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Sara K. Hunkler
shunkler@indiana.edu

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Assets, Costs, and Affordability: Why MAGI-Based Medicaid Benefits Don't Account for True Need

Note by Sara K. Hunkler*

INTRODUCTION

Meet Mary and Bob, both Medicaid applicants in 2013. Mary has a house worth \$1,000,000,¹ a gain of \$250,000 on the sale of a primary residence,² an academic scholarship worth \$150,000,³ stock with a current market value of \$60,000,⁴ a car worth \$18,000,⁵ and cash assets of \$600,000.⁶ She recently received a gift of \$150,000.⁷ Mary also has an income of \$15,000 in 2013. Bob, by contrast, makes \$16,000 in 2013, has no positive assets, and owes student loan debt of \$10,000. Which person should qualify for federal health care assistance in 2014?

* J.D. Candidate, Indiana University Maurer School of Law, Class of 2015. I am grateful to Sam Hunkler, Professor Jody Madeira, Kellen Ressimeyer, and Carl Oberdier for their insightful feedback on my ideas, and to the editors of the *Indiana Journal of Law and Social Equality* for their helpful advice and comments on my drafts. I am particularly grateful to Conor Dirks for his unwavering moral support throughout this process, and all others.

1. See I.R.C. § 61 (2012) (excluding from gross income unconverted assets, including real estate); Treas. Reg. § 1.1001-1(a) (as amended in 2007) (“[G]ain or loss realized from the conversion of property into cash . . . is treated as income or as loss sustained.”).
2. See I.R.C. § 121(a) (2012) (excluding from gross income gain from sale of principal residence in many cases); Treas. Reg. § 1.121-1(a)(2) (as amended in 2002).
3. See I.R.C. § 117 (2012) (excluding from gross income “any amount received as a qualified scholarship”).
4. See sources cited *supra* note 1 (excluding from gross income unconverted assets, including stock).
5. See *id.* (excluding from gross income unconverted assets, including cars).
6. See I.R.C. § 61 (excluding cash assets from gross income).
7. See I.R.C. § 102 (2012) (excluding from gross income “the value of property acquired by gift”).

According to the 2010 Patient Protection and Affordable Care Act (PPACA),⁸ the answer is Mary.

This Note examines current eligibility standards for Medicaid under the PPACA, arguing that these income-based eligibility standards do not adequately reflect an individual's need for federal assistance because they neglect to consider an individual's assets, debts, and the circumstantial cost of his or her health care. Assets, debts, and health care costs should be standard considerations in Medicaid eligibility requirements to ensure the fair prioritization of individuals for whom health coverage is least affordable and who thus have the greatest need for federal assistance. In this Note, I will examine the implications of excluding assets, debts, and health care costs from Medicaid eligibility determinations, propose related modifications to the Medicaid eligibility standards mandated by the PPACA, and compare Medicaid with similar government benefit programs with eligibility calculation schemes that more adequately assess individual need. This problem invites further discussion of the interplay between waste, inefficiency, and administration under the PPACA.

Part I of this Note begins with an introduction to the Medicaid system and discusses how it has been affected by the Medicaid coverage expansion introduced by the PPACA, which was passed with the intention of extending affordable medical coverage to all U.S. citizens.⁹ The PPACA preempts the states' authority to determine Medicaid eligibility requirements by imposing universal federally mandated eligibility standards. Part II of this Note examines how the new federal standards permit significant disparities in the treatment of similarly situated impoverished individuals and allow prioritization of asset-wealthy individuals over their more needy counterparts, a social injustice that contradicts the access and affordability goals the PPACA strives to achieve. It argues that Medicaid eligibility should work as a phaseout rather than a cliff cutoff and that Medicaid eligibility standards under the PPACA should be redefined to focus on holistic wealth in order to achieve fairer determinations of affordability and eligibility. Part III of this Note concludes by examining need-calculation methodologies from other federal social benefit programs that may offer fairer methodologies for Medicaid eligibility calculation, and by proposing an analogous eligibility system for Medicaid that considers assets, debts, and health care costs.

8. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

9. Aliens who are "lawfully present" in the United States are also subject to the health insurance mandate, are eligible for premium credits and cost-sharing subsidies, and are potentially eligible to participate in the high-risk pools and the exchanges. ALISON SISKIN, CONG. RESEARCH SERV., R41714, *Summary of TREATMENT OF NONCITIZENS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT* (2011).

I. THE MEDICAID PROGRAM AND PPACA EXPANSION

Medicaid is a federal health care entitlement program that was enacted in 1965.¹⁰ A keystone of the Johnson administration's "War on Poverty," the Medicaid program "reflects a fundamental concern about the health and wellbeing of the disadvantaged."¹¹ Medicaid services traditionally benefit diverse populations and "compared to both Medicare and employer-sponsored health care plans, offer[] the broadest array of medical care and related services available in the United States today."¹² Even prior to expansion under the PPACA, the number of Medicaid enrollees had swelled to an estimated sixty-eight million, and combined federal-state funding for that population topped \$400 billion in fiscal year 2010.¹³ Participation in the Medicaid program is optional for states but brings substantial federal funds.¹⁴ If states participate, as all fifty states currently do, they must follow federally mandated rules to reap the benefits of this shared funding.¹⁵ Medicaid is purchased by state and federal governments and requires no premium payment from the beneficiary in most cases.¹⁶

The federal rules regarding Medicaid require that certain groups be covered, but prior to the enactment of the PPACA, states were permitted to adjust key program parameters.¹⁷ Traditionally, an individual must satisfy five different areas of eligibility requirements to qualify for Medicaid assistance: categorical, income, resources, immigration status, and residency.¹⁸ While the federal rules required coverage of certain limited groups pre-PPACA, states retained fairly broad liberty to exclude certain other groups at their will; apply exemptions reducing countable income; and adjust eligibility, benefits, and enrollment.¹⁹ These liberties have been curtailed under the recent Medicaid expansion mandated by the PPACA.

