CPPP CENTER for PUBLIC POLICY PRIORITIES
WORKING FOR A BETTER TEXAS™

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What We Know About the Medicaid Expansion

The U.S. Supreme Court's June 28 decision to uphold the Affordable Care Act (ACA) could benefit Texas more than any other state, offering an opportunity to dramatically improve uninsured rates, increase family economic security, and reduce uncompensated care burdens. Legal experts say that the only change to the ACA was the removal of a full loss of federal Medicaid funds as a potential penalty for states denying coverage to U.S. citizen adults in 2014—all other Medicaid provisions remain in effect. Still, the Court's decision raises the possibility that Texas could refuse to expand Medicaid to adults below and just above the federal poverty line, leaving billions of federal dollars on the table and millions of our poor uninsured. Texans must now engage in a full and thoughtful conversation about what's at stake for our state so the Legislature can make an informed choice on a course of action.

This policy page provides a round-up of the latest information on how the Court's decision affects Medicaid provisions of the ACA, and describes the latest revised estimates from the Texas Health and Human Services Commission of the costs of allowing Texas adults to enroll in Medicaid in 2014.

A Snapshot for this Moment

There are several important caveats to note about the information contained in this brief. First, this is a compilation of the best expert opinion on the interpretation of the Medicaid provisions of the ACA and how they are—or are not—affected by the recent Supreme Court decision. We assume that by December 2012, new and different information will supersede some of these preliminary interpretations. It is also important to recognize that even where legal interpretation seems very clear, legal challenges will nevertheless still arise around the U.S.

Second, it is critical to recognize that the outcome of national 2012 elections will have a make or break effect on whether and how the Medicaid coverage or any other provisions of the ACA are implemented. A power shift in the U.S. Senate and in the presidency could easily result in not only a reversal of direction in ACA's public and private insurance coverage gains, but actual down-sizing of existing coverage through Medicaid and Medicare cut-backs being promoted by some in Congress today. Texas adopted a 2011 state law authorizing state government to seek a mega-block grant for Medicaid, Medicare, CHIP, and all public and mental health federal funding ("interstate compact" legislation), and under different federal leadership such a proposal might actually gain congressional approval. In other words, depending on the outcome of the elections, the conversation in 2013 related to Medicaid could be entirely different.

Finally, all public policy changes related to federal and state roles in health care will be affected by the overall movement of the federal deficit reduction. Even as the nation moves closer to making good, affordable care available to all, we must at the same time understand that a reining in of increased health spending must be a part of our long-term goals, and pressure to eliminate excessive pricing and ineffective treatments will be a part of the health care reality for many years to come. From an advocate's

perspective, it will be important to embrace and incorporate those goals, even as we seek to protect the most vulnerable and create access for those who are excluded from access today.

What Does the ACA Change about Medicaid Eligibility?

The Affordable Care Act (ACA) calls for two big changes in 2014 that, *if implemented*, would result in many more Texans gaining insurance.

First, Americans without job-based health care could buy new coverage that could not be denied or priced out of reach, with sliding-scale premium assistance for families with low-to-moderate incomes (e.g., up to about $92,000 a year for four).

Second, all adult U.S. citizens with near- and below-poverty incomes (up to 133 percent of the federal poverty income level, about $31,000 a year for a family of four) could get Medicaid coverage, with minimal out-of-pocket costs.

Currently, Texas Medicaid

- **only covers a small fraction of parents living below the poverty line.** Though Texas Medicaid covers about 2.6 million children today, only about 225,000 of their parents are covered. The Texas Legislature set the dollar-limit for parents in Medicaid in 1985, and it has never been increased or updated for inflation. A single parent with two children cannot make more than $188 per month and qualify for Medicaid; if he or she is working he or she could earn up to $308 per month because of a $120 per month earnings disregard. [1]

- **like most states, does not cover childless adults at all** (unless pregnant, fully disabled, or over 65).

What share does Texas have to pay for if we expand Medicaid to adults under the ACA?

Under the Medicaid expansion, the federal government will pick up 100 percent of the costs for the first three years of Texas' expansion, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and no less than 90 percent every year after that.

Texas will also expect to see increased enrollment—the "welcome mat" effect—by already-eligible children if we take the opportunity to cover adults in 2014. Studies show that children whose parents are enrolled in Medicaid are much more likely to be signed up themselves, and those children have fewer gaps in coverage as well.[2] So, Texas' costs for children's Medicaid would also be expected to increase, and the state's share of that growth would be our "regular" state Medicaid share—just under 42 cents per dollar in 2012, but re-calculated and updated by Congress every year.

