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Informational Hearing

Assembly Health Committee and Assembly Budget Subcommittee No. 1

The Medi-Cal Asset Test: Options for Change

Tuesday, February 2, 2021 – 9:00 a.m. to 12:00 p.m.
State Capitol, Room 4202

BACKGROUND

California's Medicaid program, called Medi-Cal, provides health coverage to nearly 14 million low income individuals, including children, families, many low-wage workers, and seniors and persons with disabilities. In addition to state residence and income limits, one of the factors used to determine eligibility for certain Medi-Cal categories (such as California's seniors and persons with disabilities) is whether they have assets above specified amounts. Referred to as a "resource limit" or "asset test," the asset test limits the amount of cash and certain types of property an applicant or beneficiary can have in order to be Medi-Cal eligible. Examples of assets include checking and savings accounts and a second car.

The asset test only applies to a subset of the total Medi-Cal population as a result of state and federal policy changes (including the Patient Protection and Affordable Care Act,[i] known as the Affordable Care Act or ACA). However, for those Medi-Cal beneficiaries subject to an asset test, the dollar limit and many of the definitions of what "counts" as an asset have remained largely unchanged over time.

The purpose of the asset test is to limit access to Medicaid to only those who do not have access to sufficient resources to pay for their own medical care. However, the asset test contrasts with the way eligibility is determined for many other populations under the ACA. Similar to the maintenance need level and the home upkeep allowance, the asset test for the non-Medicare Savings Program (MSP) remains at a level set in the 1980s. Last increased in 1989, when the state minimum wage was $4.25 an hour[ii], these $2,000 and $3,000 fixed dollar amounts with no adjustment for the Consumer Price Index or other inflator, lose ground to the increasing cost of living in a high cost state such as California.

Proponents of changing the asset test make several arguments, including:

- The principal asset amounts of $2,000 and $3,000 are fixed dollar amounts that have remained unchanged for more than 30 years;
- The dollar limits discourage savings, create financial instability, and cause low-income people to be at increased risk for homelessness;
- The dollar limits prevent low-income people from establishing a "rainy day" fund and make it difficult for low-income people to address unforeseen expenses (such as a roof or car repair);
- The paperwork and complexity of documenting assets deter people from applying to the Medi-Cal program and completing the Medi-Cal application process;
- The asset test increases county administrative costs and workload; and,
- The asset limits make it difficult for low-income beneficiaries to save enough to move and afford the cost of moving to a new apartment or house and for initial utility installation costs.

In the 2019-20 legislative session, the Medi-Cal asset test was the subject of legislation (AB 683 by Assemblymember Carrillo), which would have made several changes to the asset test. AB 683 proposed to increase the asset test from $2,000 for an individual and $3,000 for a couple to instead be $10,000 and $15,000, and required those dollar amounts to be indexed annually. Additional, AB 683 would have prohibited the use of an asset and resource test to make a Medi-Cal eligibility determination for people enrolled in the MSP (the MSP provides Medi-Cal funded payment of Medicare premium and cost-sharing but does not include Medi-Cal), would have excluded other assets from consideration, and would have narrowed the application of existing asset limits. AB 683 was never heard in the State Senate.

In addition, the asset test was discussed as part of the state Assembly Budget Subcommittee hearing process in 2019, and the Supplemental Report of the 2019-20 Budget Act required the Department of Health Care Services (DHCS) to seek technical assistance from the Centers for Medicare and Medicaid Services (CMS) regarding the possible avenues for modifying the treatment of assets for Medi-Cal, and to report to the legislative fiscal committees no later than March 10, 2020.[iii]

This hearing will provide an overview of state and federal asset test requirements, options for changing the current state requirement under federal Medicaid law, and what other states have done. Testimony will be provided on how those state and federal rules are implemented by counties (which determine Medi-Cal eligibility), the policy and fiscal options outlined in the required DHCS asset limits supplemental report, and the impact of the asset test on Medi-Cal applicants and beneficiaries.

