Jeffery A. Bernard *Legislative Service Commission*

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(As Introduced)

Sens. Stivers, Niehaus, D. Miller, Mumper, Spada, Gardner, Padgett, Goodman, Schaffer, R. Miller, Cafaro

BILL SUMMARY

MEDICAID BUY-IN FOR WORKERS WITH DISABILITIES PROGRAM

- Requires that the Director of Job and Family Services seek federal approval to establish the Medicaid Buy-In for Workers with Disabilities Program.
- Requires that an individual whose family's income exceeds 150% of the federal poverty guidelines pay an annual premium as a condition of qualifying for the program.
- Permits an individual participating in the program on the basis of being an employed individual with a medically improved disability to continue to participate for up to six months after ceasing to be employed.
- Stipulates that no individual is to be denied eligibility for the program due to receiving home or community-based services under a Medicaid waiver.
- Exempts an individual receiving services under a Medicaid home or community-based services waiver from any patient liability otherwise applicable under the Medicaid waiver for any period during which the individual also participates in the Medicaid Buy-In for Workers with Disabilities Program.
- Creates the Medicaid Buy-In Advisory Council.

QUALIFIED LONG-TERM CARE INSURANCE POLICIES

- Requires the Director of Job and Family Services to establish a program that enables an individual who exhausts the benefits payable under a qualified long-term care insurance policy to qualify for Medicaid-funded nursing facility or other Medicaid-funded long-term care services without regard, with one exception, to the value of the individual's resources if the individual meets all other eligibility requirements for the Medicaid services sought.

- Sets the initial maximum equity interest that an individual may have in a home at $750,000 for participants of the bill's program regarding qualified long-term care insurance policies.

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CONTENT AND OPERATION

MEDICAID BUY-IN FOR WORKERS WITH DISABILITIES PROGRAM

Background

To qualify for federal financial participation, a state's Medicaid program must cover certain populations. Federal law permits, but does not require, that a state's Medicaid program cover additional populations.

The Ticket to Work and Work Incentives Improvement Act of 1999 established two new populations that a state's Medicaid program may cover. However, a state may cover the second population only if it also covers the first. These two optional eligibility expansions are popularly known as the Medicaid buy-in.

The first population consists of individuals who, but for earnings in excess of a limit established under federal law, would be considered to be receiving Supplemental Security Income,[1] are at least age 16 but less than age 65, and have assets, resources, and income not exceeding such limitations, if any, as the state may establish.[2] The second population consists of employed individuals with a medically improved disability who have assets, resources, and income not exceeding such limitations, if any, as the state may establish.[3] An "employed individual with a medically improved disability" is defined as an individual who (1) is at least age 16 but less than age 65, (2) is earning at least the applicable minimum wage requirement specified in federal law and working at least 40 hours per month or is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, (3) ceases to be eligible for Medicaid under the first population described above because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer meet federal definitions of disability, and (4) continues to have a severe medically determinable impairment as determined under federal regulations.[4]

The bill

Seeking federal approval to implement buy-in option

(R.C. 5111.70)

The Director of Job and Family Services is required by the bill to submit an amendment to the state Medicaid plan and any federal waiver necessary to establish a new component of the Medicaid program to be known as the Medicaid

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[1] Supplemental Security Income (SSI) is a federal program under which monthly payments of up to $623 are made to qualified disabled individuals who do not have sufficient work history to qualify for disability payments under the Social Security program.

[2] 42 U.S.C. 1396a(a)(10)(A)(ii)(XV).

[3] 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI).

[4] 42 U.S.C. 1396d(v).

Buy-In for Workers with Disabilities Program. The amendment and, if necessary, waiver are to be submitted to the United States Secretary of Health and Human Services not later than 90 days after the bill's effective date. The program is to be established in accordance with the bill and the provision of the Ticket to Work and Work Incentives Improvement Act of 1999 that authorizes the Medicaid buy-in eligibility expansions. The Director is required to implement the program if the amendment and, if necessary, waiver are approved.

