



# Alaska Proof of Concept Analysis

## FINAL

August 5, 2019



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## 1. Executive Summary

The Alaska Department of Health and Social Services (DHSS) contracted with Public Consulting Group (PCG) to develop a “proof of concept paper for an 1115 waiver that incorporates the use of the federally facilitated health insurance marketplace to provide health coverage for specified Medicaid enrollees.”

This scope of work was further detailed in the DHSS “Proof of Concept Analysis” Informal Request for Proposal (IRFP):

*The proof of concept paper should include an analysis of the use of private market coverage for Medicaid enrollees, potential incorporation of a work requirement component into the program and waiver, the potential for use of a block grant to bring forward the concept, and recommendations for items outside of the Medicaid program, such as referenced based rates, that will enhance the redesign concept.*

The “concept” that PCG was hired to analyze is titled, “A Continuum of Coverage for Low-Income Alaskans: Engaging Medicaid Enrollees with Private Market Health Coverage and Easing Transitions Between Low Income Health Programs.” Several policy goals were articulated in this reform concept, including:

- Provide greater health coverage stability for those with variable incomes
- Eliminate barriers to upward economic mobility
- Smooth cost sharing and premium assistance levels across programs to ease transitions
- Reduce anxiety over the loss of health coverage
- Attract more carriers to the individual insurance market

PCG has been asked to assess whether transitioning a specified group of Medicaid enrollees into the federally facilitated marketplace under a Medicaid 1115 waiver would achieve these objectives while preserving quality and reducing overall costs. We have been asked to assess the likelihood of CMS approval of the waiver and to specifically consider if additional policy features such as block grants, per capita caps, work requirements and/or reference-based pricing would further strengthen the waiver.

Sections 2 through 5 explore the four key policy components considered in this proof of concept – a Private Option Medicaid Waiver, Reference Based Pricing, Community Engagement and Work Requirements and Block Grants/Per Capita Caps. These sections explore other state experiences implementing and preparing to implement these reforms. PCG has also added an analysis of Health Expense Accounts (HEAs) in Section 6 of this paper. While not called out as one of Alaska’s reform concepts, PCG added this analysis because HEAs have been adopted by other states with similar policy goals as those identified by Alaska, most notably Indiana.

A Private Option is a type of Medicaid waiver that leverages a portion of the commercial, individual health insurance market, specifically the Affordable Care Act’s Health Insurance Marketplace, to enroll a specific group of Medicaid recipients into “Qualified Health Plans (QHPs).” The QHPs then become the Medicaid delivery system for these individuals. Under a Private Option, states make Medicaid payments to cover the expense of QHP premiums and cost sharing for enrollees.

Reference Based Pricing refers to the establishment of a provider fee schedule that is referenced and used by payers to reimburse providers for the cost of patient care. This is a tool that has gained popularity in the self-funded employer insurance market in recent years. Within the context of this study, PCG considered whether the cost of a Private Option waiver would be reduced through state action that established a fee schedule for the individual insurance market.

Community Engagement and Work Requirements waivers set rules that make employment, job training, education, volunteerism and other activities mandatory for certain Medicaid recipients. Under such waivers, Medicaid enrollees can lose access to their healthcare coverage if they do not comply with the requirement.

Block grants and/or per capita caps are methods states may use to self-impose Medicaid expenditure growth caps. The “per capita” approach limits cost per person while block grants focus on aggregate spending limits. In this paper, PCG considers a third method used by New York State dating back to 2012, referred to as “global spending cap.” Like a block grant, a global spending cap measures aggregate cost, but the focus remains on state spending controls and not on a fixed amount to be allocated by the federal Centers for Medicare and Medicaid Services (CMS).

Health Expense Accounts (HEAs) are repositories of state funds that may be accessed by consumers to make discretionary healthcare purchases. Some states that have pursued policy goals similar to those identified in Alaska’s current reform concept have established HEAs as a component of their 1115 demonstration waiver. Indiana’s “Power Accounts” are the most salient example of this. The goals of these accounts are to promote consumer-driven healthcare and healthcare efficiency by creating market-like opportunities for consumers to be purchasers. Health expense accounts permit consumers to weigh healthcare benefits and costs that have a direct impact on them personally. In this way, consumers are incentivized to shop on price and overall value consistent with consumers who are covered in the commercial market. While “health expense accounts” mirror the concept and function of “health savings accounts,” they bear a different name because there are key differences. Health expense accounts house public funds that may be accessed by consumers for specific healthcare purposes. However, the funds are not “owned” by the consumer and are not available for consumer investment. Internal Revenue Service (IRS) rules also govern HSAs in ways that do not apply to HEAs.

In this report, PCG highlights three states and describes their experience administering HEAs as part of a Medicaid reform waiver. These states are, Arkansas, Michigan and Indiana.

We also note in Section 6 that CMS continues to promote health expense accounts as a preferred policy option for states. This is evidenced by the “Account-Based Subsidies” Marketplace (Section 1332) waiver concept opportunity identified by CMS in its November 29, 2018 “State Relief and Empowerment Waiver” Discussion Paper. That waiver concept outlines options for states to award marketplace premium subsidies into an account to be used by consumers to make their own health plan purchasing decision within the limits of allowable health plan choices. We will discuss this further in Section 6.

Section 7 of this paper uses the information provided in Sections 2 through 6 to establish PCG recommendations and feedback. To summarize, our key findings are as follows:

### **Moving A Subset of the Medicaid Population into Commercially Available Plans**

PCG sees a plausible path to approval of a “Private Option” waiver for Alaska, based on CMS precedence of approving such waivers, or variations of them, in four other states. However, budget neutrality requirements may be more challenging to meet than they were for states like Arkansas that only made a previously ineligible group eligible for their Private Option. This gave Arkansas the budget neutrality advantage of being able to establish an estimated rather than actual cost baseline. Alaska will also likely need to attract a second commercial carrier to the state’s health insurance marketplace, at least in metropolitan regions, to gain CMS approval.

Moving non-tribal, non-medically frail enrollees from fee-for-service into commercial QHPs will increase amounts providers are paid to deliver healthcare services. However, Alaska can control for this using reference-based pricing. Despite higher payments to providers, Arkansas continues to conclude that its Private Option is cost effective because it has achieved health care quality and access improvements that could only have been accomplished through comparable investments in the fee-for-service delivery system.

While this study did not include an actuarial component to project a cost difference using Alaska specific experience, our findings from Arkansas indicate improved healthcare quality and access outcomes that align with a rise in patient care cost, demonstrating overall cost effectiveness. The Arkansas Health Care Independence Program Final Report<sup>1</sup> is the source that concludes that substantial new investments in Fee-for-Service would have been required to achieve the improved health outcomes seen in the Private Option population.

Overall, Alaska can expect CMS to support its reform goals, which emphasize continuity of coverage and stability of coverage as Medicaid enrollees seek upward economic mobility. PCG can endorse the relevance of Alaska's reform concept to Alaska's reform goals.

### **Reference Based Pricing**

PCG computed reference-based pricing (RBP) savings under two scenarios, assuming the RBP fee schedule would be adopted at 239% or 170% of Medicare. Currently, according to a Kaiser Family Foundation, Medicaid reimbursement in Alaska is estimated to be 126% of what Medicare pays. A 2016 Milliman study estimated commercial payments in Alaska to be 353% of Medicare. PCG selected 239% and 170% as the RBP increments as the "halfway" and "three quarter" cost points between Medicaid and commercial payments. Said another way, 239% of Medicare appears to be the midpoint between Medicaid and commercial reimbursement and 170% of Medicare appears to narrow the reimbursement gap by 75%.

The overall purpose of the fiscal model we provide is to show the extent to which Alaska can control the cost of a Private Option waiver using RBP methods. In selecting targeted RBP reimbursement rates, Alaska will need to consider trade-offs between cost savings and the impact those savings may have on provider network access.

RBP has the potential to generate additional state revenue to support this reform concept. PCG recognizes that RBP could be implemented across the individual market through a Section 1332 "State Relief and Empowerment Waiver." This action would generate federal pass-through savings because federal premium tax credits in the Marketplace would decline as a result. Pass-through savings could be reinvested to further reduce premiums in the individual market and make premiums less expensive under a Private Option. These specific savings would need to be actuarially computed and validated, but they have the potential to provide a significant positive fiscal impact for the State.

PCG recognizes that reference-based pricing could create new "balance billing" challenges for Alaska and that additional consumer protections may be required to guard against this practice. We will, therefore, describe the comprehensive research assembled by the Commonwealth Fund in 2017, updated in 2019, that speaks to state practices to protect consumers from balance billing.

### **Block Grants/Per Capita Caps/Global Spending Caps**

PCG describes the mechanics of these cost containment methodologies, comparing and contrasting each of them. Ultimately, we recommend a "global cap" approach, which self-imposes spending limits, provides state flexibility for how to comply with those limits and rewards the state for doing so by permitting the state to reinvest half or more of federal savings to fund the Private Option waiver concept. Alaska could begin to do this with savings items planned in its upcoming budget cycle.

If CMS permitted Alaska to reinvest half of the federal savings associated with budget reductions that are planned, this would significantly alter the cost boundaries of this reform concept and potentially turn it into a savings initiative for Alaska. Such reinvestment has precedent in New York State, where CMS permitted the state to reinvest half of the federal savings from its Medicaid Redesign effort to fund a Delivery System Reform Incentive Pool (DSRIP) waiver.

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<sup>1</sup> <https://achi.net/wp-content/uploads/2017/05/Final-Report-no-appendices.pdf>

**Community Engagement/Work Requirements**

PCG is aware that Alaska intends to phase out its current waiver of work requirements for the Supplemental Nutrition Assistance Program (SNAP) by January 2020. Because of this, Alaska will already have infrastructure required to facilitate a work requirement program. There is also significant overlap in Medicaid and SNAP eligibility in Alaska. While state Medicaid work requirement waivers are too new to have been comprehensively evaluated, the goals are similar and aligned with Alaska's reform concept policy objectives. For these reasons, PCG sees a plausible path to CMS approval of a work requirement component of a reform waiver.

**Health Expense Accounts**

As Section 6 of this report indicates, an evaluation of the Healthy Indiana Power Accounts conducted by the Lewin Group noted a positive link to consumer engagement in their healthcare and healthcare spending. CMS also currently continues to prioritize health expense accounts as a preferred policy feature as evidenced by the "Account Based Subsidies" 1332 waiver concept released in a November 29, 2018 Discussion Paper. That waiver concept encourages states to consider approaches to depositing Health Insurance Marketplace subsidies into accounts consumers can use to purchase insurance and pay premiums. For these reasons, PCG recommends that Alaska give strong consideration to including a health expense account feature to its reform concept.

## 2. Medicaid Private Option Waivers

### 2.1 Background

#### ARKANSAS

Arkansas was the first state to utilize a section 1115 demonstration waiver to expand Medicaid within their state. The state submitted its initial demonstration on August 6, 2013, which CMS approved, agreeing to an implementation date of October 1<sup>st</sup> of that same year.<sup>2</sup> The initial request introduced a three-year Medicaid premium assistance demonstration that the state titled the “Arkansas Health Care Independence Program,” or HCIP; the program has since been commonly referred to as the Medicaid “Private Option.” It allowed the State to support Medicaid Expansion adults in purchasing coverage through qualified health plans (QHPs) on the Marketplace by means of Medicaid premium assistance.

This was initially effective from January 1, 2014 through December 31, 2016. Through offering this option, the State hoped to improve provider access for its residents, improve continuity of care, and promote quality improvement and Arkansas’ delivery reform initiatives.<sup>3</sup>

The State, as of January 1, 2017, offered coverage to beneficiaries through a renewed waiver that changed the name of the program to “Arkansas Works.”, The state continued to use premium assistance to purchase QHPs offered in the Marketplace for those residents deemed eligible under Title XIX of the Social Security Act. The demonstration simultaneously created a mandatory employer sponsored insurance (ESI) program, through which premiums were instituted for Arkansas with income over 100 percent FPL.<sup>4</sup>

The state submitted an amendment to CMS on June 30, 2017 that would (1) require community engagement (commonly deemed work requirements) as a condition for Arkansans remaining eligible for Medicaid coverage and (2) bring expansion eligibility down from 138 to 100 percent FPL. Regarding the first element of the amendment, which is described in greater detail below, the state aimed to mandate that able-bodied beneficiaries ages 19-49 to participate in specific qualifying activities for a minimum of 80 hours a month to keep their coverage. On March 5, 2018, CMS approved the work requirements of the amendment and rejected the partial expansion request.<sup>5</sup>

With the introduction of community engagement requirements, Arkansas amended its statewide waiver goals to include: bettering resident health outcomes and encouraging independence through engagement within one’s community; advancing delivery system reform initiatives and quality improvement so as to achieve success across various demographics; and mandating beneficiaries pay a monthly premium so as to promote efficiency of state health services.<sup>6</sup>

**Premiums:** In Arkansas, all individuals with incomes above 50 percent FPL are mandated by the state to make monthly payments into an Individual Health Independence Account. Contributions from enrollees are never more than 2 percent of resident income (ranging from \$5 - \$25 per month). Nonpayment of these premiums may affect an enrollee’s cost-sharing or receipt of benefits or create a debt to the state; however, it cannot result in one being disenrolled.<sup>7</sup>

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<sup>2</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-fs.pdf>

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> <https://familiesusa.org/waivers-arkansas>

<sup>6</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-fs.pdf>

<sup>7</sup> Ibid.

**Cost-Sharing:** In Arkansas, cost-sharing at the point-of-service applies only when beneficiaries fail to make contributions to their Independence account. Throughout the state, cost-sharing must be consistent with the state's standard Medicaid Plan, in which all out-of-pocket costs are capped by the state at 5 percent of an enrollee's quarterly income.<sup>8</sup>

**Retroactive Coverage:** The state's waiver shortens retroactive coverage from three months to one month for all those residents who must reapply to Medicaid. In the state's 2018-19 lawsuit, the Plaintiffs asserted that, between an individual losing coverage and their reapplying, they will not have retroactive coverage for health services received during that gap in time. Such coverage is frequently tied to a resident's fulfillment of the below described work requirements. The Plaintiffs argue that "continuous and adequate health insurance coverage is fundamental for each Plaintiff's ability to stay as healthy as possible."<sup>9</sup>

**Work Requirement:** As stated previously, Arkansas first received federal approval to include the implementation of work requirements in its state waiver in March of 2018 (with the waiver being originally submitted in June of the prior year). CMS' approval stated that the requirement could be implemented, at the earliest, June 1, 2018. The state aimed for this implementation date, making this engagement requirement effective on June 5<sup>th</sup>, at which point it applied to all individuals above the age of 30; those enrollees under 30 would not have their eligibility status affected by requirement fulfillment until 2019.<sup>10</sup> The waiver amendment mandates work or participation in other community-based activities for a minimum of 80 hours per month to maintain access to Medicaid coverage, stating that three months of non-compliance would result in termination of one's coverage.<sup>11</sup>

**Premium Assistance (Private Option):** Arkansas, as previously noted, was the first state to implement a program opting to provide premium assistance rather than a traditional Medicaid expansion to its residents. Through this program, Arkansas met the target-enrollment population of 250,000 people and, by the end of 2016, had 280,000 individuals in their expansion population; however, this expansion was in large part due to the restrictive Medicaid eligibility threshold that Arkansas previously employed.<sup>12</sup>

The Arkansas Hospital Association reported a significant reduction of uninsured patients in inpatient, outpatient, and ER care, with hospital rates averaging around 40%. The budget neutrality cap was exceeded during the initial enrollment phase, but stabilized over time as the enrollment of younger, healthier individuals brought the cumulative program costs down to an estimated cost of \$500.08 per member per month in 2015.<sup>13</sup>

According to the Arkansas Health Care Independence Program (Private Option) Final Report produced by ACHI, Arkansas's healthcare providers have reported significant clinical and financial effects under the HCIP. In 2014, federally qualified community health centers (FQHCs) reported increased success in attaining needed specialty referrals for their clients. As previously mentioned, The Arkansas Hospital Association (AHA) reported significant annualized reductions in uninsured outpatient visits (45.7 percent reduction), emergency room (ER) visits (38.8 percent reduction), and hospital admissions (48.7 percent reduction). The state's public teaching hospital reported a reduction in uninsured admissions, from 16 percent to 3 percent, during the same time period. These reductions persisted through 2016.<sup>14</sup>

Additionally, the Health Care Independence Program goals and objectives included successful enrollment, enhanced access to quality health care, improved quality of care and outcomes, and enhanced continuity of coverage and care at times of reenrollment and during income fluctuations. These goals and objectives were to be

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<sup>8</sup> Ibid.

