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To: House Committee on Vision 2020

From: Iraida Orr, Principal Research Analyst

Re: Medicaid Expansion Alternatives in Other States

This memorandum provides an overview of Medicaid expansion alternatives recently approved, being implemented, or being actively discussed in other states. Medicaid expansion alternatives are implemented in Arkansas, Iowa, Michigan, Pennsylvania, and New Hampshire. Indiana's Medicaid expansion alternative was approved by the Centers for Medicare and Medicaid Services (CMS) on January 27, 2015. States actively discussing Medicaid expansion alternatives include Tennessee, Utah, and Wyoming.

States are requesting Section 1115 waivers from CMS because these waivers allow for greater flexibility of Medicaid expansion. Waivers must be used to promote the objectives of the Medicaid program and must be budget neutral for the federal government.

States Implementing Medicaid Expansion Alternatives

Arkansas

During the 2013 Legislative Session, the Arkansas General Assembly passed the Health Care Independence Act of 2013. The Act established Arkansas' intention to apply for a federal waiver that would allow the state to use Medicaid funding to pay for private health insurance for newly eligible adults. The state submitted the waiver application in August 2013. In September 2013, CMS approved Arkansas' Section 1115 demonstration waiver through 2016.[1]

With this approval, Arkansas became the first state to implement Medicaid expansion through a premium assistance model. Arkansas uses Medicaid funds to purchase coverage for all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs). All newly eligible adults, including childless adults between 0 and 138 percent of Federal Poverty Level (FPL) and parents between 17 and 138 percent FPL, are enrolled in premium assistance.[2] The Act provides three months of retroactive coverage prior to the application date on a fee for service basis.

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1 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-fs.pdf

2 Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Arkansas,* October 2014 Fact Sheet.

In September 2014, Arkansas submitted a waiver amendment to CMS. The amendment would establish health savings accounts for non-disabled beneficiaries, impose cost-sharing for beneficiaries above 50 percent FPL, and limit non-emergency medical transportation services. CMS approved the waiver amendment in late December 2014.

Iowa

Iowa was the second state to propose implementing the Affordable Care Act's (ACA) Medicaid expansion by using Medicaid funds as premium assistance to purchase coverage for newly eligible Medicaid beneficiaries. The state submitted two waiver applications, the Iowa Wellness Plan and the Iowa Marketplace Choice Plan, in August 2013. CMS approved these two Section 1115 waivers in December 2013. These waivers were approved through 2016.[3]

Under the Iowa Marketplace Choice Plan, the state uses premium assistance to purchase QHP coverage in the individual Marketplace for newly eligible childless adults between 19 and 64 years of age with incomes from 100 percent and up to and including 133 percent FPL. Beneficiaries pay premiums of $10.00 per month. The Iowa Wellness Plan covers newly eligible adults at or below 100 percent FPL in Medicaid managed care. Beneficiaries pay premiums of $5.00 per month, but they cannot be disenrolled for non-payment of premiums.

For both plans, the premiums are waived for the first year of enrollment. Premiums are waived in subsequent years if beneficiaries complete specified healthy behavior activities. Cost-sharing is limited to five percent of quarterly income, including premiums. Copays must be paid by beneficiaries for non-emergency use of the emergency room.[4]

In September 2014, Iowa submitted a waiver amendment, seeking CMS approval to extend the non-emergency medical transportation services waiver for the life of both demonstrations. CMS approved the waiver amendment in late December 2014.

Michigan

Michigan was the third state to have a Section 1115 demonstration waiver, Healthy Michigan, approved by CMS to implement the ACA's Medicaid expansion. Unlike Arkansas and Iowa, Michigan's waiver does not use Medicaid funds as premium assistance to purchase private coverage for Medicaid beneficiaries. Instead, Michigan covers newly eligible adults through Michigan's existing Medicaid managed care delivery system. Existing Medicaid managed care organizations (MCOs) and Pre-paid Inpatient Health Plans (PIHPs) provide the services. MCOs provide acute, physical health, and pharmacy benefits. PIHPs provide inpatient and outpatient mental health, substance use disorder, and developmental disability services to all enrollees statewide. The waiver provides that benefits should be coordinated and integrated using an interdisciplinary team to coordinate physical and behavioral health.

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3 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-fs.pdf; and

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-fs.pdf

4 Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Iowa,* October 2014 Fact Sheet.

CMS approved an amendment to Michigan's Section 1115 demonstration waiver in December 2013. Michigan's approval package is available on the CMS website.[5] Prior to the Medicaid expansion, Michigan's demonstration waiver provided limited coverage to childless adults at or below 35 percent FPL.

