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New Approaches to Medicaid Expansions in the New Administration



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Alexander Graham Bell famously remarked, "Whenever one door closes, another opens." Surely that will be the case for health-care investing fueled by Medicaid expansion, even after portions of the Affordable Care Act (ACA) have been repealed and, in some cases, replaced.

A qualification before we continue: No one can say for sure whether Congress will or will not repeal the Medicaid expansion feature of the Affordable Care Act. However, most knowledgeable observers believe Congress will not act precipitously to take coverage away from the estimated 8.5 million Americans who were newly made eligible for Medicaid in the 32 states (including Washington, DC) that have expanded Medicaid. And even though the federal government's share of expansion cost is due to drop steadily from 100 percent in 2016 to 90 percent in 2020, states still see considerable economic upside from expansion.

Significantly, the state option to expand Medicaid coverage to previously uninsured adults with incomes from 101-138 percent of the federal poverty level (FPL) is one door that may not close. And in certain respects it may open wider.

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It is conceivable that some of the 19 states that did not embrace Medicaid expansion during the era of the Obama administration will do so now. It total, there are more than 6 million people who could gain Medicaid eligibility if all 19 states were to expand. Tennessee, Florida, Utah and North Carolina are a few examples of states where the impetus to expand is known to be strong. Though at least for hospitals, the benefits of expansion know no boundaries. One scholarly study found that after just one full year post-implementation, uncompensated care in hospitals in expansion states equaled just 3.1 percent of operating costs, while in non-expansion states uncompensated care amounted to 5.7 percent of operating costs.[1]

There is another reason that conservatives may hesitate to cut Medicaid expansion and might, under the right conditions, help it to grow: A fair number of members of the National Guard and Reserves are among those people who stand to benefit. The military only covers health care for National Guard and Reserves while on active duty or for brief periods following active duty. Otherwise, many work in jobs that do not offer health insurance.

The door that may open when the Trump administration settles in, with HHS under the stewardship of Secretary-designate Tom Price, will be expansion—or ACA expansion conversions—featuring attributes favored by conservatives. Expect to see adoption, state by state, of principles of "personal responsibility" and "consumer driven care." These changes could be facilitated through legislation, but, in the interim, the Centers for Medicare and Medicaid Services (CMS) could use its existing Section 1115 waiver authority to approve pending and new expansion initiatives.

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The CMS Administrator designee Seema Verma built her reputation on a Medicaid expansion by Section 1115 waiver. She was instrumental in designing Vice President-elect Pence's Healthy Indiana Plan 2.0 covering all nondisabled adults aged 19-64 with incomes up to 138 percent FPL.

''Personal responsibility'' will be the watchword for both new Medicaid expansions and Medicaid reforms impacting nonexpansion population segments. Personal responsibility requirements may manifest in the form of financial contributions, healthy behaviors and work-related requirements.

Financial contributions could take the form of sliding scale premiums (e.g., 2 percent of income) for at least the nonmedically frail expansion beneficiaries. Responsibility is enforced by, after a grace period, disenrolling those who do not pay the premiums for several months running. Then, to protect against the possibility that people would instantly re-enroll and pay the premium when they have an emergent medical need, there would be a six-month to one-year waiting period before eligibility is reinstated.

Enrollees' engagement in healthy behaviors might be judged by analyzing claims or encounter data to see whether newly covered individuals obtain preventive health services appropriate to their age and sex. Those who meet the standard might receive extra benefits or a reduction of their required financial contributions.

Personal responsibility may also feature a work requirement—either a minimum number of hours of employment as in Kentucky's pending Section 1115 waiver request or at least participation in job training and/or proof of efforts to find employment. Personal responsibility changes could impact not just expansion enrollees but also traditional nondisabled enrollees such as parents.

We can expect CMS to approve by Section 1115 waiver and Congress potentially to codify in law programs that offer Medicaid premium assistance for low-wage workers to purchase employer-sponsored insurance. The Indiana plan has a feature for state-funded assistance for the premiums, copays and deductibles in employer plans, aimed at transitioning Medicaid enrollees to private insurance.

Therein may lie open doors/opportunities. In the Republican-led states that have already expanded using Section 1115 waivers, expansion enrollees almost always have been placed into managed care organizations rather than in fee-for-service Medicaid. With all states now having to contribute a percentage of the cost of expansion, the pressure to place enrollees into full-risk-bearing plans grows ever stronger. State legislatures always want budget predictability, if not certitude. Plus, Verma is understood to have worked constructively with the managed care industry.

Private insurance plans and managed care organizations could see new enrollees thanks to Medicaid expansions in states not yet having expanded, as well as the addition of premium assistance features to existing Medicaid programs. Private plans potentially enjoying the upside could be insurer-run or provider-sponsored. Many provider-sponsored plans will outsource key business process functions. So investors will see opportunities to back some plans directly and to back a range of providers of outsourcing services to other health plans.

Helen Keller, a fan of Alexander Graham Bell, added a codicil to his closed door, open door remark. She noted that ''often we look so long at the closed door that we do not see the one which has been opened for us.'' As health lawyers and policy strategists, we would do well to heed this advice. We should explore the interesting opportunities presented in Section 1115 waivers and forthcoming legislation that seek to attain some of the same coverage goals by way of different means and incentives.

NOTES

[1] David Dranove, Craig Garthwaite and Christopher Ody, ''Uncompensated Care Decreased at Hospitals in Medicaid Expansion States But Not at Hospitals in Nonexpansion States,'' Health Affairs, August 2016, vol. 35, no. 8, 1471-1479.

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