

MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: August 2, 2010

I am providing my analysis of five (5) regulatory initiatives in anticipation of the August 5 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DOE Final Education Program for ELL Student Regulation [14 DE Reg. 103 (August 1, 2010)]

The SCPD and GACEC endorsed the proposed version of this regulation in June, 2010. The Department of Education has now acknowledged the endorsements and adopted the regulation with no further changes.

I recommend no further action.

2. DMMA Final Medicaid Non-emergency Transportation Reg. [14 DE Reg. 106 (August 1, 2010)]

The SCPD endorsed the proposed version of this regulation in June, 2010. The Division of Medicaid and Medical Assistance has now acknowledged the endorsement and adopted the regulation with no further changes.

I recommend no further action.

3. DSS Prop. Children Eligibility for GA & TANF Regulation [14 DE Reg. 91 (August 1, 2010)]

The Division of Social Services proposes to amend both its GA and TANF regulations. The impetus for the changes is summarized as follows:

The impact of the proposed changes will be that children living in the home of a non-relative custodian or legal guardian will be technically eligible for the TANF program. These

children will not longer be eligible to receive benefits through the GA program.

14 DE Reg. at 91.

I have the following observations.

First, there are positive aspects to the change. I have been informally advised that the effect of switching an eligible child from a GA to a TANF grant would be to increase the monetary benefit from \$123.00 to \$201.00. This amounts to a benefit increase of more than 60%. Approximately 300 children would be affected. Moreover, the TANF standards (Section 3010) require the caretaker to enter into a Contract of Mutual Responsibility which prompts child immunization and regular school attendance. Finally, the TANF caretaker becomes eligible to participate in work support programs. See Summary of Proposed Changes at 14 DE Reg. At 91-92.

Second, there are some potentially negative aspects to the change. TANF imposes sanctions (§3009.1) on caretakers who fail to meet the benchmarks in the Contract of Mutual Responsibility which can amount to total elimination of benefits. The GA program is less prescriptive in imposition of beneficiary obligations. Unlike TANF, there are no equivalent requirements for participating in parenting classes, cooperation with child support, and ensuring child immunization and school attendance.

Third, §3004 merits revision.

A. The existing section contains an introductory sentence defining “relatives” which incorporates a bulleted list of “relatives”. The new section retains the bulleted list but no introductory sentence (e.g. “(a) relative is defined as follows”). The result is a list of qualifying “relative” standards with no context. See, e.g., analogous references in §3004 (e.g. “(a) guardian is defined as”; “a custodian...is defined as”).

B. The definition of “relative” could be enhanced by including a reference to an adult relative caregiver with a valid Caregiver Authorization form on record with the child’s public school pursuant to Title 14 Del.C. §202.

C. The definition of “guardian” is odd. For example, it only contemplates appointment of a guardian by the Family Court. The Court of Chancery has concurrent jurisdiction to appoint guardians of minors. See Title 12 Del.C. §3902. Moreover, it characterizes persons authorized by DFS to exercise custody and care of a child as a “guardian”. This is a distortion of law. Apart from the Court of Chancery, only the Family Court has the authority to appoint a “guardian” of a minor. See Title 10 Del.C. §925(16). I am not aware of any statute which grants the DSCY&F the authority to appoint a guardian. Finally, DFS is only one of multiple agencies which may delegate care of children to adults. See, e.g., Title 10 Del.C. §1009.

Fourth, in §3004.1, first sentence, DMMA may wish to delete the reference to “parent’s”

since it is redundant. The definition of “caretaker” in §3001 ostensibly covers both parents and non-parents.

In sum, I have the following recommendations.

A. DMMA should be encourage to consider some technical amendments based on Pars. 3 and 4 above.

B. DMMA should consider whether caretakers could be given the option of applying for GA or TANF on a qualifying child’s behalf. As illustrated in §4001.1, deleted Illustration #5, a caretaker and child can currently qualify as separate G.A. assistance units. There may be circumstances in which the caretaker views the TANF requirements as unduly onerous.

C. If DMMA is precluded by federal law from offering an option, then the change would benefit most caretakers given the significant increase in the financial benefit. If an option could not be authorized, the SCPD may wish to endorse the regulation given its benefit to most eligible caretakers and children.

4. Dept. of Insurance Prop. Rescission of Long-term Care Ins. Policy Reg [14 DE Reg. 92 (8/1/10)]

The Department of Insurance proposes to amend its regulation covering long-term care insurance to update provisions and address rescission. The regulation is lengthy, i.e., it is 45 pages in length in approximately 10 point type. Parenthetically, I was bemused at the use of many low-incidence terms [e.g. “decrement” (§18.1); “lapsation” (§20.8.2)].