What did the Supreme Court decision change about the ACA and Medicaid?

In the Court's decision, Chief Justice Roberts held that the Medicaid expansion to adults was such a major shift that states should not have to risk of all of their pre-existing Medicaid program funding if they failed to comply with the expansion. (The authority to withhold federal dollars from states that violate Medicaid law has been part of Medicaid federal law since 1965, though the U.S. Secretary of Health and Human Services has never had to impose that penalty on a state.) **So, the law still directs states to expand Medicaid coverage in 2014, but if a state chooses not to accept the expansion, they do not face any penalty.**

Importantly, the decision maintains all other aspects of the ACA, and also does not change anything about pre-existing federal Medicaid law. Legal experts note that there are no references at all in Roberts' majority opinion to changing any other of the ACA's Medicaid provisions. **Most experts agree that the removal of any penalty for states failing to cover adults in 2014 was the only change brought about by the decision.**

HHS Guidance to Date

On July 10, the U.S. Secretary of Health and Human Services (HHS) made it clear that this is the federal Medicaid agency's interpretation. In a letter to the National Governors Association, the Secretary stated that the Court's decision did not affect any provision of the ACA other than the removal of a full loss of federal Medicaid funds as a potential penalty for states choosing not to participate in expanded Medicaid eligibility for adults.[3]

The Secretary also stated that HHS intends to use its authority under the ACA to ensure that no adults in poverty left uninsured because of a state's inaction would be subject to any penalty for being uninsured under the law's individual responsibility requirement. In another letter to the Republican Governor's Association, a Centers for Medicare and Medicaid Services (CMS) official further clarified that there is no deadline proposed for states to communicate their decision regarding the Medicaid coverage opportunity to federal authorities. CMS further stressed that states may continue to apply for and receive 90:10 federal match for Medicaid computer system upgrades related to the ACA regardless of their decision, as well as insurance exchange implementation grants. Neither type of funding would have to be repaid if a state chooses not to cover its Medicaid-eligible adults in 2014, or if it decides to have the federal government run its insurance exchange.

HHS will eventually provide more guidance, but experts familiar with Medicaid policy and politics do not expect that additional formal guidance will be provided in the next few month.

Expert opinion on about how the Court decision affects various ACA Medicaid provisions

Experts on Medicaid law have offered these clarifications based on the decision and the HHS letters.

- The decision does not have any effect on earlier federally-mandated Medicaid expansions.
- States that do expand adult coverage in 2014 must abide by all Medicaid provisions of the ACA in order to get the enhanced federal matching funds for the expansion.
- States that do not expand adult coverage in 2014 are still bound by all provisions of the pre-ACA federal Medicaid law, and could put the federal funds for their existing Medicaid programs at risk for non-compliance with those laws. As noted above, this pre-dates the ACA and the Court's decision and goes back to the original 1965 Medicaid statute.

The ACA's other new Medicaid provisions are unchanged by the Court decision and still are in force for *all states*, including:

- Increased primary care service Medicaid payment rates in 2013 and 2014, fully funded by the federal government for the specified services and provider types.
- Mandatory coverage of birthing centers and smoking cessation for pregnant women.
- New community services and supports state options for seniors and persons with disabilities.
- Expansion of Medicaid to youth aging out of foster care up until their 26th birthday.

- Phasing down of Disproportionate Share Hospital Medicaid reimbursements as state uninsured rates drop.

Can states do a smaller expansion (e.g., to 100 percent FPL), or phase in expansion

Experts agree that there is nothing in the ACA or the Court decision that requires HHS to allow a state to adopt an expansion that falls short of the standards laid out in the ACA. Without full adherence to the law, a state cannot expect to receive the 100 percent initial match or the phasing down to 90 percent match.

The Secretary can consider whether or not to allow any modification of the law under 1115 demonstration waiver authority. However, it is not clear how a smaller coverage group or a slower implementation schedule would demonstrate an innovation or efficiency. Another common question for which there is no answer at present is whether a state may withdraw from the adult coverage expansion in out-years, when the initial full federal mat has ended. Only time will tell whether any such variations will be allowed by HHS.

Do Maintenance-of-Effort stability protections still apply to child and adult Medicaid eligibility thresholds, and do they apply to all states?

