Medicaid Expansion and Affordable Health Care Coverage

House Committee on Appropriations (D)
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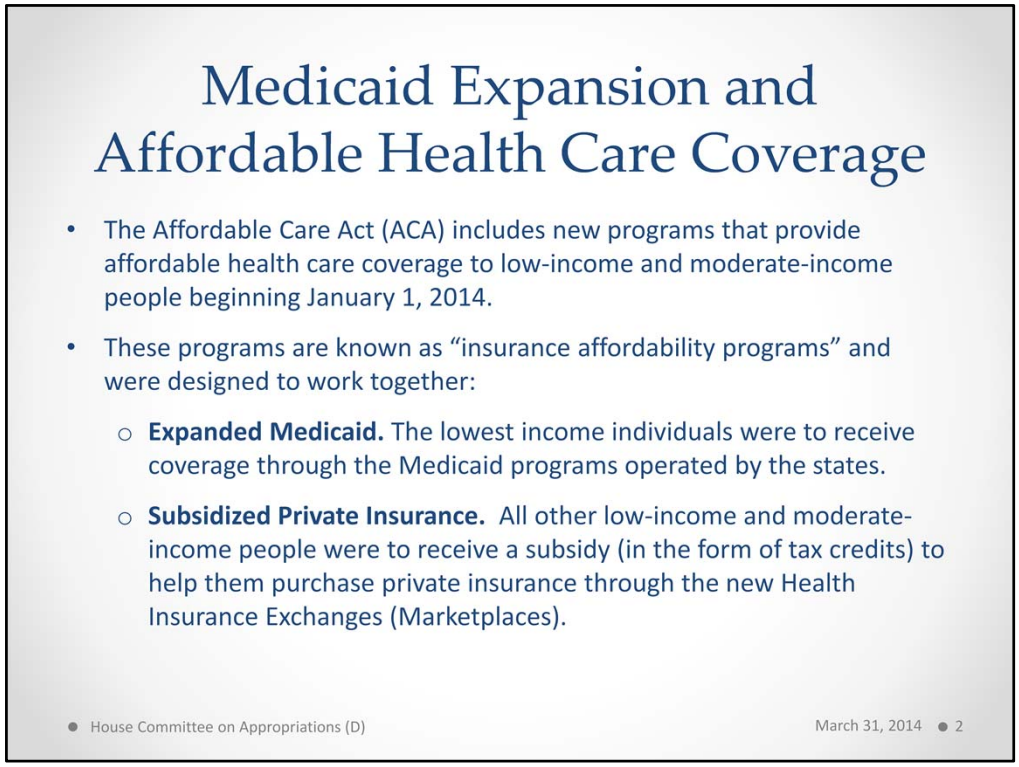
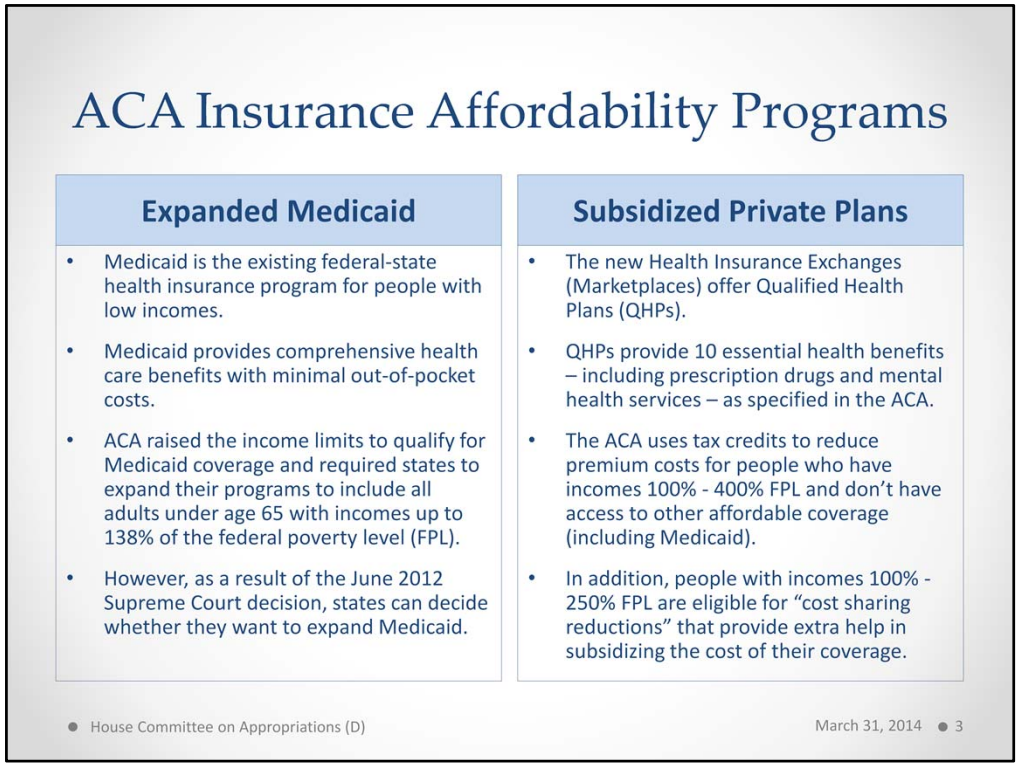


On March 23, 2010, President Obama signed federal legislation, known as the Affordable Care Act (ACA), which includes comprehensive reforms designed to provide quality, affordable health care to millions of Americans.

Among the ACA reforms are new health insurance programs for low-income and moderate-income people, beginning January 2014. These programs, known as "insurance affordability programs", were designed to work together.

For people with incomes at or below 400 percent of the federal poverty level (FPL), the ACA provides access to affordable health care either through expanded Medicaid eligibility or subsidized private health insurance coverage.

- The lowest income individuals were to receive coverage through the Medicaid programs operated by the states.
- All other low-income and moderate-income people were to receive a subsidy (in the form of tax credits) to help them purchase private insurance through the new Health Insurance Exchanges (also referred to as Marketplaces).



This table summarizes the ACA's two insurance affordability programs.

