for some time.

For the reasons stated, we strongly encourage the Department to not move forward with the current draft proposal to amend the regulation.

Agency Response: The phrase and sentence referenced in your comment have been deleted from the above "Summary of Proposal" (indicated by bracketed, bold type). An individual does not need to 'exhaust' the Long-Term Care Insurance (LTCi) benefits in order to be eligible for LTC Medicaid. Medicaid will disregard an amount of resources equal to the amount of LTCi benefits paid at the time of the Medicaid application. The individual could be eligible for Medicaid (as the payor of last resort).

DDDC, GACEC and SCPD

The program is authorized by federal law to provide an incentive to individuals to purchase a qualifying long-term care insurance. Under this scheme, an individual with a QLTCIP policy can enroll in Medicaid without having to exhaust policy benefits. The policy would then pay the authorized policy amount towards long-term care and Medicaid could cover the balance. Id. Both nursing home and home-health services would be eligible. There is no "grandfather" provision, i.e., this program is available only to individuals purchasing a QLTCIP policy after November 1, 2011 in Delaware or another state with a QLTCIP. Individuals taking advantage of this program qualify for a disregard of resources in an amount equal to LTC insurance benefits paid. Participating insurers would be required to report benefits paid under covered policies.

The Councils endorse the concept of implementing this federal option. However, we would like to also remind DMMA of concerns shared with the Department in the attached August 23, 2010 memo. See also attached Dept of Insurance commentary at 14 DE Reg. 316 (October 1, 2010). In a nutshell, the Department of Insurance allows LTC insurers to offer highly-constrictive policies which: 1) only authorize nursing home payments if an insured has limits in 3 ADLs; 2) ignore limits in IADLs; and 3) allow only ½ benefit payments for individuals opting for home health care versus institutional care. Delaware Medicaid covers both home health and nursing home services based on a deficit in 1 ADL. Effective April 2012, the DSHP Plus program will authorize home health services based on a deficit in 1 ADL and authorize nursing home coverage based on a deficit in 2 ADLs. Thus, Medicaid will be paying for both nursing home and home health services with 0 contribution by insurers since the "disability" threshold triggering insurance payment is higher. The "bottom line" is that DMMA may not realize anticipated cost savings, i.e., the expectation "that long-term care insurance policies will initially be paying for services rather than Medicaid." At p. 622, Fiscal Impact Statement.

DMMA would be well advised to collaborate with the Department of Insurance to ensure that qualifying QLTCIP policies provide nursing home benefits based on more liberal standards than limits in 3 ADLs. Moreover, the DSHP Plus program is attempting to promote home health services versus nursing home services by establishing a higher requirement for nursing home eligibility (limits in 2 ADLs) than home health care (limit of 1 ADL). This incentive is undermined by insurance policies which pay only ½ benefits for home health services. DMMA should consult the Department of Insurance to assess prospects for requiring a QLTCIP policy to pay equal benefits for home health and nursing facility care.

Agency Response: DMMA intends continued collaboration with the Department of Insurance, as required by the State plan amendment. Your comments will be considered as we move forward with implementation of the QLTCIP program in Delaware. Thank you for the endorsement.

Further analysis by Division staff resulted in the insertion of language to further clarify eligibility requirements in the Division of Social Services Manual (DSSM). Specifically, policy number DSSM 20345 is inserted; and, the policy is renumbered to add new text at number 7, *Disregarded assets may be transferred without penalty*. Also, to increase clarity, numbered headings are changed to appear in bold type face. **[Bracketed, Bold type]** indicates added text/changes made at the time the final order is issued.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the November 2011 Register of Regulations should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend Delaware Title XIX Medicaid State Plan and the Division of Social Services Manual regarding implementation of a *Qualified Long Term Care Insurance Partnership Program* is adopted and shall be final effective January 10, 2012.

Date of Signature

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #11-62a
REVISION:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: DELAWARE

1917(b)(1)(C)	(4)	X	If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership) the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

(Break in Continuity of Sections)

REVISION:

Supplement 8b to ATTACHMENT 2.6-A
Page 1

STATE PLAN UNDER TITLE OF THE SOCIAL SECURITY ACT
State: DELAWARE
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902 (r) (2) OF THE ACT

/ / Section 1902(f) State / X / Non-Section 1902 (f) State

D. Qualified State Long-Term Care Insurance Partnership

1. A resource disregard is given to an individual who has purchased a qualified long-term care insurance policy and has used such policy to pay for certain medical costs as approved or covered under Delaware Medicaid as follows:
    a. Long-term nursing care in nursing facilities. 42 CFR 440.40
    b. Home and community-based services (HCBS) as defined in the Delaware HCBS Waiver for the elderly and disabled (Elderly & Disabled Waiver DE.0136).
2. The amount of the disregard is equal to the dollar amount of insurance benefits that have been paid by the long-term care insurance company in accordance with the provisions of Section 6021 of the Deficit Reduction Act of 2005.
3. Such disregard is in effect for the lifetime of the individual who has purchased the long-term care insurance policy and used the policy to pay for long-term careservices.
4. Persons eligible for a resource disregard are categorically needy individuals in nursing facilities and home and community-based waiver programs under the special income level (250%) defined at 1902(a)(10)(A)(ii)(V).
5. Effective November 1, 2011, Delaware shall accept all of the reciprocity standards as promulgated pursuant to Section 6201(b) of Public Law 109-171 with respect to all other states agreeing to participate under such

reciprocity standards.

6. Resources disregarded under this provision are not subject to recovery of medical payments made on behalf of the individual.