10. See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1396–1396w-5 (2012)).

11. John D. Blum & Gayland O. Hethcoat II, *Medicaid Governance in the Wake of National Federation of Independent Business v. Sebelius: Finding Federalism's Middle Pathway, from Administrative Law to State Compacts*, 45 J. MARSHALL L. REV. 601, 610 (2012).

12. ELICIA J. HERZ, CONG. RESEARCH SERV., RL33202, MEDICAID: A PRIMER 11 (2010).

13. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 27, 38 (2011).

14. See *id.* at 38.

15. *Id.* at 40.

16. HERZ, *supra* note 12, at 7.

17. See *id.* at 1–5.

18. VERNON K. SMITH & EILEEN ELLIS, HEALTH MGMT. ASSOCS., CHRISTINA CHANG, KAISER COMM'N ON MEDICAID AND THE UNINSURED, ELIMINATING THE MEDICAID ASSET TEST FOR FAMILIES: A REVIEW OF STATE EXPERIENCES 2 (2001), <http://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf>.

19. See HERZ, *supra* note 12, at 1–5.

The PPACA was enacted in March 2010²⁰ and uses a variety of economic and tax measures to impose rules and responsibilities upon the federal and state governments, insurers, employers, and individuals in order to reform and improve the availability, quality, and affordability of U.S. health insurance coverage.²¹ Almost immediately, the PPACA became colloquially known as “Obamacare” for the President who signed it into law.²² As enumerated by the U.S. Department of Health and Human Services (HHS), the PPACA’s objectives are to (1) make coverage more secure for those who have health insurance and extend it to the uninsured, (2) improve health care quality and patient safety, (3) strengthen primary and preventive care, (4) reduce health care costs, (5) better serve vulnerable populations, and (6) encourage the “meaningful use” of health information technologies.²³ Two key provisions within the PPACA meant to facilitate aggressive achievement of these goals are the individual mandate and the Medicaid expansion.²⁴ The Medicaid expansion increases the scope of the Medicaid program by requiring all state programs to provide Medicaid coverage to adults with incomes up to 133% of the federal poverty level (FPL).²⁵ The expansion is estimated to make an additional seventeen million currently uninsured, nonelderly adults eligible for Medicaid based on the PPACA’s income and citizenship criteria for eligibility.²⁶

Although these new eligibility standards were intended to apply uniformly across all states, the Medicaid expansion is now effectively a state choice after the Supreme Court addressed the PPACA’s constitutionality in June 2012 in *National Federation of Independent Business v. Sebelius*.²⁷ Twenty-six states, along with private individuals and independent business organizations, challenged the constitutionality of the PPACA’s individual mandate and Medicaid expansion in

20. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, N.Y. TIMES (Mar. 23, 2010), http://www.nytimes.com/2010/03/24/health/policy/24health.html?_r=0.

21. *Questions and Answers on the Individual Shared Responsibility Provision*, IRS, <http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision> (Sept. 26, 2014).

22. James Hamblin, *What is Obamacare?*, ATLANTIC (Apr. 2, 2013), <http://www.theatlantic.com/health/archive/2013/04/what-is-obamacare/274509/>.

23. Blum & Hethcoat, *supra* note 11, at 605 (citing U.S. DEP’T OF HEALTH & HUMAN SERVS., STRATEGIC PLAN FISCAL YEARS 2010–2015, http://www.hhs.gov/secretary/about/stratplan_fy2010-15.pdf).

24. *See Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012).

25. *Id.* at 2582; HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE AFFORDABLE CARE ACT 1 (2013) [hereinafter KAISER, SUMMARY OF THE AFFORDABLE CARE ACT], <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>.

26. KAISER COMM’N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID 2 (2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8505-the-coverage-gap_uninsured-poor-adults-in-states-that-do-not-expand-medicaid.pdf.

27. 132 S. Ct. at 2608.

a suit filed against the HHS, the Treasury, and the Labor Departments and their Secretaries.²⁸ The Supreme Court upheld the constitutionality of the individual mandate,²⁹ but it concurrently ruled that the federal government is limited in its ability to pressure state acceptance of the new Medicaid provisions outlined by the PPACA.³⁰ The Court reasoned that the Tenth Amendment coercion doctrine prevents Congress from using undue financial influence to force state officials to administer federally conceived programs.³¹ The narrow holding of the Court struck down only provisions of the PPACA that conditioned federal funding for states' existing Medicaid programs on states' agreement to participate in the expansion.³² While the government *can* terminate new Medicaid funds when states refuse to comply with the law's new provisions, it *cannot* withhold the states' existing Medicaid funds to manipulate them into adopting the PPACA's Medicaid expansion. Medicaid expansion guidelines under the PPACA will still affect states that choose to participate, and there is a huge incentive for states to do so due to the federal funding involved.³³ A majority of state governors support the Medicaid expansion. As of September 2014, twenty-seven states and the District of Columbia are implementing Medicaid eligibility determinations that comply with new federal requirements; three other states are considering expansion.³⁴

The Medicaid expansion is linked to the individual mandate in that individuals who do not qualify for Medicaid will be required to maintain "minimum essential" health insurance coverage through an employer or government program or by independent purchase from a private company.³⁵ The intention behind the

28. *Id.* at 2566.

29. *Id.* at 2601.

30. *Id.* at 2607.

31. *Id.* at 2602–07 (citing *South Dakota v. Dole*, 483 U.S. 203 (1987)).

32. *Id.* at 2607–08; see also Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?*, 31 HEALTH AFF. 1663, 1665–66 (2012).

33. See, e.g., MICHELLE GREENHALGH, AM. ACAD. OF FAMILY PHYSICIANS, THE AFFORDABLE CARE ACT: MEDICAID EXPANSION & HEALTHCARE EXCHANGES 6, <http://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/ES-MedicaidExpansion.pdf> ("If a state does choose to expand its Medicaid program under the ACA, the federal government will fully fund Medicaid coverage for newly eligible individuals . . . through 2016."); Robert Pear, *Uncertainty Over States and Medicaid Expansion*, N.Y. TIMES (June 28, 2012), <http://www.nytimes.com/2012/06/29/us/uncertainty-over-whether-states-will-choose-to-expand-medicaid.html> ("Senator Max Baucus, Democrat of Montana and a principal author of the new law, said the federal government was offering states 'a big juicy carrot' as an incentive to expand Medicaid.")

