

**ON THE EXPANSION OF “WELFARE” AND “HEALTH” UNDER
MEDICAID**

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ABSTRACT

Medicaid was intended from its inception to provide financial access to health care for certain categories of impoverished Americans. While rooted in historical welfare programs, it was meant to afford the “deserving” poor access to the same sort of health care that other, wealthier Americans received. Yet despite this seemingly innocuous and laudable purpose, it has become a front in the political and social battles waged over the last several decades on the issues of welfare and the safety net. The latest battleground pits competing visions of Medicaid. One vision seeks to transform Medicaid from a health care program into something sharing key trappings of cash welfare programs. Despite the delinkage of Medicaid in most respects from cash welfare with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, some states sought to tie access to Medicaid benefits to adherence to particular healthy behaviors, completion of preventive care measures, and assumption of increased financial responsibility. This trend has increased in the post-Affordable Care Act environment. A competing vision in states seeks to include within Medicaid’s auspices various means of ameliorating not merely medical problems, but also socioeconomic determinants of health. States taking this route are heeding data supporting the premise that, in order to better and more cheaply address the health care needs of everyone, we need to address not only financial access to health care but also environmental, economic, and social factors that can lead to bad health. I will examine these competing visions of Medicaid, and consider the extent to which the Secretary of the U.S. Department of Health and Human Services can arguably grant lawful waivers to these states for these expansions or constrictions. I will further consider the implications of these visions, and their success or failure, on Medicaid’s longer-term prospects, as well as on the greater health care system.

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I. INTRODUCTION

Most Americans believe that everyone should have health insurance. A Harris poll taken in the summer of 2015 found that a large majority of Americans believe that having a system that ensures that people who get sick can obtain the care they need is a moral issue, and that the United States (U.S.) should have a universal health care system so that everyone would have affordable access to medical care.¹

Yet, we do not all agree on the best way to achieve full coverage. The same poll, for example, found that a bare majority of respondents thought that “[i]t should be everybody’s personal responsibility to figure out how to get their health insurance, not the government’s responsibility.”² At the same time, even more respondents believed that the U.S. should have universal coverage, and that, if other “advanced countries” had universal coverage, we could as well.³

This divergence may have to do with a fundamental disagreement regarding *why* everyone should have health insurance. Is it a matter of personal responsibility, or collective risk-sharing? Should people have to prove to the rest of us that they are contributing members of society before they get assistance paying for the high price of coverage, or is health coverage more properly viewed as a precondition of being able to meaningfully contribute in the first place? What help, if any, should any of us get in making sure that we are insured? Does it matter that most of us receive substantial financial subsidies from the federal and state governments in the form of tax exemptions—the value of which rise with the more money we make—and that we did so for decades before the Affordable Care Act (ACA) was ever enacted?

In the realm of Medicaid, these issues are being played out at the state level. This article will look at two different states, Indiana and Oregon, that have taken widely disparate approaches to the question of why people should have coverage, and what they should do in order to deserve it. Admittedly, available data is incomplete and at times scant. Moreover, there are many other factors besides the availability and terms of coverage that impact the factors under consideration here. Nevertheless, I will argue, based on the available data, that, of the two states, Oregon’s approach to Medicaid is not merely more likely to further the goals of Medicaid, but is also likelier than Indiana’s approach to help lead to a healthier and more productive population overall.

1. Dennis Thompson, *Most Americans View Access to Health Care as a Moral Issue*, HARRIS POLL (Sept. 8, 2015), <http://www.theharrispoll.com/politics/Health-Care-Moral-Issue.html>.

2. *Id.*; Gallup has found similar results. *Healthcare System*, GALLUP (2016), <http://www.gallup.com/poll/4708/healthcare-system.aspx?version=print>.

3. Thompson, *supra* note 1.

II. A BRIEF HISTORY OF SECTION 1115 MEDICAID WAIVERS

Medicaid is a cooperative federal-state public program that provides health care to certain low-income Americans.⁴ Generally, the federal government sets the baseline terms for the program and is responsible for overseeing the compliance with those terms by state Medicaid programs.⁵ State governments generally determine the shape and form of their Medicaid programs within the confines set by the federal government, administer their programs, and request waivers from certain federal requirements where they deem such to be desirable.⁶

Because of its hybrid nature, federal law already gives states a certain amount of discretion in designing and implementing their Medicaid programs.⁷ The potential availability of waivers under Section 1115 otherwise expands this discretion substantially.⁸ The law authorizing Section 1115 waivers predates the Medicaid program.⁹ Section 1115 gives the Secretary of the U.S. Department of Health and Human Services (HHS) broad discretion to waive requirements set forth in 42 U.S.C. § 1396a at a state’s request, in order to test an “experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Medicaid Act].”¹⁰ Such waivers are supposed to be “budget neutral;” in other words, they are not supposed to increase programmatic costs beyond what the state’s Medicaid program would have spent in the absence of the waiver.¹¹

4. *Medicaid*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid-chip-program-information/medicaid-and-chip-program-information.html> (last visited Mar. 5, 2016).

5. *Id.*; see also *Federal Policy Guidance*, MEDICAID.GOV, <https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html> (last visited Mar. 5, 2016).

6. See 42 U.S.C. §§ 1396a(a)(1), 1396a(kk)(1)-(3) (2012). Section 1396a addresses general programmatic requirements for state Medicaid programs, ranging from a state Medicaid program’s geographic coverage to provider and supplier screening, oversight, and reporting requirements within the program. *Id.*

7. See generally 42 U.S.C. § 1396a (2012).

8. 42 U.S.C. § 1315a(d)(1) (2012).

9. *Waivers*, MEDICAID & CHIP PAYMENT & ACCESS COMMISSION (2015), <https://www.macpac.gov/subtopic/waivers/>. Section 1115 was added to the Social Security Act in 1962. Lucy A. Williams, *The Abuse of Section 1115 Waivers: Welfare Reform in Search of a Standard*, 12 YALE L. & POL’Y REV. 8, 10 (1994).

10. See Social Security Act, Pub. L. No. 74–271, § 1115, 49 Stat. 620 (codified as amended at 42 U.S.C. § 1315(a) (2012)). Such requirements include, *e.g.*, rules involving premiums and cost sharing by beneficiaries (42 U.S.C. § 1396a(a)(14) (2012)), beneficiary freedom of choice of providers (42 U.S.C. § 1396a(a)(23)(A) (2012)), and timing of initial enrollment (42 U.S.C. §§ 1396a(a)(8) & (34) (2012)).

11. This requirement is not provided in the statute, but rather is based on longstanding HHS policy. See *e.g.*, Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures, 59 Fed. Reg. (Sept. 27, 1994), <https://www.gpo.gov/fdsys/pkg/FR-1994-09-27/html/94-23808.htm> [hereinafter Medicaid Program; Demonstration

Waivers were used relatively sparingly in the context of Medicaid until the early 1990s, and usually only addressed limited populations or geographic regions within a state.¹² This changed in the 1990s during the Clinton era.¹³ The General Accounting Office (now the Government Accountability Office (GAO)) found in 1995 that twenty-two states sought waivers in the preceding three years, primarily to move from a fee-for-service to a managed care delivery system, and to use anticipated savings from the transition to cover previously uninsured populations.¹⁴ Cost-containment was a primary objective of these waivers, one that has often remained a feature, to a greater or lesser degree, of such applications to the present date.¹⁵

The Administration of President George W. Bush encouraged states to become more creative in their waiver plans, and sought greater use of private coverage in the process. In 2001, the Centers for Medicare and Medicaid Services (CMS) invited states to participate in its Health Insurance Flexibility and Accountability (HIFA) program.¹⁶ This Section 1115 waiver initiative focused on expanding coverage, often through private means, to individuals earning less than 200% of the federal poverty level (FPL), ostensibly without the expenditure of any new funds.¹⁷ Because the expansions were, as per longstanding policy, supposed to be budget neutral, the administration

Proposals] (noting that “[t]he Department’s fiduciary obligations in a period of extreme budgetary stringency require maintenance of the principle of cost neutrality”).

12. The GAO notes that Oregon’s 1991 Section 1115 Medicaid waiver application was the first that the federal government had received in ten years. U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-96-44, MEDICAID SECTION 1115 WAIVERS: FLEXIBLE APPROACH TO APPROVING DEMONSTRATIONS COULD INCREASE FEDERAL COSTS 25, 25 nn.30, 31 (1995), <http://www.gao.gov/assets/160/155296.pdf> [hereinafter GAO/HEHS-96-44]. Once applications started coming in, the Centers for Medicare and Medicaid Services (CMS) issued rules for the use of such waivers in the Medicaid program. *See generally* Medicaid Program; Demonstration Proposals, *supra* note 11.

13. Sandra K. Schneider, *Medicaid Section 1115 Waivers: Shifting Health Care Reform to the States*, 27 PUBLIUS 89, 99 (1997); Paul Richter, *Clinton Orders Easier Medicaid Rules for States*, L.A. TIMES, Feb. 2, 1993.

14. GAO/HEHS-96-44, *supra* note 12, at 13.

15. *See generally id.* The Ninth Circuit, at least, has suggested that cost containment is not, on its own, a sufficient basis for the Secretary to grant a Section 1115 waiver. *Newton-Nations v. Betlach*, 660 F.3d 370, 381, 383 (9th Cir. 2011) (quoting *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (“[T]he Secretary’s obligation under § 1315 to ‘make some judgment that the project has a research or a demonstration value’ cannot be satisfied by ‘[a] simple benefits cut, which might save money, but has no research or experimental goal.’”).

16. President George W. Bush, *President Announces Medicaid Reform in Weekly Radio Address*, THE WHITE HOUSE (Aug. 4, 2001), <http://georgewbush-whitehouse.archives.gov/news/releases/2001/08/20010804.html>.

