FOCUS on Health Reform

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# FINANCING NEW MEDICAID COVERAGE UNDER HEALTH REFORM: The Role of the Federal Government and States

Under the Patient Protection and Affordable Care Act (PPACA; Public Law 111-148), signed into law on March 23, 2010, Medicaid plays a major role in covering more uninsured people. Most notably, by January 1, 2014, the program will be expanded to provide eligibility to nearly all low-income people under age 65 with income below 133 percent of the federal poverty line.[1] As a result, millions of low-income adults without children who currently cannot qualify for coverage (except in a handful of states with waivers), as well as many low-income parents and, in some instances, children now covered through the Children's Health Insurance Program (CHIP) will be made eligible for Medicaid. In addition, the health reform law is expected to result in more people who already are eligible for Medicaid under current rules learning about and signing up for coverage. In total, Medicaid, along with its smaller companion program, CHIP, is expected to cover an additional 16 million people by 2019.[2]

A key question is how the cost of the Medicaid expansion will be financed. This brief provides the details of how the federal government and the states are expected to split this responsibility.[3] Overall, the Congressional Budget Office estimates the federal government will finance the vast majority, approximately 96 percent, of the increase in Medicaid coverage attribuTable to the health reform legislation over the next ten years. While all states will see large increases in federal financing, the actual share of coverage financed by the federal government for any given state will vary based on factors such as the state's Medicaid "matching rate," coverage decisions prior to enactment of reform, and the rate at which eligible people participate in its Medicaid program. In general, states that have the furthest to climb in terms of meeting the new eligibility requirements will see the largest increases in federal financing.

One practical financing issue that will need to be addressed arises because, beginning in 2014, the federal government will pay much more for coverage of "newly-eligible" Medicaid beneficiaries than for people "already-eligible" for Medicaid under the rules in place December 1, 2009. As a result, states in the future will need to track whether someone qualifies for Medicaid under rules from 2009 versus under the expansion created by health reform. From a state administration perspective, it will be important for states to find ways to claim the appropriate matching rate without simultaneously complicating enrollment procedures.

## 1. Background

Medicaid, along with its smaller companion program, CHIP, already provides insurance to millions of people, covering 15 percent of the non-elderly population in the United States and almost 30 percent of its children.[4] Large gaps, however, remain in coverage for low-income populations. Currently, some 46 million people in the United States are uninsured, the majority of whom live in low-income working families. Low-income adults under age 65 are more likely to be uninsured than children, in large part because Medicaid and CHIP provide coverage for low-income children at income levels much further up the income scale. Prior to the passage of health reform, adults without children generally were not eligible for Medicaid unless they resided in one of a handful of states with special waivers or they qualified on the basis of being pregnant or disabled. Among uninsured adults, close to half (47 percent) have income below 133 percent of the FPL. The Medicaid expansion in health reform is designed in large part to fill these coverage gaps for low-income parents and childless adults, as there are an estimated 17.1 million uninsured adults with incomes at or below 133 percent of poverty.[5]

Since the inception of Medicaid, the federal government and states have shared in the financial responsibility for providing care to beneficiaries through a matching rate system. Currently, the federal government covers from 50 percent to 76 percent of the cost of providing care to Medicaid beneficiaries, with each state's "matching rate" (or "federal medical assistance percentage" (FMAP)) depending on its per capita income.[6] States with higher per capita incomes have a lower federal matching rate. CHIP, which serves low-income children at income levels above Medicaid, also is financed through a matching rate system. Unlike Medicaid, however, CHIP is a block grant program under which the federal government makes a capped amount of new federal matching funds available to states each fiscal year. The matching rate for CHIP is significantly higher than for Medicaid, ranging from 65 percent to 83 percent, depending on the state.

## 2. Federal and State Responsibility for Financing the New Medicaid Expansion

The health reform law establishes a new, minimum standard for Medicaid coverage that is uniform across the country and fills the biggest gaps in coverage for low-income people. Specifically, the PPACA requires states by January 1, 2014, to extend Medicaid eligibility to all groups of people (including childless adults, parents, and children) under age 65 with income up to 133 percent of the FPL who are not otherwise eligible for Medicaid.[7] This new category does not include pregnant women (who already qualify for Medicaid at this income level) or Medicare beneficiaries. For most states, this will mean providing Medicaid to adults without children for the first time, as well as increasing their income eligibility threshold for parents to 133 percent of the federal poverty line. In 20 states, it also will require moving children who are eligible for separate CHIP programs into Medicaid, allowing for all members of low-income families below 133 percent of the FPL to be covered together.[8]

