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CHAPTER 400 SOCIAL SERVICES
THE SOCIAL WELFARE ACT
COUNTY DEPARTMENTS OF SOCIAL SERVICES

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MCLS § 400.106 (2007)

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§ 400.106. "Medically indigent individual," "Medicaid contracted health plan," "medical institution," and "Title XVI" defined; notice of legal action; recovery of expenses by state department or medicaid contracted health plan; priority against proceeds.

Sec. 106. (1) A medically indigent individual is defined as:

(a) An individual receiving family independence program benefits or an individual receiving supplemental security income under title XVI or state supplementation under title XVI subject to limitations imposed by the director according to title XIX.

(b) Except as provided in section 106a, an individual who meets all of the following conditions:

(i) The individual has applied in the manner the family independence agency prescribes.

(ii) The individual's need for the type of medical assistance available under this act for which the individual applied has been professionally established and payment for it is not available through the legal obligation of a public or private contractor to pay or provide for the care without regard to the income or resources of the patient. The state department is subrogated to any right of recovery that a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the state department for the care and treatment of the patient. The patient or other person acting in the patient's behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department. A payment may be withheld under this act for medical assistance for an injury or disability for which the individual is entitled to medical care or reimbursement for the cost of medical care under sections 3101 to 3179 of the insurance code of 1956, 1956 PA 218, MCL 500.3101 to 500.3179, or under another policy of insurance providing medical or hospital benefits, or both, for the individual unless the individual's entitlement to that medical care or reimbursement is at issue. If a payment is made, the state department, to enforce its subrogation right, may do either of the following: (a) intervene or join in an action or proceeding brought by the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors, against the third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual; (b) institute and prosecute a legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. The state department may institute the proceedings in its own name or in the name of the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. As provided in section 6023 of the revised judicature act of

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1961, 1961 PA 236, MCL 600.6023, the state department, in enforcing its subrogation right, shall not satisfy a judgment against the third person's property that is exempt from levy and sale. The injured, diseased, or disabled individual may proceed in his or her own name, collecting the costs without the necessity of joining the state department or the state as a named party. The injured, diseased, or disabled individual shall notify the state department of the action or proceeding entered into upon commencement of the action or proceeding. An action taken by the state or the state department in connection with the right of recovery afforded by this section does not deny the injured, diseased, or disabled individual any part of the recovery beyond the costs expended on the individual's behalf by the state department. The costs of legal action initiated by the state shall be paid by the state. A payment shall not be made under this act for medical assistance for an injury, disease, or disability for which the individual is entitled to medical care or the cost of medical care under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941; except that payment may be made if an appropriate application for medical care or the cost of the medical care has been made under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, entitlement has not been finally determined, and an arrangement satisfactory to the state department has been made for reimbursement if the claim under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, is finally sustained.

(iii) The individual has an annual income that is below, or subject to limitations imposed by the director and because of medical expenses falls below, the protected basic maintenance level. The protected basic maintenance level for 1-person and 2-person families shall be at least 100% of the payment standards generally used to determine eligibility in the family independence program. For families of 3 or more persons, the protected basic maintenance level shall be at least 100% of the payment standard generally used to determine eligibility in the family independence program. These levels shall recognize regional variations and shall not exceed 133-1/3% of the payment standard generally used to determine eligibility in the family independence program.

(iv) The individual, if a family independence program related individual and living alone, has liquid or marketable assets of not more than \$2,000.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more than \$3,000.00 in value. The state department shall establish comparable liquid or marketable asset amounts for larger family groups. Excluded in making the determination of the value of liquid or marketable assets are the values of: the homestead; clothing; household effects; \$1,000.00 of cash surrender value of life insurance, except that if the health of the insured makes continuance of the insurance desirable, the entire cash surrender value of life insurance is excluded from consideration, up to the maximum provided or allowed by federal regulations and in accordance with state department rules; the fair market value of tangible personal property used in earning income; an amount paid as judgment or settlement for damages suffered as a result of exposure to agent orange, as defined in section 5701 of the public health code, 1978 PA 368, MCL 333.5701; and a space or plot purchased for the purposes of burial for the person. For individuals related to the title XVI program, the appropriate resource levels and property exemptions specified in title XVI shall be used.

(v) The individual is not an inmate of a public institution except as a patient in a medical institution.

(vi) The individual meets the eligibility standards for supplemental security income under title XVI or for state supplementation under the act, subject to limitations imposed by the director according to title XIX; or meets the eligibility standards for family independence program benefits; or meets the eligibility standards for optional eligibility groups under title XIX, subject to limitations imposed by the director according to title XIX.

(2) As used in this act:

(a) "Medicaid contracted health plan" means a managed care organization with whom the state department contracts to provide or arrange for the delivery of comprehensive health care services as authorized under this act.

(b) "Medical institution" means a state licensed or approved hospital, nursing home, medical care facility, psychiatric hospital, or other facility or identifiable unit of a listed institution certified as meeting established standards for a nursing home or hospital in accordance with the laws of this state.

(c) "Title XVI" means title XVI of the social security act, 42 USC 1381 to 1382j and 1383 to 1383f.

(3) An individual receiving medical assistance under this act or his or her legal counsel shall notify the state department when filing an action in which the state department may have a right to recover expenses paid under this act. If the individual is enrolled in a medicaid contracted health plan, the individual or his or her legal counsel shall provide notice to the medicaid contracted health plan in addition to providing notice to the state department.