Eligibility for Medicaid Buy-In for Workers with Disabilities Program

(R.C. 5111.701, 5111.702, 5111.703, and 5111.707)

To qualify for the Medicaid Buy-In for Workers with Disabilities Program, an individual must apply to participate and provide satisfactory evidence that the individual:

(1) Is at least age 16 and under age 65;

(2) Is either considered disabled for the purpose of the Supplemental Security Income (SSI) program (regardless of whether the individual receives SSI benefits) or meets the federal definition of "employed individual with a medically improved disability";

(3) Meets the program's asset and income requirements;

(4) Meets the additional eligibility requirements the Director of Job and Family Services is to establish in rules.[5]

An individual may also have to pay a premium for participating in the program. (See "***Premium requirements***" below.)

Under the program's asset limitation, the value of the assets of an individual's family, less assets and asset value disregarded pursuant to rules the Director is to adopt, cannot exceed $10,000. However, the Director is required to annually adjust the asset eligibility requirement by the change in the consumer price index for all items for all urban consumers for the previous calendar year, as published by the United States Bureau of Labor Statistics. The annual adjustment must go into effect on the earliest possible date.

Under the program's income limitation, the income of an individual's family, less the first $20,000 of the individual's earned income and other

[5] The rules governing the Medicaid Buy-In for Workers with Disabilities Program are to be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.).

disregarded amounts to be specified in rules, cannot exceed 250% of the federal poverty guidelines.[6] No amount that an employer of a member of the individual's family pays to obtain health insurance for one or more members of the family is to be treated as the income of the individual's family. This exclusion includes any amount of the program's premium that the employer pays.

The bill defines "family" as an applicant for or participant of the Medicaid Buy-In for Workers with Disabilities Program and the spouse and dependent children of the applicant or participant. "Family" also includes the parents of an applicant or participant who is under age 18.

Premium requirements

(R.C. 5111.704)

An individual whose family's income exceeds 150% of the federal poverty guidelines is required to pay an annual premium as a condition of qualifying for the Medicaid Buy-In for Workers with Disabilities Program. The amount of the premium is to be determined as follows:

(1) Subtract an amount equal to 150% of the federal poverty guidelines, as applicable for a family size equal to the size of the individual's family, from the amount of the income of the individual's family;

(2) Subtract any amount a member of the individual's family pays, whether by payroll deduction or otherwise, for other health insurance for one or more members of the family from the difference determined under (1) above;

(3) Multiply the difference determined under (2) above by one tenth.

The bill stipulates that no amount that an employer of a member of an individual's family pays to obtain health insurance for one or more members of the individual's family, including any amount of a premium for the Medicaid Buy-In for Workers with Disabilities Program that the employer pays, is to be treated as income of the individual's family for purposes of determining whether an individual must pay a premium or the amount of a premium an individual must pay under the program.

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[6] The bill defines "income" as including earned and unearned income. The Director of Job and Family Services is required to adopt rules defining "earned income" and "unearned income."

Six-months extended eligibility

(R.C. 5111.706)

The bill permits an individual participating in the Medicaid Buy-In for Workers with Disabilities Program on the basis of being an employed individual with a medically improved disability to continue to participate in the program for up to six months after the individual no longer meets the federal definition of "employed individual with a medically improved disability" due to ceasing to be employed. The individual would have to continue to meet all of the program's other eligibility requirements to qualify for the extended six-months eligibility.

Dual eligibility for Buy-In and home or community-based services

(R.C. 5111.705 and 5111.851)

Ohio's Medicaid program includes a number of components under which home or community-based services are provided as an alternative to services provided by a hospital, nursing facility, or intermediate care facility for the mentally retarded. The components are authorized by federal waivers granted by the United States Department of Health and Human Services.

The bill stipulates that no individual is to be denied eligibility for the Medicaid Buy-In for Workers with Disabilities Program on the basis that the individual receives home or community-based services under a Medicaid waiver. The bill correspondingly stipulates that no individual is to lose eligibility for home or community-based services under a Medicaid waiver on the basis that the individual also receives services under the Medicaid Buy-In for Workers with Disabilities Program, even if the individual's income or assets increase to an amount above the eligibility limit for the Medicaid waiver (but not above the eligibility limit for the Medicaid Buy-In for Workers with Disabilities Program). Individuals receiving services under a Medicaid waiver are exempted by the bill from any patient liability otherwise applicable under the Medicaid waiver for any period during which they also participate in the Medicaid Buy-In for Workers with Disabilities Program. "Patient liability" is defined as the cost-sharing expenses for which an individual receiving services under a Medicaid waiver is responsible.

