



States Implement Health Reform



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Medicaid and the Affordable Care Act

Overview

Medicaid, which currently covers nearly 50 million low-income Americans, funded an estimated \$339 billion in services in 2008. Medicaid is a federal/state partnership with shared authority and financing. States have the option to participate, and all 50 states do so. States must meet the federal minimum requirements, such as covering certain people and offering certain benefits, and also may cover additional “optional” people and services, although significant variations exist among states.

Most Medicaid eligibility currently is determined by income and “categories,” such as children under age 19, pregnant women, adults with dependent children, people with disabilities and the elderly. Childless adults, who typically are not eligible for Medicaid, make up a large percentage of the nation’s uninsured.

Key Federal Provisions

The 2010 Affordable Care Act (ACA) expands Medicaid to all Americans under age 65 whose family income is at or below 133 percent of federal poverty guidelines (\$14,484 for an individual and \$29,726 for a family of four in 2011) by Jan. 1, 2014. Childless adults will make up a large percentage of this newly eligible population. Full federal financing (100 percent Federal Medical Assistance Percentages) will be available for those newly eligible for Medicaid for three years (2014 to 2016). The Federal Medical Assistance Percentage falls to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond; states pick up the balance.

The Affordable Care Act includes many provisions that directly affect Medicaid, including the following.

- Requires maintenance of effort (MOE) for state Medicaid and Children’s Health Insurance Program (CHIP) eligibility levels that were in place on March 23, 2010—through 2013 for adults and 2019 for children to continue participation in the Medicaid program.
- Modifies how income is calculated for most Medicaid applicants, including those in the new eligibility group. Starting in 2014, states must use Modified Adjusted Gross Income (MAGI) for eligibility determination for most applicants. This is adjusted gross income as defined in the Internal Revenue Code, modified by applying a 5 percent “disregard.”

This method eliminates resource tests. The combined effect of requiring coverage up to 133 percent of poverty and then use of MAGI budgeting effectively raises the income level for most Medicaid applicants to 138 percent of poverty.

- Allows states to expand coverage early through the state plan amendment process, beginning on April 1, 2010. Those eligible for this early expansion will have incomes between the state’s Medicaid eligibility level as of Dec. 1, 2009, and 133 percent of poverty.
- Provides all newly eligible adults with a benchmark benefit package that meets the minimum essential health benefits that will be available in the new health insurance exchanges. Health and Human Services is charged with determining the “essential health benefits.”
- Includes new mandatory and optional benefits in Medicaid. Coverage of free-standing birth clinics and tobacco cessation services for pregnant women are examples of new mandatory benefits.
- Requires states to improve outreach and enrollment for Medicaid and to coordinate Medicaid eligibility with the new health benefit exchange, which must be operational by 2014.
- Enhances efforts to improve Medicaid program integrity, including fraud and abuse prevention, detection and recovery initiatives.
- Requires increased transparency with applications and renewals of Section 1115 waivers.



- Requires states to submit annual reports on Medicaid enrollment.
- Requires the HHS secretary to award grants to states to provide incentives for prevention of chronic diseases in Medicaid enrollees.
- Establishes a new mandatory coverage group for young adults who leave foster care, to age 26.
- Creates a new optional eligibility group for family planning services.
- Reduces Medicaid disproportionate share hospital (DSH) allotments.
- Makes various changes to Medicaid prescription drug coverage.
- Reduces and/or eliminates Medicaid payments for health care-acquired conditions.
- Increases primary care physician payment rates for selected services.
- Encourages states to test models aimed at improving the delivery and quality of payment for services.
- Provides leadership and resources to encourage states to coordinate care for dual eligibles—those who qualify for both Medicaid and Medicare. The Coordinated Health Care Office within the Centers for Medicaid and Medicare Services was established to integrate benefits and improve care for these beneficiaries.
- Creates an additional mechanism to provide home and community-based services.
- Extends the “Money Follows the Person Rebalancing Demonstration” through FY 2016 and reduces the residential stay requirement from six months to 90 days.

State Roles in Implementation

The ACA gives states primary responsibility to implement most of the changes required and encouraged for Medicaid, at the same time states are facing difficult financial times. Legislators may want to consider the following list of issues before implementation of the Medicaid expansion begins in 2014.

Medicaid Funding Issues—Expanding Medicaid may be the most pressing of the many funding issues related to the ACA that states face. Before states can estimate the cost of expansion, they must determine the number of people who currently are eligible for Medicaid but not enrolled. When the individual man-

date to obtain health insurance becomes effective on Jan. 1, 2014, many will discover their Medicaid eligibility and will choose enrollment as their most economical choice. States will receive their traditional federal match for this population—a significantly lower amount than the enhanced match for the “newly eligible.” As a result, many states will find the cost of their Medicaid programs will be higher.

Other financial implications to states include the lack of a countercyclical “trigger” for Medicaid. The ACA does not increase financing to states during economic slumps; during such times, Medicaid enrollment usually grows. As the economy recently worsened, for example, Medicaid covered an additional 3.3 million from June 2008 – June 2009. The ACA also reduces Medicaid disproportionate share hospital allotments. These reductions are meant to be offset by the increased number of people with health insurance. It is not clear, however, how this reduction will affect states, particularly those with high numbers of residents who are not eligible for new coverage programs.

Enrollment Systems and Compatibility with the Exchange—The ACA requires a coordinated and simplified application process between Medicaid and the health insurance exchange to allow consumers to apply for coverage with one application. For most states, this will require new or greatly enhanced Medicaid enrollment systems. The federal government increased the funding available to states to develop Medicaid eligibility systems from a 50 percent match to a 90 percent federal match through Dec. 31, 2015. System maintenance and operation would be eligible for an increased reimbursement rate, from a 50 percent to 75 percent federal match for an indefinite period of time, as long as the system continues to meet standards. The system update will need to occur before 2014 and will require some financial investment by states.

Resources

NCSL’s home page for health reform information:
<http://www.ncsl.org/healthreform>
 NCSL’s web page for Medicaid information:
<http://www.ncsl.org/default.aspx?tabid=14518>

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