

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-14

Subject: Medicaid Expansion Options and Alternatives

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Referred to: Reference Committee J
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1 Expanding Medicaid eligibility to all individuals with incomes up to 138 percent of the federal
2 poverty level (FPL) was a key element of the strategy to expand health insurance coverage under
3 the Affordable Care Act (ACA). The Supreme Court ruling that Medicaid expansion was optional
4 allowed states to choose to decline or delay the opportunity to expand coverage for their residents.
5 As of this report, 24 states had not expanded Medicaid. Approximately 7.6 million uninsured adults
6 in these states would be eligible for coverage under a Medicaid expansion.¹

7
8 Among the states that embraced the Medicaid expansion, the vast majority have done so in
9 accordance with the parameters set forth in the ACA. However, a few states have chosen to pursue
10 federal waivers that allow them to customize their Medicaid expansion plans in ways that would
11 not otherwise be permitted under Medicaid rules. Since there is no deadline by which states must
12 decide to expand their Medicaid program, policymakers in non-expansion states are likely to pay
13 close attention to the results of expansion efforts in other states, particularly ones that are pursuing
14 innovative strategies.

15
16 This report provides an overview of the Medicaid expansion opportunity created by the ACA,
17 describes the role of Section 1115 demonstration waivers in the Medicaid expansion process, and
18 highlights alternative Medicaid expansion strategies that are being pursued by some states. The
19 report includes recommendations to encourage innovative approaches to expanding coverage
20 options for adults who still lack access to affordable health insurance.

21 22 BACKGROUND

23
24 The ACA created two primary pathways for expanding health insurance coverage. The law created
25 private health insurance marketplaces and federally funded health insurance premium subsidies for
26 people with incomes between 100 and 400 percent of FPL. The law also provided funding for
27 states to expand their existing Medicaid programs to cover all adults with incomes up to 138
28 percent of FPL. The ACA intended to cover these newly eligible adults through a Medicaid
29 expansion that would be 100 percent federally financed through 2016, phasing down to 90 percent
30 federally financed thereafter.

31
32 Prior to the ACA, Medicaid eligibility was limited for non-elderly, low-income adults, who
33 accounted for about half of the uninsured population.² Parents of dependent children were
34 Medicaid-eligible, but the majority of states set income limits below 100 percent of FPL, and some
35 set income limits below 50 percent of FPL. Low-income childless adults were not among the core
36 groups eligible for Medicaid coverage, and the majority of states did not offer Medicaid coverage
37 to this population at any income level. Expanding Medicaid coverage to all adults with incomes up

1 to 138 percent of FPL was envisioned by the ACA as the primary mechanism through which this
 2 large segment of the uninsured would gain health insurance coverage.

3
 4 As noted, 24 states have not yet expanded their Medicaid programs. Low-income adults in these
 5 states have extremely limited coverage options. The Kaiser Family Foundation estimates that
 6 among the 7.6 million people in non-expansion states who would have been newly eligible for
 7 Medicaid coverage, only 37 percent have incomes between 100 and 138 percent of FPL and may
 8 be able to afford private coverage with the help of federal premium subsidies. The remaining 63
 9 percent have incomes below 100 percent of FPL, which makes them ineligible for premium
 10 assistance. These extremely low-income adults in non-expansion states are stuck in the “coverage
 11 gap” without access to either Medicaid or financial assistance to obtain private coverage.³

12
 13 SECTION 1115 WAIVERS AND MEDICAID EXPANSION ALTERNATIVES

14
 15 For some states that are reluctant to pursue a Medicaid expansion, Section 1115 demonstration
 16 waivers may offer an opportunity to fully implement the expansion while addressing some of the
 17 perceived limitations of the Medicaid program, including inefficiencies that some believe could be
 18 improved by introducing greater market competition and experimenting with benefit and cost-
 19 sharing designs. The Centers for Medicare & Medicaid Services (CMS) has approved waivers
 20 directly related to the Medicaid expansion population for Arkansas, Iowa, and Michigan, which
 21 began their expansions in 2014. CMS also approved a waiver request from Pennsylvania, which is
 22 scheduled to begin its expansion on January 1, 2015. At the time of this report, Indiana was
 23 developing a waiver proposal that would be based on its existing Healthy Indiana Plan, which
 24 requires low-income beneficiaries to contribute a portion of their income to individual accounts
 25 that are similar to health savings accounts. In general, states have requested approvals for waivers
 26 related to premium assistance, premium and cost sharing requirements, healthy behavior
 27 incentives, benefit changes and work requirements.

