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Partial Medicaid Expansions Fall Short of Full Medicaid Expansion With Respect to Coverage and Access to Care

By Jessica Schubel

Millions of low-income adults with incomes up to 138 percent of the federal poverty line have gained coverage in states that expanded Medicaid under the Affordable Care Act (ACA), improving their physical and financial health. But several states have discussed or proposed limiting Medicaid coverage to people with incomes below 100 percent of the poverty line — sharply reducing the number of people who would be covered by expanded Medicaid. Partial Medicaid expansion falls well short of full Medicaid expansion with respect to coverage and access to care.

To date, no state has been allowed to receive the ACA’s enhanced federal matching rate for expansion without covering near-poor as well as poor adults, but Utah is asking the Centers for Medicare & Medicaid Services (CMS) to revisit that precedent. Doing so would result in loss of coverage or worse coverage for many low-income people.

In states that do not expand Medicaid, adults with incomes above 100 percent of the poverty line can enroll in subsidized coverage through the ACA marketplaces. Those with incomes below 100 percent of the poverty line cannot, and they often fall into a “coverage gap,” ineligible for both Medicaid and marketplace subsidies.

While partial expansion addresses this “coverage gap,” allowing states to receive the ACA’s enhanced federal match for partial expansion would likely result in higher uninsured rates and worse access to care for many near-poor adults. That’s because letting states receive the enhanced match while expanding Medicaid just to those with incomes below 100 percent of the poverty line, with near-poor adults remaining in the marketplace, would create a strong financial incentive for states to roll back their existing expansions or expand Medicaid only to people below the poverty line. States pay a small share (10 percent or less) of the cost of covering near-poor adults through Medicaid, but none of the cost of covering them through the marketplace.

And replacing full expansions with partial expansions could lead to a significant loss of coverage and deterioration in access to care. While near-poor adults with incomes between 100 and 138 percent of poverty would have access to marketplace coverage, Medicaid coverage better meets their needs. It offers significantly lower premiums and cost sharing, coverage of non-emergency medical transportation (an important benefit for near-poor adults, who often face transportation barriers),

and the option to enroll at any time during the year, versus only during open enrollment. Due at least in part to these factors, uninsured rates are much lower among near-poor adults in expansion than non-expansion states. Meanwhile, per-enrollee costs are lower in Medicaid than commercial coverage, making full expansion the more cost-effective approach to covering this group.

Medicaid Expansion Has Improved Access to Care, Health, and Financial Security

The ACA's coverage expansions, and Medicaid expansion in particular, have significantly increased coverage and improved access to care. States that have taken up Medicaid expansion have seen larger declines in their uninsured rates compared to non-expansion states. Notably, this includes large drops in uninsured rates for children, who likely gained coverage as their parents did.¹

These coverage gains have resulted in improved access to care, and recent evidence suggests they are also improving health outcomes. Medicaid expansion has increased the share of low-income adults with a personal physician, getting check-ups, and getting recommended preventive care such as cholesterol and cancer screenings, and has decreased the share delaying care due to cost, skipping medications due to cost, or relying on the emergency room for care, among other improvements, studies have found.²

Improvements have been especially important for people with chronic conditions; for example, studies have shown that Medicaid expansion was associated with improved glucose monitoring for beneficiaries with diabetes and better hypertension control.³ Other health benefits associated with Medicaid expansion include increases in early-stage cancer diagnoses, decreases in the share of patients receiving surgical care inconsistent with medical guidelines,⁴ lower rates of self-reported psychological distress, fewer days of poor mental health, and improved general health, according to a recent comprehensive review of the evidence.⁵ And preliminary evidence suggests that Medicaid

¹ Robin Rudowitz and Larisa Antonisse, "Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence," Kaiser Family Foundation, May 23, 2018, <https://www.kff.org/medicaid/issue-brief/implications-of-the-aca-medicaid-expansion-a-look-at-the-data-and-evidence/>.

