

Health Reform Provides New Federal Money to Help States Expand Medicaid

Health care reform legislation recently signed into law will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This fact sheet examines how the law makes new federal dollars available to states to provide Medicaid coverage to millions of low-income adults and how special populations and situations are treated for purposes of recent changes to the Medicaid program.

Background

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) (H.R. 3590; P.L. 111-148) into law. The law creates a national floor of 133 percent of the federal poverty level (FPL) (\$14,403.90 for an individual and \$29,326.50 for a family of four in 2009)¹ for Medicaid eligibility. Because the law eliminates the historical income disregards for these new groups and establishes a new across-the-board 5 percent income disregard, the effective income eligibility threshold is 138 percent of the FPL.

This expansion of coverage is expected to increase Medicaid enrollment by an estimated 16 million people by 2019. This represents a 32 percent increase in the number of people being served by the program in that year, on an average monthly basis. It is estimated that approximately 80 percent of the net increase in Medicaid enrollment will be childless adults, a group that is expected to have greater health needs and higher medical costs than parents and children.²

Mandatory Medicaid Expansion for Childless Adults and Parents

Prior to the enactment of PPACA, certain adults (nonelderly adults who are not disabled, not pregnant, or not parents of dependent children) were generally not eligible for federally financed Medicaid benefits, no matter how poor they were. States could, however, cover this group with their own funds, or they could obtain federal Medicaid waivers to cover them, in which case they would receive federal financial participation. Fewer than half of the states currently provide Medicaid to low-income childless adults, and their levels of coverage range from being comparable to the Medicaid benefit package to far less comprehensive coverage.³

Beginning January 1, 2014, the health reform law extends coverage to childless adults with income at or below 133 percent of the federal poverty level.

Before PPACA, the federal minimum income threshold for covering parents in Medicaid was tied to eligibility for cash assistance under the former 1996 Aid to Families with Dependent Children (AFDC) program. Consequently, most states only cover parents with income less than 100 percent of the FPL (\$22,050 for a

family of four in 2009), with 34 of these states limiting parental eligibility to less than 50 percent of the FPL (\$11,025 for a family of four in 2009).⁴ In addition to requiring coverage for childless adults up to 133 percent of the FPL, the new health reform law expands mandatory coverage for parents to the same income level.^{5,6}

Method for Determining Income for Medicaid Is Changing and the Asset Test Is Eliminated for Certain Populations

Before PPACA, Medicaid eligibility was based on both income and asset levels. Historically, a combination of federal requirements and state options determined the specific income and asset eligibility requirements set by states. As a result, Medicaid eligibility criteria vary among states and among different eligibility groups within states.⁷

Beginning July 1, 2013, the asset test will be eliminated for certain groups, and a modified adjusted gross income (MAGI) standard will be the basis for determining income eligibility. These new rules will apply to Medicaid, the Children's Health Insurance Program (CHIP), and eligibility for subsidies in the health insurance exchanges. This standardized approach to determining income eligibility will eliminate wide discrepancies in how income is now counted across states and will be consistent with income counting rules for determining eligibility for subsidies in the new health insurance exchanges.⁸ MAGI is defined as an individual's (or couple's) gross income (for federal tax purposes), with some adjustments that add back in foreign income and tax-exempt interest.⁹

The elimination of the asset test and the application of MAGI will apply to most children, parents, and childless adults who qualify under existing eligibility rules as well as those who are newly eligible.¹⁰ The following Medicaid

eligibility groups will continue to employ asset rules and income disregards, and are exempt from using MAGI to determine income eligibility:

- Older adults (age 65 and older)
- Foster children
- Low-income Medicare Savings Program beneficiaries
- Persons receiving supplemental security income.¹¹
- Medically needy persons
- Persons seeking Medicare prescription drug low-income subsidies
- Persons seeking Medicaid long-term care services.¹²

Income Disregards Are Being Eliminated for Certain Groups

In determining the level of countable income for purposes of determining Medicaid eligibility, states currently have considerable flexibility to decide types and amounts of income they disregard—that is, income they do not count. For example, a state might exempt \$90 per month in earnings.¹³ Beginning January 1, 2014, the new law replaces these “traditional” income disregards for groups subject to MAGI income-counting rules with a standard 5 percentage point income disregard, which will be built into the gross income test to compensate for the loss of other, existing Medicaid disregards.¹⁴

As a result, some current beneficiaries will lose their Medicaid eligibility. Most, however, will be able to obtain subsidized health coverage under the new law. Subsidies will be available through health insurance exchanges for those with incomes up to 400 percent of the FPL starting in 2014 (\$88,200 for a family of four in 2009).

