COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 1737-01
Bill No.: HB 827
Subject: Disabilities; Medicaid; Public Assistance; Social Services Department
Type: Original
Date: April 6, 2005

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2006	FY 2007	FY 2008
General Revenue	Greater than $100,000	Greater than $100,000	Greater than $100,000
Total Estimated Net Effect on General Revenue Fund	**Greater than $100,000**	**Greater than $100,000**	**Greater than $100,000**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2006	FY 2007	FY 2008
Total Estimated Net Effect on Other State Funds	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 15 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2006	FY 2007	FY 2008
Federal*			
Total Estimated Net Effect on <u>All</u> Federal Funds	**$0**	**$0**	**$0**

*Savings and loss of greater than $100,000 would net to $0.

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2006	FY 2007	FY 2008
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Secretary of State** assume this proposal would not fiscally impact their agency.

Officials from the **Department of Health and Senior Services (DOH)** assume this proposal would not fiscally impact their agency. DOH states if an impact were to result, funds to support the program would be sought through the appropriation process.

Officials from the **Department of Mental Health (DMH)** state the fiscal impact for DMH clients will be reflected in the Department of Social Services response.

Officials from the **Department of Social Services - Division of Medical Services (DMS)** stated the following:

The proposed legislation changes the eligibility requirements for the MA-WD (Medical Assistance for Workers with Disabilities) program. This program is based on the Ticket to Work and Work Incentives Improvement Act of 1999.

The fiscal impact is based on the intent of the sponsor and not as the proposed legislation is

ASSUMPTION (continued)

currently written. DMS assumes the legislation will be changed to reflect the intent of the sponsor. Below are comments/assumptions used by FSD staff to arrive at the impact on current MA-WD eligibles.

208.146.1
RSMo Section 208.146. relates to the Medical Assistance for Workers with Disabilities (MA-WD) program. The current section and proposed changes base the program on the Ticket to Work and Work Incentives Improvement Act of 1999. DOS states to achieve the sponsor's intent the basis of the program needs to be changed to the Balance Budget Act (BBA) of 1997 (Public Law 105-33) Medicaid Buy-In group, which is in 42 U.S.C. 1396a (a)(10)(A)(ii)(XIII. To do this, the section should be changed as follows:

Pursuant to the Federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (Public Law 106-170)] 42 U.S.C. 1396a (a)(10)(A)(ii)(XIII), the medical assistance provided for in section 208.151 may be paid for a person who is employed and who...

Note: TWWIIA also limits eligibility to those aged 16 through 64 and allows for coverage of a medically improved group. The BBA group would not limit the program to persons under age 65 and does not allow for coverage of the medically improved category. Other than those things a state program for working persons with disabilities can be the same under either federal authorization. Either group allows Missouri to use our asset limits which are more restrictive than SSI. Due the premium structure in this bill FSD does not believe changing from TWWIIA to BBA would result in any persons age 65 and over moving from spenddown to MA-WD.

208.146.1(1)
The proposed revision eliminates coverage of the Medically Improved group. This would be required by changing the basis of the program to the BBA Buy-In group. There are currently only two individuals receiving MA-WD in the medically improved group.

DMS states "Disabled Beneficiary" should be defined as a person "eligible for benefits under this section". Some persons eligible under this section will not be Title II or Title XVI disability beneficiaries. Some MA-WD recipients will no longer have those benefits because they have returned to work and are earning too much to qualify for those programs, but they still meet the disability criteria. Those persons will meet all of the disability requirements Title II or Title XVI, except the requirement that earnings be below the Substantial Gainful Activity (SGA) limit, currently $830 per month ($810 in 2004).

