Center on Budget and Policy Priorities

1275 First Street NE, Suite 1200
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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Build Back Better Legislation Would Close the Medicaid Coverage Gap

By Judith Solomon

Over 2 million uninsured adults with incomes below the poverty line, most who live in the South and are people of color, don't have a pathway to health coverage, because their states have refused to adopt the Affordable Care Act's (ACA) Medicaid expansion. Budget reconciliation legislation set to be considered in the House Energy and Commerce Committee would permanently close the Medicaid coverage gap and finally, over seven years after the Medicaid expansion was supposed to take effect, get people the health care they need.[1]

The bill sets up a two-phase process that would close the coverage gap starting in January 2022. For the first three years, people would be eligible for premium tax credits that would pay for coverage in plans offered in the ACA marketplaces, which would be enhanced to better suit the needs of people with low incomes. Providing coverage in the marketplace would give the Secretary of Health and Human Services (HHS) time to establish a federal Medicaid program that would align with Medicaid rules that apply to state expansions and would be available to people in states that haven't expanded beginning in 2025.

Permanently, quickly, and comprehensively closing the coverage gap is "one of the single most important steps" toward reducing persistent racial inequities in health care and health outcomes, as leaders and members of the Congressional Black Caucus and Congressional Hispanic Caucus wrote in a letter to congressional leaders.[2] Closing the coverage gap is a key component of efforts to reduce high and increasing rates of deaths and severe health complications among Black people who give birth.[3] Beginning next year, the Energy and Commerce bill would provide stable, reliable coverage to people who have been left out, including many older adults and people with disabilities.

[1] Subtitles F and G of Energy and Commerce Legislative Recommendations for Budget Reconciliation, https://energycommerce.house.gov/committee-activity/markups/markup-of-the-build-back-better-act-full-committee-september-13-2021.

[2] Letter to Majority Leader Charles S. Schumer and Speaker Nancy Pelosi, September 5, 2021, https://drive.google.com/file/d/140TY2wr0rBUGY7S9jNeKDxTDlyKhtiXY/view.

[3] Judith Solomon, "Closing the Coverage Gap Would Improve Black Maternal Health," Center on Budget and Policy Priorities, July 26, 2021, https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.

Phase One: Coverage in Marketplace Plans

People with incomes below the poverty line generally aren't eligible for premium tax credits under current law. People with incomes between 100 and 138 percent of the poverty line who would be eligible for Medicaid if their states adopted the expansion can receive premium tax credits and enroll in marketplace plans, and many do. But the combination of states' refusal to expand and the floor on premium tax credit eligibility set at 100 percent of the federal poverty line creates a coverage gap for adults with incomes below the poverty line who aren't eligible under other Medicaid categories, such as those for very low-income parents and people with health conditions that meet a narrow definition of "disability."

Under the bill, people with incomes below the poverty line who are not eligible for Medicaid under their state's rules would be eligible for premium tax credits, giving them a pathway to affordable coverage in the marketplace. Enhancements would be made to marketplace plans to provide access to affordable health care for people with low incomes. All people who would be eligible for Medicaid if their states had expanded, including those with incomes between 100 and 138 percent of the poverty line, would be eligible to enroll in the enhanced plans.

- **People wouldn't pay a premium** for the enhanced plans, because premium credits would be enough to cover the full cost.
- The plans would have **no deductibles and only minimal co-pays**, comparable to what Medicaid allows, to make sure that people can get the health care they need without unaffordable out-of-pocket costs. The actuarial value of the plans — the percentage of total average costs of covered benefits that the plan pays — would be set at 99 percent beginning in 2023, above the 94 percent actuarial value of marketplace plans now available to people with incomes between 100 and 150 percent of the poverty line.
- **Low-paid workers wouldn't be barred from enrolling** because they have an offer of employer coverage, a barrier that exists now for many with incomes above the poverty line even when the plans aren't truly affordable for them or their families.[4]
- People could **enroll at any time** during the year.
- To align more closely to the benefits provided in Medicaid, in 2024, the plans would cover the costs of **transportation to medical appointments** for people who couldn't otherwise get the care they need. This would be in addition to emergency medical transportation, which marketplace plans already cover. The plans would also cover **family planning services and supplies,** and people would have free choice of participating family planning providers regardless of whether the providers are in their managed care network.

Phase Two: Coverage in Federal Medicaid Plans

In 2025, people covered in the marketplace plans would transition to a federally operated Medicaid program that would more fully align with Medicaid. The bill directs the HHS Secretary to solicit bids from managed care plans and third-party administrators to administer the federal

[4] Tara Straw, "Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers," Center on Budget and Policy Priorities, December 3, 2019, https://www.cbpp.org/research/health/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for.

