HMA

HEALTH MANAGEMENT ASSOCIATES

Implications and Options for State-Funded and Medicaid Expansion Coverage Programs Under Health Reform

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INTRODUCTION

A number of states and the District of Columbia currently administer health coverage programs for low-income uninsured individuals who either exceed maximum Medicaid income eligibility thresholds or who are not categorically eligible for the Medicaid program—such as childless adults. These programs were created using Medicaid state plan authority, Medicaid waivers, state-only funds or a combination of mechanisms. Examples of such programs are the Alliance program in the District of Columbia, MinnesotaCare in Minnesota and Basic Health in Washington.

In anticipation of full implementation of health reform on January 1, 2014, states that administer these programs have important decisions to make, as the majority of individuals currently covered through these programs will be eligible for other coverage pursuant to the Patient Protection and Affordable Care Act (ACA).[1]

For individuals with family income below 138 percent of the federal poverty level (FPL), a thoughtful process will need to take place to answer several questions, including whether the funding currently allocated to these programs can be leveraged to transition enrollees into Medicaid sooner than 2014, how to accomplish this and options for reprogramming funds toward other unmet needs when additional federal funding becomes available.

Individuals with family income between 138 and 400 percent of the FPL will be eligible for federal subsidies to purchase private coverage in state- or federally-run health insurance exchanges (the "Exchange"). States may also choose to pool the Exchange's federal premium and cost-sharing subsidies for people with income below 200 percent of the FPL and not eligible for Medicaid, and establish a "Basic Health Program" under Section 1331 of the ACA. State fiscal considerations, potential impact on the Exchange and ability to support the state's overall goals with respect to access, coverage, health and wellness, are all important considerations that states need to address when exploring the basic health program option.

This issue brief reviews the objectives and structure of 11 existing health coverage programs in six states and documents the legal, technical and policy issues the states are already addressing, or need to address, as they review options for transitioning program enrollees to new coverage options. It also presents possibilities for new uses of state dollars freed up by the infusion of federal funds in 2014.

[1] P.L. 111-148 and P.L. 111-152

BACKGROUND

State Health Care Coverage Programs

A wide range of health care coverage programs are currently operated by the states. This issue brief examines selected programs in the District of Columbia, Maryland, Minnesota, New York, Oklahoma and Washington. Key characteristics of these programs are provided in Table 1. In some cases, the table represents a snapshot of the programs when the ACA was enacted, and may not reflect the changes states have already implemented in preparation for 2014.

For the purpose of this project, a "coverage program" is defined as including state programs that either expand direct coverage (e.g., to childless adults) or offer premium assistance to low-income, uninsured residents. While a range of coverage initiatives are offered across the country, this report focuses on these two options because their enrollees are most likely to move to Medicaid or subsidized Exchange coverage.[2] The states examined in this report were selected using the following criteria:

- **Type of Coverage Program.** State health care coverage programs can range from coverage expansions to premium subsidies to high risk pools. Coverage expansions typically extend either Medicaid coverage or slightly less comprehensive benefits to additional populations, while premium subsidies are a defined contribution by the state toward the purchase of either private insurance or, in the case of one state, a state-administered plan option. One state combines a high-risk pool for those who are otherwise unable to buy coverage with a state-funded premium subsidy. In total, we examined 11 programs in 6 states. Because some programs have more than one type of approach under their umbrella, the case studies feature seven coverage programs, five programs that use premium subsidies, and one high-risk pool.
- **Funding Sources.** Some states rely on federal funding (through **S**ection 1115 waivers or state plan amendments) to support their health care coverage programs. Other states rely on state-only financing, which may come from general fund revenues, special state assessments, or a specific earmarked tax. As they prepare for 2014, states may face specific issues tied to how the programs are currently funded. General Fund revenue and tobacco or hospital assessments were the most common sources of funding for the selected programs.
- **Benefits Package.** States also differ in the benefit packages they offer under their coverage expansions. Some states offer a comprehensive benefit package based on the state Medicaid benefits package or on a specific benefit set offered by private plans, while others offer limited benefit packages (e.g., primary care only). Of the programs studied, seven offer full benefits, three offer limited benefits,

[2] For example, this report does not include state programs that offer tax credits to employers that offer health insurance to low-income employees, as this is a less direct form of coverage. It also does not include programs operated at the county or local level because these are less likely to have direct applicability for states, and due to the sheer complexity of data/information collection across multiple counties/localities.

and one offers benefits that vary because the program subsidizes a variety of employer plans

- **Post-Reform Eligibility.** This criterion, which is tied to income eligibility levels for existing state programs, provides information about the kind of coverage for which current enrollees will be eligible under health reform. In all of the states studied, current enrollees will be eligible for either Medicaid or Exchange-based coverage in 2014.
- **Income Eligibility Limit.** The 11 health care coverage programs examined here target maximum income levels ranging from 50 percent of the FPL to over 400 percent of the FPL. The income levels of enrollees in these programs will determine whether the enrollees will qualify for Medicaid coverage, Basic Health Program coverage, or subsidized coverage in an Exchange in 2014.
- **Geographic Diversity.** States were selected in part to reflect regional variations across the United States, though the case studies should not be viewed as representative of all states. States from the Northeast, Southeast, Midwest, and West were interviewed to capture any impacts for which a state's geographic location may play a role.

Table 1. Key Characteristics of Selected State Programs

For Maryland and New York, current eligibility levels are shown. All others are as of enactment of the ACA.

Name of Program	Type of Program	Target Population	Income Limit	1115 Waiver or State-Funded Program	Benefit Package	Source of State Funds
District of Columbia						
DC Healthcare Alliance	Coverage	Childless Adults	200% FPL	District-Funded	Limited	General Fund
Section 1115 Childless Adults Waiver	Coverage	Childless Adults	50% FPL	Section 1115 Waiver	Limited	General Fund
Maryland						
Primary Adult Care (PAC)	Coverage	Parents and Childless Adults	116% FPL	Section 1115 Waiver	Limited	General fund
Maryland Health Insurance Partnership	Premium Subsidy	Small businesses (2 to 9 employees) with an average employee sala-	No limit, but employees seeking dependent coverage	State-Funded	Varies	Information not available

Name of Program	Type of Program	Target Population	Income Limit	1115 Waiver or State-Funded Program	Benefit Package	Source of State Funds
		ry of less than $50,000	must not make more than $75,000			
Maryland Health Insurance Plan	High-Risk Pool, with Premium Subsidy for low-income individuals	Individuals denied coverage in individual market based on health status	No limit, with premium subsidies up to 300% FPL	State-Funded	Full	Hospital Rate Assessment
Minnesota						
Minnesota-Care	Coverage	Parents and childless adults	Parents up to 275% FPL or $57,500; childless adults up to 250% FPL	Section 1115 Waiver	Full, but with $10,000 annual inpatient limit	Provider taxes
New York						
Family Health Plus	Coverage or Premium Subsidy	Parents and Childless Adults	Parents - 150% FPL Childless Adults - 100% FPL%	Section 1115 Waiver	Full	Funding pool that includes General Fund and tobacco tax revenue
Child Health Plus	Coverage	Children	400% FPL, with buy-in option for children in families above 400% FPL	Both	Full	Funding pool that includes General Fund and tobacco tax revenue
Oklahoma						
Insure Oklahoma – Individual Plan	Insurance Subsidy	Working adults (and those seek-	200% FPL	Section 1115 Waiver	Full	Tobacco tax

Name of Program	Type of Program	Target Population	Income Limit	1115 Waiver or State-Funded Pro-gram	Benefit Pack-age	Source of State Funds
		ing em-ployment), college stu-dents and dependent children not eligible for SoonerCare				
Insure Okla-homa - ESI	Insurance Subsidy	Employers with less than 100 employees	200% FPL	Section 1115 Waiver	Full	Tobacco tax
Washington						
Basic Health Plan	Coverage	Parents and Childless Adults	200% FPL	State-Funded	Full	General fund

Opportunities under the Affordable Care Act

The Affordable Care Act (ACA) presents several opportunities for states that have already implemented expanded coverage programs.

Early Medicaid Expansion

Section 2001 of the ACA provides states the option of expanding their Medicaid programs early to cover populations that will be eligible for Medicaid in 2014 using a state plan amendment rather than a waiver. States can set eligibility for new coverage groups at any level up to 138[3] percent of poverty, as long as the state does not cover higher income people before covering lower income people. States that take up this early expansion option receive their current matching rate for the newly covered population but will still receive the higher matching rate for newly eligible enrollees[4] once the 2014 Medicaid expansion takes place. States are not required to implement the Modified Adjusted Gross Income (MAGI)-based method for calculating income eligibility until 2014.

[3] §2201(a)(1)(C) of the ACA specifies that childless adults are Medicaid-eligible with incomes at or below 133 percent FPL. However, §2002(a)(14)(I)(i) of ACA adds a five percentage point deduction from the FPL when calculating income to determine eligibility for Medicaid. This five percent disregard makes the Medicaid eligibility threshold effectively 138 percent FPL. States are not required to use this disregard until 2014, but in the meantime must use "methods of determining income that are reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests of the beneficiary," per State Medicaid Director Letter # 10-005, April 9, 2010 (http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10005.PDF).

[4] The matching rate for newly eligible Medicaid enrollees will be 100% for 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% for 2020 and subsequent years.

The ACA requires states to provide benchmark or benchmark-equivalent coverage described in section 2001(c) of the ACA for the early expansion population, except for those exempt from mandatory enrollment in a benchmark benefit plan[5], who must receive the benefits defined by the State's currently approved plan.[6]

Federal Exchange Subsidies

Sections 1401-1402 of the ACA establish that through the state-based or federally-run Exchanges, the federal government will provide tax credits to reduce insurance premium costs for people between 138 and 400 percent of poverty, and cost-sharing assistance for deductibles and copayments for those up to 250 percent of poverty, starting in 2014. People whose employer-sponsored coverage is not affordable (defined as having an actuarial value of less than 60 percent or premiums that exceed 9.5 percent of the employee's income) will also be able to buy coverage through either federal or state-administered Health Insurance Exchanges and qualify for subsidies.

The premium tax credit will be structured such that the premium for the second lowest cost "silver" level plan would not exceed the following income percentages:

Table 2. Limitations on Premium Costs in the Exchange, by Income Level

Income Level	Premium as a Percent of Income
Up to 133% FPL	2% of income
133-150% FPL	3 – 4% of income
150-200% FPL	4 – 6.3% of income
200-250% FPL	6.3 – 8.05% of income
250-300% FPL	8.05 – 9.5% of income
300-400% FPL	9.5% of income

For cost-sharing, subsidies will bring plan actuarial value up to the following limits:

Table 3. Actuarial Value by Income Level

Income Level	Actuarial Value
100-150% FPL	94%
150-200% FPL	87%
200-250% FPL	73%

The ACA also limits total out-of-pocket cost-sharing for the essential benefits, based on the out-of-pocket limits for Health Savings Account-qualified health plans, which were $5,950 for single coverage and $11,900 for families in 2010 (the limits will be adjusted according to changes in the Consumer Price Index until 2014 and indexed to changes in the

[5] Including pregnant women, blind or disabled individuals, and others listed in Section 1937(a)(2)(B) of the Social Security Act.

[6] U.S. Department of Health and Human Services, "New Option for Coverage of Individuals under Medicaid," State Medicaid Director Letter # 10-005, April 9, 2010.

cost of health insurance thereafter). For people at or below 400 percent of poverty, out-of-pocket costs will be capped as follows[7]:

Table 4. Reduction in Out-of-Pocket Liability by Income Level

Income Level	Reduction in Out-of-Pocket Liability
100-200% FPL	Two-thirds of the maximum
200-300% FPL	One-half of the maximum
300-400% FPL	One-third of the maximum

The reductions in cost-sharing will be accomplished through subsidies to insurers to compensate for reductions in their requirements for consumer cost-sharing, rather than by directly subsidizing consumers as in the case of the premium subsidies.

Basic Health Program

Section 1331 of the ACA allows states to establish a Basic Health Program for low-income individuals as an alternative to obtaining health coverage through the Exchange. Two groups are eligible for the basic health program:

- Adults with income between 138 and 200 percent of the FPL
- Legal immigrants with income less than or equal to 138 percent of the FPL (who are not eligible for Medicaid based on immigration status)

If a state implements a Basic Health Program, eligible individuals will not be able to obtain subsidized coverage in the Exchange. The state will receive 95 percent of the premium tax credits and cost-sharing reductions that would have otherwise been provided for coverage in the Exchange. The state will use this money to contract with one or more health plans or providers to offer Basic Health Program benefits and services, which must include at least the essential benefits package. Premiums and cost-sharing for Basic Health Program enrollees cannot be any greater than the amount for which they would have been responsible if coverage were obtained through the Exchange.

