

MARKET-BASED APPROACHES TO MEDICAID EXPANSION: A LOOK TOWARD THE FUTURE?

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KEY FINDINGS

- Department of Health and Human Services and Centers for Medicare & Medicaid Services (CMS) leaders have expressed a desire to use Section 1115 waivers to incorporate market-based features into Medicaid.
- Several existing or requested expansion waivers include market-based features, such as altered cost-sharing, healthy behavior incentives, and referral to job-training programs.
- Early findings suggest states implementing waivers have seen higher Medicaid enrollment and lower uncompensated care costs.
- Challenges remain, including clearly communicating plan structure to beneficiaries and reducing the administrative burdens on states.

OVERVIEW

States for decades have used waivers under Section 1115 of the Social Security Act to increase flexibility and implement innovative demonstration projects. As states decide whether to expand their Medicaid program, waivers offer the opportunity to do so while integrating market-based approaches into the program design.

The most common features of market-based expansion waivers include cost-

sharing premiums paid into accounts resembling health savings accounts (HSAs), incentives to engage in healthy behaviors, and job-training programs. Indiana has led the way in creating and implementing market-based approaches to Medicaid, with states like Michigan and Arizona borrowing from its approaches and adding their own requirements.

Evaluations of these waivers are underway in some states, though it is too soon to gauge long-term impact. The states implementing these market-based waivers so far have seen declines in the uninsured rate and uncompensated care (UC), although administrative burdens and lack of clarity for consumers could prove problematic as implementation continues.

SIGNALS FROM THE NEW ADMINISTRATION

In a March 2017 letter to governors, the newly appointed Secretary of Health and Human Services (HHS) Tom Price and CMS Administrator Seema Verma outlined their priorities for the Medicaid program. Expressing the view that the Affordable Care Act's (ACA's) expansion "to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the [Medicaid] program," Price and Verma signaled a desire to use Section 1115 waivers to promote

consumer direction, personal responsibility, independence, and a pathway to private coverage for the Medicaid expansion population.¹

This brief examines the possible future of market-based approaches to Medicaid expansion. It reviews the key themes of market-based approaches across states in waiver programs and outlines early results and challenges associated with such approaches to Medicaid expansion. These experiences could serve as a blueprint for future policymaking.

USING SECTION 1115 WAIVERS FOR EXPANSION ALTERNATIVES

The ACA added a new Medicaid eligibility category based on income alone, authorizing states to expand Medicaid to cover adults without dependent children up to 138 percent of the federal poverty level (FPL). At the time of this brief's publication, 32 states have elected to expand Medicaid coverage to the ACA-covered population. While a majority of states have expanded without a waiver, CMS (under the Obama administration) so far has approved eight Section 1115 waivers related to Medicaid expansion, seven of which are currently in effect: Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire.² Two expansion waivers are pending CMS approval: a new request from

Kentucky and an extension request from Indiana.

States have described a variety of goals associated with their expansion waivers, including:

- reducing the number of uninsured individuals in the state and increasing access to health care;
- promoting value-based decision-making and personal health responsibility;
- promoting disease prevention and health improvement to achieve better outcomes;
- promoting private market coverage and family coverage options to reduce network and provider fragmentation within families;
- facilitating the transition to employee-sponsored or privately purchased insurance over time; and
- reducing dependence on public assistance.

Waivers provide states with flexibility to implement expansion-related innovations that further the objectives of the Medicaid program, but would not otherwise be permitted under federal law. The Obama administration approved a variety of expansion-related policies through waivers, but consistently denied certain policies, as outlined in Table 1.

EXPANSION WAIVERS INCORPORATE MARKET-BASED FEATURES

A key theme—and one that the new administration encourages—is the incorporation of market-based features into Medicaid through waivers, designed to promote personal responsibility and decrease reliance on governmental programs over time.

