CHCS Center for Health Care Strategies, Inc.

Issue *Brief*

# Alternative Medicaid Expansion Models: Exploring State Options

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As of February 2014, 25 states and the District of Columbia have expanded Medicaid to adults up to 133 percent of the federal poverty level (FPL), while 25 states are still considering expansion or have not chosen to expand.[*] Of those implementing or pursuing expansions, four states—Arkansas, Iowa, Pennsylvania and Michigan—have bypassed the Affordable Care Act's (ACA) expansion pathway and are pursuing alternative models. These states are using authority granted by the Centers for Medicare & Medicaid Services (CMS) via Medicaid state plan amendments (SPA) or 1115 waivers to pay for health insurance outside the traditional Medicaid program.[1]

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; it is currently in negotiation with CMS about its proposed design. Michigan's waiver to expand its traditional Medicaid program, but incorporate new and unconventional features—like using health savings-like accounts and tying cost-sharing to healthy behaviors—was approved by CMS in December 2013.

These new models allow states to use federal funds to cover previously uninsured populations while potentially mitigating the political consequences associated with enlarging an existing government program. This brief provides information about these alternative models and can help inform decision-makers seeking non-traditional Medicaid expansion options. Common themes from these models include:

- Reliance on the private insurance market;
- Exemptions from current Medicaid rules on cost-sharing, benefits, time limits and work requirements;
- An emphasis on healthy behaviors and personal responsibility; and
- Limits or contingencies on the expansion, including ending the expansion program if the federal government reduces its enhanced matching rate ("circuit breaker" provision).

## IN BRIEF

This brief outlines key program design features of alternative Medicaid expansion models. It describes the premium assistance models Arkansas, Iowa, and Pennsylvania developed to use Medicaid funds to purchase private health insurance, as well as Michigan's proposal to expand Medicaid using a health savings account model. Key themes emerging from these non-traditional proposals include: (1) a preference for solutions relying more on the private insurance market than on traditional Medicaid; and (2) an emphasis on higher enrollee cost-sharing, personal responsibility, and healthy behaviors.

States that have not yet expanded Medicaid can look to these non-traditional expansion proposals for ideas on expanding coverage to previously uninsured individuals. The Center for Health Care Strategies (CHCS) developed this brief in response to interest from *Medicaid Leadership Institute fellows*.

[*] States that are in the process of submitting expansion waivers to CMS (such as Pennsylvania), or recently announced their intentions to expand Medicaid (such as Utah and New Hampshire), are not counted as expansion states.

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## Background on Premium Assistance Programs

Premium assistance programs are not new: since 1965 states have had the option to use federal Medicaid dollars to pay for private health insurance premiums through Section 1906 of the Social Security Act. In 2010, 39 states offered some sort of premium assistance program, serving as few as five and up to roughly 31,000 individuals per state.[2] These programs generally subsidize premiums for Medicaid- and CHIP-eligible individuals enrolled in employer-sponsored insurance, though they tend not to enroll many people, as low-income individuals often do not have access to health coverage through a job. No state, however, has ever chosen to cover an entire subset of beneficiaries with a premium assistance program because of:

1. *High Costs*: Private insurance tends to cost more than Medicaid, due in large part to higher provider reimbursement rates and administrative costs;[3] and
2. *Limited Coverage Options:* There are few suitable private insurance products available to purchase for the medically needy subset of the Medicaid population.

The post-ACA health care landscape makes the establishment of large-scale premium assistance programs a more affordable and realistic option for states for several reasons. First, state Medicaid programs have access to a significant influx of new funding: the federal government will pay 100 percent of the cost of expanding Medicaid between 2014 and 2016, phasing down to 90 percent of costs by 2020. Second, the newly operational health insurance marketplaces provide the infrastructure necessary to cover large numbers of Medicaid beneficiaries in non-employer-based plans. Marketplaces offer a range of private insurance options called qualified health plans (QHPs), all of which include a standard, comprehensive package of items and services known as "essential health benefits." The creation of marketplaces are especially significant for states like Arkansas that lack a strong Medicaid managed care presence, as these states previously had no public or private plans available to cover Medicaid beneficiaries in a cohesive, organized fashion.[4] Finally, marketplace plans may cost less than many pre-ACA private options thanks to greater consumer purchasing power, more plan competition, and narrower networks.