17. *See* NAT’L CONFERENCE OF STATE LEGISLATURES, USING MEDICAID DOLLARS TO COVER THE UNINSURED (2008), <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/All%20States%20Chart.pdf>.

permitted states to increase cost-sharing amounts for optional populations, obtain funding from employers and nonprofits, and—at least initially—to use unspent State Children’s Health Insurance Program (SCHIP)¹⁸ funds.¹⁹ They could also offer different benefit packages than the standard Medicaid benefit package to the expansion population.²⁰

Multiple states took up the Administration’s invitation to experiment with their Medicaid programs, whether through the HIFA initiative or otherwise. By the end of the Bush Administration, at least fifteen HIFA waivers had been approved, and at least forty-three states had at least one active Section 1115 Medicaid waiver.²¹ These waivers were used for a wide variety of purposes, including the privatization of Medicaid coverage in certain regions of a state,²² creating a single, state-run managed care organization,²³ requiring certain

18. After the GAO spent years questioning the use of SCHIP funds (now CHIP funds) to cover adults, Congress eventually restricted the use of SCHIP funds to coverage of children and fetuses. Children’s Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 112, 123 Stat. 8, 29 (2009) (codified as enacted at 42 U.S.C. § 1397kk(a) (2012)); *see also, e.g.*, Letter from Kathryn Allen, Dir., Health Care, U.S. Gov’t Accounting Office, to Senators Charles Grassley and Max Baucus, (Jan. 5, 2004), <http://www.gao.gov/assets/100/92413.pdf>.

The legal and policy concerns that we raised in our July 2002 report remain: HHS continues to approve waivers allowing states to use SCHIP to fund health insurance coverage for childless adults, despite SCHIP’s statutory objective of expanding coverage to low-income children. We believe that these approvals are inconsistent with SCHIP’s goals because they allow SCHIP funds to be diverted from the needs of low-income children. In the absence of congressional clarification of whether SCHIP funds may be used to cover parents and guardians of Medicaid- or SCHIP-eligible children without regard to cost-effectiveness, we also question HHS’s approval of additional waiver proposals for such coverage.

Id.

19. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., APPLICATION TEMPLATE FOR INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) § 1115 DEMONSTRATION PROPOSAL (2001).

20. *See, e.g., id.* at 5-6 (listing the different alternate benefit packages available for optional and expansion populations).

21. Adam Atherly et al., *The Effect of HIFA Waiver Expansions on Uninsurance Rates in Adult Populations*, 47 HEALTH SERVS. RES. 939, 941-43 (2012); *see* NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 17.

22. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., FLORIDA MANAGED MEDICAL ASSISTANCE DEMONSTRATION SPECIAL TERMS AND CONDITIONS 2 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medi-caid-reform-ca.pdf> (noting that “The Florida Medicaid Reform demonstration was approved October 19, 2005. The state implemented the demonstration July 1, 2006, in Broward and Duval Counties, and then expanded to Baker, Clay, and Nassau Counties July 1, 2007.”).

23. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., VERMONT GLOBAL COMMITMENT TO HEALTH DEMONSTRATION SPECIAL TERMS AND CONDITIONS 2 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf> [hereinafter VERMONT] (noting that “The Global Commitment to Health Section 1115(a) demonstration was initiated in September 2005, and is designed to use a

Medicaid beneficiaries to adhere to “personal responsibility” pledges or else forfeit certain benefits,²⁴ and extending private coverage to childless adults on the condition, among others, that beneficiaries contribute a set percentage of their income in a medical spending account,²⁵ complete a health needs assessment in order to match beneficiaries to different private managed care plans,²⁶ or receive only a limited ambulatory benefit package.²⁷

multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility.”).

24. *See, e.g.*, NAT’L ASS’N OF STATE BUDGET OFFICERS, REDESIGNING MEDICAID USING THE DEFICIT REDUCTION ACT 6 (2007), http://www.nasbo.org/sites/default/files/Issue%20Brief_DRA_091807.pdf.

The most unique aspect of West Virginia’s new plan is the member agreement, which adults must sign in order to have themselves or their children moved from the Basic Plan to the Enhanced Plan. The member agreement, or personal responsibility contract, includes broad responsibilities for individuals as well as beneficiary rights. If the state determines an individual has not met his or her responsibilities after one year of enrollment, the individual or the child will be moved to the Basic Plan and must wait 12 months to qualify for reenrollment in the Enhanced Plan.

Id.

25. CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: HEALTHY INDIANA PLAN 1, 2 (2010), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-HIP/in-healthy-indiana-plan-stc-01012008-12312012-amended-012010.pdf> [hereinafter HEALTHY INDIANA PLAN].

The HIP provides a high-deductible health plan and an account styled like a health savings account called a POWER Account to uninsured adults including low-income custodial parents and caretaker relatives of Medicaid and Children’s Health Insurance program (CHIP) children and uninsured non-custodial parents and childless adults. Participation in HIP is voluntary, but all enrollees will be required to receive medical care through the high deductible health plans POWER Accounts.

Id.

26. *See, e.g.*, U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-13-384, MEDICAID DEMONSTRATION WAIVERS: APPROVAL PROCESS RAISES COST CONCERNS AND LACKS TRANSPARENCY 46-47 (2013), <http://www.gao.gov/assets/660/655483.pdf> [hereinafter GAO-13-384] (noting that “The program included a variety of features: a requirement for participants to complete a health needs assessment—used to match enrollees with health maintenance organizations and providers that meet the individual’s specific health care needs . . .”).

27. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: PRIMARY CARE NETWORK DEMONSTRATION, UTAH 7 (2002), <http://www.health.utah.gov/pcn/pdf/Special%20Terms%20&%20Conditions.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY MICHIGAN SECTION 1115 DEMONSTRATION FACT SHEET (2010), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-fs.pdf>.

Prior to its amendment to authorize Healthy Michigan, the demonstration provided federal financial participation for the Adult Benefit Waiver (ABW) program, ABW provides a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the FPL who are not eligible for Medicaid. The ABW program was first approved in January 2004

The Obama Administration quietly let the HIFA waiver initiative disappear, and initially seemed intent on curbing some of the arguable excesses of Section 1115 waivers under the Bush Administration, ones that became “a substitute for rulemaking or way to circumvent the law,” or that “push[ed] states into compromising financing arrangements.”²⁸ Certain public-private partnerships in the Medicaid program continued under the Obama Administration prior to the enactment of the ACA, but it appeared that they would no longer be favored for their own sake as they were under the Bush Administration.²⁹

Additionally and notably, the ACA made significant changes in the way that Section 1115 Medicaid waivers would be evaluated. The GAO and various stakeholders had complained for years about the waiver process’s lack of transparency and public input.³⁰ Accordingly, the ACA required the Secretary to promulgate regulations putting in place “a process for public notice and comment . . . sufficient to ensure a meaningful level of public input” both before the state submits, and after the Secretary receives, a waiver application; requirements regarding project goals, state and federal costs, and state implementation plans; and a process for reporting on and evaluating the demonstration project.³¹ CMS also posted the general criteria that it uses to determine whether Medicaid’s objectives are being met.³² Additionally, it has

as a title XXI funded Health Insurance Flexibility and Accountability (HIFA) [S]ection 1115 demonstration.

Id.

28. Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J. L., MED. & ETHICS 416, 422 (2004).

29. See, e.g., Letter from Carolyn L. Yocom, U.S. Gen. Accountability Office, to Senators Charles Grassley, Max Baucus, & Henry A. Waxman, & Representative Joe Barton (Jan. 19, 2010), <http://www.gao.gov/new.items/d10258r.pdf>.

30. See, e.g., U.S. GEN. ACCOUNTING OFFICE, GAO-02-817, MEDICAID AND SCHIP: RECENT HHS APPROVALS OF DEMONSTRATION WAIVER PROJECTS RAISE CONCERNS 2-4 (2002), <http://www.gao.gov/assets/240/235107.pdf>; U.S. GEN. ACCOUNTING OFFICE, GAO-04-480, MEDICAID WAIVERS: HHS APPROVALS OF PHARMACY PLUS DEMONSTRATIONS CONTINUE TO RAISE COST AND OVERSIGHT CONCERNS 2 (2004), <http://www.gao.gov/assets/250/243286.pdf>; U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-07-694R, MEDICAID DEMONSTRATION WAIVERS: LACK OF OPPORTUNITY FOR PUBLIC INPUT DURING FEDERAL APPROVAL PROCESS STILL A CONCERN 2 (2007), <http://www.gao.gov/assets/100/95034.pdf>; U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-07-694R, MEDICAID DEMONSTRATION WAIVERS: RECENT HHS APPROVALS CONTINUE TO RAISE COST AND OVERSIGHT CONCERNS 7 (2008), <http://www.gao.gov/assets/280/271789.pdf>; GAO-13-384, *supra* note 26, at 2.

31. Social Security Act, Pub. L. No. 74–271, § 1115(d), 49 Stat. 620 (codified as amended at 42 U.S.C. § 1315(d) (2012)).

32. Those criteria are whether the proposed demonstration will:

[I]ncrease and strengthen overall coverage of low-income individuals in the state; increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state; improve health outcomes for Medicaid

sought to standardize the waiver process by promulgating a standardized waiver template and budget neutrality calculation form, and by more clearly laying out standards for independent evaluation of project outcomes.³³

III. SECTION 1115 MEDICAID WAIVERS AFTER *NATIONAL FEDERATION OF INDEPENDENT BUSINESSES V. SEBELIUS*

The direction the Obama Administration would have taken, over time, on its own accord regarding Section 1115 waivers will never quite be known because of the Supreme Court's 2012 decision in *National Federation of Independent Businesses (NFIB) v. Sebelius*. *NFIB v. Sebelius* tilted the balance of power in Medicaid waiver decisions from the federal to certain state governments by making the ACA's Medicaid expansion optional rather than mandatory.³⁴ Just over half of the states initially refused to expand Medicaid to all adults earning up to 133% FPL under the terms of the ACA.³⁵ They would only agree to expand Medicaid, if at all, if CMS waived certain programmatic conditions.³⁶ Many of these conditions both track and extend prior efforts by

and other low-income populations in the state; or increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Section 1115 Demonstrations, MEDICAID.GOV, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html> (last visited Mar. 21, 2016).

