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Proposals to Lower Medicaid Expansion Eligibility Jeopardize Coverage for Low-Income Adults

By Jessica Schubel

While a growing number of states are seeking federal waivers that would make it harder for many low-income adults to secure or retain Medicaid,[1] Arkansas and Massachusetts are proposing to go further by ending Medicaid coverage altogether for all adults with incomes between 100 and 138 percent of the poverty line. The Arkansas and Massachusetts waiver proposals, which the Secretary of Health and Human Services (HHS) would have to approve, would threaten health coverage for tens of thousands of low-income individuals. Moreover, they are inconsistent with Medicaid's core mission of providing comprehensive health coverage to low-income people, as well as with federal requirements that Medicaid waivers advance that objective.

Both states expanded Medicaid coverage to those between 100 and 138 percent of poverty but now want to use federal Medicaid waiver authority to take it away. Although many of those affected would be eligible for federal tax credits to help buy coverage in the individual health insurance market, solid evidence (described below) indicates that a sizable number of them would become uninsured, while others would be left with less affordable or less adequate coverage. That's partly because individual market plans, even with tax credits, are less affordable than Medicaid for people with incomes just above the poverty line. It's also because some in this group would be ineligible for tax credits because their employer offers them coverage, even though that coverage would require them to pay a substantial share of their income in premiums.

Although both proposals would hurt many people, Arkansas' would be worse for adults losing Medicaid. Unlike Arkansas, Massachusetts provides additional help to defray premiums and cover other costs to adults with incomes up to 300 percent of poverty who have marketplace coverage. That would help those between 100 and 138 percent of poverty who lose Medicaid, although marketplace plans generally leave out some benefits that Medicaid covers.

The HHS Secretary should not approve the Arkansas and Massachusetts proposals because, for the reasons above, they fail to meet the statutory requirements for Medicaid waivers, which are supposed to advance the objectives of the Medicaid program. Moreover, one of the main

[1] They're doing so at the invitation of then-Health and Human Services Secretary Tom Price and Centers for Medicare & Medicaid Services Administrator Seema Verma, in a March 14, 2017 letter to governors, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf.

justifications that these states provide for their waiver proposals — that they would save the states money — isn't a legally permissible use of federal waiver authority.

The Arkansas and Massachusetts Proposals

Arkansas and Massachusetts used different approaches to expand Medicaid coverage to low-income adults with incomes below 138 percent of the poverty line. Arkansas expanded Medicaid through a Medicaid waiver that allows the state to enroll eligible adults in Qualified Health Plans (QHPs) offered in Arkansas' marketplace, with the state providing additional benefits and affordability protections to comply with Medicaid rules.[2] Massachusetts has covered low-income adults since 2005 through a Medicaid waiver known as MassHealth, but starting in 2014 when the Affordable Care Act (ACA) provided a new pathway to Medicaid coverage for adults with incomes below 138 percent of the poverty line, Massachusetts moved these adults into its traditional Medicaid program. The MassHealth waiver is still in place, giving the state the authority to make delivery system changes, such as implementing managed care and testing new care delivery and payment methods through accountable care organizations.

Both states now want to amend their waivers to lower Medicaid expansion eligibility from 138 to 100 percent of the poverty line — but maintain the enhanced federal matching rate that states receive under the expansion to cover low-income adults who don't otherwise qualify for Medicaid as parents or people with serious disabilities.[3] In 2012, CMS issued guidance stating that while it would consider partial expansion proposals, the enhanced Medicaid expansion matching rate of 90 percent or more would not be available for a partial expansion. Wisconsin is the only state that has implemented a partial Medicaid expansion, providing Medicaid coverage to low-income adults with incomes up to 100 percent of the poverty line through a waiver. The state receives its regular match rate of 58.5 percent for covering these adults rather than the enhanced matching rate available to states implementing the full expansion.

Are Partial Expansion Proposals Consistent with Medicaid's Objectives?

Under section 1115 of the Social Security Act, a state can implement an "experimental, pilot or demonstration project which, in the judgment of the Secretary [of HHS], is likely to assist in promoting the objectives of [Medicaid]" in a state.[4] The law gives the HHS Secretary authority to

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[2] Arkansas must provide additional benefits that aren't included in marketplace coverage but are mandatory Medicaid services, as well as additional cost-sharing protections to comply with Medicaid law.

