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Introduction

After Congress mandated Medicaid expansion through passage of the Patient Protection and Affordable Care Act ("ACA") of 2010, and the Supreme Court rendered that expansion optional in *National Federation of Independent Business v. Sibelius*, the largest health insurance program in the nation has been left in a state of limbo, waiting for a unifying solution. Since the *NFIB v. Sebelius*, barely half of states have expanded Medicaid, due to concerns about both adopting a program with untold potential costs and the political implications of participating in the ACA. As a result, the federal and state governments were forced to compromise. The most promising compromise came when Arkansas became the first state to submit a Section 1115 demonstration waiver to the federal government under the Social Security Act. This waiver allows states to use federal funding to provide premium assistance for private health insurance for those who would otherwise have been covered under Medicaid expansion. This was a way for Arkansas to use the ACA’s generous federal funding to implement its own "version" of Medicaid expansion.

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The traditional Medicaid program is ideologically rejected by conservatives and often viewed as broken. The ACA attempted to fix the program, but since its new version of Medicaid is merely optional, that solution is fragmented between the states that have expanded Medicaid and states that have not. Arkansas’ plan is under close scrutiny because it may be the best chance the U.S. has at fixing Medicaid. The upcoming years are a transitional period with room for experimentation and new options to provide insurance across all income thresholds. FN The U.S. is at a crossroads that will either result in a bolstering of the Medicaid program, or its ultimate demise. How the federal government chooses to treat states like Arkansas that are trying to find new ways to fix an old program will have a big impact on the rest of the healthcare system.

It is imperative for the federal government to clearly lay out its expectations for future plans as many more states have indicated a plan to submit their own proposals within in the next few years. Currently, the alternative plans in effect are lacking in certain areas, especially in cost-sharing and covered service. Under the alternative plans currently in place, these areas seem to be the first to cut-back on. The alternative plans are, however, exceeding in increased access and continued coverage in line with the ACA’s goal of universal coverage. By expanding some type of insurance coverage, whether under Medicaid or private insurance, an entirely new group of people are now guaranteed coverage through these plans. The federal government should, therefore, highlight and specify requirements for future proposals to ensure that the good aspects to these alternative plans are repeated and the negative aspects disposed of. These

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5 *Id.*
7 See infra Part IV.B.
requirements should be stricter to ensure that alternative plans are a comparable alternative to Medicaid.

This note will discuss the issues and concerns surrounding the alternative plans and how they will affect the future of Medicaid. Part II will provide a background on the evolution of Medicaid, comparing “traditional” Medicaid with “expansion” Medicaid after the passage of the ACA. Part III discusses the alternative plans themselves, highlighting the differences in the five “alternative” plans that are currently in effect. Part IV takes a deeper look at how the alternative plans have accomplished or failed to accomplish the goals of Medicaid expansion under the ACA. Part V discusses the implications of the alternative plans, raising concerns regarding cost and quality of care and how they may be adversely affected by these plans as well as their implications on the healthcare system in general. Part VI concludes that clearly established, stricter requirements for these alternative plans, especially in capping the cost, will help achieve a true compromise that embodies the ideals of Medicaid.

Part II: The Three Faces of Medicaid

Medicaid is a complex program that has undergone many changes since its implementation in 1965. This series of changes, coupled with the fact that states enjoy considerable freedom when deciding how to implement their state Medicaid programs, has left

8 Supra at 3.
9 Supra at 11.
10 Supra at 16.
11 Supra at 25.
12 Supra at 29.
the program seemingly fragmented. Compared to its contemporary, Medicare, Medicaid is critiqued on the one hand because of the large gaps in coverage, and on the other hand, because of its high price tag for the state and federal government. Today Medicaid has once again been put into the spotlight, becoming one of the focal points of President Barack Obama’s healthcare reform. This time, however, it is a much larger change in structure and coverage. This change will either make the program more comprehensive and beneficial, or serve to further fracture Medicaid. For now, the states are split between three versions of Medicaid. This section will discuss Medicaid’s transition, laying out the evolution of Medicaid and discussing the new alternative plan option.

A. The Evolution of Medicaid

Originally designed as a welfare program, Medicaid is a joint federal and state program whose purpose is to provide healthcare access to the “worthy” poor. In order to qualify for Medicaid, applicants are required to meet both an income threshold and also fall under one of the categories of eligibility. Today, such eligible groups include the aged, blind, permanently and totally disabled, pregnant women, and children. The states primarily determine the details of their program, but the federal government imposes certain minimum standards to which all states must adhere.

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16 Id at 250.
17 Id.
must adhere. This structure means that state Medicaid programs often differ in who and what is covered. For example, children from ages six to eighteen are required to be covered up to one hundred percent of the Federal Poverty Level ("FPL"), however nearly all states cover them at least up to 250% FPL.