Again, because the Court decision eliminated *only* the HHS Secretary's ability to penalize funding for a state's entire existing Medicaid program for failing to expand adult coverage, experts agree that all states, regardless of their decision on adult coverage, must not reduce children's coverage before 2019 or adult coverage before insurance exchanges are fully operational in 2014.

Experts also say the provision to shift kids from 100-133 percent FPL (ages 6-18) who are in CHIP today into Medicaid in 2014 will be applied in all states, even those which have not offered the adult expansion. The increase in the children's Medicaid minimum coverage threshold from 100 percent FPL to 133 percent FPL was mandated by a separate provision of the ACA, unconnected to the adult expansion provisions which were the subject of the Court's majority opinion. Importantly, states will continue to draw the higher federal CHIP match for these children.

What about the ACA requirements for Medicaid enrollment system changes?

National experts say that the ACA's eligibility and enrollment requirements are not affected by the Court's decision and remain in place for every state, no matter what they decide on the 2014 adult coverage. This means all states will need to convert their Medicaid eligibility systems' rules to be based on a standard set of income-tax-based rules for determining eligibility (Modified Adjusted Gross Income, or "MAGI").[4]

Other key reforms required by the ACA include having a single, streamlined application that can be used for Medicaid, CHIP, or private coverage in the exchange; and the elimination of asset limits and face-to-face interview requirements. States will be required to allow application and renewal online or by phone (along with mail and in person), to rely primarily on electronic data sources to confirm eligibility, and cannot require recertification more often than once a year.

What happens to the uninsured below the poverty line if a state does not expand in 2014?

The ACA makes sliding-scale premium assistance for private coverage in the exchange available only to persons *above* 100 percent FPL (with an exception for legal immigrants excluded from Medicaid). This means without the adult Medicaid expansion, uninsured Texas adults below 100 percent FPL will have no assistance available in 2014.

Those from 100-133 percent FPL would be eligible for premium assistance, but because the system was designed with assumption that this group would have Medicaid, some of these near-poor will have difficulty affording the coverage, even with a cap on premiums of two percent of family income.

Costs of care for uninsured poor Texas adults will continue to be carried primarily by local property taxpayers, secondarily by other charity care providers, and without benefit of the 90 percent-plus federal matching dollars.

An Urban Institute analysis for the Kaiser Family Foundation estimates that there are 1.75 million uninsured TX adults under 133 percent FPL and more than three-quarters (1.33 million) of these have incomes below 100 percent FPL.[5]

An important question that cannot be answered at present is how the ACA's requirement for a **"No Wrong Door" policy** between health insurance exchanges and Medicaid programs would work if a state opts out. Under the law, all applicants for coverage must be automatically transferred to and enrolled in the correct coverage option for their income level, without any further steps, regardless of whether they applied through the exchange or the Medicaid system. If Texas leaves more than 1 million poor adults without any option for coverage assistance, the No Wrong Door scenario will include a gaping hole.

What will Texas' state budget costs be if we do offer Medicaid for our adults in and near poverty?

Prior to July 12, 2012, the Texas Health and Human Services Commission (HHSC) had projected that assuming a very large enrollment increase in Medicaid for poor adults (i.e., more than 90 percent of eligible persons enrolling) as well as by already-eligible-but-not-enrolled Texas children, our Medicaid costs would increase by $5.8 billion from 2014-2019, and the state would receive $76.3 billion in federal matching funds—a net gain of $70 billion.

HHSC revised its model and released new estimates for the period from 2013 to 2017 at a July 12 legislative hearing. State General Revenue costs for the ACA expansion (including what HHSC labels the "partial" Primary Care Provider rate increase scenario) total $3.7 billion from 2013-2017, and will draw down $25.8 billion in federal matching funds for Texas health care providers.[6]

While the agency did not yet release detailed estimates beyond 2017, agency officials told lawmakers and the media that the new model predicts 42 percent lower spending for the period from 2014-2023 compared to its earlier estimate — $15.6 billion GR in state spending, matched with $100.1 billion in federal funding (net gain of $84.5 billion).

Some of the major revised assumptions HHSC has reported include:

- **85 percent of all eligible Medicaid enrollees are assumed to actually sign up** ("take-up" or participation rate). This is down from the earlier agency assumption of 91-94 percent take-up rate.

At 85 percent, Texas take-up for all ages would be as high as the current national average for children, and higher than national rates for adults which are typically in the 65-70 percent range.