² See Benjamin D. Sommers *et al.*, "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *Journal of the American Medical Association*, October 2016, <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420>. For a review of the literature, see Assistant Secretary for Planning and Evaluation, "Medicaid Expansion Impacts on Insurance Coverage and Access to Care," Department of Health and Human Services, updated January 18, 2017, <https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf>.

³ Olena Mazurenko *et al.*, "The Effects of Medicaid Expansion Under the ACA: A Systematic Review," *Health Affairs*, June 2018, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.1491>.

⁴ Andrew Loehrer *et al.*, "Association of the Affordable Care Act Medicaid Expansion With Access to and Quality of Care for Surgical Conditions," *JAMA Surgery*, March 21, 2018, <https://jamanetwork.com/journals/jamasurgery/article-abstract/2670459>.

⁵ *Ibid.*; and Aparna Soni *et al.*, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses," *American Journal of Public Health*, January 10, 2018, <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304166>.

expansion may be reducing mortality from heart disease and substance use disorders and reducing (and narrowing racial gaps in) maternal mortality.⁶

In addition to improving access to care and health outcomes for Medicaid beneficiaries, expanding coverage also has increased financial security by lowering medical debt and reducing the risk of medical bankruptcy. Expanding Medicaid coverage results in people having fewer and smaller unpaid medical bills and fewer debts sent to third-party collection agencies, studies have found.⁷ In the expansion states of Arkansas and Kentucky, the share of low-income adults having trouble paying their medical bills dropped substantially, compared to low-income adults in the non-expansion state of Texas.⁸ Moreover, with fewer and lower unpaid medical bills, adults who gained coverage through the Medicaid expansion have been found to have better credit, qualifying them for lower-interest mortgages and auto and credit card loans — leading to estimated savings that average \$280 per adult gaining coverage per year in interest payments, and an estimated \$520 million across the expansion population.⁹

Partial Expansion Has Never Been Allowed at Enhanced Match

Following the Supreme Court’s 2012 decision in *National Federation of Independent Business (NFIB) v. Sebelius* finding that states could choose whether to take up the ACA’s Medicaid expansion, CMS issued guidance stating that while it would consider approving partial expansion proposals, the enhanced Medicaid expansion matching rate of 90 percent or more would only be available for full expansions.¹⁰

Wisconsin and Utah are the only states that have implemented a partial Medicaid expansion, providing Medicaid coverage to adults with incomes up to 100 percent of the poverty line through a waiver. Neither state is receiving the enhanced match, so both are spending more than they would

⁶ Sameed Khatana, Anjali Bhatla, and Ashwin Nathan, “Association of Medicaid Expansion with Cardiovascular Mortality,” *JAMA Cardiology*, June 5, 2019, <https://jamanetwork.com/journals/jamacardiology/fullarticle/2734704>; Julia Snider, Margaret Dunca, and Mugdha Gore, “Association Between State Medicaid Eligibility Thresholds and Deaths Due to Substance Use Disorders,” *Journal of the American Medical Association*, April 26, 2019, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2731689>; and Adam Searing and Donna Cohen Ross, “Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies,” Georgetown University Health Policy Institute: Center for Children and Families, May 2019, <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>.

⁷ Matt Broaddus, “Study: Medicaid Expansion Improves Low-Income Peoples’ Financial Health, Too,” Center on Budget and Policy Priorities, November 14, 2017, <https://www.cbpp.org/blog/study-medicaid-expansion-improves-low-income-peoples-financial-health-too>; Matt Broaddus, “Medicaid Improves Financial Well-Being, Research Finds,” Center on Budget and Policy Priorities, April 28, 2016, <http://www.cbpp.org/blog/medicaid-improves-financial-well-being-research-finds>.

⁸ Benjamin Sommers *et al.*, “Three-Year Impacts Of The Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults,” *Health Affairs*, May 2017, <http://content.healthaffairs.org/content/early/2017/05/15/hlthaff.2017.0293>.

⁹ Kenneth Brevoort, Daniel Grodzicki, and Martin Hackmann, “Medicaid and Financial Health,” National Bureau of Economic Research, November 2017, <http://www.nber.org/papers/w24002.pdf>.

