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States May See Earliest Opportunities to Alter Health Care Landscape

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While the titans on Capitol Hill clash over the best answer to the Affordable Care Act (ACA), the Trump administration is promoting action at the state level that could produce meaningful impact soon. Health industry stakeholders—from health insurers to behavioral care providers and from post-acute and long-term care providers to Medicaid managed care organizations—should watch for, and help shape, opportunities as well as threats likely to emerge in the states.

Most headlines on health policy right now concern efforts of Republicans in Congress to "repeal and replace" the ACA and to radically alter the way the federal government contributes to the cost of Medicaid. Our view, and consensus among knowledgeable observers, is that legislation in its current form is unlikely to be enacted in the near term.

Within the House Republican caucus, Speaker Paul Ryan faces a rebellion from vocal conservative members who perceive his American Health Care Act as perpetuating an unsustainable entitlement. At the same time, moderates in the caucus are chilled by the Congressional Budget Office's finding that the bill, as written, would create 24 million more uninsured people by 2026. Even if a bill passes out of the House, it will face major hurdles in the Senate.

It appears that more immediate and consequential action could come out of the states that take up a pair of invitations issued by the executive branch. With Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma freshly confirmed on March 13, Health and Human Services (HHS) Secretary Tom Price sent two significant messages to states in "Dear Governor" letters.

The first letter, dated March 13, suggested that states should seek waivers under Section 1332 of the ACA to "strengthen their health insurance markets." The letter cited Alaska's application to implement a high-risk pool/reinsurance program, meant to help sustain the state's sole insurer selling plans on the ACA marketplace. To date, only Hawaii has received a 1332 waiver; it exempted the state from relatively minor requirements pertaining to small employers that interfered with a state program that predated the ACA.

The second letter, released March 14, invited states to innovate within their Medicaid programs—in effect, to deviate more from current federal structures on Medicaid design and operation. The stated aim is to "best use taxpayer dollars to serve the truly vulnerable."

The March 14 letter proposed a number of ways that states could expect a warm federal response, such as:

- Encouraging employment and skill building among low-income non-disabled adults—an approach intended to assist "low-income adult beneficiaries to improve their economic standing . . ."

- Waivers of requirements to provide non-emergency medical transportation—presumably, to persons other than pregnant women and the frail elderly, as in Indiana, Verma's home state

- Modifying Medicaid benefit designs to look more like private insurance, such as with premium requirements, health savings accounts, and copayments—again, as Indiana does in its Medicaid expansion program

- Waivers of presumptive eligibility and retroactive coverage—provisions that help hospitals gain compensation for some people who lack insurance coverage on presenting for emergency care

As an incentive, the March 14 letter promised streamlined processing by CMS of state plan amendments and waiver applications. However, the letter also makes clear that the principle of budget neutrality in waiver programs will be upheld.

The letter further stated that HHS/CMS will give states more time to comply with the January 2014 rule on Home- and Community-Based Services, offered as alternatives to nursing facilities for beneficiaries in need of long-term services and supports (LTSS). Finally, the letter offered support for states seeking to improve services to treat people with substance use disorders, a response to the growing opioid epidemic.

While the letters say nothing about Medicare, it is conceivable that Medicare could be implicated if states try to push new ideas for dual eligibles. People dually eligible for Medicare and Medicaid comprise just one-sixth of the Medicare population and one-seventh of Medicaid, but they account for fully one-third of both programs' spending. States are eager to rein in costs of LTSS, which dual eligibles use in great volumes and for which Medicaid, not Medicare, is the primary payer. Will CMS be open to waiver proposals that constrain beneficiaries' freedom of choice on the Medicare side, currently not an option?

Also not mentioned in either letter, but hinted at in other communications from the administration, is a possible rollback of the Medicaid managed care rule that took effect in April 2016. Also speculated upon is the potential for loosened enforcement of the Mental Health Parity and Addiction Equity Act.

Taken broadly, it seems that the federal government is now giving states a wider license to act. Health industry actors often can influence policy change more rapidly at the state level and then watch those changes snowball as states copy others' innovations.

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