ISSUE BRIEF

Expanding Health Care Affordability for Older Adults and People with Disabilities: A Guide for State Medicaid Advocates

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INTRODUCTION

Medicaid provides health care coverage for 74 million people, including over 7.8 million older adults and people with disabilities who rely on the Medicaid for critical benefits like home- and community-based services (HCBS).[1] Over its 56-year history, Medicaid has undergone significant change and growth. Most notably, the enactment of the Affordable Care Act (ACA) extended Medicaid coverage to millions of low-income adults under age 65 and implemented eligibility criteria and program rules that have lifted people out of poverty and helped to address racial disparities. The ACA, however, did not change eligibility or program rules for Medicaid financial eligibility for older adults and people with disabilities. Medicaid programs across the country continue to use outdated and overly stringent eligibility criteria that force older adults and people with disabilities relying on the program to live in deep poverty in order to gain access to care.

States, however, have broad discretion to adjust their Medicaid eligibility criteria to make Medicaid and access to health care more affordable for older adults and people with disabilities. Advocates in one state, California, have had several recent successes in broadening Medicaid eligibility to better align programs with the eligibility criteria used

for the Medicaid expansion program and with the affordability principles of the ACA. This issue brief discusses three significant eligibility changes either achieved in California's Medicaid programs for older adults and people with disabilities or subject to ongoing efforts for additional improvements. They are:

- An Increase in the Aged, Blind and Disabled (ABD) Medicaid income limit to 138% of the Federal Poverty Level (FPL)
- Elimination of the asset test for Medicaid ABD, Medically Needy, and the Medicare Savings Programs
- Updating the Maintenance Need Income Level for the Medically Needy (share of cost) Medicaid program

The goal of this issue brief is to share with advocates in other states examples and resources for improving their state's Medicaid financial eligibility criteria for older adults and people with disabilities. The brief includes a summary of the eligibility and affordability cliffs older adults and people with disabilities face when turning 65 or becoming eligible for Medicare. It describes the changes in state law California enacted to address these cliffs, and provides a sampling of strategies California advocates employed to secure these changes.

ELIGIBILITY AND AFFORDABILITY CLIFFS FOR OLDER ADULTS AND PEOPLE WITH DISABILITIES

Medicaid provides access to essential care and supports for older adults and people with disabilities that are largely not available through Medicare. Most notably, Medicaid is the biggest payer for long-term care including coverage of HCBS that allow people to receive the support they need to remain living at home and connected to their communities, as well as long-term care in nursing facilities.[2] Medicaid also often covers dental, vision, and hearing and makes Medicare more affordable through the Medicare Saving Programs, which provide premium and cost sharing support that lower Medicare out-of-pocket expenses. Therefore, obtaining and maintaining access to Medicaid is critical for low-income older adults and people with disabilities, and is particularly vital for marginalized populations who have higher health care needs and fewer resources to pay for care due to systemic racism and other forms of discrimination. Yet, financial eligibility and program rules for Medicaid for these populations remain mostly unchanged despite updates to Medicaid for other covered populations including, predominately, updates enacted pursuant to the ACA.

AFFORDABLE CARE ACT

The ACA gives states the option to extend Medicaid eligibility to uninsured adults under age 65 and requires states to use a Medicaid income limit of 138% FPL (133% plus a 5% income disregard). States may not impose an asset limit for this expansion population.[3] To date, 39 states, including the District of Columbia, have opted to expand Medicaid, providing coverage for the first time to 14.8 million low-income adults under age 65 and without Medicare coverage.[4] Studies have demonstrated that the expansion of Medicaid under the ACA has lifted nearly 700,000 people out of poverty[5] and has reduced racial disparities in health coverage.[6]

The ACA also limits the amount an individual has to pay monthly for health insurance through employer-sponsored coverage to 8.5% percent of their annual household income. If individuals have to pay more than 8.5% of their income, they are eligible to purchase insurance through federal or state-based health insurance marketplaces and receive financial assistance to help pay for premiums and, in some cases, out-of-pocket costs like co-insurance and co-pays.[7]

These affordability provisions, however, do not extend to Medicare or Medicaid programs for older adults and people with disabilities. As a result, older adults and people with disabilities face cliffs when they reach age 65 or obtain Medicare (See Figure 1).

THE CLIFFS

- **Income Eligibility.** The Medicaid expansion program has a more generous income limit of 138% of FPL to qualify for coverage compared to the income eligibility limit in Medicaid ABD programs, which typically have income limits at or below 100% of FPL. Individuals 65 and over or who have Medicare coverage are not eligible for Medicaid expansion so must meet the stricter ABD eligibility limit.[8] As a result, many older adults and people with disabilities on Medicaid expansion lose access to Medicaid coverage or face an unaffordable Medicaid share of cost, despite being at a point in their lives when they likely have the highest need for Medicaid coverage.

  Financial assistance through the Medicare Savings Programs (MSPs) may cushion this cliff by helping to pay for Medicare out-of-pocket costs including premiums and cost sharing. However, MSP income limits in most states are also typically lower than the expansion Medicaid limits, particularly for the Qualified Medicare Beneficiary program, the most generous of the MSPs. As a result, many older adults and people with disabilities lose all Medicaid coverage when they obtain Medicare while simultaneously facing significant out-of-pocket expenses for Medicare coverage (See Medicare Savings Programs Text Box).

- **Asset Eligibility.** While the Medicaid expansion program does not have an asset test or limitations on resources, ABD Medicaid programs typically have an exceedingly low asset limit that mirrors that in the Supplemental Security Income (SSI) program. The limit, just $2,000 for an individual and $3,000 for a couple, results in a significant gap in health care access for individuals with even modest savings who lose eligibility for expansion Medicaid when they turn 65 or otherwise become Medicare eligible. These individuals either have to forgo essential Medicaid coverage, including access to HCBS, or are forced to spend down their assets to obtain Medicaid eligibility.

- **Affordability.** The affordability provisions in the ACA that ensure individuals do not have to pay more than 8.5% of their income for coverage do not exist in the Medicare program. When individuals become Medicare eligible, they lose the generous ACA subsidies and face either higher out-of-pocket expenses for Medicare premiums and co-insurance or the use of fewer needed health services.[9] Though, as noted above, financial assistance through the Medicare Savings Programs (MSPs) may help some individuals, many older adults and people with disabilities face significant jumps in costs when they obtain Medicare coverage.

