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Approved Demonstrations Offer Lessons for States Seeking to Expand Medicaid Through Waivers

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Twenty-eight states and the District of Columbia are implementing health reform's Medicaid expansion. In 2014, Arkansas, Iowa, and Michigan expanded through federally approved Medicaid demonstration projects, or "waivers," and on February 1, Indiana's Medicaid expansion waiver took effect. Waivers give states additional flexibility in how they operate their Medicaid programs.

The programmatic flexibility a waiver can provide, however, is limited. For example, a state cannot use a waiver to impose onerous requirements that make it difficult for eligible individuals to gain and maintain Medicaid coverage. All waivers must serve a demonstration purpose that promotes Medicaid's objectives, which are to deliver health care services to vulnerable populations who can't afford the health care services and long-term care services and supports that they need.

In approving the Arkansas, Indiana, Iowa, and Michigan expansion waivers, the federal government allowed those states to, for example, enroll some or all of their newly eligible Medicaid beneficiaries in private coverage offered through the health insurance marketplaces and to charge beneficiaries modest premiums. At the same time, the federal government scaled back state proposals to limit certain health benefits. It also rejected state proposals to condition eligibility on participation in work search activities and to condition coverage for beneficiaries with incomes below the poverty line on payment of premiums. The federal government has not allowed states to impose cost-sharing charges beyond what Medicaid rules already allow, unless the state meets strict criteria for cost-sharing waivers set forth in the Medicaid statute.

The federal government is considering a Medicaid expansion waiver proposal from New Hampshire (which has already expanded but is seeking an expansion waiver for 2016). Utah, Montana, and several other states are considering expansions during their current legislative sessions; these states will likely expand only through a waiver. The guardrails the federal government has established so far around what is and is not permissible in a Medicaid expansion waiver offer useful lessons for policymakers in states considering whether to expand Medicaid. State decisions about the Medicaid expansion are now as much about *how* to expand as about *whether* to expand.

The Evolving Role of Waivers Under the Medicaid Expansion

Prior to health reform, the typical state provided limited Medicaid coverage to parents under age 65 without a disability and did not cover non-elderly and non-disabled adults without children at all.[1] The handful of states that provided coverage to poor adults without children did so through demonstration projects authorized under section 1115 of the Social Security Act, which allows the Secretary of Health and Human Services (HHS) to waive certain provisions of Medicaid law and provide federal matching funds for state Medicaid spending that would not otherwise be matched to conduct an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives" of the Medicaid program.[2]

Section 1115 waivers must be budget neutral to the federal government. That is, the federal government cannot spend more under the waiver than it would spend without the waiver. For waivers prior to health reform, this meant that for a state to cover adults who were not otherwise eligible for Medicaid — which would raise federal costs because the federal government provides matching funds for state Medicaid spending — states had to produce offsetting savings, such as greater use of managed care, while also limiting the cost of the expansion itself. To this end, states limited expansion costs through tools like benefit and enrollment limits, premiums, and cost-sharing generally not allowed for beneficiaries eligible under traditional Medicaid rules.[3]

Health reform's Medicaid expansion established a pathway to coverage for all non-elderly adults with incomes up to 138 percent of the poverty line, including, for the first time, low-income adults without children. While the 2012 Supreme Court decision upholding the health reform law made the Medicaid expansion a state-by-state decision, health reform's explicit pathway to coverage for low-income childless adults means that they are entitled to the same protections as other mandatory groups of Medicaid beneficiaries when a state expands, even under a waiver. As a result, states can no longer implement provisions of certain waivers approved prior to health reform that treat this population as outside Medicaid's protections;[4] for example, HHS will not approve expansion proposals that include enrollment caps, limits on most mandatory benefits, and excessive premiums for individuals with very low incomes.

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[1] In the typical state, a working parent had to earn less than 61 percent of the poverty line (about $12,100 for a family of three), and an unemployed parent had to have an income below 37 percent of the poverty line (about $7,300), to be eligible for Medicaid. Most states did not provide coverage to low-income, non-disabled adults without dependent children at any income level. Under the Medicaid expansion, all adults in a state with incomes less than 138 percent of poverty (about $16,100 for an individual and $27,300 for a family of three) become eligible.

[2] Cindy Mann, "The New Medicaid and CHIP Waiver Initiatives," Kaiser Commission on Medicaid and the Uninsured, February 2002, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-new-medicaid-and-chip-waiver-initiatives-background-paper.pdf.

[3] Robin Rudowitz, Samantha Artiga, and MaryBeth Musumeci, "The ACA and Recent 1115 Medicaid Demonstration Waivers," Kaiser Commission on Medicaid and the Uninsured, February 2014, http://kaiserfamilyfoundation.files.wordpress.com/2014/02/8551-the-aca-and-recent-section-1115-medicaid-demonstration-waivers1.pdf.

