

Trends in Alternative Medicaid Coverage Initiatives

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Principles Driving Alternative Coverage Initiatives

-  Preserve and strengthen private coverage
-  Promote personal responsibility and connections to work
-  Provide coverage while protecting state tax payers
-  Tailor to a state's circumstances and larger policy agenda

Early Results in States Implementing New Coverage

Robust Enrollment

- As of January 2015, average monthly Medicaid/CHIP enrollment had increased 26% in expansion (versus 7.8% in non-expansion states); 12 states experienced an increase of 30% or more
- Take up rate data are limited, but some are available (e.g., Arkansas reports 84% take up rate; West Virginia reports 75% take up rate)

Sharp Drops in Uninsured Rates

- National surveys show all states experiencing ACA-related drops in uninsured rate, but states with Medicaid coverage up to 138% FPL had a 52.5% decline, as compared to 30.6% in other states.

Sharp Drops in Hospital Uncompensated Care Costs

- Hospital associations are documenting drops in the uncompensated care rate with expansion states reporting a 26% reduction, compared to a 16% reduction in non-expansion states.

Higher than Expected Rates of Behavioral Health Issues

- New adults have higher than expected rates of behavioral health issues, including mental health and/or substance use disorders
- Two early expansion states report substance use disorder rates of 9% and 13%

Early Estimates of Fiscal Impact of New Medicaid Coverage

Study based on actual fiscal impact in 8 states found savings/revenue increases of more than \$1.8B through end of 2015

Highlights:

- Early results now available on the **actual** impact of new Medicaid coverage
- These are early results and states are expecting greater savings over time
- Sources of savings and revenue gains are consistent across states
- In Arkansas and Kentucky, savings and revenue gains expected to offset costs through SFY 2021

Elements of fiscal impact

- Reduced state spending on programs for the uninsured
- Savings related to previously eligible Medicaid beneficiaries now eligible for the “new adult” group under expansion
- Increased revenue related to existing insurer and provider taxes



Features of Alternative Coverage Approaches

States are Using a Range of Features for Alternative Medicaid Initiatives

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- **Premiums.** CMS has granted waivers to states permitting them to charge limited premiums for expansion adults. Under certain circumstances, CMS has authorized states to condition coverage on payment of premiums. In one state, CMS permitted a six-month lockout period for individuals who did not pay their premiums within 60 days.



- **Cost Sharing.** CMS has limited authority to grant cost-sharing waivers, but states have significant discretion to charge co-payments consistent with Medicaid law.



- **Health Savings-Like Accounts.** To increase consumer sensitivity to cost, states may utilize health savings-like accounts (requires waiver).



- **Healthy Behavior Incentives.** CMS allows states to encourage healthy behaviors by forgiving co-pays and/or premiums.



- **Connecting to Work.** States are finding ways to connect newly eligible adults to job search and job training programs. CMS has never permitted a state to condition coverage on work-related requirements.



- **Benefits and Coverage.** CMS has waived the requirement to provide non-emergency medical transportation (NEMT). CMS has declined to waive the requirement to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to 19- and 20-year olds. CMS has granted limited waivers of retroactive coverage.

States are Using a Range of Delivery Models for New Medicaid Coverage

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Premium Assistance for Qualified Health Plans (QHPs). Enables states to purchase coverage for some or all new adults through qualified health plans offered on the Marketplace



Premium Assistance for Employer Sponsored Insurance (ESI). States may require Medicaid-eligible enrollees with access to ESI to take up that coverage, with Medicaid covering the employee premiums, excess cost sharing and missing benefits



Medicaid Managed Care. States with robust Medicaid Managed Care programs are using these plans to deliver services to expansion adults



Provider-Led Accountable Care Models. Both expansion and non-expansion states are pursuing reforms that require providers to assume responsibility for the cost and quality of care delivered to Medicaid enrollees

Delivery Model Options Are Not Mutually Exclusive

- States may implement more than one model simultaneously or may implement different models for different populations or in different geographic regions
- States may sequence implementation of delivery models

States Can “Mix and Match” Options

States can combine delivery system options

By Income Level

Model 1 enrolled the new adults <100% FPL in its traditional Medicaid PCCM program. New adults between 100-138% FPL were enrolled in QHPs with premium assistance.

By Health Status

Model 2 is implementing through QHPs for all new adults except medically frail who will enroll in FFS Medicaid with PCMHs and Health Homes. (Previously eligible parents also enroll in FFS Medicaid.)

By Geography

Under one Governor’s proposal, new adults initially would receive care through accountable care organizations if they resided in urban areas and via primary care physicians if they resided in rural areas.

