Bloomberg BNA

BNA's
Health Care Policy Report™



# Several States Pursue Innovative Approaches To Expanding Medicaid Under the ACA

By Caroline Brown and Philip Peisch

The Affordable Care Act (ACA) provides States with increased federal reimbursement to expand Medicaid to cover the millions of adults below 133% of the federal poverty level (FPL) who would not otherwise be eligible.[1] In 2012, the Supreme Court made covering this new low-income adult group optional, leaving States with one of the most important Medicaid policy decisions they have faced since the original decision to join the program after Medicaid's creation in 1965.

Over a year into implementation of the ACA's Medicaid expansion, 28 States plus the District of Columbia have opted to expand Medicaid. By comparison, one year after Medicaid was created in 1965, only 26 of the States had opted to implement the program. (For the most part, the remainder quickly joined over the next several years, with the last hold-out being Arizona, which did not implement a Medicaid program until 1982).

Most States that have expanded Medicaid did so by adding the new low-income adult eligibility group to the Medicaid state plan, which means that they are largely treated like the pre-existing Medicaid population, although there may be some differences in benefits.

Several States, however, have pursued a different approach and developed state-specific ''Section 1115 demonstration projects'' to cover the ACA's new low-income adult group. Today, four of these States—Arkansas, Iowa, Michigan, and Indiana—have special approval from the Department of Health and Human Services (HHS) to employ features generally not seen in Medicaid, including mandatory premium assistance, increased premiums and copayments, incentives for enrollees to engage in healthy behavior, and job training opportunities for enrollees. If the results of these demonstrations are promising, this could become a route for the hold-out States to provide coverage to uninsured adults without ''expanding Medicaid.''

## Background

Effective January 1, 2014, the ACA expanded Medicaid to cover all adults below 133% of the FPL who are under 65 years old, not pregnant, and not eligible for Medicare or any mandatory Medicaid eligibility group. Instead of the traditional Medicaid benefits package, States are required to provide this new low-income adult group with what the Centers for Medicare & Medicaid Services (CMS) calls an ''Alternative Benefit Plan,'' which the statute refers to as ''benchmark'' or ''benchmark-equivalent'' coverage comparable to the coverage that can be purchased through a Health Benefit Exchange. While traditional Medicaid reimburses States for between 50% and just over 80% of state expenditures (depending on the State's per capita income), the ACA provides States with increased federal reimbursement for newly eligible enrollees in the ACA's low-income adult group, starting at 100% in 2014 and gradually decreasing to 90% for 2020 and years thereafter. Although the ACA originally required States to cover the new low-income adult group, the expansion was made optional by the Supreme Court's decision in *National Federation of Independent Business (NFIB) v. Sebelius*, 132 S. Ct 2566 (2012).

[1] The FPL, which is adjusted annually, is approximately $11,500 for a single person and $25,000 for a family of four in 2015.

*Caroline Brown is a partner at Covington & Burling LLP, where she chairs the Federal-State Programs practice and co-chairs the Health Care Industry group. Philip Peisch is an associate at Covington and a member of the Federal-State Programs practice and the Health Care Industry group. Both have advised clients on Medicaid expansion and Section 1115 projects.*

 ISSN 1068-1213

## Covering the ACA's New Low-Income Adult Group Through Non-Traditional Avenues

The primary vehicle for innovation in the Medicaid program is Section 1115 of the Social Security Act. Section 1115 authorizes the Secretary of HHS to approve ''any experimental, pilot, or demonstration project'' that she determines ''is likely to assist in promoting the objectives of'' the Medicaid statute. Under Section 1115, the Secretary may waive compliance with certain federal requirements and may approve expenditures that would not otherwise be eligible for federal reimbursement.

Four States—Arkansas, Iowa, Michigan, and Indiana—have used Section 1115 to develop state-specific, experimental demonstrations to cover the ACA's new low-income adult group. As described in more detail below, these demonstrations experiment with several tools that are otherwise prohibited by federal Medicaid rules, including mandatory premium assistance to purchase individual market coverage, increased premiums and cost sharing, and incentives for healthy behaviors.

### *Arkansas' Private Option*

Arkansas' ''Private Option'' was the first Section 1115 demonstration approved for the specific purpose of covering the ACA's new low-income adult group in a non-traditional format. The Private Option seeks to leverage the commercial insurance market by purchasing coverage sold on the Exchange. Benefits that are required by Medicaid but not covered by the commercial plan are paid for by the State.

Premiums for enrollees below 150% of the FPL are generally prohibited in Medicaid. However, CMS recently approved an amendment to the Private Option to waive that rule to allow Arkansas to collect monthly ''Independence Account'' contributions from enrollees between 50% and 133% of the FPL. Enrollees who contribute to Independence Accounts will not be responsible for any additional cost sharing obligations. Enrollees who do not contribute will be subject to cost sharing consistent with the amounts permitted by federal regulations, but they will not be denied eligibility for the Private Option.

### *Iowa's Marketplace Choice Plan and Wellness Plan*

In December 2013, CMS approved Iowa's request to cover the ACA's new low-income adult group through two different programs, the Marketplace Choice Plan and the Wellness Plan.

The Marketplace Choice Plan is a premium assistance program that, like Arkansas, uses the commercial market to deliver health care to Medicaid enrollees. Individuals above 100% of the FPL receive premium assistance to purchase coverage through the Exchange, and the State provides any Medicaid benefits that are not covered by the commercial plan. This was originally mandatory for most enrollees above 100% of the FPL, but now all enrollees have the choice between the Marketplace Plan and traditional Medicaid.