[4] For example, several court decisions prior to enactment of the Affordable Care Act found that childless adults receiving coverage through section 1115 waivers were not entitled to the cost-sharing protections afforded to other beneficiaries as they did not constitute a traditional Medicaid population. See *Spry v. Thompson,* 487 F.3d 1272 (9th Cir. 2007).

The Arkansas "Private Option": The First Medicaid Expansion Waiver

Most states that elected to expand Medicaid after the 2012 Supreme Court decision simply amended their Medicaid state plans to extend coverage to the new adult eligibility group. In February 2013, however, Arkansas introduced a new expansion approach when it decided to apply instead for a section 1115 waiver, in part to overcome opposition in the state legislature to a straightforward expansion.

The Arkansas waiver that HHS approved in September 2013 relies on existing "premium assistance" authority in the Medicaid statute. This authority allows states to purchase private coverage with Medicaid dollars — typically to subsidize employee premiums for job-based coverage — so long as it is cost effective (i.e., doing so costs the same as or less than the cost of providing coverage through regular Medicaid). The Arkansas waiver allows the state to use federal Medicaid funds to purchase marketplace plans — known as Qualified Health Plans (QHPs) — for almost everyone newly eligible for Medicaid in the state.[5] Arkansas needed a waiver because it is requiring beneficiaries to enroll in QHPs rather than giving them a choice between a QHP and regular Medicaid, as Medicaid rules require.

Before and during negotiations with Arkansas state officials, HHS set limits on the use of waivers and other possible variations for states taking up the Medicaid expansion:

- **Expansions must extend Medicaid to adults all the way up to 138 percent of the poverty line.** Otherwise states will not qualify for the Medicaid expansion's enhanced matching rate, under which the federal government pays the entire cost of covering newly eligible beneficiaries through 2016 and no less than 90 percent in the years that follow.[6]
- **Enrollees whom the state requires to enroll in QHPs remain Medicaid beneficiaries.** As such, states must "wrap around" the QHP benefits to ensure that beneficiaries have access to the same benefits and are not subject to higher cost-sharing charges than if they were enrolled in regular Medicaid.[7]
- **Expansion waivers must articulate a clear demonstration purpose that promotes Medicaid's objectives, as with section 1115 waivers granted prior to health reform.** In Arkansas' case, the purpose of the expansion waiver is to evaluate whether enrolling in QHPs helps individuals move more easily between marketplace and Medicaid coverage as their income changes, and whether enrolling more individuals in QHP coverage can reduce premiums in the marketplace.[8]

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[5] For more information about premium assistance in Medicaid prior to the Affordable Care Act and its role going forward, see Joan Alker, "Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act," Kaiser Commission on Medicaid and the Uninsured, March 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8422.pdf.

[6] Centers for Medicare and Medicaid Services, "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid," December 10, 2012, http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

[7] Centers for Medicare and Medicaid Services, "Medicaid and the Affordable Care Act: Premium Assistance," March 29, 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf.

[8] For more information about the Arkansas waiver, see MaryBeth Musumeci, "Medicaid Expansion Through Premium Assistance: Key Issues for Beneficiaries in Arkansas' Section 1115 Demonstration Waiver Proposal," Kaiser

HHS Response to Subsequent Waiver Proposals Provides Further Direction for Expansion Waivers

Since HHS approved Arkansas' expansion waiver, three other states — Indiana, Iowa, and Michigan — have implemented HHS-approved expansion waivers.[9] In addition, New Hampshire has a waiver application pending. (See Appendix for a summary of approved and pending expansion waivers.) As additional states consider expanding Medicaid through waivers, state policymakers should consider the limits that HHS has placed on waivers so far:

- **People with incomes below the poverty line may not be disenrolled for non-payment of premiums.** Under Iowa's approved waiver, beginning this year the state can charge premiums of up to $10 a month for beneficiaries with incomes between 100 and 138 percent of the poverty line and up to $5 a month for those with incomes between 50 and 100 percent of the poverty line. For both groups, the state will waive premiums for individuals who complete a health risk assessment and wellness exam or who attest to financial hardship. If the premiums are not waived and beneficiaries do not pay their premiums, the balance of the unpaid premiums becomes a collectible debt to the state after a 90-day grace period. Importantly, individuals cannot be disenrolled from coverage if they do not pay their premiums, even though the state's initial waiver application included such a provision.[10]

  In Indiana, all beneficiaries will be subject to a monthly premium of 2 percent of their income or $1, whichever is greater. Beneficiaries with incomes between 100 and 138 percent of the poverty line who do not make a payment after a 60-day grace period will have their coverage terminated and cannot re-enroll for six months. Beneficiaries with incomes below the poverty line who do not make payments cannot be disenrolled. They will, however, receive a less generous benefit package and, unlike those below the poverty line who make premium payments, will have to pay cost-sharing charges when they utilize health services.

