Iowa Fiscal Partnership

**POLICY BRIEF**

*March 21, 2013*
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# Promoting Healthier Behaviors Among Medicaid Recipients

## *Governor Branstad's Proposed 'Healthy Iowa' Plan and Federal Law*

**By Mary Nelle Trefz**

On June 28, 2012, the U.S. Supreme Court declared that the Affordable Care Act was constitutional. In its ruling, however, the Supreme Court held that the federal government cannot withhold federal matching funds for a state's existing Medicaid program if the state does not expand Medicaid to cover adults with incomes up to 133 percent of the poverty line. The effect of the Supreme Court's decision is that states can choose whether or not to expand Medicaid. To date, 25 governors have committed to expanding Medicaid in their states.[1] Iowa Governor Terry Branstad, however, currently opposes Medicaid expansion. Instead, Governor Branstad has decided to submit an application for a section 1115 demonstration project — which he is calling the Healthy Iowa Plan (HIP) — to the federal Centers for Medicaid and Medicare Services (CMS). If Governor Branstad moves forward with his Healthy Iowa Plan, the state of Iowa will be responsible for approximately 40 percent of the additional state Medicaid expenditures. If, instead, the state decides to expand Medicaid, the federal government will bear nearly all costs — 100 percent of expenditures for the first three years of expansion and at least 90 percent thereafter.[2]

### *Section 1115 Demonstration Projects: What are They and How Do You Apply?*

States can apply for Section 1115 demonstration projects* in order to test new and experimental policy approaches (e.g., using innovative service-delivery systems designed to improve care, increase efficiency, or reduce costs). Demonstration projects must be "budget neutral" to the federal government — that is, during the course of the project, federal Medicaid expenditures must not be greater than federal spending would have been without the waiver.[3]

### *Governor Branstad's "Healthy Iowa Plan": The Blueprint and the Problems*

Few details have been provided on Governor Branstad's proposed 1115 demonstration project (see appendix), but a blueprint of the Healthy Iowa Plan that provides some information on eligibility requirements, cost-sharing measures, and the contents of the benefit package has been released. The Healthy Iowa Plan seems to be closely modeled after the Healthy Indiana Plan, a section 1115 demonstration project that Indiana implemented in 2007. The Healthy Iowa Plan would cover a projected 90,000 individuals with incomes up to 100 percent of the federal poverty level. Individuals with incomes up to 138 percent of poverty (an estimated 60,000 individuals) could receive subsidized coverage through the federally facilitated exchange (FFE) that will operate in Iowa beginning in 2014.

The Healthy Iowa Plan's benefit package includes inpatient and outpatient services, physician services, prescription drugs, home health, durable medical equipment, therapies and some transportation. The governor stated publicly that mental health services would *not* be covered in the benefit package. In an effort to promote "personal responsibility" and encourage members to be "cost-conscious consumers of healthcare as well as healthy behaviors," the Healthy Iowa Plan would require individuals to make monthly contributions to an account. The state would match these contributions that could then be used to help pay for out-of-pocket expenses. Individuals could earn bonus contributions by participating in the Healthy Behaviors Program (risk assessment, annual physicals and certain preventive services).[4]

Even with limited information, it is clear that two of the main components of the Governor's plan are in opposition to federal Medicaid rules: (1) requiring premiums and more than nominal cost-sharing for individuals below 100 percent of the federal poverty level; and (2) not providing coverage for mental health services.

### *Federal Regulations: Cost-Sharing and Essential Health Benefits*

Section 1916A of the Social Security Act (SSA) prohibits states from imposing premiums on Medicaid beneficiaries with family incomes below 150 percent of the poverty line. In general, cost-sharing is limited to maximum copayments of $4 for outpatient services for beneficiaries with incomes below the poverty line. The SSA defines "premium" as "any enrollment fee or similar charge" and "cost-sharing" as "any deduction, copayment, or similar charge."[5] Therefore, the governor's monthly contribution requirement, which is in effect a premium, is in direct opposition to Section 1916A of the Social Security Act.

