



Medicaid Expansion: Premium Assistance and Other Options

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Executive Summary

The Affordable Care Act (ACA) expanded Medicaid eligibility to all individuals with incomes up to 138% of the federal poverty level (FPL) or about \$16,242 for a single adult or \$33,465 for a family of four (in 2015). The expansion would predominantly benefit childless adults, a population historically barred from Medicaid regardless of income level, and low-income parents. Opponents of the law argued that the federal law was unduly coercive and challenged the expansion. In 2012, the United States Supreme Court ruled that it is unconstitutional for the federal government to coerce states into expanding Medicaid by withholding funding for their existing Medicaid programs if they did not. As a result, Medicaid expansion is now totally optional for the states. As of January 19, 2016, 31 states and the District of Columbia have decided to move forward with the expansion. The remaining states are still considering the matter or have decided against expansion at this time.

Following Arkansas' lead, several states have sought to expand Medicaid coverage in a manner that is more palatable to the conservative ideological leanings of their legislators and residents. Using the Medicaid waiver process, which permits Medicaid programs to seek approval from the federal government to forgo some traditional Medicaid rules, states have received approval from the federal government to increase cost-sharing and impose premiums, trim benefits, use Medicaid funds to purchase private insurance, and require or encourage enrollees to participate in wellness or health behavior initiatives. Some past waiver experiments have been widely adopted by state Medicaid programs, including managed care delivery models and benchmark benefit plans.¹ This paper will review some of the existing Medicaid expansion waivers and offer recommendations designed to influence stakeholders to ensure that Medicaid coverage is expanded in a manner that best suits patients.

Recommendations

- 1. Medicaid programs must develop and widely disseminate information to enrollees (and potential enrollees) that clearly explains in plain language health insurance concepts, plan rewards and penalties, provider and hospital network, and other pertinent information. Materials should be made available to meet the needs of the Medicaid population, including those with disabilities and/or limited English proficiency and literacy. States should work with independent enrollment brokers and community-based organizations, and other assistance entities to provide enrollee outreach and education and, when applicable, act as a liaison between the enrollee, insurer, and state program. State programs should work with such stakeholders to provide toll-free help lines, face-to-face counseling, electronic communication and other ways to access Medicaid information, education materials, and enrollment assistance.**
- 2. At a minimum, Medicaid expansion waivers should provide coverage of the essential health benefit package, nonemergency transportation, Early and Periodic Screening and Diagnostic and Treatment benefits, mental health parity, and other benefits required of Alternative Benefit Plans.**
- 3. Medicaid premiums and cost-sharing should be structured in a way that does not discourage enrollment or cause enrollees to disenroll or delay or forgo care due to cost, especially those with chronic disease. If cost-sharing is applied it should be done in a manner that encourages enrollees to seek high-value services and health care physicians and other health care professionals. Medicaid enrollees should not be**

restricted from reenrolling in coverage (i.e., locked-out). Medicaid out-of-pocket costs should remain nominal and be subject to a cap (such as no higher than 5% of family income) for those with incomes above the poverty line.

4. Work-related or job search activities should not be a condition of eligibility for Medicaid. Assistance in obtaining employment, such as through voluntary enrollment in skills- and interview-training programs, can appropriately be made available provided that is not a requirement for Medicaid eligibility.
5. Medicaid wellness programs should be structured in a manner that monitors health status and encourages healthy behavior through positive incentive-based programs. Punitive approaches that penalize enrollees for not achieving better health status, or for not changing unhealthy behaviors, should be avoided. Applicable programs should adhere to the recommendations established in the ACP policy paper “Ethical Considerations for the Use of Patient Incentives to Promote Personal Responsibility for Health: West Virginia Medicaid and Beyond.”

Background

Premium Assistance and Other Waiver Approaches

Section 1115 of the Social Security Act permits the federal government to approve state Medicaid waivers that provide states additional flexibility as long as they further program objectives. States have used 1115 waiver authority to expand eligibility, to provide new benefits, or to test delivery system reforms. The waivers must be budget neutral. Generally, they are approved for a 5-year period, and then states can apply for a 3-year extension. Some initial Medicaid expansion waivers expire after 3 years. As of January 20, 2016, seven states—Arkansas, Iowa, Michigan, New Hampshire, Indiana, Pennsylvania, and Montana—have had Medicaid expansion waivers approved by the federal government. Since the waivers share a number of characteristics, this section will summarize a selection of waivers and their requirements.

