The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 1748
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Evers
SUBJECT:	Medicaid Nursing Home Eligibility
DATE:	April 16, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Hendon	CF	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			AP	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

CS/SB 1748 provides the Department of Children and Families (DCF) with authority to review financial transactions as part of its responsibility for determining an applicant's eligibility for Medicaid. The bill also directs the DCF to exempt the value of a life insurance policy, annuity, or group certificate that pays burial expenses when determining an applicant's eligibility for Medicaid. The exclusion applies only to instruments covering burial expenses with a face value of up to $12,500 which name the state as beneficiary for payment amounts that exceed final burial costs.

The bill has an estimated negative fiscal impact on the Agency for Health Care Administration of at least $126,647 of general revenue. See Section V.

The bill has an effective date of July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 409.902 and 409.9022.

II. Present Situation:

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.3 million people in Florida, with over half of those being children and adolescents 20 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost.[1] Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

In Florida, the program is administered by the Agency for Health Care Administration (AHCA). AHCA delegates certain functions to other state agencies, including the DCF, the Agency for Persons with Disabilities (APD), and the Department of Elder Affairs (DOEA). AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services. The DCF is responsible for determining financial eligibility for Medicaid recipients. The APD operates one of the larger waiver programs under Medicaid – the Home and Community Based Waiver program serving individuals with disabilities. The DOEA assesses Medicaid recipients to determine if they require nursing home care. Specifically, an individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires care to be performed on a daily basis under the direct supervision of a health professional of medically complex services because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

The Medicaid eligibility income threshold for institutional care placement, home and community based care services, and hospice services, is 300 percent of the Supplemental Security Income (SSI) federal benefit rate.[2] The current SSI federal benefit rate is $710 for an individual.[3] Thus, individuals with incomes under $2,130 per month are eligible for Medicaid long-term care services.[4]

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[1] For the 2012-13 state fiscal year, the federal government pays 57.73 percent of the costs for Medicaid benefits provided in Florida.
[2] Rule 65A-1.713(1)(d), F.A.C.
[3] Social Security Administration, *SSI Federal Payment Amounts for 2013, available at* http://www.ssa.gov/oact/cola/SSI.html (last visited April 10, 2013).
[4] Fla. Dep't. of Children and Families, *SSI-Related Programs Fact Sheets* (April 2013), *available at* http://www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf (last visited April 10, 2013).

The February 25, 2013, Social Services Estimating Conference (SSEC) estimated that expenditures for Medicaid for the 2012-2013 fiscal year would be $20.77 billion, including $4.75 billion expended on Medicaid long-term care services.

Paying for Long-Term Care

Floridians who need nursing home care but do not qualify for Medicaid must pay for their care privately or through insurance. According to the 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, the national average annual cost of a nursing home was $78,110 for a semi-private room in 2011. Individuals who need nursing home care may be ineligible for Medicaid because of their financial assets and/or monthly income. Many individuals paying privately for nursing home care spend their assets and then become eligible for Medicaid. Some, however, have monthly income from pensions and other sources that prevent them from becoming eligible for Medicaid.

Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are not countable when Medicaid eligibility is determined. Elder law attorneys across the country actively advertise services to assist elderly individuals with personal service contracts and other asset protection methods.

According to the DCF, some individuals, prior to entering a nursing facility or enrolling in a Medicaid home and community based service waiver program, transfer accumulated assets to a relative through a contract under which the relative will provide personal services to the individual for a specified period of time while receiving all or most of the contracted payment in advance, leaving the individual with an amount of assets low enough for Medicaid eligibility. Current DCF policy does not preclude such personal care contracts with relatives when determining Medicaid eligibility. If the contracts are for an amount significantly higher than rates typically paid for similar services, however, the individual may be attempting to shield assets in order to qualify for Medicaid. DCF indicates that many of the contracted services incorporated into the contracts are services that close relatives would normally provide without charge, such as visitation, transportation, entertainment, and oversight of medical care. Current law does not contain standards for these contracts or enable DCF to monitor or enforce them to ensure that contracted services are actually provided.[5]

Section 1924 of the Social Security Act contains provisions to prevent "spousal impoverishment," which can leave the spouse who is still living at home in the community with little or no income or resources.[6] When a couple applies for Medicaid, an assessment of the couple's resources is made and a protected resource amount is set aside for the community spouse and the remainder is considered available for the individual applying for Medicaid. This protected amount is known as the Community Spouse Resource Allowance (CSRA). An individual applying for Medicaid cannot be determined ineligible for assistance based on the assets of the individual's spouse when:

[5]Fla. Dep't of Children and Families, *Staff Analysis and Economic Impact- SB 1748* (on file with the Senate Committee on Children, Families, and Elder Affairs).
[6]42 U.S.C. 1396r-5(d).

- The applicant assigns his or her rights to support from the community spouse to the state;
- The applicant is physically or mentally unable to assign his right by the state has the right to bring a support proceeding against the community spouse; or
- The state determines the denial of eligibility would cause an undue hardship.[7]

While federal law provides states the authority to seek financial support from the community spouse under these circumstances, the DCF indicates that no mechanism to recover funds from the community spouse is available in current Florida law.[8]

Federal Deficit Reduction Act of 2005

The Federal Deficit Reduction Act of 2005 (DRA)[9] contained a number of provisions that were intended to discourage the use of planning techniques and transactions which are intended to protect wealth while enabling access to public benefits.