TABLE 1 – OBAMA ADMINISTRATION EXPANSION POLICY DECISIONS

Approved

- Charging premiums for those below 150 percent FPL as a condition of eligibility
- Adopting HSAs
- Promoting healthy behaviors through incentive programs
- Eliminating retroactive coverage
- Eliminating some benefits, such as non-emergency transportation
- Using Medicaid funding as premium assistance to purchase private coverage

Denied

- Requiring premiums for those below 100 percent FPL as a condition of eligibility
- Imposing job-related requirements as a condition of eligibility
- Eliminating early and period screening, diagnostic, and treatment benefits for children
- Restricting beneficiaries' choice of a family planning provider
- Partial expansion that stops short of 138 percent FPL

Waivers often include provisions to alter cost-sharing, including payments into HSAs or copays; healthy behavior incentives; and referrals to job training programs. Components like cost sharing mirror private plans and are meant to encourage beneficiaries to use Medicaid as a temporary bridge until they can access employer-sponsored insurance or a plan through the health insurance marketplace under the ACA. Indiana's waiver, Healthy Indiana Plan (HIP), often is viewed as the hallmark of market-based waiver approaches; specific details of Indiana's waiver are provided in Table 2, on page 3.³

ENGAGING MEDICAID BENEFICIARIES IN HEALTH COVERAGE

Premiums and Cost Sharing for Consumers

There are federal limits on the extent to which states can charge Medicaid beneficiaries for premiums and cost sharing. Thus, states must obtain a

waiver to charge premiums for those below 150 percent FPL or to impose cost-sharing requirements that exceed 5 percent of a family's income. Most expansion waivers impose premiums or cost-sharing requirements, or both, beyond federal limits to engage the expansion population in their own health and encourage personal responsibility and the appropriate use of services.

Premium Amounts

Most expansion waivers set premium amounts based on a sliding scale tied to household income, capped at 2 percent, resulting in contributions ranging from \$1 to \$27 per month, depending on income. Beneficiaries who are charged premiums often are exempt from copay requirements that otherwise would apply under traditional Medicaid. All but one state charge premiums only for those above 50 or 100 percent FPL.

Indiana is different, in that beneficiaries below 50 percent FPL

TABLE 2 – KEY FEATURES OF HEALTHY INDIANA PLAN (HIP)

- Indiana started HIP enrollment in 2008 and the state now is executing its second waiver (HIP 2.0).
- HIP 2.0 is available for residents ages 19 to 64 with incomes up to 138 percent FPL and who are not eligible for Medicare or other Medicaid coverage.
- For its expansion population, Indiana pairs a \$2,500 high-deductible health plan (HDHP), administered by a managed care organization, with a \$2,500 Personal Wellness and Responsibility (POWER) account.
- POWER accounts are used to pay for medical services and, in some cases, commercial coverage premiums.
- Beneficiaries obtain a debit card to pay for services until they reach the \$2,500 deductible, at which point the HDHP is solely responsible for payment.
- Preventive services are not subject to the deductible, so beneficiaries do not face barriers to these services.
- If patients do not have enough in their account to pay their deductible, the HDHP still is responsible for paying providers, but can recover funds from the beneficiary's future POWER account contributions.
- To encourage beneficiaries to seek lower-cost services, HIP provides a monthly POWER account statement that details the cost of services received.
- The program provides options for families to be covered under the same plan.
- Incentives encourage enrollees to be cost-conscious and receive recommended preventive health care services.
- Enrollees are linked to employment services and rewarded for getting a job and disenrolling in public assistance.
- Enrollees can choose from three plans:

HIP Plus:

- This plan offers enrollees comprehensive benefits, including vision and dental.
- It is available to enrollees who make POWER account contributions. Under HIP Plus, beneficiaries pay their monthly premiums (from \$1 to \$27) into the POWER account, and the state pays the difference between the required beneficiary contribution and \$2,500.
- Enrollee contributions are determined on an income-based sliding scale.
- There are no copayments for services, except for non-emergency use of the emergency department.
- Enrollees who fail to pay premiums and earn less than 100 percent FPL will be moved to the HIP Basic plan.
- Enrollees above the poverty level who do not make their required POWER account contributions face removal from the program and a six-month re-enrollment lockout.