34. *Where the States Stand on Medicaid Expansion*, ADVISORY BOARD COMPANY (Sept. 4, 2014), <http://www.advisory.com/daily-briefing/resources/primers/medicaidmap>.

35. Press Release, Ctrs. for Medicare & Medicaid Servs., HHS Final Rule and Treasury Notices on Individual Shared Responsibility Provision Exemptions, Minimum Essential Coverage, and Related Topics (June 26, 2013), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-06-26.html>.

requirement is to stabilize insurance pools by increasing the participation of healthy individuals.³⁶ On August 27, 2013, the Treasury Department and Internal Revenue Service (IRS) released the final rules for the individual mandate and “shared responsibility payment” authorized by Internal Revenue Code § 5000A and Section 1501 of the PPACA³⁷:

Starting in 2014, the individual shared responsibility provision calls for each individual to have basic health insurance coverage (known as minimum essential coverage), qualify for an exemption,³⁸ or make a shared responsibility payment when filing a federal income tax return. Individuals will not have to make a payment if coverage is unaffordable, if they spend less than three consecutive months without coverage, or if they qualify for an exemption for several other reasons, including hardship and religious beliefs.³⁹

An individual earning above 400% of the FPL is deemed unable to afford coverage if the required contribution to purchase coverage exceeds 8% of the individual’s household income.⁴⁰ HHS also automatically exempts from the individual mandate persons who are ineligible for Medicaid based solely on a state’s decision not to implement the Medicaid expansion.⁴¹

Individuals who do not qualify for Medicaid or fit within an exemption to the individual mandate requirement will be required to maintain minimum

36. Timothy Jost, *Implementing Health Reform: Final IRS Individual Mandate Regulations*, HEALTH AFF. BLOG (Aug. 28, 2013, 7:14 AM), <http://healthaffairs.org/blog/2013/08/28/implementing-health-reform-final-irs-individual-mandate-regulations/>.

37. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 244–49 (2010) (codified as amended at I.R.C. § 5000A (2012)).

38. There are nine categories of individuals who qualify for an exemption: (1) “individuals who cannot afford coverage,” (2) “individuals with household income below the filing threshold,” (3) “members of federally recognized Indian tribes,” (4) “individuals who experience a hardship,” (5) “individuals who experience a short coverage gap,” (6) “members of certain religious sects,” (7) “members of a health care sharing ministry,” (8) “incarcerated individuals,” and (9) “individuals who are not lawfully present.” Press Release, Ctrs. for Medicare & Medicaid Servs., *supra* note 35.

39. Press Release, U.S. Dep’t. of the Treasury, Fact Sheet: Individual Shared Responsibility for Health Insurance Coverage and Minimum Essential Coverage Final Rules (Aug. 27, 2013), <http://www.treasury.gov/press-center/press-releases/Pages/jl2152.aspx>; *see also* Treas. Reg. §§ 1.5000A-1 to -4 (2013) (interpreting the minimum essential coverage and shared responsibility payment provisions).

40. Sarah Kliff, *Readers Have Questions About Obamacare’s Penalties. We Have Answers!*, WASH. POST WONKBLOG (Apr. 1, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/01/readers-have-questions-about-obamacares-penalties-we-have-answers/>.

41. Press Release, U.S. Dep’t. of the Treasury, *supra* note 39.

essential coverage (MEC).⁴² MEC includes government-sponsored coverage, an employer-sponsored plan, individual coverage, grandfathered coverage, and other coverage expressly defined as MEC.⁴³ The PPACA establishes regulated online marketplaces, administered by either the federal or state governments, where individuals and small businesses can purchase private insurance plans.⁴⁴ The online marketplaces provide subsidies for low-income enrollees.⁴⁵ Individuals with incomes between 100% and 400% of the FPL⁴⁶ who purchase insurance plans through a marketplace exchange will be eligible to receive federal subsidies to help pay premium costs.⁴⁷ A recent analysis by the Congressional Budget Office found that individuals with incomes between 250% and 300% of the FPL will receive subsidies sufficient to cover 42% of the cost of the second-lowest-cost plan, while individuals with incomes at 350% to 400% of the FPL will receive subsidies sufficient to cover just 13% of their premiums.⁴⁸

States, the HHS, and the Department of the Treasury all play a role in implementing the PPACA's eligibility requirements.⁴⁹ The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing Medicaid eligibility changes mandated by the PPACA; "providing guidance, grant funding, and other assistance to the states; overseeing enrollment provisions . . . ; and providing performance bonuses to states that meet or exceed specified Medicaid enrollment goals."⁵⁰ The IRS oversees the tax-related provisions of the PPACA and issues regulations relevant to implementing eligibility rules for the premium tax credit.⁵¹

42. KAISER, SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 25, at 1.

43. Treas. Reg. §§ 1.5000A-2 (2013) (defining minimum essential coverage).

44. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311, 124 Stat. 119, 173–81 (2010) (codified at 42 U.S.C. § 18031 (2012)) (establishing voluntary exchanges). The PPACA requires that an exchange be "a governmental agency or nonprofit entity" that facilitates the purchase of health insurance. § 1311, 124 Stat. at 176–78 (codified at 42 U.S.C. § 18031(d)).

45. See *Premium Subsidies – What You Need to Know*, AM.'S HEALTH INS. PLANS COVERAGE (Feb. 7, 2013), <http://www.ahipcoverage.com/2013/02/07/premium-subsidies-what-you-need-to-know/>.

46. See *generally* Annual Update of the HHS Poverty Guidelines, 79 Fed. Reg. 3593 (Jan. 22, 2014).

47. *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers* 12–13 (Lewin Grp., Staff Working Paper No. 11, 2010), http://www.lewin.com/~media/Lewin/Site_Sections/Publications/LewinGroupAnalysis-Patient-ProtectionandAffordableCareAct2010.pdf.

