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IMPLICATIONS AND OPTIONS FOR STATE-FUNDED AND MEDICAID EXPANSION HEALTH COVERAGE PROGRAMS UNDER HEALTH REFORM

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INTRODUCTION

A number of states and the District of Columbia currently administer health coverage programs for low-income uninsured individuals who either exceed maximum Medicaid income eligibility thresholds or who are not categorically eligible for the Medicaid program—such as childless adults. These programs were created using Medicaid state plan authority, Medicaid waivers, state-only funds or a combination of mechanisms. Examples of such programs are the Alliance program in the District of Columbia, MinnesotaCare in Minnesota and Basic Health in Washington.

In anticipation of full implementation of health reform on January 1, 2014, states that administer these programs have important decisions to make, as the majority of individuals currently covered through these programs will be eligible for other coverage pursuant to the Patient Protection and Affordable Care Act (ACA), depending on whether states go forward with the Medicaid expansion.¹ This issue brief looks at 11 existing health coverage programs in six states and documents the legal, technical and policy issues the states are already addressing, or need to address, as they review options for transitioning program enrollees to new coverage options. It also presents possibilities for new uses of state dollars freed up by the infusion of federal funds in 2014.

BACKGROUND

State Health Care Coverage Programs

¹ P.L. 111-148 and P.L. 111-152

A wide range of health care coverage programs are currently operated by the states. This issue brief examines selected programs in the District of Columbia, Maryland, Minnesota, New York, Oklahoma and Washington. Key characteristics of these programs are provided in Table 1. The table represents a snapshot of the programs when the ACA was enacted, and in some cases may not reflect the changes states have already implemented in preparation for 2014.

For the purpose of this project, a “coverage program” is defined as a state program that either expands direct coverage (e.g., to childless adults) or offers premium assistance to low-income, uninsured residents. While a range of coverage initiatives are offered across the country, this report focuses on these two options because their enrollees are most likely to move to Medicaid or subsidized Exchange coverage under the ACA.² The states examined in this report were selected to ensure that the coverage programs studied would be representative of such programs more generally when considering the following characteristics:

Type of Coverage Program

In total, we examined 11 programs in six states. Because some programs have more than one type of approach under their umbrella, the case studies feature seven coverage programs, five programs that use premium subsidies, and one high-risk pool.

² For example, this report does not include state programs that offer tax credits to employers that offer health insurance to low-income employees, as this is a less direct form of coverage. It also does not include programs operated at the county or local level because these are less likely to have direct applicability for states, and due to the sheer complexity of data/information collection across multiple counties/localities.

Funding Sources

Some states rely on federal funding (through Section 1115 waivers or state plan amendments) to support their health care coverage programs. Other states rely on state-only financing, which may come from general fund revenues, special state assessments, or a specific earmarked tax. General Fund revenue and tobacco or hospital assessments were the most common sources of funding for the selected programs.

Benefits Package

Of the programs studied, seven offer full benefits, three offer limited benefits, and one offers benefits that vary because the program subsidizes a variety of employer plans

Post-Reform Eligibility

In all of the states studied, current enrollees will be eligible for either Medicaid (assuming all six states opt-in to the ACA Medicaid expansion) or Exchange-based coverage in 2014.

Income Eligibility Limit

The 11 health care coverage programs examined here target maximum income levels ranging from 50 percent of the FPL to over 400 percent of the FPL. The income levels of enrollees in these programs will determine whether the enrollees will qualify for Medicaid coverage, Basic Health Program coverage, or subsidized coverage in an Exchange in 2014.

Geographic Diversity

States were selected in part to reflect regional variations across the United States, though the case studies should not be viewed as representative of all states. States from the Northeast, Southeast, Midwest, and West were interviewed to capture any impacts for which a state's geographic location may play a role.

OPPORTUNITIES UNDER THE ACA

The ACA presents several opportunities that states with coverage programs in place will need to consider as they think about the specifics of their coverage programs and the needs of program enrollees.

Early Medicaid Expansion

Section 2001 of the ACA provides states the option of expanding their Medicaid programs early to cover populations that will be eligible for Medicaid in 2014 using a state plan amendment rather than a waiver.

States can set eligibility for new coverage groups at any level up to 138 percent of poverty³, as long as the state does not cover higher income people before covering lower income people. States that take up this early expansion option receive their current matching rate for the newly covered population but will still receive the higher matching rate for newly eligible enrollees⁴ once the 2014 Medicaid expansion takes place.