When an individual applies for Medicaid coverage for long-term care, DCF must conduct a review, or "look-back," to determine whether the individual (or his or her spouse) transferred assets to another person or party for less than fair market value (FMV). The DRA lengthened the "look-back period" to 60 months prior to the date the individual applied for Medicaid. When individuals transfer assets at less than FMV they are subject to a penalty that delays the date they can qualify to receive Medicaid long-term care services. Previously the penalty period began with the month the assets were transferred, which created an opportunity for individuals to avoid part or all of a penalty by transferring assets months or years before they actually entered a nursing home. Under the DRA, the penalty period now begins on either the date of the asset transfer, or the date the individual enters a nursing home and is found eligible for coverage of institutional level services that Medicaid would pay for were it not for the imposition of a transfer penalty – whichever is later.[10]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) is responsible for regulating all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, solvency, viatical settlements, and premium financing.[11]

Life Insurance

Life insurance is a contract between the owner of a policy and an insurer whereby the insurer agrees, in return for premium payments, to pay a specified sum (the face value or maturity value of the policy) to the designated beneficiary upon the death of the insured. For a whole life insurance policy, premiums are collected during the life of the insured, with a payout occurring

[7] 42 U.S.C. 1396r-(5)(c)(3)(C).
[8] *See supra* note 6.
[9] Pub. Law No. 109-171, S.1932, 109th Cong. (Feb. 8, 2006).
[10] Dep't. of Health and Human Services, Centers for Medicaid and Medicare Services, *Important Facts for State Policymakers Deficit Reduction Act*, (January 8, 2008), *available at* http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/TOAbackgrounder.pdf (last visited April 10, 2013).
[11] Section 20.121(3)(a), F.S.

at the death of the insured. The premium for whole life insurance remains the same throughout the life of the policy, in large part because the policy accumulates a "dividend" cash value, which permits the insurance company to maintain the same premium level year after year. The insured can also withdraw or borrow against the cash value accumulated by the policy. Some policies will pay a portion (lump sum or monthly payments) of the death benefits for a policy before death occurs if the policyholder is diagnosed with a terminal illness or catastrophic illness, or is confined to a nursing home. Upon the death of the insured, the beneficiary receives the remainder of the death benefits. The insurer may charge a fee for the accelerated benefits.

Life insurance forms and rates are subject to approval by OIR.[12] The OIR has adopted rules relating to the advertisement and disclosure of benefits, limitations, and exclusions of policies sold as life insurance to assure that product descriptions are presented in a manner that prevents unfair, deceptive, and misleading advertising and is conducive to accurate presentations.[13]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 409.902, F.S., relating to eligibility for Medicaid, to provide that the DCF's responsibility for Medicaid eligibility determinations includes "reviewing financial transactions affecting eligibility."

Section 2 of the bill amends s. 409.9022, F.S., and directs the DCF, notwithstanding any other provision of law, to exempt the value of a life insurance policy, annuity, or group certificate that pays burial expenses, when determining an applicant's eligibility for Medicaid. The exclusion applies only to an instrument covering burial expenses with a face value of up to $12,500 which irrevocably names the state as beneficiary for benefit amounts that exceed final burial costs, up to the amount of Medicaid expenditures paid by the state on behalf of the policyholder. The bill directs the state to seek federal authority, if necessary, to implement these provisions. The bill also makes technical changes, substituting "Department of Children and Families" in place of "Department of Children and Family Services" where the term appears in this section of statute.

Section 3 provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[12] Section 627.410, F.S.
[13] Chapter 69O-150 F.A.C.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under the bill, individuals who purchase a life insurance policy, an annuity, or group certificate with a face value of up to $12,500 to pay exclusively for their burial expenses will not be determined ineligible for Medicaid due to the value of the coverage.

C. Government Sector Impact:

By exempting the value of a life insurance policy, annuity, or group certificate to pay for burial expenses in determining an applicant's Medicaid eligibility, the bill could result in additional individuals qualifying for Medicaid, which would increase the program's utilization and costs. The potential extent of that effect is indeterminate.

Because of the requirement that the burial coverage must name the state as the beneficiary of proceeds that exceed the final burial expenses, up to the amount of Medicaid assistance provided to the policyholder, the bill would require the AHCA to track and, in some cases, collect, on life insurance benefits. For similar provisions contained in CS/SB 794, the AHCA indicates a need for $126,647 of general revenue and $126,647 from the Medical Care Trust Fund to perform this function.

Additionally, the DCF would need to make programming changes to its Medicaid eligibility system to capture additional life insurance information to be used for eligibility determination. The potential costs for those programming changes have not been determined.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The intent and effect of the provision in Section 1 of the bill that the DCF's responsibility for Medicaid eligibility determinations will include "reviewing financial transactions affecting eligibility," are unclear. The bill does not define "financial transactions" nor does it specify how the DCF should use information gathered during the review of an applicant's financial transactions in its determination of Medicaid eligibility.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on April 15, 2013:

The CS:

- Removes the original bill text, which limited the use of personal services contracts for individuals applying for Medicaid long-term care services and provided DCF with authority to recover long-term care costs from the spouse of a Medicaid recipient who has assigned his or her right to the state.
- Provides DCF authority to review financial transactions made by an applicant for Medicaid that might affect eligibility.

B. Amendments:

None.