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The ACA Medicaid Expansion

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Summary

Historically, Medicaid eligibility has generally been limited to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities; however, as of January 1, 2014, states have the option to extend Medicaid coverage to most nonelderly, low-income individuals.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148 as amended) established 133% of the federal poverty level (FPL) (effectively 138% of FPL with an income disregard of 5% of FPL) as the new mandatory minimum Medicaid income eligibility level for most nonelderly individuals. On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, which effectively made the ACA Medicaid expansion optional for states.

If a state accepts the ACA Medicaid expansion funds, it must abide by the expansion coverage rules. For instance, modified adjusted gross income (MAGI) counting rules are used for determining eligibility for the ACA Medicaid expansion population, and individuals covered under the ACA Medicaid expansion are required to receive alternative benefit plan (ABP) coverage.

The ACA provides different federal Medicaid matching rates for the individuals who receive Medicaid coverage through the ACA Medicaid expansion. The federal government's share of most Medicaid expenditures is determined according to the federal medical assistance percentage (FMAP) rate, but exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. The ACA adds a few FMAP exceptions for the ACA Medicaid expansion: the "newly eligible" FMAP rate, the "expansion state" FMAP rate, and the additional FMAP increase for certain expansion states. Due to these ACA FMAP rates, the federal government pays for a vast majority of the cost of the ACA Medicaid expansion.

On January 1, 2014, when the ACA Medicaid expansion went into effect, 24 states and the District of Columbia had included the ACA Medicaid expansion as part of their Medicaid programs. Michigan and New Hampshire implemented the expansion on April 1, 2014, and July 1, 2014 (respectively). Pennsylvania recently received approval to implement the ACA Medicaid expansion beginning on January 1, 2015.

Most states implementing the ACA Medicaid expansion will do so through an expansion of their current Medicaid program. However, some states are implementing the expansion through an alternative method, such as the "private option" (i.e., premium assistance to purchase health insurance through the health insurance exchanges under the ACA) and health savings accounts.

State decisions *not* to implement the ACA Medicaid expansion could have implications for low-income individuals, large employers with low-wage workers, and hospitals. For example, most uninsured individuals with incomes under 100% of FPL will likely remain uninsured, and large employers with low-wage workers might have greater exposure to employer penalties included in the ACA. Also, Medicaid disproportionate share hospital (DSH) allotments will be reduced by the same across the nation whether or not states implement the expansion.

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Introduction

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute care services, as well as long-term services and supports.[1] It is a federal-state program, and participation in Medicaid is voluntary for states, though all states and the District of Columbia choose to participate. In order to participate in Medicaid, the federal government requires states to cover certain mandatory populations and benefits, but the federal government also allows states to cover optional populations and services. Due to this flexibility, there is substantial variation among the states in terms of factors such as Medicaid eligibility, covered benefits, and provider payment rates.

Medicaid is jointly financed by the federal government and the states. States incur Medicaid costs by making payments to service providers (e.g., for doctor visits) and performing administrative activities (e.g., making eligibility determinations), and the federal government reimburses states for a share of these costs.[2] The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP).[3] The FMAP varies by state and is inversely related to each state's per capita income. For FY2015, FMAP rates range from 50% (13 states) to 74% (Mississippi).

Historically, Medicaid eligibility has generally been limited to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities; however, starting January 1, 2014, states have the option to extend Medicaid coverage to most nonelderly, nonpregnant adults with income up to 133% of the federal poverty (FPL). This expansion of Medicaid eligibility is one of a number of changes the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) made to the Medicaid program, and it is referred to as the ACA Medicaid expansion.

This report provides an overview of the ACA Medicaid expansion, and the impact of the Supreme Court decision on the ACA Medicaid expansion. Then, the report describes who is covered under the expansion, the expansion rules, and how the expansion is financed. In addition, enrollment and expenditure estimates for the ACA Medicaid expansion are provided. Finally, the report reviews state decisions whether or not to implement the ACA Medicaid expansion, and the implications of those decisions on certain individuals, employers, and hospitals.

Medicaid Eligibility Before the Expansion

A common misconception about the Medicaid program is that all low-income individuals are eligible for Medicaid. Instead, only certain low-income individuals are eligible for Medicaid coverage. To qualify, an individual must meet both categorical (i.e., must be a member of a

[1] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[2] For an overview of Medicaid financing issues, see CRS Report R42640, *Medicaid Financing and Expenditures*, by Alison Mitchell.

[3] For more information about the FMAP rate, see CRS Report R42941, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014*, by Alison Mitchell and Evelyne P. Baumrucker.

covered group, such as children, pregnant women, parents with dependent children, the elderly, or individuals with disabilities) and financial eligibility requirements. In addition, individuals need to meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.[4]

The federal Medicaid statute (Title XIX of the Social Security Act) defines a number of distinct population groups as being potentially eligible for Medicaid coverage. Some of these populations are mandatory eligibility groups that states must cover if they choose to participate in Medicaid, while others are optional eligibility groups that states are allowed to cover if they choose to do so. In addition, states are able to provide Medicaid coverage to additional populations not listed as a mandatory or optional coverage group in statute through Section 1115 demonstration waivers.[5] Due to optional eligibility groups and the Section 1115 demonstration waivers, Medicaid eligibility varies significantly from state to state.

The bars in **Figure 1** show the federally mandated Medicaid income eligibility levels for the major population groups that were in effect prior to the implementation of the ACA Medicaid expansion. The text in **Figure 1** indicates the number of states in January 2013 using optional eligibility groups and Section 1115 waivers to provide Medicaid coverage to individuals with incomes above the federally mandated level and the highest income eligibility level for each population.

The ACA Medicaid expansion provides states with the option to increase Medicaid eligibility to 133% of FPL for nonelderly, nonpregnant adults. As shown in **Figure 1**, prior to the ACA, Medicaid income eligibility levels for parents with dependent children were low relative to the income eligibility levels for children and pregnant women, and adults without dependent children were not eligible for Medicaid in most states. For this reason, 70% of low-income children had Medicaid coverage, while 30% of low-income, nonelderly adults had Medicaid coverage. In addition, the uninsured rate for low-income, nonelderly adults was 42%, which was more than twice the national average of 18%.[6]

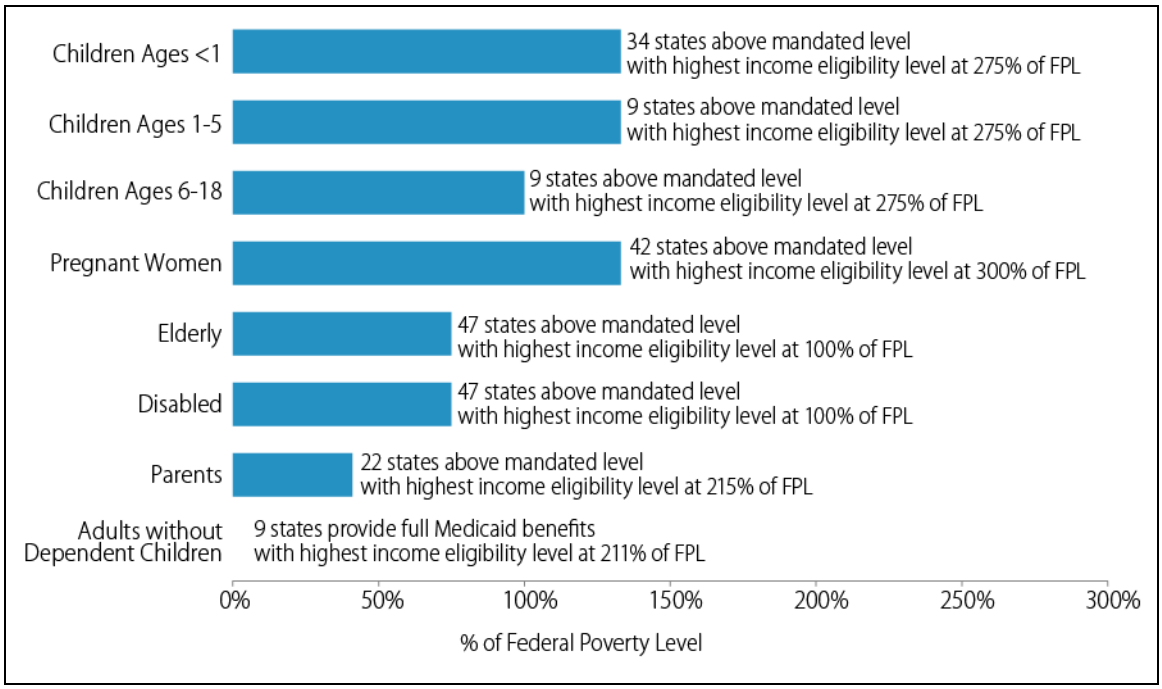
[4] Most legal permanent residents that have been in the United States for more than five years can be eligible for Medicaid if they meet the other eligibility requirements. Most legal permanent residents during their first five years, undocumented immigrants, and immigrants in the United States on a temporary basis are generally ineligible for Medicaid.

[5] Section 1115 of the Social Security Act gives the Secretary of the Department of Health and Human Services (HHS) authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program.

[6] Not all individuals eligible for Medicaid have Medicaid coverage because individuals may not know they are eligible or choose to not enroll in the program. (Kaiser Commission on Medicaid the Uninsured, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, October 2013.)

Figure 1. Federally Mandated Medicaid Income Eligibility Criteria as a Percentage of FPL, by Major Population Category

January 2013



Source: Federal statute; Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP,* March 2013.

Notes: As of January 1, 2014, the federally mandated Medicaid eligibility level for children aged 6 through 18 increased from 100% to 133% of FPL as part of the ACA but not as part of the optional ACA Medicaid expansion.

FPL: Federal poverty level.

ACA Medicaid Expansion

The primary goals of ACA are to increase access to affordable health insurance for the uninsured and to make health insurance more affordable for those already covered. The ACA Medicaid expansion is one of the major insurance coverage provisions included in the law, but the ACA Medicaid expansion is just one of a few Medicaid eligibility expansions included in the ACA.[7]

The ACA Medicaid expansion (as initially enacted) established 133% of FPL as the new mandatory minimum Medicaid income eligibility level for most nonelderly, nonpregnant adults. The law also specified that an income disregard in the amount of 5% of FPL be deducted from an individual's income when determining Medicaid eligibility based on the modified adjusted gross income (MAGI). Thus, the upper income eligibility threshold for individuals in this new

[7] The ACA also requires states to provide Medicaid coverage to certain individuals who age out of foster care, up to age 26 regardless of their income, and do not qualify under one of the other mandatory groups noted above starting in 2014. In addition, the ACA increased the federally mandated Medicaid eligibility level for children ages six through 18 from 100% to 133% of FPL beginning in 2014.

eligibility group is effectively 138% of FPL. This ACA Medicaid expansion was effective January 1, 2014 (or earlier at state option).[8]

The Supreme Court decision in *National Federation of Independent Business (NFIB) v. Sebelius* made the ACA Medicaid expansion optional rather than mandatory. In states that adopt the ACA Medicaid expansion, the three major groups of individuals gaining Medicaid coverage are adults without dependent children, parents with dependent children, and adults with disabilities. States that implement the ACA Medicaid expansion are required to follow the ACA Medicaid expansion rules. The federal government funds a vast majority of the cost for the ACA Medicaid expansion.