HIP Basic:

- This is the default plan for beneficiaries below 100 percent FPL and who do not make required POWER account contributions.
- Enrollees have a \$2,500 annual deductible, all of which Indiana contributes to their POWER account.
- The plan requires copayments for all services, which can exceed the cost of POWER account contributions under HIP Plus, making HIP Plus a less expensive option for enrollees who frequently use services.
- The benefit package is not as comprehensive as the HIP Plus plan.

HIP Link:

- This is an option for eligible enrollees that work and have access to their employer's health plan.
- HIP Link enrollees can use their POWER account to pay insurance premiums and out-of-pocket medical expenses associated with their employer's plan.
- Employers must choose to participate and register with the state. Participation requires employers to contribute at least 50 percent of the premium costs.

can pay premiums on a sliding scale up to 2 percent of income, or \$1 for those below 5 percent FPL. But premiums for this group are not mandated. Those at or below 100 percent FPL who do not pay premiums are transitioned to a more basic benefits package, as described in the next section.

The Obama administration rejected a proposal by Ohio to charge premiums up to 2 percent of income (capped at \$99 per year, regardless of income), expressing concern that “these premiums would undermine access to coverage and the affordability of care, and do not support the objectives of the Medicaid program.”⁴

Kentucky’s current proposal would impose premiums on beneficiaries on a sliding scale based on family income.⁵ The premiums would range from \$1 for individuals with incomes below 25 percent FPL to a maximum of \$15 per month in the first two years of enrollment for individuals with incomes 100 to 138 percent FPL. Under Kentucky’s proposal, premiums would increase beginning in the third year of enrollment.

Consequences of Nonpayment

Under three expansion waivers (in Arizona, Arkansas, and Iowa), nonpayment of premiums either does not result in disenrollment from Medicaid or allows beneficiaries who are disenrolled to immediately re-enroll. In these states, unpaid premiums can be treated as collectible debt. Other states, however, have sought to impose harsher penalties for nonpayment. In Indiana, beneficiaries above 100 percent FPL who fail to pay premiums are locked out of the Medicaid program for six months after a 60-day grace period (the state originally requested a one-year lockout). In addition, coverage is not effective until the first month’s

premium is paid; thus, some individuals above 100 percent FPL are never enrolled in Medicaid.

To date, CMS has approved no disenrollment or lockout provisions for those at or below the poverty line. The Obama administration rejected a proposal by Iowa to disenroll beneficiaries between 50 and 100 percent FPL who fail to pay premiums, restoring coverage only after the individual reappplies and repeats the eligibility process. The Obama administration also rejected a proposal by Ohio to exclude all expansion beneficiaries from coverage indefinitely until payment is made.

Ohio’s waiver request was unique, in that the state previously expanded without a waiver and later sought to introduce consumer- and market-oriented features into its expansion through a waiver. The Obama administration pointed to data that Ohio’s proposed disenrollment policy could result in a loss of coverage for 125,000 beneficiaries and concluded that the policy would not “support the objectives of the Medicaid program, because it could lead to a substantial population without access to affordable coverage.”

Meanwhile, Indiana proposed a six-month lockout for enrollees at all income levels who fail to complete the annual eligibility redetermination process. CMS ultimately did not approve this aspect of Indiana’s expansion waiver. It is possible that CMS, particularly under the new administration, might respond differently to a state seeking to implement lockout provisions, regardless of income.

Indiana has the only expansion waiver to date with penalties—though not disenrollment—for those at or below 100 percent FPL. In Indiana,

beneficiaries at or below 100 percent FPL who fail to make premium payments are transitioned from a more generous benefit package through HIP Plus into the state’s HIP Basic plan. The HIP Basic plan does not require premium payments, but requires traditional Medicaid copayments and lacks dental and vision coverage and certain pharmacy benefits.

