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Commentary: What to Watch for in Trump Administration Actions on Medicaid Waivers

By Judith Solomon

The Trump Administration is poised take administrative actions that will significantly weaken the Affordable Care Act's (ACA) Medicaid expansion to low-income adults, after failing in multiple unsuccessful attempts to roll it back. It remains unclear, however, how far the Administration will go in undermining coverage for people who have gained it — or would qualify in the future — under the expansion.

Over the last nine months, the Administration and Republicans in Congress have sought to unravel the expansion by repealing the ACA. These efforts have failed to date, in part due to opposition that reflects the expansion's success in covering millions of poor and near-poor uninsured adults — including low-wage workers, students, people caring for children and other relatives, and adults with significant physical or behavioral health problems, including those affected by the opioid epidemic. In Kentucky, for example, hundreds of thousands of adults who gained coverage through the expansion are finding doctors, getting regular health care, and experiencing improved health, research shows.¹

However, the Department of Health and Human Services (HHS) will likely soon approve section 1115 Medicaid waivers and make other changes in Medicaid policy that will create barriers to health coverage and care, singling out the poor and low-income adults who became eligible under the expansion.

A March 2017 letter to governors from then-HHS Secretary Tom Price and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma explained that the Trump Administration intends to give states unprecedented leeway in running their Medicaid programs. The letter indicates that HHS will approve work requirements and other changes that could impede many beneficiaries' ability to get and retain coverage and obtain needed health care.² The letter specifically targets the ACA's Medicaid expansion, claiming that expanding Medicaid to poor and low-income adults represents “a clear departure from the core, historical mission of the program.”

¹ Benjamin Sommers *et al.*, “Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance,” *JAMA Internal Medicine*, October 2016.

² Letter from Secretary Price and CMS Administrator Verma to governors, March 14, 2017, <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>.

Last week Verma reinforced these messages and again tied CMS' intention to give states "an unprecedented level of flexibility" to the Administration's opposition to Congress' decision to expand Medicaid. In a speech at the Cleveland Clinic, she said that "the policies that are in the Medicaid program are not designed for an able-bodied individual" and that the Administration's goal is to keep those people in the private insurance market, where they would not be "dependent on public assistance."³

Congress expanded Medicaid as part of the ACA to provide a path to coverage for uninsured low-income adults with incomes below 138 percent of the poverty line. Congress explicitly chose Medicaid as the vehicle for covering these poor and near-poor adults. For people with more moderate incomes who lack access to job-based or other coverage, Congress provided subsidies for the purchase of ACA marketplace coverage.

Section 1115 demonstration projects allow states to request approval from HHS to implement demonstration projects that are "likely to assist in promoting the objectives of [Medicaid]." To carry out these projects, states may waive certain provisions of the Social Security Act, but such waivers are only allowed to the extent necessary to implement the demonstration project and test new or experimental policies. Current criteria for section 1115 waivers require states to show that a proposed demonstration project will increase and strengthen coverage, increase health care access, improve health outcomes, or increase the efficiency and quality of care for Medicaid beneficiaries and other low-income populations.⁴

A number of waiver proposals now pending before HHS fall far short of meeting these requirements. The proposals would make the following changes:⁵

- condition Medicaid eligibility on work and work-related activities (AR, IN, KY, ME, NH, UT, WI) or on drug screening and testing (WI);
- impose premiums on people with incomes below the poverty line (IN, KY, ME, WI);
- impose a time limit on how long people can be enrolled in Medicaid (ME, UT, WI);
- limit the Medicaid expansion to people with incomes below the poverty line instead of 138 percent of poverty (AR, MA); and
- lock people out of coverage if they don't submit renewal paperwork on time (IN, KY) or don't report changes in employment or income within ten days (KY).

In virtually every case, these proposals would result in fewer people being covered with the waiver than without it, which is inconsistent with Medicaid's basic objectives. This is why the federal

³ Casey Ross, "Trump health official Seema Verma has a plan to slash Medicaid rolls. Here's how," STAT News, October 26, 2017, <https://www.statnews.com/2017/10/26/seema-verma-medicaid-plan/>.

⁴ For a full discussion of the requirements for approving an 1115 waiver, see Judith Solomon and Jessica Schubel, "Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care," Center on Budget and Policy Priorities, August 29, 2017, <https://www.cbpp.org/research/health/medicaid-waivers-should-further-program-objectives-not-impose-barriers-to-coverage>.