I have the following observations.

First, the regulation allows insurers to condition eligibility for benefits on the presence of a deficiency in performance of at least 3 activities of daily living (“ADLs”). See §26.1. The regulation lists the following 6 ADLs: bathing, continence, dressing, eating, toileting, and transferring (§26.2.1). This threshold will have a systemic effect on State public benefits programs. For example, if the threshold were 2 ADLs, more insureds would qualify for private insurance-funded supports, lessening reliance on public benefits.

Second, §12.2 provides a disincentive for home-based care. It recites, in pertinent part, as follows:

12.2. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year’s coverage available for nursing home benefits under the policy or certificate.

It would be preferable to prompt insurers to offer the same dollar coverage for home-based services.

Otherwise, the regulation effectively encourages nursing home placement since home care would be supported by only half the amount of payments that could be made to a nursing home.

Third, §30.1 authorizes compensation to an agent selling long-term care policies of 35% of the total of premiums paid from all the selling agent's policies each policy year. Reasonable persons might view this as "gouging" the elderly and near-elderly. Such excessive compensation likewise artificially raises premiums well beyond the insurer's risk of pay-outs.

Fourth, in §4.0, definition of "Benefit Trigger", second sentence, "purposed" should be "purposes".

Fifth, in §5.0, the definition of "bathing" is as follows:

"Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

This definition is difficult to understand. For example, if an insured can dab his/her body with a damp sponge outside of a tub or shower, does the insured have the ability to "bathe"? The use of the term "or" is disjunctive and suggests that there is no bathing deficit if someone can rub his/her body with a sponge outside of a tub or shower. This is a perversion of the normal view of bathing.

Sixth, in §5.0, the definition of "continence" is as follows:

"Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function.

The definition is "odd". The first part appears to define "continence". The second part appears to define "incontinence", i.e., lack of bowel and bladder control.

Seventh, in §5.0, definition of "home health care services", there is a lack of "people-first" language, and, indeed, use of pejorative language - "ill, disabled, or infirm persons". For example, the term "infirm" is outdated and pejorative. It is considered an insulting term which should be avoided in contemporary regulations. The Guidelines for Reporting and Writing About People with Disabilities, 5<sup>th</sup> edition, recites as follows:

PUT PEOPLE FIRST, not their disability...Crippled, deformed, suffers from, victim of, the retarded, infirm, the deaf and dumb, etc. are never acceptable under any circumstances.

Eighth, in §5.0, the definition of "mental or nervous disorder" is as follows:

"Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disorder.

According to Wikipedia, the term "neurosis" "is no longer part of mainstream psychiatric

terminology”. Indeed, it does even appear in the index to the DSM-IV. However, the more important aspect of this definition is the authorization for insurers to discriminate against applicants with “mental or nervous disorders”. While §6.2 bars policy limits and exclusions based on type of illness, treatment, or medical condition, §6.2.2 incredibly has an exception for “mental or nervous disorders”. Thus, insurers are authorized to discriminate in policy limits and coverage based on an extremely broad definition of “mental or nervous disorder”. Likewise, §6.2.3 authorizes discrimination based on alcoholism and drug addiction. Sections 6.2.2 and 6.2.3 should be stricken in their entirety. Both State and federal public policy promote parity in health insurance and discourage discrimination based on mental illness and substance abuse dependency. See, e.g. Title 18 Del.C. §3343, which recites as follows: (N)o carrier may issued for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan.” For a similar federal perspective, see attached article, SAMHSA News, “Parity: Landmark Legislation Takes Effect. What are the Implications for Millions of Americans?” (January/February, 2010).

Ninth, in §6.1.1, second sentence, delete the colon and do not capitalize “(t)hat”.

Tenth, §6.1.6.2 contains a mandatory disclosure to be provided to insureds in bold print. However, the following “disclosure” would not be understood by the ordinary policyholder:

Insurers will be allowed a carry forward of the initially disclosed maximum premium increase, but said carry forward is lost within twenty-four (24) months if not utilized.

This mandatory disclosure will be unintelligible to consumers.

Eleventh, §6.2.6 is unclear. It is common for persons in need of care to be relocated close to other relatives who may live some distance from the home/domicile of the insured, perhaps in another state. This section is unclear on whether the insurer could deny services based on such relocation, especially if the insured’s home/domicile is not immediately sold. Consider how the following text should be interpreted:

No territorial limits are permissible, except that nothing herein shall preclude limiting benefits...to specific providers within a particular geographic area. Moreover, nothing herein shall prohibit the limitation of services to a particular geographical area when the insured elects to receive services within that specific geographical area. For purposes of this clause, the location of receipt of services must be within 50 miles of the domicile of the insured at the time of entry therein or that area, including the nearest three nursing homes, whichever distance is greater.

