

ACA Implementation—Monitoring and Tracking

Medicaid Expansion, the Private Option, and Personal Responsibility Requirements:

The Use of Section 1115 Waivers to Implement
Medicaid Expansion Under the ACA

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute has been documenting changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org. The qualitative component of the project is producing analyses of the effects of the ACA on enrollment (including Medicaid expansion), insurance regulation and marketplace competition.

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to all nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL). In 2012, however, the United States Supreme Court issued a ruling that effectively made Medicaid expansion optional. As of April 1, 2015, 28 states and the District of Columbia had expanded Medicaid and several additional states were exploring expansion. The financial incentives for states to expand Medicaid and reduce the number of uninsured have led some governors and legislators who strongly oppose the ACA to support Medicaid expansion in their states—if they can develop their own programs not allowed under standard Medicaid rules.

Under Section 1115 of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) may grant states waivers from certain Medicaid requirements and allow states to operate time-limited demonstrations to experiment with new approaches to Medicaid. As of April 1, 2015, CMS had approved Section 1115 waivers in all six states that had applied for such approval as an alternative to a standard Medicaid expansion: Arkansas, New Hampshire, Indiana, Iowa, Michigan, and Pennsylvania. This paper describes and analyzes key components of the Medicaid expansion programs in these six states based on analysis of the Section 1115 waiver applications, proposed amendments, CMS' approval documents, summaries and press reports, and interviews with national experts and state officials, providers, insurance company representatives, and consumer advocates in the study states.

The following are our key observations:

First, these waivers have enabled states that were not prepared to implement a standard expansion to extend Medicaid coverage to hundreds of thousands of people who otherwise would have likely remained uninsured. Respondents from all six states reported that a standard expansion would not have been approved in their states.

Second, the use of premium assistance and payment of cost-sharing reductions to place Medicaid enrollees into qualified health plans (QHPs) in the ACA marketplace could have several advantages, including 1) providing access to a broader mix of providers, 2) promoting continuity of care when people move between eligibility for Medicaid and marketplace subsidies, 3) contributing to expanded competition in the marketplace, which in turn would lower premiums, and 4) lowering federal government subsidy costs in the marketplace and the costs of QHPs for individuals not eligible for subsidies as a result of lower premiums.

On the other hand, several potential disadvantages of placing Medicaid enrollees into QHPs were identified by some respondents, including the concern that 1) enrollees would not have effective access to wrap-around benefits required under Medicaid and not offered in the QHPs, 2) states would not effectively implement the medical frailty screens that divert less healthy individuals into traditional Medicaid, and 3) federal and state costs would be higher for covering these individuals.

Third, with respect to charging premiums or other monthly contributions, some supporters of these provisions assert that having beneficiaries make some financial contribution increases individual responsibility for health care utilization, makes participation less demeaning, and exposes Medicaid enrollees to private insurance models. However, evidence from prior research consistently indicates that low-income individuals are highly sensitive to premiums and that charging premiums or premium-like monthly contributions will lead to a reduction in enrollment, countering the goal of expanding coverage to all eligible adults. If the net result of premium payments or other monthly contributions, which are a component of all these waivers except for New Hampshire's, is lower initial enrollment and higher disenrollment rates, this would seem contrary to the purpose of the Medicaid expansion and of a Section 1115 waiver.

Fourth, the use of the Health Savings Account models that require individuals to make small contributions into an account that is then used to cover portions of their health care costs is likely to be inefficient. The administrative costs of maintaining tens of thousands of individual accounts with

very small monthly contributions from enrollees are likely to be significantly higher than the benefits, including any changes in utilization of services that might result.

Fifth, the evidence regarding the effectiveness of wellness programs generally is weak. The states that implemented these wellness programs in 2014 encouraged enrollees to obtain a wellness exam and complete a health risk assessment (HRA). But if healthy behavior programs went beyond wellness exams, protected vulnerable groups with certain health conditions, and led to innovative program designs that improved health and well-being for participants, then experimenting with such programs could test whether healthy behavior incentives improve the health of enrollees and are cost effective.

These waivers require an ongoing evaluation by the states and review by CMS to determine whether they will meet their stated objectives and which of these provisions are worth retaining and which are not. Public transparency in how all of these programs are implemented and evaluated will be essential in determining what lessons these programs may offer CMS and other states.

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) expanded Medicaid to cover all nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL).¹ Before the ACA, Medicaid provided health coverage primarily to children, pregnant women, parents of dependent children, and the aged, blind, and disabled. Some states provided coverage to childless adults, but such coverage was limited, could not rely on additional federal funding, and required a waiver under Section 1115 of the Social Security Act.² The ACA's Medicaid expansion was originally estimated to cover approximately 15.1 million newly eligible adults throughout the United States.³ In 2012, however, the Supreme Court of the United States held that the Department of Health and Human Services (HHS) could not require states to implement the ACA's Medicaid expansion by withholding funding for their overall Medicaid programs, essentially making the Medicaid expansion optional.⁴

As of April 1, 2015, 28 states and the District of Columbia had expanded Medicaid and several additional states were exploring expansion. In April, 2015, Montana's governor and legislature came to an agreement over a proposed Medicaid expansion waiver in that state. Medicaid expansion is caught up in the highly partisan politics surrounding the ACA, but the financial incentives for states to expand Medicaid and reduce the number of uninsured have led

some governors and legislators who strongly oppose the ACA to support Medicaid expansion in their states, although often with significant conditions attached. A recent example is Tennessee Governor Bill Haslam (R) who called a special session of the legislature in February 2015 to consider a Medicaid expansion called "Insure Tennessee" and told legislators, "This is not Obamacare."⁵ Legislators in Tennessee, however, quickly rejected Haslam's proposal. In many states with political leaders who generally oppose the ACA, governors and legislators have engaged in extensive debates and negotiations over both whether and how to expand Medicaid.

Beginning with the state of Arkansas, which sought and received permission from HHS' Center for Medicare and Medicaid Services (CMS) to expand Medicaid through a Section 1115 waiver by providing premium assistance to place Medicaid expansion beneficiaries into qualified health plans (QHPs) in the ACA marketplace, more states have been developing alternative approaches to Medicaid expansion that build on commercial insurance and employer-sponsored insurance models. Although it has not approved all changes sought by leaders in these states, as of April 1, 2015, CMS had approved Section 1115 waivers in all six states that had applied for such approval as an alternative to a standard Medicaid expansion: Arkansas, New Hampshire,

Indiana, Iowa, Michigan, and Pennsylvania. No two states submitted the same proposal to CMS. Moreover, over time, state legislative proposals to expand Medicaid increasingly have included provisions that CMS had not approved in earlier waivers. In January 2015, CMS approved Indiana's waiver, which included significant provisions that CMS had not previously approved. Thus the environment for Medicaid expansion remains fluid and subject to both local political and economic factors and CMS approval.

This paper addresses the Medicaid expansion programs in the six states that sought and received authority from CMS as of April 1, 2015 to implement the Medicaid expansion through a Section 1115 demonstration. Under Section 1115, CMS has the authority to waive certain requirements of the Act's Medicaid provisions and allow states to experiment with new approaches to payment and management systems through a time-limited demonstration that is designed to further the goals of the Medicaid program.

For this study, we analyzed the Section 1115 waiver applications, proposed amendments, CMS' approval documents, and state summaries and press reports describing the programs and providing some of the political context for the waiver applications in each of the study states. We also interviewed national experts and state officials, providers, insurance company representatives, and consumer advocates in the study states.

This study addresses the use of premium assistance to place individuals in QHPs in the ACA marketplace. We refer to this model as the "private option"—the name Arkansas adopted for its program—to distinguish premium assistance for QHPs from premium assistance to place Medicaid enrollees in employer-sponsored insurance plans. This study also addresses a range of provisions modeled after commercial insurance, including the imposition of

premiums, the imposition of monthly contributions designed to cover actual or anticipated cost-sharing obligations, health savings type accounts, and healthy behavior incentives. Respondents reported that supporters of these provisions describe them as requiring Medicaid enrollees to have "skin in the game." For ease of reference, we refer to them collectively as "personal responsibility requirements," although this is a term favored by proponents of these provisions, and not necessarily descriptive of their effect.

Although there is disagreement over the scope of CMS' authority to approve some of the specific proposals states have made to expand Medicaid through a Section 1115 waiver, this study does not address those legal issues. And although states have proposed other provisions, such as health care delivery and payment reforms and restrictions on benefits and work requirements, the "private option" and "personal responsibility" requirements modeled after commercial insurance are the focus of this study.⁶ The approaches taken by these six states and approved by CMS are representative of the range of approaches to both the private option and the personal responsibility requirements that other states have been considering.

We first provide an overview of these Section 1115 Medicaid expansion waivers, summarize the approaches states are taking, and describe the response of CMS as of March 2015, when it approved New Hampshire's Section 1115 waiver. We then discuss each of the six states in the order they submitted and received approval for their Section 1115 waivers. Although Pennsylvania's newly elected governor has announced that Pennsylvania will implement the standard Medicaid expansion by the end of 2015, we include Pennsylvania in this study because it received CMS approval for its plan. We then discuss several themes that emerged from our analysis and conclude by identifying trends and issues to watch in the future related to these demonstrations.

CMS' RESPONSE TO STATE PROPOSALS TO EXPAND MEDICAID USING A SECTION 1115 WAIVER

Section 1115 of the Social Security Act allows states, subject to HHS approval, to conduct "experimental, pilot, or demonstration" projects that alter certain eligibility, benefits, cost-sharing, financing, and other federal Medicaid requirements if those changes promote the objectives of the Medicaid program.⁷ Section 1115 waivers are time limited and must have specific goals, be evaluated to determine if they meet the stated goals of the demonstration project, and be budget neutral, meaning that they do not cost the federal government more than coverage of the eligible population

would have cost without the waiver. In years preceding ACA Medicaid expansion, states used Section 1115 waivers, among other things, to provide coverage to childless adults.⁸

In March 2013, after Arkansas began negotiations with CMS over its private option plan, CMS issued guidance describing the parameters of what it would consider in a private option proposal as part of a Section 1115 expansion waiver.⁹ CMS stated that any such proposal must (1) give beneficiaries a choice of at least two QHPs,

(2) ensure that beneficiaries enrolled in QHPs receive wrap-around benefits and cost-sharing assistance as needed to match Medicaid requirements, (3) may not place the medically frail or other high-need populations into QHPs, and (4) end by December 31, 2016. CMS also advised that states targeting adults between 100 and 138 percent of FPL might be more successful in receiving approval for a private option.

Since issuing its March 2013 guidance, CMS has approved six Section 1115 Medicaid expansion waivers. CMS has rejected proposals to tie Medicaid benefits to work search requirements (Pennsylvania and Indiana) and to waive benefits requirements for beneficiaries placed in QHPs, except for allowing a series of temporary waivers of the requirement that Medicaid cover nonemergency transportation to beneficiaries (Indiana, Iowa, and Pennsylvania).¹⁰ With the exception of authorizing some increased cost sharing for the non-emergent use of an emergency room, CMS has also limited cost sharing to copayment and coinsurance levels already permitted in Medicaid under federal law, including \$4 copayments for most outpatient services for enrollees at or under 100 percent of FPL and copayments/coinsurance at or under 10 percent of the Medicaid agency's costs for outpatient services for those above 100 percent of FPL.¹¹

Although several states received approval to charge enrollees monthly contributions to cover actual cost sharing incurred in prior months (Michigan) or estimated future costs (Arkansas, Iowa, and Indiana), CMS has not increased the

nominal cost-sharing caps on individual services under federal regulations and those states' approved state plans. Nor has CMS allowed any state to make such payments a condition of enrollment for individuals at or under FPL. Until Indiana's waiver was approved, CMS had also rejected proposals to eliminate retroactive coverage for Medicaid beneficiaries and lockout proposals that would have enabled states to terminate Medicaid benefits and bar beneficiaries from re-enrolling for an indefinite or specific period of time if they failed to pay approved premiums or cost sharing. Indiana's lockout policy only applies to enrollees above the federal poverty level.