Similarly, states are largely free to define the amount, duration, and scope of the services they cover provided that they cover certain minimum services such as emergency services and maternity care. Because Medicaid is jointly funded by states and the federal government, a state chooses how much it wants to spend on Medicaid and the federal government meets that spending level at rates that range from fifty-seven to seventy-three percent, depending on the state’s per capita income. The price of a state Medicaid program often reflects how many people are covered and what services are offered.

As mentioned above, Medicaid has a number of shortcomings. Arguable the most significant problem with Medicaid is that it fails to cover a large group of people, specifically non-disabled childless adults, which are not included as a category for eligibility. Consistent with its welfare roots, traditional Medicaid still distinguishes between the “worthy” and the

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21 Federal Poverty Level is a measure of income issued annually by the Department of Health and Human Services that is used to determine eligibility for certain programs and benefits. For 2014, the FPL is $11,670 for individuals and $23,850 for a family of four. FPL levels are higher for Alaska and Hawaii. See Federal Poverty Level (FPL), HEALTHCARE.GOV, https://www.healthcare.gov/glossary/federal-poverty-level-FPL/, (last visited Mar. 20, 2015).
22 The ten essential health benefits include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services and chronic disease management; and pediatric services, including oral and vision care; Medicaid Moving Forward, 2014, THE HENRY J. KAISER FAMILY FOUND., http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/.
23 Poorer states will receive more financial support from the federal government; See 42 U.S.C. §1396d(b) (2011)
“unworthy” poor; it is not simply a program for all low-income individuals and families.25 Consequently, these non-disabled childless adults are typically of working age and as such are not viewed as the “worthy” poor.26 A similar problem arises with the broad flexibility given to states. Many states establish stringent Medicaid requirements that can be quite exclusive.27 For instance, some states have asset tests or require applicants to exhaust their savings before they can qualify for Medicaid. These requirements make it nearly impossible for many to qualify.28 Finally, the application and enrollment process is overly complicated and discourages many who would be eligible for Medicaid.29 In fact, only fifty-seven percent of those who are qualified to receive Medicaid are actually enrolled in the program.30

In recognition of these shortcomings, Congress passed the ACA in 2010 as a comprehensive overhaul of the U.S. healthcare system.31 One goal of the ACA was to achieve universal coverage, a goal that Medicaid expansion played a crucial role in.32 As part of its goal of universal coverage, the ACA expanded Medicaid eligibility by raising the minimum income threshold for all categories of eligibility to 133% FPL, and by including all individuals and families that fell under 133% FPL.33 This expanded version of Medicaid no longer excluded childless, non-disabled adults.34 The federal government also agreed to pay for one hundred

26 Id.
27 Id at 253.
28 Id.
29 Id at 254.
30 Id.
31 Id.
32 Id.
34 The federal government has provided for tax credits to subsidize premiums for private health insurance for those between 100 and 400% FPL; ACA §2001(a) (1), 2011 (codified at 42 U.S.C. §1396a (2011)).
percent of the costs of Medicaid for the first three years after expansion. The government would then slowly reduce its share until 2020 when it would pay for ninety percent of the cost indefinitely, a substantial increase in funding for nearly all states.35

While the ACA did not require states to expand Medicaid per se, those states that chose not to expand Medicaid would lose funding for the program entirely.36 This condition led to a series of lawsuits filed by the states, which culminated in National Federation of Independent Business v. Sebelius,37 in which the Supreme Court held that the federal government could not compel states to expand Medicaid by conditioning its funding on adoption of the expansion.38 This decision rendered Medicaid expansion under the ACA optional among the states and, as a result, only twenty-seven states and the District of Columbia have expanded Medicaid under the ACA.39 Nearly half the states were still using the traditional, pre-ACA program, while the rest implemented “expansion” Medicaid in accordance with the ACA. As a result, the Medicaid program as a whole became further fragmented.

Among the purported reasons for rejecting Medicaid expansion, one of the states’ concerns was the untold potential cost that could come with including so many more people under Medicaid.40 With a larger population qualifying for coverage, state were apprehensive about how much this new group of individuals would cost to over.41 Traditional Medicaid has long been criticized as being too expensive, and this seemed like a move in the wrong direction.

35 Social Security Act §1396y (d) as added by §2001(a) (3) of the Affordable Care Act.
36 Kevin Russell, Court holds that states have choice whether to join Medicaid expansion, SCOTUSblog (Jun 28 2010), http://www.scotusblog.com/2012/06/court-holds-that-states-have-choice-whether-to-join-medicaid-expansion/.
38 Id.
40 Michele Johnson & Kristin Ware, Medicaid Expansion By Any Other Name: Exploring the Feasibility of Expanded Access to Care in the Wake of NFIB v. Sibelius, 1 BELMONT L. REV. 119, 122 (2014).
41 Id.
for some states. Another reason was the political implication of participating in “Obamacare.” The ACA was a politically divisive act and many so-called “red states” were not keen on giving up the fight. Even though the negative political rhetoric surrounding Obamacare reinforced many states’ opposition to expanding Medicaid, these states were also denying themselves an extremely generous amount of federal funding. In fact, some conservative states eventually expanded Medicaid simply because the funding was too good to pass up. States thus became split between two different versions of Medicaid: “traditional Medicaid,” or pre-ACA Medicaid, and “expansion” Medicaid. This polarization among states comes largely at the expense of the current and/or potential beneficiaries of Medicaid by further complicating an already inefficient program.

