

**Medi-Cal Asset Limits  
Supplemental Report**



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**Medi-Cal Asset Limits  
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## **EXECUTIVE SUMMARY**

The 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-Modified Adjusted Gross Income (Non-MAGI) Medi-Cal programs.

Through engagement with the federal Centers for Medicare and Medicaid Services (CMS), they have confirmed that California has the flexibility to change the treatment of assets for Non-MAGI Medi-Cal, Medicare Savings Programs, and Long Term Care (LTC). CMS informed the Department of Health Care Services (DHCS, hereafter referred to as “Department”) that under Section 1902(r)(2) of the Social Security Act, California would have the authority to implement any of the three asset modification options discussed in this Supplemental Report to the extent an appropriation is provided and federal approvals are obtained. Based on the discussion with CMS, the Department would need to submit a State Plan Amendment (SPA) and possibly a 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 Waiver would additionally be required if any population within a coverage group is excluded.

The Department collected data on the Non-MAGI Medi-Cal, LTC and Medicare Savings Program populations via the Statewide Automated Welfare System (SAWS) and Medi-Cal Eligibility Data System (MEDS). Based on the data provided by SAWS and MEDS, the Department identified individuals who were denied or discontinued from all Medi-Cal programs with an asset test in calendar year 2018. The Department 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. The Department used this information to best identify the impacted population and derive fiscal estimates, including opportunities for cost savings.

In the review of available data, the Department identified three options for modifying the way assets are treated for Non-MAGI Medi-Cal programs. According to CMS, California has the authority to implement any of the three asset modification options and continue to be eligible to draw down FFP for individuals impacted 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 Assembly Bill 683 (Carrillo, 2019)
- **Option 3** - Increase asset limits to \$10,000 for an individual and \$5,000 for each additional household member

Increasing the asset limits for Non-MAGI Medi-Cal programs, Medicare Savings Programs and LTC would allow individuals to retain more assets and remain eligible for

medical assistance. This may allow individuals with more assets the ability to have a safety net savings for unexpected life expenses.

## **ISSUE STATEMENT**

Pursuant to the Legislative Analyst's Office Supplemental Report of the 2019-20 Budget Act, the Department is required to seek technical assistance from CMS regarding the possible avenues for modifying the treatment of assets for Medi-Cal. The technical assistance options the Department explores are limited to 1) eliminating asset limits, 2) increasing asset limits on nonexempt property;; and 3) indexing assets annually. To the extent data allows, the cost estimates are broken out by specific populations (this report includes possible avenues for modifying the treatment of assets for Non-MAGI Medi-Cal, Medicare Savings Programs, and LTC programs). In addition, the Department includes an assessment of the federal authorities under which the modifications could be pursued and include any challenges that could arise while securing federal approval. The Department is required to report on these activities to the fiscal committees of the Legislature no later than March 10, 2020.

## **OBJECTIVES**

The objective of the Supplemental Report is to provide detailed analysis to the legislative fiscal committees on three viable options for the treatment of assets for Non-MAGI Medi-Cal, Medicare Savings Program, and LTC programs. The report includes an assessment of the federal authority under which the options could be pursued, estimates for increased program costs for each option, and estimated timelines for system implementation of the policy.

## **BACKGROUND**

### **Non-MAGI Medi-Cal Programs and Income Methodology**

California has two main income methodologies for Medi-Cal, which are Modified Adjusted Gross Income (MAGI) and Non-MAGI. MAGI eligibility looks at a household's countable income and deductions based on the Internal Revenue Service's tax code and compares it to applicable program income limits, which are percentages of the Federal Poverty Level (FPL). There is no asset test. Approximately 10.5 million individuals in California receive Medi-Cal under the MAGI methodology. This report will be focused on Medi-Cal programs that follow the Non-MAGI Methodology, which is explained below.

Non-MAGI Medi-Cal programs generally cover low-income individuals who are elderly, disabled, in a long-term care 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 (ABD-FPL) program and the Aged, Blind, and Disabled Medically Needy (ABD-MN) 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. Approximately 2 million individuals are enrolled in a Non-MAGI Medi-Cal program with 54,000 of those enrolled in LTC.

Non-MAGI Medi-Cal program eligibility is subject to limits on the amount of countable assets an individual has. Countable assets (which are not exempt or unavailable) are included in the “property reserve.” The property reserve is the total net market value of nonexempt countable assets that an individual can retain and be eligible for Medi-Cal benefits. Any amount over the asset limit will make an individual and/or family ineligible for Medi-Cal. To be eligible for most Non-MAGI Medi-Cal programs, the countable assets for one person may not exceed \$2,000 or \$3,000 for two people, excluding Medicare Savings Programs. These amounts have not changed since 1989. Appendix A provides the current policy for the treatment of assets for Non-MAGI Medi-Cal. Exempt assets include an individual’s primary home, one motor vehicle, household goods, assets used for business or trade, and other assets detailed in Appendix A.

Furthermore, an individual’s net countable income currently needs to be at or below 100 percent of the FPL and will be increased to 138 percent effective August 1, 2020 in order to be eligible for the ABD-FPL program. Certain allowable deductions, like the health insurance premiums deduction, can reduce the individual’s countable income. If an individual’s countable income exceeds ABD-FPL program income limits but their countable assets is within program limits, the individual qualifies for the MN program with a share of cost (SOC). The SOC is the monthly amount an individual must pay, or obligate themselves to pay, before Medi-Cal will pay for any remaining medical expenses for the month. The individual’s SOC is calculated by subtracting the applicable MN maintenance need level from their countable income. The maintenance need level is a fixed amount for living expenses, set by state and federal law, which increases based on family size. The more a beneficiary’s net nonexempt income exceeds the maintenance need level, the higher the SOC amount.

Medicare Savings Programs are federally-funded programs that are administered by each individual state. Medicare Savings Programs are mandatory Medicaid eligibility pathways that states must make available to individuals who qualify for them. States have the option to make the eligibility rules more generous than federal standards by not imposing asset limits or by lowering the income thresholds. These programs are for individuals with limited income and assets and help pay some or all of their Medicare premiums, deductibles, and coinsurance. Programs under Medicare Savings Program include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled and Working Individuals (QDWI). For 2019, the QMB, SLMB, and QI programs have an individual asset limit of \$7,730 and a married couple asset limit of \$11,600. The QDWI program has an individual asset limit of \$4,000 and a married couple asset limit of \$6,000.