## Premium Assistance Considerations

States should consider the likely effects a premium assistance expansion program will have on Medicaid beneficiaries and the state health care system as a whole when considering which type of expansion to pursue. A private Medicaid program's anticipated benefits and downsides include:

- ***Reduced Churn***: Research suggests that of the estimated 96 million Americans eligible to receive Medicaid or marketplace subsidies during a given year, up to 29 million are likely to "churn" between coverage options, and seven million are likely to experience coverage shifts between Medicaid and marketplace policies.[5] If Medicaid-eligible individuals are enrolled in marketplace QHPs instead of traditional Medicaid and their incomes rise above the Medicaid eligibility ceiling, they can stay in private coverage rather switch insurance plans and/or providers. In states like Arkansas with low pre-ACA thresholds for adult Medicaid eligibility,[†] this seamlessness across Medicaid and the marketplace could reduce churning by nearly two thirds, resulting in better continuity of care.[6,7] In states with higher traditional income limits for Medicaid, a premium assistance model will lead to some churning between the pre-ACA Medicaid-eligible group (still covered under

[†] Prior to ACA passage, working parents in Arkansas had to make less than 16 percent FPL to qualify for Medicaid, while childless adults were not eligible for full Medicaid coverage at any income.

publicly run plans) and the newly eligible group covered by marketplace plans—though overall churning should still be reduced.[8]

- ***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. A 2012 Government Accountability Office study found 7.8 percent of working-age adults with Medicaid had difficulty accessing needed services, compared with 3.3 percent of similar adults with private insurance, a statistically significant difference.[9] Furthermore, a national 2011 study found that almost a third of all physicians refused to accept new Medicaid patients, compared to 19 percent refusing new commercial patients and 17 percent refusing new Medicare patients.[10] Medicaid beneficiaries with private coverage may therefore gain access to a wider range of medical practitioners and care options, while those with traditional Medicaid may have a smaller pool of providers to choose from, a harder time booking appointments, and less positive provider interactions.
- ***Higher Overall Costs***: Medicaid is almost always cheaper than private plans, so any proposal to cover individuals via private coverage instead of Medicaid should have a higher immediate price tag. In 2012, the Congressional Budget Office estimated that by 2022, the average person who enrolled in a marketplace plan instead of Medicaid would cost the federal government about $3,000 more ($9,000 vs. $6,000).[11] Milliman, an actuarial consulting form, estimated premium assistance programs to cost 20 percent to 40 percent more than traditional Medicaid programs, though the amount depends on a state's provider reimbursement rates.[12]

CMS restricts enrollment in a Medicaid premium assistance expansion program to individuals whose benefits align closely with those available in QHPs.

## Federal Requirements for Premium Assistance Models

States looking to use Medicaid dollars to purchase coverage through marketplace QHPs must apply to CMS for a SPA or 1115 Medicaid demonstration waiver. Under a SPA, enrollment in a private plan is optional, while a state using a waiver may require eligible beneficiaries to enroll in private coverage. If using a waiver, states must also solicit public input through a minimum 30-day comment period. All of the states featured in this brief used an 1115 waiver to implement their premium assistance demonstrations, and the information in this section is specific to waiver-based expansions.

CMS stated in a March 2013 bulletin that it will consider approving "a limited number" of premium assistance demonstration waivers, noting that these waivers will help inform the planning and approval of State Innovation Waivers, which begin in 2017.[13] According to CMS, premium assistance demonstrations must further the objectives of the Medicaid program and should provide the same benefits and cost-sharing protections afforded traditional Medicaid enrollees. This means that if Medicaid-eligible individuals enroll in a private QHP with a more limited benefits package than traditional Medicaid, the state needs to provide "wrap-around" benefits that fill in any gaps. States must also pay for any out-of-pocket costs beyond what is allowed under Medicaid rules.