¹⁰ Centers for Medicare & Medicaid Services, “Frequently Asked Questions on Exchanges, Market Reforms and Medicaid,” December 10, 2012, <https://www.medicaid.gov/federal-policy-guidance/downloads/FAQ-12-10-2012-Exchanges.pdf>.

on full expansion, even though their partial expansions cover fewer people. Since 2014, Wisconsin has spent over \$1 billion more than it would have if it had adopted full expansion, while leaving out an estimated 82,000 people. In Utah, the legislature appropriated an additional \$50 million over the next two years to cover the state cost for partial versus full expansion, which would have provided Medicaid to about 50,000 more Utahns.¹¹

To date, the Trump Administration has maintained the Obama Administration's policy of not approving partial expansions at enhanced match. It did not approve proposals from Arkansas or Massachusetts, and remained silent on Utah's 2018 enhanced match proposal. The Utah proposal was reportedly heavily debated within the Administration, with the White House overruling CMS' recommendation to approve it.¹²

Now, Utah is again seeking enhanced match for partial expansion, along with other unprecedented waiver authorities (see box).¹³ CMS Administrator Seema Verma has said that the Administration's policy is "under review," although it is unclear whether the White House has changed its position.¹⁴

¹¹ Guy Boulton, "Cost of Wisconsin's Stance on the Affordable Care Act: \$1.1billion Through This Fiscal Year," *Milwaukee Journal Sentinel*, October 23, 2018, <https://www.jsonline.com/story/money/business/health-care/2018/10/23/cost-wisconsins-stance-affordable-care-act-1-1-billion/1735106002/>; Wisconsin Department of Health Services, "Governor Evers' Budget: Expanding Medicaid: Positive Economic Impacts," February 2019, <https://www.dhs.wisconsin.gov/publications/p02366.pdf>; and Utah Legislature, "Fiscal Note to Senate Bill 96," February 8, 2019, <https://le.utah.gov/lfa/fnotes/2019/SB0096S04.fn.pdf>.

¹² Robert Pear, "Trump Spurns Medicaid Proposal After Furious White House Debate," *New York Times*, July 30, 2018, <https://www.nytimes.com/2018/07/30/us/politics/trump-medicaid-partial-expansion.html>.

¹³ Judith Solomon, "Utah's Proposed Medicaid Waiver Would Deny Medicaid to Tens of Thousands of Low-Income Utahns, Drive More Cuts in the Future," Center on Budget and Policy Priorities, June 12, 2019, <https://www.cbpp.org/blog/utahs-proposed-medicaid-waiver-would-deny-medicaid-to-tens-of-thousands-of-low-income-utahns>.

¹⁴ Zack Stanton, "Seema Verma: Medicaid Reform Rejected by Trump Is 'Under Review,'" *Politico*, March 13, 2019, <https://www.politico.com/story/2019/03/13/verma-medicaid-reform-trump-rejected-in-2018-is-now-under-review-1218124>.

Utah's Partial Expansion Waiver and Pending Proposal Include Additional Harmful Features

In November, Utah voters approved a ballot measure proposing a full expansion of Medicaid to low-income adults up to 138 percent of the poverty line. Instead of implementing the voter-approved initiative, Utah's legislature directed the state to seek a series of Medicaid waivers. Under the first waiver, which CMS approved in March, Utah carried out its partial expansion plan, expanding Medicaid only to adults with incomes under the poverty line.

Besides leaving out about 50,000 near-poor individuals who would qualify for coverage under a full expansion, Utah's approved partial expansion waiver includes other harmful elements. For example, the state can take coverage away from people who don't complete job search and training requirements, which will likely lead to significant coverage losses among people who can't meet the requirement or can't overcome the red tape to receive an exemption. (CMS' approval of Utah's waiver came just days after federal court decisions striking down restrictive Medicaid waivers in Arkansas and Kentucky that included similar requirements.^a)

In the same waiver approval, CMS also gave Utah unprecedented authority to close enrollment and deny coverage to eligible people if Medicaid costs exceed the state's budget target, reversing guidance it issued in 2013.^b Enrollment caps such as this are arbitrary, as they limit enrollment on a first-come, first-served basis and can leave similarly situated people treated very differently, keeping some eligible low-income adults from getting necessary health care.