28
 29 Expanding Medicaid via premium assistance (also known as a “private option”) has emerged as a
 30 potential compromise for states concerned about increasing the government’s role in and
 31 responsibility for providing health insurance coverage. Under this approach, Medicaid expansion
 32 funding is used to purchase private coverage for newly eligible beneficiaries through the state’s
 33 health insurance marketplace or the private insurance market. CMS has issued broad guidance
 34 regarding waivers that support a premium assistance approach, including requiring states to provide
 35 wrap-around coverage for benefits and cost-sharing consistent with Medicaid requirements, and
 36 that beneficiaries have a choice of at least two plans. CMS has also said medically frail, dual-
 37 eligible and special needs populations cannot be included in premium assistance demonstrations.⁴

38
 39 Arkansas and Iowa received waivers to use Medicaid expansion funds to purchase “silver level”
 40 private coverage for newly eligible adults through the states’ health insurance exchanges.
 41 Pennsylvania’s waiver allows the state to contract with private managed care plans to provide
 42 coverage to newly eligible beneficiaries, although it does not specify that plans will be part of the
 43 health insurance exchange.⁵ In Arkansas and Pennsylvania, enrollment in the private option is
 44 mandatory for all newly eligible adults (except those who are medically frail). Iowa requires
 45 enrollment in the private option only for newly eligible adults with incomes between 100 and 138
 46 percent of FPL. Newly eligible Iowans with incomes below 100 percent of FPL will be covered
 47 through Medicaid managed care.⁶

48
 49 States have also sought waivers related to premium requirements for newly eligible adults. The
 50 Medicaid statute prohibits states from charging premiums to beneficiaries with incomes below 150
 51 percent of FPL. However, Iowa, Michigan and Pennsylvania have received waivers that allow them

1 to charge monthly premiums equal to two percent of income to newly eligible beneficiaries with
 2 incomes more than 100 percent of FPL. Premiums are waived for beneficiaries in Iowa who attest
 3 to financial hardship, and Iowa and Pennsylvania allow a 90-day grace period for beneficiaries to
 4 pay past premiums before coverage is terminated. Michigan’s waiver specifies that individuals may
 5 not lose coverage for failure to pay premiums. All three states’ waivers also include approval for
 6 incentives (e.g., reductions in cost-sharing) for enrollees who adopt healthy behaviors.⁷

7
 8 As noted, CMS generally requires states using a private option to provide wrap-around coverage
 9 for benefits that would normally be covered by Medicaid. However, Iowa’s waiver included
 10 approval to exclude coverage for non-emergency medical transportation for one year, after which
 11 time CMS will evaluate the impact of this policy on access to care.⁸ Pennsylvania’s waiver also
 12 allows the state to exclude coverage for non-emergency medical transportation for one year.
 13 Pennsylvania also received approval to establish two benefit packages for all Medicaid
 14 beneficiaries, based on an assessment of whether enrollees are “high risk” or “low risk” with
 15 respect to health status.⁹

16
 17 Although CMS has demonstrated some flexibility in its waiver approvals for the expansion
 18 population, it has denied certain elements of some proposals. Iowa unsuccessfully requested to
 19 waive the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
 20 to 19 and 20 year olds, and the requirement that adults have access to any family planning provider.
 21 CMS also denied requests to charge premiums to beneficiaries with incomes below 100 percent of
 22 FPL, and to impose cost-sharing requirements beyond those allowed under federal Medicaid rules.
 23 States expanding coverage via a private option must make payments on behalf of beneficiaries
 24 enrolled in qualified health plans if cost-sharing requirements exceed Medicaid limits. CMS also
 25 denied Pennsylvania’s request to link Medicaid eligibility to job training or employment
 26 requirements. CMS also announced that it will not approve requests for partial expansions (e.g.,
 27 eligibility levels below 138 of FPL) at the enhanced federal match rate, although waivers for partial
 28 expansions may still be granted at the state’s regular Federal Medical Assistance Percentage
 29 (FMAP) match rate.¹⁰