[3] Because Massachusetts provided comprehensive coverage to both parents and childless adults with incomes above the poverty line prior to ACA's enactment, it receives a different enhanced matching rate than Arkansas.

[4] Section 1901 of the Social Security Act, which governs Medicaid, 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."

Section 1115 of the Social Security Act provides broad, but not unlimited, authority to deviate from certain provisions of Medicaid law. It also authorizes federal Medicaid funding for activities that, in the absence of a waiver, would not qualify for it (e.g., providing benefits that aren't typically covered by Medicaid). For more information on section 1115 demonstration projects, see Judith Solomon and Jessica Schubel, "Medicaid Waivers Should Further Program

waive provisions in section 1902 of the Social Security Act (which lists the requirements that states must follow to qualify for federal Medicaid matching funds), but only to the extent necessary for states to implement an approved demonstration project. There are limits on waiver authority. States can't waive every provision of Medicaid law. For example, section 1115 waiver authority doesn't allow for changes to Medicaid's financing structure. In addition, states must demonstrate how their proposals further Medicaid's objectives.

The Secretary uses criteria developed by CMS to help determine whether a state's Medicaid waiver promotes Medicaid's objectives. CMS first issued these criteria in 2015 in response to several Government Accountability Office (GAO) reports that criticized HHS for the lack of clear standards guiding the Secretary's approval of demonstration projects. The criteria focused on whether a state's application would increase and strengthen coverage for low-income people, improve access to care and health outcomes, or increase the efficiency and quality of care for Medicaid beneficiaries.[5] The Trump Administration revised these criteria, eliminating increasing and strengthening coverage as a criterion and instead stating that it will consider proposals that "promote upward mobility" and "responsible decision making" as furthering Medicaid's objectives.[6]

Partial Expansions Likely to Result in Coverage Losses

Approval of Arkansas' and Massachusetts' partial expansion requests would mean that low-income adults with incomes between 100 and 138 percent of the poverty line would no longer qualify for Medicaid coverage. Although CMS no longer considers "strengthening and expanding coverage" as a criterion for granting an 1115 waiver, a *loss* in coverage would be inconsistent with Medicaid's core mission because it would increase the rate of uninsurance. Department of Treasury data show that 37 percent of adults with incomes between 100 and 138 percent of poverty who live in non-expansion states are uninsured, compared to 25 percent of such adults in expansion states. While most adults with incomes between 100 and 138 percent of poverty in non-expansion states are eligible for tax credits to help buy coverage in the insurance marketplaces, the Treasury data indicate that these very low-income adults are less likely to enroll in subsidized marketplace coverage than in Medicaid.[7]

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] Solomon and Schubel, "Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care."

[6] Centers for Medicare & Medicaid Services, "About Section 1115 Demonstrations," accessed November 21, 2017, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html. For more information, see Jessica Schubel, "Medicaid Criteria Changes Don't Ensure Waivers Will Further Program Objectives," Center on Budget and Policy Priorities, November 13, 2017, https://www.cbpp.org/blog/medicaid-criteria-changes-dont-ensure-waivers-will-further-program-objectives.

[7] Itahai Z. Lurie and Janet McCubbin, "What can Tax Data Tell Us About the Uninsured? Evidence from 2014," U.S. Department of Treasury, Office of Tax Analysis, July 2016, https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/WP-106.pdf.

Moreover, when states change Medicaid eligibility, people can sometimes get lost in the shuffle and lose coverage. This occurred in several states — Connecticut, Rhode Island, and Wisconsin — that lowered Medicaid eligibility for adults when marketplace coverage became available. Connecticut and Rhode Island lowered eligibility for parents with incomes over the eligibility limit for the Medicaid expansion (i.e., over 138 percent of the poverty line), while Wisconsin lowered eligibility for adults whom the state had covered under its pre-ACA Medicaid waiver. In Rhode Island, despite considerable efforts, 1,271 of the 6,574 people who lost Medicaid when the state rolled back eligibility — or 19 percent of them — did not subsequently apply to enroll in a QHP in the marketplace, and many likely became uninsured.[8] In Connecticut, during the first round of a similar rollback in parent eligibility, only 1 in 4 parents losing Medicaid coverage enrolled in a QHP.[9] And in Wisconsin, only one-third of those losing Medicaid coverage purchased QHPs although the state had predicted that 90 percent would.[10]

In addition, coverage for adults who do successfully transition into other coverage options generally is inferior to Medicaid coverage. It costs more, with higher premiums and cost-sharing compared to what is permitted in Medicaid,[11] even while providing a less comprehensive benefit package. Moreover, some individuals and families with an offer of employer coverage that is considered "affordable" under the law — costing less than 9.69 percent of household income for employee-only coverage, which equals $1,168 per year for a person at the poverty line — wouldn't even be eligible for financial assistance to purchase marketplace coverage. They would either have to enroll in employer coverage with premiums often much higher than they would be expected to pay in the marketplace — or become uninsured.

