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Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care

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In response to a letter from Health and Human Services (HHS) Secretary Tom Price and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma inviting states to propose Medicaid program changes that HHS has rejected in the past,¹ numerous states now have damaging “waiver” proposals in the approval pipeline or under consideration. These include requests to condition Medicaid eligibility on work and work-related activities or drug screening and testing, impose premiums on people with incomes below the poverty line, limit how long people can remain enrolled in Medicaid coverage, and lock people out of coverage if they don’t submit renewal paperwork on time or don’t report changes in employment or income within ten days. If approved, these proposals would substantially reduce coverage and impose significant barriers to needed care. Approval would sharply depart from the historical role of waivers in promoting Medicaid’s objectives.

Medicaid’s core mission is to provide comprehensive health coverage to low-income people so they can get the health care services they need.² States have numerous options to customize their Medicaid programs to suit their needs. Section 1115 of the Social Security Act provides additional flexibility by allowing states to deviate from various requirements of federal law when necessary to implement demonstration projects that promote the Medicaid program’s objectives.

Thirty-seven states currently have section 1115 demonstration projects, including projects that cover people who wouldn’t otherwise be eligible for coverage, provide additional benefits not usually covered under Medicaid, and implement innovative payment and delivery system reforms.³

¹ 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>.

² 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.”

³ Centers for Medicare & Medicaid Services, “Medicaid & CHIP: Strengthening Coverage, Improving Health,” January 2017, <https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf>

Section 1115 authority is broad, but there are limits to the changes states can make. States must show that their proposed waivers are necessary to carry out a demonstration project that not only is experimental in nature, but will promote the objectives of Medicaid, such as expanding coverage or access to care. Until now, HHS hasn't allowed states to make it *harder* for low-income people to qualify for Medicaid coverage by creating new eligibility requirements, such as work or drug testing requirements, or to set time limits for Medicaid coverage.

Waivers Only Allowed for Demonstration Projects That Promote 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. To allow states to implement their demonstration projects, the law gives the HHS Secretary authority to waive provisions in section 1902 of the Social Security Act, which lists the requirements states must follow to qualify for federal Medicaid matching funds. Waiving provisions in section 1902 is only allowed to the extent necessary to implement the state's demonstration project and test new or experimental policies.⁴ In other words, the state must show that waiving a specific statutory provision is necessary to allow the state to carry out its demonstration. Moreover, states can't waive every provision of Medicaid law, only those in section 1902. For example, they can't alter Medicaid's financing structure, which is governed by a different section of law.

Citing section 1115, the Secretary has also authorized payment of federal matching funds for expenditures on health care and related services that wouldn't otherwise be matched. States have used this “costs not otherwise matchable” authority to obtain federal matching funds to cover people not otherwise eligible for Medicaid, to offer additional benefits to Medicaid beneficiaries, and to provide upfront investments for payment and delivery system reforms that improve care, increase efficiency, and reduce costs over time. Even though states can receive federal funds for costs that wouldn't ordinarily receive a federal match, waivers must still be *budget neutral to the federal government over the life of the project*. In other words, state demonstrations cannot cost the federal government more than it would spend without the waiver.

Waivers can initially be approved for a five-year period and are often extended for additional three-year increments. Both the state and federal government must post proposals for public comment before approval.⁵ Once approved, implementation of a demonstration project is guided by “special terms and conditions” agreed upon by the state and federal government, which include requirements for evaluation and regular reporting by the state to the federal government.

⁴ Jane Perkins, “Background to Medicaid and Section 1115 of the Social Security Act,” National Health Law Program, April 3, 2017, http://www.healthlaw.org/issues/medicaid/background-to-medicaid-section-1115-social-security-act#.WT_bY02GOp0.

⁵ 42 CFR §§431.400 *et seq.*

After several reports from the Government Accountability Office (GAO)⁶ criticized HHS for the lack of clear standards guiding the Secretary’s approval of demonstration projects, CMS developed criteria issued in 2015 that the Secretary uses to determine whether a state’s Medicaid waiver promotes the objectives of the program. Under these criteria, a demonstration project must:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid beneficiaries and low-income populations in the state;
- Improve health outcomes for Medicaid beneficiaries and other low-income populations in the state; *or*
- Increase the efficiency and quality of care for Medicaid beneficiaries and other low-income populations through initiatives to transform service delivery networks.⁷