Supreme Court Decision

Originally, it was assumed that all states would implement the ACA Medicaid expansion in 2014 as required by statute because implementation was required in order for states to receive *any* federal Medicaid funding. However, with respect to Medicaid, the Supreme Court decision in *NFIB* addressed the issue of whether withholding Medicaid reimbursement to a state unless that state complies with the expansion of its Medicaid program exceeds Congress's enumerated powers under the Spending Clause and/or violates the Tenth Amendment. On June 28, 2012, the Supreme Court issued its decision in *NFIB*, and the Supreme Court held that the ACA Medicaid expansion violated the Constitution.[9]

The Supreme Court decision held that the federal government could not withhold payment for a state's entire Medicaid program for failure to implement the ACA Medicaid expansion. However, the federal government could withhold the funding for the ACA Medicaid expansion if a state did not implement the expansion. As a result, the Supreme Court's ruling in *NFIB* effectively made state participation in the ACA Medicaid expansion voluntary. The federal government cannot terminate federal Medicaid matching funds for a state's pre-ACA Medicaid program if a state doesn't implement the ACA Medicaid expansion.

After the Supreme Court ruling, the Centers for Medicare and Medicaid Services (CMS) issued guidance to states specifying that states have no deadline for deciding when to implement the ACA Medicaid expansion. Also, the guidance said states that decide to implement the expansion have the ability to end the ACA Medicaid expansion at any point in time.[10]

[8] The ACA provided states with the option to implement the ACA Medicaid expansion earlier than 2014. During the transitional period between April 1, 2010, and January 1, 2014, states had the option to expand Medicaid to individuals eligible under the new eligibility group up to 133% of FPL as long as the state did not extend coverage to (1) individuals with higher income before those with lower income or (2) parents unless their children are enrolled in the state plan, a waiver, or in other health coverage. Eight states (California, Colorado, Connecticut, Illinois, Minnesota, New Jersey, Ohio, and Washington) and the District of Columbia elected to implement the ACA Medicaid expansion prior to 2014.

[9] For more information about the Supreme Court decision, see CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

[10] As with making any other change to a state's Medicaid state plan, in order to end the ACA Medicaid expansion, states would be required to submit a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) for approval. (CMS, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, December 2012.)

Who Is Covered Under the Expansion

The three major categories of nonelderly adults that would receive Medicaid coverage under the ACA Medicaid expansion are adults without dependent children, parents with dependent children, and adults with disabilities. Prior to the implementation of the ACA Medicaid expansion, only a few states provided Medicaid coverage to adults without dependent children, and in general, the Medicaid income eligibility level for parents and adults with disabilities was significantly lower than 133% of FPL (i.e., the ACA Medicaid expansion eligibility level).

Adults Without Dependent Children

Prior to the ACA, adults without dependent children were not included in the federal statute as either a mandatory or an optional Medicaid coverage group. However, states were able to provide Medicaid coverage to these adults through Section 1115 demonstration waivers or state-funded programs.

As of January 2013, eight states (Arizona, Colorado, Connecticut, Delaware, Hawaii, Minnesota, New York, and Vermont)[11] and the District of Columbia provided full Medicaid coverage to adults without dependent children, and only two of these states and the District of Columbia covered adults without dependent children up to at least 133% of FPL. In addition, 18 states[12] provided Medicaid coverage with limited benefits to adults without dependent children.[13]

For most states, a significant portion of the population that would gain Medicaid coverage through the implementation of the ACA Medicaid expansion would be adults without dependent children. See **Figure A-1** for state-by-state Medicaid income eligibility levels for nonelderly adults without dependent children as of January 1, 2014.

Parents

Under Section 1931 of the Social Security Act, states are required to provide Medicaid coverage for parents (and their dependent children), at a minimum, at the Aid to Families with Dependent Children (AFDC) eligibility levels in place on July 16, 1996.[14] This federally mandated eligibility threshold varies by state but averages 41% of FPL.

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[11] Enrollment to new enrollees was closed in Arizona and Colorado.

[12] As of January 2013, the following 18 states provide Medicaid coverage with limited benefits to adults without dependent children: Arkansas, California, Idaho, Indiana (enrollment closed), Iowa, Maine (enrollment closed), Maryland, Massachusetts, Michigan (enrollment closed), Minnesota, New Jersey, New Mexico (enrollment closed), Oklahoma, Oregon (enrollment closed), Utah (enrollment closed to non-working childless adults), Vermont, Washington (enrollment closed), and Wisconsin (enrollment closed).

[13] Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2013, Table 110 on page 94.

[14] AFDC was a federal entitlement program to low-income families with children that provided cash assistance, which was replaced with Temporary Assistance for Needy Families (TANF), signed into law in 1996 as part of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, P.L. 104-193). Under AFDC, those receiving AFDC benefits were guaranteed Medicaid eligibility, but TANF and Medicaid eligibility are not linked. PRWORA established a new eligibility category for these low-income families under Section 1931 of the Social Security Act, which requires states to cover parents who meet the AFDC eligibility criteria in place on July 16, 1996. The AFDC eligibility criteria had a categorical and a financial requirement. The categorical requirement is that the individual is a single parent or a two-parent family in which the principal earner is unemployed. The financial requirement is the (continued...)

Section 1931 of the Social Security Act also gives states the option to cover parents with incomes above the 1996 minimum levels and most states do. As of January 2013, 12 states[15] provided full Medicaid coverage for parents of dependent children with incomes at or above 133% of FPL, and 13 states[16] provided Medicaid coverage with limited benefits to parents of dependent children with incomes of 133% of FPL or higher.[17]

In most states, the ACA Medicaid expansion would provide Medicaid coverage to a significant number of parents with dependent children. See **Figure A-2** for state-by-state Medicaid income eligibility levels for parents with dependent children as of January 1, 2014.

Adults with Disabilities

The major Medicaid eligibility pathway for nonelderly, disabled individuals is based on the program rules for the Supplemental Security Income (SSI) program. Federal law requires states to provide Medicaid coverage to recipients of SSI. The income eligibility threshold for SSI translates to 74% of FPL in 2014.[18] However, Section 209(b) of the Social Security Amendments of 1972 (P.L. 92-603) gave states the option to use Medicaid eligibility criteria for adults with disabilities with income and resources thresholds that are more restrictive than SSI but no more restrictive than those in effect on January 1, 1972.[19] Therefore, in 209(b) states, receipt of SSI does not guarantee eligibility for Medicaid.

States also have the option to provide Medicaid coverage to nonelderly adults with disabilities through other optional eligibility pathways, such as the poverty level, medically needy, and special income level.[20]

Prior to the ACA Medicaid expansion, all states had Medicaid income eligibility thresholds for nonelderly adults with disabilities below 133% of FPL. As a result, the implementation of the ACA Medicaid expansion would provide a significant increase in the Medicaid income eligibility level for nonelderly adults with disabilities. See **Figure A-3** for state-by-state Medicaid income eligibility levels for nonelderly adults with disabilities as of January 1, 2014.

(...continued)

AFDC income eligibility levels in place on July 16, 1996, which vary by state.

[15] The following 12 states have Medicaid eligibility thresholds for full Medicaid coverage for parents with dependent children at or above 133% of FPL: Connecticut, District of Columbia, Hawaii, Illinois, Maine, Massachusetts, Minnesota, New Jersey, New York, Rhode Island, Vermont, and Wisconsin.

[16] The following 13 states provide limited Medicaid coverage to parents with dependent children: Arkansas, California, Idaho, Indiana, Iowa, Massachusetts, Minnesota, New Mexico (enrollment closed), Oklahoma, Oregon (enrollment closed), Utah (enrollment closed to non-working childless adults), Vermont, and Washington (enrollment closed).

[17] Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2013, Table 110 on page 94.

[18] In 2014, the maximum federal SSI payment, referred to as the federal benefit rate, is $721 per month for an individual living independently and $1,082 for a couple living independently in 2014, which translates to 74% of FPL in 2014. For more information about SSI income and resource limits, see CRS Report RS20294, *Supplemental Security Income (SSI): Income/Resource Limits and Accounts Exempt from Benefit Determinations*, by William R. Morton.

[19] There are 11 209(b) states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

[20] For more information about the optional Medicaid eligibility pathways for nonelderly, disabled adults, see CRS Report R41899, *Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles*, by Kirsten J. Colello and Scott R. Talaga.

ACA Medicaid Expansion Rules

The requirements for the ACA Medicaid expansion vary from other aspects of the program. If a state accepts the ACA Medicaid expansion funds, it must abide by the new expansion coverage rules. For instance, MAGI counting rules are used for determining eligibility for the ACA Medicaid expansion population,[21] and individuals covered under the ACA Medicaid expansion are required to receive alternative benefit plan (ABP) coverage.

MAGI Income Counting Rules

As of January 1, 2014, the MAGI counting rules are used in determining eligibility for most of Medicaid's nonelderly populations, including the ACA Medicaid expansion. MAGI is defined as the Internal Revenue Code's adjusted gross income (AGI, which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments) increased (if applicable) by tax-exempt interest and income earned by U.S. citizens or residents living abroad.[22]

Under the MAGI counting rules, the state looks at the individual's MAGI, deduct 5%, which the law provides as a standard disregard, and compare that income to the MAGI income standards set by each state in coordination with CMS.[23]

ABP Coverage

The ACA mandates the individuals gaining Medicaid coverage through the ACA Medicaid expansion receive Medicaid benefits through ABPs, which are a Medicaid benefit structure that has different requirements than the traditional Medicaid benefits.[24] In general, ABP coverage may be less generous than traditional Medicaid coverage but more generous than most private health insurance coverage. ABPs may cover fewer benefits than traditional Medicaid, but there are some requirements, such as coverage of family planning and transportation services that private insurance generally does not cover.[25] As a result, an adult with disabilities may have access to different coverage through the ACA Medicaid expansion eligibility pathway (i.e., eligible for Medicaid based solely on their low-income status) than the adults with disabilities that have Medicaid coverage through the SSI eligibility pathway (i.e., eligible for Medicaid based on being low-income and disabled).[26] However, during the application process, states must identify those

[21] The MAGI income counting rules also apply to most other Medicaid eligibility groups.

[22] While the Internal Revenue Service's definition of MAGI excludes nontaxable Social Security benefits, P.L. 112-56, enacted on November 21, 2011, changed the definition of income for Medicaid eligibility to include such nontaxable social security benefits.

[23] For more information about MAGI rules, see CRS Report R41997, *Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA*, coordinated by Christine Scott.

[24] The traditional Medicaid program covers a wide variety of mandatory services (e.g., inpatient hospital services, lab/x-ray services, physician care, nursing facility care for persons aged 21 and over), and other services at state option (e.g., prescribed drugs, physician-directed clinic services, physical therapy, prosthetic devices) to the majority of Medicaid beneficiaries across the United States. Within broad federal guidelines, states define the amount, duration, and scope of these benefits. Thus, even mandatory services are not identical from state to state.

[25] For more information about ABPs, see CRS Report R42478, *Traditional Versus Benchmark Benefits Under Medicaid*, by Elicia J. Herz.

[26] For more information about coverage of long-term services and supports under ABPs, see CRS Report R43328, (continued...)

who are medically frail and offer them a choice of ABP or traditional Medicaid benefits as their ABP coverage.[27]

Financing

The ACA provides different federal Medicaid matching rates for the individuals that will gain Medicaid coverage through the ACA Medicaid expansion. The federal government's share of most Medicaid expenditures is determined according to the FMAP rate,[28] but exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. The ACA adds a few FMAP exceptions for the ACA Medicaid expansion: the "newly eligible" FMAP rate, the "expansion state" FMAP rate, and the additional FMAP increase for certain expansion states.

"Newly Eligible" FMAP Rates

The "newly eligible" FMAP rate is used to reimburse states for the Medicaid expenditures for "newly eligible" individuals who gained Medicaid eligibility due to the ACA Medicaid expansion. The "newly eligible" individuals are defined as nonelderly, nonpregnant adults with family income below 133% of FPL who would not have been eligible for Medicaid in the state as of December 1, 2009 (or were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment). States will receive 100% FMAP rate (i.e., full federal financing) for the cost of providing Medicaid coverage to "newly eligible" individuals, from 2014 through 2016. For "newly eligible" individuals, the FMAP rate will phase down to 95% in 2017, 94% in 2018, 93% in 2019, and 90% afterward (**Table 1**).

Federal statute specifies the "newly eligible" FMAP rate for each year, which means the "newly eligible" FMAP rates are available for these specific years regardless of when a state implements the ACA Medicaid expansion. For instance, if a state implements the ACA Medicaid expansion in 2018, then that state will receive a "newly eligible" FMAP rate of 94% in 2018, 93% in 2019, and 90% afterward.

(...continued)

Medicaid Coverage of Long-Term Services and Supports, by Kirsten J. Colello.

[27] Department of Health and Human Services, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost-Sharing; Exchanges: Eligibility and Enrollment," 78 *Federal Register* 42160, July 15, 2013.

[28] Generally determined annually, the FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%. For FY2015, regular FMAP rates range from 50.00% to 73.58%. For more information about the FMAP rate, see CRS Report R42941, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014*, by Alison Mitchell and Evelyne P. Baumrucker.

Table 1. FMAP Rates for ACA Medicaid Expansion

	2014	2015	2016	2017	2018	2019	2020+
"Newly eligible" Adults in all States	100%	100%	100%	95%	94%	93%	90%
Certain Individuals in "Expansion states"	75%-92%	80%-93%	85%-95%	86%-93%	90%-93%	93%	90%

Source: Prepared by the Congressional Research Service.

Notes: For the calculation of the "expansion state" FMAP rates, the lower bound is for a state with a regular FMAP rate of 50% (which is the statutory minimum), and the upper bound is for a state with a regular FMAP rate of 83% (which is the statutory maximum).

"Expansion State" FMAP Rates

As mentioned earlier, prior to the ACA, some states used Section 1115 waivers to provide Medicaid coverage to adults without dependent children and to parents with incomes above the threshold for the Section 1931 pathway. As a result, these states have few or no individuals who will qualify for the "newly eligible" FMAP rate. As of 2014, these states receive an increased FMAP rate, which is referred to as the "expansion state" FMAP rate.

This definition of expansion state was established prior to the Supreme Court decision making ACA Medicaid expansion optional for states. In this context, expansion state refers to states that had already implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted. Specifically, "expansion states" are defined as those that, as of March 23, 2010 (ACA's enactment date), provided health benefits coverage meeting certain criteria[29] statewide to parents with dependent children and adults without dependent children up to at least 100% of FPL.[30] As of early December 2013, the Centers for Medicare and Medicaid Services (CMS) determined the following states met the definition of "expansion state" and would be eligible for the "expansion state" FMAP rate if the state implements the ACA Medicaid expansion: Arizona, Delaware, District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, and Washington.[31]

The "expansion state" FMAP rate is available for individuals in "expansion states" that have implemented the ACA Medicaid expansion who were eligible for Medicaid on March 23, 2010 and are in the new eligibility group for nonelderly, nonpregnant adults at or below 133% of FPL. The formula[32] used to calculate the "expansion state" FMAP rates is based on a state's regular FMAP rate, so the "expansion state" FMAP rates varies from state to state until CY2019, at

[29] The coverage must include inpatient hospital services and cannot consist only of the following: premium assistance (or Medicaid coverage otherwise dependent on employer coverage or contribution), hospital-only plans, high-deductible health plans, or Health Opportunity Accounts under Section 1938 of the Social Security Act.

[30] A state that offered health benefits coverage to only parents or only nonpregnant childless adults is not considered to be an expansion state; both groups must have been covered as specified for a state to be classified as an expansion state.

[31] Communication with CMS March 4, 2014.

[32] Expansion state FMAP formula = [regular FMAP + (newly eligible FMAP – regular FMAP) × transition percentage equal to 50% in CY2014, 60% in CY2015, 70% in CY2016, 80% in CY2017, 90% in CY2018, and 100% in CY2019 and subsequent years].

which point the "newly eligible" FMAP rates and the "expansion state" FMAP rates will be equal (see **Table 1**).

"Expansion states" are not excluded from receiving the "newly eligible" FMAP rates. Populations in an "expansion state" that meet the definition for the "newly eligible" FMAP rate will receive the "newly eligible" FMAP rate. For example, an "expansion state" that prior to the ACA provided Medicaid coverage to nonelderly adults without dependent children and parents with dependent children up to 100% of FPL, will receive the higher "newly eligible" FMAP rate for individuals between 100% and 133% of FPL if it implements the ACA Medicaid expansion. Also, "expansion states" will receive the "newly eligible" FMAP rate for individuals who received limited Medicaid benefits prior to the expansion. In addition, "expansion states" that provided state-funded health benefits coverage will receive the "newly eligible" FMAP rate for individuals previously covered by the state-only program.[33]

Additional FMAP Increase for Certain "Expansion States"

During 2014 and 2015, an FMAP rate increase of 2.2 percentage points is available for "expansion states" that (1) the Secretary of the Department of Health and Human Services (HHS) determines will not receive any FMAP rate increase for "newly eligible" individuals and (2) have not been approved to use Medicaid disproportionate share hospital (DSH) funds to pay for the cost of health coverage under a waiver in effect as of July 2009.[34] The 2.2 percentage point increase is applied to the state's regular FMAP rate and is applied to those individuals who are not "newly eligible" individuals. Vermont is the only state that has been confirmed as meeting the criteria for the additional FMAP increase for certain "expansion states."

Enrollment and Expenditure

The ACA Medicaid expansion is expected to significantly increase Medicaid enrollment and federal Medicaid expenditures.

Enrollment

In terms of enrollment, the Congressional Budget Office (CBO) estimates the insurance coverage provisions from the ACA will increase Medicaid and the State Children's Health Insurance Program (CHIP) enrollment of nonelderly individuals by 13 million in FY2024.[35] A vast majority of the increase in enrollment for Medicaid and CHIP is due to the ACA Medicaid expansion, but enrollment is also impacted by other provisions, such as the expansion of Medicaid eligibility for foster care children and children ages six to 18.

[33] CMS, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, December 10, 2012.

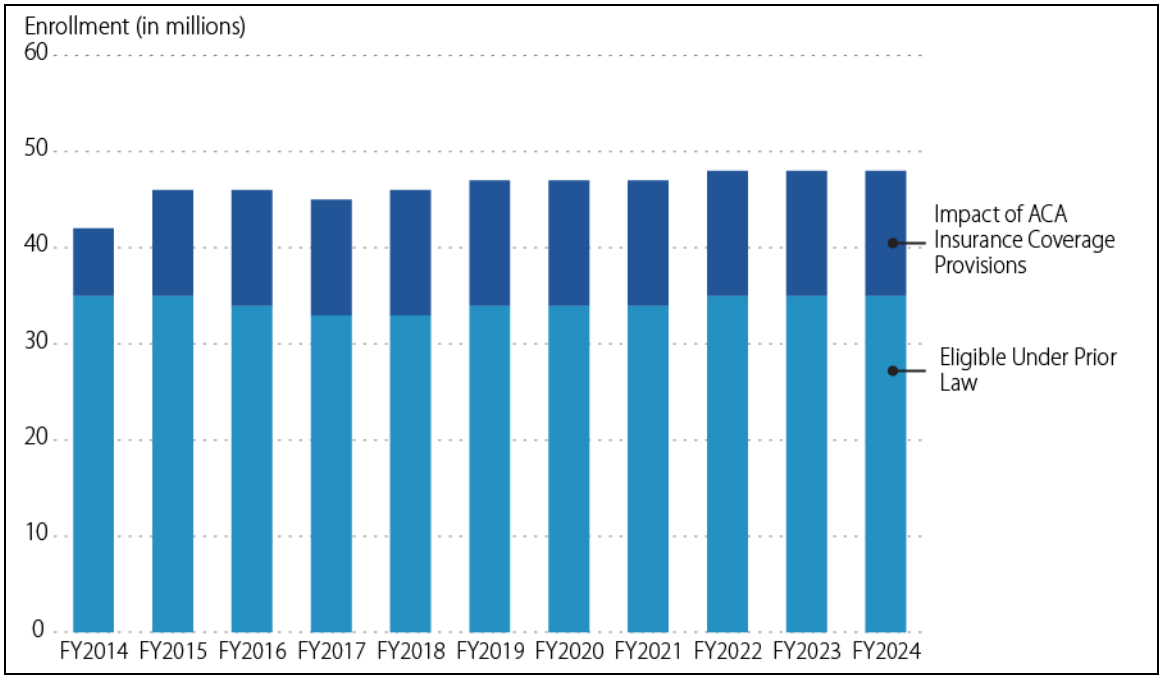
[34] Under an approved Section 1115 waiver, states may have limited authority to make Medicaid disproportionate share hospital (DSH) payments under Section 1923 of the Social Security Act because all or a portion of their DSH allotment is included in the budget neutrality calculation for an expansion of Medicaid eligibility under an approved Section 1115 waiver or to fund uncompensated care pools and/or safety net care pools. For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

[35] Congressional Budget Office, *Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act,* April 2014.

Figure 2 shows the year-by-year estimates of the effects of the ACA insurance coverage provisions on Medicaid and CHIP enrollment. Even without all states participating in the ACA Medicaid expansion, the ACA insurance coverage provisions are expected to increase Medicaid and CHIP enrollment for nonelderly individuals by more than 25% in each year after FY2015.[36]

Figure 2. Estimated Effects of ACA Insurance Coverage Provisions on Medicaid and CHIP Enrollment for Nonelderly Individuals

FY2014 to FY2024



Source: Congressional Budget Office, *Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act,* April 2014.

Notes: Figure reflects average enrollment over the course of a year.

Regardless of whether a state decides to implement the ACA Medicaid expansion or not, all states are expected to experience an increase in Medicaid enrollment due to the "woodwork" effect. This is the term for uninsured individuals who without the expansion are eligible for Medicaid but decide to enroll in Medicaid due to increased media attention and outreach efforts associated with the ACA. The impact of the woodwork effect depends on the percentage of a state's population that is eligible but not enrolled in Medicaid. Nationally, an estimated 7.3 million to 9.0 million uninsured children and adults were eligible but not enrolled in Medicaid prior to the implementation of the expansion.[37]

[36] Ibid.

[37] Genevieve M. Kenney, Lisa Dubay, Stephen Zuckerman, and Michael Huntress, *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid?*, The Urban Institute Health Policy Center, July 5, 2012; Benjamin D. Sommers and Arnold M. Epstein, "Perspective: Why States Are So Miffed about Medicaid - Economics, Politics, and the "Woodwork Effect"," *The New England Journal of Medicine*, vol. 365, no. 2, pp. 100-102 (July 14, 2011).

Actual enrollment for the ACA Medicaid expansion is not currently available. CMS has been reporting monthly Medicaid and CHIP enrollment numbers since October 2013, but this enrollment data does not break out the enrollment for the ACA Medicaid expansion. The data provides the aggregate enrollment for Medicaid and CHIP enrollees receiving comprehensive coverage on a state-by-state basis. However, the preliminary July 2014 data is the first month for which all states reported enrollment data and states are still transitioning to the standardized reporting specifications. Both of these considerations limit the conclusions that can be drawn from the monthly enrollment data.[38]

According to this data, among the 49 states reporting enrollment data for both September 2014 and the baseline period (i.e., July 2013 through September 2013), approximately 9.2 million additional individuals were enrolled in Medicaid and CHIP in September 2014 compared with the average monthly enrollment for the baseline period, which is almost a 16% increase.[39] For states that had implemented the ACA Medicaid expansion, Medicaid and CHIP enrollment increased by more than 23%, whereas states that had *not* implemented the expansion reported an increase of approximately 6% over the same period.[40]

CMS is working on Medicaid enrollment reports that will specify the number of individuals that are newly eligible due to the ACA Medicaid expansion and plans to release these enrollment reports "soon."[41]

Expenditures

Figure 3 shows the annual estimated federal budgetary effect of the ACA insurance coverage provisions on Medicaid and CHIP outlays compared to estimated Medicaid and CHIP outlays without the ACA insurance coverage provisions. Most of the federal expenditures for the Medicaid and CHIP insurance coverage provisions are due to the ACA Medicaid expansion, but these expenditures also include other provisions, such as the expansion of Medicaid eligibility for foster care children and children ages six to 18. From FY2015 through FY2024, CBO estimates the ACA Medicaid and CHIP insurance coverage provisions will increase federal Medicaid and CHIP outlays by almost 23%.[42]

The federal government will be covering a vast majority (94%) of the cost of the ACA Medicaid and CHIP insurance coverage provisions. CBO estimates these provisions will increase federal Medicaid and CHIP outlays by a total of $792 billion from FY2015 through FY2024, while states' cost of these provisions is estimated to be $46 billion over the same period of time.[43]

[38] CMS, *Medicaid & CHIP: July 2014 Monthly Applications, Eligibility Determinations and Enrollment Report*, September 22, 2014; CMS, *Medicaid & CHIP: September 2014 Monthly Applications, Eligibility Determinations and Enrollment Report*, November 18, 2014.

[39] Connecticut and Maine were not included in the enrollment figures for July through September of 2013.

[40] These figures are based on the preliminary September 2014 data. CMS, *Medicaid & CHIP: September 2014 Monthly Applications, Eligibility Determinations and Enrollment Report*, November 18, 2014.

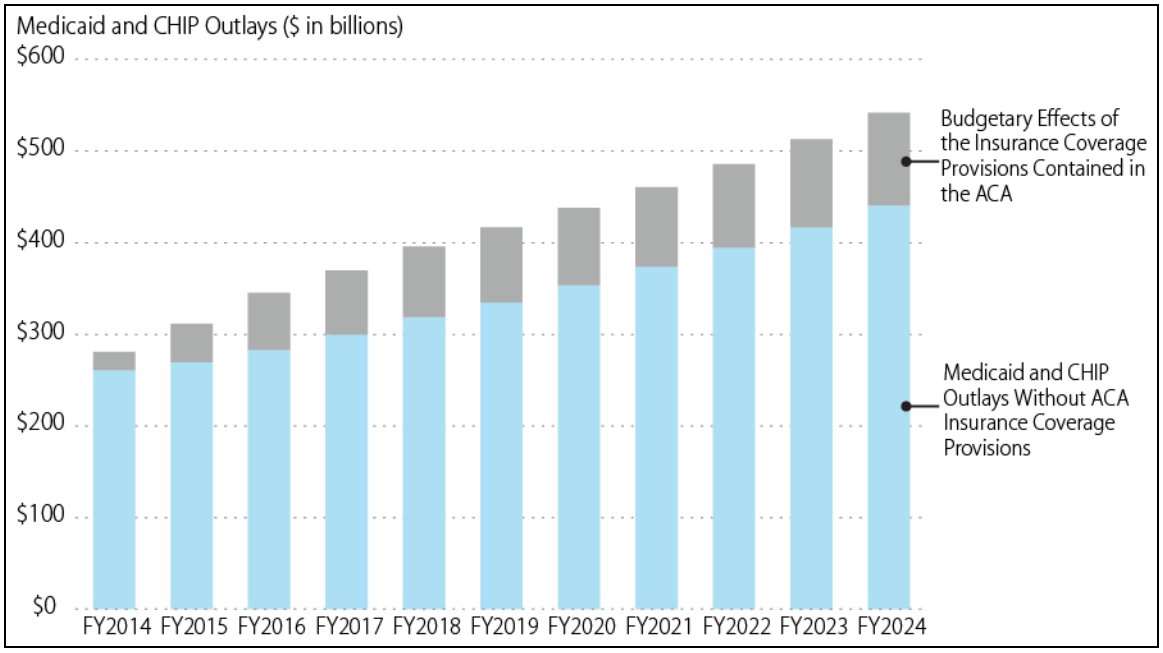
[41] Politico Pro Afternoon Pulse, *New Medicaid Enrollment Report Pending*, December 9, 2014.

[42] Congressional Budget Office, *Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act,* April 2014.

[43] Ibid.

Figure 3. Estimated Federal Medicaid and CHIP Outlays for the ACA Insurance Coverage Provisions Compared to Outlays Without the ACA Insurance Coverage Provisions

FY2014 to FY2024



Source: Congressional Budget Office, *Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act,* April 2014; Congressional Budget Office, *Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline*, April 2014; Congressional Budget Office, *Detail of Spending and Enrollment for Children's Health Insurance Program for CBO's April 2014 Baseline*, April 2014.

Notes: Federal Medicaid expenditures exclude expenditures for disproportionate share hospital payments, Vaccines for Children, and administration.

The potential impact of the ACA Medicaid expansion varies significantly from state to state. Medicaid enrollment and expenditures are estimated to increase at varying rates from state to state due to the current variation in states' Medicaid income eligibility levels for nonelderly adults and state demographics. See **Table B-1** for state-by-state estimates of the potential impact of the ACA Medicaid expansion on Medicaid expenditures and enrollment.[44]

State Decisions

On January 1, 2014, when the ACA Medicaid expansion went into effect, 24 states and the District of Columbia included the expansion as part of their Medicaid programs. Michigan implemented the expansion on April 1, 2014, and New Hampshire implemented the expansion on July 1, 2014.[45] Pennsylvania received approval for a Section 1115 waiver to implement the ACA Medicaid expansion beginning on January 1, 2015.

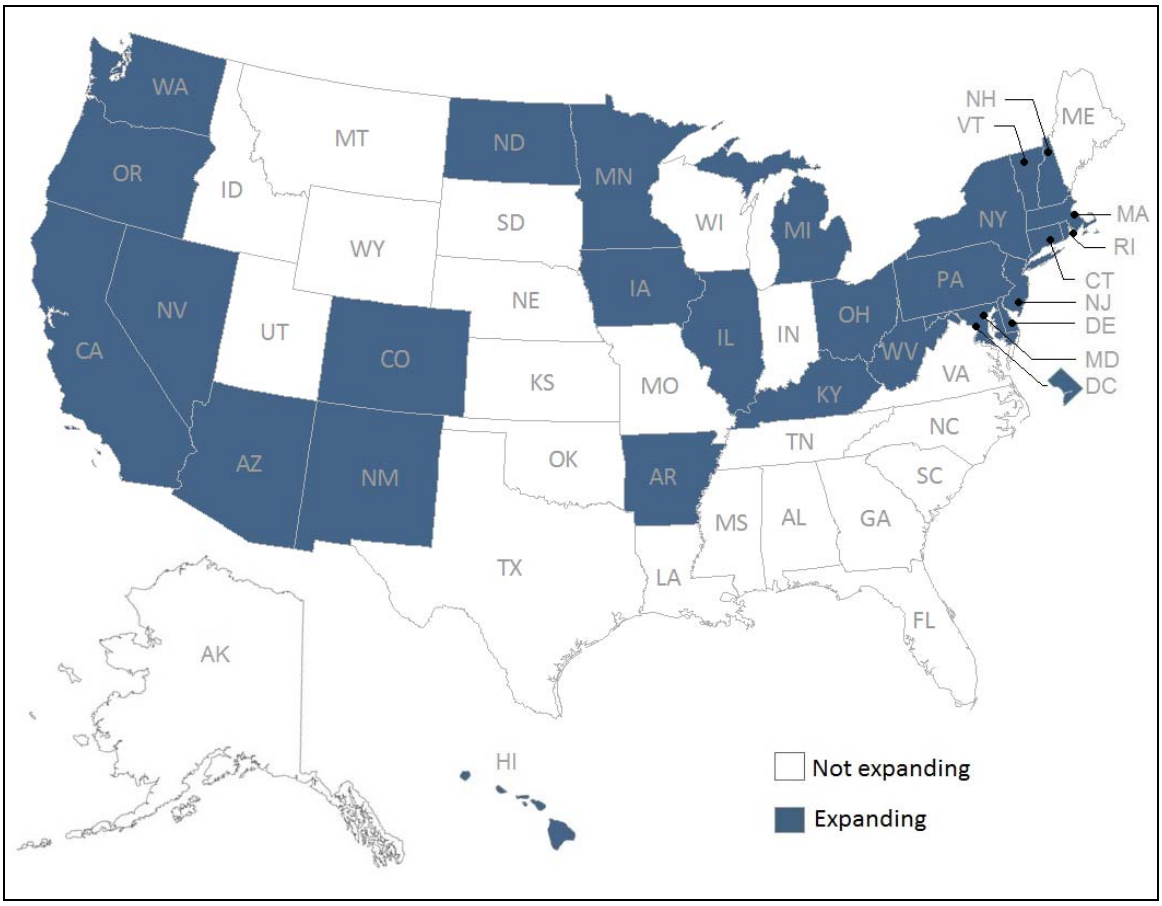
[44] Neither CMS nor CBO provide state level estimates of these changes. The appendix provides estimates conducted by the Urban Institute.

[45] Adrianne Appel, "New Hampshire: Gov. Hassan Signs Bill to Expand Medicaid Coverage Via Waiver Plan," (continued...)

See **Figure 4** for a map of the states that have and have not decided to implement the ACA Medicaid expansion as of December 2014. In six of the states that have *not* expanded (Indiana, Montana, Tennessee, Utah, Virginia, and Wyoming), the ACA Medicaid expansion is currently being debated.[46]

Figure 4. State Decisions Whether to Implement the ACA Medicaid Expansion

As of December 2014



Source: Congressional Research Service.

Note: Most states implemented the ACA Medicaid expansion on January 1, 2014, but Michigan implemented the expansion on April 1, 2014 and New Hampshire implemented the expansion on July 1, 2014. Pennsylvania plans to implement the expansion on January 1, 2015.

(...continued)

Bloomberg BNA, March 31, 2014.

[46] Jason Millman, "23 states still haven't expanded Medicaid. Which could be next?," *The Washington Post*, August 23, 2014; Sarah Wheaton, "In GOP states, division on Medicaid," *Politico Pro*, September 7, 2014; David Morgan, "Money talks: Obamacare initiative makes headway in Republican states," *Reuters*, September 26, 2014. Avalere State Reform Insights, *28 States & DC Are Expanding Medicaid Eligibility; Other May Make Decisions to Expand*, November 25, 2014; Jason Millman, "Tennessee Gov. Bill Haslam endorses Medicaid expansion," *The Washington Post*, December 15, 2014.

Although there are some exceptions, most of the states that have implemented the ACA Medicaid expansion tend to have low rates of uninsured individuals (relative to the national average) and traditionally have provided Medicaid coverage to more nonelderly adults through relatively higher Medicaid income eligibility levels. Also, in general, the states that have *not* implemented the ACA Medicaid expansion have relatively higher rates of uninsured and traditionally have covered fewer nonelderly adults under Medicaid.[47]

Because states are able to implement or discontinue the expansion at any time, the status of the ACA Medicaid expansion in states remains uncertain. State laws must be enacted and funds appropriated to implement or discontinue a Medicaid expansion decision.[48] As a result, states' decisions regarding the expansion generally occur during the legislative sessions, which typically occur during the first half of the calendar year. In response to a budget survey, Medicaid officials in several states noted that implementing the ACA Medicaid expansion would be debated during their state's next[49] legislative session.[50] Even states that have already implemented the expansion could debate the issue. For instance, in Arkansas, state law requires the legislature to approve the ACA Medicaid expansion annually and the expansion received just enough votes to pass last year.[51]

States have chosen *not* to implement the ACA Medicaid expansion for various reasons, including because they view the expansion as unaffordable to the state and the Medicaid program as "broken."[52] However, the ACA Medicaid expansion became more politically feasible for some states with CMS's approval of Arkansas's proposal to implement the ACA Medicaid expansion using the "private option," which provides premium assistance for Medicaid enrollees to purchase private health insurance through the health insurance exchange.

Alternative Models

Most states implementing the ACA Medicaid expansion will do so through an expansion of their current Medicaid program. However, some states are implementing the expansion through alternative models, such as premium assistance through the "private option"[53] and health savings accounts.[54]

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[47] U.S. Census Bureau, American Community Survey, 2012; Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, March 2013.

[48] For more information about how states make the decision whether or not to implement the ACA Medicaid expansion, see CRS Report WSLG433, *Who Gets to Say Yes or No to the Medicaid Expansion - The Governor or the State Legislature?*, by Kathleen S. Swendiman.

[49] Most states meet for their legislative sessions in the first half of the year.

[50] Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, et al., *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, Kaiser Commission on Medicaid and the Uninsured, October 14, 2014.

[51] Paul Demko, "Arkansas' Medicaid expansion model could hinge on election outcomes," *Modern Healthcare*, October 30, 2014.

[52] State Refor(u)m, *Governors Address Medicaid Expansion in "State of the State" Speeches*, March 2013.

[53] With premium assistance, states are able to use federal Medicaid funds to subsidize the cost of private health insurance coverage for Medicaid enrollees in lieu of direct Medicaid coverage. Under the "private option," the state provides premium assistance to purchase health insurance coverage under the qualified health plans offered through the health insurance exchanges.

[54] Health savings accounts are accounts with funding available to cover the cost of health care services. An HSA, in and (continued...)

Four states (Arkansas, Iowa, Michigan, and Pennsylvania) have received approval for Section 1115 waivers to implement their ACA Medicaid expansions. Arkansas and Iowa have been approved to use the "private option,"[55] and Michigan received approval to use health savings accounts. In addition, Iowa, Michigan, and Pennsylvania received approval to charge premiums in excess of what is allowed under Medicaid state plans, and in each of these states, the cost-sharing requirements can be reduced through healthy behaviors. Iowa and Pennsylvania also received waivers from being required to provide nonemergency medical transportation services[56] for the first year.[57]

States *Not* Implementing the Expansion

State decisions *not* to implement the ACA Medicaid expansion could have implications for low-income individuals, large employers with low wage workers, and hospitals. The decision for a state to opt out of the ACA Medicaid expansion is expected to increase the number of individuals in that state receiving premium tax credits and cost-sharing subsidies through the health insurance exchanges and create a coverage gap for individuals not eligible for those credits and subsidies. In addition, a state's decision *not* to implement the expansion may increase the number of ACA employer penalties in that state and make the Medicaid DSH reduction lower for that state.

Low-Income Individuals

Even if a state does *not* implement the ACA Medicaid expansion, some of the individuals that would have been covered by the Medicaid expansion may still gain health insurance coverage under the ACA health insurance coverage provisions. The ACA provides premium tax credits to individuals with household income between 100% and 400% of FPL who do not have access to minimum essential coverage, and these individuals with income between 100% and 250% of FPL could be eligible for cost-sharing subsidies.[58] As a result, most uninsured individuals with

(...continued)

of itself, is not a health insurance plan. Instead, it is an investment account in which contributions earn interest tax free. In the private market, consumers, their employers, or both may make contributions to HSAs. Consumers withdraw funds on a tax-free basis to cover medical expenses not covered by health insurance. Unused contributions roll over to the next year.

[55] Pennsylvania's waiver application included the "private option," but starting January 1, 2015, Pennsylvania is using Medicaid managed care to cover the ACA Medicaid expansion population.

[56] Nonemergency medical transportation enables Medicaid beneficiaries to obtain covered medical services from both local providers and tertiary care centers at some distance from their homes. States are required to make nonemergency medical transportation available to Medicaid beneficiaries to assure their access to medically necessary services.

[57] CMS, Section 1115 Waiver Approval Letter to Arkansas Department of Human Services for the "Arkansas Health Care Independence Program," September 27, 2013; CMS, Section 1115 Waiver Approval Letter to Iowa Department of Human Services for "Iowa Marketplace Choice," December 10, 2013; CMS, Section 1115 Waiver Approval Letter to Iowa Department of Human Services for the "Iowa Wellness Plan," May 1, 2014; CMS, Section 1115 Waiver Approval Letter to Michigan Medical Services Administration for "Healthy Michigan," December 30, 2013; CMS, Section 1115 Waiver Approval Letter to Pennsylvania Department of Public Welfare for "Healthy Pennsylvania," August 28, 2014.

[58] The definition of minimum essential coverage is broad. It includes Medicare Part A, Medicaid, the State Children's Health Insurance Program (CHIP), Tricare, the TRICARE for Life program, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Secretary of HHS in coordination with the Treasury Secretary.

incomes between 100% and 133% of FPL living in states that decide *not* to implement the ACA Medicaid expansion may become eligible for premium tax credits and cost-sharing subsidies to purchase insurance through the health insurance exchanges. However, most uninsured individuals with incomes under 100% of FPL living in states that decide *not* to implement the ACA Medicaid expansion will likely remain uninsured, because these individuals are not eligible for premium tax credits or the cost-sharing subsidies to purchase health insurance through the exchanges. However, legal permanent residents within their first five years in the country are eligible for premium tax credits with incomes ranging from zero up to 400% of FPL.[59]

For this reason, after the Supreme Court decision, some states were initially interested in implementing a partial ACA Medicaid expansion rather than the full Medicaid expansion. Under the partial Medicaid expansion, Medicaid eligibility would be increased to all nonelderly individuals up to 100% of FPL rather than to 133% of FPL, because premium tax credits and cost-sharing subsidies would be available to individuals above 100% of FPL. However, CMS informed states that the 100% federal funding for 2014 through 2016 would not be available to states that implement a partial expansion. CMS said if states wish to implement the partial expansion, they could do so and receive their regular federal Medicaid matching rate through 2016, and at that point, CMS will consider Section 1115 Medicaid demonstrations with the enhanced federal matching rates.[60]

The ACA was supposed to provide health coverage for all low income individuals by providing Medicaid coverage to the individuals with the lowest incomes and providing premium tax credits and cost-sharing subsidies for coverage through the exchanges to low-income individuals with incomes above Medicaid eligibility levels. However, the Supreme Court's decision making the Medicaid expansion optional for states has created a coverage gap in states that have *not* implemented the Medicaid expansion. Nearly 5 million uninsured adults were estimated to be in the coverage gap resulting from states' decisions *not* to implement the ACA Medicaid expansion, which means these 5 million individuals have incomes above their states' Medicaid eligibility levels and below the lower income limit for premium tax credits and cost-sharing subsidies for exchange coverage.[61] **Figure A-1**, **Figure A-2**, and **Figure A-3** show as of January 1, 2014, the coverage gaps in states for adults without dependent children, parents, and adults with disabilities (respectively).

Large Employers with Low-Wage Workers

Large employers with low-wage workers in states that do *not* implement the ACA Medicaid expansion might have greater exposure to employer penalties included in the ACA when the penalty goes into effect in 2015.[62] The ACA imposes penalties on "large" employers[63] if at least

[59] In general, legal permanent residents within their first five years in the country are not eligible for Medicaid, so the ACA extended premium tax credits to these individuals with income below 400% of FPL so that they would be able to purchase health insurance through the exchanges. After five years, legal permanent residents are eligible for Medicaid according to the Medicaid eligibility levels in their state. For more information about noncitizen eligibility for Medicaid, see CRS Report RL33809, *Noncitizen Eligibility for Federal Public Assistance: Policy Overview and Trends*, by Alison Siskin.

[60] CMS, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, December 2012.

[61] Kaiser Commission on Medicaid and the Uninsured, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, October 2013.

[62] The employer penalty was supposed to go into effect in 2014, but on July 2, 2013, the Obama Administration announced that it is delaying, until 2015, the enforcement and associated reporting requirements related to the employer (continued...)

one of their full-time employees obtains a premium credit through the exchange. Individuals who are not offered employer-sponsored coverage and who are not eligible for Medicaid or other programs may be eligible for premium tax credits for coverage through an exchange. As mentioned above, to receive premium tax credits, individuals must have income of at least 100% and up to 400% of FPL.

In states that do *not* implement the ACA Medicaid expansion, large employers with low income workers could be at greater risk of paying the ACA employer penalty. That is because more low-income workers could qualify for premium tax credits.[64]

Hospitals

The Medicaid statute requires states to make DSH payments to hospitals treating large numbers of low-income patients. This is intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates are generally lower than the rates paid by Medicare and private insurance.[65]

The federal government provides each state an annual DSH allotment, which is the maximum amount of federal matching funds that each state can claim for Medicaid DSH payments. The ACA included a provision directing the Secretary of HHS to make aggregate reductions because the ACA health insurance coverage provisions would reduce the need for Medicaid DSH payments. The ACA Medicaid DSH reductions have been amended a few times since the ACA, but under current law, the Medicaid DSH allotments will be reduced for the years FY2017 through FY2024.

Hospitals in states that are *not* expanding Medicaid are concerned because Medicaid DSH allotments will be reduced without regard to whether or not states implement the expansion. If a state implements the expansion, uncompensated care for hospitals should decline along with the DSH allotments (though not proportionally). However, if a state chooses *not* to implement the expansion, the demand for uncompensated hospital care is expected to persist but the amount of Medicaid DSH payments hospitals receive to subsidize such care may be reduced.[66] As a result, hospitals have been encouraging states to implement the ACA Medicaid expansion in order to

(...continued)

penalty. For more information about the delay to the employer penalty, see CRS Report R43150, *Delay in Implementation of Potential Employer Penalties Under ACA*, by Bernadette Fernandez and Annie L. Mach.

[63] The employer penalty will be phased-in—the penalty will apply to larger firms with 100 or more FTE employees in 2015 and employers with 50 or more FTE employees in 2016.

[64] For more information about the employer penalty, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*, by Julie M. Whittaker.

[65] For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

[66] Toluse Olorunnipa, "Obamacare Cutbacks Shut Hospitals Where Medicaid Went Unexpanded," *Bloomberg Government*, November 25, 2013. Letter from the Republican Governors Public Policy Committee to President Barack Obama dated July 10, 2012, available at http://www.scribd.com/doc/99730375/Medicaid-and-Exchange-Letter-Final. Sarah Kliff, "The super wonky reason states may join the Medicaid expansion," *The Washington Post*, July 8, 2012. Bob Neal, The Fiscal and Economic Impacts of Medicaid Expansion in Mississippi, 2014-2025, Mississippi Public Universities University Research Center, October 2012.

reduce uncompensated care for hospitals. Even though Medicaid provider rates are generally lower than the rates paid by private insurance or Medicare, hospitals are likely better off with payment for a Medicaid patient than no payment for an uninsured patient.

Appendix A. States' Current Medicaid Income Eligibility Levels

The three major categories of nonelderly adults that would receive Medicaid coverage under the ACA Medicaid expansion are adults without dependent children, parents with dependent children, and adults with disabilities. Prior to the implementation of the ACA Medicaid expansion, only a few states provided Medicaid coverage to adults without dependent children, and in general, the Medicaid income eligibility level for parents and disabled adults was significantly lower than 133% of FPL (i.e., the ACA Medicaid expansion eligibility level).

State-by-state Medicaid income eligibility levels and private health insurance exchange eligibility for subsidized coverage for nonelderly adults without dependent children, parents with dependent children, and nonelderly adults with disabilities as of January 1, 2014 are provided in **Figure A-1**, **Figure A-2**, and **Figure A-3** (respectively).

These figures show the coverage gaps in states, which means individuals with incomes that fall in the coverage gap do not have access to full Medicaid coverage or exchange subsidized coverage. States that have implemented the ACA Medicaid expansion do not have coverage gaps, while most states that have *not* implemented the expansion have coverage gaps for all three populations.

Figure A-1 shows the coverage for adults without dependent children. Most states that have implemented the ACA Medicaid expansion provide Medicaid eligibility up to 133% of FPL (effectively 138% of FPL with the 5% income disregard). Of the states that have implemented the expansion, only the District of Columbia and Minnesota have higher income eligibility levels at 210% of FPL (effectively 215% of FPL) and 200% of FPL (effectively 205% of FPL), respectively. Except for Wisconsin, the states that have *not* implemented the expansion do not have Medicaid coverage for adults without dependent children. Wisconsin provides Medicaid coverage to adults without dependent children up to 95% of FPL (effectively 100% of FPL).

Figure A-2 shows the coverage for parents with dependent children. All states provide Medicaid coverage to this population through the mandatory Medicaid eligibility pathway of Section 1931 coverage, which requires states to provide Medicaid coverage for parents (and their dependent children), at a minimum, at the Aid to Families with Dependent Children (AFDC) eligibility levels in place on July 16, 1996. Section 1931 of the Social Security Act also gives states the option to cover parents with incomes above the 1996 minimum levels and most states do. Under Section 1931 coverage, parents receive traditional Medicaid coverage. The income eligibility level for Section 1931 coverage is less than 133% of FPL for most states.

For states that have implemented the ACA Medicaid expansion and did not have Medicaid coverage for parents up to 133% of FPL (effectively 138% of FPL), parents with incomes above the pre-expansion level up to 133% of FPL (effectively 138% of FPL) receive coverage under the expansion rules (e.g., alternative benefit plan coverage).

Except for Maine and Wisconsin, the states that have *not* implemented the expansion have coverage gaps for parents with dependent children between the upper bound of their Section 1931 coverage and 100% of FPL when most of these parents are eligible for subsidized coverage through the exchange. Maine and Wisconsin provide Medicaid coverage to parents with dependent children up to 100% of FPL (effectively 105% of FPL) and 95% of FPL (effectively 100% of FPL), respectively.

Figure A-3 shows coverage for adults with disabilities. All states provide Medicaid coverage to adults with disabilities through mandatory Medicaid coverage for recipients of SSI or through optional eligibility pathways, such as Section 209(b), poverty level, medically needy, and special income level. Under these eligibility pathways, adults with disabilities receive traditional Medicaid benefits.[67] In all states, the Medicaid income eligibility levels for adults with disabilities under these eligibility pathways are significantly less than 100% of FPL.

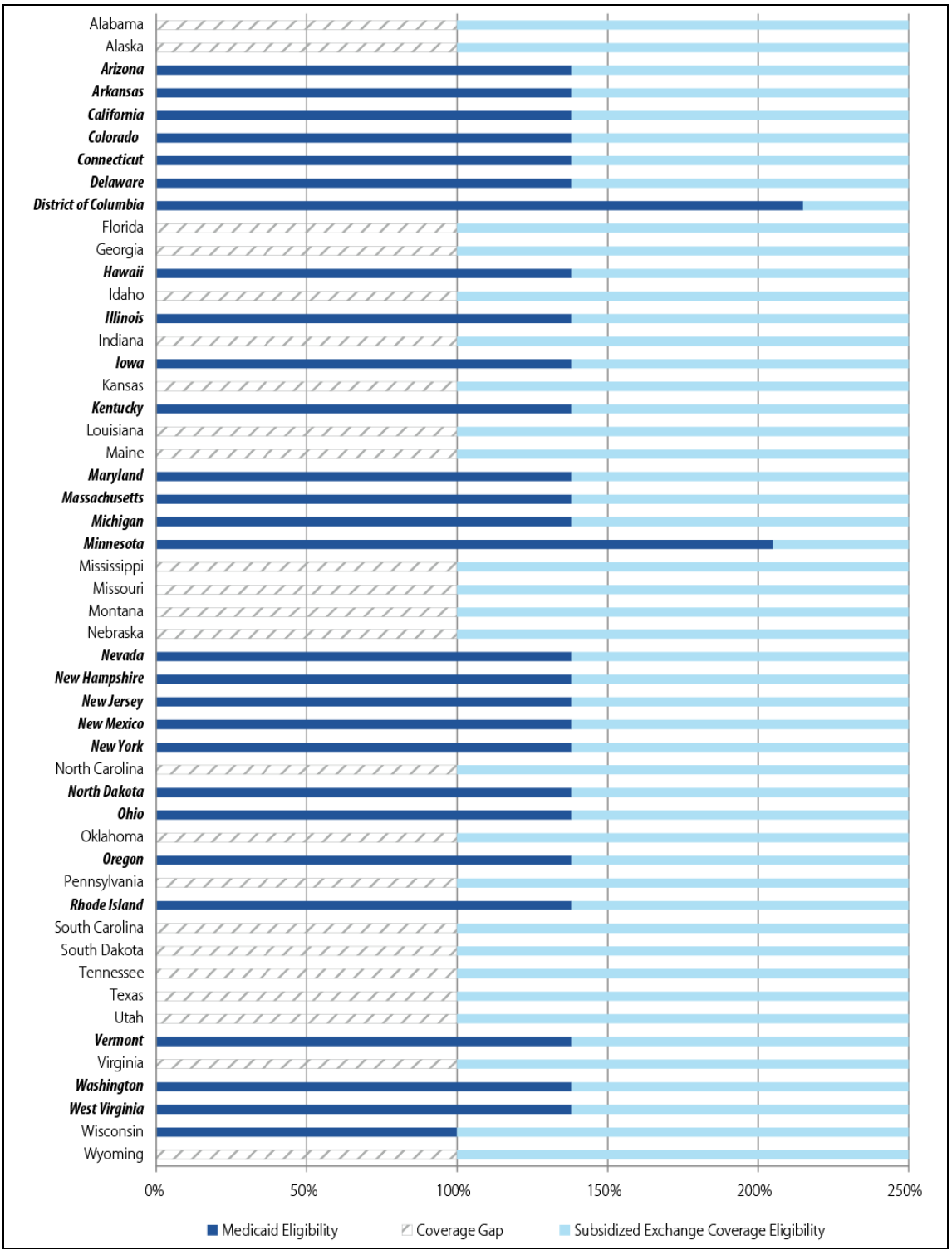
For states that have implemented the ACA Medicaid expansion, adults with disabilities with incomes above the pre-expansion level up to 133% of FPL (effectively 138% of FPL) receive coverage under the expansion rules (e.g., alternative benefit plan coverage).

The states that have *not* implemented the expansion have coverage gaps for adults with disabilities between the upper bound of their Medicaid coverage for adults with disabilities and 100% of FPL when most of these adults are eligible for subsidized coverage through the exchange.

[67] Special benefit rules apply for the medically needy pathway.

Figure A-1. State-by-State Medicaid and Exchange Subsidized Coverage Income Eligibility Levels for Adults Without Dependent Children up to 250% of FPL

As of January 1, 2014



Source: Centers for Medicare and Medicaid Services, "State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014," October 24, 2013; Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2013, Table 110 on page 94.

Note: States in bold are states that have decided to implement the ACA Medicaid expansion. Most states implemented the expansion on January 1, 2014, but Michigan and New Hampshire implemented the expansion on April 1, 2014, and July 1, 2014 (respectively). Pennsylvania plans to implement the ACA Medicaid expansion on January 1, 2015.

The "Medicaid Eligibility" category could either be the ACA Medicaid expansion implemented through state plan rules or coverage provided through a Section 1115 waiver.

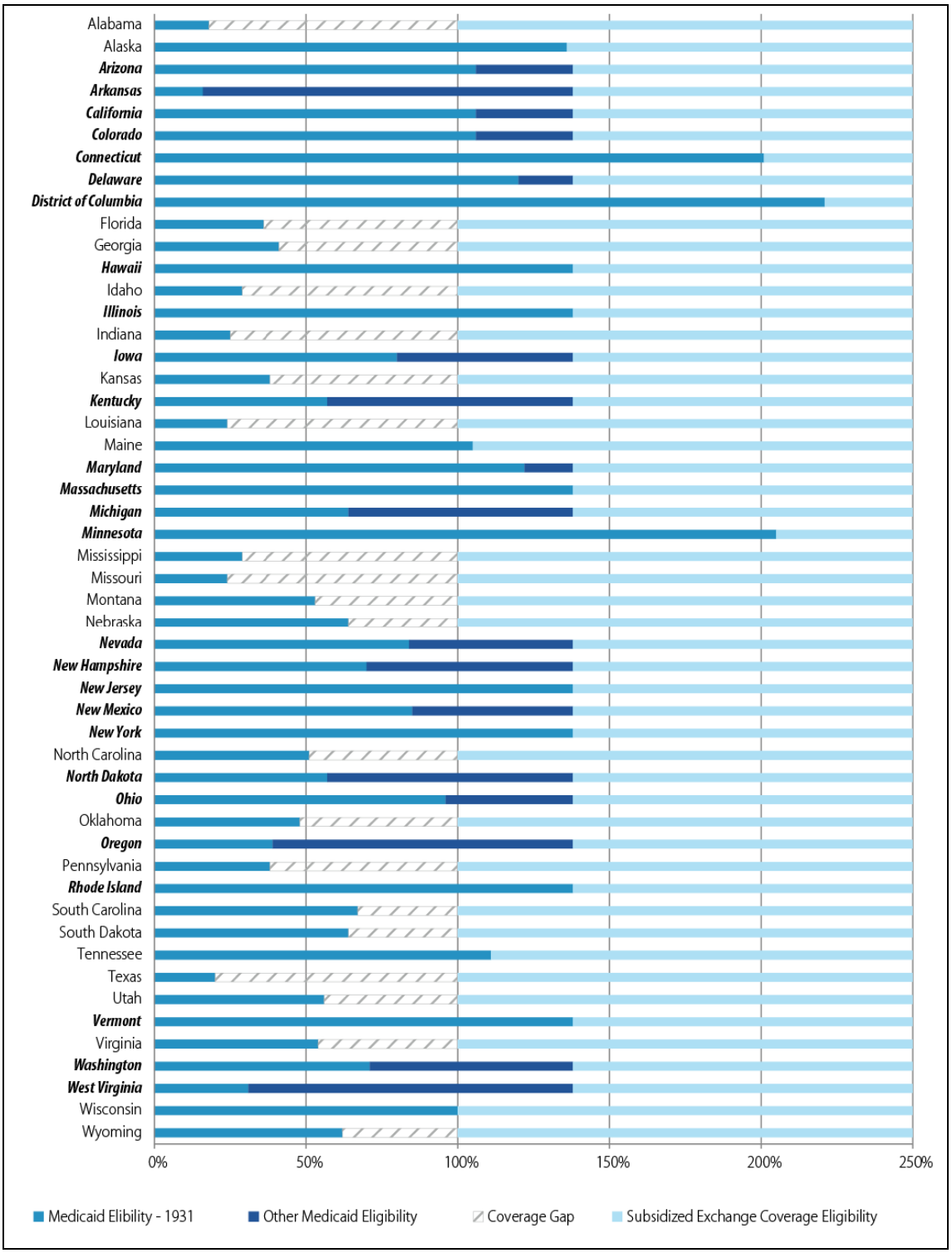
Individuals with incomes that fall in the "Coverage Gap" category do not have access to full Medicaid coverage or exchange subsidized coverage.

"Subsidized Exchange Coverage Eligibility" is available to individuals with household incomes from 100% of FPL through 400% of FPL. The ACA provides premium tax credits to individuals with household income between 100% and 400% of FPL who do not have access to minimum essential coverage, and these individuals with income between 100% and 250% of FPL could be eligible for cost-sharing subsidies.

FPL: Federal poverty level. In 2014, the federal poverty level (100% of FPL) is $11,670 for an individual and $4,060 for each additional family member in the lower 48 states and the District of Columbia.

Figure A-2. State-by-State Medicaid and Exchange Subsidized Coverage Income Eligibility Levels for Parents with Dependent Children up to 250% of FPL

As of January 1, 2014



Source: Centers for Medicare and Medicaid Services, "State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014," October 24, 2013; Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2013, Table 110 on page 94.

Note: States in bold are states that have decided to implement the ACA Medicaid expansion. Most states implemented the expansion on January 1, 2014, but Michigan and New Hampshire implemented the expansion on April 1, 2014, and July 1, 2014 (respectively). Pennsylvania plans to implement the ACA Medicaid expansion on January 1, 2015.

Under Section 1931 of the Social Security Act, states are required to provide Medicaid coverage for parents (and their dependent children), at a minimum, at the Aid to Families with Dependent Children (AFDC) eligibility levels in place on July 16, 1996. Section 1931 of the Social Security Act also gives states the option to cover parents with incomes above the 1996 minimum levels and most states do. The "Medicaid Eligibility - 1931" category is the Medicaid income eligibility level for parents as of January 2014 for states that haven't implemented the ACA Medicaid expansion and the Medicaid income eligibility level as of January 2013 for states that have implemented the ACA Medicaid expansion. Most of the parents in this category have coverage under Section 1931 of the Social Security Act, but some may have coverage under Section 1115 waivers.

The "Other Medicaid Eligibility" category could either be the ACA Medicaid expansion implemented through state plan rules or coverage provided through a Section 1115 waiver.

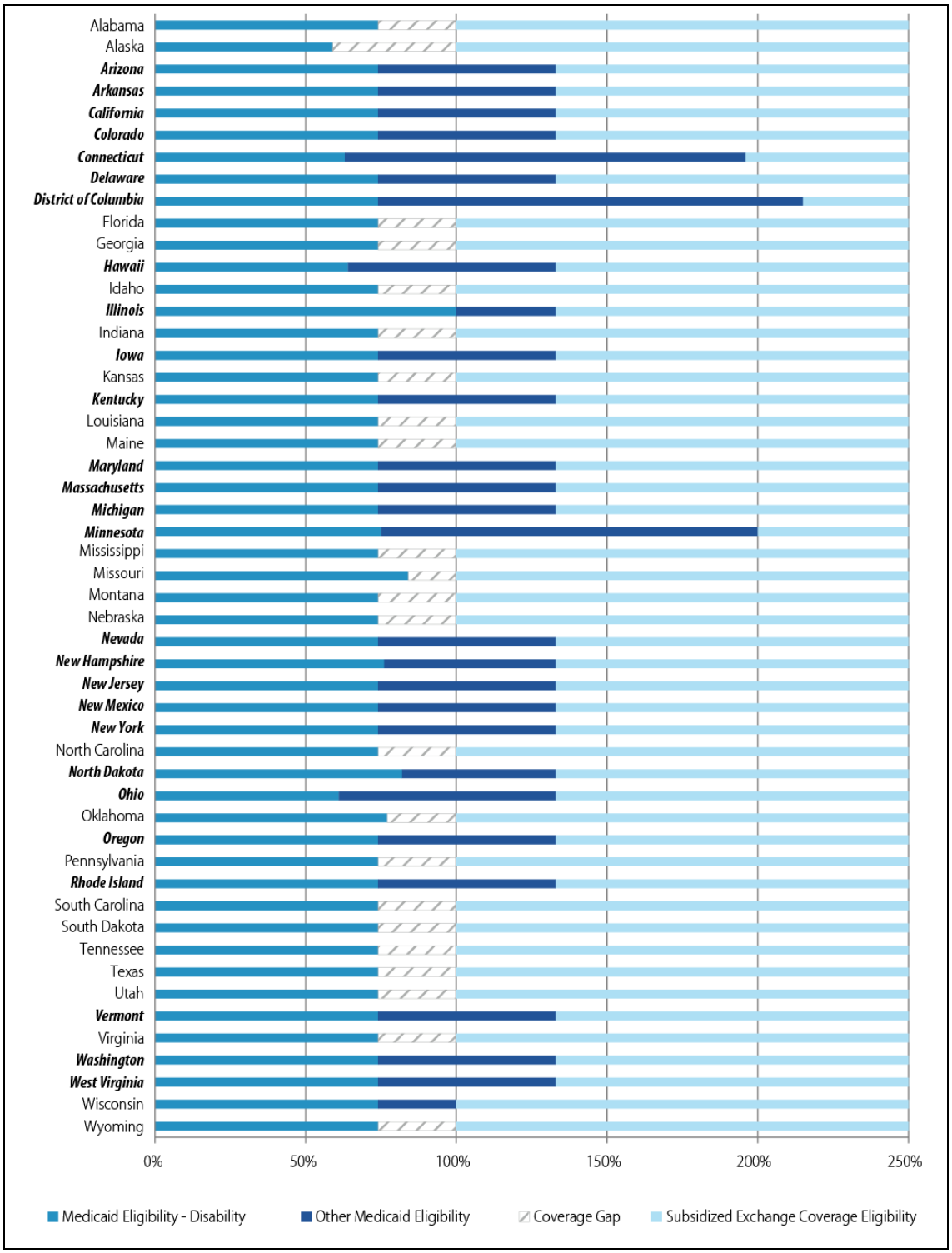
Individuals with incomes that fall in the "Coverage Gap" category do not have access to full Medicaid coverage or exchange subsidized coverage.

"Subsidized Exchange Coverage Eligibility" is available to individuals with household incomes from 100% of FPL through 400% of FPL. The ACA provides premium tax credits to individuals with household income between 100% and 400% of FPL who do not have access to minimum essential coverage, and these individuals with income between 100% and 250% of FPL could be eligible for cost-sharing subsidies.

FPL: Federal poverty level. In 2014, the federal poverty level (100% of FPL) is $11,670 for an individual and $4,060 for each additional family member in the lower 48 states and the District of Columbia.

Figure A-3. State-by-State Medicaid and Exchange Subsidized Coverage Income Eligibility Levels for Adults with Disabilities up to 250% of FPL

As of January 1, 2014



Source: Centers for Medicare and Medicaid Services, "State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014," October 24, 2013; Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2014.

Notes: States in bold are states that have decided to implement the ACA Medicaid expansion. Most states implemented the expansion on January 1, 2014, but Michigan and New Hampshire implemented the expansion on April 1, 2014, and July 1, 2014 (respectively). Pennsylvania plans to implement the ACA Medicaid expansion on January 1, 2015.

The "Medicaid Eligibility – Disability" category is based on states' eligibility levels for SSI recipients in most states and states' 209(b) eligibility level for 209(b) states. In states that have implemented the expansion, an adult with disabilities may have access to different benefit coverage through the ACA Medicaid expansion eligibility pathway (i.e., eligible for Medicaid based solely on their low-income status) than the adults with disabilities that have Medicaid coverage through the SSI eligibility pathway (i.e., eligible for Medicaid based being low-income and disabled).

The "Other Medicaid Eligibility" category could either be the ACA Medicaid expansion implemented through state plan rules or coverage provided through a Section 1115 waiver.

Individuals with incomes that fall in the "Coverage Gap" category do not have access to full Medicaid coverage or exchange subsidized coverage.

"Subsidized Exchange Coverage Eligibility" is available to individuals with household incomes from 100% of FPL through 400% of FPL. The ACA provides premium tax credits to individuals with household income between 100% and 400% of FPL who do not have access to minimum essential coverage, and these individuals with income between 100% and 250% of FPL could be eligible for cost-sharing subsidies.

FPL: Federal poverty level. In 2014, the federal poverty level (100% of FPL) is $11,670 for an individual and $4,060 for each additional family member in the lower 48 states and the District of Columbia.

Appendix B. Estimates of State-by-State Impact of ACA Medicaid Expansion

The potential impact of the ACA Medicaid expansion varies significantly from state to state. In terms of expenditures, while the federal government will be funding a vast majority of the ACA Medicaid expansion, the estimated state share of the ACA Medicaid expansion expenditures range from states that already provide Medicaid coverage to the expansion population saving money to states with the largest coverage gains seeing increases to state Medicaid expenditures. Medicaid enrollment is estimated to increase at varying rates from state to state due to the current variation in states' Medicaid income eligibility levels for parents and childless adults.

Table B-1 shows the estimated state-by-state impact of the ACA Medicaid expansion on Medicaid expenditures and enrollment for 2022 *if* a state chooses to implement the expansion.[68] According to the data in this table from an Urban Institute analysis, if all states chose to implement the ACA Medicaid expansion, Medicaid expenditures for 2022 would be $122.8 billion ($117.4 billion in federal funds and $5.4 billion in state funds) higher than if no states chose to implement the expansion. Also, if all states chose to implement the expansion, Medicaid enrollment would be 15.5 million higher in 2022 than if no states chose to implement the expansion.[69]

Table B-1. State-by-State Estimates of the Impact of the ACA Medicaid Expansion on Medicaid Expenditures and Enrollment, 2022

	Estimated Medicaid Expenditures						Estimated Medicaid Enrollment	
	Medicaid Expenditures for ACA Medicaid Expansion ($ in millions)			Percentage Change in Medicaid Expenditures with ACA Medicaid Expansion				
State	Federal	State	Total	Federal	State	Total	Medicaid Enrollment for ACA Medicaid Expansion (in millions)	Percent Increase above Medicaid Enrollment without ACA Medicaid Expansion
Alabama	$2,102	$246	$2,348	29.6%	8.0%	23.1%	313	36.1%
Alaska	$213	$31	$244	13.7%	2.4%	8.6%	37	30.1%
Arizona	$1,530	$166	$1,696	14.3%	3.3%	10.8%	238	16.8%
Arkansas	$1,828	$212	$2,041	31.8%	9.3%	25.4%	233	35.0%
California	$10,008	$1,347	$11,356	18.9%	2.7%	11.1%	1,860	18.0%
Colorado	$1,503	$188	$1,691	34.4%	4.7%	20.1%	225	39.0%

[68] Neither CMS nor CBO provide state level estimates of the impact of the ACA Medicaid expansion on Medicaid expenditures and enrollment. As a result, this table uses state level estimates conducted by the Urban Institute.

[69] John Holahan, Matthew Buettgens, and Caitlin Carroll, et al., *The Costs and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, Kaiser Commission on Medicaid and the Uninsured, Publication #8384, November 2012, Tables 8 and 9.

	Estimated Medicaid Expenditures						Estimated Medicaid Enrollment	
	Medicaid Expenditures for ACA Medicaid Expansion ($ in millions)			Percentage Change in Medicaid Expenditures with ACA Medicaid Expansion				
State	Federal	State	Total	Federal	State	Total	Medicaid Enrollment for ACA Medicaid Expansion (in millions)	Percent Increase above Medicaid Enrollment without ACA Medicaid Expansion
Connecticut	$1,196	-$109	$1,086	18.7%	-1.8%	8.8%	150	29.1%
Delaware	$292	-$168	$124	16.4%	-12.5%	4.0%	16	8.3%
District of Columbia	$123	$15	$138	4.7%	1.4%	3.7%	26	16.5%
Florida	$9,645	$1,186	$10,831	46.5%	7.7%	30.1%	1,276	45.2%
Georgia	$4,918	$573	$5,492	41.6%	10.3%	31.6%	698	41.5%
Hawaii	$486	-$36	$451	28.9%	-2.4%	14.2%	62	29.2%
Idaho	$477	$55	$533	20.3%	6.3%	16.5%	88	40.7%
Illinois	$3,160	$455	$3,615	17.5%	2.7%	10.3%	495	21.2%
Indiana	$2,591	$279	$2,870	27.3%	6.3%	20.6%	495	48.8%
Iowa	$572	-$40	$532	11.9%	-1.4%	7.0%	72	15.2%
Kansas	$767	$108	$875	19.6%	4.0%	13.3%	169	45.3%
Kentucky	$2,627	$301	$2,928	30.7%	9.0%	24.6%	268	33.5%
Louisiana	$2,312	$280	$2,592	27.2%	5.4%	18.9%	398	37.9%
Maine	$457	-$70	$387	12.6%	-3.6%	6.9%	45	14.5%
Maryland	$1,749	-$150	$1,598	23.1%	-2.1%	10.7%	146	17.7%
Massachusetts	$1,135	-$1,031	$103	8.1%	-7.8%	0.4%	16	1.1%
Michigan	$2,567	$351	$2,918	16.8%	4.9%	13.0%	345	17.8%
Minnesota	$818	$108	$926	8.2%	1.1%	4.7%	105	13.4%
Mississippi	$2,121	$241	$2,362	32.7%	11.4%	27.4%	231	31.8%
Missouri	$2,590	$336	$2,926	24.6%	5.8%	18.0%	383	37.6%
Montana	$301	$41	$342	19.9%	6.1%	15.7%	64	49.6%
Nebraska	$444	$55	$499	16.6%	2.9%	10.9%	88	37.1%
Nevada	$816	$109	$924	38.4%	7.2%	25.5%	137	48.6%
New Hampshire	$351	$42	$393	19.8%	2.7%	11.8%	42	30.2%
New Jersey	$2,209	$307	$2,516	17.9%	2.7%	10.6%	291	30.1%
New Mexico	$732	$74	$806	14.2%	3.4%	11.0%	208	41.4%
New York	$8,642	-$5,186	$3,456	12.9%	-8.3%	2.7%	320	6.2%
North Carolina	$5,781	$690	$6,471	32.8%	7.6%	24.2%	568	34.4%
North Dakota	$341	$45	$387	30.7%	6.3%	21.1%	32	44.4%
Ohio	$7,809	$920	$8,729	34.4%	7.4%	24.8%	684	32.5%

	Estimated Medicaid Expenditures						Estimated Medicaid Enrollment	
	Medicaid Expenditures for ACA Medicaid Expansion ($ in millions)			Percentage Change in Medicaid Expenditures with ACA Medicaid Expansion				
State	Federal	State	Total	Federal	State	Total	Medicaid Enrollment for ACA Medicaid Expansion (in millions)	Percent Increase above Medicaid Enrollment without ACA Medicaid Expansion
Oklahoma	$1,252	$154	$1,405	21.1%	4.8%	15.3%	204	29.8%
Oregon	$1,913	$164	$2,077	35.6%	5.7%	25.2%	400	74.8%
Pennsylvania	$5,505	$645	$6,150	23.8%	3.6%	15.0%	542	26.0%
Rhode Island	$429	$55	$484	16.5%	2.5%	10.0%	40	22.0%
South Carolina	$2,312	$265	$2,577	31.9%	9.0%	25.3%	312	35.9%
South Dakota	$307	$36	$343	25.0%	5.0%	17.6%	44	37.9%
Tennessee	$3,328	$390	$3,718	25.5%	6.2%	19.2%	363	26.0%
Texas	$9,582	$1,222	$10,804	29.9%	5.6%	20.1%	1,805	42.1%
Utah	$784	$88	$872	24.7%	7.7%	20.2%	189	57.1%
Vermont	$156	-$135	$22	9.5%	-12.5%	0.8%	3	2.0%
Virginia	$2,144	$285	$2,429	29.8%	4.2%	17.3%	327	38.5%
Washington	$1,221	$77	$1,298	14.6%	1.0%	7.9%	137	11.7%
West Virginia	$1,278	$144	$1,423	28.3%	9.2%	23.3%	116	30.9%
Wisconsin	$1,753	$56	$1,808	20.0%	1.0%	12.6%	211	23.3%
Wyoming	$198	$26	$223	23.5%	3.9%	14.8%	27	34.2%
National Total	**$117,375**	**$5,443**	**$122,819**	**23.0%**	**1.5%**	**14.0%**	**15,544**	**26.8%**

Source: John Holahan, Matthew Buettgens, and Caitlin Carroll, et al., *The Costs and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, Kaiser Commission on Medicaid and the Uninsured, Publication #8384, November 2012, Tables 8 and 9.

Notes: The state-by-state analysis was conducted using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), which is a detailed microsimulation model of the health care system that estimates the cost and coverage effects of proposed health care policy options.

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