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Even if the AHCA doesn't prevail, states can still pursue their own health care reforms

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Introduction

On May 4, 2017, the American Health Care Act (AHCA) narrowly passed the House. The bill includes a major overhaul of the Medicaid program and federal rules governing the individual health insurance market, which together cover over a quarter of the U.S. population.[1] It also gives states the option to further waive key provisions of the Affordable Care Act (ACA). Passage in the Senate is far from certain, with a number of Republicans vowing to draft their own legislation rather than take up the House's bill.[2]

While debate over the future of health care continues, some states are looking for immediate opportunities under existing law to achieve reforms they have long sought.

In March, the administration sent two letters to the nation's governors indicating it would be amenable to such reforms. The first was a **letter** from the Secretary of the Department of Health and Human Services (HHS), Tom Price, and Center for Medicare and Medicaid Services (CMS) Administrator, Seema Verma, signaling their commitment to granting states increased authority over their Medicaid programs, primarily through Section 1115 Medicaid waivers **(See Sidebar "What are Section 1115 Medicaid Waivers?")**.

Separately, Price issued a **letter** to governors encouraging states to use State Innovation Waivers created under Section 1332 of the ACA **(See Sidebar "What are Section 1332 State Innovation Waivers?").** These waivers, which became available in January 2017, allow states to pursue alternative and innovative strategies for ensuring that people have access to high-quality, affordable health insurance.

Taken together, these two letters signal that regardless of broader legislative reform efforts, the administration will likely grant states greater latitude than they've previously known to chart their own course for Medicaid and the individual market. All they need to do is ask.

For insight into what authorities states might request from HHS in the absence of legislative changes, it's instructive to look at what they've asked for in the past.

For this we reviewed:

- **Thirty-four letters from governors and state insurance commissioners to House Republican leaders.** These letters were in response to a **request** from Republican House leadership for state input on health care reform. These letters came from 16 states with Democratic Governors, 17 with Republican Governors, and one with an Independent Governor).[3]
- **A letter from four Republican governors to House Republicans,** offering alternative Medicaid policy proposals in lieu of the policies outlined in the AHCA.
- **Section 1115 Medicaid expansion waiver proposals** that were denied under the previous administration.

What are Section 1115 Medicaid Waivers?

In exchange for guaranteed federal funding for their Medicaid programs, states must adhere to minimum standards of coverage and benefits established by federal law in the Social Security Act. States may submit Section 1115 Medicaid waivers to the Secretary of the Department of Health and Human Services (HHS) to request permission to waive federal rules as part of pilot projects that promote the overall objectives of the Medicaid program. The decision over whether a proposal promotes the objectives of the Medicaid program is largely left to the HHS Secretary, who evaluates the request and interprets statute.

In addition, waivers must be budget neutral for the federal government. In other words, over the life of the waiver, federal Medicaid expenditures must not exceed what they would have been without the waiver. The statute also requires the Secretary to implement reporting requirements for states with approved demonstrations, and to establish a process for the periodic evaluation of demonstration projects to see if they work. Section 1115 waivers are generally issued for five years and may be renewed for up to 3 years.[4]

Medicaid requests

After reviewing the letters and waiver applications, several themes emerged among the subset of states that identified potential changes they would request to their Medicaid programs. Those requests can be broadly categorized under eligibility and enrollment requirements; benefits; and financing and administration.

Eligibility and enrollment requirements

The ability to freeze or cap Medicaid enrollment.

Medicaid is an entitlement program, which means that anyone who meets eligibility rules has the right to enroll in the program, and that the federal share of Medicaid funding is guaranteed without limit. According to statute, state Medicaid programs must provide medical assistance to *all individuals* who are part of mandatory coverage groups. Therefore, states may not freeze or cap enrollment for those populations.[5] Requests to freeze or cap enrollment have generally been mentioned alongside the proposal of converting Medicaid from an entitlement program to a capped funding program through block grants or per-capita caps. **(See Section on Finance and administration)**

Lower the income-eligibility threshold for expansion adults.

Prior to the ACA, states only had to cover certain categories of poor individuals under their Medicaid program, such as people who were aged, blind, and disabled; children, and pregnant women. Parents in many states had to have incomes far below poverty to be eligible, and most states did not cover childless adults, no matter how low their incomes were.