Medicare Savings Programs

Medicare Savings Programs are Medicaid programs administered by the states that make Medicare more affordable by providing financial assistance with out-of-pocket Medicare costs including premiums and co-insurance. Federal law establishes a minimum income and resource limit for each MSP, which states have the authority to increase (See Appendix B, Tables 2 and 3). The financial assistance provided and federal minimums for each program for 2022 are:

Qualified Medicare Beneficiary (QMB):

- Pays for Part A (if not free) and Part B premiums, deductibles, coinsurance, and copayments for Medicare covered services.
- Income Limit: 100% FPL

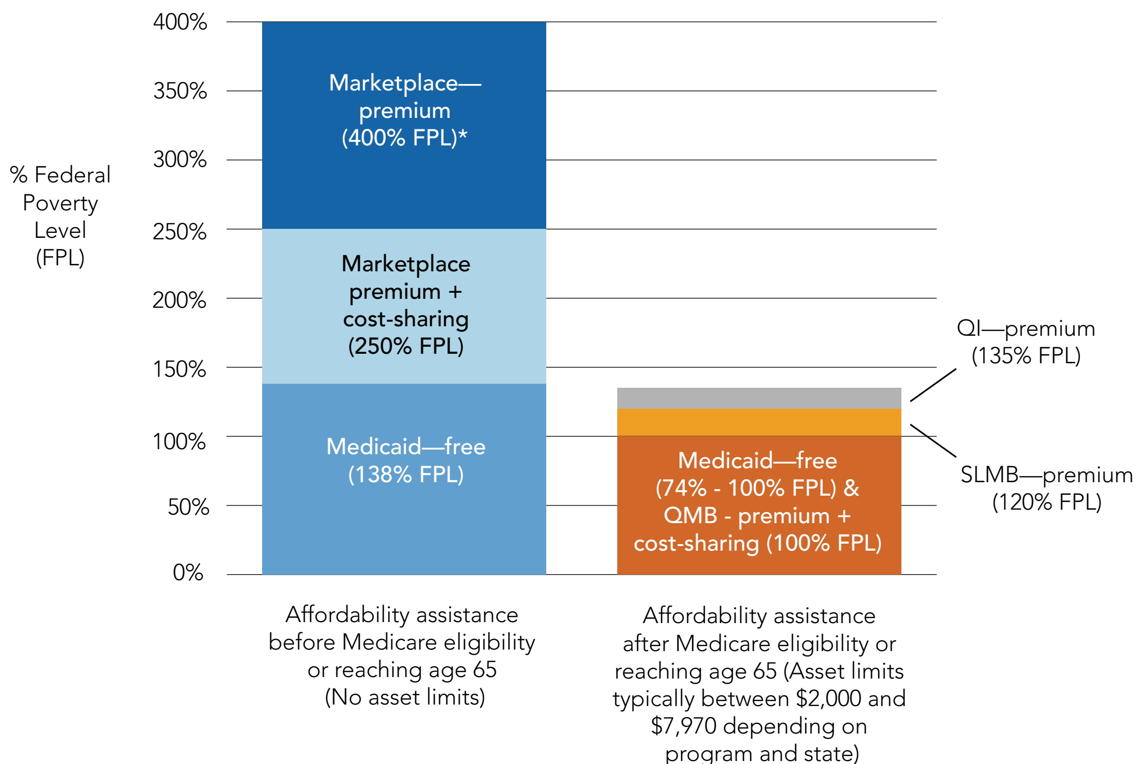
Specified Low-Income Beneficiary (SLMB):

- Pays for Part B premiums only.
- Income Limit: 120% FPL

Qualified Individual (QI):

- Pays for Part B premiums only.
- Income Limit: 135% FPL
- The asset limit for all three programs is: $7,970/individual; $11,960/couple.[10]

HEALTH CARE AFFORDABILITY ASSISTANCE



Source: This table was originally created by Northwest Health Law Advocates and included here with permission.

**Pursuant to the American Rescue Plan, there is no upper income limit on receiving premium assistance temporarily through plan year 2022.*[11]

ADDRESSING THE CLIFFS: CALIFORNIA

California was one of the first states to expand its Medicaid, or "Medi-Cal," program pursuant to the ACA to adults under 65 without Medicare coverage. California has subsequently enacted several milestone eligibility changes that made significant progress in increasing affordability and bringing parity between Medicaid programs for older adults and people with disabilities and Medicaid expansion.

INCOME LIMIT INCREASE TO 138% FPL

As noted above, one of the hallmark impacts of the ACA was its expansion of Medicaid to adults under the age of 65 who have income up to 138% of the FPL. Increasing the ABD income eligibility level to that of the expansion program is critical in maintaining health coverage even when individuals become eligible for Medicare, especially as most continue to live on a fixed income as they age.

California Response: California's income limit for its ABD program was 100% FPL and included a standard disregard that raised the limit to approximately 124% FPL. Effective December 2020, California raised the income limit to 138% FPL for ABD Medicaid, consistent with the limit in the ACA expansion program.[12] The state accomplished this change through the state budget process that was subsequently approved by CMS through a state plan amendment on November 19, 2020.[13] (See Appendix A). The legislation provides that when determining eligibility for the ABD program, counties shall "[c]ompare countable income to 138 percent of the FPL, instead of 100 percent FPL, for the applicable family size," and also eliminates the prior standard disregard.[14]

The increase to 138% of the FPL in the Medicaid ABD program expanded access to free Medicaid to over 40,000 older adults and people with disabilities in California, including individuals who were previously enrolled in California's medically needy program with an unaffordable share of cost (see more below on share of cost).[15]

Current State Landscape: As of 2018, states' income limits for their ABD programs ranged from 63% to 100% FPL for an individual to be eligible. (See Table 1).[16] For a household of one today even at the maximum limit of 100% FPL, this translates to having a monthly income of $1,133 in 2022 to qualify.[17]

To date, only California has expanded the income limit for the ABD program beyond 100% FPL. The majority of states continue to tie their ABD income limits to the Supplemental Security Income (SSI) income limit—typically 74% FPL—while just 17 states, including the District of Columbia, set an income limit of 100% FPL (See Appendix B, Table 1).[18] New York has introduced legislation this year to increase their income limit to 138% FPL.[19]

While California has not yet increased its MSP income limits beyond the federal minimums, Washington DC and four states—Connecticut, Indiana, Maine, and Massachusetts—have done so and New York introduced legislation this year.[20] (See Appendix B, Table 2).