ASSUMPTION (continued)

208.146.1(3)
The proposed change lowers the income limit to $15,000 per year ($1,250 per month). The sponsor intended this to be $18,000 per year ($1,500 per month), which is the amount referenced in other subsections of this section. This section removes the exclusion of one hundred thousand dollars of spousal income and children's income. Income of a child would continue to be excluded as Section 1902 [42 USC 1396a] (a)(17)(D) of the Social Security Act prohibits counting a child's income to determine their parent's eligibility. The sponsor stated his intent is that married couples not have combined income above $32,500 and that income of the disabled beneficiary not exceed $18,000. To accomplish this $15,000 should be replaced with $18,000. After that sentence in the subsection, the following sentence should be added:

For married couples, combined spousal and disabled beneficiary's gross income shall not exceed thirty-two thousand five hundred dollars per year; except that, the disabled beneficiary's income shall not exceed eighteen thousand dollars per year.

This subsection attempts to define earned income as that income from Medicare, Social Security, and applicable state and federal taxes must be withheld. Requiring proof of payment of Medicare and Social Security taxes is an allowable method of proving employment. We are not sure how this wording would be applied to self-employed persons, since taxes are not withheld from their income. Assuming that it would be acceptable for those persons to provide other documentation from the IRS of the payment of Medicare and Social Security taxes as proof, the Centers for Medicare and Medicaid Services (CMS) should allow this requirement. The sponsor might want to consider adding the following sentence:

Self-employed persons must provide proof of payment of Medicare and Social Security taxes for income to be considered earned.

208.146.1(4)
This subsection adds a statement that an individual is considered employed if earning at least the minimum wage and working at least 40 hours per month. CMS has informed states under the law a state cannot establish a definition of employment that sets a minimum standard for number of hours worked or a minimum level of earnings. According to CMS, any such definition would be out of compliance with the federal statute.

208.146.2(1)
This subsection removes the exclusion of spousal assets of "up to one hundred thousand dollars, one-half of any marital assets and all assets excluded pursuant to section 208.010". If the intent is to have assets for a person applying under this section meet the same asset limit as a

ASSUMPTION (continued)

non-working disabled person under other Medicaid categories, "all assets excluded pursuant to Section 208.010" should not be removed. This subsection adds an exclusion of "income up to $32,500", after talking with the sponsor it was determined this language belongs in subdivision (3) of subsection 1 rather than this subsection.

208.146.4.(1)
This seems intended to require the person to enroll in state employee insurance, but only have Medicaid pay a portion of the premium. This would not be allowed under federal law. For this eligibility category there is no requirement that the person be otherwise uninsured. Medicaid can require enrollment in cost-effective employer insurance if Medicaid pays the recipient's portion of the premium.

208.146.4(2)
This seems intended to require the person to enroll in employer-sponsored insurance, but only have Medicaid pay a portion of the premium. This would not be allowed under federal law. For this eligibility category there is no requirement that the person be otherwise uninsured. Medicaid can require enrollment in cost-effective employer insurance if Medicaid pays the recipient's portion of the premium.

208.146.5
This section proposes reducing a person's income limit for MA-WD coverage without a premium payment from 150% to 80% of the FPL. This is in conflict with the proposed subsections 7 and 12. The sponsor stated the intent of this subsection and subsection 6 was to prevent a person from working a minimal amount to avoid meeting a spenddown. To accomplish that, this subsection should read:

Any person whose income exceeds the limit for permanent and total disability benefits in subdivision (25) of subsection 1 of Section 208.151 shall pay a premium equal to the amount of the person's spenddown under that subdivision. Contributions made to medical savings and independent living development accounts up to the maximum permitted per year under subsections 2 and 3 of this section shall not be included as income for purposes of determining the premium under this subsection. Premiums calculated under subdivision (3) of subsection 12 shall be deducted from the disabled beneficiary's income to calculate under this subsection.

208.146.6
The sponsor stated the intent of this subsection is to require persons who would have been eligible for Medicaid on a spenddown basis to still have to meet the spenddown to be eligible under this Section, except that contributions to medical savings and independent living

ASSUMPTION (continued)

development accounts be deducted from income when determining the spenddown amount; and that those contributions be deducted from the disabled beneficiary's income when determining if income is below the $18,000 or $32,500 level. Also, this section was intended to have premiums paid based on earned income be deducted from the spenddown amount.

