Pennsylvania Medicaid Expansion Waiver

Overview

Pennsylvania received approval for a five-year waiver called Healthy Pennsylvania, which began enrolling individuals on January 1, 2015. Healthy Pennsylvania provided coverage to enrollees through Medicaid managed care. Outside of the demonstration, the state planned to encourage employment through job training and work-related activities. However, a new governor was elected in November 2014 who took action to end the waiver and transition the state to a traditional Medicaid expansion. The transition was fully implemented on September 1, 2015 (Office of Governor Tom Wolf 2015).

Populations Covered

The demonstration covered adults age 21 through 64 without dependent children and parents above the state's pre-ACA eligibility levels, with incomes up to 138 percent of the federal poverty level (FPL). Excluded populations included individuals who are medically frail; pregnant women (although women who become pregnant while participating in the plan may elect to stay in the plan); individuals who are institutionalized; and people who are dually eligible for Medicaid and Medicare. In addition, the premium requirements were extended to Medicaid enrollees receiving Transitional Medical Assistance.[1]

Benefits

The waiver required the state to provide retroactive coverage and all enrollees received all benefits in the alternative benefits plan (ABP). The state is not obligated to provide non-emergency medical transportation in the first year of the waiver. Although not part of the final waiver agreement, the state also proposed changes to the benefit plan for existing enrollees, providing a high risk-plan for individuals who are medically frail and a low-risk plan which would have been available to medically frail beneficiaries who opted out of the high-risk plan as well as to other beneficiaries.[2] The ABP changes did not go into effect because the state replaced the Healthy Pennsylvania waiver with a traditional Medicaid expansion.

Premiums and Cost Sharing

Premiums and cost sharing were not implemented since the transition to a traditional Medicaid expansion was completed before these provisions were set to begin. However, under the waiver, individuals with incomes at or

below 100 percent FPL would not have been charged premiums, but would have been charged copayments, including an $8 charge for non-emergency use of the emergency department.

Beginning in January 2016, if the waiver were still in effect, the state would collect and analyze data on the average amount of monthly copayments by individuals with incomes below 100 percent FPL to support a prospective amendment to charge premiums to this population.

Enrollees with incomes above 100 percent FPL would have been charged premiums beginning in the second year of the demonstration, not to exceed 2 percent of household income. Failure to pay premiums after 90 days would have resulted in disenrollment, although enrollees would have been able to re-enroll at any time if they began paying premiums again.

The waiver allowed for enrollees to be charged cost sharing under the state plan in the first year of the demonstration; however, the state does not have cost sharing in its state plan and therefore no cost sharing was operationalized. All enrollees who would have been subject to premiums would have been eligible for a reduction in the monthly amount if they completed certain healthy behaviors during the previous year of enrollment.

Cost sharing for all enrollees would have been subject to an aggregate cap of 5 percent of family income consistent with federal Medicaid requirements.

Premium Assistance

Pennsylvania did not use premium assistance in its Medicaid expansion waiver.

Delivery System

The state contracted with managed care plans to deliver waiver services. State managed care contracts were required to comply with Medicaid managed care requirements. Enrollees had the choice of an approved health plan in their region.

For a summary of the Section 1115 waivers used to expand Medicaid to the new adult group please see Expanding Medicaid to the New Adult Group through Section 1115 Waivers.

Endnotes

[1] Transitional Medical Assistance requires states to provide at least six months, and up to 12 months, of Medicaid coverage to enrollees under Section 1931 (i.e., low-income parents and their children) when the family's income has risen above a state's current eligibility levels.

[2] The high-risk plan includes almost all of the benefits included in the low-risk plan (with the exception of family planning services), and also includes dental services and dentures, emergency ambulance services, home health care, renal dialysis, coverage for intermediate care facilities for individuals with intellectual disabilities, medical supplies, tobacco cessation, extended services for pregnant women, non-emergency medical transportation, mobile mental health treatment, peer support, vision corrective lenses and contact lenses, and targeted case management for individuals with serious mental illness.

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