The waiver and associated state plan amendments provide Medicaid coverage to all adults in Michigan with incomes up to and including 138 percent FPL. The waiver requires eligible beneficiaries with incomes between 100 and 138 percent FPL to make income-based contributions to health savings accounts in an amount up to 2 percent of income. Additionally, the waiver includes cost-sharing, which can be reduced through compliance with healthy behaviors. Health behavior incentives are included in the plan. Failure to pay copays or premiums cannot result in the loss or denial of Medicaid eligibility, denial of health plan enrollment, or denial of access to services. Providers may not deny services for failure to pay copays or premiums. Beneficiaries with incomes above 100 percent FPL pay monthly premiums of 2 percent of income; however, cost-sharing and premiums cannot exceed 5 percent of household income.[6]

Pennsylvania

CMS approved Pennsylvania's Section 1115 demonstration waiver, Healthy Pennsylvania, on August 29, 2014. The demonstration covers all newly eligible adults ages 21 to 64 with incomes up to 138 percent FPL.

Governor Corbett originally sought approval to use funds available through the ACA's Medicaid expansion to purchase private health coverage for state residents. However, after the state's negotiations with CMS, the approved plan expands Medicaid through private Medicaid managed care plans.

For newly eligible adults above 100 percent FPL and certain currently eligible adults above 100 percent FPL, monthly premiums up to 2 percent of income are required, beginning with demonstration year 2. These beneficiaries may be dropped from coverage for failure to pay premiums for 90 days, but they may re-enroll without a waiting period. All beneficiaries are required to pay state plan copayments in year 1. For year 2, beneficiaries subject to monthly premiums will only have a $8.00 state plan copayment for non-emergency use of the emergency room. Beneficiaries below 100 percent FPL will continue to have copayments based on state plan amounts. Starting January 1, 2016, the state is allowed to collect and analyze data on average monthly copayments for beneficiaries below 100 percent FPL and submit a waiver amendment based on the data to seek a premium model for these beneficiaries. All cost-sharing, including premiums and copayments, is limited to five percent of household income.

Premiums and copayments may be reduced beginning in demonstration year two for beneficiaries who complete specified activities under a healthy behavior incentive plan during the previous year. After the first year, eligibility for premium or copayment reductions based on healthy behavior activities must be evaluated every six months. A protocol for healthy behavior activities must be approved annually by CMS.

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5 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf

6 Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Michigan, January* 2014 Fact Sheet.

The waiver provisions establish that non-emergency medical transportation will not be provided in 2015, but the benefit will resume in 2016. Also, the state originally sought a work requirement as a condition of Medicaid eligibility for current and newly eligible beneficiaries, but the approved demonstration instead offers incentives, such as premium discounts, for job training and work-related activities.[7] Pennsylvania's approved waiver package is available on the CMS website.[8]

New Hampshire

The New Hampshire Department of Health and Human Services (HHS) website[9] notes on March 27, 2014, Governor Hassan signed Senate Bill 413 (2014 NH Laws Chap. 3) into law. The Act established the New Hampshire Health Protection Program, expanding health coverage for adults with incomes up to 133 percent FPL. The New Hampshire Health Protection Program provides for a mandatory Health Insurance Premium Payment Program (HIPP) for individuals with access to cost-effective employer-sponsored insurance; a bridge program (known as the Voluntary Bridge to Marketplace Program) to cover the newly eligible adult group in Medicaid managed care plans through December 31, 2015; and a mandatory individual QHP premium assistance program beginning on January 1, 2016.

The New Hampshire Department of HHS, as the single state Medicaid agency, is seeking Section 1115 waiver authority from CMS to implement the third part of the new law, the mandatory QHP premium assistance program. Through the mandatory premium assistance program, the state will purchase QHPs that have been certified for sale in the individual market on the federally facilitated New Hampshire Health Insurance Marketplace for the new adult group. The premium assistance program will have no cost-sharing for beneficiaries below 100 percent of FPL. These program participants will not be required to pay a deductible or premiums. SB 413 requires the premium assistance waiver to be approved before March 31, 2015, for implementation in January 2016. If waiver approval is not received by the deadline, the Voluntary Bridge to Marketplace Program cannot be continued.[10]

The New Hampshire Department of HHS website contains material developed by the Department regarding its application for a Premium Assistance Program Section 1115 demonstration waiver. Contents include public notices, draft application documents, and dates, times, and locations for related public hearings. The final premium assistance waiver application submitted to CMS on November 20, 2014, to continue implementation of its Medicaid expansion is available on this site.

