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MEDICAID EXPANSION UNDER ACA AS MODIFIED BY THE U.S. SUPREME COURT

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(Some of the material in this article was taken from Health Care Coverage and Financing in the United States, the Actex book I wrote that was published earlier this year.)

A key component of the Affordable Care Act (ACA)[1] is the expansion of state Medicaid eligibility requirements to encompass lower income adults. Under the ACA, Medicaid eligibility is expanded to 138 percent of the federal poverty level (FPL). (It is actually 133 percent with a 5 percent income disallowance.) For all newly eligible persons, the federal government will pay for 100 percent of the costs for the calendar years 2014 – 2016. After that time period, the federal portion decreases to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter. In the case of states that have already expanded coverage, the federal portion increases in a similar step method so as not to penalize states for early expansion of coverage. States may expand their Medicaid programs prior to Jan. 1, 2014, but this expansion will be financed at the current Federal Medical Assistance Percentage (FMAP) until 2014.

The general public may think that Medicaid provides health insurance to all of the lower income populations, but that is typically not the case. Medicaid programs vary from state to state, but in many states Medicaid does not cover adults without dependent children unless they are disabled or meet some other specified criteria. This results in a large lower income population without any form of health coverage. However, some states do offer a limited program of some type for this population, often entirely funded by the state, without any federal sharing. Other programs for this population may be

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funded at the county level, especially for mental health services. The primary sources of care for the lower income, uninsured population are free clinics or the emergency room. The resulting emergency room bill may not be paid by the individual, the individual may not have insurance, and, as we'll see below, the individual may not be covered currently by Medicaid.

Note that states do typically cover the blind, aged, and disabled populations as well as pregnant women and individuals with breast cancer up to certain FPLs, possibly as high as 300 percent.

The ACA was designed to fill in the gap between Medicaid and commercial insurance coverage (individual and employer health plans) by covering those lower income non-custodial adults that typically rely on the emergency room for their medical services. The planned insurance coverage of the total legal resident population was supposed to look like the following when ACA was drafted:

FULL MEDICAID EXPANSION

- Up to 138 percent of the FPL—Medicaid (the percentage of the FPL is higher for children, up to 300 percent).
- 139 percent – 400 percent of the FPL—subsidized individual insurance in the exchange/employer coverage.
- 400 percent+ of the FPL—individual insurance in the exchange without subsidy/employer coverage.

PARTIAL/NO MEDICAID EXPANSION

- 0 – Y percent (Where Y is the percent of FPL to which a state makes a partial expansion; 100 percent is often considered) FPL—covered under existing or partially expanded Medicaid.
- Y percent – 138 percent FPL—most likely covered through individual policies in the exchange with full subsidies of out-of-pocket expenses and minimal premiums up to 100 percent FPL and less than full subsidies from 101 percent to 138 percent.
- 139 percent – 400 percent FPL—partially subsidized out-of-pocket expenses and premiums on individual policies in the exchange/employer coverage.
- 400 percent+ FPL—individual/employer in the exchange without subsidy/employer coverage.

In order to get an idea of the income levels that will qualify for Medicaid, the FPLs for 2012 for different family sizes are shown below in Figure 1.[2]

FIGURE 1:
2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890

For families/households with more than eight persons, add $3,960 for each additional person.

PARADIGM SHIFT

Since the initial design of the ACA and the early projections of the impact of the ACA on state Medicaid budgets, there have been at least a couple of material events.

SUPREME COURT DECISION

The Supreme Court of the United States (SCOTUS), in its June 29, 2012 decision, reaffirmed the right of Congress to impose the individual mandate that requires most individuals to be covered by some form of health insurance, but it struck down the ability of the federal government to impose the ACA's integral Medicaid expansion on the states. The hammer in the ACA to force states to adopt the desired increase in

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Medicaid coverage was the threatened withholding of the federal government's share of the cost of existing state Medicaid programs, the FMAP. SCOTUS determined that this withholding of the FMAP on state Medicaid Programs is unconstitutional.