To achieve expansion in conservative-leaning states, some governors and legislatures have considered approaches that permit states to use Medicaid funds to purchase private insurance through state health insurance marketplaces, a concept known as premium assistance. The Obama Administration has indicated that it would allow some states to implement premium assistance for the Medicaid expansion population, provided that cost-sharing and benefits are comparable to what enrollees would have received if covered by Medicaid. Premium assistance programs must also be cost-effective, meaning that program cost cannot exceed that of providing coverage through Medicaid.² If a health plan’s benefit package is not as comprehensive as Medicaid’s, the health plan is obligated to integrate wraparound or supplemental benefits to provide the necessary services, although Iowa, Pennsylvania, and Indiana were allowed to temporarily waive nonemergency transportation. States are obligated to fully expand eligibility, so plans that would increase eligibility up to an income level below 138% FPL would not be approved. Premium assistance programs existed before passage of the ACA, usually to help low-income individuals afford individual-market health insurance.³ Given the volatility and high cost of the individual health insurance market before implantation of the ACA’s insurance reforms, Medicaid premium assistance programs were only used to cover small numbers of people.⁴

Premium assistance has generated controversy, as patient advocates have questioned whether the private market can provide adequate coverage to meet the needs of a vulnerable population. Individuals with incomes above the poverty level would have lower out-of-pocket spending through Medicaid than if they'd enrolled in a Marketplace-based health plan.⁵ However, premium assistance may provide benefits that the traditional Medicaid program cannot. Premium assistance may reduce "churning," or a disruption in coverage as enrollee's income and eligibility status changes, if implemented in a way that ensures continuity as enrollees transition from Medicaid to private market coverage. Physicians and other health providers may be more likely to participate in private insurance than Medicaid, potentially broadening enrollee access to providers. In some states, however, cost-sharing protections for premium assistance programs are only available if the enrollee receives care from a provider that participates in both Medicaid and the enrollee's private insurance plan network.⁶

Arkansas was the first state to receive approval for its Medicaid expansion premium assistance program. Since then, several other states have taken interest in the concept. The U.S. Department of Health and Human Services has approved an amended version of Iowa's premium assistance waiver. New Hampshire will enroll eligible individuals into Medicaid-backed qualified health plans starting in January 2016.

Some states have developed Medicaid expansion waiver proposals that would require or encourage jobless beneficiaries to search for employment, participate in wellness programs, terminate coverage for nonemergency medical transportation, or pay premiums and cost-sharing. This paper will outline characteristics of Medicaid expansion waivers and consider their potential effect on patients.

Current Medicaid Expansion Waivers

Arkansas⁷

The Obama Administration approved Arkansas' Medicaid premium assistance waiver application in 2013. The waiver allows the state to purchase qualified health plan coverage through the health insurance marketplace for eligible individuals. The program will run from 2014 to 2016 and cover eligible parents and childless adults. The waiver was amended with federal approval in 2015. In the revised version, nondisabled individuals with incomes between 50%-138% FPL will be enrolled in plans with "Independence Account" (IA) health savings accounts and contribute monthly payments. These funds will be used to pay cost-sharing.⁸ Those with incomes above the poverty line will be required to contribute \$10-\$25 per month; enrollees with incomes from 50%-100% FPL will contribute \$5.⁹ An enrollee cannot lose coverage for failing to pay a premium, but point-of-service cost-sharing will be charged to enrollees with incomes above 100% FPL who do not contribute to their account. Medically frail individuals will be enrolled in traditional Medicaid. Nonemergency transportation and early and periodic screening and diagnostic treatment benefits are provided by Medicaid (wrap-around/supplemental benefits).¹⁰ The state waiver also requires prior authorization for nonemergency medical transportation for newly eligible adults.

