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MEDICAID EXPANSION: A COMPARISON OF TWO STATES UNDER SECTION 1115 DEMONSTRATION WAIVERS

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The Patient Protection and Affordable Care Act (ACA) provided states with the ability to expand coverage for low-income individuals who were historically not eligible to receive benefits under the Medicaid program. The expansion allows full Medicaid benefits coverage for parents and childless adults under the age of 65 with income levels up to 133 percent (138 percent with 5 percent income disregard under Modified Adjusted Gross Income conversion) of the federal poverty level (FPL). While initially a mandated portion of the ACA, Medicaid expansion became a state option by a June 2012 U.S. Supreme Court ruling. As of the writing of this article, 29 states and the District of Columbia have opted to expand Medicaid benefits to childless adults under the ACA provisions.[1] For states that elected to expand Medicaid coverage, the federal government will fully fund Medicaid coverage for newly eligible individuals in those states through 2016. In 2017, the federal government's Medicaid funding rate for the newly eligible beneficiaries drops to 95 percent, and then to 90 percent in 2020 and beyond. Although there is no immediate required state match for medical expenses (administrative expenses are not 100 percent federally matched), each state must consider the financial impact of maintaining the Medicaid expansion population beyond 2020, when the state share of the funding responsibility will rise to 10 percent of total cost.

The Medicaid program is operated on a state-by-state basis and displays significant variation in its operation and structure across the country. Given that the ACA does not specify the structure of expansion programs, it is no surprise that designs vary from state to state. This article provides a comparison of two Medicaid expansion programs: the Healthy Michigan Plan and the Healthy Indiana Plan (HIP) 2.0. Both Michigan and Indiana opted to use a Section 1115 demonstration waiver to implement their respective programs.

SECTION 1115 DEMONSTRATION WAIVERS

Section 1115 of the Social Security Act gives the secretary of the U.S. Department of Health and Human Services (DHHS) authority to approve experimental, pilot or demonstration projects that promote the objectives of Medicaid and the Children's Health Insurance Program (CHIP). One of the identified purposes of the demonstration waiver authority is to demonstrate and evaluate whether using an innovative service delivery system will improve care, increase efficiency and reduce costs.[2] Both the Healthy Michigan Plan and the HIP 2.0 attempt to meet these goals by using benefit designs that encourage personal responsibility and engage participants in making health care decisions based on cost and quality.

OVERVIEW OF PROGRAMS

While each of the programs was implemented to provide coverage to parents and childless adults up to 133 percent FPL under an 1115 waiver, the programs were implemented with different characteristics. The following provides an overview of each program and a comparison of a few of these characteristics.

HEALTHY MICHIGAN PLAN

On Sept. 16, 2013, Governor Rick Snyder signed the Medicaid expansion bill into law for the State of Michigan, thereby creating the Healthy Michigan Plan. The plan was implemented by amending a previously approved Section 1115 demonstration waiver—Adult Benefit Waiver. The prior demonstration waiver offered a limited benefit package to childless adults with income up to 35 percent FPL. The new Healthy Michigan Plan focuses on increasing access to quality health care while encouraging members to adopt healthy behaviors. The plan was expected to provide health coverage to nearly 500,000 Michiganders (a number that was exceeded within the first 12 months of open enrollment). Though no specific analysis has been performed, the rapid increase in enrollment may have helped to mitigate some of the pent-up demand.

HEALTHY INDIANA PLAN: HIP 2.0

The first HIP (1.0) was passed by legislation in 2007. Enrollment began on Jan. 1, 2008. This initial program was approved by the Centers for Medicare and Medicaid Services (CMS) under a Section 1115 waiver authority and provided health care benefits for parents and childless adults up to 200 percent FPL. HIP 2.0 built upon HIP 1.0 and was the result of negotiations between the State

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of Indiana and CMS to use the HIP structure to provide services to parents and childless adults up to 133 percent FPL. It is anticipated that HIP 2.0 will serve more than 450,000 Hoosiers. Similar to HIP 1.0, HIP 2.0 was implemented under a Section 1115 waiver authority. Similar to the Healthy Michigan Plan, HIP 2.0 focuses on increasing access to quality health care while encouraging members to adopt healthy behaviors and promoting personal responsibility.