Existing state law requires the Department to pay Medicare premiums under the Medicare Buy-in Agreement with the Social Security Administration for beneficiaries with no-cost Medi-Cal or those who have met their SOC (Title 22, California Code of

Regulations (CCR) Section 50773). Furthermore, the Department pays premiums, deductibles, and coinsurance for qualified Medicare beneficiaries pursuant to existing state law. The Department currently pays Medicare Part A and Part B premiums for approximately 1.5 million beneficiaries that participate in the Medicare Premium Payment program.

The In-Home Supportive Services (IHSS) program is a county-administered program under the direction of the California Department of Social Services (CDSS). IHSS provides qualified aged, blind, and disabled persons with services to permit them to remain in their own homes. Individuals must be enrolled in Medi-Cal to be eligible for IHSS. If an IHSS recipient has a SOC, the recipient must meet their SOC before Medi-Cal begins to pay for services. IHSS recipients are required to sign a letter of understanding acknowledging their obligation to pay their SOC to the IHSS provider each month as a condition of participating in the IHSS program. Both the IHSS provider and recipient receive a notice informing them of the amount the recipient must pay the IHSS provider for that month. Failure to pay the provider can result in termination from the IHSS program.

#### Reduction of Assets to be Within Asset Limits

Medi-Cal eligibility cannot be approved for a given month unless countable assets are below the asset limit sometime within the month. A Medi-Cal applicant may reduce their non-exempt assets, to be below the asset limit, in the month that Medi-Cal is being requested. For Non-MAGI Medi-Cal and Medicare Savings Programs, there is no limitation as to how the assets are reduced within the calendar month for which Medi-Cal is being requested.

If an individual is unable to reduce their assets beginning with the month of application, *Principe v. Belshé* allows individuals to reduce their excess assets retroactively on qualified medical expenses. Qualified medical expenses are medical expenses that were incurred in any month and were unpaid in the same month where there was excess assets for the entire month. Qualifying medical expenses include those that Medi-Cal would otherwise cover, such as co-payments for services and drugs along with medical equipment and supplies. Eligibility may be granted after payment of those qualified medical expenses occurs and verification of the payment is provided to the county.

An institutionalized applicant or someone who is already receiving Medi-Cal who becomes institutionalized may be ineligible due to a transfer of non-exempt assets for less than fair market value that occurred within the previous 30 months. Non-exempt assets may be transferred without incurring a period of ineligibility if:

- The asset is transferred to the spouse of the institutionalized individual, or the child of the institutionalized individual who is blind or permanently and totally disabled,

- the asset was intended to be transferred at fair market value for something of equal value,
- the asset was not transferred to establish Medi-Cal eligibility, or
- a period of ineligibility for nursing facility level of care would cause an undue hardship.

### Eligibility and Enrollment Systems

The SAWS is California's public assistance eligibility and enrollment system used by county eligibility workers. The SAWS supports eligibility determination, benefit calculation, benefit issuance, case management, and reporting for six core programs including Medi-Cal. There are three consortia that make up the SAWS eligibility and enrollment system: the LEADER Replacement System (LRS), Consortium IV (C-IV), and the CalWORKs Information Network (CalWIN).

MEDS is a statewide data hub that serves as a repository of eligibility and enrollment data for Medi-Cal and other state and federal benefits.

## **STUDY METHODOLOGY**

### Engagement with the Centers for Medicare & Medicaid Services

The Department conducted several conference calls with CMS from August through October, 2019 during the research process. CMS confirmed that California has a variety of options to choose from in regards to treatment of assets for Non-MAGI Medi-Cal, Medicare Savings Programs, and LTC programs. CMS informed the Department that under Section 1902(r)(2) of the Social Security Act, California would have the authority to implement any of the three asset modification options discussed in this Supplemental Report and continue to be eligible to draw down FFP for individuals impacted by the change. Based on the discussion with CMS, the Department would need to submit a SPA and possibly a Waiver to implement changes to the asset limits in California. A SPA is needed in order to carry out changes across a Medi-Cal coverage group. A Waiver would be required if a given population within a coverage group is excluded from the asset modification options.

### State Plan Amendments and Waiver Research

#### *State Plan Amendment*

In order to implement any changes to the treatment of assets for Non-MAGI Medi-Cal, Medicare Savings Programs, and LTC programs, the Department would be required to make changes to the Medicaid State Plan through the SPA process. Almost every state has a Medicaid State Plan that outlines the details of its Medicaid program. Each plan is different, reflecting both the uniqueness and complexity of each state's Medicaid program. States can use the SPA process to change administrative aspects of their Medicaid plan. A SPA can address any aspect of Medicaid administration (eligibility,

benefits, services, provider payments, etc.).

The following requirements also apply to SPAs:

- **Statewideness**—changes must apply to Medicaid enrollees throughout the state, not just in certain areas.
- **Comparability**—Comparable services must be available to all people eligible for Medicaid, regardless of their eligibility category. Additionally, eligibility determination rules for specific coverage groups must be the same for all programs in the coverage group.
- **Choice of Providers**—Medicaid enrollees must be free to choose among health care providers.

SPA approvals are not contingent on meeting any budgetary target, however, states are required to indicate on the transmittal form the expected federal financial impact.

Once the SPA is submitted, CMS has 90 days to make a decision regarding the SPA contents. CMS can “stop the clock” by formally requesting additional information from the state. Once the state submits the required information, a new 90-day clock begins. However, CMS may only stop the clock once per SPA. Changes can take effect retroactively to the first day of the quarter in the calendar year in which the state submitted the amendment. A SPA does not expire, but a state can change it through a subsequent SPA.

### *Waivers*

CMS grants waivers to states to initiate new programs that are not otherwise permitted under existing Medicaid rules. Federal law permits the Secretary of the U.S. Department of Health and Human Services (HHS) to waive certain federal requirements as needed by states to conduct demonstration or pilot projects to improve their Medicaid program.

There are several types of waivers available to states and each waiver is designated by the section of the Medicaid statute that gives the Secretary of HHS the legal authority to waive Medicaid requirements. While each type of waiver addresses different elements and has different requirements, all waivers have the following common aspects:

- Time limited (generally approved for three to five years and can be renewed).
- Cannot increase costs to the Medicaid program.
- Ensure consistency with the purpose of the Medicaid program, which is to provide meaningful health insurance to qualifying low-income people.

The submission and approval process depends on the type of waiver. There are standard applications for 1915 waivers, but not for 1115 waivers. There can be a considerable amount of interaction and negotiation between the state and CMS during the review and approval process.

