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Updated December 3, 2018

Overview of the ACA Medicaid Expansion

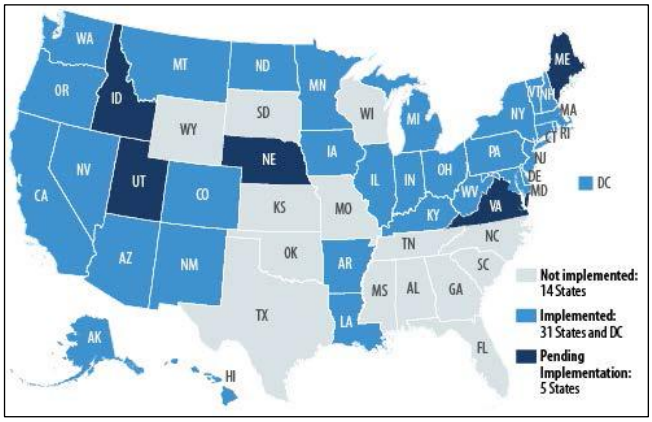
The primary goals of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) are to increase access to affordable health insurance for the uninsured and to make health insurance more affordable for those already covered. The ACA Medicaid expansion is one of the major insurance coverage provisions included in the law.

Supreme Court Decision

As enacted, the ACA Medicaid expansion was a mandatory expansion of Medicaid eligibility to non-elderly adults with incomes up to 133% of the federal poverty level (FPL). However, on June 28, 2012, in *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court found that the federal government could not withhold payment for a state's entire Medicaid program for failure to implement the ACA Medicaid expansion. Instead, the federal government could withhold only funding for the ACA Medicaid expansion if a state did not implement the expansion, which effectively made the expansion optional.

After the Supreme Court ruling, the Centers for Medicare & Medicaid Services (CMS) issued guidance specifying that states have no deadline for deciding when to implement the ACA Medicaid expansion. The guidance also stated that states opting to implement the ACA Medicaid expansion may end the expansion at any time.

Figure 1. States Implementing the ACA Medicaid Expansion, November 2018



Source: Congressional Research Service.

Note: ACA = Patient Protection and Affordable Care Act.

States' Decisions

Since January 1, 2014, states have had the option to extend Medicaid coverage to most non-elderly, nonpregnant adults with income up to 133% of FPL. Twenty-four states and the District of Columbia implemented the ACA Medicaid expansion at that time. Since then, the following seven states have implemented the expansion: Michigan (April 1, 2014), New Hampshire (July 1, 2014), Pennsylvania (January 1, 2015), Indiana (February 1, 2015), Alaska (September 1, 2015), Montana (January 1, 2016), and Louisiana (July 1, 2016). (See **Figure 1**.)

Virginia is expected to begin coverage of the ACA Medicaid expansion on January 1, 2019. Maine adopted the expansion through a ballot initiative in November 2017, and Maine's current governor has refused to implement the expansion. However, the governor-elect has stated publicly that she will implement the expansion.

The results of the November 2018 election could have implications for the ACA Medicaid expansion. In Idaho, Nebraska, and Utah, voters approved ballot initiatives to implement the expansion. Also, new governors and changes in the composition of state legislatures could change states' decisions regarding the expansion. Some non-expansion states might decide to adopt the expansion, and some expansion states could decide to end that coverage.

ACA Medicaid Expansion Waivers

Most states implementing the ACA Medicaid expansion have done so through an expansion of their existing Medicaid programs. However, seven states (Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire) operate their expansions through Section 1115 waivers. Under Section 1115 of the Social Security Act, the Secretary of the Department of Health and Human Services (HHS) may authorize a state to conduct experimental, pilot, or demonstration projects that, in the judgment of the Secretary, are likely to assist in promoting the objectives of Medicaid.

The waivers for these seven states vary significantly, but there are a few common provisions, such as: (1) premiums and/or monthly contributions on enrollees with income above 100% of FPL (Arizona, Arkansas, Indiana, Iowa, Michigan, and Montana); (2) healthy behavior incentives (Arizona, Indiana, Iowa, and Michigan); (3) waivers of the requirement to provide coverage of nonemergency medical transportation (Indiana and Iowa); and (4) disenrollment or lock-out provisions (Arizona, Arkansas, Indiana, Iowa, and Montana).

Private Option

Arkansas and Michigan have waivers that allow mandatory enrollment in the *private option*, which provides premium assistance for Medicaid enrollees to purchase private health insurance through the health insurance exchanges. Michigan is currently in the process of phasing out the private option.

