



## LONG-TERM CARE IN BRIEF: EXPLAINING THE MEDICAID EXPANSION: THE NEW MANDATORY MEDICAID ELIGIBILITY GROUP

### HR 3590, Sec. 2001, Medicaid Coverage for the Lowest Income Populations

*The Patient Protection and Affordable Care Act (The Affordable Care Act), signed into law on March 23, 2010, includes a provision requiring states to create a new mandatory Medicaid eligibility group based on income by January 1, 2014 (HR 3590, Sec. 2001). The new law provides a national floor for Medicaid coverage, eliminates the exclusion of childless adults from coverage, reduces the current eligibility variation from state to state, and provides states with new federal resources to fund the expansion.*

**In 2014, who will be newly eligible for Medicaid?** The Affordable Care Act creates a new mandatory eligibility group that expands Medicaid to include childless adults with incomes at or below 133 percent of the Federal Poverty Level (FPL); \$14,404 for an individual, or \$29,326 for a family of four, in 2009. These new eligibles will be covered by a benchmark benefit plan. Individuals who are eligible for Medicaid through another mandatory eligibility group, who are entitled to, or enrolled in, Medicare Part A, or who are enrolled in Medicare Part B, are excluded from the Medicaid expansion.

**How will income eligibility be determined?** In 2014, the Modified Adjusted Gross Income Standard (MAGI) that will be used to determine eligibility for the premium tax credits available in the Exchanges will also be used to determine eligibility in Medicaid and CHIP. The MAGI will apply to newly-eligible individuals, as well as to most existing Medicaid eligibility groups, with exceptions for the elderly, foster children, low-income Medicaid beneficiaries and those receiving SSI. A standard five percent income disregard will be built into the gross income test for Medicaid to compensate for the loss of other, existing Medicaid disregards, and to streamline the process states use for determining eligibility (HR 3590, Sec. 2002, as modified by HR 4872, Sec. 1004).

**What benefits will the new eligibles receive?** These newly-eligible individuals will be covered by a “benchmark benefit” plan unless the individual is exempt from such coverage. Benchmark benefit packages were created by the DRA, as defined by Section 1937 of the Social Security Act. Some individuals who enroll in the 133 group are excluded from the benchmark packages and would receive full Medicaid benefits. On January 1, 2014, benchmark plans will be expanded to include the “essential health benefits package” found in Section 1302 of The Affordable Care Act. The services available under the essential health benefits package will be defined by the Secretary of Health and Human Services, but must include at least 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, chronic disease management, and pediatric services.

**What coverage options are available for individuals above 133 percent FPL?** States have the option to expand Medicaid coverage above 133 FPL, up to the highest income eligibility level in the state’s Medicaid program, either through the state plan or a waiver. If a state chooses to expand beyond 133 FPL, it can phase-in coverage based on either income level or categorical groups. However, the state must provide coverage to individuals with lower incomes before it expands coverage to individuals with higher income within the same category. Additionally, individuals and families who are not eligible for federal programs, such as Medicaid and



CHIP, will be able to purchase insurance through state-based Exchanges. Individuals and families meeting the income requirements will be eligible to receive premium subsidies to make coverage in the Exchange more affordable. Specifically, tax credits will be available to help individuals and families with incomes between 133 and 400 percent FPL purchase insurance through the Exchange. Also through the Exchange, cost-sharing subsidies will be available to help limit out of pocket expenses for those with incomes between 100 and 400 FPL.

**What are the MOE requirements for existing Medicaid coverage?** Those eligible for Medicaid on March 23, 2010, will continue to be eligible for coverage. The maintenance of effort (MOE) with respect to these beneficiaries prevents states from establishing more restrictive eligibility requirements than those in effect on the date of enactment. This requirement is in effect with respect to adults until the Exchanges are operational, and until 2019 for children.

**What are the MOE exceptions?** However, from 2011 through 2013, if a state has expanded coverage to non-pregnant, non-disabled adults above 133 percent FPL, it may reduce the FPL to 133 if it can demonstrate that it has a budget deficit in the current fiscal year, or that it will have a deficit in the succeeding fiscal year. States can also transition individuals from waivers to the state plan, or can expand coverage, during the MOE period.

## IMPORTANT DATES

<b>January 1, 2014</b>	<b>Medicaid must be expanded to include the new category of beneficiaries</b>
<b>2011-2013</b>	<b>States may be eligible for exemption from the MOE requirements</b>