Memorandum

JULY 28, 2021

117TH CONGRESS: BILLS ADDRESSING THE MEDICAID EXPANSION COVERAGE GAP

I. Executive Summary

Senate Majority Leader Chuck Schumer (D-NY), Senate Budget Committee Chair Bernie Sanders (I-VT), and other Senate Democrats have asserted that their forthcoming $3.5 trillion fiscal year (FY) 2022 budget reconciliation package will include provisions addressing the Medicaid expansion coverage gap. Obstinate refusal by holdout states to expand Medicaid, despite the availability of new financial incentives provided by the American Rescue Plan Act of 2021 (ARPA) (P.L. 117-2)[i], has put pressure on lawmakers to pursue a more direct approach. The 12 states that have not yet adopted the Medicaid expansion are: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.[ii]

A proposal to create a new federal program that extends Medicaid coverage to individuals in non-expansion states appears to be a frontrunner in the ongoing federal budget reconciliation debate. Still, standing up this new coverage program may take years. Amid the twin crises of the COVID-19 pandemic and the economic recession, congressional Democrats are seeking immediate coverage gains and, therefore, are also considering making Affordable Care Act (ACA) premium subsidies available to individuals in the Medicaid expansion gap (i.e., adults who are not eligible for Medicaid in their state and fall under the minimum income to qualify for ACA marketplace subsidies). The extent to which premium subsidies expand access for these individuals will depend in part on their cost-sharing responsibility.

Securing a fix to the Medicaid expansion gap is also critically important for congressional Democrats to maintain their majority in the 2022 elections, particularly in the Senate, and for President Biden to advance his legislative agenda. Additionally, expanding access to affordable coverage is central to reducing racial and ethnic disparities in access to care and health outcomes; addressing a range of health care issues, such as maternal mortality and the opioid crisis; and advancing health equity. This memo compares several bills introduced in the 117th Congress that address the coverage gap through policies that go beyond increasing federal support. Our memo focuses on three legislative options currently deliberated by Congress:

- Medicaid Save Lives Act (S. 2315)[iii], introduced by Sen. Raphael Warnock (D-GA) that would establish a new Medicaid-like coverage program;
- Medicaid REACH Act (H.R. 1784)[iv], introduced by Rep. Lloyd Doggett (D-TX) that would establish increased reporting burden for non-expansion states with a reduction in federal support for noncompliance; and
- COVER Now Act (H.R. 3961)[v], introduced by Rep. Doggett, that would establish new demonstration authority for county-level Medicaid expansion.

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II. Background

A. Federal Medical Assistance Percentage (FMAP)

Despite financial incentives from ARPA (see Table 1 for details), 12 states have refused to adopt Medicaid expansion and over two million low-income adults, disproportionately people of color, lack access to affordable health care coverage due to this gap.[vi] The Medicaid expansion coverage gap includes adults who are not eligible for Medicaid in their state but fall under the minimum income to qualify for ACA marketplace subsidies.

Table 1. FMAP Changes Under Current Law

Authority	Pre-ACA	ACA Medicaid expansion (P.L. 111-148)	Families First Coronavirus Response Act (P.L. 116-127)	American Rescue Plan Act of 2021 (P.L. 117-2)
FMAP	A statutory minimum of 50 percent and a statutory maximum of 83 percent	Enhanced FMAP for the newly eligible adult population gradually decreasing from 100 percent for 2014 to 90 percent for 2020 and beyond	Temporary 6.2 percentage point increase conditioned on maintenance of eligibility requirements (e.g., continuous eligibility, premium increase, no cost-sharing)[vii]	5 percentage point increase for a period of 8 quarters

B. Income Eligibility Threshold for Medicaid Expansion and ACA Subsidies

While states that have expanded Medicaid pursuant to the ACA provide Medicaid coverage for adult individuals with incomes up to 138 percent of the federal poverty level (FPL), states that have not adopted the Medicaid expansion generally do not offer coverage to any adult individuals without child dependents. Additionally, non-expansion states typically impose a more restrictive threshold for eligibility. The median maximum income eligibility for adult parents in non-expansions states is 41 percent of the FPL.[viii] Additionally, the minimum income eligibility for marketplace subsidies is a household income at least 100 percent of the FPL. ARPA temporarily increased the generosity of marketplace subsidies for 2021 and 2022. Individuals with incomes from 100 to 150 percent of the FPL are eligible

for zero-premium coverage. Extending marketplace subsidies to individuals in the Medicaid expansion coverage gap, as contemplated by congressional Democrats, would require a statutory change.

