CHOICES FOR ALL PROJECT

Empower Medicaid Recipients and ACA Participants

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

Federal healthcare subsidies for those under age sixty-five will total just over $1 trillion in 2023. Spending on Medicaid and on premium subsidies for the Affordable Care Act (ACA) will account for just over half that total. That spending is intended to ensure low- and middle-income families have access to medical care. Yet, while more is spent each year, the programs continue to underperform. Long wait times and uneven health outcomes are the norm for many Medicaid recipients, while narrow networks and limited plan options are standard for ACA participants. Rather than address these issues, policy-makers have opted to expand the rolls, exacerbating these problems.

Any reform should help ensure that both Medicaid and the ACA marketplaces work for beneficiaries and enrollees, but one-size-fits-all federal reforms are unlikely to help. Instead, the Choices for All Project proposes state-level reforms that would empower patients—not the government or third-party payers. This includes giving enrollees more control over the money that is spent on their behalf. Federal policymakers have a role to play. Existing waiver authority provides states with opportunities to experiment with their health subsidies, but their use relies on the whims of federal government officials who have plenary power to deny new waivers.

KEY PLAN ELEMENTS

- Ensure existing waiver authority is broadly available to facilitate innovative state-based health reforms.

- Strengthen waiver authority rules to ensure continuity across presidential administrations.

- Allow ACA recipients to select low-cost catastrophic plans with the remaining subsidy balance deposited into our newly proposed individual health accounts (IHAs).

- Provide Medicaid recipients with an option to receive partially funded IHAs—owned by the recipient—that can fully cover new cost-sharing requirements.

- Allow states to use waivers to pay for direct primary care (DPC) memberships for Medicaid enrollees.

THE PROBLEM: A ONE-SIZE-FITS-ALL APPROACH

Federal policy has long recognized that access to affordable healthcare is a critical component of overall well-being and quality of life. Since the 1950s, the federal government has subsidized healthcare for low-income Americans who meet certain demographic requirements or who are enrolled in other assistance programs.[1]

In 1966, the federal role in healthcare was expanded when Congress enacted Medicaid. The program is administered by the states, but the federal government covers most of the costs—anywhere from 50 to 90 percent depending on the state and enrollees' demographics. Initially, the program covered only families enrolled in state welfare programs and low-income seniors and individuals with disabilities. Over the decades, Congress has expanded Medicaid eligibility to include nearly all low-income individuals. Most recently, the ACA provided states with the option to expand Medicaid to able-bodied adults (under age sixty-five) without dependents. In fact, the majority of the ACA's coverage gains came from its Medicaid expansion.[2]

While Medicaid is administered by the states, there are strict federal regulations about what services Medicaid must offer. Generally, states may not charge any premiums for those with family incomes below 150 percent of the poverty line. Similar limitations apply to cost-sharing rules. States may not charge copays for emergency, preventive, or maternity services. They may charge small cost-sharing amounts for nonemergency services, but the maximum amounts are minimal for those with incomes below 100 percent of the federal poverty level.[3] In 2020, twenty-two states required some sort of cost sharing from their Medicaid adults. The most common type of cost sharing was copayments for prescription drugs. Only about one-fourth of states charged any copayments for outpatient or inpatient services.[4]

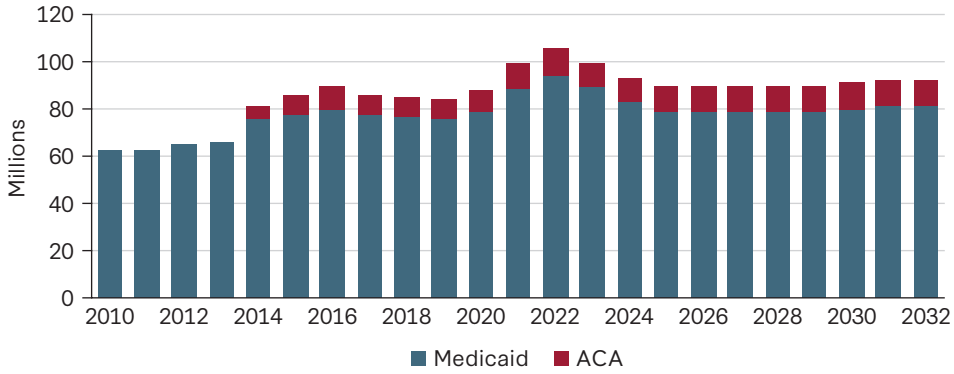
Historically, state Medicaid programs paid providers directly for services received by Medicaid enrollees. More recently, however, states have moved most Medicaid recipients to managed care organizations (MCOs). States contract with MCOs, which agree to provide comprehensive medical coverage to Medicaid recipients in exchange for a capitated payment (i.e., a set monthly payment) from the state Medicaid program. In 2022, forty-one states used MCOs for at least a portion of their Medicaid recipients, covering 72 percent of the nation's Medicaid beneficiaries.[5] MCOs must offer enrollees the same services and are bound by the same cost-sharing rules as traditional Medicaid.