According to the state waiver application, "the introduction of IAs will provide participants with direct information about the cost of health care services and out-of-pocket costs; it also has the goal of promoting independence and self-sufficiency by providing participants with the possibility of having additional credits to be distributed as cash, which can be used to pay future private market premiums."¹¹

Iowa

Iowa's Medicaid expansion waivers are similar to those of Arkansas, although newly eligible adults with incomes from 50%-100% FPL will be covered through Medicaid managed care. Adults with incomes between 101%-138% FPL may enroll in silver-level qualified health plans sold through the state's health insurance marketplace or Medicaid managed care. Iowa will require Medicaid beneficiaries to pay premiums starting in 2015: \$5 a month for managed care enrollees with incomes from 50%-100% FPL and \$10 a month for enrollees with incomes between 101%-138% FPL. Beneficiaries with incomes above the poverty level have a 90-day grace period to pay premiums before their coverage is terminated. Those below the poverty level cannot lose coverage for nonpayment of premiums. Premiums can be waived if enrollees participate in wellness activities, including receiving a health risk assessment and wellness examination.⁷ Enrollees are obligated to pay a co-pay for nonemergency use of the emergency department (ED). The benefit package for those enrolled in premium assistance will be equivalent to the state employee plan benefits package. The state is exempt from nonemergency transportation coverage requirements through July 2015.

Pennsylvania

Pennsylvania's Medicaid expansion waiver was approved under Governor Tom Corbett in August 2014. Following his election in November 2014, Governor Tom Wolf stated that he will replace the Medicaid waiver with traditional Medicaid expansion. In May 2015, the Philadelphia Inquirer reported that over 120,000 Medicaid enrollees had been transferred from the Healthy Pennsylvania private coverage option to a traditional Medicaid expansion plan called HealthChoices.¹² In July, Governor Wolf announced that the final 79,272 enrollees had been transferred to HealthChoices from the Healthy Pennsylvania waiver program.¹³

Before the transition to HealthChoices, the Healthy Pennsylvania program provided services to the expansion population through Medicaid managed care arrangements. Starting in January 2016, the state would charge premiums of up to 2% of household income for enrollees with incomes over the FPL. Enrollees required to pay premiums would not have to pay copayments except for an \$8 charge for nonemergency use of the ED.¹⁴ People with income below the poverty level would pay co-payments. Those who failed to pay the plan premium would have a 90-day grace period before coverage would be terminated. Some groups, such as pregnant women and the medically frail, would be exempt from premium requirements. Premium amounts could be reduced if the enrollee participated in healthy behavior activities, such as having an annual wellness visit. The expansion population would receive the "full complement of health services required under the law," although like the Iowa waiver, the state was exempt from non-emergency medical transportation requirements until 2016.

Pennsylvania's proposed waiver application included a provision that would reduce premiums and cost-sharing for adult enrollees who participate in a voluntary work-search pilot program. The federal government rejected this proposal but the state indicated that it would provide career coaching for enrollees who voluntarily participate in the state's Encouraging Employment program.

Indiana

The Healthy Indiana Plan 2.0 (HIP) was approved by HHS in 2015 and is scheduled to run until January 2018. A Kaiser Family Foundation summary of the waiver notes “while all [Medicaid] waivers involve some amount of administrative complexity, Indiana’s demonstration is more complex than others approved to date.”¹⁵ Under HIP 2.0, enrollees, including the adult expansion population, will be enrolled into a HIP Plus plan, which is connected to a Personal Wellness and Responsibility (POWER) health savings-style account. The POWER account seeks to “promote more efficient use of health care, encouraging preventive care and discouraging unnecessary care.”¹⁶ HIP Plus enrollees are required to contribute to a Personal Wellness and Responsibility (POWER) health savings account and in exchange will have access to a wider array of benefits, including dental and vision, in addition to the ACA-mandated essential health benefit package.¹⁷ The state will also make financial contributions to the enrollee’s POWER account to cover health care expenses. Indiana is not obligated to offer nonemergency medical transportation to the newly eligible adult population through November 2016.¹⁸

Indiana is authorized to collect monthly premiums in the form of POWER account contributions. Contributions are not to exceed 2% of household income for those with incomes up to 133% FPL. Contributions for enrollees with incomes up to 5% FPL are capped at \$1 a month. Above-the-poverty-line enrollees are required to make contributions to POWER accounts as a condition of coverage. HIP Plus enrollees will not be subject to cost-sharing except for nonemergency use of the ED (\$8 for first use, \$25 for subsequent visits).