Background

Medi-Cal is a joint federal-state program that provides health care to low-income Californians. State Medicaid programs are funded by federal and state funds and are administered by individual states. Federal law requires states using federal Medicaid funds to meet certain minimum requirements, such as covering certain populations and benefits, but also gives states the flexibility to extend eligibility to other groups or offer additional benefits, as well as to make other program choices. Medicaid is an important source of health and long-term care (LTC) coverage for seniors and persons with disabilities, including people with Medicare, because Medi-Cal covers Medicare cost-sharing (copayments and deductibles) and services Medicare does not cover (such as dental, glasses, personal care services, extended skilled nursing facility care, and non-emergency non-medical transportation).

Medi-Cal Eligibility

Medi-Cal eligibility is complex and is governed by federal law, federal regulation, state law, state regulation, and DHCS and CMS guidance. There are multiple different pathways to Medi-Cal coverage. Historically, applicants for Medi-Cal have been required to meet specified income and asset standards to qualify under each Medicaid eligibility category. California removed the asset test requirement for certain populations, such as pregnant women and infants (in the late 1980s) and children (in the late 1990s), but the asset test remained for other Medi-Cal eligibility groups.

In 2010, the ACA expanded Medicaid eligibility to nondisabled low-income adults under age 65, and restricted the use of an asset test for many Medicaid beneficiaries under a new income counting methodology. Referred to in California as the "optional expansion" after the U.S. Supreme Court allowed states to opt out of the ACA requirement for states with a Medicaid program, the Medi-Cal expansion took effect January 1, 2014.[iv] Specifically, the ACA prohibited the use of an asset test for individuals under age 65 and required the adoption of a new method for counting income based on Modified Adjusted Gross Income (MAGI).[v] The new MAGI income counting methodology applies for most people applying for Medi-Cal and people applying for federal premium tax and cost-sharing subsidies through exchanges. The MAGI methodology does not consider assets or resources other than income (meaning there is no asset test for MAGI-based eligibility determinations). DHCS estimates approximately 10.5 million individuals in California receive Medi-Cal under the MAGI methodology.[vi]

However, several categories of Medi-Cal eligible individuals, including seniors and persons with disabilities, continue to be subject to asset testing to qualify for Medi-Cal. Their eligibility is determined under what is known as the "non-MAGI methodology" which includes limits on countable assets. Non-MAGI Medi-Cal programs generally cover low-income individuals who are elderly, disabled, in a LTC facility, or who are linked to Medi-Cal through other public benefit programs, such as foster care and Supplemental Security Income (SSI). California has a large number of Non-MAGI Medi-Cal programs such as the Aged, Blind, and Disabled Federal Poverty Level program[vii] and the Aged, Blind, and Disabled Medically Needy program. Additionally, California has LTC Medi-Cal for those individuals who are admitted into a

licensed facility and require general nursing care or are unable to take care of their daily living needs. DHCS estimates approximately 2 million individuals are enrolled in a Non-MAGI Medi-Cal program with 54,000 of those enrolled in LTC Medi-Cal.

The federal Medicaid Act allows states to use less restrictive methods than those outlined in federal law to determine income and resource eligibility for some eligibility categories.[viii] In 2015, CMS provided guidance on state enrollment flexibility that includes options for asset testing such as setting an asset limit that is above the federal floor, which was one of the provisions proposed by AB 683. For example, on January 23, 2015, the CMS indicated that:

> States can simplify their administrative processes by using flexibility under Section 1902(r)(2) of the Social Security Act. For example, states can disregard the income of other individuals, such as spouses, whose income is otherwise countable toward the prospective MSP enrollee. The same provision can also be used to disregard specific amounts of income or categories of assets. In addition, states may use the flexibility authorized under Section 1902(r)(2) to set an overall asset limit at any level above the federal floor, or to disregard all assets. States have the option of using these flexibilities only for MSPs, or they may apply them to other categories of Medicaid as well. Some states have already taken these steps.[ix]

What Are the Asset Limits in Medi-Cal?

