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# THE SENATE STUDY COMMITTEE ON THE PREMIUM ASSISTANCE PROGRAM – SUMMARY OF MEETINGS

## COMMITTEE MEMBERS

**Senator Renee Unterman – Chair**
**District 45**

**Senator Michael Rhett – Vice Chair**
**District 33**

**Senator Judson Hill**
**District 32**

**Senator Lester Jackson**
**District 2**

**Senator David Shafer**
**District 48**

**Prepared by the Senate Research Office**
**2016**

# COMMITTEE FOCUS, CREATION, AND DUTIES

The Senate Study Committee on the Premium Assistance Program was created by Senate Resolution 1056 to examine the costs and benefits of expanding Medicaid coverage in Georgia under a premium assistance model.

Senator Charlie Bethel of the 54th initially served as Committee Chair until his appointment to the Georgia Court of Appeals. On November 14, 2016, Senator Renee Unterman of the 45th was appointed as Committee Chair. The other Senate members included: Senator Michael Rhett of the 33rd serving as the Committee's Vice Chair; Senator Judson Hill of the 32nd; Senator Lester Jackson of the 2nd, and Senator David Shafer of the 48th.

The Committee held one meeting at the State Capitol on October 5, 2016 and heard testimony from the following: Mr. Alexander Azarian, Deputy Director of the Senate Research Office; Ms. Cindy Zeldin, Executive Director of Georgians for a Healthy Future; Ms. Laura Harker, Health Policy Analyst with the Georgia Budget and Policy Institute; Mr. Matt Hicks, Vice President of Government Relations for Grady Health System; and Mr. Tim Kibler, Vice President of Governmental Affairs for the Georgia Alliance of Community Hospitals.

# COMMITTEE FINDINGS

## Background

Initially under the Affordable Care Act (ACA), Medicaid was expected to expand eligibility to nearly all low income adults with incomes at or below 138% of the federal poverty level (FPL, $16,394 per year for an individual in 2016) with full federal financing for the first three years (2014 – 2016), and gradually decreasing to 90% federal funding by 2020. However, the Supreme Court ruling on the ACA's constitutionality effectively made the expansion a state option. According to Centers for Medicare and Medicaid Services (CMS) guidance, states cannot receive the enhanced federal funding for the ACA expansion unless they cover all newly eligible adults through 138% FPL.

A state can only expand Medicaid eligibly under the ACA in one of the following manners:

1. Submit a State Plan Amendment (SPA) to CMS, also referred to as "traditional expansion," allowing a state to implement Medicaid expansion as outlined in the ACA; or
2. Submit a Section 1115 demonstration waiver, which allows a state to expand eligibility in a more tailored approach. This method is used by states that are politically unable or unwilling to expand Medicaid through traditional expansion while capturing federal matching funds for newly eligible adults.

Currently, 32 states including DC have adopted the expansion, and nearly all are implementing the expansion as set forth by the ACA. Six of these states, Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire, have obtained approval through Section 1115 waivers to implement the expansion in ways that extend beyond the limits provided by federal law, while Arizona and Kentucky have applied for a waiver. Ohio's waiver was recently rejected by CMS.

## Section 1115 Waiver

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. The purpose of these demonstrations is to give states additional flexibility to design, tailor, and improve their programs. There are general criteria CMS uses to determine whether each state waiver should be approved. These criteria require each waiver demonstration to:

1. Increase overall coverage of low-income individuals;
2. Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations;
3. Improve health outcomes for Medicaid and other low-income populations; or
4. Increase the efficiency and quality of care for Medicaid and other low-income populations.

Demonstrations must also be "budget neutral" to the federal government, which means that during the course of the project, federal Medicaid expenditures must not be more than federal spending without the waiver. Generally, Section 1115 demonstrations are approved for an initial five-year period and can be extended for an additional three years.

CMS also requires that each proposed waiver receive a 30-day public comment period for the general public and stakeholders to submit comments. CMS will not act on the demonstration waiver request until at least 15 days after the conclusion of the public comment period have passed. States have the option of using an interim template provided by CMS to develop their own applications. States are also encouraged to use CMS' budget neutrality template in developing their applications.