Above-poverty-level enrollees will lose coverage and be subject to a six-month “lock-out” if they begin and then subsequently stop contributing to their POWER account. They will be barred from reenrolling in coverage during the lock-out period. Those with incomes below the poverty line who do not contribute to a POWER account will receive HIP Basic benefits and be required to pay Medicaid-level cost-sharing (i.e., “nominal” amount). HIP Basic enrollees will also be denied vision, dental, and some prescription drug benefits.

For above-the-poverty-line enrollees, coverage starts on the first day of the month in which a POWER account contribution is made, rather than the date of the Medicaid application.

Recommendations

- 1. Medicaid programs must develop and widely disseminate information to enrollees (and potential enrollees) that clearly explains in plain language health insurance concepts, plan rewards and penalties, provider and hospital network, and other pertinent information. Materials should be made available to meet the needs of the Medicaid population, including those with disabilities and/or limited English proficiency and literacy. States should work with independent enrollment brokers and community-based organizations, and other assistance entities to provide enrollee outreach and education and, when applicable, act as a liaison between the enrollee, insurer, and state program. State programs should work with such stakeholders to provide toll-free help lines, face-to-face counseling, electronic communication and other ways to access Medicaid information, education materials, and enrollment assistance.**

Much of the newly eligible Medicaid population may not understand health insurance concepts like cost-sharing, networks, and formularies.¹⁹ Individuals with lower health insurance literacy and numeracy skills may be less able to adequately compare high-deductible health plans versus traditional plans²⁰ or comprehend hospital quality information.²¹ Evidence shows that Medicaid beneficiaries may have difficulty understanding and navigating health-related incentive programs, like wellness/healthy behavior incentive efforts, resulting in low participation.²² A survey of uninsured Medicaid-eligible adults found that only 18.7% were very or somewhat confident in their understanding of all insurance terms listed in the survey (i.e., premiums, deductibles, co-payments, coinsurance, maximum annual out-of-pocket spending, provider networks, annual limits on services, covered services non-covered and excluded services).¹⁹ To address this problem, public information and education campaigns initiated by State Medicaid programs and health insurance marketplaces should clearly explain insurance concepts in a manner that reflects the language and cultural needs of the target population.²³ Wellness program educational materials should be written in plain language and disseminated through multiple modes of communication to ensure that individuals are educated on how programs work and the incentives available for meeting goals or penalties for failing to meet goals.^{22, 24}

As Medicaid programs become more complex, materials need to be presented in a manner and reading level that is accessible to the Medicaid population. Ninety percent of states have reading level requirements for their Medicaid materials; most mandate that materials be written at a 6th grade reading level.²⁵ Multilingual Medicaid informational materials and translation services should be made available since more than half of people with limited English proficiency have incomes that would make them eligible for Medicaid.^{26, 27} The Medicaid and CHIP Payment Access Commission (MACPAC) has recommended that when Medicaid programs transition from fee-for-service to private managed care, it is important to communicate to enrollees "how to obtain services in the most appropriate manner; the procedures for making plan selection and the implications of those choices; the concept of auto-assignment for those who do not select a plan; and the importance of acting in a timely manner so that enrollment cards and new member materials can be issued."²⁸ Research shows that patients trust physicians and other health providers when seeking health insurance information.^{19, 29} Physicians and office staff should be prepared to provide or refer patients to health insurance enrollment and education information.

States should simplify enrollment and eligibility checks and work with health insurance marketplace-based outreach and enrollment entities to facilitate Medicaid coverage. The ACA requires that the enrollment infrastructure for Medicaid and private health insurance marketplace-based plans be streamlined and coordinated. Programs must coordinate efforts and information technology infrastructure to ensure that applicants have "no wrong door" when seeking coverage. Fast-track enrollment procedures or Express Lane enrollment can also make it easier for people to obtain coverage. Enrollment applications and plan information can be distributed in a targeted manner to those who participate in other social service programs, such as Supplemental Nutrition Assistance Program (SNAP, previously known as the Food Stamp Program).³⁰ Arkansas identified and mailed Medicaid enrollment applications to SNAP-participating individuals and families.³¹ South Carolina has used fast-track procedures to renew Medicaid coverage for individuals who are also enrolled in SNAP and the Temporary Assistance for Needy Families program, reducing administrative costs and staff time.³²