Figure 1: Key Program Characteristics

Program Characteristic	Healthy Michigan Plan	Healthy Indiana Plan 2.0
General benefit design		
Covered Services	Essential health benefits plus additional state plan services for all enrollees	State plan benefits for the medically frail and Section 1931 caretakers Alternative Benefit Plan
Benefit Options	All enrollees subject to same benefit design	(1) Basic plan: copayments, available to members who are under 100 percent FPL only (2) Plus plan: POWER account contributions, emergency room copayment, and dental and vision benefits (3) HIP Link: Employer sponsored plan coordination
Medically Frail Requirement	No	Yes
Member features		
Account Name	MI Health account	POWER account
Contributions	2 percent of household income for members above 100 percent FPL	2 percent of family income for Plus plan benefits, with a minimum contribution of $1 per month
Annual Value of HealthCare Account	$1,000	$2,500
Healthy Behavior Incentives	(1) No copays for preventive services or services associated with chronic conditions (2) Reduced contributions or other incentives if participating in healthy behavior activities	If member meets preventive service requirement: (1) Additional carry-over in Plus or (2) Discount on future Plus enrollment if in Basic
Health Risk Assessment	Limited HRA at time of enrollment with detailed completion by PCP	Screening within 90 days, detailed HRA for members with special health care needs
Penalties for Failure to Make Contributions	Loss of ability to reduce costs through healthy behaviors	Loss of coverage for six months if above 100 percent FPL, convert to Basic plan for those under 100 percent FPL
Additional program information		
Waiver Governance	Section 1115	Section 1115
Effective Date	April 1, 2014	Feb. 1, 2015
Capitation Rate Development	First dollar with consideration of contributions and copayments	Reflects $2,500 deductible and applicable copayments
Low Income Family Parent Eligibility	Prior eligible population (i.e., those under 37.5 percent FPL) retain standard Medicaid program	Converted from Hoosier Healthwise Medicaid plan to HIP 2.0 plan
Provider Reimbursement	Traditional Medicaid	Medicare or Medicaid +30 percent for non-Medicare services

COMPARISON OF KEY PROGRAM CHARACTERISTICS

The table in Figure 1 provides a high-level summary of the key characteristics associated with each of the programs.

The remainder of the article describes the components of the expansion program characteristics listed in Figure 1 in more detail.

General Benefit Design

HEALTHY MICHIGAN PLAN

Although technically established as an Alternative Benefit Plan (ABP), the list of covered services under the Healthy Michigan Plan is identical to the current state plan. As an ABP, the Healthy Michigan Plan covers federal essential health benefits along with other State Plan services and benefits. The Healthy Michigan Plan provides consistent benefits to all enrollees, with the only variation being the level of required cost sharing. Two different types of member cost sharing are required: a contribution equal to 2 percent of income along with copayments for members above 100 percent FPL and copayments only for members below 100 percent FPL. For members who agree to participate in certain healthy behavior activities, the member cost sharing can be reduced. Claims are paid on a first dollar basis at the point of service with member contributions and copayments paid to a member's MI Health Account on a six-month time lag. A $1,000 deductible is applied to the benefit coverage with a member's contributions applied to medical service payment at the price point of $1,000 minus that member's required annual contribution. For example, contributions for a member required to contribute $200 annually would only pay for services above $800 and up to $1,000.

HIP 2.0

HIP 2.0 offers a variety of different benefit packages. State plan benefits are provided to members previously eligible under Indiana's Medicaid eligibility rules, primarily parents below approximately 18 percent FPL. Members not previously eligible are offered an alternative benefit plan. Newly eligible members below 100 percent FPL have a choice between the Basic plan and the Plus plan. Plus plan members make monthly

contributions to the Personal Wellness and Responsibility (POWER) account (described below), and in return have no required copayments, and receive additional benefits of dental and vision. Basic plan members do not make contributions to the POWER account, but copayments are required for many services. Plus plan members who do not make contributions as required are automatically switched to the Basic plan. Newly eligible members between 100 percent FPL and 133 percent FPL may only enroll in the Plus plan. Individuals identified as medically frail receive benefits through an ABP that is the State Plan. A third plan option, HIP Link, is available to individuals who have access to qualified employer sponsored insurance (ESI). HIP 2.0 benefits have an annual deductible of $2,500 per person under the Basic and Plus plans, which is funded by the POWER account. Preventive benefits are not subject to the deductible. The POWER account under HIP Link is valued at $4,000.

Member Features

HEALTHY MICHIGAN PLAN

Health care account

The MI Health Account is used to collect member contributions and copayments. The account is intended to increase member awareness of their use of health care services. Following the initial six months, members receive quarterly updates on the amount of money in the account and the services provided. Member contributions that are not used to pay down services remain in a member's MI Health Account and can be repaid as a voucher for purchasing health insurance when a member leaves the Healthy Michigan Plan.

Member contributions

Members below 100 percent FPL are only required to submit copayments. A contribution equal to 2 percent of income is levied on those above 100 percent FPL, but total member cost-sharing cannot be more than 5 percent of annual household income. No alternative benefit design is offered under the Healthy Michigan Plan. Therefore, members do not have an option of selecting a different cost-sharing structure. Members who do not make required contributions are not removed from the program, but lose the ability to reduce their cost-sharing through healthy behaviors.

Health risk assessment

At the time of enrollment, members are asked to complete a health risk assessment (HRA) form, which identifies the current health of enrollees as they enter the program. Incentives have been put in place by the state to encourage health plans to submit the forms. Additionally, health plans provide incentives to providers and participants to help facilitate a higher completion rate. One specific requirement in the Healthy Michigan Plan is for members to schedule an appointment with a primary care physician within 60 days of selecting a health plan. Most members in the Healthy Michigan Plan are to be enrolled with one of the participating health plans, and therefore most will be subject to this rule. It is at the time of the appointment with their selected primary care physician that members can select a healthy behavior activity to manage, to allow for potential reduction of cost sharing requirements. Annual appointments with a physician and an updated HRA are also requested by the program.

HIP 2.0

Healthcare account

The POWER account resembles a health savings account (HSA). The POWER account funds the plan's annual deductible, providing first dollar coverage of up to $2,500 per year. If the member enrolls in the Plus plan benefit design, funding is shared by the Medicaid program and the member; otherwise the POWER account is fully funded by the Medicaid program. To encourage judicious use of health services, the member portion of unused POWER account funds may roll over and offset contribution amounts for future years. Any Medicaid funds remaining in the POWER account are returned to the Medicaid program at the end of each year or when a member leaves the program.

Member contributions

If a member is enrolled in the Plus benefit plan option, the member is required to make monthly contributions to the POWER account. Household POWER account contributions are generally 2

To encourage judicious use of health services, the member portion of unused POWER account funds may roll over and offset contribution amounts for future years.

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percent of annual family income. However, all HIP Plus members are required to make a minimum contribution of at least $1 per month.

In addition to the two managed care options of HIP Plus and HIP Basic, HIP 2.0 members with access to ESI are offered a third option: HIP Link. This option has a POWER account with total funding of $4,000. The POWER account is funded by the state Medicaid program. The larger POWER account balance under HIP Link is intended to be used to pay for the employee share of monthly employer insurance premiums as well as out-of-pocket medical expenses such as deductibles, copays, and coinsurance.

Health risk assessment

The application for HIP 2.0 allows applicants to self-identify as medically frail if they have qualifying conditions. These conditions include various high-cost medical and mental health conditions. Additionally, a member will qualify as medically frail if the member has a limitation of several activities of daily living (ADLs).

All HIP 2.0 members are enrolled in a managed care plan. The managed care plans are required to complete a health screening on all new members within 90 days of enrollment. This information may also be used to identify a member as medically frail, if the person had not self-identified any of the issues during the application process.

Members identified as having special health care needs, either from the application or the screening, receive a detailed HRA, conducted by a health care professional.

SUMMARY OF COMPARISON

The ACA provided states with the option to expand Medicaid, but did not provide a specific framework in which to establish these new programs. The potential for program variety can begin to be understood by looking at the two programs studied in this article. Although both of these Medicaid expansion programs operate under Section 1115 waivers, there are significant differences in the way each is managed. The HIP originated in 2008 and has been altered through CMS negotiations and approval of the waiver in Jan. 2015. During the design phase of the Healthy Michigan Plan, several components of the original HIP program were considered and modified to result in the program that was established. As Medicaid expansion evolves, it will be interesting to see how states manage and change their programs, or even how states yet to expand Medicaid may consider future expansion design and new program implementation.

ENDNOTES

1 http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ (as of May 18, 2015)

2 http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html