HealthReformGPS
NAVIGATING IMPLEMENTATION
A project of the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation

# Update: The IRS' Final Shared Responsibility Regulations: When Does Medicaid Eligibility Amount to "Minimum Essential Coverage"?

By Sara Rosenbaum

## Introduction

On August 30, 2013, the IRS published final regulations implementing the shared responsibility provisions of the Affordable Care Act (78 Fed. Reg. 53646-53664). The regulations address, among other matters, the complex question of when Medicaid eligibility amounts to minimum essential coverage (MEC) for purposes of the Act's tax penalties. Because people with MEC are barred from receiving premium and cost sharing assistance for Marketplace plans, the final rules also have important implications in the area of health policy for children and adults with disabilities, who may need both basic insurance and supplemental Medicaid coverage for their more extensive health care needs. Many of Medicaid's most important disability-related eligibility categories are optional with states and, therefore, monitoring whether and how agency policy on when Medicaid counts as MEC will be an important issue to watch over time.

## Background

Under the Internal Revenue Code as amended by the ACA, 26 U.S.C. §5000A, individuals who have access to affordable health insurance but fail to maintain minimum essential coverage must make a "shared responsibility" payment in the form of a tax penalty, unless they qualify for an exemption (including various forms of hardship exemptions). The size of the tax penalty is pegged roughly to the price of health insurance but is subject to caps. When fully in effect, the minimum penalty, which starts at $95 for adults for the 2014 tax year, rises to $695 by 2016, with subsequent increases indexed to inflation. For higher income taxpayers, the penalty is capped at 2.5% of adjusted gross income beginning in 2016.

The IRS and HHS have joint responsibility for implementing the shared responsibility provisions, including defining what counts as minimum essential coverage as well as the scope of the exemptions from the penalty payment. Final HHS regulations issued on July 1, 2013 (78 Fed. Reg. 39494-39519) define the hardship exemption; the policies are mirrored in the final IRS rule as well. Health Insurance Marketplaces determine eligibility for penalty exemptions as part of their operational responsibilities.

Under the ACA, Medicaid constitutes a form of minimum essential coverage as a general matter. The problem, however, is that Medicaid does not consist of one monolithic eligibility category but instead encompasses a constellation of eligibility categories created over nearly 5 decades in order to respond to critical health care needs. As a result, there are many pathways to Medicaid eligibility, and Medicaid eligibility takes many forms. Some of the pathways are tied to poverty (e.g., low-income children, the new low-income adult category under the ACA, low-income Medicare beneficiaries). Others are tied to health condition (e.g., pregnancy). Still others are tied to health status, with numerous pathways tied explicitly to disability status.

Under certain eligibility pathways, Medicaid-eligible individuals are entitled to full coverage. This is the case for eligibility based on income, and usually for disability-based eligibility. In the case of other

eligibility pathways, Medicaid coverage may be limited to certain forms of medical assistance (e.g., eligibility only for pregnancy-related care or family planning services and supplies).

Furthermore, under current Medicaid policy, having private health insurance or Medicare does not bar Medicaid eligibility. Indeed, Medicaid can function either as an individual's primary insurance or as supplemental insurance and a secondary payer. Thus, Medicaid can supplement Medicare for elderly and disabled Medicare beneficiaries. Medicaid also can supplement employer coverage or other private insurance for children and adults whose disabilities mean that private insurance alone offers inadequate coverage. For example, a family whose child has a severe disability may be covered by an employer plan for all routine health care needs. But the child can also qualify for full Medicaid benefits, depending on state policy (such eligibility is a state option). For some of the child's needs, Medicaid will function as primary insurance (for example, for services that the employer plan usually does not cover such as a personal attendant). In other cases, Medicaid will function as a supplemental insurer, covering, for example, additional forms of therapy beyond what the family's employer plan covers.

