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ISSUE BRIEF

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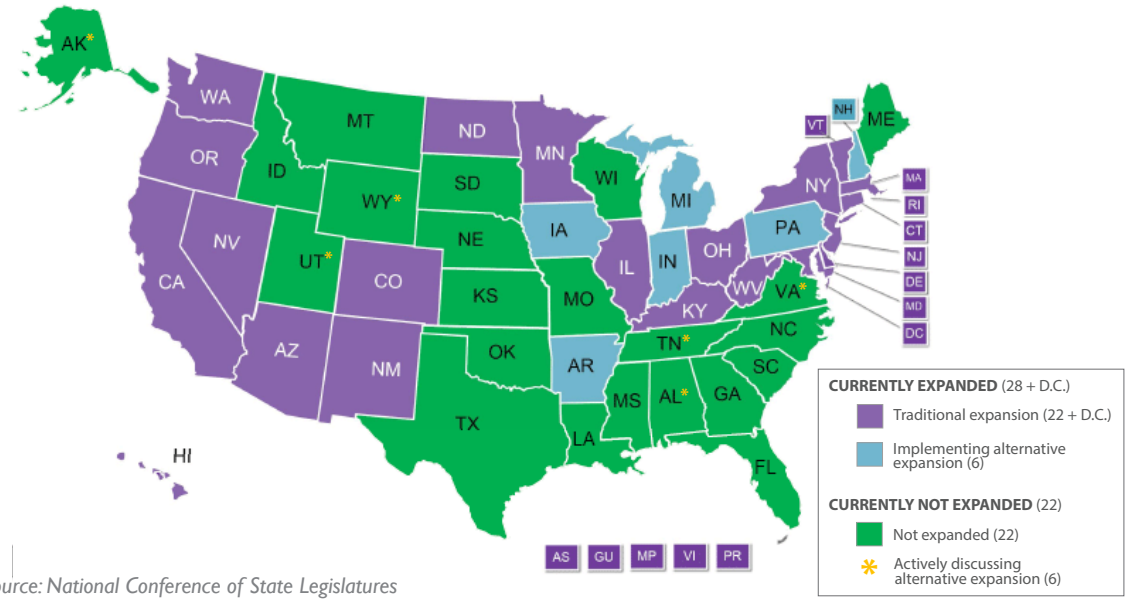
ALTERNATIVE MEDICAID EXPANSION MODELS

Case study: Indiana

The United States Supreme Court decision in June 2012 made Medicaid expansion included in the Affordable Care Act (ACA) optional for states. As of February 2015, 22 states, including Kansas, have not expanded their Medicaid programs. However, 28 states have expanded Medicaid. Twenty-two of them expanded Medicaid as originally envisioned in the ACA by simply raising the eligibility level to those in households with income up to 138 percent of the federal poverty level (FPL). An additional six states, many of them under Republican leadership, have been granted waivers to expand Medicaid in alternative fashions that provide some of the flexibility desired by states.

These so-called alternative expansion states, like other states expanding Medicaid under the ACA, receive federal funding to expand eligibility for adults with incomes up to 138 percent of FPL, or $33,465 for a family of four in 2015. Plans endorsed by a state's governor and legislature must be approved by the Centers for Medicare and Medicaid Services (CMS). A state must develop a request outlining conditions of eligibility as well as program requirements and fees. This formal request, also known as a waiver, is reviewed and must be approved by CMS prior to implementation. This brief analyzes how the state of Indiana developed its Medicaid expansion model.

Figure 1. **Current Status of Medicaid Expansion Under the ACA—as of February 12, 2015**



Source: National Conference of State Legislatures

KEY POINTS

- Many states considering expansion of their Medicaid programs are looking for alternative models to meet specific state concerns. Following endorsement by the state's governor and legislature, these models must be approved by the Centers for Medicare and Medicaid Services (CMS) through what's known as a "waiver."
- Indiana's "alternative" Medicaid expansion plan—Healthy Indiana Plan (HIP) 2.0—uses a high-deductible health plan to cover eligible adults and a $2,500 Health Savings Account (HSA) to encourage individual responsibility.
- HIP 2.0 includes two plan options for eligible adults. The HIP Basic plan excludes some services like dental and vision, and requires copayments. HIP Plus adds more covered services with lower copays, but requires monthly contributions to an HSA account.
- CMS approved HIP 2.0 features that could be of interest to other states considering Medicaid expansion, including healthy behavior incentives, optional work or job training incentives, and the use of Medicaid funds to purchase private health insurance.