Expanded Medicaid builds on the traditional Medicaid program established in 1965 to provide comprehensive health care to low-income individuals.

- The traditional Medicaid program only covers low-income individuals who fall into specific groups (or categories), each of which has its own eligibility criteria.
- Effective January 2014, the ACA expands Medicaid eligibility to include:
    - For the first time, all adults under age 65 are eligible for Medicaid coverage.
    - 138% FPL is the minimum Medicaid income eligibility level nationwide for most people.
- On June 28, 2012, the U.S. Supreme Court issued a decision which effectively made Medicaid expansion optional for states.
    - In *National Federation of Independent Business v. Sebelius,* the Court upheld most of the ACA, including Congress's authority to expand Medicaid;
    - However, it limited the ability of the federal government to penalize states that do not implement the Medicaid expansion requirements and thereby made expansion an option.

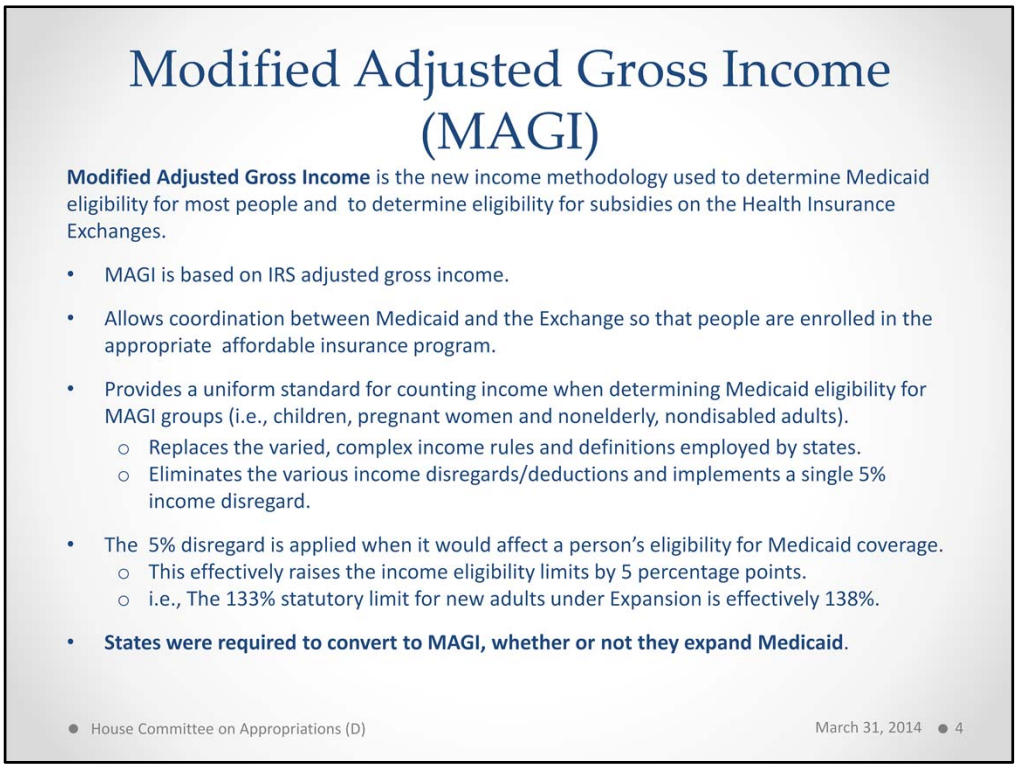
Subsidized Private Plans are available through the new insurance exchanges established in the ACA.

- All plans must offer services within the 10 Essential Health Benefits (listed on the next page).
- Subsidies in the form of tax credits are generally available to individuals and families, with incomes between 100% and 400% of the federal poverty level, to reduce their monthly premium.
- To receive the tax credit, an individual must not be eligible for public coverage – including **Medicaid** and Medicare – and must not be offered affordable employer-sponsored coverage that meets minimum standard established in the ACA.
- In addition, people with incomes between 100% and 250% of the federal poverty level are eligible for cost-sharing subsidies that further reduce the cost of their coverage.

Essential Health Benefits include at least the following 10 general categories of services:

1. Ambulatory patient services (outpatient care, such as doctor visits and care provided at a clinic or same-day surgery center)
2. Emergency Services (i.e., emergency room care)
3. Hospitalization
4. Maternity and newborn care (includes pre-natal and post-partum care for women)
5. Mental health services and addiction treatment (includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative services and devices (these services and devices help people with injuries, disabilities, or chronic conditions gain or recover their mental and physical skills)
8. Laboratory services
9. Preventive services and chronic disease management (preventive services include counseling, screenings and vaccines)
10. Pediatric services (includes dental and vision care for children under age 19)

While all qualified plans must offer the 10 essential benefits, the scope and quantity of services offered under each category can vary.



The ACA requires states to use a new income methodology, called Modified Adjusted Gross Income (MAGI), to determine Medicaid eligibility for most people and to determine eligibility for subsidies on the Health Insurance Exchanges.

- MAGI is based on IRS adjusted gross income.
- It facilitates coordination between Medicaid and the Exchange so that people are enrolled in the appropriate affordable insurance program.

Beginning in 2014, states must use MAGI when determining Medicaid income eligibility for most nonelderly, nondisabled (do not have a disability which qualifies for the federal SSI program) individuals.

- MAGI applies to children, pregnant women, parents, caretaker relatives, women eligible for family planning services, and newly-eligible adults under Medicaid expansion.
- MAGI does **not** apply to seniors age 65 and older, individuals who qualify for Medicaid based on SSI disability, and medically needy only individuals who qualify for Medicaid by spending down – existing eligibility rules continue for these groups.

