Health & Disability Advocates

What Medicaid Infrastructure Grants Need to Know about Health Care Reform: The Impact of Medicaid Expansion on the Medicaid Buy-In

In late March 2010, Congress passed comprehensive reform of the American health care and insurance system. The *Patient Protection and Affordable Care Act* (as amended by the *Health Care and Education Reconciliation Act*) will dramatically change public health programs such as Medicaid and Medicare, as well as private health insurance, that working people with disabilities rely on to support employment.

Medicaid Infrastructure Grants have a vital role to play helping to inform and educate disability and employment stakeholders about the impact of reform on working people with disabilities. This policy and practice brief is part of a series of briefs designed to help MIGs in that role. This brief explains the new law's expected impact on Medicaid eligibility for people with disabilities, and explores the potential new Medicaid enrollment dynamics that MIGs need to consider as health care reform is implemented. It addresses questions such as:

- How will Medicaid Buy-In enrollees be affected by health care reform?
- Will people with disabilities be able to get Medicaid without a disability determination?
- Can states change their MBI programs while reform is implemented?
- Will MBI income disregards still apply?

Accompanying this brief are two additional tools: 1) a table summarizing how different Medicaid programs will look before and after PPACA is implemented and 2) a set of scenarios illustrating the impact of PPACA on an individual with a disability.

Later briefs will address the high risk pool insurance program that will help individuals without Medicaid access comprehensive health care coverage as early as this year; new state options for expanding home and community based care; the potential for people with disabilities to purchase private insurance through the State Exchanges; the long-term care insurance program known as the Community Living Assistance Services and Supports (CLASS) Act; and other health care reform issues that will affect working people with disabilities. As always, we welcome your comments and questions about this and future briefs.

Overview—Medicaid Eligibility Reforms

Medicaid Expansion—the Newly-Eligible Group[1]

Under the *Patient Protection and Affordable Care Act* as amended by the *Health Care and Education Reconciliation Act* (collectively, "PPACA"), Medicaid will expand to cover children, parents and childless adults who have family income up to 133 percent of the federal poverty level (FPL). Effective January 1, 2014, this will be a new mandatory Medicaid eligibility category, referred to as the "newly-eligible."

The newly-eligible group does not have any disability or other categorical eligibility criteria. However, it is limited to people who are:

- Under age 65,
- Not pregnant,
- Not entitled to or enrolled in Medicare Part A,
- Not enrolled in Medicare Part B, and
- Not in another mandatory Medicaid category.

Given these limitations, the newly-eligible category will not be an option for many individuals who are part of the population served by Medicaid Buy-In programs in most states. The Medicare exclusions, for example, will keep many potential MBI participants from being part of the newly-eligible group.

From April 1, 2010, states have the option to pursue a state plan amendment to cover the newly eligible group and can phase in eligibility for the group based on income.[2] After January 1, 2014, states will have the option to provide coverage for individuals who have income above 133 percent FPL, under age 65 and not in another Medicaid category.

Federal Match for Newly-Eligible[3]

From 2014 to 2016, the newly-eligible group will be funded 100% by the federal government; federal funding will then decline gradually each year from 2017 to 2019, down to 90 percent where it will remain thereafter. This federal funding level is dramatically higher than the federal match most states currently receive for other mandatory and optional Medicaid categories, which range from 50 percent (or 56.2 percent with the temporary enhanced match provided by last year's American Reinvestment and Recovery Act) up to a maximum of 85 percent; only a small number of states receive more than a 75 percent match.

States that elect to cover the newly-eligible group as an optional group, before it becomes mandatory in 2014, will receive their regular federal match for the optional group. In addition, states that opt to cover those with income above 133 percent FPL (who are under 65 and not in

[1] PPACA Section 2001.
[2] PPACA Section 2001(a)(4).
[3] PPACA Section 2001(a)(3).

another Medicaid category) after 2014 will receive the regular federal match for this group as well.

Essential Benefits for Newly-Eligible[4]

States will have the option of providing the newly-eligible group with either the mandatory Medicaid services package, or with a benchmark or benchmark-equivalent package. The latter must provide the same "essential benefits"—those typical of large-employer insurance plans—to be required of private insurance plans that will be operating through the state-based insurance Exchanges. These include:

- Outpatient and lab services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Pediatric services, including oral and vision care,
- Mental health and substance abuse, including behavior health treatment, with parity to physical health services,
- Prescription drugs,
- Rehabilitative and habilitative services and devices, and
- Preventive and wellness services and chronic disease management.

As a result, Medicaid benefits for the newly-eligible group may be substantially different than benefits for those in traditional Medicaid categories, who are also entitled to a state's optional Medicaid services. However, the benchmark-equivalent option provides states with flexibility to offer service packages tailored to a group's needs.

Eligibility Methodology—MAGI[5]

Eligibility for the newly-eligible Medicaid group will be determined based on "modified adjusted gross income," or MAGI. MAGI calculates income based on taxable income as defined by the IRS, and is the same methodology that will apply to eligibility for tax credits and subsidies for the purchase of private health insurance. In addition to the newly-eligible group, the MAGI methodology will be phased in for some other Medicaid groups, such as non-disabled adults.

