all documents in the docket are listed in the index, some information may be publicly available only at the hard copy location (e.g., copyrighted material), and some may not be publicly available in either location (e.g., CBI). To inspect the hard copy materials, please schedule an appointment during normal business hours with the contact listed directly below.

FOR FURTHER INFORMATION CONTACT: Doris Lo, EPA Region IX, (415) 972–3959, *lo.doris@epa.gov.*

SUPPLEMENTARY INFORMATION: On April 21, 2008 the Regional Administrator signed a proposed rule entitled ''Approval and Promulgation of Implementation Plans; Designation of Areas for Air Quality Planning Purposes; State of California; PM–10; Revision of Designation; Redesignation of the San Joaquin Valley Air Basin PM–10 Nonattainment Area to Attainment; Approval of PM–10 Maintenance Plan for the San Joaquin Valley Air Basin; Approval of Commitments for the East Kern PM–10 Nonattainment Area.'' This rule was published on April 25, 2008 (73 FR 22307) and, among other things, proposed to approve county by county subarea motor vehicle emissions budgets (MVEB) in the 2007 San Joaquin Valley PM–10 Maintenance Plan (2007 Plan) for the San Joaquin Valley Air Basin (SJVAB) PM–10 nonattainment area [1] for the years 2005 and 2020. See 73 FR 22307, 22315–22317, Table 4. The California Air Resources Board (CARB) used its mobile source emission model, EMFAC2007, to estimate the direct particulate matter of ten microns or less (PM–10) emissions and oxides of nitrogen (NO_X) emissions for the MVEBs.

CARB has provided EPA with technical corrections to the 2020 MVEBs for Merced, San Joaquin, Stanislaus and Tulare counties in the 2007 Plan. See the May 13, 2008 letter to Mr. Wayne Nastri from James N. Goldstene. As discussed in the letter, the MVEBs for these four counties were incorrectly calculated because the input processor for the EMFAC2007 emissions model used the wrong travel activity data for 2020. The correct MVEBs are shown in revised Table 4 below, which replaces Table 4 in the proposed rule at 73 FR 22316–22317:

TABLE 4.—MOTOR VEHICLE EMISSIONS SUBAREA BUDGETS (TONS PER DAY) SAN JOAQUIN VALLEY AIR BASIN 2007 PLAN *

County	2005		2020	
	PM–10	NO_X	PM–10	NO_X
Fresno	13.5	59.2	16.1	23.2
Kern **	12.1	88.3	14.7	39.5
Kings	3.1	16.7	3.6	6.8
Madera	3.6	13.9	4.7	6.5
Merced	6.2	39.2	6.4	12.9
San Joaquin	9.1	42.6	10.6	17.0
Stanislaus	5.6	29.7	6.7	10.8
Tulare	7.3	25.1	9.4	10.9
Total	60.5	314.7	72.2	127.6

* The budgets are based on attainment and maintenance of the 24-hour PM–10 NAAQS. The annual standard was revoked on December 18, 2006. See 71 FR 61144.

** MVEBs in Table 4 are only for the SJVAB portion of Kern County.

The difference between the 2020 budgets found in the 2007 Plan and the 2020 budgets provided in the May 13, 2008 letter are small and Valley-wide result in no change in total PM–10 emissions and an increase of only 0.2 tons per day in NO_X emissions. EPA believes that the changes in the budgets do not impact the maintenance demonstration in the 2007 Plan because they are small. Therefore these technical corrections have no effect on EPA's preliminary conclusion that the subarea 2020 MVEBs for Merced, San Joaquin, Stanislaus and Tulare counties are approvable (73 FR 22316–22317) or on any other aspects of the proposed rule.

EPA is extending the public comment period for the proposed rule until June 10, 2008 in order to provide the public with the opportunity to consider these technical corrections.

Dated: May 15, 2008.

Wayne Nastri,

Regional Administrator, Region 9.

[FR Doc. E8–11605 Filed 5–22–08; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Part 144

[ASPELTCI]

RIN 0991–AB44

Office of the Assistant Secretary for Planning and Evaluation; State Long-Term Care Partnership Program: Reporting Requirements for Insurers

AGENCY: Office of the Assistant Secretary for Planning and Evaluation (OASPE), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule sets forth proposed reporting requirements for private insurers that issue qualified long-term care insurance policies in States participating in the State Long-Term Care Partnership Program established under the Deficit Reduction Act (DRA) of 2005. Section 6021 of the Deficit Reduction Act of 2005 requires that the Secretary specify a set of reporting requirements and collect data from insurers on qualifying long-term care insurance policies issued under the program and the subsequent use of the benefits under these policies. Under a State Long-Term Care Partnership Program, an amount equal to the benefits received under of the long-term care insurance policy is disregarded in determining the assets of an individual for purposes of Medicaid eligibility and estate recovery.

[1] The nonattainment area includes the entire counties of San Joaquin, Fresno, Kings, Madera, Merced, Stanislaus and Tulare and part of Kern County.