ASSET TEST ELIMINATION

In addition to meeting certain income thresholds, eligibility for ABD Medicaid also includes limitations on assets. In California and in other states that have expanded Medicaid, the ACA eliminated the asset test for the expansion program. However, once adults turn 65 or become eligible for Medicare, their Medicaid eligibility is determined under a significantly more restrictive set of rules. Although assets such as a primary residence or retirement accounts are excluded from the asset determination, the typical asset limit is $2,000 for an individual and $3,000 for a couple, which is the same limit used by the SSI program. Most individuals needing Medicaid coverage rationally

spend down their cash savings because the cost of health care without enrollment is more than they have saved. These asset limits, however, do not allow individuals to save enough to weather an emergency or pay for property taxes, especially in states with a high cost of living like California. Living according to the outdated asset limits puts renters at particularly high risk of further instability or homelessness when financial crises happen. The asset test disproportionately punishes older adults of color as they are more likely to have cash savings instead of an exempt home due to well-documented discrimination in housing.[21] Additionally, asset tests cause administrative burden both for states and for applicants. They require low-income people to go through the cumbersome process of proving their assets—including but not limited to having to get appraisals—when they already have very low income; and if their assets exceed the limit by even $1, they can lose eligibility.

California Response: California recently eliminated the asset test for ABD Medicaid, the 250% Working Disabled program, and for Medicare Savings Programs via the state's 2021-2022 budget.[22] This policy change will be accomplished in two phases:

- Effective July 1, 2022, the asset limit will increase to $130,000 for an individual with an additional $65,000 for each additional family member up to 10.
- Then, no sooner than January 1, 2024, the state will eliminate the asset test completely.

The two-phase approach accommodates technological system updates the state needs to perform to effectuate elimination of the asset test. On November 24, 2021, CMS approved a state plan amendment for the first phase, increasing the asset limit.[23]

The asset limit increase and eventual elimination applies to individuals receiving benefits in the community as well as individuals receiving care in long-term care settings through the medically needy program (share of cost).[24] As noted above, this policy will also eliminate the asset limit for Medicare Savings Programs, which is currently set at the federal minimum of $7,960 for an individual.

These changes improve affordability for the nearly 1.4 million older adults and people with disabilities currently dually enrolled in Medicaid and Medicare in California by allowing additions to their meager savings and no longer requiring them to prove their resources year after year.

These changes also expand access to new beneficiaries. According to a supplemental report from California's Department of Health Care Services, the full elimination of the asset test would make 18,000 Californians newly eligible for Medicaid without having to spend down or prove their assets.[25] About half these individuals would be eligible due to no longer being "over assets" while the other half would qualify from not "failing to provide" asset information. The supplemental report also estimates that 200 individuals will become newly eligible for MSPs because of the elimination of the asset test. [26]

Based on other states that have increased or eliminated their asset tests, California should also experience a reduction in administrative burden and see associated savings.[27]

State Landscape: Aside from California, only Arizona has eliminated its asset test for ABD Medicaid. Arizona, however, maintains the $2,000 asset limit for individuals needing HCBS or institutional long-term care.[28] Just nine states have increased ABD Medicaid asset limits above $2,000 (See Appendix B, Table 3). Two states, Connecticut and New Hampshire, have Medicaid ABD asset limits below $2,000 for an individual.

Some states have increased asset limits specifically for long-term care and/or home and community-based services. A number of states also have higher asset limits for their Medically Needy Medicaid programs. (See Appendix B, Table 3).

Far more states have eliminated the asset limits for Medicare Savings Programs – a total of 12 states including California have no asset limit for MSPs. Three additional states have increased asset limits beyond the federal minimum for MSPs (See Appendix B, Table 3). Washington state and New York have introduced legislation to eliminate their asset tests for Medicare Savings Programs this year.[29]

Eliminating asset tests is an important advocacy goal. Even in states with higher limits, these outdated rules create a ceiling for potential economic security and place individuals needlessly at risk of losing coverage who are not able to comply with the administrative requirements to prove their assets.[30]

UPDATING THE MAINTENANCE NEED LEVEL FOR SHARE-OF-COST MEDICAID—AN AREA OF CONTINUING ADVOCACY

Low-income families, older adults, and people with disabilities who have incomes just above the Medicaid eligibility limit may still receive coverage via the Medically Needy program. Through this program older adults and people with disabilities receive coverage after meeting a monthly share-of-cost, which is calculated by subtracting from their monthly countable income a Maintenance Need Income Level (MNIL)—an amount of income an individual is expected to need to pay for non-medical living expenses.

The MNIL in California is set at $600 and has not been updated since 1989. Accordingly, if an individual is $1 over the free Medicaid limit, which is currently $1,482 in California, they must pay $883 towards the cost of their care monthly before they are eligible for Medicaid coverage. In other words, being just $1 above the limit results in what is in effect a $883 monthly deductible representing more than 60% of an individual's monthly income. Meanwhile, people are not expected to pay more than 8.5% of their income for employer-based insurance or if purchasing insurance through Covered California, the state-based marketplace.

California Solution: In contrast to the other issues discussed, California has yet to address its outdated MNIL. But work is underway. This year, legislation has been introduced, AB 1900, that would raise the MNIL from a fixed $600 to 138% FPL, or the income cutoff for free Medicaid coverage.[31] For example, an individual who makes $1,500 would have a share of cost of $18—a more appropriate cost to obtain Medicaid coverage for individuals who have incomes just over the limit for free coverage.

State Landscape: The medically needy program is an eligibility pathway that was established in 1981 as a means for older adults and people with disabilities with high care needs to obtain Medicaid coverage. Thirty-three states including DC have a Medicaid medically needy program for older adults and people with disabilities. (See Appendix B, Table 4). The majority of states, maintain very low MNILs. For example, Louisiana's MNIL is at 10% FPL. To put this in perspective, in order to obtain Medicaid coverage an older adult or person with a disability in Louisiana is only allowed $100 to live on. The rest of their income must go towards the cost of care. Some states have higher MNILs, including Illinois, Vermont, and Michigan, for example, each of which has a MNIL of at least 100% FPL.[32]

Having a more affordable share-of-cost for coverage allows older adults and people with disabilities to have access to needed HCBS and remain living at home or return home rather than receiving care in an institutional setting. Furthermore, having access to Medicaid coverage provides financial protection for families as well. Older adults and

people with disabilities can rely on Medicaid rather than having families provide caregiving unpaid. Because family caregivers tend to be women and women of color, unrealistic MNILs further perpetuate existing inequity.