Governor Branstad's plan is also in conflict with section 1937 of the Social Security Act. Newly eligible individuals must be covered by a "benchmark benefit." Benchmark benefit plans that may not provide the same benefits as traditional Medicaid were first authorized in the Deficit Reduction Act, and codified in section 1937. Beginning in 2014, benchmark plans must include "essential health benefits" as defined in section 1302 of the Affordable Care Act. Section 1302 defines the following services as "essential health benefits": ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services (including oral and vision care).[6] In addition, section 1937 requires that benchmark benefits include family-planning services. Neither mental health services nor family-planning services are listed in the set of benefits presented in the Healthy Iowa Plan summary.

### *CMS' Authority Regarding Cost-Sharing and Essential Health Benefits*

While states can pursue 1115 demonstration projects to test new approaches — and prior to the Affordable Care Act, some demonstrations were approved that included premiums or limited benefit packages that would not be authorized absent a waiver of statutory provisions — CMS has provided further

**Table 1. Evidence Demonstrating that the "Healthy Iowa Plan" will NOT be Approved by CMS**

| | Federal Law | Healthy Iowa Plan | Citation |
|---|---|---|---|
| **Grounds for Granting 1115 Demonstration Project** | Demonstration projects are designed to demonstrate or pilot *new* and *experimental* policy approaches | HIP does not include a new or innovative approach. HIP closely resembles the Healthy Indiana Plan and implements cost-sharing methods that have been previously tested (and deemed ineffective) by other states in the early 2000s | CMS Info on Section 1115: [7]<br>Language from the Healthy Indiana Plan: [8]<br>States that have implemented similar cost-sharing measures: [9] |
| **Premiums** | Medicaid beneficiaries with incomes ≤150% FPL cannot be required to pay premiums | Requires individuals to make "monthly contributions" or premiums | Section 1916A of the Social Security Act: [10] * |
| **Benefit Package** | Essential Health Benefit packages must include mental health and family planning services | Mental health and family planning services are *not* included in the HIP benefit package | Section 1937 of the Social Security Act: [11] * |

* *Additional Documentation: Letter from the Deputy Administrator of CMS (Cindy Mann) to VA Secretary of HHR (William Hazel) regarding essential health benefits and cost sharing*[i]

[i] http://www.vhca.org/illuminageApps/whatsnewApp/files/8AB3376E3.PDF

guidance on its authority to approve demonstrations that deviate from federal law when ACA provisions take effect in 2014. In a letter to Virginia's Secretary of Health and Human Resources, William Hazel, Cindy Mann, Deputy Administrator of CMS, clearly states that CMS does *not* have the authority to waive cost-sharing requirements or essential health benefits requirements. The CMS letter to Secretary Hazel shows the openness of the CMS administration to support and help develop other Medicaid-reform ideas — areas such as administrative simplification, delivery system and payment reform, and commercial-like benefit packages — but the letter also is clear that this does not extend to benefit packages that do not meet essential health benefits or that impose cost-sharing beyond what is allowed under the Medicaid statute.

### *Promoting Healthy Behaviors — What Works and What Doesn't*

One of the major goals of the governor's proposal is to promote healthier and more cost-conscious behaviors among Medicaid beneficiaries. Governor Branstad proposes implementing monthly contributions in an attempt to encourage healthy and cost-conscious behaviors. This strategy has been previously tested by other states without success.

### *Unsuccessful Experimentation with Cost-Sharing: The Reason for Current Federal Cost-Sharing Law*

In the early 2000s, several states experimented with implementing cost-sharing measures in their Medicaid programs. States that implemented cost-sharing reforms found that even small changes to premiums, cost-sharing or benefit structures led to significant drops in enrollment, especially among those with the most limited financial resources. The IowaCare program, initiated in 2005, originally imposed premiums (equal to 3 percent of income for those under 100 percent of poverty), but abandoned them after one year, after a study showed they produced high rates of disenrollment, were costly to administer, were confusing and difficult to understand by recipients, and created additional difficulties in collection, as many who owed premiums could only pay in cash.[12] Experiences from Oregon and West Virginia showed dramatic drops in participation when premiums were imposed and adverse health impacts on that population.[13]

Since the majority of individuals who lost coverage were the very individuals with the fewest financial resources and the most economically vulnerable, imposing premiums and cost-sharing led to unstable coverage for many with significant dependence on safety-net providers and charity care. The conclusion has been that cost-sharing served as a barrier to obtaining and maintaining coverage, reduced access to care, led to poorer health outcomes and status, increased pressure on safety net clinics, and often did not result in any savings to state Medicaid programs.[14]
Imposing premiums, however, is not the only way to encourage healthy behaviors and promote personal responsibility around health and health costs.