In sum, deciding *which* Medicaid eligibility pathways amount to MEC and which do not is very important. When Medicaid amounts to MEC, an individual has satisfied the shared responsibility requirement. When it does not, the individual must obtain other coverage or qualify for a penalty exemption. When Medicaid *does not* amount to MEC, an individual would be entitled, if eligible based on income, for subsidized private coverage through an insurance Marketplace. If Medicaid *does* amount to MEC however, then the ACA's special anti-crowd out provisions would bar the individual from obtaining a private insurance subsidy. In other words, under Medicaid policy it would be perfectly acceptable for an individual to have private health insurance and to qualify for supplemental Medicaid coverage as well. But under ACA policy related to premium subsidies and cost-sharing assistance for Marketplace coverage, the presence of MEC-level Medicaid coverage would bar an individual from receiving subsidized Marketplace coverage.

Consequently, how a particular Medicaid eligibility pathway is classified for MEC purposes also determines whether insurance subsidies will be available in the Marketplace.

**The Final IRS Rules**

The final IRS regulations (26 C.F.R. §1.5000A-2) distinguish among a number of Medicaid eligibility pathways in determining when Medicaid does and does not amount to MEC. In so doing, the regulations also effectively determine which classes of Medicaid beneficiaries can receive subsidized Marketplace coverage, assuming of course that they meet the Marketplace eligibility threshold. For adult citizens this would be 100% FPL in states that do not expand Medicaid to cover all nonelderly low income adults and 138% FPL in states that do expand Medicaid. For children, the Marketplace threshold would be 138% FPL or a higher level based on states' Medicaid and CHIP eligibility policies.[1]

[1] Being CHIP eligible also would disqualify a child from receiving a Marketplace subsidy.

Under the final IRS regulations,[2] the following Medicaid eligibility categories will not qualify as MEC for purposes of the tax penalty:

- Optional Medicaid eligibility for family planning services (42 U.S.C. §1396a(a)(10)(A)(ii)(XXI));
- Optional Medicaid eligibility for tuberculosis-related services only (42 U.S.C. §1396a(a)(10)(A)(ii)(XII));
- Medicaid eligibility for pregnancy-related services only (42 U.S.C. §§1396a(a)(10)(A)(i)(IV) and 1396a(a)(10)(A)(ii)(IX)); and
- Medicaid eligibility limited to treatment of emergency medical conditions only (42 U.S.C. §1396b(v)).

Because people entitled to Medicaid under any of these limited-coverage eligibility categories will not be considered to have MEC for purposes of the tax penalty, they also may be able to qualify for Marketplace subsidies depending on their incomes. Examples would be pregnant women with MAGI-based incomes exceeding 138% FPL (or 100% FPL in non-expansion states),[3] or adults whose incomes exceed the Marketplace threshold in the state and who receive limited Medicaid benefits only for tuberculosis treatment and management. In effect, these individuals could have both Medicaid and subsidized private insurance coverage, because their Medicaid does not amount to MEC; consistent with federal Medicaid policy, Medicaid presumably would be acting as a secondary payer to private insurance.

In the case of Medicaid eligibility through the medically needy program (in which individuals qualify for coverage by incurring high health care costs; 42 U.S.C. §1396a(a)(10)(C)), the IRS notes in the Preamble to the final rules that the agencies have not yet made a final decision as to whether medically needy eligibility should qualify as MEC. (Typically, the medically needy have severe disabilities and "spend down" to receive long term institutional or community based care and services). The IRS also states in the Preamble that the agencies have not yet determined whether eligibility under an eligibility category recognized as part of a state's §1115 demonstration program (42 U.S.C. §1315) will count as MEC. In both instances the IRS indicates that the agencies are leaning toward classifying both categories as *not* amounting to MEC, meaning that persons covered either as medically needy or as demonstration-eligible beneficiaries also could receive subsidized private coverage through the Marketplace. The IRS indicates that further rulings will be forthcoming.

In the Preamble, the IRS also discusses at length how it intends to approach other special Medicaid eligibility categories that are typically tied to disability and that offer comprehensive coverage. In these cases, the agency states, it will consider Medicaid to amount to MEC. Children and adults covered under these categories will be considered as satisfying the shared responsibility requirement. They also will be

[2] 26 C.F.R. §1.5000A-5.