## Characteristics of Approved and Pending Waivers

No two approved, pending, or rejected waivers are identical. But similar provisions include:

1. A premium assistance model in which the state uses federal Medicaid funds to purchase private coverage for enrollees through an Exchange or other sources such as employer sponsored insurance (ESI);
2. Charging premiums beyond the limits set in federal law;
3. Using healthy behavior incentives to reduce premiums and/or copayments;
4. Eliminating non-emergency medical transportation (NEMT), an otherwise required benefit;
5. Allowing a state to waive retroactive eligibility;[1]
6. Making coverage effective beginning on the date of the first premium payment, rather than on the date of application;
7. Barring certain expansion adults from re-enrolling in coverage for six months if they are disenrolled for unpaid premiums;
8. Charging higher cost-sharing than otherwise allowed under federal rules for non-emergency use of the emergency room (Section 1916(f) waiver); and
9. Implementing a 12-month continuous eligibility for new adults to reduce the effects of churning between Medicaid and Exchange coverage due to small changes in income.

## Provisions Rejected by CMS

CMS has denied a number of provisions included in 1115 waiver proposals including:

- Premiums for individuals with incomes under 100% FPL as a condition of eligibility;
- Waiver of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits;[2]
- Waiver of free choice of family planning provider; and
- Work requirements or incentives as a condition of Medicaid eligibility.

[1] Traditionally, once an individual is determined eligible for Medicaid, coverage is effective either on the date of application or the first day of the month of application. Benefits may also be covered retroactively for up to 3 months prior to the month of application, if the individual would have been eligible during that period had he or she applied.

[2] The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT seeks to ensure that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

## *STATE PROFILES OF APPROVED, PENDING, AND REJECTED WAIVERS*

| | Key Themes in ACA Expansion Waivers | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Approved Waivers* | | | | | | | *Pending Waivers and Amendments* | | | *Rejected Waiver* |
| **Waiver Provision** | **AR** | **IA** | **MI** | **IN** | **NH** | **MT** | **AZ** | **AR*** | **KY** | **NH*** | **OH** |
| **Premium Assistance** | QHP | QHP | QHP | ESI | QHP | | QHP | ESI | ESI | | |
| **Premiums/Monthly Contributions** | | X | X | X | | X | X | X | X | | X |
| **Healthy Behavior Incentives** | | X | X | X | | | X | X | X | | X |
| **Waive Required Benefits (NEMT)** | | X | | X | | | X | | X | | |
| **Waive Retroactive Eligibility** | | | | X | X | | | X | X | | X |
| **Copayments for Non-Emergency ER Use** | | X | X | X | | | X | | | X | X |
| **12-Month Continuous Eligibility** | | | | | | X | | | | | |
| **Time limit on Coverage** | | | | | | | X | | | | |
| **Work/Education Requirement** | | | | Rejected | | | | | X | X | X |
| | *Pending Waiver Amendment | | | | | | | | | | |

## Georgia (Proposals Only)

Senate Bill 368 (2016)

In 2014, the General Assembly adopted House Bill 990 prohibiting the state from expanding Georgia Medicaid eligibility without prior legislative approval. Despite this prohibition, Senator Michael Rhett introduced Senate Bill 368 to expand Medicaid coverage through a premium assistance program that uses federal Medicaid funds to purchase health insurance off the Exchange for beneficiaries at or below 138% FPL – as opposed to providing coverage directly through the state's Medicaid program. This approach, sometimes referred to as the "private option," requires a Section 1115 demonstration waiver and typically covers copayments, deductibles, and co-insurance in addition to the premium. Arkansas, Indiana, Iowa, Michigan, and New Hampshire have all adopted some form of the private option as an alternative to traditional Medicaid expansion under the ACA. Although the bill received a hearing in the Senate Health and Human Services Committee, no vote was ever taken.

Proponents of Medicaid expansion have long-argued that expansion will not only cover up to 500,000 more uninsured Georgians, but more Medicaid dollars will help Georgia's ailing rural hospitals and its large safety net hospitals that lose hundreds of millions of dollars each year caring for the uninsured.[3] In light of this, ideas for expansion have been proposed over recent years.

