Research

PRIMER: A Survey of State Medicaid Expansion 1115 Waivers

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Introduction

The Affordable Care Act (ACA) included provisions for the expansion of state Medicaid programs to individuals and families with incomes up to 138 percent of the Federal Poverty Level (FPL). In 2012, the Supreme Court ruled that the expansion must be voluntary—states may choose whether or not to participate. With this ruling, many states have foregone the federal government's offer to pay for the vast majority of expansion and have not extended the Medicaid program to Americans up to 138 percent FPL. However, following the *King v Burwell* decision upholding key pieces of the ACA, the Obama Administration sought to put renewed pressure on states to expand the Medicaid program, even if it does little to help those most in need of medical care.

Over time, many governors and legislatures, initially resistant to expansion, relented. Some states—while feeling pressure to extend some benefits to previously ineligible individuals—were not willing to simply expand their existing Medicaid programs. To that end, ten states in particular have applied for section 1115 waivers; seven have been approved and are currently in effect, one is awaiting approval, and one (Pennsylvania) was approved but is no longer active. These waivers allow states to implement Medicaid expansion according to a unique plan developed by each respective state, subject to approval by the Secretary of the Department of Health and Human Services (HHS). Another state—Wisconsin—decided to forgo collaboration with HHS and instead created its own state-funded expansion; however, the state did recently release a draft application to amend its current waiver.

Each of the nine states (Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, New Hampshire, Kentucky, and Wisconsin) has a program designed specifically for the unique interests of that state. The success of these programs has been mixed, and the states' Medicaid directors seem to be actively working to find the best approach to expanding Medicaid eligibility, several of them having already applied for amendments to their initial waiver provisions.

As Medicaid recently observed its 50th anniversary, increased flexibility for state experimentation could provide a path to a modernized program better able to meet the needs of enrollees.

Summary of State 1115 Waiver Provisions

State	Plan Enrollment	Beneficiaries' Cost	HSA-Style Account	Healthy Behavior Incentives	Other

AZ	Managed care: mandatory if income greater than 100% FPL; voluntary for others	Premium: lesser of $25 or 2% of income Cost-sharing: $4-$10, up to 3% of income	CARE Account – "premiums" deposited as contributions; must complete "healthy behavior" to access	Must complete at least one per enrollment period to access CARE funds; exempts enrollee from additional payments for 6 months	Provider incentives for care coordination
AR	Premium assistance for any silver-level plan in state HIX or ESI, if available	Premium: 2% of income if above 100% FPL Cost-sharing: limited to 5% of income	Independence Accounts eliminated under most recent waiver amendment	N/A	N/A
IN	Managed Care (or ESI premium assistance) HIP Plus: requires enrollee contributions, no co-pays; HIP Basic: no premium, but copays required	Premium: 2% of income, min of $1, max $100; failure to payà HIP Basic	POWER Accounts of $2,500 (equal to deductible) funded by state & beneficiary through premium payments	POWER Account funds to be rolled over to next year doubled if beneficiary receives recommended preventive services	Coverage effective upon first premium payment; voluntary Gateway to Work program; apps filed for inmates before release; ESI premium assistance available
IA	Managed care enrollment mandatory	No cost first year; income-based premium 2nd year; $8 co-pay for non-emergency use of ER	N/A	Completion of Wellness Exam or Health Risk Assessment waives premium requirement	Provider incentive for using HRA in beneficiaries' treatment plan; tiered dental benefits
MI	Mandatory managed care enrollment; April 2018: beneficiaries above 100% FPL required to enroll in QHP through state HIX	Premiums: above 100% FPL, 2% of income Costsharing for all, limited to 5% of income	MI Health Account funded by premiums, paid by individual, employer, or other entity; funds roll over	Annual health risk assessment or other healthy behaviors qualify enrollees for reduced copay and no premium	Access to behavioral health plans
MT	Managed care for most individuals above 50% FPL	Premiums: 2% of income if above 50% FPL; Cost-sharing only if costs are above 2% of income, up to 5% of income	N/A	N/A	Failure to pay premium -> disenrolled after 90 days if income above 100% FPL
NH	Premium assistance for ESI or Silver-level HIX plan	No cost-sharing for those below 100% FPL; limited to 5% for others	N/A	N/A	Work requirement denied approval
KY	Premium assistance for ESI or HDHP/HSA managed care plan	Premium: income-based, $1-$15; increases after 1st year for those above 100% FPL up to $37.50	$1,000 in "Deductible Account" funded by state	½ of unused Ded. Acct funds roll over to "Reward Account"; healthy behaviors, community engagement also earn Reward credits	Reward Account funds may be used to purchase enhanced benefits or for copay for inappropriate use of ER
WI	Medicaid Managed Care	Income-based premium payment	NA	NA	Enrollee premium payments may be applied towards Transitional Medical Assistance for higher income families