<sup>9</sup> <https://arktimes.com/arkansas-blog/2018/08/14/lawsuit-challenges-arkansas-medicaid-work-rule>

<sup>10</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-court-decision-ltr-20190504.pdf>

<sup>11</sup> <https://www.healthinsurance.org/arkansas-medicaid/>

<sup>12</sup> <https://achi.net/wp-content/uploads/2018/01/Arkansas-Health-Care-Independence-Program-Final-Report.pdf>

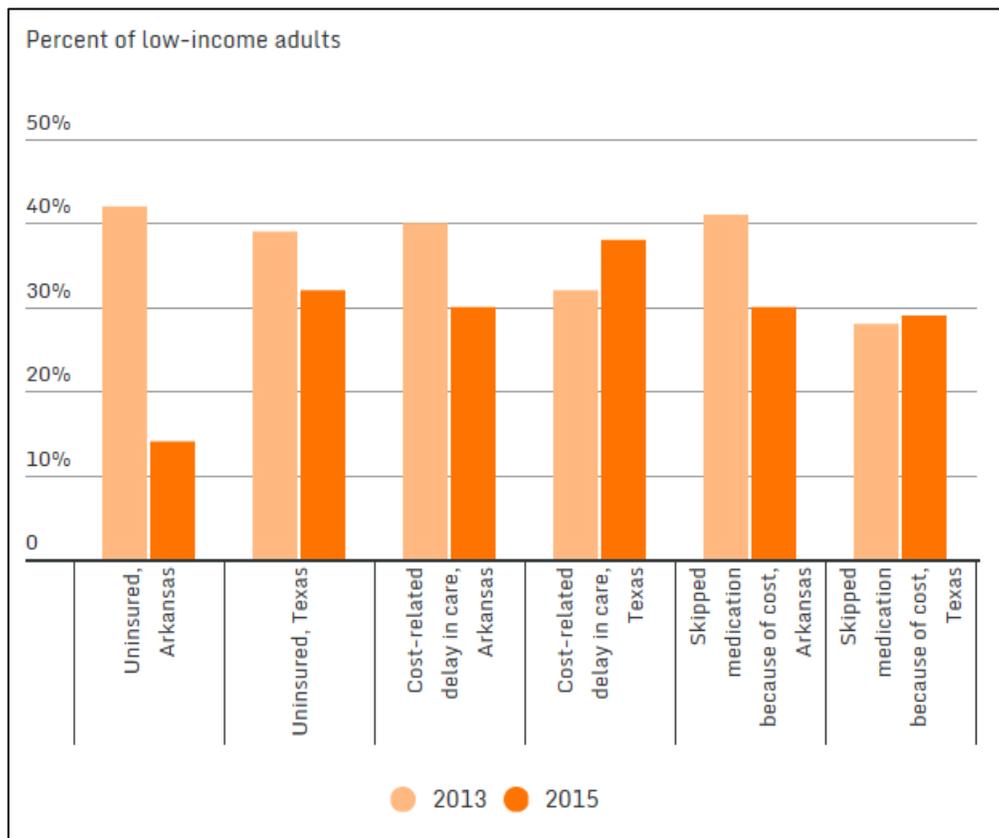
<sup>13</sup> Ibid.

<sup>14</sup> <https://achi.net/wp-content/uploads/2017/05/Final-Report-no-appendices.pdf>

achieved within a cost-effective framework for the Medicaid program, compared with what would have occurred if the state had provided coverage to the same expansion group in Arkansas’s traditional Medicaid fee-for-service (FFS) delivery system.<sup>15</sup>

The decision to implement the Private Option has also increased issuer competition in the state. Before the program began, Arkansas had only two carriers in their Marketplace; it now has four after a peak of six in 2016. In regard to enrollee access to the system and their health outcomes, Arkansas reported that their clinical performance and network adequacy was better than their Medicaid counterparts due to higher provider payment rates.

A multi-year study conducted by The Commonwealth Fund found that Arkansas’ private option did ultimately increase access to primary care and necessary prescription medications for its Medicaid population, while also increasing the use of preventive care and the overall quality of care for low-income adults in the state. The Fund’s survey consisted of low-income adults (n = 1,000) in Arkansas (which expanded with a waiver) Kentucky (which expanded without a waiver) and Texas (which did not expand). Findings showed significant gains in coverage, affordability of care, and chronic disease management for Arkansas and Kentucky. These residents also experienced more efficient systems, better health outcomes, and access to high-quality providers; the same did not hold for Texas.<sup>16</sup> The chart below compares Arkansas coverage and cost-related delays in care between Arkansas and Texas.



**Texas vs Arkansas Coverage Outcomes**

Source: <https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/evidence-private-option-arkansas-experience>

<sup>15</sup> <https://achi.net/wp-content/uploads/2017/05/Final-Report-no-appendices.pdf>

<sup>16</sup> <https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/evidence-private-option-arkansas-experience>

The Fund also considered the effect that expansion in Arkansas had on churning, finding that the State's waiver expansion had less of a benefit than originally anticipated by the State. Low-income adults in all three states had comparable churning rates amongst their low-income adult populations. Texans were more likely to drop coverage than individuals in the other two states due to lack of affordability. The proportion of beneficiaries in Texas who churned and, then subsequently, had to change doctors was twice that of Arkansas. Enrollees in Arkansas were far more likely than those in the other two states to have their old plan made unavailable. These adults then were forced to change insurance as a result.<sup>17</sup>

A round of surveys administered in late 2016 show two key findings from Arkansas' low-income residents:

(1) These individuals, generally, have a positive attitude toward the affordable care act. Of those that reported that the ACA directly affected them, 32% stated that it financially and medically helped, rather than hurt, them. Only 15% said the opposite.

(2) There is an overall reduced reliance on the state's emergency departments. Individuals are more likely to seek out preventive care and manage their chronic diseases, ultimately lowering the utilization of state ERs.<sup>18</sup>

## NEW HAMPSHIRE

The New Hampshire Health Protection Program (NHPP) expanded Medicaid in the State of New Hampshire in 2014. When Medicaid was first expanded, the bill provided coverage through Medicaid Managed Care Organizations. The new population provided coverage in the Medicaid Expansion includes adults without children between the ages of 19 and 64 who have incomes below 138% of the Federal Poverty Level.<sup>19</sup>

Later, on March 4, 2015, the federal government granted the State's demonstration application to establish the Premium Assistance Program which used Medicaid reimbursement money to pay for QHP premiums for the Medicaid-expansion population who bought insurance on the private market.<sup>20</sup> The participants were moved from the traditional Medicaid Managed Care Organizations to the individual marketplace. However, those who were medically frail continued to be covered through the MCOs and did not move to the individual marketplace. As of early 2018, the New Hampshire Health Protection Program had over 7,000 medically frail individuals and this number has continued to rise.<sup>21</sup> Of all people enrolled in the individual marketplace in August 2017, 44% of those individuals were enrolled in the Premium Assistance Program.<sup>22</sup> According to DHHS, 45,325 people were enrolled in the Premium Assistance Program as of February 2018.<sup>23</sup>

The table below from the Urban Institute and the Robert Wood Johnson Foundation details the elements of New Hampshire's Health Protection Program 1115 waiver.<sup>24</sup>

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<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> <http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html>

<sup>20</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-fs.pdf>

<sup>21</sup> <http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html>

<sup>22</sup> <https://www.dhhs.nh.gov/ombp/pap/documents/nhid-gorman.pdf> (Referenced by NHFPI)

<sup>23</sup> <https://www.dhhs.nh.gov/ombp/pap/index.htm> (Referenced by NHFPI)

<sup>24</sup> <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>

Policy	Description
Premium Assistance in QHPs	Yes. Mandatory for all nonexempt enrollees at all income levels beginning in 2016.
Monthly Premiums or Contributions	No.
Cost sharing	Cost sharing (copayments and coinsurance) is limited to allowable amounts under Medicaid rules and the state plan.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	N/A
Health Accounts	N/A
Healthy Behaviors Incentives	No

*Note: New Hampshire may submit data to CMS to establish that there is "seamless coverage" that does not result in coverage gaps for individuals eligible for the program in the period before they file their Medicaid application. CMS will review the data and may grant New Hampshire a waiver of the Medicaid requirement that it must provide retroactive coverage for up to three months prior to the date of an individual's application if the individual would have been eligible during that time period.*

Sources: Centers for Medicare and Medicaid Services, Special Terms and Conditions, New Hampshire Health Protection Program Premium Assistance, Number 11-W-00298/1. March 4, 2015. [http://www.dhhs.state.nh.us/pap-1115-waiver/documents/pa\\_termsandconditions.pdf](http://www.dhhs.state.nh.us/pap-1115-waiver/documents/pa_termsandconditions.pdf) (accessed April 2015); Centers for Medicare and Medicaid Services, "Medicaid and the Affordable Care Act: Premium Assistance." Washington, DC: March 2013. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (accessed April 2015).

Source: <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>

In 2017, New Hampshire submitted a waiver amendment to CMS to modify its Medicaid Expansion program.

This new program replaced the New Hampshire Health Protection Program and became known as the New Hampshire Granite Advantage Health Care Program.<sup>25</sup> The New Hampshire Private Option, or Premium Assistance Program, was effective between January 1, 2016 and December 31, 2018 before the State decided to switch back to the Managed Care Organization model.<sup>26</sup>

With the New Hampshire Granite Advantage Health Care Program, enrollees are provided coverage through Managed Care Organizations and do not participate in the Premium Assistance Program. The plan did not allow anyone to lose coverage simply because of the transition to the MCOs from the PAP. The contracts between the MCOs and the states must include:

- Cost transparency measures
- Ensure patients are utilizing the most appropriate level of care
- Offer cash and other incentives to enrollees to choose the lowest cost medical providers
- Set maximum payable amounts for certain medical procedures
- Assist enrollees who are over the income limitations with applying for coverage in the individual insurance marketplace while maintaining care and coverage while the application is pending<sup>27</sup>

The New Hampshire Fiscal Policy Institute (NHFPI) lists several of the State's potential cost savings from the Managed Care Organization contracts. These include:

<sup>25</sup> <http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html>

<sup>26</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-fs.pdf>

<sup>27</sup> <http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html>

- Shared incentive pools
- Differential capitation rates
- Improving use of emergency departments
- Reducing preventable admissions and short-term readmissions
- Timely follow-up after a mental illness or substance use disorder visit
- Improvements around prenatal care and neonatal abstinence births

The NHFPI also says that the MCOs would be required to arrange physical and mental health assessments for enrollees and promote responsibility through incentives and case management.

New Hampshire's Medicaid Expansion has given coverage to around 52,000 adults since expansion started in 2014.<sup>28</sup> There was a 46% reduction in the uninsured rate between 2013 and 2017. The expansion will continue to be effective through 2023.<sup>29</sup>

## MICHIGAN

Michigan's waiver (initially called the Michigan Medicaid Non-pregnant Childless Adults Waiver) was first approved on December 22<sup>nd</sup>, 2009, with its components being implemented on January 1<sup>st</sup>, 2010. The demonstration allowed the state to try novel approaches to beneficiary cost sharing and the financial responsibility of care for the newly created adult eligibility group.

An amendment to the waiver was submitted by the state in November 2013, in which it requested to both change the program's name to Healthy Michigan and phase out the ambulatory benefit package initially included for previously uninsured, low-income childless adults with incomes at or below 35 percent FPL. This amendment was approved by CMS the following month.<sup>30</sup>

On December 21, 2018, CMS approved a program renewal request sent from the state. This approval:

- Granted an extension of the Healthy Michigan pilot program through December 31, 2023;
- Included the state's request to add a work requirement to the waiver.

Michigan's plan currently covers all childless adults in the Medicaid expansion population (those ages 19-64) who make about \$16,000 per year, or, less than 138 percent of the FPL.<sup>31</sup>

Waiver components include:

**Community Engagement (Work Requirement):** By January 1, 2020, all able-bodied enrollees ages 19-62 must "complete and report 80 hours per calendar month of community engagement activities, such as employment, education, job training, job search activities, participation in substance use disorder treatment (SUD), and community service." Those who fail to report said compliance or who show obvious non-compliance for three or more months in any 12-month period will be disenrolled by the state in their fourth month.

**Premiums:** Beneficiaries with incomes above 100 percent FPL are expected to contribute a premium equal to 2 percent of their income in the form of a health expense account contribution. While non-payment cannot result in

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<sup>28</sup> <http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html>

<sup>29</sup> <https://www.healthinsurance.org/new-hampshire-medicaid/#work>

<sup>30</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-fs.pdf>

<sup>31</sup> <https://familiesusa.org/waivers-michigan>

Medicaid disenrollment, it can create a collectable debt that the beneficiary will ultimately owe back to the state. Those with incomes equal to or below poverty are not expected to pay these premiums.<sup>32</sup>

**Health Expense Account:** Every enrollee in the Healthy Michigan Plan is granted a Michigan Health Account funded through the premium and copay contributions of enrollees. Each enrolled Michigan resident receives a monthly statement of their health care expenditures against this account budget. All costs exceeding the individual's budget are paid with Michigan's Medicaid funds. Should a beneficiary become ineligible for Medicaid at any point in time, the state will place the balance of the account into a voucher that the individual may then use in their purchasing private insurance.

**Wellness Programs:** Michigan enrollees have the option to lower either their quarterly co-payments and/or their monthly premium contributions through their participation in specified healthy behaviors in an initiative called the Healthy Behaviors Incentive Program. Starting in April of 2018, all beneficiaries with incomes above FPL have been required to meet with and work alongside their primary care providers to identify healthy life practices that they could adopt. Those unwilling to do so face the threat of being moved into marketplace QHP premium assistance.