Unlike most of the alternative expansion states (see *Figure 1*, page 1), Indiana developed its expansion plan from an already operating waiver program known as Healthy Indiana Plan (HIP). The new plan is called "HIP 2.0" and was first proposed in July 2014 and approved by CMS on January 27, 2015. It was designed to serve as an extension of HIP, which consisted of a high-deductible health plan combined with a Health Savings Account (HSA) to help cover out-of-pocket costs to enrollees. By using private insurance plans with cost-sharing, HIP 2.0 has been touted by the state as a method of promoting health care consumerism and a way to give Medicaid beneficiaries "skin in the game."

Figure 2. **Indiana at a Glance**

Population
6,404,000—16th in the nation

Uninsured
765,600 or 12%

Political Majority
Executive: Republican
Senate: Republican
House: Republican

Medicaid Expansion Plan
Healthy Indiana Plan 2.0 (HIP 2.0)—effective Feb. 1, 2015

Source: Kaiser Family Foundation, 2013.

Healthy Indiana Plan (HIP)
Indiana's first alternative Medicaid program (January 1, 2008–January 31, 2015)

Eligibility

HIP was offered to parents/primary guardians ("caretakers") and to childless adults ("non-caretakers") with incomes up to 200 percent of FPL not otherwise eligible for Medicaid. When the federal government renewed the program in 2014, the income eligibility ceiling was lowered to 100 percent of FPL to encourage individuals above that threshold to sign up for subsidized health insurance through the new federal marketplace created by the ACA.

Plan structure and cost-sharing

HIP used Medicaid funds to purchase high-deductible health plans for enrollees. This plan was combined with a Personal Wellness and Responsibility (POWER) account, jointly funded by members and the state to cover cost-sharing amounts. For HIP, the account was valued at $1,100. The state pre-funded the account so it was accessible to HIP members at the beginning of the year. However, members were required to deposit two percent of their income into their POWER account each month to have money available to pay for medical services. The state contributed the difference for members contributing less than $1,100 annually (or approximately $92/month).

Additional cost-sharing was applied to emergency room (ER) visits for conditions that did not require emergency treatment. These less urgent emergency room visits had a $25 copay for non-caretakers and a $3 copay for caretakers. Total cost-sharing was limited to 5 percent of annual household income, which is the existing traditional Medicaid limit.

Benefits and incentives

In addition to the POWER accounts, each member received $500 worth of preventive care services, smoking cessation services and mammograms.

HIP covered services including pharmaceuticals, laboratory tests, inpatient and outpatient services and mental health treatment. Maternity care, dental and vision were not covered for adults. Maternity services continued to be covered by *Hoosier Healthwise*, the state's traditional Medicaid program. Members who received recommended preventive services could have their remaining POWER account balance rolled over into the next calendar year, while those who did not lost their remaining balance.

Notable exclusions or limitations

HIP had a $300,000 annual and $1,000,000 lifetime coverage limit for any member's health care costs. In addition, if members failed to pay into their POWER account regularly (with a two-month grace period), they were removed from the HIP program and prevented from re-enrolling for 12 months.

Cost and enrollment

HIP enrollment was capped to limit the cost to the state. The program averaged 40,721 members monthly between January 2008 and December 2012. Of that number, 36,500 were adults without children participating in HIP. At times, 50,000 additional Indiana residents were waiting to enroll.

Between 2008 and 2012, Indiana was about $1 billion under the budget neutrality requirement of its waiver. The state's share of the cost of HIP largely was financed through a cigarette tax.