- 2. At a minimum, Medicaid expansion waivers should provide coverage of the Essential Health Benefit package, nonemergency transportation, Early and Periodic Screening and Diagnostic and Treatment benefits, mental health parity, and other benefits required of Alternative Benefit Plans.**

Most of the Medicaid expansion population will receive a Medicaid alternative benefit plan (ABP) which includes the 10 Essential Health Benefit categories required of private market health exchange plans, mental health parity requirements, preventive services, family planning services, and nonemergency transportation services, among others. Many states have based their ABP on the benefit package available to traditional adult Medicaid enrollees. ACP policy recommends that:

States' efforts to reform their Medicaid programs should not result in reduced access to care for patients. Consumer-driven health care reforms established in Medicaid should be implemented with caution and consider the vulnerable nature of the patients typically served by Medicaid. A core set of comprehensive, evidence-based benefits must be provided to enrollees.³³

Nonemergency transportation services are a staple of state Medicaid programs and help low-income individuals without adequate transportation make their health care appointments. Limited transportation options were cited by Florida and Idaho Medicaid enrollees as barriers to participating in wellness/healthy behaviors programs.²⁴ In its Arkansas Health Reform Legislative Task Force-requested assessment of the Arkansas Medicaid program, The Stephen Group consulting firm described the nonemergency transportation benefit as a "very cost effective benefit" and recommended that the state keep the benefit in place.³⁴ Patient advocate groups in Pennsylvania criticized the state's attempt to revise benefit and cost-sharing requirements for currently eligible Medicaid enrollees, insisting that they would hurt the poor and vulnerable.³⁵ ACP has long supported policies that support an essential benefits package. The Obama Administration has maintained that premium assistance programs ensure that benefits are equal to what an enrollee would receive through a traditional expansion. Slashing transportation benefits, or making certain benefits available only to those who participate in wellness programs or similar initiatives, undermines the concept of an essential benefit package.

- 3. Medicaid premiums and cost-sharing should be structured in a way that does not discourage enrollment or cause enrollees to disenroll or delay or forgo care due to cost, especially those with chronic disease. If cost-sharing is applied it should be done in a manner that encourages enrollees to seek high-value services and health care physicians and other health care professionals. Medicaid enrollees should not be restricted from reenrolling in coverage (i.e., locked-out). Medicaid out-of-pocket costs should remain nominal and, for those with incomes above the poverty line, be subject to a cap (such as no higher than 5% of family income).**

Premiums and Cost-Sharing in Medicaid

Federal law restricts Medicaid from establishing premiums for enrollees with incomes under 150% FPL. However, the federal government has granted Medicaid expansion waivers that allow the collection of premiums or mandatory contributions to health savings accounts that may have the same effect as premiums. Premiums pose a financial barrier to low-income individuals and may discourage Medicaid enrollment or cause disenrollment.³⁶ Evidence shows that cost-sharing can be effective in reducing use of unnecessary health care services; however, it also has been shown to decrease use of effective care and have an adverse impact on the poorest and sickest patients. The large-scale, multi-year (1971-1982) RAND Health Insurance Experiment found the following:

- “Participants who paid for a share of their health care used fewer health services than a comparison group given free care.
- Cost-sharing reduced the use of both highly effective and less-effective services in roughly equal proportions.
- Cost-sharing did not significantly affect the quality of care received by participants. Cost-sharing in general had no adverse effect on participant health, but there were exceptions: free care led to improvements in hypertension, dental health, vision, and selected serious symptoms. These improvements were concentrated among the sickest and poorest patients.”³⁷
- A 2006 report on the RAND experiment “the study suggested that cost-sharing should be minimal or nonexistent for the poor, especially those with chronic disease.”