Beneficiaries are encouraged to "maintain and implement healthy behaviors as identified in collaboration with their health care provider primarily" via a standardized Health Risk Assessment (HRA).<sup>33</sup> Incentives are provided to both individuals who complete one of the healthy behaviors outlined below and to those who complete an HRA, acknowledge the need for lifestyle changes, and can cite significant physical, social, or mental barriers that would explain their inability to implement such a change. The HRA Assesses a range of health issues, including nutrition, influenza vaccination status, chronic conditions, physical activity, recommended preventive screenings (including cancer screenings), mental health, and alcohol, tobacco, and other substance use.<sup>34</sup>

Michigan's Department of Health and Human Services uses claims and encounter data to document beneficiary healthy behaviors for all managed care beneficiaries who make and keep an appointment that falls within the following categories:

- Annual preventive visits
- Preventive dental services
- ACIP recommended vaccinations
- Appropriate cancer screenings
- Tobacco cessation.<sup>35</sup>

**Cost Sharing:** For the Healthy Michigan Plan, standard state Medicaid cost-sharing applies; however, there is a pre-paid cost-sharing feature that the state connects with individual accounts.<sup>36</sup>

**Premium Assistance (Private Option):** Effective April 1, 2018, a select population of Healthy Michigan Plan enrollees have been required to transition to the Michigan Marketplace Option, should they meet the following criteria:

- Have been enrolled in a Healthy Michigan health plan for twelve consecutive months
- Are not pregnant
- Are 21 or older
- Have incomes above 100 percent FPL
- Do not have cost share exempt status

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<sup>32</sup> <https://familiesusa.org/waivers-michigan>

<sup>33</sup> [https://www.michigan.gov/documents/mdhhs/MSA\\_18-05\\_615825\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MSA_18-05_615825_7.pdf)

<sup>34</sup> [Ibid.](#)

<sup>35</sup> [Ibid.](#)

<sup>36</sup> <https://familiesusa.org/waivers-michigan>

- Have not completed a healthy behavior as described in the Updates to the Healthy Behaviors Incentives Program.<sup>37</sup>

MDHHS allowed individuals to self-attest to medically frail status using the application for care coverage. The Department also conducted a retrospective claim review for the presence of select diagnosis codes to identify individuals with serious or complex health conditions (both behavioral and medical).

The Department utilized MICHIGAN ENROLLS to facilitate the enrollment into the state's Marketplace Option health plans, through which beneficiaries could enroll online, by phone, or through the mail. Those who did not enroll in a Marketplace Option plan were informed by the state that they would be automatically assigned into a plan. These plans, altogether, provide a more limit benefit package, consistent with the ACA's required Essential Health Benefits. All Michigan residents enrolled in the MI Marketplace Option are to remain in this option until the following MI Marketplace open enrollment period unless they either lose Medicaid eligibility or are labeled medically exempt.<sup>38</sup>

## IOWA

The Iowa Health and Wellness Plan was approved in late 2013 and then implemented in January of 2014. This demonstration expanded Medicaid eligibility to individuals with incomes up to 100% of the Federal Poverty Level.<sup>39</sup> These individuals were provided coverage through Managed Care Organizations. The medically frail are provided coverage through the Iowa Health and Wellness Plan's managed care program but can elect to receive coverage through a QHP.<sup>40</sup> The State had only projected roughly 81,000 individuals would enroll, but by December 2014, 120,000 individuals were enrolled in the Iowa Health and Wellness Plan.<sup>41</sup>

CMS also approved the Marketplace Choice Plan in 2013 which expanded Medicaid coverage to individuals with incomes between 100% and 138% of the Federal Poverty Level who are not provided coverage through their employer. The individuals in this tier are offered coverage through Private Option QHPs on the individual market with premium assistance and cost sharing assistance. Because of limited QHPs in 2015, individuals have the option to choose to enroll in Medicaid Managed Care instead of QHPs.<sup>42</sup> According to the CMS Special Terms and Conditions, individuals in this plan must have at least two QHPs to choose from in their area.<sup>43</sup> However, in late 2014, one only QHP remained available in the Iowa Marketplace Choice Plan.

The Iowa Marketplace Choice Plan covered all federally required "essential health benefits". Items not covered included:

- Acupuncture
- Vision exams
- Eyeglasses
- Hearing aids

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<sup>37</sup> [https://www.michigan.gov/documents/mdhhs/MSA\\_18-05\\_615825\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MSA_18-05_615825_7.pdf)

<sup>38</sup> Ibid.

<sup>39</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-fs.pdf>

<sup>40</sup> <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>

<sup>41</sup> <https://www.healthinsurance.org/iowa-medicaid/>

<sup>42</sup> <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>

<sup>43</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Market-Place-Choice-Plan/ia-marketplace-choice-plan-stc-01012014-12312016-amended-122013.pdf> (Referenced by the Urban Institute)

- Nursing facility services (except up to 90 days for rehabilitation)
- Non-emergency transportation services
- EPSDT

There are no costs to enrollees in the first year and costs can be waived in following years if the enrollee engages in “healthy behaviors”. These healthy behaviors include participating in two of the following each year:

- Health risk assessment
- Wellness exam
- Dental exam
- Smoking cessation program or be a non-smoker
- Lower BMI
- Participate in health education programs
- Preventative screenings (mammogram) <sup>44</sup>

The table below from the Urban Institute and the Robert Wood Johnson Foundation details the elements of the Iowa Marketplace Choice Plan and the Iowa Wellness Plan.<sup>45</sup>

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<sup>44</sup> <http://www.infonetiowa.org/news/votes/116-about-the-marketplace-choice-plan/>

<sup>45</sup> <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>

Policy	Description
Premium Assistance in QHPs	Yes. Applies to nonexempt enrollees above 100–138% FPL who do not have an offer of cost-effective employer-sponsored insurance. Participation of this population in QHPs was to be mandatory, but because there is only one available QHP in Iowa in 2015, enrollees may opt to participate in Medicaid managed care in 2015.
Monthly Premiums or Contributions	Yes. Referred to by CMS as “premiums.” No premiums charged enrollees in their first year in the program. Flat monthly premium of \$10/month for nonexempt enrollees above 100–138% FPL and \$5/month for nonexempt enrollees above 50–100% FPL not to exceed 5% of quarterly aggregate household income. Enrollees are exempt from premium if they self-attest to financial hardship at the time they are invoiced for a monthly payment (must self-attest to financial hardship each time a payment is due).
Cost sharing	The premiums are “in lieu” of other cost sharing, except the state charges a copayment for nonemergency use of the emergency room consistent with the state plan.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	No lockout, but enrollees above 100–138% FPL may be disenrolled for nonpayment of premium; they are allowed to re-enroll without a lockout period, but outstanding payments will be subject to recovery by the state. No one at or below 100% FPL may be disenrolled for failure to pay premiums. All enrollees who fail to make their payments incur a debt to the state.
Health Accounts	No individual accounts are created to hold the enrollees’ premium contributions, but the state keeps track of the amounts paid and amounts owed.
Healthy Behavior Incentives	Yes. Completion of Healthy Behaviors can lead to waiver of premiums for the following year.

*Note: Iowa received approval for two separate Section 1115 demonstrations: the Iowa Marketplace Choice Plan applies to individuals above 100–138 percent of FPL; the Iowa Wellness Plan applies to individuals at or below 100 percent of FPL. This table summarizes provisions in both plans.*

Sources: Centers for Medicare and Medicaid Services, Special Terms and Conditions, Iowa Marketplace Choice Plan, Number 11-W-00288/5 (amended December 30, 2013). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Market-Place-Choice-Plan/ia-marketplace-choice-plan-stc-01012014-12312016-amended-122013.pdf> (accessed April 2015); Cover Letter and Amended Special Terms and Conditions, Iowa Marketplace Choice Plan, Number 11-W-00288/5 (December 30, 2014). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf> (accessed April 2015); Cover Letter and Amended Special Terms and Conditions, Iowa Wellness Plan, Number 11-W-00289/5 (December 30, 2014). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf> (accessed April 2015); Centers for Medicare and Medicaid Services, “Medicaid and the Affordable Care Act: Premium Assistance.” Washington, DC: March 2013. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (accessed April 2015).

Source: <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>

In 2015, Iowa decided to officially switch their entire Medicaid system to Medicaid Managed Care through the Iowa Health Link. The transition was scheduled to begin with 560,000 individuals planning to switch to Managed Care in January 2016. However, because of a delay in managed care program selection by enrollees, the federal government delayed the transition until March 2016. In April 2016, the Medicaid Managed Care System was in full effect.<sup>46</sup>

Iowa had experienced instability in the individual market which paralleled the state’s move away from the private option. It is also estimated that bureaucratic challenges and implementation difficulties contributing to the state moving away from the private option.<sup>47</sup>

Individuals with incomes between 100% and 138% of the Federal Poverty Level are still provided coverage even though Iowa no longer has private option plans. Their coverage switched to the Medicaid Managed Care Program along with other eligible Medicaid populations.

There was a 42% reduction in the uninsured rate of individuals between 2013 and 2017 through Medicaid expansion efforts.<sup>48</sup>

<sup>46</sup> <https://www.healthinsurance.org/iowa-medicaid/>

<sup>47</sup> <https://www.vox.com/policy-and-politics/2018/8/31/17806656/medicaid-private-insurance-states-work-requirements-voxcare>

<sup>48</sup> <https://www.healthinsurance.org/iowa-medicaid/>

While New Hampshire, Michigan and Iowa are all states that have also relied on a Private Option component to pursue Medicaid expansion and reform, the States did not comprehensively apply the commercial market delivery system or do so for an extended period of time necessary to evaluate impacts on care, access and cost. For this reason, PCG will rely on comparisons to Arkansas throughout this paper.

## 2.2 Relevance to Alaska

Medicaid expansion was first introduced in Alaska in 2015 under then Governor Bill Walker. Between 2015 and today, both the total cost per person and the total enrollment have been a decent amount higher than originally anticipated by the state. The state predicted that 23,737 residents would join the state Medicaid expansion population.<sup>49</sup> Alaska's Department of Health and Social Services' June 2019 Report states that the 50,535 individuals are currently covered by the expansion.<sup>50</sup> Moreover, the average cost per Alaskan has been \$10,500, which supersedes the state prediction by about \$3,000. Altogether, the expansion populations cost has overrun the state's budget by nearly \$200 million.<sup>51</sup>

Critics in Alaska note the manner in which Arkansas' private option adoption has cost the state far more money (\$7,000) per enrollee than the state's initial fee-for-service model once did. They also note that premiums have more than doubled since the state's waiver introduction. Emphasizing that Medicaid reform efforts should "focus on encouraging able-bodied recipients to become more self-sufficient and less depend on government aid," Alaskan critics assert that the state's adoption of premium assistance would have dire results for both residents and the state's Medicaid program.

While there is little evidence on the cost differential for New Hampshire, Michigan and Iowa. It was found that the cost differential in Arkansas was higher with the private option. However, this cost still resulted in cost effective elements of the program because of the improved health outcomes detailed above. It was also noted that in order to improve health outcomes in a fee-for-service delivery system, significant cost investments would have been required.

## 2.3 Cost Impact

There are cost differences between traditional Medicaid expansion and the Private Option that Alaska will need to actively manage. PCG notes several levers available to Alaska to facilitate successful management of cost pressures.

The Arkansas Center for Health Improvement ("ACHI") report shows the weighted average payment to QHPs, including both premium and cost sharing reductions, was \$486 PMPM or \$5,832 per year while Medicaid costs were \$317 PMPM or \$3,804 per year for each enrollee, bringing the differential to \$167 PMPM in 2016. The PMPM for the QHPs was 53% ( $\$486/\$317=1.53$ ) higher than the PMPM for traditional Medicaid.

ACHI constructed a model to determine "what the QHP-enrolled individuals would have cost Medicaid." "The Estimated Medicaid PMPM cost are from a model that calculates PMPM costs for QHP enrollees under the assumption that payments for services would be at the prices paid in the Medicaid program. Under this methodology, prices for services were altered to reflect the experience of the traditional Medicaid population, while holding utilization of services for the QHP enrollees constant."<sup>52</sup> For 2016, the result of this model was a QHP PMPM

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<sup>49</sup> <https://www.heartland.org/publications-resources/publications/research--commentary-alaska-should-reject-private-option-medicaid-model>

<sup>50</sup> <http://dhss.alaska.gov/healthyalaska/pages/dashboard.aspx>

<sup>51</sup> Ibid.

<sup>52</sup> <https://achi.net/wp-content/uploads/2017/05/Final-Report-no-appendices.pdf>

of \$487 compared to an estimated Medicaid PMPM of \$320 ( $\$487/\$320=1.52$  or 52% higher). This comparison factors out scope of benefit differences across MA and QHPs.

Arkansas's Private Option waiver was intended to demonstrate cost effectiveness, not necessarily lower overall costs. In its final evaluation, ACHI noted several improvements in healthcare outcomes that were achieved as a result of investing in commercial coverage for its Medicaid expansion population. There are four specific and measurable outcomes.

According to the ACHI Report, for colorectal cancer screening, the QHP group had a 94% higher relative difference in screening rates. The improvement is suggested to be an increase of 5.6% per observed 10% increase in program costs associated with use of premium assistance. For those who received clinical preventative services, the QHP relative difference of 25% greater than Medicaid suggests a 1.4% improvement in clinical performance per observed 10% increase in program costs. For individuals with Higher Needs, QHP enrollees were 26% more likely to self-report "always getting care when needed right away" and 18% more likely to find it "easy to get the care, tests, and treatment needed.". This is a 1.1% improvement in access and 10% increase in program costs. Lastly, the ACHI report says that for individuals with Higher Needs, Medicaid enrollees have fewer outpatient events and a concurrent higher rate of ER visits and hospitalizations. For every 10% increase in program costs, QHPs were projected to have seven more physician office visits and avoid 2.5 ER visits per 100 person years.<sup>53</sup>

The last part of the ACHI evaluation on the cost effectiveness of the Private Option considered what would have been required from an economic investment angle on the fee-for-service side to achieve the same health improvement outcomes as were seen with the Private Option. Researchers concluded that without a 15%-35% increase in Medicaid rates, "unequal access" between Medicaid and the commercial market would have occurred. The premise is that the 52% difference in cost measured between QHPs and Medicaid fee-for-service could not have been sustained without triggering network adequacy compliance concerns for Medicaid recipients.

While it is true that a Private Option transitions the basis of provider payments from a Medicaid fee schedule to commercial rates and has the potential to increase cost, Alaska can control for this by applying a reference-based fee schedule, which will we discuss in the next section. Alaska can also achieve budget neutrality by implementing a "global cap" that generates federal funds savings. For these reasons, PCG believes Alaska has the tools to successfully manage the cost of implementing a Private Option waiver.

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<sup>53</sup> <https://achi.net/wp-content/uploads/2017/05/Final-Report-no-appendices.pdf>

### 3. Referenced Based Pricing

#### 3.1 Background

Reference Based Pricing is a method used to by payers, especially in the self-funded employer coverage market, to establish a fair price for services. RBP is a tool that pays providers for services based on a “benchmark,” most commonly as a percentage of Medicare or provider cost data. RBP serves as a transparent price-setting methodology because the point of reference is in the public domain, which is true of Medicare reimbursement rates and fee schedules for categories of service that represent the majority of healthcare spending.