### *Incentivizing Healthy Behaviors: Developing this Important Field*

Both federal and state efforts have focused, more recently, on encouraging healthy behaviors through the use of incentives. Section 4108 of the Patient Protection and Affordable Care Act authorizes CMS to provide grants to states that develop Medicaid Incentive for Prevention of Chronic Disease (MIPCD) programs. These programs provide incentives to beneficiaries who participate in prevention programs and demonstrate change in health outcomes and the adoption of healthy behaviors. The MIPCD grant program is providing $85 million over five years to test the effectiveness of providing incentives directly to Medicaid beneficiaries. Ten states (California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas and Wisconsin) have been awarded grants. (Iowa applied for the MIPCD grant, but did not receive funding).[15]

A growing body of research suggests that programs that incentivize healthy behaviors are, in general, effective. Incentives are most effective at achieving behavior change for preventive care that requires a single activity (such as, receiving a vaccine). Incentives are less effective at changing more complex behaviors that require ongoing engagement (smoking cessation, diet/exercise, etc.).[16] The 1115

demonstration project opportunity offers a way to develop such approaches in Iowa, potentially drawing on Iowa's prior MIPCD grant application and incorporating additional features from the State Innovation in Medicaid planning grant that Iowa did receive. While financial incentives can be effective in changing health behaviors (and, in fact, most private health insurance programs to promote wellness do so primarily by offering incentives, such as the plan at Des Moines University[17]), that is not the only way to produce behavior change. By far the most promising areas are likely to be through medical homes and patient-centered care coordination, which provide hands-on guidance and continuing feedback to patients to maintain efforts and gains, particularly around changing long-standing health behaviors.

Governor Branstad's interest in promoting healthy behaviors and instilling personal responsibility for both health costs and healthy behaviors is well-placed — but his current position on doing so (through premiums and sanctions) has both proved to be ineffective and likely would result in disapproval of any demonstration project proposal submitted to CMS. Governor Branstad and Iowa lawmakers have the opportunity to go back to the drawing board and develop approaches that can achieve that end and receive approval from CMS.

***Appendix: Process and Timeline for Submission of an 1115 Medicaid Waiver*** [18]

At a minimum, from the time of development of the application materials (which are extensive and detailed), there is at least a three-month period for securing approval — which is most likely to be expedited to the extent that the initial standardized application materials are detailed and complete. The following, drawn from an April 27, 2012, letter from CMS (SHO#12-001), outlines the required application process and its public input involvement provisions.

1. *Standardized Application Materials.* State of Iowa develops and posts waiver proposal (for waiver extensions, see: section 431.412(a)(1))
2. *Public Input at the State Level.* State solicits meaningful public input from Iowans regarding waiver, **with at least a 30-day period for response and two public hearings** occurring at least 20 days before submission of waiver.
3. *Formal Submission to CMS.* **State submits waiver to CMS, including "a report of the issues raised through the public comment period** and [description of] how the state considered those comments when developing its application for submission to CMS.
4. *Assessment of Completeness of Application.* **Within 15 days of the submission of the application, CMS will report to the state whether the application is complete** or whether additional information is needed.
5. *Public Input at the Federal Level.* Once CMS notifies the state of the completeness of the waiver application, the **waiver request will be posted for a 30-day national public comment period**, with comments published, reviewed and considered.
6. *Earliest Federal Action.* No sooner than 45 days after the posting for public comment, CMS will render a final decision.
7. *Post Implementation Public Forum.* At least six months after approval, the state must convene a post-award forum to solicit public comment.