The ACA did more than expand Medicaid eligibility. The 2010 law established subsidies for the purchase of private insurance for individuals with family incomes too high to qualify for Medicaid, but below 400 percent of the federal poverty level. To qualify for subsidies, individuals must not have an offer of coverage from their employer. Plans are purchased on the ACA's marketplace exchanges. The ACA requires participating insurers to include certain services and treatments with their plans (called essential health benefits). The law also requires insurers to offer plans to all who apply, regardless of any preexisting health condition (called a guaranteed issue requirement). And the law strictly limits what enrollee characteristics an insurer may use in setting premiums. Premiums may differ due only to age, geographical area, and whether an enrollee uses tobacco products—and even then, there are strict limits (called community rating rules) on how much more can be charged.

ACA plans are divided by metal tier: platinum, gold, silver, or bronze. The tiers are based on the plan's actuarial value, which is the average share of total covered health spending the plan will cover. Plans in the most generous tier, platinum, must cover approximately 90 percent of spending. Gold plans cover 80 percent, silver plans cover 70 percent, and bronze plans cover 60 percent. Of course, the more generous the plan, the higher the premium charged. Catastrophic plans—sometimes called "copper" plans—with coverage less generous than bronze plans are available to those under age thirty and to some individuals who qualify due to a hardship (e.g., one who is not eligible for premium subsidies but cannot afford a bronze plan).

ACA subsidies vary by a recipient's income. Enrollees are required to pay a share of their income for their premiums. The subsidy is the difference between an enrollee's second-cheapest silver plan (called the benchmark plan) and the required contribution. The subsidy amount is generally fixed regardless of which plan an enrollee chooses. Enrollees who choose a gold or platinum plan pay more than their required premium share. If they choose a bronze plan or the cheapest silver plan, they pay less; in some cases, a person may not have to pay any premiums if they select a particularly low-cost bronze plan.

FIGURE 1 Medicaid and ACA enrollment by year



Note: Authors' calculations from CBO's "Federal Subsidies for Health Insurance Coverage for People under Age 65" (various years)

Like Medicaid, states play a role in administering the ACA. States can add stricter rules on insurers regarding which services must be offered, how premiums are set, and how plans' cost-sharing rules are applied. But there is an asymmetry: states may add additional rules, but they cannot create rules that would weaken federal ACA regulations without a waiver.

Since the ACA's enactment, enrollment in the Medicaid program has grown dramatically.[6] As figure 1 shows, Medicaid enrollment among those age sixty-four or younger rose by over 50 percent from 2010 to 2022. Meanwhile, subsidized ACA enrollment reached a new peak in 2022 at twelve million. While COVID expansions have temporarily expanded enrollment, the Congressional Budget Office (CBO) expects the long-term trends to continue. By 2032, 29 percent of those under age sixty-five will receive assistance through Medicaid or the Affordable Care Act.

Medicaid and ACA enrollment rose particularly fast during the COVID-19 pandemic. This was in part due to congressional action that expanded eligibility for the programs. In 2020, the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act increased the share the federal government would pay for the program. In exchange, states agreed to not disenroll anyone from their Medicaid program during the public health emergency, regardless of current eligibility. As a result, enrollment exploded. CBO estimated in 2022 that an additional 13 million were enrolled in Medicaid due to the continuous eligibility enrollment.[7] In 2023, states were finally permitted to begin disenrolling recipients who had become ineligible.

Similarly, in 2021, Congress temporarily liberalized eligibility for increased ACA coverage subsidies. The American Rescue Plan Act of 2021 (ARPA) provided premium subsidies

to individuals with incomes above 400 percent of the federal poverty level. ARPA also reduced the required contribution from all enrollees. The ARPA expansions were due to expire in December 2022, but Congress extended the subsidies for an additional three years. This change added $64 billion in spending and tax subsidies to the federal budget over the next four years.[8]

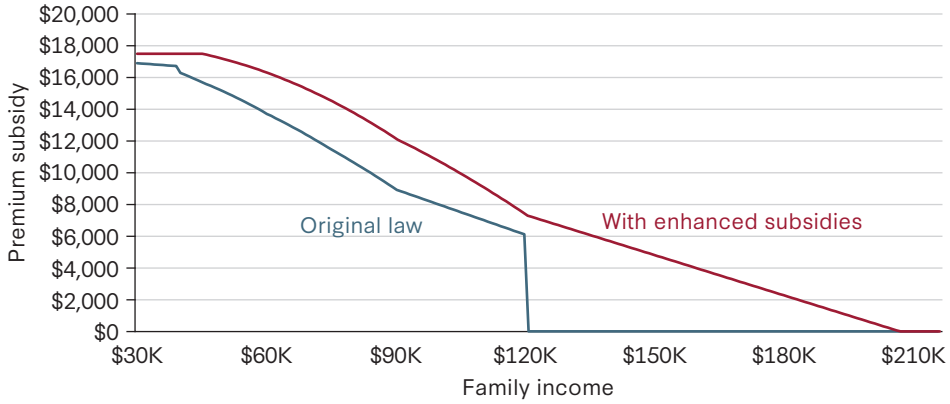
Booming enrollment and repeated liberalizations have exacerbated long-standing problems within Medicaid. Medicaid reimburses medical providers at lower rates than commercial insurers. Consequently, some doctors are leery of taking Medicaid patients. Survey data suggests that only 75 percent of doctors are willing to accept new Medicaid patients, while 95 percent are willing to accept private patients.[9] In a recent survey of fifteen metropolitan areas, the average acceptance rate was 54 percent.[10] The result is longer wait times to get an appointment.[11] Similarly, research suggests Medicaid patients are more likely to experience an extended time in waiting for a physician on the day of their appointment.[12]

