

Medicaid

Arkansas

Bills/Laws

Senate Bill 362

House Bill 2629

Hawaii

Bills/Laws

HB No. 100, Relating to Human Services

SB No. 1938, Relating to Human Services

Official Analysis

Department of Human Services Fiscal Analysis on HB 100

[HB 100 Bill Status](#)

[SB 1938 Bill Status](#)

Idaho

Administrative Rules

Idaho Admin Rule 16.03.01.315

Idaho Admin Rule 16.03.01.316

Idaho Admin Rule 16.03.01.325

Idaho Admin Rule 16.03.01.326

Idaho Admin Rule 16.03.01.327

Idaho Admin Rule 16.03.01.328

Idaho Admin Rule 16.03.01.370

Idaho Admin Rule 16.03.01.380

Illinois

Administrative Rules

Illinois Admin Code 120.336

Illinois Admin Code 120.380

Illinois Admin Code 120.382

Illinois Admin Code 120.384

Iowa

Bills/Laws

Iowa Code 249A.3

Administrative Rules

Iowa Administrative Code 441—
75.56(249A)

Michigan

Bills/Laws

Michigan Compiled Law 400.106

Michigan Compiled Law 400.106a

Michigan Compiled Law 400.112b

Michigan Compiled Law 400.112c

Michigan Act 144 (Senate Bill 838)

Official Analysis

Legislative Analysis/Fiscal Impact of
Senate bill 838

Minnesota

Bills/Laws

Minnesota Statutes 256B.056

Senate Bill SF 2214

House Bill HF 1719

Senate Bill SF 695

House Bill HF 784

Texas

Bills/Laws

House Bill 109

Fiscal Note HB 109

Official Analysis

Bill Analysis for HB 109 (House and Senate)

Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

1 State of Arkansas
2 83rd General Assembly
3 Regular Session, 2001
4

As Engrossed: H2/26/01

A Bill

Act 724 of 2001
SENATE BILL 362

5 By: Senators Fitch, P. Malone, B. Walker, Argue, Critcher, Gullett, Horn
6 By: Representatives Allison, Bevis, Biggs, Bolin, Bond, Bookout, Boyd, Bradford, Cleveland,
7 Creekmore, Dangeau, Dees, Eason, J. Elliott, Files, Fite, Gillespie, Goss, Hathorn, House, Jacobs,
8 Johnson, Jones, Judy, King, Ledbetter, Lendall, Lewellen, Lowery, Milligan, Minton, Moore, Salmon,
9 Scrimshire, Seawel, M. Steele, T. Steele, Stovall, Thomas, Trammell, White, Willis

For An Act To Be Entitled

10
11
12 AN ACT TO REMOVE THE ASSETS TEST FOR CHILDREN TO BE
13 ELIGIBLE FOR MEDICAID; AND FOR OTHER PURPOSES.
14

Subtitle

15
16 AN ACT TO REMOVE THE ASSETS TEST FOR
17 CHILDREN TO BE ELIGIBLE FOR MEDICAID.
18

19
20
21 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
22

23 SECTION 1 Arkansas Code 20-77-107(a), authorizing the Department of
24 Human Services to establish and maintain an indigent medical care program, is
25 amended to read as follows:

26 (a)(1) The appropriate division of the Department of Human Services is
27 authorized to establish and maintain an indigent medical care program.

28 (2) However, eligibility regulations for ARKids shall not include
29 an assets or a resource test for children or families of children eighteen
30 (18) years of age or younger.

31 /s/ Fitch, et al.
32
33

34 APPROVED: BECAME LAW ON 3/12/2001, WITHOUT THE GOVERNOR'S SIGNATURE.
35
36

Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

1 State of Arkansas
2 83rd General Assembly
3 Regular Session, 2001
4

As Engrossed: H3/21/01

A Bill

HOUSE BILL 2629

5 By: Representatives Haak, French, Napper
6
7

For An Act To Be Entitled

9 AN ACT TO RAISE THE ASSETS LIMIT FOR ARKIDS FIRST
10 A ELIGIBILITY TO FIVE THOUSAND DOLLARS (\$5,000);
11 TO EXEMPT ONE (1) VEHICLE PER HOUSEHOLD FROM THE
12 ASSETS ELIGIBILITY LIMIT FOR ARKIDS FIRST A; AND
13 FOR OTHER PURPOSES.
14

Subtitle

15 AN ACT TO RAISE TO FIVE THOUSAND DOLLARS
16 (\$5,000) THE ASSETS LIMIT FOR, AND TO
17 ALLOW EACH HOUSEHOLD ONE (1) VEHICLE
18 UNCOUNTED FOR ARKIDS FIRST A
19 ELIGIBILITY.
20
21

22
23
24 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
25

26 SECTION 1. Arkansas Code 20-77-107, concerning rules and regulations
27 for the program for indigent medical care, is amended by adding the following
28 additional subsection:

29 (c)(1) Rules and regulations regarding eligibility for ARKIDS First A
30 shall not include any asset test that limits aggregate countable household
31 assets to less than five thousand dollars (\$5,000), or treats as a countable
32 asset the equity in one (1) vehicle owned by the household.

33 (2) For purposes of this subsection, "ARKIDS First A" medical
34 assistance eligibility is established under 42 U.S.C. 1396(1)(B), (C), and
35 (D).
36

/s/ Haak, et al.

A BILL FOR AN ACT

RELATING TO HUMAN SERVICES.

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

1 SECTION 1. Section 346-29, Hawaii Revised Statutes, is
2 amended by amending subsection (d) to read as follows:

3 "(d) The director shall adopt rules pursuant to chapter 91
4 defining assets and to determine eligibility for medical
5 assistance; provided that [~~the~~]:

6 (1) For households with minor dependents, the department
7 shall disregard assets in determining the needs of
8 persons for medical assistance; and

9 (2) The cash surrender value of life insurance policies
10 owned by persons included in an application shall be
11 treated as assets."

12 SECTION 2. There is appropriated out of the general
13 revenues of the State of Hawaii the sum of \$, or so
14 much thereof as may be necessary for fiscal year 2007-2008, and
15 the same sum, or so much thereof as may be necessary for fiscal
16 year 2008-2009, to eliminate the asset limits for households
17 with minor dependents' applications for medical assistance.



H.B. NO. 100

1 SECTION 3. The sums appropriated shall be expended by the
2 department of human services for the purposes of this Act.

3 SECTION 4. This Act shall take effect on July 1, 2007.

4

INTRODUCED BY: *Albino L.*

Della Ann Palatti
Myra Stanek
Karl N. ...

Josh Green
John M. ...
Jim
Tom ...
Jim
Ann ...
Fell

JAN 17 2007



Report Title:

Human Services; Application for Medical Assistance

Description:

Eliminates the asset limits for households with minor dependents' applications for medical assistance and appropriates funds for this purpose.



JAN 24 2007

A BILL FOR AN ACT

RELATING TO HUMAN SERVICES.

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

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2 amended by amending subsection (d) to read as follows:

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4 defining assets and to determine eligibility for medical
5 assistance; provided that [~~the~~]:

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7 shall disregard assets in determining the needs of
8 persons for medical assistance; and

9 (2) The cash surrender value of life insurance policies
10 owned by persons included in an application shall be
11 treated as assets."

12 SECTION 2. There is appropriated out of the general
13 revenues of the State of Hawaii the sum of \$, or so
14 much thereof as may be necessary for fiscal year 2007-2008, and
15 the same sum, or so much thereof as may be necessary for fiscal
16 year 2008-2009, to eliminate the asset limits for households
17 with minor dependents' applications for medical assistance.



S.B. NO. 1938

1 SECTION 3. The sums appropriated shall be expended by the
2 department of human services for the purposes of this Act.

3 SECTION 4. This Act shall take effect on July 1, 2007.

4

INTRODUCED BY:

Ray L. Hoome

David Y. Jones
J. Kalei G. G. G.

Erzanne Chun Akalana

Will Eyo

Don Wain

Carol Fukumaga

M. S. L.

Reynold H. Baker



Report Title:

Asset Building; Application for Medical Assistance

Description:

Eliminates the asset limits for households with minor dependents' applications for medical assistance and appropriates funds for this purpose.



LINDA LINGLIM
GOVERNOR



LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

February 9, 2007

MEMORANDUM

TO: Honorable Maile S. L. Shimabukuro, Chair
House Committee on Human Services and Housing

FROM: Lillian B. Koller, Director *LBK*

SUBJECT: H.B. 100 – RELATING TO HUMAN SERVICES
Questions from House Committee on Health, January 29, 2007

Testimony on HB 100 – Eliminating the asset limits for households with minor dependents for all adults in those households to qualify for Medicaid without an asset test.

We have not, as yet, determined how to reliably estimate the cost impact of H. B. 100. In particular, the scope of the bill is very broad in that all members of households with minor dependents (children), not just the parents of those children, would be eligible for our Medicaid programs without an asset test as this bill is written. This would include all members of each household including parents, siblings, grandparents, uncles, aunts, cousins and other family members.

The information provided in this memo does not cover all members of each household with children. Instead, we based this memo on data that we could readily obtain on the parents of the children who are currently in our Medicaid programs, not all household members. Therefore, the cost projections in this memo are far less than the full cost impacts of this bill. We are still working on developing a model with which we could reliably estimate the full cost impacts of this bill.

1. What is the approximate cost estimate of eliminating the asset test?

Limiting our cost estimates to eliminating the asset test for only the parents of children in households with minor dependents, not all members in these households as proposed in this bill, the cost impacts to our Medicaid QUEST Medicaid Fee-For-Service (FFS) programs. The income standard for adults is 100% of the federal poverty level (FPL). The estimate of affected adults (parents only) is based on the number of children in the current caseload of

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Honorable Maile S. L. Shimabukuro, Chair
 House Committee on Human Services and Housing
 H.B. 100 – RELATING TO HUMAN SERVICES
 Questions from House Committee on Health, January 29, 2007
 February 9, 2007
 Page 2

households with incomes under 100% FPL. The Department does not currently have sufficient data on the number of other adults per household that would be affected by this bill.

Medicaid QUEST Cost Impact

Children <100% FPL	3,987
Factor for children with Adults in Household	0.46
QUEST Adults w/children not receiving assistance	2,153
Capitation Rate	\$185
Monthly Costs	\$398,301
Annual Costs	\$4,779,616
State Share (Less current Federal match 57.55%)	\$2,028,946

Medicaid Fee-For-Service (FFS) Cost Impact

Children <100% FPL	1,383
Factor for children with Adults in Household	0.46
Blind/Disabled Adults w/children not receiving assistance	747
Average Fee-For Service Cost	\$645
Monthly Costs	\$481,815
Annual Costs	\$5,781,780
State Share (Less current Federal match 57.55%)	\$2,454,366
Total State Cost QUEST and FFS Parents	\$4,483,312

The Department estimates that the total annual State cost increase will be \$4,483,312 based on the current State share (57.55% Federal match, reducing to 56.5% from October 1, 2007 through September 30, 2008, thus requiring more State funds).

2. Does the Department have any recommendations with regards to increasing the assets limitations?

Currently the Medicaid asset test is the same as used for SSI eligibility. Setting a different test will create a new gap group between financial, SSI and medical eligibility.

It is also important to point out that the federal match, called the Federal Medicaid Assistance Percentage (FMAP), will decrease for Federal Fiscal Year 2008 from 57.55% to 56.5% which will require additional State funds to maintain current services and reimbursement rates.

Honorable Maile S. L. Shimabukuro, Chair
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Also, in the Executive Biennium Budget 2007-2009, additional funds are requested to provide for projected enrollment and cost increases for HMS 401PE, the Aged, Blind and Disabled population. The projected rate increases are clinic services 2%, hospice services 5%, FQHC services 5%, nursing facility 3.9%, acute services 4%, and Part A/B Medicare services at 5%, equating to \$16.4 million in State general funds for FY 08 and \$18.1 million in FY 09. These increases are either required changes by the federal government or part of the Hawaii Medicaid State Plan. This request also includes additional general funds to compensate for a decrease in the FMAP, which will fall from 57.55% in FY07 to 56.50% in FY08. Additional funds were also requested to provide for projected increases in the service rates of 5% and population growth of 4% for HMS 401PQ, the QUEST managed care population including additional general funds to compensate for a decrease in the FMAP of \$16.2 million in general funds for FY 08 and \$43.4 million for FY09.

3. **What is the experience of other states that have eliminated the assets test? Testimony indicated that Oklahoma and New Mexico have dropped the test and only saw a slight increase in enrollment and realized administrative cost savings.**

We have not been able to confirm data from New Mexico or Oklahoma regarding their experience with eliminating the asset test for adults in Medicaid.

More importantly, it appears that Oklahoma and New Mexico's elimination of the asset test is much more narrow than proposed in H.B. 100. We have confirmed from the Oklahoma and New Mexico policy manuals that they do not count *assets for AFDC (able-bodied)* household members. However, if a member in the household is aged, blind or disabled (ABD), assets would count for that member.