Lockton Companies released a report on Reference Based Pricing in March 2018. According to this report, referenced-based pricing is structured in three different ways:

1. Most common: With this structure, the reference price is only for specific procedures with similar protocols. Examples include knee replacements and MRIs. Benefits of this structure include easy price comparison.
2. Mid-level implementation: With this structure, referenced-based pricing is used for all claims that are out-of-network.
3. Full implementation: With this structure, referenced based pricing is used on almost all billed claims.<sup>54</sup>

According to Modern Healthcare, Montana has implemented a referenced-based reimbursement model for the state employee health plan, and the State of Montana Benefit Plan has saved \$13.6 million in the last three years since it began. The State of Montana Benefit Plan has a reimbursement rate of 230% of Medicare. The article continues to say that the disparity between high and low-cost hospitals has reduced by 28 percentage points by setting the reimbursement rates to a percentage of Medicare.<sup>55</sup> While the population in Montana utilizing this initiative is very different, it is important to note the cost savings and rates that Montana has experienced.

North Carolina has been working to implement a referenced-based pricing model for their state employee health plans. Under their approach, reimbursement rates would be 177%-182% of Medicare. North Carolina estimates that plan cost savings would be roughly \$300 million and enrollees' cost savings would be around \$60 million in the first year.<sup>56</sup>

North Carolina is facing challenges and opposition as the House of Representatives passed a bill in April of 2019 to reject the new initiative. As expected for initiatives aimed at curbing provider reimbursement, provider groups are organized in their opposition. Negotiations between the state employee plan and hospitals continued as of late June 2019.

Another example of a payment standard initiative is the All Payer System. Maryland has been operating under an All-Payer system since 1971 and is the only state to comprehensively administer one. Maryland legislation created the Health Services Cost Review Commission (HSCRC) which sets hospital rates for all payers within Maryland. Maryland received a waiver in 1977 that required Medicaid and Medicare to pay hospitals based on HSCRC approved rates thus covering all-payers within the state.<sup>57</sup> Maryland has been able to maintain this waiver by keeping cumulative growth in Medicare inpatient payments below the national average.

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<sup>54</sup> [https://www.lockton.com/whitepapers/Long\\_Reference\\_Based\\_Pricing\\_External\\_March\\_18\\_-\\_FINAL.PDF](https://www.lockton.com/whitepapers/Long_Reference_Based_Pricing_External_March_18_-_FINAL.PDF)

<sup>55</sup> <https://www.modernhealthcare.com/insurance/montanas-experiment-reference-based-pricing-has-saved-136m-so-far>

<sup>56</sup> <http://insurancethoughtleadership.com/north-carolinas-battle-for-healthcare-value/>

<sup>57</sup> <https://hscrc.state.md.us/Documents/pdr/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf>

There were two primary reasons why this system was set up. One reason was to combat the rising cost of hospital visits that had been rising since the creation of Medicaid and Medicare. The second was the threat of hospital insolvency which would drastically reduce access to healthcare.

In 2014, Maryland updated its All Payer Model in order to shift the focus from controlling cost per admission to controlling the total payment for hospital services.<sup>58</sup> Under the new Maryland All-Payer Model, the HSCRC establishes an annual allowed revenue for each hospital which is determined using previous allowed revenues and adjusting for various changes such as population demographics or hospital quality performance. The HSCRC then sets the rates for services that the hospitals will use to bill payers so that the payments will match the global budget. Public payers such as Medicaid and Medicare are allowed a six percent discount.

### 3.2 Relevance to Alaska

Alaska implemented what is known as the “80th Percentile Rule” In 2004. That rule sets a minimum for how much health-insurance companies must pay when Alaskans with private insurance plans see doctors or other providers outside their insurers’ networks. In general, the rule applies to all individual plans and to most private group plans.

This rule was established to address those Alaska residents who had insurance but faced unexpectedly large remaining bills, after their insurance companies had paid a share. To address this issue, the 80th percentile rule requires carriers to base their payments for out of network claims on the amount at or above 80 percent of what all providers charge for a specific service, in that particular rating region.

The 80<sup>th</sup> Percentile Rule is an example of a state-established payment standard applied to the commercial market. Reference Based Pricing would also function as a state-established payment standard applied more broadly to carrier reimbursement for in-network providers. For Alaska, RBP would be developed to address well-documented concerns that healthcare costs and reimbursements to providers are substantially higher than national average. RBP would also be an important tool to contain the cost of an Alaska Private Option waiver because it would govern reimbursement rates commercial plans pay providers for those Medicaid members enrolled in Marketplace Qualified Health Plans (QHPs).

PCG wishes to draw attention to the impact RBP could have on “balance billing” and call out the need to manage this impact as part of any RBP reform initiative. This is the case because any statutory ceiling imposed on carrier reimbursement to providers could result in the “balance” of provider charges being billed to consumers. Unless managed by the state, this outcome could create two negative impacts. First, it could create gaps in current Alaska consumer protections against balance billing practices. Second, it could shift more healthcare expenditures to the “balance” portion of a claim, thereby negating cost savings gains from RBP payment standards.

The Commonwealth Fund comprehensively researched state practices to regulate balance billing in a 2017 report that they updated in 2019.<sup>59</sup> According to the 2017 report, there are four major approaches states take to curbing balance billing.<sup>60</sup> They are:

**Insurer Hold Harmless Requirement:** A requirement that insurers pay providers their billed charges or some lower amount that is acceptable to the provider.

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<sup>58</sup> <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

<sup>59</sup> <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>

<sup>60</sup> <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer>

**Prohibition on Provider Balance Billing:** A requirement that out-of-network providers cannot bill insured patients beyond any allowed cost-sharing amounts.

**Payment Standard:** A law or rule setting payment rates for out-of-network providers, such as 125 percent of the rate set by Medicare.

**Dispute Resolution Process:** An independent mediation or other process through which providers and insurers can negotiate or settle on a fair rate of payment for a claim.

Planning for an RBP model in Alaska will require parallel planning for necessary modifications to balance billing regulations. The specific approach Alaska chooses to modify balance billing regulations must be mindful of the total cost impact Alaska is seeking to derive from RBP.

### 3.3 Cost Impact

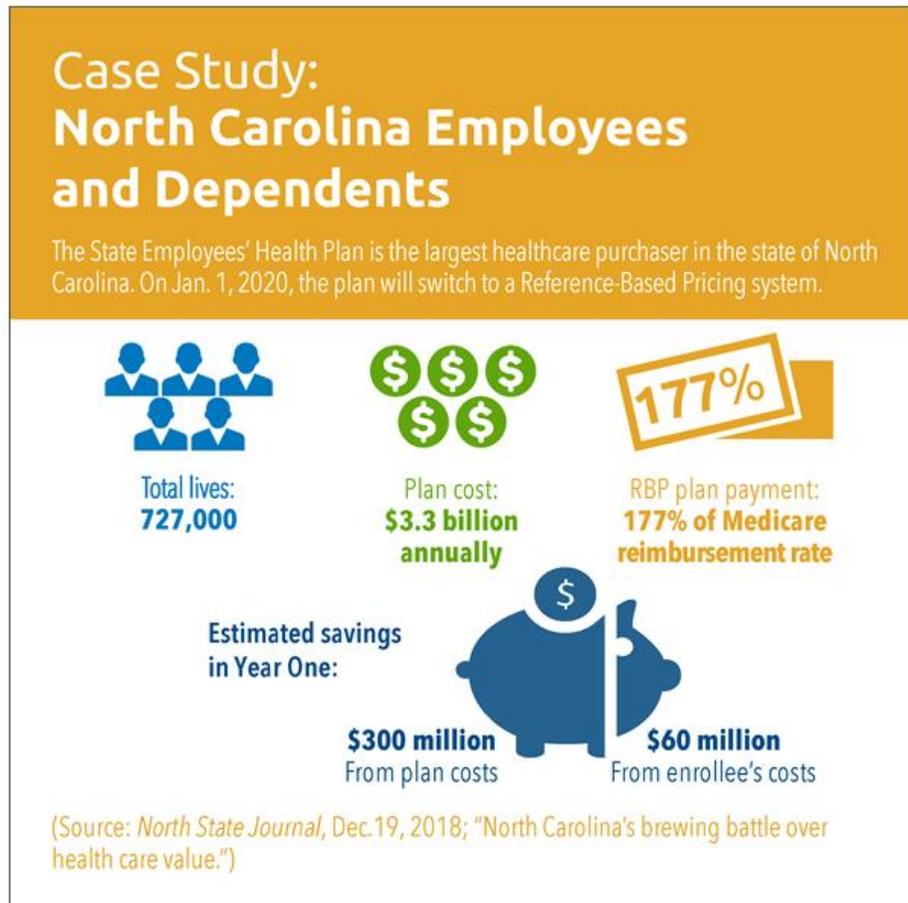
Referenced-based pricing can create major cost savings for states. As mentioned earlier, Montana has implemented the referenced-based pricing model for their state employee health plans. Since they first implemented the model three years ago, the state has saved almost \$14 million.<sup>61</sup> While this population is different than the Alaskan Medicaid Expansion population, this savings is something to be aware of.

While North Carolina has not yet implemented the referenced-based model in the state, they have projected savings of \$300 million from plan costs and \$60 million from enrollee's costs. The image below shows the cost implications of referenced-based pricing in North Carolina.<sup>62</sup>

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<sup>61</sup> <https://www.modernhealthcare.com/insurance/montanas-experiment-reference-based-pricing-has-saved-136m-so-far>

<sup>62</sup> <https://www.coresource.com/emailcampaign/reference-based-pricing>



Source: <https://www.coresource.com/emailcampaign/reference-based-pricing>

According to the Lockton report mentioned earlier, referenced based pricing can create savings of 5-15% when the program is fully implemented. This report notes that savings primarily come from claims at non-emergency facilities where the claims are normally much higher than Medicare. However, in contrast, physician claims result in much smaller savings due to being around 130% of Medicare normally.<sup>63</sup>

Based on North Carolina's expected savings and Montana's savings over the last three years, PCG estimates that significant savings can come from the referenced-based pricing model. This is an important model to consider as part of a savings initiative for Alaska.

<sup>63</sup> [https://www.lockton.com/whitepapers/Long\\_Reference\\_Based\\_Pricing\\_External\\_March\\_18\\_-\\_FINAL.PDF](https://www.lockton.com/whitepapers/Long_Reference_Based_Pricing_External_March_18_-_FINAL.PDF)

## 4. Community Engagement and Work Requirements

### 4.1 Background

State Medicaid agencies can customize their programs to meet the unique needs of their population by creating experimental, pilot, or demonstration projects through the use of a Section 1115 Demonstration Waivers (1115 waiver). Under an 1115 waiver approved by the Center for Medicare and Medicaid Services (CMS), state Medicaid agencies can request to waive certain aspects of federal regulations to test innovative ideas that they believe will benefit the Medicaid population. This allows states to continue to receive federal funds in a manner that is typically not allowed under federal guidelines.

Proposed projects must demonstrate budget neutrality and promote Medicaid objectives designed to:

1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;
2. Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term;
3. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
4. Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making;
5. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and
6. Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.<sup>64</sup>

On March 24, 2017 a joint letter was sent to State Governors from the Secretary Price and Administrator Verma confirming their commitment to partner with states to transform Medicaid programs. The letter included five key areas in which the administrations sought to partner with states and promote change within the program. Increasing employment and community activities was listed as one of the key areas.

CMS continued to provide guidance to states in the form of informational bulletins and website updates. On January 11, 2018 CMS issued a State Medicaid Director's Letter announcing new efforts to support states seeking to develop demonstration projects through an 1115 waiver in which community engagement activities – including skills training, education, job search, volunteering or caregiving – would be a condition for Medicaid eligibility for certain able-bodied individuals.<sup>65</sup> The guidance specifically excludes disabled individuals, elderly beneficiaries, children, and pregnant women.

Nineteen states have submitted 1115 waiver applications to CMS that contain work requirements or community engagement provisions. Kentucky, Indiana, and Arkansas were among the first states to receive approval to test their demonstration projects. However, a lawsuit was filed in Kentucky and a federal judge blocked the state from implementing the provisions related to work requirements set to begin on July 1, 2018. The lawsuit did not impact CMS's authority to approve additional waivers and, to date, six additional states have approved 1115 waivers containing work and community engagement and seven states have pending applications with those same requirements.

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<sup>64</sup> <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>

<sup>65</sup> <https://www.cms.gov/newsroom/press-releases/cms-announces-new-policy-guidance-states-test-community-engagement-able-bodied-adults>

The following chart depicts a summary of 1115 waivers containing work and community engagement requirements that have been approved by CMS. In addition, other features of the waiver applications have been included for reference purposes.

Approved Section 1115 Demonstration Waivers Containing Work and Community Engagement Activities									
Features	State								
	KY	IN	AR	NH	WI	MI	AZ	OH	UT
Premiums (some states with lockout)	X	X	X		X	X	X		
Cost Sharing	X	X	X	X	X		X		X
<b>Work Requirements</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
Healthy Behavior Incentives	X	X	X		X		X		
Non-Emergency Transportation Waiver	X	X							
Institution for Mental Disease (IMD) Exclusion Waiver	X	X			X		X		X
Retroactive Coverage Waiver	X	X	X	X					X
Prompt Enrollment Waiver	X								
Drug Screening					X				
Limits on Enrollment Duration					X		X		X
Partial Expansion			X						
Health Savings-Like accounts	X	X					X		
Late Renewal Paperwork Penalty/Lockout	X	X							
1927 Waiver for Closed Formularies			X						
Expansion State	X	X	X	X		X	X	X	
Approval Date	1/12/2018	2/2/2018	3/5/2018	5/7/2018	10/31/2018	12/21/2018	1/18/2019	3/15/2019	3/29/2019
Implemented	N	N	Y	N	N	N	N	N	N

### **Populations Covered**

Of particular note is that 7 of the 9 states that have approved waivers containing work and community engagement activities have chosen to expand Medicaid under the Affordable Care Act (ACA). While Wisconsin did not expand Medicaid under the ACA, the state's Medicaid program, BadgerCare, does cover childless adults aged 19 – 64 whose family income is up to 100% of the federal poverty level (FPL) and who are legal residents. The state submitted an amendment to their existing 1115 waiver to incorporate community engagement activities as a condition of Medicaid eligibility. Individuals subject to work and community engagement activities under Wisconsin's waiver include adults ages 19 – 49 who are eligible for Medicaid as childless adults.

Likewise, Utah did not expand Medicaid under the ACA but, the state's 1115 waiver approved by CMS in March 2019 authorizes the state to expand Medicaid to individuals whose income is up to 100% of the FPL. The state will not receive enhanced federal matching funds for this population as do those states that chose to expand Medicaid under the ACA. However, the waiver contains a provision that allows the state to cap enrollment if the state does not have sufficient funds to cover the costs of services provided to the new population. Individuals subject to work and community engagement activities include the Medicaid expansion population under the age of 60 and whose income is at or below 100% of the FPL.

The remaining states with approval to implement work and community engagement activities within the Medicaid program cover similar populations typically described as able-bodied individuals. Ages vary depending on the specific state. For example, Arizona and Arkansas limit the age range to the ages of 19 – 49 while Indiana, like Utah, caps the age at 60.

In addition to the mandatory exclusion including disabled individuals, elderly beneficiaries, children, and pregnant women, the majority of states also exempt a wide variety of individuals including:

- Individuals who are the caretakers of disabled children or adults;
- Individuals who are compliant with Supplemental Nutrition Assistance Program (SNAP) and Temporary Aid for Needy Families (TANF) work requirements;
- Single parents caring for a child under a certain age as defined by the state;
- Individuals with serious mental illness;
- Individuals receiving substance use disorder treatment;
- Full-time students at a high-school, accredited university, or other institution of higher learning;
- Former foster children;
- Victims of domestic violence; and
- Other exempted groups as defined by the state.

