



Medicaid Expansion by Another Name

State “Alternatives” to Expansion under ObamaCare Allow for No Significant Reforms

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Key Points

- The federal government has not allowed states flexibility to reform Medicaid for the expansion population, and states that have expanded under a waiver are seeing costs explode.
- The vast majority of Medicaid expansion enrollees face no consequences for refusing to participate in work programs or pay voluntary premiums and fees; they will not be subject to penalties and will not be kicked out of the program.
- Texas cannot afford Medicaid expansion: our Medicaid program accounts for nearly a third of the current 2014-15 All Funds budget, and spending on health care will likely exceed education spending in the next biennium.

Introduction

As originally written, the Patient Protection and Affordable Care Act (ACA), aka Obama-Care, mandated that states expand eligibility for Medicaid coverage to every resident earning less than 138 percent of the federal poverty level (FPL), or \$16,105 for an individual in 2014. If not, a state would lose federal funding for its entire Medicaid program. In 2012, the U.S. Supreme Court ruled in *NFIB v. Sebelius* that this provision amounted to a “gun to the head”—an unconstitutional coercion of the states by the federal government, and a violation of the principle of federalism.

Medicaid expansion therefore became optional. In states that expand the program to cover this new population—mostly non-disabled adults between the ages of 19 and 64—the federal government, per the ACA, pays for 100 percent of the cost until the end of 2016, then gradually reduces reimbursement to 90 percent by 2020, with the states paying for the remaining costs. As of this writing, 28 states and the District of Columbia have agreed to expand Medicaid under the ACA, while 22 states have not expanded it. Of those, three states—Utah, Wyoming, and Tennessee—are in discussions with the federal Centers for Medicare and Medicaid Services (CMS) about possible expansions.

The Texas Medicaid program accounts for more than 28 percent, or \$56.2 billion, of the current 2014-15 All Funds budget.¹ The Health and Human Services Commission has indicated in its budget request for 2016-17 that it will need an additional \$2.6 billion in All Funds supplemental spending to fund the Medicaid program through 2015.² If the Legislature provides this funding, it will bring the total biennial appropriation for Medicaid to \$58.8 billion, and total spending on health and human services (Article II) will exceed spending on education (Article III) for the first time in Texas history (*see Figure 1, next page*). Initial budget estimates for 2016-17 put Medicaid appropriations at more than \$60 billion, a figure that will likely grow through the appropriations process.³

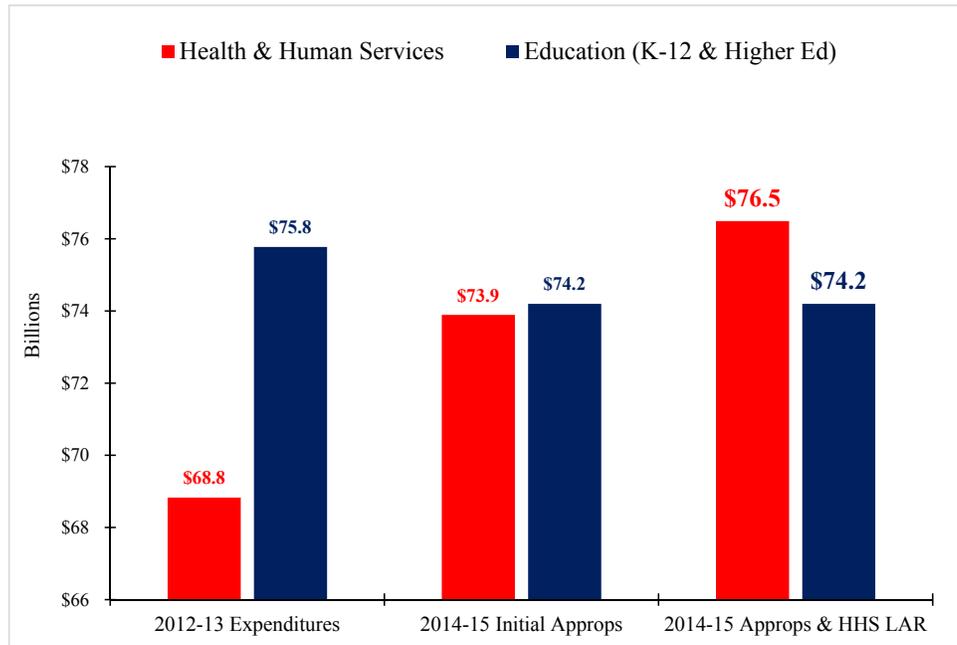
Given the rapid rise in health care spending by the state, careful consideration must be given to any expansion of Medicaid, which accounts for more than three-quarters of all health and human services spending in Texas. Even more attention should be given to the baseless argument that Texas lawmakers can craft a conservative “Texas solution”—or a “Texas way”⁴—that uses federal Medicaid dollars to cover the uninsured but includes things like premiums, copays, work requirements, and a narrower benefit package than the traditional Medicaid program. The fact is, such a solution does not exist.

