SENATE BILL NO. 69

INTRODUCED BY WATERMAN

BY REQUEST OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT AUTHORIZING THE CREATION OF LONG-TERM CARE INSURANCE PARTNERSHIPS BETWEEN INDIVIDUALS, PRIVATE HEALTH INSURERS, THE COMMISSIONER OF INSURANCE, AND THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; AUTHORIZING THE DEPARTMENT AND THE COMMISSIONER OF INSURANCE TO ADOPT STANDARDS FOR CERTIFYING CERTAIN LONG-TERM CARE INSURANCE POLICIES; ALLOWING CERTAIN ASSETS OF AN INDIVIDUAL WHO PURCHASES A CERTIFIED LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE TO BE DISREGARDED BY THE DEPARTMENT IN DETERMINING ELIGIBILITY FOR MEDICAID BENEFITS; AMENDING SECTION 53-6-143, MCA; AND PROVIDING CONTINGENT EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 4 and 5] grant rulemaking authority to the commissioner of insurance and the department of public health and human services. [Section 4] authorizes the commissioner and the department to adopt rules regarding requirements for certification of long-term care insurance policies and certificates for the purposes of qualification for medical assistance benefits. [Section 5] requires the department to adopt rules necessary for the administration of long-term care insurance partnerships, including eligibility requirements for disregard of resources and amounts of resources to be disregarded for the purposes of qualification for medical assistance benefits. In adopting rules pursuant to these sections, the commissioner and the department shall take into consideration the goal of reducing expenditures for long-term care by the Montana medicaid program.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Definitions.** As used in [sections 1 through 5], unless the context indicates otherwise, the following definitions apply:

(1) "Certificate" means a certificate as defined in 33-22-1107.

(2) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

(3) "Department" means the department of public health and human services provided for in 2-15-2201.

(4) "Dollar-for-dollar model" means a program in which the amount of resources that is disregarded in determining medical assistance eligibility for an individual is increased by $1 for each dollar paid by an insurer to an insured under the insured's long-term care insurance policy or certificate.

(5) "Long-term care insurance" means an insurance policy or certificate that provides coverage for medically necessary services in a long-term care facility, as defined in 50-5-101, or in the insured's home.

(6) "Long-term care insurance partnership" or "partnership" means a program of collaboration between the commissioner, the department, insurers, and their insureds to create an incentive, through the issuance of insurance policies or certificates certified by the commissioner and the department, for individuals to purchase long-term care insurance.

(7) "Policy" means a policy as defined in 33-22-1107.

(8) "Total assets model" means a program in which all of an individual's resources are disregarded in determining eligibility for medical assistance after all benefits paid by the individual's long-term care insurance policy or certificate providing coverage for a specified period of time have been exhausted.

NEW SECTION. **Section 2. Purpose.** The purpose of [sections 1 through 5] and the long-term care insurance partnerships authorized by [sections 1 through 5] is to encourage individuals to purchase long-term care insurance policies or certificates that will provide for their potential long-term care needs, thereby reducing the amount of money spent by the state of Montana for long-term care under the Montana medicaid program. The purpose of [sections 1 through 5] is also to provide an incentive for the purchase of the policies or certificates by providing individuals some protection from the requirement that they spend down their resources in order to qualify for medical assistance benefits in the form of payment for long-term care.

NEW SECTION. **Section 3. Long-term care insurance partnerships authorized.** (1) The commissioner and the department may in their discretion create long-term care insurance partnerships if federal law permits those partnerships. If created, the partnerships must be consistent with the requirements of Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq.

(2) The commissioner and the department may in their discretion collaborate with private insurers

to create long-term care insurance partnerships that will allow individuals who have resources in excess of the resource limit for receipt of medical assistance under the Montana medicaid program to receive medical assistance benefits if those individuals are eligible for or require the level of care provided by a long-term care facility and meet the other program requirements to qualify for those benefits.

