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 Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 794
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Brandes
SUBJECT:	Medicaid Eligibility
DATE:	March 6, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hendon	Hendon	CF	**Fav/CS**
2.			HP	
3.			AHS	
4.			AP	
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 794 allows the Department of Children and Families to not consider the value of an applicant's life insurance policy in determining eligibility for Medicaid if the applicant names the state as a beneficiary. The state would only be the beneficiary for an amount up to the cost of the applicant's care. This would make more people eligible for Medicaid, and specifically nursing home care, but would recover the cost of that care through a person's life insurance benefit. This would result in more people being able to afford nursing home care.

This bill is expected to have a fiscal impact on the state and has an effective date of October 1, 2013.

This bill creates section 409.995 of the Florida Statutes.

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. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services or CMS. The 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 Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elder Affairs. AHCA has overall responsibility for the program and qualifies providers, set payment levels, and pays for services. The Department of Children and Families is responsible for determining financial eligibility for Medicaid recipients. The Agency for Persons with Disabilities operates one of the larger waiver programs under Medicaid, the Home and Community Based Waiver program serving individuals with disabilities. The Department of Elder Affairs 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 February 25, 2013 Social Services Estimating Conference estimated that expenditures for Medicaid for FY 2012-2013 would be $20.77 billion. One of the most important and expensive components of Medicaid is long-term care. The conference estimated that $4.75 billion will be spent on long-term care under Medicaid in FY 2012-2013.

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds 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 cost of a nursing home was $78,110 per year for a semi-private room in 2011. Persons needing nursing home care are determined to be eligible for Medicaid based on financial assets and monthly income. Many persons 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. The value of any life insurance policy more than $2,500 is considered an asset would make such persons ineligible for Medicaid.

Long-Term Managed Care

In 2011, the Legislature passed and the Governor signed into law HB 7107 (Chapter 2011-134, L.O.F.) to increase the use of managed care in Medicaid. The law requires both long-term care services and other Medicaid services to be provided through managed care plans. Long-term Care Managed Care component of the law will be implemented first. Implementation of the program began July 1, 2012 with full implementation by October 1, 2013.

AHCA has chosen the plans that may participate in the program through a competitive bid process. AHCA considered many factors when choosing plans. AHCA chose a certain number of long-term care managed care plans for each region to ensure that enrollees in the program to ensure that recipients have a choice between plans. After AHCA has chosen the plans that may participate in the Florida Long-Term Care Managed Care Program, AHCA will begin to notify and transition eligible Medicaid recipients into the program. It is anticipated that the Florida Long-Term Care Managed Program will be available in certain areas of the State beginning the first quarter of 2013 and will be in all areas by October 1, 2013.

Participating managed care plans are required to provide minimum benefits that include nursing home as well as home and community based services. Plans will be free to customize and offer additional serves. The minimum benefits include:

- Nursing home
- Services provided in assisted living facilities
- Hospice
- Adult day care
- Medical equipment and supplies, including incontinence supplies
- Personal care
- Home accessibility adaptation
- Behavior management
- Home delivered meals
- Case management
- Therapies: physical, respiratory, speech, and occupational
- Intermittent and skilled nursing
- Medication administration
- Medication management
- Nutritional assessment and risk reduction
- Caregiver training
- Respite care
- Transportation
- Personal emergency response system

On February 1, 2013, the Federal Centers for Medicare and Medicaid Services, approved AHCA's request for a Home and Community Based Care Services waiver for individuals 65 and older and individuals with physical disabilities ages 18 through 64 years old. This approval will allow Florida to implement managed care for long-term care services under Medicaid.

Federal Deficit Reduction Act of 2005

The Federal Deficit Reduction Act of 2005[1] limits Medicaid payments for long-term care services for persons who transfer assets for less than fair market value (FMV) within a specified look back period of 60 months calculated from the date of the Medicaid application. As a result, when an individual applies for Medicaid long-term care, states conduct a review, or "look-back," to determine whether the individual (or his or her spouse, if married) transferred assets to another person or party and, if so, whether the transfer was for less than FMV.[2] If a transfer of assets for less than FMV is determined, the individual is ineligible for Medicaid coverage for long-term care for a period, called the penalty period. The penalty period is calculated by dividing the dollar amount of the assets transferred by the average monthly private-pay rate for nursing home care in the state (or the community, at the option of the state). For example, if an individual transferred $12,000 in assets, and private facility costs averaged $6,000 per month in the state, the penalty period would be 2 months. Federal law exempts certain transfers for less than FMV from the penalty provisions even if they are made within the look-back period. Transfers do not result in a penalty if the individual can demonstrate to the state that the transfer was made exclusively for purposes other than qualifying for Medicaid.[3]