Arizona

Arizona initially expanded its Medicaid program on January 1, 2014, but was granted approval of its waiver—a five-year extension of its existing demonstration—on September 30, 2016.[1] This waiver amends the previous demonstration program to establish a new program called Choice, Accountability, Responsibility, Engagement (CARE). The goals of Arizona's CARE program are to "build health literacy, achieve identified health targets, and encourage appropriate care."[2]

Participation in the program is mandatory for expansion population beneficiaries with income greater than 100 percent of FPL as well as parents with incomes above the state's eligibility levels prior to passage of the ACA. Others may opt to join the program but are not subject to the premiums or co-payments associated with CARE if they choose to do so.

Newly eligible beneficiaries are required to make monthly "premium" payments equal to the lesser of either two percent of household income—a standard feature of many of these waivers—or $25; these payments are deposited into the beneficiary's CARE account, which is similar to a health savings account (HSA) and roll over from year to year without limit. In order to access these funds, in addition to making timely payments, beneficiaries must complete at least one healthy target activity, which includes preventive health and chronic disease management activities. If a beneficiary meets a target, they are exempted from premium and co-payments for a six-month period.

Payments may be made on behalf of the individual by third parties, such as employers or charitable organizations, without limit. If a member fails to make the required contribution, they are provided a two-month grace period; failure to pay after such time may result in disenrollment, though individuals can reenroll at any time without penalty.[3] Individuals who voluntarily enroll in the program may also choose to make contributions to their account without being subject to the minimum requirements. Certain services—including opioid prescriptions, specialist services without a referral from a primary care provider, non-emergency use of the emergency room, and brand-name drugs when a generic is available—require co-payments ranging from $4-$10. These copayments are paid retrospectively and are limited to three percent of household income per quarter. Total out-of-pocket expenses are limited to five percent of income, which is a standard rule in the Medicaid program.

Medical benefits will not vary from those offered to other Medicaid populations in the state. CARE participants are eligible to participate in a state program designed to connect beneficiaries with employment assistance programs such as job training, but neither participation nor employment is required. The "Targeted Investments Program" which was approved as an amendment to the state's current waiver program on January 18, 2017, will allow for incentive payments to be paid to providers treating individuals with behavioral health needs if they increase physical and behavioral health care integration and coordination for these individuals.[4]

Arizona had several provisions in their waiver proposal denied which would have imposed greater costs and reduced benefits for certain beneficiaries. For example, Arizona proposed having individuals with incomes below 100 percent FPL also be subject to premiums and co-payments, and sought a six-month lockout period for failure to make premium payments for individuals with income above 100 percent FPL. The Centers for Medicare and Medicaid Services (CMS) also denied a request to impose a five-year lifetime limit on Medicaid enrollment, a requirement that individuals verify income on a monthly basis, and a one-year disenrollment for individuals who "knowingly" failed to report a change in income. Arizona's work requirements, which would have required an enrollee be employed, actively seeking employment, or attending school or participating in a job training program, were also denied.