DATES: To be assured consideration, comments must be received at the address provided below, no later than 5 p.m. on July 22, 2008.

ADDRESSES: In commenting, please refer to file code ASPE:LTCI. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically*. You may submit electronic comments on specific issues in this regulation to *http://www.Regulations.gov*. Click on the link ''Comment or Submission'' and enter the keyword ''ASPE:LTCI''. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail*. You may mail written comments (one original and two copies) to the following address only: Office of Disability, Aging, and Long-Term Care, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Attention: ASPE:LTCI, Hunter McKay, 200 Independence Avenue, SW., Room 424–E, Washington, DC 20201.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments (one original and two copies) to the following address only: Office of Disability, Aging, and Long-Term Care, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Attention: ASPE:LTCI, Hunter McKay, 200 Independence Avenue, SW., Room 424–E, Washington, DC 20201.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to the following address: Room 424–E, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the mail drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the ''Collection of Information Requirements'' section in this document.

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code ASPE:LTCI and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.Regulations.gov*. Click on the link ''Comment or Submission'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Department of Health and Human Services, 200 Independence Avenue, SW., Washington, DC 20201, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–XXX–XXXX.

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access*, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents' home page address is *http://www.gpoaccess.gov/*, by using local WAIS client software, or by telnet to *swais.access.gpo.gov*, then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then login as guest (no password required).

FOR FURTHER INFORMATION CONTACT: Hunter McKay, (202) 205–8999.

SUPPLEMENTARY INFORMATION:

I. Scope of This Proposed Rule

This proposed rule describes the reporting requirements that we are proposing to require of all insurers that issue qualified long-term care insurance policies under the State Long-Term Care Partnership Program. In addition to publishing these regulations, The Department anticipates taking other actions to further the implementation of the Partnership for Long Term Care. One such action is publication in the near future of a **Federal Register** Notice containing Partnership State Reciprocity Standards. This standard outlines an agreement whereby states can provide Medicaid asset disregards for Partnership policies purchased in other states.

II. Background

(If you choose to comment on issues in this section, please include the caption ''History of Partnership Programs'' at the beginning of your comment.)

A. Historical Overview of State Long-Term Care Partnership Programs

1. Initial Development of Programs

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 insurance for long-term care. The goal of these collaborations was to create private insurance policies that were more affordable and provide better financial protection to consumers against large liabilities for long-term care costs than the policies generally available at that time. The result of these collaborations was the establishment of State Long-Term Care Partnership Programs that provided for expanded access to Medicaid by allowing applicants who use long-term care insurance policies to have higher assets and still be eligible for Medicaid. The additional amount of assets that an individual is allowed to have is equivalent to the amount paid by the insurance policy on his or her behalf. These State partnerships provided 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. As part of the implementation process, each State outlined a set of data reporting requirements for participating insurers. The data that were to be collected were intended to allow each

State to monitor program activities and evaluate the impact of the Partnership Program on Medicaid long-term care expenditures. The insurers who participated in these partnerships recommended, as part of the design of the data collection requirements, that the participating States use a unified set of reporting requirements to streamline the reporting burden on the participating insurers. The participating insurers believed that if each State designed its own reporting requirements, the administrative costs for the program would be prohibitive. The four States agreed with the participating insurers and adopted a uniform set of reporting criteria.

The four initial States launched their Partnership Programs using existing State authority through amendments to their State Medicaid plans. Each State requested a change in the treatment of assets in the Medicaid financial eligibility test. No other Federal authority was necessary at that time to operate the programs.

2. Omnibus Reconciliation Act of 1993

The Omnibus Reconciliation Act of 1993 (OBRA 1993), Public Law 103–66, contained language that changed the conditions under which Medicaid State plan amendments relating to asset disregards for private long-term care insurance could be approved. OBRA 1993 allowed California, Connecticut, Indiana, and New York, as well as Iowa and Massachusetts, to continue their initial Long-Term Care Partnership Programs. However, OBRA 1993 specified a set of requirements for any additional States that chose to operate a Partnership Program. Any State, other than the initial four partnership States, that sought a Medicaid State plan amendment on or after May 14, 1993 was required to abide by the following additional conditions:

a. Estate Recovery

States establishing Long-Term Care Partnership Programs on or after May 14, 1993, were required to recover from the estates of Medicaid recipients in States with partnership agreements expenses incurred for the provision of long-term health care under Medicaid. Assets that were disregarded in the initial financial eligibility process were also exempt from estate recovery in the initial four States with Partnership Programs. States establishing new Partnership Programs were only allowed to disregard assets in the initial eligibility process but not in the estate recovery process. After a Medicaid recipient who had a long-term care insurance policy issued under a State Long-Term Partnership Program died, the State was required to recover an amount equivalent to what Medicaid spent on his or her behalf from the deceased recipient's estate, including any protected assets under the State Long-Term Care Partnership Program.

b. No Waiver of Estate Recovery

States establishing Long-Term Care Partnership Programs on or after May 14, 1993, were precluded from waiving the estate recovery requirement for Medicaid recipients who had obtained long-term care insurance policies under a State Long-Term Care Partnership Program.

c. Expanded Definition of Estate

States establishing Long-Term Care Partnership Program on or after May 14, 1993, were also required to use a specific definition of ''estate'' for recovery purposes when recovery of Medicaid expenditures was against the estates of Medicaid recipients who had obtained long-term care insurance policies issued under a State Long-Term Care Partnership Program. This definition was more expansive than the definition that was generally used by States.