### Waivers and Comparability

While researching the different options that California could consider for modifying the treatment of assets, eliminating asset tests for the LTC program was discussed. The cost for the implementation of this option could be very high, as the LTC population is the most expensive population for Medi-Cal to cover.

According to discussions with CMS, if the Department chooses to eliminate the asset test for one program within a coverage group, it would need to do so for all programs in that same coverage group, in order to meet the comparability requirements. The LTC population is part of the MN coverage group. If California chooses to keep the asset test as is for LTC, a waiver would be required to request an exemption from the comparability rule in this situation. The waiver would allow California to eliminate or change the asset test for other programs among the MN coverage group, but keep the asset test the same for LTC.

### Engagement with Other States

#### *Arizona*

The Department reached out to the State of Arizona Health Care Cost Containment System to learn about the elimination to their asset test for SSI Non-Cash groups. The exclusion of assets for these groups was effective on April 1, 2001. At the time Arizona eliminated their asset test, they also raised the income limit for SSI Non-Cash groups to 100 percent of the FPL. So, while they saw an increase in costs by adding individuals who were previously ineligible for benefits for exceeding income and assets, they did note an administrative cost savings for eliminating the asset test. They found savings in the following areas:

- Savings from reduced postage costs
- Savings due to reduced forms usage
- A 15-day reduction in the amount of time needed to process applications
- Better customer service
- Decreased Quality Control (QC) error rates since asset errors were eliminated

Arizona did not eliminate the asset test for their LTC population. They requested an 1115 Waiver from CMS to waive the comparability rule for this population and it was approved by CMS.

#### *New York*

The Department also reached out to the New York State Department of Health to inquire about the steps they took to increase the asset limits for Non-MAGI programs. New York raised the asset limits for their MN groups in 2007. In New York, the ABD population is covered under their MN coverage group. Like Arizona, New York raised their income limits for their MN coverage group at the same time they increased the

asset limits. New York raised their income limits to be 30 percent above the SSI benefit level. Currently, the asset limits for the MN programs in New York are \$15,750 for an individual and \$23,180 for a couple. Furthermore, New York does not have an asset test for any of the Medicare Savings Programs.

New York saw an increase in costs for Medicaid benefits by adding individuals who were previously ineligible for exceeding income.

While New York identified a savings in administrative cost with the elimination of the asset test, they did note the increase in the income limits prompted more individuals to apply and subsequently be approved for services than the increase in the asset limits.

### Research on Annually Indexing Asset Limits

The Department researched states that annually index their asset limits based on the Consumer Price Index (CPI) to adjust for inflation. At this time, no states have chosen this option in order to update their asset limit amounts on an annual basis. However, some states do utilize the SSI payment level to base the annual increase in their asset limits. When speaking with CMS regarding indexing as a possible option, CMS stated that it was an option that could be considered.

Department research also found that the asset limits used to determine Medicare Savings Program eligibility are indexed annually. Federal law sets the Medicare Savings Program asset limits at three times the SSI asset limit plus an annual percentage increase equal to the CPI. For 2020, the asset limit for Medicare Savings Programs in California is \$7,860 for an individual and \$11,800 for a couple based on the annual increase using CPI.

### Data Collection Methods

The Department collected data on the Non-MAGI Medi-Cal, LTC and Medicare Savings Program populations via SAWS and MEDS, which identified individuals who were denied or discontinued from these programs in calendar year 2018. From that population, the Department evaluated specific 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. The Department used this information to best identify the impacted population and derive fiscal estimates, including opportunities for cost savings.

The Department acknowledges that there is the potential additional population of individuals that could newly apply and be eligible for Medi-Cal as a result of an asset limit increase, and therefore the costs for each asset modification option could potentially be more than originally estimated based on this unknown variable. However, as stated above, the Department ultimately utilized data that provided the most reasonable projections based on known information.

## **FINDINGS**

In the review of available data, the Department has identified three options for modifying the way assets are treated for Non-MAGI Medi-Cal programs. California has the authority to implement any of the three asset modification options and continue to be eligible to draw down FFP for individuals impacted by the change. The SAWS consortia also has the ability to implement any of the three options in their eligibility systems. Each option is discussed in detail in this section.

### *Option 1 – Eliminate the Asset Test*

The first option would completely eliminate the asset test for all Non-MAGI programs, including Medicare Savings Programs.

The chart below displays the number of individuals who are currently over the asset limit (reflected in the chart as “over-assets”) or failed to provide asset information and would potentially be eligible to Non-MAGI Medi-Cal, LTC, and Medicare Savings Program, if the asset test was fully eliminated for these programs. The options include assumptions for including and excluding the LTC population. The Department used data from the SAWS and MEDS for calendar year 2018 in order to determine the impacted population estimates.

<b>Option 1- Eliminate the Asset Test</b>		
<b>Data Source: SAWS, MEDS</b>		
<b>Data Period: January 1, 2018-December 31, 2018</b>		
	<b># of Potentially Newly Eligible Individuals</b>	<b># of Individuals who later became eligible (Spent Down or provided verifications)</b>
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
<b>Entire Impacted Population</b>	<b>22,407</b>	<b>4,605</b>
<b>Net Newly Eligible Individuals</b>	<b>17,802</b>	

For Non-MAGI Medi-Cal programs, it was determined that approximately 12,587 individuals were denied at application for exceeding the asset limit of \$2,000. Of that population, approximately 4,092 individuals spent-down their excess assets in order to become eligible at a later date in calendar year 2018. It was also determined that 8,810 individuals were denied Non-MAGI Medi-Cal at application for failure to provide asset information. The Department did not have data to reflect the number of Non-MAGI individuals who later reapplied.

For those that applied for LTC services, 435 individuals were denied for exceeding the asset limit. Of that population, 263 individuals spent-down their excess assets in order to become eligible at a later date in 2018. In the same year, 195 individuals were denied LTC Medi-Cal for failure to provide asset information. Of those individuals, 83 later provided the necessary information or reapplied for LTC services and became eligible at a later date in 2018.

For those that applied for Medicare Savings Programs, 142 individuals were denied for exceeding the asset limit. Of that population, 40 individuals spent-down their excess assets in order to become eligible at a later date in 2018. Furthermore, 238 individuals were denied Medicare Savings Program eligibility for failure to provide asset information. Of those individuals, 127 later provided the necessary information or reapplied for a Medicare Savings Program and became eligible at a later date in 2018.