Flexibility from Federal Rules for Medicaid Expansion is a Canard

Every state that has tried to gain significant flexibility from CMS has failed. As of this writing, six states—Arkansas, Iowa, Michigan, Pennsylvania, New Hampshire and, most recently, Indiana—have implemented Medicaid expansion under a Section 1115 Demonstration waiver,

continued

Figure 1: Health care spending to exceed education spending with \$2.6 billion HHS LAR*



allowing them to make minor alterations to how Medicaid coverage is administered. Lawmakers in these states did so under pressure from state legislators or governors who wanted to implement a “conservative” version of Medicaid expansion, hoping to include things like work requirements, greater cost-sharing, and narrower benefits. They got very few of those things. Rather, in every state that has attempted a Medicaid expansion “alternative,” what they have got is Medicaid expansion by another name.

Arkansas

Arkansas’ so-called “private option” covers the Medicaid expansion population using private health insurance plans available through the ACA exchange. Here’s how it works:

- Enrollees can choose any silver plan on the exchange and the premium is paid entirely by federal Medicaid funds.
- All cost-sharing restrictions that apply to the traditional Medicaid program also apply to private option coverage, so expansion enrollees pay no portion of the premium payment.
- They also do not pay the deductible, which is paid by Medicaid as wrap-around coverage, and any copays associated with private option coverage must comply with federal rules that limit copayments for all Medicaid enrollees.†
- Private option enrollees are entitled to all the benefits that Medicaid enrollees are entitled to under federal law; whatever isn’t covered by the private exchange plan an enrollees chooses, the state Medicaid program must cover those benefits under a standard fee-for-service (FFS) model.

* During the appropriations process in 2013, the Legislature decided that the patient fees collected and spent by health-related institutions should not be included—as it has in the past—as a line item in the appropriations bill. Instead, it is now included in an informational rider. As a result, the 2014-15 appropriations bill shrunk by \$6.1 billion, even though this money continues to be spent.

† For those above the poverty line, copays are capped at 10 percent of the cost of service, while total cost-sharing is capped at 5 percent of a family’s monthly income.

“According to the Government Accountability Office (GAO) Arkansas’ three-year, \$4 billion budget cap for the private option “was approximately \$778 million more than what the spending limit would have been if it was based on the state’s actual payment rates for services provided to adult beneficiaries under the traditional Medicaid program.”

In December, CMS approved an amendment to Arkansas’ Medicaid waiver that will allow the state to require all those enrolled in the private option and earning more than 50 percent FPL to make monthly contributions to a health independence account (HIA), a version of a health savings account (HSA). Most funds in these accounts will come from the state. Monthly contributions will range from \$10 to \$25 for those with incomes between 100 and 138 percent FPL, while those between 50 and 100 percent FPL must pay \$5 a month.

However, if enrollees fail to make these payments, the state cannot revoke coverage. For those above the poverty line, failure to make payments simply means they cannot use their HIA accounts and providers may bill them for costs that would have been covered by HIA funds. For those below the poverty line, there is little incentive to make monthly payments because they will still be able to use their state-funded HIA at the point of service for copayments and other costs. Providers, via a third part administrator, will be allowed to bill enrollees for “Medicaid-level copayments or coinsurance.”⁵

In short, the vast majority of private option enrollees have little or no mandated cost-sharing. Because of these cost-sharing restrictions, and because private coverage is more expensive than traditional Medicaid, the private option is costing the state more. According to the Government Accountability Office (GAO) Arkansas’ three-year, \$4 billion budget cap for the private option “was approximately \$778 million more than what the spending limit would have been if it was based on the state’s actual payment rates for services provided to adult beneficiaries under the traditional Medicaid program.”⁶

Actual program expenditures reflect this. Arkansas has exceeded the budget for private option coverage every month since it began in January 2014. By April, the program was 15 percent over budget, and cost overruns were estimated to reach \$45 million by the end of the year.⁷