Medicaid Buy-In Advisory Council

(R.C. 5111.708 and 5111.709; Section 3)

The bill creates the Medicaid Buy-In Advisory Council consisting of the following 12 members:

- The Executive Director of Assistive Technology of Ohio or the Executive Director's designee.

- The Director of the Axis Center for Public Awareness of People with Disabilities or the Director's designee.

- The Executive Director of the Cerebral Palsy Association of Ohio or the Executive Director's designee.

- The Chief Executive Officer of the Ohio Advocates for Mental Health or the Chief Executive Officer's designee.

- The State Director of the Ohio Chapter of AARP or the State Director's designee.

- The Director of the Ohio Developmental Disabilities Council or the Director's designee.

- The Executive Director of the Governor's Council on People with Disabilities or the Executive Director's designee.

- The Administrator of the Legal Rights Service or the Administrator's designee.

- The Chairperson of the Ohio Olmstead Task Force or the Chairperson's designee.

- The Executive Director of the Ohio Statewide Independent Living Council or the Executive Director's designee.

- The President of the Ohio Chapter of the National Multiple Sclerosis Society or the President's designee.

- The Executive Director of the ARC of Ohio or the Executive Director's designee.

Members of the Council are to serve without compensation or reimbursement, except as serving on the Council is considered part of their usual job duties. A member is to be elected by the members to serve as chairperson. A chairperson is to serve a two-year term and may be re-elected to successive terms as chairperson.

The Department of Job and Family Services is required to provide the Council with accommodations for the Council to hold its meetings. The

Department must also provide the Council with other administrative assistance the Council needs to perform its duties.

The Director of Job and Family Services must call the Council to meet for the first time not later than 60 days after the bill's effective date. The Director or the Director's designee is required to meet quarterly with the Council to discuss the Medicaid Buy-in for Workers with Disabilities Program. The Council is permitted to provide the Director or Director's designee with suggestions for improving the program. The Director or designee must provide the Council with the following information:

- The number of individuals who participated in the program the previous quarter.
- The cost of the program the previous quarter.
- The amount of revenue generated the previous quarter by the premiums paid under the program.
- The average amount of earned income of participants' families.
- The average amount of time participants have participated in the program.
- The types of other health insurance participants have been able to obtain.

The Director or Director's designee is also required to consult with the Council before adopting, amending, or rescinding any rules governing the program.

Report

(R.C. 5111.7010)

The bill requires that the Director of Job and Family Services issue a report on the Medicaid Buy-In for Workers with Disabilities Program not less than once each year. The report is to be submitted to the Governor, Speaker and Minority Leader of the House of Representatives, President and Minority Leader of the Senate, and chairpersons of the House and Senate committees to which the biennial operating budget bill is referred. The report is to include the same information that the bill requires the Director or Director's designee to provide the Medicaid Buy-In Advisory Council.

QUALIFIED LONG-TERM CARE INSURANCE POLICIES

New program regarding long-term care insurance policies

(R.C. 5111.182)

The bill requires the Director of Job and Family Services to establish a program that enables an individual covered by a qualified long-term care insurance policy who exhausts the benefits payable under the policy to qualify for Medicaid-funded nursing facility or other Medicaid-funded long-term care services[7] without regard, with one exception, to the value of the individual's resources if the individual meets all other eligibility requirements for the Medicaid services. To be a qualified long-term care insurance policy, a policy must provide coverage of long-term care services for at least three years that are comparable, as determined by the Director, to Medicaid-funded nursing facility and other Medicaid-funded long-term care services. The policy must also (1) be a qualified long-term care insurance policy as defined in the Internal Revenue Code, (2) be issued no earlier than the effective date of the state Medicaid plan amendment authorizing the bill's program, (3) meet model regulations and requirements of a model act promulgated by the National Association of Insurance Commissioners, and (4) provide compound annual inflation protection if it is sold to an individual under age 61 or some level of inflation protection if it is sold to an individual at least age 61 but under age 76.