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7 Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Pennsylvania, October* 2014 Fact Sheet.

8 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf

9 http://www.dhhs.state.nh.us/pap-1115-waiver/index.htm

10 Kaiser Commission on Medicaid and the Uninsured, *Proposed Medicaid Expansion in New Hampshire, December* 2014 Fact Sheet.

Recently Approved State Medicaid Expansion Alternatives

Indiana

Indiana began using a Section 1115 Medicaid waiver prior to the enactment of the ACA. In January 2008, Indiana started enrolling adults in the Healthy Indiana Plan (HIP), which was authorized under Section 1115 waiver demonstration authority. The plan allows Indiana to use Medicaid funds to provide a benefit package modeled after a high-deductible health plan and health savings account to adults between 22 and 200 percent FPL. The Healthy Indiana Plan has an emphasis on consumerism and personal responsibility. Beneficiaries have Personal Wellness and Responsibility (POWER) accounts, similar to a Health Savings Account, to encourage them to be good "consumers" of health care. The POWER accounts are funded through an income-based sliding scale enrollee contribution and contributions from the state and participating managed care organizations. Enrollees cannot pay more than five percent of their income. Contributions from employers and non-profit organizations can be used to reduce the enrollee contribution. Enrollees may be terminated for failure to make the required contribution to their POWER account.[11]

Indiana submitted and received approval to extend the current HIP program through December 2015. In August 2014, the state submitted to CMS a proposal to amend and renew its current Section 1115 waiver. This waiver would implement HIP 2.0, which is Indiana's plan to improve and expand HIP. HIP 2.0 would provide Medicaid coverage to all non-disabled adults with incomes up to and including 133 percent FPL. The waiver was approved by CMS on January 27, 2015.[12] Service will be primarily provided through managed care organizations.

Under HIP 2.0, the state collects monthly premiums in the form of contributions to the POWER account from individuals up to 133 percent FPL in an amount not to exceed 2 percent of household income. Contributions to the POWER account from individuals below 5 percent FPL can be no more than $1.00 per month. Individuals with incomes above 100 percent FPL are required to contribute to a POWER account as a condition of eligibility. If they discontinue POWER account contributions, they will be dis-enrolled from HIP 2.0 coverage after a 60 day grace period and will be disqualified for this coverage for 6 months. This penalty for not paying into an health savings account was not approved by CMS prior to Indiana's waiver approval. Individuals with lower incomes will enroll in HIP Basic if they do not make POWER account contributions. Lower income individuals on HIP 2.0 who cease making contributions will not lose coverage, but will be automatically enrolled in HIP Basic instead of HIP Plus.

All beneficiaries are subject to a copayment for non-emergency use of the Emergency Department (ED). The state has been granted authority by CMS to show whether a graduated copayment ($8.00 for the first instance and $25.00 for recurrent non-emergency use of the ED) with education and referrals to primary care providers, will reduce ED use and lead to use of health care in the appropriate setting. Federal law requires the use of a control group for evaluation in cases of experimental approaches to cost-sharing, and CMS has granted authority for such control group for two years.

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11 *National Conference of State Legislatures, Federal Health Reform: State Actions Newsletter,* April 5, 2013

12 http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=Indiana

States Actively Discussing Medicaid Expansion Alternatives

Tennessee

On December 15, 2014, Governor Haslam released the alternative approach to Medicaid expansion he negotiated with CMS. This approach is a 2 year pilot program called Insure Tennessee that would expand health coverage to up to 200,000 low-income working Tennesseans without health insurance.[13] At the end of two years, the state will evaluate its performance and costs and determine whether it will seek an extension.

The plan will go to a special session of the legislature the governor plans to call after lawmakers convene for their regular session in January 2015. The plan allows for copays and "personal responsibility" features, like disincentives for smoking, which are common for employer-sponsored health insurance.

Although the federal government will fully fund the expanded coverage during the first two years, the Tennessee Hospital Association has agreed to fund anything not funded by the federal government during the two year period, as part of a special hospital assessment fee hospitals have been paying for nearly ten years to help offset the state's share of Medicaid.

The plan offers several options of coverage for individuals below 138 percent FPL. Individuals between 21 and 64 years old will be offered a choice of the Healthy Incentives Plan or the Volunteer Plan. The Volunteer Plan would provide a health insurance voucher to participants that could be applied to premiums and other out of pocket expenses to assist them in continuing to participate in their employer's health insurance plan. Beneficiaries would be required to pay copayments and premiums.

The Healthy Incentives Plan allows beneficiaries a choice of coverage through a redesigned component of the TennCare program, Tennessee's version of Medicaid. Healthy Incentives for Tennesseans accounts would be created and modeled after health reimbursement accounts and used to pay for a portion of required member cost-sharing.

The Legislature must first approve the governor's plan, and then CMS approval of the state's waiver request would be required. The waiver request has not been formally submitted. The specifics of both plans could change as the governor's proposal makes its way through the Legislature.

Utah

Utah released additional details for a proposal for the Healthy Utah Section 1115 Medicaid expansion demonstration in December 2014. The proposal has not been submitted to CMS and also would require approval by the Utah Legislature. In mid-December, a health reform task force chose not to recommend Governor Herbert's plan to the Utah Legislature, instead proposing its own more limited coverage alternatives.

The proposed plan would use Medicaid funds for premium assistance for Marketplace QHP coverage. Newly eligible adults with access to employer-sponsored insurance (ESI) would receive premium assistance for ESI. Newly eligible adults with incomes from 100 to 138 FPL

13 http://www.knoxnews.com/news/local-news/gov-haslam-unveils-alternative-to-medicaid-expansion_76203510

would be required to pay monthly premiums up to 2 percent of income. Included in the proposal are plans for a copay pilot program with lower monthly premiums and a $50 copayment for non-emergent use of the ED, exceeding the $8.00 maximum allowable copay under federal law. Maximum cost-sharing, including premiums and copays, would remain at five percent of income. A healthy behavior incentive program would be included.

Parents covered through a Marketplace QHP or ESI would have the option to have their Medicaid or Children's Health Insurance Program (CHIP) eligible children covered in their same plan with the state providing cost-sharing, premium, and benefits wrap-around coverage through Medicaid/CHIP.

Another provision would automatically enroll able-bodied adults in a concurrent work program when newly eligible beneficiaries apply for Medicaid. However, work program participation is not being proposed as a condition of eligibility and federal waiver authority is not being sought for the work program.

Savings generated from a previous Section 1115 waiver would be used to fund the Healthy Utah waiver. The state also plans to use savings from state-funded behavioral health and inpatient services for inmates to finance state program costs. The state would consider increasing provider assessments if the costs of Healthy Utah are higher than the savings achieved.[14]

Wyoming

A January 4, 2015, article in the *Casper Star Tribune*[15] stated the Wyoming Legislature will consider expanding Medicaid to low-income Wyomingites in 2015. The Joint Labor, Health and Social Services Interim Committee did not support the Strategy for Health, Access, Responsibility, and Employment (SHARE) Plan, a Medicaid expansion plan the state negotiated with CMS over the course of several months. The SHARE Plan would require people who earn more money to pay premiums of $20 to $50 a month and still could be considered during the 2015 Legislative Session. The plan would encourage individuals to access state resources for employment and job training.

The Interim Committee chose to support a Medicaid expansion alternative based on the Indiana program in which Medicaid recipients would contribute between $3 and $25 a month into a personal wellness account initially funded by the state. Medicaid dollars also would be deposited into the account, and patients could use the money for health care expenses. These accounts would be used in cost-sharing to pay insurance premiums and provide an incentive to keep personal health care costs low.[16]

State health leaders have stated the Interim Committee's alternative plan could create an outsized administrative burden for the Wyoming Department of Health. The Wyoming

14 Kaiser Commission on Medicaid and the Uninsured, *Proposed Medicaid Expansion in Utah,, January 2015* Fact Sheet.

15 http://powersource.post-gazette.com/powersource/latest-alternative-energy/2015/01/04/Wyoming-Legislature-considers-marijuana-firing-squads-for-death-penalty/stories/201501040230

16 http://billingsgazette.com/news/state-and-regional/wyoming/health-care-leaders-skeptical-of-medicaid-expansion-alternative/article_a7d33048-0586-5e6e-9701547440cd0ecb.html#ixzz3O1aerd8j

Hospital Association has indicted a preference for the traditional Medicaid expansion provided by the SHARE plan. The Interim Committee chairman has stated a majority of legislators will not vote for the SHARE plan because they do not support the federal government's health reform efforts. Industry leaders and members of the Interim Committee have noted they expect the SHARE plan to return as an individually sponsored bill during the 2015 Session, but no legislators have formally announced plans to sponsor the plan.

The Medicaid expansion alternatives being implemented or considered by states are varied, allowing each state to tailor a program best suited to meet the needs and resources of the state. Premium assistance, state managed care, health savings accounts, and high deductible health plans are among the most common alternatives considered to date.

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