HOUSE BILL 2940
By Hicks T

SENATE BILL 2791

By Watson

AN ACT to amend Tennessee Code Annotated, Title 71, Chapter 5, relative to TennCare.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part:

71-5-701. Short title.

This part is known and may be cited as the "TennCare for Working Individuals with Disabilities Act."

71-5-702. Part definitions.

As used in this part:

(1) "Bureau" means the bureau of TennCare;

(2) "Buy-in program" and "program" mean the Medicaid eligibility group created pursuant to this part that enables a working individual with a disability to obtain or retain Medicaid health insurance coverage through medical assistance via the payment of coverage premiums;

(3) "Director" means the director of TennCare; and

(4) "Medical assistance" means the medical assistance program described in part 1 of this chapter.

71-5-703. Legislative intent.

It is the intent of the general assembly to remove barriers to employment for individuals who, but for income and resources, meet the federal Social Security definition of having a disability, by providing medical assistance to working individuals with

disabilities through a buy-in program in accordance with § 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII)) and Medicaid eligibility, including using less-restrictive income and resource requirements through the application of § 1902(r)(2) of the Social Security Act (42 U.S.C. § 1396(r)(2)) and cost-sharing requirements established by the bureau and approved by the federal centers for medicare and medicaid services.

71-5-704. Program establishment.

(a) On or before January 1, 2025, the bureau shall establish a buy-in program for working individuals with disabilities that enables such individuals to access health insurance coverage through the medical assistance program, including as a supplement to employer-sponsored coverage.

(b) In establishing the buy-in program, the bureau:

(1) Shall establish cost-sharing requirements for the buy-in program in accordance with federal law and this part;

(2) Shall establish and modify eligibility and cost-sharing requirements in order to administer the program within available funds;

(3) Shall not establish eligibility restrictions for the buy-in program based upon a person's income, resources, or maximum age;

(4) May consider, when applicable, a person's income, excluding spousal income or assets, when establishing cost-sharing requirements;

(5) Shall include a grace period that provides continuous coverage for an individual who experiences a temporary interruption of employment; and

(6) Shall make every effort to coordinate benefits with employer-sponsored coverage available to the working individuals with disabilities receiving benefits under this chapter or other applicable law.

(c) In establishing the buy-in program for working individuals with disabilities pursuant to this part, and in order to serve a new and needy population with distinct financial or healthcare needs in accordance with § 71-5-163(a)(8), the bureau shall, to the extent permitted by federal law, utilize savings realized from the TennCare block grant funding agreement entered into with the federal government pursuant to § 71-5-163.

(d) The bureau shall seek federal approval to exclude resources accumulated in a separate account that result from earnings during an individual's enrollment in the buy-in program, including IRS-approved retirement accounts, when determining the individual's subsequent eligibility for another medical assistance program.

(e) The director is authorized to seek any federal waiver the director deems necessary to effectuate this part.

71-5-705. Program description.

The director shall ensure that the buy-in program:

(1) Provides categorically needy scope of care;

(2) Provides home- and community-based long-term services and supports for an enrollee who meets the functional requirements for those programs, is approved for those services, and chooses to enroll in the buy-in program;

(3) Approves coverage for six (6) months effective the first of the month in which a person applies and meets program requirements;

(4) Allows a person who is eligible for another TennCare program to choose not to participate in the buy-in program; and

(5) Deems a person ineligible for buy-in program coverage for a month in which the person received TennCare benefits under the medically needy program.

71-5-706. Individual eligibility requirements.

The director shall ensure that the buy-in program:

(1) Requires that, for a person to qualify for the program, the person must:

(A) Meet the following general requirements as established for the medical assistance program:

(i) Residence in this state;

(ii) Citizenship or immigration status in the United States;

(iii) Possession of a valid social security account number; and

(iv) Assignment of medical support rights to this state;

(B) Be at least eighteen (18) years of age;

(C) Meet federal disability requirements; and

(D) Be employed full- or part-time, including self-employment;

(2) Does not require a resource test;

(3) Requires that an enrollee comply with cost-sharing provisions; and

(4) Allows a person who, once approved for the program, experiences a job loss to choose to continue program coverage through the original six (6) months of eligibility, if:

(A) The job loss results from an involuntary dismissal or health crisis; and

(B) The person continues to pay the monthly premium based on the person's income.

71-5-707. Employment requirements.

The director shall ensure that, for the purpose of the buy-in program, a person is considered to be employed if the person:

(1) Gets paid for working;

(2) Has earnings that are subject to federal income tax; and

(3) Unless the person is self-employed, has payroll taxes deducted from earnings received.

71-5-708. Premium payments – Billing and payment of premiums.

(a) The director shall ensure, when determining the premium amount a person must pay for participation in the buy-in program, that:

(1) The bureau counts only the income of the person approved for the program, and does not count the income of another household member;

(2) For purposes of determining countable income to be used in the premium calculation, the bureau applies the following rules:

(A) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the person's needs for food, clothing, and shelter; and

(B) Certain receipts are not income as described in 20 C.F.R. § 416.1103;

(3) The buy-in program premium amount equals, rounded down to the nearest whole dollar, five percent (5%) of countable income described in subdivision (a)(2), including both earned and unearned income;

(4) When determining the premium amount, the bureau uses the verified income amount until a change in income is reported and processed, unless good cause for delay in verifying changes exists; and

(5) A change in the premium amount is effective the month after the change in income is reported to and processed by the bureau.

(b) The director shall ensure, when billing for and processing payments of buy-in program premiums, that:

(1) For current and ongoing coverage, the bureau bills for program premiums during the month following the benefit month;

(2) The first monthly premium begins the first full month of coverage;

(3) Pursuant to § 71-5-706(3), the bureau may terminate program coverage if premiums are not paid in full for four (4) consecutive months;

(4) The person must pay the monthly premium in full to avoid losing program coverage and, if a person makes a partial payment, the payment does not count as a full payment toward the premium;

(5) Payments received are applied to premiums owed in the following order:

(A) Past due months, beginning with the most delinquent month; and

(B) The current coverage month that has been invoiced; and

(6) A person must pay a premium for any month that program coverage is provided, including months when a redetermination of coverage is made, months when continued coverage is requested, and during the period of an aid-pending eligibility appeal.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.