HOUSE RESEARCH

Bill Summary

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Section

Article 1: Health Care Federal Compliance

Overview

This article contains provisions related to compliance with the federal Deficit Reduction Act of 2005. These provisions address MA asset availability and transfers, the state long-term care partnership program and asset recovery, and state health care program citizenship verification.

1 Payments on behalf of enrollees in government health programs. Amends § 62A.045. Requires each health insurer, as a condition of doing business in Minnesota, to comply with the requirements of the Deficit Reduction Act of 2005, including any federal regulations, to the extent the insurer imposes a requirement that is not also required by the laws of this state. Provides a definition of "health insurer."

2 Extension of limitation periods. Amends § 62S.05, by adding subd. 4. Allows the commissioner to extend the preexisting condition limitation periods to specific age group categories in specific forms, upon finding that this is in the best interest of the public.

3 Mandatory format. Amends § 62S.08, subd. 3. Makes changes in the standard format outline of coverage that must be provided to applicants for long-term care insurance. These changes relate to the provision of information on the terms under which a policy may be continued or discontinued, terms for changing premiums, eligibility for payment of benefits, and provision of contact information.

4 Forms. Amends § 62S.081, subd. 4. Adds more specific references to the forms an insurer must use to comply with rating practice disclosure requirements.

5 Contents. Amends § 62S.10, subd. 2. Requires policy summaries for individual life insurance policies that provide long-term care benefits to include a statement that any long-term care inflation protection option required by section 62S.23 is not available under the policy.

6 Death of insured. Amends § 62S.13, by adding subd. 6. Provides that in the event of the death of the insured, provisions related to rescission of a long-term care insurance policy do not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care, and that provisions related to the incontestability of life insurance policies apply.

7 Terms. Amends § 62S.14, subd. 2. Limits use of the term "level premium."

8 Authorized limitations and exclusions. Amends § 62S.15. Allows long-term care policy limits and exclusions for services or items available or paid under another long-term care insurance or health policy.

9 Renewability. Amends § 62S.20, subd. 1. Revises the language of the renewability provision of individual long-term care insurance policies to refer to coverage being guaranteed renewable or noncancelable. Also requires, when applicable, a statement that premium rates may change.

10 Required questions. Amends § 62S.24, subd. 1. Revises the language that must be included on an application form related to determining the existence of other coverage.

11 Other health insurance policies sold by agent. Amends § 62S.24, by adding subd. 1a. Requires agents to list all other health insurance policies they have sold to the applicant that are still in force or were sold in the past five years.

12 Solicitations other than direct response. Amends § 62S.24, subd. 3. Revises language of the required notice related to replacement coverage that must be provided when using non-direct response solicitation methods.

13 Direct response solicitations. Amends § 62S.24, subd. 3. Revises language of the required notice related to replacement coverage that must be provided when using direct response solicitation methods.

14 Life insurance policies. Amends § 62S.24, by adding subd. 7. Requires life insurance policies that accelerate benefits for long-term care to comply with the replacement coverage requirements that apply to long-term care insurance policies, if the policy being replaced is such a policy. Requires compliance with the replacement coverage requirements for life insurance policies, if the policy being replaced is such a policy. Requires compliance with both replacement requirements, if the policy being replaced is also a life insurance policy that accelerates benefits for long-term care.

15 Exchange for long-term care partnership policy; addition of policy rider. Amends § 62S.24, by adding subd. 8. If federal law is amended or a federal waiver granted with respect to the long-term care partnership program, allows issuers of long-term care policies to voluntarily exchange a current policy for a policy that meets the standards of the long-term care partnership program, or to add riders necessary to meet those standards. Requires the commissioner of commerce, in cooperation with the commissioner of human services, to pursue necessary federal law changes or waivers.

16 Claims denied. Amends § 62S.25, subd. 6. Requires insurers to annually report claims denied "for any reason" and provides a definition of "claim."