For Medicaid applicants to whom MAGI applies, there will be a five percent income disregard. States will not be able to apply other income disregards to these Medicaid groups. However, for these groups there will be no asset test.

The MAGI methodology will NOT apply to Medicaid categories whose eligibility is based on age or disability. The following list contains the specific Medicaid categories or eligibility determinations that the MAGI does not apply to—these categories and determinations will retain their ability to apply income disregards and asset tests.

[4] PPACA Section 2001(c).
[5] PPACA Section 2002 and Section 1302(b).

1. ***SSI and SSI-related Medicaid categories*** ("Individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI");

2. ***Children in foster care*** ("Individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State");

3. ***Older adults*** ("Individuals who have attained age 65");

4. ***People who are blind or have disabilities*** ("Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of [Social Security Act] section 1902(e)(3)");

5. ***Medically needy individuals*** ("Individuals described in subsection (a)(10)(C)" [of Social Security Act Section 1902]);

6. ***Medicare cost-sharing categories*** ("Individuals described in any clause of subsection (a)(10)(E)" [of Social Security Act Section 1902]);

7. ***Medicare Part D subsidies*** ("Determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2)"); and

8. ***Long-term care categories applying nursing facility level of care*** ("Determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).")[6]

As a result of the fourth exception listed above, the Medicaid Buy-In will NOT be subject to the MAGI methodology. States will be able to continue to apply the income disregards that are so important to encouraging increased earnings for Medicaid Buy-In participants. MBI-specific asset rules will still be applied as well.

Maintenance of Effort[7]

States may not make Medicaid eligibility standards, methodologies, or procedures more restrictive than those in effect on the date PPACA was enacted (March 23, 2010) until the

[6] PPACA Section 2002.
[7] PPACA Section 2001(b).

state's health insurance Exchange is determined by the Secretary of Health and Human Services to be fully operational. State Exchanges are supposed to be operational by January 1, 2014.

In addition, Medicaid enrollees as of January 1, 2014, when the newly-eligible category is implemented, are "grandfathered" in at least until March 31, 2014, or until their next regularly scheduled redetermination, whichever is later. Those enrollees cannot be found ineligible based on the application of the MAGI methodology during that time.

Discussion—The Impact of Medicaid Expansion for Working People with Disabilities

Q: Will the MAGI methodology limit states' ability to apply additional income disregards to the Medicaid Buy-In?
A: No, because there is a specific exception to MAGI for people who are eligible for Medicaid based on disability.

Q: Will MBI enrollees still have an asset test (if the state has one for the MBI group)?
A: Yes. Medicaid eligibility groups such as the Medicaid Buy-In that are not subject to MAGI will still be subject to whatever asset test normally applies to the group.

Q: Could a Medicaid Buy-In participant decide to go into the "newly-eligible" group instead of the Buy-In? They could avoid the asset test and a disability determination.
A: Some of them could, but only those who are not entitled to Medicare. (People who are entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B do not qualify for the newly-eligible group; this would exclude the majority of MBI participants in most states.) In addition, the Medicaid Buy-In offers the benefit of income limits that are generally much higher than 133 percent FPL. Moreover, MBI programs have much more generous income disregards than the newly-eligible group will have. For example, the SSI methodology most states use disregards $65 plus one-half of earned income; the MAGI methodology that applies to the newly-eligible group only disregards five percent of income. Another concern is whether the benchmark benefits—the "essential services—required to be provided to the newly-eligible group will include important supports such as personal assistance services or supported employment services.

Q: Will our state be able to expand its Medicaid Buy-In while health care reform is implemented?
A: Yes. The maintenance of effort requirement prevents states from making their Medicaid programs more restrictive, but it does not prevent them from making them less restrictive. CMS is expected to issue guidance on this issue soon.

Q. Will the newly-eligible group be a disincentive to work?
A. It's possible some individuals might want to keep their income below 133 percent FPL to qualify for the newly-eligible group and avoid a disability determination and an asset test. However, as explained above, Medicare beneficiaries will not be eligible for the new group, and the Medicaid Buy-In offers a higher income limit and more generous income disregards, and

possibly access to better support services such as PAS. If the asset test is an issue, states could address this by raising the asset threshold on the Medicaid Buy-In program, or disregard certain types of assets such as retirement savings.

Q. Will state Medicaid agencies want to encourage people with disabilities to go into the newly-eligible group to get a higher federal match and avoid doing disability determinations?
A. They might, but several factors make it unlikely. First of all, many working individuals with disabilities will not be eligible for the newly-eligible category because they are on Medicare. Moreover, most states are strongly committed to supporting better employment opportunities and financial independence for people with disabilities, and encouraging people to stay at 133 percent of the poverty level contradicts that. Encouraging people with disabilities to remain below 133 percent of FPL would be shortsighted and a disservice to them. For example, what would happen to individuals who decided to keep their income below 133 percent FPL and forego a disability determination for Medicaid, and then their earnings rise above 133 percent? They would have to go through a full disability determination to get back on Medicaid at the higher income level.

Have additional questions? Please contact Barb Otto (botto@hdadvocates.org) or Sara Salley (ssalley@hdadvocates.org).