Arizona's approved waiver exempts members of federally recognized tribes. Mississippi's pending 1115 waiver requests to exempt Native American Tribes and Oklahoma's pending 1115 waiver requests to exempt Native Americans and Alaskan Natives.

States that have not expanded Medicaid under the ACA limit the population subject to work and community engagement activities to individuals who meet enrollment criteria under the caretaker relative or TANF categories. To date, CMS has not approved a waiver for a state that does not have either an ACA expansion population or an approved plan to cover a segment of the childless adult population within the state.

### **State Specific Approaches**

1115 waivers provide flexibility that allows states to meet the specific needs of their population. Work and community engagement waivers contain some common characteristics, such as the number of work or community engagement hours participants are required to report. Most states with approved waivers require eligible individuals to work or participate in approved community engagement activities for at least 80 hours per month. However, New Hampshire's waiver requires 100 hours per month and Utah does not specify a specific number of hours in their approved waiver. Both Indiana and Kentucky outline a phased in approach for individuals to meet the hourly commitment.<sup>66</sup>

Indiana allows individuals to gradually achieve the required 80 hours per month based on length of enrollment in the program. For example, during the first year of participation in the Medicaid program an individual will be required to work five hours per week and will gradually increase to working 20 hours a week beginning at 18 months of enrollment. Kentucky's waiver proposed to phase in the requirements by specific regions within the state.

Ohio considered regional variations in the employment market across the state and aligned their work and community engagement activities with SNAP policies that allow the state to waive work requirements for counties whose 24-month average unemployment rate was greater than 120% of the national unemployment rate.<sup>67</sup> This results in individuals not being penalized for failure to meet the requirements due to lack of employment opportunities.

### **Penalties for Non-Compliance**

Penalties for non-compliance vary from state-to-state but all include some form of disenrollment from the Medicaid program. The majority of states provide a 3-month period for individuals to become compliant with the requirements.

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<sup>66</sup> [https://nashp.org/wp-content/uploads/2018/01/Medicaid-Work-Requirements-Chart\\_6\\_14\\_19\\_Final.pdf](https://nashp.org/wp-content/uploads/2018/01/Medicaid-Work-Requirements-Chart_6_14_19_Final.pdf)

<sup>67</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-community-engagement-pa.pdf>

Once an individual is identified as non-compliant, states apply different penalties. Arizona, for example, suspends eligibility for two months if an individual is non-compliant with the community engagement requirements. Individuals can have their benefits reinstated after the two-month period or they meet all other eligibility requirements. Arkansas, on the other hand, implemented a lock-out period for individuals who are non-compliant for 3 months during the coverage year. Individuals are locked out of coverage and must file a new application at the start of the next coverage year.

Ohio and Oklahoma disenroll non-compliant individuals from the Medicaid program but allows them to re-enroll immediately or at any time following disenrollment.

The majority of states also have “good cause” exemptions that allow individuals to maintain their Medicaid coverage if they are determined to be non-compliant. Good cause exemptions include:

- Hospitalization or serious illness of the individual or an immediate family member;
- Death of a family member;
- Natural disasters;
- Domestic violence;
- Birth or death of a family member in the home; or
- Other exemption as defined by the state.

### **Implementation**

As noted in the summary chart, only Arkansas has implemented work and community engagement provisions as outlined in their approved waiver. Arkansas implemented the requirements beginning June 2018. The waiver allowed for the requirements to be phased in for individuals aged 30 – 49 beginning June 2018. Individuals aged 19 – 29 were subject to the requirements beginning January 2019. For tracking purposes, individuals subject to work and community engagement activities were required to report their work hours on-line each month.

Shortly after implementing the new requirements, many organizations began to monitor Medicaid enrollment in Arkansas and report on the number of enrollees who were losing coverage. For example, according to the Henry J. Kaiser Family Foundation, a total of 18,164 individuals lost Medicaid coverage in 2018 for failure to meet the work and reporting requirements in Arkansas.<sup>68</sup> Thus, in December 2018 the state allowed individuals to report work hours via telephone in addition to the on-line process. However, in March 2019, similar to Kentucky, a federal judge blocked Arkansas’ ability to continue requiring individuals to participate in work and community activities as a condition of the Medicaid eligibility.

## **4.2 Relevance to Alaska**

As outlined above, both CMS and many state leaders are interested in transforming Medicaid through the use of work and community engagement activities. To date, all states with an approved 1115 waiver containing work and community engagement activities for Medicaid populations have expanded Medicaid through the ACA or have an approved plan to cover a segment of childless adults. Alaska chose to expand Medicaid under the ACA. Therefore, the state can consider implementing work and community engagement activities for individuals enrolled in the expansion category. Alaska can choose to implement work and community engagement activities as a stand-alone option under 1115 waiver authority or in conjunction with a private option.

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<sup>68</sup> <https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/>

Under a stand-alone option, cost savings would result if individuals obtain employment with an organization that offers affordable employee sponsored insurance (ESI) and who subsequently moves out of the Medicaid program. Depending on the design of the program and the relationship between work and community engagement activities and Medicaid eligibility, Alaska could see cost saving through non-compliance. As discussed earlier, states suspend or eliminate eligibility when an individual is discovered to be non-compliant with required activities. Alaska would not be responsible for paying claims for individuals during periods of ineligibility.

Work requirements could also be implemented with the private option. For those individuals who cannot find employers who offer insurance, Medicaid would be responsible for paying premiums for QHPs. Likewise, if individuals cannot afford premiums for ESI, Medicaid would be responsible for paying those premiums as well as wrap around services such as EPSDT for individual age 19 – 21 and NEMT. Therefore, while work requirements can stand alone or be used in conjunction with a private option, the practice would not make the private option less expensive to operate.

PCG is also aware that Alaska intends to end its SNAP work requirement waiver in January 2020, and, therefore, aligning a Medicaid work requirement waiver would be cost efficient. There is considerable overlap between SNAP and Medicaid eligibility in Alaska.

Key considerations for implementing work and community engagements in Alaska's Medicaid program are included in the conclusion and recommendations portion of this paper.

### 4.3 Cost Impact

One key consideration when deciding whether or not to implement work and community engagements activities in Alaska's Medicaid program includes the cost of implementation and administration of the program. The January 2018 Medicaid Director's Letter from CMS specifically states that agencies will be required to assist beneficiaries in meeting work and community engagement requirements. However, the letter also states that the opportunity does not provide authority to use Medicaid funding to finance the services designed to assist individuals by linking them to resources designed to help them meet the requirements.<sup>69</sup>

Therefore, in addition to cost associated with information technology modifications to track compliance, Medicaid agencies will be responsible for identifying state and local community resources to assist individuals with finding employment or community engagement opportunities in order to meet the requirements. In addition, many public comments received by states with currently approved waivers discussed the lack of transportation and reliable childcare for the Medicaid population, especially in rural areas. For this reason, Ohio included the unavailability of transportation in their good cause reasons an individual would not be penalized for non-compliance.<sup>70</sup>

Implementing a work and community engagement activity as a requirement to maintain Medicaid eligibility will necessitate a change to the current eligibility infrastructure. Alaska would need to modify the eligibility system to identify individuals subject to work and community engagement activities as well create a way to track compliance, regardless of the size of the population. In addition, costs associated with CMS' requirement that states assist individuals in meeting the requirements need to be considered. Such costs would be dependent on the number of individuals needing assistance and the methodology used to assist them.

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<sup>69</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>

<sup>70</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-community-engagement-pa.pdf>

Alaska may be able to receive a federal match up to 90% for Medicaid eligibility related information technology investments, depending on the degree of technology and the size of the population involved. However, costs associated with work support services, such as job training activities are not allowable for federal match.<sup>71</sup>

Currently, administrative costs, such as information technology changes and additional personnel needed to oversee the components of the 1115 waiver, are not included in the budget neutrality calculation that is required to be submitted with the waiver. However, these costs need to be considered when developing a plan to determine the true budgetary impact. In addition, consideration should be given to uncompensated care that may result if individuals who are disenrolled from the Medicaid program due to non-compliance experience a health issue that needs medical attention.

PCG recommends that Alaska align Medicaid work requirement administrative processes with its SNAP work requirement processes to achieve cost effectiveness.

Since work and community engagement activities are still a relatively new concept in the Medicaid program and have not been tested over a period of time, adequate data does not exist to support or oppose the practice.

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<sup>71</sup> <https://publichealth.wustl.edu/wp-content/uploads/2018/06/MO-Medicaid-Work-Fiscal-Brief-final.pdf>

## 5. Medicaid Block Grants and Spending Caps

Alaska has asked PCG to consider the potential for using a block grant or per capita cap strategy to support moving a specified group of Medicaid recipients into coverage in the federally facilitated marketplace. This section addresses the subject of block grants and per capita cap strategies in the context of a Private Option Medicaid waiver for Alaska.

A “block grant” is a fixed sum of federal funding provided for a specified state purpose. One example is the federal Temporary Assistance to Needy Families (TANF) program, which allocates \$16.5 billion to states to provide economic assistance to poor families with children. States have wide latitude in how they may use the funds.

### 5.1 Background

#### **Block Grants and Per Capita Caps in Republican ACA “Repeal and Replace” Legislation**

Block grants and per capita caps were key features of 2017 Republican congressional healthcare reform legislation aimed at repealing and replacing the Affordable Care Act. These bills were titled the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA). Neither of them were enacted into law. AHCA was introduced in the House of Representatives and the BCRA was introduced in the Senate.

Currently, Medicaid is a means-tested entitlement program. As such, states are obligated to pay the allowable health care costs of all individuals who meet program eligibility requirements, regardless of budgetary impact.

Block grants and per capita caps would fundamentally change the relationship between Medicaid fiscal management and eligibility management, with budgets largely driving the scope of benefits and enrollment instead of being driven by them. Proponents of block grants believe they would force healthcare to become more cost efficient without becoming less effective. Opponents believe block grants and/or per capita caps would result in arbitrary reductions in benefits and eligibility that would erode access to healthcare and healthcare quality.

Both AHCA and the BCRA proposed to reform federal Medicaid financing to a per capita cap model starting in FY2020. This involved establishing a base period as a cost benchmark, then indexing future year per capita amounts using inflationary adjustments. Inflationary adjustments varied by eligibility category but generally relied on the medical care component of the consumer price index.

AHCA and BCRA also provided state with block grant options. Language in the BCRA would have given states the option to participate in a “Medicaid Flexibility Program” beginning in FY2020 and receive a predetermined fixed amount of federal funding instead of per capita cap to provide targeted health assistance to eligibility categories specified by the state, including expansion enrollees, non-elderly, nondisabled, non-expansion adults or both of those groups.

BCRA language also would have permitted states to retain unspent block grant funds for the succeeding fiscal year as long as the state satisfied its maintenance of effort requirement. The Medicaid Flexibility Program would have also allowed state to provide targeted health assistance that differed from Medicaid, but it also would have required states to provide defined benefits to those currently eligible to inpatient and outpatient hospital services, laboratory and x-ray services, nursing facility services for individuals aged 21 and over; physician services; home health care services; rural health clinic services; federally-qualified health centers; family planning services and supplies; nurse midwife services; certified pediatric and family nurse practitioner services; freestanding birth center services; emergency medical transportation, non-cosmetic dental services and pregnancy services.

Many coverage protections would have remained. The targeted health assistance provided to any group of program enrollees would have been required to have an aggregate actuarial value equal to at least 95% of the aggregate

actuarial value of the benchmark coverage from Social Security Act (SSA) Section 1937(b)(1) that was in effect prior to the enactment of the Affordable Care Act (ACA) or benchmark-equivalent coverage from SSA Section 1937(b)(2) that was in effect prior to the enactment of the ACA. States would have been able to determine the amount, duration, and scope of the targeted health assistance provided to all program enrollees unless otherwise specified.

The targeted health assistance that would have been required to provide mental health and substance use disorder coverage would have needed to comply with federal mental health parity requirements. Pharmacy rebates would have applied, and states would have flexibility to impose premiums, deductibles, cost-sharing, or other similar charges as long as the total annual aggregate amount of all such charges did not exceed 5% of the family's annual income.

Legislative enactment of Medicaid block grants and/or per capita caps fell short when the US Senate failed to pass a repeal and replacement plan for the Affordable Care Act. More recently, the US Department of Health and Human Services (DHHS), through its Center for Medicare and Medicaid Services (CMS) has been preparing guidance intended to help states establish Medicaid spending caps within the framework of current law.

### **Current CMS Support for Block Grants and Per Capita Caps**

On June 5, 2019, *Politico Pro* reported that CMS had forwarded a State Medicaid Directors (SMD) letter to the federal Office of Management and Budget (OMB) for review. The letter was titled "Medicaid Value and Accountability Demonstration Opportunity." *Politico Pro* indicated that the letter would address methods to "let states overhaul their Medicaid programs by instituting block grants. The plan, while its exact scope is unclear, has been under development for months."

The timeframe for OMB review is not clear. While the content of the letter is not public, Alaska may be able to determine CMS goals and objectives for the demonstration initiative through direct conversations with agency leadership.

### **State Initiatives: Utah "Per Capita Caps"**

New CMS guidance is in development at the same time that state interest in per capita caps and block grants is beginning to emerge. During the 2019 General Session, the Utah State Legislature passed, and Governor Herbert signed into law, Senate Bill 96 "Medicaid Expansion Adjustments". This legislation directed the Utah Department of Health to add several new features to the partial Medicaid expansion waiver that was approved by CMS on March 29, 2019. This included establishing a per capita cap funding mechanism.

Utah's partial Medicaid expansion provides coverage to non-disabled, non-elderly childless adults and parents/caretakers up to 100% of the federal poverty level (FPL). While Utah did not qualify for the 90 percent enhanced match rate because they did not expand eligibility all the way up to 138% FPL, CMS did permit Utah to cap enrollment in the waiver to align with state budget needs on an annual basis. This approval represented a significant first step in a capped expenditure approach.

As a result of Senate Bill 96, Utah submitted amendments to its Medicaid expansion waiver on May 31. The per capita cap methodology is included in the May 31 submission that is under review by CMS at the time this report was being drafted. The amendment requests the enhanced match rate for the partial expansion population up to an established limit that results from implementation of the per capita cap methodology.