States Get Enhanced Federal Matching Funds for Covering “Newly Eligible” Individuals

Newly eligible individuals are those whose income does not exceed 133 percent of the FPL, who are between age 19 (or a higher age that the state has elected) and age 65, and who are not pregnant. In addition, as of December 1, 2009, newly eligible individuals could not have been eligible under a state plan or a waiver for full Medicaid benefits, benchmark benefits, or benchmark equivalent coverage, or were eligible but not enrolled due to a cap or other enrollment limitations.¹⁵

States will receive enhanced federal funding for expanding Medicaid coverage to newly eligible individuals. The enhanced rates over seven years are as follows: for fiscal years (FY) 2014 through 2016, the federal government will cover 100 percent of the cost of covering newly eligible individuals. Thereafter, the increased federal match will be 95 percent in FY 2017, 94 percent in FY 2018, 93 percent in FY 2019, and 90 percent in FY 2020 and subsequent years.¹⁶

States Already Covering Newly Eligible Adults Will Receive a Different Enhanced Matching Rate

States that provided comprehensive coverage (including inpatient hospital services) to parents *and* childless adults up to at least 100 percent of the FPL on the date of PPACA’s enactment are called “expansion states” and will initially receive less federal assistance than states that did not previously extend such coverage.¹⁷ However, by 2019, the federal Medicaid assistance percentage (FMAP) for these states will be equal to the enhanced FMAP available for the newly eligible adults.

Beginning in FY 2014, the expansion states will receive a phased-in FMAP increase that is 50 percent of the difference between their regular FMAP and the enhanced match rate provided to other states in 2014; 60 percent of the difference in FY 2015; 70 percent of the difference in FY 2016; 80 percent of the difference in FY 2017; 90 percent of the difference in FY 2018; and 100 percent of the difference in FY 2019 and future years (see table 1 for an example).¹⁸

Twelve states—Arizona; Washington, DC; Delaware; Hawaii; Massachusetts;

Table 1
Example of How Enhanced Match Rates for Parents and Childless Adults Are Calculated in Expansion States

| Fiscal Year | Match for Nonexpansion States | Expansion State Transition Percentage | Expansion State with Current 58 Percent Base Match (Example) |
|--------------------|--------------------------------------|--|---|
| 2014 | 100 percent | 50 percent | 79.0 percent |
| 2015 | 100 percent | 60 percent | 83.2 percent |
| 2016 | 100 percent | 70 percent | 87.4 percent |
| 2017 | 95 percent | 80 percent | 87.6 percent |
| 2018 | 94 percent | 90 percent | 90.4 percent |
| 2019 | 93 percent | 100 percent | 93.0 percent |
| 2020 | 90 percent | 100 percent | 90.0 percent |

Formula = Nonexpansion state match minus expansion state current match times transition percentage plus expansion state current match.

Maine; Minnesota; New York; Pennsylvania; Vermont; Washington; and Wisconsin—appear to qualify as expansion states;¹⁹ however, for a variety of reasons, a subset of these states may be able to claim the higher matching rate associated with “newly eligible” adults.²⁰

Expansion States with No Newly Eligible Individuals Will Receive a Temporary FMAP Increase

Some states do not have any individuals who will become Medicaid-eligible under PPACA, because they already cover the parents and childless adults with income up to 133 percent of the FPL or at higher income levels. These states will receive a 2.2 percentage point FMAP increase for all of their covered populations for the period from January 1, 2014, through December 31, 2015.²¹ According to one research report, two of these states are likely to be Massachusetts and Vermont.²²

States Are Held to Maintenance-of-Effort Requirements to Receive Enhanced Federal Matching Funds

The Medicaid maintenance-of-effort (MOE) requirements in PPACA are designed to prevent states from eliminating or reducing coverage for certain groups of eligible individuals prior to the implementation of the new law’s expansion provisions.

