



# FLEXIBILITY ON the MEDICAID EXPANSION

## Pros and Cons of Flexibility Scenarios for Utah

### Summary

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 start after the legislative session. Consistent in all of his recent statements on the study process, the Governor has expressed interest in maximizing flexibility on the expansion.<sup>i</sup> The good news for him and many 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 conservative leaders are looking to change the nature of the expansion and the operation of Medicaid in their states. UHPP 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 UHPP gains deeper insights into these proposals and configurations of the expansion, we will share additional critical perspectives on these proposals.

### New Cost-Sharing and Flexibility Options for Medicaid Expansion

The federal agency CMS (Centers for Medicare and Medicaid Services) is willing to discuss ideas from the states on flexible approaches to the Medicaid expansion—within reason and within statutory authority. 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.<sup>ii</sup> A [recent proposed rule](#) from CMS increases the maximum allowable co-payments for certain services and populations in Medicaid. 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)).

#### Rules for Medicaid Cost-Sharing Applying to Most Newly-Eligible Adults (non-pregnant, able-bodied)

	≤ 100% Federal Poverty Level (FPL)	101%-150% FPL
Most-services <sup>iii</sup>	Up to \$4 <i>(Before the recent proposed rules, the limit was dependent on what the state paid for the service. However, \$3.90 was the maximum for most services.)</i>	Up to 10% of the cost of the service
Institutional services	50% of the cost the agency pays for the first day of care (per admission)	50% of the cost the agency pays for the first day of care (per admission) or 10% of the total cost the agency pays for the stay
Prescription drugs.	<b>Preferred – up to \$4</b> <b>Non-preferred – up to \$8</b> <i>(Before the recent proposed rules, the limit was “nominal” for both preferred and non-preferred drugs)</i>	
Non-emergency use of the emergency department	Up to \$8 <i>(Before the new rules, the limit was “nominal”)</i>	Up to \$8

**Note:** The red-highlighted cells represent the services for which the recent proposed regulations significantly increase the allowable cost-sharing amounts.

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). The proposed rule specifies a few limitations on this higher cost-sharing:
  - If a state does not differentiate between preferred and non-preferred drugs, all drugs are considered preferred. *Utah already differentiates between the two, except for drugs used to treat mental illness.*
  - If an individuals' doctor determines that the preferred drugs would be less effective or have adverse effects, the individual can only be charged the preferred drug cost-sharing amount.
- **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:
  - Before charging this higher amount for non-emergency use of the ER, the hospital must first coordinate scheduling and refer the individual to an available and accessible alternative provider. *Utah may be well positioned to accept these limitations, given the commitment to accountable care and related incentives to re-direct traffic away from expensive settings like the emergency room.*
  - An emergency medical condition is defined using the "prudent layperson" standard, such that a condition is considered an "emergency" if a person "who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention" to seriously impair the individual's health. A state wishing to charge higher amounts for non-emergency use of the ER must specify how it will identify cases that meet this standard. *Of course, such a standard is meaningless unless patients and their families or advocates know about it—and how to pursue their rights in relation to it.*

It's important to note that 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 in Medicaid is available in [this Kaiser Family Foundation brief](#).

## State's Approaches to Flexibility on the Medicaid Expansion

*The information presented below is mainly for reference purposes. Our mention of these proposals should not be construed as an endorsement.* In Arkansas, Florida, Virginia, and other governors have asked for flexibility on the expansion beyond the limits described by CMS (summarized above). Below are the highlights and brief critical commentary on each.

### Arkansas: Use Medicaid expansion dollars to buy Exchange coverage

#### Summary:

- On February 26<sup>th</sup> Governor Mike Beebe [announced an agreement](#) 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.
- It appears HHS has agreed to federally fund Exchange coverage at the same matching rates as it would have funded the traditional Medicaid expansion. That means the federal government would

pay 100% of the costs of Exchange premiums for the expansion population for the first three years.<sup>iv</sup>

- 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 their cost-sharing protections up to Medicaid levels.

**Status (as of March 21, 2013):**

- We are still waiting on details from HHS to understand exactly how this compromise would work.
- Gov. Beebe has announced his support for this Medicaid expansion and this deal, but the legislature still has to approve it.
- Many advocates and consumer groups in Arkansas are still pushing for the straight or full Medicaid expansion. They are not convinced the plan is cost effective or that consumer protections will be preserved.
- A state government based study asserts the private option approach is not more expensive to the federal government than Medicaid.
- National thought leaders on health care are skeptical of the Arkansas plan.

**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 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 try—or it may be better than no coverage at all.<sup>v</sup>

**Florida: Expand Medicaid through private managed care plans** *Summary:*

- Within hours of HHS granting conditional approval for a Medicaid waiver (which would allow Florida to move almost all Medicaid recipients into managed care), Governor Rick Scott [announced his support for the Medicaid expansion](#).
- Gov. Scott supports the expansion with a sunset provision that would require the state to reauthorize the expansion after three years (i.e. once the federal funding, as scheduled by the ACA, drops below 100%).

**Status (as of March 21, 2013):**

- Though Governor Scott supports the expansion, the prospects of the expansion passing the legislature are unclear. On March 11<sup>th</sup>, the Florida Senate Select Committee on the Patient Protection and Affordable Care Act rejected the expansion, following a similar decision by a House committee the week before.
- Florida's Republican legislative leaders, however, are so far not sympathetic to Scott's plan. They would [rather see an approach](#) similar to the Arkansas plan described above. Both Florida state houses rejected Scott's plan at the committee level.<sup>vi</sup>

**UHPP Quick Take:**

Gov. Rick Scott's original proposal for flexibility through deeper involvement in managed care should resonate well in Utah, given the state's commitment to capitated managed care. Utah's original Medicaid waiver request, submitted in 2011, contained requests for cost sharing flexibility that could be explored for the expansion population.

## Virginia: Legislative will approve expansion only if certain Medicaid reforms are achieved

### Summary:

- Virginia would create a [legislative commission to assess](#) whether specific Medicaid reforms and cost-reduction and efficiency benchmarks are achieved. If the answer is “yes”, the commission will approve the Medicaid expansion.
  - The commission needs more than a simple majority to approve the Medicaid expansion. The voting members of the commission are: five members of the House Appropriations Committee and five members of the Senate Finance Committee. To go forward with the expansion, 3 of the 5 General Assembly members must approve it, as well as 3 of the 5 Senate members.
  - The 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; 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.

### Status (as of March 21, 2013):

- This compromise is included in a budget amendment. The amendment has passed the Assembly and the Senate, and is now awaiting the Governor Bob McDonnell’s approval.
- The governor appears to have agreed not to veto it, but may still “tweak” it. This decision must be made by March 25, 2013.

**UHPP Quick Take:** CMS is open to most of the required reforms listed in Virginia’s commission study plan. Their guiding principle is 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.

## CONCLUSION

Assuming states like Arkansas, Florida, 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.

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<sup>i</sup> Wendy Leonard, “Gov. Gary Herbert issues last-minute-plea to President Obama regarding health care reform,” *Deseret News*, December 11, 2012. <http://www.deseretnews.com/article/865568539/Gov-Gary-Herbert-issues-last-minute-plea-to-President-Obama-regarding-health-care-reform.html?pg=all>.

<sup>ii</sup> CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, December 10, 2012. <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>.

<sup>iii</sup> Certain services are exempt from cost-sharing, notably: emergency services.

<sup>iv</sup> Sara Rosenbaum, “Using Medicaid Funds to Buy Qualified Health Plan Coverage for Medicaid Beneficiaries,” *Health Reform GPS*, March 7, 2013. <http://www.healthreformgps.org/wp-content/uploads/SR-Arkansas-premium-support-pdf.pdf>.

<sup>v</sup> Alan Weil, “Much Ado about Arkansas: Medicaid in the Insurance Exchange,” *Once in a Weil* (blog), March 11, 2013. <http://www.nashp.org/onceinaweil/much-ado-about-arkansas-medicaid-insurance-exchange>.

<sup>vi</sup> Sarah Kliff, “Florida Senate panel rejects Medicaid expansion—but it’s not dead yet,” *Washington Post*, March 11, 2013. <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/03/11/florida-senate-panel-rejects-medicaid-expansion-but-its-not-dead-yet/>