Expenditures in excess of the cap would be matched at standard FMAP. The cap would also be measured in aggregate across the duration of the five-year waiver. This means that if Utah exceeds the cap in one year, the State may be able to offset the excess spending with savings in the next year. Utah requested three distinct per capita caps for the following populations due to differences in claims experience:

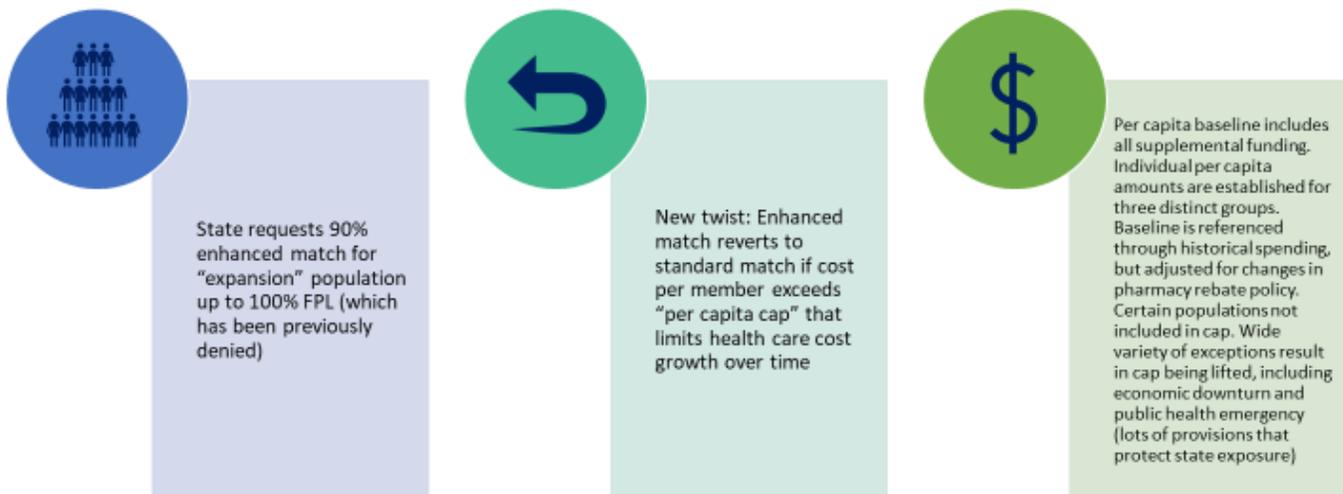
- Adults with Dependent Children;
- Adults without Dependent Children; and
- Targeted Adults and members residing in an IMD primarily to receive short-term residential treatment for SUD.

The state has included supplemental provider payments in the base per capita amount but has excluded Disproportionate Share Hospital (DSH) payments.

Utah proposed an annual growth factor that was established for the “without waiver” spending projections in the budget neutrality calculations of its approved March 29 waiver, which was 5.3%. The State also proposed that 2.5 years of growth be applied to the base period of in order to establish the demonstration year one per capita cap, which resulted in a Year One cap that is more than 13% higher than the base period.

The May 31 waiver amendment includes new benefit components that Utah sought to build into the base of its per capita cap. These benefits included supplemental payment initiatives, housing supports and bundled payments for mental health crisis services.

## Key Feature of 5/31 Utah Waiver Request: Per Capita Caps



The Utah waiver amendment application is notable for its approach to “earning” enhanced match for a partial Medicaid expansion by complying with a per capita cap that helps CMS meet its own cost containment goals. At the same time, Utah has structured the cap with assumptions and variables that are favorable to the State and does not restrict access to eligibility or benefits.

The consequence of not complying with the cap is not qualifying for enhanced match, but there is no “red line” after which program funding stops. Under the Utah waiver, Medicaid remains an entitlement program. Under current

federal law, state and CMS efforts to establish “caps” will play out in the context of Medicaid remaining an entitlement, barring a new and currently unforeseen regulatory interpretation from CMS.

### **State Initiative: Tennessee Block Grants**

Tennessee House Bill 1280 was enacted into state law on May 24, 2019. The bill is a broad directive that the Governor, acting through the Commissioner of Finance and Administration, submitted to CMS as an amendment to the “TennCare II” 1115 Demonstration Waiver. This bill directs that the waiver should seek authority to “provide medical assistance...by means of a block grant within 120 days after the date that this bill becomes a law.”

The waiver authorized by the bill would convert the federal share of Tennessee’s medical assistance funding into an allotment tailored to meet the needs of the State and indexed for inflation and population growth.

The sparse nature of the bill leaves many questions unanswered, most specifically what program restrictions would be implemented if Medicaid expenditures exceeded the block grant. Mandatory eligibility categories are not waivable under a Medicaid 1115 waiver demonstration, therefore, core pieces of the Medicaid program could not simply be “turned off” when spending exceeded the cap, under current federal law.

More likely consequences may focus on required spending reductions in subsequent years to “make up” cost overruns against the block grant. CMS could permit enrollment caps for optional coverage groups as a remedy. Any and all spending restrictions states currently pursue in managing their Medicaid budgets could be leveraged as remedies for block grant overspending.

Arguably, 1115 waivers already have spending caps. When states enter waiver agreements with CMS, the Special Terms and Conditions set budget neutrality limits. Under these limits, states have no additional access to federal matching funds once they exceed the budget neutrality cap. However, states are not typically permitted to suspend enrollment in the waiver unless an enrollment cap was negotiated as part of the waiver terms. In this way, states risk being “on the hook” for 100 percent of waiver costs that exceed budget neutrality caps.

CMS efforts to forge a regulatory pathway for state block grants may play on this well-established 1115 waiver spending limit. Budget neutrality caps could be recast as “block grants,” with waivers defining the specific remedies states would implement once spending is exceeded.

### **State Initiative: New York Global Medicaid Cap**

New York State established a global cap on the rate of Medicaid expenditure growth starting in 2011. Specifically, the State appointed a 27-member “Medicaid Redesign Team,” consisting of providers and other stakeholders, to recommend and approve initiatives to reduce expenditure growth and increase healthcare quality. Many of these initiatives centered around extending the use of managed care and implementing value-based purchasing.

New York’s global spending cap was triggered by state concerns that the rate of Medicaid expenditure growth was too high. A primary strategy in appointing the MRT was to directly bring stakeholders into the process of establishing savings initiatives to get their buy in. Under the legislation authorizing MRT, automatic spending cuts would be imposed in the absence of MRT initiatives, thereby incentivizing members to reach agreement. The state has leveraged this process to successfully meet spending targets for many successive years.

CMS permitted New York to reinvest federal funds saved under the global cap to finance a Delivery System Reform Incentive Pool (DSRIP) initiative under an 1115 demonstration waiver. The waiver was approved in April 2014. New York was able to document \$17.1 billion in federal savings through its Medicaid Redesign Team efforts. Of this amount, \$8 billion was authorized to be reinvested for delivery system reforms. The majority of the reinvestment targeted hospital transformation strategies aimed at reducing preventable hospital readmissions. New York invested one billion dollars for Health Home development and investments in long term care, workforce and enhanced behavioral health services and \$500 million in one-time funding will be used to assist safety net providers.

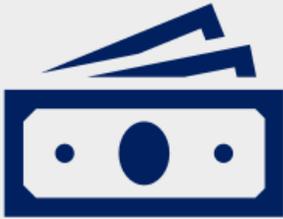
In summary, a variety of states as diverse as Utah and New York either have or plan to implement some form of a Medicaid spending cap. State waivers asking for authority to pursue such caps typically seek federal incentives for achieving savings targets. These initiatives can serve as a road map for a similar push to cap spending in Alaska. As these state models show, spending caps can be developed in a way that does not result in arbitrarily closing program enrollment at a certain point in time. Not only have states been able to meet their caps, they have sometimes been financially rewarded by CMS for doing so. In the next section, we will discuss how specific features of a spending cap may be relevant for Alaska. We will further consider the potential fiscal impact of a state per capita cap or block grant approach to Medicaid financing.

## 5.2 Relevance to Alaska

Under this “Proof of Concept” scope of work, Alaska has asked PCG to consider how a block grant or per capita cap initiative would impact a Private Option Medicaid waiver. The shortest and most direct answer to that question is that a spending cap could significantly contribute to the chances of a Private Option waiver being approved and implemented successfully due to its positive impact on budget neutrality.

At its core, a Private Option is a fundamental delivery system change for a portion of the Medicaid population. The New York DSRIP waiver establishes the precedent of CMS funding a major state delivery system reform through state reinvestment of a portion of federal dollars saved through a parallel Medicaid spending cap initiative.

### New York's Medicaid “Global Spending Cap”



Has been in place since 2012

Goal is to limit total Medicaid spending growth to no greater than the ten-year average rate for the long-term medical component of the Consumer Price Index (currently estimated at 3.2 percent).

If cap is at risk of being exceeded, state works with advisory group on a spending reduction plan. If stakeholders are unable to agree on a plan, automatic reductions are triggered. Savings from global cap has helped fund delivery system reform incentives. In a similar way, Alaska can try to get federal “credit” for \$225 million in scheduled cuts to fund a private option

Unlike New York, Alaska does not have an approved 1115 demonstration waiver that permits the State to reinvest a portion of the federal savings. Similarities between the New York Medicaid Redesign effort and Alaska’s redesign program raise the prospect of applying for such a waiver.

While CMS will not necessarily permit states to reinvest federal savings from any and all Medicaid cost savings, they have shown an openness to doing so to help fund delivery and payment reforms that can further improve Medicaid quality and efficiency within a state. A Private Option waiver that also features a Reference Based Pricing initiative may be determined by CMS to be worthy of federal savings reinvestment. For this reason, New York’s

global cap has significant relevance for Alaska. If Alaska wishes to implement a per capita or global spending cap for its Medicaid program, the State could leverage the reform items already authorized under Senate Bill 74.

Utah's current 1115 waiver application aimed at implementing per capita caps is also highly relevant to Alaska. Utah's application provides specific methodologies in several important areas, one of which is the decision about how to stratify eligibility populations and impose specific per capita caps to each of them. Importantly, Utah sees significant cost differences between childless adults in their partial Medicaid expansion and non-disabled, non-elderly parents and caretakers. Utah further stratified enrollees residing in an IMD primarily to receive short-term substance use disorder (SUD) treatment.

Also relevant to Alaska is the feature of this waiver that rewards Utah for meeting per capita cap requirements rather than imposing a negative consequence for not meeting it. This is a departure from ACA repeal and replace provisions in the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA), which envisioned states losing funding equal to 25 percent of the amount they spent in excess of their cap in the subsequent year. The "reward" for Utah is earning their way to an enhanced match under a partial Medicaid expansion. It is unclear if CMS will permit that in full or, alternatively, cap the match rate enhancement dollar for dollar against expenditure cap savings.

Alaska differs from Utah in that the State fully expanded Medicaid and already enjoys an enhanced match rate. For Alaska, earning rewards for savings under a capped expenditure model must be focused on a component other than moving from the state's standard match rate to the Medicaid Expansion enhanced match rate.

The most relevant use of savings for Alaska from a capped expenditure model would be earning budget neutrality credit for implementation of the State's Private Option reform concept. From a healthcare policy perspective, Alaska is interested in this reform in order to smooth transitions in coverage for lower-income Alaskans, engage Medicaid members in the commercial insurance market and to remove disincentives to upward economic mobility. However, without savings offsets, Alaska will spend more to cover targeted Medicaid expansion enrollees through private market coverage. Therefore, leveraging capped expenditure savings offsets to help "pay for" Private Option implementation is the recommended focus of a "reward" methodology, as we will discuss in Section 7 of this paper.

While Tennessee's intended method for managing Medicaid expenditure growth focuses on aggregate rather than per person spending, it is likely that any state "block grant" initiative will be accompanied by eligibility and fiscal management features similar to Utah. Under a "block grant" states could carve sub-aggregations of expenditures into differing buckets, thereby subjecting only a portion of the total Medicaid program to the grant. The state would also need to determine methodologies for projecting cost growth and factoring in variables outside of the State's control, such as periods of significant economic downturn.

In federal "repeal and replace" legislation introduced in Congress in 2017, per capita caps and block grants were presented side by side as options for Medicaid cost management tools for states and the federal government. Alaska should consider these as two methods for achieving the same goal.

Presented with AHCA, BCRA, Utah, New York and Tennessee all as models for how Alaska might approach a capped expenditure initiative, PCG recommends that Alaska consider the option that best accommodates being paired with a Private Option waiver. A major purpose of the expenditure cap will be contributing to the overall budget neutrality model of the 1115 waiver. For this reason, Alaska should seek the method that provides the most flexibility and capability of achieving that goal.

There are several features of New York's "global spending cap" that provide greater flexibility than either a per capita cap or block grant option. Most notably, New York's approach aligns with the Medicaid Redesign structure already in place in Alaska. It makes savings initiatives that are endorsed by stakeholders the focus, rather than singular or multiple cost ceilings. With a focus on a stakeholder process that must succeed to stave off automatic

provider rate cuts, there are greater incentives among broader groups to achieve compliance with the spending target.

As we will reinforce in section 7, PCG recommends New York’s “global spending cap” as the cost containment method that will optimize the state’s budget neutrality effort under a Private Option waiver and best engage stakeholders to help implement reforms.

### 5.3 Cost Impact

A capped expenditure initiative will have a savings impact for Alaska that will impact both state and federal expenditures. Alaska can begin this process by leveraging planned savings in its upcoming budget and using them to establish a cap that shows a positive federal fiscal impact.

#### Role of Spending Cap in Private Option Waiver



Based on the planned budget initiatives, Alaska may pursue a portion of the federal savings to reinvest into the private option program and achieve budget neutrality.

## 6. Health Expense Accounts

Some states with policy goals similar to those included in Alaska's reform concept included a Health Expense Account (HEA) feature as a component of their 1115 demonstration waiver.

Health Expense Accounts (HEAs) are repositories of state funds that may be accessed by consumers to make discretionary healthcare purchases. Some states that have pursued policy goals similar to those identified in Alaska's current reform concept have established HEAs as a component of their 1115 demonstration waiver. Indiana's "Power Accounts" are the most salient example of this. The goals of these accounts are to promote consumer-driven healthcare and healthcare efficiency by creating market-like opportunities for consumers to be purchasers. Health expense accounts permit consumers to weigh healthcare benefits and costs that have a direct impact on them personally. In this way, consumers are incentivized to shop on price and overall value consistent with consumers who are covered in the commercial market. While "health expense accounts" mirror the concept and function of "health savings accounts," they bear a different name because there are key differences. Health expense accounts house public funds that may be accessed by consumers for specific healthcare purposes. However, the funds are not "owned" by the consumer and are not available for consumer investment. Internal Revenue Service (IRS) rules also govern HSAs in ways that do not apply to HEAs.

Below, PCG provides information about three states that implemented and operate Health Expense Accounts as part of a Medicaid 1115 reform waiver. Although Arkansas no longer operates their "Health Independence Accounts", we have provided information on the structure of their program. Due to the short operational time of approximately two years, there is little evidence on the outcomes of the program. Indiana on the other hand has published valuable information and is still currently operating their "Personal Wellness and Responsibility (POWER) Accounts".

### 6.1. Indiana

As part of the Healthy Indiana Plan (HIP), an 1115 Demonstration waiver which affords health insurance coverage to most non-disabled adults who fall at or below 138% FPL, Personal Wellness and Responsibility (POWER) Accounts are established for each HIP participant. Each POWER account has a value of \$2,500 and operates similarly to a Health Savings Account. When a member makes continuous monthly payments to their POWER account, they become enrolled in HIP Plus. HIP Plus plan includes enhanced benefits such as dental and vision coverage. Members who do not make continuous monthly contributions to their POWER account are placed in the HIP Basic Plan which does not include the enhanced services and requires co-payments for most services. Those HIP Plus members who fall below 100% FPL who do not make contributions are placed in the HIP Basic plan, while those HIP Plus members who fall between 100% and 138% FPL who do not make a continuous monthly contribution are disenrolled from HIP all together.

