

# “Partial Medicaid Expansion” with ACA Enhanced Matching Funds: Implications for Financing and Coverage

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The Affordable Care Act (ACA) provides enhanced federal matching funds to states that expand Medicaid to nonelderly adults up to 138% of the federal poverty level (FPL, \$17,236/year for an individual in 2019). The ACA enhanced match (93% in 2019, and 90% in 2020 and thereafter) is substantially higher than states' traditional Medicaid matching rate.<sup>1</sup> A few states have sought [Section 1115 demonstration waiver authority](#) from the Centers for Medicare and Medicaid Services (CMS) to receive the substantially higher ACA enhanced match while limiting coverage to individuals at 100% FPL, instead of covering the full 138% FPL ACA group. To date, CMS has allowed states to receive the ACA enhanced Medicaid matching funds only if the entire expansion group is covered. CMS has not approved waiver requests seeking enhanced ACA matching funds for a partial coverage expansion in Arkansas or Massachusetts, while a request is pending in Utah. This brief explores the current rules for partial expansion and explains some of the potential implications for financing and coverage if CMS approves waivers to allow for partial expansion with enhanced matching funds.

**Coverage.** Partial expansion could result in less coverage overall, and less coverage in Medicaid, compared to a full ACA Medicaid expansion. Individuals from 100-138% FPL in Marketplace coverage could face higher out-of-pocket costs and fewer covered benefits compared to their coverage under a full Medicaid expansion.

**Costs.** Partial expansion with the ACA enhanced match could result in lower state and federal spending for Medicaid and higher federal spending in the Marketplace that could result in higher federal costs overall compared to a full ACA Medicaid expansion since the federal government pays full costs of subsidies in the Marketplace and Medicaid costs are shared between states and the federal government. There is some uncertainty around net federal cost implications as changes in enrollment are uncertain and there is variation between Medicaid and subsidy costs across states. In addition, states could experience differential cost and coverage implications from a partial expansion with ACA enhanced funds relative to where they are today, depending on their current Medicaid expansion status.

**Looking ahead.** New legislation in Utah calls for the state to submit an additional waiver request that adds per capita capped financing to its current proposal. States will be watching for developments in Utah as well as additional guidance from CMS, particularly related to how partial expansion may be tied to broader aggregate financing caps in Medicaid.

## When can states receive enhanced federal matching funds for expanding Medicaid coverage under the ACA?

To date, CMS has allowed states to receive the ACA enhanced Medicaid matching funds only if the entire expansion group is covered. The ACA describes the Medicaid expansion coverage group as including all nonelderly adults up to 138% FPL.<sup>2</sup> The [Supreme Court's decision about the ACA's constitutionality](#) effectively made Medicaid expansion optional for states. However, the authority for the ACA expansion group remains in the mandatory part of the statute, and states that adopt the expansion must provide coverage for “all individuals” described in the ACA expansion group.<sup>3</sup> CMS [guidance issued in 2012](#) concludes that “Congress directed that the enhanced matching rate be used to expand coverage to [138%] of FPL. The law does not provide for a phased-in or partial expansion.”

**States that want to extend coverage to a level less than the 138% FPL required by the ACA may do so, but can only receive their regular Medicaid match, and not the enhanced match, for that coverage.** CMS's 2012 guidance provides that these partial expansions would be considered at the state's regular federal matching rate, which is substantially lower than the ACA enhanced match available for a full expansion. States currently have flexibility within current law to expand coverage for parents above minimum thresholds without a waiver. To date, Wisconsin is the only state to extend coverage to all non-elderly adults (parents and childless adults) up to 100% FPL without implementing the full ACA Medicaid expansion. Wisconsin uses a combination of state plan<sup>4</sup> and Section 1115 [waiver](#)<sup>5</sup> authority to implement this coverage, and the state receives federal funds at its traditional Medicaid matching rate for this coverage ([59% in FY 2020](#)), not the enhanced ACA Medicaid matching rate, because it does not cover individuals from 101-138% FPL who would be eligible under a full ACA expansion.<sup>6</sup>

**CMS has not approved waiver requests seeking enhanced ACA matching funds for a partial coverage expansion in Arkansas and Massachusetts.** Both of these states have implemented the full ACA expansion and sought to roll back coverage from 138% FPL to 100% FPL while continuing to receive the ACA enhanced federal matching funds. In March 2018, CMS [did not make a decision](#) on Arkansas' request for partial expansion with enhanced ACA funds when it approved other terms of the state's waiver amendment request.<sup>7</sup> In June 2018, CMS [stated that it was “not approving at this time”](#) Massachusetts' similar request for partial expansion with enhanced ACA funds. Section 1115 authority permits the HHS Secretary to allow states to use federal Medicaid funds in ways that are not otherwise allowed under federal law, as long as the Secretary determines that the initiative is an “experimental, pilot, or demonstration project” that “is likely to assist in promoting the objectives of the program.” So, states and CMS would need to indicate, and plan to evaluate, how a partial expansion waiver with enhanced matching funds would promote the objectives of the Medicaid program.