17 Reports. Amends § 62S.25, by adding subd. 7. Specifies that required reports must be done on a statewide basis and filed with the commissioner, and makes references to specific forms.

18 Loss ratio. Amends § 62S.26. Specifies that the minimum loss ratio shall not apply to life

insurance policies that accelerate benefits for long-term care. Specifies criteria that must be met if such a policy is to be considered to provide reasonable benefits in relation to premiums paid.

19 Requirement. Amends § 62S.266, subd. 2. Specifies methods for offering nonforfeiture benefits for different types of group long-term care insurance.

20 Requirements. Amends § 62S.29, subd. 1. Modifies requirements that apply to insurers or entities marketing long-term care insurance in the state. Requires the establishment of agent training requirements, the provision of copies of disclosure forms, and the provision of an explanation of contingent benefit upon lapse, and limits use of the terms "noncancelable" and "level premium."

21 Suitability. Amends § 62S.30.

Subd. 1. Standards. Requires insurers and entities marketing long-term care insurance to develop and use suitability standards, train agents in the use of these standards, and maintain a copy of the standards and make them available for inspection by the commissioner upon request.

Subd. 2. Procedures. (a) Requires the agent and insurers to take into account ability to pay and other financial information, the applicant's goals or needs, and the values, benefits, and costs of existing insurance compared to that of the recommended purchase or replacement, when determining whether an applicant meets the standards for long-term care insurance.

(b) Requires the insurer to make reasonable efforts to obtain the information required under paragraph (a), including presentation of the Long-Term Care Insurance Personal Worksheet.

(c) Requires a completed worksheet to be returned to the insurer prior to consideration of the applicant for coverage.

(d) Requires insurers and agents to use the suitability standards.

(e) Requires a disclosure form to be provided to applicants.

(f) Specifies procedures to be followed if an applicant does not meet financial suitability standards, or has declined to provide information.

Subd. 3. Reports. Requires the insurer to report specified statistics on applications and applicants annually to the commissioner.

Subd. 4. Application. States that this section does not apply to life insurance policies that accelerate benefits for long-term care.

22 Producer training. Adds § 62S.315. Requires the commissioner of commerce to approve producer-training requirements in accordance with NAIC Long-Term Care Insurance Model Act provisions. Requires the commissioner of human services to provide technical assistance and information.

23 Medical assistance payment. Amends § 144.6501, subd. 6. Adds an exception for the Deficit Reduction Act of 2005 to the requirement that a nursing facility admission contract may not require as a condition of admission that a resident remain in private pay status for any period of time.

24 Private health coverage. Amends § 256B.02, subd. 9. Amends the definition of "private health coverage" to include any self-insured plan, pharmacy benefit manager, service benefit plan, managed care organization, and other parties that by contract are legally responsible for payment of a health care claim for an MA, GAMC, or MinnesotaCare

enrollee.

25 Homestead, exclusion and homestead equity limit for institutionalized persons. Amends § 256B.056, subd. 2. Limits the equity interest in the homestead of an individual whose eligibility for long-term care services is determined on or after January 1, 2006, to $500,000, unless it is the lawful residence of the individual's spouse or child who is under age 21, blind, or disabled. Beginning in 2011, requires this amount to be annually increased by the change in the CPI, rounded to the nearest $1,000. Allows this provision to be waived in the case of demonstrated hardship by a process to be determined by the secretary of health and human services.

26 Treatment of continuing care retirement and life care community entrance fees. Amends § 256B.056, by adding subd. 3e. Provides that an entrance fee paid to a continuing care retirement or life care community shall be treated as an available asset to the extent that:

(1) the individual has the ability to use the fee, or the contract allows the fee to be used, to pay for care should other resources or income be insufficient;

(2) the individual is eligible for a refund of remaining fees when the individual dies or terminates the contract; and

(3) the entrance fee does not confer an ownership interest.