While the state contributes the majority of the \$2,500 value of the POWER accounts, HIP Plus members who are responsible for paying the monthly contribution have a fixed payment amount that is based on income and tobacco use. The contribution amounts are somewhere between \$1 and \$20 (possibly more for tobacco users) as depicted in the chart below.<sup>72</sup> The contributions are paid directly to the member's health plan.

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<sup>72</sup> <https://www.in.gov/fssa/hip/2590.htm>

FPL	Monthly Contribution Single Individual	Monthly Contribution Spouses	Contribution with Tobacco Surcharge	Spouse Contribution When One Has Tobacco Surcharge	Spouse Contribution When Both Have Tobacco Surcharge (each)
<22%	\$1.00	\$1.00	\$1.50	\$1.00 and \$1.50	\$1.50
23-50%	\$5.00	\$2.50	\$7.50	\$2.50 and \$3.75	\$3.75
51-75%	\$10.00	\$5.00	\$15.00	\$5.00 and \$7.50	\$7.50
76-100%	\$15.00	\$7.50	\$22.50	\$7.50 and \$11.25	\$11.25
101-138%	\$20.00	\$10.00	\$30.00	\$10.00 and \$15.00	\$15.00

**Monthly POWER Account Contribution Amounts**

Source: <https://www.in.gov/fssa/hip/2590.htm>

Should a member's annual expenses exceed \$2,500, the first \$2,500 is covered by the member's POWER account, and expenses for additional health services over \$2,500 are fully covered at no additional cost to the member (except in the HIP Basic plan where the member is responsible for any required copayments).<sup>73</sup>

In a study conducted by the LewinGroup for the period of February 1, 2015 through January 31, 2018, it was found that over 90 percent of Plus members made continuous monthly contributions to their POWER account and remained in HIP Plus.<sup>74</sup> Additionally, in the first year, about eight percent of members who had already made at least one contribution to their POWER account to be in HIP Plus did not make a subsequent required contribution and were moved to HIP Basic.<sup>75</sup> Only six percent of HIP Plus members with incomes above poverty were disenrolled from HIP for not making a contribution.

The report found that almost 90 percent of HIP Basic and about 80 percent of HIP Plus members reported that they would be willing to pay \$5 more a month to retain their health insurance. A majority of each would be willing to pay \$10 more a month.<sup>76</sup> Additionally, those HIP Plus members who and have a preventive care visit receive a POWER Account rollover, which reduces the amount of required member contributions during the next benefit period.

<sup>73</sup> IBID

<sup>74</sup> [https://www.in.gov/fssa/files/Lewin\\_IN%20HIP%202%200%20Interim%20Evaluation%20Report\\_FINAL.pdf](https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf)

<sup>75</sup> IBID

<sup>76</sup> <https://www.in.gov/fssa/hip/2590.htm>

## 6.2 Arkansas

The Arkansas Health Care Independence Act of 2013 contained language which called for the development and implementation of “health savings or independence accounts” with required participation by non-aged, non-disabled participants in the Private Option. Following waiver approval and initiation of the Private Option in 2014, the State developed and received federal approval to implement Health Independence Accounts (HIAs), at the initiation of Program Year 2 (January 2015) for individuals between 100 and 138 percent of the federal poverty level (FPL).<sup>77</sup>

The HIAs were designed to serve as a mechanism to provide protection from cost-sharing, promote appropriate healthcare utilization, and offer a mechanism to enable savings for future potential premium exposure. These accounts were also intended for participants to gain knowledge about appropriate healthcare services and how much those services cost and to gain experience paying cost sharing requirements while introducing the concept of paying premiums.

All individuals in Qualified Health Plans (QHPs) between 100 and 138 percent FPL were required to participate and contribute, or a debt to their account would generate. (i.e., \$10 a month for those earning 100 to 117 percent FPL and \$15 a month for those earning 118 to 138 percent FPL). Contribution to the HIA in one month resulted in state-funded cost-sharing protection for the following month. Initial activation of an HIA gained two months’ cost-sharing protection before monthly contributions were required to maintain cost-sharing coverage. The state debited the HIA balance for a failed payment in a given month. The state matched the individual’s contribution up to \$200, if timely payments were made, and balances were allowed to roll over annually. Finally, funds were available for premium payments in the marketplace upon exit from the HIA program.<sup>78</sup> The table below depicts the amount of cost-sharing protections broken down by the service type, the number of individual transactions, the percentage total transactions to the service type and the amount of cost-sharing protections.

Type	Transactions	Percent	Amount
Pharmaceuticals	31,805	61.2%	\$289,522
Physician	9,198	17.7%	\$79,482
Non-MD Clinician	7,339	14.1%	\$59,095
Hospitals	2,884	5.6%	\$41,744
Other	710	1.4%	\$7,000
Total	51,936	100%	\$476,843

**Health Independence Accounts Cost-Sharing Expenditures**

Source: <https://achi.net/wp-content/uploads/2018/01/Arkansas-Health-Care-Independence-Program-Final-Report.pdf>

The Arkansas Department of Human Services cited low participation rates in relation to high costs as the reason the State, through legislative action, opted to end the program in June 2016.<sup>79</sup> At the time, Arkansas had many moving parts to administer in relation to the overall Private Option initiative. Due to the short duration of the program, policy outcomes related to consumer purchasing decisions and the impact those had on healthcare costs were not evaluated.

<sup>77</sup> <https://achi.net/wp-content/uploads/2018/01/Arkansas-Health-Care-Independence-Program-Final-Report.pdf>

<sup>78</sup> IBID

<sup>79</sup> <https://medicaid.mmis.arkansas.gov/Download/general/publicdata/POQrtlyRpt-oct-dec2016.pdf>

### 6.3. Michigan

The Healthy Michigan Section 1115 Waiver introduced MI Health Accounts. Michigan Health Accounts, similar to Health Expense Accounts, are available to individuals with incomes between 100% and 138% of the Federal Poverty Level who are enrolled in the Healthy Michigan Plan and allow them to participate in cost sharing. Individuals contribute up to 2% of their annual income into the MI Health Accounts.<sup>80</sup> The state establishes these accounts, but the individual contributes to the health accounts in place of premium payments to the insurers or copayments to providers.<sup>81</sup>

Payments are made to the Michigan Health Account based on the average copayments for services used the previous six months.<sup>82</sup> Maximus is a third party that adminstrates and managed the MI Helath Accounts.<sup>83</sup>

In Michigan, if an individual participates in healthy behaviors and is above poverty level, they receive a 50% reduction in future premiums. If an individual participates in healthy behaviors and is below poverty level, they receive a \$50 gift card.<sup>84</sup>

Any balance in health accounts will be rolled over at the end of the year to be used in subsequent years. If an individual no longer is qualified to enroll in Medicaid, the money will be available to use to purchase private insurance.<sup>85</sup>

The University of Michigan Institute for Healthcare Policy and Innovation is leading an evaluation of the Healthy Michigan Plan at the direction of CMS. They released a report on the Impact of Cost Sharing in the Healthy Michigan Plan in July of 2018. Some findings from the report are listed below:

- According to the report, one quarter (23%) of all enrollees who owed anything paid in full, about half (48%) of those who owed money made no payments.
- The report also showed that after 6 months of cost sharing (months 7-12 of enrollment), rates of payment dropped. For those who paid at least once, an estimated 65% paid in full for months 7-12 and 56% paid in full for months 13-18.
- People who completed Heath Risk Assessment were more likely to have a preventive visit (84% vs 50%), have a preventive screening (93% vs 71%), and use a co-pay exempt medication to control a chronic disease (66% vs 48%).<sup>86</sup>

In conclusion, the report found that cost-sharing may reduce the amount spent by plans and enrollees on medical services. Lastly, cost-sharing may cause more low-spending people to disenroll.<sup>87</sup>

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<sup>80</sup> [https://www.vumc.org/health-policy/files/health-policy/public\\_files/Health%20Savings%20Accounts%20in%20Medicaid.pdf](https://www.vumc.org/health-policy/files/health-policy/public_files/Health%20Savings%20Accounts%20in%20Medicaid.pdf)

<sup>81</sup> <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>

<sup>82</sup> <https://www.kff.org/medicaid/issue-brief/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana/>

<sup>83</sup> <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>

<sup>84</sup> <https://www.kff.org/medicaid/issue-brief/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana/>

<sup>85</sup> <https://khn.org/news/michigan-to-reward-medicaid-enrollees-who-take-personal-responsibility/>

<sup>86</sup> [https://www.michigan.gov/documents/mdhhs/UM\\_HMP\\_Eval\\_Domain\\_VVI\\_Report\\_7-30\\_Appendix\\_Included\\_629937\\_7.pdf](https://www.michigan.gov/documents/mdhhs/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf)

<sup>87</sup> [https://www.michigan.gov/documents/mdhhs/UM\\_HMP\\_Eval\\_Domain\\_VVI\\_Report\\_7-30\\_Appendix\\_Included\\_629937\\_7.pdf](https://www.michigan.gov/documents/mdhhs/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf)

## 6.4 CMS 1332 Waiver “Account-Based Subsidy” Waiver Concept

Last year CMS leveraged the HEA concept to model a new Section 1332 waiver concept, referred to as an “Account Based Subsidy” waiver concept. Section 1332 waivers, authorized under the Affordable Care Act, permit states to modify Marketplace policy and operational rules subject to federal approval and when consistent with statutory approval parameters. In a Discussion Paper released on November 29, 2018, CMS described the concept as follows:

*In the Waiver Concept C: Account-Based Subsidies waiver option, states would have the flexibility to direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay health insurance premiums or other health care expenses. The account could be primarily funded with pass-through funding made available by waiving the PTC (section 36B of the Code and section 1401 of the PPACA) or the SBTC (section 45R of the Code), along with any additional state funds to implement the 1332 waiver plan. The account could also allow individuals to aggregate funding from additional sources, including individual and employer contributions. An account-based approach, depending on how the state designs the program, could give beneficiaries more choices, improve incentives to make cost-conscious health care spending decisions through the responsibility for managing a health care budget, and better enable them to maintain health coverage regardless of changes in income or other life circumstances. This approach could also allow a consumer greater ability to select a plan based on the individual's or their family's needs, including a higher deductible plan with lower premiums.*

This 1332 waiver model demonstrates CMS' commitment to promoting consumer healthcare expense accounts as a tool for effective administration of state healthcare programs. Under the current federal Administration, Alaska can expect support for an HEA element of a waiver reform concept.

## 7. Roadmap for a Private Option Waiver Concept in Alaska

### 7.1 Recommendation: Develop a private option healthcare program that includes key payment reforms and spending caps

The previous sections of this paper have reviewed each of the major policy components Alaska asked PCG to review as part of our Proof of Concept analysis. These include a Private Option Medicaid 1115 Demonstration Waiver and additional features such as a Block Grant or Per Capita Cap, Reference-Based Pricing and Work Requirements.

The purpose of this section is to bring all those pieces together to make recommendations related to Alaska's Reform Initiative Concept Paper titled, "A Continuum of Coverage for Low-Income Alaskans." The paper described Alaska's interest in achieving several policy reforms, including:

- Provide greater health coverage stability for those with variable incomes
- Eliminate barriers to upward economic mobility
- Smooth cost sharing and premium assistance levels across programs to ease transitions
- Reduce anxiety over the loss of health coverage
- Attract more carriers to the individual insurance market

Each of those policy goals is consistent with the purpose of a Private Option Medicaid waiver under which Health Insurance Marketplace Qualified Health Plans (QHPs) become the delivery system for a portion of the Medicaid Expansion population. The central purpose of a Private Option is to create a shared delivery system across the low-income and middle-income but non-disabled and non-elderly enrollees of Medicaid and the Marketplace. This means as people's income changes, they can keep the health plan in which they are enrolled.

Arkansas' Private Option also increased carrier participation in the individual market. Before 2014, like Alaska, only one health insurance carrier sold plan in the individual market. By 2016, every region of Arkansas had at least five commercial carriers in the individual market.

For these reasons, PCG can recommend and validate that a Private Option is a good policy fit with the goals articulated by Alaska's Reform Initiative Concept Paper. That said, it is well documented through Private Option evaluations completed in Arkansas and New Hampshire that the QHP delivery system is substantially more expensive than fee-for-service or managed care Medicaid. This is the case because QHPs rely on commercial payment rates that are not directly established by the State. Alaska's reform initiative must, therefore, be accompanied by other payment reforms that will counterbalance new costs associated with Private Option implementation.

PCG details our recommendations by providing the following "Q&A" addressing specific questions raised for our consideration in the Proof of Concept statement of work. They are as follows:

**Q: Who should be included in the waiver?**

A: The Arkansas Private Option Special Terms and Conditions (STCs) indicate that "beneficiaries identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in QHPs in this demonstration but can choose to opt into a QHP." Therefore, Alaska should plan to exempt tribal members from this initiative. There is insufficient information from Arkansas to determine what percent of tribal members chose to apply. In our current fiscal impact analysis, PCG has not factored in a tribal enrollment count. The estimate assumes no tribal enrollment at the current time.

The Affordable Care Act (ACA) permits the “medically frail” population to choose between “traditional benefits” under Medicaid or the Alternative Benchmark Plan (ABP) developed for the Medicaid Expansion population. Arkansas attempted to use this provision to further triage higher-risk individuals out of the commercial market to avoid cost pressure on QHP premiums. The percent of total enrollees deemed medically frail by a health assessment screener administered at the point of eligibility in Arkansas was 10 percent. We have assumed the same percentage for our Alaska fiscal impact model. These individuals would remain covered through the traditional fee-for-service benefit program.

Alaska could further restrict Private Option access by income, if desired. One reasonable way to do this would be to limit the waiver only to non-tribal, non-medically frail individuals with incomes between 100% and 138% of poverty. This population shows the greatest current potential for economic mobility that would change their healthcare coverage source from Medicaid to the Marketplace.

However, a significant downside of restricting Private Option enrollment further by income is that reductions in the number of covered lives could also result in additional carriers not being attracted to the market. It will be critical for Alaska to attract at least one additional carrier in non-rural areas of the State to facilitate waiver approval. For this reason, PCG recommends including all enrollees of the Medicaid Expansion who are not tribal members and/or not medically frail.

Arkansas did not include non-expansion MAGI adults in its Private Option because medical costs associated with those individuals are matched at the standard FMAP rate. In this paper, PCG has included that population as participating in the waiver. We have done this to leverage sufficient numbers of enrollees estimated to be necessary to generate new carriers in the Marketplace, which we see as required to gain approval for this waiver, especially in metropolitan areas. We recognize that Alaska will need to carefully consider the state costs of doing this.

Finally, PCG notes the challenge of attempting to “mine” the Medicaid risk pool for members that Medicaid believes would result in cost savings to the State if covered under a Private Option. While some current Marketplace QHP premiums may appear to be less than total costs for specific Medicaid members, QHP premiums would increase if that kind of risk reassignment were pursued. It is also important to remember that current Medicaid fee-for-service costs per member will increase greatly under a QHP due to commercial payment rates. For these reasons, it is not possible to use comparisons of current QHP premiums and Medicaid per member costs by enrollee to guide member reassignment by risk. Actuarial analysis would be required to determine the results of program reassignment by risk factors.

