Pathways to Medicaid Expansion in Alabama

Janet M. Bronstein, Ph.D., David J. Becker, Ph.D., Amanda Coolidge, J.D. and Leonard J. Nelson, J.D., L.L.M.

UAB School of Public Health, Department of Health Care Organization and Policy

Summary

While Alabama remains one of the 22 states that have not expanded its Medicaid program to take advantage of the federal support available under the terms of the Affordable Care Act, interest remains high for this type of reform. Financially such a change would be advantageous, both to the approximately 290,000 newly insured low income adults who would be able to pay for medical care, and for the state’s health care providers, who would gain a new source of revenue that could balance out on-going changes that threaten their financial viability. Most of the costs of an expanded Medicaid program would be covered by the federal government. Increased tax revenue from the economic activity generated by new payments to health care providers should help the state offset its share of the costs of the expansion.

However, currently Alabama’s Medicaid program is undergoing a significant structural transformation. The state’s approach to Medicaid expansion must take this into account. After reviewing this transformation and the options that other states have chosen to extend Medicaid coverage to low income adults, this brief concludes that the optimal approach for Alabama is to include newly insured adults in the currently forming Regional Care Organizations (RCOs). These are community-based provider networks that will be assuming the role of managed care organizations for the Medicaid population in October 2016. A modest premium

\[\text{\small \textsuperscript{a}}\text{The opinions expressed in this Brief are those of the authors, and do not reflect the views of UAB or any of its departments or organizational units.}\]

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and cost-sharing structure can be implemented which will give newly covered adults a personal stake in maintaining such health insurance coverage.

Another choice for the state to consider in the future is an approach that would combine Medicaid expansion with an alternative to health care coverage for the segment of the adult population now purchasing health insurance with federal subsidies on the federally facilitated health insurance exchange. With this approach, Alabama could build on the current Medicaid transformation to create a viable alternative health insurance system for all low income residents of the state. Creating such a state-specific system is a way of taking advantage of the full range of available federal support through the Affordable Care Act, and a way of improving the financial viability of the new RCO system.

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Pathways to Medicaid Expansion in Alabama

Introduction

The Medicaid program is a joint Federal-State program that finances medical care for low income individuals who meet specific eligibility requirements. The program began nationally in 1965. By law, each state’s Medicaid program must cover the costs of all necessary medical treatment for enrolled individuals. States have some flexibility over who is eligible for enrollment. Alabama’s current eligibility criteria are shown in the table below.

<table>
<thead>
<tr>
<th>Age</th>
<th>Other Characteristics</th>
<th>Either one of these Criteria</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Income</td>
</tr>
<tr>
<td>0-18</td>
<td>Not otherwise insured</td>
<td>below 146% FPL</td>
</tr>
<tr>
<td>19+</td>
<td>Female, while pregnant, not otherwise insured</td>
<td>below 146% FPL</td>
</tr>
<tr>
<td>19+</td>
<td>Parent or caregiving relative to child on Medicaid, not otherwise insured</td>
<td>below 11% FPL (based on state guidelines for income supplementation (welfare))</td>
</tr>
<tr>
<td>19-55</td>
<td>Male and female, Family planning only, not otherwise insured</td>
<td>below 146% FPL</td>
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<td></td>
<td></td>
<td>Disability Status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for Federal Supplemental Security Income due to low family income and verified disability</td>
</tr>
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All Medicaid recipients must be U.S. citizens. Alabama’s eligibility thresholds for Medicaid are the minimum specified in the federal Medicaid statutes and, because of the low threshold for qualifying for income support (welfare) in the state, are the most restrictive in the nation. All state Medicaid programs also cover the costs of nursing home care, or the alternative sets of home care services, for state residents whose incomes are below a nationally-specified income.
threshold. In fiscal year 2014, payments to nursing homes constituted 16% of all Alabama Medicaid expenditures.¹

Funding for Medicaid in each state comes from a combination of state and federal funds. States provide a portion of the funding and this is matched by federal funds at a rate that depends on the per capita income of the state. Currently the federal match in Alabama is 68.12%, meaning that each state dollar put in to the Medicaid program returns $2.14 in federal funds.¹ In each fiscal year, Alabama must identify an amount of state funding that can be matched to federal funding to generate sufficient funds to cover the necessary medical costs for the eligible population. The amount of this funding requirement changes every year, increasing as the cost of medical care increases and as the size of the population that qualifies through low income and disability increases. For example, in 2012 the total budget for Alabama Medicaid was $5,027,020,046², requiring about 1.6 billion dollars in state funds to generate the sufficient amount of federal matching funds.