Despite Medicaid’s generous coverage, a study done before the 2014 Medicaid expansion found that 26% of Medicaid enrollees were underinsured, with out-of-pocket expenses higher than 5% of annual household income.³⁸ Many states impose some limited cost-sharing on Medicaid beneficiaries in an effort to fill budget gaps and curb unnecessary spending. Below-poverty-level enrollees can only be subject to “nominal” cost-sharing. The Obama Administration has given states some flexibility in the amount of cost-sharing for the expansion population while rejecting proposals to terminate coverage if a below-poverty-level enrollee does not pay the premium or out-of-pocket fee. Evidence shows that high cost-sharing can drive enrollees out of Medicaid.^{39,40} In response to an economic downturn, Oregon cut benefits, increased premiums, and established cost-sharing for some Oregon Health Plan (OHP) Standard enrollees (including nondisabled adults and couples with incomes below the poverty level), and enrollees left the program in droves. When asked why they had disenrolled, nearly half of survey respondents cited premium increases and inflexible premium payment deadlines as reasons for leaving the program within the first 6 months after the plan’s changes were implemented.⁴⁰ Those that remained in the program were more likely to report cost as a barrier to getting needed care than those in the more-generous OHP Plus plan. States that increase Medicaid cost-sharing have lower take-up rates than those with limited cost-sharing, indicating that cost-sharing influences whether an eligible individual enrolls.⁴¹ States may eventually save money, not because of premium savings but because Medicaid premiums cause people to disenroll from the program.⁴² Cost-sharing may dissuade lower-income individuals from seeking necessary care: a Commonwealth Fund survey found that insured adults with incomes under 200% FPL were more likely than their higher-income counterparts to report delaying or avoiding care because of their copayments or coinsurance.⁴³ Some have cautioned that policies intended to shift the financial burden of care to the enrollee may not control program spending in part because existing Medicaid managed care arrangements already discourage unnecessary care.⁴⁴

Nonemergency Use of the Emergency Department

ACP has expressed concern about imposing cost-sharing for nonemergency use of EDs. In a letter to CMS, the College stated:

While the College strongly supports the delivery of health care services by the most appropriate physician or other health care provider in the most appropriate setting, it should be acknowledged that patients in underserved areas may have no other option but to visit an emergency department to receive care. A patient may also believe their condition to be more severe than the reality, leading them to visit the emergency department as a precautionary measure even when the condition could be handled by a primary care physician.⁴⁵

Some Medicaid programs have established cost-sharing for nonemergency use of EDs. Federal regulations permit states to implement an \$8 copay for non-emergency use of the ED only after screening and referring beneficiaries to an appropriate provider has been attempted.⁴⁶ MACPAC found that only 10% of Medicaid-covered ED visits made by nonelderly patients were unnecessary.⁴⁷ Nonemergency use of ED may indicate that the patient cannot access the most appropriate clinician, such as a primary care physician or subspecialist.⁴⁸ Patients may also be unable to determine if their symptoms, such as chest pain, require urgent attention, and such conclusions may only be possible with a physician evaluation.⁴⁷ Further, one study found that “granting states permission to collect copayments for non-urgent visits under the [Deficit Reduction Act of 2005] did not significantly change ED or outpatient medical provider use among Medicaid beneficiaries”, indicating that requiring cost-sharing may not effectively discourage unnecessary use of the ED.⁴⁹ States should consider factors like primary care access and patient health literacy when deciding whether to require cost-sharing for nonemergency use of EDs and consider policy alternatives that direct patients to the proper health care setting.

Better collaboration, patient education, and case management can also reduce nonemergency use of the emergency department. Washington State’s “ER is for Emergencies” program, a private-public partnership involving the state’s governmental health care authority and emergency physician, hospital, and medical associations, seeks to reduce nonemergency use of the ED and Medicaid costs by promoting information exchange and collaboration. The program’s 7 best practices are to develop and share information through the Emergency Department Information Exchange system, educate patients about appropriate care settings, track frequent ED and emergency medical service users, create care plans for frequent ED users, utilize narcotic guidelines to reduce “narcotic-seeking behavior” by patients, engage in a prescription-monitoring program, and use feedback information to ensure interventions are successful.⁵⁰ In the first year of the program, 420 primary care providers were notified when their patients entered the ED, the rate of ED visits dropped by nearly 10%, the rate of visits with a low-acuity diagnosis decreased by 14.2%, and about \$34 million in emergency costs was saved.⁵¹

Premium Assistance and Health Savings Accounts

Cost-sharing for private insurance is typically much higher than Medicaid; one study found that out-of-pocket spending would be seven times higher for adults covered under private insurance than Medicaid.⁵² This underscores the need to ensure that premium assistance waivers provide a level of benefits and cost-sharing comparable to what enrollees would receive under a traditional, non-waiver eligibility expansion.