The proposal in H.B. 100 does not differentiate between a household member who is AFDC (able-bodied) or ABD (not able-bodied). In Hawaii, AFDC individuals are in our QUEST program, where the State can waive the asset test for certain adult household members. The ABD individuals are not included in our QUEST program so the asset test is required for adults (except for pregnant women for whom the asset test is waived).

4. **What would be the administrative cost savings in eliminating the assets test?**

Based on current operating procedures, there will be no administrative cost savings as a result of eliminating the asset test for household with children. The implication of the testimony was that New Mexico or Oklahoma netted administrative cost savings because staff time was not expended on asset verification. However, in Hawaii, MQD staff time for verifying assets is minimal because self-declaration is considered acceptable verification. Staff are required by federal regulations to do verification of information only when provided via IEVS (electronic reports from IRS Workers Compensation, DOL, IRS, etc.). In short, we accept the applicant's declaration on the application and, if incorrect, then they

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are subject to criminal penalties including fraud as cited on the application. Even if the asset test is removed, we are still subject to IEVS and staff will have to verify income and other information about the applicant.

Additionally, if the asset test were removed, there will be a greater increase in administrative costs associated with the provision of benefits to adults who are not currently eligible. These costs would involve staff time to enroll eligibles in plans, issue notices, cards, handling appeals, processing requests for authorization for services, processing claims, and other costs not associated with direct benefit payments.

5. Additional concerns related to removing the assets test for household with children

There is a strong possibility of a challenge under the ADA if the State disregards assets for both the AFDC (able-bodied) with children and the ABD (aged, blind or disabled) adults with children, and not for the ABD (aged, blind or disabled) adults without children.

There is a lesser possibility of a challenge under the ADA if the State disregards assets for both the AFDC (able-bodied) adults with children and the ABD (aged, blind or disabled) adults with children, and not for the ABD adults without children.

The Attorney General's office is currently attempting to contact its counterparts in New Mexico and Oklahoma to clarify how they are dealing with these potential liabilities.

IDAPA 16.03.01.315

1 of 1 DOCUMENT

IDAHO ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH JULY 1, 2006 ***

IDAPA 16: DEPARTMENT OF HEALTH AND WELFARE

TITLE 03: DIVISION OF WELFARE

CHAPTER 01: ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

IDAPA 16.03.01.315 (2006)

315. BANK ACCOUNTS.

Money deposited to a bank account by the participant is a countable resource. Income not spent in the month received is counted as a resource the next month. Effective Date: (7-1-99)

IDAHO ADMINISTRATIVE CODE
AGENCY 16. DEPARTMENT OF HEALTH AND WELFARE
TITLE 03.

CHAPTER 01. ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES
AND CHILDREN

Current through June 6, 2007.

**316. DETERMINING RESOURCE ELIGIBILITY FOR AFDC-RELATED
ADULTS AND LOW INCOME PREGNANT WOMEN.**

Resources are considered in determining eligibility for AFDC-related adult Medicaid and Low Income Pregnant Women. The following information is required to determine a participant's resource eligibility: (3-30-07)

01. Countable Resources. The equity value of all countable non-excluded resources is compared to the resource limit for AFDC Medicaid adults and Low Income Pregnant Women. (3-30-07)

02. Initial Eligibility. For initial eligibility, the value of countable resources is determined as of the application date. (3-30-07)

03. Excess Countable Resources. Excess countable resources anticipated at any time during an upcoming month, affects the entire month's eligibility. (3-30-07)

IDAPA 16.03.01.316, ID ADC 16.03.01.316

ID ADC 16.03.01.316

IDAPA 16.03.01.318

1 of 1 DOCUMENT

IDAHO ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH JULY 1, 2006 ***

IDAPA 16: DEPARTMENT OF HEALTH AND WELFARE
TITLE 03: DIVISION OF WELFARE
CHAPTER 01: ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

IDAPA 16.03.01.318 (2006)

318. RESOURCES EXCLUDED BY FEDERAL LAW.

A resource excluded by federal law is not counted in determining the resource amount available to the participant. Effective Date: (7-1-98)

IDAPA 16.03.01.318

1 of 1 DOCUMENT

IDAHO ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH JULY 1, 2006 ***

IDAPA 16: DEPARTMENT OF HEALTH AND WELFARE
TITLE 03: DIVISION OF WELFARE
CHAPTER 01: ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

IDAPA 16.03.01.318 (2006)

318. RESOURCES EXCLUDED BY FEDERAL LAW.

A resource excluded by federal law is not counted in determining the resource amount available to the participant. Effective Date: (7-1-98)

IDAPA 16.03.01.309

1 of 1 DOCUMENT

IDAHO ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH JULY 1, 2006 ***

IDAPA 16: DEPARTMENT OF HEALTH AND WELFARE
TITLE 03: DIVISION OF WELFARE
CHAPTER 01: ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

IDAPA 16.03.01.309 (2006)

309. DETERMINING RESOURCE ELIGIBILITY.

The following information is required to determine a participant's resource eligibility: Effective Date: (4-6-05)

01. Countable Resources. The value of the participant's calculated countable resources is compared to the resource limit for the appropriate Health Care Assistance coverage group. Effective Date: (4-6-05)

02. Initial Eligibility. For initial eligibility the value of their countable resources is determined as of the application date. Effective Date: (4-6-05)

03. Excess Countable Resources. Excess countable resources anticipated at any time during an upcoming month, affects the entire month's eligibility. Effective Date: (4-6-05)

IDAPA 16.03.01.310

1 of 1 DOCUMENT

IDAHO ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH JULY 1, 2006 ***

IDAPA 16: DEPARTMENT OF HEALTH AND WELFARE
TITLE 03: DIVISION OF WELFARE
CHAPTER 01: ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

IDAPA 16.03.01.310 (2006)

310. RESOURCE LIMITS.

The resource limit for AFDC-related coverage groups is one thousand dollars (\$ 1,000). The resource limit for FPG-related coverage groups is five thousand dollars (\$ 5,000). Effective Date: (4-6-05)

IDAPA 16.03.01.311

1 of 1 DOCUMENT

IDAHO ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH JULY 1, 2006 ***

IDAPA 16: DEPARTMENT OF HEALTH AND WELFARE
TITLE 03: DIVISION OF WELFARE
CHAPTER 01: ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

IDAPA 16.03.01.311 (2006)

311. RESOURCE DEFINITION.

Resources are liquid assets, vehicles, and real property with a cash value upon disposition. Resources are available when the participant has the legal right to dispose of the resource and can do so in a reasonable length of time. Effective Date: (7-1-99)

IDAPA 16.03.01.313

1 of 1 DOCUMENT

IDAHO ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH JULY 1, 2006 ***

IDAPA 16: DEPARTMENT OF HEALTH AND WELFARE
TITLE 03: DIVISION OF WELFARE
CHAPTER 01: ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

IDAPA 16.03.01.313 (2006)

313. EQUITY VALUE OF RESOURCES.

Resources are counted according to their equity value. This is the value of the resource after all liens, mortgages and other encumbrances against the resource are subtracted. Effective Date: (7-1-98)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS
PART 120 MEDICAL ASSISTANCE PROGRAMS
SECTION 120.336 EDUCATION BENEFITS

Section 120.336 Education Benefits

The following education benefits shall be exempt:

- a) Veterans Educational Assistance

Income from educational benefits paid to a veteran or to a dependent of a veteran.

- b) Social Security Administration Benefits

Income received as an SSA benefit paid to or for an individual and conditioned upon the individual's regular attendance in a school, college or university, or a course of vocational or technical learning.

- c) All other education grants and loans.

(Source: Amended at 28 Ill. Reg. 4701, effective March 3, 2004)

SUBCHAPTER b: ASSISTANCE PROGRAMS
PART 120 MEDICAL ASSISTANCE PROGRAMS
SECTION 120.380 ASSETS

Section 120.380 Assets

- a) The value of nonexempt assets shall be considered in determining eligibility for AABD MANG. Assets do not affect eligibility for TANF MANG.

- b) Jointly held assets for AABD MANG shall be treated in the same manner as described in 89 Ill. Adm. Code 113.140.

- c) Potential payments from a Medicaid qualifying trust for AABD MANG and MANG(C) shall be treated in the same manner as described in Section 120.346.

- d) Trusts established on or after August 11, 1993, shall be treated in the manner described in Section 120.347.

- e) The value of a life estate shall be determined at the time the life estate in the property is established and at the time the property (for example, assets) is liquidated. In determining the value of a life estate and remainder interest based on the value of the property at the time the life estate is established or of the amount received when the property is liquidated, the Department shall apply the values described in Section 120. Table A. The life estate and remainder interest are based on the age of the person at the time the life estate in the property is established and at the time the property is liquidated and the corresponding values described in Section 120. Table A.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS
PART 120 MEDICAL ASSISTANCE PROGRAMS
SECTION 120.382 ASSET DISREGARD

Section 120.382 Asset Disregard

In addition to the exempt assets listed in Section 120.381, the cash value of assets shall be disregarded for AABD MANG as follows:

- a) \$2000 for a client and \$3000 for a client and one dependent residing together.
- b) \$50 for each additional dependent residing in the same household.
- c) The amount equal to the sum of qualifying insurance benefit payments made as a result of coverage under a Long Term Care Partnership Insurance Policy, as described in 50 Ill. Adm. Code 2018, provided that the person has received all of the qualifying insurance benefit payments that are payable under the policy.
- d) All assets of a person who purchases a Long Term Care Partnership Insurance Policy, as described in 50 Ill. Adm. Code 2018, with coverage equal to the average cost of four years of long term care services in a nursing facility, provided that the person has received all of the qualifying insurance benefit payments that are payable under the policy.

- e) Eligibility for AABD MANG does not exist when nonexempt assets exceed the above disregard.

- f) Qualified Medicare Beneficiary (QMB)
 - 1) \$4,000 for a single person and \$6,000 for a person with one or more dependents.

 - 2) Eligibility for QMB status does not exist when countable assets exceed the above disregard.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS
PART 120 MEDICAL ASSISTANCE PROGRAMS
SECTION 120.384 SPEND-DOWN OF ASSETS (AABD MANG)

Section 120.384 Spend-down of Assets (AABD MANG)

- a) Determination of Assets
 - 1) For individuals residing in the community the Department determines the amount of non-exempt assets using the verified amount on the date of decision on the application for medical assistance. The date of verification may be prior to the date of decision. Money considered as income for a month is not considered as an asset for that same month. If income for a month is added to a bank account that month, the Department will

subtract the amount of income from the bank balance to determine the asset level. Any income remaining the following month(s) is considered as an asset.

- 2) The amount of non-exempt assets verified during the application process is used on the date of decision. If medical eligibility includes a backdated month(s), for the backdated month(s), the Department will consider the amount of assets available to apply to the cost of medical care. The Department will not determine the value of assets for a backdated month(s) of eligibility. However, the amount of the excess assets verified during the application process is used to determine spend-down status in each backdated month of eligibility.
- 3) Once the excess asset has been used to meet spend-down, whether or not the excess amount has actually been reduced, it is no longer considered. However, at reapplication/redetermination, the Department will consider any excess non-exempt assets remaining as currently available.

b) Community Cases (AABD MANG)

For AABD MANG, to determine the spend-down obligation for clients in the community, the Department will compare monthly countable income to the appropriate MANG standard and add any non-exempt assets in excess of the appropriate asset disregard to non-exempt monthly income in excess of the appropriate MANG Standard.

1) Regular AABD MANG – Community Residents

When an individual residing in the community, has countable monthly income of not more than 99 cents over the appropriate MANG Standard and has non-exempt excess assets of not more than 99 cents over the appropriate asset disregard, the case is referred to as a Regular MANG case. Payment for covered services is made for each month eligibility exists.

2) Spend-down AABD MANG

- A) When an individual resides in the community and has countable monthly income of at least \$1.00 over the MANG Standard and/or non-exempt assets of at least \$1.00 in excess of the asset disregard for the appropriate size household, the case is referred to as a community spend-down case. The spend-down amount is the sum of the amount of income in excess of the MANG Standard plus non-exempt assets in excess of the appropriate asset disregard. The Department will disregard any excess income and/or asset amounts that are not at least \$1.00 over the appropriate standard or disregard.

- B) If the individual presents verification that the excess amount is no longer available, the Department will make the appropriate changes the month following the month the assets were transferred.

- C) Individuals enrolled in spend-down are not eligible for payment of covered medical services until spend-down is met. Spend-down is met by presenting allowable medical bills or receipts to the Department that equal the amount of the individual's excess countable income and/or non-exempt excess assets. Excess assets do not have to be reduced prior to the authorization of medical assistance.

c) Group Care Cases

To determine the spend-down obligation for AABD MANG clients in group care, the Department will compare monthly countable income and non-exempt assets in excess of the appropriate asset disregard to the cost of long term care at the private pay rate or the Department rate, whichever is greater. When an individual has non-exempt excess assets, the excess amount is applied to the monthly long term care charges after the monthly countable income has been applied.