33. See Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., to State Medicaid Dir. & State Health Official (Apr. 27, 2012), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-001.pdf> [hereinafter CMS, State Medicaid Letter]; CTRS. FOR MEDICARE & MEDICAID SERVS., SECTION 1115 DEMONSTRATION PROGRAM TEMPLATE, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/fillable-1115-demo-10-12v2.pdf>.

34. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2566 (2012).

Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that all States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding. Section 1396c gives the Secretary of Health and Human Services the authority to do just that. It allows her to withhold all 'further [Medicaid] payments . . . to the State' if she determines that the State is out of compliance with any Medicaid requirement, including those contained in the expansion. 42 U.S.C. § 1396c. In light of the Court's holding, the Secretary cannot apply § 1396 to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.

Id. at 2607.

35. *Id.* at 2572, 2629.

36. See, e.g., MARYBETH MUSUMECI & ROBIN RUDOWITZ, THE ACA AND MEDICAID EXPANSION WAIVERS 1 (2015), <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers> (noting that, as of November 2015, six out of the thirty-one states participating in the expansion had received waivers through which they planned to implement their expansion, and one state, Pennsylvania, had previously sought and obtained an expansion waiver but had

some right-leaning states to make Medicaid look and feel more like private coverage, and to institute “personal responsibility” requirements.³⁷ Not wanting to leave the poorest residents of those states with no secure access to Medicaid coverage, the Obama Administration ultimately acquiesced to waiver features that it might otherwise never have contemplated granting.

As states that initially balked at implementing the Medicaid expansion slowly and ultimately contemplate taking up the expansion, the concessions extracted from CMS have grown. Initially, Arkansas sought and obtained approval in September 2013 for its “private option” expansion,³⁸ which extends at least two qualified health plans (QHPs) in the “Silver” tier available through state Exchanges to adults—other than “medically frail” adults and Native Americans—in the expansion population, and provides wrap-around Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage for individuals ages nineteen and twenty.³⁹ The state pays the individual’s premium on the individual’s behalf.⁴⁰ The following year, Arkansas sought and obtained amendments to use a state-run system of non-emergency transportation for the expansion population and, notably, to institute a system of “Independence Accounts” into which the expansion population members earning between fifty percent and 133% FPL must contribute.⁴¹ If beneficiaries fail to make the required contributions, then they must pay cost-sharing amounts out-of-pocket at the point of service, and providers may deny services

abandoned it in favor of the standard expansion mechanism when the state elected a new governor).

37. See, e.g., Laura D. Hermer, *Personal Responsibility: A Plausible Social Goal, but Not for Medicaid Reform*, 38 HASTINGS CTR. REP. 16, 16 (2008); Laura D. Hermer, *Medicaid, Low Income Pools, and the Goals of Privatization*, 17 GEO. J. ON POVERTY L. & POL’Y 405-06 (2010) [hereinafter Hermer, *Medicaid*].

38. Letter from Eliot Fishman, Dir., State Demonstrations Grp., to John Selig, Dir., Ark. Dep’t of Human Servs. (Aug. 14, 2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf>.

39. CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: ARKANSAS HEALTH CARE INDEPENDENCE PROGRAM (PRIVATE OPTION) 9-10, 13, 14 (2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf> [hereinafter ARKANSAS HC INDEPENDENCE PROGRAM].

40. *Id.* at 11.

41. Letter from Marilyn Tavenner, Adm’r, Ctrs. For Medicare & Medicaid Servs., to John Selig, Dir., Ark. Dep’t of Human Servs. (Dec. 31, 2014); ARKANSAS HC INDEPENDENCE PROGRAM, *supra* note 39, at 15-17. Individuals earning between fifty percent and 100% FPL must contribute at least five dollars per month to their Independence Account; those earning between 100% and 133% FPL must contribute between ten and twenty-five dollars, on a sliding scale. *Id.* at 16-17. If beneficiaries fail to make the required contributions, then they must pay cost-sharing amounts out of pocket at the point of service, and individuals making more than 100% FPL may be denied services. *Id.* at 18. Funds in the account may be used for cost-sharing amounts or premium payments for QHPs if the individual becomes ineligible for Medicaid. *Id.* at 6 (Attachment C).

to them.⁴² According to its own terms, the waiver is intended to promote continuity of care by smoothing out the effects of churning between Medicaid and private coverage; improve reimbursement rates for providers and accordingly improving access to care by reimbursing providers at market rates rather than Medicaid rates; and promote beneficiary responsibility by making them contribute to the cost of their care as a condition of enrollment.⁴³

These three goals are common features of many expansion state plans. Iowa, Indiana, Michigan, and New Hampshire provide premium assistance for QHPs or other coverage to part or all of the Medicaid expansion population.⁴⁴ With the exception of New Hampshire, these states require many beneficiaries, even in some cases those earning less than 100% FPL, to pay premiums or other forms of financial contribution.⁴⁵ Iowa and New Hampshire pay providers private coverage rates for services provided through a QHP.⁴⁶ Iowa

42. ARKANSAS HC INDEPENDENCE PROGRAM, *supra* note 39, at 2.

43. *Id.* at 3.

44. CTRS. FOR MEDICARE & MEDICAID SERVS., WAIVER LIST: IOWA MARKETPLACE CHOICE PLAN SECTION 1115 DEMONSTRATION IOWA 1 (2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf> [hereinafter IOWA WAIVER LIST]; CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: IOWA MARKETPLACE CHOICE PLAN 1 (2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf> [hereinafter IOWA CHOICE PLAN]; CTRS. FOR MEDICARE & MEDICAID SERVS, INDIANA SPECIAL TERMS AND CONDITIONS 9 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf> [hereinafter HEALTHY INDIANA PLAN 2.0]; CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: NEW HAMPSHIRE HEALTH PROTECTION PROGRAM PREMIUM ASSISTANCE 2 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf> [hereinafter NEW HAMPSHIRE HEALTH PROTECTION PROGRAM]; CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: HEALTHY MICHIGAN SECTION 1115 DEMONSTRATION 8 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf> [hereinafter HEALTHY MICHIGAN]. Michigan will start providing the expansion population earning over 100% FPL with the opportunity to choose a QHP rather than the Medicaid plan starting in 2018. *Id.* at 3.

45. IOWA CHOICE PLAN, *supra* note 44, at 8; HEALTHY INDIANA PLAN, *supra* note 25, at 17-18; HEALTHY MICHIGAN, *supra* note 44, at 12-13. If Arizona's proposed waiver is granted, then it too will join this list, as it proposes to charge all non-disabled adults between eighteen and sixty-four without dependent children a premium amount equal to two percent of their income or twenty-five dollars per month, whichever is less. DOUGLAS E. DUCEY, ARIZ. HEALTH CARE COST CONTAINMENT SYS., ARIZONA'S APPLICATION FOR A NEW SECTION 1115 DEMONSTRATION 5-6 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa2.pdf>.

46. IOWA WAIVER LIST, *supra* note 44, at 2; NEW HAMPSHIRE HEALTH PROTECTION PROGRAM, *supra* note 44, at 2. Presumably Michigan will as well once that program goes into effect. HEALTHY MICHIGAN, *supra* note 44, at 13. Indiana used to pay providers Medicare rates

and Indiana require members of the expansion population earning at least 100% FPL to contribute to either premium or cost-sharing accounts, or else be disenrolled.⁴⁷

These features, among others, are quite different than anything one would find within the traditional parameters of Medicaid. Medicaid is a program for impoverished Americans who typically have minimal, if any, access to health insurance, and as such, has traditionally shielded beneficiaries from premium payments, cost-sharing, and other requirements.⁴⁸ A majority of states do make use of private managed care plans in their Medicaid programs, but omit many key features commonly found in such plans when offered on the private market. They must include certain benefits, such as non-emergency medical transportation, that private market plans do not cover.⁴⁹ If they charge premiums at all, states may charge them only to beneficiaries earning at least 150% FPL.⁵⁰ Cost-sharing must be “nominal,” if imposed at all, for beneficiaries earning up to 100% FPL.⁵¹ For those earning between 100% and 150% FPL, cost-sharing amounts are limited to no more than ten percent of the cost of a given item or service, and, in aggregate over the course of a month or quarter, no more than five percent of the family’s income.⁵² States do not require “prepayment” of such costs into a health spending account, to the extent they charge them at all in their traditional Medicaid program, nor do they penalize beneficiaries for failing to make such prepayments.⁵³ They do not require beneficiaries to seek and obtain certain forms of health care, such as preventive and/or dental services, nor penalize them for failing to do so.⁵⁴

under the first iteration of Healthy Indiana Plan (HIP), but now pays only about seventy-five percent of Medicare rates. *See, e.g.*, IND. HEALTH COVERAGE PROGRAMS BULLETIN, IHCP ANNOUNCES PHYSICIAN REIMBURSEMENT RATE INCREASES WITH HIP 2.0 IMPLEMENTATION (Jan. 27, 2015), www.indianamedicaid.com/ihcp/Bulletins/BT201504.pdf.

47. IOWA CHOICE PLAN, *supra* note 44, at 2. If beneficiaries complete the required “healthy behaviors” within the relevant time periods, however, they will not be subject to premium payments. *Id.* at 17; HEALTHY INDIANA PLAN, *supra* note 25, at 24. Indiana also imposes a twenty five dollar fee for non-emergent use of emergency departments under most circumstances after the first such usage each year. *Id.* at 27. Arizona’s waiver proposal also would disenroll members under such circumstances. DUCEY, *supra* note 45, at 75.

48. *Medicaid*, *supra* note 4.

49. 42 C.F.R. § 440.170(a) (2015); 42 U.S.C. § 1396a(a)(70) (2012).

50. 42 U.S.C. § 1396o(c)(1) (2012). Most children, pregnant women, terminally ill individuals, individuals living in an institution who are required to spend nearly all their income on the cost of their care, certain women with breast or cervical cancer, certain disabled children, and Native Americans are exempt from having to pay premiums. *See id.* § 1396o-1(b)(3).