Eligibility for enrolment through non-MAGI Medi-Cal is subject to limits on the amount of countable assets.[x] To be eligible for most Non-MAGI Medi-Cal programs, the countable assets for one person may not exceed $2,000 a month for an individual or $3,000 for two people, excluding MSP, which have higher asset limits. The dollar asset limits increase with family size (as shown in the chart below), and any amount over the asset limit will make an individual and/or family ineligible for Medi-Cal.

The Medi-Cal asset limits that are in state regulation were last increased in 1989.[xi] The current limits are also not adjusted for inflation. The asset limits were increased in 1985, 1986, 1987, 1988, and 1989, by $100 annually for an individual and $150 annually for additional person. The chart below shows the current asset limits in regulation, and what were proposed under AB 683:

Asset Limits		
Number of People	**Current Law**	**AB 683**
1	$2,000	$10,000
2	$3,000	$15,000
3	$3,150	$20,000
4	$3,300	$25,000
5	$3,450	$30,000
6	$3,600	$35,000
7	$3,750	$40,000
8	$3,900	$45,000
9	$4,050	$50,000
10	$4,200	$55,000

The MSP has a different asset limit than the amounts above. Federal regulation sets the MSP property (asset) limits at three times the SSI property limits, plus a percentage increase equal to the increase in the Consumer Price Index. For 2021, these amounts are $7,860 for an individual and $11,800 for a couple.[xii] AB 683 would have repealed the current property limits used to determine MSP eligibility.

MSP provides low-income Medicare beneficiaries with Medicaid assistance with some or all of their Medicare out-of-pocket costs. The MSP pays for Medicare premiums and cost-sharing but does not provide Medi-Cal services. Medicare's out-of-pocket costs, including premiums, deductibles, and other cost-sharing, can be high. For example, Medicare Part A, which covers inpatient hospital services, has a deductible of $1,484 in 2021 for each benefit period.[xiii] Medicare Part B, which covers outpatient services, requires a monthly premium of $148.50 for most beneficiaries in 2021. Part B also requires an annual deductible of $203 in 2021 and co-insurance of 20% of the Medicare approved cost of services after the deductible is met. To help low-income enrollees afford Medicare's out-of-pocket costs, state Medicaid programs must offer three MSPs:

- Qualified Medicare Beneficiaries (QMBs) generally have incomes up to 100% of the Federal Poverty Level (FPL) ($1,064 per month for an individual and $1,437 for a couple in 2020). Medicaid pays Medicare Parts A and B premiums and cost-sharing for QMBs;
- Specified Low-Income Medicare Beneficiaries (SLMBs) have slightly higher incomes (100-120% FPL) and receive help with Medicare Part B premiums only. Most states set their SLMB income limits at 120% FPL ($1,277 per month for an individual and $1,724 for a couple in 2020); and,
- Qualified Individuals (QIs) are eligible for Medicaid assistance with Medicare Part B premiums through an expansion of the SLMB program passed by Congress in 1997. The QI program covers Medicare beneficiaries with incomes up to 135% FPL ($1,436 per month for an individual and $1,940 for a couple in 2020). However, unlike other Medicaid pathways, because Congress only appropriates a limited amount of funds to each state to pay for the QI program, once a state's QI appropriation is spent, additional individuals who meet the eligibility criteria cannot receive help.

According to a June 2019 Issue Brief by the Kaiser Family Foundation entitled "Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey," most states have the $2,000 and $3,000 asset limits that California has for the aged, blind and disabled eligibility pathway. Two states have lower asset limits than California, and 10 states have higher limits, including Arizona, which has no asset limit. For the 33 states plus the District of Columbia that have a medically needy program, one state has a lower limit (Connecticut) and 10 have a higher asset limit. Arizona eliminated its assets test completely to simplify eligibility determinations after finding administrative savings largely offset any increase in enrollment. Six states with MSPs, plus D.C. have no assets test at all for some or all of their MSP and two additional states have higher limits than the federally required minimum amounts.

What is an "Asset" for Purposes of Medi-Cal Eligibility?