1) Regular Group Care

When an individual in group care has countable monthly income plus non-exempt assets in excess of the applicable asset disregard of not more than 99 cents over the private pay rate or the Department rate, whichever is greater, the case is referred to as a Regular Group Care case. If monthly countable income plus excess non-exempt assets are less than the long term care charges at the Department rate, the Department will pay the difference.

2) Group Care Spend-down

A) When an individual in group care has countable monthly income plus non-exempt assets in excess of the applicable asset disregard of at least \$1.00 over the cost of long term care at the private pay rate or the Department rate, whichever is greater, the case is referred to as a Group Care Spend-down case. The spend-down amount is the sum of the monthly countable income plus non-exempt assets over the applicable asset disregard.

B) The transfer of asset policy set forth in Section 120.385 still applies. Once the client has been determined to have a resource spend-down because of excess non-exempt assets, the spend-down cannot be eliminated by a non-allowable transfer made to qualify for or increase the need for medical assistance.

C) If the individual presents verification that the excess amount is no longer available and the transfer of assets is allowable according to Section 120.385, the Department will make the appropriate changes the month following the month the assets were transferred. If spend-down has been met, the policy set forth in Section 120.385 regarding transfer of assets does not apply. The client may dispose of the asset as he/she wishes as it has been applied to a met spend-down.

- D) Individuals enrolled in spend-down are not eligible for payment of covered medical services until spend-down is met. Spend-down is met by presenting allowable medical bills or receipts to the Department that equal the amount of the individual's excess countable income and/or non-exempt assets. Excess assets do not have to be reduced prior to the authorization of medical assistance.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

1 of 1 DOCUMENT

LEXIS NEXIS (R) IOWA ANNOTATED STATUTES

*** THIS DOCUMENT IS CURRENT THROUGH THE 2006 EDITION (2006 LEGISLATION) ***
*** ANNOTATIONS CURRENT THROUGH JUNE 1, 2007 ***

TITLE VI. HUMAN SERVICES
SUBTITLE 6. CHILDREN AND FAMILIES
CHAPTER 249A. MEDICAL ASSISTANCE

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Iowa Code § 249A.3 (2006)

Legislative Alert: LEXSEE 2007 Ia. HF 909 -- See sections 41, 42, 43 and 124.

249A.3 Eligibility.

The extent of and the limitations upon eligibility for assistance under this chapter is prescribed by this section, subject to federal requirements, and by laws appropriating funds for assistance provided pursuant to this chapter.

1. Medical assistance shall be provided to, or on behalf of, any individual or family residing in the state of Iowa, including those residents who are temporarily absent from the state, who:

a. Is a recipient of federal supplemental security income or who would be eligible for federal supplemental security income if living in their own home.

b. Is an individual who is eligible for the family investment program or is an individual who would be eligible for unborn child payments under the family investment program, as authorized by Title IV-A of the federal Social Security Act, if the family investment program provided for unborn child payments during the entire pregnancy.

c. Was a recipient of one of the previous categorical assistance programs as of December 31, 1973, and would continue to meet the eligibility requirements for one of the previous categorical assistance programs as the requirements existed on that date.

d. Is a child up to one year of age who was born on or after October 1, 1984, to a woman receiving medical assistance on the date of the child's birth, who continues to be a member of the mother's household, and whose mother continues to receive medical assistance.

e. Is a pregnant woman whose pregnancy has been medically verified and who qualifies under either of the following:

(1) The woman would be eligible for cash assistance under the family investment program, if the child were born and living with the woman in the month of payment.

(2) The woman meets the income and resource requirements of the family investment program, provided the unborn child is considered a member of the household, and the woman's family is treated as though deprivation exists.

f. Is a child who is less than seven years of age and who meets the income and resource requirements of the family investment program.

g. (1) Is a child who is one through five years of age as prescribed by the federal Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, whose income is not more than one hundred thirty-three percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

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(2) Is a child who has attained six years of age but has not attained nineteen years of age, whose income is not more than one hundred thirty-three percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

h. Is a woman who, while pregnant, meets eligibility requirements for assistance under the federal Social Security Act, section 1902(1), and continues to meet the requirements except for income. The woman is eligible to receive assistance until sixty days after the date pregnancy ends.

i. Is a pregnant woman who is determined to be presumptively eligible by a health care provider qualified under the federal Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9407. The woman is eligible for ambulatory prenatal care assistance until the last day of the month following the month of the presumptive eligibility determination. If the department receives the woman's medical assistance application by the last day of the month following the month of the presumptive eligibility determination, the woman is eligible for ambulatory prenatal care assistance until the department actually determines the woman's eligibility or ineligibility for medical assistance. The costs of services provided during the presumptive eligibility period shall be paid by the medical assistance program for those persons who are determined to be ineligible through the regular eligibility determination process.

j. Is a pregnant woman or infant less than one year of age whose income does not exceed the federally prescribed percentage of the poverty level in accordance with the federal Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302.

k. Is a pregnant woman or infant whose income is more than the limit prescribed under the federal Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, but not more than two hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

l. Is an infant whose income is not more than two hundred percent of the federal poverty level, as defined by the most recently revised income guidelines published by the United States department of health and human services.

m. Is a child for whom adoption assistance or foster care maintenance payments are paid under Title IV-E of the federal Social Security Act.

n. Is an individual or family who is ineligible for the family investment program because of requirements that do not apply under Title XIX of the federal Social Security Act.

o. Was a federal supplemental security income or a state supplementary assistance recipient, as defined by section 249.1, and a recipient of federal social security benefits at one time since August 1, 1977, and would be eligible for federal supplemental security income or state supplementary assistance but for the increases due to the cost of living in federal social security benefits since the last date of concurrent eligibility.

p. Is an individual whose spouse is deceased and who is ineligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, due to the elimination of the actuarial reduction formula for federal social security benefits under the federal Social Security Act and subsequent cost of living increases.

q. Is an individual who is at least sixty years of age and is ineligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, because of receipt of social security widow or widower benefits and is not eligible for federal Medicare, part A coverage.

r. Is an individual with a disability, and is at least eighteen years of age, who receives parental social security benefits under the federal Social Security Act and is not eligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, because of the receipt of the social security benefits.

s. Is an individual who is no longer eligible for the family investment program due to earned income. The department shall provide transitional medical assistance to the individual for the maximum period allowed for federal financial participation under federal law.

t. Is an individual who is no longer eligible for the family investment program due to the receipt of child or spousal support. The department shall provide transitional medical assistance to the individual for the maximum period allowed for federal financial participation under federal law.

2. Medical assistance may also, within the limits of available funds and in accordance with section 249A.4, subsection 1, be provided to, or on behalf of, other individuals and families who are not excluded under subsection 5 of this

section and whose incomes and resources are insufficient to meet the cost of necessary medical care and services in accordance with the following order of priorities:

a. As allowed under 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII), individuals with disabilities, who are less than sixty-five years of age, who are members of families whose income is less than two hundred fifty percent of the most recently revised official poverty guidelines published by the United States department of health and human services for the family, who have earned income and who are eligible for medical assistance or additional medical assistance under this section if earnings are disregarded. As allowed by 42 U.S.C. § 1396a(r)(2), unearned income shall also be disregarded in determining whether an individual is eligible for assistance under this paragraph. For the purposes of determining the amount of an individual's resources under this paragraph and as allowed by 42 U.S.C. § 1396a(r)(2), a maximum of ten thousand dollars of available resources shall be disregarded, and any additional resources held in a retirement account, in a medical savings account, or in any other account approved under rules adopted by the department shall also be disregarded. Individuals eligible for assistance under this paragraph, whose individual income exceeds one hundred fifty percent of the official poverty guidelines published by the United States department of health and human services for an individual, shall pay a premium. The amount of the premium shall be based on a sliding fee schedule adopted by rule of the department and shall be based on a percentage of the individual's income. The maximum premium payable by an individual whose income exceeds one hundred fifty percent of the official poverty guidelines shall be commensurate with the cost of state employees' group health insurance in this state.

b. As provided under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, women who meet all of the following criteria:

- (1) Are not described in 42 U.S.C. § 1396a(a)(10)(A)(i).
- (2) Have not attained age sixty-five.

(3) Have been screened for breast and cervical cancer under the United States centers for disease control and prevention breast and cervical cancer early detection program established under 42 U.S.C. § 300k et seq., in accordance with the requirements of 42 U.S.C. § 300n, and need treatment for breast or cervical cancer. A woman is considered screened for breast and cervical cancer under this subparagraph if the woman is screened by any provider or entity, and the state grantee of the United States centers for disease control and prevention funds under Title XV of the federal Public Health Services Act has elected to include screening activities by that provider or entity as screening activities pursuant to Title XV of the federal Public Health Services Act. This screening includes but is not limited to breast or cervical cancer screenings or related diagnostic services provided by family planning or community health centers and breast cancer screenings funded by the Susan G. Komen foundation which are provided to women who meet the eligibility requirements established by the state grantee of the United States centers for disease control and prevention funds under Title XV of the federal Public Health Services Act.

- (4) Are not otherwise covered under creditable coverage as defined in 42 U.S.C. § 300gg(c).

A woman who meets the criteria of this paragraph shall be presumptively eligible for medical assistance.

c. Individuals who are receiving care in a hospital or in a basic nursing home, intermediate nursing home, skilled nursing home or extended care facility, as defined by section 135C.1, and who meet all eligibility requirements for federal supplemental security income except that their income exceeds the allowable maximum therefor, but whose income is not in excess of the maximum established by subsection 4 for eligibility for medical assistance and is insufficient to meet the full cost of their care in the hospital or health care facility on the basis of standards established by the department.

d. Individuals under twenty-one years of age living in a licensed foster home, or in a private home pursuant to a subsidized adoption arrangement, for whom the department accepts financial responsibility in whole or in part and who are not eligible under subsection 1.

e. Individuals who are receiving care in an institution for mental diseases, and who are under twenty-one years of age and whose income and resources are such that they are eligible for the family investment program, or who are sixty-five years of age or older and who meet the conditions for eligibility in paragraph "a" of this subsection.

f. Individuals and families whose incomes and resources are such that they are eligible for federal supplemental security income or the family investment program, but who are not actually receiving such public assistance.

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g. Individuals who are receiving state supplementary assistance as defined by section 249.1 or other persons whose needs are considered in computing the recipient's assistance grant.

h. Individuals under twenty-one years of age who qualify on a financial basis for, but who are otherwise ineligible to receive assistance under the family investment program.

i. Individuals and families who would be eligible under subsection 1 or 2 of this section except for excess income or resources, or a reasonable category of those individuals and families.

j. Individuals who have attained the age of twenty-one but have not yet attained the age of sixty-five who qualify on a financial basis for, but who are otherwise ineligible to receive, federal supplemental security income or assistance under the family investment program.

k. As allowed under 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVII), individuals under twenty-one years of age who were in foster care under the responsibility of the state on the individual's eighteenth birthday, and whose income is less than two hundred percent of the most recently revised official poverty guidelines published by the United States department of health and human services. Medical assistance may be provided for an individual described by this paragraph regardless of the individual's resources.

Notwithstanding the provisions of this subsection establishing priorities for individuals and families to receive medical assistance, the department may determine within the priorities listed in this subsection which persons shall receive medical assistance based on income levels established by the department, subject to the limitations provided in subsection 4.

3. Additional medical assistance may, within the limits of available funds and in accordance with section 249A.4, subsection 1, be provided to, or on behalf of, either:

a. Only those individuals and families described in subsection 1 of this section; or

b. Those individuals and families described in both subsections 1 and 2.

4. Discretionary medical assistance, within the limits of available funds and in accordance with section 249A.4, subsection 1, may be provided to or on behalf of those individuals and families described in subsection 2, paragraph "i" of this section.

5. Assistance shall not be granted under this chapter to:

a. An individual or family whose income, considered to be available to the individual or family, exceeds federally prescribed limitations.

b. An individual or family whose resources, considered to be available to the individual or family, exceed federally prescribed limitations.

5A. In determining eligibility for children under subsection 1, paragraphs "b", "f", "g", "j", "k", "n", and "s"; subsection 2, paragraphs "c", "e", "f", "h", and "i"; and subsection 5, paragraph "b", all resources of the family, other than monthly income, shall be disregarded.

5B. In determining eligibility for adults under subsection 1, paragraphs "b", "e", "h", "j", "k", "n", "s", and "t"; subsection 2, paragraphs "d", "e", "h", "i", and "j"; and subsection 5, paragraph "b", one motor vehicle per household shall be disregarded.

6. In determining the eligibility of an individual for medical assistance under this chapter, for resources transferred to the individual's spouse before October 1, 1989, or to a person other than the individual's spouse before July 1, 1989, the department shall include, as resources still available to the individual, those nonexempt resources or interests in resources, owned by the individual within the preceding twenty-four months, which the individual gave away or sold at less than fair market value for the purpose of establishing eligibility for medical assistance under this chapter.

a. A transaction described in this subsection is presumed to have been for the purpose of establishing eligibility for medical assistance under this chapter unless the individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

b. The value of a resource or an interest in a resource in determining eligibility under this subsection is the fair market value of the resource or interest at the time of the transaction less the amount of any compensation received.

c. If a transaction described in this subsection results in uncompensated value exceeding twelve thousand dollars, the department shall provide by rule for a period of ineligibility which exceeds twenty-four months and has a reasonable relationship to the uncompensated value above twelve thousand dollars.