Evidence is also mixed regarding whether Medicaid improves health outcomes relative to being uninsured. The Oregon Health Insurance Experiment was a randomized controlled trial that assigned a subset of low-income individuals without insurance to Medicaid. Baicker et al. (2013) found that those who enrolled in Medicaid saw their healthcare utilization rise, reported lower levels of depression, had less financial anxiety, and were more likely to be screened and treated for diabetes. Nevertheless, despite the additional health utilization, there were no statistical differences in health outcomes.

The Affordable Care Act's marketplace exchanges have also failed to live up to the aims of its proponents. Even with subsidies, ACA plans were far less popular than originally predicted. At the time of its passage, CBO (2010) estimated that in 2019, twenty-four million individuals would enroll in the marketplace exchanges, with nineteen million receiving subsidies. Instead, only nine million were enrolled in 2019 with eight million receiving subsidies.[13] There are likely several reasons why the ACA plans have proved unpopular. Without subsidies, premiums are high and cost-sharing rules are burdensome, making the plans unattractive to many. Moreover, to contain costs, insurers have developed relatively narrow provider networks that limit patient access.

The recent congressional action that dramatically liberalized eligibility has increased projected enrollment in the ACA. Nevertheless, the increased enrollment is not necessarily among low-income households. As noted above, the liberalizations expanded eligibility up the income ladder. The result is that a family of four with high incomes may qualify for health premium subsidies. Figure 2 shows the change in subsidies by

FIGURE 2 Estimated ACA subsidy for family of four before and after ARPA



Notes: Authors' calculations. We assume a family of four where parents are forty years old and children are under age fifteen. We use the estimated US average for the benchmark premiums from KFF (2023) for forty-year-olds ($5,472) and calculate children's premiums using HHS community rating age curves.

income level for a family of four with nationwide-average premiums. As the graph shows, a family of four with incomes above $200,000 may qualify for assistance. The increased subsidies have increased ACA enrollment but at a high cost: the Biden administration estimates that extending the expansions after 2026 would add $183 billion to federal deficits over the next ten years.[14]

Similarly, while the temporary Medicaid eligibility expansions offer new benefits to those who otherwise wouldn't qualify, they do little to help existing Medicaid patients. Instead, the expansions have strained the existing system, increased wait times, and exacerbated the provider shortages that have long plagued the program.[15]

As the COVID-era enrollment boom subsides, policymakers have an opportunity to rethink how Medicaid and the ACA work for remaining recipients. Real reform will require they shift their focus from expanding enrollment to ensuring the programs are working for the enrolled.

THE FUTURE: UNLEASH STATE INNOVATION

Despite the significant shortcomings of the ACA, repeal is neither politically likely nor necessary for advancing substantive health reforms in 2023.

Given the status quo, policymakers should instead focus on state-level reforms that will empower recipients and foster innovation in new pathways to coverage and cost containment. Existing waiver authority—combined with additional federal reforms—offers

the opportunity to give recipients more choices. Below we identify necessary changes in federal policy and several related reforms that states could champion.

EXPANDING STATE WAIVER AUTHORITY

To begin, states need more power to commit to reforms. That requires taking full advantage of waivers in existing laws. States are supposed to be the laboratories of democracy. Many federal policies began as reforms at the state level that succeeded and gained popularity. But today, state flexibility can be hampered by burdensome administrative requirements or simply the whims of presidential administrations and, more specifically, the leadership at the US Department of Health and Human Services.

Waiver provisions in laws governing Medicaid and private markets allow states to innovate and tailor their healthcare systems to better suit the unique needs of their populations. By granting states more flexibility in implementing healthcare reforms, these waivers can help improve efficiency, reduce costs, and promote choice and competition in healthcare.

State innovation waivers, authorized by Section 1332 of the ACA, provide a promising avenue for states to improve healthcare access and affordability in their own unique ways. These waivers allow states to deviate from certain ACA provisions, so long as they can demonstrate that their alternative approach still meets certain goals set out in the law. This flexibility gives states the ability to tailor their healthcare systems to their specific needs, which can lead to better outcomes for their residents.

Section 1332 waivers can be used by states to modify various aspects of their healthcare systems, such as the structure of health insurance marketplaces or premium subsidies. To be granted a Section 1332 waiver, a state's proposed plan must meet four essential criteria, referred to as "guardrails":

- Comprehensiveness: The plan must provide coverage that is at least as comprehensive as that mandated under the ACA.
- Affordability: The plan must ensure that coverage is as affordable as it would be under the ACA.
- Scope: The plan must cover at least as many residents as the ACA provisions would.
- Deficit neutrality: The plan must not increase the federal deficit within a ten-year window.

