



# Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families

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## Summary

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) expands health insurance coverage primarily through two mechanisms: by expanding the existing Medicaid program and by establishing new health insurance exchanges where certain individuals and businesses can purchase private health insurance. Under ACA, Medicaid and exchanges are envisioned to work in tandem, with the potential to provide a continuous source of subsidized coverage for lower-income individuals and families, beginning in 2014.

On June 28, 2012, the U.S. Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius*. The Court held that the federal government cannot terminate current Medicaid program federal matching funds if a state does not expand its Medicaid program, effectively making the ACA expansion “optional.” As a result, some states may choose not to expand their Medicaid program. Individuals who are eligible for Medicaid are not eligible for subsidies in exchange plans. Thus, some individuals in these states would not be eligible for Medicaid and could become eligible for subsidized exchange coverage, while others may remain uninsured.

Individuals who receive coverage through exchange plans will likely not receive the same benefits offered by the Medicaid program, and vice versa. For example, traditional Medicaid provides a wide range of benefits to certain beneficiaries that are not typically covered in major medical plans in the private market, such as non-emergency transportation services or Early Periodic Screening, Diagnosis, and Treatment (EPSDT). Exchange plans will reflect a “typical” private health insurance plan offered by employers, which generally includes a wide range of benefits, but not necessarily all, that are offered to various Medicaid groups of individuals. Exchange plans will be required to offer essential health benefits, which include preventive services with no cost-sharing, a benefit available to many, but not all, Medicaid beneficiaries. Thus there will likely be differences in available benefits for some individuals, depending on whether they are covered by Medicaid or exchange plans.

In lieu of traditional Medicaid benefits, states can choose to offer an alternative set of benefits (benchmark and benchmark-equivalent coverage) that will include the essential health benefits, but only to certain groups of Medicaid beneficiaries. This alternative set of benefits has the potential to more closely align the benefits under Medicaid and the exchange for certain individuals.

In addition to differences in benefits, there may also be differences with regard to the costs required of individuals. Currently, states may require certain Medicaid beneficiaries to share in the cost of services, but because of their lower income, such obligations are generally limited. Nonetheless, variation exists across the different categories of Medicaid eligibility groups with respect to costs. Similarly, ACA provides for premium and cost-sharing assistance for the purchase of exchange plans for certain lower-income individuals. However the only permissible variation across qualified individuals (or families) for these exchange subsidies is based on income.

Another group for whom the alignment between Medicaid and exchanges is important is composed of individuals who are covered by Medicaid today, but who may lose Medicaid coverage when states are allowed to scale back their Medicaid program. This state “maintenance of effort” requirement for covering certain adults will be lifted beginning in 2014 (and in 2019 for the coverage of children). Some of these individuals will qualify for subsidies through exchange plans, while others may become uninsured. Additionally, some individuals may “churn”; that is, they may go back and forth between Medicaid and exchange coverage, depending on their

financial or other situation at the time. While some “churning” may be unavoidable, minimizing its effects may be critical to the health coverage of affected individuals and families.

The 113<sup>th</sup> and future Congresses will likely continue to play a significant role in shaping U.S. health care policy. This report provides an analysis of some of the key similarities and differences between Medicaid and insurance plan structure in plans offered through exchanges. Because Medicaid services vary by population covered and by state, and exchanges’ plans can also vary by state, this report provides insight into the complexities and issues when comparing beneficiary benefits and costs to individuals for Medicaid and the exchanges. The inherent variations in Medicaid and the uncertainty about exactly how the exchanges will operate are just two of the factors that complicate a comparison.

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## Introduction

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) expands health insurance coverage primarily through two mechanisms: by expanding the existing Medicaid program and by establishing new health insurance exchanges where certain individuals and businesses can purchase private health insurance. Under ACA, Medicaid and exchanges are envisioned to work in tandem, with the potential to provide a continuous source of subsidized coverage for lower-income individuals and families, beginning in 2014.

However, a significant legal development has the potential to impact the connection and possibly coordination between Medicaid and the exchanges, as well as the overall rate of uninsurance.<sup>1</sup> On June 28, 2012, the U.S. Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius*. The Court held that the federal government cannot terminate current Medicaid program federal matching funds if a state does not expand its Medicaid program, effectively making the ACA expansion “optional.”<sup>2</sup> As a result, some states may choose not to expand their Medicaid program. Thus, some individuals in these states would not be eligible for Medicaid and could become eligible for subsidized exchange coverage, while others may remain uninsured.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) issued the original cost estimate of ACA’s coverage provisions on March 20, 2010.<sup>3</sup> Their latest estimate (February 2013 Baseline) incorporates the potential impact of the Court’s decision. According to the 2013 Baseline, by 2022, ACA’s coverage provisions will result in 12 million individuals being covered under Medicaid and the State Children’s Health Insurance Program (CHIP), and 26 million individuals obtaining health insurance through the newly established exchanges, leaving 29 million nonelderly individuals uninsured.<sup>4</sup>

The potential impact of the Court’s decision on coverage may be seen in the comparison of the baseline estimate issued prior to the Court’s decision (March 2012 Baseline) with the most recent estimate. Post the Court’s decision, 5 million *fewer* individuals would be covered under Medicaid and CHIP, and 3 million *more* individuals would be enrolled in the exchanges in 2022.<sup>5</sup> The Court’s decision on the Medicaid expansion and the subsequent estimates by CBO and JCT

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<sup>1</sup> There are a number of additional complicating factors that can impact this connection and the overall rates of insurance, such as the adequacy of Medicaid provider networks for individuals made eligible through the ACA expansion; issues related to the differences in provider payment rates between Medicaid and the exchanges; or issues related to process or administrative functions that may surface when individuals move between public and private coverage (such as the potential impact on individuals who move between provider networks, or whether a given individual will continue to have access to an electronic health record as they move from public to private coverage, or process issues related to changes in eligibility, etc.). These issues are not discussed here.

<sup>2</sup> For more information on what the Supreme Court’s decision means for the Medicaid program, see Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, December 10, 2012. Available at <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>.

<sup>3</sup> U.S. Congressional Budget Office, letter to the Honorable Harry Reid, March 11, 2010, available at [http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11307/reid\\_letter\\_hr3590.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11307/reid_letter_hr3590.pdf).

<sup>4</sup> U.S. Congressional Budget Office, *CBO’s February 2013 Estimate of the Affordable Care Act on Health Insurance Coverage*, February 13, 2013, available at [http://cbo.gov/sites/default/files/cbofiles/attachments/43900\\_ACAInsuranceCoverageEffects.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf).

<sup>5</sup> *Ibid.*, and U.S. Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012, available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.

highlight the underlying relationship between Medicaid and the exchanges.<sup>6</sup> With participation in the ACA Medicaid expansion now a choice for states, this report analyzes the implications for those who may become eligible for subsidized exchange coverage because their state chose not to expand its Medicaid program, or as a result of other small shifts in coverage.

Specifically, the differences between Medicaid and exchange coverage may have critical implications for the estimated 3 million individuals who may become eligible for subsidized coverage through the exchanges. In addition to this population, this report also considers the impact on *current* Medicaid beneficiaries who could *lose* access to Medicaid if they live in a state that scales back on currently required program eligibility policies when the ACA maintenance of effort (MOE) provisions no longer apply in 2014 for adults or 2019 for children (referred to as the “scale back population”). A third group of potentially affected individuals are those who may “churn”, that is, they may go back and forth between Medicaid and exchange coverage, depending on their financial or other situation at the time. While some “churning” may be unavoidable, minimizing its effects may be critical to the health coverage of affected individuals and families.

This report provides broad comparisons between federal statutorily required beneficiary benefits and costs associated with Medicaid and the exchanges.<sup>7</sup> The analysis is focused on the beneficiary’s perspective, and does not address costs to the federal government or the states associated with the ACA expansion provisions. The analysis of the potential implications on populations less than 65 years of age is divided into four groups: (1) non-disabled children, (2) pregnant women, (3) non-disabled adults, and (4) individuals with chronic disabling conditions (i.e., individuals whose chronic condition leads to a disability). Medicaid’s different statutory eligibility classifications determine the benefits that the individual is entitled to as well as cost sharing obligations they must meet. This report does not include an analysis of the impacts on Medicaid’s age 65+ populations (those populations who are dually eligible for Medicare and Medicaid), as these individuals, by virtue of their eligibility for Medicare, are not permitted to receive federal subsidies through the exchanges. This report does not attempt to capture state-specific details on program design, but rather provides a comparison of the federal requirements that will structure the choices available to states in designing their programs.<sup>8</sup> This analysis is by no means exhaustive; rather it is illustrative of the complexities that are inherent in the

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<sup>6</sup> The relationship between private and public coverage already exists, to some degree, with respect to employer-provided health coverage and Medicaid/CHIP. Health coverage trends have shown that loss of private, employment-based coverage for some individuals leads to a gain in eligibility for public coverage. For example, loss of private, dependent coverage among children has been partially offset in recent years by increased enrollment in public coverage programs. For additional information, see John Holahan and Vicki Chen, “Changes in Health Insurance Coverage in the Great Recession, 2007-2010,” Urban Institute, Issue Paper no. 8264, December 2011, available at <http://www.kff.org/uninsured/upload/8264.pdf>.

<sup>7</sup> For a comprehensive discussion of ACA’s exchange provisions and relevant regulation and guidance, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*. For more information on ACA’s Medicaid expansion provisions, see CRS Report R41210, *Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*.

<sup>8</sup> We rely on Medicaid statutory requirements for covered benefits as the basis for the benefit-specific impact analysis and do not attempt to capture state-specific details on program design and/or delivery systems, etc.. For example, under the Medicaid managed care delivery system there is likely to be variation in coverage of, and limits placed on, specific benefits across Medicaid managed care plans in a given state, and states may offer certain services not included in the Managed Care contract through a fee-for-service arrangement. While states must ensure that all services covered under the state plan are available and accessible to Medicaid beneficiaries enrolled in managed care organizations (as per 42 C.F.R. §438.206), a covered benefit listed in the Medicaid state plan does not necessarily translate into uniform benefit coverage across all Medicaid MC plans that contract with a given state.

interactions between Medicaid and the exchanges.<sup>9</sup> While the analysis is current, the overall coverage and regulatory landscape is evolving. This report reflects information about how the Administration will likely implement certain aspects of the coverage provisions of the ACA based on regulations and other administrative guidance and announcements that were publicly available at the time of the publication of this report. For a discussion of the fundamental differences between Medicaid and ACA exchanges that shape the interactions between these programs, see **Appendix A**.