(4) If a legal action in which the state department, a medicaid contracted health plan, or both has a right to recover expenses paid under this act is filed and settled after November 29, 2004 without notice to the state department or the medicaid contracted health plan, the state department or the medicaid contracted health plan may file a legal action against the individual or his or her legal counsel, or both, to recover expenses paid under this act. The attorney general shall recover any cost or attorney fees associated with a recovery under this subsection.

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(5) The state department has first priority against the proceeds of the net recovery from the settlement or judgment in an action settled in which notice has been provided under subsection (3). A medicaid contracted health plan has priority immediately after the state department in an action settled in which notice has been provided under subsection (3). The state department and a medicaid contracted health plan shall recover the full cost of expenses paid under this act unless the state department or the medicaid contracted health plan agrees to accept an amount less than the full amount. If the individual would recover less against the proceeds of the net recovery than the expenses paid under this act, the state department or medicaid contracted health plan, and the individual shall share equally in the proceeds of the net recovery. As used in this subsection, "net recovery" means the total settlement or judgment less the costs and fees incurred by or on behalf of the individual who obtains the settlement or judgment.

HISTORY: Act 280, 1939, p 513; imd eff June 16, 1939.

Pub Acts 1939, No. 280, § 106, as added by Pub Acts 1966, No. 321, eff September 1, 1966; amended by Pub Acts 1967, No. 289, imd eff August 1, 1967; 1970, No. 160, imd eff August 2, 1970; 1973, No. 189, imd eff January 8, 1974, by § 3 eff January 1, 1974; 1976, No. 284, imd eff October 20, 1976; 1978, No. 623, imd eff January 6, 1979; 1982, No. 405, eff March 30, 1983; 1990, No. 145, imd eff June 27, 1990.

Amended by Pub Acts 2003, No. 33, imd eff July 2, 2003 (see 2003 note below); 2004, No. 409, imd eff November 29, 2004; 2006, No. 144, imd eff May 22, 2006.

NOTES:

Editor's notes:

Pub Acts 1966, No. 321, § 2, eff September 1, 1966, provides:

"Section 2. After August 31, 1966, no medical or dental service shall be commenced under Act No. 2 of the Public Acts of the First Extra Session of 1960, as amended, being *sections 400.361 to 400.371* of the Compiled Laws of 1948, or under section 66a of Act No. 280 of the Public Acts of 1939, as amended, being *section 400.66a* of the Compiled Laws of 1948, for recipients of old age assistance, aid to dependent children, aid to the blind or aid to the permanently and totally disabled."

Pub Acts 2003, No. 33, enacting § 1, imd eff July 2, 2003, provides:

"Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 22 of the 92nd Legislature [Pub Acts 2003, No. 32] is enacted into law."

Effect of amendment notes:

The 2003 amendment revised this section to the extent that a detailed comparison would be impracticable.

The 2004 amendment in subsection (1), in paragraph (b) in subparagraph (ii) inserted "state" following "expended by the" and substituted "individual" for "patient" and "person" throughout and substituted "individual's" for "patient's" or "person's" throughout; in subsection (2) added paragraph (a), redesignated former paragraphs (a) and (b) as (b) and (c), and in paragraph (c) substituted "42 USC" for "chapter 531, 49 Stat. 620, 42 U.S.C." following "social security act,"; and added subsections (3)-(5).

The 2006 amendment revised subsection (1), paragraph (b), subparagraph (iii) from one which read: "The individual has an annual income that is below, or because of medical expenses falls below, the protected basic maintenance level. The protected basic maintenance level for 1-person and 2-person families shall be at least 100% of the higher of the payment standards generally used to determine eligibility in the family independence program and the supplemental security income program under title XVI, including state supplementation. For families of 3 or more persons, the protected basic maintenance level shall be at least 100% of the payment standard generally used to determine eligibility in the family independence program. These levels shall recognize regional variations and shall not exceed 133-1/3% of the payment standard generally used to determine eligibility in the family independence program."; in subsection (1), paragraph (b), subparagraph (iv), preceding "shall establish" substituted "state department" for "family independence agency", following "accordance with" substituted "state department" for "the", following "rules" substituted a semicolon for "of the family independence agency;"; revised subsection (1), paragraph (b), subparagraph (vi) from one which read: "The individual meets the eligibility standards for supplemental security income under title XVI or for state supplementation under the act, subject to limitations imposed by the director according to title XIX; or meets the eligibility standards for family independence program benefits, except for income or income and resources; or is a child from 18 to 21 years of age and his or her adult caretaker would be eligible for family independence program benefits except for age,

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income, or income and resources; or is a child under 21 years of age and is from a family whose income is below the basic maintenance level."; in subsection (3) following "notice to the" inserted "medicaid"; and in subsection (4), following "settled after" substituted "November 29, 2004" for "the date of the amendatory act that added this subsection".

Statutory references:

Section 106a, above referred to, is § 400.106a.

Federal Aspects:

Supplemental Security Income for the Aged, Blind, and Disabled. 42 USCS §§ 1381, 1382.
Grants to States for Medical Assistance Programs. 42 USCS §§ 1396 et seq.

LexisNexis(TM) Michigan analytical references:

Michigan Law and Practice, Public Health and Welfare § 44
Midwest Transaction Guide, Chapter 215, Nursing Homes and Other Care Facilities

ALR notes:

Collateral source rule: Injured person's hospitalization or medical insurance as affecting damages recoverable, 77 ALR3d 415.

Validity and construction of no-fault insurance plans providing for reduction of benefits otherwise payable by amounts receivable from independent collateral sources, 10 ALR4th 996.

Eligibility for welfare benefits, under maximum-assets limitations, as affected by expenditures or disposal of assets, 19 ALR4th 146.

Validity of state statutes and regulations limiting or restricting public funding for abortions sought by indigent women, 20 ALR4th 1166.

Validity of statutes or regulations denying welfare benefits to claimants who transfer property for less than its full value, 24 ALR4th 215.

Research references:

1 Am Jur 2d, Abortion § 1.5
70 Am Jur 2d, Social Security and Medicare §§ 74-93
79 Am Jur 2d, Welfare Laws §§ 72.5, 72.6

Legal periodicals:

Shartsis, Casey and Abortion Rights in Michigan, 10 *T M Cooley L Rev* 313 (1993).
Turnham, Medicaid spousal impoverishment: An introduction, 69 *Mich BJ* 522 (1990).
Wells-Stevens, Health care for indigent American Indians, 20 *Ariz S Ct LJ* 1105 (1988).

CASE NOTES

1. Construction and effect.
2. Emergency medical expenses.
3. Subrogation.

1. Construction and effect.

Personal injury protection insurance benefits payable under no-fault insurance act constitute medical assistance available through legal obligation of insurance contractor to pay or provide for care without regard to income or resources of claimant so as to come within meaning of Social Welfare Act excluding persons entitled to such assistance from definition of medical indigents qualifying for state medicaid benefits, and accordingly, claimant who was entitled to no-fault personal protection insurance benefits could have no right to state medicaid benefits as would render them deductible under no-fault act as benefits provided or required to be provided under laws of state or federal government. *Workman v Detroit Auto. Inter-Insurance Exchange* (1979) 404 *Mich* 477, 274 *NW2d* 373.

Medicaid payments provided plaintiff pending disposition of her claim for personal injury protection benefits under no-fault insurance act were not subject to set-off and did not constitute benefits provided or required to be provided by under laws of state or federal government within meaning of statute requiring set-off thereof as against amount of per-

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sonal protection benefits otherwise payable under no-fault act, where plaintiff was not medically indigent person eligible for medicaid benefits and department of social services has statutory right of subrogation or reimbursement from plaintiff to extent of benefits paid. *Workman v Detroit Auto. Inter-Insurance Exchange (1979) 404 Mich 477, 274 NW2d 373.*

A person entitled to no-fault personal protection insurance benefits for an injury caused by an automobile is not medically indigent for purposes of the Social Welfare Act and therefore is not entitled to Medicaid assistance. *Johnson v Michigan Mut. Ins. Co. (1989) 180 Mich App 314, 446 NW2d 899, app den (1990) 434 Mich 906.*

2. Emergency medical expenses.

Denial by department of social services of claimant migrant worker's application for emergency assistance benefits for medical expenses incurred by injured child, on ground that claimant's wages were above level qualifying for benefits, would be reversed by reviewing court for lack of competent, material, and substantial evidentiary support on whole record disclosing that, although examiner found wages attributed to claimant by department were in fact earned by three to five workers in claimant's family, some of whose income was statutorily required to be disregarded as earned by children under 14 years of age while full-time students living at home, examiner failed to determine whether such mandatory "disregards" would in fact reduce claimant's wages to level as would qualify him for emergency assistance. *Lopez v Michigan Dep't of Social Services (1977) 76 Mich App 505, 257 NW2d 143.*

3. Subrogation.

Under *MCLS § 400.106(1)(b)(ii)*, Medicaid can enforce a subrogation right by intervening in a lawsuit or by filing its own lawsuit against the allegedly negligent parties or against contractors that may be liable to pay for medical care. *Estate of Shinholster v Annapolis Hosp. (2003) 255 Mich App 339, 660 NW2d 361.*

A health care provider that has received Medicaid payments for medical services provided to a patient who suffered injuries in an automobile accident may seek from the patient's no-fault insurer reimbursement of any reasonable charges for services that Medicaid did not pay, even though in the absence of insurance benefits the provider would have had to accept the Medicaid payment as payment in full; the statutory right of subrogation of the state extends only to the amount of the Medicaid payments and does not automatically foreclose other claims. *Botsford General Hosp. v Citizens Ins. Co. (1992) 195 Mich App 127, 489 NW2d 137, app den (1993) 441 Mich 912, 496 NW2d 293.*

The department of social services may not seek reimbursement as a subrogee for anticipated but unpaid Medicaid benefits covering expenses to be incurred in the future. *Morrow v Shah (1989) 181 Mich App 742, 450 NW2d 96.*

The state has a right of subrogation to any right of recovery which a medically indigent individual may have for medical expenses; this right of subrogation is limited to the amount of funds expended by the state for the patient's care. *Hartman v Insurance Co. of North America (1981) 106 Mich App 731, 308 NW2d 625.*

The state has the authority to enforce its right of subrogation to a medically indigent individual's right of recovery for medical expenses by intervening or joining in an action or proceeding brought against a party who may be liable for the injury. *Hartman v Insurance Co. of North America (1981) 106 Mich App 731, 308 NW2d 625.*

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MCLS § 400.106a (2007)

MCL § 400.106a

§ 400.106a. Short title; medical assistance to individuals with earned income; establishment of program; limitation; eligibility; premium; report of earned income changes; report to governor; waiver; definitions.

Sec. 106a. (1) This section shall be known and may be cited as the "Michigan freedom to work for individuals with disabilities law".

(2) The department of community health shall establish a program to provide medical assistance to individuals who have earned income and who meet all of the following eligibility criteria:

(a) The individual has been found to be disabled under the federal supplemental security income program or the social security disability income program, or would be found to be disabled except for earnings in excess of the substantial gainful activity level as established by the United States social security administration.

(b) The individual is at least 16 years of age and younger than 65 years of age.

(c) The individual has an unearned income level of not more than 100% of the current federal poverty guidelines.

(d) The individual is a current medical assistance recipient under section 106 or meets income, asset, and eligibility requirements for the medical assistance program under section 106.

(e) The individual is employed on a regular and continuing basis.

(3) The program is limited to the medical assistance services made available to recipients under the medical assistance program administered under section 105 and does not include personal assistance services in the workplace.

(4) Without losing eligibility for medical assistance, an individual who qualifies for and is enrolled under this program is permitted to do all of the following:

(a) Accumulate personal savings and assets not to exceed \$75,000.00.

(b) Accumulate unlimited retirement and individual retirement accounts.

(c) Have temporary breaks in employment that do not exceed 24 months if the temporary breaks are the result of an involuntary layoff or are determined to be medically necessary.

(d) Work and have income that exceeds the amount permitted under section 106, but shall not have unearned income that exceeds 100% of the federal poverty guidelines.

(5) The department of community health shall establish a premium that is based on earned income for individuals enrolled in the program subject to all of the following provisions:

(a) The premium shall be based on the enrolled individual's annualized earned income above 250% of the current federal poverty guidelines for a family of 1.

(b) Individuals with an earned income of between 250% of the federal poverty guidelines for a family of 1 and \$75,000.00 shall pay a sliding fee scale premium starting at \$600.00 annually and increasing to 100% of the average

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medical assistance recipient cost as determined by the department of community health for individuals with annual income of \$75,000.00 or more.

(c) The premium sliding fee scale shall have no more than 5 tiers.

(d) The premium for an enrolled individual shall generally be assessed on an annual basis based on the annual return required to be filed under the internal revenue code of 1986 or other evidence of earned income and shall be payable on a monthly basis. The premium shall be adjusted during the year when a change in an enrolled individual's rate of annual income moves the individual to a different premium tier.

(6) An enrolled individual has an affirmative duty to report earned income changes that would result in a different premium within 30 days to the department of community health.

(7) The department of community health shall report to the governor and the legislature within 2 years of the effective date of the amendatory act that added this section regarding all of the following:

(a) The effectiveness of the program in achieving its purposes.

(b) The number of individuals enrolled in the program.

(c) The costs and benefits of the program.

(d) The opportunities and projected costs of expanding the program to working individuals with disabilities who are not currently eligible for the program.

(e) Additional services that should be covered under the program to assist working individuals with disabilities in obtaining and maintaining employment.

(8) If the terms of this section are inconsistent with federal regulations governing federal financial participation in the medical assistance program, the department of community health may to the extent necessary waive any requirement set forth in subsections (1) to (5).

(9) The program established in this section shall be implemented on or before January 1, 2004.

(10) As used in this section:

(a) "Earned income" and "unearned income" mean those terms as used by the family independence agency in determining eligibility for the medical assistance program administered under this act.

(b) "Federal poverty guidelines" means the poverty guidelines published annually in the federal register by the United States department of health and human services under its authority to revise the poverty line under section 673(2) of subtitle B of title VI of the omnibus budget reconciliation act of 1981, Public Law 97-35, 42 U.S.C. 9902.

HISTORY: Act 280, 1939, p 513; imd eff June 16, 1939.

Pub Acts 1939, No. 280, § 106a, as added by Pub Acts 2003, No. 32, imd eff July 2, 2003 (see 2003 note below).

NOTES:

Editor's notes:

Pub Acts 2003, No. 32, enacting § 1, imd eff July 2, 2003, provides:

"Enacting section 1. This amendatory act does not take effect unless House Bill No. 4270 of the 92nd Legislature [Pub Acts 2003, No. 33] is enacted into law."

Statutory references:

Sections 105 and 106, above referred to, are §§ 400.105 and 400.106.

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MCLS § 400.112b (2007)

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§ 400.112b. Definitions.

Sec. 112b. As used in this section and sections 112c to 112e:

(a) "Asset disregard" means, with regard to the state's medical assistance program, disregarding 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 qualified long-term care insurance partnership policy.

(b) "Long-term care insurance policy" means a policy described in chapter 39 of the insurance code of 1956, *1956 PA 218, MCL 500.3901 to 500.3955*.

(c) "Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in section 1917(b) of the social security act, *42 USC 1396p*.

(d) "Long-term care partnership program policy" means a qualified long-term care insurance policy that the commissioner of the office of financial and insurance services certifies as meeting the requirements of section 1917(b) of the social security act, *42 USC 1396p*, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(e) "Medicaid" means the program of medical assistance established by the department of community health under section 105.

HISTORY: Act 280, 1939, p 513; imd eff June 16, 1939.

Pub Acts 1939, No. 280, § 112b, as added by Pub Acts 1995, No. 85, imd eff June 20, 1995.

Amended by Pub Acts 2006, No. 674, imd eff January 10, 2007.

NOTES:

Effect of amendment notes:

The 2006 amendment deleted former paragraph (a) which read: " 'Home health care' means care described in section 109c."; added paragraphs (a), (c) and (d); revised paragraph (b) from one which read: " 'Long-term care insurance policy' means a policy described in chapter 39 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.3901 to 500.3955 of the Michigan Compiled Laws."; redesignated and revised former paragraph (c) as (e)

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from text which read: " 'Medicaid' means the program of medical assistance established by the department under section 105."; deleted former paragraph (d) which read: "Nursing home care' means nursing home services as described in section 109(1)(c)."; deleted former paragraph (e) which read: " 'Partnership policy" means a long-term care insurance policy that meets the requirements set forth in section 112d."; and deleted paragraph (f) which read: " 'Partnership program' means the Michigan partnership for long-term care program established under section 112c."

Statutory references:

Sections 105 and 112c to 112e, above referred to, are §§ *400.105* and *400.112c-400.112e*.

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MCLS § 400.112c (2007)

MCL § 400.112c

§ 400.112c. Michigan long-term care partnership program; establishment; purpose; eligibility; reciprocal agreements; consideration of assets; receipt of asset disregard; single point of entry agencies; notice of policy provisions; posting certain information.

Sec. 112c. (1) Subject to subsection (5), the department of community health in conjunction with the office of financial and insurance services and the department of human services shall establish a long-term care partnership program in Michigan to provide for the financing of long-term care through a combination of private insurance and medicaid. It is the intent of the long-term care partnership program to do all of the following:

- (a) Provide incentives for individuals to insure against the costs of providing for their long-term care needs.
- (b) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under medicaid without first being required to substantially exhaust their resources.
- (c) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.
- (2) An individual who is a beneficiary of a Michigan long-term care partnership program policy is eligible for assistance under the state's medical assistance program using the asset disregard as provided under subsection (5).
- (3) The department of community health shall pursue reciprocal agreements with other states to extend the asset disregard to Michigan residents who purchased long-term care partnership policies in other states that are compliant with title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.
- (4) Upon diminishment of assets below the anticipated remaining benefits under a long-term care partnership program policy, certain assets of an individual, as provided under subsection (5), shall not be considered when determining any of the following:
 - (a) Medicaid eligibility.
 - (b) The amount of any medicaid payment.
 - (c) Any subsequent recovery by the state of a payment for medical services or long-term care services.
- (5) Not later than 270 days after the effective date of the amendatory act that added this subsection, the department of community health shall apply to the United States department of health and human services for an amendment to the state's medicaid state plan to establish that the assets an individual owns and may retain under medicaid and still qualify for benefits under medicaid at the time the individual applies for benefits is increased dollar-for-dollar for each dollar paid out under the individual's long-term care insurance policy if the individual is a beneficiary of a qualified long-term care partnership program policy.

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(6) If the long-term care partnership program is discontinued, an individual who purchased a Michigan long-term care partnership program policy before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171.

(7) The department of community health shall contract with the Michigan medicare medicaid assistance program or department of community health designated single point of entry agencies, or both, to provide counseling services under the Michigan long-term care partnership program.

(8) The department of community health, in consultation with the department of human services and the office of financial and insurance services, shall develop a notice to consumers detailing in plain language the pertinent provisions of qualified state long-term care insurance partnership policies as they relate to medicaid eligibility and shall determine the appropriate distribution of the notice. The notice shall be available in a printable form on the office of financial and insurance services's website.

(9) The department, the department of community health, and the office of financial and insurance services shall post, on their respective websites, information on how to access the national clearinghouse established under the federal deficit reduction act of 2005, Public Law 109-171, when the national clearinghouse becomes available to consumers.

HISTORY: Act 280, 1939, p 513; imd eff June 16, 1939.

Pub Acts 1939, No. 280, § 112c, as added by Pub Acts 1995, No. 85, imd eff June 20, 1995.

Amended by Pub Acts 2006, No. 674, imd eff January 10, 2007.

NOTES:

Effect of amendment notes:

The 2006 amendment revised subsection (1) from one which read: "Subject to subsection (4), the department shall establish the Michigan partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medicaid."; deleted former subsections (2)-(5); and added subsections (2)-(9).

Act No. 144
Public Acts of 2006
Approved by the Governor
May 22, 2006
Filed with the Secretary of State
May 22, 2006
EFFECTIVE DATE: May 22, 2006

**STATE OF MICHIGAN
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Introduced by Senator Emerson

ENROLLED SENATE BILL No. 838

AN ACT to amend 1939 PA 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," by amending sections 106 and 107 (MCL 400.106 and 400.107), section 106 as amended by 2004 PA 409.

The People of the State of Michigan enact:

Sec. 106. (1) A medically indigent individual is defined as:

(a) An individual receiving family independence program benefits or an individual receiving supplemental security income under title XVI or state supplementation under title XVI subject to limitations imposed by the director according to title XIX.

(b) Except as provided in section 106a, an individual who meets all of the following conditions:

(i) The individual has applied in the manner the family independence agency prescribes.