Over the past two decades, the state has developed an approach to generating the state share of the Medicaid match which relies heavily on cooperation from the state’s health care provider community. Only 33% of the state’s Medicaid matching funds come directly from Alabama’s General Fund. A full 36% of the state share comes from taxes on private hospitals, matching funds from state hospitals and an estimate of the amount of non-reimbursed hospital care used by Medicaid covered patients. Taxes on nursing homes and pharmacies generate another 6%, and rebates from the use of brand name drugs provide another 5% of the state match. Intergovernmental transfers from other agencies and other revenue make up the remaining portion of the share.¹³

Despite the fact that the General Fund provides only one third of the required Medicaid match, the dollar value of this component increases unpredictably over time, as enrollment in the Medicaid program increases and as the match rate for federal funds declines. The match rate declines when the state’s economic outlook improves and per capita income rises. Alabama is a state with very limited revenue growth in the General Fund component of the state budget, so funding the expense of the Medicaid state share has been a perennial problem for the Governor and the Legislature.

The Affordable Care Act that was signed into law in March 2010 included a provision that mandated that states expand their Medicaid eligible population to include all U.S. citizens with incomes up to 138% of the FPL. This expansion was to be implemented in January 2014. The cost of the initial three years of the expansion would be covered completely by federal funds. Beginning in January 2017, the federal government share will begin to decline, and stabilize in 2020 at 90% of the costs of the expansion.
In June 2012 the Supreme Court ruled that Congress could not mandate states to expand their Medicaid programs; expansion had to be voluntary on the part of the states. So far, Alabama and 21 other states have chosen not to expand their Medicaid programs. One argument against Alabama’s expansion of Medicaid is that it is not clear where the state would acquire the required additional matching funds to cover the costs of the expansion on a long term basis.

However in recent months Governor Robert Bentley has indicated that he might be open to extending health coverage to low income adults under certain conditions. Examining gaps in health insurance coverage for Alabama adults is one of the charges to the Governor’s Health Care Improvement Task Force, which was announced in April 2015.\(^4\) To acquire federal matching funds for this extension, any plan would need to conform to the requirements maintained by the Federal Centers for Medicaid and Medicare Services (CMS) for states proposing to expand their Medicaid programs in a format other than a simple eligibility change to the existing program. This Policy Brief examines the possible pathways for expansion of the Medicaid program in Alabama, and recommends the approach that seems the most feasible for the state. The brief has five parts: 1) an examination of the current changes being implemented in the Alabama Medicaid program; (2) an examination of the likely impact of a Medicaid expansion in Alabama; (3) a review of innovative Medicaid expansions currently being implemented or considered in other states under Section 1115 waivers and the CMS requirements for such waivers; (4) a recommendation of the type of Medicaid expansion that would be most feasible and beneficial for Alabama, and (5) a review of the state innovation waivers available under Section 1332 and a possible strategy for combining a 1332 and 1115 waivers.