## Cost Effectiveness in Medicaid Premium Assistance Programs

Medicaid premium assistance programs must be comparable to the cost of coverage under a state's traditional Medicaid program. At first glance, this result seems difficult to achieve, as private health insurance is almost always more expensive than Medicaid. However, CMS has broadly interpreted "cost effectiveness" conditions for premium assistance. CMS has indicated it will allow states to recognize considerations beyond programmatic costs when calculating a proposal's cost-effectiveness, including reduced churn, increased competition in marketplaces, and the "equal access" justification (the notion that states would have to raise Medicaid rates to commercial levels in order to guarantee beneficiaries equal access to providers and services).

Despite these general guidelines entitling premium assistance enrollees to all Medicaid benefits and cost-sharing protections, CMS has approved demonstrations that provide fewer Medicaid benefits and/or additional payment requirements than under traditional Medicaid. For example, federal rules prohibit imposing premiums on traditional Medicaid beneficiaries with incomes under 150 percent FPL, yet CMS authorized Iowa to charge premiums starting at 100 percent FPL (with individuals between 100 and 133 percent FPL paying premiums up to two percent of income—the ACA's contribution limit for marketplace consumers in this income range). CMS also waived Iowa's obligation to provide non-emergency medical transportation through a wrap-around benefit for one year. Pennsylvania's waiver seeks similar exemptions from standard Medicaid rules.

CMS restricts enrollment in a Medicaid premium assistance expansion program to individuals whose benefits align closely with those available in QHPs; for most states, this means limiting the eligible population primarily or exclusively to the newly eligible adult group. Special Medicaid populations, like the medically frail,[*] do not qualify.[14] CMS also requires that premium assistance programs be "cost effective" for states and budget neutral for the federal government (see the "Cost Effectiveness" sidebar).

CMS guidance[15] suggests states may have a better chance at having their premium assistance waiver accepted if:

1. **Individuals below 100 percent FPL remain in state plan Medicaid:** CMS may be more inclined to approve a state's 1115 waiver if the state limits premium assistance enrollment to new adults with incomes between 100-133 percent FPL—those beneficiaries most likely to shift between Medicaid and marketplace coverage due to income changes.[16] While Arkansas enrolled the entirety of the expansion population in marketplace coverage, the medically needy group at all income levels will remain in state plan Medicad. Iowa is the one state thus far that has chosen to limit its premium assistance program to newly eligible beneficiaries with incomes between 100-133 percent FPL, while keeping individuals under 100 percent FPL in a traditional, public Medicaid program. Other states are considering premium assistance waivers for targeted, previously-eligible groups, such as pregnant women above 133 percent FPL.
2. **No eligibility or enrollment caps are imposed:** CMS has advised that capping eligibility at an income threshold below 133 percent FPL would make the state ineligible to receive the enhanced federal match rate. States that wish to implement a "partial expansion" (e.g., at an income level below 133 percent FPL) can apply for an 1115 waiver at the state's regular Medicaid matching rate. CMS also indicated that it will not approve expansion waivers that include enrollment caps.
3. **Waivers have short duration.** Finally, all alterative Medicaid expansion waivers will end by December 31, 2016. States looking to expand these programs into 2017 and beyond must apply for State Innovation Waivers.

[*] According to 42 CFR 440.315, a state's definition of individuals who are medically frail or otherwise have special medical needs must at least include children described in 42 CFR 438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

## States Proposing Premium Assistance Plans

As of February 2014, two states—Arkansas and Iowa—have approved 1115 waivers for premium assistance Medicaid expansions. Pennsylvania will submit its final waiver to CMS in 2014. Following are summaries of each state's approach.