B. The Compromise

As the states divided among staying with traditional Medicaid and expanding Medicaid under the ACA, a third option surfaced that may prove to be the key to fixing the Medicaid program: the alternative plan. Using a Section 1115 waiver under the Social Security Act, called a demonstration waiver, states may submit proposals to the Department of Health and Humans Services (“HHS”) to be authorized to use federal funds to pay for services that federal statutes or regulations do not otherwise provide for. With states stuck between a political and fiscal “catch-22” not wanting to be connected to “Obamacare” yet recognizing the implications of

44 Id.
45 Michele Johnson & Kristin Ware, Medicaid Expansion By Any Other Name: Exploring the Feasibility of Expanded Access to Care in the Wake of NFIB v. Sibelius, 1 BELMONT L. REV. 119, 122 (2014).
46 For example, Arizona, led by a Republican governor, voted to expand Medicaid in 2013 after Governor Brewer called a special session, David Schwartz, Arizona Governor Jan Brewer signs Medicaid expansion, REUTERS, (Jun. 17, 2013), http://www.reuters.com/article/2013/06/17/us-usa-arizona-medicaid-idUSBRE95G12N20130617.
turning down so much federal money, the alternative plan seemed to come at just the right time.

These plans, spearheaded by Arkansas’ “Private Option,” allow states to accept the federal money but be able to customize their own version of Medicaid expansion, rather than just strictly expand the program under the ACA. Since Arkansas’ approval, five other states have also had their proposals approved by HHS and several other states are considering submitting proposals.

Although Section 1115 waivers have been frequently used in the past, no state has used it to customize their own version of Medicaid. These demonstration waivers allow states to execute experimental or demonstration projects, so long as these projects serve to further promote the obligations of the Social Security Act. The Section 1115 waivers also give states flexibility in their implementation of Medicaid, but still subject them to certain limitations. States have used these waivers in the past to offer more coverage or raise the income threshold for certain categories of beneficiaries within their Medicaid program.

There are four main requirements that submitted proposals must pass to be granted, the first being that the proposal must be experimental. This reflects the use of §1115 waivers as a

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52 Id.
way for states to test new ways to deal with specific problems of welfare recipients. Second, the proposals must be sufficiently likely to further the objectives of the Social Security Administration. This means that, after the passage of the ACA, all submitted proposals must include coverage of the “newly eligible” group. Third, the proposals must be limited in scope and duration, since they are intended to be short-term solutions and are therefore only approved for a limited number of years. Finally, and perhaps most importantly, the proposals must be budget neutral; it cannot cost more to implement the proposed plan than it would have to implement Medicaid normally.

Because Arkansas is the first state to use these waivers for premium assistance, there is little guidance on the requirements or standards HHS is using to approve these proposals. In fact the only real guidance HHS has released since states have begun submitting proposals came from a March 2013 Frequently Asked Questions issued by the Secretary of HHS. According to this document, states’ proposals must meet five requirements to be considered. First, beneficiaries must be provided with a choice of at least two Qualified Health Plans. Second, plans will need to make arrangements to provide any wrap-around benefits and cost-sharing that the private market does not cover. Third, these plans should be limited to those whose necessary benefits are closely aligned with the benefits in the marketplace, meaning the medically frail should not

58 42 U.S.C. §1315(a)
59 42 U.S.C. §1315(g)
62 Id.
63 Id.
64 Id.
fall under these alternative plans because they need a broader range of services.65 Fourth, the plans must be budget-neutral (a requirement of any Section 1115 waiver), and finally, the plan must have a time limit.66 Though these are not formal guidelines promulgated by HHS, they are at least some indication of what HHS is looking for when they review these proposals, which is important for future submissions.

The success of these alternative plans could be the key to “fixing” Medicaid; the states believe they are better suited to create their own plans specific to the needs of their own residents at the same or lower cost than expanding Medicaid.67 This federal program has always varied from state to state, but no state has tried to push this population into the private market.68 Although still new, this third version of Medicaid might be the compromise that achieves universal coverage and replaces the broken federal program. The essential question thus remains whether these alternative plans offer a viable solution as compared to strict Medicaid expansion, or will they just further complicate the Medicaid program, keeping any improvements from occurring.

Part III: The Alternative Plans

Arkansas’ Private Option is touted as a game-changer, a plan that uses federal funding to pay for low-risk adult members of the newly eligible group to receive coverage in the

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66 Id.
68 Id at 1092.
On April 24, 2013 Arkansas passed the Health Care Independent Act, which created the so-called Private Option. Politicians in Arkansas described the Private Option as an alternative to Medicaid expansion that was a unique solution for the state. Under traditional Medicaid, Arkansas has one of the stingiest Medicaid coverage in the country; the state only covered parents up to seventeen percent FPL and did not cover non-disabled, childless adults at all. Arkansas also has one of the poorest and sickest populations in the country. As such, the Private Option has potential to make a big difference for a lot of people in Arkansas, especially given that the state likely would not have expanded Medicaid otherwise.

