



Affordable Care Act (ACA) proposals for 2013 Legislature

Minnesota is a national leader in health care, and the Affordable Care Act (ACA) offers the state opportunities to continue this tradition by moving our publicly funded health care programs to better levels of coverage and service. Building on the recommendations of the Health Reform Task Force and using the policy tools within the ACA, Minnesota has the opportunity to begin transforming its multiple health care programs into a streamlined one.

For the past 20 years, our state has offered meaningful health insurance to low-income working families through the bipartisan creation of MinnesotaCare. While our public health programs provide needed coverage, they are too complex. We need to end the patchwork of programs that cause thousands of Minnesotans to experience disruptions in health care because of eligibility complexity or slight changes in their income levels.

The ACA provides opportunities to build the foundation for a unified public health care program, a next-generation MinnesotaCare, that will increase access to care, simplify eligibility and lower costs. These initiatives will result in an additional 145,000 Minnesotans receiving health care coverage. These additional enrollees will be covered within existing resources.

Affordable Care Act legislative initiatives:

- **New MinnesotaCare demonstration waiver:** Use the funding mechanism of the Basic Health Plan to continue and improve upon MinnesotaCare for people under age 65 with incomes between 138 percent of federal poverty guidelines (FPG) and current MinnesotaCare income levels (275 percent of FPG for parents and 250 percent for adults without children) who are not eligible for Medicaid.
- **Expand Medical Assistance (MA) to 138 percent of FPG:** Expand MA coverage to adults without children with incomes between 75 and 138 percent of FPG at 100 percent federal funding, and parents and people ages 19 through 20 with incomes between 100 and 138 percent of FPG.
- **Streamline MA eligibility processing:** Streamline eligibility through use of the Modified Adjusted Gross Income (MAGI) methodology and automated annual renewals using electronic verification methods. In addition, ease program barriers by permitting hospitals to presume MA eligibility, eliminating asset tests for parents and providing coverage to children leaving foster care until age 26. These changes are required under ACA.
- **Expand MA for children to 275 percent FPG:** Raise the MA income limit for children ages 2 through 18 from 150 to 275 percent of FPG. Enroll pregnant women with incomes up to 275 percent FPG in MA instead of MinnesotaCare. This eliminates premiums for children and pregnant women.



Expanding Medical Assistance eligibility

Issue:

Key aspects of the federal Affordable Care Act (ACA) taking effect in 2014 will significantly change the way people access health care coverage. This proposal will expand access to affordable health coverage to low-income Minnesotans and presents opportunities and requirements for Minnesota to make changes to its publicly funded health care programs to provide a more streamlined and accessible process that makes it easier obtain and keep health care coverage.

Proposal:

Effective Jan. 1, 2014, the governor's budget proposes several changes that expand MA eligibility:

- **Implement optional MA expansions to 138 percent of FPG.**
Expand Medical Assistance (MA) coverage to adults without children with incomes between 75 and 138 percent of federal poverty guidelines (FPG) at 100 percent federal funding, and parents and people ages 19 through 20 with incomes between 100 and 138 percent of FPG.
- **Expand MA to maintain coverage for children and pregnant women up to 275 percent of FPG.**
Raise the MA income limit for children ages 2 through 18 from 150 to 275 percent of FPG. Enroll pregnant women with incomes up to 275 percent FPG in MA instead of MinnesotaCare. This eliminates premiums for children and pregnant women.
- **Makes MA eligibility and enrollment changes.**
Streamline eligibility through use of the Modified Adjusted Gross Income (MAGI) methodology and automated annual renewals using electronic verification methods. In addition, ease program barriers by permitting hospitals to presume MA eligibility, eliminating asset tests for parents and providing coverage to children leaving foster care until age 26. These changes are required under ACA.

Impact:

These three related proposals:

- Expand access to public health care programs for low-income Minnesotans.
- Maximize federal funding for public health care programs.
- Simplify the enrollment process and comply with ACA requirements.

Number of people affected (FY 2015):

- Expanding MA to adults with incomes up to 138 percent of FPG will increase average monthly enrollment by approximately 87,000 (about 53,000 of whom come from MinnesotaCare).
- Raising the income limit for children and enrollment of pregnant women will increase average monthly enrollment by roughly 107,000 (about 60,000 from MinnesotaCare).
- Streamlining eligibility and easing barriers will increase average monthly enrollment by 64,000.

Fiscal impact:

These three proposals combined provide savings to the state.