- **Individuals may not be required to pay cost-sharing charges above what Medicaid allows, unless the state meets strict criteria.** Medicaid cost-sharing rules give states flexibility while also providing significant beneficiary protections intended to minimize barriers to necessary health care services. For example, they bar cost-sharing for most children and pregnant women and for certain services, such as family planning, emergency services, and maternity care. People with incomes above the poverty line may be charged higher amounts than those with lower incomes. Also, providers cannot deny services to people with incomes below the poverty line who cannot afford to pay. While cost-sharing protections are *not* among the provisions that states can waive using section 1115 authority, Indiana gained approval for a two-year waiver from cost-sharing rules under separate waiver authority in section 1916(f) of

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Commission on Medicaid and the Uninsured, July 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8459-medicaid-expansion-through-premium-assistance.pdf.

[9] HHS approved Pennsylvania's waiver in August in 2014 and it took effect January 1, 2015. However, newly elected Governor Tom Wolf announced on February 9 that the state would not implement the waiver and would instead move to a straight Medicaid expansion.

[10] HHS initially allowed Iowa to terminate coverage for non-payment of premiums for people with incomes *above* the poverty line, but Iowa amended the terms and conditions of the waiver so that no beneficiaries will lose coverage for failure to pay premiums.

the Social Security Act.[11] Under this waiver, beneficiaries are subject to an $8 co-payment for their first non-emergency visit to an emergency room and $25 for each subsequent non-emergency visit.

- **Certain benefits may not be overly restricted.** States have significant flexibility regarding benefits for newly eligible adults and can largely align their benefits with the benefits that marketplace plans provide. However, there are certain differences in what benefits must be covered in Medicaid as compared to marketplace plans, and HHS has provided very limited waivers of Medicaid benefit requirements where they provide broader coverage than QHPs do. For example, HHS denied Iowa's request to eliminate the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for 19- and 20-year-old members of the newly eligible group. (EPSDT is a comprehensive pediatric benefit that, among other things, ensures appropriate treatment for children and young adults with special health care needs.)

  HHS did, however, grant Indiana, Iowa, and Pennsylvania one-year waivers from the requirement that non-emergency transportation to and from health care providers be available to the newly eligible population. At the end of 2014, in response to Iowa's request to extend the waiver of non-emergency transportation for two years, HHS extended it for only six months. HHS denied a longer extension because the state's preliminary data suggested the waiver was having a negative impact on beneficiaries, especially those with incomes below the poverty line.[12]

- **Medicaid eligibility cannot be conditioned on employment or participation in work search activities.** HHS rejected proposals from Indiana and Pennsylvania to make employment or participation in an employment search program a condition of eligibility. In December 2013, Pennsylvania Governor Tom Corbett proposed a Medicaid expansion waiver that would require anyone working fewer than 20 hours a week to register with the state's unemployment compensation program and engage in 12 work search activities per month to remain eligible for Medicaid; those judged not in compliance would lose their health coverage. Governor Corbett submitted a revised proposal to HHS in February 2014 that would lower the premium and cost-sharing obligations for beneficiaries who work more than 20 hours or engage in work-search activities. In Indiana, Governor Mike Pence proposed that Medicaid eligibility for anyone working fewer than 20 hours per week be conditioned on a referral to job training and job search programs. HHS rejected both states' proposals in this area, indicating that it would not approve the conditioning of Medicaid eligibility and premium obligations on work search or work-related activities.[13]

  New Hampshire and Indiana are exploring how to connect newly eligible beneficiaries to state-run job search programs in ways that do not affect Medicaid eligibility or benefits. New Hampshire's legislation authorizing the state to expand Medicaid stipulates that unemployed Medicaid beneficiaries will be referred to a job search program run by the state's Employment

[11] Section 1916(f) provides strict criteria for waivers of cost-sharing rules that can last no longer than two years. A waiver must test a "unique and previously untested use of copayments" and must use control groups, and participation must be voluntary for beneficiaries.

[12] Rudowitz, Artiga, and Musumeci, *op cit.*

[13] An HHS spokesman made this line clear during negotiations with Utah Governor Gary Herbert by saying, "work initiatives are not the purpose of the Medicaid program and cannot be a condition of Medicaid eligibility." Michelle Price, "Feds: Utah will not get Medicaid work requirement," Associated Press, January 7, 2015.

Security agency. Indiana is referring beneficiaries who work less than 20 hours a week to a voluntary workforce training program, called Gateway to Work.

