



MEDICAID AND THE AFFORDABLE CARE ACT

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MEDICAID EXPANSION

Under the Affordable Care Act (ACA), states may expand their Medicaid coverage to single, low-income childless adults without disabilities and caretaker relatives.

Starting January 1, 2014, the federal government began reimbursing "expansion states" 100% for the coverage they provided to these newly eligible individuals. This reimbursement will gradually decrease to 90% by 2020.

Connecticut became the first state to receive federal approval to expand its Medicaid coverage to this population.

According to the Kaiser Family Foundation (KFF), as of December 2015, 30 states and the District of Columbia had expanded their Medicaid programs under the ACA. Expansion was under discussion in three additional states and 17 states had neither expanded nor were considering expansion.

on income deductions to modified adjusted gross income (MAGI) for certain Medicaid applicants.

ISSUE

What changes did the federal Affordable Care Act make to the Medicaid program?

SUMMARY

On March 23, 2010, President Barack Obama signed into law the federal Patient Protection and Affordable Care Act (Affordable Care Act or ACA). The law made sweeping changes to many aspects of the health care industry, including private health insurance and Medicaid requirements.

This report focuses on the ACA's changes to the Medicaid program. The most publicized change in the initial law was a new requirement that states provide Medicaid coverage to single, low-income childless adults without disabilities and certain caretaker relatives. This requirement became optional when the U.S. Supreme Court struck down the state Medicaid expansion mandate in 2012 (*NFIB v. Sibelius*, 567 U. S. _____, (2012)). Connecticut was the first state in the nation to expand coverage to this newly eligible population in 2010 and kept the coverage in place after the Supreme Court decision.

The ACA also changed the way states must calculate income eligibility from a system based



The ACA made several additional changes to the federal Medicaid program by, among other things:

1. establishing a new mandatory coverage group for young adults under age 26 who had been in foster care;
2. modifying how income is calculated for most Medicaid applicants to a formula based on modified adjusted gross income (MAGI);
3. making tobacco cessation services for pregnant women mandatory, instead of optional, benefits;
4. temporarily increasing primary care provider reimbursement rates to equal Medicare provider rates; and
5. authorizing preventive care grants to states to establish preventive health programs and encourage healthy behavior.

This [NCSL brief](#) provides a comprehensive list of the ACA provisions that affect Medicaid.

MEDICAID EXPANSION

Coverage for Previously Ineligible Single Adults

The ACA originally required all states to expand their Medicaid coverage to single childless adults under age 65 without disabilities and caretaker relatives.

Connecticut became the first state in the nation to expand Medicaid coverage to low-income childless adults under the ACA in 2010.

The U.S. Supreme Court struck down the expansion mandate as unconstitutional in 2012 (see [NFIB v. Sebelius](#), 567 U. S. ____, (2012) below), instead leaving states with the option to expand Medicaid coverage to this population. Connecticut kept its expansion coverage in place after this Supreme Court ruling.

The federal government generally reimburses states for 50% of their Medicaid costs. In those states that chose to expand Medicaid coverage, the federal government began reimbursing 100% of the cost for the expansion population in 2014. The federal reimbursement will gradually decrease to 90% by 2020.

NFIB v. Sebelius

In [NFIB v. Sebelius](#), 26 states and several other entities, including the National Federation of Independent Business, challenged the constitutionality of the ACA's individual mandate and the Medicaid expansion. (The "individual mandate" is the ACA requirement that all uninsured legal residents obtain health insurance or pay a

tax penalty.) The Supreme Court, in a narrow 5-4 decision, upheld the (1) individual mandate and (2) law's requirement that states expand their Medicaid programs to include low-income, childless adults by 2014 but eliminated the federal government's authority to penalize states that chose not to do so.

Former Foster Children

The ACA mandates Medicaid coverage for former foster children under age 26 who (1) are not otherwise Medicaid-eligible, and (2) were enrolled in Medicaid when they aged out of the foster care system. There is no income or asset test tied to Medicaid eligibility for these individuals. Connecticut expanded its coverage to include this population in January 2014.

MAGI

Prior to the ACA's implementation, states typically based Medicaid income eligibility on an applicant's income minus certain disregards. (Disregards enabled applicants to have higher incomes and still qualify for assistance because states disregard a portion of the income.) Under the ACA, states instead base eligibility on the applicant's MAGI, which is an individual's (or couple's) total income reported to the Internal Revenue Service plus tax-exempt interest and foreign earned income.

