SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 416

SPONSOR: Health, Aging and Long-Term Care Committee

SUBJECT: Medicaid

DATE: March 22, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Favorable/CS
2.			AHS	
3.			AP	
4.				
5.				

I. Summary:

The Committee Substitute for SB 416 increases the income level for the Medicaid Medically Needy Program; extends Medicaid coverage to certain disabled individuals during the 2-year waiting period for Medicare coverage; requires the Agency for Health Care Administration to establish a Medicaid Buy-In Program to enable disabled Medicaid recipients who increase their incomes by gainful employment to retain Medicaid coverage under certain circumstances; directs the Agency for Health Care Administration and the Department of Children and Family Services to seek federal approval for a simplified methodology to determine eligibility for certain applicants for the Medically Needy Program; and requires Medicaid to pay the 20 percent co-pay for anti-rejection drugs for individuals who have had organ transplants and who are eligible for both Medicaid and Medicare.

The bill amends ss. 409.904, 409.908 and 409.914, F.S.; creates s. 409.9045, F.S.; and creates an undesignated section of law.

II. Present Situation:

Medicaid and the Medically Needy Program

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The federal government, the state, and the counties jointly fund the program. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The Department of Children and Family Services (DCFS) is responsible for determining Medicaid eligibility and managing Medicaid eligibility policy, with approval of any changes by AHCA.

The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. Section 409.903, F.S., specifies categories of individuals who are required by federal law to be covered, if determined eligible, by the Medicaid Program (mandatory coverage groups). Section 409.904, F.S., specifies categories of individuals who the federal government gives state Medicaid programs the choice of covering (optional coverage groups).

Individuals who are elderly or disabled, whose incomes are under 100 percent of the Federal Poverty Level (FPL) are an optional coverage group eligible for Medicaid under s. 409.904(1), F.S. Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S. In the 1992 special session of the Legislature, proviso language in the amended General Appropriations Act reduced the Medicaid eligibility level for elderly and disabled persons from 100 percent FPL to 90 percent FPL.

The federal Medicaid law establishes a Medically Needy eligibility category that allows states to provide Medicaid to families and individuals who have more income than allowed for Medicaid eligibility under the other mandatory or optional categorical eligibility groups described in the Social Security Act, but who have significant health care expenses. The federal Omnibus Budget Reconciliation Act (OBRA) of 1981 amended the Social Security Act to allow states more flexibility in defining the term “medically needy” and permitted states to vary Medicaid services by eligibility group.

To become eligible for the Medically Needy Program, an individual must meet the categorical criteria for Medicaid, that is, be a low-income family with children; a caretaker relative or parent of a dependent child; a pregnant woman; a dependent child; or be aged, blind or disabled; and have incurred catastrophic medical expenses to the extent that income, after medical costs are deducted in the month in question, is reduced to $180 ($241 for a couple), and have assets which do not exceed $5,000 ($6,000 for a couple). Income and asset levels increase with family size. At the point in time each month that incurred medical expenses exceed the amount necessary to reduce gross income to $180, the individual becomes eligible for Medicaid for the remainder of that month only. A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of services in a skilled nursing facility or an intermediate care facility for the developmentally disabled, and home and community-based services.

The current Medically Needy income standard ($180) is set at 100 percent of the Aid to Families with Dependent Children (AFDC) program payment standard. A state may not base its Medically Needy income standard on a needs standard or a standard other than the AFDC payments standard that was in effect July 1996, however, the state may set the Medically Needy income level up to 133 1/3 percent of the AFDC standard in effect as of July 1996. In addition, the state may increase the standard in effect in July 1996 by the Consumer Price Index increases since that date.

Since the Medically Needy Program allows Medicaid coverage only for the days remaining in a month after the point in time during the month that the person has incurred medical expenses which reduce gross income to the Medically Needy income standard, each month the worker and the applicant must array unpaid medical bills and determine which bills are counted to gain eligibility. This process is particularly burdensome for applicants who have chronic conditions

and whose medical expenses show little variation. Since coverage lasts only until the end of the month, the eligibility process must be repeated each month that an individual desires to be on the program.

On October 31, 2000, the federal Department of Health and Human Services published, in the Federal Register, a Notice of Proposed Rulemaking regarding the Medically Needy Program. The proposed rules will allow states to use less restrictive methodologies in determining eligibility for the Medically Needy Program, allowing states to disregard portions of a person's income necessary to pay for food, clothing or housing.

The "Ticket to Work and Work Incentives Improvement Act of 1999"

The federal "Ticket to Work and Work Incentives Improvement Act of 1999" was signed into law on December 17, 1999. It allows states to provide Medicaid coverage to certain disabled persons who are transitioning from public assistance to gainful employment. The program will be phased in nationally over a three-year period beginning January 1, 2001.