27 Treatment of annuities. Amends § 256B.056, by adding subd. 11. (a) Requires an individual applying for or seeking recertification of eligibility for MA payment of long-term care services to provide a complete description of any interest either the individual or the individual's spouse has in annuities, using disclosure forms provided by the department.

(b) Requires the disclosure form to include a statement that the department becomes the remainder beneficiary under the annuity or similar financial instrument by virtue of receipt of MA. Specifies form requirements. Requires the individual and the individual's spouse to execute separate disclosure forms for each annuity or similar instrument.

(c) Requires the issuer to confirm that this designation has been made and to notify the county agency when there is a change in the amount of income or principal being withdrawn. Requires the county agency to provide the issuer with contact information.

28 Long-term care partnership program. Amends § 256B.0571.

Subd. 2. Home care service. E liminates the definition of "home care service."

Subd. 5. Nursing home. E liminates the definition of "nursing home."

Subd. 6. Partnership policy. M odifies the definition of "partnership policy" by eliminating a reference to total asset protection policies and eliminating an exemption related to when a policy was issued.

Subd. 7a. Protected assets. D efines "protected assets" as assets or proceeds of assets that are protected from recovery under subdivisions 13 and 15.

Subd. 8. Program established. A dds language linking eligibility criteria for the partnership program to the effective date of the state plan amendment and makes other revisions in language. Also allows beneficiaries of policies exchanged or to which necessary riders are added under section 62S.24, subdivision 8, to participate

in the program (if federal law is amended or a federal waiver granted).

Subd. 9. Medical assistance eligibility. The amendment to paragraph (a) rephrases existing language and adjusts internal references.

The amendment to paragraph (b) rephrases existing language and adds new language governing designation of assets that are to be protected from recovery.

The amendment to paragraph (c) requires individuals to identify the designated assets and their full fair market value, and designate them as assets to be protected at the time of initial MA application. Also specifies the methodology for determining the full fair market value and ownership.

Paragraph (d) specifies that the right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided. Also provides that the right to designate assets does not include the increase in the value of the asset.

Paragraph (e) allows individuals to designate additional assets that become available if the dollar amount of benefits utilized under a partnership policy is greater than the full fair market value of assets protected at the time of MA application.

Paragraph (f) states that the section applies only to estate recovery under federal law, and does not apply to other types of recovery authorized by federal law, including but not limited to trusts and annuities.

Paragraph (g) provides that protected assets owned by an individual's spouse who applies for MA payment of long-term care services shall not be protected assets or disregarded for purposes of eligibility of the spouse, solely because they were protected assets for the individual.

Paragraph (h) exempts assets designated as protected from asset transfer penalties.

Paragraph (i) directs the commissioner to otherwise determine an individual's eligibility for payment for long-term care services according to MA eligibility requirements.

Subd. 10. Inflation protection. Specifies inflation protection requirements and eliminates provisions related to offering of an elimination period, meeting implementation requirements, and minimum daily benefits.

Subd. 11. Total asset protection policies. Language in this subdivision is stricken.

Subd. 12. Compliance with federal law. Requires issuers to comply with DEFRA 2005.

Subd. 13. Limitations on estate recovery. (a) States that protected assets shall not be subject to recovery, and that protected assets of the individual in the estate of the individual's surviving spouse are not liable to pay a claim for recovery of MA paid for

the predeceased spouse. Also states that protected assets of the individual in the surviving spouse's estate are subject to recovery for MA paid on behalf of the surviving spouse.

(b) Specifies procedures for asset protection by a personal representative.

(c) Provides that asset protection terminates when the estate distributes the assets or if the estate has not been probated within one year of the date of the individual's death.

(d) Allows the state or county agency to file and collect claims in an estate, if the estate is opened for probate more than one year after the individual's death, and no statute of limitations applies.

(e) States that except as otherwise provided, nothing in this section shall limit or prevent recovery of MA.