30
 31 CMS approved Wisconsin’s waiver for a partial expansion at the state’s regular FMAP rate in
 32 December 2013. Although Wisconsin is not participating in the Medicaid expansion, the state
 33 restructured its Medicaid program so that none of its residents fall into the coverage gap. Prior to
 34 the ACA, Wisconsin was one of the few states to offer Medicaid coverage to childless adults up to
 35 200 percent of FPL. However, the program was subject to enrollment caps that left 157,259 adults
 36 awaiting coverage as of August 2013. Wisconsin developed a federal waiver that allowed the state
 37 to improve Medicaid access for very low-income residents by transitioning higher-income residents
 38 off of Medicaid and into private coverage with the help of the federal premium subsidies made
 39 available by the ACA. CMS approved Wisconsin’s request to reduce Medicaid eligibility levels for
 40 childless adults from 200 to 100 percent of FPL and eliminate the enrollment cap that had been in
 41 place since 2009. In its waiver to CMS, Wisconsin estimated that the elimination of the cap would
 42 allow approximately 82,000 previously uninsured adults with incomes below 100 percent of FPL to
 43 obtain Medicaid coverage. The state anticipated that approximately 5,000 adults with higher
 44 incomes would transition out of Medicaid and into the exchanges, where they may be eligible for
 45 premium subsidies and federal cost-sharing assistance to help reduce out of pocket costs.¹¹

46
 47 **A NEW MEDICAID POPULATION**

48
 49 When considering Medicaid expansion models and options, it is worth noting that the ACA
 50 maintained a distinction between the traditional Medicaid population and the expansion population.
 51 The law included “maintenance of effort” requirements for children and adults previously covered

1 by Medicaid, and introduced separate financing arrangements that would apply only to the newly
 2 eligible expansion population. Specifically, coverage of the expansion population will be financed
 3 entirely by the federal government through 2016, with a minimum 90 percent federal share
 4 thereafter. States and the federal government will continue to share the responsibility for coverage
 5 of the traditional Medicaid population, according to the FMAP calculated for each state.

6
 7 In addition to a new financing structure, the ACA also established different coverage requirements
 8 for the Medicaid expansion population. Prior to the ACA, federal law required that states provide
 9 certain services for Medicaid enrollees, such as inpatient and outpatient hospital services;
 10 physician, midwife and nurse practitioner services; EPSDT services for children and young adults
 11 up to age 21; and non-emergency medical transportation. Although states had the option of
 12 providing a narrower set of “benchmark” benefits to some Medicaid enrollees, few states used this
 13 option and instead provided the same benefits to all Medicaid beneficiaries.¹²

14
 15 The ACA added two services to Medicaid’s mandatory coverage list (freestanding birthing center
 16 services and tobacco cessation services for pregnant women), but also redefined the requirements
 17 for the benchmark benefits. The ACA also specified that benefits for newly eligible adults in the
 18 expansion group would be based on these “alternative benefit plans,” the new term for benchmark
 19 plans. While there is significant overlap between Medicaid’s traditional benefit requirements and
 20 alternative benefit plans, they are not identical. Notably, alternative benefit plans must include the
 21 same 10 essential health benefits that health insurance exchange plans are required to offer.
 22 Traditional Medicaid is not required to provide these same benefits. States have the option of
 23 harmonizing the benefits offered to their traditional Medicaid population and their expansion
 24 population, but are not required to do so.¹³

25
 26 **RELEVANT AMA POLICY**

27
 28 Longstanding AMA Policy H-165.920 advocates for the use of refundable, advanceable tax credits
 29 inversely related to income over public sector expansions as a means of providing coverage to the
 30 uninsured. Policy H-165.855 specifically supports allowing Medicaid beneficiaries to purchase
 31 private health insurance coverage with income-adjusted tax credits. More generally, the AMA has
 32 long recognized the benefit of allowing states to experiment with new models for covering the
 33 uninsured (e.g., Policies D-165.966, D-165.957 and H-290.982).

