HS HCS HB 1566 -- MEDICAL ASSISTANCE BENEFITS (Stefanick)

This substitute states that persons made eligible for medical assistance benefits pursuant to the federal Ticket to Work and Work Incentives Improvement Act of 1999; needy persons who comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301 et seq.); and persons who participate in the program for health care for uninsured children will only be eligible for these benefits if annual appropriations are made. Certain medical assistance benefits will only be provided if annual appropriations are made. The substitute also makes technical corrections to references that have become obsolete.

The substitute states that recipients of medical assistance who meet the eligibility requirements for aid to families with dependent children that were in effect on July 16, 1996, are subject to an asset test of $1,000 for single parents and $2,000 for married parents. Specified assets are excluded from this asset test. Under current law, there is a $250,000 net worth asset test for families of children who participate in the state's program to pay for health care for uninsured children. The substitute changes the net worth test to a $25,000 asset test and provides for the exclusion of specified assets.

The substitute requires the Department of Social Services to conduct an annual income and eligibility verification review to be completed no later than 12 months after the recipient's last eligibility review determination. It specifies how the verification review may be completed and requires participants to provide documentation for income verification. The substitute requires the department to establish by rule procedures for requiring recipients or applicants to disclose certain information about the availability of employer-sponsored health care and the recipient or applicant's employment status at the time of application or eligibility verification review.

The substitute requires the department to promulgate rules that require recipients of medical assistance to participate in cost-sharing activities, subject to the provisions of federal law. The cost-sharing provisions do not apply to pharmaceuticals or to in-home or home-health care services. The substitute requires providers to make reasonable efforts to collect copayments from recipients and allows providers to make a claim to the Division of Medical Services for any copayment that is not made by a recipient.

Currently, parents and guardians of uninsured children with available incomes between 186% and 225% of the federal poverty level are responsible for a $5 copayment, and parents and

guardians of uninsured children with incomes between 226% and 300% of the federal poverty level are responsible for specified copayments and premiums. The substitute makes parents and guardians of uninsured children with incomes between 151% and 300% of the federal poverty responsible for specified copayments and premiums.

The substitute provides that for purposes of determining Medicaid eligibility, investments in annuities must be actuarially sound, provide for equal or nearly equal payments, and provide the State of Missouri secondary or contingent beneficiary status. The department must establish a 36-month look-back period to review investments in annuities made by applicants for Medicaid benefits.

FISCAL NOTE: Estimated Income on General Revenue Fund of $0 to $771,076,401 in FY 2005, $0 to $807,825,955 in FY 2006, and $0 to $843,005,816 in FY 2007. Estimated Income on Other State Funds of $5,800,000 in FY 2005, FY 2006, and FY 2007.