Subd. 14. Implementation. Replaces existing implementation language with a requirement that the commissioner submit a state plan amendment to the federal government to implement the long-term care partnership program.

Subd. 15. Limitation on liens. (a) Provides an individual's interest in real property shall not be subject to an MA lien or notice of potential claim while it is protected under subdivision 9.

(b) Provides that MA liens against real property designated as protected under subdivision 13, paragraph (b), shall be released to the extent of the dollar value of protection.

(c) Provides that if an interest in real property is protected under paragraph (a) or (b) from a lien for recovery of MA paid on behalf of the individual, no lien for MA recovery shall be filed against the protected property after it is distributed to the individual's heirs or devisees.

Subd. 16. Burden of proof. States that the individual who asserts that an asset is disregarded or protected shall have the initial burden of documenting and proving this by clear and convincing evidence.

Provides a July 1, 2006, effective date.

29 Payment of benefits from an annuity. Adds § 256B.0594. When a payment becomes due under an annuity that names the department a remainder beneficiary, requires the issuer to request and the department to provide a written statement of the total amount of MA paid. Requires the issuer to pay the department an amount equal to the lesser of the amount due the department under the annuity or the total amount of MA paid on behalf of the individual or individual's spouse. Specifies that any amounts remaining are payable according to the terms of the annuity. Requires the county agency or department to provide the issuer with contact information. Also provides that section 72A.201, subdivision 4, clause (3) (requiring issuers to act on claims within 30 business days) does not apply to this section until the issuer has received payment information from the department, if the issuer has notified the beneficiary.

30 Prohibited transfers. Amends § 256B.0595, subd. 1. The amendment to paragraph (b)

extends the look-back period for any disposal of assets made on or after February 8, 2006, from 36 to 60 months.

A new paragraph (f) provides that the purchase of an annuity on or after February 8, 2006, by an individual who has applied for long-term care services or the individual's spouse shall be treated as a disposal of an asset for less than fair market value, unless the department is named as a beneficiary for an amount at least equal to the amount of MA paid for the individual or the individual's spouse and the annuity meets specified standards. Provides that any change in the designation of the department as remainder beneficiary shall result in the annuity being treated as a disposal of assets for less than fair market value. Also classifies any change in the amount of income or principal being withdrawn as a transfer for less than fair market value, unless the individual or individual's spouse demonstrates that the transaction was for fair market value.

A new paragraph (h) provides that the prohibition on transfers for less than fair market value applies to the funds used to purchase a promissory note, loan, or mortgage, unless the instrument purchased: has a repayment term that is actuarially sound, provides for payments to be made in equal amounts with no deferral or balloon payments, and prohibits cancellation of the balance upon the death of the lender.

A new paragraph (i) provides that the prohibition on transfers for less than fair market value applies to the purchase of a life estate in another individual's home, unless the purchaser resides in the home for a period of at least one year after the date of purchase.

31 Period of ineligibility. Amends § 256B.0595, subd. 2. A new paragraph (c) states that for uncompensated transfers made on or after February 8, 2006, the period of ineligibility begins on the first day of the month in which advance notice can be given following the month in which the transfer occurred, or the date on which the individual is eligible for MA and would otherwise be receiving long-term care services, whichever is later, and which does not occur during any other period of ineligibility.

The amendment to paragraph (d) eliminates the $200 limit at and below which an uncompensated transfer not made during a penalty period does not result in a fractional penalty period.

A new paragraph (e) provides that in the case of multiple fractional transfers in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is determined by treating the total, cumulative uncompensated value as one transfer.

Provides that this section is effective for applications, renewals, and reports of transfers on or after July 1, 2006.

32 Homestead exception to transfer prohibition. Amends § 256B.0595, subd. 3. Allows a long-term care facility, with the written consent of the individual or the personal representative of the individual, to file an undue hardship waiver request on behalf of an individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer of a homestead on or after February 8, 2006. When a waiver is granted, allows a cause of action against the person to whom a homestead was transferred for that portion of long-term care services provided within 60 months, if the homestead was transferred on or after February 8, 2006.