Arkansas

HHS initially approved Arkansas' 1115 demonstration waiver, called the Health Care Independence Plan, to implement Medicaid expansion on September 27, 2013.[5] The plan has twice been amended, most recently on December 8, 2016, and the new program became effective on January 1, 2017, for five years. The initial waiver, better known as the "Private Option" provided eligible individuals with premium assistance to purchase a private insurance through the state's ACA exchange for the individual market. The first amendment of the waiver attempted to improve some of the plan's shortcomings by implementing "Independence Accounts"—HSA-style accounts that would provide beneficiaries with an incentive to be conscientious

consumers. The most recent amended waiver—Arkansas Works—eliminates the Independence Accounts but aims to expand coverage through premium assistance for plans purchased either through the exchange or an individual's employer.

Newly eligible adults age 21 and older with access to cost-effective employer-sponsored insurance (ESI) through an employer participating in the ESI premium assistance program are required to enroll in such coverage and will receive premium assistance for their ESI. In order to be deemed cost-effective, the employer must pay at least 25 percent of the individual premium; the state will pay any additional employer costs for newly offered coverage for three years as an incentive to the employers to participate.

For newly eligible adults with income up to 138 percent FPL who do not have access to affordable insurance through their employer or are age 19-20, participation in the Qualified Health Plan (QHP) premium assistance program is required. These individuals receive assistance making premium payments for plans purchased through the state's exchange. Individuals may enroll in any Silver-level plan available to them; if the beneficiary does not select a plan, they will be automatically enrolled in one.

Individuals in either program with income above 100 percent FPL must pay two percent of household income toward their premium payments. Cost-sharing for certain services is also required and limited to five percent of household income.

Any benefits otherwise covered by Medicaid but not available through the exchange or ESI plan in which the beneficiary is enrolled will be covered by Medicaid fee-for-service. The state will also cover non-emergency medical transportation for exchange enrollees, though prior authorization may be required; this coverage will not be provided to those enrolled in an ESI plan without a demonstrated need.

Under the initial waiver, the "Private Option," Arkansas met its targeted enrollment of approximately 250,000 through 2015, and the state expects 272,000 individuals to be enrolled in its latest demonstration program by 2021.[6] Given that roughly 80 percent of all individuals enrolled in an exchange plan in Arkansas are Medicaid beneficiaries, the state believes its premium assistance program has contributed to the robustness of its exchange. The number of carriers in the individual market increased throughout the state between 2014 and 2016, with all seven regions being served by at least five carriers.[7] While the costs did exceed the state's budget neutrality cap in 2014, program costs were constrained in the following years and within the limit in 2015 and 2016. An independent evaluation of the program credits the enrollment of younger individuals, required rebate payments by one carrier that exceeded the medical loss ratio (MLR) requirement, and improved inflationary expectations for the improved budget situation.[8]

Indiana

Indiana's first iteration of the Healthy Indiana Plan (HIP) was implemented in 2008 through an 1115 waiver, providing Medicaid coverage to working-age adults. The program was funded through a cigarette tax and relied on the use of high deductible health plans paired with Personal Wellness and Responsibility (POWER) accounts (similar to HSAs) to promote active engagement among beneficiaries in their own care. Indiana has amended and expanded this program several times, and currently has another extension pending approval.

HIP initially provided coverage to parents and caretaker relatives of Medicaid and Children's Health Insurance Program (CHIP) children as well as childless adults with income up to 100 percent FPL, who make contributions to their POWER account. However, enrollment was capped at 36,500 for budgetary purposes. The current iteration of the program, known as "HIP 2.0," began in 2015 and extends through 2017. The program is receiving additional funding from the state's hospitals which allowed for eligibility to be increased to 138 percent FPL and the transition of all non-pregnant adults previously covered under the Hoosier Healthwise program.

POWER accounts are funded by both the state and the beneficiary; enrollees must contribute two percent of their income each month, with a minimum of $1 and maximum of $100. The state funds the remainder such that the total minimum balance equals the deductible of $2,500. If a beneficiary with income less than 100 percent FPL fails to make the required contribution, they are transferred to the HIP Basic plan, after a 60-day grace period, which provides fewer benefits and requires copayments for all services. Beneficiaries with income above 100 percent FPL who fail to make contributions will be terminated from the program altogether, with exceptions for those considered medically frail. The state has found that only 5 percent of individuals who have left HIP did so for affordability reasons, and nearly 85 percent of individuals below the poverty line are making monthly contributions despite not being required.[9]

Beneficiaries are encouraged to seek high-value care by allowing them the opportunity to roll-over remaining funds at the end of the year and the possibility of having the rollover amount doubled if the beneficiary receives recommended preventive services. Rollover funds may be used to offset the required contributions in the next year.

All HIP beneficiaries are enrolled in a managed care plan, either through their own selection or auto-enrollment. All beneficiaries must first meet their deductible before the plan begins covering expenses. The plan originally covered the first $500 worth of preventive services at no charge to the beneficiary, but has removed that benefit since increasing the amount contributed to beneficiaries' POWER accounts. HIP Plus beneficiaries have no cost-sharing requirements except for non-emergency use of the emergency room—$8 the first time and $25 for each subsequent inappropriate use. Individuals who have not made monthly contributions to their POWER account and are therefore enrolled in HIP Basic will have copayments for each service, which may make the Basic plan more expensive for the beneficiary than if they had made the POWER account contributions, as copayments may range from $4-$75. Copayments are restricted to Medicaid's five percent income limit, though. The state will cover costs once an enrollee meets their deductible.

The HIP plan includes several other market-based provisions. Coverage under HIP is not effective until the beneficiary makes their first monthly contribution, similar to the commercial market where enrollees are required to first make a premium payment. This stands in contrast to traditional Medicaid which provides retroactive coverage to any eligible beneficiary. HIP also offers ESI premium assistance for those eligible for HIP but with access to insurance through their employer. The program even requires applications to be filed for inmates before their release to help ensure continuity of care and reduce the probability of recidivism. Finally, the Gateway to Work program is a voluntary assistance program that connects unemployed individuals or those working less than 20 hours per week with employment, job search, and job training program opportunities.

In 2016, independent evaluations found that of the more than 345,000 individuals enrolled in HIP 2.0, 60 percent were previously uninsured.[10] On average, 70 percent of enrollees contribute to their POWER account during the enrollment year, and 92 percent of those individuals continue making payments in subsequent years. HIP members are more likely to obtain primary care, adhere to prescription drug treatment plans, and seek routine care outside of the emergency room. Further, Indiana has been able to increase its provider reimbursement rates; 30 percent of providers have reported a decline in bad debt, and 40 percent have seen a reduction in charity care. This has led to more than 6,700 new providers serving Medicaid patients since 2015.[11]

Iowa

Iowa's Medicaid waiver, which originally took effect in January 2014 and was amended in September 2015, represents a bipartisan approach to Medicaid expansion.[12] The plan is intended to ensure the entire population below 138 percent FPL has access to high-quality care in local networks, while encouraging a shift to value based payment systems. The original waiver consisted of two parts: the Iowa Wellness Plan covered individuals between 0 and 100 percent FPL, while the Marketplace Choice Plan covered non-pregnant individuals and families between 100 and 133 percent FPL (pregnant women in this income bracket would automatically be transferred to traditional Medicaid coverage).[13]

The Iowa Marketplace Choice Plan, similar to Arkansas' Private Option, allowed its enrollees to receive private market insurance from select carriers in the state exchange, and the private insurers took on the risk of managing the cost of the enrollees' care. Medicaid paid the premiums, and enrollees had access to the plans' provider networks, just like other exchange enrollees. However, in December 2015, CMS approved an amendment to Iowa's waiver to end the marketplace premium assistance and cover all expansion population beneficiaries under the Wellness Plan; this change was necessary as there were no longer any exchange plans available for that population. Individuals who had been enrolled in an exchange plan through this waiver were transferred to the Wellness Plan at the start of 2016.

The Iowa Wellness Plan was an expansion of traditional Medicaid for most adults between 19 and 64 years old, with beneficiaries receiving the ACA's enhanced Federal Medical Assistance Percentage (FMAP).[14] However, the Wellness Plan also contracted with three Accountable Care Organizations (ACOs) to cover a portion of the new enrollees in order to investigate ways in which costs may be managed by care providers. Iowa found the ACO pilot to be successful and eventually made participation in a managed care program mandatory for the expansion population, as well as most other Medicaid beneficiaries in the state.

