HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 543 Medicaid Eligibility
SPONSOR(S): Brown and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1522

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee		Walsh	Liem
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

HB 543 provides asset transfer limitations for determination of eligibility for nursing facility services under the Medicaid program.

The bill is effective July 1, 2005, unless the provisions are prohibited by federal law. If, by October 1, 2005, any provision has not taken effect because of federal prohibition, the Agency for Health Care Administration is required to request a waiver by January 1, 2006. The provisions of the act will take effect upon receipt of the waiver or other federal approval.

The fiscal impact of this bill is indeterminate.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote Personal Responsibility --- The bill seeks to reduce eligibility for Medicaid long-term care services by limiting the allowable types of asset transfers.

B. EFFECT OF PROPOSED CHANGES:

Background

Medicaid is a health care program that is jointly funded by the federal, state, and county governments to provide medical care to the nation's poorest citizens. To qualify, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of Federal parameters and State definitions.

In the last several years, reports have surfaced in the popular press of use of the Medicaid nursing home program by persons who would appear to be able to afford to pay for their own care.[1] This practice of Medicaid estate planning has been both lauded, as a necessary and legitimate part of long-term financial planning, and vilified, as an evasion of personal responsibility through use of loopholes in a government program intended to aid the needy.

The Department of Children and Families (DCF) administers the eligibility determination portion of the Medicaid program for the Agency for Health Care Administration (AHCA). The following is a discussion of the pertinent federal and state requirements relating to eligibility for Medicaid long-term care services.

TRANSFERS OF ASSETS

Federal law (42 U.S.C. 1396p(c)) requires states to withhold payment for various long term care services for individuals who dispose of assets for less than fair market value. The term "assets" includes both resources and income.

These provisions apply when assets are transferred by individuals in long-term care facilities or receiving home and community-based waiver services, or by their spouses, or someone else acting on their behalf.

States "look back" to find transfers of assets for 36 months prior to the date the individual is institutionalized or, if later, the date he or she applies for Medicaid. For certain trusts, this look back period extends to 60 months.

If a transfer of assets for less than fair market value is found, the state must withhold payment for nursing facility care (and certain other long term care services) for a period of time referred to as the penalty period.

The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the state. Example: A transferred asset worth $66,000, divided by a $3,300 average monthly private-pay rate, results in a 20-month penalty period. There is no limit to the length of the "penalty period."

For certain types of transfers, these penalties are not applied. The principal exceptions are:

- Transfers to a spouse, or to a third party for the sole benefit of the spouse.

[1] *See, e.g.*, *Getting Poor on Purpose; States Crack Down on Families that Shed Assets to Get Free Nursing-Home Care; Doing it Legally*, Wall Street Journal, February 25, 2003.

- Transfers by a spouse to a third party for the sole benefit of the spouse.
- Transfers to certain disabled individuals, or to trusts established for those individuals.
- Transfers for a purpose other than to qualify for Medicaid.
- Transfers where imposing a penalty would cause undue hardship.

Florida follows the federal law governing the transfer of assets. The federal law does not allow for states to apply a more stringent standard. A federal waiver would be necessary to apply a more stringent standard. Minnesota, Connecticut, and Massachusetts are seeking such a waiver.

SPOUSAL IMPOVERISHMENT

In 1988, Congress enacted 42 U.S.C. 1396r-5, to prevent what has come to be called "spousal impoverishment," which can leave the spouse who is still living at home in the community with little or no income or resources. The spousal impoverishment provisions apply when one member of a couple enters a nursing facility or other medical institution and is expected to remain there for at least 30 days.

When the couple applies for Medicaid, an assessment of their resources is made. The couple's resources, regardless of ownership, are combined. The couple's home, household goods, an automobile, and burial funds are not included in the couple's combined resources. The result is the couple's combined countable resources. This amount is then used to determine the spousal share, which is one-half of the couple's combined resources.

To determine whether the spouse residing in a medical facility meets the state's resource standard for Medicaid, the following procedure is used.

From the couple's combined countable resources, a Protected Resource Amount (PRA) is subtracted. The PRA is the greatest of:

- The spousal share, up to a maximum of $92,760 in 2004.
- The state spousal resource standard, which a state can set at any amount between $18,132 and $$92,760 in 2004.
- An amount transferred to the community spouse for her/his support as directed by a court order.
- An amount designated by a state hearing officer to raise the community spouse's protected resources up to the minimum monthly maintenance needs standard.

