

# HEALTH REFORM IMPACT

## What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### **Big-Ticket Item: Medicaid Coverage Expansion**

**April 22, 2010**

#### *Introduction*

One of the single largest categories of expenditures under the newly enacted Patient Protection and Affordable Care Act (the "PPACA"), as amended by the Health Care and Education Reconciliation Act (collectively the "Health Reform Legislation"), is the expansion of Medicaid coverage to individuals with incomes up to 133% of the federal poverty level ("FPL"), without regard to any categorical limitations such as disability or parental status. The estimated cost to the federal government of this expansion, which effectively closes the gap in Medicaid eligibility, is expected to exceed \$430 billion over 10 years. On April 9, 2010, the Centers for Medicare and Medicaid Services ("CMS") issued a letter to state health officials with guidance on one aspect of the states' obligation to provide this expanded coverage, namely, the states' option to "phase in" coverage to these low income individuals effective April 1, 2010 (the "CMS Letter").

#### *Expanded Medicaid Coverage*

Effective January 1, 2014, states are required to expand Medicaid coverage to individuals who are under 65 years of age, not pregnant, not entitled to Medicare Part A or Part B benefits, and whose income does not exceed 133% of the FPL (collectively, the "Newly Eligible"). Beginning in calendar year 2014 and continuing for the first three years in which coverage for the Newly Eligible is mandatory, states will receive a federal medical assistance percentage ("FMAP") rate of 100% to cover the costs of the expansion. In subsequent years the FMAP rates will be set as follows: 95% in calendar year 2017; 94% in calendar year 2018; 93% in calendar year 2019; and 90% in calendar year 2020.<sup>1</sup>

#### *Expansion States*

An "expansion state" is one that, as of the date that the PPACA was enacted, had already expanded Medicaid coverage to both parents and non-pregnant, childless adults with incomes of at least 100% of the FPL that is not dependent on access to employer coverage, employer contribution, or employment. Expansion states will receive a phased-in increase to the FMAP rate for their coverage of non-pregnant childless adults. By calendar year 2020, expansion states will receive the same 90% FMAP as other states for these populations.

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<sup>1</sup> The Health Care Education Reconciliation Act reduced the cap on the FMAP rate, which had been set at 95% in the PPACA prior to reconciliation.

### *Voluntary Phase In*

Prior to 2014, states may elect to phase in coverage for the Newly Eligible, effective April 1, 2010. Under this option, the state may choose to set the income threshold at any level up to 133% of the FPL; however, the state cannot cover higher-income individuals and families within the population of Newly Eligible before covering those who are lower-income in the same group. The CMS Letter advises states that opting to phase in coverage does not preclude or affect the state's increased FMAP rate that begins in 2014.

The CMS Letter encourages each state that wishes to phase in coverage for the Newly Eligible to submit a State Plan Amendment ("SPA") outlining its proposal. CMS anticipates issuing a draft SPA template in the near future; however, in the interim, CMS advises states that wish to begin coverage for the Newly Eligible effective April 1, 2010 to submit their SPAs no later than June 30, 2010.

### *Benefits Available*

Medical assistance to the Newly Eligible must consist of "benchmark coverage"<sup>2</sup> or "benchmark-equivalent coverage,"<sup>3</sup> unless the individual is exempt from mandatory enrollment in a benchmark benefit plan. In such case, the individual must receive benefits under the state's currently approved plan. All benchmark and benchmark-equivalent benefit plans that are offered by entities that are not Medicaid managed care organizations and that provide both medical and surgical benefits and mental health or substance use disorder benefits must comply with the federal mental health parity law in the same manner that such requirements apply to group health plans.<sup>4</sup> In addition, beginning January 1, 2014, all state benchmark and benchmark-equivalent coverage must comply with the "essential health benefits" set forth in Section 1302(b) of the PPACA.<sup>5</sup>

### *Income Eligibility for Nonelderly Determined Using Modified Adjusted Gross Income*

Effective January 1, 2014, states must eliminate any "asset test" used to determine eligibility for medical assistance under a state Medicaid plan or Medicaid waiver. Instead, individuals and families will have their income eligibility calculated using a methodology based on their Modified Adjusted Gross Income ("MAGI"). Certain exceptions apply, such as for individuals over 65, disabled individuals, and those eligible for Medicare cost-sharing. In addition, the requirement does not apply to any determinations of eligibility for nursing facility services, a level of care in any institution equivalent to nursing facilities, or any home and community-based services furnished under a Section 1115 waiver.

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<sup>2</sup> Each of the following packages are considered "benchmark coverage" with respect to a State Medicaid plan: (1) the standard Blue Cross/Blue Shield preferred provider option service benefit plan; (2) a health benefits coverage plan that is offered and generally available to State employees in the State involved; (3) coverage offered through the HMO that has the largest insured commercial, non-Medicaid enrollment of such coverage plans offered by such an HMO in the State involved; and (4) any other health benefits coverage that the Secretary of Health & Human Services determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage. 42 U.S.C. § 1396u-7(b)(1).

<sup>3</sup> A benefit package will be considered "benchmark-equivalent coverage" if it meets the following requirements: (1) the coverage includes basic services, consisting of (i) inpatient and outpatient hospital services, (ii) surgical and medical services, (iii) laboratory and x-ray services, (iv) well-baby and well-child care, including age-appropriate immunizations, and (v) any others as determined by the Secretary of HHS; (2) the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the "benchmark coverage" packages (*supra note 2*); and (3) with respect to each of the following categories of additional services under a benchmark benefit package, the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of the category: (i) coverage of prescription drugs, (ii) mental health services, (iii) vision services, and (iv) hearing services. 42 U.S.C. § 1396u-7(b)(2).

<sup>4</sup> 42 U.S.C. § 300gg-5 et seq., as added by the Mental Health Parity Act of 1996, P.L. 104-204, and amended by the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008, P.L. 110-343.

<sup>5</sup> Section 1302(b) of the PPACA sets forth the following as minimum "essential health benefits" included in any plan: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Using the required MAGI methodology, states must establish income eligibility thresholds that are not less than the effective income eligibility levels applied under the current state plan or waiver, as of the date of the enactment of the PPACA. States are required to submit their proposed income eligibility thresholds for CMS approval, as well as the procedures to be used in determining income eligibility using the MAGI methodology.

During the transition period until the MAGI methodology requirement takes effect, each state must establish an "Equivalent Income Test" which ensures that eligible individuals do not lose coverage during this time. For the purposes of implementing the phase in option to cover the Newly Eligible, the CMS Letter recommends the methodology of the Supplemental Security Income ("SSI") program, which is currently used in Medicaid for determining income eligibility for people with disabilities, for use in the Equivalent Income Test. However, CMS advises that this recommendation does not preclude states from submitting SPAs describing alternative methodologies that meet its criteria. CMS encourages states to discuss their SPAs with CMS before submitting them.

If you have any questions about any aspect of the Medicaid coverage expansion, please contact any of the attorneys in the Bass, Berry & Sims Healthcare Practice Group.

Also, please [click here](#) to visit our special web page for Health Reform IMPACT.

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