Grady Health System's Past Proposal

Based on a model similar to the MetroHealth System in Cleveland, Ohio, the Grady plan proposed using a 1115 waiver to establish a pilot healthcare network to a defined population of 50,000 with an anchor hospital and network of medical providers. The plan focuses on how medical services are delivered and how payments are handled with a delivery system evolving from a fee-for-service model to a value-based model. The model emphasizes preventative services, while being supported by comprehensive care coordination, targeted to the population's needs for reduced utilization and improved health outcomes. For example, caseworkers could steer

[3] Testimony presented separately by Ms. Cindy Zeldin, Executive Director of Georgians for a Healthy Future; Ms. Laura Harker, Health Policy Analyst with the Georgia Budget and Policy Institute; Mr. Matt Hicks, Vice President of Government Relations for Grady Health System; and Mr. Tim Kibler, Vice President of Governmental Affairs for the Georgia Alliance of Community Hospitals; October 5, 2016.

patients toward health clinics, especially for routine medical care, instead of providing the same care in the emergency room, which costs more for hospitals.[4] The plan was ultimately rejected by the Department of Community Health (DCH) in 2015 as potentially too expensive for the State to implement administratively.

Georgia Chamber of Commerce's Three Proposals

In August 2016, the Georgia Chamber of Commerce proposed three alternatives to traditional Medicaid expansion.[5] However, none of these options include an enrollment estimate, cost, or projected savings.

*Alternative 1* proposes new coverage through the state Medicaid program to childless adults who earn less than 100% FPL. Currently, childless individuals above the poverty limit ($11,880 for an individual) qualify for tax credits in the ACA's Exchange, but do not qualify for Medicaid. The 100% FPL limit, however, is lower than what the 138% FPL ($16,394) that the ACA requires.

*Alternatives 2* and *3* increase eligibility up to 138% FPL. The second option would enroll all beneficiaries up to that income level in Medicaid, while the third option would place those who earn 100% to 138% FPL in a private insurance plan using a premium assistance model.

All three alternatives seek to increase consumer responsibility, such as payment of premiums and copays, as well as some form of a work/education requirement.

## Arkansas

Arkansas was the first state to expand Medicaid eligibility through a Section 1115 waiver when CMS approved its waiver in September 2013.[6] The expansion uses Medicaid funds as premium assistance to purchase coverage through Qualified Health Plans (QHPs) from the Exchange for newly eligible adults. The demonstration covers parents from 17-138% FPL and childless adults from 0-138% FPL. The waiver also provides services that are outside the QHP benefit package, such as Early Periodic Screening Diagnosis and Treatment for 19 and 20 year olds, free choice of family planning provider, and non-emergency medical transportation through the state's Medicaid fee-for-service delivery system.

In December 2014, CMS approved an amendment to Arkansas' demonstration waiver, based on changes required by state legislation. Arkansas' amended demonstration:

- Establishes HSAs to which non-medically frail beneficiaries from 50-138% FPL make monthly income-based contributions, ranging from $5 to $25 per month, to be used for copayments and co-insurance. (These contributions are not a condition of Medicaid eligibility); and
- Imposes cost-sharing at the point-of-service at state plan amounts for beneficiaries above 100% FPL who do not make monthly account contributions.

Initially, the state also sought waiver authority to limit NEMT to 8 trip legs per year for non-medically frail beneficiaries. Instead, the state established a prior authorization process for NEMT for newly eligible adults, which does not require waiver authority.

Arkansas Works

Although the state has indicated that its current waiver demonstration has been successful, Governor Asa Hutchinson and the Arkansas General Assembly have proposed the Arkansas Works program that expands the premium assistance model by encouraging the purchasing of employer-sponsored insurance (ESI), emphasizing wellness, and incentivizing work.

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[4] Testimony presented by Mr. Matt Hicks, Vice President of Government Relations for Grady Health System; October 5, 2016.

[5] https://cmgajcpolitics.files.wordpress.com/2016/08/georgia-chamber-proposal.pdf

[6] Much of the following individual state information was collected and synthesized from the Kaiser Family Foundation, NCSL, Health Affairs, the Medicaid and CHIP Payment and Access Commission (MACPAC), Georgia Health News, and local sources specific to each state.

