



FLEXIBILITY ON the MEDICAID EXPANSION

Balancing independence with cost-effectiveness

A Utah Health Policy Project Issue Brief (DISCUSSION DRAFT)

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Introduction

Utah's Governor Gary Herbert is committed to a thorough study of the costs and benefits of the Medicaid expansion, starting with a soon to be released \$100,000 study by Public Consulting Group, and continuing with a stakeholder commission that will begin after the legislative session. Consistent with all of his recent statements on the study process, the Governor has expressed interest¹ in maximizing flexibility on the expansion. The good news for him and other Utah leaders: The federal Department of Health and Human Services (HHS) is open to flexibility on the terms and parameters of expansion. This brief describes the recent HHS approach to flexibility and how several other governors are seeking to change the nature of the expansion and the operation of Medicaid in their states.

UHPH does not endorse any of these options. We are however, prepared to facilitate a thorough analysis and critique of each option. This paper provides a basic framework for that discussion. As UHPH gains deeper insights into these proposals and HHS' willingness to entertain the different approaches to flexibility, we will share additional critical perspectives on these proposals.

Red State Roundup on Medicaid Expansion Flexibility

Over the past few weeks a number of red states have shown interest in pursuing their own home-grown version of the Medicaid expansion. Basically, three strategies have been laid out: (1) Use all Medicaid expansion dollars to purchase private insurance on the exchange; (2) Expand Medicaid for those with annual incomes from 0 - 100% federal poverty line (FPL) and allow those from 100 - 133% FPL to participate in exchange; and (3) Implement Medicaid expansion only if certain conditions are met, for example the federal share of financing must never fall below 90%.

The Arkansas Model: Using Medicaid Expansion Dollars to Buy Exchange Coverage

On February 26th Governor Mike Beebe announced an agreement² with HHS whereby the state would accept the Medicaid expansion, but all new-eligibles would enroll in private insurance plans through the state's Exchange, rather than receiving coverage through traditional Medicaid. HHS has conditionally approved to federally fund Exchange coverage at the same matching rates as it would have funded the traditional Medicaid expansion. That means the federal government

¹ Leonard, Wendy. "Gov. Gary Herbert issues last-minute plea to President Obama regarding health care reform." *Deseret News* 11 12 2012, n. pag. Web. 1 Apr. 2013. <<http://bit.ly/14Awoy08>>.

² Kliff, Sarah. "Arkansas's unusual plan to expand Medicaid." *WonkBlog*. The Washington Post, 28 2 2013. Web. Web. 1 Apr. 2013. <<http://wapo.st/100O4Mu>>.

would pay 100% of the costs of exchange premiums for the expansion population for the first three years.

Under the Arkansas model, the expansion population would still be entitled to the same benefit guarantees and cost-sharing limits that apply in traditional Medicaid. The state may therefore have to offer wrap-around coverage for Medicaid benefits not covered in exchange plans, and to bring cost-sharing protections up to Medicaid levels.

We are still waiting on details from HHS to understand exactly how this compromise would work, and the proposal has not been approved by the Arkansas legislature. National thought leaders are not convinced the plan is cost-effective and will preserve consumer protections under Medicaid³.

The Arkansas model has emerged as the preferred choice among red states pursuing an expansion of health care coverage. States like Missouri, Texas and Tennessee, firmly in the no column on the traditional Medicaid expansion, are giving it serious consideration. Other states like Florida⁴ and Ohio, where governors' attempts to expand Medicaid met with rejection by legislative bodies, are looking to the Arkansas model as a more palatable alternative to full expansion.

UHPP Quick Take: As we await further details on the Arkansas approach to the Medicaid expansion, we will reserve judgment. Recalling Congressional Budget Office estimates showing a 50% higher premium for exchange-based coverage over the cost of traditional Medicaid, the Arkansas plan left us uneasy at best. But, as Alan Weil of the National Academy for State Health Policy (NASHP) points out, if the Affordable Care Act is designed to bring down costs in the new insurance marketplace and if Medicaid costs will increase because providers will need to be paid more to see patients, then the Arkansas plan may be worth a try⁵. It may be better than no coverage at all.

Wisconsin: the BadgerCare Hybrid

Republican Governor Scott Walker of Wisconsin rejected expanding Medicaid within his state. Instead, he proposed allowing extremely poor adults without dependent children to enroll in BadgerCare (Medicaid), while shifting those with somewhat higher incomes into the subsidized insurance marketplace. This means anyone below 100% FPL (\$11,490/year for single adult) would end up in BadgerCare and those with incomes above 100% would go into the federally subsidized marketplace.

UHPP Quick Take:

It appears as though the Wisconsin plan is a non-starter with HHS. HHS clearly stipulated that partial expansion would not be allowed, indicating that any subsidy based alternative must be for the entire 0% FPL to 133% FPL population.

³ Kliff, Sarah. "Will Arkansas's Obamacare math add up?." *WonkBlog*. Washington Post, 20 3 2013. Web. Web. 1 Apr. 2013. <<http://wapo.st/ZURjq6>>.