**Table 2. Shortest Time for Approval of a Waiver, Following its Posting**

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| **30 days** | State public comment, with two public hearings held within 10 days of posting |
| **1+ day(s)** | Write-up of public comment, including a response to any and all issues raised |
| **1-15 day(s)** | CMS review of completeness |
| **30 days** | National public comment |
| **15 days** | Review of comment and issuance of approval |
| **77 days** | *Minimum* number of days required, in a best-case scenario, for a waiver to be approved |

**Supporting Evidence: Specific Language Regarding Section 1115 Demonstration Projects, Cost-Sharing, and Essential Health Benefits from CMS, SSA, and the ACA**

| **Essential Health Benefits and Cost-Sharing Measures: Language from CMS[19]** |
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| The CMS agrees to support Virginia's interest in meaningful delivery system and payment reforms. CMS agrees to formally negotiate with Virginia to develop consistent and transparent expectations and parameters for expedited development and implementation of innovative Medicaid pilots. … |
| CMS and Virginia further agree that the federal government has very limited flexibility under the statute to waive statutory cost sharing requirements for the expansion population, or for the existing lowest income Medicaid population. **Cost sharing for the expansion and current Medicaid populations, therefore, must conform to limits as established by statute and regulation** [emphasis added]. … |
| If Virginia chooses to move forward with a benchmark coverage option for adults that is not statutorily specified, … Virginia must submit and receive 'Secretary Approved' State Plan authority (no waiver is required). **This benefit package must include all Essential Health Benefits and coverage for family planning services and supplies, and Rural Health Clinic and Federally Qualified Health Center services, and coverage of or assurance of non-emergency transportation** [emphasis added] … |
| The CMS agrees to review a preliminary submission of a proposed benefit package and will provide further guidance on the submission process and documentation needed to evaluate the proposal. |

| **Grounds for Granting Section 1115 Demonstration Project: Language from CMS[20]** |
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| Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:<br>■ Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible<br>■ Providing services not typically covered by Medicaid<br>■ Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.<br>In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver. |

| **Essential Health Benefits: Language from Sec. 1302 of the Affordable Care Act[21]** |
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| ESSENTIAL HEALTH BENEFITS.— (1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:<br>(A) Ambulatory patient services (B) Emergency services (C) Hospitalization (D) Maternity and newborn care (E) Mental health and substance use disorder services, including behavioral health treatment (F) Prescription drugs (G) Rehabilitative and habilitative services and devices (H) Laboratory services (I) Preventive and wellness services and chronic disease management (J) Pediatric services, including oral and vision care. |

[1] http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap
[2] http://www.kff.org/medicaid/upload/8384.pdf
[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html
[4] https://governor.iowa.gov/wp-content/uploads/2013/03/The-Healthy-Iowa-Plan.pdf
[5] http://www.ssa.gov/OP_Home/ssact/title19/1916A.htm
[6] Sec 1302 "Essential Health Benefits" http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
[7] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html
[8] http://www.in.gov/fssa/hip/files/HIP_WaiverforPosting.pdf
[9] http://www.kff.org/medicaid/upload/8417.pdf
[10] http://www.ssa.gov/OP_Home/ssact/title19/1916A.htm
[11] http://www.ssa.gov/OP_Home/ssact/title19/1937.htm
[12] https://www.legis.iowa.gov/DOCS/LSA/IssReview/2007/IRKRJ001.PDF
[13] http://www.kff.org/medicaid/upload/8417.pdf
[14] http://www.kff.org/medicaid/upload/8416.pdf
[15] http://innovation.cms.gov/initiatives/MIPCD/MIPCD-The-States-Awarded.html
[16] http://www.cbpp.org/files/6-1-07health.pdf
[17] http://www.wellnessiowa.org/wp-content/uploads/2011/11/Des-Moines-University-Case-Study.pdf
[18] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-12-001.pdf
[19] http://www.vhca.org/illuminageApps/whatsnewApp/files/8AB3376E3.PDF
[20] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html
[21] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf (Sec 1302 "Essential Health Benefits")

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## Iowa Fiscal Partnership

*The Iowa Fiscal Partnership is a joint initiative of the Iowa Policy Project and the Child & Family Policy Center, two nonprofit, nonpartisan Iowa-based organizations that cooperate in analysis of tax policy and budget issues facing Iowans. IFP reports are available at http://www.iowafiscal.org.*

*The Iowa Fiscal Partnership is part of the State Fiscal Analysis Initiative, a network of state-level organizations and the Center on Budget and Policy Priorities to promote sound fiscal policy analysis. IFP work is supported by the Stoneman Family Foundation and the Annie E. Casey Foundation.*