Under Option 1, the total number of individuals who were denied for exceeding the asset limit or failure to provide asset information for Non-MAGI and Medicare Savings Program's was 21,777. Of that population, 4,259 either provided the information that was needed in order to make an eligibility determination, or spent-down their excess assets in order to become eligible. As a result, these individuals would not be considered "newly" eligible to Medi-Cal, as they met the conditions of Medi-Cal eligibility at a later time in 2018. The total number of previously ineligible individuals who would be potentially eligible for Non-MAGI Medi-Cal and Medicare Savings Programs under Option 1 without spending down or providing asset information is 17,518. Furthermore, if the LTC population is included in this change, the number of individuals who would become newly eligible for Medi-Cal under Option 1 increases to 17,802.

*Option 2 – Increase Asset Limits and Change Certain Treatment of Assets Proposed in AB 683 (Carrillo, 2019)*

The second asset modification option is based on what is proposed in AB 683 (Carrillo, 2019). AB 683 would increase the amount of countable assets an individual can retain in their asset reserve and still be eligible for Medi-Cal. The bill would increase the asset limit from \$2,000 to \$10,000 for one person and from \$3,000 for a couple and \$150 for each additional household member, to \$5,000 for each additional person in the household. The term 'property reserve' is used to describe the total net market value of nonexempt countable assets that an applicant or individual can retain and be eligible for Medi-Cal.

Along with increasing the dollar amount of assets that can be retained, AB 683 would expand the types of assets to be excluded from consideration when determining Non-MAGI Medi-Cal eligibility. For example, if AB 683 was enacted, all motor vehicles would be exempt, rather than just one vehicle, which is the exemption under current Medi-Cal policy. For a complete list of all the assets AB 683 would disregard, please refer to the chart in Appendix A.

The chart below displays the number of individuals who would be potentially eligible to Non-MAGI, LTC, and Medicare Savings Program, for Option 2. The Department used data from the SAWS and MEDS for calendar year 2018 in order to determine the impacted population estimates.

<b>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</b> <b>Data Source: SAWS, MEDS</b> <b>Data Period: January 1, 2018-December 31, 2018</b>		
	# of Potentially Newly Eligible Individuals	# 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
<b>Total Newly Eligibles for All Programs</b>	<b>9,692</b>	<b>2,717</b>

<b>Net Newly Eligible Individuals</b>	<b>6,975</b>
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In order to determine who would be newly eligible for Medi-Cal under Option 2, the Department had to determine how many individuals had assets over \$10,000. Then, looking at the assets owned by each individual, it was determined who would be under the proposed \$10,000 limit, if those specified assets were excluded as proposed in AB 683.

For those applying for Non-MAGI programs, 9,408 individuals were denied for exceeding the asset limit. Of this population, 2,545 spent-down their excess assets in order to become eligible at a later date in 2018.

For those applying for LTC, 284 individuals were denied for exceeding the asset limit. Of those individuals, 172 spent-down their excess assets in order to become eligible for LTC at a later date in 2018.

For those applying for Medicare Savings Programs, no individuals were denied for exceeding the asset limit and no individuals spent-down their excess assets in order to become eligible for Medicare Savings Program at a later date in 2018.

Under Option 2, the total number of individuals who were denied for exceeding the asset limit for Non-MAGI and Medicare Savings Program’s in calendar year 2018 is 9,408. Of that population 2,545 individuals spent-down their excess assets in order to become eligible. As a result, these individuals would not be considered “newly” eligible, as they met the conditions for Medi-Cal eligibility at a later time in 2018. The total number of previously ineligible individuals who would be potentially eligible for Non-MAGI Medi-Cal and Medicare Savings Programs under Option 2 is 6,863. If the LTC population is included in this change, the number of individuals who would become newly eligible for Medi-Cal under Option 2 increases to 6,975.

*Option 3 – Increase Asset Limits to \$10,000 for an Individual and \$5,000 for Each Additional Household Member*

The third option would increase the asset limit from \$2,000 to \$10,000 for an individual and increase from \$3,000 for a couple and \$150 for each additional household member to \$5,000 for each additional household member, as proposed in Option 2. However, Option 3 would not change the treatment of certain assets, as proposed in Option 2. The recommended asset limit would increase to \$10,000 for an individual and increase by \$5,000 for each additional household member, the same recommendation which is made in Option 2.

The chart below displays the number of individuals who would be potentially eligible to Non-MAGI, LTC, and Medicare Savings Program, for Option 3. The Department used data from the SAWS and MEDS for calendar year 2018 in order to determine the impacted population estimates.

<b>Option 3- Increase the Asset Limits to \$10,000 for an individual and \$5,000 for each additional household member</b> <b>Data Source: SAWS, MEDS</b> <b>Data Period: January 1, 2018-December 31, 2018</b>		
	# of Potentially Newly Eligible Individuals	# 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
<b>All Populations</b>	<b>8,355</b>	<b>2,717</b>

<b>Net Newly Eligible Individuals</b>	<b>5,638</b>
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In order to determine who would be newly eligible for Medi-Cal under Option 3, The Department had to determine how many individuals had assets over \$10,000.

For Non-MAGI Medi-Cal programs, it was determined that 8,110 individuals were

denied for Medi-Cal for exceeding the asset limit in 2018, but were within the proposed asset limit of Option 3. Of those individuals, 2,545 spent-down their excess assets to become eligible for Non-MAGI Medi-Cal at a later date in 2018.