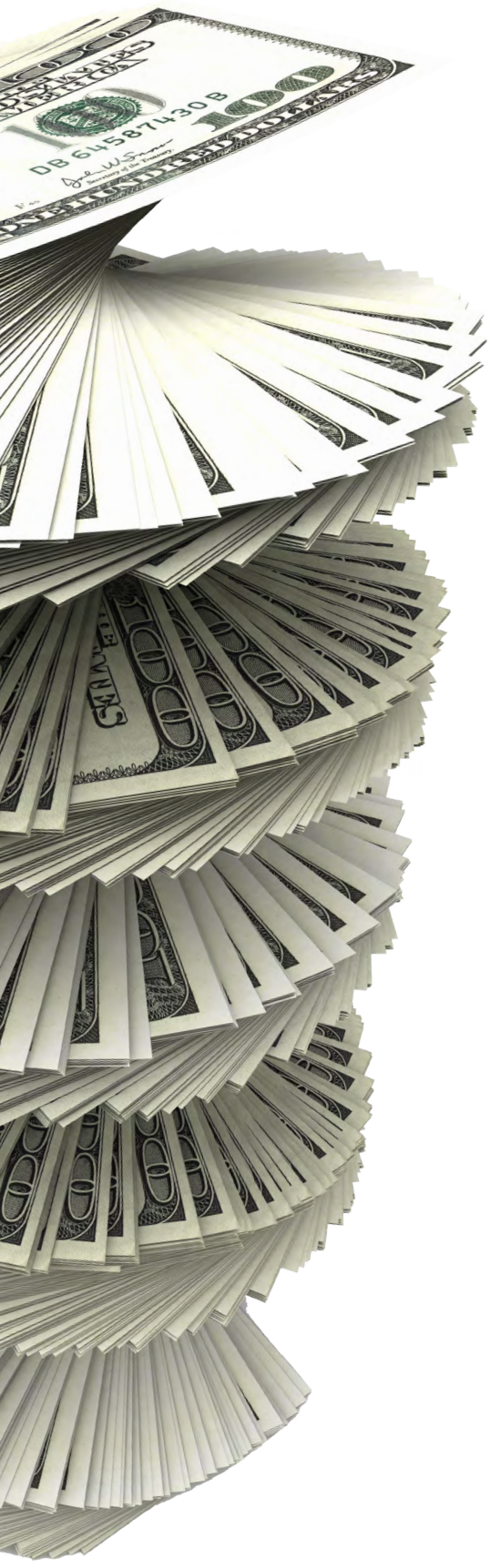
The ACA required states to expand their Medicaid program to all individuals under the age of 65 with incomes below 138 percent of the federal poverty level (FPL); however in ***NFIB v. Sebelius,*** the Supreme Court ruled that the Medicaid expansion was optional **(See Table 1 for more information on FPL)**. Thirty-one states and the District of Columbia have expanded Medicaid, while nineteen states have not. The Medicaid expansion was 100 percent funded by the federal government from 2014 until 2017, and the ACA guarantees that federal funding for the newly eligible expansion population will never dip below 90 percent. However, in order to receive the enhanced matching funds, states must expand coverage to *all individuals* who meet the ACA's requirements, meaning up to 138% FPL.[6]

A number of states have expressed interest in continuing to receive enhanced federal matching funds for the newly eligible adult population while having the option to reduce the income-eligibility level for that group to something below 138% FPL.

Table 1: 2017 Federal poverty levels for individuals and families

Percent poverty	Individual	Family of three
100%	$12,060	$20,420
138%	$16,643	$28,180
150%	$18,090	$30,630

Source: Office of the Assistant Secretary of Planning and Evaluation (ASPE), HHS Poverty Guidelines for 2017. https://aspe.hhs.gov/poverty-guidelines
Note: These Poverty Guidelines refer to the 48 contiguous states and Washington, D.C.



Apply asset tests.

The ACA established a new methodology for determining income eligibility for most Medicaid populations and premium subsidies for people who purchase coverage on a health exchange. Unlike previous policy, this methodology does not take a person's assets into account.[7] In contrast, states have the ability to limit eligibility for other government programs to those with little or no assets. The majority of states have eliminated the asset test for the Supplemental Nutrition Assistance Program (SNAP, formerly the "Food Stamp" program) and the Low Income Home Energy Assistance Program (LIHEAP), but the vast majority of states have maintained an asset test for Temporary Assistance for Needy Families (TANF).[8] Some states have expressed interest in having the option to also apply an asset test when determining Medicaid eligibility.

