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Repeal of the ACA Medicaid Expansion: Critical Questions for States

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Much of the post-election debate over the potential repeal of the Affordable Care Act (ACA) has focused on the fate of the Marketplaces, the mandate, and popular insurance reforms such as the ban on pre-existing conditions. Increasingly, however, it is clear that repeal could include elimination of the Medicaid expansion to low-income adults and other ACA Medicaid provisions, with far-reaching implications for states and the Medicaid program. This Q&A reviews available information on the potential repeal of the Medicaid expansion, and highlights the critical questions that states will want to ask as Congress and the new administration continue to debate when and how to repeal the ACA.

1. How likely is it that the repeal effort will include the Medicaid expansion?

Likely. Although the campaign debate over Obamacare was not focused on Medicaid, all of the key bills and proposals that serve as the starting point for "repeal" and "repeal and replace" plans include elimination of the Medicaid expansion. These include H.R. 3762, a budget reconciliation bill that was passed by the current Congress in late 2015 to repeal key elements of the ACA, but vetoed by President Barack Obama,[1] and the health care chapter of Speaker of the House Paul Ryan's "Better Way" plan, a report of the House Health Care Reform Task Force, of which the nominee for Secretary of Health and Human Services (HHS), Rep. Tom Price, is a member.[2] It seems likely that elimination of expansion will come with a transition period (e.g., a January 1, 2018 implementation); a repeal effort is also likely to address whether additional states would be able to expand in the interim period.

2. What would repeal of the Medicaid expansion look like?

The best guide to what repeal of the Medicaid expansion could look like is H.R. 3762, the repeal bill adopted by Congress and vetoed by President Obama. It strikes both the eligibility category for low-income adults with income up to 133 percent of the federal poverty line and the enhanced federal funding provided for

[1] 114th Congress. "H.R. 3762 – To provide for reconciliation pursuant to section 2002 of the concurrent resolution on the budget for fiscal year 2016." (January 2016). Available online at: *https://www.congress.gov/114/bills/hr3762/BILLS-114hr3762enr.pdf*.

[2] Speaker of the House Paul Ryan. "A Better Way: Our Vision for a Confident America." (June 2016). Available online at: *http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf*.

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newly-eligible adults. By eliminating the eligibility category and not just the funding, the bill precludes states from receiving even a regular Medicaid matching rate for low-income adults.

3. What process will Congress use for repeal and replace?

Congress has not yet settled on the process it will use to enact repeal, but it will likely move quickly in early 2017 to retract key elements of the ACA using a budget reconciliation bill. By using reconciliation, Congress can adopt repeal with only 51 votes in the Senate, making it unnecessary to secure Democratic support. Congress is under pressure to offer a replacement plan at the same time as repeal, but the reality is that it will be extraordinarily complex and time-consuming to do so. If it does not act quickly, the incoming administration risks losing the "honeymoon period" often afforded a new president and faces the prospect of a better organized opposition. In light of these dynamics, the most likely scenario at this point is that Congress adopts repeal early in 2017 with a delayed effective date and comes back later with a replacement plan.

4. What are the likely implications for coverage?

Without federal Medicaid funding, the vast majority of the 31 states that cover an estimated 14.4 million people through a Medicaid expansion—including more than 11 million newly eligible adults—will likely be forced to eliminate coverage (see Table 1 for state-specific enrollment estimates). The vast majority of these people lack a route to affordable coverage in the absence of expansion, especially if ACA subsidies are also eliminated.[3] The losses will hit state budgets (see Question 5), low-income families, hospitals, community health centers, and other providers across the country.

5. What is the likely impact on state budgets of eliminating the Medicaid expansion?

The Medicaid expansion brought an estimated $56 billion in federal funding to the 31 states and Washington, D.C. in calendar year 2016, including more than $1 billion in at least half of expansion states (Table 1). In a real-time look at the effect of expansions on state budgets for the Robert Wood Johnson Foundation, a Manatt analysis found that expansion allowed states to reduce state general funds and local spending on uncompensated care, mental health and substance use disorder programs, and a range of other initiatives, as well as to increase revenue from hospital and issuer taxes.[4] The unraveling of expansion funding can be expected to have the opposite effect, creating disruption to state budgets and potentially requiring new tax revenues or cuts to other state and local programs.[5]

6. What happens to the money that the federal government saves by eliminating expansion? Can it be used to finance a new approach to coverage?