Altering Medicaid Cost-Sharing Requirements

Under their expansion waivers, several states have sought to decrease inappropriate use of the emergency department (ED) by imposing copays beyond federal limits for non-emergency use of the ED. Indiana was the first state to receive approval of such copays, with a two-year demonstration period to charge an \$8 copay for the first inappropriate use of the ED and \$25 for each subsequent inappropriate visit (more than three times the amount allowed under federal law).

As part of the demonstration, Indiana was required to establish a control group subject to the standard \$8 copay for each visit. As part of its renewal request, Indiana is seeking to make this copay policy permanent. New Hampshire is seeking approval of the same policy, but first must amend its state plan to include coverage of non-emergency services furnished in the ED.

For those above 100 percent FPL, Arizona has received approval to adopt tailored cost-sharing requirements designed to steer patients to the most appropriate care settings.⁶ Called “strategic coinsurance,” beneficiaries pay the associated fees retrospectively rather than at the point of service, including:

- \$4 strategic coinsurance for opioid prescriptions or refills;
- \$8 strategic coinsurance for non-emergency use of the ED;
- \$5 or \$10 strategic coinsurance for specialist services with a referral from a primary care provider (designed to encourage the medical home model of care); and
- \$4 strategic coinsurance for brand-name drugs when a generic is available.

Strategic coinsurance cannot exceed 3 percent of household income, and overall cost-sharing is limited to 5 percent of household income.

To date, CMS has not approved overall cost-sharing above the federal 5 percent of household income limit, with one unique exception. In Michigan, legislation enacted after the initial expansion of Medicaid included conditions for the expansion to continue beyond April 2016. In particular, the legislature required that expansion enrollees have the choice between transitioning to a premium assistance model through which they use Medicaid funding to purchase private coverage, or remaining in Medicaid but paying up to 7 percent of household income in cost-sharing. CMS ultimately approved a waiver extension providing that, effective April 1, 2018, expansion enrollees who elect to remain in Medicaid will be required to engage in healthy behaviors (see next section) that will lower their out-of-pocket cost limit from 7 to 5 percent of household income.⁷ Those who do not complete the healthy behaviors will be enrolled through the ACA marketplace with a 5 percent cost-sharing limit. This compromise allowed CMS and the state to satisfy the legislative requirement to impose

up to 7 percent cost-sharing for those remaining in Medicaid while ensuring that, in effect, no patients will pay more than 5 percent cost-sharing, avoiding a precedent-setting higher cost-sharing limit.

INTRODUCING PERSONAL RESPONSIBILITY THROUGH HSAs AND HIGH-DEDUCTIBLE HEALTH PLANS (HDHPs)

Expansion waivers often pair premiums with accounts that resemble HSAs to engage Medicaid beneficiaries in health care decision making and familiarize them with commercial market features. At the time of this publication, Arizona, Indiana, and Michigan have been approved to implement Section 1115 waivers authorizing HSAs, sometimes paired with HDHPs.⁸ Kentucky has a pending waiver to implement a similar plan.

HSAs are funded primarily by the state, but beneficiaries' premium contributions are paid into the accounts, as well. In all cases, third parties, such as employers, also can contribute on behalf of a beneficiary. Two states, Indiana and Michigan, obtained approval of HSA-like accounts before the ACA, but for more limited coverage expansions. These states expanded the use of HSA-like accounts in connection with their ACA expansion, and other states have implemented similar accounts, as described below. CMS must approve details about states' account features in a separate protocol that is attached to the state's waiver terms and conditions.

Beneficiaries who are enrolled for the full year are eligible to roll over a portion of any remaining balance at the end of the year to offset future monthly contributions. The amount that can be rolled over doubles if beneficiaries complete certain

preventive services. HIP Basic enrollees who have completed preventive services and have a year-end balance are eligible for up to a 50 percent discount on premiums in the subsequent plan year.

In Arizona, a Choice Accountability Responsibility Engagement (CARE) program and CARE accounts, styled like flexible spending accounts, have been approved to implement the state's cost-sharing and healthy incentives programs. Expansion enrollees above 100 percent FPL are required to participate in the CARE program; participation is optional for those at or below the poverty level. Enrollee premium contributions and strategic coinsurance amounts for those above the poverty level are paid into the CARE account. Beneficiaries who opt in get access to a CARE account that can be funded by a third party, such as a charitable organization. Beneficiaries receive a quarterly invoice.