**Current Alabama Medicaid Reforms**

In the Fall of 2012, Governor Bentley convened an advisory commission to examine the challenges facing the Medicaid program and to offer suggestions for reform. One approach that was considered for lowering costs in the program was the utilization of commercial managed care. This approach could stabilize expenses in Medicaid by allowing the state to pay a single fee per Medicaid enrollee, no matter how many services each enrollee actually used. Three major drawbacks to this approach were identified. First, there is very little penetration of managed care in the private markets in the state, so that the provider community has no experience and little incentive to participate in such a system. Second, involving a managed care company would disrupt the current financing arrangement, which relies heavily on provider cooperation. Reductions in inpatient care use are one of the potential effects on introducing managed care into a care delivery system. However in Alabama, any decline in inpatient care use by the Medicaid population lowers the amount of unreimbursed hospital
costs currently used to generate the state share of the Medicaid budget and to accrue the federal match. In addition, representatives from both the pharmacy and the hospital sectors indicated that they were unlikely to support the continuation of the tax on their revenues if Medicaid shifted to a commercial managed care model. Third, it seemed unlikely that a shift of Medicaid to a commercial managed care program would be sustainable in the long run, because there are limited opportunities for such companies to generate profits in this arena. An alternative model for stabilizing expenditures in Medicaid is the provider community-based model on-going in the State of Oregon’s Medicaid program. In the Oregon model, local providers come together to form community care networks. These networks receive a set budget amount from the Medicaid program to provide physical, dental and mental health care to local Medicaid enrollees. The organizations have the flexibility to provide supplementary services to Medicaid enrollees, such as health education, which can assist in improving their health and lower the costs of their care. The community care networks are at financial risk for any costs of care used for their population which exceeds their set budgets. Oregon phased in the community care organizations geographically and phased in the move of Medicaid enrollees into the arrangements between 2012 and 2014. Oregon also received an 1115 waiver for non-traditional use of federal funds and federal financial support to help finance health system changes through CMS’s Designated State Health Programs (DSHP) mechanism. One of the advantages of this community care network model is that it builds on the state’s recent experience contracting with local nonprofit organizations (Patient Care Networks of Alabama, or PCNAs) that provide support services to Medicaid primary care physicians and case management services to Medicaid enrollees with chronic health conditions. With this in mind, the Alabama Medicaid Advisory Commission issued a report in January 2013 that recommended adoption of the community care network model, and legislation authorizing this change was passed and signed by Governor Bentley in May of 2013. Under this Medicaid reform, Alabama has been divided into 5 regions and 11 “Regional Care Organizations (RCO’s)” have been granted probationary status. As required in the legislation, each RCO has a governing board comprised of a mix of investors, insurers and care providers – primarily hospitals – who agree to bear the financial risk of providing care for local Medicaid enrollees, along with local physicians, pharmacists, and optometrists appointed by their professional associations, and community representatives. Each RCO also has a citizen’s advisory committee that includes at least two Medicaid enrollees. Waivers for financial flexibility and for financial support through the DSHP mechanism are pending at CMS. In January 2015, probationary RCOs had the opportunity to submit bids for contracts with the Medicaid Agency to begin providing enhanced primary care case management and primary care physician coordination in their regions. Six successful bidders began operating on April 1, 2015,
so that services such as those that have been offered by the PCNAs are now available statewide. Also on April 1, 2015, probationary RCOs submitted their description of the health care provider network that they will offer to enrollees. RCOs are required to accept any health care providers willing to see Medicaid patients into their networks. It is possible that some or all of the RCOs will be able to create expanded physician and facility networks that include local providers who have not traditionally participated in Alabama’s Medicaid program. This will expand the quantity and variety of health care providers available to the enrolled population.

By October 1, 2015, the probationary RCOs must submit documentation to Medicaid that they have sufficient financial reserves to bear the risks of providing care to Medicaid enrollees under a set budget. Those RCOs that successfully complete their probationary status will begin operating on a full risk basis on October 1, 2016. Medicaid enrollees will have the opportunity to select their primary care physicians and also their RCO, if more than one RCO is available in their residential region. Capitated payments per enrollee will be made to the RCO, and adjusted for the demographic and risk profile of the RCO enrollees. Also in 2016, maternity care services, which have operated under a separate regionalized and capitated system, will be folded in to the RCOs. Only individuals who are dually covered by Medicaid and Medicare will remain outside of the RCOs. The RCOs will be subject to financial withhold if the care provided through their system does not meet an agreed-upon set of care quality indicators.