In a pending waiver proposal, which is likely to be submitted to CMS later this year, Utah is requesting not only to maintain these restrictive waiver policies, but to add more. In addition to requesting the enhanced match for its partial expansion, Utah is requesting a cap on its federal funds, meaning that the federal government would only provide funding up to a pre-determined per-person limit. (The Utah legislature required the state Medicaid agency to seek such a cap, as part of the legislation it passed overriding the ballot initiative.)

That request, coupled with Utah's existing authority to deny coverage to eligible people based on availability of state funding and to take away coverage for not meeting a training and employment requirement, poses additional risks to Medicaid beneficiaries and further jeopardizes Medicaid's guarantee of coverage.

^a *Stewart v. Azar* and *Gresham v. Azar*.

^b Centers for Medicare & Medicaid Services, "Affordable Care Act; State Resources FAQ," April 25, 2013, <https://www.medicare.gov/state-resource-center/FAQ-medicare-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicare.pdf>

Partial Expansion Falls Short on Affordable and Comprehensive Coverage

Partial expansion falls short of full Medicaid expansion with respect to coverage and access to care for near-poor uninsured adults.

Medicaid Coverage Better Meets the Needs of Near-Poor Adults

The ACA marketplaces have expanded coverage to millions of low- and moderate-income people, but Medicaid provides coverage that better meets the needs of people with incomes just above the poverty line — part of why the ACA was designed to cover this group through Medicaid. Compared to marketplace coverage, Medicaid offers:

- **Lower premiums.** Medicaid generally doesn't impose premiums on beneficiaries with incomes below 150 percent of the poverty line.¹⁵ Under partial expansion, however, adults with incomes between 100 and 138 percent of the poverty line would be required to pay monthly premiums between 2 and 3 percent of income for “benchmark” coverage through the ACA marketplaces. As Table 1 shows, an adult with income at the poverty line usually wouldn't have to pay any premiums for Medicaid coverage, but could be required to pay 2 percent, or \$250 annually in 2019, for the benchmark marketplace plan. Research has found that even modest premiums significantly reduce coverage among low-income people.¹⁶
- **Lower out-of-pocket costs.** Medicaid also has stronger protections on out-of-pocket costs than commercial coverage through the marketplace. Co-pays are generally set at nominal levels, and out-of-pocket spending on premiums and co-pays is capped at 5 percent of an individual's quarterly or monthly income, or about \$625 per year for a person at the poverty line.¹⁷ While marketplace plans offer cost-sharing assistance to low-income individuals, these individuals would still face significantly higher out-of-pocket costs than in Medicaid, making it more difficult to afford going to the doctor or filling a prescription. A wide range of studies have found that even relatively low levels of cost-sharing on Medicaid beneficiaries, ranging from \$1 to \$5, are associated with reduced use of care, including necessary services.¹⁸
- **Access to coverage for people with costly employer plans.** People who have an offer of employer-sponsored coverage are still able to enroll in Medicaid if they are otherwise eligible. In contrast, an employer offer disqualifies a person from claiming a premium tax credit for marketplace coverage if the employer offer is deemed “affordable.” The standard used to determine affordability — whether the lowest-cost plan costs less than 9.86 percent of household income — would put coverage out of reach for many near-poor workers. For example, a worker with income at the poverty line (\$1,040 a month for a single individual in 2019) is barred from receiving marketplace financial assistance if offered a plan unless the premiums exceed about \$103 per month. Such individuals either have to enroll in employer coverage with premiums that may be much higher than they would be expected to pay in the

¹⁵ Some states have received section 1115 waivers to impose premiums on Medicaid beneficiaries with incomes as low as 50 percent of the poverty line. CMS has generally only allowed premiums up to 2 percent of annual income, consistent with the marketplace standards. However, it gave Kentucky unprecedented authority to impose premiums up to 4 percent of annual income (although this authority is currently on hold due to a federal court decision vacating CMS' decision to approve it). Some states with premiums are not only taking coverage away from people who fail to pay, but also locking them out of a coverage for a period of time.