What "counts" and what is exempt as an asset for purposes of the Medi-Cal asset test is in state and federal law but primarily in extensive state guidance and Medi-Cal regulation.[xiv] Property that is not counted in determining a person's Medi-Cal eligibility is called "exempt" or "unavailable" property. Countable property (property which is not exempt or which is not available) is included in the applicant or beneficiary's "property reserve" (the formal regulatory definition of the dollar amount of the asset limit). A person's countable property cannot exceed the property reserve limit.

Examples of assets subject to the asset test which are included in the property reserve limit include checking and savings accounts to which the beneficiary has unrestricted access[xv], cash on hand[xvi], income tax refunds,[xvii] a second car,[xviii] jewelry (except for wedding and engagement rings and heirlooms) with a net market value over $100,[xix] United States Savings bonds,[xx] and life insurance with a face value of $1,500 or more.[xxi] Exemptions from the asset test include a home,[xxii] one car,[xxiii] musical instruments,[xxiv] personal effects (such as clothing),[xxv] recreational items,[xxvi] and livestock and poultry (if used for personal use).[xxvii]

Any amount over an individual's property reserve limit makes an individual ineligible for Medi-Cal. A county Medi-Cal eligibility worker looks at how much an applicant and their family has when determining eligibility for non-MAGI Medi-Cal. If the applicant or recipient's property/assets are below the limit at any time during that month, the applicant will be Medi-Cal eligible (if the person is otherwise eligible). If a person has more than the limit for a whole month, Medi-Cal benefits will be discontinued. Individuals can reduce their property to meet the reserve limit before the end of the month in which they are requesting Medi-Cal. For example, a non-MAGI Medi-Cal applicant whose total non-exempt property consists of a savings account with a balance of $3,300 in a month must reduce the savings account to $2,000 in that month. In this same situation, where there is a couple, the savings must be reduced to $3,000.

On behalf of DHCS, county eligibility workers use a form called the "MC 605 IPS (5/14)" to gather information about an applicant's assets.[xxviii] For some of the assets listed on the form, individuals must attach verifying documentation, such as bank statements.

AB 683 would have broadened exemptions from the asset test in multiple areas. For example, AB 683 would have broadened the motor vehicle exemption to no longer limit the exemption to one vehicle, would have exempted livestock and poultry (by no longer requiring they be exempt only if for personal use), and tax refunds for up to 12 months.

Medi-Cal Asset Limits Supplemental Report by DHCS

Pursuant to the Legislative Analyst's Office Supplemental Report of the 2019-20 Budget Act, DHCS issued a report in March 2020. In its report, DHCS' stated that its Medi-Cal Asset Limit Supplemental Report is intended to provide a detailed analysis to legislative fiscal committees on three options for modifying treatment of assets for Non-MAGI Medi-Cal programs.

DHCS confirmed with the federal CMS that California has the flexibility to change the treatment of assets for Non-MAGI Medi-Cal, MSP, and LTC. CMS informed DHCS that under Section 1902(r)(2) of the Social Security Act, California has the authority to implement any of the three asset modification options discussed below to the extent an appropriation is provided and federal approvals are obtained. Based on the discussion with CMS, DHCS indicates it would need to submit a State Plan Amendment (SPA) and possibly a federal Medicaid waiver to implement changes to the asset limits in California. A SPA is needed in order to carry out changes across the Medi-Cal coverage group. A Medicaid waiver would additionally be required if any population within a coverage group is excluded.

In preparing the report, DHCS collected data on the Non-MAGI Medi-Cal, LTC and MSP populations via the Statewide Automated Welfare System (SAWS) and Medi-Cal Eligibility Data System (MEDS). Based on the data provided by SAWS and MEDS, DHCS identified individuals who were denied or discontinued from all Medi-Cal programs with an asset test in calendar year 2018. DHCS also evaluated data elements for the denied/discontinued individuals, such as the amount of countable assets, the type of assets owned by the individuals, and the programs for which the individuals were screened. DHCS used this information to best identify the impacted population and derive fiscal estimates, including opportunities for cost savings.