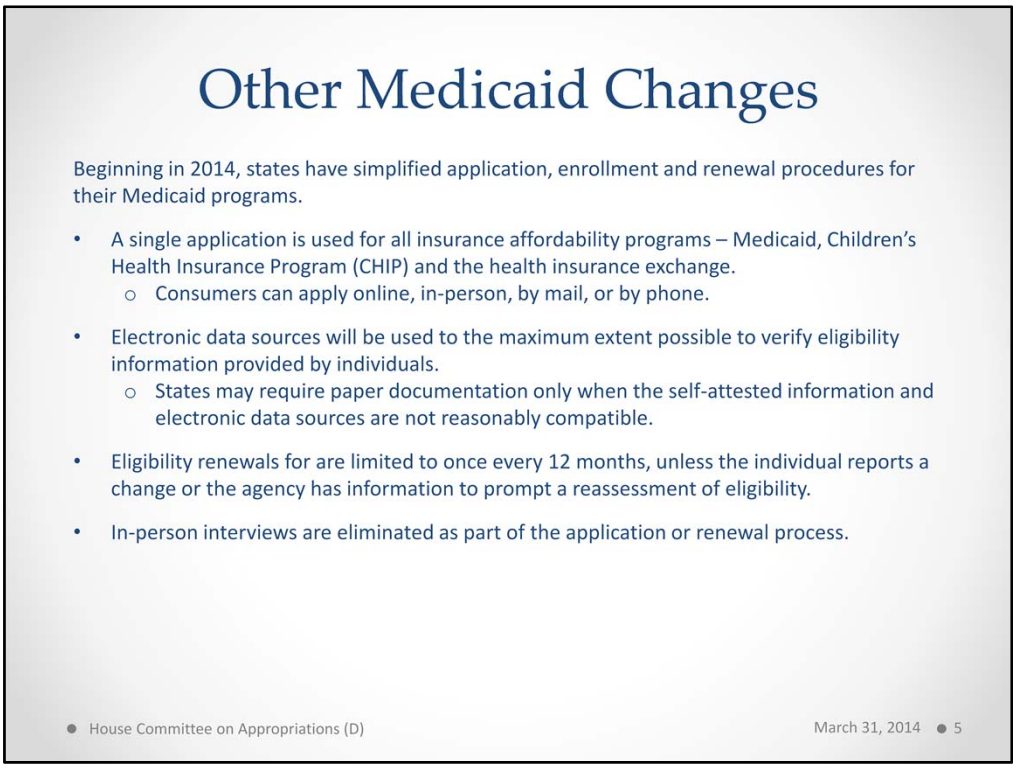
MAGI replaces the complex, varied Medicaid income rules previously in place for the MAGI groups and establishes a uniform standard for counting income.

- A 5% disregard replaces the various deductions and disregards previously used.
- The 5% disregard is applied when it would affect a person's eligibility for Medicaid coverage.
  - This effectively raises the income limit by 5 percentage points.
  - i.e., The 133% statutory limit for new adults under Expansion is effectively 138%.

States were required to convert to MAGI, whether or not they expand Medicaid.

- For new Medicaid applicants, the MAGI method for determining eligibility took effect Jan. 1, 2014. Some states – including Pennsylvania – opted for earlier implementation.
- For existing Medicaid recipients, MAGI takes effect either March 31, 2014, or at the time of the

next scheduled eligibility renewal, whichever is later.



Beginning in 2014, the ACA required states to use simplified application, enrollment and renewal procedures for their Medicaid programs.

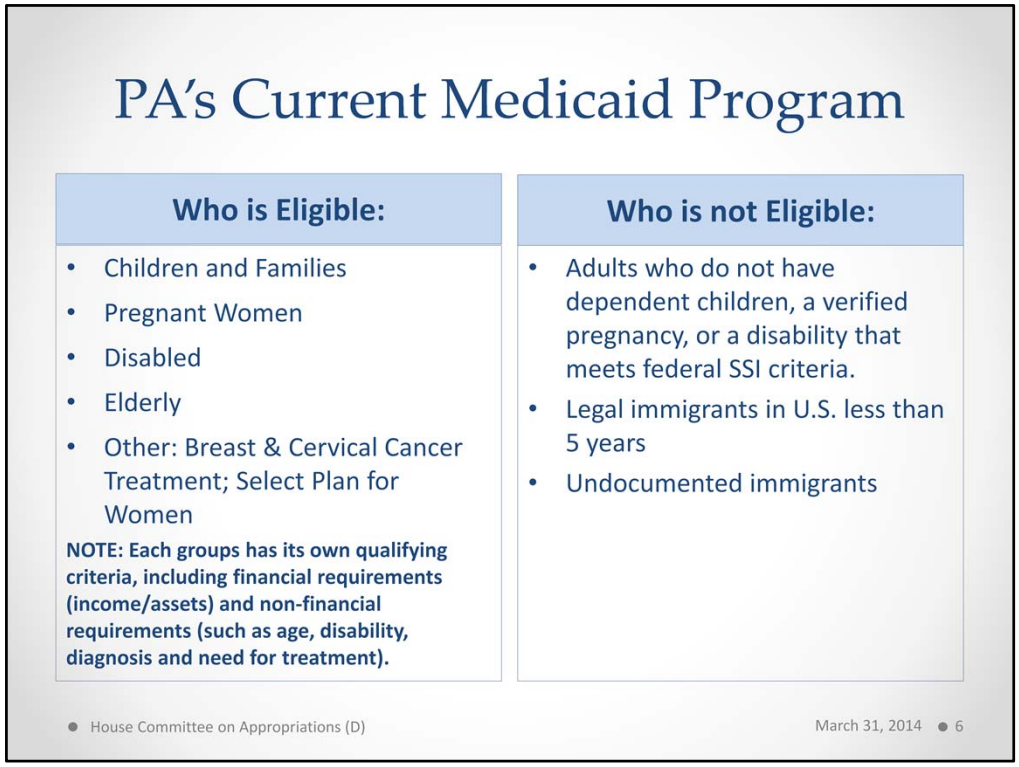
A single application is used for all insurance affordability programs – Medicaid, Children's Health Insurance Program (CHIP) and private insurance plans on the exchange. Consumers have the option to submit their application online, in-person, by mail or by phone.

Electronic data sources will be used to the maximum extent possible to verify eligibility information provided by individuals. States may require paper documentation only when the self-attested information and electronic data sources are not reasonably compatible.