### **Report Highlights**

- The challenges for expanding coverage to individuals through Medicaid (for those under age 65) and the ACA exchanges, and understanding the implications for individuals and families, are underscored by the fundamental differences between these two different sources of coverage. Medicaid is an individual entitlement program that finances the delivery of primary, preventive, and acute medical services as well as long-term services and supports (LTSS) for different groups of low-income individuals, including non-disabled children, pregnant women, adults, and individuals with chronic disabling conditions. Health insurance exchanges are fundamentally marketplaces to facilitate economic transactions: the offer and purchase of private health plans.
- Medicaid provides a wide range of benefits not typically covered in major medical plans in the private health insurance market, such as coverage of intermediate care facilities for individuals with mental retardation, non-emergency transportation to and from providers, LTSS, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children under 21 years of age, to provide services to ameliorate the effects of health problems identified through a health care screening. In contrast, the scope of benefits provided through exchanges will reflect a “typical” private health insurance plan offered by employers, which generally includes a wide range of benefits but not necessarily all benefits offered in Medicaid to its various populations. In contrast, some required benefits in exchange plans may not be required for certain Medicaid populations, such as preventive care.
- States that offer “alternative” Medicaid benefits, as permitted under the Deficit Reduction Act (DRA, P.L. 109-171), will be required to cover essential health benefits (EHBs), benefits that also will be covered under exchange plans. Thus, for certain Medicaid beneficiaries, this potential alignment of benefits will likely result in a closer matchup between Medicaid and exchange plans. Further, individuals with disabilities covered under the ACA Medicaid expansion group are entitled to alternative Medicaid benefit coverage, which does not require states to cover LTSS. Exchange plans are also not required to cover LTSS benefits.
- Because the Medicaid program serves low-income individuals it has generally been designed to keep individuals’ costs low. States may require certain Medicaid beneficiaries to share in the cost of services, although limitations generally exist on (1) the amount of costs that states can impose, (2) the beneficiary groups to which these requirements may apply, and (3) the services for which cost-sharing can be charged. In contrast, the dollar amount of an available subsidy for an individual enrolled in an exchange plan is limited only by enrollee (or family) income.
- Variation across different Medicaid populations, with respect to costs, makes it difficult to generalize the implications of moving between Medicaid and the exchanges. For example, cost-sharing for services under Medicaid is generally prohibited for children under age 18 (or at state option up to age 21). By contrast, such costs for individuals with chronic disabling conditions may vary by individuals, depending on how much of their income they are expected to contribute for covering services. While subsidies towards cost-sharing for exchange services are based on an individual’s income, the cost-sharing subsidies do not take into account any other characteristic, such as an existing health condition.

<sup>9</sup> This report captures the breadth of the statutory and regulatory requirements in Medicaid and exchanges, but does not explore other important coverage features, such as differences in health care utilization that may stem from variability in demographic and other characteristics (e.g., annual income, family composition, health status, etc.) of individuals who are no longer eligible for Medicaid and seek coverage through the exchanges. Furthermore, the analysis does not make any conclusions about the value of having coverage under Medicaid compared to the exchanges or predictions on future rulemaking, guidance, and state actions that will further shape the Medicaid and exchange interactions.



## Benefits Under Medicaid and Exchange Plans

This section provides a description of benefits under Medicaid and the exchanges. It provides a framework for the comparison of benefits, which follows.

### Benefits Under Medicaid

For many beneficiaries, states cover a comprehensive package of mandatory and optional benefits, often referred to as “traditional” Medicaid state plan coverage.<sup>10</sup> These benefits are identified in federal statute and regulations, and include a wide range of primary, preventive, and acute medical services as well as long-term services and supports (LTSS). Some benefits are items, such as eyeglasses and prosthetic devices. Other benefits are defined by the provider of the service (e.g., physicians, hospitals). Still others are a type of service (e.g., pregnancy-related services). Additional benefits include premium payments for coverage provided through managed care arrangements, for example. Finally, in certain circumstances the Medicaid program includes coverage for non-medical benefits such as habilitation services which are designed to assist individuals with disabilities in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

States define the specific features of each covered benefit within broad federal guidelines. For example, states may place different limits on the amount of inpatient hospital services a beneficiary can receive in a year (e.g., up to 15 inpatient days per year in one state versus unlimited inpatient days in another state). For these reasons, there is great variability across states in terms of their Medicaid benefit coverage. Thus, it is difficult to make benefit comparisons across the state Medicaid programs (which also varies by individuals and/or groups).

As an alternative to providing all of the mandatory and selected optional benefits under “traditional” Medicaid, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) gave states the option to enroll state-specified groups in “alternative” plans, that is, benchmark and benchmark-equivalent benefit packages.<sup>11</sup> In general, these benefit packages may cover fewer benefits than traditional Medicaid. The alternative plans include the same benefits offered under one or more of the following:

- the Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program (FEHBP),
- a plan offered to state employees,
- the largest commercial health maintenance organization (HMO) in the state,
- other Secretary-approved coverage appropriate for the targeted population,<sup>12</sup> or
- an additional option under which (benchmark-equivalent) coverage must have the same actuarial value (AV)<sup>13</sup> as one of the benchmark plans.

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<sup>10</sup> For more information on Medicaid benefits, see CRS Report R42478, *Traditional Versus Benchmark Benefits Under Medicaid*.

<sup>11</sup> When certain conditions are met, states can also offer premium assistance for health insurance offered through employer-based plans for Medicaid children and their parents. Section 1115 of the Social Security Act provides states with flexibility to test benefit package and service delivery innovations with approval from the Secretary of HHS.

<sup>12</sup> For state-level details about covered services offered through DRA Benchmark and Benchmark-equivalent coverage in the 12 states and one territory with approved benchmark plans as of July 2012, see CRS Report R42478, *Traditional Versus Benchmark Benefits Under Medicaid*, by Elicia J. Herz.

<sup>13</sup> Actuarial value (AV) is a summary measure of a health plan’s generosity. It is expressed as the percentage of (continued...)

Beginning in 2014, these alternative packages must cover at least the essential health benefits (EHBs) that will also apply to plans offered in the exchanges.<sup>14</sup> In addition, these packages must cover family planning and mental health services.

## **Benefits in Exchange Plans**

All health plans offered through the exchanges must provide a comprehensive set of covered benefits (with the exception of stand-alone dental plans), and comply with all applicable ACA private market reforms (e.g., extend dependent coverage to children under age 26). In general, exchange plans must provide coverage for EHBs. ACA does not explicitly list the benefits included in EHBs, rather the law identifies 10 broad categories of benefits that, at a minimum, must be included as part of EHBs:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness and chronic disease management; and
- pediatric services, including oral and vision care.

ACA provides the Secretary of HHS with the authority to define and periodically update EHBs. The law requires the Secretary of HHS to ensure that the scope of EHBs is equal to the scope of benefits under a typical employer-sponsored health plan. In addition, the HHS Secretary must consider the diverse needs of different consumer groups, as well as other factors, in defining EHBs.<sup>15</sup>

HHS published a bulletin on December 16, 2011, which required that “EHB be defined by a benchmark plan selected by each State.”<sup>16</sup> HHS identified four benchmark plan types that a state could use for the purpose of defining EHBs in the state (see **Table 1** for a comparison between Medicaid and exchange benchmark plans):

- One of the three largest plans in the state’s small group health insurance market;
- One of the three largest health plans offered to state employees;

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(...continued)

medical expenses estimated to be paid by the health plan, on average, for a standard population and a set of allowed charges. Generally, the higher the actuarial value, the lower the service-related cost-sharing for enrollees, on average. However, plans with the same AV do not necessarily include the same set of covered benefits, and may have different premiums.

<sup>14</sup> U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Director Letter, SMDL 312-003, ACA #21, *Essential Health Benefits in the Medicaid Program*, November 20, 2012.

<sup>15</sup> See ACA Sec. 1302(b)(4).

<sup>16</sup> Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*, December 16, 2011, p.8, available at [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf).

- One of the three largest national plans offered through the Federal Employees Health Benefits Program (FEHBP); or
- The largest commercial non-Medicaid health maintenance organization in the state.

On February 25, 2013, HHS issued final regulations on standards related to EHBs.<sup>17</sup> In the Appendix of that rule, the EHB benchmark plan for each state is listed. (For states that did not voluntarily select a benchmark plan, the default benchmark option—the largest plan by enrollment in the state’s small group market—will apply.) The number of states for which each benchmark plan type applies are:

- Small group plans: 45 states, D.C. and Puerto Rico;
- State employee plans: 2 states;
- FEHBP plans: American Samoa, Guam, Northern Mariana Islands, and Virgin Islands; and
- Commercial HMOs: 4 states.

Each state’s benchmark plan will apply to their respective exchanges for plan years 2014 and 2015. HHS will then revisit this issue for the 2016 plan year.

## **Comparing Medicaid and Exchange Plans: Potential Implications for Benefits**

Medicaid’s alternative set of benefits (benchmark and benchmark-equivalent coverage) will include the essential health benefits, and has the potential to align with the benefits available under the exchange for certain individuals. While the term “benchmark” is used both in the Medicaid program and in the ACA exchanges to define specific benefit packages and/or identify certain types of health insurance plans, the definition of “benchmark” is not the same in each of these programs. **Table 1** shows the potential overlap between the alternative plans under Medicaid and the EHB benchmark plan types in the exchanges.<sup>18</sup>

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<sup>17</sup> U.S. Department of Health and Human Services, “Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,” *78 Federal Register* 12834, February 25, 2013.

<sup>18</sup> On January 22, 2013, CMS published a proposed rule that among other changes would modify existing regulations and guidance related to Medicaid benchmark coverage, and provide guidance on: (1) the use of alternative Medicaid benefit plans for the ACA expansion group, (2) the relationship between alternative Medicaid benefit plans and Essential Health Benefits; as well as (3) the relationship between alternative Medicaid benefit plans and other Title XIX provisions. For more information see U.S. Department of Health and Human Services, “Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing,” *78 Federal Register* No. 14, January 22, 2013, Proposed Rule.