It would be preferable to simply disallow territorial limitations, at least within the United States.

Twelfth, there is a “typo” in §8.2.5.1, i.e., “proemium” should be “premium”.

Thirteenth, §22.0 contains a model outline of coverage to be shared with applicants. Par. 15

directs applicants to an undefined “State Senior Health Insurance Assistance Program”. I suspect this may be the ElderInfo program referenced in §24.1.6. It would be preferable to include more specific information in the Par.15 notice. For the same reason, more specificity should be included in Appendix C, “Things You Should Know Before You Buy Long-Term Care Insurance”, which refers generically to the “state’s insurance counseling program” and the “department of aging”. Delaware has no department of aging.

I recommend submission of commentary to the Department of Insurance based on the above critique. I also recommend sharing a copy of the Council’s commentary with the following: AARP; DHSS, including the Secretary, and Medicaid, DSAAPD, and DSAMH Directors; the Governor’s Commission on Community-based Alternatives for Persons with Disabilities; the Lt. Governor; and members of the Senate Insurance Committee and House Economic Development/ Banking/ Insurance/ Commerce Committee.

5. DMMA Consolidation of E&D, ABI, & Assisted Living Waivers, 14 DE Reg. 88 (8/1/10)]

I provided the SCPD with a July 11, 2010 critique of the May 19, 2010 version of a proposed consolidated E&D, ABI, and Assisted Living Medicaid Waiver. ABI aspects of the critique were reviewed with the SCPD Brain Injury Committee at its July 12 meeting. The SCPD forwarded the critique to DHSS as a set of “preliminary comments”. DHSS provided the attached July 29 response to each of the 26 paragraphs of the preliminary critique. DHSS has also published the proposed consolidated waiver in the August version of the Registry of Regulations. In the meantime, a Council member shared the attached set of 9 “general comments” with the SCPD.

I recommend that the Council resubmit its July critique as official comments supplemented by the following comments based on review of the 9 “general comments”.

First, based on Pars. 1, 4, and 6, I recommend noting that DSAAPD staff assuming case management duties may be familiar with the needs of persons with common physical disabilities and the elderly. However, DSAAPD staff may be less familiar with the specialized needs and services of the ABI population. Although I am supportive of DSAAPD assuming case management duties, I would request that DSAAPD commit to train all waiver case managers in the specialized needs and services related to the ABI population. Otherwise, the consolidated waiver will be unresponsive to persons with ABI.

Second, based on Par. 3 of the “general comments”, and Par. 9 of my July critique, I remain concerned that use of the standard “Long Term Care Assessment Tool” will be an invalid and unreliable tool for assessment of many individuals with ABI. Specialized assessment tools for ABI should be adopted and staff trained in their use. I am reminded of DHSS use of its standard “long term care assessment tool” years ago when evaluating level of care of children for the Children’s Community Alternative Disability Program. The form was not a valid tool for kids. It had a geriatric bias and did not adequately address mental health and cognition. I predict that use of a standard “Long Term Care Assessment Tool” for individuals with ABI will prove equally deficient and result in many unjustified determinations of ineligibility. Apart from the assessment tool(s) for level of care, the ABI population may also benefit from use of specialized assessment tools to determine need for services.

Third, based on Par. 7, it would be helpful if the waiver included some provision for supported employment. DVR's order of selection has resulted in hundreds of individuals being placed on a waiting list. Offering solely adult day care and facility-based adult habilitation is an outdated model. It would be preferable to include more robust vocational options for individuals who could benefit from something other than "day care".

Fourth, although Par. 8 suggests that reimbursement rates may be low for both assisted living and day habilitation, my Par. 14 noted that the assisted living service specifications include 9 different levels of reimbursement based on the participant's needs. I therefore believe this issue is resolved in the context of assisted living. The Council may wish to generally encourage DHSS to adopt reimbursement rates for adult habilitation sufficient to attract quality providers.

Fifth, based on Par. 9, the Council could encourage more frequent assessment of waiver implementation, especially during the initial 12 months of implementation after December 1, 2010. For example, regular reports to the SCPD BIC and/or SCPD would be appropriate. If monthly data were compiled, this information could be shared with the SCPD to facilitate review.

#### Attachments

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F:pub/bjh/legis/810bils