Beneficiaries' premium contributions and contributions by third parties (but not strategic coinsurance amounts) accrue to the CARE account. Beneficiaries who make timely payments and meet at least one healthy behavior target (see next section) qualify for a six-month elimination of their monthly contribution and can withdraw incentive payments from their CARE account balance. The Healthy Michigan Plan also uses HSA-like accounts, with enrollee contributions going toward the payment of copays for health care services. Based on income, beneficiaries must start contributing to their account six months after joining a health plan.

Arkansas also implemented HSA-like "Independence Accounts" when it received approval to charge premiums in December 2014. But after an

independent evaluation found that the accounts were ineffective, Arkansas terminated the accounts and opted to have beneficiaries instead pay premiums directly to their qualified health plans.⁹ More specifically, the evaluation—which was requested by the state legislature—found that of 45,839 Independence Account cards issued, only 10,806 were activated. Additionally, only about 2,500 individuals contributed to the accounts monthly.¹⁰ Thus, the evaluation concluded that while HSAs work well in the commercial marketplace, “the program has been far less than successful in an environment with mandated Essential Health Benefits, which means that there is little risk to care, and thus little risk for enrollees.”¹¹

Healthy Behavior Incentives

Many expansion states also have received approval to provide incentives to expansion beneficiaries when they complete behaviors designed to improve their health. These incentives are intended to reduce costs over time as beneficiaries become proactive consumers of health care and prevent more serious and expensive health problems. States typically reduce or even eliminate premium payments for beneficiaries who engage in certain healthy behaviors, which can include:

- attending a primary care visit annually;
- getting an influenza vaccination;
- getting mammograms (for women, as recommended);
- completing a health risk assessment;
- completing glucose screening;

- taking effective steps to manage a chronic illness; and
- undergoing smoking cessation.

Beneficiaries not subject to premiums (those below 50 or 100 percent FPL in most states) who complete healthy behaviors receive reduced copays or other financial incentives. In Michigan, beneficiaries can receive a \$50 gift card for completion.

Elimination of Retroactive Coverage

Compared with commercial coverage, Medicaid is unique in that beneficiaries who are eligible for and ultimately enroll in Medicaid can receive coverage retroactively for up to three months (90 days) prior to the month of application. Several states have sought a waiver of this requirement for the expansion population, asserting that it encourages individuals to enroll in coverage only when they become sick, rather than maintaining continuous coverage.

CMS under the Obama administration initially appeared hesitant to approve waivers of the 90-day retroactivity requirement, rejecting a proposal from Iowa in 2013. However, CMS ultimately approved conditional waivers, first in Indiana and more recently in Arkansas and New Hampshire. With its request to waive retroactive eligibility, Indiana expanded its presumptive eligibility program and agreed to submit data to allow for an evaluation of coverage gaps. Presumptive eligibility allows certain individuals to receive Medicaid coverage temporarily while the appropriate agency reviews their official eligibility. Arkansas must meet standards for timely eligibility determinations, offer a reasonable opportunity period for immigration

status verifications, and implement a presumptive eligibility program. Before eliminating retroactive coverage, New Hampshire must submit data demonstrating that there will be no gaps in coverage.

Work-Related Requirements

Several states have attempted to require individuals in the expansion population to meet various work-related conditions to maintain eligibility for benefits. To date, CMS has not approved work requirements tied to eligibility as part of any expansion waiver. States have instead developed programs that encourage or incentivize work outside of their expansion waivers. Indiana, for example, created a separate program called “Gateway to Work,” a work search and job training program available to unemployed HIP 2.0 enrollees and those who work fewer than 20 hours per week. The program, while not a requirement for eligibility, is meant to further Indiana’s goal of Medicaid beneficiaries using the program as a temporary bridge until they can purchase private insurance or join an employer-sponsored plan.