[3] The IRS notes that in some states pregnancy qualifies a woman for full Medicaid coverage, but in other states it does not. Because many states limit pregnancy-related coverage only to certain types of medical assistance (prenatal care, delivery, and post-partum services), the IRS considers Medicaid based on pregnancy not to constitute MEC. The IRS also notes that since women who have pregnancy-related Medicaid coverage would not necessarily know whether they have full or partial coverage, the agency will not impose any shared responsibility penalty in 2014 and will issue additional guidance on how to distinguish between partial and full coverage.

barred, effectively, from receiving subsidized private coverage, even if income-eligible, because they have MEC.

The eligibility categories affected by this decision are used by children and adults with severe disabilities. One example would be an adult with severe disabilities who works as a consultant and receives full coverage under a Medicaid home or community care demonstration program. In the absence of Medicaid, the adult would qualify for subsidized private health insurance. Another example would be a child with severe disabilities who lives in an otherwise-uninsured moderate-income working family and who receives full Medicaid coverage under one of the program's special eligibility categories for children and adults with very extensive health care needs. In the absence of Medicaid, the child, along with the rest of the family, could be expected to qualify for subsidized Marketplace coverage. Under Medicaid policy, the child or adult could have private health insurance and qualify for Medicaid. But under the ACA's premium subsidy policies, both would be barred from subsidized insurance through the Marketplace.

The disability-related eligibility categories affected by the IRS decision are as follows:

- 42 U.S.C. §1396a(e)(3), which extends eligibility to children with disabilities who require an institutional level of care, without regard to parental income;
- 42 U.S.C. §1396a(a)(10)(A)(ii)(XIX), an eligibility category for children with disabilities whose family incomes otherwise are too high (this eligibility category also provides premium assistance for employer coverage to families with access to such coverage, if the employer contribution is at least 50% of the family premium); and
- 42 U.S.C. §1396n(c), providing eligibility for home and community-based services to adults with disabilities.

In the IRS' view, because Medicaid is comprehensive under any of these categories, it would qualify as MEC. It also would *dis*qualify the individual from subsidized Marketplace insurance.

**Issues**

- *Remaining decisions about Medicaid beneficiaries whose eligibility is based on their medically needy status or participants in §1115 demonstrations.* The final rules leave both eligibility categories unaddressed, although as noted, the agencies seem to be leaning in the general direction of declaring both categories *not* to amount to MEC. It is unclear when the final decision will be made.

- *Medicaid's ongoing role as a supplemental insurer to private coverage in the case of children and adults with disabilities.* By classifying the various Medicaid disability-related eligibility categories as MEC, the agencies have clarified that persons eligible on this basis satisfy the ACA's MEC requirement. At the same time, because such coverage is treated as MEC, this means that these individuals are not entitled to subsidized private insurance through the Marketplace. Even though Medicaid policy would permit dual coverage, with Medicaid supplementing private insurance, the ACA's Marketplace subsidy system bars subsidies where MEC is available. The question thus becomes how both individuals and families will react, as well as how states will respond. Will families with children with disabilities or adults with disabilities pass up Medicaid in order to

qualify for subsidized private insurance? Will states begin to scale back, if not eliminate, optional Medicaid coverage for children and adults with disabilities (once the maintenance of effort period has passed) in order to be able to take advantage of subsidized private insurance? And what will any of these decisions mean for the sufficiency of coverage for children and adults with disabilities, for whom standard private insurance falls far short of what they need?

States might also scale back other optional eligibility categories such as those related to pregnancy or family planning. In this case, the subsidized insurance plans (qualified health plans, QHPs) offered through the Marketplace might be expected to offer comparable coverage, although with premium payments and potentially higher cost sharing. In the case of children and adults with disabilities, subsidized Marketplace plans could be expected to contain limitations and exclusions that restrict coverage to levels well below what is necessary, even with all of the ACA's insurance reforms. Understanding how the ACA's MEC and anti-crowd out policies eventually reshape Medicaid's role in the health insurance system will thus be one of the most important issues to watch, particularly in the case of children and adults with disabilities, for whom standard insurance alone is not enough.