Of the study states, only Arkansas, Iowa, and New Hampshire proposed a private option to provide premium assistance for beneficiaries to enroll in QHPs; Indiana and Michigan used existing Medicaid managed care organizations, as did Iowa for those at or under 100 percent of FPL. Pennsylvania created a new Medicaid managed care program for the expansion population. With the exception of New Hampshire, all of the study states proposed one or more personal responsibility provisions, including charging premiums or other monthly contributions, and/or creating health accounts and healthy behavior incentives, which are modeled generally on commercial insurance. The following section describes the private option and personal responsibility provisions in the Section 1115 waivers in the six study states and the local context for developing those proposals. We describe them in the order in which they were approved by CMS, reflecting the evolution of the scope of CMS' approvals.

SECTION 1115 MEDICAID EXPANSION WAIVERS APPROVED BY CMS

Arkansas Health Care Independence Program

Arkansas was the first state to seek and receive approval (in September 2013) for a Section 1115 waiver to expand Medicaid. Arkansas originally sought approval for a private option demonstration project, using premium assistance and payment of cost-sharing obligations to place all newly eligible adults up to 138 percent of FPL—except for those determined medically frail—into QHPs in the ACA marketplace. In its initial waiver application, Arkansas did not seek to impose any personal responsibility requirements on beneficiaries, but the 2013 legislation required the creation of “Independence Accounts” and imposition of monthly cost-sharing contributions beginning in 2015. Arkansas thus sought an amendment to its waiver to implement those provisions, which CMS approved at the end of December 2014. Table 1 summarizes key elements of the waiver.

As of February 15, 2015, 233,518 people were determined eligible and 219,000 had completed enrollment in a QHP through Arkansas' Medicaid private option, and nearly 65,000 non-Medicaid enrollees had signed up for QHPs through the marketplace.¹² Thus 77 percent of the enrollees in Arkansas QHPs are Medicaid expansion enrollees.

Political Context for Medicaid Expansion in Arkansas

With a population of nearly 3 million people, Arkansas had very strict Medicaid eligibility criteria prior to 2014 and nearly 1 in 5 adults was uninsured. Half of these adults—nearly 250,000—were under 138 percent of FPL and eligible for the ACA's Medicaid expansion.¹³ Before the ACA, most Medicaid enrollees in Arkansas were covered through fee-for-service reimbursement rather than through capitated managed care. Arkansas' then-Democratic governor, Mike

Table 1: Summary of Key Provisions in Arkansas’ Section 1115 Medicaid Expansion Waiver: Arkansas Health Care Independence Program

Policy	Description
Premium Assistance in QHPs	Yes. Mandatory for all nonexempt enrollees at all income levels.
Monthly Premiums or Contributions	Yes. Referred to by CMS as monthly contributions to Arkansas “Independence Accounts.” Monthly contributions for different income levels not to exceed 2% of annual household income. Above 50–100% FPL = \$5/month; above 100–115% FPL = \$10/month; above 115–129% FPL = \$17.50/month; above 129–138% FPL = \$25/month
Cost sharing	Cost sharing (copayments and coinsurance) is covered through the monthly contributions. No cost-sharing for enrollees under 50% FPL; nonexempt enrollees at or above 50% FPL will be responsible for cost-sharing amounts allowed under Medicaid rules and state plan with an aggregate cap of 5% of monthly or quarterly income.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	No, but enrollee incurs debt to the state. Enrollees above 100–138% FPL who do not make a monthly contribution will be required to pay QHP copayments or coinsurance (consistent with Medicaid rules and the state plan) at the point of service in order to receive services.
Health Accounts	Yes. Administered by a third-party administrator.
Healthy Behavior Incentives	No

Sources: Centers for Medicare and Medicaid Services, Special Terms and Conditions—Arkansas Health Care Independence Program (Private Option), Number 11-W-00287/6 (amended January 1, 2015). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar-ar-private-option-ca.pdf> (accessed April 2015).

Centers for Medicare and Medicaid Services, “Medicaid and the Affordable Care Act: Premium Assistance.” Washington, DC: March 2013. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (accessed April 2015).

Beebe, pushed for the private option in Arkansas. Though there was a Democratic majority in the House in 2012, respondents reported there was strong overall resistance to the ACA in Arkansas and that this increased following the 2012 elections, when both the Senate and the House had Republican majorities for the first time since Reconstruction.

The Arkansas private option model offered the dual advantage of buying “private” health insurance for Medicaid beneficiaries, while increasing marketplace competition by bringing in a large volume of potential consumers. A state fact sheet described several benefits including integration, efficiency, and “market-driven provider reimbursement” that could bring more providers into the Medicaid coverage system.¹⁴ State officials promoted the private option as a way to develop better-than-Medicaid provider reimbursement rates for a new Medicaid population and to help reduce the churn (movement of people in and out of eligibility for different programs) typically seen in the Medicaid population, thereby creating opportunities for better continuity of care. Additionally, the state’s marketplace would benefit from the addition of Medicaid-funded participants, potentially doubling the number of covered lives, which potentially could bring in new insurers and increase competition in the Arkansas nongroup health insurance market. As one source explained, Arkansas did not embrace “Obamacare” but rather promoted “private enterprise,” “competition,” and required beneficiaries to have “skin-in-the-game,” while using federal funds to expand coverage.

In early 2013, state officials negotiated with CMS over the basic contours of a private option. Following agreement with CMS on basic principles, the Arkansas legislature adopted the Health Care Independence Act of 2013.¹⁵ The provider and payer communities backed the expansion efforts in Arkansas.

Arkansas’ Private Option

The Arkansas private option includes all newly eligible adults in the expansion population at or below 138 percent of FPL, except those assessed as medically frail or otherwise exempt.¹⁶ Consistent with CMS’ March 2013 guidance, and in order to provide insurers with a favorable risk pool in the marketplace, the state estimated that approximately 10 percent of those eligible for Medicaid expansion would be assessed as medically frail with higher costs of care and be placed in traditional fee-for-service Medicaid.

Private option enrollees are eligible to enroll in silver plans that meet the actuarial value requirements of the program. The state covers both the cost of the premiums and all cost sharing except for the nominal cost sharing described below. All insurers offering plans in the marketplace in Arkansas are required to participate in the Medicaid private option. Beginning in 2015, all insurers must offer at least one silver plan that meets the requirements of the Medicaid private option, and those plans must contain only the essential health benefits included in the state’s essential health benefits benchmark plan for the nongroup market. The state will

reimburse providers at fee-for-service rates for wrap-around benefits not included in the state's marketplace benchmark plan: nonemergency transportation and Early Periodic Screening Diagnosis and Treatment services for individuals participating in the demonstration who are under age 21. Private option beneficiaries "will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area."¹⁷

The Arkansas Marketplace

Competition in the Arkansas marketplace increased between 2014 and 2015, both in terms of insurer participation across the state and price. The three insurers selling QHPs to individuals in the marketplace also offer plans to the Medicaid private option enrollees. On average the cost of the second lowest-cost silver plan in Arkansas dropped 3 percent in 2015.¹⁸ For rating purposes, Arkansas is divided into seven geographic rating regions. In 2014, only Blue Cross Blue Shield plans were sold in all regions; in 2015 all marketplace issuers are selling plans statewide. Traditionally, Blue Cross Blue Shield has dominated the health insurance market in Arkansas with almost a 70–80 percent market share. There are two Blue Cross Blue Shield plans in the marketplace—one is a Multi-State Plan and the other is the Blue Cross Blue Shield of Arkansas plan, but both are comparable. Centene sells plans under the name Ambetter, and QualChoice, which last year was bought out by Catholic Health Initiatives, also participates in the Arkansas marketplace.

Personal Responsibility Requirements in the Arkansas Plan

Under the Arkansas private option, the state Medicaid program pays the premiums and cost-sharing reductions to the insurers. For those in the 100–138 percent of FPL category, enrollees may be charged nominal cost sharing at point of service consistent with prevailing Medicaid rules, subject to an aggregate cap of 5 percent of household income; the program covers the cost of any other cost sharing above what Medicaid normally allows. In 2014, there were no cost-sharing requirements for individuals under 100

percent of FPL. In 2015, the exemption from cost sharing was lowered to those whose income is below 50 percent of FPL, so those between 50 and 100 percent of the FPL are now subject to cost-sharing requirements as well.

The Arkansas Health Care Independence Act of 2013 authorized the imposition of monthly contributions and the creation of individual accounts beginning in 2015, comparing these accounts to "a health savings account or medical savings account."¹⁹ On December 31, 2014, CMS approved Arkansas' request for amendments to the waiver to allow for the creation of the Arkansas Independence Accounts. Under the waiver amendment, and as shown in Table 2, Arkansas may charge enrollees a range of monthly contributions based on their income, subject to a maximum charge of 2 percent of household income:²⁰

The contributions are to be used by enrollees to cover copayments and coinsurance, but those charges are limited and must be "consistent with federal requirements regarding Medicaid cost sharing and with the State's approved state Plan" and listed in Attachment B to CMS' Special Terms and Conditions (STCs).²¹ Those amounts vary depending on income level and type of service, but charges for most services for enrollees at all income levels are capped at \$4/visit.

The payments made into the Independence Accounts are to be administered by a third-party administrator, which is also responsible for issuing debit/credit cards to the enrollees. Pursuant to STC 44, the state also contributes funds to the Independence Accounts to ensure that the individual's copayment and coinsurance obligations are covered, presumably in a case where someone has utilization that exceeds the amounts contributed. Enrollees at or below 100 percent of FPL are given the option whether to make the monthly contributions. If they do not make the monthly contributions, they must still use the debit/credit card to pay copayments and coinsurance owed at point of service, but will be billed by the third-party administrator for those charges. If they fail to pay those charges, they will incur a debt to the state, which the state may seek to collect.

Table 2: Arkansas Health Care Independence Program Monthly Charges for Nonmedically Frail Adults in the Medicaid Expansion Program Approved by CMS as of January 1, 2015

	> 50–100% of FPL	> 100–115% of FPL	> 115–129% of FPL	> 129–138% of FPL
Monthly Contributions	\$5	\$10	\$17.50	\$25

Source: Centers for Medicare and Medicaid Services, Special Terms and Conditions 44—Arkansas Health Care Independence Program (Private Option), Number 11-W-00287/6 (amended January 1, 2015). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar-ar-private-option-ca.pdf> (accessed April 2015).

Enrollees below 100 percent of FPL, however, cannot be denied services if they do not pay those charges at the point of service.