**Table 1. Comparison of the Definitions of Medicaid Benchmark Plans and Exchange Benchmark Plans**

Medicaid Benchmark Plans	Exchange Benchmark Plans	Potential for Overlap
The Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program	One of the three largest national plans offered through the Federal Employees Health Benefits Program	√
A plan offered to state employees	One of the three largest state employees' health benefits plans	√
The largest commercial health maintenance organization in the state	The largest commercial non-Medicaid health maintenance organization in the state	Direct Overlap
	One of the three largest plans in the state's small group health insurance market	NA
Secretary-approved coverage appropriate for the targeted population		NA

**Source:** CRS analysis of Section 1937 of the Social Security Act and 77 *Federal Register* 70648, November 26, 2012.

**Notes:** NA = not applicable because benchmark plan option is not available under Medicaid or the exchanges, as the case may be. For purposes of determining essential health benefits, each state will choose a plan from among these benchmarks. For exchanges, the benchmark plan will apply in 2014 and 2015, after which HHS will revisit EHBs for subsequent years.

**Table 2** summarizes key differences in benefits provided under Medicaid (whether under traditional state plan coverage or alternative benefit coverage) and exchanges for various Medicaid-eligible populations. The benefits differences and similarities identified in **Table 2** are discussed in greater detail in the following section, by four Medicaid eligibility subcategories.

**Table 2. Summary of Key Differences and Similarities in Benefits Provided Under Medicaid and Exchanges**

[Statutory authority beginning in 2014]

Medicaid Population	Relevant Program Rules
Non-disabled Children	EPSDT <sup>a</sup> eliminates benefit limits and permits coverage of all services listed in Medicaid statute. Exchange plans are not required to provide EPSDT benefit guarantees.
Pregnant Women	Pregnancy-related services are likely comparable between Medicaid and exchanges. However, the Medicaid benefit may be limited in terms of availability of additional acute care services and is limited in terms of the duration of eligibility for the coverage.  Unauthorized immigrants are eligible for emergency Medicaid only, but are not permitted to purchase insurance in the exchanges.
Non-disabled Adults	Medicaid provides a wide range of benefits including some not likely to be covered in the exchanges (e.g., non-emergency transportation). EHBs are <i>not</i> required under “traditional” Medicaid coverage, but <i>are</i> required for individuals who receive coverage through the alternative benefit option. As a result, there is a potential for adults eligible through the ACA expansion group to receive benefits (e.g., preventive health services) that may not be available to previously existing non-disabled adult coverage groups. Under Medicaid and the exchanges, services to manage chronic conditions are generally available. However, differences between covered services or benefit limits are not known at this time.
Individuals with Chronic Disabling Conditions	Traditional Medicaid coverage offers a broad range of LTSS, including institutional care, such as in a nursing home, and home and community based services (HCBS). However, under traditional Medicaid most of these LTSS are available at state option. Individuals with chronic disabling conditions in the ACA expansion group are entitled to alternative benefit coverage, which is <i>not</i> required to cover LTSS. Exchange plans are also not required to cover LTSS benefits.

**Source:** CRS analysis of Medicaid statute and ACA, as amended.

**Note:** Table does not include those Medicaid eligible individuals who are over age 65 or who are also eligible for Medicare (“dual eligibles”), as these individuals, by virtue of their Medicare eligibility, are *not* eligible for the premium tax credits available through the exchanges.

- a. The EPSDT program covers health screenings and services, including assessments of each child’s physical and mental health development; laboratory tests; appropriate immunizations; health education; and vision, dental, and hearing services. States are required to provide all federally allowed treatment to correct problems identified through screenings for nearly all children under age 21, even if the specific treatment needed is not otherwise covered under a given state’s Medicaid plan and regardless of any state-defined limits on the amount, duration, and scope of the benefit.

## Non-disabled Children

For children, Medicaid services exceed those typically available under private health insurance that will be offered through exchanges, because of the benefit protections provided under EPSDT. The EPSDT program—which is a required benefit for nearly all Medicaid beneficiaries under 21 years of age<sup>19</sup>—covers health screenings and services, including assessments of each child’s physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services. States are required to provide all federally allowed treatment to correct problems identified through screenings, even if the specific treatment needed is not otherwise covered under a given state’s Medicaid plan and regardless of any state-defined limits on the amount, duration, and scope of

<sup>19</sup> EPSDT is not a mandatory benefit for the “medically needy,” although states that choose to extend EPSDT to their medically needy population must make the benefit available to all individuals under age 21.

the benefit.<sup>20</sup> States that opt for alternative Medicaid coverage must also extend EPSDT to populations under age 21. While no information is available as to whether or not exchange plans would include EPSDT, this benefit is not typically included in private health insurance plans.

## **Pregnant Women**

Within federal guidelines, states can choose to provide full Medicaid coverage for all pregnant women, to limit services to only those related to pregnancy or complications, and/or to cover certain enhanced pregnancy-related services.<sup>21</sup> In addition, Medicaid eligibility for the pregnant women only extends for 60 days after childbirth. Unless a woman can meet the eligibility requirements of another of Medicaid's eligibility pathways (e.g., Section 1931 family coverage, or the ACA expansion group beginning in 2014), after 60 days of post-partum care she is no longer eligible for Medicaid. Exchange plans will cover maternity and newborn care, along with many other acute care services, as part of the health insurance plan, and cannot limit services to only provide coverage of a specific condition or illness. Thus while pregnancy-related services will likely be comparable between Medicaid and exchange plans, not all services to this group of women may be comparable in states that limit services.

Pregnant women who are unauthorized immigrants are eligible for emergency Medicaid services only. Emergency Medicaid services include coverage of labor and delivery, and may include limited medical care after delivery. Individuals who are not lawfully residing in the United States are *not* permitted to purchase insurance through the exchanges, even if they could pay the entire premium and all cost-sharing for services.

## **Non-disabled Adults**

States that offer alternative Medicaid benefit coverage (to specified groups including ACA expansion eligibles) will be required to cover the same EHBs provided in exchange plans.<sup>22</sup> This alignment of benefits will likely result in a closer matchup of benefits available under Medicaid and those available through the private market than what existed prior to 2014. However, the actual scope of benefits provided in the exchanges may vary across states. As discussed previously, each state is allowed to decide which existing health plan will be the model for EHBs for each state exchange for 2014-2015. Any differences that currently exist across state benchmark plans will also exist across state exchanges, further complicating comparisons with Medicaid benefits.<sup>23</sup>

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<sup>20</sup> §1905(r) of the Social Security Act.

<sup>21</sup> U.S. Department of Health and Human Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," *77 Federal Register* 17204, March 23, 2012.

<sup>22</sup> If needed, states will be required to supplement the Section 1937 coverage option to ensure that the coverage meets the EHB coverage requirements. See U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Director Letter, SMDL 312-003, ACA #21, *Essential Health Benefits in the Medicaid Program*, November 20, 2012.

<sup>23</sup> Recall that the comparison of Medicaid benchmark plans with exchange benchmark plans in **Table 1** shows there is some, but not complete, overlap between these benefit packages. So while there is the potential for greater alignment of Medicaid and private benefits, it is not guaranteed. The potential for overlap of Medicaid benchmark-equivalent plans with exchange plans is even less clear, given that benchmark-equivalent plan coverage is based on a defined set of benefits, including (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and x-ray services, (4) emergency care, (5) well-child care, including immunizations, (6) prescribed drugs, (7) mental health services, and (8) other appropriate preventive care (designated by the Secretary); and at least 75% of the actuarial value of coverage under the applicable benchmark plan for vision care and hearing services (if any). It is possible then for a Medicaid benchmark-equivalent plan to have a different benefit package in comparison to other Medicaid plans, as well as (continued...)

ACA contains other benefit-related provisions that may also facilitate a crosswalk between services available under Medicaid and the exchanges. For example, with regard to preventive health services, the ACA expanded the previously existing Medicaid state plan option to provide “other diagnostic, screening, preventive, and rehabilitation services” for adults to include immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. While coverage of preventive services for adults under traditional Medicaid is generally an optional benefit,<sup>24</sup> Medicaid alternative plan coverage *must* offer preventive health services.<sup>25</sup> Potentially, not all Medicaid beneficiaries will receive these preventive services.

In another example, the ACA contained provisions that address both the coverage of mental health and substance use disorder services and the terms under which these services are covered. While the ACA did not change the federal mental health requirements, it did extend the applicability of these requirements to Medicaid’s alternative benefit plans (as well as two types of private health plans).<sup>26</sup> Consequently, only certain Medicaid beneficiaries will be guaranteed access to federal mental health parity protections.

By contrast, there are certain provisions in ACA that preclude coordination of services available under Medicaid and the exchanges. For example, while the Medicaid program has historically provided “wrap-around coverage” to supplement coverage available through the private health insurance market, such coverage does not appear to be an available option for individuals who are eligible for exchange subsidies, because individuals may only be eligible for one low-income subsidy program (i.e., Medicaid, CHIP, subsidies to purchase coverage through the exchanges) at any given time.<sup>27</sup>

For individuals with chronic conditions such as mental health concerns or multiple chronic conditions as in the case of an individual with cardiovascular disease and diabetes, Medicaid (whether under traditional or alternative benefit coverage) generally provides access to services to manage chronic conditions. Whether Medicaid beneficiaries with chronic conditions are able to obtain the types and amount of services that treat their specific conditions depends upon the particular state and its list of Medicaid covered benefits. Exchange plans must cover “chronic disease management.” As under Medicaid, whether individuals enrolled in exchanges receive

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exchange plans.

<sup>24</sup> The Kaiser Commission on Medicaid and the Uninsured and Health Management Associates conducted a survey of Medicaid coverage of 42 recommended preventive services for adults in Medicaid fee-for-service programs as of October 2010. According to their findings, preventive services were generally well-covered by many, but not all, state Medicaid programs in 2010 although variation in cost-sharing requirements for such services exists across states. See *Coverage of Preventive Services for Adults in Medicaid*, September 2012. Available at <http://www.kff.org/medicaid/upload/8359.pdf>.

<sup>25</sup> See U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Director Letter, SMD 13-002, ACA #25, Affordable Care Act §4106 (Preventive Services), February 1, 2013.