48. *Premium Subsidies – What You Need to Know*, *supra* note 45.

49. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-648, CHILDREN'S HEALTH INSURANCE: OPPORTUNITIES EXIST FOR IMPROVED ACCESS TO AFFORDABLE INSURANCE 3 (2012).

50. *Id.*

51. *Id.*

II. PROBLEMS AND SOLUTIONS WITHIN THE PPACA'S MAGI TEST

Medicaid eligibility under the PPACA hinges on a calculation called “modified adjusted gross income” (MAGI), which is the sum of the taxpayer’s “adjusted gross income” (AGI), as determined under federal income tax calculations,⁵² and any tax-exempt interest or foreign income received.⁵³ As opposed to the previous eligibility standards set by individual states, the new federal standard does not consider an individual’s assets.⁵⁴ Supporters of the new standard view the AGI-based MAGI test as preferable in its simplification and ease of verification.⁵⁵

While MAGI is intended to simplify the administration of the Medicaid program, it also creates arbitrary distinctions in the treatment of individuals with similar incomes slightly above and below the eligibility threshold and allows the prioritization of asset-wealthy individuals over their more needy counterparts. This outcome runs counter to the Medicaid program’s intentions, and asset tests and cost considerations should be incorporated into Medicaid eligibility requirements to ensure that Medicaid funds are reserved for individuals most in need.

A. MAGI’s Cliff-like Cap on Medicaid Eligibility Creates a Harsh and Arbitrary Cutoff

The PPACA imposes uniform qualifications that states must use in determining Medicaid eligibility to qualify for expanded federal funding.⁵⁶ These new regulations extend Medicaid coverage to all individuals between ages nineteen and sixty-four whose incomes fall below 133% of the FPL,⁵⁷ a figure that works out

52. I.R.C. § 62 (2012).

53. KAISER COMM’N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., EXPLAINING HEALTH REFORM: THE NEW RULES FOR DETERMINING INCOME UNDER MEDICAID IN 2014, at 1 (2011) [hereinafter KAISER, NEW RULES FOR DETERMINING INCOME UNDER MEDICAID IN 2014], <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8194.pdf>.

54. Kip Piper, *Medicaid Expansion: Briefing for Medicaid Health Plans of America*, MEDICAID HEALTH PLANS AM. 29 (June 15, 2010), http://www.mhpa.org/_upload/SDwebinar-June2010.pdf.

55. *Id.*

56. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012); KAISER, NEW RULES FOR DETERMINING INCOME UNDER MEDICAID IN 2014, *supra* note 53, at 1–2.

57. “This income limit includes a five percentage point of income disregard that raises the effective limit to 138% FPL from 133% FPL.” KAISER COMM’N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., MEDICAID ELIGIBILITY FOR ADULTS AS OF JANUARY 1, 2014, at 4 n.1 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8497-medicare-eligibility-for-adults-as-of-january-1-2014.pdf>; *see also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2002, 124 Stat. 119, 281 (2010) (codified at 42 U.S.C. § 1396a(e)(14) (2012)) (establishing rules for determining income eligibility); Ctrs. for Medicare & Medicaid Servs., *Medicaid Expansion & What It Means for You*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-if-my-state-is-not-expanding-medicare/> (Sept. 26, 2014) (explaining differences in eligibility in relation to state Medicaid expansion).

to be \$16,105 for an individual and \$32,913 for a family of four in 2014.⁵⁸ MAGI is a strict cutoff; everyone below the line is eligible to reap full Medicaid benefits, while everyone above the line is not.⁵⁹ Federal eligibility standards are simply minimum baselines; thus, Medicaid eligibility for adults with incomes above those standards varies greatly between states depending on additional discretionary state funding.⁶⁰

This strict cutoff creates significant administrative issues. Many people in the Medicaid population “hover close to the qualifying line for eligibility” and will “cross[] back and forth over the line over the course of a year.”⁶¹ Determining eligibility status and coordinating health benefits for this population is an administrative challenge.⁶² The population is not small; an estimated 35% of adults will experience a change in eligibility within six months on these grounds, and 50% within one year.⁶³ The cliff-like cutoff compromises the fairness of Medicaid administration by removing nuance from considerations of equity and need. Income is only one component of wealth and, conversely, need. Slightly increasing the complexity of Medicaid eligibility determinations and benefit distributions would be justified by achieving more accurate allocation of benefits to those who need them most.

To counteract the arbitrary results of a black-and-white cutoff for Medicaid eligibility, the government should employ a phaseout rather than a cliff cutoff with potential subsidies for non-qualifiers.⁶⁴ A phaseout gradually reduces a taxpayer’s eligibility for a certain benefit as the taxpayer approaches a certain income limit.⁶⁵

58. Ctrs. for Medicare & Medicaid Servs., *Income Levels that Qualify for Lower Health Coverage Costs*, HEALTHCARE.GOV, <https://www.healthcare.gov/how-can-i-save-money-on-marketplace-coverage/> (Sept. 26, 2014).

59. See BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41137, HEALTH INSURANCE PREMIUM CREDITS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) 4–6 (2014).

60. See Renée M. Landers & Patrick A. Leeman, *Medicaid Expansion Under the 2010 Health Care Reform Legislation: The Continuing Evolution of Medicaid’s Central Role in American Health Care*, NAELA J., Spring 2011, at 143, 147.

61. *Id.* at 159 (citing KAISER COMM’N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., COORDINATING COVERAGE AND CARE IN MEDICAID AND HEALTH INSURANCE EXCHANGES 2 (2010), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8118.pdf>).

62. *See id.*

63. *Id.* (citing Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228, 235 (2011)).

64. *Cf.* STAFF OF J. COMM. ON TAXATION, 108TH CONG., DESCRIPTION OF REVENUE PROVISIONS CONTAINED IN THE PRESIDENT’S FISCAL YEAR 2005 BUDGET PROPOSAL 186 (J. Comm. Print 2004) (“Eliminating the disqualified investment income test eliminates the cliff effect that can deny an EIC to a taxpayer merely because he or she has an additional dollar of investment income. However, the cliff effect could be addressed by implementing a phaseout rule so that the credit is reduced as investment income exceeds certain amounts.”).

65. See ROBERTON WILLIAMS, TAX POL’Y CENTER, THE TAX POLICY BRIEFING BOOK: A CITIZENS’ GUIDE FOR THE 2012 ELECTION AND BEYOND 6–7 (2011), <http://www.taxpolicycenter.org/upload/Background/I-7IncomeTaxIssues.final.pdf> (describing how phaseouts of tax provisions affect taxpayers).

The IRS has extensive experience implementing phaseout programs because of their prevalence within the Internal Revenue Code.⁶⁶ For instance, in applying the Child Tax Credit, which credits a taxpayer up to \$1000 per qualifying child, the phaseout begins at \$110,000 for married taxpayers filing a joint return.⁶⁷ Taxpayers with a MAGI falling below this amount can claim the full credit, while taxpayers with a MAGI above this amount receive gradually reduced credits until the income phaseout limit is reached.⁶⁸ “Most phaseouts reduce benefits at a constant rate over the full phaseout range,” so “the rate depends on the width of the range.”⁶⁹ Others, such as the Child Tax Credit, phase out over a certain number of fixed increments.⁷⁰ The phaseout can be gradual or steep depending on the number of fixed increments used.⁷¹ Most phaseouts are adjusted for inflation so that “phaseout ranges remain fixed in real terms.”⁷² Otherwise, inflation would raise nominal incomes and lift taxpayers out of their appropriate thresholds.⁷³

A Medicaid eligibility phaseout would thus strengthen the relationship between ability to pay and governmental assistance and would thus promote fair and just administration of benefits. A phaseout and subsidy serve essentially the same purpose, but a phaseout that reduces benefits according to an individual’s health care costs, as a percentage of their ability to pay, is more flexible where an individual’s income changes sporadically from month-to-month or year-to-year. Within the subsidy system, individuals might hop in and out of Medicaid based on income shifts as little as one dollar, whereas the employment of a phaseout system would produce a less harsh result by linking variances in affordability to different ratios of cost coverage. Thus, small shifts in income would be more likely to change the individual’s expected co-pay than their bottom-line eligibility for Medicaid. The subsidy system is a similar conceptualization but produces jarring results and confusion. A phaseout designed around affordability also ensures that medically needy individuals are covered under the PPACA rather than left crippled by high medical bills they cannot afford despite incomes that are “too high” for Medicaid eligibility, as the next section will discuss.

66. *See id.*

67. I.R.C. § 24(a)–(b) (2012).

68. *See id.* § 24(b)(1).

69. WILLIAMS, *supra* note 65, at 6.

70. *Id.*

71. *See id.*

72. *Id.*

73. *Id.*

B. MAGI's Non-Consideration of Cost Exacerbates the Inaccurate Categorization and Prioritization of Needy Individuals

The PPACA exempts from the mandate and leaves uninsured those individuals whose coverage would cost more than 8% of their household income.⁷⁴ Although persons with income between 133% and 400% of the FPL may receive sliding scale subsidies for purchasing insurance through state exchanges, that sliding scale is based on income only, and there is currently no federal assistance available for medically needy individuals who do not qualify for Medicaid and for whom insurance is unaffordable.⁷⁵ Taxpayers whose MAGI is too high to qualify for Medicaid but whose premium or medical costs are likely to be in excess of 8% of their income should receive federal assistance under a health care system designed to provide comprehensive and affordable coverage.

“Medically needy” assistance programs administered by states prior to the PPACA traditionally presumed that there are circumstances in which people with income over the Medicaid eligibility limit may still need help with extremely high medical expenses.⁷⁶ In states that formally provide these medically needy programs, Medicaid coverage “kicks in” once a taxpayer incurs a certain amount of medical expense during a specific period, called a “spend down.”⁷⁷ Rather than impose any kind of federal coverage *requirement*, the PPACA Medicaid expansion provides a mere *continued option* for states that want to continue their preexisting medically needy programs and “extend Medicaid eligibility to individuals with high medical expenses whose income exceeds the maximum threshold.”⁷⁸ Approximately thirty-six states and the District of Columbia have some form of medically needy program,⁷⁹ and the PPACA exempts these types of programs from the general MAGI eligibility

74. Mark Trumbull, *Obama Signs Health Care Bill: Who Won't Be Covered?*, CHRISTIAN SCI. MONITOR (Mar. 23, 2010), <http://www.csmonitor.com/USA/2010/0323/Obama-signs-health-care-bill-Who-won-t-be-covered>.

75. *Id.* In 2014, an individual with a yearly income of less than \$16,105 qualifies for Medicaid, while an individual with a higher income (up to 400% of the FPL) may receive sliding scale subsidies for insurance premiums. Similarly, a family of four with a yearly income of less than \$32,913 qualifies for Medicaid, while a family earning more may receive subsidies. *See supra* text accompanying notes 57–58.

76. Shanna Hanson, *Medically Needy: Simple or Complex?*, HUM. ARC BLOG (Apr. 3, 2013), <http://www.humanarc.com/blog-entries/medically-needy-simple-or-complex/>.

77. *Id.*

78. KAISER COMM'N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., THE MEDICAID MEDICALLY NEEDED PROGRAM: SPENDING AND ENROLLMENT UPDATE 1 (2012) [hereinafter KAISER, THE MEDICAID MEDICALLY NEEDED PROGRAM], <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/4096.pdf>.