While not a specific condition of eligibility, participation in work-related programs is encouraged for unemployed beneficiaries, particularly in the expansion population. Programs vary from state to state, but could include:

- job training programs;
- case management;
- subsidies for transportation; and/or
- assistance in preparing for new jobs or interviews.

In their March 2017 letter to governors, Price and Verma expressed support for Section 1115 waiver

innovations that support “training, employment, and independence,” increasing the likelihood that work-related requirements will be approved in future waivers. Kentucky’s pending waiver, submitted to CMS in August 2016, includes work requirements and will be the first test case. Kentucky’s waiver would make enrollment for the expansion population contingent on participation in job training, a job search program, or volunteering 20 hours per week.

Other proposals CMS rejected under the Obama administration could serve as models going forward. Before implementing a traditional Medicaid expansion, Pennsylvania proposed measures in its Healthy Pennsylvania Section 1115 waiver application that would encourage enrollees to seek employment. Beneficiaries would have been offered cost-sharing reductions for premiums or copayments by meeting employment or job-search standards.

EARLY FINDINGS

Although expansion waivers are relatively new, early evaluations show they are beginning to achieve states’ goals, as listed above. At the same time, some significant challenges remain for states as they expand their Medicaid programs through Section 1115 waivers. Early evidence suggests that enrollees often face confusion as they navigate these programs and states might find themselves with increased administrative burden.¹² As the programs progress and states consider renewing waivers in their current forms or with changes, robust evaluations now required through the ACA will help determine the effects of new ways of administering Medicaid expansion.

Coverage Numbers

Market-based expansion waivers largely aim to reduce the number of

uninsured and provide access to health care. Coverage numbers are used to assess whether the waivers met these goals.

In the first year of HIP 2.0, more than 400,000 individuals were enrolled in Indiana, representing about 73 percent of the projected eligible population. Of those enrollees, about 60 percent previously were uninsured or became eligible due to a change in income. The remaining 40 percent previously were insured through HIP 1.0, Indiana’s pre-ACA expansion plan.¹³

There are some interesting differences between those enrolled in HIP Plus versus HIP Basic. Individuals enrolled in HIP Plus tend to be sicker than those in HIP Basic. HIP Plus enrollees express greater rates of satisfaction with their plan and score better on several metrics, including accessing primary and preventive care, drug adherence, and lower use of EDs. Some have interpreted this data to mean that HIP Plus beneficiaries are more likely to use the system efficiently because of their own investment in their health care. This is supported by data showing that 40 percent of HIP Plus enrollees check their HIP Plus accounts at least once per month and almost one quarter of enrollees ask their provider about cost of care. However, others note that these results could simply indicate that HIP Basic enrollees do not have adequate access to the care they require, possibly due to their copay requirement. Costs have not been commonly cited as a reason for dropping out of HIP Plus, but they may be a deterrent to accessing care for those in HIP Basic.

As of February 2017, more than 660,000 individuals have enrolled in the Healthy Michigan plan and more than half of enrollees are at or below

FPL. Between 2013 and 2015, Michigan’s uninsured rate fell by 7.7 percentage points.

Impact of Premiums

Indiana

Since implementation of HIP 2.0, significant analysis has been performed to determine the effects of premiums, cost sharing, and other unique features of the program on beneficiaries. However, interpretations of the data are mixed.

Of HIP members, 70 percent contribute to their POWER accounts. Further, 85 percent of those making contributions have incomes below FPL. Beneficiaries are required to pay monthly premiums. For enrollees below 100 percent FPL, monthly premiums averaged \$13.17. For those above FPL, the average monthly cost was \$28.48.

In the first year of HIP 2.0, 5.9 percent of those above FPL were disenrolled and locked out due to nonpayment. Eight percent of those below FPL were moved from HIP Plus to HIP Basic for the same reason. The most common reasons cited for nonpayment into POWER accounts were confusion about the payment process and plan membership, with nearly 60 percent of those who missed payment referring to those reasons versus just 16 percent who cited affordability. Among all individuals who disenrolled from HIP during the first year, only 5 percent cited affordability as the reason.