7. In determining the eligibility of an individual for medical assistance under this chapter, the department shall consider resources transferred to the individual's spouse on or after October 1, 1989, or to a person other than the individual's spouse on or after July 1, 1989, and prior to August 11, 1993, as provided by the federal Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 303(b), as amended by the federal Family Support Act of 1988, Pub. L. No. 100-485, § 608(d)(16)(B), (D), and the federal Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6411(e)(1).

8. Medicare cost sharing shall be provided in accordance with the provisions of Title XIX of the federal Social Security Act, section 1902(a)(10)(E), as codified in *42 U.S.C. § 1396a(a)(10)(E)*, to or on behalf of an individual who is a resident of the state or a resident who is temporarily absent from the state, and who is a member of any of the following eligibility categories:

a. A qualified Medicare beneficiary as defined under Title XIX of the federal Social Security Act, section 1905(p)(1), as codified in *42 U.S.C. § 1396d(p)(1)*.

b. A qualified disabled and working person as defined under Title XIX of the federal Social Security Act, section 1905(s), as codified in *42 U.S.C. § 1396d(s)*.

c. A specified low-income Medicare beneficiary as defined under Title XIX of the federal Social Security Act, section 1902(a)(10)(E)(iii), as codified in *42 U.S.C. § 1396a(a)(10)(E)(iii)*.

d. An additional specified low-income Medicare beneficiary as described under Title XIX of the federal Social Security Act, section 1902(a)(10)(E)(iv)(I), as codified in *42 U.S.C. § 1396a(a)(10)(E)(iv)(I)*.

e. An additional specified low-income Medicare beneficiary described under Title XIX of the federal Social Security Act, section 1902(a)(10)(E)(iv)(II), as codified in *42 U.S.C. § 1396a(a)(10)(E)(iv)(II)*.

9. Beginning October 1, 1990, in determining the eligibility of an institutionalized individual for assistance under this chapter, the department shall establish a minimum community spouse resource allowance amount of twenty-four thousand dollars to be retained for the benefit of the institutionalized individual's community spouse in accordance with the federal Social Security Act, section 1924(f) as codified in *42 U.S.C. § 1396r-5(f)*.

10. Group health plan cost sharing shall be provided as required by Title XIX of the federal Social Security Act, section 1906, as codified in *42 U.S.C. § 1396e*.

11. a. In determining the eligibility of an individual for medical assistance, the department shall consider transfers of assets made on or after August 11, 1993, as provided by the federal Social Security Act, section 1917(c), as codified in *42 U.S.C. § 1396p(c)*.

b. The department shall exercise the option provided in *42 U.S.C. § 1396p(c)* to provide a period of ineligibility for medical assistance due to a transfer of assets by a noninstitutionalized individual or the spouse of a noninstitutionalized individual. For noninstitutionalized individuals, the number of months of ineligibility shall be equal to the total, cumulative uncompensated value of all assets transferred by the individual or the individual's spouse on or after the look-back date specified in *42 U.S.C. § 1396p(c)(1)(B)(i)*, divided by the average monthly cost to a private patient for nursing facility services in Iowa at the time of application. The services for which noninstitutionalized individuals shall be made ineligible shall include any long-term care services for which medical assistance is otherwise available. Notwithstanding section 17A.4, the department may adopt rules providing a period of ineligibility for medical assistance due to a transfer of assets by a noninstitutionalized individual or the spouse of a noninstitutionalized individual without notice of opportunity for public comment, to be effective immediately upon filing under section 17A.5, subsection 2, paragraph "b", subparagraph (1).

c. A disclaimer of any property, interest, or right pursuant to section 633E.5 constitutes a transfer of assets for the purpose of determining eligibility for medical assistance in an amount equal to the value of the property, interest, or right disclaimed.

d. Unless a surviving spouse is precluded from making an election under the terms of a premarital agreement, the failure of a surviving spouse to take an elective share pursuant to chapter 633, division V, constitutes a transfer of assets

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for the purpose of determining eligibility for medical assistance to the extent that the value received by taking an elective share would have exceeded the value of the inheritance received under the will.

12. In determining the eligibility of an individual for medical assistance, the department shall consider income or assets relating to trusts or similar legal instruments or devices established on or before August 10, 1993, as available to the individual, in accordance with the federal Comprehensive Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, § 9506(a), as amended by the federal Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9435(c).

13. In determining the eligibility of an individual for medical assistance, the department shall consider income or assets relating to trusts or similar legal instruments or devices established after August 10, 1993, as available to the individual, in accordance with 42 U.S.C. § 1396p(d) and sections 633C.2 and 633C.3.

HISTORY: C62, 66, § 249A.3, 249A.4; C71, 73, 75, 77, 79, 81, § 249A.3; 81 Acts, ch 7, § 15, ch 82, § 1

84 Acts, ch 1297, § 3--5; 85 Acts, ch 146, § 2; 89 Acts, ch 104, § 2--4; 89 Acts, ch 304, § 202; 90 Acts, ch 1258, § 6; 90 Acts, ch 1270, § 48; 91 Acts, ch 158, § 3, 4; 92 Acts, ch 1043, § 4; 92 Acts, 2nd Ex, ch 1001, § 420; 93 Acts, ch 97, § 37; 94 Acts, ch 1120, § 1, 8, 9, 16; 95 Acts, ch 68, § 1; 96 Acts, ch 1129, § 64; 97 Acts, ch 41, § 26--28; 98 Acts, ch 1218, § 77; 99 Acts, ch 94, § 1; 99 Acts, ch 203, § 50; 99 Acts, ch 208, § 50; 2000 Acts, ch 1060, § 1--3; 2000 Acts, ch 1221, § 6; 2000 Acts, ch 1228, § 41; 2001 Acts, ch 184, § 9; 2003 Acts, ch 62, § 2; 2004 Acts, ch 1015, § 1; 2005 Acts, ch 38, § 1, 55; 2006 Acts, ch 1104, § 1; 2006 Acts, ch 1159, § 4, 8

NOTES:

Section Notes:

Spousal support debt for medical assistance to institutionalized spouse; community spouse resource allowance; chapter 249B

Subsection 2, NEW paragraph k

NEW subsection 5B

Subsection 11, paragraph d amended

LexisNexis (R) Notes:

CASE NOTES

1. Court erred in finding that a trust was terminated by the government's denial of Medicaid benefits to a patient and that, therefore, the patient was entitled to benefits. *Bidler v. Iowa Dep't of Human Servs.*, 2002 Iowa App. LEXIS 264 (Iowa Ct. App. Mar. 13 2002).

1 of 1 DOCUMENT

IOWA ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH THE JULY 18, 2007 SUPPLEMENT ***

HUMAN SERVICES DEPARTMENT[441]
TITLE VIII: MEDICAL ASSISTANCE
CHAPTER 75: CONDITIONS OF ELIGIBILITY
DIVISION II: ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO THE FAMILY
MEDICAL ASSISTANCE PROGRAM (FMAP)

441 IAC 75.56(249A) (2007)

441 -- 75.56(249A) Resources.

75.56(1) Limitation. Unless otherwise specified, an applicant or recipient may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1) "n" or "o," the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of \$ 3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of \$ 3,000 shall be counted toward the resource limit in paragraph 75.56(1) "e." When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal; not to exceed \$ 2,000 for applicant assistance units and \$ 5,000 for recipient assistance units.

EXCEPTION: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the \$ 5,000 limit.

Resources of the applicant or the recipient shall be determined in accordance with persons considered, as described at subrule 75.56(2).

441 IAC 75.56(249A)

f. Money which is counted as income in a month, during that same month; and that part of lump sum income defined at subparagraph 75.57(9) "c" (2) reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed \$ 1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$ 1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Earned income credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$ 10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph "e."

o. Nonhomestead property that produces income consistent with the property's fair market value.

75.56(2) Persons considered.

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) recipients shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid recipient in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) Homestead defined. The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed 1/2 acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) Liquidation. When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

441 IAC 75.56(249A)

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1)"d" and 75.57(7)"ag." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) Net market value defined. Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) Availability.

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or recipient owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or recipient owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) Damage judgments and insurance settlements.

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or recipient the month following the month the payment was received. When the applicant or recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) Conservatorships.

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

When the county office questions whether the funds in a conservatorship are available, the county office shall refer the conservatorship to central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments. Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available. Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)"e" and 75.24(2)"b."

75.56(9) Not considered a resource. Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax

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purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

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CHAPTER 400 SOCIAL SERVICES
THE SOCIAL WELFARE ACT
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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)

MCL § 400.112b

§ 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
93RD LEGISLATURE
REGULAR SESSION OF 2006**

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



Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536



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

SAS\S0506\sb838sa

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.

Legislative Analysis



MEDICAID ELIGIBILITY

Mitchell Bean, Director
Phone: (517) 373-8080
<http://www.house.mi.gov/hfa>

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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256B.056, Minnesota Statutes 2006

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256B.056 ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE.

Subdivision 1. **Residency.** To be eligible for medical assistance, a person must reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota in accordance with the rules of the state agency.

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section [256B.055, subdivision 12](#), or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, shall be used, except that effective October 1, 2003, the earned income disregards and deductions are limited to those in subdivision 1c. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Subd. 1b. **Aged, blind, and disabled income methodology.** The \$20 general income disregard allowed under the supplemental security income program is included in the standard and shall not be allowed as a deduction from income for a person eligible under section 256B.055, subdivisions 7, 7a, and 12 .

Subd. 1c. **Families with children income methodology.** (a)(1) [Expired, 1Sp2003 c 14 art 12 s 17]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) For children ages one through 18 whose eligibility is determined under section 256B.057, subdivision 2 , the following deductions shall be applied to income counted toward the child's eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: \$90 work expense, dependent care, and child support paid under court order. This clause is effective October 1, 2003.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall

in section ~~256B.056, subdivision 1~~, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

(c) If the four-month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

(d) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

Subd. 2. Homestead exclusion and homestead equity limit for institutionalized persons.

(a) The homestead shall be excluded for the first six calendar months of a person's stay in a long-term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return to the homestead. For purposes of this subdivision, "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources. The homestead shall continue to be excluded for persons residing in a long-term care facility if it is used as a primary residence by one of the following individuals:

- (1) the spouse;
- (2) a child under age 21;
- (3) a child of any age who is blind or permanently and totally disabled as defined in the supplemental security income program;
- (4) a sibling who has equity interest in the home and who resided in the home for at least one year immediately before the date of the person's admission to the facility; or
- (5) a child of any age, or, subject to federal approval, a grandchild of any age, who resided in the home for at least two years immediately before the date of the person's admission to the facility, and who provided care to the person that permitted the person to reside at home rather than in an institution.

(b) Effective for applications filed on or after July 1, 2006, and for renewals after July 1, 2006, for persons who first applied for payment of long-term care services on or after January 2, 2006, the equity interest in the homestead of an individual whose eligibility for long-term care services is determined on or after January 1, 2006, shall not exceed \$500,000, unless it is the lawful residence of the individual's spouse or child who is under age 21, blind, or disabled. The amount specified in this paragraph shall be increased beginning in year 2011, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000. This provision may be waived in the case of demonstrated hardship by a process to be determined by the secretary of health and human services pursuant to section 6014 of the Deficit Reduction Act of 2005, Public Law 109-171.

Subd. 3. Asset limitations for individuals and families. To be eligible for medical assistance, a person must not individually own more than \$3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than \$6,000 in assets, plus \$200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of

those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

- (a) Household goods and personal effects are not considered.
- (b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.
- (c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.
- (d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses.
- (e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

Subd. 3a.[Repealed, 1992 c 513 art 7 s 135]

Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in *Sullivan v. Zebley*, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) Trusts established after August 10, 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law 103-66.

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than \$20,000 in total net assets, and a household of one person must not own more than \$10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

- (1) household goods and personal effects are not considered;
- (2) capital and operating assets of a trade or business up to \$200,000 are not considered;
- (3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;
- (4) one burial plot and all other burial expenses equal to the supplemental security income

- program asset limit are not considered for each individual;
- (5) court-ordered settlements up to \$10,000 are not considered;
- (6) individual retirement accounts and funds are not considered; and
- (7) assets owned by children are not considered.

Subd. 3d. **Reduction of excess assets.** Assets in excess of the limits in subdivisions 3 to 3c may be reduced to allowable limits as follows:

- (a) Assets may be reduced in any of the three calendar months before the month of application in which the applicant seeks coverage by:
- (1) designating burial funds up to \$1,500 for each applicant, spouse, and MA-eligible dependent child; and
- (2) paying health service bills incurred in the retroactive period for which the applicant seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of MA-covered health services incurred in the retroactive period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.
- (b) Assets may be reduced beginning the month of application by:
- (1) paying bills for health services that would otherwise be paid by medical assistance; and
- (2) using any means other than a transfer of assets for less than fair market value as defined in section 256B.0595, subdivision 1, paragraph (b).