As stated above, DHCS identified three options for modifying the way assets are treated for Non-MAGI Medi-Cal programs. DHCS indicates CMS stated that California has the authority to implement any of the three asset modification options and continue to be eligible to draw down federal financial participation (FFP) for individuals affected by the change. Furthermore, the SAWS consortia has the ability to implement any of the three options in their eligibility systems. These options are:

- Option 1 - Eliminate the asset test;
- Option 2 - Increase asset limits and change certain treatment of assets proposed in AB 683 (Carrillo); or,
- Option 3 - Increase asset limits to $10,000 for an individual and $5,000 for each additional household member.

The three charts below show the net number of newly eligible Medi-Cal beneficiaries under each of the three options above.

The options include an estimate of the new net number of people who would become eligible for Medi-Cal as a result of either the elimination of the asset test (in Option 1) or increases in the asset test amounts (Option 2 and 3). This estimate of net newly eligible individuals are those individuals who were ineligible initially under existing law because they were “over assets” (had assets above the asset limits) and individuals who failed to provide asset-related information. The net newly eligible figure is lower than the number of potentially newly eligible individuals because the latter number includes individuals who enrolled under existing law but who were initially ineligible because of excess assets who subsequently became Medi-Cal-eligible at a later

date by reducing their assets (referred to as "spending down" or "spend down"), and individuals who applied for Medi-Cal but initially failed to provide asset-related information but who subsequently became eligible by providing asset-related information.

Option 1- Eliminate the Asset Test Data Source: SAWS, MEDS Data Period: January 1, 2018-December 31, 2018		
	Number of Potentially Newly Eligible Individuals	Number of Individuals who later became eligible (Spent Down or provided verifications)
Non-MAGI (over assets)	12,587	4,092
LTC (over assets)	435	263
Medicare Savings Program (over assets)	142	40
All Populations (over assets)	13,164	4,395
Non-MAGI (Failure to Provide)	8,810	0
LTC (Failure to Provide)	195	83
Medicare Savings Program (Failure to Provide)	238	127
All Populations (Failure to Provide)	9,243	210
Entire Impacted Population	22,407	4,605
Net Newly Eligible Individuals	17,802	

Option 2- Increase Asset Limits to $10,000 for an individual and $5,000 For Each additional household member on non-exempt countable assets and Change The treatment of certain assets as proposed in AB 683 Data Source: SAWS, MEDS Data Period: January 1, 2018-December 31, 2018		
	Number of Potentially Newly Eligible Individuals	Number of Individuals who later became eligible (Spent Down or applied at a later date)
Non-MAGI	9,408	2,545
LTC	284	172
Medicare Savings Program	0	0
Total Newly Eligibles for All Programs	9,692	2,717
Net Newly Eligible Individuals	6,975	

Option 3- Increase the Asset Limits to $10,000 for an individual and $5,000 for each additional household member Data Source: SAWS, MEDS Data Period: January 1, 2018-December 31, 2018		
	Number of Potentially Newly Eligible Individuals	Number of Individuals who later became eligible (Spent Down or applied at a later date)
Non-MAGI	8,110	2,545
LTC	245	172
Medicare Savings Program	0	0
All Populations	8,355	2,717

Net Newly Eligible Individuals	5,638

The three charts below show the net fiscal impact of the three options above, taking into account changes in Medi-Cal enrollment, required system changes and administrative costs:

Option 1 —Eliminate the Asset Test			
	Total Funds	**General Funds**	**Federal Funds**
Program	$223,515,000	$107,405,860	$116,109,140
System Change	$452,000	$226,000	$226,000
Administrative	$148,000	$74,000	$74,000
Elimination of the Asset Verification Program (Savings)	($3,960,000)	($1,980,000)	($1,980,000)
Total Cost	**$220,155,000**	**$105,725,860**	**$114,429,140**

Option 2 — Increase Asset Limits to $10,000 for an individual and $5,000 for each additional household member on non-exempt countable assets and change the treatment of certain assets as proposed in AB 683.			
	Total Funds	**General Funds**	**Federal Funds**
Program	$90,440,000	$43,435,000	$47,004,000
System Change	$334,000	$167,000	$167,000
Administrative	$148,000	$74,000	$74,000
Total Cost	**$90,992,000**	**$43,676,000**	**$47,245,000**