In regard to insurance products, for example, states are required to treat the purchase of an annuity as a transfer for less than fair market value unless the annuity meets certain conditions.[4] Annuities purchased by or on behalf of an individual who applied for Medicaid long-term care services that are considered as individual retirement accounts or purchased with the proceeds of certain retirement accounts and meet certain federal tax code requirements are not considered transfers for less than FMV.

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.[5]

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[1] Pub. Law No. 109-171, S.1932, 109th Cong. (Feb. 8, 2006).

[2] Federal law requires states to apply the transfer of asset provisions to institutionalized individuals, who are defined in the Social Security Act as individuals who are inpatients in a nursing facility or a similar institution or certain recipients of home and community-based services. See Social Security Act § 1917(e)(3). States have the option to apply such provisions to noninstitutionalized individuals.

[3] General Accounting Office, *Medicaid and Long-Term Care, Few Assets Transferred before Applying for Nursing Home Coverage; Impact of Deficit Reduction Act on Eligibility Is Uncertain,* (GAO-07-280), March 2007.

[4] States are required to treat the purchase of an annuity as a transfer for less than FMV unless the annuity names the state as either (1) the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or (2) a remainder beneficiary in the second position after the community spouse or minor or disabled child. Annuities purchased by or on the behalf of an individual who applied for Medicaid coverage for long-term care would be treated as a transfer of assets for less than FMV unless the annuity is irrevocable, nonassignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

[5] Section 20.121(3)(a), F.S.

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 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.[6] 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.[7]

Viatical Settlements

In general, a viatical settlement transaction is an agreement under which the owner of a life insurance policy (viator) sells the policy to a viatical settlement provider (provider) in exchange for an up-front payment, which is generally less than the expected death benefit under the policy. Often, the insured has been diagnosed as terminally ill, and needs money for the payment of medical and living expenses. The viatical broker and the policyholder negotiate a price for the life insurance policy with the viatical provider. Usually, the negotiated price is represented as a percentage of the policy's death benefit. A viatical settlement transaction may only be completed using an independent third party-trustee or escrow agent. All proceeds of the viatical contract must be transferred within 3 business days after receiving from the issuer of the subject policy acknowledgment of the transfer, assignment, bequest, sale, or devise.

Rather than retaining the policy, the provider usually sells all or a part of the policy to one or more investors (viatical settlement purchasers). In return for providing funds, these investors receive the death benefit, or a proportionate share thereof, upon the death of the insured. ").

The Viatical Settlement Act[8] authorizes OIR to license and regulate viatical settlements. Florida law does not differentiate between viatical settlements and life settlements. The OIR is responsible for approving provider contracts and other related forms; conducting examinations and investigations; and taking administrative action against providers when sufficient cause is present. A violation of this act is an unfair trade practice under ss. 626.9521 and 626.9541, F.S.,

[6] Section 627.410, F.S.
[7] Chapter 69O-150 F.A.C.
[8] Part X, ch. 626, F.S.

and is subject to the penalties provided in the insurance code.[9] The OIR does not regulate the rates or amount paid as consideration for entry into a viatical settlement.[10]

Section 626.9913, F.S., requires viatical settlement providers to file with OIR annual audited financial statements prepared by independent certified public accountants. The viatical settlement provider is required to maintain a deposit of $100,000 in securities to ensure performance of its obligations to viators in the event of insolvency or the loss of its license. In addition, viatical settlement providers are required to use life expectancies obtained from registered life expectancy providers or be subject to suspension, revocation, or denial of their license. As part of the application process to be registered as a life expectancy provider, an applicant must provide a general description of the policies and procedures covering all life expectancy determination criteria and protocols. This includes a description of how the life expectancy provider ensures that the provider bases its determination of life expectancies on current data.

