FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

August 2012

Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision

On June 28, 2012, the United States Supreme Court issued its decision about the constitutionality of the Affordable Care Act's (ACA) Medicaid expansion in *National Federation of Independent Business (NFIB) v. Sebelius*.[1] The ACA expands Medicaid eligibility, beginning in 2014, to nearly all people under age 65 who have incomes at or below 138% of the federal poverty level (FPL, $15,415 for an individual in 2012).[2] To fund this coverage expansion, the ACA provides that the federal government will fund 100% of most states' costs in 2014 through 2016, gradually decreasing to 90% in 2020 and thereafter.[3] The Supreme Court ruling on the ACA maintains the Medicaid expansion but limits the Secretary's authority to enforce it. If a state does not implement the expansion, the Secretary cannot withhold existing federal program funds.

As states look ahead to the implementation of health reform in 2014, the Court's decision raises a number of questions regarding the ACA's Medicaid-related provisions. This policy brief considers these questions in light of the Court's decision. A companion brief examines the Court's ruling on the Medicaid expansion in more detail.[4]

1. What parts of the ACA are affected by the Court's decision?

The ACA contains numerous provisions, many of which affect the Medicaid program. However, the Court's decision focuses only on the ACA's Medicaid expansion. The Court describes the Medicaid expansion as encompassing the ACA's requirement that states cover adults under age 65 with incomes up to 138% FPL beginning in 2014,[5] along with the ACA's requirement that states provide benchmark benefits, including essential health benefits, to the newly eligible population,[6] and the enhanced federal matching funds available for state costs in covering the newly eligible population.

2. What guidance has the Administration issued after the Court's decision?

On July 10, 2012, HHS Secretary Kathleen Sebelius sent a letter to state governors that describes the Court's decision as affecting the ACA's "expansion of Medicaid eligibility for low-income adults." The Secretary's letter goes on to note that the "Court's decision did not affect other provisions of the law.[7]

3. Does the Court's decision affect the ACA's Medicaid expansion to 138% FPL for children ages 6 to 18?

The Court's decision does not affect the ACA's Medicaid expansion for children ages 6 to 18 in households with income up to 138% FPL.[8] The ACA's Medicaid expansion for this group of children is contained in a different part of the ACA and codified in a different part of the Social Security Act than the Medicaid expansion for low-income adults considered by the Court. States

participating in the Medicaid program already were required to cover children ages 6 to 18 in households with income up to 100% FPL, and the ACA amended that existing provision to 138% FPL effective January 1, 2014.[9] Throughout its decision, the Court sometimes refers to "individuals" and sometimes refers to "adults" when describing the Medicaid expansion group. In addition, the Court contrasts the ACA's Medicaid expansion with the program's "traditional" coverage groups, which include children. Finally, the Secretary's July, 2012 letter describes the Court's decision as encompassing "adults" and as not affecting other provisions of the ACA.[10]

4. Does the Court's decision affect the ACA's maintenance of effort provisions?

The Court's decision does not affect the ACA's maintenance of effort provisions. Separate from the Medicaid expansion, the ACA requires states to maintain eligibility standards, methodologies and procedures that are no more restrictive than those in effect under the state plan or waiver as of the ACA's enactment on March 23, 2010, until the Secretary determines that an exchange is fully operational in the state for adults and through September 30, 2019 for children under age 19.[11] The maintenance of effort provisions are contained in a different part of the ACA and codified in a different part of the Social Security Act than the ACA's Medicaid expansion and were not considered by the Court. The Secretary's July, 2012 letter confirms that no provisions of the law other than the expansion of Medicaid eligibility to adults up to 138% FPL are affected by the Court's decision. The Congressional Research Service also has concluded that the ACA's maintenance of effort provisions are unaffected by the Court's decision.[12]

5. Does the Court's decision affect the ACA's eligibility and enrollment simplification procedures?

The Court's decision does not affect the ACA's eligibility and enrollment simplification procedures. The ACA requires states to determine financial eligibility for the Medicaid program based on the modified adjusted gross income (MAGI) methodology beginning in 2014. The MAGI methodology applies to the ACA's Medicaid expansion group as well as to most other coverage groups.[13] The ACA also requires states to use streamlined application and enrollment procedures in their Medicaid programs as a whole beginning in 2014.[14] The MAGI methodology and streamlined eligibility and enrollment procedures are contained in different parts of the ACA and codified in different parts of the Social Security Act than the ACA's Medicaid expansion and were not considered by the Court. The Secretary's July, 2012 letter confirms that provisions of the law other than the Medicaid expansion are unaffected by the Court's decision. The Congressional Research Service also has concluded that the ACA's MAGI provision is unaffected by the Court's decision.[15]