Work and Community Engagement Requirements

State requests to include work requirements in Section 1115 waivers for the expansion population were denied under the

Obama Administration. In January 2018, under the Trump Administration, CMS issued a State Medicaid Director Letter advising states that they could apply for Section 1115 waivers to implement work and community engagement requirements as a condition of eligibility for expansion adults and other non-elderly, nonpregnant Medicaid enrollees.

To date, four states (Arkansas, Indiana, Kentucky, and New Hampshire) have received approval to implement work and community engagement requirements that affect expansion adults. Three states (Arizona, Ohio, and Michigan) have waiver requests pending that would affect expansion adults.

Partial Expansion

In 2012, CMS issued guidance saying that states were not able to receive the enhanced federal matching rates for the expansion for 2014 and 2015 with a partial Medicaid expansion (i.e., covering expansion adults up to an income level lower than 133% of FPL). The guidance noted that, starting in 2017, a partial expansion may be considered in coordination with a Section 1332 waiver.

Two current expansion states (Arkansas and Massachusetts) and one current non-expansion state (Utah) have requested Section 1115 waivers to partially expand Medicaid. Thus far, CMS has approved other components of the waiver requests from Arkansas and Massachusetts but did not approve the partial expansion requests. Utah's waiver request is still pending.

Financing of the 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, including the *newly eligible* matching rate and the *expansion state* matching rate.

Newly Eligible Matching Rate

The *newly eligible* matching rate is used to reimburse states for Medicaid expenditures for newly eligible individuals who gained Medicaid eligibility due to the ACA Medicaid expansion. The newly eligible matching rate started at 100% in 2014 and phases down to 93% in 2019, and then down to 90% in 2020 and subsequent years. Federal statute specifies the newly eligible matching rate for each year, which means the newly eligible matching rates are available for these specific years regardless of when a state implements the ACA Medicaid expansion.

Expansion State Matching Rate

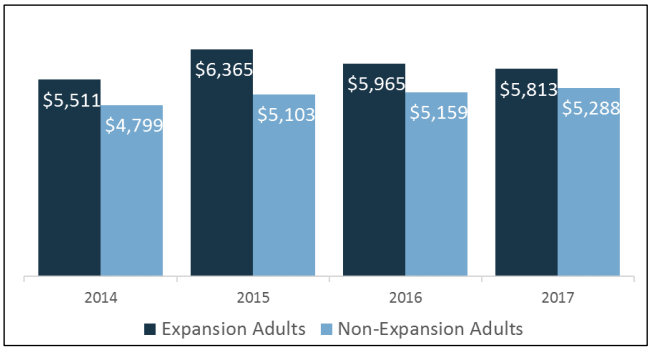
In this context, *expansion state* refers to states that had already implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted. The expansion state matching rate is available for expansion enrollees without dependent children in expansion states who were eligible for Medicaid on March 23, 2010. Before 2019, the expansion state matching rate varies by state; it is higher than states' regular FMAP rate but lower than the newly eligible matching rate. In 2019 and subsequent years, the expansion state matching rate is the same as the newly eligible matching rate (i.e., 93% in 2019 and 90% in 2020 and subsequent years).

Enrollment and Expenditures

The ACA Medicaid expansion has significantly increased Medicaid enrollment and federal Medicaid expenditures. In FY2017, an estimated 12 million individuals were newly eligible for Medicaid through the ACA Medicaid expansion (i.e., expansion adults), and total Medicaid expenditures for the expansion adults were an estimated $71 billion. Enrollment for the expansion adults is projected to be 13 million in FY2026, and expenditures for the expansion adults are projected to be $120 billion in FY2026 (with the federal government paying $108 billion and states paying $12 billion).

Between FY2014 and FY2015, the average per enrollee costs for expansion adults is projected to have increased from $5,511 to $6,365 (see **Figure 2**). States originally included adjustments to expansion adult per enrollee costs to account for pent-up demand, adverse selection, and expected higher health care needs. Per enrollee costs dropped to $5,965 in FY2016 and $5,813 in FY2017, as the effects of the pent-up demand were expected to end and evidence showed that the actual average costs for the expansion enrollees were lower than anticipated.

Figure 2. Projected ACA Medicaid Expansion and Non-Expansion Adult Per Enrollee Costs



Source: Centers for Medicare & Medicaid Services (CMS), *2017 Actuarial Report on the Financial Outlook for Medicaid*, 2018.

Note: ACA = Patient Protection and Affordable Care Act.

As shown in **Figure 2**, the projected per enrollee costs for expansion adults also have been higher than the projected per enrollee costs for non-expansion adults. After FY2017, per enrollee costs for the expansion adults are still projected to remain higher than costs for the non-expansion adults but to grow at a similar rate.

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