34
 35 The AMA encourages flexibility with respect to the way states implement their Medicaid
 36 programs, while also acknowledging the need for safeguards to protect beneficiaries. Policy
 37 H-165.855 identifies non-elderly and non-disabled Medicaid beneficiaries as populations that
 38 should be able to purchase private coverage, acknowledging that traditional Medicaid coverage
 39 may be more appropriate for more vulnerable groups of beneficiaries. Policy H-165.855 also
 40 recommends that private coverage for Medicaid individuals include EPSDT services for children
 41 with no cost-sharing, and that states provide wrap-around coverage, at least for a transitional
 42 period, for non-medical services that would otherwise be covered by Medicaid. In addition, Policy
 43 H-165.855 recommends that private coverage for Medicaid-eligible individuals include minimal or
 44 no cost sharing obligations. However, Policy H-290.982 supports the use of modest copays or
 45 income adjusted premium cost sharing for non-emergency, non-preventive services as a way of
 46 expanding access to coverage. Policy H-290.972 supports the use of health savings accounts for
 47 Medicare beneficiaries, consistent with a set of principles intended to ensure their use does not
 48 jeopardize access to necessary medical services.

49
 50 Policy also emphasizes the importance of ensuring that Medicaid demonstration projects are
 51 thoroughly monitored and evaluated to assess their effects on access to care. Policy H-165.855

1 encourages states to support a Medicaid Physician Advisory Commission to evaluate and monitor
 2 access to care in the state Medicaid program and related pilot projects. Policy H-290.982 calls for
 3 CMS to develop better measurement, monitoring and accountability systems and indices within the
 4 Medicaid program. Policy D-165.942 supports giving states the freedom to develop and test
 5 different models for covering the uninsured, provided that their proposed alternatives meet or
 6 exceed projected coverage levels while maintaining or improving upon established levels of quality
 7 of care and maximize patient choice of physician and private health plan.

8
 9 Finally, Policy D-290.979 addresses the AMA's role in supporting state efforts to participate in the
 10 Medicaid expansion. At the invitation of state medical associations, the AMA will work with state
 11 and national medical specialty societies to advocate at the state level to expand Medicaid eligibility
 12 to 138 percent of FPL, while simultaneously advocating for an increase in Medicaid payments to
 13 physicians and improvements in the Medicaid program.

14
 15 **DISCUSSION**

16
 17 At the time this report was written, 26 states and the District of Columbia had expanded their
 18 Medicaid programs, providing a pathway for all of the uninsured residents in their states to access
 19 affordable health insurance coverage. With the exception of Pennsylvania, which has plans to
 20 expand Medicaid on January 1, 2015, and Indiana, which is actively pursuing an expansion waiver,
 21 it is unclear whether the remaining states will choose to pursue or even explore full Medicaid
 22 expansions in the near future.

23
 24 Key policymakers in the states that have not expanded their Medicaid programs have significant
 25 concerns about increasing the government's role in the health care system and about the ultimate
 26 cost to the states of such a large scale expansion. Many of these states are also reluctant to expand
 27 Medicaid programs that are already struggling to serve traditional enrollees and retain sufficient
 28 numbers of providers willing to see Medicaid patients. Yet there will be increasing pressure on
 29 these states to find ways to expand health insurance coverage to their uninsured populations,
 30 especially as the disparity in coverage levels continues to grow between expansion and non-
 31 expansion states. According to research conducted by the Urban Institute, the gap in the
 32 uninsurance rates between expansion states and non-expansion states increased from 3.1 to 5.7
 33 percentage points between September 2013 and March 2014.¹⁴