The Private Option directs participants to log on to the Private Option beneficiary web portal at Insureark.org and take an online health care needs questionnaire. The questionnaire is used to assess participants and determine whether they are “medically frail.” Medically frail participants are those who are predicted to have exceptionally high health service usage in the coming year. Participants who are deemed medically frail will still be covered under Medicaid because Medicaid is more likely to cover the services this group typically needs as compared to private insurance coverage. Those who are not medically frail choose between at least two Qualified Health Plan (“QHP”) options in their insurance region, as required by the approved

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61 Id.
62 Id.
63 Id. at 1092.
64 Id.
65 Id.
66 Id.
67 Id.
Section 1115 waiver.77 The QHPs are required to be “silver level” plans.78 Arkansas currently requires all issuers of insurance on the Marketplace to offer a silver level QHP that meets the Private Option requirements.79 Participants who do not complete the online questionnaire will be auto-assigned to a QHP and will have thirty days to override the assignment by choosing their own plan.80 The Section 1115 waiver also provides that the QHPs will have to make arrangements to provide wrap-around benefits and cost-sharing.81

Since the Private Option’s approval, Iowa, Michigan, Pennsylvania and Indiana have also employed §1115 waivers in connection with Medicaid expansion, though none of these plans has been in effect as long as Arkansas’ plan. Iowa was the second state to take the alternative plan route with its “Health and Wellness Plan.” Iowa used two different waivers for their alternative plan which extends Medicaid to individuals up to 133% FPL. Additionally, Iowa will also offer premium assistance for beneficiaries to get coverage in the marketplace up to 133% FPL.82 Beneficiaries with incomes between 100% and 133% FPL will, however, be charged a small premium beginning in 2015.83 The plan will also provide an option to waive the fee if individuals complete a wellness protocol or attest to financial hardship.84

The Pennsylvania and Michigan plans look somewhat different in that they do not provide premium assistance. Under Pennsylvania’s Plan, “Healthy Pennsylvania,” beneficiaries

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78 Id.
79 Id.
80 Id.
84 Id.
will enroll in Medicaid managed care plans, referred to as “Private Care Options” (PCO).85 These beneficiaries will be diverted into high risk and low risk benefit plans which will differ on what services are provided.86 Individuals above 100% FPL will also be charged a small premium starting in 2016, but the premiums cannot be more than two percent of their household income.87 Beneficiaries will also be responsible for non-emergency use of emergency rooms.88

Similar to Pennsylvania, Michigan also provides Medicaid coverage to all adults with incomes up to, and including, 133% FPL.89 Adults between 100% and 133% FPL will be responsible for small premiums and some cost-sharing.90 Interestingly, Michigan’s plan restructures cost sharing for Medicaid beneficiaries by establishing an account that both the state and beneficiaries themselves will put money into.91 This plan also requires annual updates to ensure budget neutrality.92

In January of 2015, Indiana became the fifth state to use a demonstration waiver to expand Medicaid through the Healthy Indiana Plan (“HIP”). This plan appears to be the most complex of the alternative plan, comprising of four different benefits packages based on income

86Id.
87Id.
88Id.
90Id.
91Id; see also Joan Alker, Michigan Medicaid Expansion Waiver Approved; CMS Also Releases New Medicaid/CHIP FAQs, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE CENTER FOR CHILDREN AND FAMILIES (Jan 3, 2014), http://ccf.georgetown.edu/all/michigan-medicaid-expansion-waiver-approvedcms-also-releases-new-medicaidchip-faqs/.
level, with different levels of coverage in each. The plan encompasses premium payments or co-payments, a healthy behaviors program, and a mandatory health savings account. Unlike the alternative plans that came before it, Indiana’s plan offers more benefits coverage, for a price. The poorest beneficiaries will get basic coverage, but for a monthly premium they can expand their coverage to include benefits such as dental or vision, though they will still be subject to co-payments. Additionally, if an individual fails to pay the monthly premiums for two consecutive months, they will be locked out of coverage and unable to re-enroll for 6 months.

It is evident that these alternative expansion plans are beginning to look less and less like the Private Option as more states begin to design their proposals. States are keeping a close eye on every proposal that passes and finding ways to get the most out of their plans. Even Arkansas is considering amending its current plan to reflect some of the provisions HHS approves in subsequent plans. Outside of the four requirements listed above in Part II B, HHS has not indicated a strict set of requirements or standards for its approval of a state proposal. Reflecting the experimental purpose of Section 1115 waivers, HHS appears to be comfortable with using a number of different strategies to expand Medicaid via these demonstration waivers. Medicaid, however, is still fractured among the states between those who have stayed with traditional Medicaid, those that have strictly expanded Medicaid and those that have opted to expand using the alternative plan. The disjointed nature of the Medicaid program today begs the question of whether these alternatives are worth the further complication.