Enrollees above 100–138 percent of FPL will be required to make a contribution to their Independence Accounts and to pay their copayment and coinsurance obligations with the debit/credit cards. If enrollees above 100–138 percent of FPL do not make monthly contributions, they can be denied services if they do not pay the copayments or coinsurance at the point of service.

Even though enrollees are not subject to higher cost sharing than they could have been charged under the Medicaid state plan, the requirement to make a monthly contribution to offset future cost sharing places a burden on enrollees who are not incurring such charges at the time they pay the contributions. Moreover, by creating these accounts, the state has in effect removed the option providers have under Medicaid to waive cost-sharing charges at point of service. The individual's obligation to pay for cost sharing runs to the state, through the third-party administrator, rather than to the provider. For all enrollees, the state will contribute enough funds to ensure that the individual's copayment and coinsurance obligations are covered. For all enrollees who contribute to their Independence Accounts for at least six months in a calendar year (which may be nonconsecutive months), they will also be entitled to certain credits, which may be used to pay for future QHP premium payments, employer-sponsored insurance (ESI), or Medicare premiums if the individual continues to reside in Arkansas and loses eligibility for Medicaid. Individual credits are capped at \$200 over the lifetime of the waiver.

Consumer advocates and critics of the Independence Accounts and cost-sharing requirements say that the cost to manage and administer the program will far outweigh the nominal charges to be collected through the accounts. One report suggested that the cost of managing these accounts would be \$15 million per year.²²

Budget Neutrality

Under HHS policy, Section 1115 waivers must be budget neutral, which means that they may not cost the federal government more than it would have cost to cover the same individuals under traditional Medicaid. The budget neutrality of the Arkansas private option made headlines when the Government Accountability Office released a report saying that the nearly \$4 billion spending limit that HHS approved for Arkansas' private option was approximately \$778 million more than what the spending limit would have been if it was based on the state's actual payment rates for services under the traditional Medicaid program.²³ Arkansas officials had projected that, in order to attract enough

providers in traditional fee-for-service Medicaid to cover the expansion population, provider rates—and average costs per beneficiary—would have increased significantly with a standard expansion. This assumption was critical to the state's budget neutrality analysis.

On the other hand, the state's budget neutrality assumptions did not include savings that might be realized from lower premiums with the increased marketplace competition. Though some of this projected savings would benefit non-Medicaid enrollees, as noted above, in Arkansas the vast majority of QHP enrollees are Medicaid enrollees. State officials projected that an increase in volume of patients in QHPs would lead to greater competition and downward price pressure on provider reimbursement rates, resulting in an across-the-board 5 percent cut in provider reimbursements in the marketplace, which in turn would lower the cost of premiums in QHPs, benefiting both Medicaid and non-Medicaid enrollees in the marketplace and reducing subsidy costs paid by the federal government.²⁴

The Future of the Section 1115 Expansion Waiver in Arkansas

In 2014, Arkansas elected a Republican governor, Asa Hutchinson, who announced that he supports continuation of the private option through 2016, but called for creation of a task force to determine the future of the program in 2017 and beyond, when the state will have to start paying for a portion of the coverage. He said the purpose of the task force is “to find an alternative health coverage model to ensure healthcare services for vulnerable populations currently covered by the Private Option.”²⁵ In Arkansas, a 75 percent vote in both the House and Senate is required every year to pass appropriations bills, which include the State Medicaid budget. The legislature approved continued funding of the private option in February 2015 with more than three-quarters of the legislators' approval.

Iowa Health And Wellness Plan

Iowa's Section 1115 expansion waiver is a hybrid system, placing adults at or below 100 percent of FPL into Medicaid managed care plans operated by Managed Care Organizations (MCOs), while relying on the private option to place adults above 100–138 percent of FPL into QHPs. Iowa sought two separate waivers to implement its new plan: the Iowa Marketplace Choice Plan addresses the private option for nonelderly adults above 100–138 percent of FPL, and the Iowa Wellness Plan covers nonelderly adults who are at or below 100 percent of FPL or who are determined to be “medically frail” and therefore not required to obtain coverage through a QHP. The plan also provides premium assistance to individuals with access to “cost-effective” ESI who are eligible for Medicaid. Iowa

launched the expansion in 2014 and, in 2015, has started to implement personal responsibility provisions, charging premium-like contributions to adults beginning at 50 percent of FPL and providing healthy behavior incentives that enable beneficiaries to obtain a waiver from those payments. Table 3 summarizes key elements of the waiver.

As of March 30, 2015, 31,089 people were enrolled in the Iowa Marketplace Choice Plan and 91,717 were enrolled in the Iowa Wellness Plan, for a total of 122,806 enrollees in Iowa’s expansion programs.²⁶

The Political Context for Expansion in Iowa

Iowa’s Republican Governor, Terry Branstad initially opposed Medicaid expansion.²⁷ But the state’s general assembly is closely divided between Republicans who agreed with the governor and Democrats who supported expansion. In 2013, the Democratic majority in the state Senate approved a standard Medicaid expansion.²⁸ The Republican-led state House of Representatives, approved a partial expansion of Medicaid, but the Senate rejected the House bill.²⁹ The

governor and legislative leaders eventually negotiated an eleventh-hour compromise, resulting in adoption of the Iowa Health and Wellness Plan on the final day of the 2013 legislative session.³⁰

Prior to the Medicaid expansion, Iowa had a Section 1115 waiver called “IowaCare” that provided limited benefits through a limited provider network to adults up to 200 percent of FPL. IowaCare, which covered approximately 68,600 adults in fiscal year 2013, was scheduled to terminate at the end of 2013 and, according to a state fact sheet, was implemented to both expand access to coverage and “provide financial stability for safety net hospitals that have significant amounts of uncompensated care.”³¹ Without some type of Medicaid expansion, thousands of people in Iowa would have lost coverage and Iowa hospitals would have seen a significant increase in uncompensated care. This may explain, in part, why hospitals in Iowa reportedly agreed to a provision in the final legislative compromise that could make Iowa hospitals liable for increased fees to help

Table 3: Summary of Key Provisions in Iowa’s Two Section 1115 Medicaid Expansion Waivers: The Iowa Marketplace Choice Plan and the Iowa Wellness Plan

Policy	Description
Premium Assistance in QHPs	Yes. Applies to nonexempt enrollees above 100–138% FPL who do not have an offer of cost-effective employer-sponsored insurance. Participation of this population in QHPs was to be mandatory, but because there is only one available QHP in Iowa in 2015, enrollees may opt to participate in Medicaid managed care in 2015.
Monthly Premiums or Contributions	Yes. Referred to by CMS as “premiums.” No premiums charged enrollees in their first year in the program. Flat monthly premium of \$10/month for nonexempt enrollees above 100–138% FPL and \$5/month for nonexempt enrollees above 50–100% FPL not to exceed 5% of quarterly aggregate household income. Enrollees are exempt from premium if they self-attest to financial hardship at the time they are invoiced for a monthly payment (must self-attest to financial hardship each time a payment is due).
Cost sharing	The premiums are “in lieu” of other cost sharing, except the state charges a copayment for nonemergency use of the emergency room consistent with the state plan.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	No lockout, but enrollees above 100–138% FPL may be disenrolled for nonpayment of premium; they are allowed to re-enroll without a lockout period, but outstanding payments will be subject to recovery by the state. No one at or below 100% FPL may be disenrolled for failure to pay premiums. All enrollees who fail to make their payments incur a debt to the state.
Health Accounts	No individual accounts are created to hold the enrollees’ premium contributions, but the state keeps track of the amounts paid and amounts owed.
Healthy Behavior Incentives	Yes. Completion of Healthy Behaviors can lead to waiver of premiums for the following year.

Note: Iowa received approval for two separate Section 1115 demonstrations: the Iowa Marketplace Choice Plan applies to individuals above 100–138 percent of FPL; the Iowa Wellness Plan applies to individuals at or below 100 percent of FPL. This table summarizes provisions in both plans.

Sources: Centers for Medicare and Medicaid Services, Special Terms and Conditions, Iowa Marketplace Choice Plan, Number 11-W-00288/5 (amended December 30, 2013). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Market-Place-Choice-Plan/ia-marketplace-choice-plan-stc-01012014-12312016-amended-122013.pdf> (accessed April 2015); Cover Letter and Amended Special Terms and Conditions, Iowa Marketplace Choice Plan, Number 11-W-00288/5 (December 30, 2014). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf> (accessed April 2015); Cover Letter and Amended Special Terms and Conditions, Iowa Wellness Plan, Number 11-W-00289/5 (December 30, 2014). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf> (accessed April 2015); Centers for Medicare and Medicaid Services, “Medicaid and the Affordable Care Act: Premium Assistance.” Washington, DC: March 2013. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (accessed April 2015).

cover a shortfall if the federal government reduces the federal matching rate to below 90 percent in future years.³²

The Private Option in Iowa: The Iowa Marketplace Choice Plan

As approved by CMS in December 2013, the Marketplace Choice Plan authorizes Iowa to require adults at or above 100–138 percent of FPL to participate in QHPs in exchange for the state providing premium assistance and cost-sharing assistance for those plans. Once determined eligible for the program, individuals are given the opportunity to complete a health care needs questionnaire to determine whether they are medically frail. Those assessed as medically frail are placed in the Iowa Wellness Plan’s managed care program. Individuals may opt out of this assessment or, if determined to be medically frail, may choose to select a QHP rather than participate in the MCO program. For individuals who have “cost-effective” ESI, the state may provide premium assistance for that coverage consistent with its state plan.

Under CMS’s initial Special Terms and Conditions, and consistent with CMS’ March 2013 guidance, all participants in the Marketplace Choice Plan were required to have at least two QHPs to select from in their geographic region.³³ Iowa had only two insurers that offered statewide coverage in the federally facilitated marketplace in 2014—Coventry and CoOpportunity Health, a new ACA health insurance cooperative. Both initially participated in the Iowa Marketplace Choice Plan in 2014. But the dominant insurance carrier in the nongroup market in Iowa, Wellmark Blue Cross Blue Shield, did not participate in the federally facilitated marketplace in 2014 or 2015.³⁴ And in September 2014, CoOpportunity Health announced that it was withdrawing from the Marketplace Choice Plan, leaving only one QHP available to beneficiaries in the Marketplace Choice Plan in Iowa.³⁵

The Personal Responsibility Requirements in the Iowa Plan

Both of Iowa’s two Section 1115 expansion waivers contain monthly premium provisions, which go into effect after a beneficiary has been enrolled in the program for 12 consecutive months. Thus the payments did not begin for any beneficiaries until 2015. The payments are made to the state, not to the health plans.

Premium payments. Beneficiaries in the Marketplace Choice Plan who are at or above 100 percent of FPL but not more than 138 percent of FPL are required to make contributions of \$10/month after their first year in the program, subject to a quarterly aggregate cap of 5 percent of household income.³⁶ The contributions may be waived if the individual completes certain healthy behaviors. For

2015, beneficiaries who completed a HRA and a wellness exam in 2014 will be entitled to a waiver from the monthly contributions. Beneficiaries may also seek a financial hardship waiver at the time they receive each invoice and may self-attest to the hardship. Beneficiaries may be disenrolled from the program if they have premiums past due greater than 90 days, but they are allowed to re-enroll and may not be locked out of the program.

