NSCLC

National Senior Citizens Law Center

Protecting the Rights of Low-Income Older Adults

Special Report

Monitoring Health Care Reform Implementation

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The passage of the Affordable Care Act (ACA) directed sweeping reforms to the nation's health care system. However, the enactment of the legislation in March 2010 only represented the beginning of a lengthy and challenging process to improve the health care system. While the federal government has already taken steps to implement provisions of the ACA, the responsibilities will increasingly move towards state governments in the years ahead. As such, there is still much important work to do for both national and state advocates. Through a series of "Health Alerts," NSCLC aims to provide important updates and guidance to legal advocates in order to more effectively monitor implementation. This alert highlights three developing issues.

Medicaid Maintenance of Effort Requirement

One of the main goals of the ACA is to expand coverage to the uninsured. A major component of this is to expand Medicaid to low-income people under the age of 65 who make less than 133% of the federal poverty level (FPL) in 2014.[1] At the same time, the ACA also steps in to protect those adults insured by Medicaid at the time of the ACA's passage until Medicaid's eligibility standards expand nationally and the state health insurance exchanges (see below) become operational.[2]

The Medicaid "maintenance of effort" (MOE) provision aims to hold coverage steady for low-income individuals. This requires a state to maintain its Medicaid eligibility standards, as well as application and renewal procedures that were in place as of March 23, 2010, in order to prevent states from making it more difficult to enroll in Medicaid.[3] The Medicaid MOE provision will expire when the Secretary of the Department of Health and Human Services (HHS) determines that a state established exchange has become fully operational.[4] Based on the ACA's requirements, this will likely be January 1, 2014, but may vary depending if an exchange is fully operational prior to or later than this date.[5]

In providing guidance about the MOE provision, The Centers for Medicare and Medicaid Services (CMS) has interpreted it broadly to forbid changes in the frequency of re-eligibility determinations, irregular increases in premiums or enrollment fees, as well as more restrictive income or resource standards.[6] This MOE provision in the ACA continues a trend of recent government action to promote continued Medicaid coverage during the economic recession. Medicaid is funded jointly by the federal government and states, with the federal government's contribution, federal medical

1 ACA §2001(a); There is also a standard 5% of income disregard that effectively raises the limit to 138% of FPL.

2 ACA §2001(b).

3 Centers for Medicare & Medicaid Services, "Re: Maintenance of Effort" (Feb. 2011), *available at https://www.cms.gov/smdl/downloads/SMD11001.pdf*.

4 *Id.*

5 *Id.*

6 Centers for Medicare & Medicaid Services, "August 19, 2009 Letter to State Medicaid Director," *available at http://www.dhcs.ca.gov/Documents/Attachment5.pdf*.

assistance percentage (FMAP), varying based on a state's per capita income.[7] The American Recovery and Reinvestment Act (ARRA) of 2009 previously included a temporary FMAP increase through the end December 31, 2010, that conditioned state receipt of these funds on an MOE provision.[8]

However, as with other significant aspects of the ACA, congressional Republicans are seeking to repeal the MOE provision and permit states to restrict eligibility standards for Medicaid.[9] While this legislation is expected to pass in the Republican-controlled House of Representatives, it would face significant hurdles in the Democratic-controlled Senate.[10] At the same time, advocates are concerned about the potential for this to become a bargaining chip in the looming debate over how and when Congress will raise the nation's debt ceiling.[11] Repealing the MOE provision would almost certainly negatively impact the low-income elderly and those with disabilities.[12] The Congressional Budget Office (CBO) projected that this would result in a decrease of Medicaid enrollment of roughly 133,000 in 2013.[13] As such, the fight to protect this MOE provision must remain central during the next few months.

Temporary High-Risk Insurance Pools

The ACA also expands health insurance coverage through requiring individuals to purchase coverage and increasing the regulation of the private insurance market. Starting in 2014, the ACA bans insurance plans from excluding coverage based on a pre-existing condition.[14] In order to help those individuals before 2014 who have been unable to secure insurance due to this discrimination, the ACA established temporary high-risk pools that are already in place and operational.

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7 Chris L. Peterson, Congressional Research Service, "Medicaid: The Federal Medical Assistance Percentage (FMAP)" (Mar. 2010), at 1, *available at* *http://www.ncsl.org/documents/health/MAFMAP.pdf*.