After the federal dollars committed to financing the Medicaid expansion are eliminated, there is no easy way to get them back. Under standard congressional budget procedures, if the expansion is eliminated, the money is removed from the Medicaid baseline. It is not available to finance a replacement or for a new version of Medicaid coverage in the future. Congress, of course, can decide if it wants to raise taxes, increase the debt, or cut spending on other programs to restore the funding, but it is not obligated to do so. Medicaid has no special "right" in the future to federal savings generated by elimination of the expansion.

Similarly, several major repeal proposals strike most of the revenue provisions of the Affordable Care Act such as the tax on "Cadillac plans," the fee imposed on health insurers, and the medical device tax, eliminating the vast majority of money used to finance the Medicaid expansion and other parts of the ACA. The proposals also eliminate the reductions in disproportionate share hospital (DSH) payments included in the ACA on the grounds that coverage gains would reduce the need for these payments. Congress can elect to re-impose these taxes and the DSH cuts when it comes time to craft a replacement proposal, but it will face strong opposition from affected industry groups and hospitals, especially if they are concerned that the replacement proposal fails to provide adequate coverage.

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[3] Of the 14.4 million individuals covered by Medicaid expansion, nearly 4 million would have qualified under the Medicaid eligibility rules in place prior to Medicaid expansion. States receive the regular Medicaid matching rate, rather than the enhanced matching rate, for the cost of providing services to these "already-eligible" adults. In many states, the pre-ACA waivers and eligibility categories that they were covered under have been eliminated, but it is possible that some will be able to retain coverage.

[4] For example, the expansion has allowed individuals with disabilities to secure coverage as low-income adults without going through the time-consuming and challenging process of receiving a disability determination. Without the expansion, many such individuals may again seek a disability determination as a route into Medicaid coverage.

[5] *State Health Reform Assistance Network*. "States Expanding Medicaid See Significant Budget Savings and Revenue Gains." (March 2016.) Available online at: *http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097*.

7. Will states be able to secure the regular matching rate to cover (or continue to cover) low-income adults?

No, it doesn't look likely. As noted above, repeal proposals strip both funding and the eligibility category for low-income adults. Moreover, prior to the ACA, states had the option to expand coverage for low-income parents/custodial relatives at the regular Medicaid matching rate using less restrictive income methodologies. The ACA, however, eliminated this option as it was no longer needed when expansion was put into place and none of the repeal proposals advanced to date would restore it.[6] This means that there will be even less flexibility to cover low-income adults than existed prior to the ACA.

8. Will states be able to use a Medicaid 1115 waiver to cover low-income adults?

Possibly, but they will need to cut spending on other Medicaid beneficiaries to cover the cost or generate offsetting savings through other means. This is because Medicaid 1115 waivers must be budget neutral to the federal government. Since low-income adults no longer can be covered without a waiver, the cost of covering them via a waiver must be fully offset. During the Bush administration, states were allowed to expand coverage to groups not otherwise eligible, but only if they reduced benefits or increased cost-sharing for existing Medicaid beneficiaries to pay for it.[7] Some of the other tools used by states in the past to generate budget neutrality for expansion, such as claiming savings from implementing Medicaid managed care or relying on unspent Children's Health Insurance Program (CHIP) funds, are no longer available.[8]

9. What might replace the Medicaid expansion provisions of the ACA?

We don't know yet. There is no specific information available on what might replace the Medicaid expansion provisions of the ACA. The incoming administration's platform calls for a block grant of Medicaid, and since the election, Vice President-Elect Mike Pence has highlighted this proposal before the Republican Governors Association. Secretary nominee Price is also a strong proponent of block grants. Another key player, Speaker Ryan, has proposed giving states the choice of a block grant or a per capita cap. Regardless of the specific proposals put forth, a key question for expansion states is whether it will create a new pathway for covering low-income adults and, even more importantly, whether it will provide adequate federal funding for their costs.

10. Will states that already expanded Medicaid be able to keep their funding?

Even states that expanded prior to repeal may not be able to keep their spending on low-income adults in a block grant or per capita cap structure. As discussed above, if expansion funding is eliminated during repeal, it will not necessarily be available to finance Medicaid initiatives in the future; and it is not clear that even if some or all of the funding is made available that it would be directed to the states that had expanded coverage under the ACA. Moreover, influential groups such as the Heritage Foundation have explicitly said that states with expansions "will have to consider adjustments to accommodate elimination of the enhanced federal match rate," suggesting it would be risky to assume that any repeal package will include funding comparable to the ACA for low-income adults.