Under the Iowa Wellness Plan waiver, beneficiaries between 50 and 100 percent of FPL may be charged a premium of \$5/month subject to the same quarterly aggregate cap of 5 percent of household income, the one-year delay, the healthy behaviors waiver, and self-attestation of financial hardship. Although the failure to pay creates a debt to the state, beneficiaries at or under 100 percent of FPL may not be disenrolled from the program. Medically frail beneficiaries are exempt from the premium payment requirements in Iowa.

Copayments. According to CMS’ Special Terms and Conditions, the document describing the conditions of the Section 1115 waiver, the premium payments are imposed “in lieu of other cost sharing” and enrollees are not liable for cost sharing except for copayments for nonemergency use of the emergency room consistent with Iowa’s approved state plan.

Healthy Behaviors Incentives. All beneficiaries are entitled to a waiver of the premium payment amounts if they complete the Healthy Behaviors incentives. In the first year, this requires completion of a HRA and a wellness exam. In future years, the state may require individuals to take steps to address unhealthy behaviors, consistent with protocols that are approved by CMS.

The Future of the Section 1115 Expansion Waiver in Iowa

The future of the private option is unclear in Iowa, now that consumers do not have a choice of QHPs. Iowa has altered the Marketplace Choice Plan and no longer requires beneficiaries above 100 percent of FPL to enroll in a QHP. Instead, beneficiaries are now permitted to choose between the remaining QHP and the Wellness Plan’s Alternative Benefits Plan; the state will place people automatically in the Wellness Plan if they do not choose the QHP.³⁷ Thus, unlike Arkansas and New Hampshire, enrollment in a QHP is no longer mandatory in Iowa.

Healthy Michigan

Michigan’s Medicaid expansion program, Healthy Michigan, utilizes personal responsibility provisions—premiums, cost sharing and healthy behavior incentives—but does not place beneficiaries into QHPs or other

Table 4: Summary of Key Provisions in Michigan’s Section 1115 Medicaid Expansion Waiver: Healthy Michigan

Policy	Description
Premium Assistance in QHPs	No. Enrollees placed in existing Medicaid managed care plans.
Monthly Premiums or Contributions	Yes. After six months in the program, monthly premiums for nonexempt enrollees above 100–138% FPL up to 2% of annual household income. Paid into the MI Health Accounts.
Cost sharing	Yes. After six months in the program, copayment liability for nonexempt enrollees is billed on a quarterly basis based on actual utilization of services in a prior three-month period. Copayment liability may not exceed amounts allowed under Medicaid rules and state plan with an aggregate cap of 5% of household income. Paid into the MI Health Accounts.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	No, but enrollee incurs debt to the state. Enrollees above 100–138% FPL who do not make a monthly contribution will be required to pay QHP copayments or coinsurance (consistent with Medicaid rules and the state plan) at the point of service in order to receive services.
Health Accounts	Yes. Administered by a third-party administrator.
Healthy Behaviors Incentives	Yes, but copays must reach 2% of enrollee’s income before a reduction in payments will be applied based on healthy behaviors.

Sources: Centers for Medicare and Medicaid Services, Cover Letters and Special Terms and Conditions, Healthy Michigan Section 1115 Demonstration, Number 11-W-00245/5, including technical corrections and attached protocols (August 29, 2014). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/healthy-michigan-ca.pdf> (accessed April 2015).

commercial insurance plans. Michigan places new beneficiaries into existing MCO plans and, according to respondents, never seriously considered using QHPs given the long history of managed care in the state Medicaid program and the large number of MCO providers. Table 4 summarizes key elements of the waiver.

The Political Context for Expansion in Michigan

In February 2013, Republican Governor Rick Snyder announced his support for Medicaid expansion in Michigan.³⁸ Joined by provider organizations and the Michigan Association of Health Plans, the governor made his announcement as part of his 2014 budget recommendation. Both houses of the state legislature have Republican majorities. After several months of negotiations with legislators, the governor signed the bill into law in September 2013.³⁹ Though a “small majority” of Republicans voted against the measure, it passed both houses of the legislature with bipartisan support, but did not start until April 2014.⁴⁰

Medicaid Managed Care in Michigan

As one respondent told us, Michigan had a “sophisticated” Medicaid managed care system before the ACA. The program began in 1996 and included 13 MCOs when expansion began on April 1, 2014. None of the Michigan MCOs provides coverage in every county.⁴¹ Michigan started a separate managed care program for behavioral health services in 1998. These two separate managed care programs are used for the expansion population.

Under the Healthy Michigan program, all beneficiaries are placed in one of the existing MCO plans available in the beneficiary’s county. Enrollment brokers are available to help the beneficiary choose a plan, but beneficiaries are auto-enrolled in plans if they do not exercise that option.

The state did not issue a new Request for Proposals for its MCO plans in 2014; it relied instead on preexisting managed care contracts to serve the expansion population. The state is expected to issue a new Request for Proposals in 2015, and respondents said that they expect the composition of the Michigan MCOs to change when the state awards new managed care contracts.

Enrollment in the Medicaid expansion program began April 1, 2014. As of March 31, 2015, 605,000 people had enrolled in the program.⁴² Despite the influx of so many new patients, informants said that to date there seems to have been sufficient provider capacity. Some concern was expressed in our interviews, however, about whether there are enough behavioral health providers participating in Michigan’s Medicaid program to meet the needs of the new enrollees.

The Personal Responsibility Components of Michigan’s Expansion

Approved by CMS in December 2013 and launched on April 1, 2014, the Healthy Michigan Section 1115 waiver contains the following key elements:⁴³

Premium payments. Beneficiaries between 100 and 138 percent of FPL are subject to monthly premiums not to

exceed 2 percent of their household income. Beneficiaries are not charged for these contributions until they have participated in the program for six months.

Copayments. All beneficiaries are subject to the copayment provisions, but cost sharing is limited to what is already permitted under Medicaid regulations and Michigan's state plan.⁴⁴ Under the plan, providers no longer collect copayments from beneficiaries; instead, the state calculates what the copayment liability would have been based on actual utilization during preceding months. Beneficiaries are billed quarterly for the copayments, and those amounts may not exceed the average monthly copayments incurred during that prior period. Even though these are the same amounts nonexpansion enrollees owe under the state plan, in practice providers may choose to waive the cost-sharing amounts, rather than attempt to collect them; under Michigan's expansion waiver program, the state bills all enrollees for these charges.⁴⁵ Total copayment charges may not exceed 5 percent of a beneficiary's household income; for those who pay premiums (those between 100 and 138 percent of FPL), the copayment liability may not exceed 3 percent of the beneficiary's income plus the 2 percent in premium charges. Beneficiaries are not charged for these contributions until after participating in the program for six months. Although the state initially proposed basing these cost-sharing payments on the prior six month's experience, Michigan's protocols provide that the state will calculate each enrollee's initial copayment experience based on the enrollee's first three months in the program and recalculate the copayment liability quarterly.

Healthy Behaviors Incentives. All beneficiaries are entitled to receive incentive payments to offset their premium and copayment liability by participating in a Healthy Behaviors Incentive Program, which includes an annual examination by a primary care provider and completion of a HRA. Health plans are permitted to create incentives (e.g., paying a set fee for helping a patient complete the HRA) to encourage providers to participate, and the plans are subject to a withholding of a set percentage of their capitation rates by the state contingent on beneficiaries completing the HRAs.

MI (pronounced "my") Health Accounts. MI Health Accounts are the mechanism used to track and collect premiums and cost-sharing payments and to provide credit for meeting healthy behaviors incentives. The accounts are managed by a third-party administrator, Maximus. Cost-sharing amounts collected for those under 100 percent of FPL based on past utilization are transferred to the health plans. Premium payments are paid to a health plan only after the plan pays out a certain amount (first-dollar amount) in provider claims. Premium payments may carry over from one year to the next in a MI Health Account.

If a person leaves the Medicaid program, the amounts remaining may only be used in the form of a voucher to cover the cost of paying the premium for a private health insurance plan. Though the state may not terminate people from coverage or deny them services for failure to pay their premiums and copayments, respondents reported that the state is considering using a tax lien to help enforce these obligations.

Beginning in October 2014, six months after the first group of individuals had enrolled, the first invoices for the premiums and copayment liabilities were sent to beneficiaries. According to an analysis of the population in Healthy Michigan, as of July 15, 2014, only about 16 percent of beneficiaries had incomes above the FPL.⁴⁶ One respondent told us they believed that less than 10 percent of the expansion population was above the FPL. It thus appears that a relatively small percentage of the expansion population will be responsible for the monthly premium contributions, although all enrollees are subject to payment of prior cost-sharing amounts through the average monthly billings.

Several respondents noted that they believed that the administrative costs of monitoring the accounts, generating and distributing the quarterly statements, updating income and claims information, tracking healthy behavior compliance, and handling the payments will cost far more than the money that beneficiaries will ever pay into the system. But proponents of these provisions countered that they reflect a policy goal of requiring Medicaid beneficiaries to have responsibility for at least some portion of their medical costs, to familiarize beneficiaries with elements of private insurance, and to create incentives for healthy behaviors. One state official also emphasized that a key element of Healthy Michigan was to promote important public health goals, such as incentivizing immunizations.

The Future of the Section 1115 Expansion Waiver in Michigan

The authorizing legislation requires the Michigan Department of Community Health, which operates the state's Medicaid program, to submit two different waiver requests to CMS to implement the law. The first waiver request was approved and is discussed above. But the legislation also requires the Department of Community Health to submit an additional waiver request by September 1, 2015 that would require individuals between 100 and 138 percent of FPL who have had medical assistance for 48 "cumulative months" to choose between paying total cost sharing up to 7 percent of income (as compared to a maximum of 5 percent under the approved waiver for both premiums and cost sharing) or go into the marketplace and become eligible for premium

tax credits and cost-sharing reductions. This latter provision goes well beyond the scope of what CMS has approved to date and what may be allowed under federal law.

Governor Snyder's proposal, and the final legislation, also provided a mechanism for Michigan to set aside funds to cover the state's anticipated costs in 2017 and beyond, when the federal government's 100 percent match for the expansion population will be reduced. The set-aside funds are expected to come from the savings the state will realize between 2014 and 2017, because it will no longer incur certain expenditures in pre-ACA state programs that are being replaced by the expansion.

If Michigan does not submit, or CMS does not grant, the state's second waiver request or if the state does not realize the full savings required over the next three years to cover the state's match for the program in 2017 and beyond, it is not clear how the legislature and the governor might respond or what the legal effect on Michigan's expansion might be.

Healthy Pennsylvania

At the end of August 2014, CMS approved Healthy Pennsylvania, Pennsylvania's application for a Section 1115 waiver, under which the state expanded Medicaid effective January 1, 2015 by placing newly eligible beneficiaries into new managed care health plans that would run independently from and parallel to existing MCO plans.⁴⁷ Pennsylvania also received CMS approval to charge monthly premiums to newly eligible beneficiaries above 100–138 percent of FPL beginning in January 2016. CMS, however, did not approve several proposals relating to benefits, contributions, and work requirements.⁴⁸ Moreover, in early 2015, Pennsylvania's newly elected Democratic governor, Tom Wolf, announced that he would phase out the Healthy Pennsylvania program and implement a standard Medicaid expansion before the end of 2015.