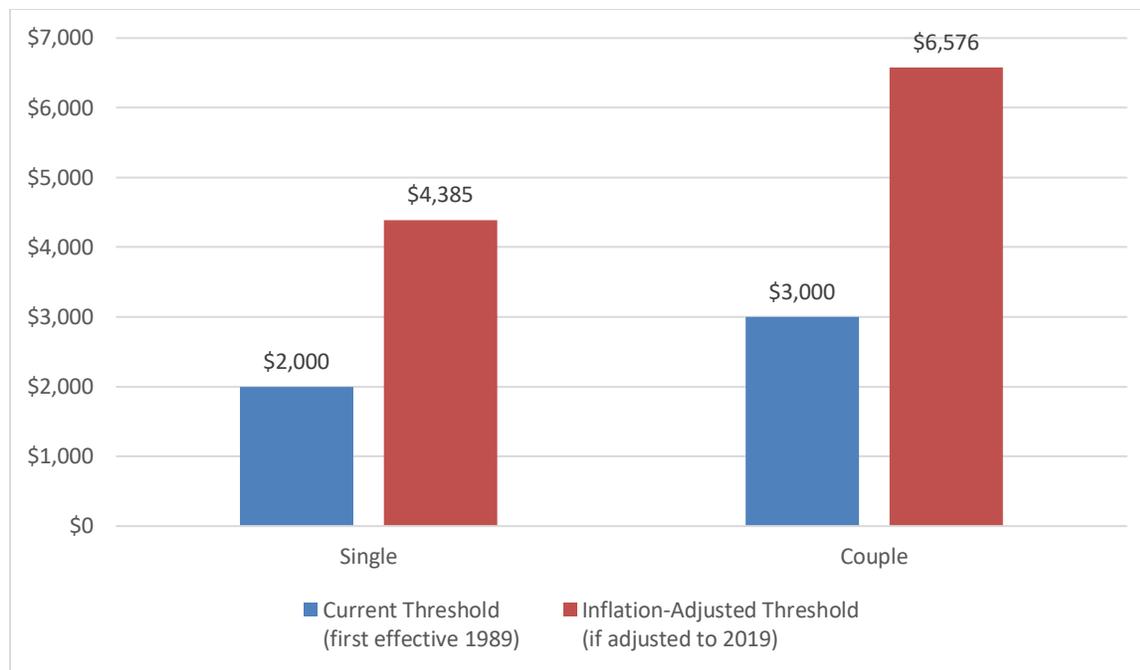
For the LTC program, 245 individuals were denied for exceeding the asset limit. Of those individuals, 172 spent-down their excess assets in order to become eligible for LTC at a later date in 2018.

For Medicare Savings Programs, no individuals were denied for exceeding the asset limit and no individuals spent-down their excess assets to become eligible for a Medicare Savings Program at a later date in 2018.

The total number of individuals who were denied for exceeding the asset limit for Non-MAGI and Medicare Savings Program's is 8,110. Of that population, 2,545 spent-down their excess assets in order to become eligible. Similar to Option 1 and 2, these individuals would not be considered "newly" eligible for Medi-Cal, since they met the conditions for eligibility at a later time in 2018. The total number of Non-MAGI and Medicare Savings Programs individuals who would be newly eligible for Medi-Cal under Option 3 is 5,565. If the LTC population is included in this change, the number of individuals who would become newly eligible for Medi-Cal under Option 3 increases to 5,638.

#### Asset Limit Increase Amounts

Some stakeholders advocate that Medi-Cal assets limits should be increased to be more consistent with 2019 costs of living. As mentioned earlier in this report, the asset limits for SSI-based Medi-Cal programs have not been updated since 1989. Based on the California Consumer Price Index, the asset limits would be \$4,385 for a single adult and \$6,576 for a couple had they been adjusted for inflation in 2019.



The proposed increase of asset limits to \$10,000 for an individual and \$5,000 for each additional household member would put the asset limits for Medi-Cal in line with states such as New York, which is similar to the population size and cost of living to California. To see how California’s current asset limits and cost of living compare with other states, please refer to Appendix B.

### Considerations for the Proposed Options

Based on the fiscal analysis, Option 1 is the most costly. In reviewing Options 2 and 3, the data indicates that a majority of individuals who are currently over the asset test would pass the asset test if the limit was increased as proposed. Utilizing the data elements from the option charts above, only an estimated 1,300 additional individuals would become potentially eligible to Non-MAGI Medi-Cal and only 39 individuals would be potentially eligible for LTC, if Option 2 was selected instead of Option 1. In contrast, the system change costs to implement Option 2 is twice the amount of Option 3.

Administratively, the implementation of Option 3 does not include the complexities of changing the treatment of assets that Option 2 proposes. Existing state regulations (Title 22, CCR Section 50401 through Section 50489.9) describes the current treatment of assets for the purposes of determining eligibility for Non-MAGI Medi-Cal. The majority of the assets that Option 2 seeks to exempt are either currently exempt in California State law or contain specific clauses that lead to their exemption or unavailability for eligibility determination purpose. Option 3 would require the Department to only make changes to the asset limits, which significantly reduces the administrative burden from an operational perspective.

While there would be a significant financial cost to index assets annually, the population

of individuals who would be newly eligible each year based on the indexing of asset limits annually would be minimal.

The Department identified two risks associated with the implementation of Option 3. One risk is that more individuals will apply and qualify for Non-MAGI Medi-Cal programs and Medicare Savings Programs than originally anticipated, thus increasing the total cost of the implementation. The second risk is that the CMS approval of the SPA and Waiver could take longer than anticipated which would impact the proposed timeline included in this report. These risks remain outside the control of the Department but should be noted when considering changes to the asset limits.

**System Implementation Timeline**

The Department presented the three potential asset modification options to our SAWS partners. Along with cost estimates, the Department also requested assistance in determining the estimated timelines in which each consortia could implement each of the three options.

The timelines below would begin **after** the Department received federal approval from CMS **and** policy is formally issued to the counties in the form of an All County Welfare Directors Letter (ACWDL) to allow for automation planning, development and testing to occur and prioritization of the initiative by each SAWS consortium:

<b>Asset Modification Option</b>	<b>Consortium</b>	<b>Timeline</b>
Option 1	LRS & C-IV	6-9 months
	CalWIN	12-18 months
Option 2	LRS & C-IV	6-9 months
	CalWIN	9-12 months
Option 3	LRS, C-IV & CalWIN	6-9 months

The Department would need a minimum of 12 to 18 months to seek federal approval, provide policy guidance, and comply with system readiness to implement any changes to the treatment of assets or the asset limits.

**IMPLEMENTATION PLAN**

**Project Work Plan Development**

The Department would develop and utilize a work plan, prior to beginning implementation. A work plan is essential in ensuring that milestones are met in a timely fashion. Critical milestones for implementing a change to the asset limits include:

- Request and Obtain CMS Approval
- Develop an ongoing communication plan to engage and inform external stakeholders on the status of implementation
- Coordinate system changes with SAWS
- Issue an ACWDL as guidance
- Provide regional trainings to county eligibility workers
- Promulgate regulations

#### SPA and Waiver Approval from CMS

The Department would review the current state plan and determine which sections are impacted and how to update each section. During the development of the SPA and waiver, CMS would work collaboratively with the Department to provide technical assistance and to facilitate a smooth and expeditious process.