The elimination of the Medicaid expansion mandate led some states to declare that they were not going to expand their Medicaid programs. These states often cited their concerns that, as the federal budget became tighter, the higher Medicaid expansion FMAP might be reduced, thus shifting a greater portion of the cost of the Medicaid expansion to the states.

In addition, some states are considering expanding Medicaid to a lower FPL: 100 percent of the FPL for the uncovered populations is a common target. This has raised a number of questions and issues. The National Governors' Association submitted a list of questions to the U.S. Department of Health and Human Services (HHS) on July 2, 2012,[3] including:

- Would the enhanced ACA FMAP be paid on an expansion to a lower FPL, say 100 percent instead of 138 percent?

- If a state does not expand its Medicaid eligibility, what other ACA provisions will still apply to its Medicaid programs?

The National Association of Medicaid Directors had many additional questions in a letter to the Centers for Medicare and Medicaid Services (CMS) on July 3, 2012, including:[4]

- What would happen to the individuals between 101 percent of FPL and 138 percent of FPL? Will they be assumed to enroll in the individual health insurance exchanges?
- Will the 5 percent income disregard used in moving Medicaid expansion from 133 percent FPL to 138 percent FPL also apply to a lesser expansion, i.e., will 100 percent FPL become 105 percent FPL after the 5 percent income disregard?
- Can states phase in their expansion over years beyond 2014?

A few additional questions are:

- Will the proposed Disproportionate Share Hospital (DSH) program reductions under ACA be unchanged? DSH is designed to compensate hospitals for unpaid care and is scheduled to be reduced under ACA because it is anticipated that there will be fewer individuals unable to pay their hospital bills because more of the lower income populations will be covered under the proposed Medicaid expansion.

- One question that has been asked and answered is this. Will a state be allowed to reverse a decision to expand Medicaid if it proves to be unaffordable? CMS has indicated that this reversal would be allowed.

- Will there be increased subsidies of premiums and out-of-pocket expenses if the people in the gap between the state's Medicaid (or expanded Medicaid) and 138 percent FPL enroll in the exchange? Such

an increased subsidy could eliminate any cost for this population and would be consistent with their coverage under Medicaid expansion.

DETERIORATION

There have been a number of nationwide reports that have analyzed the impact of Medicaid expansion on state budgets. In addition, many (if not all) states have commissioned or prepared their own reports, often politically motivated, that projected the impact of Medicaid expansion on the states' budgets. The primary source of population data by FPL and by insurance status, which is used in preparing these reports, has been the U.S. Census Bureau's Current Population Survey (CPS) data. Reports prepared prior to September 2011, would have relied on 2000 census data, adjusted using ongoing CPS results. More recent data shows that the use of this earlier-period census data understates the impact of the recent economic downturn on both the number of uninsured and the proportion of the population in lower FPL's.

The tables in Figures 2 – 4 (right) show the change in these parameters as seen in the 2008 and the 2011 census data. Note that non-residents have not been removed from this data and that the Census Bureau in their survey does not ask about legal residence. Also, note that recently published studies and articles have shown that the number of uninsured did actually decrease from 2010 to 2011, due at least in part to the ACA expansion of coverage, under family coverage, to adult children up to age 26, while the comparison below is of 2008 to 2011.

The table in Figure 2 shows the impact of the economic downturn, which moved 2 percent of the population into lower income groups, thereby increasing the population that would be eligible for Medicaid expansion.[5]

FIGURE 2
Distribution of Population

FPL	2008	2011
Below 100%	13%	15%
100% to below 200%	19%	19%
200% to below 300%	17%	17%
300% and above	51%	49%
Total	100%	100%

The table in Figure 3 shows the change in the number of uninsured by FPL where, again, non-residents have not been removed, and Medicaid is considered a form of insurance.