**Q: Would a block grant or per capita cap make a Private Option reform initiative more successful?**

A: Yes, this is the case because Alaska will need expenditure offsets to achieve budget neutrality under the waiver. As we have outlined in this paper, per capita caps, block grants and global spending caps are all differing methods of achieving the same containment of cost growth. PCG recommends a “global cap” method similar to the one implemented by New York State starting in 2012. A portion of the federal savings from the global cap was reinvested to fund New York’s Delivery System Reform Incentive Pool (DSRIP) waiver. New York’s global cap emerged from a Medicaid Redesign initiative similar to the one Alaska implemented in 2016 under Senate Bill 74. Like New York, Alaska could seek to reinvest savings from its Medicaid Redesign into its Private Option reform.

**Q: Would Reference Based Pricing make a Private Option reform initiative more successful?**

A: Yes, because establishing a fee schedule that became the basis of provider reimbursement for the individual market would reduce QHP premiums and make these premiums more affordable for Medicaid. In addition, federal pass-through savings under a 1332 waiver would be achieved as federal premium tax credits decline due to the implementation of the fee schedule. These pass-through savings could be used to further reduce Marketplace premiums. A Reference Based Pricing reform should replace the 80<sup>th</sup> percentile rule, at least for the individual

market. Alaska gathered previous stakeholder input on alternatives to the 80<sup>th</sup> percentile rule, which is noted in this paper as a good source of information for reference-based pricing methodologies.

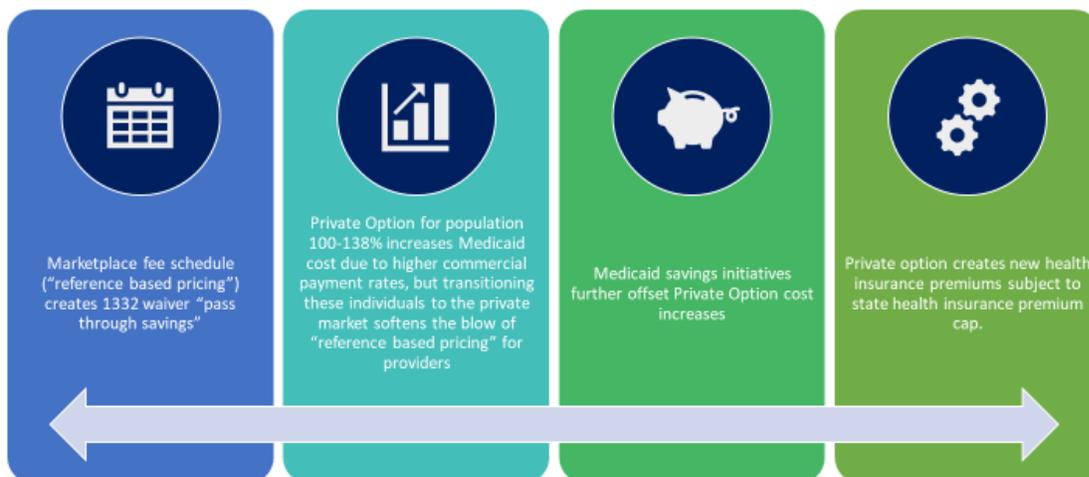
**Q: Would work requirements make a Private Option reform initiative more successful?**

A: Evidence has yet to emerge showing that work requirements result in lowering Medicaid enrollment and reducing cost. For states implementing such waivers, the new administrative costs associated with work requirement reporting and monitoring are formidable. Given the cost pressure, Alaska would already have to manage to undertake a Private Option waiver, PCG does not recommend moving forward with a work requirements waiver simultaneously. Beyond the cost challenge, PCG believes that attempting to implement work requirements and a private option at the same time adds too many new program elements all at once, making operational implementation challenging.

**Q: What Waiver types would be necessary to implement the reform?**

The Private Option would be authorized by CMS under a Medicaid Section 1115 Demonstration Waiver. Reference Based Pricing in the individual market would be authorized under a Section 1332 State Relief and Empowerment Waiver in order to capture federal pass-through savings. Submitted in coordination with each other, the waiver could be the first so called “super waiver” to be considered by CMS and Treasury.

**Combining these elements into 1115/1332 Superwaiver**



## 7.2 Fiscal Impact: Presentation of 4-part cost model

Population	Non-Tribal Member Months	Non-Tribal PMPM	Non-Tribal Expenditures	Non-Medically Frail (NMF) Member Months (90%)	NMF Expenditures (83% of total expenditures)	NMF PMPM	Apply Estimated 53% QHP Cost Differential	Estimated Annual Spending on Non-Medically Frail in QHPs	All Funds Fiscal Impact of Private Option based on FY17 Enrollment	PO State Share Fiscal Impact	PO All Funds Fiscal Impact Assuming RBP at 239% Medicare (50% Savings)	PO State Share Fiscal Impact with RBP at 239% Medicare (50% Savings)	PO All Funds Fiscal Impact Assuming RBP at 170% Medicare (75% Savings)	PO State Share Fiscal Impact with RBP at 170% Medicare (75% Savings)
Medicaid Expansion	248,978	\$799.75	\$199,120,155.50	224,080	\$165,269,729	\$737.55	\$1,128.46	\$252,865,542.49	\$87,595,813.43	\$8,759,581.34	\$43,797,906.71	\$4,379,790.67	\$21,898,953.36	\$2,189,895.34
Non-Expansion MAGI Adults	289,018	\$404.45	\$116,893,330.10	260,116	\$97,021,464	\$372.99	\$570.68	\$148,442,839.89	\$51,421,375.91	\$25,710,687.96	\$25,710,687.96	\$12,855,343.98	\$12,855,343.98	\$6,427,671.99
<b>Total</b>	<b>537,996</b>	<b>\$587.39</b>	<b>\$316,013,470.44</b>	<b>484,196</b>	<b>\$262,291,180</b>	<b>\$541.70</b>	<b>\$828.81</b>	<b>\$401,305,506.11</b>	<b>\$139,014,325.65</b>	<b>\$34,470,269.00</b>	<b>\$69,507,162.82</b>	<b>\$17,235,135.00</b>	<b>\$34,753,581.41</b>	<b>\$6,950,716.28</b>

### **Fiscal Impact Model**

PCG created a Model to show the fiscal impact of a Private Option Waiver Concept. Below are the assumptions PCG made to create the model:

- 1) Tribal members will be excluded from the waiver
- 2) 10% of enrollees will be medically frail and excluded<sup>88</sup>
- 3) Medically Frail account for 17% of cost (based on AR experience)<sup>89</sup>
- 4) Without referenced-based pricing, QHP PMPM will be 53% higher than fee-for-service based on AR experience<sup>90</sup>
- 5) Reference-based Pricing Reform will control cost growth and is modeled here at rates that reduce Private Option costs by 50% and 75%

Non-expansion MAGI Adult information is from the Milliman Alaska Medicaid Data Book.<sup>91</sup>

These factors were applied to FY17 actual enrollment and spending for the Medicaid Expansion population and MAGI Adult populations. The Private Option waiver can be budget neutral is faired with Medicaid Redesign initiatives being included in the demonstration.

*Note: This is not an actuarial analysis. An actuarial analysis may provide different results by assessing the impact on individual market premiums that would result from Medicaid's use of QHPs as a Medicaid delivery system.*

PCG calculated the Non-Tribal Expenditures by multiplying the Non-Tribal Member Months by the Non-Tribal PMPM. The total expenditures for the entire Non-Tribal population is just over \$300 million.

From there, the Non-Medically Frail Member Months was calculated by reducing the Non-Tribal Member Months by 10% to account for the medically frail population that would not enroll in the private option. With the medically frail excluded, the total estimated population for the private option is 40,349 individuals.

Based on the state experience in Arkansas, the medically frail accounted for 17% of total cost. To represent this population cost, PCG calculated the Non-Medically Frail expenditures by taking the Non-Tribal Expenditures and reducing it by 17%. This new Non-Medically frail portion of the Non-Tribal population accounts for 83% of total expenditures. The total cost is estimated to be \$262 million.

The Non-Medically Frail per member per month (PMPM) cost is calculated by dividing the total Non-Medically Frail Expenditures by the member months. The average Non-Medically Frail PMPM for Alaska is estimated to be \$541.70 in the Private Option.

Arkansas experienced a 53% difference in the PMPM under QHPs versus Medicaid. The weighted average QHP PMPM was \$486 while the Medicaid PMPM was \$317.  $(486-317)/317=.53=53\%$ . To represent this difference, PCG increased the Non-Medically Frail PMPM by 53% to show the Estimated QHP Cost Differential. Under this assumption, the average QHP PMPM cost differential is estimated to be \$828.81.

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<sup>88</sup> <https://www.kff.org/report-section/a-look-at-the-private-option-in-arkansas-issue-brief/>

<sup>89</sup> <https://www.kff.org/report-section/a-look-at-the-private-option-in-arkansas-issue-brief/>

<sup>90</sup> <https://achi.net/wp-content/uploads/2017/05/Final-Report-no-appendices.pdf>

<sup>91</sup> <http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/milliman/AlaskaMedicaidDataBookFY16-17.pdf>

The estimated annual spending for the Non-Medically Frail population in QHPs is calculated by multiplying the Estimated QHP cost differential and the Non-Medically Frail member months. The total Estimated Annual spending is just over \$401 million.

To calculate the All Funds Fiscal Impact of the Private Option based on the FY17 enrollment, PCG subtracted the Non-Medically Frail Expenditures from the Estimated Annual Spending on the Non-Medically Frail population in QHPs. This resulted in a fiscal impact of \$139 million. It should be noted that the match rate for Medicaid expansion is 90% and only 50% for the MAGI adults. This results in a much higher state fiscal impact for the non-expansion MAGI adults versus the expansion population.

The Private Option State Share Fiscal Impact was calculated by taking 10% of the All Funds Fiscal Impact of the Private Option based on FY17 Enrollment for the Medicaid expansion population and 50% for the non-expansion MAGI adult population. This scenario resulted in a fiscal impact of \$34.47 million.

Current commercial rate in AK is 353% of Medicare. 239% of Medicare is the halfway point and should reduce Private Option cost by half (50%). 170% is three quarters of the way to 126% and reduces Private Option costs by 75%.

Assuming that referenced-based pricing is 239% of Medicare, expected savings are 50%. PCG calculated the Private Option All Funds Fiscal Impact with referenced-based pricing at 239% of Medicare by multiplying the All Funds Fiscal Impact of the Private Option by 50%. This resulted in a fiscal impact of \$69.5 million.

To calculate the Private Option State Share Fiscal Impact with referenced-based pricing at 239% of Medicare, PCG multiplied the All Funds Fiscal Impact with Referenced-based pricing by 10% for the Medicaid expansion population and 50% for the non-expansion MAGI adult population. This results in a fiscal impact of \$17 million.

Assuming referenced-based pricing is 170% of Medicare, expected savings are 75%. PCG calculated the Private Option All Funds Fiscal Impact assuming referenced-based pricing at 170% of Medicare by multiplying the All Funds Fiscal Impact of Private Option by 25%. This results in an All Funds Fiscal Impact of almost \$35 million.

Lastly, PCG calculated the Private Option State Share Fiscal Impact with Referenced-based Pricing at 170% of Medicare by multiplying the Private Option all Funds Fiscal Impact with referenced-based pricing by 10% for the Medicaid expansion population and 50% for the non-expansion MAGI adult population. This results in a fiscal impact of a little under \$7 million.

With reference-based pricing expected to play a key role in controlling Private Option costs, the purpose of PCG's cost model is simply to demonstrate how that component offsets the projected impact of moving to higher commercial payment rates. We note that this is not an actuarial analysis, which is required to determine how QHP premiums will change based on the risk profile of Medicaid enrollees.

### 7.3 Analysis of Recommendation

Over the past several years, CMS has reiterated its support for states testing new projects designed to reform Medicaid programs and provide coverage to a broader array of individuals. Approvals have been granted for waivers containing a private option for Medicaid enrollees in Arkansas and New Hampshire. Therefore, the groundwork exists for Alaska to move forward with development of a private option to develop a continuum of coverage for low income Alaskans.

While a framework is in place to assist the state with moving forward, Alaska may face some challenges meeting the budget neutrality portion of the waiver. Whereas Arkansas developed a private option in conjunction with Medicaid expansion and used funds to purchase private insurance for enrollees. Likewise, New Hampshire

expanded Medicaid in a slightly different manner and, in the early stages of expansion, allowed eligible individuals to transition to subsidized private coverage. Alaska has an established Medicaid expansion population that has been utilizing services for several years. Therefore, this baseline will be used to determine costs with and without a private option waiver.

Therefore, PCG believes budget neutrality will be a key driver in approval of Alaska's private option. PCG believes that reference based pricing and global cap will be essential features in assisting the state with achieving budget neutrality. Coupled with a private option, Alaska could design a reference-based pricing program that focuses on high dollar services to reduce carrier costs associated with Medicaid expansion enrollees who transition to QHP coverage.

Alaska would need to consider a realizable global expenditure cap on Medicaid expenditures to incorporate into the budget neutrality methodology, similar to New York's Global Medicaid Cap. Alaska would be able to tailor the global cap to a specific subset of Medicaid spending and exclude non-tribal Medicaid Spend. Similar to Alaska, New York was concerned that the rate of Medicaid's expenditures was getting to the point of being unsustainable and established an expenditure cap. They were ultimately able to document \$17.1 billion in federal savings through Medicaid reform efforts and utilize those savings to reinvest in additional reform. A Medicaid global spending cap would assist Alaska in achieving budget neutrality and increase the probability that a waiver would be approved by CMS. Much like New York, Alaska would be able to invest the savings generated by the global cap in other reforms, such as the private option.

Although budget neutrality for the federal government must be demonstrated, Alaska should consider the prospect that a private option may increase costs for the state. First, transferring low utilizers of Medicaid services to a QHP product may result in Alaska paying a per-member-per-month premium that exceeds the amount that would be paid to providers absent the waiver. Second, provider payments in the private market exceed those traditionally paid by Medicaid programs. Therefore, transitioning the Medicaid expansion population into a QHP product may increase future QHP premiums. And third, Alaska must consider the cost of providing wrap-around services for certain individuals who transfer to a QHP product. These increased costs would need to be offset by referenced based pricing and a global expenditure cap.

As stated earlier in the paper, opponents believe block grants and per capita caps would result in arbitrary reductions in benefits and eligibility that would impact healthcare quality due to decreased funding of the Medicaid program. Alaska would need to consider the impact a global expenditure cap may have on benefits and access to care and how to address those concerns in the waiver application. For example, rural areas will most likely be impacted differently than urban areas. While CMS has shown an openness to states using federal savings to reinvest in reforms that promote quality and efficiency within a state, Alaska will need to assure a plan to maintain high-quality healthcare is addressed in a waiver application promoting a private option with global Medicaid growth caps for a specific subset of Medicaid spending.

Alaska has expressed a desire to create a continuum of coverage for low income Alaskans. A private option waiver would assist with that objective. Using Medicaid funds to purchase QHP products would ensure that Medicaid expansion enrollees move seamlessly from Medicaid to a QHP when their income rises above 138% of the FPL. The only noticeable change would be the enrollee would subsequently be responsible for a portion of the monthly premium. Therefore, a member education plan should be developed to ensure Alaskans moving from Medicaid to QHP understand their responsibilities to reduce the chance of loss of coverage.

Early and frequent member education will also achieve Alaska's goal to promote enrollee's connection to healthcare and be better engaged and informed of private healthcare options. Member education will be essential to the success of Alaska's reform initiatives.



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