In 2013 roughly 1.4 million people, or 13 percent of Pennsylvania's nonelderly adult population, were uninsured.⁴⁹ Medicaid expansion was expected to extend eligibility to an estimated 600,000 people in the state.⁵⁰ Opposed to the ACA but wanting to expand Medicaid, Republican Governor Tom Corbett initially faced significant opposition in the legislature but eventually was able to garner the support needed. He framed the plan as a "private coverage option." Some respondents reported that Pennsylvania initially planned to follow the Arkansas private option model by bringing newly eligible enrollees into the marketplace and potentially increasing market competition among the plans. But the proposal changed

instead to expanding the well-established MCO structure in Pennsylvania and placing the expansion population in a second managed care market in the state that would run parallel to the existing MCO market and be subject to the Medicaid managed care rules. The new MCO plans would offer the same benefits as those offered in the marketplace. This new MCO market was divided into nine geographical regions, similar to those set up for the QHPs on the marketplace.

At the same time, the Corbett administration also sought approval to divide all Medicaid beneficiaries—not just the expansion population—into two groups that would receive different benefits: a high-risk plan for high utilizers, including the medically frail, and a low-risk plan for most enrollees who would either be in the new expansion MCO plans or the traditional MCO plans. The two plan designs had different benefits, with the high-risk plan having more comprehensive benefits than the low-risk plan, but both plans still having less generous benefits compared to what traditional Medicaid offered in the state. Consumer advocates and some providers opposed the two-plan design strategy.

Providers also expressed concern about the provider reimbursement rates in the new MCO market. Providers had anticipated that reimbursement rates in the new managed care market would be closer to QHP marketplace rates, but respondents reported that the provider rates in the new MCO market are closer to what traditional Medicaid pays. This in turn raised concerns about network adequacy because there would be fewer provider contracts with the new plans. Some respondents also expressed concerns over the capacity of the new MCO market to adequately cover mental health services.

Governor Corbett also received a waiver to implement several personal responsibility provisions beginning in 2016. Those approved provisions included (1) charging monthly premiums to nonexempt individuals between 100 and 138 percent of FPL up to 2 percent of household income, (2) waiving cost sharing for enrollees subject to the premium payments except for the state plan amounts for nonemergency use of the emergency department, (3) creating healthy behaviors incentives that could reduce the premium payments owed, and (4) disenrolling people who did not pay their premiums for three consecutive months but enabling them to re-enroll without a waiting period.

Governor Wolf has announced that he will implement a standard Medicaid expansion by the fall of 2015. He is eliminating the high risk/low risk distinction in the Medicaid

Table 5: Summary of Key Provisions in Pennsylvania’s Section 1115 Medicaid Expansion Waiver: Healthy Pennsylvania

(Note that Pennsylvania will implement a standard expansion by the end of 2015.)

Policy	Description
Premium Assistance in QHPs	No. Enrollees were placed in new Medicaid managed care plans in 2015 that were created for the expansion population. Enrollees will be transferred to traditional MCOs by the end of 2015.
Monthly Premiums or Contributions	Yes, but will not be implemented. Beginning in 2016, the state was authorized to charge monthly premiums to nonexempt enrollees above 100–138% FPL up to 2% of annual household income. State could have submitted a premium model proposal for CMS to consider for enrollees with incomes at or below 100% FPL in later years.
Cost sharing	Regular cost sharing under state plan applied in 2015. Cost sharing would have been waived for those paying premiums except for state plan amounts for non-emergency use of the emergency room.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	Never implemented. No lockout, but enrollees above 100–138% FPL could have been disenrolled for nonpayment of premium; they would have been allowed to re-enroll without a lockout period, but outstanding payments would have been subject to recovery by the state.
Health Accounts	No individual accounts were proposed to hold the enrollees’ premium contributions, but the state would have kept track of the amounts paid and amounts owed.
Healthy Behaviors Incentives	Yes, but will not be implemented. Could have reduced premiums owed.

Sources: Centers for Medicare and Medicaid Services, Cover Letter and Special Terms and Conditions, Healthy Pennsylvania Section 1115 Demonstration, Number 11-W-00295/3 August 28, 2014. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf> (accessed April 2015).

program, phasing out the new expansion MCO programs, and will not implement any of the personal responsibility provisions that had been approved for 2016. Table 5 summarizes key elements of the waiver.

Healthy Indiana Plan (HIP) 2.0

Indiana’s Section 1115 expansion waiver, approved by CMS on January 27, 2015, relies primarily on Medicaid managed care plans. It does not place any beneficiaries in QHPs but includes an optional premium assistance program for eligible adults with access to ESI. Indiana’s Section 1115 waiver also has the most significant premium contribution requirements of any approved plan to date, requiring every enrollee—regardless of income—to pay a monthly contribution. Moreover, for the first time, CMS approved a lockout provision; CMS authorized Indiana to lock people above 100–138 percent of FPL out of Medicaid coverage for up to six months after they have been disenrolled for failing to pay their premiums. CMS also authorized the state to eliminate retroactive coverage, a waiver it had not granted previously to any other state seeking a Section 1115 expansion waiver, and acknowledged the state’s plan to implement a voluntary job search and training initiative for beneficiaries, but noted that it was being implemented “outside this demonstration.”⁵¹ Indiana began to enroll people in the expansion program on February 1, 2015. Table 6 summarizes key elements of the waiver.

The Political Context for Expansion in Indiana

In 2008, Indiana began implementing a limited Section 1115 waiver to enroll nonelderly adults in what it called its Healthy Indiana Plan (HIP). HIP, which used a variation on health savings accounts (HSAs), became the basis for Indiana’s August 2014 application to expand Medicaid through a Section 1115 waiver. Indiana has a Republican governor and Republican majorities in both houses of the legislature. Governor Mike Pence announced in 2013 that he would only expand Medicaid if he could do so through HIP. Unlike other states where there were extensive negotiations between legislators and the governor, respondents reported that there was bipartisan support for using HIP as the basis for Indiana’s waiver request, particularly given that the governor would not support a standard Medicaid expansion.

There were extensive negotiations between Pence and CMS over Indiana’s proposed HIP 2.0. Pence estimated that between 334,000 and 598,000 people would be covered under the plan.⁵² According to a state respondent, Indiana launched HIP 2.0 as soon as CMS approved the waiver, transitioning approximately 170,000 enrollees from other Medicaid programs into HIP 2.0 on February 1, 2015. As of early April 2015, approximately 137,000 new applicants had enrolled in HIP 2.0.

Medicaid Managed Care in Indiana

Indiana has used risk-based managed care in some of its Medicaid programs for 20 years. Three MCOs provide

Table 6: Summary of Key Provisions in Indiana’s Section 1115 Medicaid Expansion Waiver: HIP 2.0

Policy	Description
Premium Assistance in QHPs	No. Enrollees placed in existing Medicaid managed care plans, but provider reimbursement rates in the HIP managed care plans are higher than standard Medicaid reimbursement rates.
Monthly Premiums or Contributions	Yes. CMS refers to these as both “premiums” and “monthly contributions” to individual health accounts. All nonexempt enrollees must pay at least \$1/month, regardless of income or 2% of annual household income, whichever is greater.
Cost sharing	No copayments if the enrollee stays current on monthly premiums. Enrollees who remain in the program (see disenrollment/lockout provision below) are responsible for making copayments at the point of service in amounts allowed under Medicaid rules and state plan with an aggregate cap of 5% of quarterly household income. Through Section 1916(f) of the Social Security Act, CMS also granted Indiana approval to charge higher copayments for multiple visits to an emergency room for nonemergency services. Individuals will be charged \$8 for the first nonemergency visit in a 12-month period and \$25 for other nonemergency visits during the same period.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	Yes. Indiana is the only state authorized to disenroll and lock out individuals otherwise eligible for coverage for failure to pay a monthly contribution within 60 days from the first day of the coverage month for which the contribution is owed. Disenrollment and lockout only apply to enrollees above 100–138% FPL. The lockout period is six months. Medically frail enrollees may not be disenrolled.
Health Accounts	Yes. Medicaid Managed Care Organizations are responsible for maintaining these accounts for their HIP 2.0 members and billing and collecting the contributions.
Healthy Behaviors Incentives	HIP 2.0 provides an incentive for enrollees to obtain preventive health services, which would entitle them to a partial reduction in their monthly contributions.

Note: Indiana also was granted a one-year waiver from the Medicaid requirement that it provide retroactive coverage for up to three months prior to the date of an individual’s application if the individual would have been eligible during that time period. This waiver may be renewed, but the state must submit data regarding whether there were gaps in coverage that could be “remediated” by providing retroactive coverage.

Sources: Centers for Medicare and Medicaid Services, Cover Letter and STCs, Healthy Indiana Plan (HIP) 2.0, Number 11-W-00296/5. Approved February 1, 2015 through January 31, 2018. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf> (accessed April 2015).

statewide coverage for HIP 2.0. When the state first implemented HIP in 2008, it required the MCOs to pay physicians at prevailing Medicare rates, a requirement that has continued in HIP 2.0. One respondent reported that because of these higher reimbursement rates, more providers have participated in HIP than in other Medicaid programs. As of April 2015, several hundred new providers had reportedly enrolled in HIP 2.0 since its launch.

Personal Responsibility Components of Indiana’s Expansion

Indiana’s waiver has a complicated set of requirements affecting different populations within the newly eligible population. The contribution requirements are built around Personal Wellness and Responsibility (POWER) accounts, which were an integral part of HIP 1.0 and are modeled after HSAs. They are also designed to incentivize people to make their monthly payments by providing a more generous benefits package (called “HIP Plus”), which includes dental and vision coverage, for those who stay current on their monthly payments. These additional benefits are not required benefits for adults eligible for Medicaid expansion

under the ACA. Although CMS’ approval refers to these payments as “premiums,” a state respondent emphasized that state officials refer to them as monthly “contributions” analogous to monthly payments into a HSA.

Premium payments/contributions. As was true in other Section 1115 waiver approvals, CMS has distinguished between individuals at or below the poverty level and those above 100–138 percent of FPL. But unlike the other waivers, CMS authorized Indiana to charge premiums for those below 50 percent of FPL. All beneficiaries are required to pay 2 percent of household income or \$1/month, whichever is greater. Thus all enrollees—regardless of income—must pay at least \$1/month. Enrollees who pay these amounts will be eligible for HIP Plus.⁵³

Premiums are based on the beneficiary’s household income, as determined at the time of the initial enrollment or annual redetermination. Each beneficiary has his or her own account, but the total contributions within a household cannot exceed 2 percent of the household’s monthly income. The beneficiary’s MCO is responsible for billing and collecting the contribution; monthly invoices must state

how beneficiaries should report a change in income and the consequences of failing to pay the premium.⁵⁴

In general, beneficiaries above 100–138 percent of FPL who fail to make their monthly premium contributions within a 60-day grace period will be disenrolled and locked out of the program for six months. The MCO is required to provide at least two written notices to the beneficiary regarding the amount owed and when it must be paid to avoid disenrollment. The notices must also set forth the option to request a screening for medical frailty (which exempts individuals from the disenrollment penalty) and the beneficiary's appeal rights.

Adults whose incomes are at or below 100 percent of FPL will be enrolled in HIP Basic if they do not pay their monthly premiums within the 60-day grace period. The HIP Basic plan provides all mandatory Essential Health Benefits but does not include vision or dental benefits. Individuals at or below 100 percent of FPL may not be disenrolled or locked out of HIP 2.0 for failure to pay their premiums or the copayments described below.