During the first year of enrollment, beneficiaries have no cost-sharing. During the second year, beneficiaries with income of 50 percent or more of the FPL will be required to pay a monthly premium if they did not complete required healthy behavior activities, such as completing a health risk assessment (HRA) or a wellness exam, during their first year of enrollment. The incentive seems to be working: Iowa Department of Medicaid Services found that over 50 percent of beneficiaries with incomes between 50 and 133 percent FPL successfully completed two required healthy behaviors.[15] Providers are also eligible to receive an additional reimbursement of $25 if they use a beneficiary's HRA in the course of the individual's care.[16]

For nonexempt households between 50 and 100 percent FPL, monthly premiums will be limited to $5, and $10 for households between 100 and 133 percent FPL. A 90-day grace period is provided for payment of premiums, and beneficiaries with income below 100 percent FPL cannot be disenrolled for nonpayment. However, following the grace period, unpaid premiums may be considered a collectible debt owed to the state. An $8 co-payment will also be charged for non-emergency use of the emergency room.

Dental benefits are provided through a tiered incentive program. All beneficiaries receive basic dental benefits, at a minimum, but may be moved into higher tiers with greater benefits upon completion of one or more

periodic dental exams.

As of September 2016, more than 150,000 individuals were enrolled in the IWP. Following satisfactory evaluation of the program, CMS recently approved an extension of the state's current waivers through December 2019.[17] Iowa also received extension of a waiver from providing non-emergency medical transportation upon concluding that the lack of service has not had a statistically significant impact on access to care for this population.

Michigan

Michigan began operating its Health Michigan Plan through an 1115 waiver on April 1, 2014.[18] This waiver replaced its previous 1115 waiver—which covered childless adults with income up to 35 percent FPL—significantly expanding coverage and the benefits available. Newly eligible non-pregnant adults earning up to 138 percent FPL are now covered through a new managed care program.

Beneficiaries in this group have the ability to choose an insurance plan from among the Medicaid managed care organizations (MCOs) operating in the state or will be auto-enrolled into one if no selection is made.[19] Individuals who self-select a plan will have 90 days to decide whether they want to change plans; after that, they will be locked into the plan for 12 months. Individuals who are auto-assigned to a plan will be able to change plans at any time. Beneficiaries will also have access to behavioral health plans known as Pre-paid Inpatient Health Plans, which are also available to other Medicaid beneficiaries. Beginning April 1, 2018, enrollees above 100 percent FPL will be required to enroll in a qualified health plan through the state's exchange or complete certain healthy behaviors to remain enrolled in the Healthy Michigan Plan's managed care programs. Individuals enrolling in a QHP through the exchange will still be protected by Medicaid's limits on costsharing and the two percent cap on premiums; Medicaid will pay the remainder of the premium due. The plans available to beneficiaries through this "Marketplace Option" will be selected by the state Medicaid agency. If an individual does not select a plan and has not completed a healthy behavior to remain in a Medicaid managed care plan, they will be auto-assigned to one of the state-approved QHPs.

All enrollees are subject to costsharing, limited to five percent of income. All copayments are made semi-annually based on utilization during the previous six months. Enrollees with income above 100 percent FPL are also required to pay premiums—in the form of monthly contributions to an HSA-like account; the contribution amount is income-based and may not exceed two percent of household income. Copayments are collected by the state rather than providers to help ensure access to care. An individual's responsibility for co-pays and premiums may be reduced by participating in health behavior activities, such as an annual health risk assessment. No individual may lose eligibility or be denied access to care by a provider for failure to make owed payments. Payments into the account may be made by the individual, an employer, or any other public or private entity. These contributions will roll over from year to year and may be used towards future years' costsharing responsibilities.

In September 2016, nearly 500,000 individuals were enrolled in Healthy Michigan; 72 percent of these beneficiaries self-selected a health plan.[20] Health Risk Assessments were completed by 95 percent of beneficiaries, and 74 percent self-reported being in "good", "very good", or "excellent" health. Michigan continues to be well below projections of its per member per month expenditures, though Health Account contributions and copayments collected continue to fall short.

