

# **Supporting Statement for Partnership for Long Term Care Insurer Reporting Requirements**

## **Background**

In the late 1980's, a number of State Medicaid programs began to work with private insurance companies to create a bridge between Medicaid and private insurance for long-term care. The result was the establishment of State Long-Term Care Partnership Programs that provide expanded access to Medicaid by allowing private long-term care insurance policyholders to keep additional assets when financial eligibility under the Medicaid program is determined. State partnerships provide an incentive for insurers to offer affordable, high quality benefits and for consumers to protect themselves against the high cost of long-term care through the purchase of insurance policies that can be used in conjunction with benefits provided under Medicaid. Four States (California, Connecticut, Indiana, and New York) initially implemented Partnership Programs in 1993.

The Omnibus Reconciliation Act of 1993 (OBRA 1993), contained language that changed the conditions under which CMS could approve Medicaid State Plan Amendments relating to asset disregards for private long-term care insurance. States with approved Plan Amendments (CA, CT, IN, NY, IA, MA) were allowed to continue implementation on the terms outlined in the Plan Amendments, however, new states would have to meet a new set of requirements. OBRA 1993's requirements for state Partnership Programs proved extremely difficult to satisfy. While OBRA 1993 did not forbid additional States from attempting to establish Long-Term Care Partnership Programs, the impact was essentially the same as a ban. A few States tried unsuccessfully to launch partnership programs under the new conditions. Other interested States passed enabling legislation with contingency language that allowed the

State to proceed if the OBRA 1993 partnership provisions were repealed. No subsequent Federal legislation related to Long-Term Care Partnership Programs was enacted until the Deficit Reduction Act (DRA) of 2005.

Section 6021(a)(1) of the DRA of 2005 amended section 1917(b)(1)(C)(i) and added new sections 1917(b)(1)(C)(iii) through (vi) to the Act that provide for an expansion of State long-term care insurance partnerships through a new set of conditions. Under this provision, States may establish qualified State long-term care insurance partnerships, defined in the Act as an approved Medicaid State plan amendment under Title XIX of the Act that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if certain requirements specified in sections 1917(b)(1)(C)(iii)(I) through (VII) of the Act are met. In other words, States establishing Partnership Programs must offer a dollar of asset disregard for every dollar paid under a long-term care insurance policy issued under a State Long-Term Care Partnership Program.

## **A. Justification**

### **1. Need and Legal Basis**

Section 1917(b)(1)(C)(v) of the Act provides that the regulations required under section 1917(b)(1)(C)(iii)(VI) of the Act shall be promulgated and shall specify the type and format of the data to be reported and the frequency with which such reports are to be made by participating insurers to the Secretary. Issuers of long-term care insurance policies under a State qualified long-term care insurance partnership must provide 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 State long-term care insurance partnerships. In addition, the Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the States involved.

## **2. Information Users**

The users of the information are made of two groups; state governments (principally Medicaid officials and insurance regulators) and federal policy officials. Medicaid officials need the information to accurately process Medicaid eligibility for persons participating in the Partnership program. HHS also needs access to the data to determine the impact of the Partnership on Medicaid long term care expenditures. HHS was charged with collecting the data so as to avoid the need for every state to draft its own reporting requirements.

## **3. Improved Information Technology**

Data submission for this project will be done electronically through a secure web site. All aspects of collecting data and providing access to states will be done using the web so as to reduce the burden on insurers and states. All of the data requested of insurers is already collected and present in their data systems. Complying with these reporting requirements will require that companies do initial programming to extract the data, but should not present an ongoing burden as the reporting requirements are unlikely to change frequently.

## **4. Duplication of Similar Information**

This information will not be collected by any other entity within or outside of the federal

government. These reporting requirements represent a unified approach to reporting that avoids the need for each state to develop their own reporting requirements. Participating insurers will be creating one report that will be used by all participating states thereby dramatically reducing the burden of creating unique reports for each participating state.

#### **5. Small Businesses**

No small businesses will be involved in this study.

#### **6. Less Frequent Collection**

These requirements include reports from insurers on policies sales activity every six months and on long term care insurance claims every quarter. These intervals were selected because they provide enough information to serve their intended purpose while not being so frequent as to be burdensome. This schedule allows states and the federal government to effectively monitor activity in the sales area. Reports once a year would not provide sufficient information to determine program trends in a timely fashion. Claims reports are more frequent because states need accurate information on the amount of asset protection Medicaid applicants have earned. Also, should the data be collected on a less frequent basis, state governments may determine that federal reports are not sufficiently timely, resulting in duplicative state reporting requirements.

#### **7. Special Circumstances**

The data collection is somewhat different in that the data is being collected from private

insurers and not from individuals. Otherwise, there are no special circumstances.