#### Stakeholder Engagement and SAWS Coordination

Should a change be made to the asset limits, the Department would follow existing processes for engaging stakeholders and interested parties during the development of county guidance, and the revision of existing eligibility forms, etc. The engagement process includes:

- Establish stakeholder workgroups with external stakeholders (consumer advocates, provider communities, health plans, County Welfare Directors Association, counties, SAWS) and internal stakeholders (other impacted divisions of the Department) to discuss the proposed changes and targeted implementation timelines;
- Request written input regarding the proposed changes and implementation timelines from stakeholders;
- Develop consumer-facing materials which consider and incorporate external and internal stakeholder feedback, ensuring materials are in simple, plain language and translated into Medi-Cal threshold languages;
- Provide advance notice on the implementation and effective date of the changes.

#### Draft Policy Guidance and County Training

Upon changes to the asset limits, the Department would issue new guidance to counties in the form of an ACWDL. The Department would also provide regional training to the counties and make the necessary updates to regulations and the Medi-Cal Eligibility Procedures Manual (MEPM).

Per current process, CMS approval and updated policy guidance are crucial for the implementation of any new system changes. The drafting of this guidance would be concurrent with the SPA process so the SAWS can begin their work on the changes as soon as possible.

Promulgate Regulations

Regulations regarding changes to the asset limit would be required. The Department would follow the current process for updating regulations.

**PROGRAM/FISCAL IMPACT**

Estimated Benefit Costs for Each Asset Modification Option

The charts below provide a breakdown of the estimated costs by program for each of the three options:

<b>Option 1—Eliminate the Asset Test</b>			
	<b>Total Funds</b>	<b>General Funds</b>	<b>Federal Funds</b>
Non-MAGI	\$88,232,000	\$44,116,000	\$44,116,000
LTC	\$25,758,000	\$12,879,000	\$12,879,000
Medicare Savings Programs	\$734,000	\$367,000	\$367,000
IHSS*	\$108,791,000	\$50,043,860	\$58,747,140
<b>Total</b>	<b>\$223,515,000</b>	<b>\$107,405,860</b>	<b>\$116,109,140</b>

<b>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.</b>			
	<b>Total Funds</b>	<b>General Funds</b>	<b>Federal Funds</b>
Non-MAGI	\$35,752,000	\$17,876,000	\$17,876,000
LTC	\$10,614,000	\$5,307,000	\$5,307,000

Medicare Savings Programs	-	-	-
IHSS*	\$44,074,000	\$20,252,000	\$23,821,000
<b>Total</b>	<b>\$90,440,000</b>	<b>\$43,435,000</b>	<b>\$47,004,000</b>

<b>Option 3— Increase Asset Limits to \$10,000 for an individual and \$5,000 for each additional household member</b>			
	<b>Total Funds</b>	<b>General Funds</b>	<b>Federal Funds</b>
Non-MAGI	\$29,329,000	\$14,664,500	\$14,664,500
LTC	\$7,684,000	\$3,842,000	\$3,842,000
Medicare Savings Programs	-	-	-
IHSS*	\$36,215,000	\$16,658,900	\$19,556,100
<b>Total</b>	<b>\$73,228,000</b>	<b>\$35,165,400</b>	<b>\$38,062,600</b>

Estimated Administrative Resource Need

The Department would need an additional Health Program Specialist I (HPS) in the Medi-Cal Eligibility Division at a cost of \$148,000 Total Funds (TF) (\$74,000 General Funds [GF]) for Fiscal Year (FY) 2020-21. For FY 2021-22 and ongoing, this change would incur a cost of \$139,000 of TF (\$69,500 GF). The HPS I would be needed to manage the workload increase that will result from a change in the asset limits.

Changes to SAWS will be required, which will result in lengthy system design work that is driven by these new policies. New guidance to counties in the form of ACWDLs and training will be needed as well as updates to the regulations and the MEPM.

Furthermore, revisions will be required to the Medi-Cal online application, along with revisions to various supplemental forms in order to comport with a change in asset limits.

The IHSS program would see an increase in individuals eligible for their program and as a result, they would see an increase in program and administrative costs. For FY 2020-2021, the cost for IHSS services and administrative costs would be \$44,073,558 (TF) (\$23,821,231 in Federal Funds (FF) and \$20,252,327 GF).

Estimated Cost for System Updates

Each eligibility consortia within SAWS provided the Department with the one-time estimated cost to implement each of the three asset modification options. Due to varying SAWS system architecture and system integrators, there are three different costs for each impacted eligibility system. System changes are prioritized in conjunction with the California Department of Social Services (CDSS), which is the other state sponsor of SAWS.

Before the three consortia can begin implementing a system change, they must receive final and complete policy guidance from the state sponsors prior to beginning work on the change. Furthermore, system change initiatives must be prioritized by each consortia and each change requires adequate time to design, build and test prior to fully automating the change.

CalWIN uses older system architecture than the other two consortia. Therefore, their costs are significantly higher and their timeline longer for implementation of new policies.

The chart below outlines the one-time estimated cost for the implementation of each option by the consortia:

<b>Asset Modification Option</b>	<b>Consortium</b>	<b>Estimated Cost</b>
<b>Option 1</b>	LRS	\$78,822
	C-IV	\$73,434
	CalWIN	\$150,000-\$300,000
<b>Option 2</b>	LRS	\$17,052
	C-IV	\$16,140
	CalWIN	\$150,000-\$300,000
<b>Option 3</b>	LRS	\$8,700
	C-IV	\$8,505
	CalWIN	\$75,000-\$150,000

Cost of Annually Indexing Asset Limits

The chart below outlines the estimated annual cost of indexing asset limits by each consortia:

Asset Modification Option	Consortium	Estimated Cost
Annually Indexing Assets	LRS	\$8,700
	C-IV	\$8,505
	CalWIN	\$75,000-\$150,000

Potential Cost Savings

The Department identified potential administrative cost savings if Option 1 is selected. California is required to have an Asset Verification Program (AVP) to determine unreported assets at application and redetermination for the aged, blind, and disabled individuals on Non-MAGI Medi-Cal and LTC. If California was to eliminate the asset test requirement for Non-MAGI Medi-Cal and LTC, AVP would no longer be required. This would lead to a cost savings of approximately \$3,960,000. In addition, Option 1 could provide administrative time savings, as eligibility workers would no longer be required to request asset information at application and redetermination or process the AVP reports.