Figure 3. **Comparing Indiana Medicaid Expansion Waiver Options Under HIP 2.0**

	HIP BASIC	HIP PLUS
Eligibility	HIP Basic is offered to non-disabled Indiana residents with incomes between 0 and 100 percent of FPL.	HIP Plus is offered to non-disabled residents with incomes between 100 and 138 percent of FPL. However, individuals with incomes between 0 and 100 percent of FPL are eligible to upgrade to HIP Plus if they make monthly POWER contributions.
Benefits	HIP Basic benefits have been updated to meet the standards of an Alternative Benefit Plan*. Dental and vision coverage is not included. All maternity and preventive services are covered. Preventive services are covered at 100 percent and not subject to any deductible.	HIP Plus includes all benefits of HIP Basic as well as additional ("plus") services, such as dental and vision coverage.
Cost-sharing	Each HIP Basic member has a $2,500 POWER account funded solely by the state. The POWER Account funds can be used to pay for the numerous copays, including $8 for non-preferred drugs, $75 for inpatient services, and non-emergency ER use ($8 first instance, $25 thereafter). Cost-sharing is limited to 5 percent of annual household income.	Monthly HIP Plus POWER contributions are flat rates based on income brackets and cannot exceed 2 percent of household income. For individuals with incomes below 5 percent of FPL, POWER account contributions cannot exceed $1/month. HIP Plus members have a copay for non-emergency ER use ($8 first instance, $25 thereafter). Cost-sharing is limited annually to 5 percent of household income.
Notable exclusions or limitations	No annual or lifetime coverage limit. No cap on enrollment.	No annual or lifetime coverage limit. No cap on enrollment. Members between 100 and 138 percent of FPL will be locked out of the program for six months if they fail to contribute to their POWER account (with a two-month grace period). They will be responsible for any debts accrued due to non-payment.
Plans and enrollment	The total cost (federal and state) for HIP 2.0 is anticipated to be $20.9 billion over five years. For 2015, the estimated per member/per month cost with POWER account pre-funding is $668.87 for HIP non-caretakers and $537.63 for HIP caretakers. HIP 2.0 enrollment is expected to grow to approximately 600,000 by 2019.	

*Note: An 'Alternative Benefit Plan' is a Medicaid plan meeting ACA standards that provides coverage similar to what an employer plan might offer, and must provide ten essential health benefits that include emergency services, chronic disease management and prescription drugs.

Indiana's HIP 2.0

Medicaid expansion plan (February 1, 2015–present)

With the availability of 100 percent federal funding until 2017 for Medicaid expansion under the ACA, Indiana proposed an updated version of its Healthy Indiana Plan. HIP 2.0 moves all low-income, non-disabled adults from traditional Medicaid into two private programs, HIP Basic and HIP Plus, as shown in *Figure 3* (page 3). These programs have different coverage and cost-sharing requirements.

Indiana Governor Mike Pence announced that CMS approved HIP 2.0 on January 27, 2015. The new plan maintains the model of a high-deductible health plan with an HSA-like POWER account. For HIP 2.0, the POWER account amount was increased to $2,500 annually. According to Debra Minott, former secretary of the Indiana Family and Social Services Administration, the plan has been updated to be "more like commercial insurance, which can build a gateway to employment."

Hallmarks of the HIP 2.0 Program

Healthy behavior incentives

A notable provision contained in HIP 2.0 is the "Health Incentive Program." Members that complete a health risk assessment and take part in healthy behaviors such as weight loss can reduce their share of POWER account contributions. Similar provisions have been approved in other state waivers including Iowa, Michigan and Pennsylvania.

Work requirements

The original HIP 2.0 proposal mandated that all adult members working fewer than 20 hours per week be enrolled in a job search and training program.

However, the waiver approval for HIP 2.0 made enrollment in the job program optional. To date, no work requirements have been approved by CMS in state Medicaid expansion programs. Pennsylvania requested similar provisions in its waiver, and CMS approved work incentives that would reduce premiums, but not work requirements.

Private option

Indiana was approved to use Medicaid funds to purchase commercial insurance plans for their enrollees in HIP 2.0. Indiana removed all non-disabled, low-income adults from the traditional Medicaid program in their waiver. Indiana will retain other current *Hoosier Healthwise* members on the existing program, and pregnant women will have the choice of remaining in the HIP program or transferring to *Hoosier Healthwise*. Arkansas, Iowa and New Hampshire placed their most medically frail enrollees in the traditional Medicaid program rather than providing them financial assistance to enroll in private insurance plans.

Conclusion

The 2012 U.S. Supreme Court ruling on the ACA gave states the option to expand Medicaid to childless adults with incomes up to 138 percent of the federal poverty level. Under fiscal and political pressures, many states are considering "alternative" expansion models from states like Indiana. During the 2015 Kansas Legislative session, there has been some discussion about expansion models, and state provider associations sought guidance from CMS on proposals similar to Indiana's program. As of the date of this publication, no formal legislative action or executive branch sponsorship exists for Medicaid expansion in Kansas.

About the Issue Brief

This brief is based on work done by Andrea Hinton and Scott C. Brunner, M.A. It is available online at www.khi.org.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute delivers credible information and research enabling policy leaders to make informed health policy decisions that enhance their effectiveness as champions for a healthier Kansas. The Kansas Health Institute is a nonprofit, nonpartisan health policy and research organization based in Topeka that was established in 1995 with a multiyear grant from the Kansas Health Foundation.

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