Considerations Related to Marketplace Premium Assistance

Advantages:

- Enables continuity of coverage and care as individuals' and families' income fluctuates
- Enables comparable access to providers for individuals insured by Medicaid and private insurance
- May encourage Marketplace competition
- Increases alignment of regulation and oversight across government and private markets
- Enhances stability of Marketplace risk pool through increasing potential enrollees

Challenges:

- More complex for states to operationalize than a “straight” expansion
- Different considerations for states with Medicaid Managed Care
- Requires an 1115 waiver if state's goal is to make the program mandatory
- Requires robust coordination between Medicaid agency and insurance department



Premiums and Cost-Sharing

States are charging limited premiums for certain populations

MODEL 1

- Premiums up to \$5/month for those 50-100% FPL, and up to \$10/month for > 100% FPL
- Payment is not a condition of eligibility for 50-100% FPL
- Failure to pay within 90 days for > 100% FPL results in disenrollment—but hardship waivers are available based on self-attestation
- Cost-sharing limited to non-emergency use of the ER

MODEL 2

- Premiums up to 2% of income for those > 100% FPL
- Payment is not a condition of eligibility; but non-payment results in debt to state
- Cost-sharing for range of services for individuals 0-138% FPL, consistent with Medicaid law

Healthy Behavior Incentives

States are seeking to incent healthy behaviors by forgiving co-pays or premiums for meeting certain health standards

MODEL 1

Premiums for individuals >50% FPL are waived for completion of health risk assessment and wellness exam during previous year.

Individuals <50% FPL and those deemed 'medically exempt' are eligible for financial rewards based on completion of health risk assessment and wellness exam during previous year.

MODEL 2

Individuals >100% FPL receive 50% reductions in required premium contributions to HSA-like accounts for completing specified healthy behaviors.

Individuals <100% FPL, who are not required to pay monthly premium contributions to HSA-like accounts, can receive a \$50 gift card for completing specified healthy behaviors.

MODEL 3

Individuals enrolled in enhanced benefit package who receive recommended preventive services and meet other specific conditions may be able to receive state match for their HSA-like account rollover funds. The rollover funds can be used to reduce or eliminate HSA-like account contributions during the next plan year.

Individuals enrolled in standard benefit package who have received recommended preventive health services and meet other conditions may be eligible for discounted enhanced benefit package contributions the following year.

Health Savings Accounts

States are seeking to promote consumer engagement and raise awareness of the cost of health care services by providing Health Savings Accounts (or other similar products) for beneficiaries

MODEL 1

- Premiums in the form of contributions to HSA-like, accounts, which are administered by MCOs. The accounts are funded by enrollee contributions, Medicaid funds, and potentially contributions from employers, providers, or other third parties.
- For >5% FPL, contributions are 2% of income; for <5% FPL, contributions are minimum of \$1 per month
- Payment is a condition of eligibility for >100% FPL who are not medically frail; all individuals >100% receive enhanced benefit package. Failure to pay within 60 days results in disenrollment and six-month lockout period
- Payment is not a condition of eligibility for <100% FPL; those who make contributions receive enhanced benefits; those who do not make contributions receive standard benefits subject to maximum permitted Medicaid cost sharing

MODEL 2

- HSA program implemented for participants 100-138% FPL
- HSAs are funded by enrollee contributions and federal funds, and are administered by a third party vendor
 - All eligible individuals are expected to make a monthly contribution of \$5-\$17.50 (depending upon income)
 - \$5 per month for enrollees with income from 50-100% FPL
 - \$10-\$17.50 per month for enrollees with income from 100-138% FPL
- Enrollees use their HSA to pay their co-payments and deductible, up to maximum out-of-pocket limit
- If enrollee does not make monthly contribution, must either pay QHP cost-sharing out-of-pocket at point of service or will be billed for Medicaid-level cost sharing



States may be able to link coverage for newly-eligible adults with enrollment into work programs



CMS does not allow states to condition Medicaid eligibility on work requirements



CMS may allow states to auto-enroll beneficiaries in work programs

Connecting Individuals to Work

States can help connect individuals to employment and career assistance services

MODEL 1

Under its prior Administration, state intended to use state funding to establish incentives for job-training and work-related activities for newly-eligible adults. This effort was not included in its Medicaid 1115 waiver and did not rely on any federal Medicaid funds.



MODEL 2

Unemployed beneficiaries are referred to the Department of Employment Security for employment and career assistance services.



INCLUDE SUNSET PROVISION

Expansion would be terminated should the Federal match rate drop below Affordable Care Act levels.

“A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.”

CMS Guidance, 12/10/2012

PROVIDER FINANCING

States are using provider assessments to finance state share of new coverage costs, ensuring general revenue funds will not be used.

ESTABLISH TRUST FUND

Savings from new coverage are set aside in a trust fund to cover the state share in future years.

Sunset Provisions

States are including sunset provisions and/or reauthorization requirements in authorizing legislation

MODEL 1

Financing for new coverage must be re-authorized each year, and should the federal match rate drop below the promised levels, the program terminates after 120 days.



MODEL 2

New coverage terminates (and must be reauthorized) on December 31, 2016, unless federal match drops below 100% before that time, which would cause immediate termination.



Trust Funds

States are setting up trust funds to invest savings from new coverage to finance state share of costs in future years when federal matching rate dips

MODEL 1

Established a trust fund, in which state savings realized in the first year of expansion are deposited in the fund to offset state risk related to new coverage in future years.



MODEL 2

Established a trust fund to hold and expend federal dollars for the new Medicaid population. The trust fund is administered by the Health & Human Services Commissioner, who will submit an annual report to the Governor and general assembly.



