

State Approaches to Medicaid Expansion

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Vernon K. Smith, PhD

Health Management Associates

Vsmith@HealthManagement.com

Medicaid Is a State Program: A State- Federal Partnership

- States operate Medicaid programs under federal law and regulations that define the terms and conditions for a state to receive federal matching funds
- States are *entitled* to federal Medicaid matching funds on all *qualifying* expenditures, as defined in
 - Medicaid state plan, including
 - Any federally-approved waivers that allow expenditures that otherwise would not qualify

Within Federal Rules, States Define Their Own Medicaid Programs

- State Medicaid programs are designed and administered by state policy makers, within federal rules.
 - Each state Medicaid program is unique
 - State programs vary based on state decisions on
 - Eligibility, provider payment levels, benefits and limits on benefits, cost sharing, delivery systems, use and types of managed care, quality requirements, special initiatives and innovations
 - Decisions reflect state priorities, fiscal realities, health care systems, traditions and values

Virginia Has a Tradition of a Strong Medicaid Program

- Strong leadership, professional staff
- Initiatives to improve care and control costs through Virginia Medicaid; a few recent examples:
 - Statewide managed care
 - Development of a demonstration plan to integrate and coordinate care for dual Medicaid – Medicare eligibles
 - Development of initiative to coordinate behavioral health services
 - Working toward managed long term services and supports

Medicaid Expansion Debate Has Highlighted Medicaid Concerns

- Concern that federal government might not live up to its commitment for ongoing funding, due to its focus on federal debt
- Concern about local political backlash
- Concern about access and lack of providers to serve more Medicaid patients
- Concern that current Medicaid program can be improved and should be reformed first.

Debate Has Also Highlighted the Value of Medicaid

Studies show that Medicaid:

- Improves access to medically needed care
- Improves health status
- Improves financial security
- Improves school performance and health of current and future workforce
- Benefits medical providers, especially hospitals
- Lowers cost of health insurance for business
- Adds economic activity and jobs
- Federal funding helps the state budget
- Very low administrative costs

Possible State Approaches to Expanding Medicaid

1. Extend current state Medicaid coverage to non-elderly adults up to 133% of FPL
 - Builds on current payment and delivery systems, using all current tools for managing care, controlling costs and improving quality.
 - Incorporates any new initiatives for payment and delivery system reform as they are adopted
2. Use private / commercial insurance options, including managed care organizations
3. Develop new state approaches, with reforms

CMS Latitude is Limited by Federal Law in Approving State Proposals for Premiums

- **Premiums:** Federal rules do not permit premiums for persons with incomes below 150 percent of poverty
 - CMS has indicated that it does not anticipate approving Section 1115 demonstration projects which impose premiums on individuals below 100 percent of poverty.
- **Copayments:** Federal rules limit copays to “nominal.” Proposed regulations issued January 22, 2013 define new limits, to be effective in 2014.

New Maximum Medicaid Copays; to be effective 1/1/2014 (Per Proposed Regulations)

- **Outpatient services**
 - \$4 for individuals with family income at or below 100% of FPL
 - 10% of the cost for those at 101% to 150% of FPL
 - 20% of the cost for those above 150% of FPL
- **Non-preferred drugs**
 - \$8 for those at or below 150% of poverty of FPL
 - 20% of the cost for those above 150% of FPL
- **Nonemergency use of the emergency department**
 - \$8 for those with family income at or below 150% of FPL
 - No limit for those above 150% of FPL

Source: "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing," Centers for Medicare & Medicaid Services, Federal Register, Jan. 22, 2013.

Medicaid Expansion Reform Options

1. Cost Sharing:

Premiums or co-payments, above historic Medicaid levels.

2. Premium Assistance:

Medicaid coverage is purchased for enrollee through a Health Benefit Exchange (HBE) / “Marketplace”

3. Sunsets:

Authorizing expansion for limited time or linking participation to guarantees of Federal matching funds.

4. Benefit Limits:

Capping benefits or linking to “alternative benefit plans”.

5. Behavior Incentive:

Linking cost sharing to enrollee health behavior.

6. Health Savings Account:

Funding HSA so enrollee can cover cost-sharing/services.