Eligibility renewals for individuals who enroll through the new MAGI rules are limited to once every 12 months, unless the individual reports a change or the agency has information to prompt a reassessment of eligibility.

- If eligibility can be renewed based on available data, the agency will send the appropriate notice to the enrollee without requiring any additional action from the enrollee (such as signing and returning the notice) as a condition of continued eligibility enrollee.
- If renewal can not be completed using available information, the state agency must send a pre-populated form containing the information available to the agency and allow the individual at least 30 days to provide the necessary information or correct any inaccuracies.

In-person interviews are eliminated as part of the application or renewal process for individuals who are Medicaid eligible based on MAGI.



This table lists the groups that are currently eligible, and not eligible, for Medicaid in Pennsylvania.

- 2.2 million Pennsylvanians receive Medical Assistance (Pennsylvania's Medicaid program).
- Almost half are children under age 19 (1,078,000 children as of January 2014) .

Low-Income children, families and pregnant women comprise more than half of Pennsylvania's current Medicaid enrollees.

- This is the largest and the least expensive group.
- These are the MAGI groups – their Medicaid eligibility is determined using the new MAGI rules.

About one-fourth of our Medicaid Enrollees fall into a **disability** category.

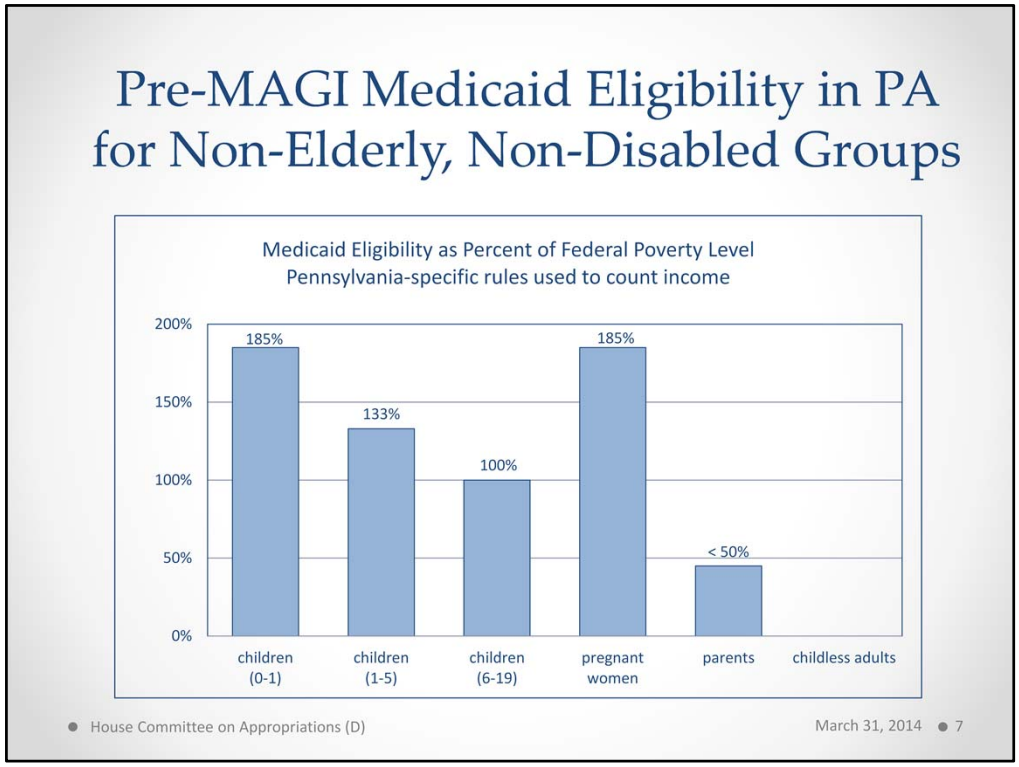
- These are non-elderly people with physical disabilities, intellectual disabilities (ID) and autism.
- More than 8,000 reside in an institution – such as an ID facility or nursing facility.
- Roughly 47,000 receive community-based services through a waiver program to avoid institutionalization.

About 17 percent are **elderly.**

- Includes about 52,000 seniors in a nursing facility.
- Includes about 27,000 seniors who receive community-based services, which allows them life safely at home rather than in a nursing facility.

Additionally, Pennsylvania provides optional Medicaid programs serving these specific groups:

- **Breast & Cervical Cancer Prevention & Treatment Program** serves 1,900 women with incomes up to 250% of the federal poverty level and who need treatment for breast or cervical cancer, or a pre-cancerous condition of the breast or cervix.
- **SelectPlan for Women Program** provides contraceptives, screenings, and primary health care to 90,000 women with incomes up to 185% of the federal poverty level.



This chart shows Pennsylvania's old income eligibility thresholds for Medicaid for people who are not elderly or have a disability that meets federal SSI criteria. It reflects income eligibility under the Pennsylvania-specific income rules that were in effect before the switch to the new MAGI method for counting income.