States must bid Basic Health Program contracts competitively and consider at least the following in the procurement process: innovation, performance measures, managed care concepts and the special needs of enrollees. The contracted plans will be required to maintain a medical loss ratio of at least 85 percent.

FINDINGS

This analysis is drawn from interviews with state Medicaid agency officials and other staff in the District of Columbia, Maryland, Minnesota, New York, Oklahoma and Washington during mid- to late-2011 (see Appendix B for complete interview guides used in

[7] The Patient Protection and Affordable Care Act, Sections 1401-2; "Explaining Health Care Reform: Questions About Health Insurance Subsidies," publication #7962-02 (Washington, DC: The Henry J. Kaiser Family Foundation, April 2010).

discussions with states). A number of common themes emerged that reflect the shared context for state decision-making on coverage programs.

States are planning for 2014 with a variety of goals in mind. These include:

- **Continuity of coverage:** Ensuring smooth transitions between Medicaid, Exchange coverage, and basic health programs is a major concern and priority for states. To promote continuity, some states are considering requiring that all plans, or all plans in the Exchange, also do business in Medicaid. Others may consider requiring Exchange plans to participate in a basic health program. However, states are keenly aware that many plans do not have experience serving Medicaid populations and their willingness and preparedness to do so will vary. In addition to continuity of coverage, states are also concerned with the availability and continuity of provider networks in the new coverage landscape.
- **Creating robust exchanges:** States also place a high priority on attracting enough insurers for the Exchange and basic health programs (if they are considering offering one) to ensure that consumers have a choice of high-quality plans. They are also considering the potential impact of a basic health program on the size and composition of the Exchange, in addition to the operational issues associated with establishing a basic health program. States also raised the possibility of combining Medicaid and basic health program funding to create a single program for people below 200 percent of poverty. These dynamics will continue to play out as states develop their plans for 2014 and as additional federal guidance is released.
- **Streamlining eligibility**: States recognize the need to align and coordinate eligibility standards and processes across programs leading up to 2014. Multiple states noted the need to implement the MAGI income definition required by the ACA, and some states also noted that their eligibility technology systems will be overhauled before 2014.
- **Affordability:** Achieving and maintaining affordability is a major goal for states. While people moving to Medicaid from state-funded or waiver programs will typically gain richer benefits at a lower cost to them, people moving to Exchange coverage from state-funded or waiver programs will likely face higher cost-sharing in Exchanges. Some states may opt to design a basic health program benefit that is intermediate between the two, and some are considering wrap-around subsidies for lower-income people in the Exchange. Other states said that budget constraints would probably not permit them to offer additional Exchange subsidies.
- **Promoting universal coverage:** States highlighted the importance of making coverage available to all. In considering potential program changes, states are examining what coverage gaps will remain after the 2014 coverage expansion, and what will be the most effective and feasible strategies—from both a fiscal and political point of view—to fill them. In addition to adjusting their coverage programs, some states may finance safety net care for populations that remain uninsured with block grants to safety net providers.

States have had limited time and bandwidth for a close focus on the future of state health care coverage programs and opportunities under the ACA. At the time of these interviews (Summer to late Fall 2011), many states were focused intensively on Exchange planning, though all had begun exploring options for their coverage programs and some had commissioned and received analyses of their options. Three of the states interviewed for this paper were among the seven recipients of "Early Innovator" grants to develop the information technology infrastructure necessary to establish their Exchanges. One state highlighted that this application process and project implementation in particular had required substantial time investment. State staff continue to be stretched thin, and more than one state noted that the success of ACA implementation depends upon state staff capacity.

States were also continuing to struggle to close budget gaps, and Medicaid agencies were frequently drawn into these challenges. In some cases these developments affected state-funded coverage program policies and waivers, as well as the core Medicaid programs. Minnesota even experienced a brief government shutdown during Fall 2011. At the beginning of 2011, some states also went through administration transitions following the many gubernatorial elections that took place in 2010, and these transitions may have slowed or complicated planning efforts.

In many states, all options are on the table for coverage programs. States have many analyses under way, and some already completed, that will help them decide on and implement policy changes. However, even where findings are already available, most have not yet been translated into policy. Multiple states recently renewed Medicaid waivers through the end of 2013 and do not anticipate major changes in their coverage programs before then. Some states are further along in their planning than others, but all still need to make many important decisions about their coverage programs.

States also noted that political factors, including support for the ACA (or lack thereof), are influencing the range of policy options they are considering. The history of state coverage programs—especially for programs that have been particularly popular—is also a consideration as states determine how to modify them. States will seek to preserve the options and features that have proven successful, and they may seek additional flexibility from the Department of Health and Human Services (HHS) beyond the options laid out in the ACA if that turns out to be necessary.

Programs that might otherwise be at risk of termination are being maintained as a critical bridge to 2014. The expectation that the populations covered by waivers and state-funded programs will gain coverage in 2014, in combination with the early Medicaid expansion option, has helped sustain some programs as a transition to the coverage expansion. In Washington, for example, Basic Health was nearly eliminated due to the state's budget situation, but a scaled-back incarnation of the program was preserved as the result of a successful waiver application that described it as a short-term bridge to national health care reform. As a result the program will receive federal matching funds until 2014.

Some states have already taken steps to transition people into Medicaid, while others are maintaining the current structure of programs until 2014. Of the six states interviewed, Minnesota and Washington, D.C., have implemented early Medicaid expansions since the passage of the ACA. None of the other states plan to do so before 2014.

In the District of Columbia, the DC Alliance program was greatly reduced in size after the District expanded Medicaid to cover many of its members. The program also secured a new waiver that covered still more of its members, potentially extending its financial sustainability because it was left with a smaller number of people to cover using a similar amount of funding. However, multiple states also noted that when state-funded programs shrink as a result of the coverage expansion, the programs may become easy targets for elimination.

Fiscal considerations also influenced state decisions not to implement an early Medicaid expansion. Some states were reluctant to create a new entitlement in their difficult budgetary environments, and considered an early Medicaid expansion to be potentially too costly. Current state-funded or waiver programs often have less comprehensive benefits than Medicaid or allow cost-sharing, which Medicaid prohibits. Washington opted to apply for a Medicaid waiver for its state-only program rather than develop an early Medicaid expansion state plan amendment in an effort to maintain coverage for those in its state-funded program without creating a new entitlement or having to modify existing benefits or cost-sharing.

States varied in their responses to the ACA's Maintenance of Eligibility (MOE) requirement, which largely prohibits the reduction of adult Medicaid eligibility until Exchanges are operational and altogether prohibits the reduction of Children's Health Insurance Program eligibility until 2019. Some states reported that the MOE requirement had not affected their decision-making, while in at least one state, the MOE requirement served to discourage an early Medicaid expansion. However, Washington, D.C., proceeded with its early Medicaid expansion despite the MOE requirement, acknowledging that it would have one less option for cost-containment until 2014.

A variety of policy considerations are influencing state decisions about the Basic Health Program. States are aware that they may need to make decisions on the program soon so that any necessary enabling legislation can be introduced in the next state legislative session. They are analyzing the potential impact of a Basic Health Program on the Exchange and other programs, taking into consideration the following issues:

- **Churn[8] and how to address it**: States see the Basic Health Program as a possible way to reduce breaks in coverage for people who would be near the threshold of Medicaid and Exchange eligibility (though they note that a new threshold would be created between the Basic Health Program and the Exchange at 200 percent of poverty). States also suggested that Medicaid managed care plans could offer coverage in a basic health option, further promoting coverage continuity.

[8] The term "churn" refers to movement back and forth between different types of coverage, for example Medicaid and private coverage, or between having Medicaid coverage and being uninsured, particularly for people who are near the Medicaid eligibility income threshold and may have frequent changes in income.

- **Continuity of care:** In addition to promoting continuity of coverage, a Basic Health Program could promote continuity of care by using a similar provider network to Medicaid, thereby reducing the need for enrollees to change providers after moving from one source of coverage to the other.
- **Exchange participation, leverage and risk pool:** States that are already analyzing the potential impact of a Basic Health Program on an Exchange have estimated that the program could draw a substantial number of people away from the Exchange. The population that selects Basic Health coverage may be less healthy than the remaining Exchange risk pool, resulting in a better risk profile and lower premiums in the Exchange than would otherwise occur; however, reducing the overall size of the Exchange could discourage some plans from participating and limit its market leverage to a degree that limits its long-term sustainability. To avoid this type of scenario, states may consider requirements for Exchange plan participation in Medicaid managed care, as well as risk adjustment between the two programs.
- **Administrative complexity:** While administrative complexity was not viewed as a defining concern, states did raise the expectation that establishing a Basic Health Program would add a layer of administrative complexity to eligibility determinations, require additional attention to technology system interfaces, and potentially require the state to create a new set of benefits in addition to the Medicaid, Exchange, and any remaining state-funded program benefits.

States are examining ways to assure continuity of care for low-income populations. States reported considering requirements that the same plans that serve Medicaid participate in a Basic Health Program and/or the Exchange (or conversely, setting requirements for Exchange plan participation in Medicaid managed care; however, as mentioned earlier, states are wary of forcing plans with Medicaid expertise to broaden their scope to the commercial market or of unintentionally discouraging commercial plans from Exchange participation because they lack expertise with low-income populations). States raised longstanding concerns about the adequacy of provider networks, and some noted that they would consider using any surplus funding to increase provider rates in order to promote network expansions.

Political realities may make it difficult for states to maintain current programs for those who are likely "to fall through the cracks" under the ACA. States expect their state-funded programs to shrink substantially once the ACA's coverage expansion takes place in 2014, and in some cases the coverage shifts that have already taken place have dramatically reduced the size of these programs. The remaining enrollment in state-funded coverage may be limited to populations for whom there is little political support (e.g., undocumented immigrants). Accordingly, pressure to eliminate such programs may increase. States may consider redirecting some funding to the providers that serve such populations in order to support access to care, particularly since safety net providers will already face significant reductions in their federal payments for uncompensated care under health reform.

There are still many areas where the states are waiting for key guidance from the federal government. All states highlighted the Essential Health Benefits (EHB) as an area

where they needed additional federal guidance to proceed in developing their benefit packages and estimating the costs of covering their populations in the various coverage options. While the guidance released since December 2011 may help states begin to narrow down their options and preferred approaches, states are still dependent on further federal-level guidance. Additionally, eligibility coordination between Medicaid and the Exchange is still a major area of uncertainty, even after the release of final rules in early 2012.

Current state economic conditions mean any state funding that is freed up by the reduction and/or elimination of state-funded programs is likely to used to fill budget holes, although this may change if state fiscal conditions improve. Potential uses of any funding that might be newly available as a result of state program changes has not been a major focus for states. However, states with programs that are funded with a provider assessment or tobacco tax rather than from state general funds noted that these programs have been less vulnerable to cuts, and these states may have more flexibility and independence in redirecting state dollars in 2014.

To the extent that states are considering other uses of funds from state health programs, options range from shoring up the safety net to raising primary care physician rates under Medicaid. While states typically felt it was premature to predict potential uses of any newly-available funds, they did mention several options, including:

- Raising provider rates (though this was often raised as a hypothetical rather than an inevitable--or even likely--outcome)
- Wraparound subsidies for Exchange coverage
- Subsidies for coverage for pregnant women
- Additional funding for a Basic Health Program
- Subsidizing the cost to the state of requiring benefits beyond the EHB in the Exchange
- Supporting safety net providers

SELECTED STATE CASE STUDIES

District of Columbia

The HealthCare Alliance Program

The HealthCare Alliance (the "Alliance") is a health care coverage expansion program in Washington, D.C. Created in 2001, the program provides a comprehensive benefit package to low-income, uninsured residents who are not eligible for Medicaid. It is financed with District-only general funds and, before the District's recent Medicaid expansion, covered non-disabled childless adults under 200 percent of the FPL.

Covered benefits under the Alliance include preventive services, primary care, clinic services, hospital care, emergency care, immunizations, physician services and prescription drugs. Mental health services, long-term care and non-emergency transportation are not covered. The same managed care organizations that serve the Medicaid population administer the program's benefits, and enrollees are subject to little or no cost-sharing.

Preparing for 2014: Expanding Coverage

After passage of the ACA in March 2010, the District immediately set out to leverage federal financing available for many of the populations covered under its Alliance program and to get as many people into Medicaid as possible. The District was among the first to take advantage of the ACA's SPA option, which allows states to expand Medicaid eligibility to adults with incomes under 138 percent of the FPL without regard to disability or other status. Often referred to as the "early adopter" option under Section 1902(k)(2) of the Social Security Act, this section allowed the District to shift 30,000 individuals from the Alliance to Medicaid. The move resulted in a more comprehensive benefit package for affected enrollees and is saving the District money.