On April 19, 2011, CMS published a final rule that makes available 90% federal matching funds for states to upgrade their information technology systems to prepare for health reform.[16] Acting CMS Administrator Marilyn Tavenner issued a July 13, 2012 letter confirming that states can receive these grants even if they have not yet decided whether to comply with the ACA's

Medicaid expansion, and states will not have to repay these funds if they ultimately do not expand their Medicaid programs.[17]

6. Does the Court's decision affect other ACA changes to Medicaid?

The ACA makes a number of other changes to the Medicaid program that are not impacted by the Court's decision and remain in effect.[18] These include:

- The extension of coverage to young adults formerly in foster care
- New state options to provide home and community-based long-term services and supports for people with disabilities
- New opportunities for states to coordinate care for people with chronic conditions, such as health homes and the financial alignment demonstrations for people dually eligible for Medicare and Medicaid
- The primary care provider payment rate increase for 2013 and 2014
- Scheduled reductions in disproportionate share hospital payments

7. Can states expand eligibility to an income limit less than 138% FPL and still receive the enhanced FMAP?

While the Secretary has not yet issued guidance on this issue, it does not appear that states can access enhanced federal matching funds without covering the entire group of people up to 138% FPL based on the plain language of the ACA.[19] The Court's decision leaves unchanged all of the ACA's provisions, including the Medicaid expansion. The ACA's Medicaid expansion is in the part of the law that delineates the mandatory eligibility groups and encompasses "all individuals . . . whose income . . . does not exceed 133 percent of the poverty line. . . ."[20] (The ACA also provides for an income disregard of 5% FPL, effectively extending eligibility for the expansion group to 138% FPL.) The enhanced federal funding provided by the ACA is tied to the individuals encompassed by the expansion group. The language describing the expansion group does not on its face provide the option for states to set a lower income threshold to cover a portion of individuals in the group. By contrast, the existing optional eligibility categories in the law expressly permit states the "option" of offering Medicaid to "any group or groups of individuals" within the listed optional categories.[21]

8. Can states opt in and opt out of the ACA's Medicaid expansion over time?

Regarding the timing of state implementation of the ACA's Medicaid expansion, CMS has stated that states may "decide whether and when to expand, and if a state covers the expansion group, it may later drop the coverage."[22] This means that states can implement the ACA's Medicaid

expansion for a period of time and then stop doing so, presumably without risking the loss of existing non-ACA expansion Medicaid funds. States also can decide not to implement the Medicaid expansion initially but then do so later at some point after 2014. CMS did not clarify whether states would still receive the enhanced federal matching funds in that situation. States that do not implement the expansion in the first three years that it is available will forgo 100% federal funding for their costs, because the ACA specifies that 100% federal funds are available in the years 2014, 2015 and 2016. In subsequent years, the ACA provides for enhanced federal funds to match states' Medicaid expansion costs of 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and each year thereafter.[23]

9. Will the Secretary apply her § 1115 waiver authority to the ACA Medicaid expansion group?

Section 1115 of the Social Security Act grants authority to the HHS Secretary to waive state compliance with certain Medicaid requirements in the context of an "experimental, pilot, or demonstration project which, in the judgment of the Secretary is likely to assist in promoting the objectives of" the Medicaid program.[24] The ACA's Medicaid expansion group is included among the specific provisions over which the Secretary has waiver authority. However, HHS has not yet issued guidance on this issue, leaving a number of open questions about whether and how the Secretary would exercise her § 1115 waiver authority in the context of the ACA's Medicaid expansion, including:

- What research or demonstration purpose will such waivers be designed to achieve if the Secretary permits expansions to a threshold less than 138% FPL?
- Will enhanced federal matching funds be available for expansion populations covered under such waivers?
- How will the traditional budget neutrality requirement impact such waivers?

10. If a state does not take up the Medicaid expansion, will its DSH funds still be reduced?

As noted above, the Court's decision does not affect the scheduled reductions in federal matching funds for payments to disproportionate share (DSH) hospitals. Under current law, states are required to make additional payments to hospitals serving disproportionate numbers of Medicaid and uninsured low-income patients. The federal government matches these DSH payments up to the amount of an allotment for each state.[25] The ACA reduces federal DSH allotments to all states by a total of $18.1 billion beginning in 2014 through 2020; the amount by which any individual state's allotment is reduced is to be determined by a DSH health reform methodology developed by the Secretary of HHS. Under this methodology, the largest percentage reductions are to apply to states with the lowest percentages of uninsured individuals and to states that do not target their DSH payments to hospitals with high volumes

of Medicaid inpatients or high level of uncompensated care.[26] The Secretary has not yet published this methodology, leaving unanswered a number of questions, including:

- Will the DSH health reform methodology provide for reductions in DSH funds in every state, or will the reductions be concentrated in certain states?