Accelerated Life Benefits Technical Advisory Workgroup

In the 2012 session, the legislature added proviso (specific appropriation 224) in the General Appropriations Act that required the Agency for Health Care Administration, in coordination with the Department of Children and Families and the Office of Insurance Regulation, to establish a technical advisory workgroup to examine methods to allow an insured under a life insurance policy or the contract holder of an annuity, to convert the policy or annuity to a long term care benefit. The workgroup was also to examine the feasibility and benefits of mandating life insurance companies to include an offer of accelerated death benefits as a means to fund long term care institutional services in their standard policies. The advisory workgroup included representatives from nursing home providers, life insurance companies, and life insurance agents. The agency submitted a report of findings and activities of the workgroup, including recommendations and proposed legislation January 15, 2013.

The workgroup recommended both a public and private model to allow the applicant to use the value of an in force life insurance policy to offset the costs of long-term care services. The public model leverages current state agencies and allows them to transfer the value of a life insurance contract to offset the cost of a long-term care confinement. The state acts as a fiduciary intermediary converting assets held in a life insurance contract to periodic payments offsetting the cost of long-term care confinement. Any applicant that meets the state nursing home level of care could qualify for this public model assistance. The workgroup proposed legislation to require that the assets of the life insurance contract are used solely to offset the cost of long-term care confinement with any residual value being returned to the original beneficiary of the life insurance contract. The workgroup pointed out that the disadvantage of the public model is its requirement of the state to become a fiduciary in the area of life insurance contracts. This would increase the workload of the Office of Insurance Regulation.

The private model would allow an applicant for Medicaid to be determined eligible even though they may own a life insurance contract which would otherwise disqualify them from eligibility.

[9] Section 626.9927(1), F.S.
[10] Section 626.9926, F.S.

This model would allow for a viatical settlement of a life insurance contract with payments to be used solely to provide Medicaid covered long-term care costs. The workgroup proposed legislation to use current viatical statutes and adds protections for the state and the viator (the owner of the life insurance contract who enters into a settlement arrangement for the sale of that contract). The protections for the state require the benefits of the viatication be used to offset the cost of long-term care confinement and provide additional safeguards for the Medicaid applicant.

III. Effect of Proposed Changes:

The bill creates s. 409.995, F.S., to allow the Department of Children and Families to disregard the value of a life insurance policy in determining an individual's eligibility for Medicaid if certain conditions are met. The value of a life insurance policy would be disregarded if an applicant makes an irrevocable election to designate the state as a beneficiary of the policy for an amount that is less than or equal to the cost of the Medicaid benefits provided plus any premiums or other costs incurred by the department. The applicant must make this election through an assignment to the state under a written agreement submitted to the issuing insurer of the policy or an irrevocable assignment of the ownership of the policy to the state.

Any designation is void if the application for Medicaid is not approved. The bill authorizes the state to pay the recipient's policy premium. The policy cannot be sold. Any death benefit in excess of the cost of the Medicaid benefits received will be paid to the named beneficiaries of the policy.

As an alternative to designating the state as beneficiary of a life insurance policy, the owner of a life insurance policy with a face value of more than $10,000 may enter into a viatical settlement contract that would provide payments to a health care provider, chosen by the viator, for the payment of Medicaid-covered long-term care services. The viatical settlement provider contract must comply with part X of ch. 626, F.S. Contracts, marketing materials, benefit projections, pricing methodologies, and valuation materials are subject to approval by the OIR. The OIR is required to conduct periodic market conduct examinations and financial audits of the viatical settlement providers.

The Department of Children and Families must provide notice of the two options as part of the application for Medicaid.

The Agency for Health Care Administration is required to seek any state plan amendments or federal waivers required to implement the bill.

The Department of Children and Families, the Agency for Health Care Administration, and the Office of Insurance Regulation may adopt rules to implement the bill.

The bill takes effect October 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Additional residents of Florida will be able to qualify for Medicaid for long-term care services. It is unknown at this time how many people will benefit from this bill. Persons named as beneficiaries of life insurance policies for persons qualifying for Medicaid under the provisions of this bill would see a reduced benefit paid by the policy.

Nursing homes in the state of Florida will be able to serve more Medicaid residents under the bill.