Subd. 3e. **Continuing care retirement and life care community entrance fees.** An entrance fee paid by an individual to a continuing care retirement or life care community shall be treated as an available asset to the extent that:

- (1) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for care;
- (2) the individual is eligible for a refund of any remaining entrance fees when the individual dies or terminates the continuing care retirement or life care community contract and leaves the community; and
- (3) the entrance fee does not confer an ownership interest in the continuing care retirement or life care community.

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, subdivision 12, may have income up to 100 percent of the federal poverty guidelines. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size.

(d) In computing income to determine eligibility of persons under paragraphs (a) to (c) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

Subd. 4a. **Asset verification.** For purposes of verification, the value of a life estate shall be considered not saleable unless the owner of the remainder interest intends to purchase the life

CONSIDERED NOT SALABLE UNLESS THE OWNER OF THE REMAINDER INTEREST INTENDS TO PURCHASE THE ESTATE, OR THE OWNER OF THE LIFE ESTATE AND THE OWNER OF THE REMAINDER SELL THE ENTIRE PROPERTY.

Subd. 4b. Income verification. The local agency shall not require a monthly income verification form for a recipient who is a resident of a long-term care facility and who has monthly earned income of \$80 or less. The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification.

Subd. 5. Excess income. A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the last business day of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before noon on the last business day of the month in order to be eligible for this option in the following month.

Subd. 5a. Individuals on fixed or excluded income. Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income every 12 months. The 12-month period begins with the month of application.

Subd. 5b. Individuals with low income. Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income every six months. The six-month period begins the month of application.

Subd. 5c. Excess income standard. (a) The excess income standard for families with children is the standard specified in subdivision 4.

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the family size. Effective July 1, 2002, the excess income standard for this paragraph shall equal 75 percent of the federal poverty guidelines.

Subd. 6. Assignment of benefits. To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's legal representative from any third party liable for the costs of medical care. By accepting or receiving assistance, the person is deemed to have assigned the person's rights to medical support and third party payments as required by title 19 of the Social Security Act. Persons must cooperate with the state in establishing paternity and obtaining third party payments. By accepting medical assistance, a person assigns to the Department of Human Services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon

the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. For the purposes of this section, "the Department of Human Services or the state" includes prepaid health plans under contract with the commissioner according to sections 256B.031, 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and the county-based purchasing entities under section 256B.692.

Subd. 7. Period of eligibility. Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. Eligibility for months prior to application is determined independently from eligibility for the month of application and future months. A redetermination of eligibility must occur every 12 months. The 12-month period begins with the month of application.

Subd. 8. Cooperation. To be eligible for medical assistance, applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payers and assist the state in obtaining third party payments, unless good cause for noncooperation is determined according to Code of Federal Regulations, title 42, part 433.147. "Cooperation" includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. Cooperation also includes providing information about a group health plan for which the person may be eligible and if the plan is determined cost-effective by the state agency and premiums are paid by the local agency or there is no cost to the recipient, they must enroll or remain enrolled with the group. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to section 256B.19.

Subd. 9. Notice. The state agency must be given notice of monetary claims against a person, entity, or corporation that may be liable to pay all or part of the cost of medical care when the state agency has paid or becomes liable for the cost of that care. Notice must be given according to paragraphs (a) to (d).

(a) An applicant for medical assistance shall notify the state or local agency of any possible claims when the applicant submits the application. A recipient of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A party to a claim that may be assigned to the state agency under this section shall notify the state agency of its potential assignment claim in writing at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

(d) Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the

claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice for that stage of the claim. If the required notice under this paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required notice. A party to the claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual assignment claim.

Subd. 10. Eligibility verification. (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall modify the application for Minnesota health care programs to require more detailed information related to verification of assets and income, and shall verify assets and income for all applicants, and for all recipients upon renewal.

(d) The commissioner shall require Minnesota health care program recipients to report new or an increase in earned income within ten days of the change, and to verify new or an increase in earned income that affects eligibility within ten days of notification by the agency that the new or increased earned income affects eligibility. Recipients who fail to verify new or an increase in earned income that affects eligibility shall be disenrolled.

Subd. 11. Treatment of annuities. (a) Any individual applying for or seeking recertification of eligibility for medical assistance payment of long-term care services shall provide a complete description of any interest either the individual or the individual's spouse has in annuities. The individual and the individual's spouse shall furnish the agency responsible for determining eligibility with complete current copies of their annuities and related documents for review as part of the application process on disclosure forms provided by the department as part of their application.

(b) The disclosure form shall include a statement that the department becomes the remainder beneficiary under the annuity or similar financial instrument by virtue of the receipt of medical assistance. The disclosure form shall include a notice to the issuer of the department's right under this section as a preferred remainder beneficiary under the annuity or similar financial instrument for medical assistance furnished to the individual or the individual's spouse, and require the issuer to provide confirmation that a remainder beneficiary designation has been made and to notify the county agency when there is a change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure required under this section. The individual and the individual's spouse shall execute separate disclosure forms for each annuity or similar financial instrument that they are required to disclose under this section and in which they have an interest.

(c) An issuer of an annuity or similar financial instrument who receives notice on a disclosure form as described in paragraph (b) shall provide confirmation to the requesting agency that a remainder beneficiary designating the state has been made and shall notify the county agency when there is a change in the amount of income or principal being withdrawn from the annuity or other similar financial instrument. The county agency shall provide the issuer with the name, address, and telephone number of a unit within the department that the issuer can contact to

comply with this paragraph.

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5; 1987 c 403 art 2 s 79,80; 1988 c 689 art 2 s 144,145,268; 1989 c 282 art 3 s 45-47; 1989 c 332 s 1; 1990 c 568 art 3 s 28-32; 1992 c 513 art 7 s 34-38; 1993 c 339 s 13; 1Sp1993 c 1 art 5 s 31; art 6 s 25; 1995 c 207 art 6 s 28,29; 1995 c 248 art 17 s 1-4; 1996 c 451 art 2 s 8,9; 1997 c 85 art 3 s 13-15; 1997 c 203 art 4 s 20,21; 1997 c 225 art 6 s 4; 1998 c 407 art 4 s 15,16; 1999 c 245 art 4 s 32; art 10 s 10; 2001 c 203 s 5,6; 1Sp2001 c 9 art 2 s 16-24; 2002 c 220 art 15 s 6; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 16; art 12 s 16-18; 2004 c 228 art 1 s 75; 2005 c 56 s 1; 2005 c 98 art 2 s 2; 1Sp2005 c 4 art 8 s 20-26; 2006 c 282 art 17 s 25-27*

NOTE: The amendments to subdivisions 5, 5a, 5b, and 7, by Laws 2005, First Special Session chapter 4, article 8, sections 21 to 24, are effective August 1, 2007, or upon HealthMatch implementation, whichever is later. Laws 2005, First Special Session chapter 4, article 8, sections 21 to 24, the effective dates.

1.1 A bill for an act

1.2 relating to human services; modifying treatment of assets for medical assistance
1.3 eligibility; amending Minnesota Statutes 2006, section 256B.059, subdivision 5.

1.4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.5 Section 1. Minnesota Statutes 2006, section 256B.059, subdivision 5, is amended to
1.6 read:

1.7 Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for
1.8 medical assistance benefits following the first continuous period of institutionalization on
1.9 or after October 1, 1989, assets considered available to the institutionalized spouse shall
1.10 be the total value of all assets in which either spouse has an ownership interest, reduced by
1.11 the following amount for the community spouse:

1.12 (1) prior to July 1, 1994, the greater of:

1.13 (i) \$14,148;

1.14 (ii) the lesser of the spousal share or \$70,740; or

1.15 (iii) the amount required by court order to be paid to the community spouse;

1.16 (2) for persons whose date of initial determination of eligibility for medical
1.17 assistance following their first continuous period of institutionalization occurs on or after
1.18 July 1, 1994, the greater of:

1.19 (i) \$20,000;

1.20 (ii) the lesser of the spousal share or \$70,740; or

1.21 (iii) the amount required by court order to be paid to the community spouse.

1.22 The value of assets transferred for the sole benefit of the community spouse under section
1.23 256B.0595, subdivision 4, in combination with other assets available to the community
1.24 spouse under this section, cannot exceed the limit for the community spouse asset

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2.1 allowance determined under subdivision 3 or 4. ~~Assets that exceed this allowance shall be~~
2.2 ~~considered available to the institutionalized spouse whether or not converted to income.~~ If
2.3 the community spouse asset allowance has been increased under subdivision 4, then the
2.4 assets considered available to the institutionalized spouse under this subdivision shall be
2.5 further reduced by the value of additional amounts allowed under subdivision 4.

2.6 (b) An institutionalized spouse may be found eligible for medical assistance even
2.7 though assets in excess of the allowable amount are found to be available under paragraph
2.8 (a) if the assets are owned jointly or individually by the community spouse, and the
2.9 institutionalized spouse cannot use those assets to pay for the cost of care without the
2.10 consent of the community spouse, and if: (i) the institutionalized spouse assigns to the
2.11 commissioner the right to support from the community spouse under section 256B.14,
2.12 subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment
2.13 due to a physical or mental impairment; or (iii) the denial of eligibility would cause an
2.14 imminent threat to the institutionalized spouse's health and well-being.

2.15 (c) After the month in which the institutionalized spouse is determined eligible for
2.16 medical assistance, during the continuous period of institutionalization, no assets of the
2.17 community spouse are considered available to the institutionalized spouse, unless the
2.18 institutionalized spouse has been found eligible under paragraph (b).

2.19 (d) Assets determined to be available to the institutionalized spouse under this
2.20 section must be used for the health care or personal needs of the institutionalized spouse.

2.21 (e) For purposes of this section, assets do not include assets excluded under the
2.22 supplemental security income program.

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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE No. 1719

March 5, 2007

Authored by Huntley, Otremba and Murphy, E.

The bill was read for the first time and referred to the Committee on Health and Human Services

March 27, 2007

Committee Recommendation and Adoption of Report:

To Pass as Amended and re-referred to the Committee on Finance

1.1 A bill for an act
1.2 relating to human services; modifying treatment of assets for medical assistance
1.3 eligibility; amending Minnesota Statutes 2006, section 256B.059, subdivision 5.

1.4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.5 Section 1. Minnesota Statutes 2006, section 256B.059, subdivision 5, is amended to
1.6 read:

1.7 Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for
1.8 medical assistance benefits following the first continuous period of institutionalization on
1.9 or after October 1, 1989, assets considered available to the institutionalized spouse shall
1.10 be the total value of all assets in which either spouse has an ownership interest, reduced by
1.11 the following amount for the community spouse:

1.12 (1) prior to July 1, 1994, the greater of:

1.13 (i) \$14,148;

1.14 (ii) the lesser of the spousal share or \$70,740; or

1.15 (iii) the amount required by court order to be paid to the community spouse;

1.16 (2) for persons whose date of initial determination of eligibility for medical

1.17 assistance following their first continuous period of institutionalization occurs on or after

1.18 July 1, 1994, the greater of:

1.19 (i) \$20,000;

1.20 (ii) the lesser of the spousal share or \$70,740; or

1.21 (iii) the amount required by court order to be paid to the community spouse.

1.22 The value of assets transferred for the sole benefit of the community spouse under section
1.23 256B.0595, subdivision 4, in combination with other assets available to the community
1.24 spouse under this section, cannot exceed the limit for the community spouse asset

2.1 allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be
2.2 considered available to the institutionalized spouse ~~whether or not converted to income~~. If
2.3 the community spouse asset allowance has been increased under subdivision 4, then the
2.4 assets considered available to the institutionalized spouse under this subdivision shall be
2.5 further reduced by the value of additional amounts allowed under subdivision 4.

2.6 (b) An institutionalized spouse may be found eligible for medical assistance even
2.7 though assets in excess of the allowable amount are found to be available under paragraph

2.8 (a) if the assets are owned jointly or individually by the community spouse, and the
2.9 institutionalized spouse cannot use those assets to pay for the cost of care without the
2.10 consent of the community spouse, and if: (i) the institutionalized spouse assigns to the
2.11 commissioner the right to support from the community spouse under section 256B.14,
2.12 subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment
2.13 due to a physical or mental impairment; or (iii) the denial of eligibility would cause an
2.14 imminent threat to the institutionalized spouse's health and well-being.

2.15 (c) After the month in which the institutionalized spouse is determined eligible for
2.16 medical assistance, during the continuous period of institutionalization, no assets of the
2.17 community spouse are considered available to the institutionalized spouse, unless the
2.18 institutionalized spouse has been found eligible under paragraph (b).

2.19 (d) Assets determined to be available to the institutionalized spouse under this
2.20 section must be used for the health care or personal needs of the institutionalized spouse.

2.21 (e) For purposes of this section, assets do not include assets excluded under the
2.22 supplemental security income program.