For more information on states that impose premiums, see Marybeth Musumeci *et al.*, “Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers,” Kaiser Family Foundation, March 8, 2018, <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/>; and Jessica Schubel, “Kentucky's Medicaid Waiver Gives State Unprecedented Power to Raise Premiums, Impose Fines,” Center on Budget and Policy Priorities, March 5, 2018, <https://www.cbpp.org/blog/kentuckys-medicaid-waiver-gives-state-unprecedented-power-to-raise-premiums-impose-fines>.

¹⁶ Samantha Artiga, Petry Ubri, and Julia Zur, “The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings,” Kaiser Family Foundation, June 1, 2017, <https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/>.

¹⁷ In states that impose premiums, premiums are included in calculating the 5 percent out-of-pocket spending cap.

¹⁸ Artiga, Ubri, and Zur.

marketplace — or else go uninsured. Moreover, even if they managed to pay the premium for employer coverage, they would likely still face deductibles and other cost sharing well above what is allowable in Medicaid.

- **Additional benefits that ensure access to care and treatment.** Medicaid provides additional and important benefits to near-poor adults that aren't available in marketplace or employer plans. For example, Medicaid covers non-emergency medical transportation to ensure that lack of transportation doesn't prevent near-poor adults from getting to the doctor. This is an important benefit for near-poor adults, as 3.6 million people miss or delay medical care each year because they lack access to affordable transportation.¹⁹

Medicaid also provides additional benefits that help 19- and 20-year-olds successfully transition into young adulthood by ensuring access to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Medicaid's EPSDT benefit guarantees access to a robust set of comprehensive and preventive health services, including regular well-child exams; hearing, vision, and dental screenings; and other services to treat physical, mental, and developmental illnesses and disabilities, such as speech and physical therapy and medical equipment and supplies. Medicaid eligibility as a child ends at 19 years of age, but 19- and 20-year-olds enrolled through expansion are still entitled to this important benefit.

- **More opportunities to enroll in coverage.** Another important feature of Medicaid is that near-poor adults can enroll at any point during the year rather than during the time-limited open enrollment period for marketplace or employer coverage. For near-poor adults with complex medical and financial circumstances, signing up for coverage during a time-limited period may not be realistic. Medicaid ensures that these individuals don't lose out on coverage by allowing them to enroll at any point during the year.

¹⁹ MaryBeth Musumeci and Robin Rudowitz, "Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers," Kaiser Family Foundation, February 24, 2016, <https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/>.

TABLE 1

Coverage Options for a Single Adult With Income at the Poverty Line, 2019

	Full Expansion: Medicaid Coverage	Partial Expansion: ACA Marketplace
Typical Premiums	\$0	\$21/month
Typical Deductibles	\$0	\$239 ^a
Out-of-Pocket Spending Limit	\$625 (\$52/month or \$156/quarter)	\$1,073 ^b
Benefits Covered	Essential health benefits + non-emergency medical transportation and EPSDT ^c	Essential health benefits
Availability of Coverage	When needed	Open enrollment, or if people lose coverage or have a major life change
Impact of Employer Coverage	Qualification based on income, regardless of an employer offer	Barred from subsidized coverage if offered a plan with a premium less than \$103 per month

^a Kaiser Family Foundation, “Cost-Sharing for Plans Offered in the Federal Marketplace for 2019,” December 5, 2018, <https://www.kff.org/health-reform/fact-sheet/cost-sharing-for-plans-offered-in-the-federal-marketplace-for-2019/>

Annual amount shown is the average for plans with actuarial value of 94 percent, which would be available to an adult with income at 100 percent of poverty.