(3) Under partnerships created pursuant to this section, individuals may qualify for special treatment of their resources if they purchase a long-term care insurance policy or certificate certified by the commissioner and the department as provided in [section 4] prior to becoming eligible for medical assistance benefits.

(4) The long-term care insurance partnerships may in the department's discretion be based on a total assets model or a dollar-for-dollar model or may be structured in another manner intended to accomplish the purpose of the partnerships.

NEW SECTION. **Section 4. Rulemaking and certification of policies by commissioner and department.** (1) The commissioner and the department may by rule adopt requirements for certification of long-term care insurance policies and certificates. These requirements may include but are not limited to:

(a) minimum levels and durations of benefits;

(b) mandatory inflation protection;

(c) mandatory home and community care coverage;

(d) case management; and

(e) procedures for the insured to appeal a denial of benefits.

(2) The commissioner and the department shall review long-term care insurance policies and certificates to determine whether policies and certificates meet the requirements for certification pursuant to this section.

NEW SECTION. **Section 5. Department to make rules.** The department shall adopt rules necessary or desirable for the administration of the partnerships, including but not limited to rules concerning:

(1) the populations and age groups eligible to have resources disregarded for the purposes of qualification for medical assistance benefits under the Montana medicaid program;

(2) the level of care that an individual requires in order to have resources disregarded in determining eligibility for medical assistance benefits;

(3) the amount and type of resources of an individual that will be disregarded in determining eligibility for medical assistance benefits;

(4) requirements for the disregard of resources of an individual in determining eligibility for medical assistance benefits; and

(5) the exemption of protected resources from a lien provided in 53-6-171 through 53-6-189 for the recovery of medical assistance benefits paid by the state.

Section 6. Section 53-6-143, MCA, is amended to read:

"**53-6-143. Medical assistance liens and recoveries.** (1) Except as provided in this section, the department may not impose a lien upon the property of an applicant for or recipient of medical assistance.

(2) A lien for recovery of medical assistance paid or to be paid under this chapter may be imposed against the real or personal property of a medicaid applicant or recipient prior to the applicant's or recipient's death only:

(a) pursuant to a judgment of a court for recovery of medical assistance paid on behalf of the recipient;

(b) on a third-party recovery as provided in 53-2-612; ~~or~~

(c) as provided in 53-6-171 through 53-6-188; or

(d) to the extent that the recipient has received medical assistance based upon resources not disregarded pursuant to [sections 1 through 5].

(3) The department may recover medical assistance correctly paid on behalf of a recipient only as provided in 53-2-612, 53-6-167 through 53-6-169, or 53-6-171 through 53-6-188 or as provided in a written agreement between the department and the recipient or the recipient's representative pursuant to 42 U.S.C. 1382b(b).

(4) Except as otherwise specifically provided by 53-6-144, 53-6-165 through 53-6-169, 53-6-171 through 53-6-189, and this section, the department may pursue recovery under any section or combination of sections as may be applicable in a particular case. However, the department may not recover pursuant to 53-6-167 through 53-6-169 or 53-6-171 through 53-6-188 more than the total amount of recoverable medical assistance paid on behalf of a recipient, plus any applicable costs, interest, or other charges specifically allowed by law. The fact that the department has or may have a lien on particular property does not preclude the department from pursuing recovery under another section against other assets of the

recipient or assets of another person as provided in 53-6-144, 53-6-165 through 53-6-169, 53-6-171 through 53-6-189, and this section."

NEW SECTION. **Section 7. Codification instruction.** [Sections 1 through 5] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through 5].

NEW SECTION. **Section 8. Contingent effective dates.** (1) [Sections 4, 5, and 7 and this section] are effective on the effective date of the repeal of 42 U.S.C. 1396p(b)(1)(A) and (b)(1)(B) or of the amendment of that section in a manner prohibiting adjustment or recovery of medical assistance paid to individuals described in that section.

(2) [Sections 1 through 3 and 6] are effective 6 months after [the effective date of sections 4 and 5].

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0069, as revised

DESCRIPTION OF PROPOSED LEGISLATION:
An act authorizing the creation of long-term care insurance partnerships between individuals, private health insurers, the Commissioner of Insurance, and the Department of Public Health and Human Services (DPHHS); authorizing the department and the Commissioner of Insurance to adopt standards for certifying certain long-term care insurance policies; and allowing certain assets of an individual who purchases a certified long-term care insurance policy or certificate to be disregarded by the department in determining eligibility for Medicaid benefits.

ASSUMPTIONS:
1. There are two long term care insurance partnership models that are in use at the present time nationally: the Dollar-for-Dollar model and the Total Assets model.

Dollar-For-Dollar Model:
2. The dollar-for-dollar model is where the amount of resources disregarded in determining medical assistance eligibility for an individual is increased by $1 for each dollar paid by an insurer to an insured under the insured's long-term care insurance policy or certificate.
3. There will by definition be no fiscal impact for the dollar-for-dollar model since the costs for Medicaid eligible nursing home care will decrease equal to the amount of long-term care insurance benefits paid.
4. Passage of this bill will require the State Auditor's Office to adopt ten pages of administrative rules at $35 per page. This will be absorbed within the current law budget.
5. Long-term care insurers will be required to file additional long-term care insurance policies and certificates with the State Auditor's Office. Review of these policies and certificates must be completed by the State Auditor's Office. This added review process will slow the current review process and be absorbed by existing staff.

Total Assets Model
6. All of an individual's resources are disregarded in determining eligibility for medical assistance after all benefits paid by the individual's long-term care insurance policy or certificate providing coverage for a specified period of time have been exhausted.
7. In the participating states that currently use the Total Assets model (California, Connecticut, Indiana, and New York), 15,000 long term policies have been sold to a population over 17 years of age totaling 43,166,309 or .03475%. In Montana, based on the population over 17 years of age, using .03475%, an estimate of 211 policies would be sold.
8. Assuming each policy has coverage for 3 years of nursing home care, the earliest fiscal impact would be three years after implementation, in FY2000.
9. Federal legislation allowing this partnership plan will be modified at the federal level by July 1, 1997.
10. The average length of stay in a nursing facility is projected to be 2 years.
11. About 75% of the 211 policy holders will stay less than the two year average length of stay in a facility, and will be covered by insurance. This totals 158 individuals. (211 x 75% = 158)
12. About 25% of the 211 policy holders will stay one year longer than the three year benefit period and will be eligible for Medicaid under the total assets model. This totals 53 individuals (25% x 211 = 53).

(Continued)

Dave Lewis 1-13-97

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Mignon Waterman 1-14-97

MIGNON WATERMAN, PRIMARY SPONSOR DATE

13. About 5% of the 158 individuals who purchased long-term care coverage under the partnership plan would have originally become eligible without the purchase of long-term care insurance because of asset transfers. This totals 8 individuals (158 x 5% = 8). It is assumed that these people would opt to buy the insurance to maintain control over their assets rather than transferring these assets to heirs.
14. About 5% of the 53 individuals who will stay longer than three years would have divested themselves of assets through asset transfers without partnership programs in place in order to become eligible for Medicaid. This totals 3 individuals (53 x 5% = 3).
15. Average federal/state share of the Medicaid nursing facility rate per day for 1997 is $69.22.
16. Average total cost per year for nursing home costs is 365 x $69.22 = $25,265.
17. The 53 people who will stay one year longer than the coverage minimum will incur costs of $1,339,045 (53 X $25,265), which will be the total state/federal cost to Medicaid for one additional year of nursing facility coverage. These individuals will be eligible for Medicaid benefits because all of their resources will be disregarded in the calculation of eligibility under the total assets model.
18. The 8 people who would have originally transferred assets, and had an average length of stay of two years, would have been eligible for Medicaid benefits on day one of admission under current law. They did not transfer assets due to the partnership program. This saves the program $404,240 (8 people x $25,265 x 2 years = $404,240).
19. The 3 people who stayed one year longer than the three year coverage period would have transferred assets, without a partnership program in place, and would have been eligible for Medicaid benefits on day one of admission. Medicaid savings due to their costs total $303,180 (3 x $25,265 x 4 years = $303,180).
20. The federal medical assistance percentage (federal cost share rate) is assumed to remain at the fiscal 1999 level of 71.12%.