Under the Act, effective October 1, 2000, states will have the option to provide Medicaid coverage to people ages 16-64 who are disabled but who are able to work. Under the program, states will have the option to permit working individuals to "buy-in" to Medicaid. If a state provides Medicaid coverage to individuals described above who return to work, the state may also opt to continue to provide coverage to certain individuals whose improved medical condition would otherwise make them ineligible.

Individuals covered under these options could "buy into" Medicaid coverage by paying premiums or other cost-sharing charges on a sliding fee scale based on an individual's income. The state would be required to make premium or other cost-sharing charges the same for both of these two new eligibility groups.

During the 2000 Legislative session SB 591 contained a requirement for the Agency for Health Care Administration to perform a cost and feasibility study of the implementation of the Ticket to Work and Work Incentives Act, and to report its findings to the Speaker of the House and President of the Senate.

Public input received at forums conducted as part of the study indicated strong support among persons with disabilities for access to medical care under Medicaid for disabled persons who can work. However, a survey of current working-age Medicaid recipients who are disabled as apart of the study suggested that participation in a buy-in program might be low. Few (less that 10 percent) disabled Medicaid recipients reported having turned down a job, refused a raise or refused working additional hours due to fear of losing Medicaid coverage. The study suggested that the fact that the majority of many working disabled Medicaid recipients worked less than 21 hours per week was due to their disabling conditions.

The study notes the difficulty in projecting the number of disabled individuals who might elect to participate in a Medicaid Buy-In Program. A survey of states which had similar buy-in programs indicated that enrollment was highly dependant on how the state defined the parameters of the program, particularly in terms of income and asset limitations. In the survey, Minnesota's buy-in

program had no income limitation and a liberal asset limitation, resulting in an enrollment of over 4,000 individuals. The other four states surveyed, which had income limitations, had a combined enrollment of about 800 individuals.

The study concludes "that there are persons with disabilities in Florida who would be encouraged to enter or re-enter the workforce if they were able to maintain their Medicaid health care coverage through a Medicaid 'Buy-In' program and that benefits would accrue to both the individual participant and the state."

SSI and OSDI Disability Programs, Medicaid and Medicare

Individuals who are disabled may be eligible for federal economic assistance under either the Supplemental Security Income program (SSI) or the Social Security Disability Insurance (SSDI) program. For most people, the medical requirements for disability payments are the same under both programs and the same process determines a person's disability. Individuals eligible for SSI economic assistance also automatically receive Medicaid coverage. SSI cash payments are based on an individual's economic need, but do not exceed $512 per month. For Medicaid purposes, a spouse or parent's income is deemed to be available to an applicant. If the total family income exceeds the SSI standard, the individual is ineligible for SSI, but may qualify for the Medical Assistance Only eligibility group (MEDS-A/D), which provides Medicaid only, with no cash assistance. The MEDS-A/D income limit was set at 100 percent FPL in Florida until 1992, when the limit was reduced to 90 percent FPL ($627 per month for an individual, $844 per month for a family) in proviso language in the General Appropriations Act in the special session of the Legislature. Individuals over these income limits are ineligible for Medicaid, leaving the Medically Needy Program as the only option available to gain medical assistance.

Individuals who have enough creditable quarters of work experience and who become disabled may be eligible for SSDI. To be eligible for SSDI a person must have worked and paid Social Security taxes, be medically disabled and wait five calendar months to receive benefits after having been determined eligible.

Individuals who are receiving SSDI do not receive Medicaid (unless their disability benefit is below the SSI or MEDS-A/D income standard) but are eligible to receive Medicare after a two-year waiting period. Cash benefits an individual will receive under Social Security Disability Insurance are based on an individual's work history and wages. If an individual has end-stage renal disease, there is no two-year waiting period for Medicare.

Surviving the two-year Medicare waiting period often represents a major challenge for individuals on Social Security Disability Insurance. Due to the disabling condition, these individuals often have higher medical expenses, and few resources to meet these expenses. Since the Medically Needy Program requires, prior to eligibility, that the individual have incurred medical expenses that consume all but $180 of monthly income, nearly all of an individual's SSDI income must be spent on medical expenses in order to gain Medicaid coverage.

If and individual is eligible for both Medicaid and Medicare, Medicare is the primary payer for health services. Services which are not covered benefits under Medicare are reimbursable by Medicaid, if the care rendered is a Medicaid-covered service by a Medicaid-enrolled provider. In

the instance of a service, which is covered by both Medicaid and Medicare, if Medicare's payment rate is less than the Medicaid rate, Medicaid will reimburse up to the Medicaid payment limit.

