



House of Representatives

General Assembly

File No. 369

January Session, 2001

House Bill No. 5203

House of Representatives, April 19, 2001

The Committee on Human Services reported through REP. GERRATANA of the 23rd Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

***AN ACT CONCERNING CONSIDERATION OF MONEYS IN DEFERRED
COMPENSATION RETIREMENT ACCOUNTS AS ASSETS IN
DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER
TITLE XIX OF THE SOCIAL SECURITY ACT.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) The Commissioner of Social Services shall seek a
2 federal waiver to exempt moneys invested in a deferred compensation
3 retirement account in an amount not to exceed one hundred thousand
4 dollars that is owned by the community spouse from consideration as
5 assets of the couple in the determination of eligibility for medical
6 assistance for long-term care under Title XIX of the Social Security
7 Amendments of 1965 for the spouse of such community spouse.

8 Sec. 2. This act shall take effect from its passage.

HS *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: Significant Cost

Affected Agencies: Department of Social Services

Municipal Impact: None

Explanation

State Impact:

This bill requires the Department of Social Services (DSS) to seek a federal Medicaid waiver in order to exclude up to \$100,000 in a deferred compensation account owned by the community spouse of an individual applying for Medicaid long term care services. This is expected to result in a significant cost to DSS. Currently, the annual state cost for long-term care averages \$45,000 per year. As clients will be able to protect additional assets from the spend-down requirements of the Medicaid program, Medicaid will be required to assume responsibility for the cost of the long-term care sooner.

DSS currently receives approximately 12,000 Medicaid long-term care applications annually, of which approximately 10% have community spouses. A breakout of the asset data on applicants is not available. Assuming that 25% of these spouses have deferred compensation accounts with an average balance of \$50,000, it is estimated that Medicaid could incur additional costs of approximately \$11 million annually. This estimate assumes that not all of these

deferred compensations assets would have been used to pay for long term care.

OLR Bill Analysis

HB 5203

AN ACT CONCERNING CONSIDERATION OF MONEYS IN DEFERRED COMPENSATION RETIREMENT ACCOUNTS AS ASSETS IN DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT.**SUMMARY:**

This bill requires the Department of Social Services (DSS) commissioner to seek a waiver of federal Medicaid law to allow her to exclude up to \$100,000 in a deferred compensation account owned by the spouse of an individual applying for Medicaid coverage for long-term care services. Generally, under current law, when the commissioner determines eligibility in these cases, she must (1) combine the assets of both spouses (which would include monies in deferred compensation accounts); (2) divide them in half; and (3) allow the community spouse to keep her half, up to an established limit. The applicant may keep no more than \$1,600. If either spouse's share is higher than the limits, they must spend the excess before the applicant can qualify for assistance.

If the federal government approves the waiver, the community spouse could keep more money, theoretically enabling the Medicaid applicant to qualify for assistance sooner.

EFFECTIVE DATE: Upon passage

BACKGROUND***Medicaid Spousal Impoverishment Provisions***

Medicaid is a federal-state program of health insurance coverage for people who meet certain financial and non-financial eligibility criteria. One group of individuals Medicaid covers is those who require "institutional" (either nursing home or home-and community-based) care.

When one of these individuals goes into a nursing home for a continuous period of at least 30 days, applies for Medicaid, and has a spouse living in the community, a portion of the couple's combined assets can be protected to prevent the community spouse from becoming impoverished. (Individuals receiving home- and community-based services under a Medicaid waiver can also have this done.)

The Community Spouse Protected Amount (CSPA) is calculated by combining all of the assets that are considered "non-excluded" (an excluded asset would include home property) and "available", and dividing by two. One half, currently up to \$87,000, goes to the community spouse. The other half is considered available to the Medicaid applicant. Any excess, less the \$1,600 the applicant is allowed to keep, can be transferred as long as fair market value is received. (Once asset eligibility is determined the state no longer looks at the community spouse's assets.)

Federal law also permits the community spouse to have a monthly income allowance. This income, called the community spouse allowance (CSA), is determined by subtracting the spouse's monthly gross income from a minimum monthly needs allowance (MMNA), which is set in state regulation and is calculated according to a formula that uses the community spouse's actual monthly shelter costs, including a utility allowance. While the allowance may vary, the maximum is \$2,175.

Federal law allows both the CSPA and MMNA to be adjusted upwards if the community spouse is determined to need the money. DSS holds fair hearings to make these determinations. For CSPA exceptions, the court can also order a higher allowance.

In the case of deferred compensation accounts, DSS would normally require the community spouse to liquefy these monies. The amount DSS would consider to be "available" would be the proceeds, less any penalty incurred for early withdrawal. Only a DSS fair hearing officer or a court could determine that all or some of these monies were considered necessary to produce enough income to meet the MMNA.

Federal Approval—Waivers and State Plan Amendments

The federal Health Care Financing Administration (HCFA) grants waivers of federal Medicaid rules in certain circumstances. These waivers allow states to be more flexible in how they provide health care coverage to needy individuals, including expanding the program to cover more people or covering services not normally allowed. Typically, these waivers are time-limited; some require an evaluation.

If a state wishes to make a policy change in its Medicaid program that is not contrary to federal law, it can bypass the waiver route and simply ask HCFA to approve a “state plan” amendment. This approach is usually much faster than requesting a waiver.

A provision in the federal Medicaid law permits states to have Medicaid coverage groups that use less restrictive eligibility criteria than those prescribed in federal law (Section 1902(r)(2) of the Social Security Act). This provision would probably enable the state to exclude part of deferred compensation through a state plan amendment, provided that all the people in that coverage group (most likely the “medically needy”) would be able to exclude these assets, not just elderly people seeking long-term care. (In theory, a waiver would allow the state to target a smaller group of individuals.)

COMMITTEE ACTION

Human Services Committee

Joint Favorable Report

Yea 15 Nay 1