FISCAL IMPACT:

DOLLAR-FOR-DOLLAR MODEL:

None.

TOTAL ASSETS MODEL:

None during the 1999 biennium.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION (Total Assets Model):

During the 2001 biennium:	FY2000	FY2001
Expenditures:		
General Fund	386,716	386,716
Federal Fund	952,329	952,329
Total	1,339,045	1,339,045
Revenues:		
(Savings to Medicaid)		
General Fund	204,303	204,303
Federal Fund	503,117	503,117
Total	707,420	707,420
Net Impact on Fund Balance: (Revenue minus expenditures)		
General Fund	(182,413)	(182,413)
Federal Fund	(449,212)	(449,212)
Total	(631,625)	(631,625)

APPROVED BY COM ON
BUSINESS & INDUSTRY

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STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 4 and 5] grant rulemaking authority to the commissioner of insurance and the department of public health and human services. [Section 4] authorizes the commissioner and the department to adopt rules regarding requirements for certification of long-term care insurance policies and certificates for the purposes of qualification for medical assistance benefits. [Section 5] requires the department to adopt rules necessary for the administration of long-term care insurance partnerships, including eligibility requirements for disregard of resources and amounts of resources to be disregarded for the purposes of qualification for medical assistance benefits. In adopting rules pursuant to these sections, the commissioner and the department shall take into consideration the goal of reducing expenditures for long-term care by the Montana medicaid program.

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(5) "Long-term care insurance" means an insurance policy or certificate that provides coverage for medically necessary services in a long-term care facility, as defined in 50-5-101, or in the insured's home.

(6) "Long-term care insurance partnership" or "partnership" means a program of collaboration between the commissioner, the department, insurers, and their insureds to create an incentive, through the issuance of insurance policies or certificates certified by the commissioner and the department, for individuals to purchase long-term care insurance.

(7) "Policy" means a policy as defined in 33-22-1107.

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NEW SECTION. **Section 3. Long-term care insurance partnerships authorized.** (1) The commissioner and the department may in their discretion create long-term care insurance partnerships if federal law permits those partnerships. If created, the partnerships must be consistent with the requirements of Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq.

(2) The commissioner and the department may in their discretion collaborate with private insurers

to create long-term care insurance partnerships that will allow individuals who have resources in excess of the resource limit for receipt of medical assistance under the Montana medicaid program to receive medical assistance benefits if those individuals are eligible for or require the level of care provided by a long-term care facility and meet the other program requirements to qualify for those benefits.

(3) Under partnerships created pursuant to this section, individuals may qualify for special treatment of their resources if they purchase a long-term care insurance policy or certificate certified by the commissioner and the department as provided in [section 4] prior to becoming eligible for medical assistance benefits.

(4) The long-term care insurance partnerships may in the department's discretion be based on a ~~total-assets-model-or-a~~ dollar-for-dollar model or ~~may-be-structured-in-another-manner-intended-to-accomplish-the-purpose-of-the-partnerships~~ ANY OTHER MODEL THAT IS COST-NEUTRAL.

NEW SECTION. **Section 4. Rulemaking and certification of policies by commissioner and department.** (1) The commissioner and the department may by rule adopt requirements for certification of long-term care insurance policies and certificates. These requirements may include but are not limited to:

(a) minimum levels and durations of benefits;

(b) mandatory inflation protection;

(c) mandatory home and community care coverage;

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(e) procedures for the insured to appeal a denial of benefits.