Medicare does not pay for prescribed drugs, except in certain circumstances. One of these instances is anti-rejection drugs for individuals who have had organ transplants, in which case Medicare will reimburse for these drugs for two years with a 20 percent co-pay required on the part of the Medicare beneficiary. If an individual is dually eligible for Medicare and Medicaid, Medicaid will pay pharmacies for the difference between the Medicare payment rate, and the Medicaid cost of the drug, but will not pay the required Medicare 20 percent co-payment.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.904, F.S., to increase the Medically Needy income limit to 133 1/3 percent of the Temporary Assistance to Needy Families (TANF), formerly AFDC, standard. This change will increase the income individuals applying for the Medically Needy Program may retain for food, shelter and clothing from the current $180 per month ($241 for a couple) to $241 per month ($321 per couple). Beginning July 1, 2002, this amount will increase annually by the amount of the consumer price index.

Section 2. Creates s. 409.9045, F.S., to extend Medicaid coverage to individuals who are receiving payments under the Social Security Disability Insurance program during the 2-year waiting period for Medicare. The agency is directed to seek federal waivers necessary to earn federal matching funds for these services.

Section 3. Amends s. 409.914, F.S., to delete obsolete language applying to the Florida Health Security Program, and require the Agency for Health Care Administration to establish a Medicaid Buy-In Program for disabled Medicaid recipients who increase their income due to employment. The program is limited to individuals who have been on Medicaid for at least 6 months. The agency is required to determine program parameters including cost-sharing requirements, managed care provisions, and other systems to operate the program. The agency is permitted to apply for necessary waivers to ensure that the program operates within existing general revenue and is limited to individuals who would otherwise remain unemployed and on Medicaid.

Section 4. Clarifies that it is the intent of the Legislature to simplify the eligibility process of the Medically Needy Program and directs the Agency for Health Care Administration and the Department of Children and Family Services to seek federal approval to use projected medical expenses for 6 months based on expenses of the prior 6 months for individuals with chronic conditions. The applicant's physician must certify that the individual suffers from a chronic condition and that the medical expenses are likely to remain constant.

Section 5. Amends s. 409.908, F.S., to require Medicaid to pay the 20% Medicare co-pay on medications which are medically necessary for organ transplant recipients to prevent rejection of transplanted organs and to add these drugs to the list of services for which Medicaid will pay up to the Medicare payment limit.

Section 6. The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Implementation of the Medicaid Buy-In Program will allow disabled individuals to seek employment and give employers access to a larger pool of potential employees.

Exempting anti-rejection drugs for dually-eligible organ transplant recipients from the Medicaid upper payment limit will increase revenues to pharmacies.

C. Government Sector Impact:

The Agency for Health Care Administration, in its fiscal analysis of the bill, estimated that the cost of raising the Medically Needy Income Limit would be $15,776,700, based on the assumption that the increase would result in a shift in payment of costs of $60 from a recipient's share of cost to an additional amount Medicaid would pay.

The feasibility study for the Medicaid Buy-In Program states that estimating the cost of implementing the buy-in is difficult, since there is no data on the number of current Medicaid recipients who would become employed due to the presence of the program. In developing the fiscal impact analysis for the study, the Agency assumed that the program would increase Medicaid caseload by 1,500 individuals in Florida for a first-year fiscal impact of approximately $8.1 million. In addition, the feasibility study recommended more liberal asset allowances than allowed under the current Medicaid Program, and recommended that Medicaid Buy-In participants not be charged premiums for participation.

This bill, however, requires the Buy-In Program to be available only to existing Medicaid recipients who increase their incomes due to increased earnings, and who would otherwise remain unemployed and on Medicaid. The bill also requires cost-sharing on the part of participants, and that the program operate within existing General Revenue.

The Agency for Health Care Administration reports that there may be an increase in the average length of eligibility for some individuals due to simplifying the Medically Needy eligibility process, but cannot calculate the cost of this increase at this time.

The Agency for Health Care Administration has estimated that extending Medicaid converge to disabled individuals during the 2-year Medicare waiting period may cost $121 million.

The fiscal impact of paying the 20 percent Medicare co-pay on anti-rejection drugs has not been determined at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

According to the federal Health Care Financing Administration, in order for the state to limit the Medicaid buy-in program to recipients who had been on Medicaid for at least 6 months, the state will be required to obtain a section 1115 waiver, which must be cost-neutral. The bill allows the agency to seek such a waiver to implement the program.

For further information regarding the Medicaid Medically Needy Program, the reader should refer to Senate Interim Project Report 2001-24.

VIII. Amendments:

None.