While OBRA 1993 did not forbid additional States from attempting to establish new Long-Term Care Partnership Programs under the new conditions, 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 Public Law 109–171 (the DRA of 2005). As discussed in detail under section II.A.3. of this proposed rule, the DRA of 2005 included provisions that allow States to offer specific asset disregards for Medicaid eligibility purposes under a new set of conditions.

3. 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 out under a long-term care insurance policy issued under a State Long-Term Care Partnership Program.

Section 1917(b)(1)(C)(iii)(II) of the Act provides that the insurance policy must be a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986, that is issued not earlier than the effective date of the State plan amendment. (If an individual has an existing long-term care insurance policy that does not qualify as a qualified partnership policy due to the issue date of the policy, and that policy is exchanged for another policy, the State insurance commissioner or other State authority must determine the issue date for the policy that is received in exchange. Under this provision, a long-term care insurance policy includes a certificate issued under a group insurance contract.)

Among other requirements specified in the statute for qualified long-term care insurance partnerships—

- The long-term care insurance policy must (1) be issued to an insured individual who is a resident of the State in which coverage first became effective under the policy (sections 1917(b)(1)(C)(iii)(I) of the Act); (2) be certified by the State insurance commissioner or other appropriate authority that the policy meets specific provisions of the National Association of Insurance Commissioners (NAIC) October 2000 Model Regulation and Model Act (sections 1917(b)(1)(C)(iii)(III) and 1917(b)(5)(B) of the Act); and (3) include certain protections against inflation on an annual basis (section 1917(b)(1)(C)(iii)(IV) of the Act).
- The State Medicaid agency must provide information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care (section 1917(b)(1)(C)(iii)(V) of the Act).
- Issuers of long-term care insurance policies under a State qualified long-

term care insurance partnership must provide regular reports to the Secretary, in accordance with regulations of 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 (section 1917(b)(1)(C)(iii)(VI) of the Act). 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 after consultation with the NAIC, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data to be reported and the frequency with which such reports are to be made. In addition, the Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

- The State may not impose any requirement affecting the terms of benefits of a policy under the partnership program unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership (section 1917(b)(1)(C)(iii)(VII) of the Act).

Section 1917(b)(1)(C)(iv) of the Act provides that a State that had a State plan amendment approved as of May 14, 1993, satisfies the requirements of the statute under clause (II) and may continue as a qualified partnership program if the Secretary determines that the State plan amendment provides for consumer protection standards that are no less stringent than the consumer protection standards that applied under such a State plan amendment as of December 31, 2005.

B. Implementing Regulations

Currently, there are no Federal regulations directly related to State operation of State Long-Term Care Partnership Programs. In areas in which the program coordinates benefits with Medicaid coverage of long-term care, the existing Medicaid regulations at 42 CFR Chapter IV, Subchapter C, are applicable. In 2006, States were provided with guidance on the implementation of State Long-Term Care Partnership Programs under the DRA of 2005.

To implement section 1917(b)(1)(C)(iii)(VI) and 1917(b)(1)(C)(iv) of the Act, as directed by the statute, we are proposing to set forth in regulations the requirements for reporting information and data on qualified long-term care insurance policies issued under State Long-Term Care Partnership Programs under an approved State plan amendment.

C. States Currently Operating Long-Term Care Partnership Programs

California, Connecticut, Indiana, Iowa, Massachusetts, and New York had approved State Long-Term Partnership Programs under an approved State plan amendment as of May 14, 1993. They were ''grandfathered'' as satisfying the statutorily imposed requirements when pursuant to section 1917(b)(1)(C)(iv) of the Act, the Secretary determined that the State plan amendments of these States provide protection no less stringent than that applied under their State plan amendments as of December 31, 2005.

As of December 2007, seven other States offer State Long-Term Care Partnership policies for sale under the DRA provisions: Florida, Idaho, Kansas, Minnesota, Nebraska, South Dakota, and Virginia. Nine States have approved State plan amendments for qualified State Long-Term Care Partnership Programs although policies had not yet been issued pursuant to those programs: Colorado, Florida, Georgia, Iowa, Minnesota, Missouri, North Dakota, Nevada, Ohio, and Oregon. Four States have submitted State plan amendments for which approval is pending: Arizona, New Hampshire, Oklahoma, and Pennsylvania. Ten other States are in the process of developing Partnership Programs: Illinois, Maine, Maryland, Michigan, Montana, New Jersey, Rhode Island, Texas, Vermont, and Wisconsin.