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96 Roby Brock, State Legislators Hear About Private Option 2.0, TALK BUSINESS AND POLITICS (Jun 17, 2014), http://talkbusiness.net/2014/06/state-legislators-hear-private-option-2-0/.
Part IV: What is the Difference?

The first step to determine the viability of the alternative plans is to address to what extent they differ from simple Medicaid expansion. The alternative plans described earlier are more expensive and have a potentially devastating effect on those who remain in Medicaid. They are also likely to create more confusion and expense among the states than strict Medicaid expansion would. They are not, however entirely a waste. There are redeeming qualities that should be highlighted for future plans, and there are aspects of the plans that can be fixed. This section describes the similarities and differences between expansion Medicaid and the state alternative plans, highlighting the successful trends and the trends that will likely have negative long-term effects.

A. Closing the Gap and Continuity of Coverage

Two important achievements of these alternative plans, in addition to effectively expanding Medicaid and maintaining access: are 1) that they close the coverage gap, and 2) they provide continuity of coverage. If the goal of the ACA is to have universal coverage, both eligibility and continuity are important and necessary. Traditional Medicaid coverage among the states varies substantially and as such, many—especially the nondisabled childless adults—are left out of the program. In raising the income threshold level for Medicaid, the ACA ensured that a substantial number of people were entitled to coverage for the first time, specifically the

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nondisabled childless adults. This group in particular is generally excluded from traditional Medicaid coverage as it is not a federally required category of persons that must be covered, and most states have not opted to extend coverage to the group or if they did, it was not much.

The ACA intended that all individuals receive coverage somehow, whether through Medicaid or private insurance, but when many states did not expand Medicaid, a coverage gap was created. Some individuals in states still under traditional Medicaid may be too rich to qualify for the state Medicaid but too poor to qualify for the federal tax credits and other subsidies provided under the ACA. For any alternative plan to be comparable to expansion Medicaid, it would have to extend its coverage to groups such as nondisabled childless adults who would otherwise get stuck in this gap. For instance, neither Arkansas nor Pennsylvania extended coverage to non-disabled, childless adults under their traditional Medicaid program; therefore both states would have experienced a coverage gap absent these alternative plans.

Arkansas has shown notable progress on closing this gap, with the most recent numbers showing that almost 200,000 have enrolled in the Private Option since its implementation. The other state plans will most likely achieve similar results as they too extend eligibility to a group of people that has traditionally been excluded from health care access. For now, only

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101 Id.
102 Even if individuals are not in a state that has expanded Medicaid under the ACA, they are still eligible for federal tax credits under the ACA. This issue, however, is currently up for debate in the Supreme Court, See King v. Burwell, 759 F.3d 358 (4th Cir.) cert. granted, 135 S. Ct. 475, 190 L. Ed. 2d 355 (2014).
Arkansas' plan has been in operation long enough to determine whether enough this gap is closing in the other states with alternative plans.

Similar to closing the coverage gap, the alternative plans also help provide continuity of coverage by decreasing "churning" for beneficiaries. Churning refers to when an individual's income fluctuates above and below the income threshold for Medicaid eligibility, resulting in repeatedly losing and gaining insurance; These individuals constantly shift between needing coverage through private insurance and qualifying for Medicaid.104 Churning is largely a result of the fragmented nature of our healthcare system; with so many distinct providers and Medicaid coverage conditioned on income, someone whose income fluctuates from year to year will have a difficult time maintaining insurance with the same provider.105 This change can be jarring as it often means a new network of providers and different cost for the insured, which can be especially devastating for someone with pre-existing conditions.106

The ACA attempted to change this by providing the Basic Health Plan (BHP), which is an optional plan states can offer that covers low-income individuals who would otherwise be eligible for coverage through the marketplace.107 Essentially a low cost plan for those between the 133 and 200% FPL, the Basic Health plan helps to maintain similar benefits and networks as

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106 Insurance companies prior to the ACA would deny coverage for preexisting conditions, meaning that if an individual ever lost their coverage, they would likely face a nearly impossible battle going back into the private market. Heather Howard, Churn and the ACA, THE HEALTH CARE BLOG (Aug 11 2014), http://thehealthcareblog.com/blog/2014/08/11/churn-and-the-aca/.
107 Basic Health Program, MEDICID.GOV http://www.medicaid.gov/basic-health-program/basic-health-program.html.
Medicaid so that the individuals at risk of experiencing churn will not risk losing coverage.\textsuperscript{108} Another way the ACA helps reduce churning is through Medicaid Managed Care, which allows private insurance companies to contract with the state to provide Medicaid coverage.\textsuperscript{109} Under the Medicaid Managed Care, private insurance companies provide QHPs that beneficiaries can choose from as their provider.\textsuperscript{110}

Arkansas’ Private Option creates a similar situation: Medicaid eligible individuals who are not medically frail have their choice of at least two QHPs.\textsuperscript{111} By placing this group into the private market, the Private Option plan is alleviating the churn by reducing the change in coverage to a mere change in price rather than kind; beneficiaries will only see a change in price from month to month, rather than an entire new plan month to month because they will already be covered by a private health plan.\textsuperscript{112} Among the other alternative plans, most also attempt to reduce churn.\textsuperscript{113} For example, the Iowa demonstration waiver also uses premium assistance to extend coverage in the private market and Pennsylvania uses Managed Care Organizations to provide benefits from private insurance companies.\textsuperscript{114}

Neither Michigan nor Indiana, however, provides coverage through the private market.