However, data on those who leave HIP Plus do not paint the full picture. Enrollment in HIP Plus begins at the time that the first premium payment is made. Up to 30,000 people each month are given “conditional eligibility status.” These individuals have been found eligible for

enrollment but are not enrolled because they have not made their first payment. This represents up to one-third of HIP 2.0 applicants, indicating that premium payments might be a challenge for a significant number of potential enrollees. It seems that potential enrollees for whom premium costs are prohibitive are never covered to begin with, and are therefore not captured in evaluation data indicating whether costs are a barrier to coverage.

Michigan

In Michigan, payment of premiums has been a more substantial problem. From October 2014 to July 2016, only 38 percent of premiums owed had been collected. More than 112,000 beneficiaries were past due on premiums or copays in July 2016, including 44,200 (almost 40 percent) in “consistent failure to pay” status. This status describes enrollees who have failed to pay for three consecutive months and owe at least \$50 in premiums or copays, or who have failed to pay at least half of the money they owe for the year. In addition, Michigan enrollees cited barriers in the process of paying—Michigan does not accept credit cards as a means of payment, unlike Indiana. More than 70 percent of enrollees send their payment through the mail, many using money orders which can include fees as high, or higher, than the amount being paid.

Impact on Uncompensated Care Costs

Under the ACA, expanding the eligibility for the Medicaid program sought to address UC costs incurred by individuals without health coverage and shouldered by providers. The expansion waivers outlined here provide health coverage, but cost-sharing requirements raise the question of whether these alternatives alleviate UC cost burden for the state

and providers—a crucial concern for essential hospitals. A survey aimed at capturing UC in Indiana since the implementation of HIP 2.0 found most providers reported either a decrease or no change in the amount of UC provided. In the case of both charity care and bad debt, about two thirds of providers said UC costs had either decreased or stayed the same. Available data reflect only the first year of HIP 2.0 implementation. Michigan saw a more drastic drop in its UC costs. UC costs decreased by nearly half for hospitals that operated under Healthy Michigan for a full calendar year at the time of the study. These hospitals saw UC costs drop from an average of \$7.21 million per hospital to \$3.77 million per hospital. In total, UC costs at these 88 Michigan hospitals dropped from \$627 million to just more than \$332 million.

Challenges

Despite the goals of market-based expansion described above, early evaluations of expansion waivers also have identified several challenges. Research has shown that the complex nature of these plans, confusing renewal notices and processes, and cost-sharing requirements might act as a barrier for newly eligible Medicaid beneficiaries. An initial evaluation of HIP 2.0 found that participants often found rules around their POWER accounts confusing. Some rules intended to encourage consumer engagement in health care could instead cause uncertainty.

Last, states themselves might find administrative challenges as they continue to implement these waivers. In Michigan, enrollees with complex income situations, such as self-employment, have experienced delays in eligibility determinations. Indiana transitioned enrollees under HIP 1.0 to HIP 2.0 seamlessly. But new

Medicaid enrollees have faced difficulty in obtaining a timely eligibility determination. Also, keeping track of and coordinating payments into thousands of individual HSAs could present a costly administrative burden. Further study is warranted as the waivers progress to determine whether states can efficiently manage the programs to achieve state Medicaid program goals.

MOVING FORWARD

Despite leadership changes at HHS and CMS, states continue to move forward on new waiver renewal and extension requests. If the agency shows willingness to approve new features, it may encourage new states to expand and states with current market-based expansions to seek an amendment of their current waivers. In their March 2017 letter to governors, HHS and CMS signaled a willingness to consider work and other requirements rejected by the previous administration.

Due to the change in federal leadership, states might find themselves with greater flexibility to adopt restrictive requirements for the expansion population, such as requiring greater beneficiary financial contributions and restricting enrollment. How the new administration handles waiver requests from states that first expanded Medicaid under the traditional approach will signal CMS' willingness to balance state flexibility with overall coverage goals.

Notes

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