34
 35 The Council is particularly concerned about adults in non-expansion states with incomes below 100
 36 percent of the FPL. This population is ineligible for the federally funded premium subsidies to
 37 purchase private exchange coverage, and will continue to have few if any options for securing
 38 affordable health insurance coverage. The states that are pursuing Medicaid expansions have
 39 eliminated the coverage gap, and have seen significant reductions in the number of uninsured
 40 adults in this population. In July 2014, the Commonwealth Fund estimated that the rate of
 41 uninsured adults with incomes below 100 percent of FPL declined in expansion states from 28
 42 percent to 17 percent. Conversely, the rate of uninsured adults with incomes below the poverty
 43 level has remained statistically unchanged at 36 percent among the states that have not expanded
 44 Medicaid.¹⁵ It is critical that policymakers at all levels focus their efforts on working together to
 45 identify realistic coverage options for adults currently in the coverage gap.

46
 47 The Council is mindful that there may be ways for states to address the coverage gap without
 48 pursuing the ACA Medicaid expansion, such as Wisconsin's efforts to capitalize on the continuum
 49 of coverage options created by the ACA. Using the tools provided in the ACA, specifically the
 50 availability of premium and cost-sharing subsidies for people with incomes over 100 percent of
 51 FPL, policymakers were able to design a plan that allowed the state to potentially expand Medicaid

1 coverage to more than 80,000 previously uninsured residents, without actually participating in the
2 Medicaid expansion.

3
4 The Council is sensitive to states' concerns about the potential costs and inefficiencies associated
5 with expanding Medicaid in the traditional manner. Nevertheless, the Council believes that the
6 enhanced federal match associated with the full Medicaid expansion is an important opportunity for
7 states to reduce the numbers of uninsured adults. The ACA's treatment of the Medicaid expansion
8 population as a unique and distinct group of Medicaid beneficiaries provides an opportunity for
9 increased flexibility in the way states and CMS approach coverage options for this population.

10
11 Consistent with AMA policies that support state efforts to pursue innovative strategies for covering
12 the uninsured, the Council believes that the AMA should encourage states that would otherwise
13 reject the opportunity to expand their Medicaid programs to develop Medicaid expansion waivers,
14 and encourage CMS to exercise broad authority in granting such waivers, provided that the waivers
15 are consistent with the goals and spirit of expanding health insurance coverage and eliminating the
16 coverage gap for low income residents.

17
18 Ultimately the success of Wisconsin's Medicaid redesign and the Medicaid expansions in states
19 that obtain waivers to pursue a private option and other plan modifications will be determined by
20 the effects the policies have on the number of uninsured and their access to care. Experimentation
21 and evaluation are equally important components of the Medicaid waiver process. States should be
22 required to develop a transparent process for monitoring and evaluating the effects of their
23 Medicaid expansion plans on health insurance coverage levels and access to care, and should be
24 required to report the results annually on the state Medicaid web site.

25 26 RECOMMENDATIONS

27
28 The Council on Medical Service recommends that the following recommendations be adopted and
29 that the remainder of the report be filed.

- 30
31 1. That our American Medical Association (AMA) encourage policymakers at all levels to
32 focus their efforts on working together to identify realistic coverage options for adults
33 currently in the coverage gap. (New HOD Policy)
34
35 2. That our AMA encourage states that are not participating in the Medicaid expansion to
36 develop waivers that support expansion plans that best meet the needs and priorities of
37 their low income adult populations. (New HOD Policy)
38
39 3. That our AMA encourage the Centers for Medicare & Medicaid Services to review
40 Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in
41 approving such waivers, provided that the waivers are consistent with the goals and spirit
42 of expanding health insurance coverage and eliminating the coverage gap for low-income
43 adults. (New HOD Policy)
44
45 4. That our AMA advocate that states be required to develop a transparent process for
46 monitoring and evaluating the effects of their Medicaid expansion plans on health
47 insurance coverage levels and access to care, and to report the results annually on the state
48 Medicaid web site. (New HOD Policy)

Fiscal Note: Less than \$500.

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