

---

Revised January 8, 2014

## Expiring Medicaid and CHIP Provisions Should Be Extended in Medicare Physician Payment Legislation

By Edwin Park and Judith Solomon

Four important Medicaid and Children's Health Insurance Program (CHIP) provisions that provide health coverage to families that leave welfare for work, assist low-income seniors and people with disabilities with their Medicare premiums, and increase the proportion of eligible low-income children who are enrolled in Medicaid and CHIP, are expiring and need to be extended. Extensions of these measures should be included in legislation that Congress is expected to move early this year to extend the relief provided to doctors from scheduled cuts in Medicare reimbursement rates.

It's possible that this time, such legislation will cancel the scheduled Medicare payment cuts to doctors on a *permanent* basis, rather than again providing one year of relief. The Senate Finance Committee, the House Energy and Commerce Committee, and the House Ways and Means Committee have all reported legislation that provides a *permanent* physician payment fix. If such a measure moves forward, the expiring Medicaid and CHIP provisions should also be made permanent. If, instead, legislation once again provides *temporary* relief from the physician payment cuts through the end of 2014, the expiring Medicaid and CHIP provisions should similarly be extended through the end of the year.

The rest of this analysis describes the four Medicaid and CHIP provisions that need to be extended.

### Transitional Medical Assistance (TMA)

The Transitional Medical Assistance (TMA) program was established in 1984 under President Ronald Reagan, expanded in 1988 under Reagan, and given its current form in 1996 as part of welfare reform. Under TMA, some low-income families who would otherwise lose Medicaid because of an increase in their earnings (or in the child support they receive) can receive up to 12

months of temporary Medicaid coverage. TMA has become a critical source of health care coverage for a substantial number of low-income working families.<sup>1</sup>

TMA is of particular importance to parents who have the opportunity to work their way off welfare — but otherwise could lose their Medicaid coverage — by taking a low-wage job that lifts their income over their state’s Medicaid income threshold, without gaining access to affordable coverage through their employer. The Government Accountability Office (GAO) has testified that “transitional Medicaid assistance is a key protection offered to families at a critical juncture in their efforts to move from welfare to work.”<sup>2</sup> In 2007, the National Governors Association called TMA a “crucial work support,” noting that, “without access to regular health care, health problems of a new worker or the worker’s family members are likely to lead to greater absenteeism and possibly to job loss.”<sup>3</sup>

TMA diminishes any incentive for families on Medicaid to *avoid* finding a job or forgoing a raise because doing so would mean losing their health coverage.

TMA is periodically scheduled to expire, but Congress has always extended it on a bipartisan basis, most recently as part of December’s budget agreement. TMA is currently scheduled to expire on March 31 and needs to be renewed again.

Instead of a straightforward extension, the Administration proposed in its fiscal year 2014 budget to modify TMA while preserving its essential function. Under the Administration’s proposal, states that don’t adopt health reform’s Medicaid expansion would continue to provide TMA, but TMA would become a state option for expansion states.<sup>4</sup> That’s because families residing in a Medicaid expansion state can now remain on Medicaid if they have incomes up to 133 percent of the poverty line and can receive subsidies to purchase coverage in the new health insurance marketplaces (also known as exchanges) if their income rises above that level.

In states *not* adopting the Medicaid expansion, however, many parents whose earnings increase but who remain poor (and thus ineligible for exchange subsidies) will end up uninsured if TMA is not extended. In the typical state, the income level at which a working parent loses eligibility for Medicaid is just 61 percent of the poverty line, or \$11,913 for a family of three. In some of the

---

<sup>1</sup> For a discussion of TMA, see Sarah Lueck, “States Should Tap New Tools to Help Medicaid Beneficiaries Maintain Coverage,” Center on Budget and Policy Priorities, March 12, 2009, <http://www.cbpp.org/cms/index.cfm?fa=view&id=2711>.

<sup>2</sup> William J. Scanlon, “Medicaid: Transitional Coverage Can Help Families Move from Welfare to Work,” Testimony before the Health Subcommittee, House Energy and Commerce Committee, General Accounting Office, GAO-02-679T, April 23, 2002, <http://gao.gov/assets/110/109281.pdf>.

<sup>3</sup> National Governors Association, “Policy Position, HHS-21. Welfare Reform,” March 5, 2007.

