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ResearchReport

Medicaid Expansion Debate

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February 2, 2021 | 2021-R-0042

Issue

This report discusses Connecticut's decision to expand Medicaid to low-income adults as authorized under the federal Affordable Care Act.

Summary

As originally enacted in 2010, the Affordable Care Act (ACA) required states, by 2014, to extend Medicaid coverage to childless adults with incomes up to 133% of the federal poverty level (FPL). The act allowed states to begin coverage as early as April 1, 2010. A 2012 U.S. Supreme Court decision made the expansion optional for states.

Connecticut implemented its Medicaid expansion in two phases. First, the state transferred State Administered General Assistance medical assistance (SAGA-medical) to Medicaid in 2010, creating the Low-Income Adult program (LIA). SAGA-medical was largely state-funded and provided coverage to childless adults between the ages of 19 and 64 with low incomes (approximately 60% of the FPL). Secondly, in 2013 and 2014, the state replaced the LIA program with a new coverage group with the higher income limit authorized under the ACA (133% of FPL). The new coverage group provided coverage to some residents who may have been enrolled in or eligible for the Charter Oak Health Plan, which the state eliminated as it expanded Medicaid.

Generally, legislation implementing these phases was budgetary, passed through emergency certification processes, and sometimes required executive branch actions that had already occurred in practice. As a result, public hearing testimony and floor debate on Connecticut's Medicaid expansion is limited. Furthermore, the state began implementing the Medicaid expansion before the U.S. Supreme Court made doing so optional for states. While other states debated whether to proceed with a Medicaid expansion in the years following the decision, Connecticut had already begun.

Arguments for implementing the Medicaid expansion were also generally budgetary in nature. Because Medicaid is jointly funded by the state and federal government, moving SAGA-medical, a largely state-funded program, to Medicaid in 2010 allowed the state to use a larger proportion of federal funds to provide coverage for this group. In fact, before Congress passed the ACA, the state legislature had repeatedly required the Department of Social Services (DSS) to request a federal waiver to move SAGA-medical to Medicaid. The later part of the expansion similarly allowed the state to provide benefits to former Charter Oak Health Plan participants, using state and federal Medicaid funds.

There was significant debate around a 2012 effort to apply to the Centers for Medicare and Medicaid Services (CMS) for an 1115 waiver to apply an asset test to the LIA coverage group and count certain parental income and assets for individuals ages 19 through 25. State agencies, including DSS and the Office of Policy and Management (OPM), argued the asset test would provide a cost-effective and sustainable approach to providing Medicaid coverage to low-income childless adults until the ACA's provisions were fully implemented. Advocates testified in opposition, arguing that the asset test would result in the loss of Medicaid coverage for many low-income people. The Appropriations and Human Services committees declined to vote on the waiver. In March 2013, CMS rejected it.

Before the Affordable Care Act

For several years, the state legislature considered making the state-funded SAGA program a Medicaid-funded coverage group (entitling the state to a 50% federal match for its expenditures). Before the ACA, the state would have needed a federal waiver to do this since, traditionally, Medicaid had not paid for childless adults who are not elderly or living with disabilities.

Most testimony on these bills was in support of this idea. For example, testimony in 2009 on SB 988 included support from the Connecticut Behavioral Health Partnership Oversight Council, the Connecticut Hospital Association, and the Permanent Commission on the Status of Women. Other groups (Connecticut Voices for Children, the National Alliance on Mental Illness, and the New Haven Legal Assistance Association) also expressed support for the idea, but were concerned about a requirement that the waiver be a Health Insurance Flexibility and Accountability (HIFA) demonstration waiver. They testified that HIFA waivers may require or encourage the state to limit coverage or impose new costs on existing beneficiaries.

That same year, the legislature passed a law requiring DSS to seek an 1115 demonstration waiver (not a HIFA waiver) and included reporting and legislative oversight provisions. (An 1115 waiver generally seeks to waive Medicaid requirements to allow states to experiment with policies that otherwise would not be permitted.) The law generally required DSS to apply for the waiver or report to the Appropriations and Human Services committees by February 2010 (PA 09-5, September Special Session (§ 55)).