Option 3 — Increase Asset Limits to $10,000 for an individual and $5,000 for each additional household member			
	Total Funds	**General Funds**	**Federal Funds**
Program	$73,228,000	$35,165,400	$38,062,600
System Change	$168,000	$84,000	$84,000
Administrative	$148,000	$74,000	$74,000
Total Cost	**$73,544,000**	**$35,323,400**	**$38,220,600**

Conclusion

The current $2,000 and $3,000 asset limits were last adjusted in 1989, have no built-in cost-of-living adjustment, discourage savings, prevent low-income people from establishing a "rainy day" fund and make it difficult for low-income to address unforeseen expenses. In addition, the limits result in low-income people being unable to receive the additional dental, vision, transportation and long-term services and supports covered by Medi-Cal that may not be covered by Medicare or private health plans. DHCS' Supplemental Report provides detailed caseload and fiscal impact estimates and information on other states that have adjusted their asset limits and provides fiscal and policy options for the Legislature to consider under federal Medicaid law for changing the existing asset limits.

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[i] Public Law 111-148) as originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
[ii] State of California Department of Industrial Relations, "History of California Minimum Wage" available at: https://www.dir.ca.gov/iwc/MinimumWageHistory.htm
[iii] "Supplemental Report of the 2019-20 Budget Act" Containing Statements of Intent And Requests for Studies Adopted by the Legislature Compiled by the Legislative Analyst's Office, Revised October 2019, p. 11 at: https://lao.ca.gov/reports/2019/4084/supplemental-language-2019.pdf
[iv] AB X1 1 (J. Perez), Chapter 3, Statutes of 2013.
[v] Section 1902(e)(14) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)).
[vi] Medi-Cal Asset Limits Supplemental Report, Department of Health Care Services, March 2020, p. 2.
[vii] The Aged, Blind, and Disabled Federal Poverty Level (ABD-FPL) program covers individuals with incomes up to 138% of the federal poverty level (FPL). The Aged, Blind, and Disabled Medically Needy (ABD-MN) program covers individuals with incomes above 138% of the FPL, but these individuals must spend all but $600 of their income for an individual (referred to as "share of cost" or "spending down") on their own medical care before Medi-Cal will cover the rest of their health care for a given month.
[viii] Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2).
[ix] CMCS Information Bulletin "Enrollment and Retention Flexibilities to Better Serve Medicare-Eligible Medicaid Enrollees," Centers for Medicare & Medicaid Services, January 23, 2015 at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-23-2015.

[x] Title 22 of the CCR, Section 50420.
[xi] Title 22 of the CCR, Section 50419 and 50420.
[xii] All County Welfare Directors Letter (ACWDL) 20-07 at https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c20-07.pdf.
[xiii] Medicare Costs at a Glance at https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance
[xiv] Title 22 of the CCR, Sections 50401 through 50489.5
[xv] Title 22 of the CCR, Section 50453.
[xvi] Title 22 of the CCR, Section 50451, unless the cash on hand is income received in that month.
[xvii] Title 22 of the CCR, Section 50454.

[xviii] Title 22 of the CCR, Section 50461.
[xix] Title 22 of the CCR, Section 50467.
[xx] Title 22 of the CCR, Section 50457.
[xxi] Title 22 of the CCR, Section 50475.
[xxii] Title 22 of the CCR, Section 50425.
[xxiii] Title 22 of the CCR, Section 50461.
[xxiv] Title 22 of the CCR, Section 50471.
[xxv] Title 22 of the CCR, Section 50467.
[xxvi] Title 22 of the CCR, Section 50469.
[xxvii] Title 22 of the CCR, Section 50473.
[xxviii] MC 604 IPS (5/14) "Additional Income and Property Information Needed for Medi-Cal" https://www.dhcs.ca.gov/formsandpubs/forms/Forms/MC%20600/MC_604_IPS_ENG_0514%20(2).pdf