At the same time that it pursued an early Medicaid expansion, the District also sought federal approval of a Section 1115 waiver that would provide full Medicaid benefits to many of the higher-income Alliance enrollees who would have otherwise remained on the program. The waiver was approved by CMS in November 2010 and covers eligible childless adults with incomes between 133 and 200 percent of the FPL. The waiver does not expire until the end of 2013, and in combination with the early adopter SPA, it covers populations previously getting care under waivers for low-income individuals with HIV and low-income childless adults aged 50 to 64. The waiver is not subject to an enrollment cap and provides full Medicaid benefits.

Table 5. Childless Adult Coverage Pre-ACA

	DC HealthCare Alliance	Program to Enhance Medicaid Access for Low-Income HIV-Infected Individuals	DC 1115 for Childless Adults
Covered Population	Non-disabled childless adults and undocumented District	HIV positive individuals	Non-disabled childless adults age 50-64

	residents		
Income Eligibility	Up to 200% FPL	Up to 100% FPL	Up to 50% FPL
Enrollment	57,000	300	1,500

Table 6. Childless Adult Coverage Post-ACA

	DC HealthCare Alliance	1902(k)(2) SPA	Section 1115 Waiver
Covered Population	Undocumented District residents	Childless Adults	Childless Adults
Income Eligibility	Up to 200% FPL	Up to 133% FPL	133-200% FPL
Enrollment	24,000	40,000	3,200

In planning for the transition of Alliance enrollees to Medicaid, the District's Department of Human Services compared Alliance enrollment files with files from the Social Security Administration to see how many individuals would meet Medicaid's citizenship requirements. It also tightened the Alliance program's eligibility criteria to ensure individuals eligible for Medicaid could not default into the Alliance program. Given that Medicaid benefits are more expansive than Alliance benefits, but the delivery system is the same, the transition was relatively smooth from a policy perspective. The biggest hurdles were administrative: the District had trouble reaching out to the population that could be transitioning to Medicaid, because they were often hard to contact by mail or phone. The District relied in part on the provider community to reach out to this population, contacting all providers to inform them about the transition and relying on provider records for the most recent contact information for eligible individuals. Posters were also created for placement in provider offices. Additionally, those who transitioned to Medicaid were required to verify citizenship or eligible residency status, which sometimes proved to be a significant burden, and those unable to verify their Medicaid eligible status remained in the Alliance.

The District continues to move forward with health reform implementation activities. These include the development of a new integrated health and human services eligibility system as part of Exchange planning efforts. On the horizon, the District will need to determine whether the childless adults covered under the new Section 1115 waiver will move to the Exchange in 2014 or to some other coverage mechanism. A variety of analyses are under way to facilitate this decision, including an examination of the Basic Health Program and its potential impact on the Exchange. With the exception of participating in a federal Exchange, all options "are on the table". The District is examining the option of providing wrap-around subsidies to low-income populations in the Exchange.

The District considers itself a "pro-coverage" jurisdiction that prioritizes access and comprehensive benefits. Conversations around health care reform have thus revolved around opportunities to address the consequences of churn and ways to smooth the transition between different coverage options as an individual's income changes. The District intends to ensure that individuals do not lose access to coverage or to their providers as they move from coverage option to coverage option. To accomplish this, stakeholders are

very interested in bridging the potential gap between Medicaid coverage and coverage under the Exchange. For this reason, and to broaden the risk pool of the Exchange[9], the District is considering a requirement that all health plans doing business in the District serve the Medicaid population. These discussions are very preliminary, and commercial health plans are pushing back. The District will be examining the legal and policy implications of such a requirement more closely in the near future.

Maintenance of Eligibility

Overall, the Medicaid Maintenance of Eligibility (MOE) requirements have had little to no impact on policy decisions in the District. The District moved populations from the Alliance program, which is state-funded and not subject to MOE requirements, to Medicaid, where MOE applies. Although the MOE requirements mean that the District will have one less option for containing costs going forward, it did not elect to include any enrollment caps or similar provisions in the waiver that would allow it to shrink enrollment if necessary due to budgetary pressures.

Implications of Health Reform on Program Enrollees

With respect to the changes that have already been made, affected populations are enjoying a more generous benefit package—including pharmacy and transportation—by the same basic delivery system. Most people moved from one managed care program to another managed care program, and the same health plans participate in both programs. The previous HIV waiver population is the only population to become newly enrolled in managed care.

After the early adopter SPA and Section 1115 waiver, the Alliance has become a much smaller program—covering populations that, due to citizenship or other status, do not qualify for Medicaid. With a smaller population and related drop in expenses, officials indicate that this program will probably benefit "from a longer lifeline" because it should not need to cover as many people. However, sustaining funding for the program has become a challenge because the remaining enrollees are predominantly people who would not be eligible for Medicaid or other coverage.

The District does not anticipate many people moving from Alliance coverage to the Exchange in 2014 but does recognize that individuals currently covered under the new Section 1115 waiver will be eligible for the Exchange. The District has not yet analyzed the differences in benefits and cost-sharing between waiver coverage and commercial coverage under the Exchange, but it is examining the costs of providing a wrap-around premium subsidy to this population or establishing a Basic Health Program.

Options for Reprogramming Newly Available State Funds

Moving individuals from the Alliance program to Medicaid under the early adopter SPA and the Section 1115 waiver is already saving the District money, and the transition is estimated to result in total cost savings of approximately $66 million over the next four

[9] The District of Columbia does not have large numbers of uninsured that will be looking to the Exchange for coverage in 2014.

years.[10] For a population that used to be covered with district-only dollars, the District is now able to draw down federal money at a matching rate of 70 percent. Beginning in 2014, this rate will increase to 100 percent under the ACA. Currently, the federal matching dollars are being used to offset gaps in the Medicaid budget created by the expiration of the enhanced federal match that was available under the Stimulus Package. Any additional savings in the future will also likely be used to fill Medicaid or other budget needs.

When asked whether the district has analyzed other ways in which health reform will free up state dollars, the District indicated that it had not yet done so formally. Staff does believe some programs run by the Department of Health, such as mental health services, will see savings.

The district has considered transforming the Alliance program from a coverage program to a grant program for safety net providers. The remaining Alliance population is rather transient and typically enters the system when they are sick. Instead of a capitated benefit program, one option would be to provide grants to the core safety net providers that serve the Alliance population. In exchange, they would serve any patient who comes through the door. This would constitute a shift in existing funding rather than the use of new funding.

Maryland

Primary Adult Care, the Maryland Health Insurance Partnership and the Maryland Health Insurance Plan

Maryland has at least three health coverage programs subsidized in whole or in part with state funds that will experience changes upon implementation of health care reform in 2014. These programs are Primary Adult Care (PAC), the Maryland Health Insurance Partnership (the "Partnership") and the Maryland Health Insurance Plan (MHIP).

PAC is a limited benefit plan for childless adults with incomes up to 116 percent of the FPL. It covers emergencies, primary care, prescription medications, and outpatient specialty substance abuse services, but it does not cover inpatient hospital or other specialty services. PAC was established in 2006 under a Section 1115 waiver and currently covers 60,000 individuals. Existing Medicaid managed care plans can participate in PAC, and five out of the seven plans do.

The Partnership was created in 2007 to help Maryland's small businesses offer health insurance to their employees. The state will pay up to half the cost of health insurance to qualifying small businesses.[11] At the end of 2010, there were 350 small businesses and 1,450 individuals participating in the Partnership.[12]

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[10] D.C. Department of Health Care Finance. "DHCF Expands Medicaid Program" (August 6, 2010), available at http://newsroom.dc.gov/show.aspx/agency/dhcf/section/2/release/20289/year/2010/month/8.

[11] Average employee wage must be under $50,000 for the employer. An employee seeking coverage for dependents must have income below $75,000.

[12] Maryland Health Care Reform Coordinating Council. Final Report and Recommendations (January 1, 2011), available at http://dhmh.maryland.gov/healthreform/html/finalreport.html.

MHIP is the country's third largest high-risk pool and the fastest growing. It was created in 2003 and now covers over 20,000 individuals, representing more than 10 percent of the state's individual market.[13] Individuals who cannot purchase affordable coverage elsewhere, due to their health status, are eligible for MHIP, and individuals with incomes less than 300 percent of the FPL receive state subsidies to help them purchase the coverage. MHIP existed before the creation of federal high-risk pools under the Affordable Care Act. MHIP now enrolls individuals in its federal high-risk pool if they are eligible and continues to offer a "state" product for individuals who cannot qualify for the federal product (typically because the individuals have not gone without health insurance for at least six months or are undocumented).

MHIP is funded through a hospital assessment levied through Maryland's all-payer hospital rate-setting system. In the most recent year, the assessment generated approximately $114 million in funding.

Preparing for 2014

Maryland acknowledges being farther along in its efforts to prepare for 2014 than other states but knows that it still has a long way to go. Key goals that are guiding the state as it prepares for full implementation of health reform include:

- Ensuring everyone who is eligible for insurance becomes insured
- Bending the cost curve, in part to ensure that people with employer-sponsored health coverage also experience the benefits of health reform
- Reducing health disparities
- Creating a sustainable model for the Exchange, for Medicaid and for commercial insurance

While these are Maryland's primary goals, other objectives such as supporting an adequate provider network are also important.

Individuals now eligible for PAC, which covers individuals with incomes under 116 percent of the FPL, will become entitled to full Medicaid benefits under the coverage expansion in 2014. The Partnership will be replaced by the ACA's small business tax credits.[14] MHIP will become obsolete after the ACA is fully implemented in 2014.[15] These populations will be able to purchase community-rated insurance under the Exchange or move into Medicaid.

Maryland is discussing the option of creating a Basic Health Program for those with incomes between 138 percent of the FPL and 200 percent of the FPL as an alternative to Exchange coverage.

With respect to the question about financial exposure and potential loss of leverage for the Exchange should a Basic Health Program be implemented, Maryland is thinking through a number of issues. For example, spreading operational costs across a smaller

[13] *Ibid.*
[14] *Ibid*.
[15] *Ibid*.

population is one issue. The ability to attract and negotiate with insurance carriers also becomes an issue when a large group is removed from the Exchange. With fewer people, the Exchange may lose its ability compete with insurance sold outside of the Exchange. It may also experience adverse selection or selection bias in terms of the kinds of carriers participating inside and outside of the Exchange.

If Maryland opts for Exchange coverage instead of offering a Basic Health Program for individuals with incomes between 138 percent of the FPL and 200 percent of the FPL, it is not likely to seriously consider offering state subsidies on top of the federal subsidies available to this population. The only context where the state might consider offering a subsidy would be for pregnant women between 138 percent of the FPL and 185 percent of the FPL who might otherwise switch to Medicaid during pregnancy and their post-partum period. Providing a subsidy in these cases would help these women keep their current insurance coverage.

Maryland is also working through other issues associated with health reform. The state's insurance market is currently heavily underwritten, and when the high-risk, high-cost individuals in MHIP are combined with the rest of the individual market in a community-rated system, many individuals will see sharp spikes in their insurance premiums. The state is considering offering reinsurance or risk corridors to try to mitigate the anticipated rise in premiums.

PAC, the Partnership and MHIP are all governed by Maryland state law and rely in part on state-mandated provider assessments. These laws will require revision to the extent the programs become obsolete or change in 2014.

Maintenance of Eligibility

Medicaid's MOE requirements did play a role in decisions that Maryland has already made about PAC. In its last Section 1115 waiver renewal negotiation, the state inserted a provision that will allow the state to impose an enrollment cap. Though the state currently has no plans to make changes to PAC, it believes, based on Arizona's unsuccessful attempt to roll back Medicaid coverage, that such a provision was necessary to give the state the flexibility it might need to react to future pressures on its budget.

Implications of Health Reform on Program Enrollees

PAC enrollees will experience a much more generous benefit package when they shift from PAC coverage to Medicaid in 2014. How benefits will change for other populations in state-funded programs such as the Partnership and MHIP is not yet clear. The state is examining how closely the benefits in these programs resemble commercial coverage, and whether and how premiums, benefits and cost-sharing would change under the Exchange or in a Basic Health Program.

Undocumented immigrants are currently eligible for coverage under the MHIP high-risk pool, but their coverage options may change starting in 2014. Maryland is engaging in very preliminary discussions about whether MHIP will be maintained in a scaled back form for this population, or whether funds currently being expended on this population should be diverted in other ways—such as supporting safety net providers who care for them.