<sup>4</sup> The Senate Finance Committee’s physician payment bill takes a similar approach. It would make TMA an option for states if they both expand Medicaid and adopt 12-month continuous eligibility for adults and children. Providing for continuous eligibility would help reduce “churning”— individuals moving between Medicaid, CHIP, and subsidized coverage through the new marketplaces (also known as exchanges) due to changes in income and family circumstances over the course of the year — that would otherwise disrupt the continuity of care and raise administrative costs for states, health care providers, and health plans. See Medicaid and CHIP Payment and Access Commission, “Report to the Congress on Medicaid and CHIP,” March 2013, [http://www.macpac.gov/reports/2013-03-15\\_MACPAC\\_Report.pdf?attredirects=0&d=1](http://www.macpac.gov/reports/2013-03-15_MACPAC_Report.pdf?attredirects=0&d=1).

states that aren't expanding Medicaid at this time — like Alabama, Louisiana, and Texas — the Medicaid eligibility limit for working parents is below 25 percent of the poverty line.<sup>5</sup>

Congress' Medicaid and CHIP Payment and Access Commission (MACPAC) endorsed an approach similar to the Administration proposal.<sup>6</sup> The cost of the Administration's proposal to extend TMA for one year is \$500 million, according to Congressional Budget Office (CBO) estimates, which is less than half of the cost of previous one-year extensions.

## Qualifying Individuals (QI) Program

Under what are known as the Medicare Savings Programs (MSPs), *Medicaid* helps low-income *Medicare* beneficiaries pay their Medicare premiums and/or deductibles and other cost-sharing charges. One of these programs is the Qualifying Individuals (QI) program, under which states receive a fixed allotment of federal funding to defray Medicare Part B premiums for beneficiaries with incomes between 120 percent and 135 percent of the poverty line.<sup>7</sup> About 520,000 near-poor elderly and disabled people received this assistance through QI in fiscal year 2011.<sup>8</sup>

Unlike the other MSPs, which are permanent features of Medicaid, QI periodically needs to be extended. Like TMA, QI has always been extended on a bipartisan basis. It was last extended as part of the December 2013 budget agreement. It is currently scheduled to expire at the end of March.

Without an extension, low-income seniors and people with disabilities will lose QI benefits that cover the full cost of their Part B premiums, which amounted to \$1,259 in 2013. Thus, if QI isn't renewed, these people will be made over \$1,250 poorer. (Because people enrolled in QI, like other MSPs, are automatically enrolled in the Medicare drug benefit's Low Income Subsidy, they would be at risk of losing that assistance as well.) The cost of a one-year extension of the QI program is about \$900 million, according to CBO.

## CHIPRA Performance Bonuses

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), various states qualify to receive annual "performance bonuses" financed through CHIP. To qualify for these bonuses, states must: 1) implement at least five of eight specified strategies that make it less

---

<sup>5</sup> Martha Heberlein *et al.*, "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013," Kaiser Commission on Medicaid and the Uninsured, January 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf>.

<sup>6</sup> MACPAC also recommended that TMA be made permanent. Medicaid and CHIP Payment and Access Commission, *op cit.*

<sup>7</sup> To qualify, Medicare beneficiaries also must have assets of no more than \$7,080 for individuals and \$10,620 for couples in 2013, though states have some flexibility to modify these limits.

<sup>8</sup> Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services, "Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011," February 2013, [http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual\\_Enrollment\\_2006-2011\\_Final\\_Document.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf).

cumbersome and bureaucratic for states to enroll eligible low-income children in Medicaid and CHIP (such as no longer applying an assets test, providing for 12-month continuous eligibility, and adopting Express Lane Eligibility, which is described below); *and 2*) achieve state-specific targets for increasing Medicaid enrollment among eligible children. The bonuses are intended to offset some of the costs that states incur in enrolling more eligible children.

For fiscal year 2013, some 23 states received about \$307 million in bonuses.<sup>9</sup> These CHIPRA performance bonuses encouraged states to simplify enrollment procedures, despite the budget deficits that many states have had to close in recent years as a result of the economic downturn. The simplifications that states instituted have contributed to coverage gains among children; Census data show that in 2012 — a year in which nearly half of the states instituted one or more simplification procedures<sup>10</sup> — the share of children without health coverage reached a historic low of 8.9 percent, a 25 percent reduction since 1999.