MEDICAID EXPANSION REFORM OPTIONS

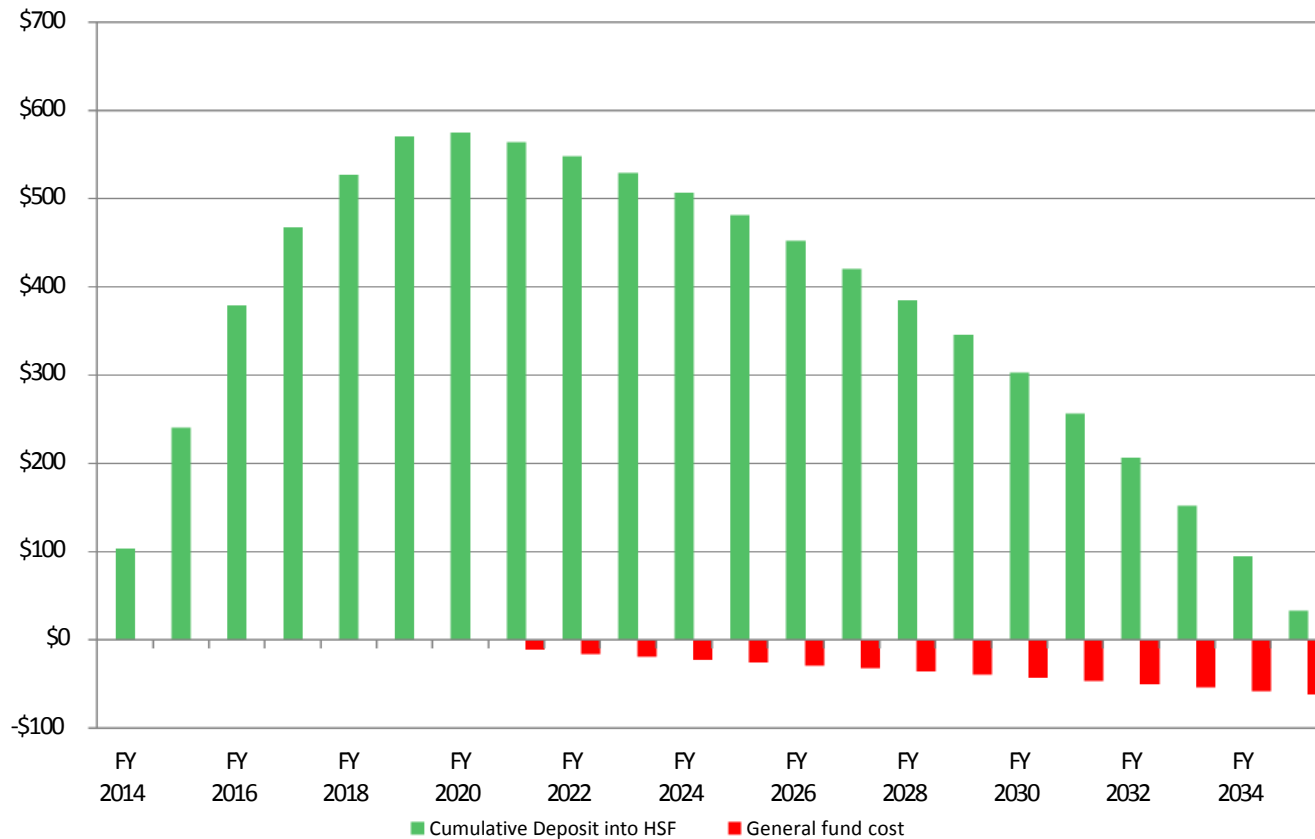
Selected State Proposals

STATE	COST SHARE	HBE	SUNSET	ALT. BENEFIT	HEALTH INCENTIVE	HSA
MI	X	X	X		X	X
OH	X					
IN	X		X	X	X	X
AR	X	X	X	X		X
IA	X	X	X	X	X	
AZ			X			

Medicaid Expansion in Michigan: Governor Rick Snyder's Proposal

- Expand Medicaid eligibility to 133% of Federal poverty level
- Full Medicaid benefit package
- All mandatorily enrolled in Medicaid managed care plans
- GF savings of \$192 million in FY 2014 (9 mos.)
 - From mental health, corrections, replacing spend-down, state funded waiver program for adults
 - Half of state savings deposited into a “Health Savings Fund” to cover all state costs for next 21 years, to FY 2035.

Cumulative deposits into the Health Savings Fund will finance Medicaid expansion for the next 21 years



*in millions

Michigan: Current Status

- FY 2014 budget enacted without expansion
- Medicaid expansion bill (HB 4714) passed House in May 2013
- Special Senate committee reported Medicaid expansion bill (HB 4714) on August 1, 2013
 - Committee also voted out two alternate bills
 - Full Senate may vote when return August 27

Michigan Medicaid Expansion Bill (HB 4714) Includes Several Reforms

- Mandated cost share of 5% of income for adults with incomes 100-133% FPL (~ \$25.00 / month)
- Cost share increases to 7% of income when enrolled in program longer than 48 months
 - Or, option to enroll in HBE (waiver by 12/2015)
- Health Savings Account is to be created
 - Contributions to HSA can be made by enrollee, employer or public/private entities
- MCOs can adjust cost sharing to encourage enrollee health behavior.
 - MCOs have incentives: withholds of 0.25% to enforce cost sharing; and 0.75% for quality metrics

Ohio Medicaid Expansion Proposal

- Governor John Kasich proposed expansion, but Legislature did not include in adopted budget.
- Discussion continues; Governor has asked to have a bill he can sign by “late summer.”
- Governor’s proposal included:
 - Simplification of eligibility requirements program-wide.
 - Information technology upgrades.
 - Increased cost sharing for adults 100-133% FPL
- New cabinet-level “Ohio Department of Medicaid” established effective October 1, 2013.