Options for Reprogramming Newly Available State Funds

Implementation of the ACA is estimated to save Maryland between $622 million and $1.036 billion over the next 10 years, with much of the savings attributable to freed-up hospital assessment revenue that will no longer be needed to subsidize MHIP after the program is phased out (or down) in 2014, along with savings the state will realize as PAC (currently funded with a 50/50 state/federal matching structure) becomes a Medicaid expansion (with 100 percent federal funds for the first three years).[16] Although the state is a long way from making any decisions about alternate uses of state funds freed up by health reform, there are a few popular options. The options include: 1) providing state reinsurance or risk corridors to reduce the cost of insurance under the Exchange; 2) increasing Medicaid reimbursement rates to assure adequate provider participation in Medicaid, particularly for primary care; 3) supporting safety net providers who care for populations that will be uninsured in 2014, as well as providers of benefits that are not included in the essential health benefit package, such as residential services (whether with grant funding or another strategy); and 4) reducing costs for taxpayers and other payers by reducing assessments currently collected or other taxes.

[16] Maryland Health Care Reform Coordinating Council. Interim Report and Recommendations (July 26, 2010), Appendix F, available at http://dhmh.maryland.gov/healthreform/html/interimreport.html.

Minnesota

MinnesotaCare

Established in 1992, MinnesotaCare is a waiver program for families with children and for childless adults that covers approximately 147,000 people. MinnesotaCare covers children under age 21 to 275 percent of the FPL; parents up to 275 percent of the FPL or $50,000 annual income, whichever is less; and childless adults up to 250 percent of the FPL.

The Minnesota Legislature approved an early Medicaid expansion to include childless adults up to 75 percent of the FPL in 2010, when the state-financed General Assistance Medical Care program (GAMC), which had previously covered this income group, faced significant funding reductions. In January 2011, the incoming governor issued an executive order implementing the early Medicaid expansion, which took effect in March 2011, and the GAMC program ended completely in February of that year. Because the expansion population was moving from the then-state-funded portion of GAMC or MinnesotaCare (MinnesotaCare enrollees paid premiums), the state did not incur additional costs by moving them to Medicaid because the federal match offset the cost differences. Minnesota did not pursue an early expansion up to 133 percent of poverty for budgetary reasons, though its fiscal situation has improved dramatically since the time of that decision.[17] In August 2011, Minnesota received approval for federal matching payments for MinnesotaCare childless adults between 75 and 250 percent of poverty, making this previously state-funded component (i.e., the component covering childless adults) of the program federally funded.

Effective July 2012 until health reform takes effect, childless adults in Minnesota with income between 200 and 250 percent of poverty will be able to choose to receive a defined contribution to use toward purchasing a health plan in the state's individual market instead of receiving health benefits directly from MinnesotaCare. The amount of an enrollee's defined amount will be determined on a sliding scale based on age and income. There are few specific parameters for the benefits that must be included or excluded in the plans enrollees may purchase with their defined benefits. The state will seek federal matching funds but plans to implement the change to a defined contribution regardless of federal financial participation. There are now relatively few individuals with solely state-funded coverage remaining in Minnesota's coverage programs.

Preparing for 2014

Minnesota is currently considering all options for the populations now covered by the MinnesotaCare waiver, who may or may not be eligible for Medicaid in 2014, depending on federal maintenance of eligibility requirements. This includes children, parents, and childless adults with incomes above the yet-to-be-determined MAGI equivalent state plan income limits. All Minnesota waivers will be in effect through December 2013, making further substantial changes before that time unlikely. A Basic Health Program, Exchange coverage, or Exchange coverage with a wrap-around are all potential options that

[17] Condon P, "Good news: Minnesota expects $876 million surplus," The Associated Press, December 1, 2011. http://news.yahoo.com/good-news-minnesota-expects-876-million-surplus-162544182.html

the administration and the legislature may consider. Though the state is still in the early stages of analyzing options for transitioning coverage, the health insurance Exchange planning staff commissioned economic and actuarial modeling of the ACA on the state's insurance markets.[18] The study estimated that almost 300,000 people would gain coverage under the ACA and that the state Exchange could have more than 1.1 million users. The potential demographics of the population that would participate in a Basic Health Program option, and the impact of a Basic Health Program on the remaining Exchange market, are important considerations. The commissioned actuarial analysis found that the population between 133 and 200 percent of poverty would have higher health risks than higher-income populations, meaning that separating this population could lower premiums in the remaining market (though this would mean the Basic Health Program would consist of higher-risk, higher-cost enrollees). Whether the state realized savings from the Basic Health Program would depend on the specific design of the program.

Minnesota has estimated that its Medicaid enrollment will increase by 16 percent, or 95,000, in 2014 under the ACA.[19] The new populations gaining Medicaid coverage will include childless adults between 75 and 133 percent of poverty, parents between 100 and 133 percent of poverty, and disabled people who currently "spend down" their income to 75 percent of poverty when their high medical costs are subtracted from their income. The state will be examining whether to maintain its optional Medicaid eligibility categories given the new coverage options that will be available under health reform. For example, the state will need to evaluate whether there is overlap between the coverage provided by its medically needy program or family planning waiver and coverage available through a Basic Health Program and/or the Exchange.

The state will consider how to facilitate transitions between different types of coverage to provide as seamless an experience as possible across the insurance affordability coverage options. Another priority is to ensure that people in different parts of the market will have sufficient choice of plans. There are currently three large health plans that participate in both the Medicaid managed care and commercial markets, which will position the state well to provide seamless options to enrollees who will be changing coverage. Provider network coverage and continuity of care will also be a priority, and Medicaid staff are working with their Exchange planning counterparts on strategies to encourage continuity of care at the provider level. If the Minnesota were to establish a Basic Health Program, the state would look for opportunities to incorporate delivery system and payment reforms that are already being developed and implemented. These reforms include competitive bidding in Medicaid managed care, as well as payment and care models that allow providers to share financial risk and benefits.

Maintenance of Eligibility

Maintenance of eligibility requirements in Medicaid and CHIP will be a key consideration for Minnesota's coverage of children in particular, including whether the state establishes a basic health program. The state is evaluating where it will be able to set its eligi-

[18] Gruber J and Gorman B, "2014-16 Market Analysis Study: Implications for a Basic Health Plan," presentation to discussion hosted by Human Services Commissioner Lucinda Jesson, November 18, 2011. http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs16_165329.pdf

[19] http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs16_165330.pdf

bility levels for children while complying with the maintenance of eligibility requirements in the ACA. For example, if children aged two to 18 must be maintained in the Medicaid waiver portion of MinnesotaCare up to 275 percent of poverty, they would not be eligible to participate in a Basic Health Program. However, if the state could set eligibility at 150 percent of poverty, as defined in its state plan, a larger group of children could move to the Basic Health Program, which would improve the composition of the risk pool and decrease the average cost of coverage in the program.

Implications of Health Reform for Program Enrollees

Like all states, Minnesota is awaiting further federal guidance on the essential health benefits. The state plans to analyze its mandated benefits to determine the extent to which it can align benefits in the Exchange and Medicaid, in order to avoid major disruptions in coverage for people transitioning between the two. The state would also need to consider how to align Basic Health Program benefits with Medicaid to minimize disruptions between those programs.

The current Medicaid expansion population receives full Medicaid benefits, but since the state would have the opportunity to design benefits for the population over 133 percent in a Basic Health Program, it would evaluate their needs and potentially design a benefit package that differs from commercial coverage. For example, because transportation needs are a potential barrier to care for many people in Minnesota, transportation services might be a valuable benefit to include for the Basic Health Program population. Mental health coverage is another area the state will examine, since childless adults newly eligible for Medicaid and other coverage may be particularly likely to need these services. Minnesota will be looking at Medicaid benefits, benchmark options, and state employee coverage to evaluate what benefits would be appropriate and how they could be aligned across programs.

Options for Reprogramming Newly Available State Funds

Because Minnesota is still analyzing its options for coverage programs in 2014, it is not yet clear whether any state funding will be newly available or where such funding might be needed. Potential uses of funding include deficit reduction (depending on the state's fiscal condition); the provision of wrap-around services; and the financing of a Basic Health Program if the state pursues that option.

Financial sustainability of coverage programs is a key consideration in planning for reform. The mechanism by which the Centers for Medicare and Medicaid Services calculates risk adjustment for the Basic Health Program option will be an important issue in determining the likely financial viability and sustainability of a Basic Health Program in Minnesota.

New York

Family Health Plus Medicaid Waiver and Child Health Plus (CHIP) Programs

New York's Family Health Plus program, which was implemented as a Medicaid 1115 waiver in 2001, currently covers 402,610 people, including parents up to 150 percent of the FPL and childless adults up to 100 percent of the FPL. The program provides full benefits that are less comprehensive than traditional Medicaid, and it is funded with about $488 million in federal funding and $651 million in state funds. Child Health Plus, New York's CHIP program, provides comprehensive benefits to over 400,000 children up to 400 percent of poverty. Families pay a monthly premium on a sliding scale based on income. A buy-in option is available above 400 percent of poverty at the full cost of coverage. The program also has a solely state-funded component that covers approximately 45,000 children who are otherwise ineligible for Medicaid or CHIP.

Preparing for 2014

New York's health reform planning focused on preparation for establishing a health insurance Exchange, including information technology development and efforts to enact Exchange legislation (the Exchange was subsequently established by executive order of the Governor). As one of seven states that received an "Early Innovator" grant in February 2011 to design and implement the information technology infrastructure necessary for an Exchange, New York has devoted a great deal of energy to this topic.

The Medicaid waiver under which Family Health Plus operates was recently renewed through 2014, making it unlikely that any substantial changes to the program will occur before the 2014 Medicaid expansion under health reform. The Family Health Plus component of the waiver will expire on December 31, 2013, and by July 2012 New York must develop a transition plan for the Family Health Plus population that will not be covered by Medicaid starting in 2014 (i.e., enrollees between 133 percent and 150 percent of poverty).

New York is currently analyzing whether to establish a Basic Health Program to cover people who are above Medicaid eligibility but below 200 percent of poverty. One major consideration will be whether a Basic Health Program would draw too many people away from the Exchange risk pool, the success of which is a major priority for the State. Continuity of coverage for people who would be near the 133 percent of poverty threshold is another consideration, because Medicaid plans that might not have the capabilities to become Exchange plans might find a BHP to be a better fit and could potentially provide seamless coverage for people moving between Medicaid and a BHP. If New York does decide to establish a BHP, it would be likely to start in 2014.

Maintenance of Eligibility

New York is unlikely to make major changes to its coverage programs prior to 2014, and the existence of the maintenance of eligibility requirements in the ACA have likely helped to prevent Family Health Plus eligibility from being cut.

Implications of Health Reform on Program Enrollees

People transitioning to the Exchange from Family Health Plus, and eventually from Child Health Plus when the CHIP maintenance of eligibility provision expires, would face a transition to higher cost-sharing and most likely a reduced benefit package. A Basic Health Program might provide a middle ground between Exchange and Medicaid coverage, if the state opts to establish one.

New York is analyzing the benchmark choices for the Essential Health Benefits that were described in the federal guidance bulletin issued in December 2011. The State will also examine whether to merge the individual and group markets within the Exchange and whether to standardize benefits within and outside the Exchange.

Options for Reprogramming Newly Available State Funds

New York has not yet fully explored potential alternative uses of any state funds that would be newly available as a result of the ACA coverage expansion, but the state would examine several possibilities if the overall state budget situation permits (currently, any savings would probably be used to help fill other needs in the state budget). Potential uses the state might consider, probably in combination with state budget savings, include subsidizing the cost to the state of providing benefits above the Essential Health Benefits in the Exchange.

Oklahoma

Insure Oklahoma

Insure Oklahoma is a premium assistance program established in 2005 that serves just under 33,000 people. The Insure Oklahoma employer-sponsored insurance program (IO-ESI) provides a subsidy (similar to the refundable tax credits that will be available under the ACA) to individuals who meet income criteria and are employed by a qualified employer that offers insurance. Qualified employers must have fewer than 100 employees (previously limited to 50 or fewer employees). The other component of the program, the Insure Oklahoma Individual Plan (IO-IP) is a health plan operated directly by the state, without the involvement of commercial plans, for people who would qualify for IO-ESI except that they do not have access to insurance through their employer. Participants must still be employed, and they pay sliding scale premiums based on income as well as some copays. Both IO-EDI and IO-IP were implemented under a Medicaid 1115 waiver that has been renewed several times, undergoing modifications along the way. Income limits for both programs are 200 percent of the FPL for adults and children. Insure Oklahoma has legislative authority to increase adult eligibility to 250 percent of poverty, to expand child eligibility to 300 percent of poverty, and to include larger employers having up to 250 employees, but has not yet done so. As of mid-2011, the program was close to reaching its enrollment cap of 35,000. Roughly 60 percent of enrollees are in the employer portion of the program, though enrollment in the individual portion has been growing more rapidly.