<sup>26</sup> For additional information about mental health parity and its applicability to certain types of plans, see CRS Report R41768, *Mental Health Parity and Mandated Coverage of Mental Health and Substance Use Disorder Services After the ACA*, by Amanda K. Sarata.

<sup>27</sup> CMS’ final Medicaid eligibility rule states, “However, we affirm that to the extent that an individual is enrolled in any insurance plan, including an Exchange plan, Medicaid would be a secondary payer. No change has been made to section 1902(a)(25) of the Act which provides generally that Medicaid pays secondary to legally liable third parties.” U.S. Department of Health and Human Services, “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010,” 77 Federal Register 17150, March 23, 2012. While the Medicaid final eligibility rule addresses the question of Medicaid as a secondary payer, it does not speak to the ACA requirements that individuals may only be eligible for one low-income subsidy program (i.e., Medicaid, CHIP, subsidies to purchase coverage through the exchanges) at any given time.

health services that treat their chronic conditions will depend on each individual's specific needs and the breadth of the benefits covered in the specific plan in which they enroll.

Regardless of the potential matchup between many services available under the private market with those available through Medicaid, under Medicaid states must also cover *additional* services such as non-emergency transportation for medical care,<sup>28</sup> and the cost of an attendant if necessary. Such benefits are not required under the exchanges, as part of EHBs. In another example, Medicaid covers family planning services.<sup>29</sup> While family planning is not specifically required to be covered in exchanges, such plans are required to cover, for example, "prescription drugs" and "ambulatory patient services" which potentially could include services and supplies for family planning purposes. Moreover, exchange coverage must cover a wide range of preventive services, including FDA-approved contraceptives.<sup>30</sup>

### **Non-elderly Individuals with Chronic Disabling Conditions**

Medicaid covers certain individuals with chronic disabling conditions (i.e., individuals whose chronic condition leads to a disability), such as individuals with physical disabilities, including blindness or spinal cord injury; and/or intellectual, or cognitive impairments as in the case of individuals born with intellectual disabilities or individuals with Alzheimer's disease or other forms of dementia. Some recipients enroll in Medicaid as children after being born with disabling conditions; others enroll as working-age adults with inherited or acquired disabling conditions; and still others enroll much later after they have lost the ability to care for themselves.

For individuals with chronic disabling conditions who are eligible for LTSS, traditional Medicaid offers care in both institutional and home and community-based settings. State Medicaid programs are required to cover nursing facility services for certain Medicaid beneficiaries, while states have the option to cover services in other institutional settings (e.g., Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)). States also have the option of offering home and community-based services. This flexibility under Medicaid law has led to widespread variation in state Medicaid LTSS benefits.<sup>31</sup> Coverage available to individuals eligible through the ACA expansion and exchange plans may *not* cover comprehensive LTSS.

States may continue to provide coverage to medically needy<sup>32</sup> individuals after 2014, and are required to offer such coverage with respect to children until the MOE requirements expire in

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<sup>28</sup> States are required to ensure necessary transportation for beneficiaries to and from providers (42 C.F.R. §431.53), and federal Medicaid matching funds are available for transportation expenses (42 C.F.R. §440.170). Also see, U. S. Department of Health and Human Services, "Medicaid Program: State Flexibility for Medicaid Benefit Packages," 75 Federal Register 23068, April 30, 2010.

<sup>29</sup> See Social Security Act §1905(a)(4); 42 C.F.R. §440.250(c).

<sup>30</sup> Certain religious employers are exempt from contraception coverage requirements. See Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46,621 (August 3, 2011) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

<sup>31</sup> Examples of such covered services are nursing home care, home health; personal care; extensive speech, occupational and physical therapy, habilitation; and transportation.

<sup>32</sup> Two broad categories described in Medicaid statute are "categorically needy" and "medically needy." These categories dictate benefit coverage for Medicaid beneficiaries. Categorically needy refers to low-income families and children, aged, or individuals who are blind or have a disability, certain pregnant women who are eligible for Medicaid as well as the new ACA expansion group. Medically needy individuals are persons who fall into one of the categorically needy groups but whose income and resources are too high to qualify as categorically needy. Under the statute, states may limit the categories of individuals who can qualify as medically needy. However, if a State provides any medically needy program, it must include children under 18 who would qualify under one of the welfare-related groups, and pregnant women who would qualify under either a mandatory or optional group, if their income or assets (continued...)



2019. In states that continue to cover medically needy adults groups, eligible adults will have the ability to spend down to the medically needy income standard and receive the benefits covered for medically needy individuals in the state,<sup>33</sup> or enroll in the ACA expansion group if they meet the eligibility requirements for that group. Then benefits may vary depending on whether or not they access Medicaid through the medically needy pathway or through the ACA expansion pathway.<sup>34</sup>

Some individuals with chronic disabling conditions who are not currently eligible for a state's Medicaid program may qualify for Medicaid under the ACA expansion group. ACA expansion individuals are entitled to Medicaid alternative coverage. Generally speaking, individuals with disabilities are exempted from mandatory enrollment in Medicaid alternative coverage. However, because individuals in the ACA expansion group are not eligible for any other existing mandatory or optional Medicaid eligibility pathway there appears to be no associated state plan services (including LTSS) available to these enrollees. To date, CMS has indicated that they "intend to propose that states may select more than one benchmark plan to define EHBs for different segments of the Medicaid population in keeping with states' flexibility to design benefit plans appropriate to meet the needs of targeted populations."<sup>35</sup>

Without access to LTSS, some individuals may seek long-term care insurance policies outside of such coverage;<sup>36</sup> pay for formal services up to an individual's ability to pay; or receive assistance from informal caregivers, such as a relative or neighbor. Without these options, many people with disabilities may forgo care altogether.

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were lower. States typically use this this pathway to expand Medicaid coverage for individuals with chronic disabling conditions.

For more information, see Medicaid Regulations, 42 C.F.R. §435.4.

<sup>33</sup> For states that choose to cover medically needy populations, in general, Medicaid law specifies what services must be covered. However, if the state covers medically needy persons in institutions for mental disease or in intermediate care facilities for persons with mental retardation, then Medicaid law gives states a choice of covering either a subset of the mandatory services, or alternatively, any seven services from a list of mandatory and optional services identified in Medicaid statute.

<sup>34</sup> Source: U.S. Department of Health and Human Services, "Medicaid/CHIP Affordable Care Act Implementation: Answers to Frequently Asked Questions; Eligibility Policy," March 22, 2012. Available at <http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Eligibility-Policy-FAQs.pdf>

<sup>35</sup> U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Director Letter, SMDL 312-003, ACA #21, Essential Health Benefits in the Medicaid Program, November 20, 2012.

<sup>36</sup> Long-term care insurance often covers nursing home and home and community-based services. The cost of the coverage can vary not only based on covered benefit (i.e., higher premiums for more comprehensive coverage), but also the age and health status of the individual seeking coverage. Currently, very few individuals have private long-term care insurance. Furthermore, private long-term care insurance is *not* a viable option for those who currently need LTSS as such individuals will likely be denied coverage and/or priced out of the market. For more information see, CRS Report R40601, *Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress*.

## Costs for Individuals Under Medicaid and Exchange Plans

### Costs for Individuals and Families

In the exchanges, individuals (and families) will be required to pay premiums in order to purchase private health insurance (PHI). Such costs will be applied regardless of whether any health care services are used. Similarly, individuals under Medicaid may be required to pay fees associated with enrollment<sup>37</sup> (usually on a monthly basis) to participate in the Medicaid program.

When individuals with PHI actually use health care, they may be required to pay cost-sharing for those services, which can include (1) a deductible—a specified dollar amount that beneficiaries must incur before the plan begins to pay for covered services; (2) coinsurance—a fixed percentage amount that beneficiaries must pay when they receive a covered service (e.g., 20% of the total amount that a plan pays for each physician visit); and (3) a copayment—a fixed dollar amount that beneficiaries must pay when they receive a covered service (e.g., \$20 for each physician visit). Some services may not be subject to a deductible, such as a well-child visit, but may still require coinsurance or copayments. Similarly, under Medicaid, cost-sharing for services can include deductibles, coinsurance, or copayments. While deductibles and coinsurance are rarely used in traditional Medicaid, copayments are applied to some services and eligibility groups.

Certain individuals enrolled in Medicaid (whether as “medically needy,” or through some other eligibility pathway) are required to use a portion of their income for cost-sharing.<sup>38</sup> Once an individual has met this requirement, Medicaid will pay its share of any other medically necessary Medicaid-covered services, and the individual would be responsible for additional cost-sharing. This is similar to the cost-sharing subsidies offered through the exchanges, which are also based on income.

### Beneficiary Costs Under Medicaid

Under Medicaid, states may require certain beneficiaries to share in the cost of Medicaid services, although limitations generally exist on (1) the dollar or percentage amount, (2) the beneficiary groups to whom these requirements apply, and (3) the services on which cost-sharing can be charged. In addition, the DRA provided states with other options for beneficiary obligations for some populations. In general, these rules vary by beneficiary income level and some types of service (as described below).<sup>39,40</sup>

<sup>37</sup> Under Medicaid, enrollment fees are referred to as “premiums.” While Medicaid uses this term, it does not entail the explicit transfer of insurance risk as the term generally implies in the private insurance context. Nor does “premium” in the Medicaid context reflect the typical components of insurance premiums; e.g., expected utilization based on experience of insured individual/group.

<sup>38</sup> See 42 C.F.R. §§434.700-434.735, and 42 C.F.R. §435.832.

<sup>39</sup> Medicaid cost-sharing regulations for selected populations can be found at 42 C.F.R. §447.52 (for nominal enrollment fees) and 42 C.F.R. §447.54 (for nominal service-related cost-sharing amounts). Regulations for the DRA cost-sharing provisions, including indexing of the Medicaid nominal amounts by medical inflation, can be found at 42 C.F.R. §§447.50-447.82.

<sup>40</sup> On January 22, 2013, CMS published a proposed rule that would allow state Medicaid programs to increase cost-sharing requirements for Medicaid enrollees. Among the proposed changes, states would be permitted to impose higher copayments for nonpreferred drugs and nonemergency use of emergency departments. See U.S. Department of Health and Human Services, “Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing,” 78 *Federal Register* No. 14, January 22, 2013, Proposed Rule.