Enabling legislation for Arkansas Works was passed during the General Assembly's second special session in 2016, and was signed into law on April 8, 2016. On June 28, 2016, Arkansas submitted its waiver application to CMS and a decision is expected in late 2016. If approved by CMS, this waiver authorizes the state to implement Arkansas Works on January 1, 2017 and continue its 1115 Demonstration through 2021. The key features of the program include the following:

1. ESI premium assistance;
2. Premium obligation for select participants;
3. Retroactive eligibility;
4. Incentivizing work for program participants;
5. Wellness promotion activities; and
6. A plan to cancel the waiver demonstration within 120 days if federal medical match percentages drop below the previously established thresholds.

## Iowa

In 2013, Iowa received approval for two Section 1115 waivers to expand Medicaid. Originally, one of Iowa's waivers required newly eligible adults with an income from 101%-138% of the FPL to enroll in an Exchange QHP using Medicaid funds as premium assistance. The other waiver required newly eligible beneficiaries at or below 100% FPL to enroll in Medicaid managed care.

In October 2014, CMS approved Iowa's request to make Exchange QHP enrollment voluntary for beneficiaries from 101-138% FPL, after one of the two insurers withdrew from the Exchange. Beneficiaries that chose not to enroll in the remaining QHP were enrolled in Medicaid managed care. Subsequently, the remaining insurer informed Iowa that it would no longer accept new Medicaid members. As a result, Iowa submitted a waiver amendment request to CMS in September 2015 seeking to require all newly eligible adults to enroll in capitated Medicaid MCOs as of January, 2016.[7] Iowa also submitted a Section 1915(b) waiver request to expand its capitated Medicaid managed care delivery system statewide for nearly all beneficiaries, including newly eligible adults. On December 24, 2015, the state received approval to transition all eligible adults to Medicaid MCOs. The state is maintaining its demonstration authority to enroll Medicaid beneficiaries from 101-138% FPL in Exchange coverage using Medicaid as premium assistance should another insurer offer coverage in the future.

Iowa's demonstration also:

- Includes premiums of $10 per month for beneficiaries from 101-138% FPL and $5 per month for beneficiaries from 50-100% FPL, beginning in the second year of enrollment. Medically frail beneficiaries are exempt from premiums. Premiums can be waived by completing specified healthy behavior activities. Medicaid eligibility cannot be terminated for non-payment of premiums for beneficiaries at or below 100% FPL. Those from 101-138% FPL can be disenrolled for non-payment but may reenroll at any time;
- Authorizes the state to charge an $8 copayment for non-emergency use of the ER to all waiver enrollees;
- The Medicaid cap on out-of-pocket spending of 5% of income remains in place;
- Offers additional dental benefits to those who complete periodic dental exams. The state created three tiers of dental services with the higher tiers offering additional benefits, such as restoration services; and
- Waives NEMT services. Iowa continues to provide NEMT to beneficiaries who are medically frail and those under age 21. The state's original waiver of NEMT was for the first year of the demonstration, running through July 31, 2015. The state secured extensions of the waiver through December 31, 2016 in order to collect additional data for CMS on the effect of not providing NEMT.

[7] Capitation is a payment arrangement with a healthcare provider that pays the provider a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

## Michigan

On December 30, 2013, CMS approved Michigan's Section 1115 demonstration waiver, known as the Healthy Michigan Plan. On December 17, 2015, CMS approved an amendment to Michigan's waiver, with new provisions to take effect in April 2018, after the original expansion has been in effect for 48 months.

Under the current Healthy Michigan Plan, the state provides Medicaid coverage to all newly eligible adults with an income up to and including 138% FPL. The plan requires cost-sharing capped at 5% of income of all of its enrollees and all enrollees are assessed copayments for services on a quarterly basis rather than at the point of service. The amount owed is calculated based on the prior six months of service use. Enrollees with incomes 101-138% FPL are also required to make income-based monthly premium contributions, which may not exceed 2% of household income. These premiums, when applicable, accrue in a MI Health Account and premium and cost-sharing liabilities are reflected in the account's quarterly statement. The MI Health Account statements also record any credits for the completion of health behavior incentives.