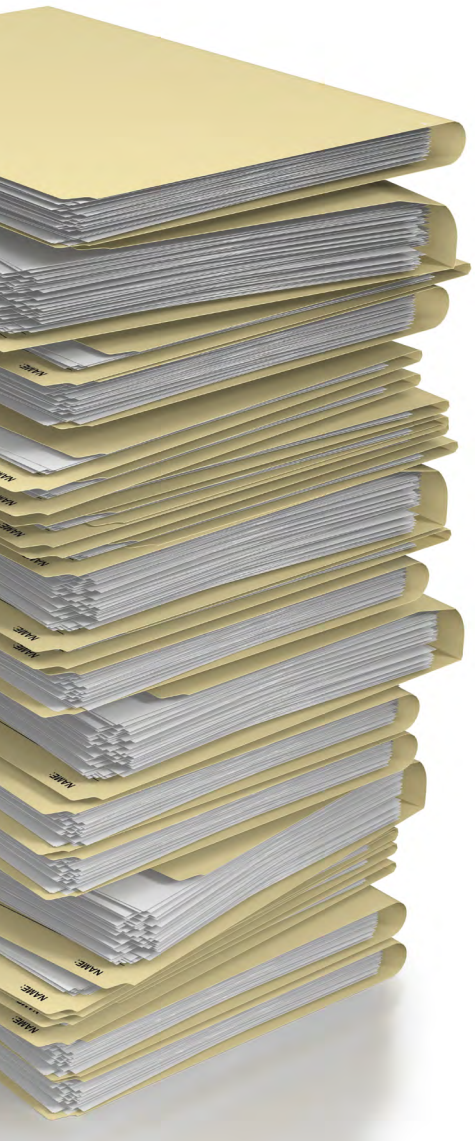
Apply work requirements.

A number of states have proposed attaching work requirements as a condition for Medicaid eligibility for 'able-bodied' adults. Such requirements could include completing a number of hours (typically 20) of work, job searching, or job training. Under the previous administration, CMS denied 1115 waiver requests that included work requirements, saying that these requests were inconsistent with the overarching goals of the Medicaid program. Arizona[9] and Kentucky[10] currently have waivers pending with CMS that include work requirements. Arkansas has recently signaled interest in amending its waiver to include a work requirement, and Wisconsin's forthcoming waiver includes this provision as well.[11] [12]

Increase premiums and out-of-pocket costs.

Currently, states can and do require certain beneficiaries, typically those with incomes above 150% FPL, to pay Medicaid premiums. In addition, states may apply nominal out-of-pocket costs to all Medicaid enrollees except those specifically exempted by law. Combined, premiums and co-pays may not exceed 5 percent of a beneficiary's household income.[13] Several states have expressed interest in incorporating premiums and cost sharing for other beneficiaries (such as those below poverty), and charging higher amounts. While the previous administration approved 1115 waivers that sought to charge premiums above federal limits, it denied waivers that would have required premiums from adults with incomes below the poverty line.

Some states support converting Medicaid from an open-ended entitlement program to a capped allotment, in exchange for greater state authority to determine eligibility, benefits and conditions of enrollment.



Dis-enroll or lock-out individuals who breach conditions of enrollment.

Premiums and out-of-pocket costs are not new in Medicaid, but enforcing them through dis-enrollments and lock-out periods are. Indiana was the first state to receive approval from CMS to dis-enroll childless adults from Medicaid for failing to pay premiums, followed by Montana.[14] Wisconsin's forthcoming waiver contains a similar provision. Kentucky and Indiana have new waivers pending with CMS seeking lock-out periods of up to six months.[15] [16]

Benefits

Limit or eliminate Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and non-emergency medical transportation (NEMT).

Under federal law, children under age 21 must receive the EPSDT benefit, which includes regular screenings (including physical, behavioral, developmental and lead screenings), vision, dental, and hearing services, and other medically necessary care.[17] States are required to control, correct or reduce health problems found during screenings and periodic tests. Some states have proposed making this benefit optional, except for children with disabilities and other special populations. There have also been proposals to reduce the age of the EPSDT benefit to 18 years.