- Implement optional MA expansion to 138 percent of FPG.
 - FY 2014: \$257.08 million General Fund savings; \$141.43 million HCAF costs
 - FY 2015: \$5.94 million General Fund savings; \$251.50 million HCAF savings
 - FY 2016: \$16.44 million General Fund costs; \$350.56 million HCAF savings
 - FY 2017: \$23.26 million General Fund savings; \$297.27 million HCAF savings

- Expand MA to maintain coverage for children and pregnant women up to 275 FPG.
 - FY 2014: \$47.36 million General Fund costs; \$26.88 million HCAF savings
 - FY 2015: \$141.99 million General Fund costs; \$73.08 million HCAF savings
 - FY 2016: \$182.25 million General Fund costs; \$84.09 million HCAF savings
 - FY 2017: \$184.85 million General Fund costs; \$87.71 million HCAF savings

- Make MA eligibility and enrollment changes.
 - FY 2014: \$30.24 million General Fund costs
 - FY 2015: \$136.07 million General Fund costs
 - FY 2016: \$152.65 million General Fund costs
 - FY 2017: \$165.69 million General Fund costs

Related information:

- Minnesota Management & Budget website: <http://www.mmb.state.mn.us>

DHS Communications: January 2013



New MinnesotaCare demonstration waiver

Issue:

Key aspects of the federal Affordable Care Act (ACA) taking effect in 2014 will significantly change the way people access health care coverage. Minnesota intends to expand the Medical Assistance program for low-income individuals and is developing a Health Insurance Exchange through which others who qualify may get help paying for health care coverage in the private market.

The state's MinnesotaCare waiver that provides federal funding for that program ends Dec. 31, 2013. As the ACA is implemented, it is unlikely that the waiver in its current form would be extended. The ACA includes a provision for states to receive federal funding through a Basic Health Plan option to serve people with incomes above 138 percent of federal poverty guidelines (FPG) who are covered by current state public health care programs and who will not be eligible for Medicaid after Jan. 1, 2014. This option allows states to receive payments equivalent to 95 percent of the cost of Advance Premium Tax Credits and cost-sharing reductions had those individuals been enrolled in the exchange. The Centers for Medicare & Medicaid Services (CMS) have not yet issued federal guidance on the Basic Health Plan, so as an alternative DHS anticipates that Minnesota may need to negotiate a waiver to establish such a plan.

Proposal:

The governor's budget proposal recommends that the state pursue a demonstration waiver to provide coverage for people under age 65 with incomes between 138 percent of FPG and current MinnesotaCare income levels (275 percent of FPG for parents and 250 percent for adults without children) who are not eligible for Medicaid. The waiver would:

- Improve MinnesotaCare to include benefits equal to or better than exchange coverage, reduced enrollee cost sharing as compared to exchange coverage, and no health care tax liability for certain enrollees whose income fluctuates during the year.
- Change MinnesotaCare eligibility rules to comply with the ACA, including aligning the income calculation with the new Modified Adjusted Gross Income (MAGI) Medicaid income methodology, and the exchange's insurance affordability test, eliminating the current asset test and eliminating the current four-month insurance barrier.
- Set enrollee premiums on a sliding scale ranging from 3 percent to no more than 6.3 percent of income.
- Cover essential health benefits as defined by the state within ACA guidelines, and eliminate the \$10,000 limit and \$1,000 copay on inpatient hospital services.

Some aspects of the proposal described here may change when CMS provides additional detail on requirements for federal funding for Basic Health Plans.

Impact:

This proposal will:

- Maintain coverage for many people currently enrolled in MinnesotaCare who would otherwise struggle to afford private insurance even with subsidies offered through the exchange.
- Maximize federal funding for public health care programs.
- Provide seamless coverage options at a time when significant changes in how people access health care coverage will occur.

Number of people affected (FY 2015):

- An estimated 120,000 people with incomes between 138 and 200 percent of FPG could qualify for the program. This would include about 38,000 people covered by current programs.

Fiscal impact (FY 2014-15):

- The governor's budget sets aside \$300 million in the Health Care Access Fund in the 2014-15 biennium for the state share of this program. Actual cost will depend on what is negotiated with the federal government.

Related information:

- Minnesota Management & Budget website: <http://www.mmb.state.mn.us>
- 2013 Legislative Session Fast Facts: Expanding Medical Assistance eligibility
- Patient Protection and Affordable Care Act:
<http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

DHS Communications: January 2013