No individual may lose or be denied eligibility or be denied access to services for failure to pay premiums or copayments. In addition, beneficiaries are eligible for cost-sharing reductions if they meet healthy behavior objectives. Beneficiaries with incomes at or below 100% FPL can receive reductions in the amount of copayment liability as well as receive a gift card. Those with incomes above 100% FPL can receive reductions in liability for copayments, monthly premiums, or both.

Beginning on April 1, 2018, enrollees with incomes 101-138% FPL may choose to receive either premium assistance that allows them to enroll in an Exchange plan or complete a healthy behavior requirement to enroll in the Healthy Michigan Plan. Newly eligible individuals are enrolled in the Healthy Michigan Plan for one year to allow time for completing healthy behavior requirements. Enrollees who are medically frail are exempt from enrollment in the Exchange option.

## Indiana

Indiana's Medicaid expansion began on February 1, 2015 and is authorized through January 31, 2018. Indiana's demonstration is widely regarded as the most complex waiver approved to date. The program has multiple parts, including four different Medicaid benefit packages for the populations covered by the waiver (aside from premium assistance for employer-sponsored insurance). Beneficiaries are treated differently based on their coverage group, and beneficiaries within the same coverage group are treated differently depending upon their income level, medical frailty status, and whether they have premiums. The waiver also requires administering and tracking a number of elements, such as premium payments or copayments, compliance with healthy behaviors, and services that would have been covered retroactively for certain groups.

Key elements of Indiana's waiver include:

- Establishing premiums through monthly contributions to a Personal Wellness and Responsibility (POWER) HSA for most newly eligible adults with an income from 0-138% FPL, with services delivered through capitated MCOs. The POWER accounts are used to pay enrollee claims, not enrollee copayments.[8] Premiums are a condition of eligibility for non-medically frail beneficiaries from 101-138% FPL and are limited to 2% of income (about $27/month for those at 138% FPL); premiums for those with income below 5% FPL are $1.00 per month. All enrollees may reduce their monthly contributions if they receive preventive services;[9]
    - Beneficiaries who pay premiums will be eligible for the Healthy Indiana Plan (HIP) Plus, which includes expanded benefits and copayments only for non-emergency use of the ER;

[8] The POWER account is used to pay for the first $2,500 in claims and anything beyond that amount is covered by Indiana. Indiana contributes the difference between the enrollee's expected contribution and $2,500 to the POWER account, which holds the state and enrollee contributions, as well as any employer contributions.

[9] These reductions are based on the remaining balance in the POWER account. For HIP Plus enrollees, receipt of preventive services will double the balance to be carried over for the new enrollment period, although the amount cannot exceed enrollees' total required contribution for the year. HIP Basic enrollees are eligible for a discount of up to 50% on POWER account contributions for the subsequent year.

- Most beneficiaries with income from 101-138% FPL who fail to pay premiums within a 60 day grace period will be disenrolled from coverage and barred from re-enrolling for 6 months;
- Beneficiaries at or below 100% FPL who fail to pay premiums will receive HIP Basic, with fewer benefits (such as no coverage for adult dental and vision) and required copayments;
- Non-expansion parent/caretaker relatives and those receiving Transitional Medical Assistance have the option of paying premiums in lieu of copayments for services. These beneficiaries receive the Medicaid state plan benefit package;

- Waiving NEMT for most newly eligible adults for one year, to be extended based on the results of an evaluation assessing the impact on access to care;
- Establishing a two year demonstration under a Section 1916(f) with a control group to evaluate whether graduated copayments (first instance $8, subsequent $25) discourage non-emergency use of the ER; and
- Offering optional Medicaid premium assistance for ESI.

Indiana sought wavier authority to require a work referral as a condition of eligibility, which was not approved by CMS. Indiana's request to waive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits (specifically, vision and dental) for 19 and 20 year olds in the HIP Basic plan was also denied by CMS.