**Utah currently has a waiver request for partial expansion with enhanced ACA funds pending with CMS.** In addition, the state passed legislation in February calling for the state to submit additional waiver requests, described in Box 1.

### Box 1: Utah's Proposal for Partial Expansion with Enhanced ACA Funds

In February 2019, Utah enacted [S.B. 96](#), which substantially changes the state law established by a November 2018 ballot initiative that had adopted the full ACA Medicaid expansion.<sup>8</sup> According to the new Utah legislation, the state must seek a Section 1115 waiver to implement a partial expansion under various scenarios that build on the state's pending [June 2018 Section 1115 waiver amendment request](#).<sup>9</sup> The legislation directs the state to seek authority from CMS to:

- Implement a partial coverage expansion at the state's regular matching rate to a capped number of nonelderly adults up to 100% FPL,<sup>10</sup> and
- Implement a partial coverage expansion with ACA enhanced matching funds to a capped number of nonelderly adults up to 100% FPL, with federal funding for the expansion administered "according to a per capita cap."<sup>11</sup>

If CMS does not approve the state's request under the latter scenario by January 1, 2020,<sup>12</sup> the legislation directs the state to request, by March 15, 2020, a full Medicaid expansion up to 138% FPL with an enrollment cap, which would include the ACA enhanced federal matching funds. The state's waiver request to CMS also must include "additional flexibilities and cost controls, including cost sharing tools" and an employment and training program for expansion adults (modeled on the SNAP work requirement program). If this waiver authority is not approved by CMS, a full Medicaid expansion, without an enrollment cap, and with ACA enhanced matching funds, will be effective on July 1, 2020.

## What are some of the potential effects of allowing states to adopt a partial Medicaid expansion with enhanced federal matching funds?

**Partial expansion could result in less coverage overall, and less coverage in Medicaid, compared to a full ACA Medicaid expansion.** Without a full Medicaid expansion, most individuals from 100-138% FPL would be eligible for Marketplace subsidies but could face [higher premiums and cost sharing](#) compared to Medicaid.<sup>13</sup> These higher premiums would likely result in fewer individuals enrolling in coverage compared to full Medicaid expansion. [Research shows](#) that increases in premiums and cost sharing for low-income populations result in decreased enrollment, higher numbers of uninsured, decreased utilization of needed services and increased administrative costs for states. [Studies examining the 100-138% FPL population](#) in expansion and non-expansion states found that Medicaid expansion coverage produced far greater reductions than subsidized Marketplace coverage in average total out-of-pocket spending, average out-of-pocket premium spending, and average cost-sharing spending.

**Individuals from 100-138% FPL in Marketplace coverage also could face fewer covered benefits compared to their coverage under a full Medicaid expansion.** A study from early implementation of the ACA showed that while specialty behavioral health services, including mental health and substance use disorder services, were covered by both Marketplace plans and Medicaid, [Medicaid behavioral health coverage was generally more comprehensive](#). Another study examining early ACA implementation found that coverage of [behavioral health services, prescription drugs, rehabilitative and habilitative services, and long-term services and supports](#) may be more limited in the Marketplace compared to Medicaid.

**Partial expansion with the ACA enhanced match could result in higher federal costs compared to a full ACA Medicaid expansion.** Shifting more enrollees from a full Medicaid expansion to Marketplace coverage could increase federal costs because the federal government pays 100 percent of the costs for subsidies in the Marketplace, while Medicaid costs are shared by the states and the federal government. In addition, costs of coverage in the Marketplace could outweigh federal Medicaid costs because [Medicaid is low-cost](#) compared to private insurance, largely due to lower Medicaid payment rates for providers. However, there would be a scenario where federal costs would decline if coverage losses outweigh the increased federal costs of coverage in the Marketplace.

**In addition, [studies](#) show that the full ACA Medicaid expansion supports and strengthens the Marketplaces.** Providing Medicaid coverage for the 100-138% FPL group improves the Marketplace risk pool, resulting in lower Marketplace premiums. For example, [one study](#) found that Marketplace premiums are about 7% lower in expansion states, compared to non-expansion states.<sup>14</sup>

**States could experience differential cost and coverage implications from a partial expansion with ACA enhanced funds relative to where they are today, depending on their current Medicaid expansion status.** Implications for national changes in coverage and cost could depend on which states might adopt a partial expansion with enhanced ACA funds, if available.