Both the Arkansas and the Massachusetts proposals would be harmful for these reasons, but Arkansas' would be more damaging to adults losing Medicaid coverage. That's because Massachusetts, unlike Arkansas, would use its Medicaid waiver to provide marketplace enrollees with incomes below 300 percent of the poverty line with further premium and cost-sharing assistance in addition to the marketplace subsidies available from the federal government. For people with incomes between 100 and 138 percent of the poverty line, these extra subsidies would make coverage more affordable and more comparable to what they would have experienced had they remained in Medicaid. However, the additional assistance doesn't provide the full coverage benefits they would have received under Medicaid, and Massachusetts' additional financial assistance is only authorized until 2022, the end of the demonstration's current approval period. A subsequent loss of the additional assistance for adults in Massachusetts is a real possibility, because the state finances

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[8] Kate Lewandowski, "Parent Eligibility Roll-Back in Rhode Island: Causes, Effects and Lessons Learned," Community Catalyst, September 2015, https://www.communitycatalyst.org/resources/publications/document/RI-parent-rollback-081215-KL.pdf?1439834245.

[9] Sharon Langer, Mary Alice Lee, and Dumingu Aparna Gomes, "Husky Program Coverage for Parents: Most Families Will Feel the Full Impact of Income Eligibility Cut Later in 2016," Connecticut Voices for Children, April 2016, http://www.ctvoices.org/sites/default/files/h16HUSKYIncomeEligibilityCut.pdf.

[10] Guy Boulton, "One-third who lost BadgerCare coverage bought plans on federal marketplace," *Journal Sentinel*, July 16, 2014, http://archive.jsonline.com/business/almost-19000-badgercare-plus-recipients-enrolled-in-obamacare-b99312352z1-267339331.html.

[11] Under Medicaid, premiums and cost-sharing are limited to 5 percent of an individual's monthly or quarterly income.

that assistance through federal Medicaid matching funds that it receives under a policy that CMS has recently said it will not continue in extensions or renewals of current waivers.[12]

Partial Expansions Are Not Experimental

Medicaid waivers must be experimental in nature — they must test a new policy or approach to delivering care to Medicaid beneficiaries. The Arkansas and Massachusetts proposals, however, have no experimental nature; in essence, they propose to take Medicaid coverage away from low-income adults with incomes above the poverty line. These waiver proposals neither identify any policy that the state would be testing by rolling back coverage for current beneficiaries nor explain how rolling back coverage furthers Medicaid's objectives. Moreover, the one rationale that's included in both proposals — saving money for the states — is not a permissible use of section 1115 demonstration authority.[13]

Arkansas also failed to include in its waiver request any hypotheses to support its proposal, while Massachusetts included hypotheses that aren't sound. For example, Massachusetts' proposal states that the proposed rollback in coverage would "improve continuity and reduce churn." But lowering eligibility would just create a new Medicaid cut-off at 100 percent of poverty instead of at 138 percent, and there are better ways to address churn, such as guaranteeing Medicaid enrollment for a period of 12 months or encouraging Medicaid managed care plans to participate in the state's marketplace or vice versa (i.e., encouraging QHPs to participate in MassHealth). These alternative approaches would be consistent with the Trump Administration's new criteria for Medicaid waivers because they would test ways to "enhance alignment" between Medicaid and "commercial health insurance products to facilitate smoother beneficiary transitions," and "advance innovative delivery system…models…and drive greater value for Medicaid."[14]

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[12] Centers for Medicare & Medicaid Services, State Medicaid Director Letter #17-005, "Phase-out of Expenditure Authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations," December 15, 2017, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17005.pdf.

[13] See *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

[14] Centers for Medicare & Medicaid Services, "About Section 1115 Demonstrations," accessed December 15, 2017, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.