Michigan’s plan maintains coverage under the state Medicaid program, which may put its

\textsuperscript{108} Basic Health Program, MEDICID.GOV http://www.medicaid.gov/basic-health-program/basic-health-program.html.


\textsuperscript{110} Id.


alternative plan at risk for churning. Indiana seems to have increased the risk of churning by creating multiple levels of coverage options dependent on income. This could further exacerbate the problem of churning. Further, although the alternative plans are likely to reduce churn, one concern is individuals who are choosing QHPs or a private plan will have little incentive to choose the cheapest plan. Without factoring in costs, these beneficiaries may choose plans that they will not be able to afford if their income rises above 133% FPL and they are no longer receiving premium assistance, even with the federal tax credits and subsidies. So long as individuals are educated about the true cost of their plan and understand that they may be responsible for higher payments should their income rise, having continuous coverage in the private market is a good way to help maintain continuous coverage.

B. Benefits and Their Cost to Beneficiaries

Though these alternative plans have all been successful in providing the necessary coverage to the newly eligible nondisabled childless adults, the plans do differ in what benefits are provided and the cost of each plan. All alternative plans provide the 10 essential health benefits required by both traditional Medicaid and expansion Medicaid. Some of the alternative plans, specifically Arkansas’ and Michigan’s, provide more robust coverage that is

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118 Id.
119 Id.
comparable to expansion Medicaid coverage.\textsuperscript{120} Others, such as Indiana’s, seem to strive to provide the minimum coverage possible, or, alternatively, more coverage for a higher price.\textsuperscript{121} Additionally, many of these plans impose premium payments, making the cost of coverage higher for some individuals, indicating that the alternative plans tend to move farther away from what expansion Medicaid provides for.\textsuperscript{122}

Traditional Medicaid covers a wide range of benefits, indicative of its diverse population with a large range of needs.\textsuperscript{123} States are required, under traditional Medicaid, to model the benefits they provide from one of four “benchmark plans.” Under the ACA, these benchmark plans have been re-named Alternative Benefits Plans (“ABP”).\textsuperscript{124} The plans are required to cover, at a minimum, the “ten essential health benefits”,\textsuperscript{125} as well as a few other requirements such as non-emergency transportation and Early Periodic Screening, Diagnosis and Treatment for children (EPSDT).\textsuperscript{126}

Among the alternative plans, most provide relatively robust services, with Arkansas and Michigan providing the most benefits.\textsuperscript{127} Beyond providing the most comprehensive coverage through its QHPs, state is responsible for covering wrap-around benefits for non-emergency transportation and limited EPSDT.\textsuperscript{128} Unlike other plans, Arkansas did not waive any benefits

\textsuperscript{121} Id.
\textsuperscript{122} Id.
\textsuperscript{124} Sec. 1937(b)(1) and Sec. 1937(b)(2).
\textsuperscript{125} Defined infra at note 21.
\textsuperscript{128} Id.
for individuals receiving premium assistance. Both Arkansas and Michigan’s plans will look very similar to the alternative benefits plans under Medicaid expansion; however Michigan’s plan goes beyond strict Medicaid and provides some additional benefits. Not only does Michigan’s plan provide the ten essential health benefits, but it also provides enhanced services for mental health and substance abuse programs. Iowa also provides similar coverage to Arkansas under its QHPs, but it will not provide wrap-around coverage for non-emergency transportation. Of the current plans, Arkansas’ and Michigan’s offer the most robust services, though Iowa is not far behind.

The most concerning plans, however, are Pennsylvania’s and Indiana’s because they seem to downsize rather than expand coverage. Beneficiaries in Pennsylvania receiving their coverage through the private marketplace will only be guaranteed the Ten Essential Health Benefits, essentially just providing the basic health plan that is available in the marketplace with no additional services. Similarly, Indiana’s “HIP Basic” plan provides only the minimum coverage. Additional coverage such as vision and dental will only be provided to individuals who pay a premium.

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130 Id.
136 Id.
A drawback of putting beneficiaries into the private market is that the state may have to cover wrap-around benefits, as with Arkansas, or will have to substantially limit its coverage, as with Pennsylvania. When private coverage does not look enough like Medicaid, it can become complicated and costly for the state to make up the difference. It is encouraging that Michigan and Arkansas provide a broader range of coverage with their alternative plans. However, it is discouraging that Iowa has been exempt from providing certain benefits, and that legislators is Arkansas have expressed a desire to amend their proposal to reflect similar exemptions to those in Iowa.\textsuperscript{137} It seems that coverage will continue to be cut back with each new alternative plan, as illustrated by Indiana’s plan.

Another key aspect besides benefits is how much these services will cost the beneficiaries. For most plans, there is at least some cost-sharing between the state and beneficiaries. Part of the benefit of being Medicaid-eligible under traditional Medicaid is the limited cost-sharing for necessary services.\textsuperscript{138} Currently, Arkansas’ plan does not impose a premium at any level to beneficiaries within its state and does not require co-payments and deductibles from anyone under 100\% FPL.\textsuperscript{139} Overall cost-sharing for beneficiaries will be capped at five percent of annual income and the state will additionally cover any costs under private insurance in excess of Medicaid costs.\textsuperscript{140} Iowa’s plan charges premiums for beneficiaries over one hundred percent FPL and caps cost sharing at two percent of annual income.\textsuperscript{141}

\textsuperscript{140} Id.
Beginning in 2015, however, all beneficiaries in Iowa will be charged a monthly premium that can be waived by a meeting certain health goals. An additional co-pay for non-emergency use of emergency room will also be imposed in 2015. As discussed above, Indiana’s beneficiaries will be subject to a premium to get access to more services.

Interestingly, Pennsylvania and Michigan have implemented health behavior incentives to reduce costs of their plans. Pennsylvania’s plan charges monthly premiums as well, but it also provides a waiver for those premiums subject to a showing of financial need or certain healthy behaviors. Similarly, Michigan’s plan will also charge premiums and certain co-payments, but establishes the Michigan Health Account in which both the beneficiaries and the state deposit money for expenses. Encouraging healthy behavior is certainly important but it can be discriminatory towards those who are inherently sick or disabled. In this instance, however, with all five plans distinguishing between the relatively healthy and the medically frail, those who are already sick and unable to take advantage of those incentives will still be covered under the traditional Medicaid program within their state. As such, these healthy behavior incentives could be a success in the long run.

In light of this, HHS should establish stricter regulations for approval of alternative plans that will help ensure the ideals of the ACA are upheld and that the newly eligible individuals receive the coverage that they are entitled. Although some aspects of these alternative plans are a

143 Id.
decent alternative to strict Medicaid expansion, the plans themselves pose some serious concerns that could outweigh their benefits in the long run. If the federal government wants to continue to encourage Medicaid expansion it will have to maintain stricter standards for future plans and hold the states accountable for any additional expenses they incur in implementing these plans.

**Part V: The Horns of the Dilemma, Future Implications of the Alternative Plans**

The alternative plans, in theory, offer a unique compromise that can help bridge the political divide on the issue of Medicaid, but only if HHS establishes concrete rules and regulations that govern the plans. Under the Obama Administration, HHS will have more freedom to decide which proposals to approve, but under a new administration it may not. Racing a majority Republican Congress now and the possibility of a Republican White House, HHS should take the time to establish clear cut requirements before they risk facing political pressure from Congress to impose less strict standards. The HHS should therefore establish regulations now to help solidify them for future proposals. These regulations should include both an assurance of cost control, like the one imposed on the Michigan plan, and consider establishing benefits or cost requirements to help ensure that those covered under alternative plans are receiving at least comparable coverage to states that expand Medicaid. HHS should also take into consideration the effects of allowing more states to push its low-risk beneficiaries into private coverage while leaving its high-risk population under Medicaid as this may weaken the program overall at the expense of those who need the coverage the most.

HHS does require budget-neutrality for proposals under Section 1115 waivers, but it failed to ensure that requirement for Arkansas.\(^\text{147}\) In a recent report released by the Government Accountability Office, REP. NO. GAO-14-689R, MEDICAID DEMONSTRATIONS, 2014 http://www.gao.gov/assets/670/665265.pdf.

Accountability Office ("GAO") regarding the Private Option, the GAO criticized HHS for failing to properly ensure budget-neutrality.\(^{148}\) According to the report, not only did HHS allow Arkansas to use hypothetical payment rates to estimate how much they would have spent on Medicaid as a comparison for their spending limit, but HHS also gave Arkansas the flexibility to adjust that limit in the future.\(^{149}\) The GAO report indicates that these compromises resulted in a spending limit that is nearly $778 million over what it would be if the limit were based on actual rates.\(^{150}\) There are no specific recommendations made in the report and HHS has defended its use of the numbers provided by Arkansas, but HHS has certainly become stricter on what it allows.\(^{151}\) The Michigan plan, for instance, which came after the Arkansas plan, requires annual updates to ensure budget-neutrality.\(^{152}\) If HHS imposes annual updates or stricter prediction methods in the future, perhaps the cost of these alternative plans can be contained. That is not to say, however that the cost would go down, per se; the cost of these plans must be equivalent to what the state would have spent on Medicaid which does not have a set limit.\(^{153}\)