1.1 A bill for an act

1.2 relating to human services; increasing the medical assistance asset limit
1.3 and excess income standard for aged, blind, or disabled persons; modifying
1.4 a Minnesota disabilities health options program provision; modifying the
1.5 medical assistance employed persons with disabilities program; directing the
1.6 commissioner of human services to seek federal approval; amending Minnesota
1.7 Statutes 2006, sections 256B.056, subdivisions 1a, 3, 5c; 256B.69, subdivision
1.8 23.

1.9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.10 Section 1. Minnesota Statutes 2006, section 256B.056, subdivision 1a, is amended to
1.11 read:

1.12 Subd. 1a. **Income and assets generally.** Unless specifically required by state law or
1.13 rule or federal law or regulation, the methodologies used in counting income and assets
1.14 to determine eligibility for medical assistance for persons whose eligibility category is
1.15 based on blindness, disability, or age of 65 or more years, the methodologies for the
1.16 supplemental security income program shall be used, except as provided under subdivision
1.17 3, paragraph (f). Increases in benefits under title II of the Social Security Act shall not be
1.18 counted as income for purposes of this subdivision until July 1 of each year. Effective
1.19 upon federal approval, for children eligible under section 256B.055, subdivision 12, or
1.20 for home and community-based waiver services whose eligibility for medical assistance
1.21 is determined without regard to parental income, child support payments, including any
1.22 payments made by an obligor in satisfaction of or in addition to a temporary or permanent
1.23 order for child support, and Social Security payments are not counted as income. For
1.24 families and children, which includes all other eligibility categories, the methodologies
1.25 under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal
1.26 Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public

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2.1 Law 104-193, shall be used, except that effective October 1, 2003, the earned income
2.2 disregards and deductions are limited to those in subdivision 1c. For these purposes, a
2.3 "methodology" does not include an asset or income standard, or accounting method,
2.4 or method of determining effective dates.

2.5 Sec. 2. Minnesota Statutes 2006, section 256B.056, subdivision 3, is amended to read:

2.6 Subd. 3. **Asset limitations for aged, blind, or disabled individuals ~~and families~~.**

2.7 To be eligible for medical assistance, a person whose eligibility is based on blindness,
2.8 disability, or age of 65 or more years must not individually own more than ~~\$3,000~~ \$6,000
2.9 in assets, or if a member of a household with two family members, husband and wife, or
2.10 parent and child, the household must not own more than ~~\$6,000~~ \$12,000 in assets, plus
2.11 ~~\$200~~ \$400 for each additional legal dependent. In addition to these maximum amounts,
2.12 an eligible individual or family may accrue interest on these amounts, but they must be
2.13 reduced to the maximum at the time of an eligibility redetermination. The accumulation
2.14 of the clothing and personal needs allowance according to section 256B.35 must also be
2.15 reduced to the maximum at the time of the eligibility redetermination. The value of assets
2.16 that are not considered in determining eligibility for medical assistance is the value of
2.17 those assets excluded under the supplemental security income program for aged, blind,
2.18 and disabled persons, with the following exceptions:

2.19 (a) Household goods and personal effects are not considered.

2.20 (b) Capital and operating assets of a trade or business that the local agency
2.21 determines are necessary to the person's ability to earn an income are not considered.

2.22 (c) Motor vehicles are excluded to the same extent excluded by the supplemental
2.23 security income program.

2.24 (d) Assets designated as burial expenses are excluded to the same extent excluded by
2.25 the supplemental security income program. Burial expenses funded by annuity contracts
2.26 or life insurance policies must irrevocably designate the individual's estate as contingent
2.27 beneficiary to the extent proceeds are not used for payment of selected burial expenses.

2.28 (e) Effective upon federal approval, for a person who no longer qualifies as an
2.29 employed person with a disability due to loss of earnings, assets allowed while eligible
2.30 for medical assistance under section 256B.057, subdivision 9, are not considered for 12
2.31 months, beginning with the first month of ineligibility as an employed person with a
2.32 disability, to the extent that the person's total assets remain within the allowed limits of
2.33 section 256B.057, subdivision 9, paragraph (b).

2.34 (f) When a person enrolled in medical assistance under section 256B.057,
2.35 subdivision 9, reaches age 65 and has been enrolled during each of the 24 consecutive

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3.1 months before the person's 65th birthday, the assets owned by the person and the person's
3.2 spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph
3.3 (b), when determining eligibility for medical assistance under section 256B.055,
3.4 subdivision 7. The income of a spouse of a person enrolled in medical assistance under
3.5 section 256B.057, subdivision 9, during each of the 24 consecutive months before the
3.6 person's 65th birthday must be disregarded when determining eligibility for medical
3.7 assistance under section 256B.055, subdivision 7, when the person reaches age 65. This
3.8 paragraph does not apply at the time the person or the person's spouse requests medical
3.9 assistance payment for long-term care services.

3.10 **EFFECTIVE DATE.** This section is effective July 1, 2007.

3.11 Sec. 3. Minnesota Statutes 2006, section 256B.056, subdivision 5c, is amended to read:

3.12 Subd. 5c. **Excess income standard.** (a) The excess income standard for families
3.13 with children is the standard specified in subdivision 4.

3.14 (b) The excess income standard for a person whose eligibility is based on blindness,
3.15 disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the
3.16 family size. Effective July 1, 2002, the excess income standard for this paragraph shall
3.17 equal 75 percent of the federal poverty guidelines. Effective July 1, 2007, the excess
3.18 income standard for this paragraph shall equal 85 percent of the federal poverty guidelines.
3.19 The excess income standard for this paragraph shall be increased by five percentage points
3.20 on July 1 of each of the next three years, so that the excess income standard shall equal
3.21 100 percent of the federal poverty guidelines effective July 1, 2010.

3.22 **EFFECTIVE DATE.** This section is effective July 1, 2007.

3.23 Sec. 4. Minnesota Statutes 2006, section 256B.69, subdivision 23, is amended to read:

3.24 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
3.25 commissioner may implement demonstration projects to create alternative integrated
3.26 delivery systems for acute and long-term care services to elderly persons and persons
3.27 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
3.28 coordination, improve access to quality services, and mitigate future cost increases.
3.29 The commissioner may seek federal authority to combine Medicare and Medicaid
3.30 capitation payments for the purpose of such demonstrations and may contract with
3.31 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
3.32 services shall be administered according to the terms and conditions of the federal contract
3.33 and demonstration provisions. For the purpose of administering medical assistance funds,

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4.1 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
4.2 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
4.3 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
4.4 items B and C, which do not apply to persons enrolling in demonstrations under this
4.5 section. An initial open enrollment period may be provided. Persons who disenroll from
4.6 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
4.7 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
4.8 the health plan's participation is subsequently terminated for any reason, the person shall
4.9 be provided an opportunity to select a new health plan and shall have the right to change
4.10 health plans within the first 60 days of enrollment in the second health plan. Persons
4.11 required to participate in health plans under this section who fail to make a choice of
4.12 health plan shall not be randomly assigned to health plans under these demonstrations.
4.13 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
4.14 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
4.15 the commissioner may contract with managed care organizations, including counties, to
4.16 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
4.17 disabled persons only. For persons with a primary diagnosis of developmental disability,
4.18 serious and persistent mental illness, or serious emotional disturbance, the commissioner
4.19 must ensure that the county authority has approved the demonstration and contracting
4.20 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
4.21 commissioner shall not implement any demonstration project under this subdivision for
4.22 persons with a primary diagnosis of developmental disabilities, serious and persistent
4.23 mental illness, or serious emotional disturbance, without approval of the county board of
4.24 the county in which the demonstration is being implemented.

4.25 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
4.26 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
4.27 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
4.28 under this section projects for persons with developmental disabilities. The commissioner
4.29 may capitate payments for ICF/MR services, waived services for developmental
4.30 disabilities, including case management services, day training and habilitation and
4.31 alternative active treatment services, and other services as approved by the state and by the
4.32 federal government. Case management and active treatment must be individualized and
4.33 developed in accordance with a person-centered plan. Costs under these projects may not
4.34 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
4.35 and until two years after the pilot project implementation date, subcontractor participation
4.36 in the long-term care developmental disability pilot is limited to a nonprofit long-term

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5.1 care system providing ICF/MR services, home and community-based waiver services,
5.2 and in-home services to no more than 120 consumers with developmental disabilities in
5.3 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
5.4 prior to expansion of the developmental disability pilot project. This paragraph expires
5.5 two years after the implementation date of the pilot project.

5.6 (c) Before implementation of a demonstration project for disabled persons, the
5.7 commissioner must provide information to appropriate committees of the house of
5.8 representatives and senate and must involve representatives of affected disability groups
5.9 in the design of the demonstration projects.

5.10 (d) A nursing facility reimbursed under the alternative reimbursement methodology
5.11 in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity
5.12 provide services under paragraph (a). The commissioner shall amend the state plan and
5.13 seek any federal waivers necessary to implement this paragraph.

5.14 (e) The commissioner, in consultation with the commissioners of commerce and
5.15 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
5.16 according to federal laws and regulations governing that program and state laws or rules
5.17 applicable to participating providers. The process for approval of these programs shall
5.18 begin only after the commissioner receives grant money in an amount sufficient to cover
5.19 the state share of the administrative and actuarial costs to implement the programs during
5.20 state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an
5.21 account in the special revenue fund and are appropriated to the commissioner to be used
5.22 solely for the purpose of PACE administrative and actuarial costs. A PACE provider is
5.23 not required to be licensed or certified as a health plan company as defined in section
5.24 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
5.25 and found to be eligible for services under the elderly waiver or community alternatives
5.26 for disabled individuals or who are already eligible for Medicaid but meet level of
5.27 care criteria for receipt of waiver services may choose to enroll in the PACE program.
5.28 Medicare and Medicaid services will be provided according to this subdivision and
5.29 federal Medicare and Medicaid requirements governing PACE providers and programs.
5.30 PACE enrollees will receive Medicaid home and community-based services through the
5.31 PACE provider as an alternative to services for which they would otherwise be eligible
5.32 through home and community-based waiver programs and Medicaid State Plan Services.
5.33 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
5.34 costs that would have been incurred under fee-for-service or other relevant managed care
5.35 programs operated by the state.

6.1 (f) The commissioner shall seek federal approval to expand the Minnesota disability
6.2 health options (MnDHO) program established under this subdivision in stages, first to
6.3 regional population centers outside the seven-county metro area and then to all areas
6.4 of the state. ~~Until January 1, 2008~~ July 1, 2009, expansion for MnDHO projects that
6.5 include home and community-based services is limited to the two projects and service
6.6 areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that
6.7 include home and community-based services shall remain voluntary. Costs for home
6.8 and community-based services included under MnDHO must not exceed costs that
6.9 would have been incurred under the fee-for-service program. In developing program
6.10 specifications for expansion of integrated programs, the commissioner shall involve and
6.11 consult the state-level stakeholder group established in subdivision 28, paragraph (d),
6.12 including consultation on whether and how to include home and community-based waiver
6.13 programs. Plans for further expansion of MnDHO projects shall be presented to the chairs
6.14 of the house and senate committees with jurisdiction over health and human services
6.15 policy and finance by February 1, 2007.

6.16 (g) Notwithstanding section 256B.0261, health plans providing services under this
6.17 section are responsible for home care targeted case management and relocation targeted
6.18 case management. Services must be provided according to the terms of the waivers and
6.19 contracts approved by the federal government.

6.20 **Sec. 5. COMMISSIONER REQUIRED TO SEEK FEDERAL APPROVAL.**

6.21 By October 1, 2007, the commissioner shall seek federal approval to allow persons
6.22 who have been eligible for medical assistance for employed persons with disabilities
6.23 (MA-EPD) under Minnesota Statutes, section 256B.057, subdivision 9, for each of the 24
6.24 consecutive months prior to becoming age 65 to continue using the MA-EPD eligibility
6.25 rules as long as they qualify.

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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE No. 784

February 8, 2007

Authored by Murphy, E.; Huntley; Abeler and Hosch

The bill was read for the first time and referred to the Committee on Finance

February 12, 2007

By motion, recalled and re-referred to the Committee on Health and Human Services

February 15, 2007

Committee Recommendation and Adoption of Report:

To Pass and re-referred to the Committee on Finance

1.1 A bill for an act
1.2 relating to human services; increasing the medical assistance asset limit and
1.3 excess income standard for aged, blind, or disabled persons; amending Minnesota
1.4 Statutes 2006, section 256B.056, subdivisions 3, 5c.