- If a state does not take up the Medicaid expansion and, as a result, has a high percentage of uninsured adults with incomes under 100% of the FPL, will that state be subject to less of a reduction in federal DSH funds than a state that does take up the Medicaid expansion and, as a result, significantly reduces its percentage of uninsured adults?

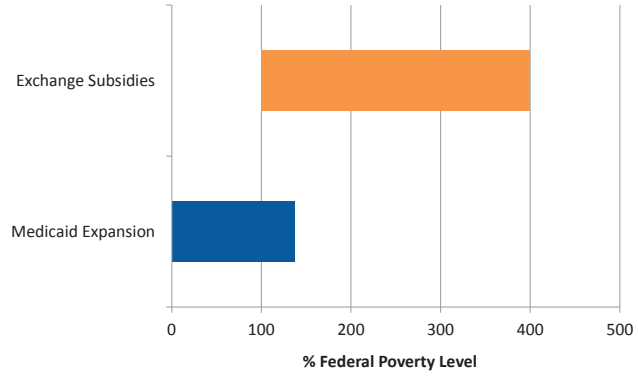
Looking Ahead

Between now and 2014, states will determine whether to implement the ACA's Medicaid expansion and receive the associated enhanced federal matching funds. CMS's July 13, 2012 letter indicates that there is no deadline by which states must tell CMS about their Medicaid expansion plans.[27] By contrast, states must submit an Exchange Blueprint to HHS by November 16, 2012 if they seek to operate a state-based exchange or participate in a state partnership exchange for plan year 2014.[28]

In making the decision about the Medicaid expansion, states will have to consider a number of factors including the impact on their uninsured residents whom the Medicaid expansion was designed to reach, the impact on state budgets, the impact on uncompensated care costs, and the economic impact of enhanced federal matching funds flowing into the state.

Figure 1

Eligibility for ACA Insurance Affordability Programs



NOTES: Exchange subsidies include advance payment of premium tax credits and cost-sharing reductions. If a person with household income between 100-138% FPL is eligible for Medicaid, she is ineligible for exchange subsidies. (The ACA expands Medicaid to 133% FPL and also provides for a 5% FPL income disregard, effectively expanding eligibility to 138% FPL.) Legal immigrants with incomes below 100% FPL who are ineligible for Medicaid based upon immigration status (generally due to having been in the country for less than 5 years) are eligible for exchange subsidies. This chart omits CHIP and optional state Basic Health Programs.

In states that do not implement the Medicaid expansion, there will be a gap in coverage that was not intended by the ACA. The ACA's Medicaid expansion will cover nearly all people with household incomes up to 138% FPL. The premium tax credits and cost-sharing reductions to purchase qualified health plans through the insurance exchanges are available to people with household income between 100% and 400% FPL (Figure 1). Without Medicaid, some people with incomes below the poverty line will lack access to affordable health insurance coverage, making state decisions about the ACA's Medicaid expansion important for this vulnerable population.

This policy brief was prepared by MaryBeth Musumeci of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Endnotes

[1] 567 U.S. ___ (2012), available at http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf. The Court's decision also upheld the constitutionality of the ACA's individual mandate. For a general discussion of the Court's decision, *see* Kaiser Family Foundation, *A Guide to the Supreme Court's Affordable Care Act Decision* (July 2012), available at http://www.kff.org/healthreform/8332.cfm.

[2] ACA § 2001(a)(1), codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). The ACA expanded coverage to 133% FPL and also provides for an income disregard of 5% FPL, effectively extending eligibility to 138% FPL. ACA § 2002(a), adding 42 U.S.C. § 1396a(e)(14)(I).

[3] For states that were covering childless adults at their existing federal matching rates prior to March 23, 2010, the ACA phases in an increase in the federal matching rate so that by 2019, federal matching rates for this population will equal the rate for the newly eligible Medicaid expansion population at 93% in 2019 and 90% in 2020 and prospectively. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* (May 2010), available at http://www.kff.org/healthereform/8076.cfm.

[4] Kaiser Family Foundation, *A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion* (Aug. 2012), available at http://www.kff.org/healthreform/8347.cfm.

[5] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), codifying ACA § 2001(a)(1). The ACA also provides for an income disregard of 5% FPL, effectively extending eligibility to 138% FPL. ACA § 2002(a), adding 42 U.S.C. § 1396a(e)(14)(I).