Preparing for 2014

Insure Oklahoma enrollees will be eligible for either Medicaid or the Exchange in 2014. The state is considering all options available under health reform, including establishing a Basic Health Program; however, the state will most likely move all Insure Oklahoma enrollees above 133 percent of poverty to the Exchange or continue the current IO-IP program in its present form, if possible. The state would need to evaluate potential costs of the Basic Health Program. The IO-IP product is more affordable for enrollees than Exchange coverage is likely to be, another factor the state will consider, given the overall popularity of the Insure Oklahoma program. If the IO-IP program continues in any form, eligibility will need to be de-linked from employment status, and would need to be aligned with MAGI as described in the ACA.

Making an IO-IP option available in the Exchange is another possibility, though Oklahoma's political environment makes such a scenario unlikely. Health plans in the state may oppose the offering of an IO-IP plan in which the state would provide the insurance package without contracting with a commercial insurer, since the coverage would effectively be a public option competitor. Conversely, plans may favor this option because the IO-IP program is currently subject to a certain amount of adverse selection, attracting people with increased health care needs and risks and taking them out of the commercial market pool.

Oklahoma noted that an IO-IP option run by the state could help address churning issues at the Medicaid eligibility threshold and could also be made available to people at higher incomes in the Exchange, potentially spanning a wide range of enrollee incomes, which could enhance the financial viability of the program and broaden its risk pool. Medicaid and Insure Oklahoma enrollees are currently in the same system, helping to create continuity of coverage between the two populations. In addition, the state uses a rolling 12-month certification period, so each time an enrollee makes a change to their record (e.g., switching to a different primary care provider), they can initiate a new 12-month eligibility period by answering a few additional questions. State legislative authority would be necessary to make the IO-IP plan more widely available, but it is unclear what if any additional federal approval would be required. There is currently virtually no private individual insurance market in Oklahoma, making the role of an IO-IP-type public product more attractive, even once an Exchange exists.

Oklahoma's current coverage policies address many gaps in coverage, which will ease the state's transition to the ACA's coverage expansion. Remaining coverage gaps include employees of large companies (i.e., those with more than 99 employees) that do not offer coverage and undocumented residents. Insure Oklahoma's enrollee surveys show very high rates of satisfaction with the program, and its popularity will be a consideration in the decision on whether to convert it to a Basic Health Program.

Oklahoma highlighted a technical issue that has arisen for states with substantial Native American populations, which is that federal law does not permit any cost-sharing for Native American children. Additionally, Native American adults may not be assessed cost-sharing for any contracted services provided through an Indian Health Service/ Tribal Health Center / Urban Indian Clinic (I/T/U) facility. This rule applies to the IO-IP program, and it could be extremely complex for states to implement in exchanges if it is con-

tinued under the ACA. Oklahoma noted that in general, the ease of the transition to a post-2014 coverage structure will depend on the availability of state resources to work on the many technical and policy issues involved.

Maintenance of Eligibility

Maintenance of eligibility requirements do not apply to the Insure Oklahoma program, though the state is not planning to make any reductions in the program prior to 2014, other than adhering to the enrollment cap that was established by agreement with CMS. Insure Oklahoma is very popular, is supported by a tobacco tax rather than general revenue, and is viewed within the state as an important program that addresses a key gap in the availability of affordable coverage.

Implications of Health Reform on Program Enrollees

Insure Oklahoma enrollees moving to Medicaid will transition to a more comprehensive benefit package, without cost-sharing requirements. For those above the Medicaid threshold moving to the Exchange, premiums would likely increase for the IO-IP enrollees and remain comparable for the IO-ESI group. The Insure Oklahoma benefit packages are designed to be consistent with commercial offerings, so the state does not anticipate that there would be dramatic benefit changes for people transitioning to the Exchange. There have not been discussions of the possibility of offering enhanced subsidies to enrollees in the Exchange.

Options for Reprogramming Newly Available State Funds

Oklahoma currently spends between $35 and $40 million annually in state tobacco tax funds on Insure Oklahoma. It will be relieved of all this spending when enrollees transition to Medicaid and the Exchange. If the funding were instead available to Medicaid, the state's priorities would be to potentially address provider network issues through higher Medicaid rates or other mechanisms. A study of the adequacy of states' primary care capacity to provide access following the Medicaid expansion in 2014 found that Oklahoma was the least prepared of all states, suggesting that strengthening provider networks will be a key challenge.[20] Oklahoma's Medicaid rates are currently relatively high--96.75 percent of Medicare rates, reduced from 100 percent as of April 1, 2010--so rate increases alone probably will not be sufficient to address provider network adequacy challenges. It is also possible that the funding would be used to cover additional benefits or enhance existing ones. However, if the funding were rolled into the state's general revenue, the Medicaid program would have little influence on how it was used. Other health programs may also see savings as their enrollment transitions to Medicaid in 2014, including the mental health, corrections, and public health departments. Alternate uses of that funding have not been determined.

[20] Ku L et al., "The States' Next Challenge — Securing Primary Care for Expanded Medicaid Populations." *N Engl J Med* 2011; 364:493-495.
http://www.nejm.org/doi/full/10.1056/NEJMp1011623#t=article

Washington

Basic Health

Washington's Basic Health Plan (BH) was created in 1988. It provides subsidized health care coverage to low-income individuals and families. It is offered statewide, with benefits provided by managed care companies selected by the Washington Health Care Authority (the "Authority") on a competitive basis. The state subsidizes premiums, which vary by plan, according to a sliding scale. If an individual selects a higher cost plan, he or she is responsible for the difference between the applicable subsidy and the total monthly premium. Higher income individuals may be eligible for a similar program called Washington Health without a state subsidy, but this population represents a very small segment of BH's total membership.

Benefits under BH are comprehensive. A $250 deductible, co-insurance and $1,500 out-of-pocket maximum apply to certain services, including but not limited to hospital services, inpatient substance abuse treatment, ambulance services and chiropractic services.[21] Some services are not subject to the annual deductible, co-insurance, or the annual out-of-pocket maximum, and instead require co-pays. For example, pharmacy benefits are separated into Tier 1 for generic medications in the health plan's formulary, or Tier 2 for brand name drugs in the formulary, with a copay of 50 percent of the cost of the drug. Other services, such as preventive care services, do not require co-pays or other cost sharing. [22]

There is currently a wait list for BH coverage, but certain groups such as foster parents, individuals who moved from BH to Medicaid and then lost Medicaid coverage, and personal care workers can bypass the wait list.[23] As of January 2012, 158,638 individuals were on the waiting list.

Preparing for 2014

In an effort to protect the BH program, which was slated for elimination in Governor Chris Gregoire's 2011 budget, the state applied for a Section 1115 waiver. The waiver resulted in a scaled-back program but secured federal matching dollars for what had historically been a state-funded program. Described as a "short-term bridge to national health care reform"[24], the waiver maintains coverage for many individuals who would otherwise have lost coverage in the short term but who will be eligible for Medicaid in 2014.

Washington's "Bridge" waiver enables the state to share the cost of the BH program with the federal government at a matching rate of 50 percent. It is also helping the state and its

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[21] Washington State Health Care Authority. Basic Health Benefits and Services, available at http://www.basichealth.hca.wa.gov/benefits/html.

[22] *Ibid*.

[23] Washington State Health Care Authority. Washington Basic Health, available at http://www.basichealth.hca.wa.gov/.

[24] Washington State Health Care Authority. "Washington State Medicaid Receives Federal Approval of National Health Care Reform 'Bridge'" (January 5, 2011), available at http://www.basichealth.hca.wa.gov/press_release/washington-state-medicaid-receives-federal-approval-of.html.

systems get ready for 2014. For example, the waiver allows the state to use Modified Adjusted Gross Income (MAGI) one year early—in 2013. The waiver is also being used to support the state in conversations it is having with the Centers for Medicare and Medicaid Innovations (CMMI) about restructuring Washington's adult Medicaid program to more closely resemble the BH program: the state is interested in extending some of BH's more effective cost-sharing rules, particularly those around pharmacy, to Medicaid in an effort to change client behavior. The state would also like to provide the essential benefits package to Medicaid's non-elderly adult population. The essential health benefit package is modeled after BH, and implementing it would support consistency in the benefit packages available to low-income individuals.

Before the Bridge waiver was approved, BH covered individuals and families with *gross* income at or below 200 percent of the FPL. It now requires that applicants also have income[25] at or below 133 percent of the FPL. Other eligibility requirements have also been implemented as a result of the Bridge waiver and the federal Medicaid rules attached to it, including Medicaid's citizenship requirements and a requirement that individuals be checked for Medicaid eligibility before BH enrollment. Premiums for BH enrollees, specifically for those with incomes under 65 percent FPL, have been modified in order to comply with Medicaid cost-sharing limits.

Ten years ago, at the height of the program, BH reached as many as 136,500 individuals. By the beginning of 2011, after a series of cost-cutting enrollment caps, enrollment had dropped to about 56,000. Another 20,000 individuals have now lost coverage under the Bridge waiver, primarily due to Medicaid's additional eligibility requirements. These individuals were predominantly undocumented immigrants; however, some individuals lost BH coverage because they were determined to be Medicaid-eligible and were transitioned to Washington's Medicaid program, or they had countable income above 133 percent of the FPL.

Table 7. Basic Health Plan Pre- and Post-Waiver

	Basic Health Plan Pre-Waiver	**Basic Health Plan Post-Waiver**
Covered Population	Parents and childless adults, including undocumented immigrants	Parents and childless adults
Income Eligibility	Gross income up to 200% FPL	Gross income up to 200% FPL, countable income up to 133% FPL
Enrollment	66,000	37,873

Washington's Bridge waiver expires at the end of 2013, at which time its entire enrolled BH population will move to Medicaid.[26] For individuals not currently eligible for BH, such as those with incomes over 133 percent of the FPL and undocumented immigrants

[25] After any income disregards are subtracted.

[26] The Bridge waiver also covers low-income adults not otherwise eligible for Medicaid who receive coverage under Washington's Disability Lifeline or Alcohol and Drug Addiction Treatment Support Act (ADATSA) programs. These populations have incomes under 133 percent of the FPL and will also be eligible for the Medicaid expansion in 2014.

who once had coverage under BH, the future under health care reform is less certain. The state has not made any decisions regarding these populations and recently commissioned several white papers on the subject. The state is considering the following options:

- A Basic Health Program for individuals with incomes between 133 percent and 200 percent of the FPL
- Exchange coverage for individuals with incomes between 133 percent and 200 percent of the FPL
- A combined program for all individuals under 200 percent FPL, using pooled Medicaid and Basic Health Program funding

A Milliman report indicates that transforming BH into a Basic Health Program under Section 1331 of the ACA—which would seem to be a logical step for the program—could reduce the number of individuals purchasing individual coverage in the state Exchange from anywhere between 60,000 and 140,000. Removing such a sizeable population from the Exchange might improve the Exchange's risk pool and result in lower premiums, but it could limit the Exchange's long-term sustainability and limit the number of plans willing to participate. Other white papers are analyzing the administrative complexity of various options, particularly a Basic Health Program versus Exchange-based coverage. The state is also considering the option of pooling Medicaid and Basic Health Program funding to create a re-branded program for low-income individuals that would offer the same benefits and provider network to anyone under 200 percent FPL, thus improving continuity of care and reducing the number of transitions for individuals with income under 200 percent of the FPL.

Existing Medicaid health plans are receptive to the idea of retaining BH as a Basic Health Program because it provides an opportunity to avoid competing in the Exchange for low-income individuals. A Basic Health Program would also be good for consumers if it were modeled like Medicaid—enrollees would have fewer out-of-pocket expenses than under the Exchange and better continuity of care as they transition out of Medicaid. However, a Basic Health Plan would add a layer of administrative complexity to the state's eligibility determination process, information technology systems and interfaces and benefit plans.

It is unclear at this time whether the state would experience any cost savings in offering a Basic Health Program. It is researching this issue, as well as the potential impacts of a Basic Health Program on individuals between 133 and 200 percent FPL; the state; providers; and the private insurance market. These issues need to be worked out soon, as any policy decisions must be made in the next legislative session in order to be ready for 2014.