In addition, several states requested that non-emergency medical transportation (NEMT), a benefit that provides transportation for individuals who do not have access to transportation to and from their medical appointments, not be mandated. The Code of Federal Regulations requires states to ensure that eligible and qualified beneficiaries have this benefit.[18] Indiana, Iowa and Arkansas have received approval to waive NEMT for some populations for a test period. Kentucky is also seeking this in a waiver currently under review with CMS.[19]

Lift the "IMD exclusion".

Under Medicaid law, federal Medicaid funds cannot be used to pay "institutions of medical disease" (IMDs) with more than 16 beds for beneficiaries aged 21 to 64.[20] The so-called "IMD exclusion" is a rare instance of Medicaid law that prohibits the use of federal funds for medically necessary care. It was intended to ensure that states, which had historically assumed the responsibility of caring for people with mental health issues, continue to be the primary payer of these services. The provision has long been debated by the mental health and substance abuse community, and has been criticized for potentially reducing access to care for those who need it.[21]

CMS issued a State Medicaid Director Letter in 2015 saying states could submit 1115 waivers that included coverage for substance use disorder (SUD) services in inpatient and/or residential settings that are within the definition of IMDs.[22] Wisconsin's forthcoming waiver includes a request to lift the IMD exclusion, stating that this is critical for fighting the state's opioid epidemic.

Finance and administration

Convert Medicaid to a block grant or per capita cap.

Each Medicaid program is jointly financed by the federal government and the state, according to a matching formula based on the relative wealth of the state.[23] As long as states provide their share of Medicaid funds, the federal government guarantees its share without limit. In exchange, the federal government establishes minimum standards of eligibility and benefits, but provides states with many optional coverage groups and benefits that are guaranteed federal matching funds.

Some states support converting Medicaid from an open-ended entitlement program to a capped allotment (at least for some populations), in exchange for greater state authority to determine eligibility, benefits and conditions of enrollment.

Use Medicaid to offer premium assistance.

States have long been able to use Medicaid dollars to purchase private insurance for eligible individuals. Before the ACA, premium assistance was typically used to help individuals afford employer-sponsored insurance, but states had to ensure that cost-sharing and benefits were equivalent to Medicaid through "wrap-around" benefits and cost-sharing protections. Though most adults enrolled in Medicaid work or are in working families, they generally work in firms or industries that have low rates of employer sponsored health insurance.[24] Since few Medicaid beneficiaries have access to employer coverage or private insurance, enrollment in premium assistance programs has been relatively small.[25]

Arkansas and New Hampshire use Medicaid premium assistance to purchase ACA coverage for their expansion population, and Michigan will do the same beginning in 2018.[26] Under the previous administration, CMS had generally required states to maintain wrap-around benefits and cost-sharing protections to individuals receiving premium assistance through Medicaid.

Streamline, expedite and simplify 1115 waiver approval process.

Some states have expressed concerns with the current waiver approval process, stating that it is overly resource intensive; that approvals take too long; that there should be a mechanism for making waivers permanent rather than having to renew them every five years; and that there should be a "fast-track" to approve waivers in one state that have already been approved in another state.