After the PRA is subtracted from the couple's combined countable resources, the remainder is considered available to the spouse residing in the medical institution as countable resources. If the amount of countable resources is below the state's resource standard, the individual is eligible for Medicaid. Once resource eligibility is determined, any resources belonging to the community spouse are no longer considered available to the spouse in the medical facility.

The community spouse's income is not considered available to the spouse who is in the medical facility, and the two individuals are not considered a couple for income eligibility purposes. The state uses the income eligibility standard for one person rather than two, and the standard income eligibility process for Medicaid is used.

The post-eligibility process is used to determine how much the spouse in the medical facility must contribute toward his/her cost of nursing facility/institutional care. This process also determines how much of the income of the spouse who is in the medical facility is actually protected for use by the community spouse.

The process starts by determining the total income of the spouse in the medical facility. From that spouse's total income, the following items are deducted:

- A personal needs allowance of at least $30.

- A community spouse's monthly income allowance (between $1515 and $2319 for 2004), as long as the income is actually made available to her/him.
- A family monthly income allowance, if there are other family members living in the household.
- An amount for medical expenses incurred by the spouse who is in the medical facility.

The community spouse's monthly income allowance is the amount of the institutionalized spouse's income that is actually made available to the community spouse. If the community spouse has income of his or her own, the amount of that income is deducted from the community spouse's monthly income allowance. Similarly, any income of family members, such as dependent children, is deducted from the family monthly income allowance.

Florida allows the community spouse to keep $92,760 of the couple's total resources. This is the federal maximum. Florida determines the community spouse income allowance by adding the federal minimum monthly maintenance needs allowance of $1515 with the excess shelter cost, which is the amount by which the community spouse's shelter costs exceeds $455 per month. Shelter costs may include rent or mortgage payment, homeowner's insurance, and a standard utility allowance of $198 per month. However, the total income allowance cannot exceed the federal maximum monthly maintenance needs allowance of $2,319.

Effect of Proposed Changes [This analysis is structured by line and section references for ease of review.]

In determining eligibility for nursing facility services under the Medicaid program, DCF shall apply the following asset transfer limitations effective for transfers made after October 1, 2005:

Lines 43-44 (s. (2)(a)1.)

All transfers of assets for less than fair market value are prohibited.

Lines 45-47 (s. (2)(a)2.)

Current federal law requires that transfers of assets for less than fair market value are subject to a look back period of 36 months for most transfers and 60 months for certain transfers to trusts when determining eligibility.

Lines 45-47 intend that all transfers for less than fair market value are subject to a 72 month look back period.

Lines 48-56 (s. (2)(a)3.)

Current federal law specifies that the penalty of non-payment for long term care begins in the month the assets are transferred.

This federal requirement allows individuals to transfer assets for less than fair market value, calculate the number of months of penalty that will result, and then keep only that much more in assets to pay for long term care during the penalty period. (Sometimes referred to as "half a loaf.")

Lines 48-56 require that the penalty period for applicants would start at the beginning of the month a person applies for medical assistance and is otherwise eligible. The penalty period for recipients would start at the beginning of the month the agencies become aware that the transfer was made. This would discourage use of half a loaf techniques.

Lines 57-61 (s. 2.(a)4.)

Current federal law permits transfers of homesteads for less than fair market value to specified relatives (adult children who provide physician-certified care for the person for at least two years in the person's home that kept him or her out of a long term care facility; spouses; siblings; minor children; or disabled children) without regard to whether the relative is in need of housing or resides in the homestead at the time of the transfer.

Lines 57-61 prohibit the transfer of the institutionalized person's interest in the homestead for less than fair market value to those specified relatives. However, it allows for the homestead to retain its status as an excluded asset during the period the relative actually lives in the home.

This parallels the federal law on medical assistance estate recovery, which prohibits recovery against the same group of relatives only if they are residing in the homestead at the time of probate.

Lines 62-66 (s. 2(a)5.)

Current federal law permits unrestricted transfers for less than fair market value by the institutionalized recipient to or for the benefit of the community spouse.

Lines 62-66 allow such transfers from the recipient only to the amount of the spousal impoverishment asset limits (currently approximately $95,000).

Examples of such transfers might be lottery winnings, inheritances, or lawsuit settlements. Lines 62-65 would require that assets acquired by or made available to the institutionalized recipient would first be spent on his or her long term care costs.

Lines 66-75 (s. 2(a)6.)

