



MEDICAID FINANCING FOR THE UNINSURED UNDER THE AFFORDABLE CARE ACT

HB6253

Rep. Sara Feigenholtz and Sen. Heather Steans

SUMMARY:

Today, for adults without dependent children, no matter how poor are, they are not eligible for Medicaid. This gap in coverage is eliminated by the Affordable Care Act (ACA). HB6253 authorizes Illinois to take advantage of the ACA to provide healthcare under Medicaid to about 342,000 low-income Illinois citizens who are currently uninsured. The ACA offers generous federal matching funds for this newly eligible population: 100% for the first 3 years, then phased down to 90% by 2020.

The legislation has three parts:

- It revises the Public Aid Code to eliminate the coverage gap for adults ages 19 through 64 whose income is at or below 133% of the Federal poverty level (the level required by ACA). This is the current level of eligibility for parents and other caretaker relatives raising dependent children.
- It provides that the state will establish the specific benefit package for these newly eligible adults through rule, which at a minimum must cover 10 “essential health benefits” including hospitalizations, pharmaceuticals, mental health and substance use disorder services, preventive and wellness services, chronic disease management and more.
- It amends the moratorium on new eligibility categories to take advantage of the favorable federal match rates.

HOW WE ALL BENEFIT:

This legislation will enable Illinois to receive federal revenue to cover the costs of providing healthcare to uninsured, low-income adults, and thereby replace costs already borne by Illinois taxpayers and numerous other institutions. That's why everyone benefits from HB6253:

1. Keeps people healthier: The legislation will provide access to healthcare services for low income adults, not now covered by Medicaid but often with complex health and behavioral health conditions. Healthier people result in reduced costs to Medicaid and to local governments, community agencies and healthcare providers.
2. Brings new Medicaid dollars into Illinois: Through 2016, this legislation will bring an estimated \$4.6 billion into Illinois in Medicaid provider payments for the newly eligible adults, with no net state costs for their healthcare.
3. Replaces state GRF spending with 90%-100% federal match. Although Illinois has made progress in limiting healthcare and certain human services to Medicaid-eligible clients, there are still pockets of GRF expense funded with no federal match, much of it on behalf of people who will become eligible for Medicaid under this legislation. Going forward, these expenses will be federally matched at 100% for the next three years, subsequently declining to 90%.
4. Reimburses hospitals and clinics for uncompensated and charity care for the uninsured: Medicaid reimbursements funded with the new federal match will be available for healthcare providers who now collect little or no payments for the uninsured, and some providers routinely have to shift costs to those with private health insurance.
5. Increases federal reimbursements to Cook County Health & Hospitals System: The new federal 1115 Waiver for the newly eligible Medicaid clients now reimburses at 50% match (authorized by the SMART Act), but will increase reimbursements to 100% match as of January 1, 2014, if this legislation is approved by the General Assembly. If not, these clients of Cook County would become uninsured again, with \$0 federal reimbursement.
6. Replaces local spending for the care of the uninsured: By enrolling low-income uninsured adults in Medicaid, the legislation will provide federal dollars to alleviate pressure on county and local governments for healthcare costs now borne by local health departments, social service agencies, homeless shelters, mental health clinics, drug treatment centers, township organizations and the like.

For more information, contact Kurt Anderson, Governor's Office of Legislative Affairs at Kurt.Anderson@illinois.gov or Selma D'Souza, HFS Legislative Director, at Selma.D'Souza@illinois.gov

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HOW THE REVENUES AND COSTS ARE COMPUTED

1. It is estimated that 342,000 total “newly eligibles” in IL will enroll by 2017: mostly adults without dependent children who have not qualified for Medicaid in the past, but who have income under 133% federal poverty level.

2014	299,000	
2015	298,000	
2016	328,000	
2017	342,000	Assumes a stable population after 2017 (10% will never enroll)

2. It is estimated that the “newly eligibles” will receive the same service package as the adults in FamilyCare; however, since this population’s medical history is unknown, 10% was added to accommodate for potential differences in health status.

The cost for FamilyCare clients is \$412 per member/per month (PMPM)
The cost for the “newly eligibles” is therefore \$454 PMPM, inflated by 2% per year

3. The federal government will pay 90%-100% of the costs for this new population.

	<u>Federal Match</u>	<u>Federal revenues</u>	<u>State portion</u>
2014	100%	\$1,081,863,840	-0-
2015	100%	\$1,656,168,574	-0-
2016	100%	\$1,858,408,187	-0-
2017	95%	\$1,877,271,898	\$98,803,784
2018	94%	\$1,894,661,364	\$120,935,832
2019	93%	\$1,911,995,499	\$143,913,640
2020	90%	\$1,887,324,590	\$209,702,732

4. The new funds being provided by the Federal government will replace spending by hospitals, clinics, other providers, state GRF and local governments who have absorbed huge healthcare costs for the uninsured as uncompensated care. Because this new money would have such favorable impact across a broad section of Illinois, there is wide-spread support for HB6253. For the most current list of supporters, please see the attached.