8 *Id.* at 9-10. The ARRA MOE provision forbid states from enacting more restrictive Medicaid standards than those in place on July 1, 2008. The Education, Jobs, and Medicaid Assistance Act of August 2010 extended ARRA's FMAP/MOE provision through June 30, 2011. *See* Centers for Medicare and Medicaid Services, "FMAP Extension Guidance" (Aug. 2010), *available at* *https://www.cms.gov/apps/docs/08-18-10-cmcs-informational-bulletin-FMAP-Extension-Guidance.pdf*.

9 Mary Agnes Carey & Phil Galewitz, Kaiser Health News, "GOP Pushes to Let States Reduce Medicaid Rolls" (May 23rd, 2011), *available at* *http://www.kaiserhealthnews.org/Stories/2011/May/24/medicaid-maintenance-of-effort-republicans.aspx*.

10 *Id.*; The State Flexibility Act has been introduced in both the House and the Senate. The House version, sponsored by Rep. Phil Gingrey (R-GA), has already been voted out of the House Energy and Commerce Health Subcommittee. The Senate version was sponsored by Sen. Orrin Hatch (R-UT).

11 *Id.*

12 Judith Solomon, Center on Budget and Policy Priorities, "Repealing Health Reform's Maintenance of Effort Provision Could Cause Millions of Children, Parents, Seniors, and People With Disabilities To Lose Coverage" (Feb. 2011) at 1, *available at* *http://www.cbpp.org/files/2-10-11health.pdf*.

13 Congressional Budget Office, "Cost Estimate: H.R. 1683- State Flexibility Act" (May 2011), at 3, *available at* *http://www.cbo.gov/ftpdocs/121xx/doc12184/hr1683.pdf*.

14 ACA § 1201 (amending the Public Health Service Act).

The ACA outlined guidelines for these pools, officially known as the Pre-Existing Condition Insurance Plan, such that either individual states of the federal government could operate the program.[15] There are basic eligibility requirements for the program's minimum benefits and cost-sharing, and individuals are only eligible if they have a pre-existing condition and have not had creditable health insurance for the previous six months.[16] These pools will expire in January 1, 2014, at which point participants will transition to coverage in the state exchanges.[17]

Participation in the high-risk pools has increased recently to 18,000 nationwide, but enrollment still falls below initial estimates.[18] While high premiums and lack of awareness have been cited for the lower than expected participation in the pools, the federal government and states recently expanded their outreach and lowered rates to attract more participants.[19] On May 31st, HHS lowered the premiums by 40% in 18 states and eased the paperwork requirements for applicants.[20] It is important to note that these high-risk pools are only temporary measures designed to serve as a "bridge" until private insurance market regulations become fully implemented in 2014.[21] Thus, while these high-risk pools may be costly, they have the potential to serve a crucial role to help individuals who need insurance now and have been unable to gain coverage for several months.

State Exchanges

American Health Benefit (AHB) Exchanges serve as the backbone for reforming the private insurance market under the ACA. Exchanges act to help supervise insurance plan marketing and competition, through regulating insurers and assisting consumers understand different plans.[22] As the exchanges must provide a website and telephone assistance, they will act similarly to travel websites in helping consumers shop for medical coverage.[23] As discussed above, the new insurance market regulations that the exchanges will impose includes banning exclusion for coverage due to pre-existing conditions.

15 The Henry J. Kaiser Family Foundation, "Explaining Health Care Reform: Questions About the Temporary High-Risk Pool" (July 2010), at 1, *available at* http://www.kff.org/healthreform/upload/8066.pdf.

16 *Id.*

17 *Id.* at 2.

18 Phil Galewitz, Kaiser Health News, "High-Risk Health Coverage Pools Grow By 6,000 Enrollees" (May 6th, 2011), *available at* http://www.kaiserhealthnews.org/Stories/2011/May/06/high-risk-pool-health-insurance-low-enrollment.aspx.

19 *Id.*

20 Megan McCarthy, National Journal, "U.S. Lowers Premiums for High-Risk Insurance Plan" (May 31, 2011), *available at* http://www.nationaljournal.com/healthcare/u-s-lowers-premiums-for-nobr-high-risk-nobr-insurance-plan-20110531.

21 Galewitz, *supra* note 18.

22 The Henry J. Kaiser Family Foundation, "Explaining Health Care Reform: What are Health Insurance Exchanges" (May 2009), at 1, *available at* http://www.kff.org/healthreform/upload/7908.pdf.

23 Guy Gugliotta, Kaiser Health News, "Minnesota GOP Between a Rock and Hard Place on Health Exchange Options" (May 16th, 2011), *available at* http://www.kaiserhealthnews.org/Stories/2011/May/17/minnesota-health-exchange.aspx?p=1.