Early Expansion through the Affordable Care Act

The ACA created a path for states to provide Medicaid coverage to childless adults. As originally enacted, the law (1) required states to expand Medicaid coverage by 2014 for all adults up to age 65 with incomes up to 133% of the FPL and (2) allowed states to do so as early as April 2010.

Beginning in 2010, the state legislature passed several bills to transfer SAGA medical assistance recipients to Medicaid, while the executive branch also proceeded with the transfer. PA 10-3 (§ 23) required DSS to submit a state plan amendment (SPA) to CMS to extend Medicaid coverage to SAGA enrollees; in practice, DSS had already submitted the SPA on April 6. CMS approved it June 21. PA 10-1 June Special Session (§ 23) further implemented the transfer by, among other things, appropriating SAGA funds to the state's Medicaid account. PA 11-44 (§ 116) allowed the DSS commissioner to establish an alternative benefit package for this group. All of these acts were budgetary (either budget implementation acts or deficit mitigation acts) and approved through emergency certification processes. As a result, there is no testimony on these provisions and little mention of them in floor debate.

Public documents and comments also suggest that budget impacts drove the debate. For example, in its initial February 2010 report, the Commission on Enhancing Agency Outcomes recommended providing coverage to the SAGA population under Medicaid in its initial report and estimated that doing so would save $36.8 million annually. On June 21, 2010, when CMS approved the SPA, Governor Rell described the expansion as follows: "For many years, Connecticut has provided state assistance to ensure that our most vulnerable adults have access to health care. Now with this federal help, we will be able to provide increased medical benefits for them through Medicaid while relieving the burden on state taxpayers."

As described by CMS in the 2010 press release, Connecticut would receive the regular federal Medicaid matching rate (50%) for this new coverage starting April 1, 2010, which would save the state at least $53 million by July 2011. Beginning January 1, 2014, the federal government would (1) require states to expand their Medicaid programs to cover low-income individuals with incomes up to 133 % of the FPL and (2) pay 100% of the costs related to the new eligibility group for three years, at which point the matching rate would decline gradually to 90%, where it would remain indefinitely.

Related Debates

Asset Test

In 2012, the state attempted to implement an asset test for the LIA coverage group at a time when the state was still covering half the costs to provide Medicaid to this group. (Under the ACA, the enhanced federal match did not apply until the expansion requirement became effective in 2014.) In June 2012, the legislature approved a budget that included savings from applying the asset test

(PA 12-104). In the days that followed, DSS sent a letter to enrollees notifying them of the policy change and the legislature reconvened in special session to approve legislation implementing the budget (PA 12-1, June 12 Special Session).

The process to implement the asset test provision was controversial, as reported in the Connecticut Mirror. Legislators criticized the process, noting that DSS had sent the letter to LIA enrollees before the legislature voted on budget implementation language and arguing that the agency was improperly cutting legislators out of the process. Legislators also stated that enrollees could not reach DSS to ask questions about the policy change due to insufficient staff and full voicemail boxes, and that a related public hearing was not sufficiently advertised.

The asset test itself also prompted debate. DSS applied to CMS for an 1115 demonstration waiver to (1) impose a $10,000 asset limit and (2) count parental assets and income above 185% of the FPL for individuals age 19 through 25 who live with their parents (or are claimed by one or both parents as a tax dependent). State law requires the department to submit applications for federal waivers to the Appropriations and Human Services committees before submitting them to CMS. The committees must hold a hearing and advise the commissioner of their approval, denial, or modifications, if any. If the committees do not advise the commissioner within a specified time period after receiving the proposed waiver, it is deemed approved (CGS § 17b-8).