### Arkansas

Arkansas became the first state to gain federal approval for a Medicaid premium assistance expansion plan, with CMS approving Arkansas' three-year waiver on September 27, 2013. The state began open enrollment October 1, alongside states expanding Medicaid through traditional means, and started covering newly eligible adults on January 1, 2014. In order for Arkansas to continue its Arkansas Health Care Independence Program past the current state fiscal year on June 30, 2014, three-fourths of both legislative houses must approve a new appropriation to accept federal matching funds. It is unclear at this time whether there are enough votes to accept the funding and maintain the expansion program.[17]

- ***Populations Covered***. Arkansas' waiver will cover an estimated 200,000 newly eligible adults (parents 17-133 percent FPL and childless adults 0-133 percent FPL) through QHPs on the state's marketplace. Medically frail adults are not eligible and will receive coverage via traditional fee-for-service Medicaid. Participation is mandatory for all non-medically needy, newly Medicaid-eligible adults in the state.

- ***Cost-Sharing***. Arkansas is not imposing any premiums on beneficiaries; the state will pay all premium costs directly to commercial plans. Co-pays and deductibles will apply only to individuals with incomes between 100 percent and 133 percent FPL in 2014, though the state has proposed applying them to beneficiaries with incomes between 50 percent and 133 percent FPL in 2015-2016. Cost-sharing is limited to 5 percent of annual income and all other federal beneficiary cost-sharing limits apply. The state will advance monthly cost-sharing reduction payments to QHPs to cover the difference between private cost-sharing rates and Medicaid requirements.

- ***Benefits***. New enrollees can choose to enroll in any silver-level QHP on the state marketplace available in their service area; at least one QHP in every service area is required to contract with a local community health center. The only notable benefits the state must provide through a 'wrap' of the QHP are non-emergency transportation and limited Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits for 19- and 20-year-olds. Unlike other states, Arkansas did not choose to waive any benefits for its premium assistance Medicaid beneficiaries.

- ***Cost-Effectiveness***. CMS officially waived Arkansas' cost-effectiveness requirement, noting that the state may use "state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness."[18] The state estimates the cost of its premium assistance Medicaid expansion to be comparable to a public Medicaid expansion plan, though this estimate takes into account "equal access" considerations (discussed in call-out box). The state's actuaries initially estimated that per-person, per-month private option costs would be about 24 percent higher than costs under traditional Medicaid expansion. After taking into account the effects of more marketplace competition, more efficient health plan management, and more astute consumer decision-making, this initial estimate was reduced to 13-14 percent.[19] Ultimately, the state's actuaries argued that while the premium assistance program might cost 13-14 percent more, this estimate does not take into account the likely increase in Medicaid provider reimbursement rates that the state argued would be required to secure access for a Medicaid expansion population.[20] In other words, the state made the case to

CMS that the higher cost of purchasing marketplace coverage for Medicaid eligible individuals buys better access to care, thereby making the program "cost effective."

## Iowa

Iowa's two complimentary 1115 Medicaid demonstration waivers were approved by CMS on December 10, 2013. While the state had requested a waiver until 2018, CMS approved the demonstration through December 31, 2016. Iowa's governor accepted the federal government's terms and implementation began on January 1, 2014. State law contains "circuit breaker" language, making the expansion contingent upon the federal government not reducing current federal Medicaid matching funding rates.

- ***Populations Covered***. Iowa's 1115 waivers create two new programs to cover the anticipated 190,000 Iowans below 133 percent FPL:

  1. The Iowa Marketplace Choice Plan provides private coverage to newly Medicaid-eligible adults between 101-133 percent FPL who meet all other eligibility criteria for the Medicaid expansion and do not have access to employer-sponsored insurance. Those with access to affordable employer-based coverage will receive premium assistance for this coverage—a continuation of the state's existing Section 1906 premium assistance program.
  2. The Iowa Wellness Plan is a new public Medicaid program available to newly eligible individuals below 100 percent FPL. It will be administered by Iowa Medicaid and provide access to the same providers available in the state's current Medicaid program. Beneficiaries will be eligible for 12 months of coverage via Medicaid managed care arrangements. Medically frail individuals have the choice to enroll in the Iowa Wellness Plan or regular Medicaid.