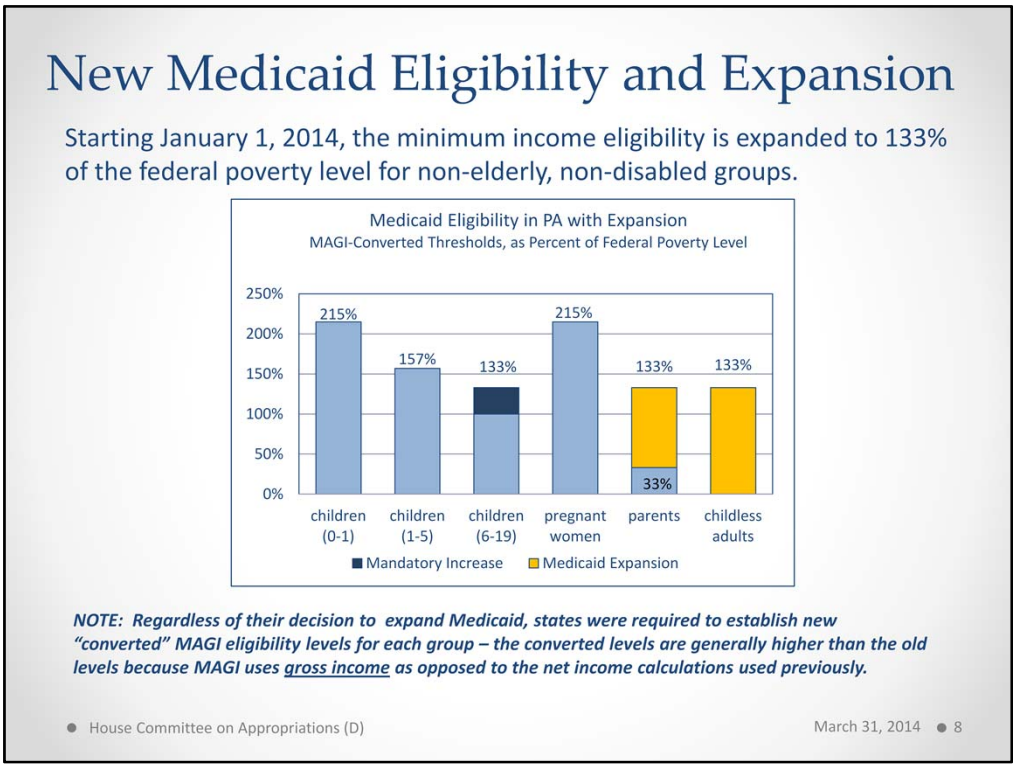
When it comes to kids, Pennsylvania has different income eligibility levels depending upon the age of the child:

- **Children under age 1** in families with income at or below 185% of the federal poverty level.
- **Children age 1 through 5** in families with income at or below 133% of the federal poverty level.
- **Children age 6 until 19** in families with income at or below 100% of the federal poverty level

When it comes to non-elderly non-disabled adults, Pennsylvania only covers pregnant women and very poor parents. **Childless adults** are not eligible for Medicaid – these are adults with no dependent children and who are not pregnant or have a disability that meets the federal SSI level.

Under Pennsylvania's old income rules, the following adults were eligible for Medicaid:

- **Pregnant women** with income at or below 185% of the federal poverty level.
  - When determining eligibility, household size includes the unborn child (or children).
  - For example, if a woman verifies she is pregnant with twins, then she counts as a household of three.
- **Parents** with income generally less than 50% of the federal poverty level.
  - Although parents may earn too much to qualify for Medicaid, their children may still be eligible for Medicaid if family income is sufficiently low (below the income limits for children).



This chart shows Medicaid Eligibility in Pennsylvania under the new MAGI rules and the ACA income eligibility thresholds (before the 5% disregard).

- The "yellow bars" are newly eligible adults under Medicaid Expansion for whom Pennsylvania would be reimbursed at the enhanced ACA federal match (see Slide #9).
- The "blue bars" are people who qualify for the current program -- including kids age 6 to 19 -- for whom PA is reimbursed at the standard FMAP (currently 53.52%).

The converted MAGI eligibility levels are a new way of expressing the older levels, using gross income (under MAGI) rather than net income (under the old rules).

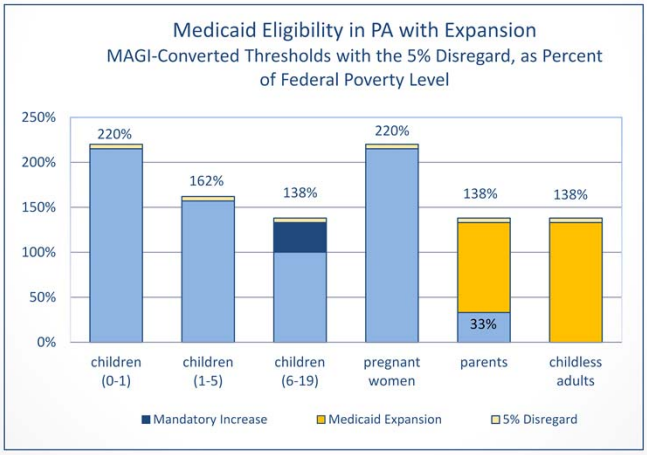
- For example, under the old rules, a pregnant woman qualified for Medicaid if her net income after allowable deductions/disregards was up to 185% of the federal poverty level (FPL).
- To convert to MAGI, DPW determined the deductions/disregards under the old rules had an average value equal to 30% of the FPL. That value was added to the old eligibility level of 185% to get the new MAGI equivalent of 215% of the FPL.
- Pennsylvania opted for early implementation of the new MAGI rules, effective October 2013.
- Overall, the new MAGI methodology does not change the number eligible for Medicaid.
    - Approximately the same number of people will qualify; however, there may be some differences in which people qualify – and do not qualify – due to the conversion.

Beginning January 2014, the minimum income eligibility is 133% of the federal poverty level for most people under age 65.

- For children, ages 6 to 19, Pennsylvania was required to increase its income eligibility from 100% of the federal poverty level to 133% (this mandatory increase is illustrated by the dark blue box).
- Whenever Pennsylvania opts to expand Medicaid, the following adults, age 19 through 64, will become "newly eligible" (illustrated by the yellow bars):
    - Working parents with incomes above 33% of the federal poverty level.
    - All childless adults.

Medicaid Eligibility with 5% Disregard

When combined with the converted MAGI thresholds, the 5% disregard effectively increases income eligibility for each group by 5 percentage points.



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This chart shows Medicaid eligibility for each group – children, pregnant women and adults – with the 5% income disregard.

Remember, the new MAGI rules discontinued the old sets of disallowances and disregards previously used by states and replaced them with a standard income disregard of five percentage points.

- The 5% disregard will be applied, but only if it affects an individual's eligibility.
    - For example, a pregnant woman with income at 220% percent of federal poverty would be eligible for Medicaid because after applying the 5% disregard, her income meets the 215% MAGI income threshold (shown on the previous slide).
- Consequently, the effective income eligibility for each group is 5 percentage points above the MAGI income threshold.
    - For example, income eligibility for "newly eligible" adults is effectively 138% of the federal poverty level (the 133% statutory limit plus the 5% disregard).
    - Similarly, income eligibility for pregnant women is effectively 220% of the federal poverty level (the 215% MAGI converted limit plus the 5% disregard).