C. Implications of Cost-Sharing Limitations on Extending ACA Subsidies

The impact of extending marketplace subsidies to individual in the Medicaid expansion coverage gap will depend in part on their cost-sharing responsibilities. Under Medicaid law, states may not charge premiums for beneficiaries with incomes less than 150 percent FPL and may not impose out-of-pocket costs that exceed five percent of a family's income.[ix] Cost-sharing amounts are therefore heavily limited. For example, states may not charge more than $4 for outpatient services for beneficiaries with incomes less than 100 percent FPL. For the same population, costs cannot exceed $8 for non-emergency use of the emergency department, nor can they exceed $75 per stay for inpatient services. With regard to ACA marketplace plans, the maximum annual limitation on cost-sharing for the 2022 plan year will be $8,700 for self-only coverage, and $17,400 for other than self-only coverage.[x]

III. Comparison of Key Federal Bills

Table 2 provides an overview of key federal bills considered by the 117th Congress: (1) Medicaid REACH Act (H.R. 1784); (2) COVER Now Act (H.R. 3961); and (3) Medicaid Saves Lives Act (S. 2315).

Additionally, House and Senate Democrats introduced legislation to adjust FMAP rates and apply the ACA's initial declining schedule of enhanced FMAP relative to year of state expansion (i.e., 100 percent for the first three 12-month consecutive periods; with a phased-down FMAP of 90 percent in the seventh consecutive 12-month period and each subsequent period thereafter). The House Energy & Commerce (E&C) Subcommittee on Health discussed the House version of the legislation, H.R. 340, at a recent hearing, but Democrats did not signal any plans for further action (i.e., bill markup).[xi]

Table 2. Bill Overview

Bill	Medicaid Saves Lives Act (S. 2315)	Medicaid REACH Act (H.R. 1784)	COVER Now Act (H.R. 3961)
Primary Policy Lever	New Medicaid like coverage program and enhanced FMAP	Increased reporting burden with FMAP reduction for noncompliance	New demonstration authority
Sponsors	Sens. Raphael Warnock (D-GA),	Rep. Lloyd Doggett (D-TX) (23	Rep. Lloyd Doggett (D-TX) (47

	Tammy Baldwin (D-WI), and John Ossoff (D-GA) (3 co-sponsors)	co-sponsors)	co-sponsors)
Latest Developments	Introduced and referred to Senate Health, Education, Labor, and Pensions (HELP) Committee on July 12.	Discussed in a Health Subcommittee legislative hearing on March 23.[xii]	Introduced and referred to House E&C Committee on June 17.

A. Design Elements of the Medicaid Saves Lives Act (S.2315)

S. 2315 would authorize the Department of Health and Human Services (HHS) to establish a new Medicaid-like federal program for individuals who would be eligible for Medicaid under expansion but reside in a non-expansion state. The main elements of the bill are as follows.

- **Administration –** The federal program would be administered by the Centers for Medicare and Medicaid Services (CMS) directly or by contract with a third party such as a Medicaid managed care organization (MCO).
- **Coverage and Cost-Sharing** – The federal program would cover the same health benefits, impose no premiums, and impose cost sharing requirements in accordance with Medicaid statute and regulations.
- **Enhanced FMAP** – Newly expanding states would receive a temporary increase in their respective FMAP for a specified period, namely: an enhanced FMAP by 10 percentage points for a 10-year period (compared to the 5-percentage point increase for a 2-year period as enacted in ARPA). The FMAP provisions would apply as if included in the enactment of section 9814 of the ARPA.