Similarly, waivers under Section 1115 of the Social Security Act allow states to request federal approval for experimental, pilot, or demonstration projects related to their Medicaid program and their Children's Health Insurance Program (CHIP). The primary objective of these waivers is to provide states with flexibility to design and implement innovative approaches that promote the objectives of Medicaid and CHIP. These waivers are widely used by states today and have been the source of some of the most significant innovations in the Medicaid program, such as the adoption of MCOs, the Oregon Health Insurance Experiment, and more recently the Healthy Indiana Plan.[16]

The most common uses of Section 1332 waivers are reinsurance policies that allow states to relax ACA rules about common risk pools. The result is that insurers can offer lower premiums that better reflect the expected health costs of healthy enrollees. But waivers offer states far more opportunities to deliver more healthcare choices to their residents. Expanding the use of these waivers could help address some of the challenges facing the US healthcare system. The current waiver process undermines this goal. To ensure that states can take full advantage of waivers, federal policymakers need to liberalize the process. Reforms include the following:

1. Streamlining the Waiver Application Process

Federal policymakers should simplify the waiver application process to make it more transparent while providing guidance and support to states seeking to implement innovative approaches to healthcare reform. Policymakers might also consider a provision that presumptively approves waivers that states certify will meet the existing Section 1332 guardrails. Finally, there should be a fast-track process for states that have already received a waiver and want to renew or modify it. This would allow states to bypass another lengthy application process and receive approvals more quickly.

2. Increasing Flexibility in Existing Waiver Requirements

The requirements for the approval of Section 1332 waivers should be loosened to give states more freedom to design their own healthcare systems if they meet the overall goals of the ACA. Under 2018 guidance from the Department of Health and Human Services (HHS), the Trump administration allowed states greater flexibility in interpreting the existing guardrails. Specifically, states could satisfy the scope guardrail by offering plans that were not as comprehensive as standard ACA plans.[17] Importantly, they were still required to offer other plans that met the comprehensiveness and affordability requirements.

The Biden administration repealed the 2018 guidance in its own 2021 rule. In repealing the additional flexibility, the administration argued that "the guardrails should be focused

on the types of coverage residents actually purchase such that individuals are enrolled in affordable, comprehensive coverage and not just that there is generalized access to such coverage."[18] In short, the Trump administration's guidance recognized that many individuals don't value any of the existing ACA plans. They want more choices. But the Biden administration took the Section 1332 waiver process in a different direction. It argued that mere choice was insufficient.

Returning to the 2018 guidance would thus increase choice in the individual market. For example, the ACA requires that insurance companies cover a set of essential health benefits (EHBs) in all plans sold in the individual and small-group markets. While EHBs have proved to be popular and important to many Americans, fully comprehensive plans may not be attractive to people who defer buying coverage because of the costs. Under the 2018 guidance, states could create health plans to target currently uninsured individuals who are forgoing coverage because they don't think the benefits provided by plans are worth the cost. Waivers could give states more flexibility to design insurance plans that meet the unique needs of these residents, if the states *also offer* alternative coverage that meets the comprehensiveness guardrails. This could be particularly beneficial for states with high healthcare costs, high numbers of voluntarily uninsured individuals, or for those that are struggling to attract insurers to their markets.

3. Strengthening Waiver Language to Ensure Continuity across Administrations

The Biden administration's effective repeal of the 2018 guidance reflects the often ideological nature of waiver approvals and denials. While policy changes are inevitable during new administrations, states need assurances that approved waivers will not be unilaterally suspended or altered by skeptical administrations.

In November 2020, Georgia secured approval for an innovation waiver to implement the Georgia Access Model. The plan called for the state to work with private brokers and insurance companies to directly sell qualified health plans through private channels rather than rely on the federally run HealthCare.gov.[19] In granting the waiver, HHS determined that Georgia had met the Section 1332 guardrails. Months later, however, the new Biden administration objected. They claimed the temporary changes to ACA eligibility in the American Rescue Plan Act of 2021 meant that the Georgia Access Model no longer met the guardrails. They demanded that Georgia redo its earlier analysis—within thirty days—to account for the effects of the temporary expansions. The state objected, claiming that the HHS request was effectively forcing the state to undergo reapproval for the same waiver.[20] After completing its own analysis of the Georgia Access Model, HHS suspended the state's waiver in August 2022.[21] Georgia authorities continue to contest

the HHS suspension, arguing it will cost the state millions of dollars and that HHS is violating the initial terms of the waiver.

The recent Georgia experience will ultimately discourage other states from seeking waivers. Applying for waivers is expensive. States must complete complex filing requirements and actuarial analyses. They must also regularly report the results of their waiver-initiated policies to HHS. These processes are intended to ensure the guardrails are met and federal tax dollars are spent wisely. But once given approval, states should have confidence that they can implement policies without having to relitigate the initial approval. Consequently, future waivers should include language that ensures states can commence approved policies without having to repeatedly show that their initial analyses remain true. HHS must still evaluate the efficacy of policies initiated by Section 1332 waivers; the department should terminate or modify experiments that are not meeting the agreed-upon benchmarks.