Copayments. CMS has authorized Indiana to test a graduated copayment for nonemergent use of the emergency room. Following an \$8 charge for the first nonemergency visit to the ER, the state is authorized to charge up to \$25 for recurring nonemergency visits in a 12-month period.

Except for this copayment for nonemergency use of the emergency room, HIP 2.0 exempts beneficiaries from copayments if they pay their monthly premiums into their POWER accounts. Only HIP Basic enrollees are subject to these other copayments. Beneficiaries at or below 100 percent of FPL who do not pay their monthly premiums will be enrolled in HIP Basic and charged copayments at point of service consistent with Medicaid regulations, subject to a 5 percent monthly or quarterly aggregate cap, including a \$4 copayment for a doctor's visit and \$75 for a hospitalization.⁵⁵ HIP Plus enrollees above 100–138% of FPL who do not pay their premiums will be disenrolled rather than transferred to HIP Basic.⁵⁶

POWER Accounts. According to CMS' Special Terms and Conditions, "[t]he POWER account is styled like a health savings account arrangement under a consumer-directed health plan."⁵⁷ The POWER account funds will cover the first \$2,500 in claims for each beneficiary in a Medicaid managed care plan; the remaining claims will be covered through capitation rates or other payments made by the state to the MCO. Preventive services are not charged to the POWER accounts.

The state will fund the POWER accounts on an annual basis in an amount equal to the difference between the beneficiary's required contribution and \$2,500. The MCO is responsible for fully reimbursing the providers up to the full \$2,500 regardless of the beneficiary's current balance. If an enrollee has any of his or her own contributed funds left in the account at the end of the year, those funds will be rolled over and will reduce the enrollee's liability for the next year; the rollover amount will be doubled if the enrollee obtains "age and gender appropriate preventive services." This is the only healthy behavior incentive in HIP 2.0.

If an individual loses eligibility for HIP 2.0 or leaves the program and there are leftover funds that the enrollee contributed, following payment of any remaining debt to the MCO, the enrollee may receive a refund from the state. The amount of the refund is determined based on the individual's pro rata share of the total amount remaining in the account. Unlike other states, Indiana refunds the contributions to the enrollee rather than requiring the funds to be used for other health coverage programs. This is consistent with the state's position that these payments are not premiums.

The New Hampshire Health Protection Program

On March 4, 2015, CMS approved New Hampshire's Section 1115 waiver to provide premium assistance to enroll eligible adults into QHPs.⁵⁸ New Hampshire estimates that approximately 45,000 low-income adults will be placed in QHPs under the program.⁵⁹ New Hampshire has used a three-step approach to implement its plan: (1) a mandatory Health Insurance Premium Payment Program for individuals with access to cost-effective ESI, including the payment of enrollees' cost-sharing charges; (2) a bridge program to cover the new adult group in MCO plans beginning August 2014 through December 31, 2015, which did not require a Section 1115 waiver; and (3) a mandatory QHP premium assistance program that will begin on January 1, 2016, which will also include payments by the Medicaid program to the QHPs to cover the cost-sharing reductions for enrollees.

Under New Hampshire's waiver, newly eligible beneficiaries above 100–138 percent of FPL will be responsible only for cost sharing that is already permitted under Medicaid law; those at or under 100 percent of FPL will have no cost sharing obligations. Except for standard Medicaid cost sharing for those between 100 and 138 percent of FPL, New Hampshire did not include any mandatory premiums, contributions, health accounts, or healthy behaviors incentives in its proposal. As is true for other cost sharing plans approved by CMS, cost sharing will be capped at 5 percent of quarterly household income. Enrollees will have no deductibles, and premiums and other cost-sharing

Table 7: Summary of Key Provisions in New Hampshire’s Section 1115 Medicaid Expansion Waiver: The New Hampshire Health Protection Program

Policy	Description
Premium Assistance in QHPs	Yes. Mandatory for all nonexempt enrollees at all income levels beginning in 2016.
Monthly Premiums or Contributions	No.
Cost sharing	Cost sharing (copayments and coinsurance) is limited to allowable amounts under Medicaid rules and the state plan.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	N/A
Health Accounts	N/A
Healthy Behaviors Incentives	No

Note: New Hampshire may submit data to CMS to establish that there is “seamless coverage” that does not result in coverage gaps for individuals eligible for the program in the period before they file their Medicaid application. CMS will review the data and may grant New Hampshire a waiver of the Medicaid requirement that it must provide retroactive coverage for up to three months prior to the date of an individual’s application if the individual would have been eligible during that time period.

Sources: Centers for Medicare and Medicaid Services, Special Terms and Conditions, New Hampshire Health Protection Program Premium Assistance, Number 11-W-00298/1. March 4, 2015. http://www.dhhs.state.nh.us/pap-1115-waiver/documents/pa_termsandconditions.pdf (accessed April 2015); Centers for Medicare and Medicaid Services, “Medicaid and the Affordable Care Act: Premium Assistance.” Washington, DC: March 2013. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (accessed April 2015).

expenses will be paid by the state. Table 7 summarizes key elements of the waiver.

The Political Context for Expansion in New Hampshire

New Hampshire had several key goals in designing its expansion through this three-step process. First and foremost, New Hampshire needed a bipartisan plan in order to adopt the Medicaid expansion. Although New Hampshire’s governor and house of representatives were Democratic, the Republican-controlled Senate objected to a traditional Medicaid expansion. According to respondents, utilizing a private option made expansion politically feasible in New Hampshire. A bipartisan bill was passed and signed into law in March 2014.⁶⁰

Second, New Hampshire wanted to take advantage of the 100 percent federal funding available until 2016. The first phase of the Medicaid expansion plan allowed New Hampshire to expand quickly without a Section 1115 waiver. Moreover, because there was only one carrier in the New Hampshire marketplace in 2014, there would have been only one option for Medicaid beneficiaries if New Hampshire initially expanded using QHPs rather than MCOs. In light of CMS’ March 2013 guidelines stating that Medicaid beneficiaries must have a choice of at least two plans, it was unlikely that CMS would have approved the private option in New Hampshire with only one carrier in the marketplace. By using the bridge program, New Hampshire was able to expand quickly using MCOs and give the marketplace more time to have multiple insurers participate in time for Medicaid beneficiaries to enroll in QHPs. Coverage for the

new adult group became effective on August 15, 2014 and as of March 17, 2015, 37,009 people had enrolled.⁶¹

Third, the second phase of the program will allow New Hampshire to implement a private option by requiring most beneficiaries to participate in QHPs in exchange for the Medicaid program providing premium and cost-sharing assistance. The state’s Section 1115 waiver application states that it seeks to attract more insurers to the marketplace and thereby increase competition. Under state law, if CMS had not approved the private option by March 31, 2015, the bridge program would have terminated effective June 30, 2015.⁶²

New Hampshire’s Private Option

In the first phase of New Hampshire’s Medicaid expansion, New Hampshire has used its existing Health Insurance Premium Payment Program to cover newly eligible adults through employer-sponsored coverage. If an employer-sponsored plan is available and is deemed to be cost-effective, the state will pay the enrollee’s portion of the premium and cost-sharing expenses.

Eligible individuals who do not have an offer of cost-effective health insurance through their employer have been enrolled in an existing MCO plan (or in a QHP on a voluntary basis if cost effective) through the newly created bridge program. Under the waiver, when the state implements the private option in 2016, the state plans to promote continuity of coverage and care by automatically enrolling individuals who are in MCO plans into comparable QHPs offered by the same MCOs if such plans are available; beneficiaries

will have the option to select an alternative plan during the enrollment period.⁶³ People will be allowed to select from at least two silver QHPs, and if they do not select one, they will be auto-assigned to one. For new applicants, the state will provide fee-for-service coverage until the individual can be enrolled in a QHP. New Hampshire's STCs provided that "[t]he QHPs available for selection by the beneficiary will be determined by the Medicaid agency."⁶⁴

New Hampshire will provide wrap-around benefits through fee-for-service Medicaid that are not covered by QHPs, including nonemergency transportation, Early Periodic Screening Diagnosis and Treatment services for those under age 21 and what STC 36 describes as "certain limited adult dental and adult vision services." New Hampshire sought a waiver from the requirement that it provide retroactive coverage to applicants. While not rejecting the request, CMS established several requirements before waiver of retroactive coverage will be permitted. CMS is requiring the state to submit data "to establish that there is seamless coverage that does not result in gaps in coverage prior to the time that a Medicaid application is filed" and to describe its renewal process and related data to determine whether individuals are losing coverage at the time of renewal.⁶⁵ Only if and when CMS determines that there is sufficient data to establish that retroactive coverage prior to the date of the application is not necessary to fill gaps in coverage, will New Hampshire be allowed to provide coverage beginning at the date of application.

As approved by CMS, New Hampshire's goals for the Section 1115 expansion waiver include 1) reducing coverage disruptions and promoting continuity of care, 2) having wider provider networks and higher provider payment rates, and 3) lowering costs through increased competition in the marketplace. There already may be signs of the latter. Four new insurers entered the New Hampshire marketplace in 2015. In 2014, only Anthem Blue Cross Blue Shield offered plans on the marketplace, however in 2015, Anthem was joined by Assurant, Harvard Pilgrim, Minuteman, and Community Health Options. Assurant is a large national commercial carrier, Harvard Pilgrim is a regional carrier, and Minuteman and Community Health Options are co-ops entering from neighboring states

(Massachusetts and Maine respectively). The substantial increase in insurer participation is likely one of the driving forces behind the 17.5 percent drop in the premium of the second lowest cost silver plan between 2014 and 2015.⁶⁶ For the 2015 plan year, Minuteman displaced Anthem as the lowest- and second lowest-cost silver plans. Respondents reported that they believed that the Medicaid private option (which passed in March 2014) was a major reason for this increased competition in the New Hampshire marketplace.

The Future of the Section 1115 Expansion Waiver in New Hampshire

New Hampshire's private option is valid for 2016 with the possibility of two additional years, contingent on the legislature's support. The expansion is contingent on 100 percent federal funding and will expire on December 31, 2016 or earlier if the federal government does not keep its commitment to finance 100 percent of the cost of expansion through the end of 2016.⁶⁷ The program will have to be reauthorized by the state legislature when the state begins paying for a portion of the costs.⁶⁸ Following the 2014 election, the New Hampshire House of Representatives shifted from Democrat to Republican, which could have an impact on implementation of the program in 2016 and renewal of the plan in later years.

Other States Are Considering Expansion Alternatives

Several other states have also been looking at alternatives to a standard Medicaid expansion. Under Montana's legislation, all nonexempt enrollees would be charged 2 percent of household income and individuals above 100 to 138 percent of FPL would be disenrolled from the program and locked out for a period of time for nonpayment of premiums. By early March 2015, the legislatures in Tennessee, Wyoming, and Utah had rejected their governors' call for a Medicaid expansion waiver, but the proposals they and other states have considered are informative. Both Tennessee and Wyoming were considering utilizing HSAs as a means for instituting personal responsibility.⁶⁹ Tennessee and Utah were both looking at using healthy behaviors incentives and premiums, but only Tennessee was looking at using lockouts, at least before CMS approved the Indiana lockout provision.⁷⁰

DISCUSSION

Several states have proposed policy changes to traditional Medicaid in an effort to expand the program, add coverage, and bring in federal dollars in ways that are acceptable to state political leaders. Respondents in all six states

reported that a standard expansion would not have been approved in their states. In general, many leaders in the states that have debated these alternatives have a strong aversion to traditional Medicaid, and tend to support placing

stronger requirements on beneficiaries of public programs in general. The Medicaid expansion debate has created an opportunity for public officials in those states to advocate for policies that reflect those broader philosophic views, such as imposing work requirements on enrollees. The proposed alternatives include placing people in private insurance plans through the marketplaces (in QHPs). This has been attractive because it places enrollees in private health insurance plans instead of government administered fee-for-service plans or managed care plans that are subject to significant governmental oversight—including contractual obligations placed on the MCOs by state Medicaid agencies. According to some respondents, QHPs differ from Medicaid fee-for-service programs or existing Medicaid managed care programs in the minds of many legislators.