ADVOCACY STRATEGIES

Advocacy in California to address cliff issues began shortly after California enacted legislation to expand Medicaid under the ACA. To frame initial advocacy, Justice in Aging (then NSCLC) produced an issue brief that identified cliffs and proposed complementary recommendations.[33] The brief functioned as a roadmap for advocates and policymakers in the state. But it was just a starting point.

It took years of committed advocacy among a diverse set of advocates, stakeholders, and legislative champions employing a wide range of strategies to move these policies forward. The years of groundwork were key. When there were positive changes in the budget and political landscape in California, including the Governor's commitment to a Master Plan for Aging in January 2019, the groundwork had already been laid to move the legislation forward.

Over years, advocates cultivated legislative champions, developed educational materials, built diverse coalitions, organized sign-on letters, participated in press conferences, met regularly with lawmakers, testified at hearings, and much more. While it is impossible to identify what strategies or combination of strategies were the most impactful, there are a handful worth highlighting. Recognizing that the size, demographics, and political landscape in states vary widely, these strategies would likely need to be modified to respond to the dynamics in any given state.

- **Equity.** Equity was a guiding principle in both formulating the legislative solutions to address Medicaid cliffs as well as in the advocacy strategies to move those solutions forward. Foremost, advocates stressed the inequities in coverage and eligibility standards for low-income older adults and people with disabilities compared to populations covered under other health insurance programs and the disproportionate impact of those stricter standards on communities of color.

  The centering of racial equity evolved over the years of advocacy. For example, the initial legislative solution to address the asset test proposed to raise the limit, not eliminate it. However, after evaluating the historical origins of asset tests and their impact on communities of color, advocates proposed to instead eliminate the test altogether – a solution that proved to be more politically viable following the state's report that full elimination would be financially feasible.

  Factsheets and educational materials also were updated to more clearly outline the impact of the stricter eligibility standards on communities of color and those points were communicated to lawmakers.

- **Messaging.** In 2019, aging and disability advocates coalesced around common messaging to move the legislative proposals forward. For example, advocates developed a "Senior Package" of legislation that together made four distinct fixes to Medicaid eligibility. A shareable fact sheet created with partners for partners complemented each bill. Advocates also used consistent messaging of the need for change. For the income cliff, characterization of the problem as a "senior penalty" or "senior and disability penalty" served as an easy to understand shorthand and simple social media hashtag. Currently, advocates are using "Ditch the Deductible" to communicate more clearly the complex issue of fixing the outdated share of cost program.

- **Coalition.** In addition to engaging a broad coalition of aging and disability advocates and providers, there were some additional partnerships that proved to be particularly beneficial. The Care4All coalition

is composed of more than 70 organizations all working towards a health care system that is universal, equitable, affordable, and high quality. The coalition's support of the Medicaid cliff legislative proposals was and continues to be key in elevating the proposals as priorities across a diverse set of stakeholders and with the legislature. The California Budget & Policy Center has also been a key partner in providing additional educational resources and policy analysis for Medicaid cliff issues. Most states have a budget and policy center that could prove to be a valuable partner in this advocacy.

- **Legislative & Administrative Champions.** Having legislative champions in key committees has proven very effective. For example, authors of the legislation served (or continue to serve) as chairs of the health committee and health budget subcommittees. Further, a non-author legislative champion on the asset bill on the budget committee was responsible for directing California's Medicaid agency to develop the report on eliminating California's asset test – a key resource that made ultimate passage possible. Likewise, having support from the aging and long-term care committee was crucial.

  Another key opportunity was leveraging the state's commitment to older adults and people with disabilities through the Master Plan for Aging (MPA). The MPA provided an overarching structure for legislative and administrative change and also gave the aging and disability community a natural forum for policy discussions with leaders in the Administration and policymakers in the state legislature.

CONCLUSION

Improving Medicaid eligibility requirements for older adults and people with disabilities so that they align with ACA requirements for expansion Medicaid makes good policy sense. It prevents older adults and persons with disabilities from losing coverage when they turn 65 or become eligible for Medicare, a time when many have increasing health care needs. Because the Medicaid population consists disproportionately people of color and other historically oppressed groups, eligibility improvements also promote equity and help to address health disparities.

Advocates in California found that policymakers were receptive to focused arguments, but concerted advocacy by a broad coalition with consistent messaging was critical. Justice in Aging and its California advocacy partners are available to share experiences and strategies with advocates in other states who are seeking similar improvements in their Medicaid programs.

ACKNOWLEDGEMENTS

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APPENDIX A: CALIFORNIA RESOURCES

Policy: Income Limit Increase to 138% FPL

Legislative History

- SB 104 Budget Trailer Bill, amending WIC § 14005.40 originally introduced as AB 715. Passed and signed into Law on July 9, 2019.
- AB 2430 introduced February 14, 2018; died in Appropriations on November 30, 2018.
- Assembly Budget Subcommittee proposed to include increase to 138% in the 2016/2017 budget. This effort did not move forward (Issue 60, May 24, 2016).
- AB 763 introduced February 25, 2015; died in Appropriations on January 31, 2016.

California Welfare and Institutions Code

- WIC § 14005.40.

  "(3) (A) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), all countable income over 100 percent of the federal poverty level, up to 138 percent of the federal poverty level, shall be disregarded, after taking all other disregards, deductions, and exclusions into account for those persons eligible pursuant to this section."

State Plan Amendment

- CA-20-0045 – submitted September 2, 2020, and approved November 19, 2020.
- CA-19-0050 – submitted September 30, 2019, and approved December 20, 2019.