- Current non-expansion states that would adopt a partial expansion with enhanced ACA financing could have coverage gains that fall short of what would be expected under full Medicaid expansion, although these states would have coverage gains relative to no expansion. Lower coverage in partial expansion compared to full expansion could mitigate the fiscal benefits for state budgets and economies as well as reductions in uncompensated care.
- Current expansion states that choose to roll back coverage under a partial expansion could see an increase in uninsured if some enrollees in the 100-138% FPL group do not enroll in Marketplace coverage due to higher out-of-pocket costs. Federal costs would be higher for enrollees who do enroll in the Marketplace compared to Medicaid.

## What is next for states' requests for partial Medicaid expansion with enhanced ACA matching funds?

States will be watching for developments in Utah as well as additional guidance from CMS. In the near-term, it appears that Utah will pursue an additional amendment to its existing waiver, requesting a partial expansion up to 100% FPL, with an enrollment cap, at the state's regular Medicaid matching rate.<sup>15</sup> The state also will continue to pursue its pending amendment seeking a work requirement, among other provisions, for the partial expansion.<sup>16</sup> The second phase of Utah's waiver calls for partial expansion with an enrollment cap at the ACA enhanced match but with aggregate limits on federal funding administered through a per capita cap financing model.<sup>17</sup>

These broader financing changes included in the Utah proposal might relate to January 2019 [media reports](#) that CMS may be working to release new Section 1115 waiver guidance to states on Medicaid "block grants" or aggregate spending caps in exchange for unspecified additional state "flexibility." Broader financing changes including Medicaid per capita cap and block grant proposals were debated as part of [ACA repeal and replace legislation that was defeated in Congress in 2017](#). Debate over these legislative proposals showed that reduced funding and new "flexibility" under a capped financing approach [could result in less coverage, fewer benefits, and/or higher out-of-pocket costs for enrollees](#) relative to traditional Medicaid as states would have to limit program spending to fit within a pre-set aggregate cap.

## ENDNOTES

<sup>1</sup> Traditional Medicaid match rates range from [50% to 77% in FY 2020](#).

<sup>2</sup> The statute specifies 133% FPL but also includes a 5 percentage point FPL income disregard, bringing the eligibility limit up to 138% FPL. The ACA expansion group excludes individuals who are age 65 or older, pregnant, dually eligible for Medicare, or otherwise described in another mandatory coverage group.

<sup>3</sup> A state plan for medical assistance must. . . provide for making medical assistance available. . . to all individuals. . . beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of [Medicare], or enrolled for benefits under part B of [Medicare], and are not described in a previous subclause of this clause, and whose income. . . does not exceed 133 percent of the poverty line. . . “ 42 U.S.C. § 1396a (a)(10)(A)(VIII) (emphasis added).

<sup>4</sup> Wisconsin covers parent and caretaker relatives up to 100% FPL (95% FPL plus the 5 percentage point FPL disregard under the modified adjusted gross income methodology) pursuant to state plan authority. WI SPA #14-005-MM1, *Eligibility Groups – Mandatory Coverage Parents and Other Caretaker Relatives* (approval date 4/24/14, effective date 1/1/14), <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WI/WI-14-005-MM1.pdf>; WI SPA #14-011-MM1, *Eligibility Groups – Mandatory Coverage Parents and Other Caretaker Relatives* (approval date 4/24/14, effective date 1/1/14), <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WI/WI-14-011-MM1.pdf>.

<sup>5</sup> Wisconsin had a Section 1115 waiver that expanded Medicaid coverage before the ACA allowed states to receive federal matching funds for coverage expansions without a waiver. Instead of adopting the full ACA expansion and receiving the accompanying enhanced federal matching funds in 2014, Wisconsin chose to modify its existing waiver and provide coverage for childless adults up to the poverty level at its traditional Medicaid matching rate. CMS Special Terms and Conditions, #11-W-00293/5, Wisconsin Badger Care Reform (current approval period Oct. 31, 2018-Dec. 31, 2023), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf>.

<sup>6</sup> The newly elected governor in Wisconsin has supported implementation of the full ACA Medicaid expansion which would include access to the enhanced matching funds. Kaiser Family Foundation, *Medicaid: What to Watch in 2019 from the Administration, Congress, and the States* (Jan. 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-what-to-watch-in-2019-from-the-administration-congress-and-the-states/>.

<sup>7</sup> Arkansas [has indicated](#) that it is continuing to discuss approval for a partial expansion with enhanced ACA matching funds with CMS.

<sup>8</sup> Utah voters passed a ballot measure in November 2018 that requires the state to expand Medicaid coverage under the ACA to 138% FPL beginning April 1, 2019, and increases the state sales tax to finance the expansion.