Federal Exchange Subsidies

Sections 1401-1402 of the ACA establish that through the state-based or federally-run Exchanges, the federal government will provide tax credits to reduce insurance premium costs for people between 138 and 400 percent of poverty, and cost-sharing assistance for deductibles and copayments for people up to 250 percent of poverty, starting in 2014. People whose employer-sponsored coverage is not affordable (defined as having an actuarial value of less than 60 percent of premiums that exceed 9.5 percent of the employee's income) will also be able to buy coverage through either federal or state-administered Health Insurance Exchanges and qualify for subsidies. The ACA also limits total out-of-pocket cost-sharing for the essential benefits based on the out-of-pocket limits for Health Savings Account-qualified health plans, which were \$5,950 for single coverage and \$11,900 for families in 2010 (the limits will be adjusted according to changes in the Consumer Price Index until 2014 and indexed to changes in the cost of health insurance thereafter).

³ §2201(a)(1)(C) of the ACA specifies that childless adults are Medicaid-eligible with incomes at or below 133 percent FPL. However, §2002(a)(14)(I)(i) of ACA adds a five percentage point deduction from the FPL when calculating income to determine eligibility for Medicaid. This five percent disregard makes the Medicaid eligibility threshold effectively 138 percent FPL. States are not required to use this disregard until 2014, but in the meantime must use "methods of determining income that are reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests of the beneficiary," per State Medicaid Director Letter # 10-005, April 9, 2010 (<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10005.PDF>).

⁴ The matching rate for newly eligible Medicaid enrollees will be 100% for 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% for 2020 and subsequent years.

Table 1. Key Characteristics of Selected State Programs*

Name of Program	Type of Program	Target Population	Income Limit	Funding Mechanism	Benefit Package	Source of State Funds
District of Columbia						
DC Healthcare Alliance	Coverage	Childless adults	200% FPL	District-funded	Limited	General Fund
1115 Childless Adults Waiver	Coverage	Childless adults	50% FPL	1115 Waiver	Limited	General Fund
Maryland						
Primary Adult Care (PAC)	Coverage	Parents and childless adults	116% FPL	1115 Waiver	Limited	General Fund
Maryland Health Insurance Partnership	Premium subsidy	Firms with 2-9 workers, avg salary < \$50K	No dependent coverage if salary > \$75K	State-funded	Varies	Information not available
Maryland Health Insurance Plan	High-risk pool with low-income premium subsidy	Those denied coverage b/c of health status	No limit; premium subsidies < 300% FPL	State-funded	Full	Hospital rate assessment
Minnesota						
MinnesotaCare	Coverage	Parents and childless adults	Parents < 275% FPL; childless adults < 250% FPL	1115 Waiver	Full, but \$10K annual inpatient limit	Provider taxes
New York						
Family Health Plus	Coverage or premium subsidy	Parents and childless adults	Parents < 150% FPL; Childless adults < 100% FPL	1115 Waiver	Full	General fund and tobacco tax
Child Health Plus	Coverage	Children	< 400% FPL; buy-in option for those > 400% FPL	State-funded and 1115 Waiver	Full	General fund and tobacco tax
Oklahoma						
Insure Oklahoma – Individual Plan	Insurance Subsidy	Working adults (and those seeking work), college students, dependents ineligible for SoonerCare	200% FPL	1115 Waiver	Full	Tobacco tax
Insure Oklahoma – ESI	Insurance Subsidy	Employers with <100 employees	200% FPL	1115 Waiver	Full	Tobacco tax
Washington						
Basic Health Plan	Coverage	Parents and childless adults	200% FPL	State-Funded	Full	General Fund

*For Maryland and New York, eligibility levels shown are current as of June 2012. All other levels are as of enactment of the ACA.

Basic Health Program

Section 1331 of the ACA allows states to establish a Basic Health Program (BHP) for low-income individuals as an alternative to obtaining health coverage through the Exchange. Two groups are eligible for the BHP: Adults with income between 138 and 200 percent of the FPL and legal immigrants with income less than or equal to 138 percent of the FPL (who are not eligible for Medicaid based on immigration status).

If a state implements a BHP, eligible individuals will not be able to obtain subsidized coverage in the Exchange. The state will receive 95 percent of the premium tax credits and cost-sharing reductions that would have otherwise been provided for coverage in the Exchange. The state will use this money to contract with one or more health plans or providers to offer BHP benefits and services, which must include at least the essential benefits package. Premiums and cost-sharing for BHP enrollees cannot be any greater than the amount for which they would have been responsible if coverage were obtained through the Exchange.

all plans, or all plans in the Exchange, do business in Medicaid. Other states may require Exchange plans to participate in a Basic Health Program. However, states are keenly aware that many insurance plans do not have experience serving Medicaid populations, and their willingness and preparedness to do so will vary. In addition to continuity of coverage, states are also concerned with the availability and continuity of provider networks in the new coverage landscape.