^b *Ibid.*

^c The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is only available for 19- and 20-year-olds.

Fewer People Will Be Covered and Experience Benefits of Expansion

Likely in large part because of the differences described above, uninsured rates among people with incomes between 100 and 138 percent of the poverty line are significantly higher in non-expansion states — where they can enroll in subsidized coverage through the marketplaces — than in expansion states — where they can enroll in Medicaid. Census data show that 33.6 percent of near-poor, non-elderly adults in non-expansion states were uninsured in 2017, compared to 16.7 percent in expansion states.²⁰ Consistent with that, the CMS actuary reportedly estimates that 30 percent of near-poor adults who would be covered under full expansion would be uninsured under partial expansion.²¹

Similarly, people have lost coverage when states lowered Medicaid eligibility levels for adults after marketplace coverage became available. Connecticut and Rhode Island lowered eligibility for parents with incomes over the eligibility limit for Medicaid expansion (i.e., over 138 percent of the poverty line), while Wisconsin lowered eligibility for adults whom the state had covered under its pre-ACA

²⁰ Based on Center on Budget and Policy Priorities’ analysis using the Census Bureau’s 2017 American Community Survey. Non-elderly adults are defined as those aged 19 through 64. Near-poor is defined as having family income between 100 percent and 138 percent of the poverty line. States’ Medicaid expansion status is as of January 1, 2017.

²¹ Christopher Jacobs, “Exclusive: Inside the Trump Administration’s Debate Over Expanding Obamacare,” *The Federalist*, January 7, 2019, <https://www.dhs.wisconsin.gov/publications/p02366.pdf>.

Medicaid waiver. These states assumed that people would move out of Medicaid into marketplace coverage, but large numbers did not make the transition. In Connecticut, during the first round of a rollback in parent eligibility, only 1 in 4 parents losing Medicaid coverage enrolled in a marketplace plan.²² In Wisconsin, only one-third of those losing Medicaid coverage in 2014 purchased marketplace plans, although the state had predicted that 90 percent would.²³ And in Rhode Island, despite considerable efforts at outreach to enroll parents losing Medicaid, 1,271 of the 6,574 people who lost Medicaid — or 19 percent of them — did not subsequently apply to enroll in a marketplace plan, and many likely became uninsured.²⁴ While participation rates may have improved since the initial transition, they're likely to still be lower than they were in Medicaid.

²² Sharon Langer, Mary Alice Lee, and Dumingo Aparna Gomes, “Husky Program Coverage for Parents: Most Families Will Feel the Full Impact of Income Eligibility Cut Later in 2016,” Connecticut Voices for Children, April 2016, <http://www.ctvoices.org/sites/default/files/h16HUSKYIncomeEligibilityCut.pdf>.

²³ Guy Boulton, “One-third who lost BadgerCare coverage bought plans on federal marketplace,” *Journal Sentinel*, July 16, 2014, <http://archive.jsonline.com/business/almost-19000-badgercare-plus-recipients-enrolled-in-obamacare-b99312352z1-267339331.html>.

²⁴ Kate Lewandowski, “Parent Eligibility Roll-Back in Rhode Island: Causes, Effects and Lessons Learned,” Community Catalyst, September 2015, <https://www.communitycatalyst.org/resources/publications/document/RI-parent-rollback-081215-KL.pdf?1439834245>.

Medicaid Expansion Makes the Marketplace Work Better

Studies show that marketplace premiums are lower in states that expanded Medicaid and that expansion states, on average, have healthier individual market risk pools.^a For example, marketplace premiums in border counties in states that border Wisconsin but that fully expanded Medicaid (Minnesota, Michigan, and Illinois) were 19 percent (or roughly \$57 per month) lower than in Wisconsin over the 2014-2018 period.^b

