A flurry of state governors - in the 24 states that have not yet expanded Medicaid - are talking about expanding Medicaid eligibility as allowed under the Affordable Care Act. Many of these governors are offering up solutions that they say are designed uniquely for their state, carefully differentiating the new proposals from “traditional” Medicaid. This activity is likely to continue throughout 2015. Outside ACA issues, states will consider a number of health delivery issues. These include how to match the workforce to the need for professionals and how to expand some service areas such as mental health and substance abuse.

#1 Medicaid Expansion: A Number of States Reexamine Their Options

A flurry of state governors are talking about expanding Medicaid eligibility as allowed under the Affordable Care Act. Many of these governors are offering up solutions that they say are designed uniquely for their state, carefully differentiating the new proposals from “traditional” Medicaid.

The first week of January, during the National Governors Association meeting, governors who met with President Obama told the Associated Press, the president was open to state-specific plans as well as working to reach agreement on work requirements, according to Utah Gov. Gary Herbert.

The current count for Medicaid expansion is 27 states and the District of Columbia.
Indiana

The submitted waiver plan – called Healthy Indiana Plan 2.0 by Gov. Mike Pence – is still under review by the federal government. It would require all enrollees to put money into a health savings account each month to pay part of the costs of their Medicaid coverage.

In a year-end review of policy accomplishments with WISH-TV, the governor said “All the way through late last week [Dec. 5, 2014] I’ve been in direct discussions with the Secretary of Health and Human Services on the subject of our waiver and I continue to remain hopeful.”

Utah

Healthy Utah is what Gov. Gary Herbert calls his proposal to extend Medicaid coverage to more low-income state residents. After his January 2015 meeting with Pres. Obama, he said “that [the work requirement] door’s not closed.”

The proposal, which has not been formally submitted to Washington, D.C., has met some pushback. Rep. Jim Dunnigan presented several alternatives to the legislature’s Health Reform Task Force on Dec. 4, 2014.

Tennessee

Gov. Haslam has proposed a “unique Tennessee solution,” a two year pilot that would reward healthy behaviors and promote personal responsibility. He has called a special session in February to take up the plan.

Under the Volunteer Plan, Tennessee participants would receive vouchers to pay premiums for their employer’s plan and meet other out-of-pocket expenses. The other option, the Healthy Incentives Plan, would create health reimbursement accounts to pay a portion of enrollees’ required cost-sharing.

The Tennessee Hospital Association has agreed to help fund the state’s share of the program, according to a report from Nashville Public Radio.

Wyoming

Even though Gov. Matt Mead had offered a lukewarm endorsement of an expansion plan developed by the state Medicaid agency, it failed to pass the state health committee in late December 2014. A substitute plan was approved to create health savings accounts to which enrollees would be required to contribute, the Casper Star Tribune reported.

Any expansion plan will require passage by the full legislature in 2015 and then approval by the federal government.

Idaho

A 15-member work group appointed by Gov. Butch Otter revised its Medicaid expansion recommendation in November in order to increase the likelihood of legislative approval in 2015, according to Boise Public Radio. Now they recommend a so-called hybrid plan, bringing adults below 100 percent of poverty into the traditional Medicaid program and purchasing private health insurance through the state-run exchange for adults with incomes between 100 and 138 percent of poverty.
“We are trying to figure out something that will work out not just practically but also politically,” said work group member Corey Surber, executive director of health and public policy at St. Alphonsus Health System in Boise, according to The Associated Press [11].

The latest plan is projected to save Idaho money, eliminating county and state payments for indigent and catastrophic care, which will cost approximately $50 million in 2015.

Senate President Pro Tem Brent Hill wrote in a Jan. 2, 2015, blog posting [12], “Although there are financial incentives for state and local governments, there is currently no appetite in the Idaho Legislature to extend that federal program beyond what the law requires.”

**Alabama**

Gov. Robert Bentley said in a December speech to legislators that he is open to Medicaid expansion if it is designed by the state and has a work requirement, according to the Tuscaloosa News [13]. He says his administration is looking at what he called a Medicaid block grant to buy private insurance for people at or slightly above the poverty line. He said his administration is only in the early planning stage.

“We really have not gone into detail. Other states have talked about it, and they may have turned them down, but now they have a Republican Congress, and things may be different,” the Clarion-Ledger [14] quoted the governor.