- **Financing Newly-Eligible Medicaid Beneficiaries:** Initially, the federal government will finance the full cost of covering most of these "newly-eligible" Medicaid beneficiaries. In later years, the federal matching rate will decline slightly, but still will remain well above the regular Medicaid matching rate at 90 percent. Specifically, for calendar years 2014 through 2016, the federal government will pick up 100 percent of the cost of newly-eligible adults up to 133 percent of the FPL. In 2017, the matching rate will be 95 percent; in 2018, it will be 94 percent; in 2019, it will be 93 percent; and in 2020 and future years, it will be 90 percent. (See Table 1.) This enhanced matching rate for newly eligible beneficiaries is limited to adults ages 19 (or a higher age if a state has opted to cover older children) and up to age 65. It also is restricted to people who were not eligible for Medicaid as of December 1, 2009, including under a Medicaid waiver. (If the waiver only covered a limited benefit package or capped enrollment, a state may be able to treat the adult as newly eligible and qualify for the much higher newly eligible matching rate.)[9]

- **Children Moving from CHIP to Medicaid:** States already must provide Medicaid to children under age six with family income up to 133 percent of the FPL and those ages six through 18 with family income up to 100 percent of the FPL. In 2014, states will provide all children regardless of age with family income up to 133 percent of the FPL with Medicaid (including those currently covered through separate CHIP programs). As a result of this policy, estimates suggest that approximately 24 percent of children enrolled in separate CHIP programs will move into Medicaid. Recent data suggest that if this change were to take place today, about 700,000 CHIP enrollees in 20 states would need to move from separate CHIP programs into Medicaid.[10] Since CHIP funds can be used for Medicaid expansions, it is likely that states will be able to continue to secure the CHIP enhanced matching rate for the cost of covering these children even after they move to Medicaid.[11]

- **Early Expansion Option:** Beginning April 1, 2010, states have the option of moving early to provide Medicaid coverage through a state plan amendment to people up to 133 percent of the FPL. Since states long have had the chance to provide coverage at this income level for both parents and children, the primary import of the early expansion option is that states can now cover childless adults with the help of federal Medicaid matching funds and without having to pursue a waiver. A state that takes up the option early will receive its regular Medicaid matching rate for this population until January 1, 2014, and then still qualify for even more generous federal support.[12]

## 3. Federal and State Responsibility for "Already-Eligible" Beneficiaries

The PPACA requires that states maintain their current eligibility standards and enrollment procedures in Medicaid and CHIP. These maintenance-of-effort requirements apply to adults until the new health exchanges are fully operational on January 1, 2014, and to children until September 30, 2019.[13] Along with preserving existing eligibility rules through these maintenance-of-effort requirements, the health reform legislation also is expected to increase participation in Medicaid and CHIP. As people come forward to learn about the new coverage opportunities created by the legislation, many who are already eligible for Medicaid or CHIP under current rules are likely to enroll in these programs. A similar dynamic, often referred to as the "welcome mat effect," occurred after CHIP was adopted in 1997, spurring families to come forward and seek coverage for their children. Many were found to have children who already were eligible for Medicaid, and, as a result, states experienced a boost in their Medicaid enrollment at the same time that their CHIP programs gained beneficiaries. In the context of health reform, the welcome mat effect is likely to be even more marked because of the broader reach of the legislation and the mandate that people purchase coverage.[14]

- **Matching Rates for "Already-Eligible" Beneficiaries.** The PPACA continues current matching rates for "already-eligible" beneficiaries who enroll in Medicaid as a result of health reform. Children who qualify for Medicaid will be covered at a state's regular matching rate, as will parents and other groups who are eligible under the rules a state had in place on December 1, 2009. States currently are receiving a temporary boost in their regular Medicaid matching rates to ease the impact of the economic downturn. This temporary increase in matching rates is slated to expire on December 31, 2010, but Congress is considering legislation that might extend it for an additional six months.

- **Special Treatment for Certain "Expansion" States.** The PPACA provides some additional federal support to leading or "expansion" states (those covering parents and childless adults at least up to 100 percent of the FPL on the date of enactment of PPACA) for the cost of covering childless adults who are already eligible for Medicaid as of December 1, 2009. States meeting these criteria can receive a phased-in increase in their federal matching rate for childless adults that by 2019 will equal the enhanced matching rate available for newly-eligible adults. The formula for this enhanced matching rate is equal to 50 percent of the gap between an expansion state's regular Medicaid matching rate and the enhanced matching rate provided to other states in 2014, 60 percent in 2015, 70 percent in 2016, 80 percent in 2017, 90 percent in 2018, and 100 percent in 2019 and future years. While twelve states appear to meet the definition of an expansion state, a subset of seven states appear to be eligible for this special expansion state match rate (Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont).[15] (See Table 1.)