Written Resources

- AB 715, Raise the Medi-Cal Aged & Disabled Income Level: End the Senior Penalty. Fact Sheet. (Authors: advocacy organizations co-sponsoring the legislation)
- California Senior Legislative Package 2019. Fact Sheet. (Authors: advocacy organizations co-sponsoring the legislation)
- California Policymakers Can End Medi-Cal Senior Penalty. Fact Sheet. (Author: California Budget & Policy Center)
- AB 2430, Raise the Medi-Cal Aged & Disabled Income Level: Make Health Care Affordable for Vulnerable Californians. Fact Sheet. (Authors: advocacy organizations co-sponsoring the legislation)

Policy: Asset Test Elimination

Legislative History

- AB 133 Budget Trailer Bill, adding WIC § 14005.62. Passed and signed into law on July 27, 2021.
- AB 683 introduced on February 15, 2019 and died in committee on November 30, 2020.

California Welfare and Institutions Code

- WIC § 14005.62.

  (a) (1) Notwithstanding any other law, for an applicant or beneficiary whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial methods, as specified in Section 1396a(e)(14) of Title 42 of the United States Code, the department shall seek federal approval to implement a disregard of one hundred thirty thousand dollars ($130,000) in nonexempt property for a case with one member and sixty five thousand dollars ($65,000) for each additional household member, up to a maximum of ten members.

  (2) This subdivision shall be implemented only after the director determines that systems have been programmed for the disregards specified in paragraph (1) and they communicate that determination in writing to the Department of Finance, and no sooner than July 1, 2022.

  (b) (1) Notwithstanding any other law, for an applicant or beneficiary described in subdivision (a), resources, including property or other assets, shall not be used to determine eligibility under the Medi-Cal program to the extent permitted by federal law. The department shall seek federal authority to disregard all resources as authorized by the flexibilities provided under Section 1396a(r)(2) of Title 42 of the United States Code or other available authorities.

  (2) This subdivision shall be implemented only after the director determines that systems have been programmed for these disregards and they communicate that determination in writing to the Department of Finance, and no sooner than January 1, 2024.

  (c) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

  (2) Within two years of implementing the requirements set forth in subdivision (b), the department shall do both of the following:

  (A) Adopt, amend, or repeal regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and this section.

  (B) Update its notices and forms to delete any reference to limitations on resources or assets.

  (d) This section shall only be implemented to the extent consistent with federal law, upon the department obtaining any necessary federal approvals, and to the extent federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

State Plan Amendment

- CA-21-0053 – submitted August 31, 2021, and approved November 24, 2021.

Written Resources

- AB 683, Medi-Cal Assets Test, Enable Self-Sufficiency for Seniors on Medi-Cal. Fact Sheet. (Authors: advocacy organizations co-sponsoring the legislation)
- California Senior Legislative Package 2019. Fact Sheet. (Authors: advocacy organizations co-sponsoring the legislation)

Policy: Medically Needy Share of Cost: Increase Maintenance Need Income Level

Legislative History

- AB 1900 – introduced February 9, 2022.

California Welfare and Institutions Code

- Proposed WIC § 14005.62

  (b) To the extent that any necessary federal authorization is obtained, the amount of the income level for maintenance per month shall be equal to the income limit for Medi-Cal without a share of cost for individuals described in Section 1396a(m)(1)(A) of Title 42 of the United States Code, as that income limit is calculated pursuant to paragraph (3) of subdivision (c) of Section 14005.40.

State Plan Amendment

- N/A

Written Resources

- AB 1900, Increase Maintenance Need Income Levels Make the Medi-Cal Share-of-Cost Program Affordable. Fact Sheet. (Authors: advocacy organizations co-sponsoring the legislation)
- It's Time to Ditch the Deductible. Fact Sheet. (Authors: advocacy organizations co-sponsoring the legislation)

APPENDIX B. MEDICAID ELIGIBILITY TABLES

TABLE 1. STATE MEDICAID AGED, BLIND, DISABLED INCOME LIMITS, 2018

State	Income Limit as Percent of FPL	Income Disregard
Alabama	74%	$20
Alaska	74%**	$20
Arizona	100%	$20
Arkansas	80%	$20
California*	138%	N/A
Colorado	74%	$20
Connecticut	63%	$339
Delaware	74%	$20
DC	100%	$20/individual $100/couple
Florida	88%	$20
Georgia	74%	$20
Hawaii	100%**	$20
Idaho	80%	$20
Illinois	100%	$20
Indiana	100%	$20
Iowa	74%	$20
Kansas	74%	$20
Kentucky	74%	$20
Louisiana	74%	$20
Maine	100%	$75
Maryland	74%	$20
Massachusetts	100%	$20
Michigan	100%	$20
Minnesota	100%	$20
Mississippi	74%	$20
Missouri	87%	$20
Montana	74%	$20

State	Income Limit as Percent of FPL	Income Disregard
Nebraska	100%	$20
New Hampshire	74%	$13/individual $20/couple
New Jersey	100%	$20
Nevada	74%	$20
New Mexico	74%	$20
New York***	83%	$20
North Carolina	100%	$20
North Dakota	74%	$20
Ohio	74%	$20
Oklahoma	100%	$20
Oregon	74%	$20
Pennsylvania	100%	$20
Rhode Island	100%	$20
South Carolina	100%	$20
South Dakota	74%	$20
Tennessee	74%	$20
Texas	74%	$20
Utah	100%	$20
Vermont	74%	$20
Virginia	81%	$20
Washington	74%	$20
West Virginia	74%	$20
Wisconsin	83%	$20
Wyoming	74%	$20

Source: Kaiser Family Foundation, Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2018

*In December 2020, California's income limit was raised to 138% FPL and the standard disregard amounts of $230.00 for an individual and $310.00 for a couple were removed – all other table data is 2018 data.