- **Medicaid caseload assumed to grow at 1.2 percent per year**. This is down from earlier model's 2 percent assumption.
- **Enrollment ramp-up** is assumed to not exceed 50 percent of eligibles in year one and 75 percent in year two. The older model assumed immediate 91 percent enrollment.
- **Medical cost inflation assumed to be 4 percent annually;** old model assumed 6 percent.
- **Corrected timeline:** old model erroneously included costs prior to January 2014.

More Detail Needed on New HHSC Medicaid Expansion Cost Estimates

As this policy page goes to press, a number of questions remain regarding the HHSC estimates. As the agency has an opportunity to provide additional detail, we will update this analysis. In the meantime, here are some important questions related to the new model and estimates:

1. In the Medicaid enrollment numbers associated with the HHSC cost projections:
    a. Of the adult enrollees, what share are parents and which are childless adults?
    b. Of the "increased enrollment (of already eligible Texans) due to the ACA" group, what percentage are children, parents, maternity coverage, et. cetera?
2. What portion of the HHSC-estimated state costs for primary care service rate increases is actually ACA-mandated, and which are optional costs that HHSC has added to the model?
3. Does HHSC's new model assume any Texans drop private insurance to get Medicaid ("crowd-out"), or is the model strictly based on uninsured Texans? If crowd-out is assumed, what are the specific assumptions?
4. What is the Texas Medicaid cost-per-beneficiary starting point assumed (or multiple values for different kinds of enrollees) for the model? Is this base cost assumed to increase by 4 percent annually for each enrollee?
5. Are the participation (enrollment take-up) rates assumed to be the same for the newly eligible adults as for children and adults the existing Texas Medicaid program population? Are 85 percent of all groups assumed to enroll?
6. The new model does not seem to include state savings offsets from increased Medicaid drug rebates. Can these be provided?

HHSC has mentioned that they add on 8 percent in administrative costs to every year of expansion in their model. It is not clear whether that percentage is reduced each year as enrollment grows to reflect that the dollar value of medical services delivered is not directly reflected in administrative costs.

Updated CBO Score Projects Fewer Insured because of Court's Medicaid Ruling

This week, the Congressional Budget Office updated its scoring of the ACA to model the impact of the Court's changes to the Medicaid coverage for adults. The CBO now projects that compared to the ACA as passed, 6 million fewer people will be covered in Medicaid, 3 million more people will be covered in the Exchanges, and 3 million more people will remain uninsured in 2022. As a result, federal spending on the Medicaid expansion and exchange coverage will also be lower, by $84 billion over 2012-2022. Nationally,

CBO projects that only a third of the adults who lose out on Medicaid access because their state fails to offer coverage will fall into the income range (100 percent to 133 percent[7] of the FPL) that allows them to qualify for sliding-scale help with exchange coverage. The other two-thirds will be ineligible for coverage in the exchanges because they have income below 100 percent of the federal poverty level. And, CBO assumes that because the third eligible for exchange coverage will have to pay 2 percent of their income towards premiums, plus cost sharing, significant numbers will not be able to afford coverage and will remain uninsured.

Coming Next from CPPP

The center will provide additional information on the real track record of Medicaid costs and its place in Texas' and other state budgets in an upcoming policy brief. We will also update and revise information on how ACA's Medicaid provisions will be implemented, and on HHSC's projected budget and enrollment figures related to ACA and Medicaid as new information becomes available.

ENDNOTES

1 http://www.kff.org/medicaid/upload/8272.pdf , Table 4 page 39;
http://www.cppp.org/files/3/HlthCare_08_FinalScreen.pdf , page 11;
http://www.dads.state.tx.us/handbooks/TexasWorks/C/100/100.htm#secC-131 second table

2 http://ccf.georgetown.edu/ Expanding Coverage for Parents Helps Children

3 http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf ; http://www.ffis.org/sites/ffis.org/files/public/CMS_Response_VA.pdf

4 These requirements do not apply to eligibility for seniors and persons with disabilities based on SSI eligibility or functional need for care.

5 http://www.urban.org/health_policy/url.cfm?ID=412607

6 You can see the HHSC presentations at this link: http://www.hhsc.state.tx.us/news/present82.asp.

7 Because the ACA establishes a 5percent income disregard for all Medicaid enrollees, the upper limit for adult Medicaid coverage is sometimes expressed as 138 percent FPL (133 percent+ 5 percent).

For More Information

For more information or to request an interview, please contact Brian Stephens at stephens@cppp.org or 512.320.0222, ext. 112.

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