The CHIPRA performance bonuses were available only through fiscal year 2013; they expired at the end of September. Continuing the bonuses would help maintain progress in shrinking the numbers of uninsured low-income children.

Accordingly, the bonuses should be renewed. The criteria for states to receive bonuses should be modified, however, to encourage and reward states that take specific steps to facilitate the enrollment of eligible children — steps *not* already required under the Affordable Care Act (ACA), which directs states to adopt some of these enrollment strategies starting in 2014. For example, the ACA requires states to drop asset tests for non-elderly adults and children starting in 2014, so not having an asset test should no longer count as a simplification that qualifies a state for a performance bonus.

## **Express Lane Eligibility (ELE)**

Under Express Lane Eligibility (ELE), also enacted as part of CHIPRA, states have the option of using eligibility information obtained from other low-income programs — such as the School Lunch Program, SNAP (formerly the Food Stamp Program), Temporary Assistance for Needy Families (TANF), Head Start, and WIC — to streamline enrollment of eligible children in Medicaid and CHIP. ELE enables states to avoid making duplicative requests for eligibility information and thereby lowers administrative costs and paperwork burdens. It relies upon information on income, household size, and other eligibility factors that a state agency has already collected in determining an individual's eligibility for another low-income program, rather than collecting and evaluating the same information all over again for Medicaid or CHIP.

---

<sup>9</sup> The 2013 performance bonus states are Alabama, Alaska, Colorado, Connecticut, Idaho, Illinois, Iowa, Kansas, Maryland, Michigan, Montana, New Jersey, New Mexico, North Carolina, North Dakota, New York, Ohio, Oregon, South Carolina, Utah, Virginia, Washington, and Wisconsin. See Centers for Medicare and Medicaid Services, “CHIPRA Performance Bonuses: A History (FY 2009-FY 2013),” December 2013, <http://www.insurekidsnow.gov/professionals/eligibility/pb-2013-chart.pdf>.

<sup>10</sup> Heberlein, *op cit*.

As of July 2013, 12 states (and the U.S. Virgin Islands) had taken up the ELE option in their Medicaid or CHIP programs or both.<sup>11</sup> The GAO found in a recent performance audit that ELE saved states time and reduced their administrative costs, while increasing the enrollment of eligible children. (The impact varies depending on how a state designs its ELE. The states adopting ELE that automated the enrollment process were more likely to experience savings and to increase enrollment, the GAO found.<sup>12</sup>) A just-completed federal evaluation of ELE, conducted by Mathematica Policy Research, similarly found that ELE increased enrollment among eligible children, and also reduced state administrative costs if states adopted an automated ELE process.<sup>13</sup>

While ELE doesn't expire until the end of fiscal year 2014, extending it now will assure states that the option will remain in place and thereby encourage more states to take it. That is the same reason that the December 2012 "fiscal cliff" budget agreement included an early extension of ELE through 2014, at a time when the ELE was scheduled to expire at the end of fiscal year 2013.

Any extension should also allow ELE, which is permitted now only for children, to be explicitly used to enroll parents and other newly eligible adults under the ACA's Medicaid expansion, many of whom also qualify for other low-income programs like SNAP.<sup>14</sup> Extending ELE to adults would further reduce administrative costs and paperwork and would enhance state efforts to reach and enroll newly eligible parents and childless adults, while minimizing the workload burdens on already stretched state eligibility workers.

---

<sup>11</sup> See Centers for Medicare and Medicaid Services, "Express Lane Eligibility for Medicaid and CHIP," [http://www.insurekidsnow.gov/professionals/eligibility/express\\_lane.html](http://www.insurekidsnow.gov/professionals/eligibility/express_lane.html).

<sup>12</sup> Government Accountability Office, "Medicaid and CHIP: Considerations for Express Lane Eligibility," GAO-13-178R, December 5, 2012, <http://gao.gov/assets/660/650529.pdf>.

<sup>13</sup> Mathematica Policy Research, "CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings," December 2013, <http://aspe.hhs.gov/health/reports/2013/ELE/ELE%20Final%20Report%20to%20ASPE%2012%2011%2013.pdf>.

<sup>14</sup> Several states have extended the use of ELE to parents through waivers, but the federal government has indicated that such waivers may not continue to be available after 2014. That's because without an explicit ELE option for adults, the health reform law does not appear to permit states to vary from the new rules for counting income in determining eligibility for Medicaid and CHIP.