## **Enrollment Fees Associated with Medicaid Enrollment**

Following is a summary of Medicaid program rules that generally apply for enrollment-related costs by population group. Enrollment-related costs are applied regardless of whether services are utilized.

### *Children, Pregnant Women, and Non-disabled Adults*

- *Income less than 150% FPL:* Those with annual income less than 150% FPL are exempt from enrollment-related costs under Medicaid.
- *Income above 150% FPL:* Under “traditional” Medicaid, enrollment fees are prohibited under Medicaid for many eligibility groups. Other groups (e.g., medically needy) may be charged “nominal” amounts. These nominal amounts, which are set in regulations, range from \$1 to \$19 per month, depending on monthly family income and size, and can be collected from (1) certain families moving from welfare to work who qualify for transitional assistance under Medicaid, and (2) pregnant women and infants. Enrollment fees can exceed these nominal amounts for other specific groups under Medicaid.<sup>41</sup> For example, under the DRA alternative plans, there is no limit on the cost of enrollment; however, the cumulative maximum cost-sharing (i.e., enrollment-related costs plus cost-sharing for services) is subject to an annual cap. Enrollment fees can also be charged to individuals enrolled in certain Medicaid waiver programs.

### *Non-aged Individuals with Chronic Disabling Conditions*

Generally speaking, non-aged individuals with chronic disabling conditions are exempt from enrollment-related costs with the exception of the buy-in groups that are available at state option.<sup>42</sup>

## **Medicaid Cost-Sharing for Services**

Under traditional Medicaid, regulations specify nominal cost-sharing for services in amounts by type of service, regardless of income. In general, cost-sharing is prohibited for children under age 18 (or at state option individuals not older than 21), pregnant women for pregnancy-related services, institutionalized individuals (e.g., individuals who are inpatients in a hospital, long-term care facility, or other medical institution), emergency services, and family planning services and supplies.

For non-institutional services (1) deductibles may not exceed \$2.65 per month per family, (2) coinsurance may not exceed 5% of the payment for the service, and (3) copayments may range from \$0.65 to \$3.90 depending on the payment for the item or service.<sup>43</sup> Other cost-sharing rules

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<sup>41</sup> In no case may a “monthly premium” imposed on individuals with annual income >150% FPL under “traditional” Medicaid exceed 10% of the amount by which the family income (less child care expenses) exceeds 150% FPL. See §1916 (c)(2) of the Social Security Act.

<sup>42</sup> Under buy-in rules, states can allow certain individuals with chronic disabling conditions who work to purchase or “buy into” Medicaid through the payment of “premiums” or “other cost-sharing charges,” sometimes on a sliding scale based on income. See §1916 of the Social Security Act.

<sup>43</sup> DRA required the Secretary of HHS to increase nominal amounts for cost-sharing by the annual percentage increase in the medical care component of the Consumer Price Index (CPI-M). These increases apply to service-related cost-sharing for both traditional Medicaid and the DRA state plan option. For FY2013 Maximum Nominal Service-related Cost-sharing amounts see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/> (continued...)

apply for non-emergency services provided in an emergency room and institutional services. Beneficiary costs for services for certain institutional services may not exceed 50% of payment for first day of care per admission. Finally, states may specify a cumulative maximum for cost-sharing for certain services and populations.

Different rules apply to cost-sharing for services under the DRA alternative plans. As under traditional Medicaid, certain groups and services are exempt from the DRA service-related cost-sharing rules. These rules vary by beneficiary income level:

- *Individuals with incomes below 100% FPL:* For non-institutional services (1) deductibles may not exceed \$2.65 per month per family, (2) coinsurance may not exceed 5% of the payment the Medicaid agency makes for the service, and (3) copayments may range from \$0.65 to \$3.90 depending on the payment for the item or service.
- *Individuals with income from 100% through 150% FPL:* Cost-sharing for services for non-institutional and certain institutional services cannot exceed 10% of the cost of the item or service.
- *Individuals with income exceeding 150% FPL:* Cost-sharing for services for non-institutional and institutional services cannot exceed 20% of the cost of the item or service.

As under traditional Medicaid, certain groups and services are exempt from the DRA service-related cost-sharing rules. Under DRA state plan option, pregnant women are exempt from cost-sharing for pregnancy-related services. Children under age 18 in mandatory coverage groups and certain foster care children, regardless of age, are also exempt. Under the DRA option, groups generally designated as exempt may be subject to cost-sharing for non-emergency care provided in an emergency room and for non-preferred prescription drugs.

Other cost-sharing rules apply for non-emergency services provided in an emergency room (maximum allowable copayments range from \$3.90 to “no limit”), prescription drugs (maximum allowable copayments range from \$3.90 to 20% of the cost of the drug (for non-preferred drugs only)) and institutional services regardless of an individual’s annual income. Cost-sharing for institutional services may not exceed 50% of payment for first day of care per admission. Finally, a cumulative maximum for all costs (enrollment-related costs plus cost-sharing for services) cannot exceed 5% of monthly or quarterly income.

Still other rules apply regarding service-related costs for persons residing in nursing homes or receiving LTSS under HCBS waivers.<sup>44</sup> Certain individuals are required to apply some of their income toward the cost of their care. The amounts they may retain vary by setting and by state rules.<sup>45</sup> Medicaid beneficiaries in nursing homes may retain a personal needs allowance (PNA). Federal law sets a minimum PNA amount of \$30, but states may elect higher amounts. Persons receiving services through HCBS waivers may retain a monthly maintenance needs allowance (MMNA), which varies by state.

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Cost-Sharing-Out-of-Pocket-Costs.html.

<sup>44</sup> Authorized under §1915(c)-(e) of the Social Security Act.

<sup>45</sup> See 42 C.F.R. §§434.700-434.735.

## Costs in Exchange Plans

There are two broad categories of enrollee costs related to exchanges: premiums to purchase insurance and cost-sharing related to the use of health care services. Certain individuals enrolled in exchange plans will receive federal tax credits to cover all or part of exchange premiums. In addition, all exchange plans are subject to certain cost-sharing limits, and certain exchange enrollees may receive subsidies towards cost-sharing expenses.<sup>46</sup>

### Premium Tax Credits

To be eligible for a premium credit in an exchange, an individual must:

- have household income<sup>47</sup> between 100% and 400% FPL, with exceptions;<sup>48</sup>
- *not* be eligible for Medicaid<sup>49</sup> or Medicare or other types of “minimum essential coverage”<sup>50</sup> (other than through the individual health insurance market);<sup>51</sup>
- be enrolled in an exchange plan; and
- be part of a tax-filing unit.

The amount of the premium credit depends on the income of the tax filer (and dependents), the premium for the exchange plan in which the tax filer (and dependents) is/are enrolled, and the cost of exchange plans in the tax filer’s local area. Depending on the circumstances, the credit amount (1) may cover the entire premium and the tax filer will pay nothing towards the premium; or (2) may not cover the entire premium and the tax filer may be required to pay part (or all) of

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<sup>46</sup> For a discussion about the premium credits and cost-sharing subsidies established under ACA, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

<sup>47</sup> For purposes of premium credit eligibility, household income is measured according to the tax definition for “modified adjusted gross income” (MAGI). MAGI will also be used to determine eligibility under Medicaid for certain groups.

<sup>48</sup> An exception is made for lawfully present aliens with income below 100% FPL who are ineligible for Medicaid for the first five years that they are lawfully present. These taxpayers will be treated as though their income is exactly 100% FPL for purposes of the premium credit.

<sup>49</sup> The final regulation on Medicaid eligibility changes under ACA acknowledged that several commenters raised as an issue the situation in which an individual who is eligible for a limited set of benefits under Medicaid would be considered having minimum essential coverage (MEC), making that individual ineligible for subsidized exchange coverage. Commenters asked CMS to clarify that such limited coverage would not be considered MEC, for premium credit eligibility purposes. CMS stated that it lacks the authority to define MEC, but that the Treasury Secretary will address this issue in future guidance. *77 Federal Register* 17150, March 23, 2012.

<sup>50</sup> The definition of minimum essential coverage is broad. It includes Medicare Part A, Medicaid, the State Children’s Health Insurance Program (CHIP), TriCare, the TRICARE for Life program, a health care program administered by the Department of Veteran’s Affairs, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.

<sup>51</sup> The private health insurance market is made up of 3 segments—the large group, small group and nongroup markets. The nongroup (individual) market refers to insurance policies offered to individuals and families buying insurance on their own. Group insurance refers to health plans offered through a plan sponsor, typically an employer. Before 2016, states will have the option to define “small employers” either as those with 100 or fewer employees, or 50 or fewer employees. Beginning in 2016, small employers must be defined as those with 100 or fewer employees, for exchange purposes.

the premium.<sup>52</sup> If the tax filer is required to pay any portion of the premium, the amount is capped as a percentage of income, as specified in the law.

### **Cost-Sharing Limits and Subsidies**

ACA includes several cost-sharing provisions applicable to exchange coverage. In general, exchange plans must comply with the following cost-sharing requirements:

- Prohibit any deductible applicable to preventive health services;
- Limit deductibles, in small group health plans, to no more than \$2,000 for self-only coverage, or \$4,000 for any other coverage in 2014 (annually adjusted thereafter); and
- Prohibit annual cost-sharing limits<sup>53</sup> that exceed existing limits specified in the federal tax code.<sup>54</sup>

In addition, ACA requires most exchange plans, to cover certain preventive health services and impose no cost-sharing on such services.<sup>55</sup>

Finally, certain individuals who are eligible for premium credits in the exchanges will also be eligible for subsidies towards cost-sharing for services. An individual who qualifies for a premium credit *and* is enrolled in a silver plan (actuarial value of 70%)<sup>56</sup> offered in an exchange will also be eligible for a cost-sharing subsidy. The size of the subsidy will be based on the taxfiler's (or family's) income.

## **Comparing Medicaid and Exchange Plans: Potential Implications for Costs for Individuals**

When the premium credits become available in 2014, some non-elderly individuals with income at or below 133% FPL (effectively 138% FPL with the MAGI 5% FPL income disregard) may be

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<sup>52</sup> Given the statutory formula for determining the amount for a premium credit, it is *theoretically* possible that the premium credit calculation will result in zero, thus leaving the individual (or family) responsible for covering the entire premium amount.