In most cases, CMS works with states to design their projects to meet these criteria, but the Secretary has rejected proposals in whole or in part when agreement can’t be reached or the Secretary determines that the state’s proposal doesn’t promote Medicaid’s objectives. For example, in September 2016, Secretary Sylvia Mathews Burwell denied Ohio’s Medicaid waiver because she found that the premiums the state wanted to impose would “undermine access to coverage and affordability of care,” citing the state’s own estimate that 125,000 beneficiaries would lose coverage.⁸ Also, in April 2016, Secretary Burwell wrote Arkansas governor Asa Hutchinson that the state’s proposed work requirement couldn’t be approved because it was inconsistent with the purposes of Medicaid.⁹ The federal government also rejected the work requirement and coverage time limit in Arizona’s 2016 proposal, but it did approve other aspects of the state’s demonstration request.¹⁰

Recent Waiver Proposals Don’t Promote Medicaid Objectives

The Trump Administration has not revised the criteria for approval of demonstration projects, but the letter that Secretary Price and CMS Administrator Verma sent to governors earlier this year suggests that it will favorably consider work requirements and enforceable premiums for people with incomes below the poverty line, despite past disapprovals of such measures. In response, some states have proposed or are considering work requirements and enforceable premiums for people

⁶ “Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives,” Government Accountability Office, GAO-15-239, April 2015, <http://www.gao.gov/products/GAO-15-239>.

⁷ Centers for Medicare & Medicaid Services, “About Section 1115 Demonstrations,” <https://www.medicaid.gov/medicaid/section-1115-demo/index.html>.

⁸ Letter from the Centers for Medicare & Medicaid Services to Ohio’s Medicaid Director, September 9, 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/healthy-ohio-program/oh-healthy-oh-program-disapproval-ltr-09092016.pdf>. The Ohio Medicaid agency was unable to negotiate an agreement with CMS because it didn’t have authority to deviate from the proposal dictated by the Ohio legislature.

⁹ Letter from Sylvia Mathews Burwell to Asa Hutchinson, April 5, 2016, http://governor.arkansas.gov/images/uploads/Burwell_Letter_to_Governor.pdf.

¹⁰ Approval letter from the Centers for Medicare & Medicaid Services to the Arizona Health Care Cost Containment System, September 30, 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf>.

with incomes below the poverty line, as well as waivers that go beyond the areas highlighted in the Price-Verma letter:

- **Imposing work requirements.** Six states (Arizona, Arkansas, Indiana, Kentucky, Maine, and Wisconsin) have proposed requiring that “able-bodied adult” Medicaid beneficiaries engage in work or work-related activities as a condition of receiving Medicaid coverage.
- **Requiring drug testing to obtain Medicaid coverage.** Wisconsin wants to deny Medicaid coverage to otherwise eligible adults if they don’t complete a drug screening test, don’t submit to drug testing after a positive screen, or decline treatment after a positive test.¹¹
- **Limiting how long people can have Medicaid coverage.** Three states (Arizona, Maine, and Wisconsin) would limit how long beneficiaries can have Medicaid coverage. As noted, Secretary Burwell denied Arizona’s request for a five-year lifetime limit on Medicaid coverage because it could undermine access to health care and thereby failed to promote the objectives of Medicaid.¹²
- **Lowering eligibility for the Medicaid expansion.** Arkansas has proposed, and Massachusetts is considering, rolling back Medicaid expansion eligibility from 138 to 100 percent of the poverty line. Low-income adults losing Medicaid coverage who don’t have an offer of affordable employer coverage would have to purchase more expensive and less comprehensive marketplace coverage.¹³ Guidance that CMS issued in 2012 states that partial expansions would not qualify for federal funds at the enhanced Medicaid expansion rate.¹⁴
- **Conditioning Medicaid eligibility for adults living below the poverty line on payment of premiums.** Wisconsin and Maine have proposed imposing premiums on people with incomes below the poverty line and cutting off their coverage if they don’t come up with the money for the premiums.¹⁵ Wisconsin would charge \$8 a month to households between 51 and 100 percent of the poverty line. Maine would charge \$10 a month to households between 51 and 100 percent of the poverty line and larger premiums for those just above the poverty

¹¹ State of Wisconsin, BadgerCare Reform Demonstration Project, Section 1115 Demonstration Waiver Amendment Application, June 7, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-pa.pdf>.

¹² Arizona posted a new waiver proposal with a work requirement and five-year time limit for comments at the state level in February 2017. The comment period ended on March 29, but to date the state has not submitted the proposal to CMS.

¹³ Arkansas Works 1115 Demonstration Waiver Public Notice and Amended Application, <https://www.medicaid.state.ar.us/general/comment/demowaivers.aspx#finalapp>.

¹⁴ Centers for Medicare & Medicaid Services, Frequently Asked Questions on Exchanges, Market Reforms and Medicaid, December 10, 2012, <https://www.medicaid.gov/federal-policy-guidance/downloads/FAQ-12-10-2012-Exchanges.pdf>.