In addition, proposed alternatives include a range of personal responsibility provisions such as imposing monthly premiums, requiring premium-like monthly contributions to cover either past or anticipated future cost-sharing expenses, using variations on the model of health savings accounts used in high-deductible ESI plans, and providing incentives for healthy behaviors. This new set of policy prescriptions raises a number of questions about how well they can promote the goals of the Medicaid program. CMS has responded to these waiver applications by placing restrictions on what states can do and has rejected some proposals, such as tying benefits to work-related requirements. However, CMS seems to be growing increasingly receptive to certain state requests, as shown by the recent approval of the Indiana waiver, for example, which includes a lockout period for nonpayment of premiums, elimination of retroactive coverage, and charging premiums to people below 50 percent of FPL. The benefit of CMS flexibility is the expansion of coverage to many more Americans than would have had it if their states refused to participate in the Medicaid expansion. However, it remains to be seen whether these newly designed programs will significantly inhibit participation and/or access to care relative to more traditional approaches to Medicaid eligibility expansion.

Premium Assistance for QHPs

Arkansas led the way in using premium assistance to place its entire expansion population—except the medically frail and other exempt populations—into QHPs within its marketplace; New Hampshire will do the same in 2016. Iowa used premium assistance to place nonexempt enrollees in QHPs but on a more limited basis (for those at 100–138 percent of FPL) and has run into challenges providing consumers with choices among QHPs. Michigan, Indiana, Iowa (for those below 100 percent of FPL), and Pennsylvania enrolled individuals in Medicaid managed care plans. Placing individuals in QHPs within exchanges seems

to have a number of advantages, but whether it makes sense for a state depends largely on that state's current Medicaid managed care program and its QHP market. It also depends on whether states can effectively provide access to wrap-around services and to safety net providers for enrollees in QHPs, and whether they can adequately identify the medically frail. Finally, some respondents from Arkansas emphasized how complex it was to implement the private option and coordinate with the marketplace and participating health plans, noting that states seeking to implement a private option may have to invest considerable time and resources into making it work effectively for Medicaid enrollees.

Medicaid managed care is a precursor to QHPs in the sense that individuals were placed into managed care plans run by private entities. Sometimes these were commercial insurance plans; in other cases they were national Medicaid managed care organizations, and still others were local plans begun and operated by safety net facilities. If the state has a robust managed care program that is well designed, with strong provider networks and good access to care, it may make sense to place the expansion population in Medicaid managed care rather than in QHPs. A major advantage of well-run Medicaid managed care plans is that they have experience with Medicaid populations and the complexity of the benefits package. Providing full benefits is less complicated because there is no need to cover wrap-around services; they are already part of the Medicaid managed care benefits package.

Critics of the private option contend that it will cost significantly more than traditional Medicaid, add complexity for enrollees accessing wrap-around benefits required under Medicaid but not included in the QHP benefits packages, and take away the ability to hold managed care plans accountable for delivery of benefits and adherence to Medicaid requirements under the obligations of the MCO contracts. Concerns have also been raised regarding whether enrollees will have adequate access to safety net providers in QHPs and how effectively states will implement the medical frailty screens that divert less healthy individuals into traditional Medicaid. Finally, some respondents have raised concerns that moving the relatively healthier portion of the Medicaid population into QHPs might make it even harder to attract providers to serve those Medicaid enrollees with more complex health care needs who remain in the traditional Medicaid program.

QHPs offer a number of potential advantages. The use of QHPs could reduce the problems associated with churn; when individuals have income changes, they may not have to change insurance plans. All three states that adopted the

private option identified reduction of churn and increased continuity of care during coverage transitions between Medicaid and eligibility for subsidies in the marketplace as a major goal of their programs.⁷¹

Proponents of the private option also contend that individuals would more or less be in the mainstream of health insurance coverage in the country by enrolling in a private health insurance plan, without the stigma—rightly or wrongly—sometimes attached to Medicaid. Providers are also likely to be better paid and participate at higher rates in QHPs than in traditional Medicaid or Medicaid managed care plans. Provider participation, of course, can vary among plans and may depend on the breadth of networks in the QHPs. Some are relatively narrow networks paying Medicaid-like rates, in which case there may be less of an advantage. But in many states where the insurance market is heavily dominated by single insurers, typically a Blue Cross plan, placing the Medicaid expansion population in QHPs could make these markets more competitive.

Finally, proponents also contend that placing the expansion population into QHPs will increase competition in the marketplace and thereby lower premiums. In Arkansas, insurers offered plans in more regions in 2015, increasing competition in most areas of the state. New Hampshire has seen several new entrants to its marketplace since it launched plans to implement a private option Medicaid expansion, though it is not completely clear whether new insurers entered the marketplace because of the anticipated expansion. If a number of insurers enter and the marketplace is larger than expected, this should increase competition and lower premiums. This increase will provide benefits for a broader population within these states, not just Medicaid enrollees. There will be more choice, more price competition, and lower premiums, which will result in lower subsidy costs to the federal government and lower prices to marketplace enrollees who are not eligible for federal subsidies.

CMS has required states adopting premium assistance for QHPs to incorporate the cost-sharing limitations from standard Medicaid; all other cost sharing is covered by the Medicaid program.⁷² On balance, moving the Medicaid expansion population into QHPs in many states seems to offer considerable promise. Setting aside the role of personal responsibility provisions and assuming that enrollees continue to receive the wrap-around benefits that would otherwise be available to them in a standard expansion, the key questions are whether placing the Medicaid population in QHPs really stimulates more competition and constrains marketplace premiums, whether network providers are paid more than in Medicaid, whether provider networks are adequate, and whether coverage

gaps are reduced when people transition between eligibility for Medicaid and eligibility for marketplace subsidies.

Premiums and Cost Sharing

Several states have adopted premiums up to 2 percent of income for those between 100 and 138 percent of FPL. These charges are expected to offset costs somewhat, but more important to proponents is their contention that monthly contributions will increase enrollees' responsibility for their health coverage and familiarize enrollees with private insurance models. Some states are also turning standard Medicaid copayment obligations into premium-like monthly contributions and extending these "contributions" to individuals below the poverty level. In Indiana, even individuals with zero income are expected to pay \$1/ month, although CMS has not permitted any state to disenroll or lock out anyone at or under FPL for failure to make any of these payments.

As reflected in the premiums charged in the CHIP program, there has been bipartisan support for some of these provisions in the past. But they raise a number of questions. Most moderate- and high-income Americans are used to paying premiums, as well as cost sharing, in their insurance plans. But the Medicaid expansion population has much lower incomes. Whether these standard provisions of private insurance should be applicable to such populations is questionable. Even 2 percent of income at these levels is considerable and, based on earlier research, charging such amounts is highly likely to result in lower enrollment or higher rates of disenrollment. Budgetary savings are unlikely to be significant because these premiums and contributions are still small relative to health care costs, but savings could be more significant if these payment requirements deter people from enrolling or using necessary care. Deterring enrollment seems inconsistent with the goals of a Section 1115 waiver and with the ACA.

There is plenty of evidence that suggests that low-income individuals are highly sensitive to premiums when enrolling in programs.⁷³ Ku et al. found that participation rates in Medicaid were 67 percent with zero premiums, but fell to 57 percent with premiums equal to 1 percent of income, and 45 percent with premiums at 2 percent of income.⁷⁴ Kenney et al. found that higher premiums reduced enrollment of a CHIP population and had greater effects the lower the family income.⁷⁵ Prior to the ACA, Oregon increased premiums on the population of childless adults below FPL from \$6 to \$20/month. The result was a 50 percent reduction in enrollment. Researchers found that premiums disproportionately affected low-income individuals and that individuals with health problems were more likely to enroll.⁷⁶ Abdus et al. used the Medical

Expenditure Panel Survey⁷⁷ to estimate the impact of premiums on CHIP. They found that a \$10 monthly premium for those above 150 percent of FPL resulted in a 1.6 percentage point reduction in enrollment, while a \$10 monthly premium on those between 101 and 150 percent of FPL resulted in a 6.7 percentage point reduction in enrollment.⁷⁸

Though the impact of premiums varies in these studies, they clearly indicate that premiums would lead to lower enrollment, although how much is uncertain. For example, some states disenroll individuals for not paying premiums, but then allow them to re-enroll. In Indiana, there is a six-month lockout period. The use of premiums at very low income levels that may have serious effects on enrollment outcomes seems inconsistent with the purposes of the Medicaid program and the goal of the ACA, which is to expand enrollment.

Individual Health Accounts

One popular element of the personal responsibility initiatives is to introduce some form of personal account that proponents often compare to HSAs. These were initially introduced in Michigan, were added more recently in Arkansas, and are most prominent now in Indiana, building on an existing program there. HSAs have become popular for high-income individuals with high deductible insurance plans. In the case of the higher-income population, on top of an insurance plan with a high deductible, individuals are allowed to set up a HSA, typically with an employer contribution. Both employer and employee contributions are made pre-tax, and are thus more valuable the higher one's marginal tax bracket. As individuals build up funds in these accounts, they can be used to pay for services, including those subject to the deductible.

Health savings accounts are designed to equalize the tax treatment of out-of-pocket contributions and premiums, allowing unused portions of the savings accounts to increase tax free. The theory is that individuals have a strong incentive to use the funds in their accounts judiciously because the funds could be carried over and used for health services when needed in the future. The approach is intended to encourage people to be careful users of services and reduce unnecessary utilization. There is some evidence that high deductible plans may contribute to lower rates of growth in health spending.⁷⁹ The effect of the HSA feature, however, is less clear.

The accounts being implemented in the Medicaid context in these states are intended as variations on HSAs, applied to low-income populations. In the typical plan, individuals would make contributions to the accounts instead of

making premium payments to the insurer or copayments to providers. In one case (Michigan), after an enrollee has been in the plan for six months, the state calculates the monthly contribution amount based on actual copayments that enrollee would have been charged for his or her utilization of services in the initial three months in the program, and charges the enrollee that amount payable over three months; these amounts are recalculated quarterly. In other cases (Arkansas, Iowa, and Indiana), contributions are set independently of actual utilization; instead enrollees pay a monthly flat rate based on income. Typically, these payments are made in lieu of copayments at the point of service. Because CMS has only allowed states to charge enrollees the nominal copayments allowed under existing Medicaid rules, low utilizers of health care services will slowly accumulate funds in their accounts.