Medicaid Expansion for Adults

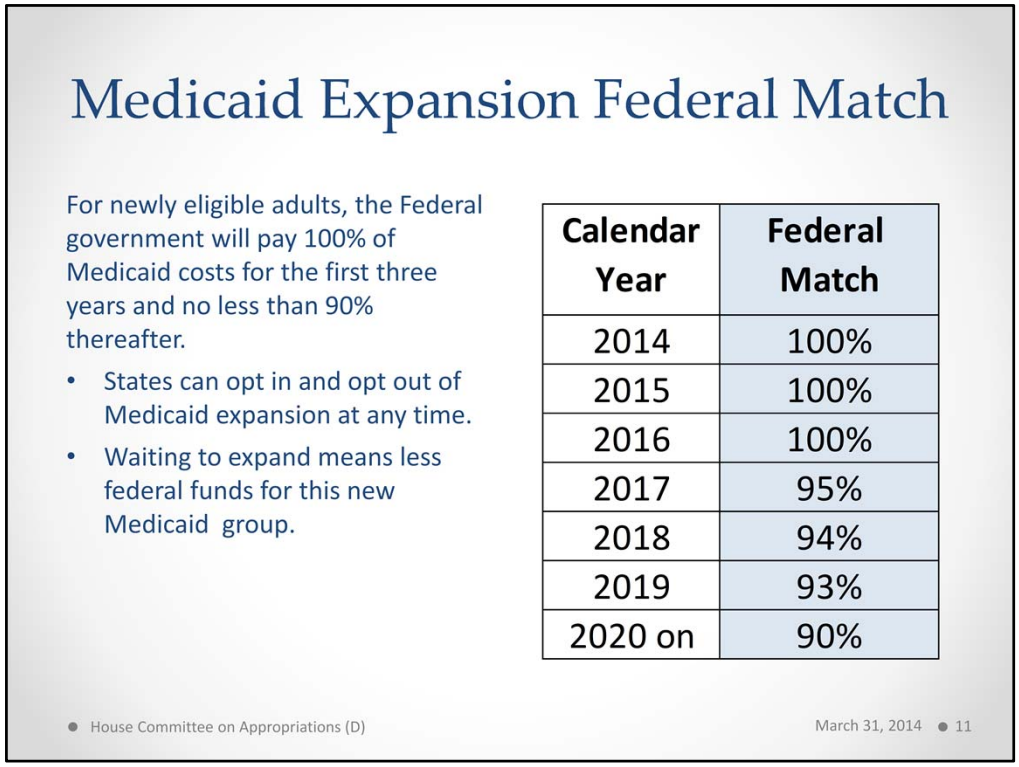
Beginning January 2014, the Affordable Care Act allows states to cover adults age 19 through 64 with incomes up to 138% of federal poverty level. The following adults will become "newly eligible" for Medicaid under Expansion:

- Childless adults, including those with a disability that does not meet the SSI criteria.
- Poor working parents who made too much income to qualify for Medicaid, but their children were covered.

138% Federal Poverty Level for 2014			
Family Size	**Annual Income**	**Monthly Income**	**Hourly Income**
1	$16,105	$1,342	$8.39
2	$21,707	$1,809	$11.31
3	$27,310	$2,276	$14.22
4	$32,913	$2,743	$17.14
5	$38,516	$3,210	$20.06
6	$44,119	$3,677	$22.98
7	$49,721	$4,143	$25.90
8	$55,324	$4,610	$28.81

This chart illustrates what 138% of federal poverty means in 2014:

- It is the single adult who makes $8.39 per hour.
  - i.e., A fast-food worker.
- It is the working mom with 2 kids who earns less than $27,310 a year.
  - i.e., The caregiver who provides personal assistance to our seniors.



The ACA provides generous federal matching funds to states that expand Medicaid.

This table shows the enhanced federal match that expanding states will receive for the health care costs of newly eligible adults.

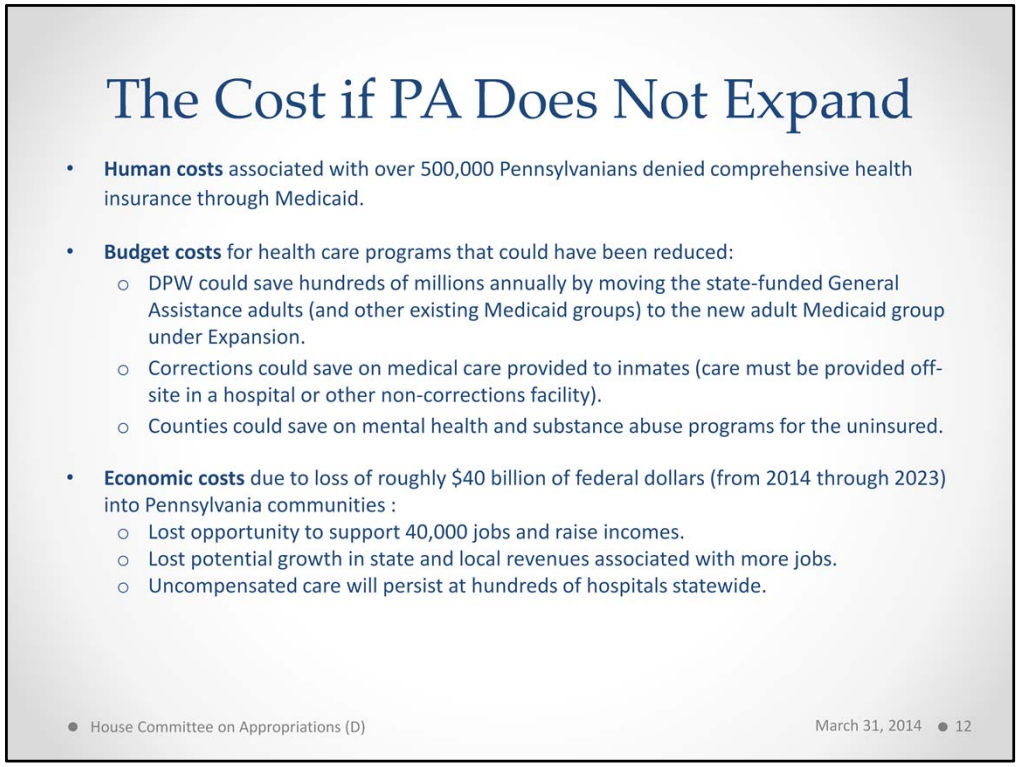
- The federal match is 100% during calendar years 2014 through 2016.
- The federal match decreases to 95% in 2017 and declines to 90% for 2020 and each year thereafter.
- These rates are stipulated in the ACA and can only be changed if legislation is passed by Congress and signed by the President.