<sup>53</sup> A cost-sharing limit refers to the maximum dollar amount that an enrollee would be required to pay to use *covered* services under a plan which has such a limit (also referred to as an out-of-pocket limit). In PHI, cost-sharing limits do *not* include premiums.

<sup>54</sup> The cost-sharing limits are based on maximum spending amounts applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs); these maximum amounts are updated annually. For 2012, the maximums applicable to HSA-qualified HDHPs were \$6,050 for self-only coverage and \$12,100 for family coverage. Given that the HSA-qualified HDHP maximums are updated every year, the cost-sharing limits for 2014 (when exchanges are required to become operational) will likely be different than the 2012 maximum amounts.

<sup>55</sup> These preventive services include (1) evidence-based items or services that have a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF); (2) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and (4) with respect to women, such additional preventive care and screenings not described by the USPSTF but provided in comprehensive guidelines supported by HRSA. For a summary of these prevention coverage requirements, see Kaiser Family Foundation, "Preventive Services Covered by Private Health Plans under the Affordable Care Act," Sept. 2011, <http://www.kff.org/healthreform/upload/8219.pdf>.

<sup>56</sup> Nearly all health plans that will be available through exchanges will represent one of four cost-sharing levels, designated by a precious metal: bronze, silver, gold, or platinum, with each level meeting a specific actuarial value: 60%, 70%, 80% or 90%, respectively.

eligible for Medicaid, and therefore ineligible for premium credits in the exchanges. For individuals in states that do not expand their Medicaid program up to 138% FPL, eligibility for subsidies will depend on their income. Those with incomes of at least 100% FPL could qualify for subsidies, but not most of those with incomes below 100% FPL due to statutory requirements. The lack of Medicaid eligibility or private insurance subsidies could result in individuals in this group continuing to not have health insurance. (This group is discussed briefly in **Appendix B**.) This disconnect will occur because the law envisions that all states would expand their programs, while the U.S. Supreme Court effectively makes the expansion optional for states. Several states have publically indicated that they will not expand their Medicaid programs.<sup>57</sup>

Additionally, if a state were to scale back its eligibility criteria after expiration of the MOE, and some individuals lost eligibility for Medicaid, they could also become eligible for premium credits in the exchanges, again depending in part on their income.

**Table 3** summarizes key differences and similarities in costs for individuals depending on whether they are covered by Medicaid or enrolled in an exchange plan. Detailed explanation and examples follow in the text of this section.

**Table 3. Summary of Key Differences and Similarities in Costs Under Medicaid and Exchanges**  
Beginning in 2014

Medicaid Population <sup>a</sup>	Relevant Program Rules
<b>Enrollment-Related Costs</b>	
<i>Children, Pregnant Women, and Certain Non-disabled Adults</i>	
Income at or above 100% through 150% FPL	No Medicaid enrollment-related costs. Exchange premium credits available, but enrollees may be required to pay part of the insurance premium.
Income above 150% FPL	Medicaid nominal enrollment-related costs, or higher fees under DRA option (subject to 5% cap). Exchange premium credits available, but enrollees may be required to pay part of the insurance premium.
<i>Non-elderly Individuals with Chronic Disabling Conditions</i>	
Income at or above 100% FPL	Enrollment-related costs (variable amounts) required for buy-in groups. Exchange premium credits available, but enrollees may be required to pay part of the insurance premium.
<b>Cost-Sharing for Services</b>	
<i>Pregnant Women, Children</i>	Medicaid cost-sharing for services is generally prohibited for individuals < age 18 and for pregnancy-related services. Subsidies towards cost-sharing will be available in exchanges for certain low-income individuals, but all enrollees will be required to pay some amount for use of services, regardless of age or health condition.
<i>Non-disabled Adults</i>	
Income from 100% through 150% FPL	Medicaid nominal cost-sharing for services if applicable, or higher under DRA option (subject to 5% cap). Subsidies towards cost-sharing will be available in exchanges for certain low-income individuals, but all enrollees will be required to pay some amount for use of services.
Income above 150% FPL	Medicaid nominal cost-sharing for services if applicable or higher fees under DRA option (subject to 5% cap). Subsidies towards cost-sharing will be available in exchanges for certain low-income individuals, but all enrollees will be required to pay some amount for use of services.

<sup>57</sup> For a survey of what states are saying with regard to the Medicaid expansion as of January 15, 2013, see <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>.

Medicaid Population <sup>a</sup>	Relevant Program Rules
Individuals with Chronic Disabling Conditions	<p>At or above 100% FPL</p> <p><i>Those not residing in nursing homes or using HCBS waivers:</i>                      Medicaid nominal cost-sharing for services if applicable. Subsidies towards cost-sharing will be available in exchanges for certain low-income individuals, but all enrollees will be required to pay some amount for use of services, regardless of health condition.</p> <p><i>Those residing in nursing homes or using HCBS waivers:</i>                      Medicaid beneficiary may pay all income above the PNA or MMNA toward the cost of care. Subsidies towards cost-sharing will be available in exchanges for certain low-income individuals, but all enrollees will be required to pay some amount for use of services, regardless of health condition.<sup>b</sup></p>

**Source:** CRS analysis of Medicaid statute and ACA, as amended.

**Notes:** In 2013, the FPL for a family of four in the 48 contiguous states and the District of Columbia is \$23,550; income at 200% FPL for such a family is \$47,100. See 78 *Federal Register* 5182, <http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf>. While individuals with income below 100% FPL would be ineligible for cost assistance in the exchanges, such individuals would be exempt from ACA's requirement for nearly all individuals to have health coverage ("individual mandate"). Such an exemption would allow low-income individuals to avoid any penalty associated with not having coverage; however, it would not make exchange coverage more affordable for this population should they still want health insurance through the exchanges.

- a. Lawfully present immigrants with income below 100% of the FPL are ineligible for Medicaid for the first five years that they are lawfully present.
- b. Once eligible for Medicaid, persons qualifying through certain eligibility groups are required to apply their income above specified amounts toward the cost of their care. The amounts the beneficiary may retain vary by setting. For example, Medicaid beneficiaries in a nursing home may retain a personal needs allowance (PNA). Persons receiving services in home and community-based settings may retain a monthly maintenance needs allowance (MMNA). These amounts vary by states. All income amounts above these levels, including what may be available in a Miller Trust, must be applied toward the cost of their care. Under a Miller Trust in 2012, for certain other eligibility pathways associated with individuals with disabilities, federal law permits individuals to not count some of their assets (e.g., \$2,000 for individuals and \$3,000 for a couple, the equity on a home up to \$525,000 (or up to \$768,000 at state option), one automobile, income producing property, etc.) when determining income eligibility for Medicaid. Under these rules, states cannot require an individual to divest certain assets to remain eligible for care.

## Non-disabled Children, Pregnant Women, and Adults

### Enrollment Costs

As stated above, under traditional Medicaid, children, pregnant women, and non-disabled adults either are exempt from enrollment-related costs or are charged nominal amounts. In exchanges, whether or not enrollees are eligible for tax credits to cover all/some of the premiums depends, to a great extent, on their income relative to the federal poverty level.<sup>58</sup>

**Individuals with income at or above 100% FPL**, in states in which they would not have access to Medicaid (if a state were to scale back eligibility or choose not to participate in the Medicaid expansion), may qualify for premium credits, as long as they meet the other required eligibility criteria. However, if the premium credits only covered part of the premium, the enrollee would be responsible for covering the remaining amount.

<sup>58</sup> **Appendix B** discusses individuals with income less than 100% FPL who do not have access to either Medicaid or premium credits.



For example, an individual with income at 200% FPL<sup>59</sup> may be required to spend up to 6.3% of household income towards the cost of exchange coverage. For illustrative purposes only, if premium credits were available in 2013, 6.3% of income at 200% FPL would be approximately \$121 per month. In other words, an individual with income at that level with a premium credit (based on 2013 data) could be required to contribute \$121 towards the monthly premium. This contrasts with the Medicaid program where an individual with the same income could be charged between zero and approximately \$96 a month (for details, see **Table 4**). This example underscores how a given eligibility pathway under Medicaid may affect possible enrollment-related costs (as well as benefits) for individuals and families, and contrasts Medicaid’s beneficiary-specific approach with eligibility for the premium tax credit primarily relying on income.

**Table 4. Illustrative Example: Monthly Enrollment-Related Costs for a Non-disabled Individual with Income at 200% FPL, 2013**

Exchanges <sup>a</sup>	Medicaid
	(1) \$0 <sup>b</sup>
	(2) \$1-\$19 <sup>c</sup>
\$121	(3) \$48 maximum <sup>d</sup>
	(4) \$96 maximum <sup>e</sup>

**Notes:** Beginning January 1, 2014, the definition of income for eligibility for certain Medicaid populations and premium credits in the exchanges is based on modified adjusted gross income.

- a. Assumes premium credits were available in 2013 (for illustrative purposes only), and that this individual is eligible for a credit and pays the full contribution amount towards the premium, based on his/her income.
- b. For any member of a group for whom enrollment fees cannot be charged.
- c. For any member of a certain specified group where nominal enrollment-related costs apply.
- d. For any individual of the specified groups under Medicaid where enrollment-related costs are permitted to exceed nominal amounts, but cannot exceed 10% of the amount by which family income (less childcare expenses) exceeds 150% FPL. (For this example  $200\% \text{ FPL} - 150\% \text{ FPL} * 10\% / 12$ , or  $\$22,980 - \$17,235 = \$5,745 * 0.1 = \$575 / 12 = \$47.88$ )
- e. For an individual who is subject to the DRA cost-sharing maximum (costs may not exceed 5% of income) and only has enrollment-related costs. (For this example  $200\% \text{ FPL} * 5\% / 12$ , or  $\$22,980 * 0.05 = \$1,149 / 12 = \$95.75$ )

### Cost-Sharing for Services

Under Medicaid, cost-sharing for services is generally prohibited for children under age 18 and for pregnancy-related services delivered to pregnant women. For those for whom cost-sharing may be imposed, the requirements are generally nominal amounts.

### Cumulative Maximum Cost-Sharing

Similar to the analysis regarding benefits, if a state were to scale back eligibility for adult populations beginning in 2014, many of its former Medicaid beneficiaries may have higher costs under exchange plans compared with Medicaid. Absent any state specific assistance, this may adversely impact their ability to afford health care, even with insurance.<sup>60</sup>

<sup>59</sup> For FY2013, income at 200% FPL for one person was equal to \$22,980.