Robust Exchanges

States place a high priority on attracting enough insurers for the Exchange and Basic Health Programs to ensure that consumers have a choice of high-quality plans. They are also considering the potential impact of a BHP on the size and composition of the Exchange.

Streamlined Eligibility

States recognize the need to align and coordinate eligibility standards and processes across programs leading up to 2014. Multiple states noted the need to implement the Modified Adjusted Gross Income (MAGI) definition required by the ACA, and some also noted that their eligibility technology systems will be overhauled before 2014.

Affordability

Achieving and maintaining affordability is a major goal for states. While people moving to Medicaid from state-funded or waiver programs will typically gain richer benefits at a lower cost to them, people moving to Exchange coverage from state-funded or waiver programs will likely face higher cost-sharing in Exchanges. Some states may opt to design a Basic Health Program benefit that is intermediate between the two, and some are considering wrap-around subsidies for lower-income people in the Exchange. Other states said that budget constraints would probably not permit them to offer additional Exchange subsidies.

Universal Coverage

In considering potential program changes, states are

FINDINGS

Interviews with state Medicaid agency officials and other staff in the District of Columbia, Maryland, Minnesota, New York, Oklahoma, and Washington (conducted from mid- to late-2011) reveal a number of common themes.

State Have a Variety of Goals for 2014

States are planning for 2014 with a variety of goals in mind. These goals include the following:

Continuity of Coverage

Ensuring smooth transitions between Medicaid, Exchange coverage and Basic Health Programs is a major concern and priority for states. To promote continuity, some states are considering requiring that

Snapshot: Washington, D.C.

- *“Pro-coverage” jurisdiction that prioritizes access and comprehensive benefits, focusing on churn and coverage transitions*
- *As “early adopter” has expanded Medicaid eligibility to all adults below 138 percent of the Federal Poverty Level (FPL)*
- *Has considered transforming its Alliance program (for low-income childless adults up to 200 percent FPL) from a coverage program to a grant program for safety net providers in 2014*

examining what coverage gaps will remain after the 2014 coverage expansion, and what will be the most effective and feasible strategies—from both a fiscal and political point of view—to fill them. In addition to adjusting their coverage programs, some states may finance safety net care for populations that remain uninsured with block grants to safety net providers.

Snapshot: Maryland

- *Maryland is farther along in its 2014 preparations than most states*
- *Options for alternate uses of state funds that will be available in 2014:*
 - *Providing state reinsurance or risk corridors to reduce the cost of Exchange coverage*
 - *Increasing Medicaid reimbursement rates*
 - *Supporting safety net providers who care for populations that will be uninsured in 2014 and providers of benefits that are excluded from the Essential Health Benefits package*
 - *Reducing costs for taxpayers and other payers by reducing assessments currently collected or other taxes*

State Capacity is Limited

States have had limited time and bandwidth for a close focus on the future of state health care coverage programs and opportunities under the ACA. State staff are stretched thin, and more than one state noted that the success of ACA implementation depends upon state staff capacity. Planning efforts have also been hampered by state budget struggles, which in some cases have affected state-funded coverage programs and waivers as well as the core Medicaid programs. Post-election transitions in state administrations have also slowed or complicated planning efforts in some states.

Options Open for Coverage Programs

States have many analyses under way, and some already completed, that will help them decide on and implement policy changes. However, even where findings are already available, most have not yet been translated into policy. Some states are further along in their planning than others, but all still need to make many important decisions about their coverage programs.

States noted that political factors, including support for the ACA (or lack thereof), are influencing the range of policy options they are considering. The history of state coverage programs—especially for programs that have been particularly popular—is also a consideration as states determine how to modify them. States will seek to preserve the options and features that have proven successful, and they may seek additional flexibility from the Department of Health and Human Services (HHS) beyond the options laid out in the ACA if that turns out to be necessary.

Bridge Role Sustains Some State Programs

The expectation that the populations covered by waivers and state-funded programs will gain coverage in 2014, in combination with the early Medicaid expansion option, has helped sustain some programs that might otherwise be at risk of termination as a critical bridge to the 2014 coverage expansion.

Early Expansion Carries Risks

Of the six states interviewed, Minnesota and Washington, D.C., have implemented early Medicaid expansions since the passage of the ACA. None of the other states plan to do so before 2014. Several states noted that when state-funded programs shrink as a result of the coverage expansions, the programs may become easy targets for elimination. Fiscal considerations also influenced state decisions not to implement an early Medicaid expansion.