¹⁵ Maine is also asking for permission to impose an asset test on all beneficiaries except seniors and people with disabilities (who already are subject to an asset limit). The Affordable Care Act prohibits the use of asset tests for children, parents, and other adults, including pregnant women; it also prohibits waiver of the ban on asset tests for these groups. Section 1902(e)(14)(F) of the Social Security Act. Maine Department of Health and Human Services 1115 Waiver Application, http://www.maine.gov/dhhs/oms/rules/MaineCare_1115_application_080217_to%20submit.pdf.

line.¹⁶ While HHS has allowed states to charge premiums (which federal law prohibits for people with incomes below 150 percent of the poverty line), it has not allowed states to terminate coverage for people with incomes below the poverty line if they don't come up with the payments.¹⁷ A large body of research has already shown that premiums decrease enrollment for people with incomes below the poverty line.¹⁸

- **Charging copays for emergency room visits.** Wisconsin wants to charge beneficiaries \$8 every time they use the emergency room, regardless of the reason. Maine proposes a \$10 copayment for “non-emergent diagnoses.” Maine’s list of diagnoses, however, includes conditions that could be emergencies in some cases, such as asthma attacks.
- **Locking beneficiaries out of coverage for failure to meet procedural requirements.** Indiana and Kentucky want to lock beneficiaries out of coverage for six months if they fail to submit their renewal paperwork on time. Kentucky also wants to disqualify beneficiaries for six months if they don't report changes in income or employment within ten days.

Why These Current Waiver Proposals Fail to Promote Medicaid’s Objectives

As explained, section 1115 authority is limited to waivers that are necessary to implement experimental projects intended to promote the objectives of Medicaid. Projects should test new ways of providing coverage or delivering care that improve health outcomes and the program’s overall effectiveness or efficiency, and they should have sound evaluation plans. They should *not* cause fewer people to get or retain coverage or make it harder to obtain necessary health care. All the proposals described would have those harmful impacts.

In virtually every case, the current proposals to require work or drug testing, impose time limits, or cut people off for procedural reasons would result in fewer people being covered with the waiver than without it, in direct conflict with Medicaid’s objectives — as well as with the requirement that waiver proposals not weaken coverage. For example:

- Kentucky estimates that about 95,000 fewer people would be covered by the fifth year of its proposed waiver than under its current program, in large part because of its work requirement and its lock-out for failure to report timely changes. Indiana and Maine also forecast

¹⁶ Wisconsin and Maine did not expand Medicaid. Wisconsin covers parents and childless adults with incomes below the poverty line. Maine covers parents up to the poverty line but doesn't cover childless adults. The premiums Maine is proposing would apply to parents, former foster care youth, people with breast or cervical cancer, and people with HIV/AIDS. MaryBeth Musumeci, Elizabeth Hinton, and Robin Rudowitz, “Proposed Medicaid Section 1115 Waivers in Maine and Wisconsin,” Kaiser Family Foundation, May 2017, <http://www.kff.org/medicaid/issue-brief/proposed-medicaid-section-1115-waivers-in-maine-and-wisconsin/>.

¹⁷ A few states have been allowed to terminate coverage for people with incomes above the poverty line when they don't pay their premiums. These individuals would be subject to enforceable premiums in the private insurance marketplace had their states not expanded Medicaid.

¹⁸ 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/>.

enrollment declines, due in large part to their proposed work requirements.¹⁹ And Arkansas' proposal would end coverage for all beneficiaries with incomes between 100 and 138 percent of the poverty line.

- Kentucky describes its request to disqualify people for six months if they don't promptly report changes in their income or employment as a way to "prepare enrollees for commercial market insurance policies." This purpose is both unrelated to the objectives of Medicaid and unsound, given that enrollees in commercial coverage don't have to report changes in their work hours or small income changes. Under Kentucky's proposal, a worker who takes on an extra shift and fails to report it could lose health coverage for six months.
- Wisconsin proposes to impose a 48-month coverage limit, as well as a work requirement, drug screening and testing, and a co-payment for emergency room use. These proposals, too, would reduce coverage. (In addition, evidence is lacking that Medicaid applicants are likelier than the general population to use illicit drugs.²⁰)
- Maine asserts, without evidence, that earned income would increase for people leaving the program after the state starts limiting Medicaid coverage to three months out of a 36-month period for people who do not work or engage in work-related activities for at least 20 hours a week. The state's focus on increased wages shows that its proposal is not designed to promote the objectives of Medicaid, which are to ensure that people can obtain needed health care. Moreover, limiting benefits to three months likely wouldn't lead to increased wages for those who lose coverage but *would* harm such individuals — and the resulting loss of health coverage could make it harder for them to secure and retain jobs. In Ohio, newly eligible beneficiaries reported that having Medicaid made it easier for them to search for work, and more than half of working beneficiaries said Medicaid made it easier to keep their jobs.²¹

