HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 543 CS 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	8 Y, 0 N, w/CS	Walsh	Liem
2) Health Care Appropriations Committee		Speir	Massengale
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

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

Although the amount cannot be determined, it is expected that savings or cost-avoidance to state, federal and local governments will occur from the changes to eligibility for Medicaid long-term care services proposed in this bill. The reimbursement for bad debt to nursing facilities, however, could offset some of the savings.

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.

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; for 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."

[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.

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.
- 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 $1,562 and $2,378 for 2005), 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 $95,100 (2005) 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 $1,562 (2005) with the excess shelter cost, which is the amount by which the community spouse's shelter costs exceeds $469 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 $2,378 (2005).

Effect of Proposed Changes

Lines 52–65 (subsection (2)(a)1.a)

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.

The bill requires that for transfers made on or after October 1, 2005, the Department of Children and Family Services (DCF) shall impose a penalty period for assets transferred for less than fair market value on the first day of the month of application for benefits. For those persons who are already receiving benefits, the penalty period begins on the first day of the month in which DCF becomes aware of the transfer or the first day of the month following a period of ineligibility for an earlier transfer.

Application of this provision would require a federal waiver. However, the federal Centers for Medicare and Medicaid Services (CMS) advises DCF that President Bush has included this issue in his 2006 Proposed Budget.[2]

Lines 66–84 (section 409.902(2)(a)1.b., F.S.)

The bill requires the Agency for Health Care Administration (AHCA) to amend the Medicaid State Plan to create a methodology to reimburse facilities for bad debts associated with their obligation to serve residents during the proposed period of ineligibility. Frequently, persons are admitted to long-term care facilities either as private pay patients or while Medicare coverage is in effect. In either case, however, it is before eligibility for Medicaid is established. Florida law imposes stringent requirements on how a facility may discharge a patient even in the face of non-payment for services.

[2] *Major Savings and Reforms in the President's 2006 Budget*, February 11, 2005, page 190-191.

The bill recognizes that the new penalty period may result in situations where persons, who are being served by facilities, have their Medicaid applications denied for a longer penalty period than under current standards. Accordingly, the bill requires AHCA to devise a method by which facilities may be reimbursed for any bad debts accruing from this new period of ineligibility. Those reimbursements are limited to the daily Medicaid payment rate, must be offset by collections from any other responsible party, and are limited to the period of ineligibility from the date of application to the date of discharge or eligibility, whichever is earlier. This payment methodology is in effect for a period of two years after a change in federal law or the waiver is approved. After that time, bad debts incurred during the period of ineligibility are to be deemed allowable bad debt, reportable on a facility's Medicaid cost report.

Lines 85–109 (section 409.902(2)(a)2., F.S.)

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.

The bill specifies that individuals who enter into personal services contracts which do not meet all the enumerated criteria will be considered to have transferred assets without fair compensation to qualify for Medicaid. DCF advises that the bill incorporates concepts and language in use by the state of Louisiana. This provision will not require a waiver or change to the federal requirements to implement.

Lines 110–116 (section 409.902(2)(a)3., F.S.)

Current federal law does not prohibit the use of financial instruments paying a monthly income stream with a final deferred, graduated or balloon payment, nor provide guidelines to the states to determine their reasonableness. Such instruments are designed to provide limited monthly income to the individual until some distant future date, at which time a large balloon or deferred payment representing the bulk of the asset transfer takes place. That distant date is generally past the end of the individual's life expectancy, resulting in the final payment going to the named beneficiary. Similar instruments transfer an individual's assets to a second party in the form of a loan, require minimal monthly repayments, then provide for forgiveness of the balance upon the individual's death.

The bill requires that those types of instruments, entered into during the look-back period, shall be considered a countable asset to the individual in the amount of the remaining value of the financial instrument. This provision will not require a federal waiver.

Lines 117–156 (section 409.902(2)(b), F.S.)

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 that 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).

The bill excludes an annuity as an asset for purposes of determining Medicaid eligibility when the following conditions are met:

- The annuity was purchased from an insurance company or financial institution licensed or regulated in Florida or another state.
- The annuity is irrevocable.
- The annuity pays out principal and interest in equal monthly installments and the principal is paid within the annuitant's life expectancy based on Social Security Administration life expectancy tables or a shorter life expectancy, if the annuitant has a condition that would shorten his or her life and that was diagnosed by a physician before the annuity was funded.
- The annuity names the state of Florida or AHCA as the beneficiary of any funds remaining in the annuity, not exceeding the amount of Medicaid funds paid on the annuitant's behalf during his or her lifetime; however, annuities for a community spouse who is not requested Medicaid services are an exception.

However, the income generated by the annuity becomes part of the recipient's patient responsibility and offsets Medicaid payments.

The bill further specifies that if all the conditions above are not met, the annuity's fair market value is counted as a resource with one exception. When the annuity does not provide for payout of principal and interest in equal installments over the annuitant's lifetime, and the issuing company indicates that the payout arrangement cannot be changed, then the annuity shall be excluded as a resource if the contract is amended to name the state of Florida as the beneficiary of any funds in the annuity to the amount of Medicaid benefits paid on the individual's behalf. These requirements would apply to those annuities purchased on or after October 1, 2005, and would not require federal waiver.

Lines 157–166 (section 409.902(2)(c), F.S.)

Under federal requirements, states first have the option to count resources or income when adjusting community spouse allowances. The bill requires that state hearing officers first consider all sources of income, including the income that would be available to a community spouse if the institutionalized spouse was determined Medicaid eligible, before raising the community spouse's asset or income allowance. This would not require a federal waiver.

Lines 170–185

The bill is effective July 1, 2005, unless its provisions are prohibited by federal law. 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.; adds subsection (2); 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. If the reimbursement for bad debt to nursing facilities does not receive federal approval, and therefore, federal match, then this bill would have a greater negative fiscal impact on state funds that cannot be determined at this time.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Because counties participate in the cost of nursing facility care for the Medicaid program, shifting the cost, or some portion thereof, to the resident could result in savings or cost-avoidance to the counties.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Nursing facilities would be reimbursed for bad debt incurred as the result of the obligation to care for residents without payment during the period of Medicaid ineligibility.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to take an action requiring the expenditure of funds, does not reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

Because the reimbursement to nursing facilities for bad debt as the result of the obligation to care for residents without payment during the period of Medicaid ineligibility may not receive federal approval or federal match, the cost to the state would be greater. The Health Care Appropriations Committee recommends that the reimbursement be contingent upon federal approval.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its March 30, 2005, meeting, the Committee on Elder & Long-Term Care adopted a committee substitute to House Bill 543, which significantly changed the bill as filed. The committee substitute does the following:

- Changes the beginning month of the penalty period for transferring assets to become Medicaid eligible from the month of the transfer to the first month in which the individual applies for medical assistance and is otherwise Medicaid eligible.
- Requires AHCA to develop a payment methodology by which facilities would be reimbursed for the bad debt arising from the cost of care for those persons already in the facility that are determined ineligible for Medicaid due to penalty period beginning at time of application.
- Provides criteria for personal services contracts for exclusion as assets for Medicaid eligibility purposes.
- Limits the conditions under which funds can be transferred into instruments that defer, delay or eliminate compensation and still be excluded as assets for Medicaid eligibility purposes.
- Provides criteria for fair compensation and accountability for annuities purchased within the transfer look-back period.
- Requires that the state hearing officers consider all sources of income that would be available to a community spouse if the institutionalized spouse was determined Medicaid eligible before raising the community spouse's asset or income allowance.

This analysis is drafted to the committee substitute.