A number of states have sought to place Medicaid enrollees into health plans connected to health savings accounts or other medical expense savings accounts, such as Indiana’s POWER accounts. Proponents of such plans argue that they

teach enrollees to be more cost-conscious about health care purchases, cultivate personal responsibility, and encourage shopping around for the best price or highest quality provider or service. However, a April 2015 Kaiser Family Foundation survey reported that information on medical care costs is hard to find, with 64% responding that finding cost and quality information was difficult.⁵³ Those that do report finding cost and quality information on hospitals, physicians, or health plans, do not use such information when making a decision about health care. Similarly, some Medicaid experiments, such as the mid-2000s Florida consumer-driven health insurance pilot, seek to encourage enrollees to comparison shop for plans based on cost-sharing, quality, and additional services. In the case of the Florida experiments, most enrollees made their decisions based on physician location, physician network, and prior enrollment in the plan, rather than cost or generosity of benefits.²¹ This may indicate that enrollees are overwhelmed by the number of plan choices (which may lead them to stay in their existing plan), do not understand plan explanations, or that physician and other health care professional preferences are a substantial motivator of plan choice.

Value-Driven Cost-Sharing

Cost-sharing cannot be used as a blunt instrument, especially because the Medicaid-eligible population is particularly price sensitive. Increased cost-sharing for medications is associated with higher use of inpatient services and the ED among the chronically ill.⁵⁴ Cost-sharing structures that reduce prescription drug utilization have been found to increase Medicare costs and hospital use.⁵⁵ ACP policy supports cost-sharing requirements for the adult Medicaid expansion population if they are structured in a way that encourages use of high-value services and do not deter patients from accessing necessary care. For instance, reducing co-payments for cholesterol-lowering medication for sicker patients has been shown to reduce both hospitalizations and health care spending.⁵⁶ Such efforts should be closely monitored to determine potential underutilization of necessary care and whether access to high-quality care is compromised.

- 4. Work-related or job search activities should not be a condition of eligibility for Medicaid. Assistance in obtaining employment, such as through voluntary enrollment in skills- and interview-training programs, can appropriately be made available provided that is not a requirement for Medicaid eligibility.**

Most Medicaid-eligible individuals are already working or have a family member working. Those that are uninsured and unemployed report they are unable to find employment (20%), taking care of home or a family member (29%), ill or disabled (17%) are going to school (18%) as their main reason for unemployment.⁵⁷ The work search requirement provisions originally proposed by Pennsylvania drew substantial criticism from advocates for the poor as well as health policy experts, who argued that work programs are outside of the health-focused intent of the Medicaid statute.³⁵ Early versions of the state's waiver required participation in a work search program but subsequent versions made participation voluntary.⁵⁸ The work search pilot was part of the waiver's "personal responsibility" section, which also included premiums for higher-income enrollees and premium and cost-sharing reductions for those who pay copayments on time and receive an annual wellness visit, followed by a Health Risk Assessment in year 2.⁵⁹ The work search provision intended to "enable low-income, able bodied Pennsylvanians [to] move out of poverty while also gaining access to health coverage."⁵⁹ The state argued that the program is necessary

because research shows that “being employed results in improved physical and mental health.” Pennsylvania’s final waiver omitted a work search requirement. In its place, Medicaid enrollees can voluntarily participate in state-sponsored job-training and work-related activities.

Proponents argue that work requirements were central to the 1990s welfare reform effort and would reduce dependency on the public insurance program.⁶⁰ However, Medicaid was established to provide medical assistance for low-income individuals. It is not designed to provide job training to enrollees.⁶¹ There may also be jurisdictional limitations to imposing work or job-search requirements, since the U.S. Department of Health and Human Services does not have the authority to restrict coverage based on such requirements.¹ Waiver proposals that would require such activities should not be approved. Similar to wellness programs, there is also the concern that voluntary work-related programs that reduce premiums and cost-sharing for participants could be coercive and effectively non-voluntary if they penalize those who do not participate by imposing higher costs. Such structures should be discouraged in expansion waiver programs.