79. *Id.* at 2 (“As of 2009, 33 states and the District of Columbia had Medicaid medically needy programs that covered 2.8 million people.”).

requirements.⁸⁰ But, because consideration of medical need is absent in the formal federal standards for Medicaid eligibility as outlined by the PPACA, the contours of what constitutes medical need can shift from state to state, and states that do not offer extended assistance based on medical need still leave a number of taxpayers at the mercy of high and unaffordable medical costs.⁸¹ Additionally, states' respective abilities to self-finance this type of program are widely disparate due to varying levels of financial stability, resources, and available staff.⁸²

Cost of health care should be a factor in determining Medicaid eligibility under the PPACA expansion. Rather than allowing states the option of retaining a medically needy program that exempts an individual from MAGI requirements, the federal government should mandate assistance for medically needy individuals. The retention of optional medically needy programs produces inconsistency between various state programs and large disparities in treatment of medically needy populations between states that do and do not offer such programs. The wholly voluntary nature of the state programs presents a risk that, "rather than incur these added expenses, states will curtail the scope of covered services, restrict eligibility, or even withdraw from [providing such a] program altogether."⁸³

Medically needy individuals can potentially spend a greater proportion of their income than either Medicaid recipients or those who qualify for low-income insurance subsidies. Exempting such persons from the individual mandate does not solve this problem; while some states will provide further assistance to them, some will not. Additionally, Medicaid under the PPACA works as a priority system: states must cover people with lower incomes before covering people with higher incomes, regardless of individual circumstances.⁸⁴ Incorporation of medical need as an eligibility factor in the PPACA's Medicaid expansion would provide consistent standards throughout states and prevent these truly needy persons from falling through the cracks in a system striving to provide affordable health care for all.

C. MAGI's Non-Consideration of Assets Leads to Inaccurate Categorization and Prioritization of Needy Individuals

Welfare reform in 1996 gave states increased authority over eligibility rules for Medicaid by decoupling these rules from welfare eligibility rules that required

80. KAISER COMM'N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., THE AFFORDABLE CARE ACT'S IMPACT ON MEDICAID ELIGIBILITY, ENROLLMENT, AND BENEFITS FOR PEOPLE WITH DISABILITIES 5 (2014), <http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8390-02-the-affordable-care-acts-impact-on-medicaid-eligibility.pdf>.

81. See KAISER, THE MEDICAID MEDICALLY NEEDED PROGRAM, *supra* note 78, at 2–3.

82. Landers & Leeman, *supra* note 60, at 160 (citing Leighton Ku, *Ready, Set, Plan, Implement: Executing the Expansion of Medicaid*, 29 HEALTH AFF. 1173, 1176 (2010)).

83. Brief for the United States as Amicus Curiae Supporting Petitioner at 2, *Atkins v. Rivera*, 477 U.S. 154 (1986) (No. 85-632), 1986 WL 727844, at *2.

84. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 278–79 (2010) (codified at 42 U.S.C. § 1396a(k)(2) (2012)).

asset examination.⁸⁵ By March 2011, approximately half of states had eliminated Medicaid eligibility asset tests as a result of concerns that asset test implementation was overly burdensome and that asset tests themselves sent troubling policy messages.⁸⁶ While the purpose of asset tests is to ensure that programs meant to benefit low-income people “focus benefits on truly low-income people and exclude those with limited incomes but substantial assets,”⁸⁷ states that eliminated the tests felt that imposing an eligibility asset test was more problematic than beneficial because asset tests were “expensive to administer,” weeded out “very few applicants,” and sent the wrong message to families, namely “that they should not save for their future.”⁸⁸ Asset tests have continued to gain a reputation as cruel and unnecessary, steadily becoming more unpopular as the media increasingly highlights the association between asset tests with very low asset caps and perceived attempts by Republicans to sabotage poor populations.⁸⁹ In popular opinion, all asset testing, even programs with better designs that allow for more significant savings, has become associated with attempts to untowardly restrict or dismantle social insurance.

The elimination of asset tests in determining eligibility for Medicaid benefits, though, weakens the link between neediness and benefit within this means-based social benefit program. According to the new eligibility requirements for Medicaid imposed by the PPACA,⁹⁰ in the scenario presented in the Introduction, Mary will be eligible to receive federal health care assistance, while Bob will have to purchase insurance. None of Mary’s forms of wealth or assets constitute gross income under

85. SMITH ET AL., *supra* note 18, at 1.

86. See *Working Families Featured State: Rhode Island*, NAT’L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/labor-and-employment/working-families-featured-state-rhode-island.aspx> (Sept. 26, 2014).

87. THOMAS RICE & KATHERINE A. DESMOND, HENRY J. KAISER FAMILY FOUND., *Executive Summary of Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test* (2005), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/low-income-subsidies-for-the-medicare-prescription-drug-benefit-the-impact-of-the-asset-test-report.pdf>.

88. UTAH HEALTH POL’Y PROJECT, *REMOVE UTAH’S ASSET TEST: ELIMINATE BARRIERS TO SELF-SUFFICIENCY 1* (2009), http://www.healthpolicyproject.org/Publications_files/Medicaid/assettestfactsheet6-9-09.pdf.

89. See, e.g., Mike Konczal, *The House’s Food Stamps Cuts Aren’t Just Cruel. They’re Dumb.*, WASH. POST WONKBLOG (Sept. 28, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/09/28/the-houses-food-stamps-cuts-arent-just-cruel-theyre-dumb/>; Nicholas Kristof, Op-Ed., *Prudence or Cruelty?*, N.Y. TIMES (Nov. 16, 2013), <http://www.nytimes.com/2013/11/17/opinion/sunday/prudence-or-cruelty.html>; Laura Pereyra, *TANF’s Counterproductive Asset Tests: Eliminating the Tests Will Help Families While Saving States Money*, CENTER FOR AM. PROGRESS (May 6, 2010), <http://www.americanprogress.org/issues/poverty/news/2010/05/06/7846/tanfs-counterproductive-asset-tests/>.

90. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 §§ 2001–2002, 124 Stat. 119, 271–82 (2010) (codified as amended in scattered sections of 42 U.S.C.).

the current Internal Revenue Code,⁹¹ and thus none will be included in determining her eligibility under the MAGI test.⁹² This extreme example⁹³ is a clear illustration of the way individuals with higher wealth may reap Medicaid benefits over needier populations under a strictly MAGI-based evaluation system that does not consider assets. The amount of asset wealth a person can retain while still qualifying for Medicaid benefits is unlimited in theory, and will be unexamined under the new law. Equally concerning is the possibility that a person's income may put him or her over the MAGI eligibility cutoff, when in reality, negative assets and debts render his or her ability to afford insurance far less than his or her income would suggest. Student loan debt, for instance, has become staggering, and such outstanding debt is not included in MAGI-based affordability analysis.⁹⁴

Instead of eliminating asset tests, the PPACA should include assets as a factor in determining ability to pay. What popular opinion against asset testing overlooks is that more appropriate asset tests can prevent potentially egregious abuses of benefit programs that lessen available funds for the needy and may even *increase* enrollment through consideration of negative assets and debts. The inclusion of asset testing would be more sensitive to individual circumstances like Mary's or Bob's because incorporating positive and negative assets and debts into an individual's eligibility profile more accurately portrays whether or not a person can truly afford health care premiums. This more comprehensive approach to benefit eligibility may also assist in preventing benefit reductions to enrollees due to budgetary strain from an unnecessarily overburdened system.⁹⁵

91. See *supra* notes 1–7 and accompanying text.

92. See *supra* text accompanying notes 52–54.

93. In actuality, an individual like Mary with significant cash wealth would be unlikely to qualify for Medicaid if she kept any of her gift or cash assets in a savings account, since the interest generated on the high amount would likely be enough to disqualify the individual from Medicaid eligibility under the MAGI test. See I.R.C. § 61(a)(4) (2012); Treas. Reg. § 1.61-7 (as amended in 1966).

94. E.g., Gary Lapon, *Drowning in Student Debt*, SOCIALISTWORKER.ORG (Nov. 7, 2011), <http://socialistworker.org/2011/11/07/drowning-in-student-debt>; Naomi Schaefer Riley, 'Predator' Student Loans, N.Y. POST (Jul. 23, 2013, 4:00 AM), <http://nypost.com/2013/07/23/predator-student-loans/> ("Young people across America are putting off marriage and starting a family because they're so weighed down by the collective \$1 trillion in accumulated student debt.").

95. See, e.g., Andrew G. Biggs, *Means Testing and Its Limits*, NAT'L AFF., Fall 2011, at 97, 111–12; Deborah Moldover, Note, *An Analysis of the Federal Medicaid Statute's Spousal Anti-Im impoverishment Provision in Light of the Patient Protection and Affordable Care Act's Medicaid Expansion and Current Federal Budgetary Constraints*, ANNALS HEALTH L. ADVANCE DIRECTIVE, Spring 2013, at 168 n.62, <http://www.luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/issue10/moldover.pdf> ("The number of Medicaid enrollees has been steadily increasing nationally, coinciding with a growth in the overall amount of Medicaid spending. While the growth has not been linear, it is logical to conclude that reducing the number of potential beneficiaries would lead to some reduction in Medicaid spending.").

There are a number of ways to design an appropriate asset test that does not implicate the aforementioned public policy concerns. Exemption of certain types of assets with reasonable capped values is one way to address this issue.⁹⁶ Another is to raise the total net amount of allowable assets. The third approach is an extension of the second. Although a full discussion of the third option exceeds the scope of this Note, the idea is worth mentioning both for its novelty and political import.

In fiscal year 2011 budget discussions, President Obama proposed imposing a uniform \$10,000 asset limit for all federally funded means-tested programs serving low-income adults and their families.⁹⁷ The uniformity of such an asset limit would make the application process clear and encourage savings by providing a reasonable, consistent, and clear asset limit for all public assistance programs. Separating the administration of similarly purposed social benefits programs creates situations where several agencies might be tasked with performing analogous duties, which leads to waste and confuses program beneficiaries who must navigate each related program's distinct rules and requirements. The limit proposed by President Obama would relieve administrative burden by fostering coordination between programs and shifting all social benefits toward coordinated eligibility criteria.⁹⁸

Streamlined rules would improve cross-program coordination and promote better access to public benefits of all types. Families would be able to accumulate a modest amount of savings while still qualifying for assistance, and those without additional significant assets would qualify for care before wealthier individuals. Allowing these savings would remove the disincentive for families to save and build assets, as well as help families withstand crises such as job loss, health emergencies, or transportation issues.

96. Cf. LYNN M. LOPUCKI & ELIZABETH WARREN, *SECURED CREDIT: A SYSTEMS APPROACH* 14–16 (5th ed. 2006) (explaining the concept of foreclosure exemption statutes, which exist in all fifty states and prevent seizing certain property in foreclosure, such as houses, cars, consumer goods, and business property below certain values); Kerry A. Ryan, *Access Assured: Restoring Progressivity in the Tax and Spending Programs for Higher Education*, 38 *SETON HALL L. REV.* 1, 17–18 (2008) (discussing calculation of the expected family contribution in a student aid context and exemptions for home equity and retirement accounts).

97. REBECCA VALLAS & JOE VALENTI, *CTR. FOR AM. PROGRESS, ASSET LIMITS ARE A BARRIER TO ECONOMIC SECURITY AND MOBILITY* 5 (2014), http://cdn.americanprogress.org/wp-content/uploads/2014/09/Asset_Limits_Brief.pdf; see also Supplemental Security Income Restoration Act of 2014, S. 2089, 113th Cong. (proposing an increase in asset limits for the Supplemental Security Income (SSI) program, from \$2,000 to \$10,000 for unmarried individuals). Studies have suggested that the limit could or should be even higher, but the concept remains the same. See, e.g., CHILDREN & FAMILY SERVS. ADMIN., MINN. DEP'T OF HUMAN SERVS., *REPORT ON UNIFORM ASSET LIMIT REQUIREMENTS* 5–6 (2013), http://cfed.org/assets/pdfs/Uniform_Asset_Limit_Requirements_Report_Final.pdf (analyzing a proposed program under both a \$10,000 and \$20,000 asset limit).

