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The Affordable Care Act's Medicaid Expansion: State Alternatives and 1115 Waivers

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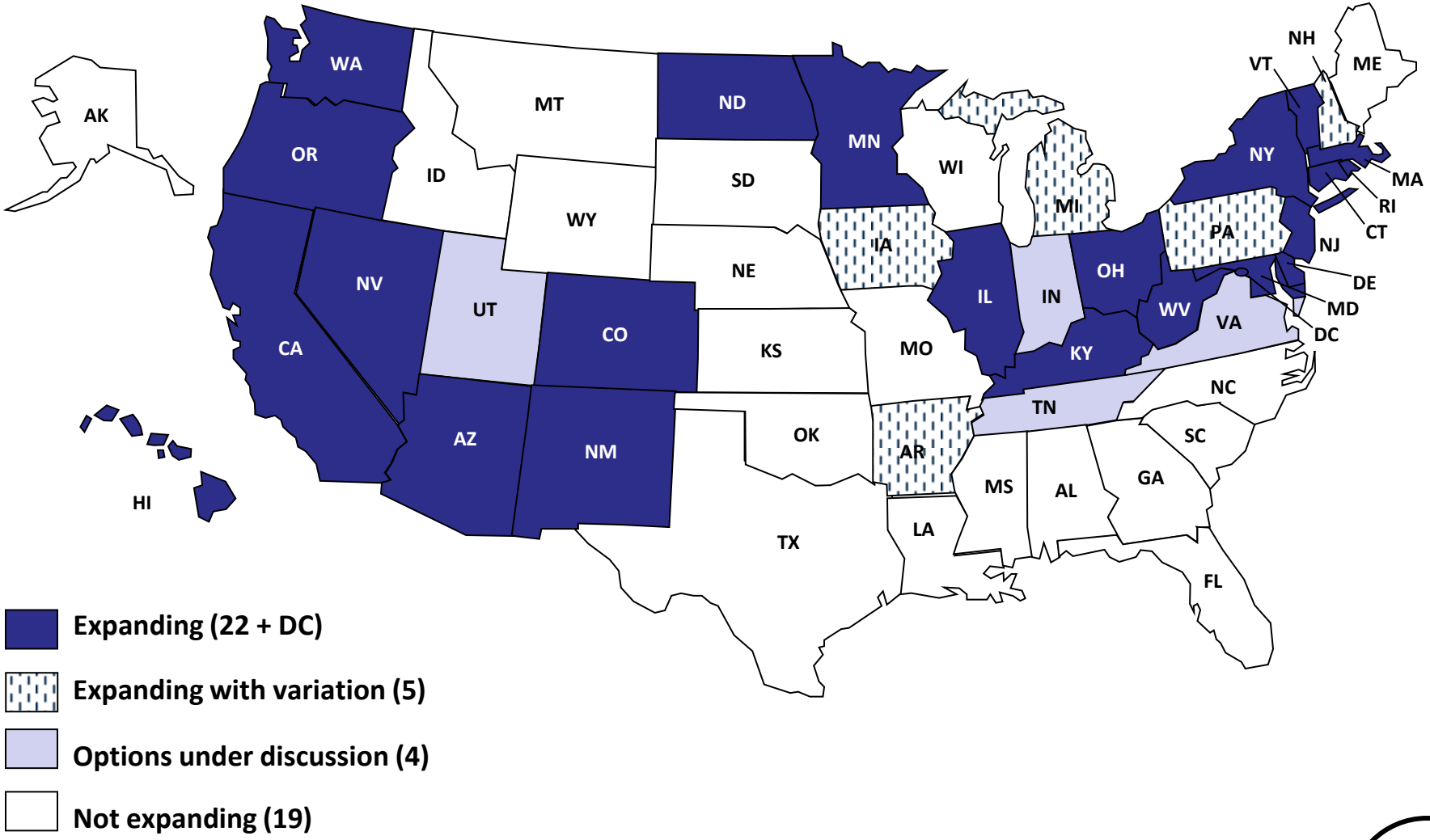
Exhibit 1. Status of State Participation in Medicaid Expansion, As of May 2014



Note: CMS has approved waivers for expansion with variation in Arkansas, Iowa, and Michigan. Pennsylvania's waiver is currently under review by CMS.