The program the Director establishes must cover nursing facility and other Medicaid-funded long-term care services. But, an individual participating in the program is to choose, subject to the individual's eligibility for the nursing facility services and the availability of the other Medicaid-funded long-term care services, whether to receive nursing facility or other Medicaid-funded long-term care services.

The Director is permitted to adopt rules as necessary to implement the program. Those rules are to be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.).

Exception to disregard

(R.C. 5111.0118)

Federal Medicaid law requires that states deny an individual's eligibility for Medicaid-funded nursing facility and other long-term care services if the

[7] The Director of Job and Family Services is required by current law to define the term "other Medicaid-funded long-term care services." (R.C. 5111.011.)

individual's equity interest in the individual's home exceeds $500,000 (or at a state's option, $750,000). This amount is to be increased annually beginning in 2011 based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest $1,000. However, an individual is not to be denied eligibility on this basis if either of the following lawfully resides in the home: (1) a spouse or (2) a child who is under age 21, blind, or disabled. The United States Secretary of Health and Human Services is required to establish a process for waiving ineligibility in cases of demonstrated hardship. Also, an individual may use a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

Current law provides for the implementation of this federal requirement. The initial maximum equity interest is set at $500,000.

The bill sets the initial maximum equity interest at $750,000, the maximum permitted by federal law, for participants of the bill's program regarding qualified long-term care insurance policies.

Administrative rules subject to statutory requirements

(R.C. 5111.011)

The Director of Job and Family Services is required to adopt rules establishing standards consistent with federal law for allocating income and resources as income and resources of the spouse, children, parents, or stepparents of a Medicaid applicant or recipient. Current law stipulates that the standards established by the rules are to be used to determine Medicaid eligibility notwithstanding any provision of state law (including statutes, administrative rules, common law, and court rules) regarding real or personal property or domestic relations. The bill provides that the rules' standards do not prevail over the program regarding qualified long-term care insurance policies or state law governing the maximum equity interest an individual may have in a home to qualify for Medicaid-funded nursing facility and other long-term care services.

Existing qualified long-term care insurance partnership program

(R.C. 5111.18)

The 126th Ohio General Assembly, in Am. Sub. H.B. 530, required the Department of Job and Family Services to establish a qualified long-term care insurance partnership program. The program regarding qualified long-term care insurance policies that the bill requires the Director of Job and Family Services to establish is different from H.B. 530's qualified long-term care insurance partnership program in at least two ways.

First, the estate of an individual who participates in H.B. 530's partnership program may be subject to a reduced recovery under the Medicaid estate recovery program.[8] Due to federal law, no such reduction is available for the estate of an individual who participates in the bill's program.[9]

The second difference is that, under federal law, an individual participating in H.B. 530's partnership program may have resources or income disregarded for Medicaid eligibility purposes only in an amount equal to the insurance benefit payments made to or on behalf of the individual under the qualifying long-term care insurance policy.[10] An individual participating in the bill's program is to have all of the individual's resources disregarded (other than any part of the equity interest in the individual's home that exceeds, initially, $750,000) for Medicaid eligibility purposes.

HISTORY

ACTION	DATE
Introduced	02-20-07

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[8] The Department of Job and Family Services is required to institute the Medicaid estate recovery program under which the Department, with certain exceptions, must seek recovery from the estates of certain deceased Medicaid recipients. The Department must also seek recovery on the sale of property of a permanently institutionalized individual (or such an individual's spouse) that is subject to a lien imposed on account of Medicaid paid or to be paid on the individual's behalf. The recoveries are for the costs of Medicaid services the Medicaid program correctly paid or will pay on an individual's behalf. (R.C. 5111.11.)

[9] 42 U.S.C. 1396p(b)(1)(C).

[10] 42 U.S.C. 1396p(b)(1)(C)(iii).