Clearly, Alabama’s Medicaid system is in the midst of a major structural transformation. It is unclear at this juncture what provider networks will be available to enrollees in 18 months, what supplementary services will be available or whether the system will be financially stable over the long run. Any plan for expanding the state’s Medicaid program to cover more enrollees must be designed to take these changes into account.

**Advantages of Medicaid Expansion**

Under the Affordable Care Act, subsidies to purchase health insurance through the state’s insurance exchange (which is actually the federal exchange, Healthcare.gov) are available to individuals in families with incomes between 100% and 400% of the Federal Poverty Level. As the legislation was originally written, adults up to 138% of the FPL would qualify for expanded state Medicaid programs, while children under 213% of the FPL would qualify for Medicaid or CHIP (State Children’s Health Insurance Program). Without Medicaid expansion, Alabama children with incomes up to 317% of the FPL are covered by the state’s CHIP program, AllKids, but adults who do not qualify for the current Medicaid program have no access to publicly supported health insurance. It has been estimated that, while about 531,000 adults would be eligible for Medicaid under an expansion, only about 292,000 adults are likely to enroll. The remainder either already has existing private health insurance coverage or would choose not to take up Medicaid enrollment.
The primary advantage of supporting insurance coverage for these individuals is that it would allow them to access health care services without incurring large personal debts which they are unlikely to be able to repay. Expansion of insurance increases the likelihood that individuals will be able to use primary care, avoiding the use emergency departments and inpatient care which creates an uncompensated care burden for hospitals in the state. Some estimates suggest that having health insurance coverage improves physical and mental health and lowers mortality rates; for Alabama in particular, one study estimates that 210 deaths in the state could be averted annually with a Medicaid expansion.

The federal share of the spending on health care services that would be generated by expanding Medicaid coverage is estimated, based on survey data, to be about $5,695 each for newly insured adults in 2015. In aggregate, this represents about 1.7 billion dollars per year in new revenue for state health care providers if Medicaid were expanded to cover the estimated 292,000 adults likely to enroll. The impact of these additional expenditures flows through the rest of the state’s economy, generating an additional estimated 1.2 billion dollars in new income per year. Studies of the experience of states that have expanded Medicaid and estimates of the likely impact of Medicaid expansion in other states confirm that expansions have the positive impacts of decreasing uncompensated care, decreasing the financial burden on low income residents and increasing state revenue.

The additional revenue to health care providers is important, because other changes in their operating environment associated with the Affordable Care Act, including the phasing out of direct hospital subsidies for uncompensated care (DSH or Disproportionate Share Hospital funds) and changes in Medicare payments, are creating financial challenges, particularly for small care providers in more rural areas. Medicaid expansion is potentially a win-win scenario in this sense, creating a benefit for low income uninsured adults and a benefit for Alabama’s health care infrastructure.

Ordinarily, the benefits of this expenditure for individuals and the providers who care for them would need to be balanced against the cost to the State of Alabama and the federal government of such a Medicaid expansion. However, the immediate costs to the state are moderated by the terms of the Affordable Care Act, because all but a small administrative portion of the Medicaid expansion expenditures through 2017 come from federal funds. When the state share rises to 10% of the costs of the expansion in 2020, we estimate that the entire expansion will cost about 1.8 billion dollars per year, and Alabama’s total obligation will be 222 million dollars per year, or about 15% more than the current total state match requirement. If the current approach to funding the state’s match requirement is maintained, the Alabama General Fund would be responsible for 33% of this amount, or about $73 million dollars per year.
State policy makers are wise to consider how this additional dollar amount in the state Medicaid match will be funded. Prior research has shown that even when the state becomes responsible for 10% of the cost of the expanded program, new tax revenues generated through the additional economic activity flowing from the insurance expansion could fully offset those costs to the states. Before 2017, the new tax revenues will greatly exceed the new financial obligations to the state. The 3 billion dollar increase in economic activity per year generated by expansion would yield significant increases in tax revenues to the state and local municipalities. Through 2017 these increases in tax revenues would exceed the total cost to the state by over 200 million dollars per year. With one third of the state’s share financed directly through the Alabama General Fund, the impact of expansion on net tax revenues will be positive even as the state’s share of the cost increases to 10% in 2010 and beyond.