To collect the ACA federal match, an expansion state must submit data to the federal government [Centers for Medicare and Medicaid Services (CMS)] showing the health care bills it actually paid for newly eligible adults during that calendar year.

- Bills paid by the state in 2014 will be reimbursed 100% by the feds, with no cost to the state.
- Bills paid by the state in 2017 will be reimbursed 95%, with the state responsible for the remaining 5%.
- Bills paid by the state in 2020, and each year thereafter, will be reimbursed 90% with the state responsible for the remaining 10 percent.

States have the flexibility to decide whether and when to expand.

- An expanding state indicates its intention to adopt the new coverage group by submitting a Medicaid state plan amendment to CMS.
- A state can decide to implement the expansion for a period of time and then stop, by submitting another state plan amendment to CMS.



Waiting to expand Medicaid means significant costs – budgetary, economic and human – for PA.

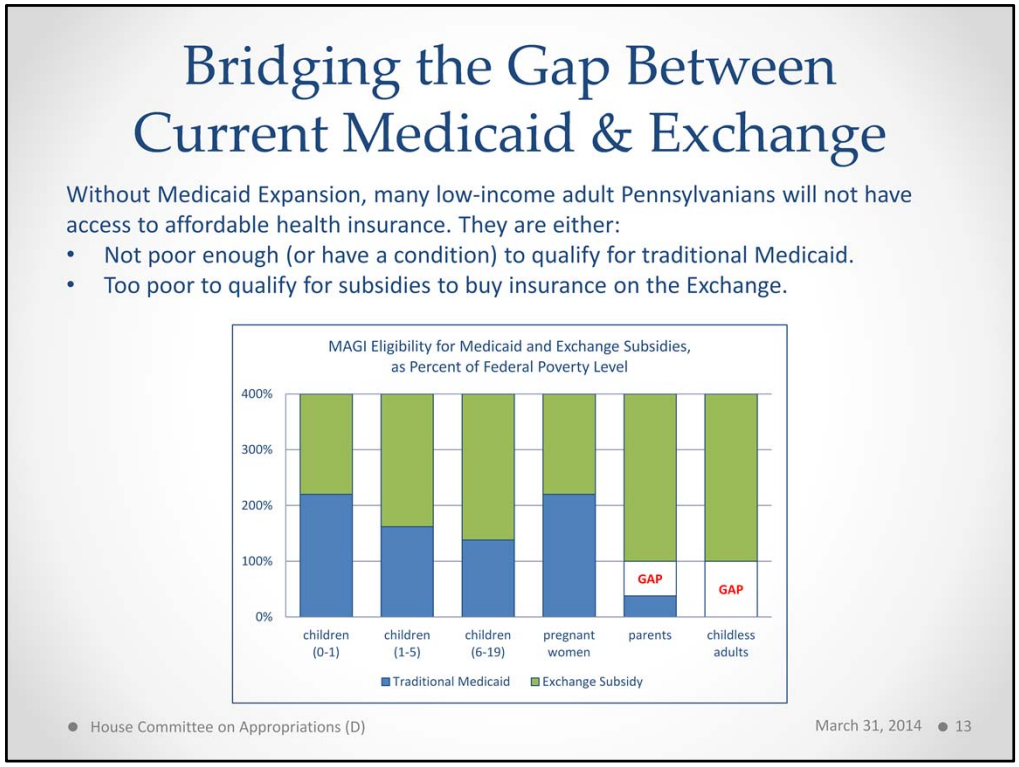
First is the human cost associated with thousands of Pennsylvanians denied health care. Note: Based on Kaiser Family Foundation estimates, roughly 200,000 of these individuals have incomes between 100%-138% of federal poverty level and could therefore qualify for subsidized private insurance through the exchange.

State and local budgets continue to pay for health care programs that could have been reduced:

- DPW could save an estimated $300 million annually by moving the state-funded General Assistance adults to the new adult expansion group funded with federal dollars.
- Additional savings could be realized by moving other "optional" Medicaid populations to the new adult group – for example, adults in the Medical Assistance for Workers with Disabilities (MAWD) program and women in the SelectPlan for Women program (see Slide #5).
- Corrections could save millions of dollars in medical care for low-income inmates who could qualify for Medicaid when treated off-site in a hospital (i.e, for surgery) or other non-corrections facility (i.e., for outpatient psychiatric care).
    - At least 6 states (and their counties) are currently saving money for inmates hospitalized off- site 24 hours or longer – Ohio expects to save $18 million a year.

Pennsylvania loses out on billions of federal dollars and the resultant economic benefits.

- Each of the independent studies -- the Rand study commissioned by HAPP, the Independent Fiscal Office (IFO) study, the PA Economy League (PEL) study commissioned by PA Health Funders Collaborative, and the Urban Institute Study for the Kaiser Family Foundation – estimate Medicaid expansion would bring **tens of billions of federal dollars** to Pennsylvania over the first 10 years.
- These studies also estimated Medicaid Expansion would support between 35,000 jobs (Rand) and 42,000 jobs (PEL), including new jobs in health care and other sectors of PA's economy.
- Delayed expansion means lost opportunities for more jobs and higher incomes for Pennsylvanians. Also lost are additional state and local tax revenues that would be generated.
- Without Medicaid Expansion, uncompensated care will persist at hospitals across the state. DSH payments hospitals receive to subsidize such care are drastically reduced beginning in 2017.