11. Will states that have not yet expanded Medicaid be able to receive new funding in the future to cover the costs of low-income adults?

It is even more unlikely that states that have not yet expanded will be given the flexibility and funds to do so under a replacement plan. In his "Better Way" proposal, Speaker Ryan explicitly says that states that have not expanded as of January 1, 2016 will "not be able to do so" under his per capita cap option. Moreover, block grant proposals often use historical spending as the starting point for state allotments which, for non-expansion states, will not include the costs of covering low-income adults. Congress, of course, could elect to include an adjustment for non-expansion states, but doing so will cost money and funds would

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[6] Specifically, the flexibility was based on the state option to use less restrictive income methodologies for the Section 1931 eligibility category for parents and caretaker relatives. In Section 1902(e)(14) of Title XIX, the ACA required the use of "Modified Adjusted Gross Income" ("MAGI") to evaluate eligibility for the 1931 category (and for a number of eligibility categories, including most categories for children and pregnant women) and precluded the use of less restrictive income or expense disregards.

[7] Kaiser Commission on Medicaid and the Uninsured. "The Role of Section 1115 Waivers in Medicaid and *CHIP: Looking Back and Looking Forward." (March 2009.) Available online at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7874.pdf*.

[8] Now that most states already have managed care and the remaining states can readily implement via a state plan amendment, it does not appear likely that a state could "claim" Medicaid managed care savings to offset a Medicaid expansion. Unspent CHIP funds are no longer an option; Congress imposed a statutory ban on the unspent funds being used for adults via waiver.

need to be provided. Congress could also elect to use a formula that does not rely on historical spending, but doing so will require a high-stakes and controversial redistribution of Medicaid funds among states.

Finally, it should be noted that one of the major repeal proposals to date, H.R. 3762, did leave the window on expansion open until January 1, 2018. Non-expansion states are likely to be unwilling to implement a new expansion that would be terminated within a matter of months. One exception might be if states believe that expanding would put them in a better position for future funding formula fights in the context of a block grant or per capita cap.

12. What questions should states ask about the implications of repealing the Medicaid expansion?

As Congress and the new administration continue to decide when and how to repeal the ACA Medicaid expansion and funding, it will be important for states to ask the following:

- What is the replacement plan? How can states be assured before a repeal vote that they will have the financing and flexibility needed to cover their low-income population?
- Will the savings associated with repeal of expansion be available to finance a replacement plan for the Medicaid provisions?
- Will any replacement plan provide a pathway to cover low-income adults? As important, will it provide the funding to do so and, if so, at what matching rate/level of support?
- Will states that already expanded be able to continue their expansions? Will they face a cut in the matching rate or even elimination of federal support?
- Will non-expansion states be able to expand in the future? And if not, how will any replacement plan address the inequities created by freezing states in place based on decisions made about expansion during the Obama administration?

Conclusion

If the Medicaid expansion is repealed, it will have sweeping implications for coverage, state budgets, and future opportunities in Congress to finance Medicaid restructuring and new approaches to providing care for low-income Americans. Repeal—particularly without a plan for replacement—leaves states vulnerable to the loss of funds with no assurance that they will be able to maintain coverage, benefits, or payment rates to providers or other key features of the Medicaid program. In the weeks and months ahead, it will be important for states and other stakeholders to work closely with Congress and the new administration to ensure that the implications of the repeal of Medicaid expansion are fully understood and key questions are answered.

Table 1: Medicaid Expansion: Key Data on Coverage, Enrollment, and Federal Funding