33 Other exceptions to transfer prohibition. Amends § 256B.0595, subd. 4. Allows a long-term

care facility, with the written consent of the individual or the personal representative of the individual, to file an undue hardship waiver request on behalf of an individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer made on or after February 8, 2006. Requires the local agency, in evaluating the waiver request, to take into account whether the individual has taken any action to prevent designation of the department as a remainder beneficiary on an annuity. When a waiver is granted, allows a cause of action against the person to whom assets were transferred for that portion of long-term care services provided within 60 months, if the assets were transferred on or after February 8, 2006.

34 Citizenship requirements. Amends § 256B.06, subd. 4. Requires citizens or nationals of the U.S. to cooperate in obtaining satisfactory documentary evidence of citizenship or nationality for purposes of MA, according to the requirements of DEFRA 2005. Provides a July 1, 2006, effective date.

35 General assistance medical care; eligibility. Amends § 256D.03, subd. 3. Requires citizens or nationals of the U.S. to cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of DEFRA 2005, for purposes of GAMC. Provides a July 1, 2006, effective date.

36 Citizenship requirements. Amends § 256L.04, subd. 10. Requires citizens or nationals of the U.S. to cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of DEFRA 2005, for purposes of MinnesotaCare. Provides a July 1, 2006, effective date.

37 **Designation of assets as contingently exempt under long-term care partnership program.** Requires the commissioner of human services to develop and present to the legislature, by December 15, 2006, a plan and draft legislation to allow individuals participating in the long-term care partnership program to designate assets as contingently exempt. The value of the contingently exempt assets must not exceed a percentage, specified by the commissioner, of the value of the assets protected under the partnership program. If the assets protected decrease in value, the plan and draft legislation must allow the individual or personal representative to designate contingently exempt assets as protected, up to the amount of the decrease in value. Specifies that any contingently exempt assets not designated as protected are to be subject to recovery.

38 Repealer. Repeals the following provisions of section 256B.0571 relating to the long-term care partnership program: subdivisions 2 (definition of "home care services"), 5 (definition of "nursing home"), and 11 (total asset protection policies).

Article 2: Children and Families Federal Compliance

Overview

This article contains provisions related to compliance with the federal Deficit Reduction Act of 2005. These provisions address the TANF program and child support.

1. 1 Separate state program for use of state money. Amends § 256J.021. Paragraph (a) until October 1, 2006, requires the commissioner to treat MFIP expenditures made on behalf of any minor child who is part of a two-parent eligible household as expenditures under a separately funded state program and to report those expenditures as separate state program expenditures under the Code of Federal Regulations. This is current law.

Adds paragraph (b). Beginning October 1, 2006, paragraph (b) requires the commissioner to

treat MFIP expenditures made on behalf of any minor child who is part of a two-parent eligible household as expenditures under a separately funded state program. Provides that these expenditures do not count toward the state's TANF MOE requirement, unless counting certain families would allow the commissioner to avoid a federal penalty. Requires families receiving assistance under this section to comply with all applicable MFIP requirements.

2 Allowable expenditures. Amends § 256J.626, subd. 2. Adds paragraph (e), which allows the commissioner to waive the cap on administrative costs for a county or tribe that elects to provide an approved supported employment, unpaid work, or community work experience program for a major segment of the county's or tribe's MFIP population. Requires the county or tribe to apply for the waiver on forms provided by the commissioner. Prohibits total administrative costs from exceeding the TANF limits.

3 Fees for IV-D services. Amends § 518.551, subd. 7. Adds that the public authority is to impose an annual federal collection fee of $25 for each child support case in which the public authority has collected at least $500 of support for individuals who have never received public assistance. This fee is not to be retained from the first $500 collected. This section is effective October 1, 2006, or later if the commissioner determines a later implementation date will not result in federal financial penalties.