Currently as noted, Alabama is the state with the lowest income thresholds for Medicaid eligibility in the nation (Texas, Missouri, Idaho and Mississippi are next, in that order). Expanding Medicaid will put the state on par with three other Southern states – Arkansas, Kentucky and West Virginia – and 26 other states and the District of Columbia across the country.  

**Current Approaches to Medicaid Expansion in Other States**

States that develop approaches to Medicaid expansion which vary from the template provided by the ACA are required to obtain permission for these alternative approaches from CMS through a State Plan Amendment (SPA) and/or a Section 1115 demonstration waiver. While the SPA is not time limited, Section 1115 waivers are limited to five years; however they can be renewed. Each State Plan constitutes an agreement with the federal government that outlines the details of the implementation of Medicaid in that particular state. States can submit a SPA to CMS at any time in order to obtain approval for the modification of the administrative aspects of their State Medicaid Plan (e.g., changing provider payment rates, adding or cutting optional services, adding managed care, changing benefit structures, or cost-sharing). While it is easier for a state to make changes to its Medicaid program under the SPA process than under the waiver process, the SPA can only be used to change optional benefits and any changes must comply with federal regulations. CMS reviews the SPA to determine whether it complies with federal Medicaid statutes.

More significant alterations in a state Medicaid program may be permitted under a Section 1115 Research and Demonstration waiver. These waivers permit “experimental, pilot or demonstration projects” that meet the objectives of the Medicaid program. Under Section 1115, the Secretary of Health and Human Services) has the authority to waive compliance with certain federal Medicaid requirements, and to provide funds for costs not ordinarily matched under the federal program. In order for states to expand Medicaid using a Section 1115 waiver,
a state must submit a formal request to CMS to waive a particular federal Medicaid requirement.

CMS notes that the purpose of these waivers is to “give States additional flexibility to design and improve their programs” by expanding eligibility, providing new services, and developing “innovative delivery services” that will lead to better quality care, increased efficiency, and lower costs. A waiver will not be granted under Section 1115 unless its impact will be budget neutral for the federal government, which means that innovative expansions cannot cost more than simply raising the eligibility thresholds for existing Medicaid programs. Furthermore, CMS will not approve an expansion waiver unless the state covers all newly eligible adults through 138% of the federal poverty level (FPL) without enrollment caps. This means that these federal funds cannot be used as though they were a “block grant” to the state. Under a block grant, a specific amount of funds are made available to pay for care for a set of individuals, and individuals can be denied enrollment when the funds run out. In contrast, AllKids, Alabama’s CHIP program, is funded as a block grant. Over its 20 year history in the state, eligibility for AllKids has expanded and contracted, and enrollment has been capped at times, even for eligible children, as the amount of funds available and the number of children enrolled has varied.

As of February 2015, five states had received approval from CMS for Section 1115 waivers to implement innovative approaches to Medicaid expansion under the ACA, and a sixth state has a waiver proposal under consideration. Two states, Arkansas and Iowa, are already using federal Medicaid funds to purchase private insurance coverage for newly eligible adults through the insurance exchange. Arkansas’ waiver covers all newly eligible adults, while Iowa gives adults with incomes between 101-138% of the FPL a choice to enroll in a private plan (only one plan currently offers “silver” level coverage on Iowa’s insurance exchange) or join the state’s Medicaid managed care program. In Arkansas, Medicaid eligible privately insured individuals do not pay premiums, but they do owe co-pays to providers when they receive services. As of January 2015, the state had approval to establish Health Savings Accounts (HSAs) for adults between 50% and 138% of the FPL. Enrollees pay into this account, use it for co-payments to providers, and retain any funds which they do not use for co-pays. Enrollees with incomes over 100% of the FPL must make their own co-payments if they do not participate in the HSA. In Arkansas, “medically fragile” adults who are eligible under the expansion are not placed in private plans, but are absorbed into the existing Medicaid program. In Iowa, newly eligible adults with incomes between 100% and 138% of the FPL pay premiums of $10 per month for whichever coverage they choose. These premiums can be waived if individuals meet certain health goals, determined after a wellness exam and a health
assessment. They can also be waived if the individual attests to financial hardship. Otherwise the payments are considered a debt owed to the state. New Hampshire has a waiver pending approval at CMS which also proposes to offer premium assistance to newly eligible Medicaid enrollees to purchase insurance on the state insurance exchange. Indiana’s new waiver, approved January 2015, includes a component that helps Medicaid expansion eligible individuals pay premiums towards their employer’s insurance.