**Alaska and Hawaii employ higher poverty limits than the 48 contiguous states.

***New York has introduced legislation this year to raise the income limit to 138% FPL.[34]

TABLE 2. STATE MEDICARE SAVINGS PROGRAMS INCOME LIMITS, 2022

State	QMB	SLMB	QI	Income Disregard
Federal	100% FPL $1,333	120% FPL $1,359	135% FPL $1,529	$20
Alabama	Federal	Federal	Federal	$20
Alaska*	Federal	Federal	Federal	$20
Arizona	Federal	Federal	Federal	$20
Arkansas	Federal	Federal	Federal	$20
California	Federal	Federal	Federal	$20
Colorado	Federal	Federal	Federal	$20
Connecticut	$2,390/$3,220	$2,616/$3,525	$2,786/$3,754	N/A
Delaware	Federal	Federal	Federal	$20
DC	$3,398/$4,578	N/A	N/A	N/A
Florida	Federal	Federal	Federal	$20
Georgia	Federal	Federal	Federal	$20
Hawaii	Federal	Federal	Federal	$20
Idaho	Federal	Federal	Federal	$20
Illinois	Federal	Federal	Federal	$25
Indiana	$1,699/$2,289	$1,925/$2,594	$2,095/$2,823	N/A
Iowa	Federal	Federal	Federal	$20
Kansas	Federal	Federal	Federal	$20
Kentucky	Federal	Federal	Federal	$20
Louisiana	Federal	Federal	Federal	$20
Maine	$1,699/$2,289	$1,925/$2,594	$2,095/$2,823	$20
Maryland	Federal	Federal	Federal	$20
Massachusetts	$1,472/$1,984	$1,699/$2,289	$1,869/$2,518	$20
Michigan	Federal	Federal	Federal	$20
Minnesota	Federal	Federal	Federal	$20
Mississippi	Federal	Federal	Federal	$50
Missouri	Federal	Federal	Federal	$20
Montana	Federal	Federal	Federal	$20
Nebraska	Federal	Federal	Federal	$20
Nevada	Federal	Federal	Federal	$20
New Hampshire	Federal	Federal	Federal	$20
New Jersey	Federal	Federal	Federal	$20
New Mexico	Federal	Federal	Federal	$20
New York	Federal	Federal	Federal	$20
North Carolina	Federal	Federal	Federal	$20
North Dakota	Federal	Federal	Federal	$20
Ohio	Federal	Federal	Federal	$20
Oklahoma	Federal	Federal	Federal	$20
Oregon	Federal	Federal	Federal	$20
Pennsylvania	Federal	Federal	Federal	$20
Rhode Island	Federal	Federal	Federal	$20

State	QMB	SLMB	QI	Income Disregard
South Carolina	Federal	Federal	Federal	$20
South Dakota	Federal	Federal	Federal	$20
Tennessee	Federal	Federal	Federal	$20
Texas	Federal	Federal	Federal	$20
Utah	Federal	Federal	Federal	$20
Vermont	Federal	Federal	Federal	$20
Virginia	Federal	Federal	Federal	$20
Washington	Federal	Federal	Federal	$20
West Virginia	Federal	Federal	Federal	$20
Wisconsin	Federal	Federal	Federal	$20
Wyoming	Federal	Federal	Federal	$20

Source: NCOA, National Council on Aging, State-Specific MSP Guidelines, 2022.
*Alaska and Hawaii employ higher federal poverty income limit
**New York has introduced legislation in 2022 to increase its income limits for MSPs[35]

TABLE 3. ASSET LIMITS BY MEDICAID PROGRAM, 2018; 2022

State	Medicaid ABD	LTSS	Medically Needy	MSPs
Alabama	$2,000/$3,000	$2,000/$3,000	No Program	No Limit
Alaska	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340
Arizona	No Limit	$2,000/$3,000	No Program	No Limit
Arkansas	$7,560/$11,340	$2,000/$3,000	$2,000/$3,000	$7,560/$11,340
California*	$130,000/$195,000	No Program	$130,000/$195,000	$130,000/$195,000
Colorado	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340
Connecticut	$1,600/$2,400	$1,600/$2,400	$1,600/$2,400	No limit
Delaware	$2,000/$3,000	$2,000/$3,000	No Program	No Limit
DC	$4,000/$6,000	$4,000/$6,000	$4,000/$6,000	No Limit
Florida	$5,000/$6,000	$2,000/$3,000	$5,000/$6,000	$7,560/$11,340
Georgia	$2,000/$3,000	$2,000/$3,000	$2,000/$4,000	$7,560/$11,340
Hawaii	$2,000/$3,000	No Program	$2,000/$3,000	$7,560/$11,340
Idaho	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340
Illinois**	$2,000/$3,000	No Program	$2,000/$3,000	$7,560/$11,340
Indiana	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340
Iowa	$2,000/$3,000	$2,000/$3,000	$10,000/$10,000	$7,560/$11,340
Kansas	$2,000/$3,000	$2,000/N/A	$2,000/$3,000	$7,560/$11,340
Kentucky	$2,000/$3,000	$2,000/N/A	$2,000/$3,000	$7,560/$11,340
Louisiana	$2,000/$3,000	$2,000/$3,000	$2,000/$3,000	No Limit
Maine	$2,000/$3,000	$2,000/$3,000	$2,000/$3,000	$50,000/$75,000
Maryland	$2,000/$3,000	$2,000/$3,000	$2,500/$3,000	$7,560/$11,340
Massachusetts	$2,000/$3,000	$2,000/N/A	$2,000/$3,000	$16,800/$25,200
Michigan	$2,000/$3,000	$2,000/$3,000	$2,000/$3,000	$7,560/$11,340
Minnesota	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000	$10,000/$18,000
Mississippi	$2,000/$3,000	$4,000/$6,000	No Program	No Limit
Missouri	$3,000/$6,000	Varies by program	No Program	$7,560/$11,340
Montana	$2,000/$3,000	No Program	$2,000/$3,000	$7,560/$11,340
Nebraska	$4,000/$6,000	No Program	$4,000/$6,000	$7,560/$11,340
Nevada	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340
New Hampshire	$1,500/$1,500	$2,500/N/A	$2,500/$4,000	$7,560/$11,340
New Jersey	$4,000/$6,000	$2,000/$3,000	$4,000/$6,000	$7,560/$11,340
New Mexico	$2,000/$3,000	$2,000/N/A	No Program	No Limit
New York***	$2,000/$3,000	No Program	$15,150/$22,200	No Limit
North Carolina	$2,000/$3,000	No Program	$2,000/$3,000	$7,560/$11,340
North Dakota	$3,000/$6,000	No Program	$3,000/$6,000	$7,560/$11,340
Ohio	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340
Oklahoma	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340
Oregon	$2,000/$3,000	$2,000/N/A	No Program	No Limit
Pennsylvania	$2,000/$3,000	$2,000/$3,000	$2,400/$3,200	$7,560/$11,340
Rhode Island	$4,000/$6,000	$4,000/$6,000	$4,000/$6,000	$7,560/$11,340
South Carolina	$7,560/$11,340	$2,000/$3,000	$2,000/$3,000	$7,560/$11,340
South Dakota	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340