<sup>60</sup> Analytical comparisons of cost-sharing under Medicaid compared with exchanges are in its infancy. Researchers and others identify these issues as important for beneficiaries in terms of out-of-pocket costs, as well as for states that are weighing the merits and drawbacks of ACA’s Medicaid expansion. For examples of preliminary analysis of costs, see (continued...)

For illustrative purposes only, compare the maximum allowable costs (i.e., enrollment-related costs plus cost-sharing for services) for a non-disabled family of four enrolled in Medicaid with annual income at the ACA expansion income eligibility threshold to that same family enrolled in an exchange plan, assuming availability in 2013. (Note: the following is just one example to illustrate the potential difference in maximum allowable costs. The example is not meant to be fully representative of the breadth of possible experiences of Medicaid beneficiaries who enroll in exchange plans.) Under Medicaid's alternative rules for costs for individuals, for example, the maximum allowable costs for a non-disabled family of four with annual income equal to 138% FPL (based on 2013 poverty guidelines) is equal to approximately \$1,625 per year.<sup>61</sup> Should that same family lose access to Medicaid and enroll in an exchange plan, they potentially could face a required premium contribution of \$1,069, and a maximum cost-sharing limit of \$4,167, resulting in a potential maximum of \$5,236 for covered services.<sup>62</sup> This example represents the extreme in terms of total out of pocket costs. While the typical family enrolled in an exchange plan may not actually have health care expenses that reach this limit, in those cases when a family uses a great deal of health care, such a family potentially could face an additional \$3,611 in costs per year under an exchange plan compared with Medicaid.<sup>63</sup> This spending difference represents approximately 11% of that family's 2013 income.<sup>64</sup>

Another approach for comparing individual/family spending under Medicaid and exchanges is to compare actuarial value (AV) estimates<sup>65</sup> for public and private coverage. (Actuarial value is a measure of a health plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the health plan for a standard population and a set of allowed charges. Generally, the higher the actuarial value, the lower the service-related cost-sharing for enrollees, on average.) According to analysis prepared by Actuarial Research Corporation (ARC) for CRS, the average AV for a non-disabled adult enrolled in a 2011 Medicaid plan, assuming the highest potential cost-sharing scenario based on statutory requirements, was 97%.<sup>66</sup> In contrast, ARC estimates that

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(...continued)

U.S. Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012, available at <http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf#page=8>; and G. Kenney et al., *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid?*, July 5, 2012, available at <http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf>.

<sup>61</sup> In 2013, the FPL for a family of four in the 48 contiguous states was \$23,550; income at 138% FPL for such a family was equal to \$32,499. The maximum allowable total annual costs cannot exceed 5% of monthly or quarterly family income (as specified by the state). Five percent of \$32,499 is equal to \$1,624.95 per year.

<sup>62</sup> If available in 2013, a family of four with income at 138% FPL (\$32,499) would potentially be required to contribute 3.29% of their income towards the premium for exchange coverage; \$32,499 multiplied by 3.29% is equal to approximately \$1,069. For this same family, the maximum cost-sharing limit in an exchange plan (\$12,500, if available in 2013) would be *reduced* by two-thirds, which is approximately equal to \$4,167. The sum of the required premium contribution and maximum cost-sharing limit, for this particular family, would be around \$5,236.

<sup>63</sup> Consistent with this illustrative example, insurers will likely be able to offer plans that meet both the reduced maximum cost-sharing limit and AV of 94%, based on actuarial analysis conducted by Actuarial Research Corporation for CRS.

<sup>64</sup> For this family, the difference between the maximum costs under an exchange plan (\$5,236, if available in 2013), and the maximum costs under Medicaid (\$1,625) is equal to \$3,611. This cost difference divided by this family's income at 138% FPL (\$32,499) is equal to approximately 11%.

<sup>65</sup> However, plans with the same AV do not necessarily include the same set of covered benefits, and may have different premiums.

<sup>66</sup> In general, AV estimates associated with Medicaid are high. Because the Medicaid program serves low-income individuals, it has generally been designed to keep individuals' costs low. Note that ARC calculated the AV estimates (continued...)

the average AV for an employer plan was 86% in 2011. Moreover, all the plans that will be offered through the exchanges will have actuarial values below the average Medicaid AV. Generally, exchange plans must meet one of four AV levels: 60%, 70%, 80% or 90%. Lower-income individuals, who are enrolled in a silver plan (70% AV) and meet other eligibility criteria, may receive cost-sharing subsidies that will effectively increase the AVs of the silver plans in which they are enrolled to 73%, 87%, or 94%, depending on income.<sup>67</sup>

### **Non-elderly Individuals with Chronic Disabling Conditions**

The following describes potential implications for individuals with income *at 100% FPL or above* regarding enrollment-related costs and cost-sharing for services.

- **Enrollment-related costs.** For individuals with income above 100% FPL, Medicaid costs vary *by individual*. Generally speaking, non-aged individuals with chronic disabling conditions are exempt from enrollment-related costs with the exception of the buy-in groups that are available at state option.<sup>68</sup> If an individual who no longer has access to Medicaid purchases insurance through the exchange, s/he will most likely qualify for premium credits. Whether someone will pay more or less under Medicaid compared to an exchange plan depends upon his/her specific enrollment-related cost requirements under Medicaid, as compared to such amounts under a subsidized exchange plan. As explained earlier, premium credit amounts vary by income and other factors. Even with a credit, individuals may still have to pay some portion of the premium.
- **Cost-sharing for services.** Individuals with chronic disabling conditions who have no or limited cost-sharing for Medicaid services might see an increase in the amount they have to pay when receiving services covered under exchange plans. Yet, these individuals may also qualify for federal cost-sharing subsidies. If they do, their cost-sharing for services will vary depending upon the amount of subsidy they receive. However, even with the most generous cost-sharing subsidies, an exchange enrollee could still be responsible for up to \$2,000 (\$4,000 for a family) in annual cost-sharing expenses (using 2012 information for illustrative purposes only). Individuals who would otherwise have paid significant cost-sharing for services in a nursing home (i.e., income amounts

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(...continued)

using data based on a *commercially insured, under-age-65 population*. The diversity of risks that comprise a commercial population is not the same composition of risks that reflect the various populations currently enrolled in Medicaid.

<sup>67</sup> Larger cost-sharing subsidies are provided to eligible individuals with lower incomes. For additional information about the exchange cost-sharing subsidies, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

<sup>68</sup> Under buy-in rules, states can allow certain individuals with chronic disabling conditions who work to purchase or “buy into” Medicaid through the payment of “premiums” or “other cost-sharing charges,” sometimes on a sliding scale based on income. According to a 2010 Mathematica Policy Research study, monthly premiums among states with Medicaid buy-in programs ranged from \$7 (in Maine) to \$185 (in Arizona) with an average monthly premium across all states with Medicaid Buy-in programs equal to \$56 in 2009. This study further notes that average monthly premiums across Medicaid Buy-in programs are low by comparison to the private health insurance market. “According to a 2009 survey of [non-subsidized] premiums conducted by America’s Health Insurance Plan’s Center for Policy and Research, nongroup coverage for a single individual cost an average of \$249 a month.” Kehn, Croake, and Schimmel, *A Government Performance and Results Act (GPRA) Report: The Status of the Medicaid Infrastructure*, Mathematica Policy Research, Inc., Final Report, Washington, DC, December 23, 2010, p. 17.

above the PNA) or under a home and community-based waiver (i.e., income amounts above the MMNA), may see a drop in their costs for service-related cost-sharing. However, if their cost-sharing was relatively low in a nursing home or under a home and community-based waiver, they could see an increase in cost-sharing in an exchange.

As an illustration of the potential variation in cost-sharing for services among non-institutional Medicaid adult enrollees with chronic disabling conditions, a 2010 *Health Affairs* study found the median annual beneficiary spending (on prescription drugs, ambulatory care, home health care, dental, durable medical supplies and equipment, and inpatient and emergency hospital care), to be \$87 in 2004 dollars. Cost-sharing for services rose to \$406 in 2004 dollars for individuals with costs at the 75<sup>th</sup> percentile of the spending distribution, and exceeded \$1,200 in 2004 dollars for individuals with service related costs at the 90<sup>th</sup> percentile of the spending distribution. This study did not take into account the amount of a beneficiary's income above the MMNA that may have been applied to the cost of the beneficiary's care in addition to their costs for services.<sup>69</sup>

### ***Medicaid Asset Protections***

Finally, certain Medicaid beneficiaries can retain assets, such as a primary home or automobile, and remain eligible for care.<sup>70</sup> By contrast, private health insurance plans typically do not cover LTSS. Individuals must instead turn to private long-term care insurance policies or pay out-of-pocket to cover the cost of their care. Over time, such individuals may deplete their assets and may even become eligible for Medicaid.

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<sup>69</sup> For more information, see Marguerite Burns, Nilay Shah and Maureen Smith, "Why Some Disabled Adults in Medicaid Face Large Out-Of-Pocket Expenses," *Health Affairs*, vol. 29, no. 8 (2010).

<sup>70</sup> Beginning in 2014, the SSI-related pathway will continue to apply to those disabled individuals who qualify through that mandatory pathway. Those individuals with disabilities, who come into Medicaid through the new ACA expansion group, may be subject to different income counting rules. However, official guidance from CMS about who, if anyone, might be exempt from MAGI rules for this new eligibility pathway has not yet been released. If MAGI income counting rules apply to individuals with disabilities, assets tests will no longer apply. See Centers for Medicare and Medicaid Services, *New Option for Coverage of Individuals Under Medicaid*, April 9, 2010, available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10005.PDF>.