- **Treatment of States with No Newly-Eligible Individuals.** Those expansion states that do not have any newly-eligible Medicaid beneficiaries because they already cover people up to 133 percent of the federal poverty level or higher will also receive a temporary (January 1, 2014 through December 31, 2015) 2.2 percentage point increase in their federal matching rate for all populations. It is likely that these states will include at least Massachusetts and Vermont, which already use Medicaid to provide coverage to people with income at or above 133 percent of the federal poverty level.

**Table 1. Enhanced Matching Rates for Parents and Childless Adults, 2014 and Beyond**

| Year | Newly-Eligible Parents & Childless Adults (up to 133% FPL) | Medicaid-Eligible Childless Adults in "Expansion" States Only | | |
|---|---|---|---|---|
| | | Transition Percentage used to Calculate Enhanced Match | Example: State with 50% Original FMAP *Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]* | Example: State with 60% Original FMAP *Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]* |
| 2014 | 100% | 50% | 75% | 80% |
| 2015 | 100% | 60% | 80% | 84% |
| 2016 | 100% | 70% | 85% | 88% |
| 2017 | 95% | 80% | 86% | 88% |
| 2018 | 94% | 90% | 89.60% | 90.60% |
| 2019 | 93% | 100% | 93% | 93% |
| 2020 on | 90% | 100% | 90% | 90% |

## 4. State and Federal Responsibility for CHIP

The PPACA continues the Children's Health Insurance Program (CHIP) through September 30, 2019, and also requires states to at least maintain their current eligibility standards in CHIP until this date. Funding for the program is provided through September 30, 2015 (fiscal year 2015), two years beyond its current expiration date. The current enhanced (CHIP) matching rate applies to children enrolled in CHIP, whether they are covered through a Medicaid expansion, a separate CHIP program, or some combination. Starting October 1, 2015, states will receive an increase of 23 percentage points (up to a maximum of 100 percent) in their CHIP matching rate.

If a state runs out of federal CHIP funding, children can be enrolled in Exchange plans with comparable coverage. The Secretary of Health and Human Services will be required to review and certify which plans in the Exchanges provide CHIP-comparable benefits and cost sharing. However, recent data show that states have had the federal resources they need to sustain and strengthen their CHIP programs since it was reauthorized in February 2009, and they will likely continue to have adequate federal funding through 2015.[16]

## 5. Other Medicaid Financing Provisions Related to Coverage

- **Former Foster Care Children.** Effective January 1, 2014, children up to age 26 who "age out" of foster care will be able to maintain Medicaid coverage. States will receive their regular Medicaid matching rate for covering this population.
- **New coverage of state employee through CHIP.** Children of state employees can now be enrolled in CHIP on the same terms as other uninsured children as long as a state has not reduced its spending on dependent coverage for state employees below its 1997 level (adjusted for medical inflation). Even if it has, a state can enroll uninsured children of state employees in CHIP on a case-by-case basis if the cost of the state employee plan would exceed five percent of the family's income.

## Policy Implications

As a result of the Medicaid expansion, millions of low-income childless adults, parents, and children now covered through CHIP will be made newly eligible for Medicaid. In addition, health reform is expected to increase participation in Medicaid and CHIP for those who are eligible under current rules as they learn about and sign up for coverage.

The federal government is taking an expansive role in financing the new Medicaid expansion. In total, the Congressional Budget Office estimates that the federal government will spend an additional $434 billion dollars on Medicaid and CHIP coverage increases between fiscal year 2010 and 2019 and states will contribute on net an additional $20 billion. These estimates suggest the federal government will finance some 96 percent of the new Medicaid and CHIP costs associated with coverage initiatives under health reform, while states will finance roughly four percent. While all states are expected to see significant increases in federal financing with health reform, the actual increase and the share of new coverage financed by the federal government will depend heavily on the design of each state's current public programs (Medicaid and state funded coverage) and the number and composition of its uninsured population. Working with CMS, states will need to develop systems to claim the higher federal matching rate available for newly-eligible (versus already-eligible) Medicaid beneficiaries. One practical challenge that states face is accurately determining who is eligible for Medicaid under the new rules rather than the old rules, and establishing procedures for states to claim the different matching rates for their Medicaid and CHIP populations without imposing additional barriers to enrollment.