If the spenddown issue is addressed in 208.146.5 as suggested above, this subsection would only need to address the deduction of contributions to medical savings and independent living developments from the income limits. The wording could be as follows:

Contributions made to medical savings and independent living development accounts up to the maximum permitted per year under subsections 2 and 3 of this section shall not be included as income for purposes of determining if income is below the limits set in subdivision (3) of subsection 1 of this section.

208.146.7(1)
Requires all enrollees to pay premium, which the sponsor stated is the intent. The sponsor stated the intent is the total amount of the monthly premium should be the amount of that a person's spenddown would have been if not working, as calculated in subsection 5, plus an amount for earned income as calculated in subdivision (3) of subsection 12. To accomplish this, the wording should be as follows:

All enrollees shall pay a premium to be eligible for medical assistance under this section. The total monthly premium an enrollee shall pay will be the premium calculated in subsection 5 plus the premium calculated in subdivision (3) of subsection 12.

208.146.7(2)
Requires the premium to be determined at application and at the enrollee's six-month income review or when a change in income or household size is reported. Based on this it appears FSD would have to re-verify income every six months, in addition to the annual full reinvestigation of eligibility required for all Medicaid programs. It further states that any decrease or increase in premium shall be effective the first day of the month following the report. If a reported change results in a decreased premium, this is what is done currently. The change is effective the first day of the next month and the client is issued a refund if they have already paid.

For changes that result in an increase the change is effective for the month of the next invoice that is scheduled to be sent following the month the change is entered in the system. The change cannot be entered until the client is sent a due process notice advising them of the change and the right to appeal. The reason the increase is effective with the month of the next invoice, rather the

ASSUMPTION (continued)

next month is the client may have already paid the billed amount for the next month. For example, the change that results in an increase is reported in March, the client would already have been sent an invoice for April and may have even paid for April.

208.146.8(1) and 208.146.15
Requires the annual eligibility reinvestigations for all persons receiving MA-WD due for completion by February 21st of each year, beginning February 15, 2006. Currently annual reinvestigations are due 12 months following the month of approval, so that they are staggered throughout the year. Doing all MA-WD reinvestigations in February will not overburden staff as long as the caseload remains low.

208.146.8.(2)
Not sure what is intended. It says for persons applying after Jan. 1, 2006 that the department shall initiate a determination for continued assistance within 30 days of application. Is this intended to require we determine if the applicant is eligible within 30 days of the date they apply instead of the current 90 days? It reads like coverage would have begun when the person applied and then needs to be re-determined within 30 days. This is not the case now; coverage does not begin until the initial eligibility determination is completed. We do not believe that the sponsor intends to have coverage begin prior to a full eligibility determination is completed.

208.146.8.(4)
This is not a change from what FSD policy currently requires.

208.146.9
This will be a requirement for all Medicaid/Medicare dual eligibles effective Jan. 1, 2006.

208.146.12.(2)(a)
Makes a person who fails to pay a premium ineligible unless they demonstrate good cause. This language would allow the person with good cause to continue to receive coverage without paying the premium. Is this what is intended, or does the sponsor intend to allow them to be reenrolled if they have good cause and pay the premium as is stated in 208.146.12(2)(c)?

208.146.12.(2)(b)
Makes a person who fails to pay a premium for any month, without good cause, ineligible for the remainder of the program year. We believe this is allowable, but will need to check with the Centers for Medicare and Medicaid Services (CMS).

ASSUMPTION (continued)

208.146.12(3)
This subsection proposes "any person whose income exceeds $18,000 per year shall not be eligible for participation in the program." This statement seems unnecessary as the revised subdivision (3) of subsection 1 would make any such person ineligible.

This section also states that monthly premiums shall be based on the individual's income in the previous month. This would require additional reporting requirements and monthly adjustments by the caseworker. It also seems somewhat in conflict with the proposed subdivision (2) of subsection 7, which says "any required premium shall be re-determined at the enrollee's six-month income review or when a change is reported, and that changes are effective the first day of the following month.