Iowa's Wellness Plan demonstration covers individuals in the low-income adult group at or below 100% of the FPL. Wellness Plan enrollees receive coverage directly from the State, not through a premium assistance program.

Both the Marketplace Choice Plan and the Wellness Plan provide incentives to encourage behaviors that will improve enrollees' health and drive down costs. Starting in the second year of the program, enrollees above 50% of the FPL are required to pay premiums, unless they complete certain healthy behaviors in the previous year (or self-attest to a financial hardship).

In addition to allowing premiums, CMS also waived for one year the federal requirement that States cover ''non-emergency transportation'' to medical appointments. CMS recently extended this waiver to July 31, 2015. It remains to be seen whether CMS will authorize this waiver beyond July 31.

### *Healthy Michigan*

Unlike Arkansas and Iowa, Michigan did not cover the new low-income adult group through a premium assistance program. Instead, the Healthy Michigan program covers this group through a managed care delivery system.

Healthy Michigan enrollees contribute to the cost of their care, and take a stake in their utilization of Medicaid services, by making monthly contributions to ''MI Health Accounts'' based on their aggregate copayment liability in the previous quarter. In addition, nonexempt enrollees with income above 100% of the FPL make payments up to 2% of household income into these accounts (which required a CMS waiver of the federal premium rules).

Healthy Michigan also incentivizes healthy behavior. Enrollees will receive reductions in their MI Health Accounts obligations for certain healthy behaviors. For example, enrollees may receive a reduction for completing a health assessment and visiting a primary care provider.

### *Healthy Indiana Plan 2.0*

In January 2015, Indiana became the latest State to obtain CMS approval for a Section 1115 demonstration to cover the ACA's low-income adult group. Under the Healthy Indiana Plan (HIP) 2.0, the new low-income adult population will receive coverage through one of three programs: HIP Basic, HIP Plus, or HIP Link. Both HIP Basic and HIP Plus provide enrollees with coverage through a managed care delivery system. HIP Basic provides basic Medicaid services with copayments for many services; HIP Plus provides additional services such as vision and dental, without any copayments; however, enrollees are required to pay a premium. HIP Link is a separate premium assistance program available as an option for enrollees with access to qualified employer-sponsored coverage.

The Secretary waived the federal premium rules to allow the State to require most enrollees above 100% of FPL to contribute to the cost of their care through payments to a Personal Wellness and Responsibility (POWER) account, which operates like a health savings account. If these enrollees do not make these payments, they will be disenrolled from the program and prohibited from re-enrolling for six months.

HIP 2.0 also encourages individuals with income below 100% of the FPL to contribute to the cost of their care by providing them with access to HIP Plus if they make POWER account contributions. Enrollees below 100% of the FPL who do not make the POWER account contribution will be enrolled in HIP Basic.

  HCPR ISSN 1068-1213

As part of HIP 2.0, CMS approved a ''Section 1916(f) waiver'' to allow cost sharing in excess of the amounts permitted by federal Medicaid regulations to discourage the inappropriate use of hospital emergency rooms. Specifically, enrollees in both HIP Basic and HIP Plus will be subject to an $8 copayment for the first instance and a $25 copayment for recurrent non-emergency uses of an emergency department. To meet the statutory standard for a Section 1916(f) waiver, Indiana had to establish a 500-person control group and assume liability for preventable damage to the health of recipients of medical assistance resulting from imposition of the higher copayments. *See* SSA § 1916(f), 42 U.S.C. § 1396o(f).

Finally, Indiana's voluntary ''Gateway to Work'' program offers to connect HIP 2.0 enrollees with workforce training programs, work search resources, and potential employers. The Gateway to Work program is outside of the HIP 2.0 demonstration and will not be funded with Medicaid dollars.

## The Future of the Medicaid Expansion

The status of the Medicaid expansion remains fluid, with many States continuing to analyze (and reanalyze) their positions. Earlier this year, recently elected Arkansas Governor Asa Hutchinson announced that he would support the continuation of the Private Option through 2016, but that he would also explore a systemic overhaul to replace it in 2017. Recently elected Pennsylvania Governor Tom Wolf withdrew the CMS-approved Healthy Pennsylvania demonstration in favor of implementing a traditional Medicaid expansion. And recently-reelected Tennessee Governor Bill Haslam proposed an innovative approach that drew from some of the previously approved demonstrations, but it was not approved by the state legislature.

In addition, starting in 2017, States also have the ability to apply for an ''Innovation Waiver'' that permits them to circumvent many of the requirements of the ACA, including the ''individual mandate'' and the ''employer mandate.'' The Innovation Waivers themselves do not authorize departures from Medicaid requirements, but they can be combined with Section 1115 waivers to implement statewide changes to how health care is delivered within the State.

Political, policy and economic considerations are likely to drive States to continue to explore expanding Medicaid through Section 1115 demonstrations that allow for the development of state-specific programs. Several States are currently working on programs to implement the expansion, and two States (Utah and New Hampshire) have Section 1115 expansion demonstration requests pending with CMS. With 22 States that have yet to cover the ACA's new low-income adult group, we expect to continue to see new innovative state approaches to covering the ACA's low-income adult group in the future.