FIGURE 3
Number of Uninsured (000s)

FPL	2008	2011	Percent Increase
Below 100%	11,900	13,674	15%
100% to below 200%	13,305	14,754	11%
200% to below 300%	8,869	9,312	5%
300% and above	10,631	10,811	2%
Total	44,705	47,052	5%

The table in Figure 4 shows the percentage of each FPL group that is uninsured. These results indicate consistent percentages of the FPL groups remaining uninsured, with the change in the number of uninsured by group being driven primarily by the change in the size of the group.

FIGURE 4
Uninsured Percentage by FPL Percentage Uninsured

FPL	2008	2011
Below 100%	30%	30%
100% to below 200%	24%	25%
200% to below 300%	17%	18%
300% and above	7%	7%
Total Population	15%	16%

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UPDATE

Based on the charts above, it is probably time to update earlier projections of the impact of the Medicaid expansion under ACA on state Medicaid budgets.

As state Medicaid ACA impact models are updated, a couple of additional items that were at times missed in some earlier projections should be considered.

NON-RESIDENTS

One of the early political issues for the ACA was the debate over the potential eligibility within the ACA health insurance process of individuals not legally residing in the United States. It is now quite clear that one must prove legal residence in order to qualify for participation in the exchange or to demonstrate eligibility for Medicaid. In addition, legal immigrants must typically wait for five years before becoming eligible for Medicaid. Our review of some of the earlier nationwide projections of the impact of ACA on state Medicaid budgets found that these projections did not adjust for these excluded populations.

VARYING STATE MEDICAID PROGRAMS

Various state Medicaid and related programs are not always the same. It is not possible to accurately model the impact of ACA for the states without knowing the specifics of the states' many Medicaid and related programs. A review of the details of a state's various state Medicaid programs will likely show that some of the state's existing programs may be absorbed by ACA's Medicaid expansion at the higher expansion level of FMAPs. This would result in the federal government picking up a greater portion of the Medicaid costs of a population that was already covered under a Medicaid waiver. It may even result in an entire state-funded program being swept into Medicaid expansion. In one state we noted hundreds of millions of dollars shifting from the state to the Federal Government under the auspices of the ACA. This state had programs already covering large numbers of individuals who would move either to Medicaid expansion or to the ACA health insurance exchanges with heavy subsidies.

MEASURE TWICE AND CUT ONCE

A state's decision of whether or not to expand the Medicaid program is certainly something that requires considerable investigation, modeling, input from stakeholders, and, ultimately, a decision.

Medicaid expansion is an important piece of the puzzle that is being pulled together with ACA to provide increased healthcare through health insurance to more Americans. Procrastination and inaction by the states will complicate the other moving pieces of ACA, including the operation of state health insurance exchanges and employer health insurance where employers may actually be subject to increased penalties, while lack of a thorough review of the financial implications for a state may lead to budgetary constraints.

ENDNOTES

1. The Patient Protection and Affordable Care Act of 2010 and the Healthcare and Education Reconciliation Act of 2010 are collectively referred to as the Affordable Care Act (ACA).
2. U.S. Department of Health and Human Services (HHS, February 9, 2012) 2102 HHS Poverty Guidelines. Retrieved Oct. 10, 2102, from http://aspe.hhs.gov/poverty/12poverty.shtml
3. Crippen, D. (July 2, 2012). Affordable Care Act: Letter to Secretary Kathleen Sebelius, HHS. National Governors Association. Retrieved Oct. 10, 2012, from http://www.nga.org/cms/home/federal-relations/nga-letters/executive-committee-letters/col2-content/main-content-list/july-2-2012-letter---affordable.html#
4. National Association of Medicaid Directors (July 3, 2012). NAMD's SCOTUS questions. Retrieved Oct. 10, 2012, from http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_submitted_questions_120703.pdf
5. U.S. Census Bureau Current Population Survey. A Joint Effort Between the Bureau of Labor Statistics and the Census Bureau Retrieved Oct. 10, 2012, from http://www.census.gov/cps/