C. Government Sector Impact:

The bill will allow additional residents to qualify for Medicaid, which will increase utilization and costs. It is unclear whether the full costs of the care for these recipients would be recouped from the proceeds of their respective life insurance policies or viatical settlements.

The bill would however require programming changes to the state's Medicaid eligibility system, the FLORIDA system, maintained by the Department of Children and Families. See below for the cost of these changes.

The bill would require AHCA to track and collect on life insurance contracts. The bill would also require OIR to review and approve marketing materials, pricing and valuation methods or actuarial methodologies used in a viatical settlement. The bill requires OIR to periodic market conduct examinations and financial audits of each viatical settlement provider, which would require additional personnel and resources. Currently, s. 626.992, F.S., authorizes but does not require OIR to conduct periodic examinations and audits. In order to implement the bill, OIR would need to adopt rules, and modify the online I-file system to accommodate the newly required filings of rates and forms. The OIR would need additional personnel and other resources to implement the provisions of the bill.

Fiscal Impact	Fiscal Year 2013-14	
Agency	**FTE**	**Total**
Department of Children and Families – programming changes to the FLORIDA system		$614,000
Agency for Health Care Administration – to track and collect on life insurance contracts	4	$253,295
Office of Insurance Regulation	3	$131,320
Total	7	$998,615

VI. Technical Deficiencies:

Subsection 5 of the bill allows an owner of a life insurance policy to enter into a viatical settlement contract in exchange for payments to a health care provider chosen by the viator for the provision of Medicaid-covered long-term care services. The bill also provides that an attempt by any person to require the use of a specific long-term care provider is prohibited and constitutes an unfair trade practice under s. 626.9927, F.S. Effective 2013, Medicaid recipients will receive their long-term care services through the Statewide Medicaid Managed Care Long-term Care managed care program. The agency is responsible for the payment of Medicaid providers.

It is unclear whether part X of ch. 626, F.S. allows periodic payments under a viatical settlement. Section 626.9924(3), F.S., requires viatical settlement transactions to be completed only using an independent third party escrow agent or trustee, and that immediately upon receipt by the trustee or escrow agent of the documents to transfer the policy, the provider must escrow the funds. In addition, an advance or partial payment of the proceeds due under a viatical settlement contract may not be used to effect transfer of the subject policy. Section 626.9924(5), F.S., provides that the independent third-party trustee or escrow agent must transfer all proceeds of the viatical settlement contract within 3 business days after receiving from the issuer of the subject policy acknowledgement of the transfer, assignment, bequest, sale or devise. The failure of a viatical settlement provider to transfer proceeds as required by this subsection renders the viatical settlement contract and the transfer, assignment, bequest, sale or devise voidable.

The bill also provides for payments to the viator's estate upon the death of the viator. However, the viator is the owner of the policy and may not be the insured individual. Section 626.9911(14), F.S., defines a viator as the owner of a life insurance policy.

VII. Related Issues:

It is unclear whether a viatical settlement transaction would result in a transfer of assets for less than fair market thus triggering a penalty period.

As an alternative to designating the state as beneficiary of a life insurance policy, the bill would allow the owner of a life insurance policy with a face value of more than $10,000 may enter into a viatical settlement contract that would provide payments to a health care provider, chosen by the viator, for the payment of Medicaid-covered long-term care services. Long-term care services under Medicaid are paid to the provider through the state's fiscal intermediary. It would be

significant change in policy to allow private entities pay for Medicaid services on behalf of the state.

Section 5 of the bill provides that the owner of a policy with a face amount of $10,000 or more can sell the policy via a viatical settlement contract approved by the OIR in exchange for payments from the viatical settlement provider to a health services provider selected by the policy owner (viator). Part X of Ch. 626, F.S., does not address solvency requirements for viatical settlement providers other than to maintain a deposit of $100,000 with OIR. Currently, there are not reserve requirements to assure future periodic payments. According to the OIR, if the viatical settlement provider sells the policy to another party, the transaction is no longer regulated by OIR and future payments could not be assured. Under these circumstances, it is unclear what regulatory entity would monitor the funds to ensure that they are held in an irrevocable state or a federally insured account.

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 March 6, 2013:

- The committee substitute changed the effective date to October 1, 2013.

B. Amendments:

None.