Effective March 23, 2010, all states are required to maintain eligibility standards for adults in Medicaid until January 1, 2014, when the new health exchanges are operational; and for children in Medicaid and CHIP until October 1 2019. Violating the MOE requirement will result in a state losing *all* Medicaid funding,²³ including funding for children, parents, pregnant women,

seniors, people with disabilities, and administrative costs.²⁴

Beginning in 2011, a state that provides coverage to adults with incomes over 133 percent of the FPL is allowed to lower eligibility standards for nonpregnant, nondisabled adults with income above 133 percent of the FPL *if* the state can demonstrate that it is facing or projects that it will face a budget deficit.²⁵ It is important to note that while states are barred, through the MOE requirement, from ratcheting down eligibility standards, methodologies, or procedures, they can still cut provider rates and optional services, such as home and community-based long-term care services.²⁶

Treatment of Former Foster Care Children

Studies have found that children in the foster care system are more likely than other children to suffer from chronic medical and behavioral health conditions. In addition, significant numbers of these children have unmet health needs.²⁷

Recognizing that children aging out of the foster care system continue to need access to health care, the Foster Care Independence Act of 1999 gave states the option to extend Medicaid coverage to former foster children ages 18 to 21. Despite the good intentions of the law, a report published by the American Public Human Services Association found that few states were taking advantage of the option.²⁸ Consequently, these vulnerable young adults continued to go without needed care.

Under PPACA, beginning January 1, 2014, states will be required to provide Medicaid and Early and Periodic Screening, Diagnosis and Treatment (EPSDT)²⁹ to young adults below age 25 who were in the foster care system for

more than six months and were enrolled in Medicaid when they aged out of the system.³⁰

Treatment of Legal Immigrants

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 imposed a five-year bar on receipt of federally financed Medicaid for immigrants who are lawful permanent residents (LPRs) of the United States.^{31,32} An LPR is defined as a non-U.S. citizen who has been given legal permission to make a permanent home (and work) in the United States by qualifying for an immigrant visa abroad or adjusting to permanent resident status in the United States.

Prior to the enactment of PRWORA, otherwise qualified LPRs enjoyed the same access to Medicaid as qualified citizens.³³ After PRWORA became law, LPRs who entered the United States on or after August 22, 1996, were denied access to Medicaid for the first five years they lived in the United States, no matter how poor they were. States had the option to provide Medicaid coverage to those LPRs who are subject to the five-year bar with their own funds, and as of 2004, nearly half (23 states) did so.³⁴

In 2009, states got a new option, in the law reauthorizing CHIP to cover children and pregnant women lawfully residing in the United States, regardless of the duration of their residency.³⁵

Beginning January 1, 2014, LPRs who are subject to the five-year Medicaid bar will be able purchase coverage and receive subsidies through the health insurance exchanges. The new health reform law gives states an option to establish basic health programs for low-income individuals who are not eligible for Medicaid. This option would be available for people to use instead of seeking subsidies through health insurance

exchanges. Immigrants subject to the five-year bar may be able to access coverage through basic health programs in states that elect this option.³⁶

Treatment of Territories with Respect to the Medicaid Expansion

Beginning January 2014, the U.S. territories are required to provide coverage to childless adults who meet income eligibility standards consistent with the current eligibility levels for parents in the territories. The cost of covering this new mandatory group *will not* count against their spending caps.³⁷

Conclusion

The federal health reform law makes Medicaid the building block for expanding health insurance coverage to all low-income persons in this country. It also recognizes that states will need extra help to cover the costs of this population, many of whom are expected to have significant unmet health needs. This unprecedented coverage expansion creates both challenges and opportunities. One challenge will be to identify and enroll the maximum number of eligible persons into the program, creating new opportunities to get people into needed care and help them to manage their health conditions.

An equal challenge will be to ensure that there are enough providers to provide quality services to so many new enrollees. The existing safety net delivery system could easily become overwhelmed without adequate planning for the anticipated demand for care. There are a number of opportunities to explore promising policy strategies designed to increase the safety net workforce.

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¹ Congress has extended the 2009 Poverty Guidelines until at least May 31, 2010 (Continuing Extension Act of 2010, Pub. L. 111-157, April 15, 2010).

² United Health, *Center for Health Reform and Modernization*.

³ Kaiser Commission on Medicaid and the Uninsured, *Covering New Americans*.

⁴ Kaiser Commission on Medicaid and the Uninsured, *Covering New Americans*.

⁵ All states, including expansion states, will receive their regular federal Medicaid assistance percentage for parents eligible for coverage under the rules in place on March 23, 2010 (National Conference of State Legislatures, *Patient Protection and Affordable Care Act*).