Under the ACA, 5% of an individual's income must be disregarded (i.e., not counted towards the income limit), which means that an individual may have income that was 5% more than the 133% federal poverty limit (FPL) income cap and still qualify because the excess 5% income would be disregarded. Using current poverty guidelines, an individual could meet the 133% of the FPL limit (\$15,654 annually or \$1,305 per month) if his or her income was 5% higher (\$16,243 annually or \$1,354 per month).

The ACA also prohibits states from using an asset test for Medicaid eligibility determinations for the groups affected by the MAGI provision.

The traditional Medicaid income calculations still apply for certain exempted groups, including:

1. individuals eligible for Medicaid through another program (categorically eligible, e.g., foster care, Supplemental Security Income);
2. elderly or Social Security Disability Insurance program beneficiaries;
3. the medically needy; and
4. enrollees in the state's Medicare Savings Program.

OTHER CHANGES

Family Planning

Prior to the passage of the ACA, states were required to provide coverage for family planning services to Medicaid recipients. The ACA gave states the option to amend their Medicaid state plans to provide expanded family planning coverage to individuals who were not pregnant and were otherwise ineligible for Medicaid. The Department of Social Services (DSS) implemented a limited family planning coverage group in March 2012 that provided those services to individuals not otherwise eligible for Medicaid and whose income was up to 250% of the FPL. In January 2014, the income limit for those services increased to 258% of the FPL.

Tobacco Cessation

The ACA requires states to provide comprehensive tobacco cessation services to pregnant Medicaid recipients, including counseling and pharmacotherapy (i.e., tobacco cessation drugs), without recipients paying for any portion of the cost.

Connecticut began covering pharmacotherapy coverage for pregnant recipients in October 2010 and expanded to counseling services for these recipients in December 2010. DSS expanded these services to all Medicaid recipients in January 2012.

Primary Care Provider Reimbursement

For the 2013 and 2014 calendar years, the ACA increased Medicaid reimbursement rates for primary care services provided by physicians who specialize in family medicine, general internal medicine, or pediatric medicine. The increase made reimbursement rates for those services equivalent to the rates providers receive from Medicare Part B patients. For those calendar years, the federal government reimbursed states 100% for the payment increases. For FY 15, the state legislature appropriated funds to continue to reimburse Medicaid primary care providers at an increased rate, though at a reduced rate from that provided during FYs 13 and 14.

Preventive Care Grants

The ACA also authorized grants to states to encourage Medicaid recipients to participate in preventive health programs and adopt healthy behaviors. DSS received a five-year grant under the program and used it to launch the "Connecticut Rewards to Quit" program in 2013. Under the program, local mental health authorities, federally qualified health centers, and primary care offices help Medicaid recipients quit tobacco use by providing to program participants tobacco cessation counseling and training sessions, as well as peer coaching and tobacco cessation techniques.

Participants receive financial incentives from the program (up to \$350 per 12-month enrollment period) for staying enrolled and achieving certain milestones.

RESOURCES

CMS Guidance on Coverage of Former Foster Care Children (December 2013), available at: <http://www.medicaid.gov/state-resource-center/downloads/medicaid-and-chip-faqs-coverage-of-former-foster-care-children.pdf>

CMS Guidance on Tobacco Cessation Services (June 2011), available at: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11-007.pdf>

CMS Model Summary: Medicaid Incentives for the Prevention of Chronic Diseases Model (August 2015), available at: <https://innovation.cms.gov/initiatives/MIPCD/index.html>

KFF Issue Brief on Medicaid Family Planning Services (July 2015), available at: <http://files.kff.org/attachment/issue-brief-medicaid-and-family-planning-background-and-implications-of-the-aca>

KFF Summary of Medicaid Expansion States (December 2015), available at: <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

NCSL Brief: States Implement Health Reform (June 2011), available at: <http://www.ncsl.org/documents/health/HRMedicaid.pdf>

NFIB v. Sebelius, 567 U. S. ____, (2012), available at: <https://www.law.cornell.edu/supremecourt/text/11-393>

OLR Report 2010-R-0279, OLR Background: Medicaid Provisions in Federal Health Reform – Implications for Connecticut, available at: <https://www.cga.ct.gov/2010/rpt/2010-R-0279.htm>

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