III. Provisions of This Proposed Rule

A. Legislative Authority

As stated earlier, the DRA of 2005 requires insurers participating in State Long-Term Care Partnership Programs to provide regular reports to the Secretary in a manner in accordance with regulations of the Secretary. The reports must include notification regarding when benefits provided under the policy have been paid and the amount of the benefits paid, notification regarding when the policy otherwise terminates, and any other information as the Secretary determines may be appropriate to the administration of State long-term care insurance partnerships. Section 1917(b)(1)(C)(iv) of the Act provides that the regulations required under section 1917(b)(1)(C)(iii)(VI) must be promulgated after consultation with the NAIC, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and must specify the type and format of the data to be reported and the frequency with which the reports are to be made. In addition, the Secretary, as appropriate, must provide copies of the reports provided in accordance with that clause to the State involved.

B. Collaboration With States, Insurers, Insurance Regulators, and Consumers in the Development of Reporting Requirements

(If you choose to comment on issues in this section, please include the caption ''Consultations with Stakeholders'' at the beginning of your comment.)

In accordance with section 1917(b)(1)(C)(iv) of the Act, as added by the DRA of 2005, we have consulted with numerous stakeholders in the development of the reporting requirements presented in this proposed rule. In addition to one-on-one consultations with stakeholders representing States, insurers, consumers, and regulators, we have established a Technical Expert Panel to provide a forum for the exchange of ideas, perspectives, and expertise regarding the specification of individual data items. The Technical Expert Panel consists of approximately 25 members representing insurers, States, consumer organizations, the NAIC, the Federal Government, and the policy research community. The panel members were selected in January 2007, from responses to invitations sent by HHS along with an initial draft of the reporting requirements. We held numerous meetings and teleconferences with the panel members to discuss and further develop the draft reporting requirements and to obtain further input on partnership implementation. The reporting requirements presented in this proposed rule represent the product of this ongoing stakeholder input process. We plan to work on an ongoing basis with the Technical Expert Panel.

C. Specific Proposed Reporting Requirements

(If you choose to comment on issues in this section, please include the caption ''Types of Data to be Reported'' at the beginning of your comment.)

In consultation with stakeholders and the Technical Expert Panel, we have developed proposed requirements for insurers for reporting data under the State Long-Term Care Partnership Program under two categories: (1) Registry data; and (2) claims data. These two categories would require the submission of data in four distinct file types. Generally, participating long-term care insurers would report under only two of these files. For all four file types, we are proposing to require insurers to report on only those insured individuals, policyholders, and claimants who have active qualified long-term care insurance partnership policies or certificates. The proposed reporting requirements would not apply to insurance policies or certificates that are not partnership qualified.

Insurer reporting specifications would be detailed in an HHS document entitled ''State Long-Term Care Partnership Insurer Reporting Requirements'' which we expect will be available from *http://aspe.hhs.gov/daltcp/reports/2008/PartRepReq.pdf* no later than June 1, 2008. We are in the process of developing an integrated database through which insurers would submit these data. We are proposing that data would be submitted through a secure Web site that meets all current Health Insurance Portability and Accountability Act requirements for security of personal health information.

1. Registry Data

We are proposing to require insurers to report data, on a semiannual basis, on all insured individuals who have been issued qualified long-term care insurance policies or certificates under qualified State Long-Term Care Partnership Programs; that is, for the 6-month reporting periods of January 1 through June 30 and July 1 through December 31 of each year. The reports must include data on qualified long-term care insurance partnership policies sold on either an individual basis or a group basis, as long as individual-level data are available to the insurer. These data include, but are not limited to, the following:

- Current identifying information on each insured individual.
- The name of the insurance company and the issuing State.
- The effective date and terms of coverage under the policy.
- The coverage period and benefits.
- The annual premium.
- Other information as specified by the Secretary in ''State Long-Term Care Insurance Partnership Insurer Reporting Instructions.''

2. Claims Data

We are proposing to require insurers to report data, for each quarter of the calendar year, on all benefit claims paid for all insured individuals who have been issued qualified long-term care insurance policies or certificates (individual policies or under group coverage plans) under qualified State Long-Term Care Partnership Programs. These data include, but are not limited to, the following:

- Current identifying information on the insured individual.
- The type and cash amount of the benefits paid during the reporting period and lifetime to date.
- Remaining lifetime benefits.
- Other information as specified by the Secretary in ''State Long-Term Care Insurance Partnership Insurer Reporting Instructions.''

3. Frequency of Reports and Deadlines for Submission

(If you choose to comment on issues in this section, please include the caption ''Frequency and Deadlines for Reports'' at the beginning of your comment.)

We are proposing to require insurers to submit data for different reporting periods, depending upon the file type.

We are proposing to require insurers to submit the required registry data to the Secretary on a semiannual basis; that is, for the 6-month reporting period of January 1 through June 30 and July 1 through December 31 of each year. The proposed deadline for submittal of registry data reports is 30 days after the end of the reporting period.

