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Medicaid Matters: States Weigh Medicaid Expansion Options

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In late June of 2012 the Supreme Court overturned the "Medicaid Expansion Penalty" that required each state to expand its Medicaid eligibility requirements on January 1, 2014 to include all non-elderly persons with incomes below 133% of the federal poverty level (FPL) or else risk losing that state's entire federal matching funds for Medicaid. *National Federation of Independent Business v. Sebelius* [PDF] effectively made sweeping Medicaid expansion in the Patient Protection and Affordable Care Act (PPACA) optional. Three months after *National Federation of Independent Business* and 15 months before the January 2014 deadline, health care facilities need to assess how their respective states are approaching Medicaid and plan accordingly.

Medicaid expansion was touted as both a significant federal expense and a means of controlling health care spending when the Patient Protection and Affordable Care Act was enacted in April 2010. CMS estimated that the expansion would cost the federal government $410 billion from 2014-2019. A more recent estimate [PDF] from the Congressional Budget Office noted that the Medicaid expansion (pre-*National Federation of Independent Business*) was projected to cost $931 billion from 2012-23. It was expected that these new Medicaid beneficiaries would more likely seek primary and non-emergency care which would prevent those people from developing more costly health care conditions in the future. These beneficiaries would also seek care from facilities other than hospital emergency departments, resulting in a lowering of overall health care expenditures because the health care services would be provided in a less costly setting like a physician's office or clinic.

Many states are considering whether to opt in or have determined not to opt in. Other states have determined to opt in to the Medicaid expansion.

For those states that have decided not to opt in or are considering their options, many have weighed, or are weighing, financial, legislative, and political concerns. Although the federal government will pay for 100% of the initial increase in Medicaid for the first three years and 90% of the cost by 2016, state governments will make substantial long term financial commitments to expand Medicaid because the increase in the number of new Medicaid beneficiaries will be significant. For example, a recent Government Accountability Office report [PDF] noted that states that currently did not permit childless adults to be eligible for Medicaid should expect significant increases in their Medicaid population and expenditures if they opt in to the Medicaid expansion. Other states like Illinois have legislative moratoriums that prohibit the expansion of Medicaid eligibility and would need legislative approval to lift the moratorium and permit the state to opt in to the Medicaid expansion. At least one state, Maine, has filed suit against CMS to reduce its Medicaid eligibility standards to pre-PPACA levels. Other state officials remain concerned about the political fallout in this election year of taking too strong of a position for or against Medicaid expansion. A position for Medicaid expansion could be viewed as fiscally irresponsible while the opposite position could be viewed as denying access to care to an underserved population.

If a state chooses not to expand its Medicaid program, then those people who are not eligible under traditional Medicaid will remain uninsured, although still required to have health insurance or be subject to the taxing provisions of the individual mandate. These people will likely neither have nor seek health insurance. Health care facilities in these states should not expect to see a noticeable change in its uninsured / Medicaid population and may see less of a change in the amount of health care delivered in 2014 than those states that expand Medicaid eligibility. However, one of the cost-saving measures of PPACA reduced subsidy payments

to hospitals that accept a disproportionate share of Medicare and Medicaid beneficiaries. A disproportionate share hospital (DSH) in a state that opts out of the expanded Medicaid program may receive lower DSH payments and will not see a significant increase in Medicaid patients to offset that DSH payment reduction.

Some states have already announced that they will opt in to the Medicaid eligibility requirements and expand their Medicaid health care safety net. People who seek health insurance in these states and whose modified adjusted gross incomes fall below 133% of the FPL will be eligible for the expanded Medicaid program on January 1, 2014. In these opt-in states health care facilities that currently serve a disproportionate share of uninsured individuals may see an increase in the number of Medicaid patients (and decrease in uninsured patients). However, it is uncertain if Medicaid reimbursement will be sufficient to cover a facility's aggregate cost of providing care. For example, a facility could see an increase in aggregate patient use if patients had previously not sought care because they could not afford care but will now seek care because they will not have to pay coinsurance or deductibles under Medicaid. To offset this concern, it is anticipated that there will be a decrease in uninsured individuals seeking routine care in more expensive care settings like emergency departments.

Ober|Kaler's Comments

Many states will wait until after the fall 2012 elections before deciding whether to opt out or opt in to the PPACA Medicaid expansion. State governments, regardless of a particular political proclivity, continue to wrestle with their commitments to balance their respective budgets and pay for Medicaid—even without opting in to the Medicaid expansion. Health care facilities should be mindful that many of the same factors explained previously in our Payment Matters and Client Alerts remain prevalent as the January 1, 2014 deadline approaches.