Current federal law does not prohibit the use of personal care contracts or provide guidelines to the states in determining their reasonableness. These agreements are designed to compensate individuals, often relatives, for the provision of certain services to the institutionalized recipient. The contracts are frequently structured to pay a lump sum amount in advance to the caregiver for services to be rendered during the institutionalized recipients' remaining lifetime; when the recipient dies, the caregiver retains the remaining value of the contract with no obligation to return the "unearned" funds to the estate. In addition, the services to be performed frequently are services that would ordinarily be performed by a relative out of love and affection or are duplications of services paid for by Medicaid.

Lines 66-75 prohibit the payment for care or personal services provided by a relative, unless: there is a notarized written agreement in place; the services directly benefit the person, are reasonably related to his or her health condition, and do not duplicate services provided by Medicaid; and the payments represent reasonable compensation for the services rendered.

Lines 76-99 (s. (2)(a)7.)

Current federal law does not prohibit the use of annuities. Guidelines to the states for determining the reasonableness of an annuity require use of life expectancy tables based on the anticipated life spans of "healthy" individuals (the SSI Tables), rather than the (much shorter) actual life expectancy of an already gravely-ill nursing home resident.

Annuities can be purchased which provide very low monthly income payments to the institutionalized recipient (low enough to maintain his or her Medicaid eligibility) and provide a large balloon payment at the end of the term, which is generally well after the recipient and his or her community spouse's death.

In addition, annuities can be purchased from companies that are unlicensed and unregulated (some so-called “internet annuities”).

Lines 76-89 prohibits the transfer of assets to an annuity that exceeds the benefit likely to be returned during the life of the (institutionalized recipient) annuitant or his or her spouse, using SSI Tables or a shorter life expectancy if the annuitant has a medical condition which would shorten his or her life and was diagnosed at the time of the annuity purchase. DCF may request and receive a physician’s statement, and if the life-shortening medical condition is verified, they are granted the authority to determine the expected value of the benefits based on the statement.

Lines 89-99 provide that the above standards apply to an annuity purchased after October 1, 2005. In addition, the annuity must be purchased from an insurance company or financial institution licensed or regulated in Florida or another state; or it must pay out principal and interest in equal monthly installments; or its payments must begin at the earliest possible date after annuitization.

Lines 100-102 (s. 2(b))

DCF is granted rulemaking authority to implement the section.

Lines 103-115

The bill is effective July 1, 2005, unless its provisions are prohibited by federal law. (These changes are all prohibited or require waiver authority.) If, by October 1, 2005, any provision has not taken effect because of federal prohibition, AHCA is required to request a waiver by January 1, 2006.
The provisions of the act will take effect upon receipt of the waiver or other federal approval. To effectuate the change, notice must be given to the Secretary of State and published in the Florida Administrative Weekly; no further legislative action is necessary.

C. SECTION DIRECTORY:

Section 1: Amends s. 409.902, F.S.; provides asset transfer limitations for determination of eligibility for nursing facility services under the Medicaid program; provides DCF grant of rulemaking authority.

Section 2: Provides a contingent effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   It is expected that savings will accrue from the changes to eligibility for Medicaid long-term care services proposed in this bill. However, the level of savings is indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not apply to counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DCF is granted rulemaking authority to implement the provisions of the act.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Department of Children and Families notes that some of the language in the bill is unnecessary or overly regulatory without addressing the intended policy changes. It recommends significant amendments to the bill as filed.

The Agency for Health Care Administration notes that the proposed revisions to s. 409.902(2)(a), F.S., indicate that the provisions apply only to the determination of eligibility for nursing facility services. The current federal statute requires the application to eligibility determinations for Home and Community Based Services, institutional care for Hospice patients, as well as nursing facility services. In addition, the proposed revisions to s. 409.902(a)1, F.S., indicate that all transfers without fair compensation are prohibited. It is not clear if the intent of this paragraph is to eliminate the exclusions from the transfer penalty as prescribed in Section 1917 (c) (2) of the Social Security Act. The Agency recommends significant amendment to the bill as filed.

The Florida Health Care Association expressed concern that beginning the penalty period at the time of application for services would have unintended financial consequences for nursing homes. The Association recommends an amendment to the bill to address this issue.

The Academy of Florida Elder Law Attorneys notes considerable concern with the bill. In general, the Academy believes that the transfer rules currently used are very effective in achieving the public policy of requiring individuals to pay privately for their care for a substantial period of time, while allowing a modest amount of resources to be preserved for items not otherwise covered by the Medicaid program. The Academy states that the proposed legislation is both demeaning to the elderly and unnecessary. The Academy also notes that because the effective date of this statute is prospective, the more prudent position would be to wait until the state obtains the waiver it is requesting from the federal government and then write new legislation to codify those changes.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES