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MEMORANDUM January 30, 2015

To: [redacted]

From: Alison Mitchell, Analyst in Health Care Financing, [redacted]

Subject: **Questions About the ACA Medicaid Expansion**

This memorandum addresses the specific questions that you emailed on January 5, 2015 about the alternative delivery models and the funding for the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) Medicaid expansion. The first section of this memo provides an overview of the ACA Medicaid expansion, including a brief description of the alternative models states are using to implement the ACA Medicaid expansion. Then, the second section answers your specific questions about the ACA Medicaid expansion.

Because the issues addressed in this memorandum are of general interest to Congress, information included in this memorandum may be provided to other congressional requesters or incorporated into a CRS report for general distribution.

Overview of ACA Medicaid Expansion

Historically, Medicaid eligibility has generally been limited to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities;[1] however, as of January 1, 2014, states have the option to extend Medicaid coverage to most nonelderly, low-income individuals.[2]

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.[3]

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

[2] For more information about the ACA Medicaid expansion, see CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

[3] 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.

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.

Enhanced Federal Matching Rate for the ACA Medicaid Expansion

The ACA provided enhanced 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,[4] but exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. The ACA added another FMAP exception called the "newly eligible" FMAP rate.

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 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 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.

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.

States' Decisions

On January 1, 2014, when the ACA Medicaid expansion went into effect, 24 states[5] and the District of Columbia included the ACA Medicaid expansion as part of their Medicaid programs. Since then, Michigan, New Hampshire, and Pennsylvania have implemented the expansion.

Most states implementing the ACA Medicaid expansion have done so through an expansion of their existing Medicaid program. However, some states have implemented the expansion through an alternative method, such as the "private option"[6] or health savings accounts.[7] Some other states that have not

[4] 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 R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by Alison Mitchell.

[5] The 24 state that implemented the ACA Medicaid expansion on January 1, 2014 are Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia.

[6] Under the "private option," the state provides premium assistance to Medicaid enrollees to purchase health insurance coverage under the qualified health plans offered through the health insurance exchanges. 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.

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

implemented the expansion have indicated interest in implementing the expansion through an alternative method.

Questions about the ACA Medicaid Expansion

Below are your two questions about the ACA Medicaid expansion in bold with the responses following each question.

1. Are the "alternative" Medicaid expansions that have been approved by the Centers for Medicare & Medicaid Services (CMS) for several states in which states leverage Exchanges to provide coverage to childless adults (Iowa, and Arkansas) part of Affordable Care Act/Obamacare's Medicaid expansion? (As you know, similar ideas have been proposed in Pennsylvania, Indiana, Tennessee, Utah)

a. **Are enrollees considered Medicaid beneficiaries?**

b. **Do these beneficiaries receive Medicaid benefits?**

c. **Is the coverage for these beneficiaries paid through the Medicaid program?**

d. **Do these expansions require Medicaid state plan amendments and Medicaid waivers to implement?**

Yes. States using an "alternative Medicaid expansion" have implemented the ACA Medicaid expansion.

Five states (Arkansas, Indiana,[8] Iowa, Michigan, and Pennsylvania) have received approval for Section 1115 waivers to implement their ACA Medicaid expansion.[9] Section 1115 waivers have been commonly used prior to the ACA Medicaid expansion. Currently, 27 states and the District of Columbia use a total of 52 Section 1115 waivers for their Medicaid programs.[10] Section 1115 waivers can be used to modify a portion of a state's Medicaid program or the entire Medicaid program. States use this waiver authority to change eligibility criteria in order to offer coverage to new groups of people, to provide services that are not otherwise covered, to offer different service packages or a combination of services in different parts of the state, to cap program enrollment, and to implement innovative service delivery systems, among other purposes.

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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. For Medicaid, health savings accounts are generally used to account for enrollees' out-of-pocket costs, such as premiums and copayments.

[8] Arkansas, Iowa, Michigan, and Pennsylvania have implemented the ACA Medicaid expansion, but Indiana has not yet implemented the ACA Medicaid expansion. Indiana received a Section 1115 waiver approval on January 27, 2015.

[9] Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services may waive Medicaid requirements contained in Section 1902 (including, but not limited to, what is known as "freedom of choice" of provider, "comparability" of services, and "statewideness").

[10] Centers for Medicare & Medicaid Services website as of January 14, 2015.

When states use Section 1115 waivers, the individuals covered by the Medicaid waivers are still considered Medicaid enrollees. They still receive Medicaid benefits according to the federal Medicaid rules, but states' Section 1115 waivers may include the waiver of certain Medicaid benefit requirements. Medicaid funding is used to pay for the services provided to Medicaid enrollees receiving Medicaid coverage through a Section 1115 waiver.

Some of these waivers impact portions of the coverage under the ACA Medicaid expansion, while other waivers impact the full coverage under the expansion. Under the Section 1115 waivers for the ACA Medicaid expansion, Arkansas and Iowa have been approved to use the "private option,"[11] and Michigan, Arkansas, and Indiana have received approval to use health savings accounts. In addition, all five states have received approval to charge premiums in excess of what is allowed under Medicaid state plans, and in Iowa, Michigan, and Pennsylvania, the cost sharing requirements can be reduced through healthy behaviors.[12] Iowa, Pennsylvania, and Indiana have received waivers from being required to provide non-emergency medical transportation services.[13] (See **Table 1** for key components in the approved Section 1115 waivers for the ACA Medicaid expansion.)

"Private Option"

Under the "private option," states use Medicaid funding to provides premium assistance to purchase health insurance coverage under the qualified health plans offered through the health insurance exchanges.[14] Premium assistance is not a new concept for Medicaid coverage.[15] States have several options to pay premiums for adults and children to purchase coverage through private group (including employer-sponsored) health plans, and in some cases individual plans. States may pursue premium assistance as a state plan option without a Section 1115 waiver. However, most states receive waivers to use premium assistance for their ACA Medicaid expansion because states want to implement the premium assistance in a way not permitted through a state plan amendment. For instance, a state needs a waiver in order to mandate enrollment in the "private option."[16]

To date, two states (Arkansas and Iowa) have implemented the ACA Medicaid expansion using the "private option." Arkansas uses the "private option" for its entire ACA Medicaid expansion population, and Iowa uses the "private option" for a portion of its ACA Medicaid expansion. Specifically, the "private option" in Iowa is used for coverage of Medicaid enrollees with income between 100% and 133% of FPL.[17]

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

[12] These states are offering incentives, such as reduced premiums, to Medicaid beneficiaries who complete a health risk assessment and/or participate in other healthy behaviors.

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

[14] For more information about the Health Insurance Exchanges, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

[15] Under premium assistance, states are permitted to use federal Medicaid funds to subsidize the cost of private health insurance coverage for Medicaid enrollees in lieu of direct Medicaid coverage.

[16] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, March 2014.

[17] As of January 1, 2015, enrollment in the "private option" for the expansion population with incomes above 100% of FPL is no longer mandatory, due to the December 1, 2014 withdrawal of one of the qualified health plans that offered coverage to Medicaid enrollees. (Centers for Medicare & Medicaid Services, Section 1115 Waiver Approval Letter to Iowa Department of Human Services for "Iowa Marketplace Choice," December 30, 2014.)

Health Savings Accounts

Michigan received CMS approval for a Section 1115 waiver to implement the ACA Medicaid expansion using health savings accounts. Specifically, in Michigan, Medicaid enrollees gaining Medicaid coverage through the ACA Medicaid expansion receive coverage through Medicaid managed care plans, but health savings accounts are to be used for cost sharing (i.e., copayments and income-based contributions). All expansion enrollees are required to pay copayments,[18] and expansion enrollees with incomes between 100% and 138% of FPL are required to make contributions of 2% of income. The copayments and premiums are to be deposited into health savings accounts, which are called MI Health Accounts. The accounts became operational October 1, 2014 for enrollees with incomes below 100% of FPL.[19]

In December 2014, Arkansas received approval to use Independence Accounts to collect premiums from enrollees. However, Arkansas still needs to submit the operational protocol for CMS to review before the use of the Independence Accounts can be implemented.

In addition, Indiana received a waiver approval on January 27, 2015 for the ACA Medicaid expansion that incorporates Personal Wellness and Responsibility (POWER) accounts, which is the delivery model that Indiana currently uses for part of its Medicaid program. Since 2008, Indiana has had a Section 1115 waiver to use Medicaid funds to provide Medicaid coverage to previously uninsured low-income adults under the Health Indiana Plan, which is a benefit package modeled after a high-deductible health plan and health savings account. For the ACA Medicaid expansion, Indiana has approval to extend the Healthy Indiana Plan to all Medicaid enrollees ages 19 through 64 with incomes at or below 133% of FPL.[20]

Premiums

In general, premiums and enrollment fees are often prohibited in the Medicaid program. However, premiums may be imposed on enrollees with incomes above 150% of FPL. In the waivers for Arkansas, Indiana, Iowa, Michigan, and Pennsylvania, the states received approval to charge premiums to ACA Medicaid expansion enrollees outside of what is allowed under the federal statute. Arkansas and Iowa can charge premiums to certain enrollees with incomes above 50% of FPL, and Michigan and Pennsylvania can charge premiums to certain enrollees with incomes above 100% of FPL. Indiana received approval to charge premiums for certain Medicaid enrollees in the ACA Medicaid expansion at any income, but the premium amounts for individuals with income below 5% of FPL can be no more than $1 per month. Under each of these waivers, cost sharing (including premiums, copayments, etc.) cannot exceed 5% of family income, which the aggregate cap on out-of-pocket cost sharing under the Medicaid statute.[21]

Work Requirements

The waiver application for both Pennsylvania and Indiana included a provision to make job training and employment-related activities a requirement for Medicaid enrollment.[22] These work requirements were

[18] Copayments and income-based contributions are not required for the first six months of enrollment, and copayment amounts can be reduced if enrollees participate in specified health behavior activities.

[19] Centers for Medicare & Medicaid Services, Healthy Michigan waiver approval letter, December 30, 2013 (technical corrections approved August 29, 2014).

[20] Indiana received approval of the Section 1115 waiver, but Indiana has not yet implemented the ACA Medicaid expansion.

[21] Section 1916A of the Social Security Act.

[22] Pennsylvania Department of Public Welfare, *Healthy Pennsylvania 1115 Demonstration Application*, February 2014; Indiana Family and Social Services Administration, *HIP 2.0 1115 Waiver Application*, August 2014.

not approved as part of either Pennsylvania or Indiana's waiver. Both states plan to fund and administer a separate program to link people gaining coverage under the waiver to job training and placement services for those who choose to participate, but Medicaid coverage will not be affected.

Non-Emergency Medical Transportation (NEMT)

Federal rules require states to make NEMT available to Medicaid beneficiaries to assure their access to medically necessary services. Iowa, Pennsylvania, and Indiana received the authority not to offer NEMT for the first year of their expansions. Recently, Iowa received approval for a six month extension of the waiver of the NEMT requirement. However, CMS noted some concern about Iowa's waiver of NEMT because the data submitted by Iowa indicates access issues for enrollees with income below 100% of FPL. Since the data is considered preliminary, CMS has extended the waiver for six months, but CMS requested the collection of additional data.

Table 1 shows the key components in the approved Section 1115 waivers for the ACA Medicaid expansion.

Table 1. Key Components in Approved Section 1115 Waivers for ACA Medicaid Expansion

	Private Option[a]	Health Savings Account[b]	Premiums[c]	Healthy Behavior Incentives[d]	Work Requirements	Non-Emergency Medical Transportation
Arkansas	Most ACA Medicaid expansion enrollees are required to receive coverage through the "private option."	Independence Accounts are to be used to collect monthly contributions from enrollees.[e]	Premiums can be charged to certain enrollees with incomes between 50% and 100% of the FPL of $5/month and certain enrollees with incomes between 100% and 133% of FPL of $10 to $25 per month depending on income.			
Indiana[f]		Personal Wellness and Responsibility (POWER) accounts to collect enrollee and state contributions to pay some health care expenses.	Monthly premiums can be charged to individuals up to 133% of FPL with contribution amounts based on monthly income.			For one year, the state is not required to provide non-emergency medical transportation.

	Private Option[a]	Health Savings Account[b]	Premiums[c]	Healthy Behavior Incentives[d]	Work Requirements	Non-Emergency Medical Transportation
Iowa[g]	Enrollees in the ACA Medicaid expansion with income between 100% and 133% of FPL have the option to receive coverage through the "private option."		Starting in the second year, premiums can be charged to certain enrollees with incomes between 50% and 100% of the FPL of $5/month and certain enrollees with incomes between 100% and 133% of FPL of $10/month.	Premiums shall be waived for enrollees that complete all of the required healthy behaviors in the prior year.		For the first and second year, the state is not required to provide non-emergency medical transportation.
Michigan		Health savings accounts (called MI Health Accounts) are used to track and record beneficiary payments and liabilities.	The state may require monthly premiums for individuals with incomes between 100% and 133% of the FPL not to exceed 2% of income.	Enrollees may achieve reduction in their copayment liability if certain healthy behaviors are maintained or attained.		
Pennsylvania[f]			Beginning in 2016, the state may charge premiums not to exceed 2% of household income for certain adults with incomes above 100% of the FPL.	Enrollees who complete specified healthy behaviors during the prior year of enrollment shall have their cost sharing obligations reduced.		For one year, the state is not required to provide non-emergency medical transportation.

Source: Centers for Medicare & Medicaid Services(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; CMS, Section 1115 Waiver Approval Letter to Iowa Department of Human Services for "Iowa Marketplace Choice," December 30, 2014; CMS, Section 1115 Waiver Approval Letter to Arkansas Department of Human Services for the "Arkansas Health Care Independence Program," December 31, 2014; CMS, Section 1115 Waiver Approval Letter to Indiana Family and Social Services Administration for "Healthy Indiana Plan 2.0," January 27, 2015.

ACA: Patient Protection and Affordable Care Act (P.L. 111-148 as amended).

FPL: Federal poverty level.

a. Under the "private option," the state provides premium assistance to Medicaid enrollees to purchase health insurance coverage under the qualified health plans offered through the health insurance exchanges. 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.

b. Health savings accounts are accounts with funding available to cover the cost of health care services. An HSA, in and 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. For Medicaid, health savings accounts are generally used to account for enrollees' out-of-pocket costs, such as premiums and copayments.

c. Under each of these waivers, cost sharing (including premiums, copayments, etc.) cannot exceed 5% of family income.

d. States are offering incentives, such as reduced premiums, to Medicaid beneficiaries who complete a health risk assessment and/or participate in other healthy behaviors.

e. Arkansas still needs to submit the operational protocol for the Centers for Medicare & Medicaid Services to review before the use of the Independence Accounts can be implemented.

f. The waiver application for both Pennsylvania and Indiana included a provision to make job training and employment-related activities a requirement for Medicaid enrollment. These work requirements were not approved as part of either Pennsylvania or Indiana's waiver.

g. Iowa has two waivers. The first waiver is the Health and Wellness Demonstration, which serves enrollees in the ACA Medicaid expansion with income up to and including 100% of the FPL and enrollees up to and including 133 % of the FPL who are medically frail, are American Indians and Alaska Natives, or have access to employer sponsored insurance. The second waiver is the Iowa Marketplace Choice Plan, which services enrollees in the ACA Medicaid expansion with incomes from 100% to 133% of the FPL.

2. If a state chooses not to expand Medicaid to childless adults as specified under the Affordable Care Act/"Obamacare," are the federal funds that would have otherwise been spent on that state's Medicaid expansion funds somehow being sent to other states?

No. If a state doesn't implement the ACA Medicaid expansion, the federal funds that would have been used for that state's expansion are not being sent to another state. There is not a set amount of federal funding for Medicaid. Each states gets the federal funding necessary for their Medicaid program.

- If a state *has* implemented the ACA Medicaid expansion, then the states receive federal Medicaid funding for their approved expenditures under the ACA Medicaid expansion.

- If a state *hasn't* implemented the ACA Medicaid expansion, the state would not receive any federal Medicaid funding for the expansion. However, this doesn't mean any additional federal Medicaid funding would be allocated to states that *have* implemented the expansion.

Medicaid Financing

The federal government and states share the cost of Medicaid.[23] The federal government reimburses states for a portion (i.e., the federal share) of each state's Medicaid program costs. Because federal Medicaid

[23] For more information about Medicaid financing, see CRS Report R42640, *Medicaid Financing and Expenditures*, by Alison
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funding is an open-ended entitlement to states, there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations). The federal government reimburses states for a share of each dollar spent in accordance with their federally-approved Medicaid state plans.

Medicaid is an entitlement for both states and individuals. The Medicaid entitlement to states ensures that, so long as states operate their programs within the federal requirements, states are entitled to federal Medicaid matching funds. This means that federal Medicaid spending is open-ended. Medicaid is also an individual entitlement, which means that anyone eligible for Medicaid under his or her state's eligibility standards is guaranteed Medicaid coverage.

The level of federal funding for Medicaid, like other entitlement programs, is based on the benefit and eligibility criteria established in law. The amount of budget authority provided in the appropriations acts for Medicaid is based on budget projections for meeting the funding needs of the program.

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