4. Transition Provision

For insurers who have issued or exchanged a qualified Partnership policy prior to the effective date of the final regulations we issue, we are proposing a transition provision. We are proposing that the first reports required for these insurers will be the reports that pertain to the reporting period that begins no more than 120 days after the effective date of the final regulations.

5. Format and Manner of Reporting Data

(If you choose to comment on issues in this section, please include the caption ''Format for Reports'' at the beginning of your comment.)

We are proposing to require that insurers submit the required data in the format and manner specified by the Secretary in the HHS-issued insurer reporting specifications document, ''State Long-Term Care Insurance Partnership Insurer Reporting Instructions.'' As we mentioned earlier, we are in the process of developing an integrated database that would be accessible through a secure Web site, and we plan to issue instructions as to how insurers would access and input the required data into the HHS reporting system.

6. Use of Submitted Reports

(If you choose to comment on issues in this section, please include the caption ''Use of Reports'' at the beginning of your comment.)

The overall purpose of the data is twofold, first to be used in efforts to monitor program performance at both the state and federal level, and second to provide data for a longer-term evaluation of the effectiveness of the Partnership program. HHS and the States participating in the State Long-Term Care Partnership Program would use the information provided by insurers in compliance with the proposed reporting requirements for analytical studies and for program monitoring. The data provided by each insurer would reflect the combined experience of all State Long-Term Care Partnership Programs in terms of policies sold and benefits used. We plan to use the data to produce reports for Congress and other interested stakeholders on the implementation of the State Long-Term Care Partnership Program. In addition, we plan to use the data to generate individual State-level reports that would be used by the States to track the implementation of the Partnership Program at the State level.

HHS does not intend to use the data to determine asset disregard levels for individuals who participate in the State Long-Term Care Partnership Program and eventually apply for Medicaid coverage. We would not collect data on ''point in time'' information regarding the amount of insurance benefits used by claimants, nor exact information on when private insurance benefits may be exhausted, which clearly would depend upon how claimants use benefits to purchase long-term care services. The computation of asset disregard levels and the determination of Medicaid eligibility coverage are matters that will be dealt with among the insurer, the insured individual, and the State Medicaid eligibility office. We expect that when insured individuals exhaust their insurance coverage (or otherwise become eligible for Medicaid prior to the exhaustion of benefits), insurers will provide them with documentation of their participation in the State Long-Term Care Partnership Program and of the amount of benefits that the insured received. This documentation will become part of the entire documentation provided by the insured individual at

the time he or she applies for Medicaid. The Medicaid eligibility office will then determine, based upon the documentation provided by the applicant, the asset disregard level that will be applied.

It is possible that State Medicaid programs may wish to access the collected data for monitoring purposes, to help them anticipate the number of insured individuals who may become eligible for Medicaid asset disregards over a projected time period. For example, through reports provided to each State from the integrated database, States would know how many partnership policyholders are ''in claim'' during any 3-month reporting period. States would also know, approximately, to what extent policyholders who are in claim have utilized the insurance benefits for which they are eligible and the amount of benefits remaining under their policy maximums. However, once an insured individual exhausts his or her insurance benefits under the policy, his or her eligibility for Medicaid would still depend upon the amount of available assets he or she retains, relative to his or her asset disregard, as well as other Medicaid eligibility criteria. For example, an insured individual may be eligible for an asset disregard of $150,000, but still retains $250,000 in countable assets. In this case, he or she would have to spend down $100,000 of his or her available assets before applying for Medicaid coverage. Thus, in general terms, States would be able to use the data to project future applications for Medicaid (and their potential budgetary impacts) but, at the individual level, the specific financial circumstances of each insured individual would determine his or her eligibility for Medicaid coverage.

D. Additional State-Mandated Reporting Requirements

(If you choose to comment on issues in this section, please include the caption ''Additional State Reporting'' at the beginning of your comment.)

The DRA explicitly states that there is nothing in the statute that prohibits States from imposing additional reporting requirements on insurers participating in the Long-Term Care Partnership Program, beyond the Federal reporting requirements that we are proposing in this proposed rule. However, we believe that the information that would be made available to the Secretary and to the States participating in the Long-Term Care Partnership Program through these proposed mandated reporting requirements would be sufficient to meet the policy analysis and program monitoring needs of the States. We, as well as the stakeholders participating in the development of these proposed reporting requirements, attempted to achieve a proper balance between the legitimate needs of the Federal Government and State governments to monitor the implementation and operation of the State Long-Term Care Partnership Program, and the desire not to impose undue cost burdens on participating insurers, to the point where they may consider it not economically beneficial to participate in the Partnership Program.

E. Confidentiality of Information

(If you choose to comment on issues in this section, please include the caption ''Confidentiality'' at the beginning of your comment.)