Regardless of partisan affiliation, offering states assurances that waivers will not be arbitrarily suspended is in the best interest of both the states and the federal government. Nevada has been issued a waiver to commence a public option experiment. The state plans to begin offering coverage in 2026, but the state has already committed significant resources in designing the plan. An incoming Republican administration in 2025 may object to the concept of a public option, but Nevada should not have to worry that the new administration will force it to recomplete its analysis before it can begin enrollment as scheduled.

Indeed, Section 1332 waivers can be used for more ambitious reforms like Nevada's public option or Georgia's attempt to redesign its marketplace for individual health insurance. The ACA gives broad latitude for states to consider a variety of coverage arrangements and, perhaps more importantly, a consolidated stream of federal funding to break down existing coverage silos among Medicaid beneficiaries, ACA-subsidized low- and middle-income individuals and families, and even Medicare beneficiaries. States should have the freedom and flexibility to pursue these reforms without regard to ideological, partisan, or other political restrictions at the federal level.

Liberalizing and expanding the use of waivers still requires finding policies that can improve state health programs. Below we identify potential reforms that states could champion.

EXPAND ACCESS TO CATASTROPHIC ("COPPER") PLANS

Catastrophic insurance plans are rare in America, yet they make sense for many young and healthy Americans. As discussed above, these plans are often labeled "copper"

plans because insurance companies are expected to cover only 50 percent of expected health costs (compared to 70 percent for silver plans). The ACA clamped down on consumers' freedom to choose catastrophic coverage. To be eligible, individuals need to be under age thirty or qualify for an exemption based on hardship or affordability. On top of that, tax credits for premiums generally cannot be used for the purchase of copper plans. Because of these issues, only about 1 percent of ACA enrollees choose a copper plan.[22]

The result is that the ACA is a bad deal for many healthy individuals, whose expected healthcare costs are far below the premiums they must pay. Many of these individuals opt to avoid coverage—a prospect made easier since the ACA individual mandate penalties were eliminated in 2019. Expanding access to copper plans to more individuals would fill an important need. As we discuss next, subsidized ACA enrollees who choose copper plans could have any excess subsidy directed to the individual health accounts we propose, giving them more control over their healthcare spending.

States that want to experiment with various copper plans are currently limited by ACA rules. Waivers would be needed to give states flexibility to design insurance products that fit the needs of their residents—many of whom are currently left with few affordable options. Unfortunately, the Biden administration's restrictive interpretation of ACA Section 1332 will impede states' ability to offer policies that consumers demand.

OFFER INDIVIDUAL HEALTH ACCOUNTS TO ACA RECIPIENTS

In another essay in this series, we propose a new healthcare savings account, the individual health account (IHA). IHAs would be akin to a mix of health savings accounts (HSAs) and individual retirement accounts. The aim of these accounts is twofold: First, the accounts will offer more Americans an opportunity to save for their future healthcare needs. Second, IHAs will give people an incentive to be more price conscious regarding their healthcare purchases.

As we noted in the IHA essay, HSAs are not available for most ACA recipients. Plans offered on the ACA exchanges have cost-sharing rules that don't meet the requirements of high-deductible health plans (HDHPs), which are required if individuals wish to contribute to an HSA. Since IHA participation wouldn't require HDHPs, ACA participants would be permitted to open and contribute to an IHA.

Unsubsidized ACA participants would face the same IHA contribution rules as employer-sponsored insurance (ESI) participants. They could make tax-free contributions to their

IHA up to a maximum level, less the premiums they pay. For subsidized recipients, however, the tax benefits from making pretax IHA contributions would be minimal; few recipients earn enough to pay income taxes, particularly after accounting for premium tax credits. To ensure low-income Americans can benefit, states should be able to experiment with models in which federal and state contributions are deposited into a recipient's IHA.

For example, recipients of subsidized coverage could select copper or bronze plans, with any remaining subsidy deposited into their IHA. Unlike those with ESI and unsubsidized plans, there would be limits on when they could withdraw their IHA funds for unqualified medical spending. Early withdrawal could be outright prohibited, or there could be a penalty attached to discourage individuals from immediately withdrawing their available IHA funds.

Pairing ACA subsidies with health account contributions is not a new idea. The Paragon Health Institute recently published one proposal in *The HSA Option*.[23] This option would redirect money currently going to cost-sharing reduction subsidies toward individual HSAs. Under current law, those with incomes below 250 percent of the poverty line may purchase silver plans with reduced cost-sharing requirements. The federal government gives these subsidies directly to insurance companies. Paragon's proposed option would instead direct the money to individuals, giving them more control over their healthcare choices and providing better incentives for them to be price conscious about their healthcare consumption.

INDIVIDUAL HEALTH ACCOUNTS FOR MEDICAID RECIPIENTS

Similarly, IHAs could be made available to Medicaid recipients through Section 1115 waivers. Currently, federal rules force most Medicaid recipients into a one-size-fits-all system of healthcare. Choice is minimal. IHAs offer an opportunity to empower these recipients. We propose that states pursue experiments that offer Medicaid recipients the option to have an IHA with contributions made to the account by the state's Medicaid program. In exchange, states would increase cost-sharing requirements one-for-one with the contributions made. Exemptions from cost sharing could be made for certain preventive services. Importantly, the requirements would include annual out-of-pocket maximums that match the annual contribution to the recipient's IHA. This ensures recipients would not be made worse off.