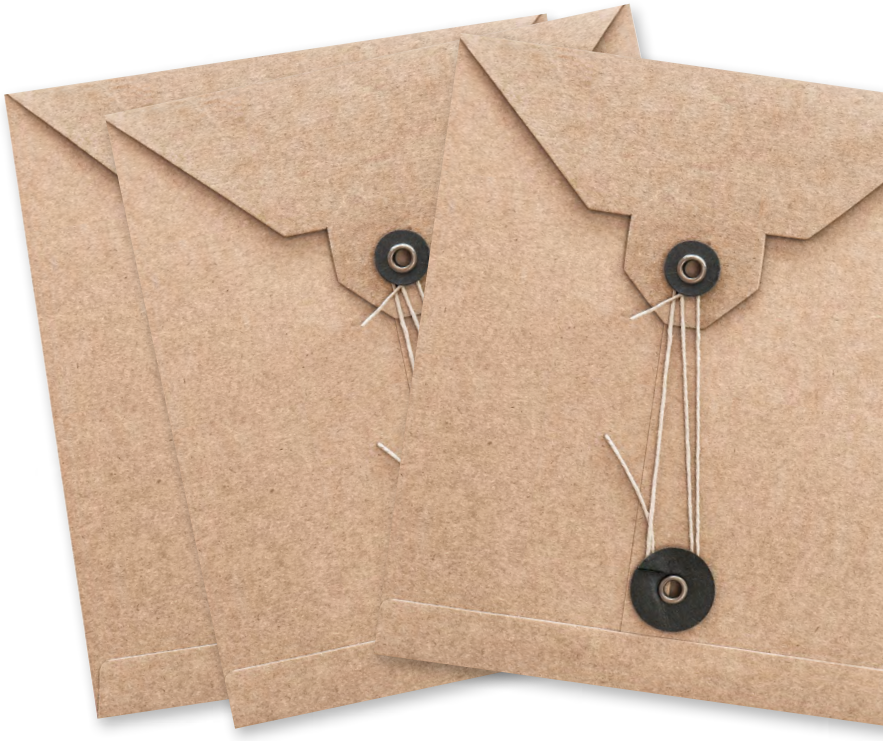


Table 2: Summary of Medicaid requests

Eligibility and enrollment requirements	Benefits	Financing and administration
• Freeze or cap Medicaid enrollment	• Lift or eliminate EPSDT	• Convert Medicaid to a block-grant or per-capita cap
• Lower the income-eligibility threshold for expansion adults	• Lift or eliminate NEMT	• Use Medicaid to provide premium assistance
• Apply asset tests	• Lift the "IMD exclusion"	• Streamline, expedite and simplify 1115 waiver approval process
• Apply work requirements		
• Increase premiums and out-of-pocket costs		
• Dis-enroll or lock-out individuals who breach conditions of enrollment		

ACA and individual insurance market requests

In the 34 letters from governors and insurance commissioners to the Republican House leadership, states had a wide variety of requests, ranging from pleas to keep the individual market intact and maintain the federal subsidies to calls for completely eliminating the Affordable Care Act and all of its taxes, mandates and regulatory requirements. Below, we focus only on the major themes that emerged from states that recommended changes to the individual market that are consistent with current law or achievable through a waiver.

Eliminate essential health benefits.

Under the ACA, plans offered on the exchange are required to cover ten essential health benefit (EHB) categories, but some states have called for removing this requirement so that "skinnier" plans with fewer covered benefits could be offered for lower premium prices. The new Administration could use its authority under section 1332 of the ACA to approve a state plan alternative to the ACA's rules that would alter the ten EHBs.[27] It could also redefine what some of the benefits are required to include.

Establish high-risk pools.

A few states have expressed interest in receiving federal funds to help establish insurance pools made up exclusively of individuals with high health care costs, or "high-risk pools." The thinking behind high-risk pools is that by taking the costliest people out of the market, health care costs would fall for everyone else.

35 states offered high-risk pools in the decades prior to passage of the ACA. Such state programs were instrumental at providing coverage to those who would have otherwise been uninsurable due to pre-existing conditions. However, there is considerable evidence that high-risk pools were not successful overall at providing access to high-quality, affordable coverage.[28] [29] [30] The history of high-risk pools is marked by underfunding, limited choice of plans, benefit restrictions and high costs. Most pools have operated with negative budgets. Minnesota no longer operates a high-risk pool but is often cited as a state that ran a successful program. There are various theories about why Minnesota's program was successful, but the most important may have been adequate funding.[31]

In their letters, a number of states said they supported high-risk pools, though most strongly emphasized the need for substantial federal contributions in order for these pools to be viable. Alaska recently applied for a Section 1332 State Innovation Waiver which would, among other things, use federal funds toward a state high-risk pool.[32]

Establish reinsurance programs.

The ACA established a 3-year reinsurance program (2014-2016), which provided some funds to ACA-compliant plans that had enrollees with higher costs relative to other plans. The purpose of a reinsurance program is to preemptively stabilize premium costs by alleviating insurers' concerns through the offsetting of costs associated with high-cost enrollees. In several letters, states mentioned the importance of maintaining a robust reinsurance program for health plans.