(2) The commissioner and the department shall review long-term care insurance policies and certificates to determine whether policies and certificates meet the requirements for certification pursuant to this section.

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(5) the exemption of protected resources from a lien provided in 53-6-171 through 53-6-189 for the recovery of medical assistance benefits paid by the state.

Section 6. Section 53-6-143, MCA, is amended to read:

"**53-6-143. Medical assistance liens and recoveries.** (1) Except as provided in this section, the department may not impose a lien upon the property of an applicant for or recipient of medical assistance.

(2) A lien for recovery of medical assistance paid or to be paid under this chapter may be imposed against the real or personal property of a medicaid applicant or recipient prior to the applicant's or recipient's death only:

(a) pursuant to a judgment of a court for recovery of medical assistance paid on behalf of the recipient;

(b) on a third-party recovery as provided in 53-2-612; ~~or~~

(c) as provided in 53-6-171 through 53-6-188; or

(d) to the extent that the recipient has received medical assistance based upon resources not disregarded pursuant to [sections 1 through 5].

(3) The department may recover medical assistance correctly paid on behalf of a recipient only as provided in 53-2-612, 53-6-167 through 53-6-169, or 53-6-171 through 53-6-188 or as provided in a written agreement between the department and the recipient or the recipient's representative pursuant to 42 U.S.C. 1382b(b).

(4) Except as otherwise specifically provided by 53-6-144, 53-6-165 through 53-6-169, 53-6-171 through 53-6-189, and this section, the department may pursue recovery under any section or combination of sections as may be applicable in a particular case. However, the department may not recover pursuant to 53-6-167 through 53-6-169 or 53-6-171 through 53-6-188 more than the total amount of recoverable medical assistance paid on behalf of a recipient, plus any applicable costs, interest, or other charges specifically allowed by law. The fact that the department has or may have a lien on particular property does not preclude the department from pursuing recovery under another section against other assets of the

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(2) [Sections 1 through 3 and 6] are effective 6 months after [the effective date of sections 4 and 5].

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THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO SECOND READING COPY (YELLOW) FOR COMPLETE TEXT.

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(d) to the extent that the recipient has received medical assistance based upon resources not disregarded pursuant to [sections 1 through 5].

(3) The department may recover medical assistance correctly paid on behalf of a recipient only as provided in 53-2-612, 53-6-167 through 53-6-169, or 53-6-171 through 53-6-188 or as provided in a written agreement between the department and the recipient or the recipient's representative pursuant to 42 U.S.C. 1382b(b).

(4) Except as otherwise specifically provided by 53-6-144, 53-6-165 through 53-6-169, 53-6-171 through 53-6-189, and this section, the department may pursue recovery under any section or combination of sections as may be applicable in a particular case. However, the department may not recover pursuant to 53-6-167 through 53-6-169 or 53-6-171 through 53-6-188 more than the total amount of recoverable medical assistance paid on behalf of a recipient, plus any applicable costs, interest, or other charges specifically allowed by law. The fact that the department has or may have a lien on particular property does not preclude the department from pursuing recovery under another section against other assets of the

recipient or assets of another person as provided in 53-6-144, 53-6-165 through 53-6-169, 53-6-171 through 53-6-189, and this section."

NEW SECTION. **Section 7. Codification instruction.** [Sections 1 through 5] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through 5].

NEW SECTION. **Section 8. Contingent effective dates.** (1) [Sections 4, 5, and 7 and this section] are effective on the effective date of the repeal of 42 U.S.C. 1396p(b)(1)(A) and (b)(1)(B) or of the amendment of that section in a manner prohibiting adjustment or recovery of medical assistance paid to individuals described in that section.

