FactSHEET

Understanding the New Health Reform Law

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Early Medicaid Expansions under Health Reform

The health reform law *requires* states to expand Medicaid coverage to non-elderly individuals with incomes less than 133 percent of the federal poverty level ($24,352 for a family of three in 2010) by January 1, 2014. However, it *allows* states to phase in this expansion beginning on April 1, 2010, through the state plan amendment process.[1] In order to take advantage of the earliest possible effective date (April 1, 2010), states must submit a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) by June 30, 2010.

This option is available to all states, although most states are facing budget shortfalls that make it difficult for them to expand their Medicaid programs until the higher federal matching rate becomes available in 2014. Therefore, this option is probably most advantageous for the small number of states that already provide state-funded coverage to low-income individuals. The early Medicaid expansion option allows these states to draw down federal dollars for the coverage that they already provide.[2] It is important to note that taking up the early Medicaid expansion option will not affect a state's ability to receive the higher matching rate for newly eligible populations beginning in 2014.

Eligibility

For the first time ever, states can expand Medicaid to adults without dependent children through the state plan amendment process, rather than being required to apply for a waiver.

- **Categories**: This new eligibility group consists largely of adults without dependent children, although it includes any non-elderly, non-pregnant adults who are not already eligible for coverage under their state's existing Medicaid plan. Depending on current eligibility levels in the state and the income level the state expands to, this new category can also include some parents, as well as people with disabilities who are in the two-year waiting period for Medicare.
- **Income**: States can expand gradually beginning at any income level below 133 percent of poverty, but they must use the same income eligibility level for all individuals in the new eligibility group, and they must expand to lower-income groups before expanding to higher-income groups.

Although states are required to use the new modified adjusted gross income (MAGI) methodology when calculating most Medicaid eligibility categories beginning in 2014, they are not required to use this methodology for an early expansion. They can use any reasonable income methodology that is simple to administer and in the best interest of consumers. Guidance from CMS states that the SSI program's income eligibility rules exemplify one income methodology that would meet these criteria, although less restrictive methodologies will also be considered. (The CMS guidance on the early Medicaid expansion is available online at http://www.cms.gov/smdl/downloads/SMD10005.PDF.)

- **Asset Test**: States may not use an asset test when determining eligibility for an early expansion group. Furthermore, asset tests will no longer be permitted for most Medicaid eligibility categories beginning in 2014.[3]
- **Parents:** States can already expand Medicaid to parents without using a waiver (by using the pathway described in Section 1931 of the Medicaid statute). However, parents that become eligible through the new early expansion option can enroll only if their children also have health insurance (either through Medicaid, a waiver program, or private coverage).
- **Other Requirements:** All other existing Medicaid eligibility rules (including those regarding immigration status, citizenship documentation, cost-sharing, etc.) apply.

Benefits

States must provide benefits through the so-called benchmark/benchmark equivalent benefits structure.[4] This can be a more limited benefit package than what is required in traditional Medicaid, although health reform does require that all benchmark/benchmark equivalent benefit plans cover prescription drugs and mental health benefits.[5] States can choose benefits that are actuarially equivalent to the Federal Employees Health Benefits Program (FEHBP), the state's own state employees' health benefits plan, the HMO with the largest non-Medicaid enrollment in the state, the actuarial equivalent of any of these plans, or Secretary-approved coverage. States that want to make their existing Medicaid benefit package available to the early expansion group may be able to do this through the Secretary-approved coverage option.

- **Groups that Are Exempt from Mandatory Enrollment in Benchmark Plans***:* Certain groups of people cannot be required to enroll in benchmark/benchmark equivalent benefit plans, and states must cover these individuals through their existing Medicaid plans.[6]
- **Children:** Children can be enrolled in benchmark/benchmark-equivalent plans, but they must be provided with the full children's Medicaid benefit package (Early and Periodic Screening, Diagnosis and Treatment, or EPSDT), either directly or through wrap-around coverage.

States with state-funded coverage will need to determine whether their existing coverage meets the benchmark/benchmark equivalent requirements. States may need to make some additional investments to bring their coverage up to these standards. However, they would still be drawing down federal dollars for coverage that used to be entirely state-financed, which would help pay for any investments that would need to be made to bring their benefits package up to acceptable Medicaid benchmark/benchmark equivalent standards.

Federal Matching Rates

States that expand Medicaid early will receive their regular federal medical assistance percentage (FMAP) for this expansion, not the enhanced FMAP that states are currently receiving as a result of the economic recovery package (the American Recovery and Reinvestment Act, or ARRA). Expanding Medicaid early does not affect a state's ability to receive this higher matching rate for expansion populations beginning in 2014. States will still receive full federal financing for three years (2014-2016) and a much higher federal matching rate in 2017 and future years for their expansion populations. Expansion populations are defined as those with incomes between the state's Medicaid eligibility level as of December 1, 2009, and 133 percent of poverty.

Issues to Consider

States that submit state plan amendments for this new option by June 30, 2010, can make the expansion effective as of April 1, 2010, which will maximize the amount of federal support the state can receive for providing this coverage. If your state is interested in pursuing this option, here are some key questions that can guide your efforts:

- If your state already provides state-funded coverage for some adults, how do the benefits compare with what would be required to convert this coverage to a Medicaid expansion?
- How much federal funding would this option draw down (using your state's current, non-ARRA-enhanced federal matching rate)?
- Even if your state can't expand to 133 percent of poverty immediately, can a case be made for phasing in coverage gradually (starting with the lowest-income adults and rising up the income scale)?
- Has your state considered expanding adult Medicaid coverage in the past using a waiver? What were the barriers, and does this new option make it easier to cover them now?

Endnotes

[1] See Section 2001(a)(2)(A) of the health reform statute (H.R. 3590), which amends Section 1902 of the Medicaid statute. The early expansion option is described in Section 1902 (k)(2).

[2] States with state-funded coverage for adults include (but are not limited to) Connecticut, the District of Columbia, Illinois, Minnesota, New Mexico, Pennsylvania, and Washington.

[3] Beginning in 2014, states may use asset tests only for determining Medicaid eligibility for individuals who are eligible because of other aid or assistance, elderly individuals, medically needy individuals, and individuals who are eligible for Medicare cost-sharing.

[4] Section 1937 of the Medicaid statute describes the benchmark benefits.

[5] Benchmark/benchmark equivalent plans must cover prescription drugs and mental health benefits in the early Medicaid expansion option effective April 1, 2010, and in all benchmark and benchmark equivalent benefit plans beginning on January 1, 2014.

[6] Individuals who are exempt from benchmark/benchmark equivalent benefits include pregnant women, dual eligibles, blind and disabled individuals, children in foster care, TANF and Section 1931 (mandatory) parents, women in the breast or cervical cancer eligibility categories, terminally ill hospice patients, some institutionalized populations, medically frail and special needs populations, beneficiaries who qualify for long-term care, and medically needy individuals and those who spend down to qualify for Medicaid.

Part of a series of fact sheets, issue briefs, and special reports designed to help the public understand the new health reform law.

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