## Appendix A. Fundamental Differences Between Medicaid and Exchanges

The challenges for expanding coverage through Medicaid and the ACA exchanges, and understanding the implications for individuals and families who move between these two programs are underscored by the fundamental differences between these two sources of coverage. Medicaid is a long-standing individual entitlement program that finances the delivery of primary, preventive, and acute medical services as well as long-term services and supports (LTSS) for a diverse low-income population, including non-disabled children, pregnant women, adults, individuals with chronic disabling conditions, and people age 65 and older. Medicaid was designed to provide coverage to groups with a wide range of health care needs that were historically unaddressed in the private health insurance market (e.g., individuals with chronic disabling conditions who require LTSS, or care for indigent populations in geographic locations where access to providers is limited). Because of the diversity of the populations that Medicaid serves and their unique health care needs, Medicaid offers benefits that are not typically covered in major insurance plans offered in the private market. Further, with regard to benefit design states define the specific features of each covered benefit within four broad federal guidelines:

- Within a state, each covered service must be sufficient in “amount, duration and scope” to reasonably achieve its purpose. However, states may place appropriate limits on a service based in criteria such as medical necessity.
- Within a state, services available to the various categorically needy groups must be equal in amount, duration, and scope. These requirements are called the “comparability” rule.
- Benefits must be the same throughout the state, referred to as the “statewideness” rule.
- With certain exceptions, beneficiaries must have “freedom of choice” among health care providers or managed care entities participating in Medicaid. These same coverage guidelines do not exist in the private market.<sup>71</sup>

The Medicaid program is also unique in that it includes special classes of providers, such as Federally-qualified health centers (FQHCs) and rural health clinics (RHCs), which provide health care services to populations in areas where access to traditional physician care has been limited and for which the federal statute specifies preferential reimbursement methods. In addition, under Medicaid states use federal funds to make Disproportionate Share Hospital (DSH) payments to hospitals that treat large numbers of low-income and Medicaid patients.<sup>72</sup> The main purpose of these payments is to compensate hospitals for otherwise low Medicaid payment rates and uncompensated care.

Because of these unique coverage and financing requirements, the Medicaid program finances care through the nation’s safety net for low-income populations. Health insurance exchanges, on

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<sup>71</sup> While individual states have the regulatory authority to require private health plans to provide coverage for certain benefit (“benefit mandates”), the benefit guidelines as specified under Medicaid do not apply to state benefit mandates applicable to the private market.

<sup>72</sup> Section 2551 of ACA (as amended including The Middle Class Tax Relief and Jobs Creation Act of 2012 [P.L. 112-96] and the American Taxpayer Relief Act [P.L. 112-240]) requires an overall reduction in federal DSH allotments to states by specified amounts for each of fiscal years 2014-2022 by a method to be determined by the Secretary of HHS. For additional information on DSH, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

the other hand, are fundamentally marketplaces to facilitate economic transactions: the offer and purchase of private health plans. While the exchanges established under ACA do include regulatory components, the plans offered through these exchanges are supposed to reflect a “typical” health plan offered by employers, which generally do not have different benefit packages tailored to the specific health care needs of each individual seeking coverage.

At state option, ACA allows for a bridge program between Medicaid and exchanges. ACA requires the HHS Secretary to establish a basic health program (BHP) that meets certain statutorily specified requirements, which states may choose to implement. The purpose of the program is to provide federal funding to states to finance coverage for individuals with income between 133% and 200% FPL who are not eligible for Medicaid. BHP coverage would be offered in lieu of obtaining coverage through a health insurance exchange for this population. (Individuals with income above 200% FPL may still be able to access subsidies through exchanges.) Given that implementation of a BHP would be at state option, an exchange will only interact with a BHP in a state that deliberately chooses to implement a BHP. (Implementation of a BHP does not affect exchange establishment; exchanges must still be established in every state by 2014.) Given the focus of this report, the analysis does not consider the potential impact of BHP implementation by states.<sup>73</sup>

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<sup>73</sup> For additional information about BHP, see Kaiser Family Foundation, “The Role of the Basic Health Program in the Coverage Continuum,” March 2012, <http://www.kff.org/healthreform/upload/8283.pdf>. For information regarding state progress towards establishing BHP, see <http://www.statereforum.org/discussions/basic-health-program>.

## Appendix B. Individuals with Annual Income Less Than 100% FPL

As previously discussed, ACA established a mandatory expansion of the Medicaid program to include all non-elderly individuals with income up to 133% of the federal poverty level (FPL). (This income standard effectively would be 138% FPL, as a result of the 5% income disregard.) The effective date for this mandatory expansion was January 1, 2014 (or earlier at state option), to dovetail with the establishment of health insurance exchanges. However, a significant development has the potential to impact the connection between Medicaid and the exchanges, as well as the overall rate of uninsurance. On June 28, 2012, the U.S. Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius*. The Court held that the federal government cannot terminate current Medicaid program federal matching funds if a state does not expand its Medicaid program, effectively making the ACA expansion “optional.” As a result, some states may choose not to expand their Medicaid program.

Under the ACA, premium tax credits and cost-sharing subsidies that will be provided to individuals eligible through the exchanges are only available to individuals and families with income between 100% and 400% FPL. Therefore, individuals and families with incomes below 100% FPL are *not* eligible for either the credits or subsidies.

Given that the ACA Medicaid expansion is at state option, it leaves open the possibility that, beginning in 2014, certain individuals with incomes less than 100% FPL will not be eligible for either Medicaid or premium credits.<sup>74</sup> To provide some context, **Table B-1** lists the current Medicaid income eligibility thresholds for non-disabled adults, by state; income is measured as a percent of the federal poverty level. The cells in which the thresholds are under 100% FPL (i.e., the minimum income requirement for eligibility for premium credits) indicate where low-income residents may not have access to subsidized coverage, under the status quo.<sup>75</sup> While Medicaid eligibility rules consider factors beyond just income, these thresholds provide a starting point for identifying where low-income adults may lack access to both Medicaid and premium credits, if a state decides not to do the ACA Medicaid expansion.

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<sup>74</sup> While health insurance coverage is not necessary to obtain medical services, it is useful for accessing services in an environment of increasingly expensive health care. Coverage is considered important also because of the well-documented, far-reaching consequences of uninsurance. For instance, uninsured persons are more likely to forgo needed health care than people with health coverage, which may lead to worse health outcomes that require complex, expensive health services to treat. Health care providers that serve uninsured individuals often receive no direct compensation for those services, leading to some providers increasing costs elsewhere to offset those losses. Thus uninsurance has implications beyond just the individuals themselves. For additional information about these issues, see Kaiser Family Foundation, “The Uninsured And The Difference Health Insurance Makes,” September 1, 2012, <http://kff.org/health-reform/fact-sheet/the-uninsured-and-the-difference-health-insurance/>; Katherine Baicker, et al., “The Oregon Experiment—Effects of Medicaid on Clinical Outcomes,” *New England Journal of Medicine*, May 2, 2013; and Thomas DeLeire, et al., “Wisconsin Experience Indicates That Expanding Public Insurance To Low-Income Childless Adults Has Health Care Impacts,” *Health Affairs*, June 2013.

<sup>75</sup> Currently, states use different income counting rules to determine eligibility for Medicaid. Under ACA, the determination of income for both the ACA Medicaid expansion and premium credits in the exchanges will rely on a different definition of income: modified adjusted gross income (MAGI). Given this transition to MAGI, the current Medicaid income thresholds provide only an approximation of which states may have poor residents without access to either Medicaid or premium credits. For additional information about MAGI, see CRS Report R41997, *Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA*, coordinated by Janemarie Mulvey.

**Table B-1. Current Medicaid Income Eligibility Thresholds for Non-disabled Adults, by State, January 2013**

Eligibility based on Income as a Percent of the Federal Poverty Level

State	Parents of Dependent Children		Other Adults	
	Jobless	Working	Jobless	Working
Alabama	10%	23%	-	-
Alaska	74	78	-	-
Arizona	100	106	100	100
Arkansas	13	16	-	-
California	100	106	-	-
Colorado	100	106	10	20
Connecticut	185	191	55	70
Delaware	100	120	100	110
District of Columbia	200	206	200	211
Florida	19	56	-	-
Georgia	27	48	-	-
Hawaii	133	133	133	133
Idaho	20	37	-	-
Illinois	133	139	-	-
Indiana	18	24	-	-
Iowa	27	80	-	-
Kansas	25	31	-	-
Kentucky	33	57	-	-
Louisiana	11	24	-	-
Maine	200	200	-	-
Maryland	116	122	-	-
Massachusetts	133	133	-	-
Michigan	37	64	-	-
Minnesota	215	215	75	75
Mississippi	23	29	-	-
Missouri	18	35	-	-
Montana	31	54	-	-
Nebraska	47	58	-	-
Nevada	24	84	-	-
New Hampshire	38	47	-	-
New Jersey	200	200	-	-
New Mexico	28	85	-	-



State	Parents of Dependent Children		Other Adults	
New York	150	150	100	100
North Carolina	34	47	-	-
North Dakota	33	57	-	-
Ohio	90	96	-	-
Oklahoma	36	51	-	-
Oregon	30	39	-	-
Pennsylvania	25	58	-	-
Rhode Island	175	181	-	-
South Carolina	50	89	-	-
South Dakota	50	50	-	-
Tennessee*	67	122	-	-
Texas	12	25	-	-
Utah	37	42	-	-
Vermont	185	191	150	160
Virginia	25	30	-	-
Washington	35	71	-	-
West Virginia	16	31	-	-
Wisconsin	200	200	-	-
Wyoming	37	50	-	-

**Source:** CRS compilation of Medicaid eligibility rules for adults with access to full Medicaid benefits, January 2013. See MACPAC, “MACStats: Medicaid and CHIP Program Statistics,” March 2013. MACPAC tables include state-specific details about eligibility and other operational issues.

**Notes:** For 2013, 100% FPL is equal to \$11,490 for one person residing in the 48 contiguous states and D.C. Higher income levels apply to Alaska, Hawaii, and families. “Annual Update of the HHS Poverty Guidelines,” 78 *Federal Register* 5182.

Individuals with annual income less than 100% FPL could still enroll in an exchange plan if they wish, but they would be responsible for covering the entire premium and associated cost-sharing (with one exception described below). It is likely that individuals and families in this income group would consider the premiums and cost-sharing requirements unaffordable. Such a possibility may lead to a situation where some of the poorest residents may be without insurance, but other low to middle income individuals can get subsidized coverage.

An exception to this rule is made for lawfully present immigrants with income below 100% FPL who are ineligible for Medicaid for the first five years that they are lawfully present. These taxpayers will be treated as though their income is exactly 100% FPL for purposes of qualifying for a premium credit. After five years, they will be eligible for Medicaid if their income is still less than 100% FPL and they otherwise meet the income eligibility requirements applicable in their state.

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