State Waiver Alternatives to Medicaid Expansion
January 2015

Under the Affordable Care Act (ACA), states have the option to expand Medicaid coverage to individuals typically not eligible for Medicaid. These individuals make too much money for Medicaid, but not enough to participate in the ACA Marketplace- even with subsidy assistance. As of February 1, a total of 28 states and the District of Columbia expanded Medicaid. Twenty-four states expanded Medicaid through the route proposed under the ACA, while five states applied for and received waivers to expand Medicaid in alternative ways. Details about the five states and their alternative plans are below.

APPROVED WAIVERS

Plan Features	Arkansas	Iowa	Michigan	Pennsylvania	Indiana
General Plan	Approved 9/2013- 12/2016 1115 Medicaid funds used by state to pay premiums for newly eligible adults. Beneficiaries do not pay premiums. Approved 12/2014 Amendment to establish Independence Accounts for expanded population.	Two waivers approved 12/2013-12/2016 1) Waiver 1 provides premium assistance for persons above 100% through 138% FPL to purchase qualified health plans (QHPs) in the Marketplace. Beneficiaries with Employer Sponsored Insurance (ESI) receive premium assistance for ESI. Beneficiaries between 100-138% FPL pay $10/month premiums beginning in year 2. Premiums can be waived by healthy behaviors.	Approved 12/2013-12/2018 Beneficiaries 0-138% FPL pay premiums. Beneficiaries 100-138%FPL pay premiums and HSAs. Medicaid benefits provided through managed care plans. Premiums limited to 2% of income for persons above 100%FPL. Premiums and co-pays can be reduced by healthy behaviors. No lock out for non-payment.	Approved: 1/2015-12/2019 No premiums in year 1. In year 2, beneficiaries above 100% FPL pay premiums. No lock out for non-payment. Newly eligible and certain currently eligible persons above 100% FPL pay premiums up to 2% of income. Premiums and co-pays can be reduced by healthy behaviors.	Approved 2/2015- 1/2018 Waiver expands coverage to adults up 138% FPL by adding on to existing 111 waiver, Healthy Indiana Plan (HIP) Bas Plan. Expanded waiver is known as HI or HIP Plus. State contributes to a Personal Wellne and Responsibility (POWER) account f persons enrolled in HIP and HIP 2.0. Individuals with incomes above 100% F are required to make monthly premium contributions to POWER account up to household income. All others may contribute to POWER account, but are not required. Those w do not contribute are enrolled in HIP Ba

		2) Waiver 2 provides premium assistance for Medicaid/Managed Care coverage for at or below 100% FPL. 19-64 aged beneficiaries at 50-100% FPL pay $5/month premium in year 2 although there is no lock out for non-payment.			
Persons Covered	Parents 17-138%Federal Poverty Level (FPL) Childless adults 0-138% FPL	Adults 19-64 above 100-138%FPL in Marketplace. Adults 19-64 at or below 100%FPL in Medicaid managed care.	Adults 19-64, 0-138%FPL. Non-working parents 37-138%FPL. Working parents 64-138% FPL.	Adults 21-64 0-138% FPL. Parents 33-138%FPL. Childless adults 0-138%FPL.	Adults 19-64 with incomes up to 138%I
Cost Sharing	Yes, as allowed by Medicaid for 50-138% FPL population. Cost sharing payments to Health Savings Account based on income approved as part of year 2 amendment. Cost sharing limited to 5% annual income.	Yes as allowed by Medicaid for non-emergency use of ER. Cost-sharing and premiums limited to 5% of income.	Yes all beneficiaries have income-based cost-sharing either through co-payments or contributions to HSAs. Cost-sharing and premiums limited to 5% of income.	Yes all participants have co-payments in year 1. In year 2, participants subject to monthly premiums have co-payment for non-emergency use of ER. All others have co-payments. Cost-sharing is limited to 5% income.	HIP Basic requires co-payments for all services. Persons enrolled in HIP Plus are requi make monthly POWER account contributions and are not subject to cos sharing, except for non-emergency use ER. Non-payment for 100-138% FPL result loss of coverage for 6 months. Non-payment for persons below 100% FPL results in transfer to HIP Basic. Demonstration includes a 2-year test o graduated co-payments for use of ER-S first visit and $25 for re-current non-emergent visits and education and refe to primary care providers.