Additionally, for plans that resemble the Private Option, the Medicaid program would lose market power because these plans divert a large number of people into the private market. Though the Michigan, Pennsylvania and Indiana plans extend coverage within the Medicaid program, Iowa and Arkansas do not; this weakens Medicaid’s market power in those states. Medicaid and other federal governmental programs providing health coverage play an important

\(^{149}\) Id.
\(^{150}\) Id.
\(^{151}\) Id.
role in the health care market as they cover a large number of consumers in the United States.\textsuperscript{154} Traditionally, Medicaid represented such a large group of people that it was better to accept Medicaid than not because so many of the patients hospitals received were indigent and unable to pay for medical services.\textsuperscript{155} But Medicaid reimburses services at a much lower rate than private coverage is likely to, which has been a point of contention for physicians and hospitals, especially those in impoverished areas who depend on Medicaid payments.\textsuperscript{156}

Since the ACA was passed, hospitals have been able to save billions of dollars because more of the patients they are treating have insurance, and part of that success comes from more individuals being covered under Medicaid.\textsuperscript{157} Hospitals no longer lose money providing services to patients who cannot afford to pay.\textsuperscript{158} But for states that did not expand Medicaid, there are still a number of uninsured people that must be treated without the ability to pay for healthcare services.\textsuperscript{159} For these states, alternative plans that push beneficiaries into private coverage leads to a small number of high-risk people being covered under Medicaid. By separating the high-risk population into Medicaid while allowing the low-risk population into the private market, the costs for Medicaid recipients will raise but reimbursement rates will still be comparatively low compared to private insurance.

Hospitals that serve higher-income areas may be less inclined to accept Medicaid payments which would reduce the access to better care for the medically frail that remain in

\textsuperscript{155} Id.
\textsuperscript{156} Id.
\textsuperscript{158} Id.
Community Hospitals that rely on Medicaid payments might be eliminated from the network for QHPs, and consequently may be forced to shut down—an adverse effect in predominately rural areas that rely on these types of hospitals to get their care. 161 This will ultimately have adverse effects on the quality of services Medicaid’s remaining beneficiaries will receive. Not only will Medicaid recipients be forced to go to lower quality facilities that are not likely to have specialty services, but they might also have to travel farther to receive care in the first place.162 Private insurance coverage is beneficial to the low-risk population that receives it at a reduced cost; their quality of services will improve as they will have access to better networks of providers.163 This improvement, however, is likely to be at the expense of the high-risk population that is left in Medicaid.

Ultimately, the big picture is key when dealing with these alternative plans: compared to states who maintain their traditional Medicaid program, where the expansion population is largely ignored, the alternative plans are a big step in the direction of universal coverage. They help eliminate the coverage gap in states that otherwise would have a large portion of their population fall within in that gap. Further Americans living in states that remain in traditional Medicaid are already paying for expansion Medicaid through their federal taxes, yet not receiving coverage, a fact that states with alternatives plans can now take advantage of.164 The alternative plans illustrate, however, that there may not be a right way to fix or improve Medicaid completely.

161 Katie Bo Williams, Does the Private Option sink or save providers? HEALTHCAREDIVE (Mar 14, 2014), http://www.healthcaredive.com/news/does-the-private-option-sink-or-save-providers/239242/.
162 Id.
163 Id.
164 Id.
Medicaid has been patched and changed so many times over the course of its implementation that many feel it is not worth the time and effort to save. Under the ACA, Medicaid was expanded in an effort to change the program and make it more usable. The more people who receive Medicaid, the more political power the program will have to improve its influence. There are a lot of ideological concerns opponents have about Medicaid, but these alternative plans are not replacements to Medicaid by any stretch. These plans should be watched closely as they progress, especially with regard to pricing and quality of care concerns because those are the key to deciding Medicaid’s fate. If these plans can give insight into a cheaper way to provide quality coverage for all beneficiaries, they will be instrumental to fixing Medicaid in the future. If, however, they simply increase costs and decrease quality for some, they will only highlight the horns of the dilemma: either we keep people in Medicaid and improve the program, or we pay for its recipients to get private insurance at a higher cost to the government.

Part VI: Conclusion

Comparing the alternative plans to expansion Medicaid is a complicated problem; it is hard to see how states will fare under these alternative plans over simply expanding Medicaid. It is clear, however, that the alternative plans are more beneficial to states than remaining with traditional Medicare, especially for states like Arkansas that historically provide minimal coverage under Medicaid. Perhaps Arkansas’ Private Option using premium assistance is too expensive, but overall these alternative plans have a lot of value for experimenting with ways to improve healthcare across the United States. These plans will likely be the future of Medicaid, and perhaps one of them may lead to a better version of Medicaid in the long run. Ultimately, it is important that HHS monitor these experimental alternative plans and continuously update and revise their requirements to reflect the best aspects of the plans and exclude the worst.