⁴ Associated Press, . "Republicans' firm 'no' on Medicaid expansion is shifting toward "Let's make a deal." *Washington Post*. 24 3 2013: n. page. Web. 1 Apr. 2013. <<http://bit.ly/16saavt>>.

⁵ Weil, Alan. "Much Ado About Arkansas: Medicaid in the Insurance Exchange." *Once in A Weil*. National Academy for State Health Policy, 11 3 2013. Web. Web. 1 Apr. 2013. <<http://bit.ly/10iW9NX>>.

Virginia: Legislature Approval of Medicaid Expansion Contingent on Medicaid reforms

Virginia would create a legislative commission to assess⁶ whether specific conditions and reforms are met⁷. If the answer is “yes”, the commission will vote to approve the Medicaid expansion. Required reforms include:

- Implementation of the duals demonstration program;
- Cost-sharing and wellness activities in Medicaid;
- A Medicaid benefit package similar to those provided by commercial insurers; and
- An agreement on a streamlined process for developing regional health-care delivery systems that improve quality and reduce costs.

If approved by the commission, the Medicaid expansion would include a “circuit breaker” which would automatically end the Medicaid expansion if the federal matching rate is reduced below the rates specified in the ACA.

Governor Bob McDonnell, recently clarified that, despite the bill’s passage, Medicaid would not be formally expanded under his plan. The process of determining *whether* to expand in Virginia will take at least a year. The commission’s constitutionality was recently called into question by Virginia’s Attorney General (a potential candidate for governor) as it undermines the governor’s authority⁸.

UHPP Quick Take: CMS Centers for Medicare and Medicaid Services), the federal agency with oversight of flexibility decisions, is open to most of the required reforms listed in Virginia’s commission study plan. As its general guiding principle CMS stipulates that as long as Medicaid program objectives with respect to cost-effectiveness and quality are met, there is no reason why states cannot innovate in the areas listed above. The only downside of Virginia’s prolonged study process: depending on how long it takes, it will cut into the three-year period during which states receive 100% federal financing for the expansion. There is a cost to this delay, and it should be figured into any cost/benefit analysis.

New Cost-Sharing and Flexibility Options for Medicaid Expansion

CMS is willing to discuss ideas from the states on flexible approaches to the Medicaid expansion—within reason and within statutory authority⁹. For example, for newly eligible adults, states can set the benefit standards closer to commercial plans. They can also vary the plan design by segments of the expansion population. A recent proposed rule from CMS

⁶ “Va. Lawmakers Establish Panel To Work On Medicaid Expansion.” *Kaiser Health News*. (2013): n. page. Web. 1 Apr. 2013. <<http://bit.ly/YrIXsh>>.

⁷ Martz, Michael. “Conditions for expanding Virginia’s Medicaid program.” *Richmond Times-Dispatch*. (2013): n. page. Web. 1 Apr. 2013. <<http://bit.ly/11IeGHw>>.

⁸ Karmasek, Jessica M. “Va. AG: Commission set up to expand Medicaid unconstitutional.” *Legal Journal*. Legal Newline, 27 3 2013. Web. Web. 1 Apr. 2013. <<http://bit.ly/16sbu1q>>.

⁹ “Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid.” *Department of Health and Human Services* (2012): 1-18. *Centers for Medicare and Medicaid Services*. Web. 1 Apr 2013. <<http://1.usa.gov/10tdVNm>>.

increases the maximum allowable co-payments for certain services and populations in Medicaid¹⁰. In the context of expanding Medicaid under the ACA, some states may be interested in taking advantage of additional options to increase cost-sharing for the expansion population. The table below outlines the allowable cost-sharing under the recent proposed rules for this group (non-pregnant, able-bodied adults earning up to 138% of the federal poverty level (FPL)).

There are two areas in particular where states state may have increased flexibility by this proposed rule:

- **Prescription drugs.** The rule allows states to charge higher amounts (up to \$8) for non-preferred drugs, compared with what they can charge for drugs on the preferred list (up to \$4).
- **Certain ER visits.** The proposed rule allows states to charge higher amounts (up to \$8) for non-emergency use of the ER. The proposed rules stipulate several limitations on this higher cost-sharing:

It's important to note Utah's request for flexibility around cost sharing in its 2011 Medicaid accountable care waiver application was denied. Now some of these options are on the table for the Medicaid expansion population. A much more detailed description of existing and proposed premium and cost-sharing standards is available in this Kaiser Family Foundation brief¹¹.

CONCLUSION

Assuming states like Arkansas, Wisconsin, Virginia, and others move ahead with some version of their proposals for flexibility, it will be important to measure their results and share lessons across the states. Given the many centers of excellence in our midst, Utah may be well positioned to explore innovative approaches to the Medicaid expansion.

¹⁰ "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeals Processes for Medicaid and Exchange Eligibility Appeals, etc." *Regulations.gov* (2013): n.pag. Web. 1 Apr 2013. <<http://1.usa.gov/10iYwAl>>.

¹¹ "Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid." *Policy Brief: Kaiser Commission*(2013): 1-6. Web. 1 Apr 2013. <<http://bit.ly/1294wMy>>.