(2) [Sections 1 through 3 and 6] are effective 6 months after [the effective date of sections 4 and 5].

-END-

SENATE BILL NO. 69

INTRODUCED BY WATERMAN

BY REQUEST OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT AUTHORIZING THE CREATION OF LONG-TERM CARE INSURANCE PARTNERSHIPS BETWEEN INDIVIDUALS, PRIVATE HEALTH INSURERS, THE COMMISSIONER OF INSURANCE, AND THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; AUTHORIZING THE DEPARTMENT AND THE COMMISSIONER OF INSURANCE TO ADOPT STANDARDS FOR CERTIFYING CERTAIN LONG-TERM CARE INSURANCE POLICIES; ALLOWING CERTAIN ASSETS OF AN INDIVIDUAL WHO PURCHASES A CERTIFIED LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE TO BE DISREGARDED BY THE DEPARTMENT IN DETERMINING ELIGIBILITY FOR MEDICAID BENEFITS; AMENDING SECTION 53-6-143, MCA; AND PROVIDING CONTINGENT EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 4 and 5] grant rulemaking authority to the commissioner of insurance and the department of public health and human services. [Section 4] authorizes the commissioner and the department to adopt rules regarding requirements for certification of long-term care insurance policies and certificates for the purposes of qualification for medical assistance benefits. [Section 5] requires the department to adopt rules necessary for the administration of long-term care insurance partnerships, including eligibility requirements for disregard of resources and amounts of resources to be disregarded for the purposes of qualification for medical assistance benefits. In adopting rules pursuant to these sections, the commissioner and the department shall take into consideration the goal of reducing expenditures for long-term care by the Montana medicaid program.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Definitions.** As used in [sections 1 through 5], unless the context indicates otherwise, the following definitions apply:

(1) "Certificate" means a certificate as defined in 33-22-1107.

(2) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

(3) "Department" means the department of public health and human services provided for in 2-15-2201.

(4) "Dollar-for-dollar model" means a program in which the amount of resources that is disregarded in determining medical assistance eligibility for an individual is increased by $1 for each dollar paid by an insurer to an insured under the insured's long-term care insurance policy or certificate.

(5) "Long-term care insurance" means an insurance policy or certificate that provides coverage for medically necessary services in a long-term care facility, as defined in 50-5-101, or in the insured's home.

(6) "Long-term care insurance partnership" or "partnership" means a program of collaboration between the commissioner, the department, insurers, and their insureds to create an incentive, through the issuance of insurance policies or certificates certified by the commissioner and the department, for individuals to purchase long-term care insurance.

(7) "Policy" means a policy as defined in 33-22-1107.

~~(8) "Total assets model" means a program in which all of an individual's resources are disregarded in determining eligibility for medical assistance after all benefits paid by the individual's long-term care insurance policy or certificate providing coverage for a specified period of time have been exhausted.~~

NEW SECTION. **Section 2. Purpose.** The purpose of [sections 1 through 5] and the long-term care insurance partnerships authorized by [sections 1 through 5] is to encourage individuals to purchase long-term care insurance policies or certificates that will provide for their potential long-term care needs, thereby reducing the amount of money spent by the state of Montana for long-term care under the Montana medicaid program. The purpose of [sections 1 through 5] is also to provide an incentive for the purchase of the policies or certificates by providing individuals some protection from the requirement that they spend down their resources in order to qualify for medical assistance benefits in the form of payment for long-term care.

NEW SECTION. **Section 3. Long-term care insurance partnerships authorized.** (1) The commissioner and the department may in their discretion create long-term care insurance partnerships if federal law permits those partnerships. If created, the partnerships must be consistent with the requirements of Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq.

(2) The commissioner and the department may in their discretion collaborate with private insurers

to create long-term care insurance partnerships that will allow individuals who have resources in excess of the resource limit for receipt of medical assistance under the Montana medicaid program to receive medical assistance benefits if those individuals are eligible for or require the level of care provided by a long-term care facility and meet the other program requirements to qualify for those benefits.

