Alternative Medicaid Expansion Models: Common Themes

Of the states implementing or pursuing Medicaid expansions, four states—Arkansas, Iowa, Michigan, and Pennsylvania*—have bypassed the Affordable Care Act's (ACA) conventional expansion pathway and are pursuing alternative models. These states are using authority granted by 1115 waivers from the Centers for Medicare & Medicaid Services (CMS) to run demonstrations testing new coverage approaches. The expansion demonstrations allow states to use federal funds to cover previously uninsured populations while potentially mitigating the political consequences associated with enlarging an existing Medicaid program. Four common themes from these models include:

Themes from Alternative Expansion Models

- **Reliance on the private insurance market** through premium assistance programs;
- An **emphasis on healthy behaviors** and personal responsibility;
- **Exemptions from current Medicaid rules** on cost-sharing, benefits, enrollment time limits, and work requirements; and
- **Limits or contingencies** on the expansion in the event federal funding is reduced (a.k.a., the "circuit breaker" provision).

1. Reliance on the Private Insurance Market: Premium Assistance Programs

Arkansas and Iowa received CMS approval in 2013 to create premium assistance programs that use Medicaid funds to purchase private coverage for newly-eligible Medicaid beneficiaries. Pennsylvania is also seeking to implement a premium assistance program and is in negotiation with CMS about its proposed design. Under all three demonstrations, Medicaid beneficiaries receive health coverage through qualified health plans (QHPs) in health insurance marketplaces. Anticipated benefits and downsides to providing private, marketplace-based health coverage to Medicaid beneficiaries include:

- ***Reduced churn***: Research suggests that up to 29 million Americans eligible to receive Medicaid or marketplace subsidies are likely to "churn" between coverage options, and seven million are likely to experience coverage shifts between Medicaid and marketplace policies.[i] Medicaid beneficiaries in QHPs can stay enrolled in private coverage, rather than switch insurance plans and/or providers.
- ***Better access to providers***: Individuals enrolled in private commercial plans may have better access to health care than traditional Medicaid beneficiaries, as more providers accept commercial insurance than Medicaid.
- ***Higher costs***: Private coverage is almost always more expensive than traditional Medicaid, so premium assistance programs will likely have a higher immediate price tag. Milliman, an actuarial consulting firm, estimated premium assistance programs to cost 20 to 40 percent more than traditional Medicaid programs, though the precise amount depends on a state's provider reimbursement rates.[ii]

2. Healthy Behaviors and Personal Responsibility

Iowa, Michigan, and Pennsylvania's alternative expansion models include policies that aim to promote healthy behaviors and individual responsibility. Their plans seek to:

- ***Deter unnecessary use of the emergency room:*** Iowa and Pennsylvania plan to charge co-payments for non-emergency visits to the emergency room.
- ***Tie premiums to wellness activities***: Iowa will waive premiums for beneficiaries who meet health goals (undergoing a health risk assessment and wellness exam in the first year, and completing preventive health activities in later years); Pennsylvania's proposed plan would reduce premiums

*Pennsylvania's 1115 waiver has been submitted to CMS and is currently under review. New Hampshire recently passed legislation to expand Medicaid through direct coverage starting in July 2014 and will submit a waiver to establish a premium assistance program in 2016.

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by 25 percent for engaging in healthy behaviors; and Michigan's program reduces out-of-pocket costs for completing wellness activities — starting with a yearly health-risk assessment.

- ***Require use of health savings accounts***: Michigan requires Medicaid beneficiaries to deposit money for co-pays and other health expenses into a health savings-like account to help individuals become more actively engaged in their health care decisions.

3. Exemptions from Current Medicaid Rules

CMS has issued guidance requiring premium assistance programs to further the objectives of the Medicaid program and provide the same benefits and cost-sharing protections afforded traditional Medicaid enrollees. CMS, however, waived some aspects of this requirement by allowing alternative expansion programs to offer fewer benefits and/or additional payment requirements than under traditional Medicaid (see table below).

Alternative Expansion Models: Key Exemptions from Medicaid Requirements

	TRADITIONAL MEDICAID REQUIREMENTS	ALTERNATIVE EXPANSION MODEL EXEMPTIONS
PREMIUMS	• Medicaid programs cannot charge premiums to individuals under 150% FPL.	• Iowa is charging premiums for individuals from 100 –133% FPL, capped at $10/month, after the first year of enrollment. • Michigan is charging premiums equal to 2% of income for individuals from 100–133% FPL. • *Pennsylvania is proposing charging premiums for individuals from 100–133% FPL: $25 a month for an individual or $35 for a family after year one.*
BENEFITS	• Medicaid programs are required to cover 15 mandatory benefits, including non-emergency transportation, family planning services, and community health center services.	• Iowa is not covering non-emergency transportation for the first year. • *Pennsylvania is proposing to waive the provision of Medicaid benefits not covered by QHPs, such as family planning, non-emergency transportation, and community health center services.*
TIME LIMITS	• Current federal requirements do not allow states to impose time limits for Medicaid eligibility or enrollment.	• *Through a future 1115 waiver, Michigan intends to implement a "soft cap" on coverage duration: after 48 months, beneficiaries will have the choice to pay higher premiums or seek private insurance through the marketplace.*
WORK REQUIREMENTS	• Medicaid programs cannot add additional requirements for Medicaid eligibility.	• *Pennsylvania is proposing a voluntary, one-year pilot program to encourage work or work search activities by reducing premiums up to 40%.*

NOTE*: Italicized text denotes a policy that was proposed, but not yet approved.*

4. Expansion Contingencies

Iowa and Michigan's Medicaid expansion plans contain "circuit breaker" language, making expansion contingent on sustained 100 percent federal funding for the newly eligible population through 2016. Expanded coverage would automatically roll back if the federal government reduces its match rate.

The expansion models highlighted above could be precursors to state innovation waivers, set to begin in 2017, as well as models for states that have not yet developed expansion plans.

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[i] M. Buettgens, A. Nichols, and S. Dorn. *Churning Under the ACA and State Policy Options for Mitigation*. Urban Institute. June 2012. Available at: http://www.urban.org/publications/412587.html.

[ii] R. M. Damler, K. Shaw, and S. Verma. "Considerations for Medicaid Expansion through Health Insurance Exchange Coverage." Milliman Health Care Reform Briefing Paper, 2013. Available at: http://publications.milliman.com/publications/healthreform/pdfs/considerations-medicaid-expansion.pdf.