1.5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.6 Section 1. Minnesota Statutes 2006, section 256B.056, subdivision 3, is amended to
1.7 read:

1.8 Subd. 3. **Asset limitations for aged, blind, or disabled individuals ~~and families~~.**

1.9 To be eligible for medical assistance, a person whose eligibility is based on blindness,
1.10 disability, or age of 65 or more years must not individually own more than ~~\$3,000~~ \$6,000
1.11 in assets, or if a member of a household with two family members, husband and wife, or
1.12 parent and child, the household must not own more than ~~\$6,000~~ \$12,000 in assets, plus
1.13 ~~\$200~~ \$400 for each additional legal dependent. In addition to these maximum amounts,
1.14 an eligible individual or family may accrue interest on these amounts, but they must be
1.15 reduced to the maximum at the time of an eligibility redetermination. The accumulation
1.16 of the clothing and personal needs allowance according to section 256B.35 must also be
1.17 reduced to the maximum at the time of the eligibility redetermination. The value of assets
1.18 that are not considered in determining eligibility for medical assistance is the value of
1.19 those assets excluded under the supplemental security income program for aged, blind,
1.20 and disabled persons, with the following exceptions:

1.21 (a) Household goods and personal effects are not considered.

1.22 (b) Capital and operating assets of a trade or business that the local agency
1.23 determines are necessary to the person's ability to earn an income are not considered.

2.1 (c) Motor vehicles are excluded to the same extent excluded by the supplemental
2.2 security income program.

2.3 (d) Assets designated as burial expenses are excluded to the same extent excluded by
2.4 the supplemental security income program. Burial expenses funded by annuity contracts
2.5 or life insurance policies must irrevocably designate the individual's estate as contingent
2.6 beneficiary to the extent proceeds are not used for payment of selected burial expenses.

2.7 (e) Effective upon federal approval, for a person who no longer qualifies as an
2.8 employed person with a disability due to loss of earnings, assets allowed while eligible
2.9 for medical assistance under section 256B.057, subdivision 9, are not considered for 12
2.10 months, beginning with the first month of ineligibility as an employed person with a
2.11 disability, to the extent that the person's total assets remain within the allowed limits of
2.12 section 256B.057, subdivision 9, paragraph (b).

2.13 **EFFECTIVE DATE.** This section is effective July 1, 2007.

2.14 Sec. 2. Minnesota Statutes 2006, section 256B.056, subdivision 5c, is amended to read:

2.15 Subd. 5c. **Excess income standard.** (a) The excess income standard for families
2.16 with children is the standard specified in subdivision 4.

2.17 (b) The excess income standard for a person whose eligibility is based on blindness,
2.18 disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the
2.19 family size. Effective July 1, 2002, the excess income standard for this paragraph shall
2.20 equal 75 percent of the federal poverty guidelines. Effective July 1, 2007, the excess
2.21 income standard for this paragraph shall equal 85 percent of the federal poverty guidelines.
2.22 The excess income standard for this paragraph shall be increased by five percentage points
2.23 on July 1 of each of the next three years, so that the excess income standard shall equal
2.24 100 percent of the federal poverty guidelines effective July 1, 2010.

2.25 **EFFECTIVE DATE.** This section is effective July 1, 2007.

AN ACT

relating to eligibility for and information regarding the child health plan program.

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

SECTION 1. Section 62.002(4), Health and Safety Code, is amended to read as follows:

(4) "Net [~~Gross~~] family income" means the [~~total~~] amount of income established for a family after reduction for offsets for child care expenses, in accordance with standards applicable under the Medicaid [~~without consideration of any reduction for offsets that may be available to the family under any other~~] program.

SECTION 2. Subchapter B, Chapter 62, Health and Safety Code, is amended by adding Section 62.056 to read as follows:

Sec. 62.056. COMMUNITY OUTREACH CAMPAIGN; TOLL-FREE HOTLINE.

(a) The commission shall conduct a community outreach and education campaign to provide information relating to the availability of health benefits for children under this chapter. The commission shall conduct the campaign in a manner that promotes enrollment in, and minimizes duplication of effort among, all state-administered child health programs.

(b) The community outreach campaign must include:

(1) outreach efforts that involve school-based health clinics;

(2) a toll-free telephone number through which families may obtain information about health benefits coverage for children;
and

(3) information regarding the importance of each conservator of a child promptly informing the other conservator of the child about the child's health benefits coverage.

(c) The commission shall contract with community-based organizations or coalitions of community-based organizations to implement the community outreach campaign and shall also promote and encourage voluntary efforts to implement the community outreach campaign. The commission shall procure the contracts through a process designed by the commission to encourage broad participation of organizations, including organizations that target population groups with high levels of uninsured children.

(d) The commission may direct that the Department of State Health Services perform all or part of the community outreach campaign.

(e) The commission shall ensure that information provided under this section is available in both English and Spanish.

SECTION 3. Section 62.101, Health and Safety Code, is amended by amending Subsection (b) and adding Subsection (b-1) to read as follows:

(b) The commission shall establish income eligibility levels

H.B. No. 109

consistent with Title XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, and subject to the availability of appropriated money, so that a child who is younger than 19 years of age and whose net [~~gross~~] family income is at or below 200 percent of the federal poverty level is eligible for health benefits coverage under the program. In addition, the commission may establish eligibility standards regarding the amount and types of allowable assets for a family whose net [~~gross~~] family income is above 150 percent of the federal poverty level.

(b-1) The eligibility standards adopted under Subsection (b) related to allowable assets:

(1) must allow a family to own at least \$10,000 in allowable assets; and

(2) may not in calculating the amount of allowable assets under Subdivision (1) consider:

(A) the value of one vehicle that qualifies for an exemption under commission rule based on its use;

(B) the value of a second or subsequent vehicle that qualifies for an exemption under commission rule based on its use if:

(i) the vehicle is worth \$18,000 or less; or

(ii) the vehicle has been modified to provide transportation for a household member with a disability;

(C) if no vehicle qualifies for an exemption based

on its use under commission rule, the first \$18,000 of value of the highest valued vehicle; or

(D) the first \$7,500 of value of any vehicle not described by Paragraph (A), (B), or (C).

SECTION 4. Subchapter C, Chapter 62, Health and Safety Code, is amended by adding Section 62.1011 to read as follows:

Sec. 62.1011. VERIFICATION OF INCOME. The commission shall continue employing methods of verifying the net income of the individuals considered in the calculation of an applicant's net family income. The commission shall verify income under this section unless the applicant reports a net family income that exceeds the income eligibility level established under Section 62.101(b).

SECTION 5. Section 62.102, Health and Safety Code, is amended to read as follows:

Sec. 62.102. CONTINUOUS COVERAGE. (a) Subject to a review under Subsection (b), the [The] commission shall provide that an individual who is determined to be eligible for coverage under the child health plan remains eligible for those benefits until the earlier of:

(1) the end of a period not to exceed 12 months, beginning the first day of the month [the six-month period] following the date of the eligibility determination; or

(2) the individual's 19th birthday.

(b) During the sixth month following the date of initial

enrollment or reenrollment of an individual whose net family income exceeds 185 percent of the federal poverty level, the commission shall:

(1) review the individual's net family income and may use electronic technology if available and appropriate; and

(2) continue to provide coverage if the individual's net family income does not exceed the income eligibility limits prescribed by this chapter.

(c) If, during the review required under Subsection (b), the commission determines that the individual's net family income exceeds the income eligibility limits prescribed by this chapter, the commission may not disenroll the individual until:

(1) the commission has provided the family an opportunity to demonstrate that the family's net family income is within the income eligibility limits prescribed by this chapter; and

(2) the family fails to demonstrate such eligibility.

(d) The commission shall provide written notice of termination of eligibility to the individual not later than the 30th day before the date the individual's eligibility terminates.

SECTION 6. Sections 62.154(a) and (d), Health and Safety Code, are amended to read as follows:

(a) To the extent permitted under Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, the child health plan must

include a waiting period and [~~the child health plan~~] may include copayments and other provisions intended to discourage:

(1) employers and other persons from electing to discontinue offering coverage for children under employee or other group health benefit plans; and

(2) individuals with access to adequate health benefit plan coverage, other than coverage under the child health plan, from electing not to obtain or to discontinue that coverage for a child.

(d) The waiting period required by Subsection (a) must:

(1) extend for a period of 90 days after [+

~~(1)]~~ the last date on [~~first day of the month in~~] which the applicant was covered under a health benefits plan; and

(2) apply to a child who was covered by a health benefits plan at any time during the 90 days before the date of application for coverage under the child health plan [~~is enrolled under the child health plan, if the date of enrollment is on or before the 15th day of the month; or~~

~~(2) the first day of the month after which the applicant is enrolled under the child health plan, if the date of enrollment is after the 15th day of the month].~~

SECTION 7. To ensure the reliability and accuracy of the review process, the Health and Human Services Commission shall phase in the review required by Subsection (b), Section 62.102, Health and Safety Code, as added by this Act, with full

implementation not later than September 1, 2008.

SECTION 8. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2007.

President of the Senate

Speaker of the House

I certify that H.B. No. 109 was passed by the House on April 4, 2007, by the following vote: Yeas 128, Nays 17, 2 present, not voting; that the House refused to concur in Senate amendments to H.B. No. 109 on May 24, 2007, and requested the appointment of a conference committee to consider the differences between the two houses; and that the House adopted the conference committee report on H.B. No. 109 on May 27, 2007, by the following vote: Yeas 134, Nays 14, 1 present, not voting.

Chief Clerk of the House

H.B. No. 109

I certify that H.B. No. 109 was passed by the Senate, with amendments, on May 22, 2007, by the following vote: Yeas 30, Nays 1; at the request of the House, the Senate appointed a conference committee to consider the differences between the two houses; and that the Senate adopted the conference committee report on H.B. No. 109 on May 27, 2007, by the following vote: Yeas 29, Nays 1.

Secretary of the Senate

APPROVED: _____

Date

Governor

LEGISLATIVE BUDGET BOARD

Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

May 26, 2007

TO: Honorable David Dewhurst , Lieutenant Governor, Senate
 Honorable Tom Craddick, Speaker of the House, House of Representatives

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB109** by Turner (Relating to eligibility for and information regarding the child health plan program.), **Conference Committee Report**

Estimated Two-year Net Impact to General Revenue Related Funds for HB109, Conference Committee Report: a negative impact of (\$76,277,422) through the biennium ending August 31, 2009.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2008	(\$30,633,506)
2009	(\$45,643,916)
2010	(\$45,643,916)
2011	(\$45,643,916)
2012	(\$45,643,916)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from GENERAL REVENUE FUND 1	Probable (Cost) from PREMIUM CO-PAYMENTS 3643	Probable (Cost) from EXPERIENCE REBATES-CHIP 8054	Probable (Cost) from VENDOR DRUG REBATES-CHIP 8070
2008	(\$30,633,506)	(\$5,881,120)	(\$391,760)	(\$497,944)
2009	(\$45,643,916)	(\$3,064,365)	(\$573,803)	(\$729,376)
2010	(\$45,643,916)	(\$3,064,365)	(\$573,803)	(\$729,376)
2011	(\$45,643,916)	(\$3,064,365)	(\$573,803)	(\$729,376)
2012	(\$45,643,916)	(\$3,064,365)	(\$573,803)	(\$729,376)

Fiscal Year	Probable (Cost) from FEDERAL FUNDS 555	Probable Revenue Gain from PREMIUM CO-PAYMENTS 3643	Probable Revenue Gain from EXPERIENCE REBATES-CHIP 8054	Probable Revenue Gain from VENDOR DRUG REBATES-CHIP 8070
2008	(\$64,074,913)	\$5,881,120	\$391,760	\$497,944
2009	(\$94,521,765)	\$3,064,365	\$573,803	\$729,376
2010	(\$94,521,765)	\$3,064,365	\$573,803	\$729,376
2011	(\$94,521,765)	\$3,064,365	\$573,803	\$729,376
2012	(\$94,521,765)	\$3,064,365	\$573,803	\$729,376

Fiscal Analysis

Section 1: Net income in the Children's Health Insurance Program (CHIP) is defined as income after reduction for child care expenses, in accordance with Medicaid standards.

Section 2: This section of the bill requires the Health and Human Services Commission (HHSC) to conduct a community outreach and education campaign for CHIP including involving school-based health clinics, a toll-free hotline, and information regarding the importance of joint conservators of a child notifying each other regarding the child's health benefits coverage.

Section 3: This section of the bill restores some income disregards in CHIP, meaning income eligibility levels would apply to net instead of gross income. The assets test used to determine eligibility is made less restrictive.

Section 4: This section of the bill requires HHSC to continue verifying income for CHIP applicants, unless the reported income exceeds established income eligibility levels.

Section 5: This section of the bill replaces the current six months of continuous eligibility for CHIP with a period of 12 months, beginning the first day of the month following the date of the eligibility determination. For persons whose family income exceeds 185 percent of the federal poverty level (FPL), HHSC would be required to review income during the sixth month of eligibility. If the family's income is determined to exceed income eligibility limits for CHIP, HHSC must provide the family with an opportunity to demonstrate that their income remains within the required income eligibility limits prior to disenrolling the family's child(ren) from the program. HHSC is required to provide written notice of termination of eligibility to the family at least 30 days before terminating eligibility.

Section 6: This section of the bill would revise the requirements for a waiting period in CHIP. The waiting period would apply only to children who had health insurance during the 90 days prior to applying for CHIP coverage and would extend for 90 days after the last date on which a child was insured under a health benefits plan.

Section 7: This section of the bill requires HHSC to phase in the income review requirements from Section 5 of the bill. Income review must be fully implemented by September 1, 2008.