98. See *infra* text accompanying note 108.

III. A BETTER WAY TO EXPAND MEDICAID: MEDICAID ELIGIBILITY SHOULD FUNCTION SIMILARLY TO STUDENT AID ELIGIBILITY & EFC SHOULD SERVE AS A MODEL CALCULATION METHODOLOGY

In order to adequately address the problems discussed above, Medicaid eligibility considerations should mirror those of certain other federal aid programs where contributions are determined by need. One extremely practical model for comparison is federal student aid eligibility. Student eligibility for Pell Grant and subsidized loan programs under Title IV is determined on the basis of financial need calculated by a formula that considers the cost of attendance less the student's expected family contribution (EFC), which is the federal government's measure of a family's ability to pay postsecondary education expenses out of their own resources.⁹⁹ The first step in calculating EFC is to determine a family's available income, which is gross income less certain allowances.¹⁰⁰ EFC is similar to MAGI in this regard. Unlike MAGI, EFC then goes on to add a parental contribution based on asset wealth, while excluding certain assets from consideration.¹⁰¹ Assets includable in EFC are "the current balance of checking and savings accounts and cash on hand; the net value of investments and real estate, excluding the net value of the principal place of residence; and the adjusted net worth of a business or farm."¹⁰² EFC also takes negative assets into account,¹⁰³ which guards against overestimating a family's ability to pay where their assets have depreciated or they are saddled with significant debt obligations.

In 2008, the Congressional Research Service found that administrative functions represent about 5% of total Medicaid program expenditures, a fraction of what private insurers spend on plan administration.¹⁰⁴ Because administering Medicaid involves much more than determining eligibility based on MAGI, it is unlikely that the intended simplification will dramatically affect administrative costs. For instance, the PPACA includes means-testing provisions for premium

99. Ryan, *supra* note 96, at 16 (citing 20 U.S.C. § 1087mm (2000)).

100. *Id.* at 17.

101. *Id.*

102. 20 U.S.C. § 1087oo(d)(2) (2012).

103. 20 U.S.C. § 1087vv(g) (2012).

104. Compare APRIL GRADY, CONG. RESEARCH SERV., RS22101, STATE MEDICAID PROGRAM ADMINISTRATION: A BRIEF OVERVIEW 3 (2008), with GARY DORRIEN, THE OBAMA QUESTION: A PROGRESSIVE PERSPECTIVE 117 (2012) ("[O]verhead costs for self-insured large companies are 5 to 10 percent of premiums; HMOs range between 15 and 25 percent; companies in the small group market average 26 percent; and individual insurance averages 40 percent of premiums."). *But see* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 137 (2010) (codified at 42 U.S.C. § 300gg-18 (2012)) (requiring insurance companies offering coverage in the small group or individual market to spend at least 80% of premium dollars on medical care and those in the large group market to spend at least 85% of premium dollars on medical care).

structures under the Medicare prescription drug benefit program.¹⁰⁵ Administrators are thus tasked with making ongoing income-based eligibility determinations, subsidy determinations, and exemption investigations, while maintaining an average administrative cost of 3% of Medicare program expenditures.¹⁰⁶ In some states, the new MAGI test will actually increase health officials' workloads. In Texas, for instance, the Health and Human Services Commission believes that health officials' workloads will be increased because applicants for Medicaid are also evaluated for the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families program (TANF), which are unaffected by the PPACA and continue to consider assets.¹⁰⁷ In such cases, the state's decision to participate in the PPACA's Medicaid expansion turns a once single-process evaluation of assets and wealth into a multi-process evaluation.

Consider how this approach might apply to our old friends, Mary and Bob. If Medicaid worked like student aid, when undertaking an evaluation of assistance eligibility, the reviewer would begin by exempting a standard amount of Bob or Mary's income and assets from consideration.¹⁰⁸ Certain additional types of assets might be categorically excluded from consideration—529 college savings accounts and the value of a primary residence, farm, or small business are all, for instance, excluded from the Free Application for Federal Student Aid (FAFSA) ability-to-pay calculations.¹⁰⁹ The net worth of the remaining income and assets would be compared to the estimated cost of the individual's health care. If the individual's net worth was lower than a certain amount, or if the ratio of his or her health care costs to net worth exceeded a certain percentage, he or she would be eligible for Medicaid assistance. Because of the phaseout, an individual with greater need would be 100% covered while an individual just over the eligibility line would likely be expected to provide a co-pay. Under these guidelines, it's difficult to imagine a scenario in which Mary could ever qualify for Medicaid assistance ahead of Bob.

CONCLUSION

By expanding the Medicaid program to provide greater access to health care services for low-income people, the PPACA takes a giant step towards providing affordable health care access to all U.S. citizens. However, the PPACA faces many

105. Patient Protection and Affordable Care Act § 3308, 124 Stat. at 472–75 (codified 42 U.S.C. § 1395w-113 (2012)).

106. DORRIEN, *supra* note 104, at 117.

107. Lyndsay Knecht, *Texans Applying for Medicaid Will Be Judged Only on Income, Not Assets*, KERA NEWS (July 31, 2013, 9:15 AM), <http://keranews.org/post/texans-applying-medicaid-will-be-judged-only-income-not-assets>.

108. See 20 U.S.C. § 108700 (2012).

109. *Id.* § 108700(d); William Baldwin, *Paying for College: How the Financial Aid Formulas Work*, FORBES (Feb. 28, 2013, 12:04 PM), <http://www.forbes.com/sites/baldwin/2013/02/28/college-aid-formulas-fafsa-profile-and-consensus/>.

substantial legal, political, and practical hurdles, including wrangling with how best to achieve its goals. Some of these goals require more long-term analysis, but the effects of other implementation decisions can be more clearly forecasted. An individual's ability to afford marketplace products like health care depends on more than just income. MAGI should be a factor in determining Medicaid eligibility, but it should not be the sole point of determination. Delivering adequate and wide-reaching health care benefits to impoverished populations is a goal that will be better served if eligibility is determined by a figure that considers income, assets, and costs to more accurately reflect an individual's ability to afford health care costs within their comprehensive life circumstances. Such an approach will produce more accurate, fairer results for people with high medical costs or debt and better propel the PPACA toward its goal of delivering health insurance to all citizens at a cost they can truly afford.