Pennsylvania

For Pennsylvania’s Medicaid expansion, dubbed “Healthy PA,” Governor Tom Corbett asked for 24 changes to Medicaid designed to increase cost-sharing and improve efficiency among the expansion group. In its own assessment prior to expansion, the Pennsylvania Department of Public Welfare said that it would only expand Medicaid, “if DPW is allowed to pursue meaningful reforms and program flexibility.”⁸

But Pennsylvania got only three of the changes it asked for, and those came in severely water-down forms. The Obama administration gave the state even less flexibility than it gave Arkansas, denying a request to enroll the expansion population in qualified health plans (QHPs) on the exchange, as Arkansas did, and also denying a request to charge premiums to those above the poverty level for the first year.⁹ Other requests that CMS denied include:

- Increase co-pays for non-emergency ER visits from \$8 to \$10.
- Customize benefits and disallow wrap-around coverage.
- Reduce cost-sharing for enrollees based on work search and training.
- Charge \$25-\$35 premiums for Medicaid enrollees earning above the poverty level.*

* According to the waiver, in year one the state may not charge any premium. In year two, the state may charge premiums only for those above 100 percent FPL but must cover all copays (excluding the \$8 non-emergency ER use fee). All premiums are capped at 2 percent of income. Those who don’t pay premiums for three consecutive months will be kicked off their plan but may re-enroll immediately.

“Since its launch, Iowa’s coverage scheme for those above the poverty line has been beset by problems. In October, one of those two carriers announced it was pulling out of the program, citing major cost overruns and skyrocketing premiums. As a result, 9,700 Iowans that had been on the plan were dumped back into the regular state Medicaid program or forced to switch to the sole remaining private carrier participating in the waiver program.”

It’s notable that Pennsylvania’s expansion waiver is more generous to the expansion enrollees than it is to those in the traditional Medicaid program, which allows for premiums of up to 5 percent of an enrollee’s income. Healthy PA caps premiums at 2 percent of income.

Iowa

In Iowa, Governor Terry Branstad agreed to expand Medicaid if new enrollees could be placed on private coverage, as in Arkansas and Pennsylvania. The Iowa Health and Wellness Plan, which divides expansion enrollees into three different programs based on income, is simply another Medicaid expansion scheme going by another name. Those with incomes above the federal poverty limit are eligible to enroll in private coverage on the ACA exchange through the Iowa Marketplace Choice Plan. They will be charged premiums for coverage, but CMS capped those premiums at \$10 and required the state to cover all benefits not included in private plans as wraparound benefits. As in Arkansas and Pennsylvania, CMS denied almost every request from Iowa for flexibility.¹⁰ Consider:

- Iowa cannot deny coverage to any enrollee below the poverty line for failing to pay premiums.
- For enrollees with incomes above the poverty line, Iowa may not require cost-sharing above what is allowed for the general Medicaid population.
- Like Pennsylvania, Iowa was denied a request to increase non-emergency ER fees from \$8 to \$10.
- The only change CMS approved for Iowa’s Medicaid expansion was to exclude non-emergency medical transportation (NEMT) services—but only through July 31. Such services represent only about 0.3 percent of the total cost of Medicaid benefits.¹¹
- Iowa may charge monthly premiums not to exceed \$5 for those between 50 and 100 percent FPL and \$10 for those above 100 percent FPL. If enrollees complete a wellness exam and health risk assessment, these monthly payments can be reduced or eliminated altogether.
- As in the Arkansas plan, Iowa cannot revoke coverage for anyone below the poverty line, even if they fail to pay their portion of the monthly premium—a restriction that effectively renders the premium payment optional. Those above the poverty line can be kicked off their plan if they fail to make premium contributions for 90 days, and the debt will be subject to collection. However, such a scenario is unlikely given special provisions in the waiver that state: “all beneficiaries have an opportunity to self-attest to and be granted a hardship exemption on a monthly basis.”¹² In addition, those in the Iowa Marketplace Choice Plan will be exempt from making premium payments if they complete a healthy behaviors program.

Since its launch, Iowa’s coverage scheme for those above the poverty line has been beset by problems. Last year, the Iowa Marketplace Choice Plan attracted only two insurers in the state. In October, one of those two carriers announced it was pulling out of the program, citing major cost overruns and skyrocketing premiums.¹³ As a result, 9,700 Iowans that had

been on the plan were dumped back into the regular state Medicaid program or forced to switch to the sole remaining private carrier participating in the waiver program.