Montana

CMS approved Montana's Health and Economic Livelihood Partnership (HELP) Program on November 2, 2015, and implementation of their waiver program began January 1, 2016.[21] The HELP program uses a defined provider network managed by a third party administrator to provide services and payment for most of

the individuals covered under the expansion; certain exempt individuals receive their care through the state's traditional fee-for-service Medicaid program.[22] Exempt individuals include those "who are medically frail or have exceptional health care needs, who are living in areas without a sufficient number of providers serving the Medicaid population, or who require continuity of coverage that is not available through the third-party administrator," as well as "individuals with income at or below 50 percent FPL."[23]

Monthly premiums equal to two percent of household income are required of individuals with income greater than 50 percent FPL. These premiums will serve as credit toward copayments such that enrollees are not required to pay copayments unless and until their charges exceed two percent of income. No copayments will be owed for preventive health services or medically necessary health screenings, and total out-of-pocket spending will be limited to five percent of income, as is required for all Medicaid beneficiaries. Only individuals with income above 100 percent FPL may be disenrolled for failure to pay premiums, pending a 90-day grace period. Third parties are permitted to contribute to a beneficiary's premiums or copayments.

CMS will soon begin its evaluation of the HELP plan to determine whether or not the premiums permitted are having a negative impact on access to care and whether the use of copayments are successfully steering patients to cost-effective and appropriate care settings.[24] The current waiver is set to expire at the end of 2020.

New Hampshire

New Hampshire's 1115 waiver establishing the Health Protection Program was approved on March 4, 2015, and took effect in January 2016. The waiver was initially approved for only one year, but CMS granted an extension of the program through 2018 upon determining the program had thus far proven successful.[25] This waiver complemented legislation passed in the state which established the Health Insurance Premium Payment program that helps low-income individuals with access to ESI pay the employee's portion of the plan's premium.

Individuals aged 19-64 with income up to 138 percent FPL without access to ESI will be provided premium assistance where they will have the option to choose from among at least two Silver level QHPs on the state's health insurance exchange; if the beneficiary fails to choose, they will be auto-enrolled in a plan. New Hampshire's Medicaid program will cover any wrap-around benefits mandated under Medicaid but not offered by the QHPs. Enrollees with incomes below 100 percent FPL will be enrolled in plans that have an effective actuarial value (AV) of 100 percent. Those between 100 and 138 percent FPL will be enrolled in Silver plans with 94 percent AV, and will be required to contribute towards cost-sharing in the program, but only up to the Medicaid five percent of income limit. Copayments will typically range between $3-$8; inpatient services will require copayments of $125 for the entire stay.[26]

Nearly 48,000 individuals were enrolled as of September 2016. New Hampshire's most recent proposed amendment to its waiver included several provisions that were denied by CMS. These provisions include work requirements, additional eligibility verification requirements, and a provision that would have required hospitals providing services to demonstration beneficiaries to also provide services to beneficiaries of veteran's health programs.[27]

Wisconsin

Wisconsin began providing managed care to parent and child Medicaid beneficiaries in 1999 with a program known as BadgerCare.[28] Eligibility for the program has been amended several times with varying coverage levels as Wisconsin experimented with various policies to try and cover the most people in the most cost-effective manner. For example, the state has coupled income eligibility increases with capped enrollment provisions, benefit limitations, premium charges, and applying deductibles similar to other Medicaid "spend down" policies.

Wisconsin's most recent 1115 waiver—effective April 1, 2014—provides coverage to childless adults, as well as parents and caretaker relatives, up to 100 percent of FPL, and children and pregnant women up to 300 percent FPL. Because the coverage is not extended to childless adults with income up to 138 percent FPL, Wisconsin will not receive the enhanced federal match rate available under the ACA.[29] In fact, this income eligibility level is actually a decrease in eligibility from the previous level of 200 percent FPL; in making this change, Wisconsin expected approximately 5,000 childless adults to transition to marketplace coverage where they would receive federal subsidies. All beneficiaries are required to enroll in a managed care plan. Cost-sharing is permitted for these individuals up to the five percent limit allowed for Medicaid beneficiaries.