Methodology

It is assumed that beginning September 1, 2007 some income disregards would be restored to the CHIP program; a less restrictive assets test would be applied; a period of 12 months continuous eligibility would replace the current six months of eligibility; and that children applying for benefits would not be subject to the waiting period unless they were insured in the

previous 90 days. It is assumed that children enrolled in the program prior to September 1, 2007 would receive six months of continuous eligibility until their next renewal. If the bill were implemented such that 12 months continuous eligibility would apply to all clients on September 1, 2007, including those already enrolled in the program, the cost of implementation would be higher. It is assumed that 95 percent of children currently subject to a waiting period would now be enrolled in the program immediately; it is assumed the remaining 5 percent were insured in the previous 90 days and would be subject to a waiting period that would begin on the day of application. It is assumed that children who applied for benefits prior to September 1, 2007 would be subject to the waiting period requirement in place at the time of application. It is assumed that clients enrolling or renewing on or after September 1, 2007 would be subject to income review during their sixth month of enrollment. It is assumed that children who enrolled in CHIP prior to September 1, 2007 would not be subject to income review until the sixth month following their next renewal.

Implementation of the requirements of this bill would result in an additional 66,668 average monthly recipient months in fiscal year 2008 and 96,396 in fiscal year 2009 and subsequent years. Allocation between General Revenue-funded CHIP programs (School Employee Children and Legal Immigrants) and the federally matched program is assumed to be the same as under current policy. It is assumed there would be no impact to the CHIP Perinatal program. Clients enrolled in that program are not currently subject to a waiting period or assets test and they already receive 12 months of continuous eligibility; there could be a small impact if income disregards or income review were applied to the CHIP Perinatal program, but none is assumed here.

The additional CHIP caseload would result in higher Premium Co-payment (enrollment fee) collections, estimated to be an additional \$5.9 million in fiscal year 2008 and \$3.1 million in fiscal year 2009 and subsequent years. It is assumed that the higher caseload would also result in additional collection of Experience Rebates, estimated to be an additional \$0.4 million in fiscal year 2008 and \$0.6 million in fiscal year 2009 and beyond. Caseload differences would also impact Vendor Drug Rebate collections for CHIP resulting in an additional \$0.5 million in fiscal year 2008 and \$0.7 million in fiscal year 2009 forward. Total net revenue gain would be \$6.8 million in fiscal year 2008, \$4.4 million in fiscal year 2009 and beyond.

The average cost per recipient month in CHIP is assumed to be \$121.66 in fiscal year 2008 and \$121.65 in the following years. The additional cost to the program from higher caseloads would be \$97.3 million All Funds in fiscal year 2008 increasing to \$140.7 million All Funds in fiscal year 2009 and subsequent years. These amounts include a cost of \$36.3 million in General Revenue Funds in fiscal year 2008 and \$48.9 million in General Revenue Funds in fiscal year 2009 and beyond. These estimated General Revenue Funds amounts include expenditure of the higher Premium Co-payment, Experience Rebate, and Vendor Drug Rebates for CHIP collections.

It is estimated that there would be additional administrative costs of \$4.2 million All Funds in fiscal year 2008 (including \$1.2 million in General Revenue Funds). This includes one-time costs for system changes, technology work, and training and policy updates as well as changes

in variable fee payments for enrollment broker services and eligibility determination. In fiscal year 2009 and beyond administrative costs would be an additional \$3.8 million All Funds (including \$1.1 million in General Revenue Funds) for enrollment broker services and eligibility determination. HHSC indicates there would be no additional cost to implement the required community outreach campaign. HHSC also indicates there would be no additional cost from the income verification requirement in Section 4 as it does not represent a change from current policy. HHSC also indicates no additional administrative cost, other than that related to caseload, to implement the income review requirements in Section 5.

The total net cost of the bill would be \$94.7 million All Funds in fiscal year 2008 and \$140.2 million All Funds in fiscal year 2009 and subsequent years. These amounts include a net impact to General Revenue Funds of \$30.6 million in fiscal year 2008 and \$45.6 million in fiscal year 2009 and beyond. Also included are \$64.1 million in Federal Funds in fiscal year 2008 and \$94.5 million in fiscal year 2009 and beyond. It is assumed that these federal matching funds would be available; however, if the state exhausts its capped federal allotment, General Revenue Funds would be required in lieu of assumed Federal Funds.

Technology

Technology costs included above total \$1.3 million All Funds, including \$0.3 million in General Revenue Funds, in fiscal year 2008 for one-time costs associated with system changes.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission, 537 State Health Services,
Department of

LBB Staff: JOB, CT, SD, CL, PP, LR

BILL ANALYSIS

C.S.H.B. 109
By: Turner
Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The Children's Health Insurance Program (CHIP) was first established in 1999 during the 76th Legislative Session. This program was created to provide primary and preventative health care to low-income, uninsured children across the state. Under current law, CHIP contains a number of requirements for eligibility which have strained working families who were unable to participate.

The purpose of C.S.H.B. 109 is to increase enrollment in and public awareness of the Children's Health Insurance Program. As of February 2007, CHIP served 325,479 kids; there are approximately 700,000 children that are eligible, but not currently enrolled in CHIP. Texas is 25,653 below budgeted CHIP caseloads for Fiscal Year 2007.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 109 amends the Health and Safety Code by defining "net family income" and allowing for reduction for offsets for child care expenses when determining eligibility. The bill further amends the code to define income eligibility levels for the child health plan program by net family income rather than gross family income.

The bill requires the Health and Human Services Commission (Commission) to conduct a community outreach and education campaign that promotes enrollment in, and minimizes duplication of effort among, all state-administered child health programs. The information must include outreach efforts involving school-based health clinics and a toll-free number through which families may obtain information about health benefits coverage for children. Requires the commission to contract with community-based organizations or coalitions of the like to implement the community outreach campaign. The bill requires the commission to procure the contracts through a process designed by the commission to encourage broad participation of organizations. Authorizes the commission to direct that the Department of State Health Services perform all or part of the campaign.

The bill provides that eligibility standards adopted under Section 62.101 (b) must allow a family to own at least \$10,000 in allowable assets. In calculating allowable assets, the eligibility standards may not consider the value of a first vehicle that qualifies for exemption under commission rule based on use. The value of a second or subsequent vehicle that qualifies for an exemption under commission rule based on use may not be considered if the vehicle is worth \$18,000 or less or if it has been modified to provide transportation for a household member with a disability. If no vehicle qualifies for an exemption based on its use under commission rule, the first \$18,000 of value of the highest valued vehicle may not be considered. The first \$7,500 of any vehicle not described above may not be considered.

The bill requires the commission to continue employing methods of verifying net income of the individuals considered in the calculation of an applicant's net family income. Extends the period during which an individual remains eligible for coverage under the child health plan from six months after eligibility determination to the end of a period, not to exceed 12 months, following the date of the eligibility determination or the individual's 19th birthday. The bill eliminates the 90-day new enrollee waiting period, unless the child was previously covered under another health benefits plan.

C.S.H.B. 109 80(R)

EFFECTIVE DATE

This Act takes effect immediately if it receives a vote of two-thirds or on September 1, 2007 should it not receive the necessary vote.

COMPARISON OF ORIGINAL TO SUBSTITUTE

The original bill allowed for the deduction of work-related expenses when calculating net family income whereas the substitute does not. The original bill eliminated the authority of the Health and Human Services Commission (Commission) to establish eligibility standards for allowable assets for a family whose gross family income is above 150 percent of the federal poverty level, whereas the substitute bill leaves these standards intact while increasing both the value of allowable assets and the value of exemptions for primary and subsequent vehicles. The substitute requires the commission to continue employing methods of verifying net income of the individuals considered in the calculation of an applicant's net family income.

BILL ANALYSIS

Senate Research Center
80R20624 JTS-D

C.S.H.B. 109
By: Turner et al. (Averitt)
Finance
5/18/2007
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Children's Health Insurance Program (CHIP) was created in 1999 by S.B. 445 with bipartisan support in the Texas Legislature to provide primary and preventative care such as immunizations, wellness exams, eye exams, and dental check-ups to the millions of children who do not have private health insurance or who do not qualify for Medicaid. At its peak, in 2002, CHIP served more than 525,000 children (529,211 in May 2002) and Texas was lauded nationally for the success of the program. As of January 2007, CHIP is serving only 321,815 children when there are 1.4 million children in the state of Texas lacking health care coverage. Out of those children, there are over 700,000 children that are currently eligible but not currently enrolled in CHIP.

Currently, Texas is 18,000 children below CHIP budgeted caseloads for 2006. The statewide disenrollment rate for CHIP has climbed from 3.4 percent in September 2003 to 12.2 percent in April 2006, indicating enrollment trends that will continue to drop unless action is taken now to allow families eligible for CHIP greater access and coverage of this vital program. It has been reported that children without health insurance are 25 percent more likely to miss school because of illnesses, and school districts in Texas lost \$4 million per day in funding because of absenteeism.

C.S.H.B. 109 reinstates 12 months of continuous coverage instead of six months, and reinstates "income disregards" expenses that drop a family's income to the eligibility level, such as child care expenses or work related expenses. This bill will also eliminate the assets test, and will reinstate a community outreach and education campaign to utilize school-based health clinics, community based organizations and coalitions to provide information and educate the community on CHIP, and eliminate the 90-day waiting period during all stages of the application process, unless the child was previously covered under another health benefits plan.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 62.002(4), Health and Safety Code, by defining "net family income" rather than "gross family income."

SECTION 2. Amends Subchapter B, Chapter 62, Health and Safety Code, by adding Section 62.056, as follows:

Sec. 62.056. COMMUNITY OUTREACH CAMPAIGN; TOLL-FREE HOTLINE. (a) Requires the Health and Human Services Commission (HHSC) to conduct a community outreach and education campaign (campaign) to provide information regarding the availability of health benefits for children. Requires HHSC to conduct the campaign so that enrollment is promoted and duplication of effort among state-administered child health programs is minimized.

(b) Requires the campaign to include outreach efforts that involve school-based health clinics, a toll-free telephone number to provide information about health benefits coverage for children to families, and information regarding the

importance of each conservator of a child promptly informing the other conservator of the child about the child's health benefits coverage.

(c) Requires HHSC to contract with community-based organizations or coalitions of community-based organizations to implement the campaign. Requires HHSC to promote and encourage voluntary efforts to implement the campaign. Requires HHSC to procure the contracts through a process designed by HHSC to encourage the broad participation of organizations, including those that target populations with high levels of uninsured children.

(d) Authorizes HHSC to direct the Department of State Health Services to perform all or part of the campaign.

(e) Requires HHSC to ensure that the information provided under this section is available in both English and Spanish.

SECTION 3. Amends Section 62.101, Health and Safety Code, by amending Subsection (b) and adding Subsection (b-1), as follows:

(b) Makes conforming changes.

(b-1) Requires the eligibility standards adopted under Subsection (b) related to allowable assets to allow a family to own at least \$10,000 in allowable assets and prohibits the eligibility standards from considering the value of certain vehicles.

SECTION 4. Amends Subchapter C, Chapter 62, Health and Safety Code, by adding Section 62.1011, as follows:

Sec. 62.1011. VERIFICATION OF INCOME. Requires HHSC to continue employing methods of verifying the net income of the individuals considered in the calculation of an applicant's net family income. Requires HHSC to verify income under this section unless the applicant reports a net family income that exceeds the income eligibility level established under Section 62.101(b).

SECTION 5. Amends Section 62.102, Health and Safety Code, as follows:

Sec. 62.102. CONTINUOUS COVERAGE. (a) Increases the period of time an individual is eligible to receive benefits under the child health plan from six months to a period not to exceed 12 months, beginning on the first day of the month, subject to a review under Subsection (b).

(b) Requires HHSC, during the sixth month following the date of initial enrollment or reenrollment of an individual whose family income exceeds 150 percent of the federal poverty level, to review the individual's family income, authorizing HHSC to use electronic technology if available and appropriate, and to continue to provide coverage if the individual's family income remains within the income eligibility limits prescribed by this chapter (eligibility limits).

(c) Prohibits the commission from disenrolling the individual if HHSC determines during the review required under Subsection (b) that the individual's family income exceeds eligibility limits until HHSC has provided the family an opportunity to demonstrate that the family's family income is within the eligibility limits and the family fails to demonstrate such eligibility.

(d) Requires HHSC to provide written notice of termination of eligibility to the individual not later than the 30th day before the date the individual's eligibility terminates.

SECTION 6. Amends Sections 62.154(a) and (d), Health and Safety Code, by redesignating existing text as part of Subdivision (1). Requires the waiting period for coverage under the child health plan to extend for a period of 90 days after the last day the applicant was covered under a

health benefits plan and only apply to a child who was covered by a health benefits plan during the 90 days before the date of the application for the child health plan. Deletes existing text specifying when coverage under the child health begins for applicants after the waiting period. Makes nonsubstantive changes.

SECTION 7. Effective date: upon passage or September 1, 2007.