### A Simplified Look At Medicaid and CHIP Matching Rates in Health Reform

- **Regular Medicaid Matching Rate:** The regular Medicaid matching rate is determined by a formula that has been in place since the program was enacted in 1965. It ranges from 50 percent to 76 percent, and is designed to provide more federal support to states with lower per capita incomes. In 2014, it will continue to be used for "already-eligible" individuals (people who qualify for Medicaid under the rules in effect on December 1, 2009).
- **CHIP Matching Rate:** The CHIP matching rate is available for children who are covered through a Medicaid expansion or through a separate CHIP program. It ranges from 65 percent to 83 percent, and, in effect, it reduce the cost to a state of covering a child by 30 percent when compared to the regular Medicaid matching rate. It will remain available to states through the end of fiscal year 2015, and then assuming Congress extends funding for CHIP past this date, it will increase by an additional 23 percentage points.
- **Newly-Eligible Matching Rate:** The newly-eligible matching rate is designed to assure that the federal government finances much of the cost of the Medicaid expansion to 133 percent of the FPL included in the health reform legislation. It is set at 100 percent in 2014 through 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. Beginning in 2014, it is available for non-elderly adults with income up to 133 percent of the FPL who are not eligible for Medicaid under the rules that a state had in place on December 1, 2009.
- **"Expansion" States Matching Rate:** The "expansion" or "transition" matching rate is designed to provide some additional federal help to "expansion" states (states that expanded coverage for adults to at least 100 percent of the FPL prior to enactment of health reform). These states can receive a phased-in increase in their federal matching rate for adults without children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults.

[1] As under prior law, undocumented immigrants will remain ineligible for Medicaid and CHIP, and only certain legal immigrants can secure coverage.

[2] Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)" (March 20, 2010).

[3] As noted, some areas are open to interpretation. Until the Centers for Medicare and Medicaid Services (CMS) issues guidance that answers these questions definitively, it is important to treat all of these answers as educated guesses.

[4] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey, Annual Social and Economic Supplements.

[5] Kaiser Commission on Medicaid and the Uninsured. "Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty" (April 2010). Bureau's March 2008 and 2009 Current Population Survey, Annual Social and Economic Supplements.

[6] Note that this does not include the temporary increase under the American Recovery and Reinvestment Act of 2009 (ARRA).

[7] To promote coordination, the gross income standard that will be used for the premium tax credits available in the Exchanges also will apply to most existing Medicaid eligibility groups. A standard five percent of income disregard will be built into the income test for Medicaid. In addition, states will no longer be able to impose asset tests on most Medicaid populations.

[8] D. Cohen Ross, et al., "A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009," Kaiser Commission on Medicaid and the Uninsured (December 2009).

[9] It appears as if states will receive the enhanced matching rate for individuals enrolled above a cap. For example, if a state has a cap of 45,000, it will receive the enhanced match for any enrollees in excess of 45,000.

[10] G. Kenney & A. Cook, "Potential Impacts of Alternative Health Care Reform Proposals for Children with Medicaid and CHIP Coverage," Urban Institute (January 2010).

[11] In the past, coverage for children made newly eligible for Medicaid, including lawfully residing immigrant children covered at state option, has been matched at the enhanced CHIP matching rate.

[12] CMS released guidance on the new option on April 9, 2010. The letter is available at: www.cms.gov/SMDL.

[13] For more on the maintenance-of-effort requirements, see Georgetown Center for Children and Families & Center on Budget and Policy Priorities, "Holding the Line in Medicaid and CHIP: Key Questions and Answers About Health Care Reform's Maintenance-of-Effort Requirements" (March 26, 2010).

[14] It is important to note that the vast majority of those who will be eligible for Medicaid under the expansion, while still required to purchase coverage, will not be subject to a penalty for failing to do so as it applies only to those with income at or above 100 percent of the FPL. However, as individuals may not fully understand this distinction, the mandate still can be expected to contribute to increased coverage.

[15] Coverage for an expansion state must include inpatient hospital care; cannot be limited only to people with access to employer-based insurance; and cannot provide hospital-only benefits or be a high deductible health plan. The list of states meeting the criteria for covering adults to at least 100 percent of the FPL appears to include Arizona, Delaware, the District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington, and Wisconsin. However, some of these states are not likely to use the expansion state matching rate for a variety of reasons, including because they can secure the higher matching rate available for "newly eligible" Medicaid beneficiaries. The subset that is likely to rely on the expansion state matching rate appears to include: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont. While Wisconsin covers adults to at least 100 percent of the FPL, it is unclear whether the benefits it provides to these adults meet the definition of "benchmark" coverage and, thus, whether it will receive the expansion state matching rate or the newly eligible matching rate. For states like Hawaii and Maine that have caps on coverage for childless adults, the expansion state matching rate would apply to coverage below the cap, but the newly eligible matching rate may be available for enrollment in excess of cap levels. Finally, states that cover adults to at least 100 percent of the FPL using state funds also can secure the higher matching rate available for newly eligible beneficiaries and will not need to rely on the expansion state matching rate.

[16] Georgetown Center for Children and Families, "CHIP Allotments: Federal Funding Remains Secure for States" (March 2010).

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