The waiver also allows premiums to be charged to those covered under the Transitional Medicaid Assistance (TMA) program; this program allows individuals who are enrolled in Medicaid but experience an increase in income which would otherwise make them ineligible for Medicaid to remain enrolled for up to a year in order to lessen the potential for a disruption in care.[30] The premium charged to these individuals will align with what they would be required to pay if they purchased a QHP through the exchange, which is no more than two percent of income for this population under the ACA. If an individual enrolled under TMA fails to pay their premium, they may be disenrolled from the program following a 30-day grace period, and prohibited from re-enrolling for up to three months unless the owed premium is paid.

A study done by the Wisconsin Department of Health Services found that only 14 percent of enrollees left the program because of a failure to pay premiums; a small percentage compared to the 55 percent that left the program overall. Despite not being eligible for the enhanced FMAP, Wisconsin has made health coverage available to nearly 100 percent of its population through BadgerCare, and an estimated 88,000 newly eligible individuals gained coverage through BadgerCare (or used it for premium assistance in purchasing private plan coverage). Without federal assistance, Wisconsin has still eliminated the coverage gap between Medicaid and the private market and mitigated the disincentives to work inherent in traditional Medicaid.

In recognition of the state's success with their program thus far, Wisconsin released a draft application to amend its current waiver on April 19, 2017.[31] This amendment would maintain all currently approved provisions, but would add additional features which would affect only the childless adult expansion population, and would not further amend eligibility for the state's Medicaid program. Through this amendment, Wisconsin proposes to impose monthly premiums; engagement in healthy behaviors to manage health risks would allow for the reduction of such premiums. Copayments would also be charged for use of the emergency department. Beneficiaries would be required to complete a health risk assessment, and before enrolling would have to complete a drug screening and possibly also a drug test. Individuals would not be allowed to remain enrolled in Medicaid for more than four years; however, time towards this limit would not accrue while a beneficiary was enrolled if they met certain work requirements or were eligible for an exemption under certain circumstances. This draft application will first be reviewed by residents of the state and open to public comment before being formally submitted to HHS.

Kentucky

Kentucky originally expanded its Medicaid program to individuals with income up to 138 percent FPL through a traditional expansion in January 2014. With the election of a new governor, the state submitted an 1115

demonstration waiver in August 2016 seeking reforms to the program, and it remains under review at this time. [32] The reforms sought, if approved, would closely resemble many provisions included in Indiana's HIP 2.0 demonstration. The Kentucky Helping to Engage and Achieve Long Term Health (HEALTH) plan would provide eligible individuals with either premium assistance if ESI is available or funding for an HSA-style account paired with a high deductible health plan managed by an MCO. The Kentucky HEALTH waiver will cover newly eligible expansion population adults, as well as children and non-disabled adults currently covered under the state's traditional program.

Individuals with ESI available to them would have the option of enrolling in either the premium assistance or Kentucky HEALTH plan the first year of Medicaid enrollment, but would be required to enroll in their ESI plan the second year if that option is still available. The state will pay the employee's portion of the premium, save for the small monthly contribution required of the enrollee. To ensure the beneficiary is receiving all benefits Medicaid beneficiaries are entitled to, the state will provide wrap-around coverage for any services not covered by the ESI plan. The state will also pay for family coverage for any individual that has Medicaid or CHIP-eligible children so that they may all enroll in the same plan and not have to keep track of multiple insurance policies. The state will also assist with the beneficiary's cost-sharing responsibilities, and will provide opportunities for members to earn incentive dollars in their "My Rewards Account."

The Kentucky HEALTH high deductible health plan will be paired with both a "Deductible Account" and a "Rewards Account". The Deductible Account will be fully funded by the state to match the $1,000 deductible for each eligible individual. This account covers the cost of services up to the deductible, except for preventive services which are covered in full. The state then covers the cost of additional claims in full. Half of any unused funds will be transferred to the individual's My Rewards Account.