- ***Cost-Sharing***. Iowa had requested the ability to require monthly premiums for all Medicaid enrollees between 50-133 percent FPL, but the final terms and conditions issued by CMS only allow the state to charge premiums up to two percent of annual income for individuals with incomes over 100 percent FPL. Starting in the second year of the demonstration, $20 monthly premiums will be required for all beneficiaries in the Iowa Marketplace Choice Plan unless they demonstrate they have met certain health goals (this includes completing a health risk assessment and undergoing a wellness exam in Year One and completing preventive health activities in later years). Beneficiaries cannot be disenrolled if they are unable to pay the premium costs. Beginning in the second year of the demonstration, beneficiaries will also be charged a $10 co-pay for non-emergent use of the emergency room. Out-of-pocket costs cannot exceed 5 percent of income, and beneficiaries can apply for hardship waivers if they have difficulty paying their premiums.

- ***Benefits***. The benefits offered in both the Iowa Wellness Plan and marketplace QHPs are equivalent to state employee coverage. CMS approved Iowa's request to waive the requirement to provide non-emergency transportation to all new Medicaid enrollees for the first year (though the state must conduct an evaluation of this policy decision). The state will provide wrap-around EPSDT services for 19- and 20-year-olds.

- ***Cost-Effectiveness***. Iowa's waivers provided little detail on the issue of cost-effectiveness or budget neutrality.

## Pennsylvania

Pennsylvania's submitted a draft 1115 premium assistance waiver to CMS on Friday, December 6, 2013; the final waiver is expected to be submitted to CMS in early 2014, after the state reads and incorporates suggestions submitted during the public comment period. The Medicaid expansion would begin in 2015. This waiver proposal, like Iowa's, has a strong health and wellness component, though it seeks more dramatic changes to traditional Medicaid than Arkansas or Iowa. Pennsylvania's proposal contains 23 requests to waive or change federal law, while Arkansas's waiver included just three.

- ***Populations Covered***. Pennsylvania's premium assistance proposal would cover newly eligible adults in marketplace QHPs (parents 33-133 percent FPL and childless adults 0-133 percent FPL), including individuals currently enrolled in several state-funded programs. The Commonwealth's proposal to CMS requires individuals who are unemployed or working less than 20 hours a week to complete work-search activities (such as enrollment in a job search or training program) as a condition of Medicaid eligibility. Those who fail to meet the work requirements risk losing Medicaid for up to nine months. CMS has never approved a waiver that included a work-search provision. The waiver also seeks to waive the 90-day retroactive eligibility provided by Medicaid.

- ***Cost-Sharing***. Pennsylvania is proposing monthly premiums up to $25 for individuals and $35 for families earning more than 50 percent FPL, with exemptions for pregnant women, people with disabilities, the elderly, and residents of institutions. The waiver proposes a $13 monthly premium for individuals earning between 50-100 percent FPL and a $17 premium for families in this income range. The state would reduce premiums by 25 percent for beneficiaries who engage in certain healthy behaviors (which initially include completing a health risk assessment and physical). The waiver seeks significant flexibility to determine the types of healthy behaviors to promote. Pennsylvania's plan would reduce premiums by another 25 percent for individuals who work 30 or more hours per week. Pennsylvania does not include any co-pays except for a $10 change for a non-emergency visit to the emergency room.

- ***Benefits***. Single adults eligible for the Medicaid expansion who are not medically frail will receive the essential health benefits package through a commercial plan. The proposal seeks to waive the requirement to offer an alternative benefit plan to the Medicaid population, which would allow the state to limit benefits to the EHB package offered by QHPs. Effectively, the Commonwealth is proposing to not offer family planning services, non-emergency transportation, community health center services, and certain drugs to newly eligible beneficiaries. For the state's currently eligible Medicaid population, Pennsylvania's proposal creates two new benefit plans: (1) a low-risk benefits package for healthier individuals that would include a limited set of services; and (2) a high-risk package for individuals with complex health conditions that would include more a comprehensive set of benefits. Individuals' health status will be measured using a health screening questionnaire. All newly eligible medically frail individuals, SSI beneficiaries, pregnant women, dually-eligible individuals, residents of institutions, and individuals receiving home- and community-based services will be enrolled into the High-Risk Alternative Benefit Plan. Others eligible for current Medicaid will receive the Low-Risk Alternative Benefit Plan. Children under 21 and newly eligible adults who are 19 or 20 will receive the EPSDT benefits package.