<sup>9</sup> Utah Code § § 26-18-3.9, (2)(b), 26-18-415 (as amended by S.B. 96, Feb. 11, 2018), <https://le.utah.gov/~2019/bills/static/SB0096.html>. [Utah's June 2018 pending waiver amendment](#) would cover adults ages 19 to 64 up to 95% FPL (effectively 100% FPL with the 5 percentage point FPL disregard). The pending waiver amendment also seeks CMS approval for a work requirement and an enrollment cap on the expansion group. The state estimates that 70,000 to 90,000 individuals would gain coverage under this waiver amendment. The pending waiver amendment also seeks to waive EPSDT for 19 and 20 year olds and authority for mandatory Medicaid premium assistance for individuals with access to ESI. [Utah's existing Section 1115 waiver](#) covers two groups that would be subsumed into the new partial expansion group if the June 2018 waiver amendment is approved: (1) the Primary Care Network (PCN) group and (2) the Targeted Adult group. The PCN group was first implemented in 2002, and currently provides a limited benefit package of primary and preventive care services to a capped number (to be closed to new enrollment at the state's election or upon reaching 25,000 average annual enrollment) of nonelderly parents with incomes above state plan amounts up to 100% FPL and childless adults from 0-100% of poverty. The Targeted Adult group, added in November 2017, provides full state plan benefits to a capped number (to be closed to new enrollment at the state's election) of childless adults up to 5% FPL who are chronically homeless or involved in the criminal justice system and in need of behavioral health treatment.

<sup>10</sup> Utah Code § 26-18-3.9, (3) (as amended by S.B. 96, Feb. 11, 2018), <https://le.utah.gov/~2019/bills/static/SB0096.html>.

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<sup>11</sup> Utah Code § 26-18-3.9, (4) (as amended by S.B. 96, Feb. 11, 2018), <https://le.utah.gov/~2019/bills/static/SB0096.html>. The state legislation does not explain how such a per capita cap would operate other than to say that it would include an annual inflationary adjustment, account for “differences in cost among categories of Medicaid expansion enrollees,” and provide “greater flexibility to the state than the current Medicaid payment model. This waiver request also would seek to limit presumptive eligibility for the expansion group and impose a lock-out period if an expansion enrollee violated “certain program requirements as defined by the department,” 12-month continuous eligibility, and housing supports.

<sup>12</sup> This section is only contingent on CMS approval of the partial expansion with an enrollment cap and enhanced ACA matching funds; it does not require CMS approval of the financing “per capita cap.”

<sup>13</sup> The vast majority of individuals with incomes 100-138% FPL would be eligible for tax credits to subsidize the cost of coverage in the Marketplace, though some (e.g., people with an offer of employer coverage) may not qualify for tax credits.

<sup>14</sup> These studies pre-date policy changes that eliminated the cost sharing reduction (CSR) payments. Without CSR, adding individuals with incomes 100-138% FPL to the Marketplace could have different implications.

<sup>15</sup> Utah Code § 26-18-3.9, (3) (as amended by S.B. 96, Feb. 11, 2018), <https://le.utah.gov/~2019/bills/static/SB0096.html>.

<sup>16</sup> Utah Code § § 26-18-3.9, (2)(b), 26-18-415 (as amended by S.B. 96, Feb. 11, 2018), <https://le.utah.gov/~2019/bills/static/SB0096.html>; State of Utah, *1115 Primary Care Network Demonstration Waiver, Adult Expansion Amendment Request* (June 22, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa4.pdf>; see also *supra*. n.10.

<sup>17</sup> This section is only contingent on CMS approval of the partial expansion with an enrollment cap and enhanced ACA matching funds; it does not require CMS approval of the financing “per capita cap.” The state legislation also requires this waiver request to include limits on presumptive eligibility, a lock-out period for enrollees who violate certain program requirements to be specified by the state, 12-month continuous eligibility, and housing supports. Utah Code § 26-18-3.9, (4) (as amended by S.B. 96, Feb. 11, 2018), <https://le.utah.gov/~2019/bills/static/SB0096.html>. If partial expansion with an enrollment cap and enhanced matching funds is not approved by January 1, 2020, the state law directs Utah to seek authority for a full Medicaid expansion up to 138% FPL, with an enrollment cap and “additional flexibilities and cost controls” including cost-sharing and a work requirement. The state legislation also requires this waiver request to include mandatory Medicaid premium assistance for enrollees with access to employer sponsored insurance, delivery of benefits through accountable care organizations with physical and behavioral health services integration, limits on presumptive eligibility, and a lock-out period for enrollees who violation certain program requirements to be specified by the state. If expansion to 138% FPL with a work requirement and mandatory ESI premium assistance is not approved by July 1, 2020, full Medicaid expansion shall take effect. Utah Code § 26-18-3.9, (5) (as amended by S.B. 96, Feb. 11, 2018), <https://le.utah.gov/~2019/bills/static/SB0096.html>.