State	Medicaid ABD	LTSS	Medically Needy	MSPs
Tennessee	$2,000/$3,000	$2,000/N/A	No Program	$7,560/$11,340
Texas	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340
Utah	$2,000/$3,000	$2,000/$3,000	$2,000/$3,000	$7,560/$11,340
Vermont	$2,000/$3,000	$2,000/$3,000	$2,000/$3,000	No Limit
Virginia	$2,000/$3,000	$2,000/N/A	$2,000/$3,000	$7,560/$11,340
Washington****	$2,000/$3,000	$2,000/$3,000	$2,000/$3,000	$7,560/$11,340
West Virginia	$2,000/$3,000	$2,000/$3,000	$2,000/$3,000	$7,560/$11,340
Wisconsin	$2,000/$3,000	$2,000/$3,000	$2,000/$3,000	$7,560/$11,340
Wyoming	$2,000/$3,000	$2,000/$3,000	No Program	$7,560/$11,340

Sources: Kaiser Family Foundation, Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2018; National Council on Aging, State-Specific MSP Guidelines, 2022.

*California will eliminate its asset test effective by January 1, 2024.

**Illinois has eliminated its asset test for Medicare Savings Programs for the duration of the COVID-19 pandemic and there are efforts currently underway to make that policy permanent.[36]

***New York's Governor has proposed to eliminate the Medicaid ABD asset test in the 2022 budget.[37]

****Washington state has proposed to eliminate the asset test for its Medicare Savings Programs.[38]

TABLE 4. MEDICAID MEDICALLY NEEDY PROGRAM, MONTHLY MAINTENANCE NEED INCOME LEVEL BY STATE, 2018

State	Monthly Maintenance Need
Arkansas	$108/$217
California	$600/$934
Connecticut	$523/$696
DC	$652/$652
Florida	$180/$241
Georgia	$317/$375
Hawaii	$469/$632
Illinois	$1,012/$1372
Iowa	$483/$483
Kansas	$475/$475
Kentucky	$235/$235
Louisiana	$100/$192
Maine	$315/$341
Maryland	$350/$392
Massachusetts	$522/$650
Michigan	$1,012/$1,372
Minnesota	$810/$1,098
Montana	$525/$525
Nebraska	$392/$392
New Hampshire	$591/$675

State	Monthly Maintenance Need
New Jersey	$367/$434
New York	$842/$1,233
North Carolina	$242/$317
North Dakota	$840/$1,139
Pennsylvania	$425/$442
Rhode Island	$903/$947
Utah	$1,012/$1,372
Texas	$104/$216
Vermont	$1,041/$1,041
Virginia	$493/$493
Washington	$750/$750
West Virginia	$200/$275
Wisconsin	$592/$592

Source: Kaiser Family Foundation, Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2018.

ENDNOTES

1 Kaiser Family Foundation, Number of Dual Eligible Beneficiaries, 2013, available at https://www.kff.org/medicaid/state-indicator/dual-eligible-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

2 ASPE, ""An Overview of Long-Term Services and Supports and Medicaid: Final Report," Aug. 7, 2018, available at https://aspe.hhs.gov/reports/overview-long-term-services-supports-medicaid-final-report-0.

3 42 U.S.C. §1396a(a)(10)(A)(i)(VIII) "a state beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line…"; See also, 42 U.S.C. §1396a(e)(14)(C), "A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan."

4 Kaiser Family Foundation, "Status of State Medicaid Expansion Decisions: Interactive Map," Feb. 24, 2022, available at https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

5 Zewde, N. & Wimer, C., "Antipoverty Impact of Medicaid Growing with State Expansions Over Time," (2019), Health Affairs, available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05155

6 Kaiser Family Foundation, "Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care," Sep. 30, 2020, available at https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/.

7 See 26 U.S.C. § 36B. The ACA originally set the affordability threshold at 9.5% of household income. Each year, the affordability cap is adjusted by the IRS. For 2021, the IRS set the affordability threshold at 9.83%. However, pursuant to the American Rescue Plan enacted into law on March, 11, 2021, the affordability threshold was set at 8.5% for the 2021 and 2022 tax years.

8 Forty-three states employ the special income rule for eligibility for home and community-based services delivered through waiver programs. Forty-two states employ this rule for Medicaid eligibility in institutional settings (Massachusetts does not use the rule for institutional care). This rule allows individuals who have gross income up to 300% of the Supplemental Security Income (SSI) rate to be eligible for Medicaid who meet an institutional level of care. Seven states do not employ the special income rule, including California, Hawaii, Illinois, Montana, Nebraska, New York, North Carolina, and North Dakota. See, Kaiser Family Foundation, "Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey," (Appendix Table 5) (Jun. 14, 2019), available at https://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey.

9 Roberts, E., et al., "Medicaid Coverage 'Cliff' Increases Expenses and Decreases Care for Near-Poor Medicare Beneficiaries," Apr. 2021, Health Affairs, available at https://doi.org/10.1377/hlthaff.2020.02272.

10 National Center on Law & Elder Rights, "Legal Basics: Medicare Savings Programs," Dec. 2017, available at https://ncler.acl.gov/pdf/Legal%20Basics%20-%20Medicare%20Savings%20Programs%20-%20Chapter%20Summary.pdf.

11 American Rescue Plan, H.R. 1319 § 9661 (Mar. 11, 2021).

12 California SB 104 (2019), the Budget Trailer Bill; See also, All County Welfare Directors Letter, No. 20-24, "Income Disregard for the Aged, Blind & Disabled Federal Poverty Level Program," Nov. 23, 2020, available at https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/20-24.pdf.

13 Centers for Medicare & Medicaid Services, State Plan Amendment (SPA) Approval dated November 19, 2020, available at https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-20-0045-Approval.pdf. California originally submitted the SPA to CMS to increase the income limit in 2019 and received CMS approval dated December 31, 2019, to implement the change effective July 2020. However, in light of the COVID-19 pandemic, the Governor proposed to rescind the expansion. Advocates were successful in maintaining the increase and the state resubmitted the SPA to CMS on September 2, 2020, which was approved on November 19, 2020.