On programs that require premiums DMS or the private contractor (when allowed) have sent the premium notices at the beginning of the month prior for which the client needs to pay for coverage. For example, the individual is sent the invoice for April coverage on March 1. The premium amount on the invoice is based on the client's current income at the time it is created. Income is projected to be the same for the month in which the client pays for coverage, unless a change is reported. If a reported change results in a decreased premium, the change is effective the first day of the next month and the client is issued a refund if they have already paid. For changes that result in an increase the change is effective for the month of the next invoice that is scheduled to be sent following the month the change is entered in the system. The change cannot be entered until the client is sent a due process notice advising them of the change and the right to appeal. The reason the increase is effective with the month of the next invoice, rather than the next month is the client may have already paid the billed amount for the next month. For example, the change that results in an increase is reported in March, the client would already have been sent an invoice for April and may have even paid for April.

Subsections 12(3)(a) through 12(3)(d) propose a change to the current premium payment schedule. The sponsor stated his intent is for this subsection to determine a premium based on the disabled beneficiary's earned income which would be combined with the premium based on the spenddown calculation. This is allowable under the BBA Buy-In group.

208.146.14
This proposes to put a time limit on a person's coverage under this category. This is not a Medicaid category for which Title XIX of the Social Security Act allows coverage to be time-limited.

ASSUMPTION (continued)

208.146.16
Anyone who provides false documentation to establish Medicaid eligibility for any category is subject to prosecution under current law. We do not believe that Title XIX of the Social Security Act allows a person to be banned from the program if they are currently eligible, even if they have committed fraud in the past. We can check with CMS on this.

208.146.17
This subsection would allow coverage to continue for up to three months while a person is not working under certain conditions. The state would have to provide this coverage with 100% state funds, as it is not allowed under the federal statute.

There were 17,795 MA-WD eligibles as of September 2004. The following assumptions are based on information from a Family Support Division's (FSD) Quality Control Review of MA-WD cases from October and November 2004. Count of eligibles provided by the FSD.

It is assumed the current MA-WD eligibles will fall into one of five groups if this legislation passes.

Group 1: Lose eligibility because of resource limits - 279 individuals.
It is estimated that 279 individuals will lose medical assistance because of changes in the resource limit. The FY 05 average cost/MA-WD eligible is $960.21 ($705.35 medical and $254.86 mental health services). This cost includes NF, hospital, dental, pharmacy, physician services, in-home, rehab & specialty and mental health services. The cost savings is 279 x $960.21 = $267,898.95 month. Savings total $1.6 million for FY 06 and $3.2 million for FY 07 and FY 08.

Group 2: Move to another Medicaid non-spenddown category - 3,513 individuals.
No savings or increased cost would result from this group.

Group 3: Meet spenddown/premium equal to spenddown - 4,541 individuals.
Individuals would convert to and meet spenddown or remain MA-WD by paying a premium equal to the spenddown amount. Savings would be the amount of their spenddown. The average spenddown $180.94/month. Savings total $4.9 million for FY 06 and $9.9 million for FY 07 and FY 08.

Group 4: Move to spenddown but not meet spenddown - 8,528 individuals.
Individuals in this group could spenddown to receive medical assistance but for whatever reason would not. Savings would be seen from this group. The FY 05 average cost/MA-WD eligible is

ASSUMPTION (continued)

$532.49. It was assumed the individuals would not need/receive NF, hospital or mental health services. Projected savings would total $27.2 million for FY 06 and $54.5 million for FY 07 and FY 08.

Group 5: Individuals who will remain in MA-WD - 934 individuals.
This group would now be responsible for paying a premium or a higher premium to remain eligible for medical assistance under MA-WD.

Monthly premiums would total $159,600 however, current monthly premium collections for MA-WD total $204,062.35. This will result in a loss of premium funds of $44,462.35/month. The total loss of funds will total $266,774 in FY 06 and $533,548 in FY 07 and FY 08.

The proposed legislation will have a fiscal impact on the DMS. The projected savings is $33.5 million for FY 06 and $67 million for FY 07 and FY 08.

Officials from the **Department of Social Services - Family Support Division (FSD)** state the following:

For this fiscal note FSD is using the same assumptions about what would happen to MA-WD recipients that were used for the Governor's budget. The savings are reduced by cost to continue MA-WD for persons who remain eligible under this proposal. The estimate is based on clarifications from the sponsor as to the intended meaning of some of the revised subsections. FSD's comment memorandum notes changes that need to be made to some subsections so that the revised statute clearly reflects the sponsor's intent.