## New Hampshire

On August 15, 2014, New Hampshire implemented the ACA's Medicaid expansion through a state plan amendment that followed the traditional expansion guidelines in the ACA. However, the legislation authorizing the expansion included a sunset provision that terminates the traditional expansion by the end of 2016 and requires the state to obtain waiver authority to enroll newly eligible adults in Exchange QHPs using a premium assistance model for the expansion to continue. On March 4, 2015, CMS approved New Hampshire's Section 1115 waiver to convert its traditional ACA Medicaid expansion to its Exchange premium assistance model starting January 1, 2016. The expansion covers non-working parents from 38-138% FPL, working parents from 47-138% FPL, and childless adults from 0-138% FPL.

On August 10, 2016, New Hampshire submitted an amendment further modifying the state's expanded Medicaid program, which is awaiting a decision from CMS. The proposed amendment, which will become effective on January 1, 2017, seeks to implement the following changes:

- Require newly eligible adults who are unemployed to receive benefits only if the state determines that the individual is engaging in at least 30 hours per week of work, job training, education towards obtaining a job, high school diploma, or GED, or other related activities.[10] The legislation authorizing this waiver amendment allows the expansion to continue even if CMS does not approve the work requirement; and
- Require adults who visit the ER for non-emergency purposes to make a copayment of $8 for the first visit and $25 for subsequent visits.

## Montana

Montana's 1115 waiver was approved by CMS on November 2, 2015.[11] CMS also approved Montana's Section 1915(b) selective contracting waiver to use a managed Fee-For-Service Third Party Administrator (TPA) to deliver services to the newly eligible adults. Adults who are newly eligible for Medicaid under Montana's expansion are parents from 50-138% FPL and childless adults from 0-138% FPL.[12] Provisions of the 1115 waiver include the following:

- In order to implement the Fee-For-Service TPA, the state has approval to waive freedom of choice requirements (except for family planning providers) so that newly eligible adults will receive services from the TPA's provider network;

[10] CMS has yet to approve a Medicaid expansion waiver in any state with a work requirement.
[11] CMS approved the demonstration through December 31, 2020, pending reauthorization beyond June 30, 2019 by the State Legislature.
[12] Prior to the enactment of this demonstration, Montana did not offer Medicaid eligibility to any non-aged, non-disabled adults who did not have dependent children. Parents of dependent children with incomes at or below 47% FPL and pregnant women with incomes at or below 157% FPL were eligible for Medicaid.

- Implements 12-month continuous eligibility for all newly eligible adults to reduce the effects of churning between Medicaid and Exchange coverage as income fluctuates;
- Exempts the following groups of people from being required to enroll in the TPA and all other Section 1115 waiver provisions (except the 12-month continuous eligibility):
    - Individuals with incomes at or below 50% FPL;
    - American Indian/Alaskan Natives;
    - Medically frail;
    - Individuals with exceptional health care needs as determined by the state;
    - Individuals who live in regions where there are an insufficient number of providers contracted with the TPA; and
    - Individuals who require continuity of coverage not effectively delivered through the TPA;[13]
- Requires beneficiaries with incomes 51-138% FPL to pay monthly premiums equal to 2% of household income. These premium payments are credited toward the enrollee's first 2% of copayments, meaning that they will not pay at the point of service until charges exceed 2% of income. Out-of-pocket spending, including premiums and copayments, must not exceed 5% of household income.

As mentioned above, the state also was granted Section 1915(b) selective contracting waiver authority to use a managed Fee-For-Service TPA to deliver services to the newly eligible adults. Given the low population density of the state, Montana contracted with Blue Cross and Blue Shield of Montana in order to use its existing provider network and administrative infrastructure. The state chose a company already offering a QHP on the Montana Exchange with the goal of decreasing churn and increasing continuity of care between Medicaid and the Exchange. The Section 1915(b) waiver application also defined network adequacy standards for the TPA.