[6] The benchmark benefits package (which at state option may be the same as the state's traditional state plan benefits package) must include the 10 categories of "essential health benefits" specified elsewhere in the ACA. Certain people are exempt from mandatory enrollment in benchmark coverage and must receive the Medicaid state plan benefits package. *See* Kaiser Family Foundation, *Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries* (Aug. 2010), available at http://www.kff.org/healthreform/8092.cfm; *see also* 42 C.F.R. § 440.330(d); CMS, *Frequently Asked Questions on Essential Health Benefits Bulletin*, available at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

[7] Available at http://www.scribd.com/doc/99753526/Secretary-Sebelius-Letter-to-the-Governors-071012.

[8] Existing Medicaid law already required participating states to cover children from birth to age 6 in households with incomes up to 133% FPL. The ACA's income disregard of 5% FPL will effectively extend eligibility for this group to 138% FPL.

[9] The amendment extended eligibility to 133% FPL. ACA § 2001(a)(5), amending 42 U.S.C. § 1396a(l)(2)(C). The ACA also provides for an income disregard of 5% FPL, effectively extending eligibility to 138% FPL. ACA § 2002(a), adding 42 U.S.C. § 1396a(e)(14)(I).

[10] *See also* Memorandum from Kathleen S. Swendiman and Evelyne P. Baumrucker, Congressional Research Service, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act* at 8, n.38 (July 16, 2012), available at http://www.ncsl.org/documents/health/aca_medicaid_expansion_memo_1.pdf.

[11] ACA § 2001(b), adding 42 U.S.C. § 1396a(a)(74) and § 1396a(gg).

[12] Memorandum from Kathleen S. Swendiman and Evelyne P. Baumrucker, Congressional Research Service, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act* at 5-6 (July 16, 2012), available at http://www.ncsl.org/documents/health/aca_medicaid_expansion_memo_1.pdf.

[13] ACA § 2002(a), amending 42 U.S.C. § 1396a(e). Groups exempt from the MAGI methodology generally include people over age 65, people who are blind, people with disabilities, people with long-term care needs, people eligible for Medicare cost-sharing assistance, and people eligible for Medicaid through a spend-down.

[14] ACA § 1413.

[15] Memorandum from Kathleen S. Swendiman and Evelyne P. Baumrucker, Congressional Research Service, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act* at 5, 6-7 (July 16, 2012), available at http://www.ncsl.org/documents/health/aca_medicaid_expansion_memo_1.pdf.

[16] 42 C.F.R. § 433.112, published at 76 *Fed. Reg.* 21974 (April 19, 2011).

[17] Available at http://online.wsj.com/public/resources/documents/HHSLETTER071312.pdf.

[18] *See generally* Kaiser Family Foundation, *Medicaid and CHIP Health Reform Implementation Timeline*, available at http://www.kff.org/healthreform/8064.cfm.

[19] *See also* Memorandum from Kathleen S. Swendiman and Evelyne P. Baumrucker, Congressional Research Service, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act* at 9 (July 16, 2012), available at http://www.ncsl.org/documents/health/aca_medicaid_expansion_memo_1.pdf (concluding that "it may be argued that coverage [of the ACA expansion group up to 138% FPL] is an all-or-nothing proposition for the states.")

[20] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

[21] 42 U.S.C. § 1396a(a)(10)(A)(ii).

[22] Presentation of Cindy Mann, CMS Deputy Administrator to National Conference of State Legislatures, *Medicaid and CHIP: Today and Moving Forward* (Aug. 6, 2012), available at http://www.ncsl.org/portals/1/documents/health/TFCMannLS12.pdf.

[23] ACA § 2001(a)(3), adding 42 U.S.C. § 1396d(y). For states that were covering childless adults at their existing federal matching rates prior to March 23, 2010, the ACA phases in an increase in the federal matching rate so that federal matching rates for this population will equal the rate for the newly eligible Medicaid expansion population at 93% in 2019 and 90% in 2020 and each year thereafter. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* (May, 2010), available at http://www.kff.org/healthreform/8076.cfm.

[24] 42 U.S.C. § 1315. For a summary of recent § 1115 waiver activity, *see* Kaiser Commission on Medicaid and the Uninsured, *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity* (May, 2012), available at http://www.kff.org/medicaid/8318.cfm. The ACA added new public notice and comment requirements to make the § 1115 waiver process more transparent. *See* Kaiser Commission on Medicaid and the Uninsured, *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers* (March, 2012), available at http://www.kff.org/medicaid/8292.cfm.

[25] Social Security Act § 1923, codified at 42 U.S.C. § 1396r-4.

[26] Patient Protection and Affordable Care Act § 2551, P.L. 111-148.

[27] Available at http://online.wsj.com/public/resources/documents/HHSLETTER071312.pdf.

[28] Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges, available at http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf.

This publication (#8348) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION www.kff.org
Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274