We are proposing to provide in the regulations that the data collected and reported under the requirements of the regulations in this proposed rule would be subject to the confidentiality of information requirements specified in regulations under 42 CFR Part 401, Subpart B, and 45 CFR Part 5, Subpart F and any other applicable confidentiality statute or regulation.

F. Provision of Reports to Partnership States

(If you choose to comment on issues in this section, please include the caption ''Furnishing Reports to States'' at the beginning of your comment.)

Section 1917(b)(1)(C)(v) of the Act provides that the Secretary, as appropriate, must provide copies of the reports provided by insurers to the State involved. We plan to make reports containing the reported data available to States in a timely and efficient manner.

G. Incorporation of Reporting Requirements in the Code of Federal Regulations

(If you choose to comment on issues in this section, please include the caption ''Regulation Text'' at the beginning of your comment.)

We are proposing to establish under Title 45, Subtitle A, Subchapter B, Part 144 of the Code of Federal Regulations a new Subpart B to incorporate the requirements for the reporting of data by insurers on qualified long-term care insurance policies issued under State Long-Term Care Partnership Programs that are established under an approved Medicaid State plan amendment.

Specifically—

Proposed § 144.200 contains the basis for the regulations.

Proposed § 144.202 includes definitions used throughout the subpart.

Proposed § 144.204 specifies the applicability of the regulations under the subpart.

Proposed § 144.206 specifies the requirements for reporting of long-term care partnership program data and the frequency with which insurers must report the data.

Proposed § 144.208 specifies the deadlines for submission of reports.

Proposed § 144.210 specifies the format and manner in which the data are to be reported.

Proposed § 144.212 specifies the confidentiality of information requirements that will be applied.

Proposed § 144.214 specifies the action that the Secretary will take if an insurer fails to report the required data by the specified deadlines.

IV. Response to Public Comments

Because of the large number of public comments that we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of the preamble of this proposed rule, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Collection of Information Requirements

The Department of Health and Human Services has determined that this notice of proposed rulemaking contains information collections that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520). In compliance with the requirement of section 3506(c)(2)(A) of the PRA, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed information collection request for public comment. Further, the Department acknowledges that this regulation is covered under the Privacy Act and that this collection of data constitutes a System of Records. The Department anticipates publishing a System of Records Notice. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection

techniques or other forms of information technology to minimize the information collection burden.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections described below, e-mail your request, including your name, address, phone number, as well as the caption ''Collection of Information Requirements'' at the beginning of your comment, to *Sherette.funncoleman@hhs.gov*, or call the Reports Clearance Office on (202) 690–6162. Written comments and recommendations for the proposed information collections must be received with 60 days.

Title: Partnership for Long-Term Care Insurer Reporting Requirements.

Description: This information collected under the proposed rule is intended for insurers participating in the Partnership for Long-Term Care as authorized by the Deficit Reduction Act of 2005. Insurers will provide data in the proscribed format to the Department on Partnership certified long-term care insurance policies. The requirements include the identity of the policy holder, the type of coverage purchased and the amount of insurance benefits used. Data from this submission will be provided to state Medicaid agencies to assist in determining the amount of asset protection earned by program participants.

It is estimated that insurers participating in the Partnership will be able to provide the necessary reports from data currently within their insurance operations systems. Fulfilling the reporting requirements will require that they write programs to extract the data in the manner specified by the Department. There are no costs to the respondents, other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS AND BURDEN COSTS

CFR section	Type of respondent	Number of respondents	Number of responses per respondents	Average response per respondent (in hours)	Total burden hours
45 CFR 144.206	Insurers	30	6	45/60	135

Public comments addressed as a result of this notice will be taken into account in the formal OMB request for clearance for this data collection. Prior to the effective date of this final rule, HHS will publish a notice in the **Federal Register** announcing OMB's decision to approve, modify, or disapprove the new information collection provisions in the final rule. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

VI. Regulatory Impact Analysis

(If you choose to comment on issues in this section, please include the caption ''Impact'' at the beginning of your comment.)

A. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

B. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

While we have determined that this proposed rule is not economically significant, it is however a significant regulatory action. We estimate that the aggregate cost to participating private insurers of implementing the reporting requirements in this proposed rule would be approximately $1,500,000.

C. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most insurance companies are not considered to be small entities because they generally have revenues of more than $29 million in any 1 year. (For details, see the Small Business Administration's final rule that sets forth size standards for industries at 65 FR 69432, November 17, 2000.) For purposes of the RFA, all insurance companies are not considered to be small entities. Individuals and States are not included in the definition of a small entity. However, we are soliciting comments on our estimates and analysis of the impact of this proposed rule on insurers.

There are approximately 100 insurance companies located nationwide that issue long-term care insurance policies. We expect that, of these 100 companies, approximately 30 insurance companies will participate in qualified State Long-Term Care Partnership Programs. Currently, there are 15 to 20 companies operating in States that are selling or have issued qualified long-term care insurance policies under the State Long-Term Care Partnership Programs. As of December 2007, approximately 300,000 policies have been sold. We believe this represents approximately 80 percent of the policies that might be sold when the Partnership Programs are established nationwide. We anticipate that the number of insurance companies selling qualified long-term care insurance partnership policies might increase by about 10 as more States obtain approved State plan amendments to operate State Long-Term Care Partnership Programs.

As we stated earlier, insurers participating in the original four Partnership Programs have been reporting data on policies sold and benefits used in the program for more than a decade. The proposed reporting requirements in this proposed rule were designed to take advantage of data already available in insurer data sets. Insurers would not be asked to collect new data, but simply to recode existing data into a common format for submission to the Secretary. It is estimated that participating insurers would have to make a one-time investment to produce the computer programs necessary to compile the reports. Should the reporting requirement change in the future there will also be a cost to make the necessary changes. We are estimating that the

programming would require 400 hours of labor on average (this number will vary widely by company depending the type of systems used) to create the necessary changes. We also estimate an average cost per hour of programming time of $125. The cost per company is estimated at $50,000 and the total estimate for all companies is estimated at $1.5 million.

Subsequently, there would be a much smaller investment to run the quarterly and semi-annually reports. The data submissions were designed to be primarily snapshots of data elements in the insurers' files with very little tabulation or summary reporting. We note that all of the currently participating insurers participated in the development of the proposed reporting requirements in this proposed rule and have given their consensus to the proposed requirements.

D. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule (and subsequent final rule) that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. This proposed rule does not affect small rural hospitals.

E. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This proposed rule would not mandate any requirements for State, local, or tribal governments. However, it would affect private sector costs to insurance companies who sell qualified long-term care insurance partnership policies. We note that participation by insurers in the Partnership Program is voluntary. We have also determined that the costs of reporting the required data are not significant.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule would not have a substantial effect on State and local governments.

List of Subjects in 45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping.

For the reasons stated in the preamble of this proposed rule, we are proposing to amend 45 CFR subtitle A, subchapter B, part 144 as set forth below:

Subchapter B—Requirements Relating to Health Care Access

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

1. The authority citation for part 144 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92 as amended by HIPAA (Pub. L. 104–191, 110 Stat. 1936), MHPA (Pub. L. 104–204, 110 Stat. 2944, as amended by Pub. L. 107–116, 115 Stat. 2177), NMHPA (Pub. L. 104–204, 110 Stat. 2935), WHCRA (Pub. L. 105–227, 112 Stat. 2681–436)) and section 103(c)(4) of HIPAA; and secs. 1102 and 1917(b)(1)(C)(iii)(VI) of the Social Security Act (42 U.S.C. 1302 and 1396p(b)(1)(C)(iii)(VI)).

2. A new subpart B is added to read as follows:

Subpart B—Qualified State Long-Term Care Insurance Partnerships: Reporting Requirements for Insurers

Sec.

Subpart B—Qualified State Long-Term Care Insurance Partnerships: Reporting Requirements for Insurers

§ 144.200 Basis.

This subpart implements—

(a) Section 1917(b)(1)(C) (iii)(VI) of the Social Security Act, (Act) which requires the issuer of a long-term care insurance policy issued under a qualified State long-term care insurance partnership to provide specified regular reports to the Secretary. (b) Section 1917(b)(1)(C)(v) of the Act, which specifies that the regulations of the Secretary under section 1917(b)(1)(C)(iii)(VI) of the Act shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representative of consumers of long-term care insurance policies, and shall specify the type and format of the data to be reported and the frequency with which such reports are to be made. This section of the statute also provides that the Secretary provide copies of the reports to the States involved.

§ 144.202 Definitions.

As used in this subpart—

Partnership qualified policy refers to a qualified long-term insurance policy issued under a qualified State long-term care insurance partnership.

Qualified long-term insurance care policy means an insurance policy that has been determined by a state insurance commissioner to meet the requirements of sections 1917(b)(1)(C)(iii)(I) through (IV) and 1917(b)(5) of the Act. It includes a certificate issued under a group insurance contract.

Qualified State long-term care insurance partnership means an approved Medicaid State plan amendment 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 that has been determined by a state insurance commissioner to meet the requirements of section 1917(b)(a)(C)(iii) of the Act. It includes any Medicaid State plan amendment approved as of May 4, 1993, that meets the requirements of section 1917(b)(1)(C)(iii) of the Act and for which the Secretary determines that the State plan amendment provides for consumer protection standards that are no less stringent than the consumer protection standards that applied under the State plan amendment as of December 31, 2005.

§ 144.204 Applicability of regulations.

The regulations contained in this subpart for reporting data apply only to those insurers that have issued qualified long-term care insurance policies to individuals under a qualified State long-term care insurance partnership.

§ 144.206 Reporting requirements.

(a) *General requirement.* Any insurer that sells a qualified long-term care insurance policy under a qualified State long-term care insurance partnership must submit, in accordance with the requirements of this section, data on insured individuals, policyholders, and claimants who have active partnership

qualified policies or certificates for a reporting period.

(b) *Specific requirements.* Insurers of qualified long-term care insurance policies must submit the following data to the Secretary by the deadlines specified in paragraph (c) of this section:

(1) *Registry of active individual and group partnership qualified policies or certificates.* (i) Insurers must submit data on—

(A) Any insured individual who held an active partnership qualified policy or certificate at any point during a reporting period, even if the policy or certificate was subsequently cancelled, lost partnership qualified status, or otherwise terminated during the reporting period; and

(B) All active group long-term care partnership qualified insurance policies, even if the identity of the individual policy/certificate holder is unavailable.

(ii) The data required under paragraph (b)(1)(i) of this section must cover a 6-month reporting period of January through June 30 or July 1 through December 31 of each year; and

(iii) The data must include, but are not limited to—

(A) Current identifying information on the insured individual;

(B) The name of the insurance company and issuing State;

(C) The effective date and terms of coverage under the policy.

(D) The annual premium.

(E) The coverage period.

(F) Other information, as specified by the Secretary in ''State Long-Term Care Partnership Insurer Reporting Instructions.''

(2) *Claims paid under partnership qualified policies or certificates.* Insurers must submit data on all partnership qualified policies or certificates for which the insurer paid at least one claim during the reporting period. This includes data for employer-paid core plans and buy-up plans without individual insured data. The data must—

(i) Cover a quarterly reporting period of 3 months;

(ii) Include, but are not limited to—

(A) Current identifying information on the insured individual;

(B) The type and cash amount of the benefits paid during the reporting period and lifetime to date;

(C) Remaining lifetime benefits;

(D) Other information, as specified by the Secretary in ''State Long-Term Care Partnership Insurer Reporting Instructions.''

§ 144.208 Deadlines for submission of reports.

(a) Transition provision for insurers who have issued or exchanged a qualified partnership policy prior to the effective date of these regulations. The first reports required for these insurers will be the reports that pertain to the reporting period that begins no more than 120 days after the effective date of the final regulations.

(b) All reports on the registry of qualified long-term care insurance policies issued to individual and individuals under group coverage specified in § 144.206(b)(1)(ii) must be submitted within 30 days of the end of the 6-month reporting period.

(c) All reports on the claims paid under qualified long-term care insurance policies issued to individual and individuals under group coverage specified in § 144.206(b)(2)(i) must be submitted within 30 days of the end of the 3-month quarterly reporting period.

§ 144.210 Form and manner of reports.

All reports specified in § 144.206 must be submitted in the form and manner specified by the Secretary in insurer reporting instructions.

§ 144.212 Confidentiality of information.

Data collected and reported under the requirements of this subpart are subject to the confidentiality of information requirements specified in regulations under 42 CFR part 401, subpart B, and 45 CFR part 5, subpart F.

§ 144.214 Notifications of noncompliance with reporting requirements.

If an insurer of a qualified long-term care insurance policy does not submit the required reports by the due dates specified in this subpart, the Secretary notifies the appropriate State insurance commissioner within 45 days after the deadline for submission of the information and data specified in § 144.208.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: February 12, 2008.

Ben Sasse,

Assistant Secretary for Planning and Evaluation.

Dated: February 12, 2008.

Michael O. Leavitt,

Secretary.

Editorial Note: The Office of the Federal Register received this document on May 20, 2008.]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 665

RIN 0648–AV30

Fisheries in the Western Pacific; Precious Corals Fisheries; Black Coral Quota and Gold Coral Moratorium

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of availability of fishery management plan amendment; request for comments.

SUMMARY: NMFS announces that the Western Pacific Fishery Management Council proposes to amend the Fishery Management Plan for the Precious Corals Fisheries of the Western Pacific Region (Amendment 7). If approved by the Secretary of Commerce, Amendment 7 would designate the Au'au Channel, Hawaii, black coral bed as an ''Established Bed'' with a harvest quota of 5,000 kg every two years that applies to Federal and State of Hawaii waters, and establish a 5–year moratorium on the harvest of gold coral throughout the U.S. western Pacific. The proposed amendment is intended to prevent overfishing and achieve optimum yield of precious coral resources.

DATES: Comments on Amendment 7, which includes an environmental assessment, must be received by July 22, 2008.

ADDRESSES: Comments on the amendment, identified by 0648–AV30, may be sent to either of the following addresses:

- Electronic Submission: Submit all electronic public comments via the Federal e-Rulemaking Portal www.regulations.gov; or
- Mail: William L. Robinson, Regional Administrator, NMFS, Pacific Islands Region (PIR), 1601 Kapiolani Blvd., Suite 1110, Honolulu, HI 96814–4700.

Instructions: All comments received are a part of the public record and will generally be posted to *www.regulations.gov* without change. All Personal Identifying Information (e.g., name, address, etc.) submitted voluntarily by the commenter may be publicly accessible. Do not submit Confidential Business Information, or otherwise sensitive or protected information. NMFS will accept anonymous comments. Attachments to electronic comments will be accepted in