As with the ACA subsidies, rules would be needed to prevent withdrawals for nonqualified spending for a certain amount of time. Importantly, Medicaid participants with an IHA could spend their IHA funds on qualified medical expenses or even services not

broadly covered by Medicaid, such as dental benefits or access to direct primary care arrangements.

Why offer Medicaid recipients IHAs? First and most importantly, Medicaid recipients would be *better* off. As noted above, the current Medicaid program isn't working well for some Medicaid recipients, and their choices are generally limited. IHAs paired with Medicaid would maintain health coverage, but unlike with standard Medicaid, recipients would have an asset that offers value beyond their Medicaid coverage. The accounts would offer them more choice in the healthcare they consume along with the potential for greater financial security.

Second, IHAs are explicitly designed to discourage unnecessary health spending by consumers—not through heavy-handed rules, but through better incentives. IHAs would provide the same incentives to Medicaid recipients.

Seemingly similar reforms have been tried. The Healthy Indiana Plan (HIP) offers Medicaid recipients an alternative plan that includes contributions to a savings account.[24] But, as shown in table 1, there are important differences between Medicaid with IHAs and the Healthy Indiana Plan.

In the Healthy Indiana Plan, participating individuals are required to make contributions to the plan—anywhere from $1 to $20 per month. State and personal contributions to the accounts total $2,500 per year. In exchange, participants have an annual deductible

TABLE 1 A COMPARISON BETWEEN THE HEALTHY INDIANA PLAN AND MEDICAID WITH IHAs

	Healthy Indiana Plan	**Medicaid with individual health accounts**
Premiums	From $1 to $20 per month	No premiums
Government contributions	State makes $2,500 in contributions, less enrollee premiums	State contributions with no required individual contribution
Account ownership	Premiums belong to enrollee, but state contributions remain with state	All contributions belong to enrollee, with limits on non-qualified withdrawals
Qualified spending	Only services offered by state Medicaid program	Any IHA qualified medical spending
Cost sharing	Annual deductible of $2,500	Cost sharing limited to amount of state IHA contribution

of $2,500. In other words, the first $2,500 of Medicaid spending each year is financed through the accounts. Any spending above that amount is covered directly by the state's Medicaid program. The aim of HIP is to incentivize participants to think about their healthcare consumption. Nevertheless, HIP incudes many complex rules that limit its efficacy. Unlike IHAs with Medicaid, HIP account balances are never fully owned by the participants. Their contributions are generally returned to them if they leave the program in good standing. But the state contributions are returned to the state. This ultimately reduces incentives to contain costs.

In the short run, an IHA with Medicaid wouldn't be costless. Some individuals will receive more in contributions than Medicaid would have otherwise spent on them. Nevertheless, depending on the design, the long-term savings from improved incentives could be substantial.

DIRECT PRIMARY CARE FOR MEDICAID RECIPIENTS

Medicaid is now the fourth largest noninterest spending program in the federal budget. In most states, Medicaid spending reflects almost one-fifth of state budgets and is expected to grow over time.[25] With the rapid growth of Medicaid MCOs contracting with state governments to cover enrollees for a capitated cost, finding ways to reduce the growth of per capita Medicaid spending is in the federal and each state government's interest.

One idea is for states to obtain a Section 1115 waiver to experiment with offering direct primary care (DPC) coverage to Medicaid enrollees, either as a carve-out from existing per capita spending or on top of traditional coverage. The goal would be to lower long-term per capita Medicaid spending by having direct primary care needs covered at much lower cost than in existing arrangements.

Most annual DPC coverage costs are between $500 and $1,000 per year for adults. And the Society of Actuaries found that DPC coverage was associated with a statistically significant decrease in healthcare demands of 12 percent, including a 40 percent drop in emergency room services.[26] If states could get their Medicaid patients to first go through their DPC doctor and then through the existing Medicaid system, the savings could be significant.

The Medicaid Primary Care Improvement Act is one bipartisan proposal that would explicitly allow states to provide DPC coverage to their Medicaid enrollees.[27] The advantage would be to either simplify or skip the waiver process altogether. Access, quality, and satisfaction metrics among DPC enrollees suggest that supplementing traditional Medicaid coverage with DPC coverage could improve those metrics without adding new costs.

CONCLUSION

Low- and middle-income Americans deserve access to high-quality medical care that gives them genuine choices. There are many more ideas that states could champion that are worthwhile. While some of these reforms may prove unsuccessful, the long-term benefits to recipients from successful innovations are worth the short-term costs.

The success of the 1996 welfare reforms serve as a template. The ideas underpinning the act did not originate from the halls of Congress. Instead, the ideas came from state capitals where policymakers—aware of the challenges the federal programs were creating for recipients—were given opportunities to experiment with different welfare models.

The same opportunity could be available to states across America—for the benefit of the tens of millions of Americans who benefit from Medicaid or ACA subsidies today.

NOTES

1. The Social Security Act Amendments of 1950, for example, provided matching grants to states to provide health services to those enrolled in a state's welfare program. Even prior to 1950, the Social Security Act provided subsidies to states for certain health services. See Cogan (2017) for a history of federal healthcare subsidies.

2. See figure 7 in HHS (2022).

3. In 2013, individuals with family incomes below 100 percent of the federal poverty level could pay up to $4 for most noninpatient services, $8 for nonemergency use of emergency rooms, $75 for inpatient care copays, and $4 to $8 for prescription drugs. These amounts are indexed to inflation. States are permitted to charge coinsurance rates of 10 to 20 percent of total Medicaid costs to those with incomes above 100 percent. See https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs/index.html for an overview.

4. For an overview of Medicaid cost-sharing rules by state, see KFF (2020).

5. See KFF (2023) for an overview of MCOs.

6. Throughout this essay, when discussing Medicaid enrollment or spending, we include those who qualify through the Children's Health Insurance Program (CHIP).

7. See page 3 in CBO (2022a).

8. See table 1 in CBO (2022b).

9. See SHADAC (2022) for an overview of the survey results.

10. AMN Healthcare (2022).

11. For example, Gotlieb, Rhodes, and Candon (2020) find Medicaid patients wait a day longer to see their primary-care doctors than those with private coverage.

12. Oostram, Einav, and Finkelstein (2017) find Medicaid patients are 20 percent more likely to experience a wait time longer than 20 minutes. The longer Medicaid wait times were correlated with states with lower Medicaid reimbursement rates.

13. Some of the decline can be attributed to the effective elimination of the individual mandate in the Tax Cuts and Jobs Act of 2017 (TCJA). However, even prior to the passage of TCJA, CBO's

enrollment projections had fallen. In 2017, CBO (2017) estimated that 2019 ACA enrollment would be twelve million with ten million receiving subsidies—half of the number that CBO originally projected.

14. See page 140 in White House (2023).

15. Wang (2022) finds that the Medicaid expansion increased wait times in emergency departments, while Auty and Griffith (2022) find that the expansion increased physician appointment wait times in some cases.

16. For more on the history of Section 1115 waivers, see Guth et al. (2020).

17. See CMS (2018) for an overview of the 2018 guidance.

18. Page 53462 in the Federal Register, https://www.govinfo.gov/content/pkg/FR-2021-09-27/pdf/2021-20509.pdf.

19. HHS' original approval letter is here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Approval-Letter-STCs.pdf.

20. The state also noted that the temporary eligibility expansions were scheduled to end prior to the start of the Georgia Access Model. HHS, however, argued that even though the expansions were set to expire, there would be increased enrollment following the expansions, and thus the initial analysis was no longer applicable. Ultimately, Congress extended the expansions for an additional three years.

21. Correspondence between Georgia and HHS is available here: https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers.

22. See page 10 in CMS (2023).

23. See Blase et al. (2022) for a description of the proposal.

24. For an overview of the plan, see https://www.in.gov/fssa/hip/about-hip/frequently-asked-questions/.

25. See MACPAC (2017).

26. Society of Actuaries (2020).

27. For example, see Representative Dan Crenshaw's recent proposed bill discussed in Choi and Weixel (2023).

WORKS CITED

AMN Healthcare. 2022. *2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates*. https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/News_and_Insights/Articles/mha-2022-wait-time-survey.pdf.

Auty, Samantha G., and Kevin N. Griffith. 2022. "Medicaid Expansion Increased Appointment Wait Times in Maine and Virginia." *Journal of General Internal Medicine* 37, no. 10 (August): 2594–96. https://link.springer.com/article/10.1007/s11606-021-07086-9.

Baicker, Katherine, Sarah L. Taubman, Heidi L. Allen, Mira Bernstein, Jonathan H. Gruber, Joseph P. Newhouse, Eric C. Schneider et al. 2013. "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes." *New England Journal of Medicine* 368, no. 18 (May 2, 2013): 1713–22. https://www.nejm.org/doi/full/10.1056/NEJMsa1212321.

Blase, Brian C., Dean Clancy, Andrew Lautz, and Roy Ramthun. 2022. *The HSA Option*. Paragon Health Institute, November. https://paragoninstitute.org/wp-content/uploads/2022/11/202211_Blase_TheHSAOption_DRAFT_11-16-22-V4.pdf.

Centers for Medicare and Medicaid Services [CMS]. 2018. *Overview of 1332 Guidance for State Relief and Empowerment Waivers*. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/State-Relief-Empowerment.PDF.

———. 2023. *Health Insurance Marketplaces 2023 Open Enrollment Report*. https://www.cms.gov/files/document/health-insurance-exchanges-2023-open-enrollment-report-final.pdf.

Choi, Joseph, and Nathaniel Weixel. 2023. "Crenshaw to Introduce Bill on Medicaid Payment Model." *The Hill*, April 26, 2023. https://thehill.com/newsletters/health-care/3974313-fauci-says-time-to-move-forward-from-covid.

Cogan, John F. 2017. *The High Cost of Good Intentions: A History of US Federal Entitlement Programs*. Stanford, CA: Stanford University Press.

Congressional Budget Office [CBO]. 2010. *H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)*. https://www.cbo.gov/publication/21351.