(3) Under partnerships created pursuant to this section, individuals may qualify for special treatment of their resources if they purchase a long-term care insurance policy or certificate certified by the commissioner and the department as provided in [section 4] prior to becoming eligible for medical assistance benefits.

(4) The long-term care insurance partnerships may in the department's discretion be based on a ~~total assets model or a~~ dollar-for-dollar model or ~~may be structured in another manner intended to accomplish the purpose of the partnerships~~ ANY OTHER MODEL THAT IS COST-NEUTRAL.

NEW SECTION. **Section 4. Rulemaking and certification of policies by commissioner and department.** (1) The commissioner and the department may by rule adopt requirements for certification of long-term care insurance policies and certificates. These requirements may include but are not limited to:

(a) minimum levels and durations of benefits;

(b) mandatory inflation protection;

(c) mandatory home and community care coverage;

(d) case management; and

(e) procedures for the insured to appeal a denial of benefits.

(2) The commissioner and the department shall review long-term care insurance policies and certificates to determine whether policies and certificates meet the requirements for certification pursuant to this section.

NEW SECTION. **Section 5. Department to make rules.** The department shall adopt rules necessary ~~or desirable~~ for the administration of the partnerships, including but not limited to rules concerning:

(1) the populations and age groups eligible to have resources disregarded for the purposes of qualification for medical assistance benefits under the Montana medicaid program;

(2) the level of care that an individual requires in order to have resources disregarded in determining eligibility for medical assistance benefits;

(3) the amount and type of resources of an individual that will be disregarded in determining eligibility for medical assistance benefits;

(4) requirements for the disregard of resources of an individual in determining eligibility for medical assistance benefits; and

(5) the exemption of protected resources from a lien provided in 53-6-171 through 53-6-189 for the recovery of medical assistance benefits paid by the state.

Section 6. Section 53-6-143, MCA, is amended to read:

"**53-6-143. Medical assistance liens and recoveries.** (1) Except as provided in this section, the department may not impose a lien upon the property of an applicant for or recipient of medical assistance.

(2) A lien for recovery of medical assistance paid or to be paid under this chapter may be imposed against the real or personal property of a medicaid applicant or recipient prior to the applicant's or recipient's death only:

(a) pursuant to a judgment of a court for recovery of medical assistance paid on behalf of the recipient;

(b) on a third-party recovery as provided in 53-2-612; ~~or~~

(c) as provided in 53-6-171 through 53-6-188; or

(d) to the extent that the recipient has received medical assistance based upon resources not disregarded pursuant to [sections 1 through 5].

(3) The department may recover medical assistance correctly paid on behalf of a recipient only as provided in 53-2-612, 53-6-167 through 53-6-169, or 53-6-171 through 53-6-188 or as provided in a written agreement between the department and the recipient or the recipient's representative pursuant to 42 U.S.C. 1382b(b).

(4) Except as otherwise specifically provided by 53-6-144, 53-6-165 through 53-6-169, 53-6-171 through 53-6-189, and this section, the department may pursue recovery under any section or combination of sections as may be applicable in a particular case. However, the department may not recover pursuant to 53-6-167 through 53-6-169 or 53-6-171 through 53-6-188 more than the total amount of recoverable medical assistance paid on behalf of a recipient, plus any applicable costs, interest, or other charges specifically allowed by law. The fact that the department has or may have a lien on particular property does not preclude the department from pursuing recovery under another section against other assets of the

recipient or assets of another person as provided in 53-6-144, 53-6-165 through 53-6-169, 53-6-171 through 53-6-189, and this section."

NEW SECTION. **Section 7. Codification instruction.** [Sections 1 through 5] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through 5].

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(2) [Sections 1 through 3 and 6] are effective 6 months after [the effective date of sections 4 and 5].

-END-