⁶ Before the enactment of PPACA, states were required to provide Medicaid to children under age 6 with household income at or below 133 percent of the FPL, and children ages 6 through 18 with household income at or below 100 percent of the FPL. PPACA now requires states to provide Medicaid coverage to all children with household income at or below 133 percent of the FPL, including those covered through a separate CHIP.

⁷ Kaiser Commission on Medicaid and the Uninsured, *Covering New Americans*.

⁸ A health insurance “exchange” is an entity intended to create a more organized and competitive market for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them (Henry J. Kaiser Family Foundation, *Explaining Health Care Reform*). The exchanges will provide subsidies to low-income people who are above Medicaid eligibility levels but below 400 percent of the FPL.

⁹ Internal Revenue Code of 1986.

¹⁰ Georgetown University Health Policy Institute, *Key Medicaid, CHIP, and Low-Income Provisions*.

¹¹ Georgetown University Health Policy Institute, *Key Medicaid, CHIP, and Low-Income Provisions*.

¹² National Council of State Legislatures, *Patient Protection and Affordable Care Act*.

¹³ Henry J. Kaiser Family Foundation, *Explaining Health Care Reform*.

¹⁴ National Council of State Legislatures, *Patient Protection and Affordable Care Act*.

¹⁵ Health Policy Alternatives, Inc., *Summary of the Patient Protection and Affordable Care Act*; National Council of State Legislatures, *Patient Protection and Affordable Care Act*.

¹⁶ Georgetown University Health Policy Institute, *Key Medicaid, CHIP, and Low-Income Provisions*.

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¹⁷ Some of these states are already covering childless adults through waivers and are receiving higher federal matching funds for doing so.

¹⁸ Georgetown University Health Policy Institute, *Key Medicaid, CHIP, and Low-Income Provisions*.

¹⁹ Georgetown University Health Policy Institute, *Key Medicaid, CHIP, and Low-Income Provisions*.

²⁰ Henry J. Kaiser Family Foundation, *Focus on Health Reform*.

²¹ Congressional Research Service, *Medicaid and CHIP*.

²² The Henry J. Kaiser Family Foundation, *Focus on Health Reform*.

²³ Georgetown University Health Policy Institute, Georgetown Center for Children and Families, and Center on Budget and Policy Priorities, *Holding the Line on Medicaid and CHIP*.

²⁴ Georgetown University Health Policy Institute, Georgetown Center for Children and Families, and Center on Budget and Policy Priorities, *Holding the Line on Medicaid and CHIP*.

²⁵ Georgetown University Health Policy Institute, Georgetown Center for Children and Families, and Center on Budget and Policy Priorities, *Holding the Line on Medicaid and CHIP*.

²⁶ States will have less incentive to cut provider rates in 2013 and 2014 because the federal government is going to pay 100 percent of the cost of paying certain primary care providers 100 percent of the Medicare rate during those years. States can still cut rates to other providers who are not going to receive the rate increase under this provision of law.

²⁷ First Focus, *Addressing the Health Care Needs of Foster Children*.

²⁸ First Focus, *Addressing the Health Care Needs of Foster Children*.

²⁹ EPSDT is a mandatory Medicaid service for all Medicaid-eligible children. EPSDT services

include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. When conditions are identified during EPSDT screenings, states are required to provide follow-up diagnostic and Patient Protection and Affordable Care Act treatment to correct those conditions, whether or not the state Medicaid plan covers the same services for adults (Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book*).

³⁰ Patient Protection and Affordable Care Act.

³¹ Flowers, *America's Newcomers*.

³² PRWORA does allow immigrants who are subject to the bar to receive federally supported emergency Medicaid services.

³³ Ku and Kessler, *Number and Cost of Immigrants on Medicaid*.

³⁴ Kaiser Commission on Medicaid and the Uninsured, *Covering New Americans*.

³⁵ Flowers and Nonnemaker, *Treatment of Legal Immigrants in Health Reform*.

³⁶ People would access care through the basic health plan instead of the exchange. There are limits on the amount of premium and cost sharing that can be imposed on people who purchase a basic health plan. In addition, the basic plan must provide the essential benefit package as defined in the health reform law.

³⁷ Henry J. Kaiser Family Foundation, *Focus on Health Reform*.

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Written by Lynda Flowers
AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3889, ppi@aarp.org
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