#### **8. Federal Register Notice/Outside Consultation**

The Department published a Notice of Public Rule Making (NPRM) in the Federal Register on May 23, 2008 (Vol. 73, No.101, p30030) entitled “Office of the Assistant Secretary for Planning and Evaluation; State Long-Term Care Partnership Program: Reporting Requirements for Insurers.” The Office of Management and Budget determined that this NPRM would obviate the need for 30 and 60 day notices requesting public comments related to this information collection.

In accordance with the provisions of the DRA, HHS consulted with numerous stakeholders in the development of the Reporting Requirements. In addition to one-on-one consultations with stakeholders representing states, insurers, consumers, and regulators, HHS assembled a Technical Expert Panel (TEP) to provide a forum for the exchange of ideas, perspectives, and expertise regarding the specification of individual data items. The TEP consisted of 17 members representing insurers, states, consumer organizations, the NAIC, the Federal government, and the policy research community.

Invitations to members to participate on the Technical Expert Panel were sent by HHS in January 2007, along with an initial draft of the Reporting Requirements. Two conference calls with the TEP were then held on January 30, 2007 and February 13, 2007 to discuss the draft reporting requirements and to provide TEP members with the opportunity to suggest changes. A revised set of Reporting Requirements was then distributed to TEP members on February 23, 2007, prior to a face-to-face all-day meeting of the TEP held in Washington, DC on February 27,

2007. Subsequent to the face-to-face meeting, further revisions were made to the Reporting Requirements and distributed to the TEP, after which another conference call was held on April 12, 2007. These reporting requirements represent the end product of this stakeholder input process. The names and contact information for the Technical Panel are as follows:

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### **9. Payment/Gift to Respondents**

No gifts or payments will be made to respondents.

### **10. Confidentiality**

This data collection represents a system of records and does fall under the requirements of Privacy Act. This System of Records is entitled “Partnership for Long Term Care Data Set” and has been issued the following identification number: 09-90-0085.

The data will be collected, manipulated and stored by a contractor to The Office of the Assistant Secretary for Planning and Evaluation. Thomson HealthCare has a sophisticated system for maintaining large data sets as they do so for CMS and for a number of health insurers. They have control over the technical, administrative and physical aspects of the data.

### **11. Sensitive Questions**

The reporting requirements do not include any fields of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

### **12. Burden Estimate (Total Hours & Wages)**

The respondents for this collection are participating long term care insurance companies. We estimate that 30 insurance companies will participate in the Partnership program. The

following estimate is for the initial programming to compile the data files necessary to comply. Once the software programs have been written, the ongoing burden of reporting is minimal.

12A. Estimated Annualized Burden Hours

<b>Type of Respondent</b>	<b>No. of Respondents</b>	<b>No. of Responses per Respondent</b>	<b>Average Burden per Response (in hours)</b>	<b>Total Burden Hours</b>
<b>LTC Insurers</b>	<b>30</b>	<b>1</b>	<b>400</b>	<b>12,000</b>

12B. Estimated Annualized Burden Cost

<b>Type of Respondent</b>	<b>Total Burden Hours</b>	<b>Hourly Wage Rate</b>	<b>Total Respondent Costs</b>
<b>LTC Insurers</b>	<b>12,000</b>	<b>\$125</b>	<b>\$1,500,000</b>

### **13. Capital Costs (Maintenance of Capital Costs)**

The information collected with this instrument are currently collected and housed by the insurance industry. Submission of the data required here is only a sub-set of the much larger data collection and maintenance systems already in place. It is not anticipated that the required reports will require that the insurance industry expand their computer capacity or their system staff.

### **14. Cost to Federal Government**

The total costs of collecting the requested information is as follows:

Contractor: \$200,000 per year.

Federal Staff Contract Monitor: \$30,000 .

Total Average Cost to Government: \$230,000.

Funds for these costs were earmarked in the DRA of 2005 for the years 2006 through 2010.

**15. Program or Burden Changes**

NA

**16. Publication and Tabulation Dates**

The DRA of 2005 requires that the Secretary provide a report to Congress on the implementation status of the Partnership. Data from this collection will be summarized and presented in this report. Included in this report will be data on the number of Partnership policies sold nationwide. The amount of asset protection earned by program participants, and the amount of insurance company benefit by claim types. Also included will be summary statistics on Partnership policy purchasers. The data will also be made available to states, mandated in the DRA of 2005. .

**17. Expiration Date**

This is a permanent and ongoing collection of information for an active program. No termination of information is expected.

**18. Certification Statement**

“There are no exceptions to the certification.” .

**B. Collection of Information Employing Statistical Methods If statistical methods will not be used to select respondents and item 17 on Form 83-I is checked “No” use this section to describe data collection procedures.**

This data collection is comprised of all Partnership long term care insurance policies sold

in the country. There is no sampling methodology and insurers are responsible for providing data on all policies that they sell. One of the uses of the data is to assist states in identifying persons participating in the Partnership program and to provide an estimate of the total amount of asset disregards that have been earned by persons participating in the program.