## Arizona

Arizona chose to traditionally expand Medicaid through the ACA in 2013, but the state submitted a 1115 waiver proposal that was approved by CMS on September 30, 2016. Arizona's waiver makes several changes that affect the expansion population in the following ways:

- Impose monthly premiums of 2% of income or $25, whichever is less, on all Medicaid expansion adults from 0-138% FPL and paid into HSAs;
- Require that copayments, up to 3% of income, be paid monthly into HSAs based on services already used (state legislation requires Arizona to pursue cost-sharing to the maximum allowed under federal law);
- Establish copayments for missed appointments and copayments for non-emergency use of the ER;
- Disenroll for six months beneficiaries from 100-138% FPL for nonpayment of premiums and copayments. Beneficiaries below poverty who fail to make a payment would not result in a lock out but would be counted as a debt to the state;
- Create a healthy behavior incentive program that would allow beneficiaries to use HSA funds for non-covered services or reduce future account contributions if they make timely account payments and comply with one target healthy behavior and work incentive;
- Create a work incentive program, which would not be a condition of eligibility, for beneficiaries to engage in activities such as connecting to a state employment support program, attending a job fair, enrolling in job seekers' assistance, taking a class, or other similar goals; and
- Waive NEMT services for beneficiaries from 100-138% FPL for one year.

## Kentucky (Pending CMS Approval)

Kentucky implemented a traditional Medicaid expansion in 2014. In 2016, newly-elected Governor Matt Bevin, who ran on a platform to end the Medicaid expansion and dismantle the state-based Exchange, directed the state to instead seek a Section 1115 waiver to change the state's traditional Medicaid expansion. On August 24, 2016, the state officially submitted its waiver application to CMS, where it is now pending. Kentucky's waiver seeks authority to modify the current terms of Medicaid coverage by:

[13] These individuals instead are served through Montana's traditional Medicaid program.

- Imposing premiums on a sliding scale based on income, ranging from $1.00 per month for incomes below 25% FPL and up to $15.00 per month in the first two years of enrollment for those from 100-138% FPL, and increasing in year three;
- Requiring payment of the first premium before coverage is effective for those from 100-138% FPL (coverage would be effective after 60 days for those below 100% FPL who do not pay a premium);
- Disenrolling those above 100% FPL for failure to pay a premium after a 60-day grace period and barring reenrollment for 6 months unless the beneficiary pays past due and current premiums and completes a financial or health literacy course;
- Requiring up to 20 hours per month of employment activities as a condition of eligibility for most adults;[14]
- Waiving NEMT for expansion adults;
- Adding a high deductible HSA (funded by the state) to existing capitated managed care coverage;
- Offering an incentive account to purchase extra benefits (dental, vision, over the counter medications, and gym memberships), which would be funded through completion of specified health-related or employment activities and/or up to half of any deductible funds remaining each year; and
- Requiring premium assistance to purchase ESI after the first year of Medicaid enrollment and employment.

## Ohio (Rejected by CMS)

Ohio originally implemented a traditional Medicaid expansion according to the terms set out in the ACA in January 2014. On June 15, 2016, Ohio submitted a Section 1115 demonstration waiver application to CMS as required by the operating budget passed by the state legislature in June 2015. However, on September 9, 2016, CMS denied Ohio's waiver application. CMS determined that Ohio's proposal to impose premiums regardless of income and excluding individuals from coverage indefinitely until all debts are paid would undermine access to coverage and the affordability of care. CMS also concluded that Ohio's waiver "would lead to over 125,000 people losing coverage each year" compared to the state's existing traditional Medicaid expansion.[15] While Section 1115 waivers typically involve negotiation between CMS and the state, Ohio's waiver application specifically prohibited any modification to its terms due to the state law that required it to seek the waiver.

Significant provisions of the rejected waiver included:

- Creating HSAs, which would be used to pay a $1,000 annual deductible (funded by the state) and copayments at maximum state plan amounts (funded by beneficiary contributions);
- Imposing monthly contributions, equal to the lesser of 2% of annual income or $99 per year, as a condition of eligibility for all beneficiaries except pregnant women and those with no income;
- Conditioning the start of coverage on payment of the first monthly contribution;
- Disenrolling beneficiaries for failing to pay monthly contributions or failing to provide requested renewal documentation after 60 days;
- Establishing a healthy behavior program that would allow beneficiaries to earn HSA dollars to fund copayments or medically necessary services that are not covered by Medicaid;
- Allowing beneficiaries to carry forward any monthly contributions remaining in their HSA to reduce the next year's required contributions;
- Allowing beneficiaries who lose eligibility due to increased income to transfer any remaining HSA funds into a separate account to pay private health insurance costs;
- Referring all beneficiaries working fewer than 20 hours per week to a workforce development agency; and
- Requiring copayments for all beneficiaries covered by the waiver at the maximum amounts allowable under federal law: $75 for inpatient services; $4 for outpatient services and preferred drugs; and $8 for non-preferred drugs and non-emergency use of the emergency room.