NEW:

STATE PLAN UNDER TITLE OF THE SOCIAL SECURITY ACT
State: DELAWARE
STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2)
1917(b)(1)(C)

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

Individuals who meet the requirements under the following sections of the Social Security Act:
Categorically needy individuals in nursing facilities and home and community-based waiver programs under the special income level (250%) defined at 1902 (a)(10)(A)(ii)(V).

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

X The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
- The policy was issued no earlier than the effective date of this State plan amendment.
- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

NEW:

STATE PLAN UNDER TITLE OF THE SOCIAL SECURITY ACT
State: DELAWARE
STATE LONG-TERM CARE INSURANCE PARTNERSHIP CONTINUED

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
- The State Insurance Department assures that any individual who sells a partnership policy 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.
- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

DMMA FINAL ORDER REGULATION #11-62b
REVISION:

[(~~Policy Number Pending~~ DSSM 20345]) **Qualified State Long-Term Care Insurance Partnership Program**

This policy applies to Long-Term Care Insurance Partnership policies purchased on or after November 1, 2011.

1. Defining a Qualified State Long-Term Care Insurance Partnership.

The Delaware Qualified State Long-Term Care (LTC) Insurance Partnership is a partnership between States that implement a Partnership program, private insurance companies that offer long term care insurance policies and State insurance departments. The term "Qualified State Long-Term Care Insurance Partnership" means an approved State plan amendment (SPA) that provides for the disregard of any assets or resources from Medicaid estate recovery in an amount equal to the insurance benefits paid by certain LTC insurance policies, where those benefits were disregarded in determining an individual's Medicaid eligibility. The term "long-term care insurance policy" includes a certificate issued under agroup insurance contract.

Purchasing or owning a Qualified State Long-Term Care Insurance Partnership policy does not guarantee Medicaid eligibility. All other financial, non-financial and medical eligibility requirements must be met.

Policies must meet specific conditions and the State Insurance Commissioner must certify that a policy meets those conditions, in order for the State to apply the disregard from estate recovery.

The long-term care partnership policy is designed to do all of the following:

a. Provide incentives for individuals to insure against the costs of providing for their long-term care needs.

b. Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

c. Reduce Medicaid expenditures by delaying or eliminating the need for Long-Term Care Medicaid.

2. Long-term care insurance policies purchased prior to November 1, 2011 are not Partnership policies.

3. Long-term care insurance policies purchased on or after November 1, 2011 may or may not be Partnership policies.

A long-term care partnership program policy means a policy that must meet all of the following requirements:

a. The policy must have been issued on or after November 1, 2011.

b. The covered individual must be a resident of a Qualified Partnership State when coverage first becomes effective. If a policy is exchanged for another policy, the residency rule applies to the issuance date of the original policy.

c. The policy must meet the definition of a "qualified long-term care insurance policy" as stated in section 7702B(b) of the Internal Revenue Code of 1986.

d. The policy must meet specific requirement of the National Association of Insurance Commissioners (NAIC) Long Term Care Insurance Model Regulations Act and Model Act.

e. The policy must include inflation protection.

i. For purchasers under 61 years of age, compound annual inflation protection.

ii. For purchasers 61 to 76 years of age, some level of inflation protection; or

iii. For purchasers 76 years of age or older, inflation protection may be offered, but is not required.

4. A Partnership policy allows for assets to be disregarded from eligibility.

The amount of the disregard is equal to the dollar amount of insurance benefits that have been paid to or on behalf of the individual.

This amount is limited to the amount paid as of the month of application, even if additional benefits are available under the terms of the policy.

5. Assets are also protected from the Medicaid Estate Recovery Program.

The amount of the assets disregarded in the eligibility process is not recoverable under the Medicaid estate recovery program.

6. Disregarded assets are counted in the Spousal Resource Assessment.

The disregarded assets are included in determining the amount of the community spouse resource allowance in a Spousal Impoverishment case.

However, the disregarded asset is not counted in determining the individual's eligibility.

[7. Disregarded assets may be transferred without penalty.

If an individual becomes eligible for Medicaid through the application of a QLTCP disregard, then transfers all or part of the disregarded resources that would otherwise be considered an improper transfer, no restricted Medicaid coverage period applies. The disregarded value of the transferred resource continues to be considered part of the individual's QLTCP disregard.

If an individual becomes eligible for Medicaid through the application of a QLTCP disregard after making a transfer that would otherwise be considered an improper transfer:

a. If the individual's QLTCP disregard plus resource limit equals or exceeds the individual's countable resources plus the value of the transferred resource, no penalty period applies. The disregarded value of the transferred resource is considered part of the individual's QLTCP disregard.

b. If the individual's QLTCP disregard plus resource limit is less than the individual's countable resources plus the value of the transferred resource:

i. Determine the individual's available QLTCP disregard by adding the individual's QLTCP disregard to the individual's resource limit, then subtracting the individual's current countable resources and any amounts that have previously been transferred without a restricted Medicaid coverage period as a result of a QLTCP disregard.

ii. Subtract the individual' available QLTCP disregard from the amount that would otherwise have been considered improperly transferred. The remainder is the amount improperly transferred; a restricted Medicaid coverage period is calculated for the remainder.]

[~~7~~8].Reciprocity with other states.

DMMA will accept partnership policies issued in other States with qualified long-term care insurance partnership programs.

[~~8~~9].Exhaustion of Benefits.

An individual who owns a Qualified State Long-Term Care Insurance Partnership policy can apply for Medicaid before exhausting policy benefits.

The partnership policy is treated as a third party liability and Medicaid will pay for services not covered. Medicaid will be payor of last resort.

[~~9~~10].Verification of the Partnership policy.

A Qualified State Long-Term Care Insurance Partnership policy must meet all relevant requirements of federal and state law. Qualified partnership policies are certified by the Delaware Department of Insurance (DOI).