The incentives in these kinds of accounts for low-income populations are quite different than those that apply to higher-income populations with HSAs. Except for Michigan, individuals make contributions to their accounts regardless of their use of services. The incentives to use services more carefully is already in place through allowable Medicaid copayments. These copayments have led to reduced utilization,⁸⁰ including that of essential as well as arguably unnecessary services, but now the incentives for individuals change from paying a price when they use services to having, as many respondents noted, "skin in the game" in the form of a monthly payment that is charged regardless of utilization of services. These monthly payments are more like premiums than the out-of-pocket costs for which higher-income people use their HSA balances.

If the purpose of these accounts is to reduce unnecessary utilization, traditional Medicaid copayments already create such incentives. It would seem that replacing copayments at point of service with regular monthly contributions would tend to reduce those incentives. Individuals' balances will accumulate over time, very slowly since the payments are small, and the size of the balances will depend on how much health services are used. In most states, individual contributions to the accounts would be used to cover enrollees' copayment requirements; the remainder of the provider payment would be paid by Medicaid. In Indiana, the individual's contribution is combined with the significantly larger contribution by the state and paid out like a deductible to cover claims. In both types of systems, individuals could also have savings simply because they are healthy. In this case they get a financial benefit essentially because of good luck. Balances that remain can generally be used if individuals leave Medicaid to cover premiums in ESI or Medicare. In Indiana, individuals may receive refunds for their pro-rata share of unused balances (essentially the remaining share of

their own contributions) after they leave the program. For this population, however, these are probably very weak incentives to reduce unnecessary utilization.

In addition to likely being a weak deterrent to unnecessary use of services, HSAs for the poor are highly likely to be administratively inefficient. The amounts collected from individuals would be small relative to health care costs. Because there are large numbers of individuals in these programs, there would be a relatively large number of small monthly transactions. Similarly, the money that flows out of these accounts, also small amounts each time a service is used, would have to be managed. Several respondents indicated that the administrative costs will likely far exceed the benefits in terms of fees collected and lower utilization. But some proponents contend there are benefits merely from having enrollees manage HSAs—because it familiarizes them with private insurance models, including the requirement to contribute to the costs of obtaining care. The utilization effects would have to be very large to offset the higher administrative costs. Although these payments may lead to lower enrollment rates and more disenrollment, it is unlikely they will lead to more appropriate use of care by enrollees.

Healthy Behaviors Incentives

Some states have also used premiums, cost sharing and individual health accounts to create incentives for enrollees to engage in healthy behaviors. States usually offer to reduce or eliminate premiums or cost sharing or both if individuals engage in healthy behaviors. Typically, in the first year, these incentives involve having a wellness exam and completing a HRA, but in the future could eventually include other features as well, such as incentives for receiving immunizations. Low-income populations have higher rates of obesity, smoking, and substance abuse than the general population,⁸¹ so in principle, encouraging healthy

behaviors may be a positive. But the evidence for the effectiveness of such wellness programs is not clear cut.⁸² A complete physical exam is expensive and could lead to more utilization of services in the short run, though possibly improving health and reducing utilization in the long run.

For wellness programs to work, they must change habits (e.g., encourage individuals to stop smoking, reduce weight, reduce or eliminate alcohol consumption or drug abuse, and increase physical fitness). Whether merely having a physical exam can change personal behavior is a large unknown. The ACA authorized \$100 million for the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) program “to test the effectiveness of providing incentives directly to Medicaid beneficiaries of all ages who participate in MIPCD prevention programs, and change their health risks and outcomes by adopting healthy behaviors.”⁸³ These programs may provide evidence regarding the effectiveness of particular strategies to meet specific prevention goals such as weight loss and tobacco cessation.

If individuals do not change health habits or do not comply with wellness programs, then these Section 1115 healthy behaviors programs will be ineffective and costly. Depending on how they are structured, they also could punish people who have certain medical conditions. On the other hand, if healthy behaviors incentives were to encourage people to participate in fully covered programs that have been proven effective, it might be worth the cost of experimentation. If states make serious investments in the design of these programs and, as a result, individuals make essential lifestyle changes, their health status will likely improve and long-term Medicaid expenditures could be lower, thereby promoting Medicaid’s goals. But there is currently no convincing empirical evidence that wellness programs will have this effect.

CONCLUSION

The bottom line is that some state initiatives under Section 1115 may be effective, while others are unlikely to achieve their stated objectives. But regardless of their ultimate effectiveness, all of them have extended health coverage to large numbers of people, which appears to be the rationale behind CMS’s approval of these approaches.

Moving people into QHPs appears to be worth the experimentation; doing so could improve access and stimulate private insurance markets in the states that adopt QHPs, but these plans will likely be more expensive than traditional Medicaid.

The premium contribution policies will likely reduce enrollment. This is also true of policies that turn copayments into premium-like monthly contributions. And the same result is even more likely when, as in Indiana, the state is permitted to implement a lockout—but there will likely be a deterrent effect in any case. The administrative and financial challenge of making monthly payments or having to re-enroll if dropped from the program creates more barriers for eligible individuals.

Using HSA principles in Medicaid seems dubious as well. Health savings accounts have high administrative costs and

will probably eliminate any deterrent effect on utilization that arises from charging copayments at point of service under standard Medicaid. The attraction of HSAs for the privately insured are the associated tax advantages, and no such advantages apply to the low-income population. Whether incentives for healthy behaviors will be effective is currently unknown, but might be worth some experimentation, for example, if tied to counseling and other programs that have been determined effective, such as in helping people lose weight or cease tobacco use.

The reality is that Medicaid is not a high-cost program when enrollees' health status is taken into account, as shown by Hadley et al. and Coughlin et al.,⁸⁴ and as reflected in CBO budget projections that score Medicaid expansions to be considerably less costly than private expansions.⁸⁵ Adopting policies that will reduce enrollment, may impede access to particular services, or add to costs appears to be inconsistent with Medicaid's goals and with the purpose of Section 1115 demonstration waivers, although the trade-off is getting states to adopt the coverage expansion.

All of the policy options discussed in this paper have been part of one or more of the Section 1115 waivers approved by CMS for the Medicaid expansion population in the six states we have covered. These waivers require an ongoing evaluation by the states and review by CMS to determine whether they will meet their stated objectives.⁸⁶ Key questions that result from our review that should be considered in an evaluation are as follows:

First, with respect to placing Medicaid expansion enrollees in QHPs, the questions are these: Will use of QHPs be budget neutral for federal and state Medicaid budgets? Will there be other savings to the federal government because of lower subsidy costs for non-Medicaid enrollees in those states' QHPs? Will access to providers under QHPs be the same, better, or worse than access through a standard Medicaid expansion? Will beneficiaries have better access to specialists? Will they have the same or better access to safety net hospitals and other safety net providers? Will individuals with serious medical conditions be properly identified as medically frail? Even if not the goal of a Section 1115 waiver, will putting the Medicaid expansion population

in QHPs stimulate the marketplace, providing spillover benefits to individuals not eligible for Medicaid but eligible for subsidies, and to individuals above 400 percent of FPL who would benefit from lower premiums?

The second set of questions relates to premiums and other monthly contribution requirements: What is the impact of these contributions on enrollment and disenrollment? If enrollment is lower, what are the characteristics of those who do not enroll that otherwise would have enrolled? Who are the beneficiaries most likely to disenroll? Do healthier people tend to stay out of the program until they need health care services? What are the cost implications of covering those individuals who remain in Medicaid compared to the savings that states might have expected from charging premiums or other monthly contributions?

Third, in HSA proposals: What are the administrative costs relative to the expected benefits, however defined? How difficult is it for individuals and providers to interact with an HSA-like system? What are the effects on utilization of eliminating copayments at point of service and using savings accounts to cover those costs? Has utilization increased or decreased? Are these changes positive or negative relative to imposition of copayments? What services appear to be affected?

Fourth, with respect to health behaviors, how do states move beyond basic physical exams to design programs that achieve the goals of healthy lifestyles? What program designs are effective in reducing smoking, obesity, and substance abuse? Do healthy behaviors incentives in Medicaid change people's behaviors or improve health outcomes? Do any of these programs have punitive (cost-increasing) effects for those with health problems or who are logistically challenged in participating?

Finally, in all these areas, what lessons do these programs, if any, offer other states? To answer that overarching question, public transparency in the implementation and evaluation of these programs will be essential.

ENDNOTES

1. Throughout this paper we refer to the upper limit for coverage under the ACA's Medicaid expansion as 138 percent of FPL. Although the ACA set 133 percent of FPL as the upper limit for expansion, it also authorized a 5 percent across-the-board income disregard, thus setting the maximum effective coverage at 138 percent of FPL. States in this study used 133 percent or 138 percent of FPL to describe some of their proposals; for consistency we use 138 percent of FPL.
2. Rudowitz, R, Artiga, S and Musumeci, M, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. November 2014. <http://files.kff.org/attachment/the-aca-and-recent-section-1115-medicaid-demonstration-issue-brief> (accessed April 2015).
3. Kenney, G, Dubay, L, Zuckerman, S and Huntress, M, "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid." Washington, DC: Urban Institute. July 2012. <http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf> (accessed April 2015). See also Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," Table 1. Washington, DC: Congressional Budget Office (CBO). March 2012. <http://www.cbo.gov/sites/default/files/03-13-Coverage%20Estimates.pdf> (accessed April 2015). CBO estimated that by 2016, approximately 17 million more people would have been enrolled in Medicaid and CHIP under the ACA.
4. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012).
5. Office of Tennessee Governor Bill Haslam, "Haslam Makes Case for Insure Tennessee to General Assembly." Press release, February 2, 2015. <https://news.tn.gov/node/13492> (accessed April 2015).
6. Several recent reports address these Section 1115 Medicaid expansion waivers. See Medicaid and CHIP Payment Advisory Commission (MACPAC), March 2015 Report to Congress on Medicaid and CHIP, Chapter 5, "Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market." Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/03/Premium-Assistance-Medicaid%E2%80%99s-Expanding-Role-in-the-Private-Insurance-Market.pdf> (accessed April 2015); Cross-Call, J and Solomon, J, *Approved Demonstrations Offer Lessons for States Seeking to Expand Medicaid Through Waivers*. Washington, DC: Center on Budget and Policy Priorities (updated March 4, 2015). <http://www.cbpp.org/research/approved-demonstrations-offer-lessons-for-states-seeking-to-expand-medicaid-through-waivers>; Rudowitz, R, Artiga, S and Musumeci, M, *The ACA and Medicaid Expansion Waivers*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation (updated February 2015). <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>
7. 42 U.S.C. § 1315. For more information about Section 1115 waivers and how they work in the context of Medicaid expansion, see Rosenbaum, C and Hurt, C, *How States are Expanding Medicaid to Low-Income Adults through Section 1115 Demonstration Waivers*. Washington, DC: Commonwealth Fund. December 2014. http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/dec/1794_rosenbaum_states_expanding_medicaid_section_1115_rb_v3.pdf?la=en (accessed May 2015); Rudowitz, R, Artiga, S, and Musumeci, M, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. November 2014. <http://files.kff.org/attachment/the-aca-and-recent-section-1115-medicaid-demonstration-issue-brief> (accessed April 2015).
8. For a discussion of these pre-expansion waivers, see Rudowitz, R, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*.
9. Centers for Medicare and Medicaid Services (CMS), "Medicaid and the Affordable Care Act: Premium Assistance." Washington, DC: CMS. March 2013. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (accessed April 2015).
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