Total Cost of Implementation

The chart below illustrates the total estimated cost of implementation for each option which includes program (Non-MAGI, LTC, Medicare Savings Programs, IHSS), system change, 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	(\$3,960,000)	(\$1,980,000)	(\$1,980,000)

Program (Savings)			
<b>Total Cost</b>	<b>\$220,155,000</b>	<b>\$105,725,860</b>	<b>\$114,429,140</b>

<b>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.</b>			
	<b><u>Total Funds</u></b>	<b><u>General Funds</u></b>	<b><u>Federal Funds</u></b>
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
<b>Total Cost</b>	<b>\$90,922,000</b>	<b>\$43,676,000</b>	<b>\$47,245,000</b>

<b>Option 3 — Increase Asset Limits to \$10,000 for an individual and \$5,000 for each additional household member</b>			
	<b>Total Funds</b>	<b>General Funds</b>	<b>Federal Funds</b>
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
<b>Total</b>	<b>\$73,544,000</b>	<b>\$35,323,400</b>	<b>\$38,220,600</b>

**Appendix A: Asset Comparison Chart**

The following chart displays a complete list of assets, how they are treated under current Non-MAGI Medi-Cal policy, and how they would be treated should AB 683 (Carrillo, 2019) be enacted.

Asset Type	Current Medi-Cal Asset Policy	Asset as proposed in AB 683
One piece of real assets	<ul style="list-style-type: none"> <li>• <b>Exempt</b> if used as a home.                             <ul style="list-style-type: none"> <li>○ If an applicant/beneficiary is, absent from the home, it exempt as long as they intend to return home someday.</li> <li>○ The home continues to be exempt of an applicant/beneficiary's spouse or dependent continues to live in it.</li> </ul> </li> <li>• Money received from the sale of a home is <b>exempt</b> for <b>six months</b> if it is going to be used to purchase another home.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> one piece of real assets.</li> <li>• The applicant or beneficiary <b>need not reside on the real asset.</b></li> <li>• Money received from the sale of real assets shall be <b>exempt</b> for <b>one year</b> if the money from the sale is intended to be used for the purchase of a home, costs of moving, necessary furnishings, and repair or alteration to the principal residence.</li> </ul>
Assets used in a business or trade	<ul style="list-style-type: none"> <li>• <b>Exempt</b> assets used in a business or trade.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> assets used in a business or trade.</li> </ul>
Other real assets mortgages, deeds of trust, and other promissory notes	<ul style="list-style-type: none"> <li>• <b>Exempt up to \$6000</b> of the equity value of other real assets, mortgages, deeds of trust, or other promissory notes.</li> <li>• In order to receive the exemption, the property <b>must produce</b> an <b>annual income of 6%</b> the net market value or current face value.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> other real assets, mortgages, deeds of trust, or other promissory notes <b>valued at up \$20,000.00.</b></li> </ul>
Availability of assets	<ul style="list-style-type: none"> <li>• <b>Unavailable</b> if an applicant/beneficiary shows they are making a “<b>bona fide effort to sell.</b>”</li> <li>• A good faith effort is being made to sell the asset, offers at FMV are accepted, and the individual is supplying proof of compliance to the county.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> assets that the applicant or beneficiary is attempting to sell, but has been unable to sell at Fair Market Value (FMV).</li> </ul>
Motor Vehicles	<ul style="list-style-type: none"> <li>• <b>Exempt one</b> motor vehicle.</li> <li>• The net market value of all other motor vehicles shall be included in the property reserve.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> all motor vehicles.</li> </ul>
Assets used in trade or business	<ul style="list-style-type: none"> <li>• <b>Exempt</b> assets used for business or trade.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> personal assets used in trade or business.</li> </ul>
Household items	<ul style="list-style-type: none"> <li>• <b>Exempt</b> all items used to furnish and equip a home.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> household Items.</li> </ul>

Asset Type	Current Medi-Cal Asset Policy	Asset as proposed in AB 683
Personal effects	<ul style="list-style-type: none"> <li>• <b>Exempt</b> personal effects such as clothing.</li> <li>• <b>Exempt</b> wedding rings, engagement rings, heirlooms, and jewelry with a net market value <u>under</u> \$100.</li> <li>• The net market value of jewelry over \$100 is included in the property reserve.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> personal effects.</li> </ul>
Annuities, retirement accounts, work-related pensions	<ul style="list-style-type: none"> <li>• <b>Unavailable</b> as assets if the balance of the <b>annuity payments</b> of principal and interest are being received.                             <ul style="list-style-type: none"> <li>○ The cash surrender value (CSV) of the annuity shall be included in the property reserve if payments are deferred at any time.</li> </ul> </li> <li>• <b>Unavailable</b> as assets if the balance of Individual Retirement Accounts (<b>IRAs</b>), <b>Keogh plans, and other work-related pension plans payments</b> of principal and interest are being received.</li> <li>• Payments are considered income.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> retirement accounts, including an IRA or individual retirement annuity under Section 408(a), 408(b), or 408A of Title 26 of the United States Code, a Keogh plan, a work-related pension plan, a 401(k) or 403(b) plan or a payroll deduction IRA arrangement offered pursuant to the CalSavers Retirement Savings Program.</li> </ul>
College Savings Plans	<p><b>Exempt</b> 529 and 529A savings plans (WIC Section 14005.38)</p>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> 529 savings plan and 529A savings plans.</li> </ul>
Burial Fund, burial plots, vaults, and crypts	<ul style="list-style-type: none"> <li>• <b>Exempt</b> burial space items, irrevocable burial trusts and irrevocable prepaid burial contracts.</li> <li>• <b>Exempt</b> the <b>first \$1500</b> of a revocable burial fund or prepaid burial contract.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> burial funds, plots, trusts or prepaid burial contracts.</li> </ul>
Musical instruments	<ul style="list-style-type: none"> <li>• <b>Exempt</b> musical instruments.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> musical instruments.</li> </ul>
Recreational Items	<ul style="list-style-type: none"> <li>• <b>Exempt</b> recreational items except for: recreational motor vehicles, boats, campers and trailers.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> recreation items.</li> </ul>
Livestock and poultry	<ul style="list-style-type: none"> <li>• <b>Exempt</b> livestock poultry retained for personal use are exempt.</li> <li>• The net market value of livestock and poultry that are retained for profit are included as assets, except to the extent they are exempt as business assets.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> livestock, poultry, crops, or pets.</li> </ul>