Current MAWD Eligibles

As of September 2004, 17,795 individuals were receiving MA-WD. A Quality Control (QC) Review of MA-WD cases in October-November 2004 provided the following information:

--.5% would be ineligible if spousal assets were counted to determine eligibility in the same manner they are for the OAA/PTD Medical Assistance program;

–6.3% of MA-WD recipients had earned above the Substantial Gainful Activity (SGA) limit, $810 at the time of the review..

--54.7% are earning less than $100 per month working for private individuals or in self-employment. Social Security tax is most likely not being withheld from the income of these

ASSUMPTION (continued)

individuals.

--9.4% are earning less that $100 from employers that would be required to withhold Social Security tax.

--8.6% have earnings between $581 and $810 per month.

--21% have earnings between $100 and $580 per month.

--13.3% are spouse cases that would have a spenddown of over $700 per month if the MA-WD were eliminated.

Revised subsection 208.146.1(3) sets an income limit for the disabled worker of $18,000 per year ($1,250 per month). The current income limit is $1,940 per month. Lowering the income limit will result in 667 (3.7%) of the total MA-Wd clients being over the individual income limit.

Of the current MA-WD population, 1.5% (267) would be ineligible based on the revised asset limits in Subsection 2.

Based on the assumption that was used in the Governor's budget, an estimated 335 of 1,121 MA-WD recipients with earnings above the SGA are not receiving Social Security Disability benefits and would have been ineligible for Medicaid. These persons would not have a spenddown as their earnings would cause ineligibility. This bill would allow these persons to remain eligible by paying a premium based on the amount of earned income under subsection 208,146.12. It is estimated that 3.7% (12) will be ineligible based on the $18,000 income limit, leaving 323 eligible for MA-WD.

If the premiums are raised 3,513 MA-WD recipients would move to another Medicaid non-spenddown category. This is based on the assumption that was used in the Governor's budget which proposed eliminating the MA-WD program.

Based on discussions with the sponsor, the intent of the language in subsection 208.146.6 is to have the premium for persons who would have been PTD spenddown if they were not working equal that spenddown amount. This would result 13,680 recipients having a premium equal to their spenddown amount, the same number that would become spenddown if the program were eliminated. It is estimated that 4,753 would pay the premium and 8,927 would lose eligibility due to not paying.

ASSUMPTION (continued)

Subsection 208.146.6 would allow the premium to be reduced by the amount of earnings placed in a medical savings account or Independent Living Development account. To eliminate the spenddown premium and pay a premium based on earned income a person would need earnings to exceed the spenddown amount they would have if not working and put all of the earnings into an allowable account. This would not benefit persons with a spenddown of $100 or less as the minimum premium based on earnings is $100. As 64.1% of the MA-WD recipients have earnings less than $100 only 35.9% (4,911) of the 13,680 with a spenddown are potentially eligible under this provision. Of the 4,911, 3.7% (182) would be over the individual income limit and 13.3% (653) would be over the couple limit. This would leave 4,076, of these it is estimated 15% (611) would have earnings above the spenddown amount and put all of the earnings into an allowable account. If MA-WD were totally eliminated 212 of the 611 would have met spenddown and 399 would not.

If this proposal is passed and the non-spenddown Medicaid income limit is reduced to the SSI limit, FSD estimates the following would occur:

--3,513 recipients move to a non-spenddown Medicaid category.

--4,541 recipients would convert to and meet spenddown, or remain MA-WD by paying a premium equal to the spenddown amount.

--8,528 recipients would convert to spenddown, but not meet spenddown.

-- 279 recipients would be totally ineligible.

-- 934 recipients would remain eligible for MA-WD with a premium based on earned income.