———. 2017. "Federal Subsidies for Health Insurance Coverage for People under Age 65: Tables from CBO's September 2017 Projections." https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-09-healthinsurance.pdf.

———. 2019. "Federal Subsidies for Health Insurance Coverage for People under Age 65: Tables from CBO's May 2019 Projections." https://www.cbo.gov/system/files?file=2019-05/51298-2019-05-healthinsurance.pdf.

———. 2022a. "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2022 to 2032." https://www.cbo.gov/system/files/2022-06/57962-health-insurance-subsidies.pdf.

———. 2022b. "Estimated Budgetary Effects of H.R. 5376, the Inflation Reduction Act of 2022." https://www.cbo.gov/system/files/2022-08/hr5376_IR_Act_8-3-22.pdf.

Gotlieb, Evelyn G., Karin V. Rhodes, and Molly K. Candon. 2020. "Disparities in Primary Care Wait Times in Medicaid versus Commercial Insurance." *Journal of the American Board of Family Medicine* 34, no. 3 (May): 571–78. https://www.jabfm.org/content/34/3/571.long.

Guth, Madeline, Elizabeth Hinton, MaryBeth Musumeci, and Robin Rudowitz. 2020. "The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election." https://www.kff.org/report-section/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election-appendices.

Kaiser Family Foundation [KFF]. 2020. "Premium and Cost-Sharing Requirements for Selected Services for Medicaid Adults" (as of January 1, 2020). https://www.kff.org/health-reform/state-indicator/premium-and-cost-sharing-requirements-for-selected-services-for-medicaid-expansion-adults.

———. 2023. "10 Things to Know about Medicaid Managed Care" (updated March 1, 2023). https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care.

Medicaid and CHIP Payment and Access Commission [MACPAC]. 2017. "Medicaid's Share of State Budgets." https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets.

Oostrom, Tamar, Liran Einav, and Amy Finkelstein. 2017. "Outpatient Office Wait Times and Quality of Care for Medicaid Patients." *Health Affairs* 36, no. 5 (May): 826–32. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1478.

Society of Actuaries. 2020. "Direct Primary Care: Evaluating a New Model of Delivery and Financing" (May). https://www.soa.org/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf.

State Health Access Data Assistance Center [SHADAC]. 2022. "Assessing Physician Acceptance of Medicaid Patients Using State Health Compare" (August 25, 2022). https://www.shadac.org/news/14-17-physician-Mcaid-SHC.

US Department of Health and Human Services [HHS]. 2022. "Health Coverage Changes under the Affordable Care Act: End of 2021 Update." ASPE Office of Health Policy. Issue Brief HP-2022-17 (April 29, 2022). https://aspe.hhs.gov/sites/default/files/documents/77ba3e9c99264d4f76dd662d3b2498c0/aspe-ib-uninsured-aca.pdf.

Wang, Guihua. 2022. "The Effect of Medicaid Expansion on Wait Time in the Emergency Department." *Management Science* 68, no. 9 (September): 6648–65. https://pubsonline.informs.org/doi/epdf/10.1287/mnsc.2021.4239.

White House. 2023. *Budget of the US Government, Fiscal Year 2024*. https://www.whitehouse.gov/wp-content/uploads/2023/03/budget_fy2024.pdf.

29 28 27 26 25 24 23 7 6 5 4 3 2 1

ABOUT THE AUTHORS

LANHEE J. CHEN, PHD

Lanhee J. Chen, PhD, is the David and Diane Steffy Fellow in American Public Policy Studies at the Hoover Institution and the director of domestic policy studies in the Public Policy Program at Stanford University. He has advised four presidential campaigns and previously served as a member of the Social Security Advisory Board and at the US Department of Health and Human Services.

TOM CHURCH

Tom Church is a policy fellow at the Hoover Institution whose work focuses on healthcare policy, entitlement reform, income inequality, poverty, and the federal budget. He holds a master's degree in public policy with honors from Pepperdine University.

DANIEL L. HEIL

Daniel L. Heil is a policy fellow at the Hoover Institution whose work focuses on the federal budget, healthcare, tax policy, and antipoverty programs. Heil served as Florida governor Jeb Bush's economic policy adviser, counseling him on these issues, during the 2016 presidential campaign. He holds a master's degree in public policy from Pepperdine University.

The Choices for All Project: Healthcare Reforms for the Future

There is near-universal agreement that the US healthcare system fails to deliver affordable, accessible, and high-quality care for many Americans. Fixing our system requires putting more decisions in the hands of patients. That means introducing meaningful prices into the system, reducing supply-side regulations that limit the supply of medical care, and finding innovative ways to deliver insurance and medical care that better meet the demands of patients. The Choices for All Project offers healthcare reforms that would jump-start competition, encourage meaningful and transparent prices to patients, and bring consumer sovereignty to the healthcare market for millions of working-age Americans.

Hoover Institution, Stanford University
434 Galvez Mall
Stanford, CA 94305-6003
650-723-1754

Hoover Institution in Washington
1399 New York Avenue NW, Suite 500
Washington, DC 20005
202-760-3200

HOOVER INSTITUTION