Asset Type	Current Medi-Cal Asset Policy	Asset as proposed in AB 683
Life Insurance	<ul style="list-style-type: none"> <li>• <b>Exempt</b> term life insurance policies.</li> <li>• <b>Exempt</b> life insurance policies, except term insurance, owned by an individual, on the life of any individual in the Medi-Cal family, if the combined face value of all of the policies on the insured individual is \$1,500 or less.</li> <li>• If combined face value of all policies exceeds \$1500, net Cash Surrender Value of policies shall be included in the property reserve.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> life insurance policies.</li> </ul>
Long-Term Care Insurance Exemption	<ul style="list-style-type: none"> <li>• <b>Exempt</b> countable assets <b>equal</b> to the <b>amount of benefits paid</b> under a state-certified LTC insurance policy.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> long-term care insurance policies and the payments made therein.</li> </ul>
Reparation or restitution payments	<ul style="list-style-type: none"> <li>• <b>Exempt</b> Japanese Reparation payments made by the United States and Canadian governments as income and assets.</li> <li>• <b>Exempt</b> payments to Holocaust victims from consideration as personal assets if funds are not spent and are <b>kept identifiable</b>.</li> <li>• <b>Exempt</b> federal payments made to American Indians and Alaskan Natives, as long as the payments or the amount held as assets <b>do not exceed \$2,000</b>.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> reparation or restitution payments, including: <ul style="list-style-type: none"> <li>○ Japanese reparation payments made by the Canadian or United States government.</li> <li>○ Restitution payments made to Holocaust victims.</li> <li>○ Federal payments made to Alaska Natives and American Indians.</li> </ul> </li> </ul>
Value of item for sale	<ul style="list-style-type: none"> <li>• <b>Unavailable</b> if the applicant/beneficiary continuously demonstrates they are making a bona fide effort and good faith intent to liquidate/sell the asset.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> the value of any item that the applicant or beneficiary is making a good faith effort to sell, but is unable to sell at fair market value.</li> </ul>
Assets for unpaid medical bills	<ul style="list-style-type: none"> <li>• <b>Not Exempt</b> - Applicants with assets that exceeds the limit for the month Medi-Cal is requested can use excess asset to pay unpaid medical bills which were unpaid in the same month where there was excess assets.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> assets intended to be used to pay unpaid medical bills at the time of application.</li> </ul>
Earned Income Tax Credit (EITC) or income tax refunds	<ul style="list-style-type: none"> <li>• <b>Exempt</b> EITC or tax refunds for 12 months.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> EITC or tax refunds for up to 12 months.</li> </ul>
Disaster and emergency assistance payments	<ul style="list-style-type: none"> <li>• <b>Exempt</b> disaster and emergency assistance payments.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> disaster and emergency payments.</li> </ul>

Asset Type	Current Medi-Cal Asset Policy	Asset as proposed in AB 683
Payments to Victims of Crimes—Treatment as Assets	<ul style="list-style-type: none"> <li>• <b>Exempt</b> the payments as assets for a <b>9-month period</b> beginning after the month in which the payment was received.</li> <li>• <b>Exempt</b> payments made under the California Victims of Crimes as income in the month of receipt.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> payments made by the California Victim Compensation Board, as specified in Section 13901 of the Government Code.</li> </ul>
Savings of a Child	<ul style="list-style-type: none"> <li>• <b>Exempt</b> amounts saved from a child's exempt earnings for <b>future education</b> or for other <b>future identifiable needs</b>.</li> <li>• Any other savings amount is included in the property reserve.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> savings of a child under 21 years of age.</li> </ul>
Assets exempt by federal law	<ul style="list-style-type: none"> <li>• <b>Exempt</b> assets under in accordance with State and Federal law.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> any other asset that is exempt by federal law.</li> </ul>
Asset Limits	<ul style="list-style-type: none"> <li>• <b>Exempt</b> \$2,000 in nonexempt assets for an individual and \$3,000 for a couple. \$150 is added to the asset limit for each additional household member.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exempt</b> ten thousand dollars (\$10,000) in nonexempt assets for an individual and five thousand dollars (\$5,000) for each additional household member to be indexed annually.</li> </ul>

**Appendix B—Asset Policy & Cost of Living Comparison Chart**

The chart below depicts current asset policy and cost of living for California and several other states. These states were chosen because of their similarity in population and cost of living. Arizona was added as a comparable state due to their elimination of the asset test. Real Personal Income by State percentage rates for 2018 from the Bureau of Economic Analysis are used for the cost of living comparisons.

State	Asset Treatment Policy	Real Personal Income Percent Change
California	<p><b><u>ABD Asset Limit</u></b>                      \$2,000 Individual                      \$3,000 Couple</p> <p>+\$150 for each additional household member.</p> <p><b><u>QMB Asset Limit:</u></b>                      \$7,860 Individual                      \$11,800 Couple</p> <p><b><u>SLMB Asset Limit</u></b>                      \$7,860 Individual                      \$11,800 Couple</p> <p><b><u>QI Asset Limit</u></b>                      \$7,860 Individual                      \$11,800 Couple</p>	3.6%
Arizona	<p><b>*All Assets are exempt for Non-MAGI*</b></p> <p><b><u>Asset Limit</u></b>                      (LTC &amp; HCBS only)                      \$2,000 Individual                      \$4,000 Couple.</p> <p>No Asset Limits for QMB,SLMB, or QI</p>	3.5%

<p>Washington DC</p>	<p><b><u>ABD Asset Limit</u></b>                  \$4,000 Individual                  \$6,000 Couple</p> <p>No Asset Limits for QMB,                  SLMB, or QI</p>	<p>2.8%</p>
<p>Florida</p>	<p><b><u>ABD Asset Limit</u></b>                  \$5,000 Individual                  \$6,000 Couple</p> <p><b><u>QMB Asset Limit:</u></b>                  \$7,860 Individual                  \$11,800 Couple</p> <p><b><u>SLMB Asset Limit</u></b>                  \$7,860 Individual                  \$11,800 Couple</p> <p><b><u>QI Asset Limit</u></b>                  \$7,860 Individual                  \$11,800 Couple</p>	<p>3.7%</p>
<p>New York</p>	<p><b><u>ABD Asset Limit</u></b>                  \$15,750 Individual                  \$23,100 Couple</p> <p>No Asset Limits for QMB,                  SLMB, or QI</p>	<p>2.0%</p>

<p>New Jersey</p>	<p><b><u>ABD Asset Limit</u></b>                  \$4,000 Individual                  \$6,000 Couple</p> <p><b><u>QMB Asset Limit:</u></b>                  \$7,860 Individual                  \$11,800 Couple</p> <p><b><u>SLMB Asset Limit</u></b>                  \$7,860 Individual                  \$11,800 Couple</p> <p><b><u>QI Asset Limit</u></b>                  \$7,860 Individual                  \$11,800 Couple</p>	<p>1.9%</p>
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