Four states have approved waivers for enrolling newly eligible adults into existing or new Medicaid managed care plans. They required waivers because the states added financial requirements for the expansion population which are not in place for individuals eligible without the expansion. In Iowa, newly eligible enrollees with incomes between 50% and 100% of the FPL enroll in a managed care program and pay a $5 per month premium. As with the higher income group in Iowa, premiums can be waived if health goals are met or if the enrollees attest to financial hardship. Michigan is placing newly eligible adults in the state’s existing Medicaid managed care plans, which are run by commercial managed care organizations. Newly eligible adults with incomes over 100% of the FPL contribute to premiums equal to 2% of their family incomes. These enrollees are also billed for cost sharing quarterly, based on previous health care use. The amount owed can be reduced if they comply with a set of specified “healthy behaviors”, and are capped so that the total of premiums and copays do not exceed 5% of the family income. Pennsylvania received an approved waiver similar to the one in place in Michigan, but the governor of that state has decided to implement a full Medicaid expansion under the terms of the ACA rather than implementing the waiver.

Finally, Indiana has an approved waiver which offers newly eligible Medicaid enrollees coverage in a Medicaid managed care program with benefits starting after the enrollees satisfy a $2,500 deductible (excluding $500 first dollar coverage of preventive services). Deductible costs are paid from an HSA which is created by enrollee premium payments of up to 2% of family income, for enrollees with incomes between 100% and 138% of the FPL. The state puts the difference between the enrollee contribution and the $2,500 into the account. Enrollees who engage in healthy behaviors and use specified preventive care services, along with those who do not use the full amount of their HSA dollars for care, can retain the funds and use them to pay premiums in future years. But those who do not make their premium payments are disenrolled from Medicaid and barred from the program for six months. Indiana enrollees with incomes below 100% of the FPL are not locked out of the program, but if they fail to pay $1 per month into their HSA, they are subject to additional cost sharing payments and are not eligible for supplemental benefits including vision and dental coverage.

So far there are three proposals which states have made in conjunction with their waiver applications which have not been approved by CMS. CMS has not approved charging significant
premiums for Medicaid coverage for individuals with incomes under 100% of the FPL. CMS refused Indiana’s proposal to dis-enroll individuals at that income level from Medicaid if they failed to make payments into their HSA. In addition, CMS did not approve Pennsylvania’s and Indiana’s requests to require that new Medicaid beneficiaries be working or looking for work. Still, the January 2015 approval of the Indiana waiver suggests that the permissible bounds for Medicaid expansion waivers is evolving.20

**Options for Medicaid Expansion in Alabama**

Based on the approaches taken by other states, Alabama has three choices for ways to expand the Medicaid program. The first is to simply expand the current program, as outlined in the ACA, so that it covers adults with incomes up to 138% FPL. Beginning in October 2016, these individuals, along with all of the other Medicaid beneficiaries in the state, would be enrolled in the new community-based managed care model.

This approach has some important advantages. First, the sooner the state’s Medicaid program expands, the longer the period of time the state has to take advantage of the most generous federal payments for the costs of Medicaid coverage. As noted above, federal funds cover 100% of the expansion (except for some administrative costs) through December 2016. Second, adding these adults to the enrollment base for the community care networks has the potential to add financial stability to the plans. Revenue will follow newly covered individuals as capitated payments to the plans from state and federal funds. While the plans will need to cover the costs of the medical care used by these adults, they are likely to be less costly than the adults currently covered by Medicaid, because they do not include individuals who qualify for SSI disability payments.

