



Senate

General Assembly

File No. 762

January Session, 2001

Substitute Senate Bill No. 927

Senate, May 14, 2001

The Committee on Appropriations reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute 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2 repealed and the following is substituted in lieu thereof: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 physicians and
9 those providers whose rates are established by the Commissioner of
10 Public Health pursuant to chapter 368d, for coinsurance and
11 deductible payments under Title XVIII of the Social Security Act to
12 assure that the combined Medicare and Medicaid payment to the
13 provider shall not exceed the maximum allowable under the Medicaid

14 program fee schedules.

15 Sec. 2. This act shall take effect July 1, 2001.

APP *Joint Favorable Subst.*

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: Implements a Provision of the Budget

Affected Agencies: Department of Social Services

Municipal Impact: None

Explanation

State Impact:

This bill exempts physicians from the requirement that the Commissioner of the Department of Social Services (DSS) 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 for all providers reduces Medicaid expenditures by \$25 million to \$30 million annually. Allowing DSS to give full reimbursement to physicians is expected to cost \$5.2 million annually. sHB 6668 (the Appropriations Act, as favorable approved by the Appropriations Committee) includes the necessary funding to implement this provision.

OLR BILL ANALYSIS

sSB 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 physicians serving people eligible for both Medicare and Medicaid (“dually-eligible”). Other medical providers who serve these individuals, such as hospitals, are still subject to the limits. 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, and these limits do not apply to rates the Department of Public Health sets for emergency medical services providers.

EFFECTIVE DATE: July 1, 2001

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, and it said that providers could not bill the recipient for the balance. 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.)

Legislative History

The Senate referred the bill (File 332) to the Appropriations Committee on April 25. On May 2, the committee reported this substitute favorably, reinstating the limits on co-payments for all medical providers, except physicians, and changing the effective date from upon passage to July 1, 2001.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Report

Yea 16 Nay 1

Appropriations Committee

Joint Favorable Substitute

Yea 42 Nay 0