



## Senate

General Assembly

January Session, 2001

**File No. 332**

Senate Bill No. 927

*Senate, April 18, 2001*

The Committee on Human Services reported through SEN. HANDLEY of the 4th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

### **AN ACT REINSTATING MEDICAID FUNDING FOR DUALY-ELIGIBLE PATIENTS.**

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

1 Section 1. Subsection (b) of section 17b-265 of the general statutes is  
2 repealed and the following is substituted in lieu thereof:

3 (b) When a recipient of medical assistance has personal health  
4 insurance in force covering care or other benefits provided under such  
5 program, payment or part-payment of the premium for such insurance  
6 may be made when deemed appropriate by the Commissioner of  
7 Social Services. [Effective January 1, 1992, the commissioner shall limit  
8 reimbursement to medical assistance providers, except those providers  
9 whose rates are established by the Commissioner of Public Health  
10 pursuant to chapter 368d, for coinsurance and deductible payments  
11 under Title XVIII of the Social Security Act to assure that the combined  
12 Medicare and Medicaid payment to the provider shall not exceed the  
13 maximum allowable under the Medicaid program fee schedules.]

14      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:

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**OFA Fiscal Note**

**State Impact:** See Explanation Below

**Affected Agencies:** Department of Social Services

**Municipal Impact:** None

**Explanation****State Impact:**

This bill repeals the language that required the Commissioner of the Department of Social Services (DSS) to limit reimbursement to medical providers for coinsurance and deductible payments for individuals eligible for both Medicaid and Medicare. The state began limiting this reimbursement during FY00, and it is estimated that this effort reduces Medicaid expenditures by \$25 million to \$30 million annually. It is unclear what the effect of this bill would be as the statutory language authorizing the reimbursement of coinsurance and deductibles by DSS remains permissive. Therefore, unless there is affirmative action by the General Assembly to appropriate additional funds for this purpose, it is likely that DSS would not reinstate these reimbursements. The Governor's proposed budget for the FY02-FY03 biennium contains no additional funding for this initiative.

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**OLR Bill Analysis**

SB 927

***AN ACT REINSTATING MEDICAID FUNDING FOR DUALY-ELIGIBLE PATIENTS.*****SUMMARY:**

This bill removes the limit on what the Department of Social Services (DSS) may pay in coinsurance and deductibles to health care providers serving people eligible for both Medicare and Medicaid (“dually-eligible”). Under current law, the amount that Medicare pays, when combined with the Medicaid payment, cannot exceed the amount that Medicaid alone would pay for the same service. These limits do not apply to rates the Department of Public Health sets for emergency medical services providers.

EFFECTIVE DATE: Upon passage

**BACKGROUND*****Medicaid—Dually Eligible***

The federal Medicaid program establishes a category or coverage group called the “dually-eligible,” which consists of several subcategories. Medicaid pays the Medicare Part A and B premiums, deductibles, and coinsurance as a means to help certain Medicare beneficiaries avoid needing full Medicaid coverage.

It provides assistance with coinsurance and deductibles to Qualified Medicare Beneficiaries (QMB). These individuals cannot have income greater than 100% of the federal poverty level (currently \$8,590 per year for one person), and their assets cannot exceed more than twice the asset limit in the Supplemental Security Income program (currently \$4,000 for a single person). For QMBs, Medicaid (which provides most states with a 50% federal match) generally pays the Medicare Part A and B premiums and cost-sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers.

Congress passed the cost-sharing requirement in 1988. The State Medicaid Manual, which provides guidance to state agencies administering Medicaid, gave states the option to pay Medicare cost-sharing in an amount based either on (1) the full Medicare-approved amount for a particular service or (2) the amount that the state pays for the same service for a Medicaid recipient who was not entitled to Medicare. Connecticut passed its law limiting these amounts in 1991, however it was not immediately implemented.

In the intervening years, courts in some jurisdictions have held that states cannot limit cost-sharing amounts to those in the Medicaid fee schedule. In 1997, Congress made it clear that states had this flexibility. The 1999-00 DSS budget included a \$54 million reduction to reflect the statute's implementation.

The effect of this change was that providers in many cases stopped getting co-payments. (DSS never stopped paying the \$100 Medicare deductible.)

Here's an example to show what occurred. Before the state began implementing the change in 1999, a QMB would have a medical procedure for which the provider billed Medicare \$120. Medicare determined what it considered to be an "allowable" or approved amount for that procedure (\$100) and paid the provider 80% of that amount (\$80). Medicaid would then pay the remaining 20% (co-payment) of the approved amount, or \$20.

With the implementation of the statutory limits on coinsurance, DSS compares the Medicare payment to the amount that Medicaid would pay a provider for the same service. If the Medicaid fee is lower or the same, DSS pays the provider nothing. If it is higher, Medicaid pays the difference. (In most cases, the Medicare-approved amount is higher than the amount in the Medicaid fee schedule.)

## **COMMITTEE ACTION**

Human Services Committee

Joint Favorable Report

Yea 16    Nay 0