The Rewards Account will be funded through the beneficiary's completion of specific health-related or community engagement activities. Money earned through rewards will allow the beneficiary to purchase enhanced benefits, not required by Medicaid, such as dental and vision services, over the counter medications, and even the purchase of a gym membership. These funds may also be used to pay copayments charged for inappropriate use of the emergency department or penalties they may face for excessive missed appointments. Members who transition to ESI for at least 18 months will be eligible to receive the balance of their My Rewards Account in cash, up to $500.

Eligible households for either program will be required to contribute premiums, depending on income, between $1 and $15. Individuals with income greater than 100 percent FPL will see their premium requirements increase beginning in the third year of enrollment and the next two consecutive years until reaching $37.50 per month, or four percent of income, below Medicaid's five percent limit. Individuals with income at or below 100 percent FPL (except for pregnant women, children, and medically frail individuals) may choose to not make premium payments and instead be subject to copayments. However, if they choose this option, their My Rewards Account will be suspended and $25 will be deducted from it. Coverage will begin once the beneficiary has made their initial premium payment. If an individual above 100 percent FPL is disenrolled for failure to make payments or comply with annual redetermination of eligibility, there will be a six-month waiting period before they may reenroll. The waiting period will be waived if the individual completes a financial or health literacy course.

One of the more controversial provisions of Kentucky's waiver proposal is the requirement for all able-bodied working age adults without dependents to participate in the community engagement and employment initiative. In order to maintain enrollment, these individuals must either be employed, volunteering, actively seeking employment, participating in a job training program, or a caretaker. The longer the individual is enrolled, the more hours per week they will be required to engage in these activities.

In April 2016, more than 428,000 individuals were enrolled in Medicaid as a result of Kentucky's eligibility

expansion, representing nearly one-third of all Medicaid enrollees in the state. However, the state is concerned that the traditional Medicaid program is not doing enough to improve the health of these individuals as less than 10 percent of beneficiaries received an annual wellness or physical exam during the first year of implementation. Kentucky projects total enrollment in these waiver programs will be between 530,000 and 600,000, and believes these reforms will save the state $2.2 billion over five years.[33]

Conclusion

Despite the relative failures and successes of these states' Medicaid expansion program designs, they all provide value as a demonstration of how different Medicaid models may work, and should help guide both HHS and other states in future Medicaid reforms. The ability to learn from the successes and failures of sister states is one of the great strengths of the federalist system, and nowhere is there more potential for state-based alternatives to improve upon the current system than in Medicaid.

Research by Brittany La Couture, conducted while she was an employee of the American Action Forum, contributed substantially to this publication.

[1] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf

[2] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-fs.pdf

[3] Hardship exemptions may be provided for certain circumstances.

[4] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf

[5] http://www.achi.net/Docs/219/

[6] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-fs.pdf

[7] http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=357

[8] http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=357

[9] http://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf

[10] http://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf

[11] http://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf

[12] http://dhs.iowa.gov/sites/default/files/IHAWPEventTimeline_0.pdf

[13] http://www.iowamedical.org/documents/news/061713_IowaHealthWellnessPlanSummary.pdf

[14] http://dhs.iowa.gov/sites/default/files/WellnessSTCsTechnicalCorrections_020215.pdf

[15] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa.pdf

[16] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf

[17] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-jul-sep-2016.pdf

[18] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-waiver-amend-req-11082013.pdf

[19] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf

[20] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-qtrly-rpt-jul-sep-2016.pdf

[21] http://dphhs.mt.gov/Portals/85/hrd/documents/1115/ApprovedMTHELPSection1115Waiver.pdf

[22] https://www.macpac.gov/wp-content/uploads/2016/02/Montana-Medicaid-Expansion-Waiver.pdf

[23] https://www.macpac.gov/wp-content/uploads/2016/02/Montana-Medicaid-Expansion-Waiver.pdf

[24] http://www.modernhealthcare.com/article/20170418/NEWS/170419863?utm_source=modernhealthcare&utm_medium=NEWS-170419863&utm_campaign=dose

[25] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf

[26] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf

[27] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf

[28] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/wisconsin-mcp.pdf

[29] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf

[30] http://congressionalresearch.com/RL31698/document.php?study=Transitional+Medical+Assistance+TMA+Under+Med

[31] https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-app.pdf

[32] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf

[33] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf