# State Waivers to Expand Medicaid

## Delivery system for expansion enrollees

Requiring some or all Medicaid expansion enrollees to get coverage through a choice of at least 2 private marketplace plans, also known as the "private option."
*Approved for:* **AR, IA, NH, MI**

**AR**: Approved for all expansion enrollees
**NH:** Approved for all expansion enrollees
**IA**: Approved for expansion enrollees with incomes above 100% of poverty. Currently not an option for enrollees because there is only one plan available.

**MI:** Enrollees above 100% FPL who fail to complete certain wellness plan activities will be required to enroll in a Marketplace plan with a Medicaid wrap (begins April, 2018)

In all states, medically frail are not required to join marketplace plans.

State contracts with managed care plans to provide coverage; plans must meet federal Medicaid standards
*Approved for*: **MI, IN, AZ**

State contracts with a "third party administrator" for claims processing, provider networks and other administrative functions in a managed fee-for-service structure.
*Approved for*: **MT**

## Premiums

### Generally

The ability to charge some expansion enrollees premiums.
*Approved for*: **IA, MI, IN, AR, MT, AZ**

Individuals do not have to pay premiums until 6 months to one year after enrollment.
*Approved for:* **IA, MI**

The ability to require individuals to pay premiums before enrolling. Individuals below 100% to FPL may choose to wait 60 days and then be enrolled in a premium-free basic benefit plan.
*Approved for:* **IN**

Allowing all cost sharing, including premiums, that does not exceed 5% of income calculated by monthly/quarterly income (in all programs).
*Approved for:* **AR, IA, MI, IN, AZ**

*Note: Enrollees who have to pay premiums do not have any other cost sharing except for non-emergency use of the ER.*
*Approved for*: **AR, IA, IN**

### Enrollees with incomes above 100% FPL (101%- 138%)

For enrollees with incomes of 101-138% FPL, charging them premiums of up to 2% of income (same as marketplace premiums for this population).
*Approved for*: **AR, IN, MI, MT, AZ**

The ability to charge individuals in this group premiums of $10/month.
*Approved for*: **IA**

The ability to charge individuals in this group premiums between $10 and $25 per month depending on income.
*Approved for:* **AR**

Non-payment penalties allowed—see *Enrollees with incomes at and below 100% FPL*

**Enrollees with incomes at and below 100% FPL**

Charging premiums at $5/month for individuals with incomes of 50-100% FPL (approximately 1% of income for an individual at 50% FPL). No penalty for non-payment.
*Approved for*: **IA, AR**

Charging premiums at 2% of income for individuals with incomes over 50% FPL.
*Approved for:* **MT**

Giving individuals below poverty the choice of an enhanced benefit package with premiums of 2% of income or $1, (whichever is larger), or a basic benefit package with no premiums and Medicaid-level co-pays. *Approved for:* **IN**

**Penalty for non-payment of premiums**

Allowing disenrollment for individuals with incomes of 101-138% FPL with 90-day grace period. Individuals, however, must be able to immediately re-enroll.
*Approved for*: **IA,, AZ**

Allowing disenrollment for individuals with incomes of 101-138% FPL with 90-day grace period. Individuals may re-enroll upon payment of back premiums.

Allowing disenrollment for individuals with incomes of 101-138% FPL with a 60-day grace period followed by a 6 month lock-out period
*Approved for:* **IN**

Allowing individuals below poverty to be moved from an enhanced benefit package with vision and dental coverage to a basic benefit package for non-payment of premiums.
*Approved for:* **IN**

State may consider unpaid premiums or coinsurance a collectable debt.
*Approved for*: **AR, IA, MI, MT, AZ**

**Cost-sharing (that is different from what is allowed under Medicaid rules)**

Pre-paid cost-sharing placed in individual accounts. No cost-sharing for the first 6 months. Starting in month 7, enrollee has monthly pre-paid cost sharing, based on pro-rated cost-sharing experience of the first 6 months. Thereafter, enrollees' monthly cost-sharing payments are adjusted quarterly, based on the prior quarter's service use. Enrollees receive account statements, but funds do not accumulate in accounts. Cost-sharing payments are disbursed to providers.
*Approved for*: **MI**

Monthly premiums based on income paid into individual accounts. Accounts are fully funded by the state and premium contributions and used to pay co-pays at point of service, unless enrollee fails to pay premiums. If an individual fails to pay the monthly premium, they must pay out-of-pocket for Medicaid level co-pays at point of service.
*Approved for:* **AR**

Monthly premiums based on income are paid into individual accounts. Nonprofits and employers may pay premium contributions on behalf of an individual. Account funds will be used to pay for the first $2,500 in claims; claims beyond the initial $2,500 will be fully covered by Medicaid managed care. Accounts are fully funded by the state and premium contributions.
*Approved for:* **IN**

2-year demonstration allowing cost sharing for non-emergency use of the ER exceeding Medicaid rules for a test group of enrollees. $8 first non-emergent use and $25 for the second.
*Approved for:* **IN**

Strategic cost-sharing structure. No coinsurance will be assessed for preventive services, wellness visits, services to manage chronic illness and mental illness, primary care and/or OB-GYN services, prescriptions and specialty visits with a referral. An $8 co-pay will be charged for non-emergency use of the ER, a $5 or $10 co-pay will be charged for seeing a specialist without a referral and a $4 co-pay will be charged for using brand name drugs when a generic is available. The copays must add up to no more than 3% of household income.
*Approved for:* **IA**

***For more detail on Indiana, Arkansas, and Michigan's cost sharing structure, see Health savings account-like features.***

## Wraparound benefits

One-year waiver exempting state from paying for enrollees' non-emergency transportation. Medically frail enrollees are still provided non-emergency transportation.
*Approved for*: **IA (with a one-year extension), IN**

## Three-month retroactive coverage

Waiver of 3-month retroactive coverage.
*Approved for:* **IN**

## Wellness programs

Allowing state to use wellness plans with premium costs, penalties, and/or cost-sharing amounts waived or reduced for enrollees who complete wellness program requirements.
*Approved for*: **IA, IN, MI, MT, AZ**

## Health savings account-like features

Enrollee premiums and cost-sharing payments are placed into individual health accounts. Cost-sharing is distributed to providers. However, premiums accumulate in accounts and are used to offset the costs of care. Health plans provide coverage before drawing on enrollee accounts. Once these accounts are empty, the plan covers all services. Enrollees are never denied care. Unused individual payments roll over to the next year. If an enrollee is no longer eligible for the demonstration, unused payments are returned to the enrollee or used to purchase other coverage. Entities such as employers and nonprofits may also contribute to accounts.
*Approved for*: **MI**

Individuals above 50% FPL make monthly contributions based on income into "Independence" Health Savings Accounts. Independence Accounts are used to pay co-pays at the point of service. Medicaid fully funds account if co-pay costs exceed account balance. If individuals make 6 months of consecutive contributions, they receive a cash credit that may be used for future premium bills.
*Approved for:* **AR**

All income level enrollees have the option to make payments into POWER accounts with contributions equaling 2% of income or $1, whichever is greater. POWER accounts are fully funded by premium payments and Medicaid, and used to pay for the first $2,500 in claims. Individuals who use POWER accounts have access to HIP Plus, a more generous benefit package including vision and dental services.
*Approved for:* **IN**

Individuals above 100% FPL are required to make monthly contributions, not more than 2% of income, into AHCCCS CARE accounts. Individuals below 100% FPL have the option to make monthly contributions into AHCCCS CARE accounts. AHCCCS care funds can be used for the purchase of non-covered benefits including dental and vision services, chiropractic services, nutrition counseling, recognized weight loss programs, gym membership, and sunscreen. Individuals who meet a healthy behaviors target will not have to pay their monthly contribution for sixth months and are eligible for incentive payments from their AHCCCS CARE account.
*Approved for:* **AZ**

## Employment and job search

Allowing state to use state funds to develop a program to encourage employment. .
*Approved for*: **IN, AZ**