Utah

Utah is in the process of negotiating Medicaid expansion under the slogan, “Healthy Utah: An Alternative to Medicaid Expansion”—but the details of the plan reveal it to be, yet again, Medicaid expansion by another name. Essentially, the Utah plan is a slightly modified version of the Arkansas plan, with the state using state and federal Medicaid dollars to enroll the expansion population in private coverage through the exchange.

Governor Gary Herbert had promised to include a work requirement for the expansion population, but this was dropped in subsequent negotiations with the feds in favor of a voluntary state program that helps enrollees find work or improve their job skills.¹⁴ According to the published details of his proposal, there is no requirement for able-bodied, unemployed adults even to engage in “work effort” activities, let alone to be employed. Instead, able-bodied adults who are unemployed will be enrolled in a “work effort benefit,” but the consequences of “not engaging in the work effort benefit” include merely a consideration of a “loss of State benefits”—not federal Medicaid benefits.¹⁵

Likewise, the premiums that Gov. Herbert proposed for Healthy Utah enrollees earning above the poverty line, up to \$15 a month, carry no consequences if they are not paid. Nothing in Utah’s proposal creates a penalty for those who refuse to pay their premiums. As Josh Archambault of the Foundation for Government Accountability noted at *Forbes*, “Even if the state gets permission to disenroll those who fail to pay their premiums, these adults will be allowed to re-enroll immediately, as nothing in the plan proposes any sort of lock-out period or other penalty. In fact, some enrollees may even use this strategy to switch plans in the middle of the year if they find that they don’t like the one they picked.”

As in Arkansas, Iowa, Michigan, and Pennsylvania, so too in Utah: work requirements and premiums that exceed federally-mandated minimums are not allowed under the federal rules that govern the Medicaid program, and are therefore not allowed under a Medicaid expansion waiver.

Tennessee

Tennessee Governor Bill Haslam recently announced his intention to seek a waiver to expand Medicaid in his state under the name, “Insure Tennessee,” although he released almost no details about the plan other than to claim it would “not add any cost to the state budget,”¹⁶ and that it is “an alternative approach that forges a different path and is a unique Tennessee solution.” Yet the Urban Institute estimates expansion in Tennessee would cost the state \$400 million annually by 2022.¹⁷

What sort of changes to traditional Medicaid does Gov. Haslam have in mind? As in the other states, relatively small ones. For example, if a Medicaid enrollee is working part-time and takes a smoking cessation program, they might get a small credit to their account that they could use to offset a \$3 copay, instead of paying out of pocket.¹⁸

As of this writing, details of the plan have not been made public, but what is known appears to mimic elements of state plans outlined above, especially those in Arkansas and Iowa. The Insure Tennessee plan, which Gov. Haslam has called a special session of the state Legislature to consider beginning February 2, features a number of familiar elements:

- Vouchers to purchase private coverage for those above the federal poverty limit.
- Voluntary benefits account for enrollees who participate in healthy behaviors (much like Medicaid managed care organizations have offered for years).
- \$20 monthly premiums for those above the poverty line—which, like those discussed above, are largely voluntary since there is no penalty for those who fail to pay.
- Taxpayer subsidies to offset the cost of employer coverage for some enrollees.

“A close examination of Medicaid expansion waivers to date reveals that no state has been granted flexibility to offer more tailored benefits, and all are subject to virtually the same cost-sharing limits required by the traditional Medicaid program.”

In a departure from other states, Gov. Haslam’s plan claims that the Tennessee Hospital Association will cover all costs to the state once the federal match for expansion enrollees drops below 100 percent. It also claims the program “will automatically terminate in the event that either federal funding or support from the hospitals is modified in any way,” even though there is much disagreement about whether such a proviso is allowed under federal law.¹⁹

Indiana

In late January, Indiana Governor Mike Pence announced CMS had approved his state’s application to expand Medicaid using the Healthy Indiana Plan (HIP), a waiver program established in 2008 that extended Medicaid coverage to those earning up to the federal poverty limit via Personal Wellness and Responsibility (POWER) accounts. Essentially, POWER accounts are HSA accounts funded almost entirely with taxpayer dollars. Pence’s Medicaid expansion, dubbed HIP 2.0, extends POWER accounts to all those earning less than 138 percent FPL and does away with traditional Medicaid for the entire nondisabled population.²⁰