51. *Id.* § 1396o-1(a)(2).

52. *Id.* § 1396o-1(b)(1).

53. For penalties that may be imposed on certain populations for failing to pay premiums and/or cost-sharing, *see id.* § 1396o-1(d).

54. 42 U.S.C. §§ 1396d(a)(10), 1396d(a)(13) (2012).

They are strictly limited in the amount they may charge beneficiaries as a co-payment for obtaining non-emergency care in an emergency department.⁵⁵ Mindful of the public purse, they also typically reimburse providers, especially physicians, at substantially lower than private market rates for services provided under state Medicaid programs.⁵⁶

What difference, if any, do these variances between traditional Medicaid and private market plans make? Do they make traditional Medicaid beneficiaries less mindful of the amount of care they use, or do they have little impact in that respect? Do they make it easier for traditional Medicaid beneficiaries to keep their coverage, as long as they remain eligible for the program, or is there little quantifiable evidence of their effect in that regard? Is there any difference in health outcomes between individuals enrolled in one versus the other type of plan? Does the provision of coverage with private market trappings make recipients more likely to eschew cash welfare programs, remain employed, keep their medical appointments, and be otherwise respectable members of society than their peers with traditional Medicaid coverage? How, if at all, do these outcomes differ between states utilizing one of the two different types of approaches?

Before we move on to address these questions, I would like to introduce a different collection of waiver programs, one that takes a different philosophy toward Medicaid coverage. This group is not as amenable to pigeonholing as the last. However, one can argue that, rather than the “welfare” approach of the last group, this one takes more of a “public health” approach to Medicaid. None of the states in this group have sought their waivers as a condition of participating in the ACA’s Medicaid expansion. Instead, they have, for the most part, taken an expansive approach to health coverage that predates the ACA, in many cases on the theory that, because federal health reform, pre-ACA, seemed unlikely to occur, they should work on reforming their own coverage systems as best as possible. Following enactment of the ACA, some states have continued with this project and are using or seeking to use Section 1115 Medicaid waivers in the process. These states include Vermont,⁵⁷ California,⁵⁸ and Oregon.⁵⁹

55. 42 U.S.C. § 1396o-1(e).

56. See, e.g., *Medicaid-to-Medicare Fee Index*, KAISER FAM. FOUND. (2012), <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>. Medicare rates typically are lower than private market rates. See Cristina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades*, 22 HEALTH AFF. 230, 230 (2003).

57. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., VERMONT SECTION 1115 DEMONSTRATION FACT SHEET (2015), <http://www.aucd.org/docs/policy/hcbs/vt-global-commitment-to-health-fs.pdf>.

58. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., CALIFORNIA BRIDGE TO REFORM SECTION 1115 DEMONSTRATION FACT SHEET (2015), <https://www.medicaid.gov/Medi>

While these states’ waiver programs are quite different, there are a number of common features to them. Foremost, they are seeking a more unified and systematic approach that extends coverage to as many of their residents as possible.⁶⁰ They are creating integrated health care delivery systems that take a holistic approach to patient needs.⁶¹ These systems go beyond encouraging changes to delivery systems by paying for outcomes rather than services, for example. Rather, they often expressly utilize medical home-based models and include coverage for non-traditional services such as child care, housing and homeless services, foster care supports, and job training.⁶² These waiver

caid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-bridge-to-health-reform-fs.pdf.

59. CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: OREGON HEALTH PLAN 5 (2012), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf> [hereinafter OREGON HEALTH PLAN].

60. See CAL. DEP’T OF HEALTH CARE SERVS., MEDI-CAL 2020: KEY CONCEPTS FOR RENEWAL 4, 30-34 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-bridge-to-health-reform-pa.pdf> [hereinafter CAL. DEP’T OF HEALTH CARE SERVS.]. California is presently seeking to reform its Medicaid disproportionate share hospital program (DSH), which provides federal and state funding to hospitals that care for a disproportionately large share of uninsured and Medicaid patients. *Id.* DSH funds have often been provided in many states with few strings attached. *Id.* California, however, is proposing to disburse DSH funds under a “global payment” system which would direct care for the remaining uninsured population to designated public hospitals that would receive a set budget within which to provide a set list of services to them. *Id.* But see, e.g., Soumya Karlamangla, *Civil Rights Complaint Filed Against Medi-Cal*, L.A. TIMES (Dec. 15, 2015), <http://www.latimes.com/local/lanow/la-me-ln-civil-rights-complaint-filed-against-medi-cal-20151213-story.html> (reporting on a complaint that several California civil rights organizations filed with the federal Department of Health and Human Services, complaining that reimbursement rates are so low that beneficiaries cannot access care). Oregon has sought a more rational and cost-effective approach over the last few decades to health care in order, in part, to extend coverage to a greater portion of the state’s population. OREGON HEALTH PLAN, *supra* note 59, at 5-7. In addition to covering the expansion population and others through its Global Commitment to Health waiver, Vermont is also providing additional subsidies to Vermonters earning less than 300% FPL to purchase coverage on the state Exchange. VERMONT, *supra* note 23, at 2.

61. CAL. DEP’T OF HEALTH CARE SERVS., *supra* note 60, at 5; VERMONT, *supra* note 23, at 32; OREGON HEALTH PLAN, *supra* note 59, at 7.

62. CAL. DEP’T OF HEALTH CARE SERVS., *supra* note 60, at 27-28. Oregon has been instituting Patient-Centered Primary Care Homes intended to not only manage and coordinate members’ health care services but also provide individual and family support services provided by community health workers, peer support and wellness specialists, doulas, and others. OREGON HEALTH PLAN, *supra* note 59, at 19, 22, 26. Vermont’s Blueprint for Health Model takes a community-based approach to health. See STATE OF VT. AGENCY OF HUMAN SERVS., QUARTERLY REPORT FOR THE PERIOD JANUARY 1, 2015-MARCH 31, 2015 16-17 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/down>

programs are also taking a more expansive approach to population health, under the theory that health care, as traditionally conceived, plays only one part in achieving the larger goal of ensuring that people have access to the conditions necessary to lead healthy lives.⁶³ They typically do so, moreover, without requiring beneficiaries to pay additional premiums or cost-sharing for services, and without imposing other “personal responsibility” requirements.⁶⁴

Expanding coverage while improving population health within the resource constraints of state Medicaid programs, particularly given the federal policy of requiring budget neutrality for waiver programs, may appear to be a daunting task, particularly without requiring funding from additional sources, such as from the beneficiaries themselves. But as we will see, it may in fact be less costly to take the population health approach espoused by states such as Vermont, California, and Oregon, than it is to take the approach championed by states such as Indiana, Iowa, and Michigan. Additionally, to the extent data is available, health and other outcomes for programs such as Oregon’s are better than those of programs such as Indiana’s.

IV. THE HEALTHY INDIANA PLAN 2.0

Governor Mike Pence of Indiana had no intention of participating in the ACA’s Medicaid expansion under the terms given in the ACA when he took office in 2013.⁶⁵ At the time, the state had a program covering traditional Medicaid eligibility categories.⁶⁶ It additionally covered an expansion population under the “Healthy Indiana” Plan (HIP), a Section 1115 waiver granted by the second Bush Administration at the end of 2007.⁶⁷ HIP allowed the State to extend private coverage of a relatively broad range of health care

loads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-qtrly-rpt-jan-mar-2015.pdf [hereinafter VERMONT QUARTERLY REPORT].

63. Thus, for example, California is proposing to use Medicaid funds to cover services intended to help at-risk beneficiaries to stay in their homes or to secure stable housing. CAL. DEP’T OF HEALTH CARE SERVS., *supra* note 60, at 24-26. Oregon’s Coordinated Care Organizations are charged with taking a population-health approach to health care. *See* OREGON HEALTH PLAN, *supra* note 59, at 5, 7, 26 (referencing Section VII of the plan relating to measurement of quality care and access to care).

64. *See* CAL. DEP’T OF HEALTH CARE SERVS., *supra* note 60, at 3; OREGON HEALTH PLAN, *supra* note 59 at 10, 19; VERMONT QUARTERLY REPORT, *supra* note 62, at 4.

65. Maureen Groppe Star & Mary Beth Schneider, *Expansion is a Bad Idea, Say Daniels, Pence*, INDIANAPOLIS STAR, June 29, 2012, at A1. Mitch Daniels, the governor at the time of the decision in 2012, was leaving office and left the decision regarding expansion to the incoming governor. *Id.*

66. *See* Hermer, *Medicaid*, *supra* note 37, at 419.

67. IND. FAMILY & SOC. SERVS. ADMIN., HIP HEALTHY INDIANA PLANSM HEALTH COVERAGE = PEACE OF MIND 4 (2014), [http://www.in.gov/fssa/hip/files/HIP_Waiver_Renewal_\(Final_6_30_14\).pdf](http://www.in.gov/fssa/hip/files/HIP_Waiver_Renewal_(Final_6_30_14).pdf).

benefits to a small, capped number of the State’s uninsured adult population who did not otherwise qualify for Medicaid.⁶⁸

In February 2013, Governor Pence initially proposed a mere extension of HIP.⁶⁹ He wrote in his letter to then-Secretary Sebelius:

Medicaid is broken. It has a well-documented history of substantial waste, fraud and abuse. It has failed to keep pace with private market innovations that have created efficiencies, controlled costs, and improved quality. It has done little to improve health outcomes and does not adequately reimburse providers. Its burdensome rules and unwieldy regulations do not allow states to effectively manage their programs.⁷⁰

Pence claimed that HIP offered a better potential vehicle for expanding Medicaid, and that his State would not consider expanding Medicaid unless CMS first agreed to an extension of HIP, which was set to expire in 2013.⁷¹ CMS summarily denied the request less than two weeks later, due to the State’s failure to comply with the ACA’s public notice and comment provisions.⁷² Notwithstanding the unpromising start, the Pence Administration and CMS ultimately reached an agreement in January 2015—Indiana would participate in the ACA’s Medicaid expansion, but would do so using HIP as a vehicle.⁷³

HIP 2.0’s provisions and requirements are complex. HIP 2.0 offers benchmark coverage through managed care organizations (MCO)⁷⁴ to non-disabled, non-elderly adults earning 133% FPL or less,⁷⁵ and who are not

68. Typically, the waiver covered only about five percent of the eligible, uninsured population at any given time. *See, e.g.*, Laura D. Hermer & Merle Lenihan, *The Future of Medicaid Supplemental Payments: Can They Promote Patient-Centered Care?*, 102 KY. L.J. 287, 308, 313 (2013-2014).