With the end of the ACA reinsurance program, premiums in Alaska's individual market were projected to increase by 42 percent, but the state created the Alaska Reinsurance Program (ARP) with $55 million in state funds, which resulted in a modest premium increase of roughly 7 percent for 2017. Now, the state has a Section 1332 State Innovation Waiver under review that would redirect some ACA premium subsidies to help fund Alaska's reinsurance program. The state believes that this program would reduce premiums for 2018 by up to 4 percent.[33] Minnesota recently passed a state law that would establish a similar reinsurance program.[34]

What are Section 1332 State Innovation Waivers?

During ACA congressional deliberations, Section 1332 State Innovation Waivers were envisioned as a way for states to achieve ACA coverage goals by pursuing alternative approaches that might better suit their specific health care market needs. States were able to apply for State Innovation Waivers in 2016 and waivers could go into effect as early as January 2017.

There are several requirements written in statute that states must adhere to when developing their alternative approaches to health care coverage. Specifically:

- Be federal budget-neutral over the period of the waiver and federal deficit-neutral over a ten-year budget window;
- Provide coverage "at least as comprehensive as" under the ACA;
- Ensure that as many or more individuals will have health coverage than as under the ACA; and
- Implement affordability standards equal to or greater than the ACA.

Although waivers were originally designed to give states the opportunity to launch pilot projects, they have become a major tool for states to carve their own path with Medicaid, and could potentially do the same with the individual market.

How might states get what they are asking for?

In a word: waivers. Although waivers were originally designed to give states the opportunity to launch pilot projects, they have become a major tool for states to carve their own path with Medicaid, and could potentially do the same with the individual market.

The two letters issued to governors from HHS in March 2017 each addressed waivers as a major vehicle for state-level reforms. The letter penned by Price and Verma acknowledged the significant demographic, geographic and health system variation among states, and signaled a commitment to "ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population."[35]

The following priorities laid out in the letter address some of the states' specific requests on Medicaid:

- Make the Medicaid waiver approval process more transparent, efficient and less burdensome
- Approve Section 1115 waivers that have a work component
- Allow states to design their Medicaid programs to resemble commercial insurance for expansion adults. This would include premiums and cost-sharing, health savings accounts (HSAs) for individuals at all income levels, waivers of NEMT, and others.

Price's letter reminds states of the flexibilities they have under State Innovation Waivers, and encourages them to follow Alaska's lead in using such waivers to establish high-risk pools and reinsurance programs. The establishment of high-risk pools and reinsurance programs are not at odds with federal law (in fact, the ACA established temporary funds for both programs), and therefore do not require a waiver. However, by using Section 1332 State Innovation Waivers, states can reallocate their share of federal ACA dollars to help fund these programs.

Together, these letters send a clear message that the administration is amenable to approving state proposals that make changes to their Medicaid programs and individual insurance markets. They also make clear that, absent new federal legislation, waivers are the primary lever states should rely upon to achieve this. Indeed, as noted earlier, some of these requests have already been granted to states through waiver approval under the previous administration, but the current administration appears committed to even broader and more expeditious approval of these waiver requests.

While the emphasis is often on states themselves, waivers can come about through a multi-stakeholder engagement process. For example, Minnesota's Health Care Financing Task Force, which advises the state on Medicaid and 1332 State Innovation Waivers, includes members from health plans, providers, and academic institutions, as well as elected officials.[36] South Dakota also established the Medicaid Opportunities and Challenges Task Force in 2013, primarily for the purpose of discussing the pros and cons of Medicaid expansion. Task force members included a broad group of stakeholders, including legislators, physicians, providers, community health groups, and hospital officials.[37] In addition, before states are eligible to submit their waiver applications to the federal government, they must allow for a public notice and comment period, giving interest groups and citizens an opportunity to weigh in on waiver proposals. Still, state governors and legislators have the final say on what goes into waiver applications, and the federal government has the ultimate say in what gets approved. State waivers appear poised for broad federal approval.

Medicaid programs and, indeed, the American health care system as a whole are marked by vast variation that differ by state and insurance type. As states move to make further changes to their Medicaid programs and, now, to the individual market, we are likely to see even greater state-by-state health care variation. But even as they go their own way, states will continue to rely on federal health agencies like HHS and CMS for financial investments and technical support. The strength of these state-federal partnerships will likely determine the success of state health reform efforts now and in the future.

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