- 5. Medicaid wellness programs should be structured in a manner that monitors health status and encourages healthy behavior through positive incentive-based programs. Punitive approaches that penalize enrollees for not achieving better health status or for not changing unhealthy behaviors, should be avoided. Applicable programs should adhere to the recommendations established in the ACP policy paper “Ethical Considerations for the Use of Patient Incentives to Promote Personal Responsibility for Health: West Virginia Medicaid and Beyond.”**

Some premium assistance programs would also encourage participation in health promotion and wellness activities. Pennsylvania proposed to reduce cost-sharing and premiums for enrollees that receive an annual wellness visit and health risk assessment. Wellness programs are popular among employers and may help reduce cost and improve health. A literature review of workplace wellness programs found that medical costs dropped by \$3.27 for every dollar spent on wellness programs and employee absenteeism costs were reduced by \$2.73 for every dollar spent.⁶² The literature supports that preventive care incentives may be most effective to encourage a single activity, like getting vaccinated, than for regular activity like participation in smoking cessation program.²² However, only a handful of states have initiated wellness programs to influence Medicaid enrollee health behavior. The ACA-authorized Medicaid Incentives for Prevention of Chronic Diseases grant program is designed to help states create, implement, and evaluate health prevention programs that aim to curb tobacco use, control weight, lower blood pressure, and reach other goals.

Generally, the College believes that as long as patient privacy protections are in place, nondiscrimination rules are strongly enforced, and physician administrative cost and burden are minimized, evidence-based wellness programs can have a positive impact on health by encouraging prevention and discouraging unhealthy behaviors. College policy recommends that employers and health plans should fund programs proven to be effective in reducing obesity, stopping smoking, deterring alcohol abuse, and promoting wellness and providing coverage or subsidies for individuals to participate in such programs.⁶³

However, important safeguards must be established to prevent wellness programs from discriminating against or disproportionately penalizing patients or impeding access to care. ACP policy recommends that:

Incentives to promote behavior change be designed to allocate health care resources fairly without discriminating against a class or category of people. The incentive structure must not penalize individuals by withholding benefits for behaviors or actions that may be beyond their control.

The College supports “use of positive incentives for patients such as programs and services that effectively and justly promote physical and mental health and well-being.”⁶⁴

The College’s position paper notes that patient advocacy organizations are skeptical of using financial incentives to change behavior: “These advocacy organizations do not believe that the use of financial incentives linked to health insurance premiums, deductibles or other patient costs are an appropriate way to motivate behavior change.” Preliminary evidence from the Iowa Health and Wellness Plan, where 2015 Medicaid premiums are waived if enrollees receive a physical examination and participate in a health risk assessment in the previous year, found that only 15% had completed both required activities as of January 2015.⁶⁵ One explanation for the low response rate is that the education materials were not distributed until May 2014, about 5 months after the beginning of enrollment.⁶⁶ A study evaluating Medicaid wellness incentive demonstration programs recommended offering substantial incentives to encourage participation, comprehensible and accessible instructions on how to participate and the benefits of doing so, and ongoing evaluation to determine program efficacy. Wellness incentive programs adopted by state Medicaid programs should be evidence-based and proven to effectively encourage health behavior before widespread implementation. Wellness programs should not impose any excessive administrative burden on physicians or require them to infringe on their patient’s right to privacy. ACP discourages programs that deny benefits or impose higher premiums or cost-sharing to enrollees that opt out of wellness programs.

Conclusion

Waivers are intended to grant states flexibility to expand Medicaid in a way that recognizes local considerations and conditions. States that have pursued post-expansion waivers have generally sought to increase the reach and influence of private insurance market concepts through premium assistance, premiums, cost-sharing, and health savings accounts. Some states have attempted to expand Medicaid’s breadth to influence enrollee work status and job-search habits, an area traditionally beyond the program’s charge. Since waivers are temporary, it is important that state Medicaid programs, patient advocacy organizations, physician and other health care professional groups, and others closely monitor the effects of waiver experiments to better understand the effect of premiums on poor and/or chronically ill patients; provider accessibility and participation; whether Marketplace-based plans are preferable to existing Medicaid managed care arrangements; and the effect of these waivers on administrative complexities, enrollee satisfaction, and overall cost.

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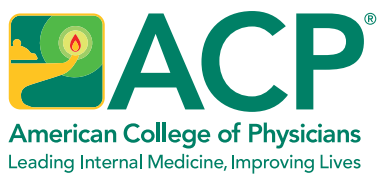
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