Based on the QC review of the MA-WD with earnings above $100 per month, 58.7% have earnings from $100-$580, 23.9% earn from $581- $810, and 17.4% earn above $810 per month. Based on this FSD estimates the following number of persons in each of the earned income premium groups:

ASSUMPTION (continued)

Premium groups:

12(3)(a) - $1-$399 earned income, $100 premium	= 467 (50%)
12(3)(b) - $400-$899 earned income, $200 premium	= 337 (36%)
12(3)(c)- $900-$1,199 gross income	= 65 (7%)
12(3)(d) - $1,200 - $1,499	= 65 (7%)
Total MA-WD Eligibles paying premiums based on earned income	= 934

Staffing:
FSD determines that there will be no additional staffing costs, as the proposed MA-WD population will consist of the current caseload as well as current OAA/PTD Medical Assistance cases. There is an assumption that no new population of individuals unknown to FSD will be added to this program.

Oversight assumes since DOS does not address proposed legislation there are unknown savings greater than $100,000.

FISCAL IMPACT - State Government	FY 2006 (10 Mo.)	FY 2007	FY 2008
GENERAL REVENUE			
Savings - Department of Social Services			
Program savings	Greater than $100,000	Greater than $100,000	Greater than $100,000
ESTIMATED NET EFFECT ON GENERAL REVENUE	**Greater than $100,000**	**Greater than $100,000**	**Greater than $100,000**
FEDERAL			
Savings - Department of Social Services			
Program savings	Greater than $100,000	Greater than $100,000	Greater than $100,000
Loss–Department of Social Services			
Loss of Reimbursements	(Greater than $100,000)	(Greater than $100,000)	(Greater than $100,000)
ESTIMATED NET EFFECT ON FEDERAL	**$0**	**$0**	**$0**

FISCAL IMPACT - Local Government	FY 2006 (10 Mo.)	FY 2007	FY 2008
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

No direct fiscal impact to small businesses would be expected as a result of this proposal.

DESCRIPTION

This proposal requires the Department of Social Services to determine the eligibility of an employed disabled person requesting medical assistance under the federal Ticket to Work and Work Incentives Improvement Act of 1999. The proposal:

(1) Requires an applicant to work at least 40 hours per month, have a gross annual income of less than $15,000, and pay a one-time $65 application fee;

(2) Specifies that an individual's personal assets cannot exceed $1,000, while a couple's assets cannot exceed $2,000;

(3) Specifies that an independent living development account with a value less than $10,000 per year, a medical expense account with a value less than $5,000 per year, and a combined spousal income up to $32,500 per year will not be considered assets for determining eligibility;

(4) Specifies that an individual whose income is greater than 80% of the federal poverty guidelines will have to pay a premium between $100 and $400 based on their previous month's income;

(5) States that if an eligible individual is receiving or is eligible to receive state-sponsored health insurance, and the premiums are less than the amount the Missouri Medicaid Program would pay then the individual will participate in the state-sponsored insurance. The department will pay for state-sponsored health insurance and employer-sponsored health insurance premiums that exceed an individual's monthly premium. Nonpayment of a premium will result in the denial or termination of medical assistance;

(6) Allows an individual who is receiving medical assistance before January 1, 2006, to renew their eligibility for the program by February 15, 2006. The department will initiate a determination within 30 days for any individual who applies for medical assistance after January 1, 2006;

DESCRIPTION

(7) Specifies that in no case will the eligibility for continued medical assistance exceed five years; and during the fourth and fifth years, the individual may continue by paying a premium equal to 40% of the average monthly per person expenditure in the Medicaid Program;

(8) Requires an applicant to provide documentation of eligibility by February 21 of each year or be denied participation in the program for that year;

(9) Prohibits an individual who is eligible under this section but is also eligible for Medicaid and the federal Medicare Program from being eligible for continued prescription drugs or medication assistance; and

(10) Allows an individual who has been enrolled four consecutive months and lost his or her job due to a medical condition or some other reason not attributable to the enrollee to retain eligibility in this program for an additional three months. The provisions of this section will become effective January 1, 2006, and will terminate on December 31, 2011.

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Social Services -
Division of Medical Services
Family Support Division
Department of Health and Senior Services
Department of Mental Health
Secretary of State

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Director
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