Provider Financing

States are relying on providers to finance the state share and protect against any unexpected costs

MODEL 1

State assesses a provider fee on hospitals to fund the state share of expansion costs.



MODEL 2

If the federal match drops below promised levels, state may implement an alternative coverage plan (with statutory approval). If match drops below 90%, hospital reimbursement will be reduced by the same percentage in the following fiscal year (up to 5%).



Flexibility to Phase-in Implementation

States decide when to implement new coverage



No deadline to implement



Federal matching rate is linked to calendar year and declines over time regardless of when a state implements



Many factors affect timing of implementation



Existing versus new delivery system



IT changes required to implement state's model



Waiver versus State Plan Amendment (SPA)

Emerging Issues in Medicaid Expansion Debates

- **Relationship Between Medicaid Expansion and Uncompensated Care Funding for Hospitals through 1115 Waivers**
- **1332 Waivers Surfacing as Part of Coverage Landscape**

Relationship Between Expansion and Uncompensated Care Funding for Hospitals through 1115 Waivers

CMS PERSPECTIVE

- More efficient to use Medicaid funds for coverage rather than pools
- Uncompensated care dollars should not be spent on expenses that would be eliminated by expansion
- Underpayments should be addressed through changes to provider payment rates

- “We believe that the future of LIP, sufficient provider rates, and Medicaid expansion are linked in considering a solution for Florida’s low income citizens, safety net providers, and taxpayers.”
- “(...) coverage rather than uncompensated care pools is the best way to secure affordable access to health care for low-income individuals, and uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion.”
- “Provider payment rates must be sufficient to promote provider participation and access.”

CMS Letter to Justin Senior, Deputy Secretary for Medicaid, Florida, April 14, 2015

1332 Waivers Surfacing as Part of Coverage Landscape

States can seek to waive key elements of the ACA related to the individual mandate, employer mandate, and Marketplaces if they meet standards designed to ensure comparable outcomes for consumers

Medicaid implications

- Section 1332 does **not** expand waiver authority for Medicaid, but does establish procedures for “coordination” of 1332 and Medicaid waivers
- Under existing Medicaid 1115 waiver authority, HHS has the authority to waive most Medicaid requirements so long as HHS determines waiver is “likely to assist in promoting the objectives” of the Medicaid statute.
- Coordinated waivers may create different dynamics and opportunities for states to develop new coverage structures, smooth differences across federal programs, and facilitate multi-payer delivery reform.
- 1115 waivers must be budget neutral; 1332 waivers may not increase the federal deficit.
- Combining 1115 and 1332 waivers may allow savings and costs to be considered across programs when assessing budget neutrality and impact on the federal deficit.

Conclusion

- **Opportunities to design alternative Medicaid coverage initiatives consistent with a state's larger objectives are significant**
- **CMS remains deeply interested in working with states on finding ways to cover newly-eligible adults**
- **Expect continued flexibility to tailor Medicaid coverage initiatives to a state's political and fiscal environment, but with clear lines on selected issues**
 - **Partial expansion**
 - **Work requirements and other "welfare-like" provisions**
 - **Premiums and cost-sharing in excess of already-waived levels**
- **Continue to monitor trends in other states, linkages with other elements of Medicaid, and emergence of 1332 waivers**

Appendix

Statute and Guidance on Premiums & Cost Sharing

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	< 100% FPL ¹	100% - 150% FPL	≥ 150% FPL
Maximum Allowable Medicaid Premiums and Cost-Sharing:			
Aggregate cost-sharing cap	5% household income	5% household income	5% household income
Premiums	Not allowed	Not allowed	Permitted, subject to aggregate cap
Maximum Service-Related Co-pays/Co-Insurance:			
Outpatient Services	\$4	10% of the cost state pays	20% of the cost state pays
Non-emergency ER	\$8	\$8	No limit
Prescription drugs ²	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: 20% of cost state pays
Inpatient Services	\$75 per stay	10% of the total cost state pays for the entire stay	20% of the total cost state pays for the entire stay

(1) Cost sharing may **not** be mandatory for individuals with household incomes < 100% FPL. Providers may not deny services for failure to receive beneficiary copayments.

(2) If non-preferred drugs are medically necessary, preferred drug cost sharing applies.

Federal Rules on Personal Responsibility Initiatives

CO-PAYMENTS

- Maximum allowable co-payments set by federal law and regulation (see appendix)
- Must be voluntary < 100% FPL
- May impose higher co-payments (up to \$8) for non-emergency use of the ER and for non-preferred drugs
- Inpatient hospital co-payments may be as much as \$75 for those < 100% FPL and 10% of the cost of the hospital stay for those > 100% FPL
- States can seek waiver of these rules under highly-defined circumstances (see appendix)

PREMIUMS

- Premiums of up to 2% of income may be imposed under a waiver for those 100-138% FPL. This level of premiums is consistent with premiums for individuals with the same income in the Exchange

WELLNESS INCENTIVES & HEALTH SAVINGS ACCOUNTS

- States may establish wellness incentives and health savings accounts under a waiver
- Requires evidentiary base
 - Requires protocols to track
 - May be linked to reductions in cost sharing or premiums