[14] Such as working, job training, education towards obtaining a job, high school diploma, or GED, or other related activities.

[15] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/healthy-ohio-program/oh-healthy-oh-program-disapproval-ltr-09092016.pdf

## Tennessee (Rejected by the General Assembly)

In January 2015, Governor Bill Haslam called for a special session of the Tennessee legislature to address his Insure Tennessee plan. On February 4th, the Senate Health and Welfare Committee voted 7-4 against Haslam's Medicaid expansion proposal, blocking it from going any further in the legislative process. The failed proposal included a premium assistance model and also called for copays for some enrollees, payment systems for providers that are based on outcomes rather than fee-for-service, and a clause that requires future renewal of Medicaid expansion to be approved by the legislature. The proposal would have covered newly eligible parents from 100-138% FPL and childless adults from 0-138% FPL. Tennessee hospitals would have funded the state's costs of the Medicaid expansion through an increased state assessment on hospitals.

Other provisions of the proposed waiver included the following:

- Expand Medicaid coverage through capitated Medicaid MCOs already operating in the state. MCOs would have administered HSAs in which newly eligible adults would accrue credits by participating in certain designated healthy behaviors. These credits could then be used to decrease premiums and copayments;
- Require monthly premiums up to 2% of income for newly eligible adults from 100-138% FPL and impose copays within existing limits in federal regulations;
- Disenroll beneficiaries for failing to pay premiums for 60 days and seek waiver authority for a lock-out period before these individuals could reenroll based on Indiana's lock-out provision;[16]
- Offer premium assistance for ESI;
- Enroll individuals ages 19 and 20 into the regular TennCare Medicaid program and provide them with all TennCare benefits, including Early and Periodic Screening, Diagnosis, and Treatment; and
- Waive 3 months retroactive eligibility for all newly eligible adults.

## Utah (Rejected by the General Assembly)

Utah's General Assembly has repeatedly blocked any attempt to expand Medicaid, with the latest effort, known as Utah Access Plus, being defeated in October 2015. Predictably, much of the debate over Utah Access Plus involved funding. Utah needed to generate about $50 million in order to cover the state's portion of the cost of expanding Medicaid. Utah Access Plus relied on fees spread across the state's medical providers and stakeholders, including hospitals, doctors, and managed care plans. A public hearing on the proposal in October 2015 drew significant criticism from healthcare providers who worried about the impact of the fees, particularly the fact that they could grow over time. For physicians, the fee was initially set at $67 per month.

The plan never reached the waiver stage, but if implemented on January 1, 2017, the plan would have provided for the following:

- Medically frail individuals in the expansion population would receive benefits under the current state Medicaid program;
- Individuals with an offer of ESI would be required to enroll in the ESI and receive premium assistance;
- Individuals not eligible for ESI who are above the FPL receive premium assistance to purchase a private plan that is actuarially equivalent to a silver level plan on the Exchange, plus cost sharing reductions similar to what the individual would receive on the federal Exchange;
- Individuals not eligible for ESI who are below the FPL receive premium assistance to purchase a private plan that is actuarially equivalent to a silver level plan on the Exchange, with maximum cost-sharing by the enrollee as allowed by CMS; and
- Waive coverage for payment for non-emergent use of the ER and NEMT.

[16] CMS approved a six-month lock-out after disenrollment for failure to pay premiums for individuals from 100-138% FPL who are not medically frail in Indiana.

Respectfully Submitted,

# THE SENATE STUDY COMMITTEE ON THE PREMIUM ASSISTANCE PROGRAM

**Senator Renee Unterman – Chair**
**District 45**