14 See, California SB 104.

15 Western Center on Law & Poverty, "What Advocates Need to Know About the Aged, Blind & Disabled FPL Medi-Cal Expansion Starting on December 1, 2021," Nov. 2020, available at https://wclp.org/wp-content/uploads/2020/11/Health-Care-Practice-Tip-Nov-2020-11-30-20.pdf.

16 Kaiser Family Foundation, "Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey," (Jun. 14, 2019), available at https://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-

People-with-Disabilities-Findings-from-a-50-State-Survey.

17 ASPE, "HHS Poverty Guidelines for 2022," effective Jan. 12, 2022, available at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. For a household of one, the poverty guideline is $13,590, or $1,132.50 per month.

18 Kaiser Family Foundation, 50-State Survey.

19 See, FY 2023 New York State Executive Budget, Health and Mental Hygiene Article VII Legislation, Part N, available at https://www.budget.ny.gov/pubs/archive/fy23/ex/artvii/hmh-bill.pdf. See also, Memorandum in Support, Part N, available at https://www.budget.ny.gov/pubs/archive/fy23/ex/artvii/hmh-memo.pdf.

20 NCOA, "Medicare Savings Programs Eligibility and Coverage," Jan. 20, 2022, available at https://www.ncoa.org/article/medicare-savings-programs-eligibility-coverage. See also, New York Senate Bill, S8228 introduced Feb. 3, 2022, available at https://legislation.nysenate.gov/pdf/bills/2021/S8228, and New York Assembly Bill A9245, introduced February 9, 2022, available at https://legislation.nysenate.gov/pdf/bills/2021/A9245.

21 See e.g. NAHB, "Homeownership Rates by Race and Ethnicity," Mar. 1, 2018, available at http://www.nahbclassic.org/generic.aspx?genericContentID=261136&fromGSA=1. This report found Black homeownership to be 29 percentage points lower than white and Latinx homeownership to be 26 percentage points lower.

22 California AB 133 (2021), the Budget Trailer Bill; See also, California Department of Health Care Services (DHCS), "Asset Limit Changes for Non-MAGI Medi-Cal: Eligibility and Enrollment Plan," 2021, available at https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Asset-Limit-Changes-Non-MAGI/Eligibility-and-Enrollment-Plan-Asset-Test-Changes-for-Non-MAGI-MC.pdf.

23 Centers for Medicare & Medicaid Services, State Plan Amendment (SPA) Approval dated November 24, 2021, available at https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-21-0053-Approval.pdf; See also, CMCS Informational Bulletin, "Enrollment and Retention Flexibilities to Better Serve Medicare-Medicaid Enrollees," Jan. 23, 2015, available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-23-2015.pdf.

24 Medicaid estate recovery is still required by federal law in all states. Accordingly, while asset limits have been eliminated, estate recovery is still in effect. In California, advocates have been successful in significantly limiting the impact and scope of estate recovery in the state through changes in state law that became effective on January 1, 2017. See, CANHR, "The New Medi-Cal Recovery Laws," Updated June 2019, available at http://www.canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf. There have also been recent efforts to eliminate estate recovery at the federal level. The Stop Unfair Medicaid Recoveries Act of 2022, HR 6698, was introduced on February 9, 2022.

25 California Department of Health Care Services (DHCS), "Medi-Cal Asset Limits Supplemental Report," Mar. 2020, available at https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Medi-Cal-Asset-Limits-Supplemental-Report.pdf.

26 Id.

27 Id.

28 Arizona eliminated its asset limit in 2000 for its ABD program and Medicare Savings Programs. See, Kaiser Family Foundation, "Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Working Paper on Medicare Savings Programs in Arizona," Dec. 2002, available at https://www.kff.org/wp-content/uploads/2013/01/medicaid-programs-to-assist-low-income-medicare-beneficiaries-working-paper-on-medicare-savings-programs-in-arizona-background-paper.pdf.

29 Washington Senate Bill 5693 (p. 221) introduced Jan. 6, 2022, available at https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Bills/5693.pdf?q=20220131070326.

30 See, ASPE, "Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors and Implications," May 2019, available at https://aspe.hhs.gov/reports/loss-medicare-medicaid-dual-eligible-status-frequency-contributing-factors-implications-0, finding that Medicaid eligibility losses are in part attributable to administrative requirements in the Medicaid program versus changes in income, assets, or functional status. States that have implemented more inclusive Medicaid eligibility coverage policies decrease the number of individuals losing Medicaid coverage versus states that have more restrictive Medicaid coverage. The study demonstrates disparities in Medicaid coverage loss based on gender, age, and race.

31 California AB 1900 (2021-2022); see bill details, available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1900.

32 Kaiser Family Foundation, 50-State Survey.

33 Justice in Aging (previously NSCLC), "Medicaid Expansion in California: Opportunities and Challenges for Older Adults and People with Disabilities," Nov. 2013, available at http://nsclcarchives.org/wp-content/uploads/2013/11/1CA-Eligibility-Brief-4.pdf.

34 See, FY 2023 New York State Executive Budget, Health and Mental Hygiene Article VII Legislation, Part N, available at https://www.budget.ny.gov/pubs/archive/fy23/ex/artvii/hmh-bill.pdf. See also, Memorandum in Support, Part N, available at https://www.budget.ny.gov/pubs/archive/fy23/ex/artvii/hmh-memo.pdf.

35 See New York Senate Bill, S8228 introduced Feb. 3, 2022, available at https://legislation.nysenate.gov/pdf/bills/2021/S8228 and A9245, introduced February 9, 2022, available at https://legislation.nysenate.gov/pdf/bills/2021/A9245.

36 CMS SPA Approval dated April 24, 2020, available at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IL/IL-20-0004.pdf

37 See, FY 2023 New York State Executive Budget, Health and Mental Hygiene Article VII Legislation, Part N, available at https://www.budget.ny.gov/pubs/archive/fy23/ex/artvii/hmh-bill.pdf. See also, Memorandum in Support, Part N, available at https://www.budget.ny.gov/pubs/archive/fy23/ex/artvii/hmh-memo.pdf.

38 Washington Senate Bill 5693 (p. 221) introduced Jan. 6, 2022, available at https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Bills/5693.pdf?q=20220131070326.