Snapshot: Minnesota

- *Implemented an early Medicaid expansion for adults up to 75 percent FPL effective March 2011*
- *Maintenance of eligibility requirement will be a key consideration for the state's 2014 coverage of children in particular, including whether the state establishes a Basic Health Program (BHP): If eligibility for children ages two to 18 must be maintained in the Medicaid waiver portion of MinnesotaCare up to 275 percent FPL, this would reduce the number of children that could move the Basic Health Program, which would in turn decline the composition of the BHP risk pool and increase the average cost of coverage in the program*

MOE Has Mixed Impact on Expansion

States varied in their responses to the ACA's Maintenance of Eligibility (MOE) requirement, which largely prohibits the reduction of adult Medicaid eligibility until Exchanges are operational and altogether prohibits the reduction of Children's Health Insurance Program Eligibility until 2014. Some states reported that the MOE requirement had not affected their decision-making, while in at least one state, the MOE requirement served to discourage an early Medicaid expansion. However, Washington, D.C., proceeded with its early Medicaid expansion despite the MOE requirement, acknowledging that it would have one less option for cost-containment until 2014.

Several Policy Considerations Surround Basic Health Program Decisions

A variety of policy considerations are influencing state decisions about the Basic Health Program.

Churn

States see the Basic Health Program as a possible way to reduce breaks in coverage for people who would be near the threshold of Medicaid and Exchange eligibility (though they note that a new threshold would be created between the Basic Health Program and the Exchange at 200 percent of poverty). States also suggested that Medicaid managed care plans could offer coverage in a basic health option, further promoting coverage continuity.

Continuity of Care

In addition to promoting continuity of coverage, a Basic Health Program could promote continuity of care by using a similar provider network to Medicaid, thereby reducing the need for enrollees to change providers after moving from one source of coverage to the other.

Exchange Participation, Leverage, and Risk Pool

States that are already analyzing the potential impact of a Basic Health Program on an Exchange have estimated that the program could draw a substantial number of people away from the Exchange. The population that selects BHP coverage may be less healthy than the remaining Exchange risk pool, resulting in a better risk profile and lower premiums in the Exchange than would otherwise occur; however, reducing the overall size of the Exchange could

Snapshot: New York

- *Has focused on preparation for establishing a health insurance Exchange*
- *Is currently analyzing whether to establish a Basic Health Program (BHP), taking into consideration the following issues:*
 - *A BHP might draw too many people away from the Exchange pool*
 - *Medicaid plans that might not have the capability to become Exchange plans might find a BHP to be a better fit and could potentially provide seamless coverage for people moving between Medicaid and a BHP*
 - *A BHP might provide a middle ground between Medicaid coverage (generous, little cost-sharing) and Exchange coverage (higher cost-sharing and likely a reduced benefit package)*

discourage some plans from participating and limit the market leverage of the Exchange to a degree that limits its long-term sustainability. To avoid this type of scenario, states may consider requirements for Exchange plan participation in Medicaid managed care, as well as risk adjustment between the two programs.

Administrative Complexity

While administrative complexity was not viewed as a defining concern, states did raise the expectation that establishing a Basic Health Program would add a layer of administrative complexity to eligibility determinations, require additional attention to technology system interfaces, and potentially necessitate that the state create a new set of benefits in addition to the Medicaid, Exchange, and any remaining state-funded program benefits.

States Are Exploring How to Ensure Continuity of Care

As indicated above, states are examining ways to ensure continuity of care for low-income populations. One possibility under consideration is requiring that the same plans that serve Medicaid also participate in a Basic Health Program and/or the Exchange (or conversely, setting requirements for Exchange plan participation in Medicaid managed care; however, as mentioned earlier, states are wary of forcing plans with Medicaid expertise to broaden their scope to the commercial market or of unintentionally discouraging

Snapshot: Oklahoma

- *Is considering the possibility of continuing its Insure Oklahoma Individual Plan (IO-IP), a health plan operated directly by the state for low-income employees of small firms who don't have access to employer coverage (authorized under a 1115 waiver), in some form after 2014*
- *If IO-IP does not continue, state will most likely move all enrollees above 133 percent FPL to the Exchange (rather than establish a Basic Health Program), although Exchange coverage will likely be less affordable*
- *Is concerned about the implementation of the ACA's prohibition of cost-sharing for Native American children (and adults, depending on where services are received), as the state has substantial Native American population*
- *If newly-available state funds were made available to Medicaid, the state's priorities would be to address provider network issues, as Oklahoma's primary care capacity is particularly low among states*

commercial plans from Exchange participation because they lack expertise with low-income populations). States raised longstanding concerns about the adequacy of provider networks, and some noted that they would consider using any surplus funding to increase provider rates in order to promote network expansions.