The exchanges also provide subsidies to help individuals afford to purchase insurance. Individuals with incomes between 138% and 400% of the FPL are eligible to receive tax credits to offset insurance costs, and those who earn between 138% and 250% of FPL are also eligible for additional reduced cost-sharing.[24] The ACA streamlines enrollment to ensure individuals are screened for all relevant health subsidy programs.[25] Only "qualified health insurance" may be offered through the exchange, which means the plans must comply with the ACA's insurance market regulations and cover essential benefits.[26] Based on the average amount of medial costs covered by the plan (actuarial value), plans will be categorized as platinum, gold, silver, or bronze.[27]

The ACA requires that each state establish an exchange by 2014, which will serve both the individual and small group markets.[28] A state may also choose to adopt a regional exchange with other states.[29] The CBO estimates that roughly 24 million people will purchase coverage through the exchanges by 2019.[30] While the ACA provides broad guidelines and grants for states to create exchanges, if states fail to have a plan by 2013 that demonstrates their exchange will meet the relevant standards and be operational by January 1, 2014, then the federal government will step in to develop their exchange.[31]

This deadline for state action has sparked legislative activity and debate in statehouses across the nation. Currently, only four states have enacted legislation to create exchanges: California, Maryland, West Virginia, and Washington.[32] However, opponents to the ACA in a number of states, both Governors and state legislators, have been successful in delaying the implementation of the exchanges.[33] Tactics ranged from passing legislation to bar states from setting up exchanges

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24 The Henry J. Kaiser Family Foundation, "Determining Income for Adults Applying for Medicaid and Exchange Coverage Subsidies: How Income Measured With a Prior Tax Return Compares to Current Income at Enrollment" (March 2011), at 1, *available at* http://www.kff.org/healthreform/upload/8168.pdf.

25 *Id.* at 2.

26 Timothy Stotzfus Jost, The Commonwealth Fund, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues" (July 2010), at 1, *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf. HHS will provide the definition of essential benefits via regulations.

27 *Id.* at 12. Platinum covers the most medical costs, gold the second most, and so forth.

28 The Henry J. Kaiser Family Foundation, "A Profile of Health Insurance Exchange Enrollees" (Mar. 2011), at 1, *available at* http://www.kff.org/healthreform/upload/8147.pdf. States can choose whether to have a separate Small Business Health Options Program (SHOP) Exchange, which can be merged with the AHB Exchange, or offered separately.

29 *Id.*

30 *Id.*

31 Guy Gugliotta, Kaiser Health News, *supra* note 19.

32 *See* Mike Baker, The Seattle Times/ Associated Press, "Washington State Preps for Federal Health Law, " (May 11th, 2011), *available at* http://seattletimes.nwsource.com/html/localnews/2015028940_apwahealthcarelegislation1stldwritethru.html. Prior to the ACA, Massachusetts and Utah already had been utilizing exchanges to assist their residents obtain insurance.

33 *See* Sarah Kliff, Politico, "Tea Party Find Success Blocking Reform"" (March 30th, 2011), *available at* http://www.politico.com/news/stories/0311/52231.html.

to Governors announcing their refusal to sign pro-exchange legislation.[34] Many states still have exchange legislation pending and winding through the legislative process.

For advocates tracking the development of state legislation, there may be hidden benefits behind the opposition to establishing exchanges. Since the federal government must step in to create an exchange if a state fails to do so, they have the ability to set up more robust and active exchanges than a conservative state would. As such, individuals who want greater assistance in shopping for insurance plans and stronger market regulations might ultimately fare better if state inaction forces the federal government to step in. Thus, Republicans in states such as Minnesota are considering steps to create minimal exchanges in order to limit the federal government's role.[35]

Conclusion

The brief discussion of these issues demonstrates the challenges of health care reform implementation, and the need for advocates to remain engaged in the months and years ahead. While Congress will continue debate over repealing provisions of the ACA or cutting funding, as long as President Obama remains in the White House, the ACA's foundation will remain largely intact. However, states will begin to play an increasingly important role in implementing provisions of the ACA that have a direct impact on members of your communities. NSCLC will continue to track relevant legislation and regulations to help advocates keep track of these significant developments.

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation and the education and counseling of local advocates, we seek to ensure the health and economic security of older adults with limited income and resources, and access to the courts for all.

34 *Id.*; Republican Governors in Georgia, Idaho, Texas, New Mexico, and Louisiana have adopted actions or made statements to oppose implementation of the exchanges.

35 Guy Gugliotta, Kaiser Health News, *supra* note 19.