In a public announcement [15] about moving Alabama Medicaid to managed care, Gov. Bentley said any plans for eligibility expansion would be separate from the changes to managed care.

**North Carolina**

Gov. McCrory met with President Obama in January 2015 and talked about Medicaid expansion. “My main message was, we want a North Carolina plan, not a Washington plan,” McCrory said, according to the Charlotte Observer [16].

McCrory said he asked the president about a waiver that could allow the state to require a job or job training as a condition of eligibility.

N.C. Gov. Pat McCrory signed a bill into law in 2012 that blocks Medicaid expansion without the express approval of the legislature.

Key legislators remain opposed. Senator Ralph Hise, the co-chair of the Senate Appropriations on Health and Human Services Standing Committee, says "I think it would be impossible for us to expand Medicaid at this point" in a WUNC [17] report.

A Dec. 2014 study [18] sponsored by two North Carolina foundations concludes that the state will lose 43,000 jobs and more than $160 million in tax revenue by 2020 if it does not expand Medicaid.

**Alaska**

Newly elected governor of Alaska, Bill Walker, is an independent and campaigned on the issue of Medicaid expansion. Up to 40,000 could receive coverage.

**Arkansas**

Perhaps moving in the opposite direction is Arkansas, which must take up again its decision to expand
Medicaid through the private option, using federal Medicaid funds to purchase commercial insurance policies from the exchange. Governor-elect Asa Hutchinson told a forum in Little Rock, according to Associated Press reports, he plans to give a major speech on health care reform, including Medicaid expansion, later in January.

#2 Growing the Health Workforce

Health care spending, both in the public and the private sectors, continues to grow as a share of the economy although more slowly than in the last decade. National health expenditure projections from the Centers for Medicare and Medicaid Services anticipate a 5.8 percent growth rate between 2012 and 2022, outpacing the growth in the gross domestic product by 1 percentage point.

![Chart 2. Projected rate of employment change by major occupational group, 2012-22](chart.png)
In the past six years, the health care profession also added 2.1 million jobs to the economy, more than any other employment sector. Kentucky Gov. Steve Beshear mentioned in his 2015 State of the Commonwealth address, that 5,300 new health care jobs were created between Nov. 2013 and Nov. 2014. He attributed the growth to Medicaid expansion and the state exchange.

Critical shortages, however, remain in some health care professions and in certain geographic areas. Important areas of debate for state leaders include scope of practice laws, reimbursement rates, professional education standards, licensing requirements and telemedicine standards. A few medical schools are experimenting with three year programs, to put doctors, especially in the primary care specialties, into practice more quickly according to a recent Washington Post [20] article.

#3 Integrating Health and Human Services

With the increased emphasis on improving health care outcomes and population health indicators, state leaders will continue to break down health and human services silos. This focus on integration extends beyond one-stop shop service configurations and combined eligibility applications. Medicaid administrators, at the state level and within Medicaid managed care organizations, will look to control costs by focusing on underlying problems that can lead to expensive health care services. It may be less expensive to provide housing to a homeless individual than to meet increased hospital bills that result from substandard living conditions. Public health advocates in particular have been building an understanding of the social determinants of health and the importance of these upstream factors to downstream health costs.

States are experimenting with a number of programs, including patient-centered medical homes and other intensive case management programs. Both Medicaid and Medicare on the federal level are funding these innovative programs.

#4 Long-Term Care

Baby boomers have transformed just about everything they have lived through. Now comes old age and long-term care issues. Baby boomers will live longer and become a larger proportion of the states’ populations. According to the U.S. Census [21], between 1990 and 2020, the population age 65 to 74 will increase by 74 percent, while the population under age 65 would increase by only 24 percent.
These baby boomers will demand more services, delivered in the communities and the homes where they live and directed by themselves and their loved ones, not service providers. The service system will face many challenges. Growing numbers of older seniors with Alzheimer’s disease and other dementias will need extra assistance. The larger number of cognitively impaired seniors will complicate the movement to self-directed medical care. Many older Americans will need financial assistance on top of federal Medicare. States also will face pressure to create a range of alternatives to more traditional nursing home care.

#5 Mental Health and Substance Abuse

One in five Americans suffers from mental health issues and increasingly they are coming out of the shadows. As some states have expanded their Medicaid programs to include broader eligibility, they also have expanded their coverage of behavioral health and substance abuse issues. Advocates will continue to push for parity between behavioral health and physical health in insurance policy coverage, Medicaid and state systems development and funding.