69. Letter from Michael Pence, Governor of Ind., to Kathleen Sebelius, Sec’y of Health & Human Servs. (Feb. 13, 2013), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-HIP/in-healthy-indiana-plan-ext-req-ltr-02132013.pdf> [hereinafter Letter from Pence to Sebelius].

70. *Id.*

71. *Id.*

72. Letter from Diane T. Gerrits, Dir., Div. of State Demonstrations & Waivers, to Patricia Casanova, Dir., Office of Medicaid Policy & Planning (Feb. 25, 2013), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-HIP/in-healthy-indiana-plan-ext-deny-ltr-02252013.pdf>.

73. HEALTHY INDIANA PLAN, *supra* note 25, at 2.

74. For a summary of the plans available under HIP 2.0, *see generally Healthy Ind. Plan, Health Plan Summary*, IN. GOV., http://www.in.gov/fssa/hip/files/IN-HIP-PlanChartSmmry_41MAX_031015.pdf (last visited Mar. 24, 2016).

75. 138% with the five percent income disregard. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012).

otherwise eligible for Medicaid.⁷⁶ It differs from the original HIP in a number of respects. Unlike the original HIP, HIP 2.0 has no annual or lifetime limits on coverage, and also offers broader coverage—though at a lower reimbursement rate than the original HIP.⁷⁷ There are three different types of plans under HIP 2.0. HIP Basic covers all “essential health benefits,” including but not limited to primary care, inpatient and outpatient medical care, hospice care, home health care, maternal care, mental and behavioral health care, and pharmaceuticals.⁷⁸ HIP Plus covers the essential health benefits, plus vision and dental care.⁷⁹ HIP Link is not coverage per se, but rather contributes up to \$4,000 toward the premium and cost-sharing amounts owed by HIP-eligible individuals who have employer-sponsored coverage rather than HIP.⁸⁰ HIP does not cover non-emergency medical transportation, and beneficiaries who make non-emergent use of emergency department services are charged a higher co-payment.⁸¹

Coverage under HIP 2.0 is modeled on a private, high-deductible health plan, just as it was under the original HIP.⁸² Accordingly, the coverage comes with a health savings account.⁸³ This account, called, as it was under the original HIP, a Personal Wellness and Responsibility, or “POWER” account, is funded by contributions from both the state and the beneficiary.⁸⁴ Beneficiaries—no matter how impoverished—must contribute two percent of their income⁸⁵ each month to their POWER account; the state contributes the

76. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 8. Pregnant women who choose to stay in HIP during their pregnancy may remain in HIP rather than being transferred to the state’s traditional Medicaid program. *Id.* at 9.

77. IND. FAMILY & SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN 2.0: INTRODUCTION, PLAN OPTIONS, COST SHARING, AND BENEFITS 32 (2015), http://www.in.gov/fssa/hip/files/HIP_2_0_Training_-_Introduction_Plans_Cost-Sharing_Benefits.pdf; IND. FAMILY & SOC. SERVS. ADMIN., HIP 2.0 APPROVED! (2016), http://www.in.gov/fssa/hip/files/HIP_PPT_2.0_2.16.15.pdf.

78. *Healthy Indiana Plan FAQ*, IN.GOV, <http://www.in.gov/fssa/hip/2452.htm> (last visited Mar. 24, 2016). For a list of Indiana’s essential health benefits through 2016, *see generally* *Indiana EHB Benchmark Plan*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Indiana-Benchmark-Summary.pdf> (last visited Mar. 24, 2016).

79. *Healthy Indiana Plan FAQ*, *supra* note 78.

80. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 15-16.

81. *Id.* at 14, 27.

82. KAISER FAMILY FOUND., HEALTHY INDIANA PLAN AND THE AFFORDABLE CARE ACT 1 (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/12/8529-healthy-indiana-plan-and-the-affordable-care-act1.pdf>.

83. *Id.*

84. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 17.

85. HEALTHY INDIANA PLAN, *supra* note 25, at 20. Beneficiaries earning less than five percent FPL must only contribute one dollar per month. CTRS. FOR MEDICARE & MEDICAID SERVS., WAIVER LIST: HEALTHY INDIANA PLAN (HIP) 2.0 1 (2015), <https://www.medicaid.gov/>

remainder.⁸⁶ When a beneficiary who makes such contributions uses covered health care services, he must pay for them using a card issued in connection with the account.⁸⁷ If a beneficiary uses more than \$2,500—the maximum amount in the POWER account—then the state will cover the remainder, other than the twenty-five dollar copayment a beneficiary might owe due to non-emergent use of an emergency department.⁸⁸ If a beneficiary uses less than the \$2,500 in covered health care services, then she may roll over a portion of that amount to the next year and thereby reduce the contributions she must make to the account, provided she has never been disenrolled from HIP during a coverage year.⁸⁹ Regardless of the amount in a beneficiary’s POWER account, the MCO must pay for a covered service.⁹⁰ However, if a beneficiary is terminated from the HIP for nonpayment of POWER account contributions, and has used more health care than the value of his POWER account at the time he received the service, he must repay the MCO up to the full value of the contributions he would have owed that year.⁹¹ Any amount such a beneficiary fails to pay is treated as debt.⁹²

Rather than commencing on the date the individual applies for coverage, as in traditional Medicaid, eligibility starts on the date an individual makes her first payment to her POWER account, and is not retroactive.⁹³ Beneficiaries

Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf [hereinafter INDIANA WAIVER LIST].

86. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 24.

87. *Id.* at 21-22. Preventive services are covered by the state at first dollar, rather than from the POWER account. *Id.* at 22.

88. *Id.* at 27. The state is randomizing 5,000 HIP beneficiaries into a group that owes only eight dollars per non-emergent use of the emergency department and will compare the emergency department use of the two groups. *Id.* at 28.

89. *Id.* at 22-24. If the beneficiary is enrolled in HIP Basic, then he must obtain at least one age and gender appropriate preventive service in order to roll over any applicable amount in his POWER account. *Id.* at 23. If a beneficiary is enrolled in HIP Plus, then she can have her contribution doubled by obtaining such preventive care. *Id.*

90. *Id.* at 26.

91. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 20, 24-25. Individuals who fail to pay due to a “qualifying event” are exempt from this requirement. *Id.* “Qualifying events” include obtaining and then losing private coverage; having a loss of income after disqualification due to increased income; taking up residence in another state; being a victim of a declared disaster; being a domestic violence victim; and being or becoming medically frail. *Id.*

92. *Id.* at 17.

93. *Id.* at 10-11. If an individual who is not required to make POWER account payments as a condition of continued eligibility fails to make their first payment within sixty days, then their eligibility for HIP starts on the first day of the first month in which the sixty day period ends. *Id.* If an individual is screened for eligibility at a federally-qualified health center, a rural health center, a community mental health center, or a public health department and is found to be eligible for HIP, then, unlike other beneficiaries, the individual will be deemed presumptively eligible at that time for a minimum of sixty days. *Id.*

earning more than 100% FPL are required to make such contributions.⁹⁴ If they fail to do so for more than sixty days, then their coverage is revoked and they become ineligible for further coverage under HIP for six months.⁹⁵ Beneficiaries earning less than 100% FPL must make contributions to their POWER account if they want HIP Plus; otherwise, they are only eligible for HIP Basic.⁹⁶ Additionally, they become responsible for cost-sharing payments.⁹⁷

As of July 31, 2015, only 27,828 individuals with incomes over 100% FPL enrolled in HIP 2.0; the remainder of the 264,004 enrollees earned less than 100% FPL.⁹⁸ As the second HIP quarterly report observes, the low number of individuals subject to the mandatory POWER account contribution may be due to their enrollment, instead, in Marketplace coverage.⁹⁹ This is possible, as individuals buying a Silver Marketplace plan would only be responsible for paying two percent of their income toward premiums, and up to six percent of out-of-pocket costs.¹⁰⁰ Individuals enrolled in HIP, on the other hand, are responsible for paying only up to a maximum of five percent of their income, an amount they will not likely reach, provided they diligently pay two percent of their income monthly toward their POWER account.¹⁰¹ While costs would accordingly be higher in perhaps most cases for Marketplace coverage, it is possible that some individuals would prefer to pay those costs rather than be subject to the requirements and welfare trappings of HIP 2.0. The “Gateway to Work” program is one such “welfare” feature of HIP 2.0.¹⁰² It offers no-cost assistance to HIP beneficiaries in finding work.¹⁰³ Although participation in the program is voluntary,¹⁰⁴ and although the CMS approval letter expressly

94. *Id.* at 18.

95. *Id.* at 17, 24.

96. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 17. Rules for medically-frail individuals and low-income individuals ages nineteen and twenty differ slightly, but neither group may be disenrolled for failing to pay into their POWER account. *Id.* at 24-25.

97. *Id.* at 17.

98. IND. FAMILY & SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN DEMONSTRATION: SECTION 1115 QUARTERLY REPORT tbl. 1 (2015), www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-qtrly-rpt-may-july-10082015.pdf [hereinafter HIP 2D QUARTERLY REPORT].

99. *Id.*

100. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 311 (2010) (codified at 26 U.S.C. § 36B (2012)).

101. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 25. Only three percent of HIP beneficiaries earning more than 100% FPL were disenrolled due to a failure to pay their POWER account contribution. HIP 2D QUARTERLY REPORT, *supra* note 98.

102. *Gateway to Work*, HEALTHY IND. PLAN, www.in.gov/fssa/hip/2466.htm (last visited Feb. 26, 2016).

103. *Id.*

104. *Id.*

noted that the program was “outside” of the HIP demonstration,¹⁰⁵ all HIP beneficiaries who are either unemployed or who work less than twenty hours per week are automatically referred to the program.¹⁰⁶

HIP’s POWER accounts are the program’s cornerstone.¹⁰⁷ Indiana expects that contributing regularly to a POWER account will “encourage personal responsibility, improve healthy behaviors, and develop cost conscious consumer behaviors among all beneficiaries.”¹⁰⁸ POWER accounts and the requirements associated with them are expressly intended to sharply distinguish HIP from Medicaid. As an advisor to Governor Pence claimed, “[i]t’s that we require people to make contributions. That really flies in the face of the entitlement thing.”¹⁰⁹ And indeed, the mere requirement of contribution, at least for those earning more than 100% FPL, does appear to be the main point of the POWER account. There does not appear to be any serious belief that the contributions will in fact substantially defray state costs.¹¹⁰ They do not count toward the federal match.¹¹¹ Their connection with healthy behaviors is tenuous at best.¹¹² And they certainly do not improve the financial status of

105. Letter from Marilyn Tavenner, Adm’r, Ctrs. for Medicare & Medicaid Servs., to Joseph Moser, Dir., Ind. Family & Soc. Servs. Admin. (Jan. 27, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf>.

106. *Gateway to Work*, *supra* note 102.

107. *See, e.g.*, Letter from Senator Richard Lugar et al., to Kathleen Sebelius, Sec’y Health & Human Servs. (Nov. 4, 2011), www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-ar.pdf (noting that “the POWER account was designed to be the cornerstone of HIP”).

108. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 2.

109. J. K. Wall, *Pence Still Angling to Use Healthy Indiana Plan to Expand Medicaid*, IND. BUS. J. (Feb. 23, 2013), www.ibj.com/articles/39757-pence-still-angling-to-use-healthy-indiana-plan-to-expand-medicaid. HIP 2.0 also offers, for beneficiaries who choose to use it, job training and employment-related services. *See, e.g.*, HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 3. While the employment features are voluntary under HIP 2.0, the state has sought to include them among the objectives of the waiver. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN, DRAFT EVALUATION DESIGN 1 (2015), www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-draft-eval-design-10292015.pdf [hereinafter HIP DRAFT EVALUATION].

110. *See* ROBERT M. DAMLER & CHRISTINE MYTELKA, MILLIMAN CLIENT REPORT: 1115 WAIVER – HEALTHY INDIANA PLAN EXPANSION PROPOSAL 7 (2014), www.in.gov/fssa/hip/files/15-1115_Waiver_Expansion_-_2015.pdf (referring to Table 4).

111. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 40.

112. *See, e.g.*, HEALTHY INDIANA PLAN DEMONSTRATION, 1115 ANNUAL REPORT 50, 64 (2014), http://in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf [hereinafter HEALTHY INDIANA ANNUAL REPORT 2012]. While claiming that HIP copays caused HIP members to make more judicious use of the emergency room than traditional Medicaid beneficiaries, the report observed that “Survey respondents were also asked whether the [emergency room (ER)] copayment policy ever caused them to decide not to go to the emergency room. Less than seven percent of members reported that they avoided the ER because of the copayment.” *Id.*

the poor and near-poor Indiana residents who must make contributions. Nevertheless, the waiver's special terms and conditions describe the purpose given above for POWER accounts, among HIP 2.0's other goals as "promot[ing] the objectives of Title XIX [Medicaid]."¹¹³

How well has HIP 2.0 been accomplishing these goals? Unfortunately, there is not yet much publicly available information on which to base any assessment. Data from the original waiver shows that individuals who received HIP were largely grateful to have any health insurance at all, quite likely because in most cases their alternative was to have none.¹¹⁴ HIP members were surveyed on their opinions of the program and whether it changed their health habits, and demographic and economic data were collected, but the data—or at least the portion of it that was released publicly—yielded few if any results that would suggest that HIP yields better coverage and care outcomes for low-income populations.¹¹⁵ Finally, per member per month costs were greater for the HIP population, overall, than for the traditional Medicaid population, notwithstanding HIP's POWER account that was intended to encourage "responsible" use of health care services.¹¹⁶ As for the present waiver, while it has been in effect for nearly a year, Indiana is still negotiating with CMS over

113. HEALTHY INDIANA PLAN 2.0, *supra* note 44, at 2. Other goals include promoting "increased access to health care services," "increasing quality of care and efficiency of the health care delivery system," and "promoting private market coverage and family coverage options through HIP Link to reduce network and provider fragmentation within families." *Id.* Indiana is testing the following as a condition of the waiver:

Whether a monthly payment obligation linked to a POWER account will result in more efficient use of health care services; whether the incentives established in this demonstration for beneficiaries to obtain preventive services and engage in healthy behaviors will result in better health outcomes and lower overall health care costs; and whether POWER account contributions in lieu of cost sharing for individuals participating in the HIP Plus Plan will affect enrollment, utilization, and the use of preventive and other services by beneficiaries.

Id.

114. *See, e.g.*, HEALTHY INDIANA ANNUAL REPORT 2012, *supra* note 112, at 91 (reporting that, according to an unreleased 2013 Mathematica survey, seventy-six percent of HIP beneficiaries were "very satisfied" with their coverage).

115. *See generally id.* (reporting demographic data, POWER account contribution and rollover information, emergency department usage, use of preventive care services, chronic disease prevalence, and HIP beneficiary opinion, but failing to compare the data to one or more relevant control groups).

116. *See, e.g.*, IND. OFFICE OF MEDICAID POLICY & PLANNING, QUARTERLY FINANCIAL REVIEW 6, 13 (Dec. 2011) (showing that, while Hoosier Healthwise (traditional Medicaid) adults receiving risk-based managed care cost an average of \$293.48/month from July 2011 to December 2011, HIP adults cost \$2,486.71 per month. Even when one removes the highest-cost HIP population (those in the Enhanced Services Plan), costs still were about 140% greater for caretaker adults and 290% greater for non-caretaker adults in HIP than for comparable adults in Hoosier Healthwise).

the evaluation design for the program.¹¹⁷ CMS, under the Obama Administration, has standardized key features of Section 1115 waiver applications, and has issued regulations making the evaluation component of waivers more stringent than they were previously.¹¹⁸ Hence, the evaluation of HIP 2.0 may ultimately yield more useful data, which will actually be made public, than the first HIP waiver did.¹¹⁹

This will depend, however, on the study design CMS ultimately accepts. Indiana’s proposed evaluation design for HIP offers few comparisons between HIP and traditional Medicaid. Rather, to the extent that comparisons are made at all, most of the comparisons are between HIP 2.0 beneficiaries and those who are eligible but do not enroll, HIP 2.0 and HIP beneficiaries, or different classes of HIP 2.0 beneficiaries.¹²⁰ This is problematic. The baseline hypothesis of HIP 2.0 does not concern, for example, an assertion that the second iteration contains programmatic improvements over the first, or that HIP 2.0 beneficiaries are better off as compared to the uninsured. Rather, it is that HIP 2.0—an ostensibly “consumer-driven” plan—is superior to Medicaid qua “entitlement program.”¹²¹ As such, it would seem that, if Indiana truly wants to prove its point, it would seek to compare HIP 2.0 as against either traditional Medicaid, with respect to its coverage of congruent beneficiaries, or as against the standard ACA Medicaid expansion as carried out in similar states wherever possible and relevant.

Yet that is neither what Indiana proposes, nor what CMS appears to be seeking. On the one hand, this may have something to do with difficulties in crafting a congruent in-state comparison. Because of the way the waiver is structured, HIP 2.0 now covers most non-disabled, non-elderly adults who used to be eligible for Medicaid in Indiana.¹²² One needs to make apples-to-apples comparisons, and without a sufficiently numerically robust comparison group of non-disabled, non-elderly adults in traditional Medicaid in Indiana,

117. See, e.g., Letter from Andrea J. Casart, Acting Dir., Div. of Medicaid Expansion Demonstrations, to Joseph Moser, Medicaid Dir., Ind. Family & Soc. Servs. Admin. (Oct. 29, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-draft-eval-design-10292015.pdf> (noting that CMS has concerns about Indiana’s proposed study design, and suggesting revision).

118. See CMS, State Medicaid Letter, *supra* note 33 and accompanying text; see also SECTION 1115 DEMONSTRATION PROGRAM TEMPLATE, *supra* note 33 and accompanying text.

119. Hermer & Lenihan, *supra* note 68, at 310 (noting some of the studies and data from the original HIP waiver were never publicly released, though in some cases ostensible findings from them were cited by Indiana’s Family and Social Services Administration).

120. See HIP DRAFT EVALUATION, *supra* note 109, at 26-30, 34-38, 40-41, 45-47, 50, 52-53.

121. See, e.g., Niki Kelly, *HIP 2.0 Receives Federal Funding*, J. GAZETTE (Jan. 25, 2015), www.journalgazette.net/news/local/indiana/HIP-2-0-receives-federal-approval-4712263; see also J.K. Wall, *supra* note 109.

122. See HIP DRAFT EVALUATION, *supra* note 109, at 4.

comparing outcomes in HIP 2.0 against those in traditional Medicaid makes little sense. On the other hand, parents and caretakers who are eligible for Medicaid under the old cash welfare limits are still enrolled in traditional Medicaid in Indiana.¹²³ Additionally, many states opted for the standard Medicaid expansion under the ACA.¹²⁴ It could be useful to know how features such as health outcomes, health care use, perceived health status, and ease of benefit use compare between these two populations and the lowest-income HIP 2.0 beneficiaries.¹²⁵

Really, what we need from Indiana and the other waiver expansion states is data that would help prove or disprove the assertion that providing lower-income beneficiaries with personal responsibility requirements and the trappings of private plans in fact furthers the objectives of Medicaid. Those objectives, as provided by CMS, are to:

- increase and strengthen overall coverage of low-income individuals in the state;
- increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- improve health outcomes for Medicaid and other low-income populations in the state; or
- increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.¹²⁶

One suspects that CMS granted Indiana's and other waiver expansion states' waiver requests on the theory that coverage expansion testing nearly any theory that arguably fits within the Secretary's waiver authority is better than no coverage expansion at all. If one compares Indiana's demonstration against the prospect of no coverage expansion at all, then indeed the proposal "increase[s] and strengthen[s] overall coverage of low-income individuals in the state," and will likely also further others of CMS's stated objectives.¹²⁷

Because the coverage expansion is optional, courtesy of *NFIB v. Sebelius*, it is difficult to argue that CMS got the comparison group wrong here, at least

123. See 42 C.F.R. § 435.110(c) (2015) (enumerating the cash welfare limits); see also HIP DRAFT EVALUATION, *supra* note 109, at 10.

124. See *Status of State Action on the Medicaid Expansion*, KAISER FAM. FOUND., <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (last visited Mar. 15, 2016) (compiling the list of states that have opted for the standard Medicaid expansion under the ACA).

125. See HIP DRAFT EVALUATION, *supra* note 109 (exploring how Indiana proposes in some cases to compare HIP 2.0 to expansion populations in other states, but not to the extent one might expect for a robust comparison).

126. *Section 1115 Demonstrations*, *supra* note 32.

127. *Id.*

with respect to doing the right thing for Indiana's expansion population. But in terms of doing what is right for Medicaid, granting the waiver does not appear to be the right move. How does requiring non-nominal cost-sharing from low-income beneficiaries, or designing the benefit plan to mimic a high-deductible health plan, or delaying the start of coverage in most cases until the beneficiary makes a POWER account contribution, or disenrolling and imposing a six-month lockout on a beneficiary for non-payment of required contributions, or referring beneficiaries to employment services "increase and strengthen overall coverage of low-income individuals in the state,"¹²⁸ or otherwise further Medicaid's goals? On the contrary, if one assumes that having stable access to health care is a good,¹²⁹ then it would appear to weaken them. Ample evidence already exists that imposing cost-sharing requirements on low-income individuals has a deleterious effect on both their coverage and care.¹³⁰ It is not obvious, then, how Indiana's demonstration, among the other studies that

128. *Id.*

129. *See, e.g.*, Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults after State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025, 1028-29 (2012) (finding a significant reduction in all-cause mortality, a significant reduction in uninsurance, a significant decline in delayed care, and a significant increase in rates of "excellent" or "very good" health following state Medicaid expansions); Helen Levy & David Meltzer, *What Do We Really Know About Whether Health Insurance Affects Health?* 33-34 (Dec. 20, 2001) (unpublished manuscript) (on file with the University of Chicago) (summarizing studies evaluating the effect of health insurance on health, and finding that all but one suggest a positive effect); Joseph J. Sudano & David W. Baker, *Intermittent Lack of Health Insurance Coverage and Use of Preventive Services*, 93 AM. J. PUB. HEALTH 130, 133-34 (2003) (finding that, the greater the number of intermittent coverage gaps a person has, the less likely they are to use preventive care services when covered). The ACA has been improving the stability of coverage, even over only the first year of its implementation. *See, e.g.*, Adele Shartzter & Sharon K. Long, *Quick Take: More Adults Have Stable Health Insurance Coverage as ACA Implementation Proceeds*, *Urban Institute Health Reform Monitoring Survey*, URB. INST. HEALTH POL'Y CTR. (Dec. 2, 2015), <http://hrms.urban.org/quicktakes/More-Adults-Have-Stable-Health-Insurance-Coverage-as-ACA-Implementation-Proceeds.html>; SARA R. COLLINS ET AL., *THE RISE IN HEALTH CARE COVERAGE AND AFFORDABILITY SINCE HEALTH REFORM TOOK EFFECT* 4-6 (David Blumenthal et al. eds., 2015) (finding a decline in the number of adults reporting that they did not receive medical care because of cost, and that uninsured adults reported difficulty in obtaining care due to cost at twice the rate as insured adults).

130. Lauren Snyder and Robin Rudowitz, in their review of the relevant literature, found in summary, among other findings, that premiums often impose a barrier to coverage for low-income individuals; cost-sharing imposes substantial barriers to obtaining necessary care for low-income individuals and can cause them to delay or omit treatment, whether necessary or unnecessary, as well as sometimes substitute lower-cost treatment for higher-cost services; the effect of cost-sharing on non-emergent use of emergency department services is mixed; and that savings from cost-sharing accrue more from a decline in utilization rather than an increase in patient revenue. LAUREN SNYDER & ROBIN RUDOWITZ, *PREMIUMS AND COST-SHARING IN MEDICAID: A REVIEW OF RESEARCH FINDINGS* 3, 6-7, 11 (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf>.

require increased premium and/or cost-sharing from low-income beneficiaries, could add anything sufficiently useful to what is already known on the subject to warrant waiver approval.¹³¹

There is no evidence that the purpose of Medicaid is to teach low-income Americans the virtues of personal responsibility, whether they need such education or not. Nor is there any evidence that the purpose of Medicaid is to inculcate a respect for the free market, or small government, or any other political or economic theory for that matter. Rather, Medicaid is intended to extend financial access to a robust package of health services to populations that typically lack such access via other means.¹³² Should a state wish to “test” a demonstration project that clearly, based on available evidence, either is known not to further such a purpose, or otherwise falls outside of the Secretary’s statutory authority to grant, the Secretary should deny the proposal.

V. THE OREGON HEALTH PLAN

Oregon’s Section 1115 waiver—the Oregon Health Plan (OHP)—presents a very different case from Indiana’s. The original waiver began in 1994.¹³³ Oregon initially sought to achieve universal health coverage in the state, but when that reform fell through, it instead focused on extending Medicaid coverage to all state residents earning 100% FPL or less.¹³⁴ Because budget neutrality required the state to find sufficient savings elsewhere in the program to cover the expansion population it wanted to cover, Oregon proposed to ration the services it offered through Medicaid.¹³⁵ It developed, and over the years has refined and revised, a list of health condition and treatment pairs, ranked in order of priority based on clinical and cost effectiveness.¹³⁶ Depending on available funding, the program draws a line on the list after a

131. Sidney Watson argues persuasively that, even where provisions in demonstration proposals technically fall within the authority of the Secretary to grant, it may be an abuse of discretion to grant a waiver purporting to study an issue where prior research has consistently yielded a known result. Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act’s Medicaid Expansion*, 15 YALE J. HEALTH POL’Y, L., & ETHICS 213, 218, 226 (2015).

132. Hermer, *Medicaid*, *supra* note 37, at 419.

133. OREGON HEALTH PLAN, *supra* note 59, at 5.

134. Jonathan Oberlander, *Health Reform Interrupted: The Unraveling of the Oregon Health Plan*, 26 HEALTH AFF. w96, w97 (2007).

135. *Id.* at w96. Nevertheless, in the current iteration of its waiver, Oregon received a \$1.1 million dollar investment from HHS. See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-15-239, MEDICAID DEMONSTRATIONS: APPROVAL CRITERIA AND DOCUMENTATION NEED TO SHOW HOW SPENDING FURTHERS MEDICAID OBJECTIONS 17 (2015) [hereinafter GAO MEDICAID DEMONSTRATIONS].

136. OREGON HEALTH PLAN, *supra* note 59, at 17; see Thomas Bodenheimer, *The Oregon Health Plan: Lessons for the Nation*, 337 NEW ENG. J. MED. 720, 720 (1997).

particular condition-treatment pair.¹³⁷ Conditions falling below that line are not reimbursed; those falling above it are.¹³⁸ This feature of the OHP remains today.¹³⁹

Under the current iteration of the OHP, all Medicaid beneficiaries other than expansion adults (non-disabled, non-elderly, non-caretaker individuals between eighteen and sixty-four years of age, earning up to 133% FPL) and women eligible through the Breast and Cervical Cancer Treatment Program¹⁴⁰ receive OHP Plus.¹⁴¹ OHP Plus provides all approved services on the prioritized list, EPSDT services for individuals under age twenty-one, services provided by “non-traditional health workers,”¹⁴² person-centered primary care home services, mental health facility services, long term care services, intermediate care facility services for individuals with mental retardation, and Medicare premium payments and cost-sharing.¹⁴³ Expansion adults receive the Alternative Benefit Plan, which consists of essential health benefits on the prioritized list.¹⁴⁴

These features of the OHP, however, are largely old news. The innovative features have to do with the delivery system reforms that the State started in 2012.¹⁴⁵ Oregon’s goals for the current demonstration project are to “reduce the trend in statewide Medicaid per capita spending” while “improving access and quality.”¹⁴⁶ Toward those ends, rather than continuing to deliver and pay

137. Bodenheimer, *supra* note 136, at 723.

138. *Id.* at 653-54. If a treatment is not funded, providers are directed to inform patients of appropriate treatments, even if not funded, and to write a prescription for such treatment where relevant. OREGON HEALTH PLAN, *supra* note 59, at 17-18.

139. OREGON HEALTH PLAN, *supra* note 59, at 17. The prioritized list of services, current as of October 1, 2015, draws the line below:

Condition: ACQUIRED PTOSIS AND OTHER EYELID DISORDERS WITH VISION IMPAIRMENT (See Guideline Notes 64, 65, 130). Treatment: PTOSIS REPAIR.

HEALTH EVIDENCE REVIEW COMM’N, PRIORITIZED LIST OF HEALTH SERVICES 115 (2015), <http://www.oregon.gov/oha/herc/PrioritizedList/10-1-2015%20Prioritized%20List%20of%20Health%20Services.pdf>.

140. OREGON HEALTH PLAN, *supra* note 59, at 16. This population receives coverage for relevant treatment for breast and/or cervical cancer or precancerous lesions for which they are otherwise uninsured. *See id.* at 20.

141. *Id.* at 16, 20. Oregon covers pregnant women up to 185% FPL, children ages zero to one up to 185% FPL, children one to eighteen up to 133% FPL, the aged, blind, and disabled at Supplemental Security Income (SSI) eligibility (seventy-four percent FPL), women in the Breast and Cervical Cancer Treatment Program up to 250% FPL, and expansion adults up to 133% FPL. *See id.* at Attachment D.

142. *Id.* at 16. These individuals include community health workers, peer wellness specialists, patient navigators, and doulas. *Id.* at 175.

143. *Id.* at 16-17.

144. *Id.* at 19.

145. OREGON HEALTH PLAN, *supra* note 59, at 22.

146. *Id.* at 174.

for care in ways that have become standard in many state Medicaid programs, Oregon is developing Care Coordination Organizations (CCO) through which all care is delivered to its Medicaid population.¹⁴⁷ CCOs resemble state-created, geographically demarcated accountable care organizations.¹⁴⁸ They are community-based managed care organizations that are paid to deliver primary care-based, full-spectrum care to a regional Medicaid population via a global budget consisting of capitated per member per month payments and a separate per member per month payment based on other services.¹⁴⁹ A portion of the CCO's reimbursement is withheld and disbursed based on whether the CCO met certain quality and access metrics.¹⁵⁰ Providers who share in the financial risk constitute a majority on each CCO's governing board, and they are given input through a community advisory council.¹⁵¹

While CCOs primarily deliver medical care, their services go beyond traditional health care offerings.¹⁵² Community health workers and others provide training, support, and case management services to certain mentally ill and substance abusing populations.¹⁵³ Non-traditional health workers provide home visits for newborns and their mothers.¹⁵⁴ Some job training and support services for certain at-risk populations are provided.¹⁵⁵

CCOs are also charged with partnering with relevant agencies and organizations. Partnering arrangements include, in particular, working with the state Public Health Division to address social contributors to chronic diseases.¹⁵⁶ CCOs are specifically charged under the waiver with developing "Transformation Plans."¹⁵⁷ These Plans address "social conditions beyond the immediate control of a single individual or Coordinated Care Organization" that constitute "systemic barriers and root causes of poor health outcomes," such as "persistent mental illness, addiction, homelessness, unemployment,

147. *Id.* at 7.

148. Or. Health Policy Bd., *Coordinated care: the Oregon difference*, OREGON.GOV, <http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx> (last visited Mar. 6, 2016).

149. OREGON HEALTH PLAN, *supra* note 59, at 25, 31; *see also* OR. CTR. FOR PUB. POLICY, UPDATED ABCS OF CCOS: THE BASICS OF HOW OREGON AIMS TO TRANSFORM HEALTH CARE 1, 2 (2012), <http://www.ocpp.org/media/uploads/pdf/2012/04/fs20120430CCOBasicsUpdatedfnl.pdf>; Lauren Broffman & Kristin Brown, *Year Two: Capturing the Evolution of Oregon's CCOs*, HEALTH AFF. BLOG (July 15, 2015), <http://healthaffairs.org/blog/2015/07/15/year-two-capturing-the-evolution-of-oregons-ccos/>.

150. OREGON HEALTH PLAN, *supra* note 59, at 33-34. The Special Terms and Conditions contain detailed specifications regarding the relevant metrics. *Id.* at 34-37, 179-245.

151. *Id.* at 25.

152. *Id.* at 25, 130.

153. *Id.* at 130-35.

154. *Id.* at 132.

155. OREGON HEALTH PLAN, *supra* note 59, at 135.

156. *Id.* at 194-95.

157. *Id.* at 183-84.

lack of transportation and lack of quality education,” through “the community needs assessment, community health improvement plan, the Community Advisory Council and collaboration with state and local public health agencies and community partners.”¹⁵⁸ In this and other goals, such as the elimination of health care disparities, CCOs receive assistance from state entities that offer training to CCOs and disseminate best practices developed at local levels.¹⁵⁹

Oregon is not alone in using Medicaid dollars for non-traditional services. However, the State does stand out in being one of the only states that has, for the most part, successfully justified to the satisfaction of the GAO that its coverage of such services using Medicaid funds is reasonable under federal requirements.¹⁶⁰ While the GAO admittedly did not look at the substance behind the justifications, substantial research supports transforming health care delivery systems from ones that reward increased care, regardless of quality or outcomes, to ones that reward more efficient achievement of improved population health outcomes and higher quality of care.¹⁶¹

158. *Id.* at 195. The state asked CCOs to submit Transformation Plans addressing the following eight areas:

- Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions. This plan must specifically address the needs of individuals with severe and persistent mental illness.
- Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).
- Implementing consistent alternative payment methodologies that align payment with health outcomes.
- Preparing a strategy for developing Contractor’s Community Health Assessment (CHA) and adopting an annual Community Health Improvement Plan (CHIP) consistent with 2012 Oregon Laws, Chapter 8 (Enrolled SB 1580), Section 13.
- Developing electronic health records; health information exchange; and meaningful use.
- Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.
- Assuring provider network and staff ability to meet cultural diverse needs of community (cultural competence training, provider composition reflects Member diversity, nontraditional health care workers composition reflects Member diversity).
- Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Or. Health Auth., *Transformation Plan Key Component Guidance and Technical Assistance*, OREGON.GOV, <https://cco.health.oregon.gov/Pages/transformationplan.aspx> (last visited Mar. 6, 2016).

159. OREGON HEALTH PLAN, *supra* note 59, at 195-98.

160. GAO MEDICAID DEMONSTRATIONS, *supra* note 135, at 28-34.

161. *See, e.g.*, Scott Buris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 U. PA. L. REV. 1649, 1650 (2011); regarding health care delivery, *see* Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 761-62 (2008); MAUREEN BISOGNANO & CHARLES KENNEY, PURSUING THE TRIPLE

To date, CCOs appear to be making some positive differences in the health of the populations they serve, as well as decreasing utilization of unnecessary services. Not all outcomes were good. For example, utilization of some preventive care services, such as Pap and chlamydia tests, declined, as did, children's access to primary care providers.¹⁶² Nevertheless, reported access to care improved slightly in 2014.¹⁶³ All-cause readmission rates declined from 12.8% in 2013 to 11.4% in 2014.¹⁶⁴ Emergency department use declined from 50.5 per 1,000 member months in 2013 to 47.3 in 2014.¹⁶⁵ Avoidable emergency department use declined by almost half from 2011 to 2014.¹⁶⁶ More physicians reported seeing Medicaid patients, and patient satisfaction scores improved.¹⁶⁷ Both inpatient and outpatient costs have decreased since 2011.¹⁶⁸ At the same time, most CCOs are receiving 100% or more of their quality pool payments, and all CCOs met at least ten of their seventeen quality improvement targets.¹⁶⁹

An initiative such as Oregon's could easily flounder in many different respects. For example, the state could merely be paying lip service to the triple aim of cost containment, better care, and improved population health. The state could support the program's goals, but fail to provide adequate centralized guidance, support, and funding to local CCOs in the latter's pursuit of them. Local providers could fail to trust each other and/or the state program adequately to work together efficiently and responsively. So far, however, it appears that none of these issues have yet materialized to a sufficiently substantial degree to put the program in jeopardy. As Lauren Broffman and Kristin Brown observe, CCOs realized the state had a vested interest in their success, and started to act accordingly.¹⁷⁰ Providers' intrinsic interests in "working with the others to figure out how to do things better" are also having a positive effect, in conjunction with other drivers, particularly financial ones.¹⁷¹ It remains to be seen, though, whether the program will build

AIM: SEVEN INNOVATORS SHOW THE WAY TO BETTER CARE, BETTER HEALTH, AND LOWER COSTS 4-5 (Jossey-Bass, 1st ed. 2012); John W. Whittington et al., *Pursuing the Triple Aim: The First 7 Years*, 93 MILBANK Q. 263, 296-98 (2015).

162. Or. Health Auth., *Oregon's Health System Transformation: 2014 Performance Report* 26, 28-32, 35 (June 24, 2015), <http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf>.

163. *Id.* at 9.

164. *Id.* at 16.

165. *Id.* at 18.

166. *Id.* at 20.

167. Or. Health Auth., *supra* note 162, at 92-95.

168. *Id.* at 111-12.

169. *Id.* at 4, 6.

170. Broffman & Brown, *supra* note 149.

171. *Id.*

momentum while managing to avoid or successfully manage the many potential pitfalls that may arise in the process.

VI. CONCLUSION

Medicaid waivers granted under Section 1115 of the Social Security Act are supposed to be reserved only for testing “any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [Medicaid].”¹⁷² Those objectives have been clearly stated by CMS. Yet CMS has granted, and continues to grant, waivers for demonstration projects that either do not need to be tested because the outcome is already known, or that do not promote the stated objectives of Medicaid, such as Indiana’s HIP waiver and others like it.

Medicaid is a program intended to provide health care to individuals who would otherwise likely lack it.¹⁷³ It is in the business of health promotion and preservation. Oregon’s waiver is among those that seek to further such goals. Indiana’s, however, is not. Its punitively-structured, non cost-effective benefit package does not seek to test better, more efficient and effective ways to provide access to care and promotion of health. Rather, it is more likely that it is intended, as suggested by some comments made by those in the Pence Administration,¹⁷⁴ to point the way toward dismantling Medicaid, and perhaps providing something else in its place. States ought not to play games with the lives and health of their most impoverished residents. At the same time, CMS ought not to play games with the nature of Medicaid. CMS should more strictly adhere to the purposes of Medicaid in deciding whether to grant Section 1115 Medicaid waivers.

172. 42 U.S.C.A. § 1315(a) (2014) (codifying Section 1115 of the Social Security Act).

173. See Social Security Act, 42 U.S.C. § 1396a(10) (2012).

174. Letter from Pence to Sebelius, *supra* note 69.