⁵ Maine, Wisconsin, and Utah have not expanded Medicaid. The changes these states would make would affect low-income parents and adults eligible under longstanding Medicaid waivers.

government has never allowed these departures from Medicaid rules.⁶ But the Trump Administration’s continued hostility to the Medicaid expansion suggests that many of these proposals will now receive approval, with Kentucky’s most likely the first up for action.⁷

Kentucky Likely a Bellwether on New Waiver Policy

While both HHS’ March 2017 letter to governors and CMS Administrator Verma’s recent remarks make clear that the Administration intends to use waivers to shrink and weaken the Medicaid expansion, there are significant questions about *how* it will go about doing so. The terms and conditions of Kentucky’s waiver will be a bellwether on how far the Administration will go in deviating from previous administrations. Key policy decisions ahead include:

- **Will HHS approve waivers that the state *itself* forecasts will cause people to lose coverage?** Under the current criteria for approving Medicaid waivers, a waiver must not reduce coverage, reduce access to health care services, or worsen health outcomes. A number of pending state waiver proposals, however, — including Kentucky’s — forecast *declines* in participation. Will HHS change its criteria to allow approval of proposals that would cause beneficiaries to lose coverage or make it harder for them to get care?
- **Will HHS allow states to condition Medicaid eligibility on work or work-related activities?** Medicaid eligibility for adults under the Medicaid expansion is based on three criteria: having income below 138 percent of the poverty line, meeting citizenship or lawful immigration status, and meeting state residency requirements. HHS has rejected the imposition of work requirements as inconsistent with Medicaid’s objectives of providing health care to poor and low-income people.⁸ Will HHS reinterpret Medicaid’s objectives to allow conditioning health coverage on meeting work requirements, in apparent contradiction to what the federal statute defines as the requirements for establishing eligibility? If it does, will HHS also require states to help beneficiaries find work and provide work supports such as child care and transportation, or will it leave them on their own — and at heightened risk of losing their health coverage?
- **Will HHS approve higher and more broadly applicable premiums than it has ever allowed in Medicaid, despite evidence that premiums significantly reduce coverage among people who are poor?** A recent review of research over several decades found that

⁶ Letter from HHS Secretary Sylvia Mathews Burwell to Arkansas Governor Asa Hutchinson, April 5, 2016, http://governor.arkansas.gov/images/uploads/Burwell_Letter_to_Governor.pdf; letter from CMS Director Vikki Wachino to New Hampshire Department of Health and Human Services Commissioner Jeffrey A. Meyers, November 1, 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf>.

⁷ Kentucky submitted its waiver proposal to the Obama Administration in September 2016. In February 2017 the state proposed modifications to its proposal, including a stricter work requirement and a lock-out penalty for failure to quickly report changes in employment or income.

⁸ Section 1901 of the Social Security Act appropriates funds so states can “furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.”

Medicaid and Children’s Health Insurance Program premiums reduce coverage for both children and adults by deterring enrollment, increasing disenrollment, and shortening people’s time on the program. The impact is greatest on people with incomes below the poverty line, who are also likelier to become uninsured if they lose coverage.⁹ Given that premiums have already been shown to erode coverage, how will HHS justify demonstration projects or experiments that impose premiums more widely, especially on people below the poverty line?

- **Will HHS approve coverage “lockouts” for people in poverty?** To date, HHS has allowed states to terminate coverage for non-payment of premiums only for people with incomes above the poverty line. Will HHS allow states to terminate coverage for up to six months for people with incomes *below* the poverty line who do not come up with the premium payments, do not complete renewal paperwork on time, or neglect to report even small changes in income or employment? Under Kentucky’s waiver proposal, for example, a beneficiary working 20 hours per week at \$11 per hour would pay an \$8 monthly premium. If she picks up one extra shift in a month, the extra income would increase her monthly premium to \$15. She would have to know that the extra shift affects her premium and report the change; if she failed to do so, she could be locked out of Medicaid for six months.
- **Will HHS consider the administrative costs of these proposals, which would require considerable tracking and monitoring of work activities, exemptions from work activities, payment of premiums, and reporting changes?** In some cases, those costs can exceed any state savings from the new policies. Arkansas, for example, ended its experiment of utilizing health savings accounts in its Medicaid program because the state spent \$9 million while collecting just \$425,000 in payments from beneficiaries.¹⁰

The answers to these and related questions will help determine the extent to which HHS’ actions will undermine coverage for expansion enrollees. Nevertheless, the Administration’s overall intent seems clear: it will allow states to institute harmful changes in Medicaid, in large part because it doesn’t want to accept Congress’ decision in the ACA to provide Medicaid coverage to millions of uninsured low-income adults.

⁹ Samantha Artiga, Petry Ubri, and Julia Zur, “The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings,” Kaiser Family Foundation, June 21, 2017, <http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

¹⁰ “Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population,” Academy Health Annual Research Meeting, June 2017, <https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18272>.