Indiana: Healthy Indiana Plan (HIP)

- Governor Mike Pence has requested an extension of Healthy Indiana Plan
- HIP is a current Medicaid waiver program for low- income, uninsured adults up to 200% FPL
 - Medicaid-funded “POWER Account,” \$1,100 / year, funded by state and premiums; modeled on Health Savings Account (HSA)
 - Premiums (2% of income up to 100% FPL, up to 5% @ 200%)
 - One-Year lockout if don’t pay premium
 - Limited benefits (e.g., no vision, dental, maternity)
 - Enrollment cap (currently 34,000 adults)
- If expand, population to be enrolled in HIP.
- Unresolved CMS issues: mandatory premiums/ cost sharing, lockout, limited benefits

Arkansas: Premium Support with Private Insurers

- Arkansas waiver links Medicaid expansion to enrollment in private insurance plans in the Health Benefit Exchange (Marketplace).
- Choice between at least two Exchange plans.
 - Each enrollee will complete a health assessment; Frail enrollees are exempt and will go to regular fee-for-service Medicaid
 - Premiums to be paid by state to commercial plan.
 - Cost sharing for those with income 100-133% FPL.
 - Proposed in future years to extend to adults with incomes between 50-100% FPL.

Arkansas: Benefits

- Exchange benefit linked to Medicaid Alternative Benefit Plan.
 - Benefits linked to large commercial health plan in state.
 - Other benefits not in commercial plan available as “wraparound”.
- Pilot project is proposed to use Health Savings Accounts in 2015 or 2016.
- Approval discussions ongoing; Federal approval not yet granted.

Iowa “Health and Wellness Plan”

- An “Iowa Compromise” between Governor’s proposal for a limited benefit plan and a Medicaid expansion
- **Two part plan**, with incentives for healthy behavior, emphasis on care coordination and access to care.

1) **Iowa Wellness Plan** for adults up to 100% FPL

2) **Iowa Marketplace Choice Plan** for adults with incomes between 101% and 133% of FPL

- Federal approval is being negotiated; not yet approved.

1: Iowa Wellness Plan

- 1) For adults ages 19 – 64, incomes up to 100% FPL
 - Comprehensive benefits: equivalent to state employee health insurance.
 - Medicaid provider network, with medical home
 - Care coordinated by Accountable Care Organizations
 - ACOs are accountable for cost, quality outcomes for population attributed to them
 - ACOs assist in care, do preventive care, outreach
 - Share savings, if meet quality and cost metrics
 - No copayments (except \$8 for non-emergency ER)
 - First year, no monthly premiums
 - After 1st year, premiums only if income > 50% FPL and if preventive care / wellness activities not done
 - Out of pocket costs never > 5% of income

2: Iowa Marketplace Choice Plan

- 2) For adults ages 19 – 64, incomes 100% - 133% FPL
 - A Premium Assistance program
 - Members select a commercial health plan through the Health Benefit Exchange (“Marketplace”)
 - Medicaid will pay the premium to the health plan
 - Commercial health plan will meet standards for benefits, out-of-pocket costs, statewide network
 - Benefits equivalent to state employee insurance
 - Copay, premium rules same as for < 100% FPL
 - Use of commercial plans through Marketplace will
 - Allow continuous enrollment when income rises
 - Allow access to same plans as other lowans seeking private insurance through the Marketplace

Arizona

- Arizona has always enrolled all beneficiaries in capitated managed care organizations
- Previously expanded Medicaid to adults up to 100% of FPL, using a Section 1115 waiver
- Over 200,000 persons lost coverage when eligibility was cut due to severe budget reductions beginning in 2008
- Medicaid expansion restored coverage
- All enroll in MCOs, for all services, including long term care
- Legislation provided an opt-out if federal matching funds drop below 80% in future.

Other States Considering Expansion

- **Pennsylvania:** Looking at incentives for work, and “instituting reasonable copays for able-bodied Pennsylvanians,” and the ability to buy private insurance on state’s Exchange.”
 - Christine Cronkright, spokeswoman for Governor Tom Corbett
- **Tennessee:** “Our goal has been to create a plan that would be as close to commercial insurance as possible and that would include flexibility with cost sharing.”
 - Alexia Poe, spokeswoman for Governor Bill Haslam

Source: “Medicaid Expansion Quandary,” Washington Times, August 12, 2013.

Summary

- States have several options to include reforms when covering adults to 133% of FPL
 - **Personal responsibility requirements**, through cost sharing, premiums, incentives for healthy behaviors
 - **Private insurance options**
 - **Managed care**, with mandatory enrollment
 - **Coordinated, integrated care** tailored to populations with chronic conditions.
- CMS must approve plans, within federal law.

CMS Says: “We Want to Help States Cover Adults the Way States Want To”

“We are eager to continue these conversations with states around the country.”

--Secretary Sebelius, speaking to NCSL on August 12, 2013

“We are open for business, eager to partner.”

-- Cindy Mann, Deputy CMS Administrator for Medicaid, at NCSL, August 12, 2013

Source: *Atlanta Journal – Constitution*, August 13, 2013.