The committees held a joint hearing on July 24, 2012. DSS testified that the LIA program had seen dramatic and unanticipated growth, both in numbers of clients and program expenditures, arguing that the asset test would manage growth in both. The department noted that it believed that the Medicaid program was not intended to crowd out private health insurance coverage and the waiver would study whether eliminating the asset test for the early expansion population had created an unintended incentive for individuals and families with dependents under age 26 to forgo private coverage and seek coverage under Medicaid. The department also argued that the LIA program provides access to long-term care, but traditionally federal law has required asset tests and cost sharing for long-term care, and so the asset test could assess whether LIA eligibility rules are at cross-purposes with eligibility rules for populations seeking long-term care (i.e., the aged, blind, or living with disabilities coverage group under HUSKY C). OPM submitted similar testimony in support of the waiver, arguing that it would provide a cost-effective and sustainable approach to providing Medicaid coverage to low-income childless adults until the ACA's provisions are fully implemented. The Department of Mental Health and Addiction Services (DMHAS) testified in support, stating that the department provided services to 36,000 clients in the program and would work closely with affected individuals to assess whether they were eligible for other coverage. DMHAS believed that the $10,000 asset limit would not eliminate individuals from the department's system of care.

Several advocacy groups testified in opposition to the waiver, including Connecticut Voices for Children, Connecticut Association of Non-Profits, Greater Hartford Legal Aid, New Haven Legal Assistance Association, and the National Alliance on Mental Illness. Among other things, groups

argued that the waiver would terminate coverage for many needy low-income individuals and further strain the department's resources to make prompt eligibility determinations. They also argued that because parents have no legal liability for adult children, young adults may be disqualified even if they do not have access to private insurance through their parents. Noting that the coverage group would be federally funded in 2014, groups argued that it was unnecessary to make disruptive cuts for a year of uncertain savings.

Groups representing Medicaid providers also submitted testimony. The Connecticut Hospital Association testified in opposition, noting that Medicaid eligibility cuts generally negatively impact hospitals. The Connecticut Association of Health Care Facilities and Leading Age testified in support of the department's decision to omit from the waiver a proposed 90-day limit on nursing facility benefits for LIA enrollees.

As reported in the Connecticut Mirror, the committees adjourned their meeting without a vote, allowing the waiver to be eventually deemed approved. However, in March 2013, CMS rejected the waiver, stating that the agency "determined that Connecticut's demonstration proposal is not likely to assist in promoting the objectives of title XIX [federal Medicaid statutes] and, therefore, cannot be approved. As described in the state's proposal, the demonstration would eliminate coverage for as many as 13,381 very low-income individuals for an approximate one year period, which is not consistent with the general statutory objective to extend coverage to low-income populations."

Supreme Court Makes Expansion Optional

In 2012, the U.S. Supreme Court issued a decision that, among other things, limited the Department of Health and Human Services' ability to enforce the Medicaid expansion requirement, essentially making the expansion optional for states (*National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012)). In some states that had not begun implementing the expansion, debate ensued over whether to proceed.

The state generally considered the expansion in budgetary bills, with no public hearing testimony and limited floor debate, but public statements and articles from that time may reflect some of the debate. In a March 2013 Forbes article, a Senior Fellow from the Foundation for Government Accountability argued that Connecticut's experience with attempting to implement an asset test "should prove that there are underlying fiscal issues with Medicaid. These pitfalls transcend party lines, regardless of who is paying the bills, and they highlight the heavy hand D.C. retains by denying state flexibility." According to the article, states, including Connecticut, also struggled to comply with new regulations related to the ACA.

In an April 2013 report, Connecticut Voices for Children argued that "Connecticut should take swift action to expand Medicaid to the low-income childless adults soon eligible for coverage under the ACA – as Governor Malloy proposes in his FY 2014-2015 biennial budget. The significant expansion of coverage and the attendant benefits to the health of those who become insured, coupled with

minimal direct cost to the state that will result in savings of hundreds of millions of dollars relative to current policy, make this a bargain for Connecticut. Through a crucial part of health reform, the LIA Medicaid expansion is only one component of what should be viewed as a comprehensive, holistic effort to implement the Affordable Care Act in Connecticut."

Connecticut continued with its Medicaid expansion, largely in budgetary legislation. In 2013 and 2014, the state replaced the LIA program with the new coverage group of single individuals with income up to 133% of the FPL (PA 13-184 (§§ 67-69) and PA 13-234 (§§ 102, 103 & 156)). The state also eliminated the Charter Oak Health Plan as it expanded Medicaid (PA 13-234 (§§ 86, 87, 90-93, 118, 119 & 156)).

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