Article 3: Appropriations and Related Provisions

Overview

This article adjusts appropriations and makes base level adjustments related to the federal compliance provisions in Article 1, and also funds certain initiatives.

1. 1 Supplemental appropriations. States that the appropriations in this article modify appropriations made in prior law.

2 Commissioner of human services.

Subd. 1. Total appropriation. Provides the total appropriation for the commissioner of human services.

Subd. 2. Children and economic assistance management.

- Children and economic assistance operations base adjustment. Decreases the general fund base for children and economic assistance operations in fiscal years 2008 and 2009.

Subd. 3. Health care grants. Provides the total appropriation decrease for health care grants.

Subd. 4. Health care management.

- Health care administration base level adjustment . Decreases the general fund base for health care administration in fiscal years 2008 and 2009.

- Health care operations base level adjustment . Decreases the general fund base for health care operations in fiscal year 2008 and increases it in fiscal year 2009.

- Health care operations base level adjustment . Decreases the health care access fund base for health care operations in fiscal years 2008 and 2009.

Subd. 5. Continuing care grants.

- Aging and adult services grants for Medicare Part D. Provides an appropriation from the general fund to the commissioner of human services in fiscal year 2007 for grants awarded through the Minnesota Board on Aging to Area Agencies on Aging to provide enrollment information for the Medicare Part D program.

- Medicare Part D information and assistance reimbursement. Provides that federal reimbursement obtained from information and assistance services provided by the Senior Linkage or Disability Linkage lines is appropriated to the commissioner for this activity.

- Aging and adult services grants base adjustment. Decreases the general fund base for aging and adult services grants in fiscal years 2008 and 2009.

Subd. 6. Continuing care management.

Continuing care management base adjustment . Decreases the general fund base for continuing care management in fiscal years 2008 and 2009.

3 Employment and economic development.

- Biotech Partnership. Appropriates money from the general fund to the commissioner of employment and economic development for direct and indirect expenses of the collaborative research partnership between the University of Minnesota and the Mayo Foundation for research in biotechnology and medical genomics. Requires an annual report to be submitted to the governor and relevant legislative chairs.

4 Physician and dental reimbursement. Amends § 256B.76. Requires the commissioner of human services to annually establish a reimbursement schedule for critical access dental providers and provider-specific limits on total reimbursement received under the reimbursement schedule. Requires the commissioner to notify each critical access dental provider of the schedule and limit.

5 Pharmacy payment reform advisory committee.

Subd. 1. Definitions. Defines terms used in this section.

Subd. 2. Advisory committee. Creates a Pharmacy Payment Reform Advisory Committee to be convened by the commissioner of human services. The committee will advise the commissioner and make recommendations to the legislature on implementation of pharmacy reforms contained in the federal 2005 deficit reduction act. Specifies membership, provides the members serve without compensation, and provides that the committee expires January 31, 2008.

Subd. 3. Cost of dispensing study. Requires Department of Human Services to conduct a prescription drug cost of dispensing study to determine the average cost of dispensing Medicaid prescriptions in Minnesota. Requires contracting with an independent third-party, who must report to the department and the advisory

committee by October 1,2006.

Subd. 4. Content of study. Specifies topics to be covered in the study required by subdivision 3.

Subd. 5. Methodology. Requires disclosure of the study's methodology and required collected data to be published in a manner that doesn't identify the source.

Subd. 6. Recommendations. Requires the advisory committee to use the information from the study to make recommendations. Requires the commissioner to report the findings of the cost of dispensing study and the recommendations of the advisory committee to the legislature by January 15, 2007. Requires the department to conduct a cost of dispensing study every three years. Requires the commissioner, in consultation with the advisory committee, to make recommendations to the legislature on how to adjust reimbursement rates to pharmacies to cover pharmacy costs, and to meet other requirements specified in this subdivision.

Provides an immediate effective date.