A second approach would be to use the federal, and eventually the state funds for the Medicaid expansion to purchase private insurance plans on the insurance exchange. Additional Medicaid funds would also be required to help these individuals meet the deductibles and co-pays required in any private insurance plans that they select. This presents a private sector approach to Medicaid expansion, but it has some potential disadvantages. While these adults will likely be less costly to cover than current Medicaid enrollees, they may be more costly to cover than higher income adults currently purchasing coverage on the exchange. Including them in the insured pool may increase the costs of premiums for everyone buying insurance coverage through this mechanism. Also, the availability of Medicaid coverage for private insurance premiums may attract people who would qualify by income for the Medicaid expansion but who currently have insurance through their employers. This phenomenon is termed “crowd out”. It was observed when the State Children’s Health Insurance Programs
were begun in the 1990s, and families had the option to take-up public insurance as a substitute for their employer plans. Crowd out rates are variable, but are arguably more common in the private option scenario, when Medicaid plans are not clearly differentiated from private insurance plans.\footnote{21}

A third approach for Alabama would be to wait until the state’s community care capitated networks are fully launched in October 2016, and to enroll the Medicaid expansion adults into the plans at that point, perhaps with premium and co-pay requirements such as those implemented in Michigan and Indiana. This has the same advantage, described above, of potentially increasing the financial stability of these plans. It has the disadvantage that the state will forego the opportunity to have costs for coverage defrayed at 100% by the federal government until the end of 2016. It also adds a population with unknown characteristics and claims experience in to the community-based networks’ covered populations, just as they are starting to operate on a risk-basis with their plans.

It is too soon to say what the actual impact of requiring premium payments and cost-sharing for expansion enrollees in other states will be. Because the incomes of these individuals are very low, and CMS has restricted the level of the premium that can be charged, it is unlikely that the premium payment process will generate enough funds to meaningfully offset the public costs of these Medicaid programs, or even the costs of collecting the premiums and copays. Previous research on the CHIP program in Alabama indicated that charging even very moderate premiums discourages enrollment in public insurance programs.\footnote{22} The jury is still out on the effectiveness of wellness incentives; it depends in part on how they are designed and whether enrollees understand how they work.\footnote{23} The primary value of these cost sharing requirements may be symbolic. They clearly indicate to participants, to politicians and to the public that the Medicaid expansions are more like insurance plans than entitlements.

The best Medicaid expansion approach for Alabama is a combination of the first and third approaches. If Alabama proposes a waiver now that enrolls individuals into the existing Medicaid program with some type of premium requirement, perhaps paid for with an HSA as in Indiana, the state can gain experience covering this population. These adults will then enter into the state’s Medicaid managed care program when it launches in 2016 as known quantities for the RCOs and the State Medicaid Agency. Proposing a waiver rather than simply expanding Medicaid under the ACA has the advantage of allowing the state to incorporate a premium requirement.

**Section 1332 Waivers**

There is another approach to improving health insurance coverage for low income populations in Alabama which should be seriously considered. No state has proposed this yet, although it is
under discussion in several states. Section 1332 of the ACA authorizes states to request five-year renewable state innovation waivers from the U.S. Departments of Health and Human Services (HHS) and the Treasury. These waivers could be implemented as early as January, 1, 2017, to exempt states from many of the specific requirements of the ACA. Under a Section 1332 waiver, the State of Alabama could adopt an alternative approach to providing affordable health care coverage for individuals between 138% and 400% of the FPL. This would include not only the segment of the population that would benefit from a Medicaid expansion, but also the 90% of the 168,000 who are individuals currently purchasing insurance and receiving subsidies through the federally facilitated exchange. This would bring the total number of Alabama adults covered under such a program to about 444,000, or about 12% of the adult population of the state.