Medicaid program in the non-expansion states and to enter into contracts with at least two such entities.[5] People would apply, and the federal marketplace would determine their eligibility using Medicaid rules, including rules governing fair hearings for people who want to appeal eligibility determinations. Medicaid rules requiring rebates from drug manufacturers, which help offset the costs of outpatient drugs provided to Medicaid enrollees, would also apply.

The most significant difference between the benefits offered by the federal Medicaid program and the plans provided through the marketplace in the first phase would be the addition of specialized benefits available to people with chronic illnesses and disabilities. Under the ACA, people eligible under the Medicaid expansion have coverage that includes the same ten categories of essential health benefits that marketplace plans cover.[6] On top of these benefits, Medicaid coverage includes additional benefits and other differences, which would apply in the second phase.[7]

- **Additional services required by people who are "medically frail."** People who are "medically frail," which includes people with serious mental illness, chronic substance use disorders, serious and complex medical conditions, and physical, intellectual, or developmental disabilities that significantly impair their ability to perform one or more activities of daily living, must receive the full range of benefits available under the state's Medicaid plan including long-term services and supports that aren't included in the ten essential benefits.[8]
- **Additional services required under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for 19- and 20-year-olds.** EPSDT ensures that children and young adults under 21 have access to all services that Medicaid covers regardless of any limits states put on benefits for adults. It is especially important to children and young adults with disabilities or serious health conditions who need services, equipment, or supplies that commercial insurance plans don't ordinarily cover.
- **Retroactive coverage for three months prior to application.** Medicaid covers medical expenses incurred in the three months prior to the month an individual applies if the person is found eligible during those months, and the federal Medicaid plan would eventually provide retroactive coverage.

Enrollees would not have to pay any cost-sharing in the federal Medicaid plan. As in the marketplace plans in the first phase, they would have coverage for family planning services and supplies with free choice of participating family planning providers as well as coverage for non-emergency transportation.

Non-expansion states that take up expansion would still qualify for the financial incentive enacted in the American Rescue Plan Act, which provides a two-year, 5 percentage-point increase in the

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[5] Third-party administrators would be paid a fee to develop networks to provide services, pay claims, and perform other functions needed to manage the provision of health care to people in a geographic area, but unlike managed care organizations, they would not be at risk for the costs of medical care people in their area receive.

[6] Sara Rosenbaum *et al.,* "Medicaid Benefit Designs for Newly Eligible Adults: State Approaches," Commonwealth Fund, May 11, 2015, https://www.commonwealthfund.org/publications/issue-briefs/2015/may/medicaid-benefit-designs-newly-eligible-adults-state-approaches.

[7] The bill gives the HHS Secretary time to phase in some Medicaid rules, including retroactive coverage.

[8] The definition of "medically frail" is at 42 CFR 440.315(f).

amount the federal government pays toward a state's Medicaid expenditures (known as the "federal medical assistance percentage" or FMAP) for all groups other than those eligible through expansion. States that expand would still receive the 90 percent enhanced FMAP for the expansion group.[9] And the bill includes a maintenance of effort requirement to incentivize states to maintain Medicaid coverage at current eligibility levels.

Conclusion

The Energy and Commerce bill would quickly and permanently provide coverage to people who have been shut out of the ACA's benefits. Most of those who would benefit are Black or Latino people,[10] making passage of these bills a "test of [Congress'] commitment to racial equity," according to Wade Henderson, who leads the Leadership Conference on Civil and Human Rights.[11]

Making coverage permanent is essential for those in the coverage gap and those who need coverage in the future. People need stable, reliable coverage that won't end on an arbitrary date, especially older adults and people with chronic illnesses and disabilities. Permanently closing the coverage gap is also key to reducing high and increasing rates of deaths and severe health complications among people who give birth, so they have access to preconception health care and early prenatal care.[12]

A temporary solution could mean HHS won't have time to implement the federal Medicaid plan that, as explained above, will fully align with Medicaid benefits and beneficiary protections. There's no guarantee that a temporary policy would be extended, and states that have refused to expand Medicaid are very unlikely to change course if the federal coverage gap policy isn't extended. The opportunity to close the coverage gap may not come again for many years, if not decades. The risk is too great to do anything but a permanent solution.

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[9] Manatt Health, "Assessing the Fiscal Impact of Medicaid Expansion Following the Enactment of the American Rescue Plan Act of 2021," April 2021, https://www.manatt.com/Manatt/media/Documents/Articles/ARP-Medicaid-Expansion.pdf.

[10] Gideon Lukens and Breanna Sharer, "Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities," Center on Budget and Policy Priorities, June 14, 2021, https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial.

[11] Wade Henderson, "A Racial Equity Test for the Build Back Better Package," Leadership Conference on Civil and Human Rights, https://civilrights.org/blog/a-racial-equity-test-for-the-build-back-better-package/.

[12] Solomon, *op. cit.*