The HIP 2.0 plan is by far the most generous of the Medicaid expansion waivers. Not only does it offer more benefits than the original HIP plan, it reduces and in many cases eliminates the cost-sharing provisions that were supposed to make the HIP plan a model for “consumer-driven” Medicaid. Under the old plan, enrollees had to contribute a monthly amount to their POWER account based on income. Failure to make monthly payments resulted in a 12-month lockout, and enrollment was capped based on available funding. By contrast, HIP 2.0 has no funding or enrollment cap but much weaker cost controls. The mostly taxpayer-funded deductibles are higher (\$2,500 compared to \$1,100 under HIP) and the “basic” plan (for those below the poverty line) contains no penalties for failure to make monthly contributions while the “plus” plan relaxes the lockout period to six months and includes a host of loopholes for enrollees.²¹

In addition, these more generous terms effectively make HIP 2.0 a poverty trap. Under the Pence plan, Hoosiers earning \$16,104 (or 138 percent of the federal poverty level, the income limit for Medicaid expansion under ObamaCare) will pay a maximum of \$322 a year for very generous HIP 2.0 coverage with no other out-of-pocket costs. If an enrollee’s income increases at all, he will no longer be eligible for Medicaid, lose his HIP account and be forced to buy coverage on the ACA exchange, where his health care costs will skyrocket to nearly \$2,800 a year in deductibles and copays for the benchmark silver plan. Perhaps this is why HIP 2.0 contains no work requirement.

Indiana’s Medicaid expansion waiver might be more flexible than the others, but it lacks sufficient incentives for able-bodied enrollees to increase their income and reduce dependence on taxpayer subsidies, and at the same time offers far more generous benefits than traditional Medicaid. That combination makes HIP 2.0 perhaps the most pernicious of all the expansion waivers.

Conclusion

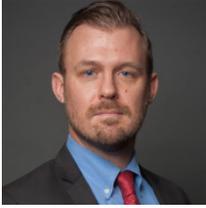
A close examination of Medicaid expansion waivers to date reveals that no state has been granted flexibility to offer more tailored benefits, and all are subject to virtually the same cost-sharing limits required by the traditional Medicaid program. In all of these Medicaid expansions, enrollees face few, if any, consequences for refusing to participate in work training programs or pay what are *de facto* voluntary premiums and fees. In almost every case, enrollees won’t lose eligibility, won’t pay higher premiums, won’t be subject to a penalty, and will likely not lose Medicaid coverage.²²

It is therefore reasonable to conclude that the federal government will not grant Texas flexibility to implement meaningful reform to its Medicaid program, just as it has not granted other states such flexibility. Texas lawmakers should pay close attention to what other states have been able to do—and what they have not been able to do—before buying into the false hope that a “Texas solution” could be anything other than Medicaid expansion by another name. ★

Endnotes

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- ⁴ Ted Shaw, “The ‘Texas Way’ to fiscally responsible health coverage,” *San Antonio Express-News* (6 Dec. 2014).
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- ⁶ Medicaid Demonstrations: HHS’s Approval Process for Arkansas’s Medicaid Expansion Waiver Raises Cost Concerns, Government Accountability Office (8 Aug. 2014).
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- ⁸ FACT SHEET: Medicaid Expansion and Pennsylvania, Pennsylvania Department of Public Welfare.
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- ¹⁰ Jonathan Ingram, “Window Dressing: The Iowa Health and Wellness Plan is an ObamaCare Expansion in Disguise,” *Foundation for Government Accountability* (May 2014).
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- ¹² Iowa Marketplace Choice Plan Section 1115 Demonstration, Center for Medicare and Medicaid Services (30 Dec. 2014) 16-17.
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- ¹⁹ Robert Alt, “Medicaid: Waivers Are Temporary, Expansion is Forever,” *The Buckeye Institute* (Aug. 2013).
- ²⁰ HIP 2.0 1115 Waiver Application, Indiana Family and Social Services Administration (July 2014).
- ²¹ Josh Archambault, “Gov. Pence’s New Deal: Same Old Obamacare Medicaid Expansion,” *Forbes* (27 Jan. 2015).
- ²² Jesse Cross-Call and Judith Solomon, “Approved Demonstrations Offer Lessons for States Seeking to Expand Medicaid Through Waivers,” *Center on Budget and Policy Priorities* (20 Aug. 2014).

About the Author



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A graduate of Hillsdale College, Davidson is a 2013 Lincoln Fellow of the Claremont Institute. He is a senior contributor at *The Federalist* and his writing has appeared in *The Wall Street Journal*, *National Review*, *Texas Monthly*, *First Things*, *Claremont Review of Books*, *n+1*, and elsewhere.

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