(ii) The individual's need for the type of medical assistance available under this act for which the individual applied has been professionally established and payment for it is not available through the legal obligation of a public or private contractor to pay or provide for the care without regard to the income or resources of the patient. The state department is subrogated to any right of recovery that a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the state department for the care and treatment of the patient. The patient or other person acting in the patient's behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department. A payment may be withheld under this act for medical assistance for an injury or disability for which the individual is entitled to medical care or reimbursement for the cost of medical care under sections 3101 to 3179 of

the insurance code of 1956, 1956 PA 218, MCL 500.3101 to 500.3179, or under another policy of insurance providing medical or hospital benefits, or both, for the individual unless the individual's entitlement to that medical care or reimbursement is at issue. If a payment is made, the state department, to enforce its subrogation right, may do either of the following: (a) intervene or join in an action or proceeding brought by the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors, against the third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual; (b) institute and prosecute a legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. The state department may institute the proceedings in its own name or in the name of the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. As provided in section 6023 of the revised judicature act of 1961, 1961 PA 236, MCL 600.6023, the state department, in enforcing its subrogation right, shall not satisfy a judgment against the third person's property that is exempt from levy and sale. The injured, diseased, or disabled individual may proceed in his or her own name, collecting the costs without the necessity of joining the state department or the state as a named party. The injured, diseased, or disabled individual shall notify the state department of the action or proceeding entered into upon commencement of the action or proceeding. An action taken by the state or the state department in connection with the right of recovery afforded by this section does not deny the injured, diseased, or disabled individual any part of the recovery beyond the costs expended on the individual's behalf by the state department. The costs of legal action initiated by the state shall be paid by the state. A payment shall not be made under this act for medical assistance for an injury, disease, or disability for which the individual is entitled to medical care or the cost of medical care under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941; except that payment may be made if an appropriate application for medical care or the cost of the medical care has been made under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, entitlement has not been finally determined, and an arrangement satisfactory to the state department has been made for reimbursement if the claim under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, is finally sustained.

(iii) The individual has an annual income that is below, or subject to limitations imposed by the director and because of medical expenses falls below, the protected basic maintenance level. The protected basic maintenance level for 1-person and 2-person families shall be at least 100% of the payment standards generally used to determine eligibility in the family independence program. For families of 3 or more persons, the protected basic maintenance level shall be at least 100% of the payment standard generally used to determine eligibility in the family independence program. These levels shall recognize regional variations and shall not exceed 133-1/3% of the payment standard generally used to determine eligibility in the family independence program.

(iv) The individual, if a family independence program related individual and living alone, has liquid or marketable assets of not more than \$2,000.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more than \$3,000.00 in value. The state department shall establish comparable liquid or marketable asset amounts for larger family groups. Excluded in making the determination of the value of liquid or marketable assets are the values of: the homestead; clothing; household effects; \$1,000.00 of cash surrender value of life insurance, except that if the health of the insured makes continuance of the insurance desirable, the entire cash surrender value of life insurance is excluded from consideration, up to the maximum provided or allowed by federal regulations and in accordance with state department rules; the fair market value of tangible personal property used in earning income; an amount paid as judgment or settlement for damages suffered as a result of exposure to agent orange, as defined in section 5701 of the public health code, 1978 PA 368, MCL 333.5701; and a space or plot purchased for the purposes of burial for the person. For individuals related to the title XVI program, the appropriate resource levels and property exemptions specified in title XVI shall be used.

(v) The individual is not an inmate of a public institution except as a patient in a medical institution.

(vi) The individual meets the eligibility standards for supplemental security income under title XVI or for state supplementation under the act, subject to limitations imposed by the director according to title XIX; or meets the eligibility standards for family independence program benefits; or meets the eligibility standards for optional eligibility groups under title XIX, subject to limitations imposed by the director according to title XIX.

(2) As used in this act:

(a) "Medicaid contracted health plan" means a managed care organization with whom the state department contracts to provide or arrange for the delivery of comprehensive health care services as authorized under this act.

(b) "Medical institution" means a state licensed or approved hospital, nursing home, medical care facility, psychiatric hospital, or other facility or identifiable unit of a listed institution certified as meeting established standards for a nursing home or hospital in accordance with the laws of this state.

(c) "Title XVI" means title XVI of the social security act, 42 USC 1381 to 1382j and 1383 to 1383f.

(3) An individual receiving medical assistance under this act or his or her legal counsel shall notify the state department when filing an action in which the state department may have a right to recover expenses paid under this act. If the individual is enrolled in a medicaid contracted health plan, the individual or his or her legal counsel shall provide notice to the medicaid contracted health plan in addition to providing notice to the state department.

(4) If a legal action in which the state department, a medicaid contracted health plan, or both has a right to recover expenses paid under this act is filed and settled after November 29, 2004 without notice to the state department or the medicaid contracted health plan, the state department or the medicaid contracted health plan may file a legal action against the individual or his or her legal counsel, or both, to recover expenses paid under this act. The attorney general shall recover any cost or attorney fees associated with a recovery under this subsection.

(5) The state department has first priority against the proceeds of the net recovery from the settlement or judgment in an action settled in which notice has been provided under subsection (3). A medicaid contracted health plan has priority immediately after the state department in an action settled in which notice has been provided under subsection (3). The state department and a medicaid contracted health plan shall recover the full cost of expenses paid under this act unless the state department or the medicaid contracted health plan agrees to accept an amount less than the full amount. If the individual would recover less against the proceeds of the net recovery than the expenses paid under this act, the state department or medicaid contracted health plan, and the individual shall share equally in the proceeds of the net recovery. As used in this subsection, "net recovery" means the total settlement or judgment less the costs and fees incurred by or on behalf of the individual who obtains the settlement or judgment.

Sec. 107. In establishing financial eligibility for the medically indigent as defined in section 106, income shall be disregarded in accordance with standards established for the related categorical assistance program. For medical assistance only, income shall include the amount of contribution that an estranged spouse or parent for a minor child is making to the applicant according to the standards of the state department, or according to a court determination, if there is a court determination. Nothing in this section eliminates the responsibility of support established in section 76 for cash assistance received under this act.

This act is ordered to take immediate effect.

Carol Morey Viventi

Secretary of the Senate

Jay E. Randall

Clerk of the House of Representatives

Approved

.....
Governor

Legislative Analysis



MEDICAID ELIGIBILITY

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Phone: (517) 373-8080
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Senate Bill 838

Sponsor: Sen. Bob Emerson

Committee: Appropriations

Complete to 2-22-06

A SUMMARY OF SENATE BILL 838 AS PASSED BY THE SENATE 2-15-06

Senate Bill 838 would amend the Social Welfare Act by eliminating the provision that defines caretaker relatives and 19 and 20 year-olds who meet certain requirements as medically indigent, and therefore, categorically eligible for Medicaid. The bill replaces references to categorical Medicaid eligibility for 19 and 20 year-olds, and caretaker relatives with language that eligibility would be subject to Title XIX eligibility standards for optional groups, subject to limitations imposed by the Director according to Title XIX.

Under federal Medicaid law there are certain population groups that states are required to include in their Medicaid programs in order to qualify for federal matching funds. In addition, the federal government also provides matching funds to states that elect to provide coverage for certain other populations beyond those that are mandated.

Michigan currently provides Medicaid coverage to 19 and 20 year-olds at or below 50% of the federal poverty level and to Medicaid caretaker relatives, both of which are optional groups. Caretaker relatives include individuals who care for children who are not their own, but are related to, and whose income is low enough to meet the cash welfare assets and income standards. There are approximately 13,000 individuals that make up the 19 and 20 year-old optional group and 42,700 caretaker relative eligibles.

The FY 2005-06 Department of Community Health budget, as passed by the Legislature, assumes savings to be generated by freezing enrollment for 19 and 20 year-olds and by limiting benefit coverage for both 19 and 20 year-olds and caretaker relatives. In June 2005 DCH staff submitted a waiver to the federal government seeking to limit benefits for these two groups. To date this waiver has not yet been approved.


FISCAL IMPACT: Savings of \$11.4 million Gross (\$4.9 million GF/GP) were assumed with passage of the FY 2005-06 DCH budget due to implementation of an enrollment freeze for 19 and 20 year-olds and reduced coverage for both the 19 and 20 year-olds as well as the caretaker relative populations. The potential savings for FY 2005-06 are dependent on when the waiver is approved.

Fiscal Analyst: Steve Stauff
Bill Fairgrieve

■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.



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BILL ANALYSIS

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Senate Bill 838 (as reported without amendment)
Sponsor: Senator Bob Emerson
Committee: Appropriations

(as enrolled)

CONTENT

States have the option of providing Medicaid coverage to 19- and 20-year-olds who have incomes that meet the Federal cash welfare or Supplemental Security Income assets and income standards. Individuals aged 21 and older are categorically eligible for Medicaid only if they are disabled or if they are parents of minor children and meet the cash welfare assets and income standards.

States also have the option of covering a group generally known as Medicaid caretaker relatives. These are individuals, often grandparents, aunts, or uncles, who care for children who are not their own and whose income is low enough to meet the cash welfare assets and income standards.

Michigan has opted to cover both eligibility categories in the State's Medicaid program, and explicitly refers to these two groups' eligibility in the Social Welfare Act. It is estimated that about 9,000 individuals are eligible in the 19- to 20-year-old group and that about 40,000 individuals are eligible as caretaker relatives.

As a general rule, Federal law has required states to provide full benefits to any optional group a state chooses to cover in its Medicaid program. In recent years, waivers have been granted to states that have proposed providing more limited benefits to optional Medicaid eligibility groups.

The FY 2005-06 Department of Community Health (DCH) appropriation includes provisions directing that the State seek a waiver to change the benefit structure for 19- to 20-year-olds and caretaker relatives. Enrollment for 19- to 20-year-olds would be frozen, so no new people could enter the program (which would have the effect of phasing out coverage over the next two years). Benefits would be limited for both groups, with limits on payments for inpatient hospital days, limits on prescriptions, and limits on services.

Senate Bill 838 would change the Social Welfare Act to allow for flexibility in Medicaid coverage for 19- and 20-year-old individuals as well as caretaker relatives. This would enable the State to seek and implement a waiver of Federal regulations to limit benefits for these groups.

The bill would replace the references to categorical eligibility for these two groups with a statement that eligibility would be subject to Title XIX of the Social Security Act, subject to limitations imposed by the Department Director. This would allow implementation of limited benefits if a Federal waiver were granted pursuant to Title XIX.

MCL 400.106 & 400.107

FISCAL IMPACT

The FY 2005-06 DCH budget assumes net savings of \$11.0 million Gross and \$4.8 million GF/GP from implementation of an enrollment freeze and limited benefits for 19- and 20-year-olds who are Medicaid eligible. The amount assumed in the budget appears to be a realistic estimate of the potential savings.

Date Completed: 2-13-06

Fiscal Analyst: Steve Angelotti

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.

Issue Alert - 06-04-07

Date: 04/10/2006

Program Area: Medicaid (MA)

Issue Summary: Individuals who receive Medicaid under the "Caretaker Relative" or "Under 21" eligibility categories must meet an asset test beginning May 1, 2006

Persons Affected: Parents and kinship caregivers who receive Medicaid as Caretaker Relatives; 19 and 20-year olds who receive Medicaid because they are Under 21.

For More Information: Center for Civil Justice
320 S. Washington, 2nd Floor
Saginaw, MI 48607
Phone: (989) 755-3120, (800)724-7441
Fax: (989) 755-3558
E-mail: info@ccj-mi.org

Michigan Poverty Law Program
611 Church Street, Suite 4A
Ann Arbor, MI 48104-3000
Phone: (734) 998-6100
Fax: (734) 998-9125

Background

In the Fiscal Year 2006 Appropriations Act for the Department of Community Health (DCH), the legislature required DCH to impose an asset test for the Caretaker Relative (G2C) and Under 21 (G2U) Medicaid categories. 2005 Public Act 154, section 1731(1).

There are about 48,000 Medicaid recipients in these categories.

Both of these categories are "medically needy" or "Group 2" categories, which means that individuals may qualify for coverage under the categories either by having income below the income limit for their group size, or by meeting a deductible (formerly known as a spenddown) in the month for which they seek coverage.

Income and asset eligibility for the Caretaker Relative and Under 21 categories is based on the income and assets of the applicant/recipient and the applicant/recipient's spouse if they are living together. Income and assets of the applicant/recipient's children are not

considered. A portion of the income of the applicant/recipient (and spouse, if applicable) is excluded through pro-rating if the applicant/recipient has minor children in the home, or if the caregiver relative for minor children in the home.

Healthy Kids Medicaid categories and Medicaid for pregnant women are now the only Medicaid eligibility categories that do not have asset tests.

What's Happening?

Beginning May 1, 2006, Medicaid recipients must have less than \$3,000 in "cash assets" in order to qualify for Medicaid under the Caretaker Relative or Under 21 Medicaid eligibility categories. This is the same asset test as is used for the Low Income Family (LIF) Medicaid category and the Family Independence Program (FIP).

Notices were sent on March 15, 2006 to all Medicaid recipients who are receiving Medicaid in these categories, requiring the recipients to complete and return an Asset verification form along with verification of the current value of any cash assets, by April 10, 2006. DHS workers have been authorized to work overtime to review asset eligibility for these cases by May 31, 2006. Workers have been instructed to resolve any discrepancies between the information disclosed on the Asset Verification form and the information contained on the recipient's 1171 Assistance Application form. Negative action notices will be sent to any recipients who are determined to be ineligible for Medicaid because of the asset test.

Individuals who have a deductible that they must meet in order to receive coverage under these categories received a notice explaining the new asset limit. They must report and verify assets when they submit proof that they have met their deductible.

Cash assets include bank accounts, stocks and bonds, mutual funds, Certificates of Deposit, etc. They also include IRAs, 401k Plans, and other retirement accounts that can be cashed out, even if there is a penalty for early withdrawal. Burial plans and funeral contracts also are considered cash assets if the recipient is able to access the funds. For a full description of countable cash assets, see the Department of Human Services (DHS) Program Eligibility Manual (PEM) Item 400. DHS's Program Policy Bulletins and Manuals are available online at <http://www.mfia.state.mi.us/olmweb/ex/htm> [<http://www.mfia.state.mi.us/olmweb/ex/htm>] or by using the "Quick Link" at www.mplp.org [<http://www.mplp.org/>].

For Medicaid, individuals meet the asset test if the countable assets for their group are below the limit on ANY day during the month. See PEM 400.

DHS must consider the recipient's eligibility for other Medicaid categories (such as Healthy Kids Medicaid or Medicaid for pregnant women) before closing the Medicaid case based on excess assets.

DHS should consider the LIF category for individuals who were placed on Caretaker Relative Medicaid because they did not provide verification of assets in the past. Both the LIF and Caretaker Relative categories now have a \$3,000 cash asset limit, but the methodology for determining income eligibility for the two categories is different. LIF is a better category for many families because it allows the family to receive 12 months of Transitional Medicaid (TMA) if the family has earned income and becomes ineligible for LIF due to excess income.

What Should Advocates Do?

Be aware of the policy change and encourage clients to seek legal advice if they have questions or concerns about how the policy will affect them.

Advise clients who believe they have been wrongfully terminated to request a hearing immediately in order to keep Medicaid during the administrative appeal process. If the recipient wants to keep Medicaid pending the outcome of the hearing, DHS must receive an original (not faxed or copied) signed hearing request from the recipient before the date indicated on the notice (12 days from the date the notice was issued).

What Should Clients Do?

Request a hearing immediately if you believe your Medicaid should continue because:

(1) Your available cash assets do not total more than \$3,000, or were below \$3,000 for at least one day in the month for which you are being terminated.

(2) You are pregnant or are age 19 or younger.

If you want to keep Medicaid pending the outcome of the hearing, DHS must receive an original (not faxed or copied) signed hearing request from you before the date indicated on the notice (12 days from the date the notice was issued).

Seek legal advice if you are requesting a hearing.

Seek legal advice if your cash assets are over the \$3,000 limit.

Finding Help

Most legal aid and legal services offices handle these types of cases, and they do not charge a fee.

You can locate various sources of legal and related services, including the free legal aid office that serves your county, at MichiganLegalAid.org.

You can also look in the yellow pages under "attorneys" or call the toll-free lawyer referral number, (800) 968-0738.