Beyond establishing some guardrails regarding coverage, the bill does not set detailed parameters for the design of the new coverage program. Therefore, much of the program's design would be decided by HHS and likely entail public comment opportunities. S. 2315 could intersect with the ongoing development of a legislative proposal for a public option, spearheaded by the Senate Health, Education, Labor and Pensions (HELP) Committee and the House Energy and Commerce (E&C) Committee.[xiii] Design considerations raised by stakeholders in the request for information from Senate HELP Committee Chair Patty Murray (D-WA) and House E&C Committee Chairman Frank Pallone, Jr. (D-NJ) may inform the design of the Medicaid-like coverage program proposed by Sen. Warnock and others.

B. Design Elements of the Medicaid REACH Act (H.R. 1784)

This bill H.R. 1784 would reduce the FMAP for non-expansion states that do not comply with new reporting requirements specified in the legislation. The main elements of the bill are as follows.

- **Reporting Requirements** – Non-expansion states would be required to report: 1) the number of uninsured individuals under the age of 65; 2) the estimated percent of such individuals who would be eligible for coverage under expansion; 3) a list of State income eligibility criteria for all groups eligible for the state's Medicaid program; 4) the total amount of hospital uncompensated care (UC) costs; and 5) the total amount received through an UC pool.
- **Timeline and Public Comment** – States would be required to post the new reporting requirements on the state Medicaid agency's public website by January 1 of each year with at least a 30-day notice and comment period. States would be required to submit a final report to HHS by March 1 of each year, with the state's response to each comment on the proposed requirements.
- **Reduced FMAP** – Non-expansion states that fail to comply with the new reporting requirements would receive FMAP rates reduced by: 0.5 percentage points for Q3 of the fiscal year; 1.0 percentage point for Q4 of the fiscal year; and 1.5 percentage points for Q1 of the following fiscal year.

C. Design Elements of the COVER Now Act (H.R. 3961)

H.R. 3961 would authorize CMS to work directly with, at most, 100 political subdivisions of non-expansion states (e.g., counties) to establish demonstrations to expand Medicaid (up to seven years with an optional five-year extension). The main elements of the bill are as follows.

- **Regional Partnerships** – Subdivisions would be permitted to form partnerships to apply jointly for a regional expansion project.
- **Enhanced FMAP** – Participating subdivisions would receive an enhanced FMAP based on rural status. Rural subdivisions would receive 100 percent for the first four years, phasing down to 90 percent by the eighth year and each subsequent year of the demonstration, if applicable, while non-rural subdivisions receive 100 percent in the first three years, phasing down to 90 percent in the seventh year and each subsequent year of the demonstration, if applicable.
- **Budget Neutrality** – Subdivisions would not be required to ensure budget neutrality.
- **State Participation** – States would be required to cooperate and authorize access to state Medicaid systems for participating subdivisions. States would receive an increase of five percentage points in federal administrative Medicaid funding for every 100,000 individuals enrolled in the new demonstration project for cooperation or a 25 percent reduction

in federal funding for noncompliance, including disenrolling individuals in a participating subdivision from the state Medicaid plan, withholding funding, increasing taxes, or taking other punitive measures against the subdivision.

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[i] https://www.congress.gov/bill/117th-congress/house-bill/1319/text
[ii] Missouri adopted expansion through a ballot measure but has faced political and judicial challenges in implementation and thus expansion has yet to be implemented in the state.
[iii] https://www.congress.gov/bill/117th-congress/senate-bill/2315
[iv] https://www.congress.gov/bill/117th-congress/house-bill/1784
[v] https://www.congress.gov/bill/117th-congress/house-bill/3961
[vi] https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/
[vii] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
[viii] Ibid.
[ix] https://fas.org/sgp/crs/misc/R42978.pdf
[x] Ibid.
[xi] https://energycommerce.house.gov/committee-activity/hearings/hearing-on-building-on-the-aca-legislation-to-expand-health-coverage-and
[xii] Ibid.
[xiii] https://www.help.senate.gov/chair/newsroom/press/murray-pallone-announce-plans-to-develop-a-public-option-proposal-to-lower-health-care-costs