- ***Cost-Effectiveness***. Pennsylvania is currently negotiating the financing mechanism for its waiver, but in its initial proposal outlined plans to use a "per capita" budget neutrality cap for the populations covered under the demonstration, including the Healthy Pennsylvania Private Coverage Option. This is a typical approach for an 1115 waiver,

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which puts the state at financial risk for higher per person costs, but not overall higher than expected enrollment.[21]

## Other Alternative Medicaid Expansion Models

Premium assistance is not the only model states are pursuing to expand Medicaid. Michigan, for example, will enroll its expansion population in public plans, but plans to require beneficiaries to deposit money into health accounts to actively participate in paying for their care, similar to a model used by Indiana. It is also working to create incentives for healthier behaviors among beneficiaries.

### Michigan

In December 2013, CMS approved Michigan's amendment to an existing 1115 waiver to create an alternative Medicaid expansion option. The state anticipates enrollment in "Healthy Michigan" to begin April 1, 2014. The five-year demonstration will enroll newly eligible adults in Medicaid managed care plans and will require all beneficiaries to use health savings accounts to pay for health expenses. Like Iowa's plan, cost-sharing amounts will be tied to health behaviors. Like Iowa, Michigan's expansion contains "circuit breaker" language, making implementation contingent on sustained 100 percent federal funding for the 0-133 percent newly eligible population through 2016.

- ***Populations Covered***. Healthy Michigan will cover an estimated 400,000 newly Medicaid-eligible Michigan residents: childless adults between 35-133 percent FPL (those under 35 percent FPL currently qualify for a limited benefits program) and working parents between 64-133 percent FPL. The state is also separately pursuing a second waiver that would allow it to limit Medicaid enrollment for many of the newly eligible population to 48 months.

- ***Cost-Sharing***. Michigan's plan will establish health savings-like accounts (called MI Health Accounts) into which Medicaid beneficiaries and the state will deposit money for health expenses. Enrollees with incomes between 100-133 percent FPL will pay a monthly premium of two percent of their income into the account (e.g., $20 a month for someone with an income of $12,000). All beneficiaries will also be required to pay co-pays after the first six months (except those exempt from paying under federal law), totaling no more than three percent of their income, with total out-of-pocket costs not exceeding five percent of income. Co-pays will not exceed amounts in the ACA's cost-sharing regulations and will go directly to health plans instead of to providers. There will not be co-pays for preventive services, high-value drugs, emergency services, or emergency hospital admissions.

  Beneficiaries who complete an annual health risk assessment and are deemed to have healthy behaviors will have their out-of-pocket costs reduced. The state is also considering collecting missing payments through a lien on tax refunds, though it has not officially requested this authority.

- ***Benefits***. Healthy Michigan benefits will include the ACA's essential health benefits, which will add habilitative services, hearing aids, and additional preventive health care services to the state's current Medicaid benefits package. The state is also planning to use enhanced Medicaid financing to help pay for early identification, care coordination, and treatment in its existing mental health and substance abuse programs.

- ***Cost-Effectiveness***. Michigan has concluded that its expansion plan has no net cost to state. The proposal is estimated to save the state $320 million in uncompensated care costs by 2022.[22]

## Conclusion

While it is too early to tell how these Medicaid experiments will work, Arkansas has already enrolled over 80,000 individuals in Medicaid since January 1, 2014, and Iowa and Michigan are on track for implementation in early 2014. As intended in the law, these experiments could be precursors to more widespread state-driven innovations in 2017 under Section 1332 of the ACA. States that have not yet developed expansion plans can look to these early innovators for insights, though may wish to consider unique models that will further inform national Medicaid program design. Once again, states are meeting the challenge of Justice Brandeis and others who expect them to be laboratories for innovation in American domestic policy.

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## About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

## Endnotes


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