- **Premium assistance waivers are available only for three years.** HHS approved Arkansas' and Iowa's premium assistance waivers through 2016.[14] In guidance, HHS limited the waivers to three years so that the states' experience in using premium assistance to deliver Medicaid coverage through QHPs can inform whether such an approach could be a companion to future "waivers for state innovation."[15] Under health reform, states may apply to the federal government to waive certain provisions of the law, including those related to the marketplaces and to reforms in the individual and small-group markets. (The state's alternative approach must cover as many people as under health reform, must be at least as comprehensive and affordable, and must not increase federal costs relative to what they would have been under health reform.) These waivers can take effect starting in 2017.

Conclusion

States considering a waiver as the way to expand Medicaid should be mindful of the limitations HHS has established so far. For example, while HHS has permitted states to use federal Medicaid funds to purchase QHP coverage in the marketplaces for newly eligible beneficiaries and to explore ways to encourage healthy behaviors, it has indicated that any waiver must be "likely to assist in promoting the objectives" of Medicaid and cannot make it more difficult for individuals to access and maintain coverage. As a result, state policymakers should understand that HHS is unlikely to approve waiver proposals that include premiums and cost-sharing charges beyond what a low-income person can reasonably afford, impose restrictive limits on certain health benefits, or deny or terminate Medicaid coverage for someone judged not to be complying with work requirements.

[14] Indiana's waiver was approved for three years even though it does not utilize premium assistance, but this is because it amended the state's existing Healthy Indiana waiver. Waiver amendments generally last three years. Michigan's waiver was approved for five years because it does not use premium assistance.

[15] For more information about waivers for state innovation, see Jessica Schubel and Sarah Lueck, "Understanding the Affordable Care Act's State Innovation ("1332") Waivers," Center on Budget and Policy Priorities, February 5, 2015, http://www.cbpp.org/cms/index.cfm?fa=view&id=5265.

Appendix:
State Medicaid Expansion Waivers

Arkansas

All newly eligible adults except those who are "medically frail" receive premium assistance to purchase coverage in a marketplace Qualified Health Plan (QHP). This is an especially large group in Arkansas: prior to health reform, among adults, the state only covered parents with incomes up to 17 percent of the poverty line and provided no coverage for childless adults. Beneficiaries in Arkansas are not charged premiums, and only those with incomes above the poverty line pay cost-sharing charges. (State legislation passed in 2014 requires the state to seek approval for an amendment to its waiver so that, beginning in 2015, beneficiaries with incomes above 50 percent of the poverty line will be liable for cost-sharing charges and limits will be placed on Medicaid's non-emergency transportation benefit.)

Indiana

Indiana expanded Medicaid in January 2015 through an amendment to its longstanding Healthy Indiana Plan (HIP) section 1115 waiver. Under the expansion waiver, all newly eligible beneficiaries, even those with no income, are charged a premium. Premiums are set at the greater of 2 percent of income or $1 a month. Individuals with incomes above the poverty line who do not make premium payments for 60 days will be disenrolled from coverage and ineligible to re-enroll for six months. Individuals with incomes below the poverty line who do not make premium payments for 60 days will not be disenrolled but will receive a less-generous benefit package.

A beneficiary's premium payments are deposited into a "POWER" account, which can be used to pay for co-payments and other cost-sharing charges.

Iowa

Iowa expanded Medicaid through two waivers. The state gives eligible individuals with incomes between 100 and 138 percent of the poverty line premium assistance to purchase coverage in a QHP. The state will charge a monthly premium of up to a $10 for individuals in this income range who do not complete a wellness protocol or attest to financial hardship. Beneficiaries with incomes between 50 and 100 percent of the poverty line are enrolled in coverage through Medicaid, not a QHP, but still pay up to $5 in monthly premiums. For both groups, these premium requirements do not apply until an individual's second year of enrollment and coverage cannot be terminated for non-payment of premiums.

Michigan

Similar to Iowa, Michigan gained approval to charge premiums to individuals with incomes between 100 and 138 percent of the poverty line (though Michigan enrolls these individuals in Medicaid, not QHPs). Michigan's waiver also sets up "MI Health Accounts"; beneficiaries with incomes between 100 and 138 percent of the poverty line must pay a monthly premium into their account of up to 2 percent of their income, and their copayment amounts will be based on their previous six months of copayments. Individuals with incomes below 100 percent of poverty will make contributions to their accounts to go toward copayment liabilities but will not be charged premiums. For all beneficiaries, copayments cannot exceed those allowed under Medicaid rules.

New Hampshire *(Pending HHS Approval)*

In March 2014, the New Hampshire legislature passed, and Governor Maggie Hassan signed into law, legislation that expands Medicaid and directs the state to apply for a waiver. Beginning July 1, newly eligible individuals began enrolling in Medicaid through the state's managed care program, and their coverage became effective beginning August 15. As required by the legislation, the state submitted a waiver application to HHS in November 2014. If approved, the waiver would have newly eligible individuals use premium assistance to purchase coverage in a QHP through the state's marketplace, beginning in 2016.