Source: Avalere *State Reform Insights*; Center of Budget and Policy Priorities; Politico.com; Commonwealth Fund analysis

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Exhibit 2. Alternative Approaches to Expand Medicaid

- **Some states that have struggled to reach consensus on expansion have found agreement in alternatives.**
- **To do this, states must expand eligibility to 138% of poverty, get permission from HHS for program changes.**
- **HHS has used its authority under Section 1115 of the Social Security Act to grant permission to states.**
- **Section 1115 allows demonstrations that advance the objectives of the Medicaid program.**
- **Secretary is required to:**
  - **Determine that a demonstration meets Medicaid objectives.**
  - **Provide additional oversight including evaluation.**
  - **Ensure public input into proposal and renewal.**
  - **Ensure federal budget neutrality.**

Source: Sara Rosenbaum, Carla Hurt, *How Section 1115 Demonstrations are Supporting the Affordable Care Act's Adult Medicaid Expansion*, The Commonwealth Fund, Forthcoming.

Exhibit 3. State Alternative Approaches to Medicaid Expansion Vary

	Arkansas	Iowa	Michigan	Pennsylvania	New Hampshire
Who is covered	Childless adults ages 19-64 up to 138% FPL and parents/guard. ages 19-64 from 17-138% FPL	Adults up to 138% FPL	Adults up to 138% FPL	Childless adults ages 21-64 up to 138% FPL and ages 19-20 from 44%-138% FPL, and parents/guardians ages 21-64 from 33-138% FPL	Childless adults ages 19-64 up to 138% FPL and parents/guardians ages 19-64 from 48-138% FPL
Approach	Uses federal funds to pay beneficiaries' premiums for QHPs	Medicaid to those up to 100% FPL, federal funds to pay premiums for QHPs for those 100-138% FPL	Medicaid to those up to 138% FPL with cost-sharing using health accounts	Uses federal funds to pay beneficiaries' premiums for QHPs	Uses Federal funds to pay beneficiaries' premiums with employer coverage; premiums for QHP or a Medicaid plan for those without employer– which ever is more cost effective. Beginning Jan 2016 federal funds pay beneficiaries' premiums for QHPs.
Date effective	January 1, 2014	January 1, 2014	April 1, 2014	Waiver under review	Legislation signed by governor
Premium and cost sharing	Beneficiaries >100% FPL are subject to Medicaid requirements	Premiums of $5/month for those 50-100% FPL, $10/month for those 100-138% FPL; copays for non-emergency use of ER	Beneficiaries >100% FPL pay 2% of family income for premiums, all beneficiaries make copays using MI Health Accounts; $3 copay for non-emergency use of ER	Beneficiaries subject to copayments; $25 monthly premium for single adult or $35 for household with multiple adults applies in year 2 to those >100% FPL; $10 copay for non-emergency use of ER	Beneficiaries subject to copayments, deductibles, copays for non-emergency use of ER. Level of exposure unspecified.
Estimated coverage	200,000 people	150,000 people	300,000- 500,000 people	500,000 people	15,000 people

Note: QHP refers to Qualified Health Plan. FPL refers to Federal Poverty Level. ER refers to Emergency Room. ESI refers to employer sponsored insurance.
Sources: State Medicaid Demonstration 1115 Waivers: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf; http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-fs.pdf; http://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf; http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_071204.pdf. New Hampshire legislation: http://www.gencourt.state.nh.us/legislation/2014/SB0413.pdf.

Exhibit 4. Alternative Approaches to Medicaid Expansion: Pros and Cons

PROS:

- **Allows states to insure their poorest residents.**
- **Helps reduce "churn" when incomes change.**
- **Increases size of marketplace risk pools.**
- **Reduces administrative costs to federal and state governments.**

CONS:

- **Higher premium and out-of-pocket costs for enrollees with limited budgets.**
- **May reduce traditional Medicaid benefits.**
- **Premiums may lower participation.**
- **Out-of-pocket costs and fewer benefits may reduce access to care.**

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