The Authority's vision for 2014 includes moving most of Medicaid, including the Medicaid expansion population, into managed care. Work is already under way to move the aged, blind and disabled (ABD) population into managed care plans—a managed care request for proposal was released earlier this year that included ABD as a covered population and is intended to lay the groundwork for implementing health reform in 2014.

The state is also hoping to take advantage of the Medicaid health home option[27] to improve quality while reducing costs for this population, although implementation of this option may present some challenges within a managed care environment.

Maintenance of Eligibility

The ACA's maintenance of eligibility requirement has impacted Washington's recent decisions about the BH program. The state is operating under a severe budget crisis, and could not create an entitlement program that would be subject to the ACA's maintenance of eligibility rules. For this reason, the state elected to apply for a Section 1115 waiver instead of filing an early adopter state plan amendment. The waiver allowed them to maintain coverage for many of those enrolled in the BH program without creating a new entitlement or having to modify the program's existing benefit package or cost-sharing rules.

Implications of Health Reform on Program Enrollees

According to Doug Porter, Director of the Authority, "effective cost-sharing has been one of the cornerstones of the [BH] program since its creation." The state would be supportive of similar cost-sharing under Medicaid but is limited in the extent to which it can do so under federal Medicaid rules. Enrollees in the BH program will therefore likely benefit from fewer out-of-pocket expenses when they move to Medicaid in 2014. Benefits will not change significantly, because Medicaid benefits were cut in the state's last legislative session and now closely resemble the BH program's comprehensive benefit package. Also, the BH program contracts with most of the same managed care companies who participate in Medicaid, so enrollees will not be subject to a changing delivery system; however, this may change when new contracts are awarded for services beginning in July 2012.

Options for Reprogramming Newly Available State Funds

The state anticipates drawing down a 100 percent federal match starting in 2014 for BH enrollees who will be transitioning to Medicaid under health reform. Such a change will free up approximately $40 million in state funds annually, but this cost-savings is expected to be used to fill existing budget holes rather than to make health system improvements such as expanding access, providing enhanced subsidies or benefits under the Exchange, or shoring up the safety net.

[27] Section 2703 of the Affordable Care Act, which provides enhanced federal funding in Medicaid for states that establish or enhance a medical home program in Medicaid to serve people with chronic conditions.

APPENDIX A: STATE PROGRAM SUMMARY TABLES

Washington, D.C.	D.C. Healthcare Alliance Pre-Waiver/SPA	D.C. Healthcare Alliance Post Waiver/SPA	Childless Adult Medicaid Waiver
Type of Coverage Program (e.g., coverage expansion vs. premium subsidy)	State funded coverage expansion	State/Federal coverage expansion	State/Federal coverage expansion
Total Enrollment	56,814 (as of June 2010)	24,000 (as of September 2011)	3,200 (as of September 2011)
Enrollment by Income (% above/below 133% FPL)	Approximately 30,000 (or 53%) were under 133% FPL and met federal citizenship requirements—already transitioned to Medicaid under a SPA	Those remaining are largely the undocumented workers	100% above 133% FPL
Enrollment open or closed?		Open	Open – No Cap
Enrollee coverage in 2014	Medicaid BHP or Exchange (for those over 133% FPL)	Unclear, because program serves many undocumented. Possible conversion to DSH-like program to support safety net providers.	All options under consideration
Annual Program Expenditures (State and Federal)	Funded entirely through the District's General Fund	Funded entirely through the District's General Fund. Through waiver and SPA, were able to draw down federal funding for 2/3 of expenditures for those moved to Medicaid.	
Eligible Population	Non-disabled childless adults and undocumented District residents	Undocumented District residents	Childless adults
Income Eligibility Limits	Up to 200% FPL	Up to 200% FPL for those not eligible for Medicaid or the waiver, including undocumented. DC has recently done two Medicaid expansions, one through a SPA covering those up to 133% FPL, and then in December a waiver covering childless adults 133-200% FPL.	134- 200% [the HIV waiver and childless adult waiver for 50-64 FPL were rolled into this waiver]
Benefits Offered	Limited • Preventive Care • Health screenings	Limited • Preventive Care • Health screenings	Full

Washington, D.C.	D.C. Healthcare Alliance Pre-Waiver/SPA	D.C. Healthcare Alliance Post Waiver/SPA	Childless Adult Medicaid Waiver
	• Prescription drugs • Dental services (cleanings or fillings) • Family planning services (birth control) • Urgent and emergency care • Immunizations • Prenatal care • Well child care • Wellness programs • Hospital care • Limited vision and nursing home/long-term care	• Prescription drugs • Dental services (cleanings or fillings) • Family planning services (birth control) • Urgent and emergency care • Immunizations • Prenatal care • Well child care • Wellness programs • Hospital care • Limited vision and nursing home/long-term care	
Cost-sharing/Premium Requirements	No cost-sharing	No cost-sharing	No cost-sharing
Program Implementation Date	2001	Changes effective July 2010	December 2010
Early Medicaid Expansion/Anticipated 2014 Enrollment Shifts	Those under 133% of poverty already transitioned to Medicaid. In 2014, BHP or Exchange for those over 133%.	Unclear, because program serves many undocumented. Possible conversion to DSH-like program to support safety net providers.	No additional changes anticipated before 2014; all options under consideration for 2014 and beyond.

Source: Department of Health Care Finance, February 2012.

Maryland	Primary Adult Care (PAC)	Maryland Health Insurance Plan	Maryland Health Insurance Partnership
Type of Coverage Program (e.g., coverage expansion vs. premium subsidy)	Coverage expansion (waiver)	High-risk pool	State-funded small-employer subsidy program
Total Enrollment	60,000	22-23,000	1,450
Enrollment by Income (% above/below 133% FPL)	100% below 133% FPL	Roughly 9% below 133%	Eligibility is determined at firm level. To qualify: 1. Firm must have between 2 and 9 fulltime employees and NOT offered insurance the last year. 2. Firm must have an average wage less than $50,000. To be eligible for dependent coverage, a fulltime employee must have a family income of less than $75,000.
Enrollment open or closed?	There is currently no cap, though the state has the authority to establish one	Open	Open
Enrollee coverage in 2014	Medicaid	Exchange primarily, with about 2,000 moving to Medicaid ; program could become subsidy program for safety net providers, but this is still to be determined	SHOP Exchange
Annual Program Expenditures (State and Federal)	Estimated FY 2012 general fund expenditures of about $72 million[28]	Roughly $184 million in 2010 ($114 million from a hospital assessment, which made up 62% of the program's budget). State anticipates substantial savings (just over $1 billion) on this program from 2014-20 once health reform is implemented	Approximately $2 million.
Eligible Population	Childless adults who do not qualify for full Medicaid benefits (parents are now in full Medicaid up to	Individuals whose income is too high for PAC, and childless adults who need more comprehensive	Small businesses with 2 to 9 fulltime employees that have not offered employees health insurance

[28] Source: Analysis of the FY 2012 Maryland Executive Budget, 2011. "Medical Care Programs Administration." http://mlis.state.md.us/2011rs/budget_docs/all/Operating/M00Q_-_DHMH_Medical_Care_Programs_Administration.pdf

Maryland	Primary Adult Care (PAC)	Maryland Health Insurance Plan	Maryland Health Insurance Partnership
	116% FPL, but no longer part of the expansion population in the waiver. Parents are covered through income disregards as state population).	benefits than PAC offers; no citizenship requirements but must be denied coverage in non-group market based on health status	during the previous 12 months, and whose employees' average wage is less than $50,000, can receive subsidies of up to 50% of their premiums. Subsidies go to both the employer and employees.
Income Eligibility Limits	Up to 116%	No maximum—Enhanced subsidies are available for those under 300% FPL	Average employee wage must be under $50,000 for the employer. An employee seeking coverage for dependents must have income below $75,000.
Benefits Offered	Limited • Free primary health care • Prescription drugs ○ Co-payment of up to $2.50 for generic drugs and $7.50 for brand name drugs (pharmacist can deny drug if copayment is not paid) • Free in-office mental health services through a counselor or psychiatrist • Limited lab and diagnostic services • Community-based substance abuse services (January 2010) • Facility fees for emergency room visits (January 2010) • Some benefits are carved out and covered fee for service, including Specialty Mental Health System services and drugs, and HIV/AIDS drugs Benefits are limited, and do not in-	Comprehensive	Depends on coverage provided by employer. Includes products available in the CSHBP (small group)

Maryland	Primary Adult Care (PAC)	Maryland Health Insurance Plan	Maryland Health Insurance Partnership
	clude hospital or other specialty services. They are administered through managed care companies. Existing Medicaid plans can decide whether to participate in PAC, which five of the seven current plans do.		
Cost-sharing/Premium Requirements	Co-payment of up to $2.50 for generic drugs and $7.50 for brand name drugs; ER visit fees	MHIP plan options include: •HMO Plan •PPO Plan with $500 medical deductible •PPO Plan with $1,000 medical deductible •High Deductible Health Plan with $2,600 combined medical and pharmacy deductible •HealthyBlue Triple Option with an individual deductible starting at $1,500 or $3,000 for a family with free preventive and routine PCP visits **MHIP Federal** The component of the high-risk pool established by the ACA. •High Deductible Plan with a $1,500 combined medical and pharmacy deductible •PPO plan with $500 medical deductible •PPO plan with $500 medical deductible for those eligible for MHIP+ **MHIP+** MHIP+ provides discounted pre-	Subsidy amounts vary by income level and the coverage chosen by the employer. Subsidy tables are available at http://mhcc.maryland.gov/partnership/subsidy.aspx

Maryland	Primary Adult Care (PAC)	Maryland Health Insurance Plan	Maryland Health Insurance Partnership
		miums and, in some cases, cost sharing to low-income MHIP members . (MHIP+ is not available to members of MHIP Federal.) Plan options: •HMO Plan •PPO Plan with $200 medical deductible •PPO Plan with $500 medical deductible Prescription drug cost-sharing for MHIP is summarized at http://www.marylandhealthinsurancep-lan.state.md.us/mhip/html/PrescriptionDrugCoverage.html	
Program Implementation Date	July 2006	2003	2007
Early Medicaid Expansion/Anticipated 2014 Enrollment Shifts	No plans to make changes before 2014.	No plans to make changes before 2014.	No plans to make changes before 2014. Small businesses will be able to participate in the Exchange in 2014.

Sources: Maryland Department of Health and Mental Hygiene and Maryland Health Care Commission, January 2012.

Minnesota	MinnesotaCare Waiver	MinnesotaCare (previously State-Only, now waiver)
Type of Coverage Program (e.g., coverage expansion vs. premium subsidy)	Coverage	Coverage
Total Enrollment	Average monthly enrollment (SFY 2011): 85,511	Average monthly enrollment (SFY 2011): 61,626
Enrollment by Income (% above/below 133% FPL)	47% above 133% FPL, 53% below	45% above 133% FPL, 55% below
Enrollment open or closed?	Open	Open
Enrollee coverage in 2014	Medicaid for those below 133% FPL; all options under consideration for those above	Medicaid for those below 133% FPL; all options under consideration for those above
Annual Program Expenditures (Enrollee Premiums, State[1] and Federal[2])	Enrollee Premiums: $20,417,446 State: $125,289,873 Federal: $196,522,386 Total: $342,229,706	Enrollee Premiums: $19,031,635 State: $0 Federal: $361,587,431 Total: $380,619,066
Eligible Population	Parents, Children, Pregnant Women	Childless adults
Income Eligibility Limits	Up to 275% FPL, Infants to 280% FPL	Up to 250% FPL
Benefits Offered	Full – parents above 215% categorized as limited benefits because have $10,000 inpatient annual limit • Adult mental health rehab/crisis • Alcohol/drug treatment • Chiropractic • Dental (limited) • Emergency room • Eye exams • Eyeglasses • Family planning • Hearing aids • Home care (limited) • Hospice care • Hospital stay • Immunizations • Interpreters (hearing, language) • Lab, x-ray, diagnostic • Medical equipment and supplies • Mental health • Mental health case management • Outpatient surgical center	Full - childless adults above 215% categorized as limited benefits because have $10,000 inpatient annual limit • Adult mental health rehab/crisis • Alcohol/drug treatment • Chiropractic • Dental (limited) • Emergency room • Eye exams • Eyeglasses • Family planning • Hearing aids • Home care (limited) • Hospice care • Hospital stay • Immunizations • Interpreters (hearing, language) • Lab, x-ray, diagnostic • Medical equipment and supplies • Mental health • Mental health case management • Outpatient surgical center

Minnesota	MinnesotaCare Waiver	MinnesotaCare (previously State-Only, now waiver)
	• Physicians and clinics • Physicals/preventive care • Prescriptions • Rehabilitative therapies • Transportation: emergency	• Physicians and clinics • Physicals/preventive care • Prescriptions • Rehabilitative therapies • Transportation: emergency
Cost-sharing/Premium Requirements	Sliding scale premiums; $4 premiums for children up to 150% FPL Copays: • $10,000 annual limit for inpatient hospital services (for those above 215% FPL) • $25 eyeglasses • $3 prescriptions • $3 nonpreventive visit • $6 nonemergency visit to hospital ER No copays for children or pregnant women	Sliding scale premiums Copays: • $10,000 annual limit for inpatient hospital services • $25 eyeglasses • $3 prescriptions • $3 nonpreventive visit • $6 nonemergency visit to hospital ER • 10% inpatient hospital, up to $1,000
Program Implementation Date	1992	1995
Early Medicaid Expansion/Anticipated 2014 Enrollment Shifts	All options under consideration for 2014 – further changes not anticipated before then.	All options under consideration for 2014 – further changes not anticipated before then.