In order to obtain a 1332 waiver, the state must establish that its innovations will not increase the federal deficit and will provide: (1) coverage at least as comprehensive as the coverage defined in section 1302(b) of the ACA [the essential health benefits package] and offered through the exchanges; (2) cost sharing protections against excessive out-of-pocket spending that are at least as affordable as those available under the ACA; and (3) coverage of at least a comparable number of its residents as the ACA. Under a Section 1332 waiver, Alabama could replace the federally facilitated exchange and qualified health plans required under the ACA with alternative mechanisms to provide affordable coverage to its residents. As noted by Howard and Benshoof (2014):

Also known as 2017 waivers or Wyden waivers, 1332s offer wide latitude to states for transforming their health insurance and health care delivery systems. According to the statute, states can request that the federal government waive basically every major coverage component of the ACA, including exchanges, benefit packages, and the individual and employer mandates. But the cornerstone of 1332 waivers is the financing. To fund their reforms, states can receive the aggregate amount of subsidies—including premium tax credits, cost-sharing reductions, and small business tax credits—that would have otherwise gone to the state’s residents. Depending on the size of the state, the annual payment from the federal government for alternate coverage reform could reach into the hundreds of millions or even billions of dollars.

An application for a 1332 waiver could be coupled with an application for a Section 1115 Medicaid expansion waiver. Thus Alabama could propose a 1332/1115 waiver to CMS to provide coverage for those eligible under the Medicaid expansion as well as those individuals between 138-400% of FPL that are currently eligible for premium/cost sharing subsidies in the
federally facilitated insurance exchange. The Medicaid expansion funds as well as the premium/cost sharing subsidies could be used to provide coverage for this entire population through the Regional Care Organizations (RCOs), Alabama’s new community-based managed care program. Enrollees with incomes above 100% FPL could be required to pay premiums and cost sharing on a sliding scale.

This approach could strengthen the RCO system while offering enrollees a more beneficial and less cumbersome arrangement for accessing high quality health care than the current health insurance exchange. The approach is beneficial for the new RCOs, in part because it increases their covered pool of individuals and includes generally healthier individuals than those currently in the Medicaid program. In addition, the broader income eligibility category will reduce the extent of enrollee turnover in those capitated plans. Under this type of reform, as enrollees’ incomes change, the amount of their premiums would change, but they would not be required to exit the plan, only to re-enter it again if their incomes change again. Opening up the RCOs to a non-Medicaid population would require amending legislation, since the current legislation restricts RCOs to serving only Medicaid beneficiaries.

Bottom Line

Alabama’s Medicaid program is undergoing a significant transformation. Financial risks are high, but it is possible that provider network expansion, more flexibility and more local control will improve the efficiency and effectiveness of care provided to the Medicaid population. Adding the adults who can be covered under a Medicaid expansion into the covered population can strengthen this new system, provide a support for these low income individuals and deliver needed revenue to the hospitals and medical providers whom they use for care. The sooner this expansion is undertaken, the more benefit the state can realize from the federal commitments included in the Affordable Care Act. We recommend, at minimum, that the state apply for an 1115 waiver to set terms for inclusion of adults with incomes under 138% of the FPL into the existing Medicaid program, and moving them into the transformed program when it launches in 2016.

A more long-range proposal should consider whether combining some of the subsidies available for low income families to purchase health insurance on the insurance exchange with the federal support available to expand the Medicaid program could result in an innovative system that improves access to care, supports the state’s critical health care infrastructure and keeps state taxpayer support at sustainable levels.
Notes


6 This enhanced primary care case management program, called Patient Care Networks of Alabama, began operating in selected areas of the state in August 2011. The program is partially supported by the Health Homes for Individuals with Chronic Conditions component of the Affordable Care Act. Organizations in each locale provide case management services to enrollees with chronic conditions, and offer support services to primary care physicians and other community health initiatives. A publication by UAB faculty reporting the initial experience of the Patient Care Networks can be found here: http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12319/abstract


13 CMS issued a final regulation on February 27, 2012, outlining the new regulatory requirements for initial section 1115 demonstration applications and extension requests, public notice procedures, and reporting and evaluation requirements.