State	Percentage Point Change in Nonelderly Adult Uninsurance Rate 2013 - 2015[1]	Estimated Federal Funding for Newly Eligible Adults 2016[2]***	Estimated Newly Eligible Enrollees[3]***
Alaska*	-	*Not Yet Available*	24,354[4]
Arizona	-9.6%	$304,192,732	105,711
Arkansas	-11.8%	$1,404,355,160	266,741
California	-12.6%	$18,088,590,624	3,466,100[5]
Colorado	-9.8%	$1,439,301,114	346,164[6]
Connecticut	-5.6%	$1,197,061,262	186,967
Delaware	-5.5%	$48,509,516	9,280
District of Columbia	-	$325,789,966	61,946
Hawaii	-	$388,346,600	33,427
Illinois	-7.9%	$4,487,430,348	616,265
Indiana	-4.2%	$687,167,548	222,364
Iowa	-4.2%	$792,752,398	135,963
Kentucky	-15.7%	$2,624,338,032	439,044
Louisiana*	-4.3%	*Not Yet Available*	304,684[7]
Maryland	-7.1%	$1,584,188,130	231,484
Massachusetts**	-3.0%	-	-
Michigan	-7.4%	$3,108,722,450	579,378
Minnesota	-3.3%	$1,202,024,182	207,683
Montana*	-	*Not Yet Available*	61,233[8]
Nevada	-14.2%	$942,426,762	187,110[9]
New Hampshire	-7.8%	$294,268,398	48,759
New Jersey	-7.3%	$3,009,860,442	532,917[10]
New Mexico	-	$1,427,646,188	235,425
New York	-6.6%	$1,107,806,938	285,564
North Dakota	-	$103,910,900	*Not Available*[11]
Ohio	-7.0%	$3,363,898,104	607,139
Oregon	-8.7%	$2,893,318,032	452,269
Pennsylvania	-5.5%	$1,458,238,116	547,962
Rhode Island	-6.8%	$404,616,346	59,280
Vermont**	-	-	-
Washington	-12.3%	$2,629,666,858	577,422
West Virginia	-19.9%	$668,461,730	174,999
TOTAL		**$55,986,888,876**	**11,007,634**

* Louisiana expanded in July, 2016, Montana expanded in January 2016, and Alaska expanded in September 2015. Uninsurance rate data does not reflect expansion impacts in these states, and expenditure data on newly eligible enrollees is not yet available.

** In Massachusetts and Vermont, all expansion enrollees were previously eligible for Medicaid, so no federal funding was provided for newly eligible enrollees. Expenditure data does not reflect enhanced funding provided by the ACA to these states and others that expanded before the ACA ("early expansion states").

*** Although not displayed in this table, CMS data indicate that an additional 3.3 million adults are enrolled nationwide through the Medicaid expansion who could have qualified under eligibility rules in place prior to the ACA. The federal funding displayed here does not reflect spending on these enrollees. Total federal funding for all expansion adult enrollees (not just those that were newly eligible) from January 2014 through June 2015 was $78.8 billion.

Data sources:

[1] National Health Interview Survey, 2013 – 2015. Available online at: *http://www.cdc.gov/nchs/nhis/releases.htm#health_insurance_coverage*.

[2] Manatt analysis based on November 2016 CMS-64 expenditure data. Data available online at: *https://www.medicaid.gov/medicaid/financing-and-reimbursement/state-expenditure-reporting/expenditure-reports/index.html*.

[3] Unless otherwise noted, December 2015 CMS-64 enrollment data. Available online at: *https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-oct-dec-2015.pdf*.

[4] Data shows "lives covered by Medicaid expansion"; October 31, 2016 Medicaid in Alaska Dashboard. Available online at: *http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx*.

[5] Kaiser Family Foundation estimate of newly eligible adults based on December 2015 Department of Health Care Services Medi-Cal monthly enrollment data. Kaiser estimate available online at: *http://files.kff.org/attachment/Issue-Brief-What-Coverage-and-Financing-is-at-Risk-Under-a-Repeal-of-the-ACA-Medicaid-Expansion;* Data available online at: *http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_June_2016_ADA.pdf*.

[6] March 2015 CMS-64 enrollment data. Available online at: *https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2015.pdf*.

[7] Data shows "adult group" enrollment; September 2016 Louisiana Medicaid Enrollment Report. Available online at: *http://new.dhh.louisiana.gov/assets/medicaid/MedicaidEnrollmentReports/EnrollmentTrends/EnrollmentTrends-09.2016.pdf*.

[8] Data shows "HELP Program enrolled" expansion adults; November 15, 2016 HELP Program Enrolled by County. Available online at: *http://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/Enrollment%20by%20County.pdf*.

[9] September 2015 CMS-64 enrollment data. Available online at: *https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-july-sept-2015.pdf*.

[10] January 2015 CMS-64 enrollment data. Available online at: *https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2015.pdf*.

[11] No CMS or state data source is publicly available for North Dakota's Medicaid expansion enrollment.