Source: Minnesota Department of Human Services, January 2012.

New York	Family Health Plus (waiver)	Child Health Plus (CHIP)
Type of Coverage Program (e.g., coverage expansion vs. premium subsidy)	Coverage or premium assistance for ESI	Coverage
Total Enrollment	402,610	406,800
Enrollment by Income (% above/below 133% FPL)	Not available	April 2011 Enrollment under 160% FPL (gross income) = 210,700 April 2011 Enrollment under 133% FPL (net income) = 141,400
Enrollment open or closed?	Open	Open
Enrollee coverage in 2014	Up to 133% will be covered by Medicaid; 133-150% to be determined	To be determined
Annual Program Expenditures (State and Federal)	Federal: $488 million State: $651 million	Federal: $478 million State: $335 million
Eligible Population	Parents up to 150% FPL and childless adults up to 100% FPL	Children up to 400% on sliding scale; buy-in allowed above 400% FPL at full cost of program. State-only program currently covers about 45,000 children.
Income Eligibility Limits	Up to 150% FPL (parents); up to 100% FPL (childless adults)	<400% FPL; buy-in option available above 400% FPL
Benefits Offered	Full (less than traditional Medicaid) • Physician services • Inpatient and outpatient hospital care • Prescription drugs and smoking cessation products • Lab tests and x-rays • Vision, speech and hearing services • Rehabilitative services (with some limits) • Durable medical equipment • Emergency room and emergency ambulance services • Behavioral health and chemical dependence services (which includes drug, alcohol and mental health treatment - some limits apply) • Diabetic supplies and equipment • Hospice care • Radiation therapy, chemotherapy and hemodialysis • Dental services (if offered by the	Full • Well-child care • Physical exams • Immunizations • Diagnosis and treatment of illness and injury • X-ray and lab tests • Outpatient surgery • Emergency care • Prescription and non-prescription drugs if ordered • Inpatient hospital medical or surgical care • Short-term therapeutic outpatient services (chemotherapy, hemodialysis) • Limited inpatient and outpatient treatment for alcoholism and substance abuse, and mental health • Dental care • Vision care

New York	Family Health Plus (waiver)	Child Health Plus (CHIP)
	health plan) • Family planning and reproductive health services	• Speech and hearing • Durable medical equipment • Emergency ambulance transportation to a hospital • Hospice
Cost-sharing/Premium Requirements	Copayments for some services for most members: http://www.healthplus-ny.org/data/CL_-_203_FHP_Co-Payments.pdf	Premiums vary by income and family size, up to $60 per child per month; those buying in with higher incomes pay full premiums: http://www.health.state.ny.us/nysdoh/chplus/who_is_eligible.htm No copayments
Program Implementation Date	Established December 1999; waiver requested June 2000; implemented 2001	1990
Early Medicaid Expansion/Anticipated 2014 Enrollment Shifts	Up to 133% FPL to be covered by Medicaid. All options being considered for those over 133% FPL – if Basic Health option selected, Family Health Plus enrollees between 133-200% and legal immigrants would shift to Basic Health.	To be determined.

Sources: New York State Department of Health, January 2012.

Oklahoma	Insure Oklahoma (waiver)
Type of Coverage Program (e.g., coverage expansion vs. premium subsidy)	Premium Assistance
Total Enrollment	32,272 as of August 2011. Enrollment breakdown about 60/40 between employer-sponsored and individual coverage, with the individual program growing at a faster rate than the employer-sponsored program. Additional enrollment data at: http://www.okhca.org/research.aspx?id=87&parts=7447
Enrollment by Income (% above/below 133% FPL)	49% below 133% FPL
Enrollment open or closed?	Open, but close to the cap of 35,000
Enrollee coverage in 2014	Medicaid expansion, Exchange
Annual Program Expenditures (State and Federal)	Insure Oklahoma Individual Plan (IP): $57,817,978 total state and federal funding; state share $20,270,983 Insure Oklahoma Employer-Sponsored Insurance (ESI): $52,824,367 total state and federal funding; state share $18,520,223
Eligible Population	Insure Oklahoma ESI: Working parents, childless adults, and qualified college students with access to an employer's qualified health plan. Insure Oklahoma IP: Working adults not eligible to participate in an employer's qualified health plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students. Both programs are phasing in coverage for dependent children in families with income 185-300% FPL who are not eligible for SoonerCare (Medicaid). Dependents up to 200% FPL became eligible in 2010.
Income Eligibility Limits	Currently eligibility is at 200%. The program is authorized to go to 250% for adults; 300% for children, but is phasing in the increase for adults gradually, possibly with an incremental increase to 220%. There is not currently a detailed plan to raise it, but rather the decision will be dictated by how fast the cap of 35,000 is reached. While the state has legislative authority to enroll children up to 300% FPL, 200% is the current eligibility level in practice. An increase may be phased in alongside an eligibility increase for adults.
Benefits Offered	Health plans participating in the Insure Oklahoma Employer Sponsored Insurance program (for workers and their dependents employed by company with <100 workers) must offer, at a minimum, benefits that include: • Hospital services • Physician services • Clinical laboratory and radiology • Pharmacy • Office visits • Well baby/well child exams • Age appropriate immunizations as required by law • Emergency services as required by law

Oklahoma	Insure Oklahoma (waiver)
	Benefits in the Individual Plan include the minimum categories listed above, and are similar to those available to SoonerCare (Medicaid) members. The Oklahoma Health Care Authority (OHCA) provides dental services to children who qualify for the Insure Oklahoma Individual Plan.[29]
Cost-sharing/Premium Requirements	Individual Plan members contribute a portion of the premium for themselves and any enrolled dependents. The member contribution rate is 15 percent of the premium. The combined portion of the enrollee's premium cost sharing cannot exceed four percent of his/her annual gross household income computed monthly. Out-of-pocket medical expenses are limited to 5 percent of annual gross household income. For Employer Sponsored Insurance qualified health plans, an annual in-network out-of-pocket maximum cannot exceed $3,000 per individual, excluding pharmacy deductibles. Office visits cannot require a co-payment exceeding $50 per visit. Annual in-network pharmacy deductibles cannot exceed $500 per individual. The premium cap and out-of-pocket cap are different in the two products. For an employer with a participating employee, the employee pays up to 15% of whatever the commercial rate is. Dependent participation is also 15%. The employer must pay a minimum of 25% (or more at their discretion) for the employee only, and no contribution is required for any dependents. For dependents, the state covers at least 85% of the cost. The total out-of-pocket cap is 5% of income, so it is not uncommon for an employee to pay 15% of their own coverage, but none of their dependent's cost because they have met the income cap. Deductibles are capped at $1000. On IP side, sliding scale premium is based on approx 4% of income. There are no deductibles, but some copays are required.
Program Implementation Date	November 2005
Early Medicaid Expansion/Anticipated 2014 Enrollment Shifts	All eligible residents under 133% FPL will shift to Medicaid. State may consider Basic Health option; all options are currently under consideration.

Source: Oklahoma Health Care Authority, January 2012.

[29] For a summary of specific services and copayments, see http://www.okhca.org/xPolicy.aspx?id=734

Washington	Basic Health Pre-Waiver	Basic Health Post-Waiver
Type of Coverage Program (e.g., coverage expansion vs. premium subsidy)	State funded coverage	State/Federal funded coverage
Total Enrollment	66,000 as of May 2010	34,046 as of November 2011
Enrollment by Income (% above/below 133% FPL)	Approximately 73% are below 133% FPL **and** meet citizenship requirements (from Bridge waiver proposal, which estimated that 48,000 current enrollees would be eligible for federal match)	100% at or below 133% FPL
Enrollment open or closed?	Closed	Closed. 158,638 people on waiting list as of January 2012
Enrollee coverage in 2014	Medicaid expansion, Federal BHP or Exchange coverage; non-citizens will lose coverage	Medicaid expansion; waiver covers individuals who would be eligible for Medicaid under the ACA.
Annual Program Expenditures (State and Federal)	$251,549,720 in 2009 (state only) (from Bridge waiver proposal)	FY 2012 State funds $47million + GF-Federal $40 million; Total: $ 87 million [30]
Eligible Population	State residents not eligible for free or purchased Medicare who meet income eligibility requirements; licensed foster parents with incomes at or below 300% FPL.	U.S. citizens/qualified noncitizens between 19 and 64 who meet income requirements.
Income Eligibility Limits	Gross income at or below 200% FPL except licensed foster parents, who may have family income not exceeding 300% FPL.	Gross income at or below 200% FPL, countable income at or below 133% FPL; licensed foster parents with family income at or below 300% FPL.
Benefits Offered	The following benefits are not subject to a deductible or coinsurance, but require co-pays, unless indicated otherwise. • Preventive care (no co-pay) • Office visits • Pharmacy • Emergency room visit • Out-of-area emergency services • Urgent care • Skilled nursing, hospice, and home health care (No co-pay, covered as an alternative to hospital care at health plan's discretion.)	The following benefits are not subject to a deductible or coinsurance, but require co-pays, unless indicated otherwise. • Preventive care (no co-pay) • Office visits • Pharmacy • Emergency room visit • Out-of-area emergency services • Urgent care • Skilled nursing, hospice, and home health care (No co-pay, covered as an alternative to hospital care at health plan's discretion.)

[30] Does not include administrative expenditures or the share of costs paid by members.

Washington	Basic Health Pre-Waiver	Basic Health Post-Waiver
	• Maternity care (no co-pay) • Oxygen (no co-pay) The following benefits are subject to deductible and coinsurance: • Hospital, inpatient • Hospital, outpatient • Other professional services • Mental health, facility • Laboratory • Radiology • Ambulance services • Chiropractic/physical therapy • Chemical dependency • Organ transplants	• Maternity care (no co-pay) • Oxygen (no co-pay) The following benefits are subject to deductible and coinsurance: • Hospital, inpatient • Hospital, outpatient • Other professional services • Mental health, facility • Laboratory • Radiology • Ambulance services • Chiropractic/physical therapy • Chemical dependency • Organ transplants
Cost-sharing/Premium Requirements	Premium contributions vary by family size, age, income and health plan choice. $250 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year. Enrollees generally pay 20% coinsurance for certain services up to the out-of-pocket maximum. Copayments for specific services are listed at http://www.basichealth.hca.wa.gov/benefits/html	Premium contributions vary by family size, age, income and health plan choice. $250 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year (the entire population is subject to the same fees, with no sliding scale). Enrollees generally pay 20% coinsurance for certain services up to the out-of-pocket maximum. Some benefits not subject to the deductible or coinsurance, but subject to co-payments. Copayments for specific services are listed at www.basichealth.hca.wa.gov/benefits/html Members who meet the definition of American Indian or Alaska Native are not required to pay premiums or cost sharing for covered services.
Program Implementation Date	February 1989	Changes effective January 1, 2011
Early Medicaid Expansion/Anticipated 2014 Enrollment Shifts	N/A	All options are under consideration for 2014.

Source: Washington Health Care Authority, January 2012.

APPENDIX B: INTERVIEW GUIDES

Interview Guide – State Funded and Medicaid Expansion States

Introduction

By January 1, 2014, the Patient Protection and Affordable Care Act (ACA) will significantly expand the health coverage options for low-income, uninsured individuals currently covered under programs administered by the states. Through a SHARE grant from the Robert Wood Johnson Foundation, Health Management Associates (HMA) is analyzing the legal, technical, and policy issues that states will need to address as they review options for transitioning health coverage program enrollees to new coverage options (e.g., Medicaid or subsidized coverage available via health insurance exchanges) and identifying possible opportunities for re-programming the state dollars freed up by the infusion of federal funds under the ACA. A key component of the project involves interviews with six states that currently administer state-funded and/or Medicaid expansion health coverage programs for groups that have traditionally been ineligible for Medicaid. Through these interviews, we hope to (1) gain a better understanding of the State's health coverage program(s); (2) explore high-level policy issues and concerns regarding the future of the program(s); and (3) discuss potential alternative uses of existing state dollars that may be freed up with health reform.