Medicaid expansion affects marketplace premiums because it affects who's in the marketplace risk pool. In non-expansion states, adults with incomes between 100 and 138 percent of the poverty line, who are eligible for subsidies to purchase marketplace coverage, make up an estimated 40 percent of the marketplace population.^c Lower-income individuals tend to be in worse health than those with higher incomes, which means they're often sicker and have higher health care costs. Almost 20 percent of people with incomes between 100 and 138 percent of the poverty line report being in fair or poor health, compared to about 8 percent of people with incomes above 138 percent of the poverty line.^d

Moreover, there's probably some adverse selection in which near-poor individuals sign up for marketplace coverage. Even with subsidies, marketplace premiums strain near-poor workers' budgets, which is part of why the ACA envisioned this group getting coverage through Medicaid. Although a large share of marketplace enrollees in non-expansion states are in this income group, the people who most need health coverage are most likely to sign up for it, making an already sicker-than-average population even sicker.

^a Aditi P. Sen and Thomas DeLeire, "The Effect of Medicaid Expansion on Marketplace Premiums," Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, September 6, 2016, <https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf>, and Ashley Semanskee, Cynthia Cox, and Larry Levitt, "Data Note: Effect of State Decisions on State Risk Pools," Kaiser Family Foundation, October 2016, <http://files.kff.org/attachment/Data-Note-Effect-of-State-Decisions-on-State-Risk-Pools>.

^b Aditi Sen and Thomas DeLeire, "Medicaid Expansion in Wisconsin Would Lower Premiums for Those With Private Insurance," *Health Affairs Blog*, June 6, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20190605.87178/full/>.

^c Sen and DeLeire, and Semanskee *et al.*

^d *Ibid.*

Spending More to Achieve Less

A key problem with approving partial expansion proposals at enhanced match is that doing so would create a strong financial incentive for states to roll back their existing expansions or expand Medicaid only to people below the poverty line, even if they would otherwise adopt expansion in full. That's because states pay a small share (10 percent or less) of the cost of covering near-poor adults through Medicaid, but none of the cost of covering them through the marketplace.

If states did roll back their expansions, the federal government could end up spending more to achieve less improvement in coverage and access to care. As discussed above, partial expansions would result in higher uninsured rates and worse coverage for people with incomes between 100 and 138 percent of the poverty line. Meanwhile, commercial coverage generally costs substantially more per person than Medicaid. For example, in 2018, when Idaho was considering a waiver that would have moved some near-poor adults out of the marketplace and into Medicaid, it estimated that the federal government would spend \$7,700 per person for marketplace coverage but only \$3,878 per

person for Medicaid coverage.²⁵ More generally, per capita spending in Medicaid — as well as spending growth per Medicaid enrollee — is lower compared to private insurers after adjusting for the greater health needs of Medicaid enrollees.²⁶

Because commercial coverage costs more than Medicaid, total federal and state costs per person covered would be higher under partial expansion than full expansion. Given these higher per-person costs, and because the federal government would bear all of, rather than the large majority of, that cost, it would certainly spend more per person, and could well end up spending more *in total* to cover fewer people and offer them worse coverage.

Conclusion

Partial expansions may expand coverage to some low-income adults in non-expansion states, but they would cause a significant loss of coverage if approved in current expansion states. With fewer people covered, partial expansion would achieve smaller improvements in access to care and physical and financial health than full Medicaid expansion. Moreover, partial Medicaid expansions would provide near-poor adults with less affordable and comprehensive coverage. While the Trump Administration has taken a broad view of the types of demonstration projects that promote Medicaid objectives, limiting coverage and access to care doesn't further the objectives of Medicaid, making such proposals an inappropriate use of Medicaid waiver authority.

²⁵ Idaho Department of Insurance, “Fair Access to Health Coverage Waiver Application,” February 12, 2018, <https://doi.idaho.gov/DisplayPDF?id=Draft1332Application&cat=publicinformation>.

²⁶ Lisa Clemans-Cope, John Holahan, and Rachel Garfield, “Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence,” Kaiser Family Foundation, April 13, 2016, <https://www.kff.org/report-section/medicaid-spending-growth-compared-to-other-payers-issue-brief/>.