Political Issues May Hinder Maintenance of Current Programs under the ACA

Political realities may make it difficult for states to maintain current programs for those who are likely to “fall through the cracks” under the ACA. States expect their state-funded programs to shrink substantially once the ACA's coverage expansion takes place in 2014, and in some cases the coverage shifts that have already taken place have dramatically reduced the size of these programs. The remaining enrollment in state-funded coverage may be limited to populations for whom there is little political support (e.g., undocumented immigrants). Accordingly, pressure to eliminate such programs may increase. States may consider redirecting some funding to the providers that serve such populations in order to support access to care, particularly since safety net providers will already face significant reductions in their federal payments for uncompensated care under health reform.

States Still Await Key Federal Guidance

There are still many areas where the states are waiting for key guidance from the federal government. In particular, all states highlighted the Essential Health Benefits (EHB) as an area where they needed additional federal guidance to proceed in developing their benefit packages. While the guidance released since December 2011 may help states begin to narrow down their options and preferred approaches, states are still dependent on further federal-level guidance. Additionally, eligibility coordination between Medicaid and the Exchange is still a major area of uncertainty, even after the release of final rules in early 2012.

Funds from State-Funded Programs Will Likely Fill State Budget Holes

Current state economic conditions mean any state funding that is freed up by the reduction and/or elimination of state-funded programs is likely to be used to fill budget holes, although this may change if state fiscal conditions improve. Potential uses of any funding that might be newly available as a result of state program changes has not been a major focus for states. However, states with programs that are funded with a provider assessment or tobacco tax rather than from state general funds noted that these programs

Snapshot: Washington State

- *Secured a Section 1115 waiver to save its Basic Health Program through federal matching funds and thereby maintain coverage for individuals who would otherwise be uninsured but who will be eligible for Medicaid in 2014*
- *Washington's 1115 waiver, termed a “short-term bridge to national reform,” gives the state a 50 percent matching rate and allows the state to convert to the ACA's Modified Adjusted Gross Income (MAGI) definition one year early*
- *Washington's “Bridge” waiver expires at the end of 2013, at which time the entire Basic Health population will move to Medicaid*
- *The ACA's Maintenance of Eligibility (MOE) requirement influenced the state's decision to apply for a Section 1115 waiver instead of filing an “early adopter” state plan amendment (like Washington, D.C. did), as the state could not create an entitlement program that would be subject to the MOE rules during a time of severe budget crisis*

have been less vulnerable to cuts, and these states may have more flexibility and independence in redirecting state dollars in 2014.

States Considering Multiple Uses of Newly-Available Funds

To the extent that states are considering other uses of funds from state health programs, options range from shoring up the safety net to raising primary care physician rates under Medicaid. While states typically felt it was premature to predict potential uses of newly-available funds, they did mention several options, including: raising provider rates; providing wraparound subsidies for Exchange coverage; providing subsidies for coverage for pregnant women; providing additional funding for a Basic Health Program; subsidizing the cost to the state of requiring benefits beyond the EHB in the Exchange; and supporting safety net providers.

cannot be penalized for opting out of the Medicaid expansion, adds a new wrinkle to this decision-making process in the case of states where the 2014 expansion of Medicaid is no longer a certainty. Regardless, each state will need to consider the future of its state-funded programs since the ACA's insurance Exchanges, the Basic Health Plan option, and cost-sharing and premium subsidies, were all upheld by the Court.⁵

Further Reading...

This brief is a companion to an in-depth report of the same name that is available at <http://www.shadac.org/share/grant/implications-and-options-state-funded-programs-under-health-reform>. Profiles of the six states featured in this project are available at the same link.

CONCLUSION

States that currently administer health coverage programs for low-income uninsured individuals have critical decisions to make about transitioning their state program enrollees to new coverage under full implementation of the ACA in 2014. Each state must consider its options within the context of complicated political realities, facing specific legal, technical, and policy issues. The recent U.S. Supreme Court ruling on the Affordable Care Act, with its decision that states

ABOUT SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that supports rigorous research on health reform issues at a state level, with a focus on state-level implementation of the Affordable Care Act (ACA) and other efforts designed to increase coverage and access. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. More information is available at www.shadac.org/share.

⁵ National Federation of Independent Business v. Sebelius. 567 U.S. _____. (2012).