ISSUES REGARDING THE FUTURE OF THE HEALTH COVERAGE PROGRAM(S)

1. Please provide a general description of the State's plan with respect to the future of its Medicaid expansion and state-funded programs. What options are being considered as the State prepares for 2014? What goals does the State hope to achieve?

Medicaid Expansion

2. Has the State/will the State transition individuals with incomes < 133/138% FPL to Medicaid prior to 2014 as a bridge to implementation of the ACA? If so:
    a. How has this been done or how will this be accomplished? What significant legal or policy issues did/does the State need to address?
    b. What groups have been/will be included?
    c. What is the rationale for pursuing the change now? Will the transition allow the State to leverage new federal funding?

3. If the State is not considering transitioning individuals with incomes < 133/138% FPL to Medicaid prior to 2014, why has the State rejected this option?

Coverage for Individuals with Incomes > 133/138% FPL

4. What options are being considered for those individuals enrolled in Medicaid expansion and state-funded programs that have income above 133/138% of the FPL? Are different options being considered for different eligibility groups?
    a. Basic Health Plan
    b. Insurance Exchange
    c. Insurance Exchange w/ enhanced subsidies
    d. Medicaid
    e. Maintain current program
    f. Other

5. Please describe the rationale for the options being considered.
    a. From the State's perspective, what are some of the greatest benefits of the options being considered? Greatest challenges?
    b. To what extent has the potential impact on current enrollees been considered?

6. To the extent known, how does the State anticipate implementing the changes being considered?
    a. What State and/or federal approvals are necessary?
    b. How will these approvals be obtained (e.g., legislation, SPA, waiver, etc.)?

7. To the extent options under the ACA are being considered, will there be a need to modify eligibility for populations currently enrolled in Medicaid expansion and state-funded programs in order to meet federal requirements?
    a. Are there any populations currently eligible for Medicaid expansion or state-funded programs that may "fall through the cracks" as the State transitions coverage?
    b. How will these gaps be addressed?

Benefits and Cost-Sharing

8. Please discuss the potential implications of the benefit designs established by the ACA for the Medicaid expansion population, Basic Health Plan, and Exchange coverage.
    a. How might individuals currently enrolled in Medicaid expansion and state-funded programs see their benefits changing?
    b. To the extent benefits may be less generous, has the State considered a wrap-around benefit package or other mechanism to ensure continuity of care?

9. Please discuss the potential implications of premiums and cost-sharing for individuals enrolled in the Exchange.
    a. To what extent may individuals have greater out-of-pocket expenses?
    b. Has the State considered establishing enhanced premium subsidies for this population?

Maintenance of Eligibility (MOE) Requirements

10. Have the ACA's MOE requirements had any impact on making policy decisions about the future of Medicaid expansion and state-funded programs? If so, please describe.

11. If the State is considering terminating Medicaid expansion or state-funded programs or restricting its eligibility prior to 2014—
    a. Will the State be providing a certification to HHS of a projected budget deficit?
    b. Will the State be letting its Waiver expire?
    c. If not, how will the changes be accomplished? Has the State considered seeking an exemption from the MOE requirements, like Arizona did?

Other Issues

12. What are the State's biggest concerns regarding the future of Medicaid expansion and state-funded programs?

13. Has the State thought about the implications of "churn" in the options it is considering for individuals in different income categories?

14. Has the State considered how it might ensure a seamless transition of individuals to the new coverage options?

15. Are there any other significant legal or policy issues not already discussed that the State will need to address?

16. Have any analyses of the impact of the ACA on Medicaid expansion and state-funded programs been conducted (or are they being conducted)? If so, would you be willing to share the results of the analyses?

ALTERNATIVE USES OF STATE FUNDS

17. Describe the manner and extent to which State funds currently directed to Medicaid expansion and state-funded programs will be freed up due to implementation of the ACA.

18. Has the State considered other ways in which the ACA may free up State funds, such as enhanced federal match for certain individuals that currently "spend down" to Medicaid eligibility? If so, please describe.

19. Is there flexibility to reallocate State funds that will be freed up due to health reform?
    a. If so, what options are being considered?
    b. Does the State face unique challenges due to the manner in which Medicaid expansion and state-funded programs is currently financed? Please describe.
    c. What goals does the State hope to achieve?

Examples—

- Establish a Basic Health Plan
- Expand Medicaid beyond 133/138% of FPL
- Provide wrap around benefits
- Provide enhanced subsidies for low-income Exchange participants
- Establish or maintain coverage for individuals included in ACA exempt categories
- Expand and enhance the safety-net to improve access (e.g., DSH-like payments to offset remaining uninsured costs)
- Create programs designed to improve quality through enhanced reimbursement, targeted grants or other mechanisms (e.g., performance-related payment pools, grants to providers/plans for certain types of activities)
- Fund other State priorities or ACA mandates

20. To the extent the State is considering establishing a Basic Health Plan versus enhanced premium subsidies for low-income exchange participants, what roles have the following considerations played in the policy making process:
    a. Risk
    b. Control of network, rates, benefits, etc.
    c. Administrative ease
    d. Continuity of care

Interview Guide – State-funded Health Coverage Program States

ISSUES REGARDING THE FUTURE OF THE HEALTH COVERAGE PROGRAM(S)

1. Please provide a general description of the State's plan with respect to the future of its programs. What options are being considered as the State prepares for 2014? What goals does the State hope to achieve?

Medicaid Expansion

2. Has the State/will the State transition individuals with incomes < 133/138% FPL to Medicaid prior to 2014 as a bridge to implementation of the ACA? If so:
    a. How has this been done or how will this be accomplished? What significant legal or policy issues did/does the State need to address?
    b. What groups have been/will be included?
    c. What is the rationale for pursuing the change now? Will the transition allow the State to leverage new federal funding?

3. If the State is not considering transitioning individuals with incomes < 133/138% FPL to Medicaid prior to 2014, why has the State rejected this option?

Coverage for Individuals with Incomes > 133/138% FPL

4. What options are being considered for those individuals enrolled in the program(s) that have income above 133/138% of the FPL? Are different options being considered for different eligibility groups?
    a. Basic Health Plan
    b. Insurance Exchange
    c. Insurance Exchange w/ enhanced subsidies
    d. Medicaid
    e. Maintain current program
    f. Other

5. Please describe the rationale for the options being considered.
    a. From the State's perspective, what are some of the greatest benefits of the options being considered? Greatest challenges?
    b. To what extent has the potential impact on current enrollees been considered?

6. To the extent known, how does the State anticipate implementing the changes being considered?
    a. What State and/or federal approvals are necessary?
    b. How will these approvals be obtained (e.g., legislation, SPA, waiver, etc.)?

7. To the extent options under the ACA are being considered, will there be a need to modify eligibility for populations currently enrolled in the programs in order to meet federal requirements?
    a. Are there any populations currently eligible for the programs that may "fall through the cracks" as the State transitions coverage?
    b. How will these gaps be addressed?

Benefits and Cost-Sharing

8. Please discuss the potential implications of the benefit designs established by the ACA for the Medicaid expansion population, Basic Health Plan, and Exchange coverage.
    a. How might individuals currently enrolled in the state-funded program see their benefits changing?
    b. To the extent benefits may be less generous, has the State considered a wrap-around benefit package or other mechanism to ensure continuity of care?

9. Please discuss the potential implications of premiums and cost-sharing for individuals enrolled in the Exchange.
    a. To what extent may individuals have greater out-of-pocket expenses?
    b. Has the State considered establishing enhanced premium subsidies for this population?

Other Issues

10. What are the State's biggest concerns regarding the future of the state-funded coverage program(s)?

11. Has the State thought about the implications of "churn" in the options it is considering for individuals in different income categories?

12. Has the State considered how it might ensure a seamless transition of individuals to the new coverage options?

13. Are there any other significant legal or policy issues not already discussed that the State will need to address?

14. Have any analyses of the impact of the ACA on the state-funded program(s) been conducted (or are they being conducted)? If so, would you be willing to share the results of the analyses?

ALTERNATIVE USES OF STATE FUNDS

15. Describe the manner and extent to which State funds currently directed to the state-funded program(s) will be freed up due to implementation of the ACA.

16. Has the State considered other ways in which the ACA may free up State funds, such as enhanced federal match for certain individuals that currently "spend down" to Medicaid eligibility? If so, please describe.

17. Is there flexibility to reallocate State funds that will be freed up due to health reform?
    a. If so, what options are being considered?
    b. Does the State face unique challenges due to the manner in which the state-funded program is currently financed? Please describe.
    c. What goals does the State hope to achieve?

    Examples—
    - Establish a Basic Health Plan
    - Expand Medicaid beyond 133/138% of FPL
    - Provide wrap around benefits
    - Provide enhanced subsidies for low-income Exchange participants
    - Establish or maintain coverage for individuals included in ACA exempt categories
    - Expand and enhance the safety-net to improve access (e.g., DSH-like payments to offset remaining uninsured costs)
    - Create programs designed to improve quality through enhanced reimbursement, targeted grants or other mechanisms (e.g., performance-related payment pools, grants to providers/plans for certain types of activities)
    - Fund other State priorities or ACA mandates

18. To the extent the State is considering establishing a Basic Health Plan versus enhanced premium subsidies for low-income exchange participants, what roles have the following considerations played in the policy making process:
    a. Risk
    b. Control of network, rates, benefits, etc.
    c. Administrative ease
    d. Continuity of care

Interview Guide – Medicaid Expansion States

ISSUES REGARDING THE FUTURE OF THE HEALTH COVERAGE PROGRAM(S)

1. Please provide a general description of the State's plan with respect to the future of its Medicaid expansion program(s). What options are being considered as the State prepares for 2014? What goals does the State hope to achieve?

Coverage for Individuals with Incomes > 133/138% FPL

2. What options are being considered for those individuals enrolled in the Medicaid expansion program(s) that have income above 133/138% of the FPL? Are different options being considered for different eligibility groups?
    a. Basic Health Plan
    b. Insurance Exchange
    c. Insurance Exchange w/ enhanced subsidies
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5. To the extent options under the ACA are being considered, will there be a need to modify eligibility for populations currently enrolled in Medicaid expansion program(s) in order to meet federal requirements?
    a. Are there any populations currently eligible for the Medicaid expansion program(s) that may "fall through the cracks" as the State transitions coverage?
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Benefits and Cost-Sharing

6. Please discuss the potential implications of the benefit designs established by the ACA for the Medicaid expansion population, Basic Health Plan, and Exchange coverage.
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    a. To what extent may individuals have greater out-of-pocket expenses?
    b. Has the State considered establishing enhanced premium subsidies for this population?

Maintenance of Eligibility (MOE) Requirements

8. Have the ACA's MOE requirements had any impact on making policy decisions about the future of the Medicaid expansion program(s)? If so, please describe.

9. If the State is considering terminating the Medicaid expansion program(s) or restricting its eligibility prior to 2014—
    a. Will the State be providing a certification to HHS of a projected budget deficit?
    b. Will the State be letting its Waiver expire?
    c. If not, how will the changes be accomplished? Has the State considered seeking an exemption from the MOE requirements, like Arizona did?

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11. Has the State thought about the implications of "churn" in the options it is considering for individuals in different income categories?

12. Has the State considered how it might ensure a seamless transition of individuals to the new coverage options?

13. Are there any other significant legal or policy issues not already discussed that the State will need to address?

14. Have any analyses of the impact of the ACA on the Medicaid expansion program(s) been conducted (or are they being conducted)? If so, would you be willing to share the results of the analyses?

ALTERNATIVE USES OF STATE FUNDS

15. Describe the manner and extent to which State funds currently directed to the Medicaid expansion program(s) will be freed up due to implementation of the ACA.

16. Has the State considered other ways in which the ACA may free up State funds, such as enhanced federal match for certain individuals that currently "spend down" to Medicaid eligibility? If so, please describe.

17. Is there flexibility to reallocate State funds that will be freed up due to health reform?

a. If so, what options are being considered?
b. Does the State face unique challenges due to the manner in which [insert name of health coverage program(s)] is currently financed? Please describe.
c. What goals does the State hope to achieve?

Examples—

- Establish a Basic Health Plan
- Expand Medicaid beyond 133/138% of FPL
- Provide wrap around benefits
- Provide enhanced subsidies for low-income Exchange participants
- Establish or maintain coverage for individuals included in ACA exempt categories
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