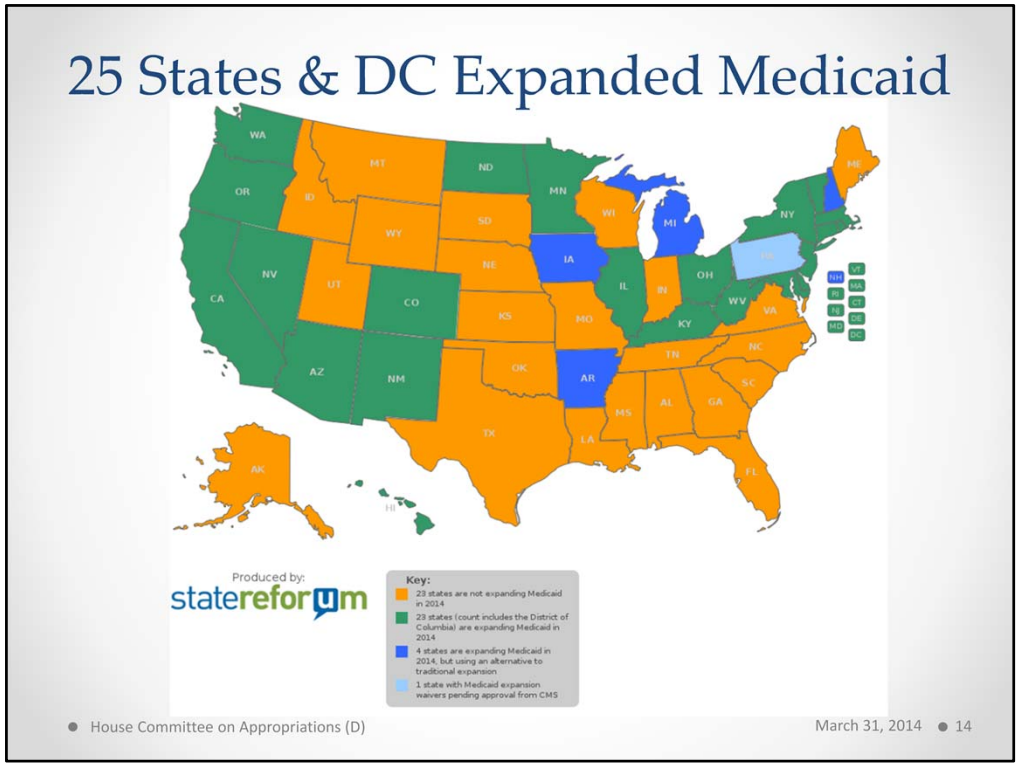
Remember, Medicaid Expansion and subsidized private insurance were designed to work together in providing affordable health insurance to low-income and moderate-income people.

- The blue bars on this chart show current Medicaid eligibility in PA, without Expansion.
- The green bars show eligibility for the sliding scale subsidies available on the exchange for individuals with incomes between 100% and 400% of the federal poverty level. For each group, eligibility for subsidies on the exchange begins after Medicaid eligibility ends.
- Without expansion, many adults with incomes below 100% of the federal poverty level fall will into the "coverage gap" and will not have access to affordable health care (**illustrated by the white box)**.
    - Those who are not poor enough (or do not have a condition) to qualify for traditional Medicaid under Pennsylvania's eligibility rules, AND
    - Those who are too poor to qualify for the subsidies to help purchase coverage through the new Exchange.

Adults falling in the coverage gap include:

- **Working parents** who earn too much income to qualify for Medicaid under existing rules, but earn too little to be eligible for a subsidy on the exchange.
    - For a household of three (i.e., a parent with 2 children), this means a working parent who earns between $6,445 (33% FPL) and $19,530 (100% FPL).
    - NOTE: The children of these parents would be covered under Medicaid.
- **Childless adults**, without an SSI disability or verified pregnancy, who do not earn enough to qualify for a subsidy on the exchange.
    - This is a single working person who makes less than $11,490 (100% FPL for an individual).
    - This is the couple that earns less than $15,510 (100% FPL for household of two).

NOTE: Adults in the coverage gap are generally exempt from the individual mandate because of their low income, and so they will not have to pay a fee if they do not obtain insurance.



This map shows states that have opted to expand Medicaid, as of March 28, 2014.

26 states and Washington, DC have expanded Medicaid to included newly eligible adults with incomes up to 138% of the federal poverty level (FPL).

- 22 states and DC expanded their traditional Medicaid programs **(green states)**
    - Includes all of Pennsylvania's neighboring states.
- 4 states are using Section 1115 (demonstration) Waivers from the federal government to expand Medicaid through alternative programs **(dark blue states)**
    - **Arkansas** and **Iowa** were approved to use their ACA federal funds to purchase private insurance for newly eligible adults – i.e., They are operating new mandatory "premium assistance" programs for newly eligible adults.
    - **New Hampshire** will seek a waiver to purchase private insurance, beginning 2016, for newly eligible adults – until then, adults are covered either through the state's existing Medicaid program or HIPP program (which purchases employer-sponsored coverage).
    - **Michigan** was approved to require all adults to pay copayments which be deposited into Health Accounts established for each enrollee and to additionally require adults with incomes over 100% FPL to pay monthly premiums equal to 2% of their income – adults will be enrolled in Michigan's existing Medicaid managed care program.

In February, Pennsylvania submitted to the federal government (CMS) its Section 1115 Waiver application describing its plan to expand Medicaid on January 1, 2015 and seeking approval to:

- Purchase private insurance for newly-eligible adults.
- Require premiums for newly-eligible adults over 100% FPL.
- Revise current Medicaid adult benefits by establishing two plans with reduced benefits: a High Risk plan (for adults with more complex health needs) and a Low Risk plan for all other adults.
- Impose a work/job search requirement on "able-bodied" adults as a condition for eligibility.
    - Within one week of submitting the waiver, the Corbett Administration dropped the

mandatory work requirement and is now proposing a voluntary pilot instead.
The 30-day public comment period ends April 11, after which the federal government will begin negotiations with DPW.