Consumer Driven Incentives	No	Yes premiums waived in year 1 for completing wellness exams. Premiums waived in subsequent years when beneficiaries complete healthy behavior activities.	Payments to HSAs can be offset by healthy behaviors. Details still under development.	Healthy behavior incentive benefits begin in year 2 when participants can reduce premiums and co-pays for healthy behaviors and timely payments demonstrated in year 1.	Consistent and timely contributions to POWER account are incentivized by enhanced benefits and roll over of unu balance. Receipt of recommended preventive services earns increased POWER account dollars.
Private Insurance/ Marketplace/ Managed Care	Participants enroll in Marketplace Qualified Health Plans (QHPs).	Participants enroll in Marketplace QHPs or Medicaid Managed Care coverage depending on income.	Coverage provided by Managed Care Organizations (MCOs) and Pre-paid Inpatient Health Plans (PIHP).	Beneficiaries covered through private Medicaid managed care plans.	HIP 2.0 beneficiaries receive coverage through a managed care organization t contracts with the state.
Work Requirement	No	No	No	No work requirement. Incentives for job training and work-related activities.	All HIP 2.0 beneficiaries will have a wo search and job training program availa them. There is no requirement for participation.
Health Savings Accounts (HSA)	Independence Accounts (IA) approved as a year 2 amendment. Persons 50-138% FPL contribute cost sharing payments to HSAs consistent with federal regulations.	No	A Michigan, or "MI Health Account" will be set up for each beneficiary to track deposits and health spending. MI Health Account contributions can come from sources including the beneficiary, the state, an employer, or others and pays for out of pocket costs.	No	All beneficiaries may contribute to a POWER account that functions like a H account. Individuals with incomes above 100%F are required to make monthly premium contributions to POWER account. Penalty for non-payment includes disenrollment for 100-138% FPL or cha to HIP Basic with cost sharing for 0-100%FPL.
Benefit Notes	Benefits include 3 month retroactive coverage, non-emergency transportation, early periodic screening, diagnosis and treatment (EPSDT) for 19-20 year olds, and free choice of family planning provider through Medicaid fee for service (FFS) system.	Dental benefits through Alternative Benefits Package (ABP). EPSDT for 19-20 year olds, and free choice of family planning provider through Medicaid fee for service (FFS) system. Medicaid health plan coverage that includes non-	Medicaid ABP based on the ACA 10 Essential Health Benefits. Coverage includes coordination and integration of behavioral and physical health.	Non-emergency medical transportation waived for 2015. Benefit available in 2016. Benefits include 3 month retroactive coverage and free choice of family planning provider.	HIP Plus and HIP Basic beneficiaries w have a full Alternative Benefit Plan (AB with access to essential health benefits

		emergency medical transportation has been waived through July 31, 2015.			
Key Concepts	Accountability, personal responsibility, transparency, and encourages responsible choices. Continuity of care and access.	Individual responsibility for personal health. Continuity of coverage. Promotes access to care and encourage healthy behaviors.	Reduce numbers of uninsured. Reduce uncompensated care. Encourage healthy behaviors.	Personal responsibility. Improve healthy behaviors. Cost conscious use of healthcare. Prevention and wellness. Quality and efficiency of care.	Personal responsibility. Cost conscious consumer behaviors. Improve healthy behaviors. Increased access Quality of care.

STATES TO WATCH - Alaska, Idaho, Montana, Utah, and Wyoming

The Republican governors of these states support a customized and alternative form of coverage expansion. They have outlined expansion plans and are currently working with their respective state legislatures to secure the approval required to submit a formal proposal to the Centers for Medicare and Medicaid Services (CMS) in the form of an 1115 waiver.