Some states are also proposing to change how Medicaid works, using policies that have proved unsuccessful and sometimes harmful to beneficiaries. Such policies, like the use of premiums and cost-sharing, should not be replicated, as they do not promote Medicaid's objectives. A recent review of research over several decades found that premiums result in reduced coverage for both children and adults by deterring enrollment, increasing disenrollment, and shortening how long people remain enrolled.²² The impact is greatest for people with incomes below the poverty line, who are also likelier to become uninsured when they lose coverage. For example, in the Healthy Indiana Plan, which Indiana now seeks to extend, 55 percent of eligible individuals either didn't

¹⁹ Indiana also forecasts decreased participation from its proposal to lock people out of coverage for six months when they don't complete their renewal paperwork in a timely manner. Amendment Request to Healthy Indiana Plan (HIP), Indiana Family and Social Services Administration, July 20, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa5.pdf>.

²⁰ Jamila Michener and Julilly Kohler-Hausmann, "Why We Shouldn't Drug Test Poor People," *New York Times*, June 28, 2017, <https://www.nytimes.com/2017/06/28/opinion/drug-test-poor-medicaid-walker-trump.html>.

²¹ Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

²² Artiga, Ubri, and Zur.

make an initial premium payment or missed a payment.²³ Studies also found that low-income people who become uninsured due to premiums “face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens.” Continuing to allow states to impose enforceable premiums should not be considered a proper use of 1115 authority, since premiums will keep eligible people from participating and cause hardship.

Family Planning Waivers: An Example of How Waivers *Should* Work

Over 20 years ago, states began to use section 1115 to test whether providing low-income women — and, in some states, men — with access to family planning services would prevent unplanned pregnancies. The idea was that providing family planning services to individuals not otherwise eligible for Medicaid could avoid state costs to cover pregnant women and their babies due to unplanned pregnancies.

Family planning waivers were rigorously evaluated and found highly successful, and policymakers eventually made providing coverage in this way a state Medicaid option.^a As of June 2017, twenty-six states had family planning waivers or used the state option to provide these services, according to the Kaiser Family Foundation.^b

^a Usha Ranji, Yali Bair, and Alina Salganicoff, “Medicaid and Family Planning: Background and Implications of the ACA,” Kaiser Family Foundation, February 3, 2016, <http://www.kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy/>.

^b Kaiser Family Foundation, State Health Facts, <http://www.kff.org/medicaid/state-indicator/family-planning-services-waivers/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Indiana’s requirement that those people with incomes below the poverty line who do not pay premiums must pay copayments — a requirement Kentucky wants to replicate — also raises concerns. Indiana shifts people with incomes below poverty who don’t pay premiums from its Medicaid “Plus” plan to its “Basic” plan, under which they must pay copayments to access care. About one-third of Healthy Indiana Plan participants are in the Basic plan because they didn’t make a premium payment, and an evaluation of the first year of the program showed that enrollees in Basic are less likely to get primary and preventive care, less likely to adhere to prescription drug regimens for chronic conditions such as asthma and heart disease, and more likely to use the emergency room (including for non-emergency care).

Indiana’s extension proposal focuses on the fact that Plus enrollees are doing better than Basic enrollees. But nothing in the evaluation (and no other data) shows that Plus enrollees are getting more preventive and primary care *because* they are paying premiums. It’s just as likely that they are getting more care because, unlike beneficiaries enrolled in the Basic plan, they don’t have to make copayments. A key fact in deciding whether Indiana’s experiment should continue is that a significant share of beneficiaries in Healthy Indiana — including half of African American enrollees — appear to be experiencing barriers to care, and other people either aren’t enrolling in the first place or are subsequently losing coverage for non-payment of premiums.

²³ The Lewin Group, “Healthy Indiana Plan 2.0: POWER Account Contribution Assessment,” March 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf>.

Conclusion

New administrations often put their stamp on Medicaid through the types of section 1115 waivers they encourage, but the Secretary's discretion is limited by the scope of authority that the statute provides.²⁴ Waivers of statutory provisions must be necessary to implement demonstration projects that are experimental in nature and promote Medicaid's objectives of providing coverage to low-income and vulnerable people who wouldn't otherwise have a pathway to coverage and care. Waivers should not limit participation or purport to test policies already shown to limit coverage and access to care. In deciding whether to approve state waiver proposals, the Secretary should be mindful to uphold the Hippocratic oath and "do no harm."

²⁴ Elizabeth Hinton, Robin Rudowitz and MaryBeth Musumeci, "3 Key Questions: Section 1115 Medicaid Demonstration Waivers," Kaiser Commission on Medicaid and the Uninsured, February 2017, <http://www.kff.org/medicaid/issue-brief/3-key-questions-section-1115-medicaid-demonstration-waivers/>.