Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

August 20, 2014

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

By Jesse Cross-Call and Judith Solomon

Twenty-six states and the District of Columbia are now implementing health reform's Medicaid expansion. Arkansas, Iowa, and Michigan have expanded through federally approved Medicaid demonstration projects, or "waivers." Waivers provide 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 the objectives of the Medicaid program, 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, 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 some beneficiaries modest premiums. At the same time, the federal government scaled back proposals to limit certain health benefits, rejected policies that would condition a beneficiary's eligibility on participation in work search activities, and did not permit the states to impose cost-sharing charges beyond what Medicaid rules already allow.

The federal government is now considering Medicaid expansion waiver proposals from Pennsylvania and Indiana, and New Hampshire will soon submit its own. As most future state expansions are likely to be implemented through waivers of some kind, 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. Future state decisions about the Medicaid expansion will likely be 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 who did not have 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 a "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 in the absence of the waiver. For waivers prior to health reform, this budget neutrality requirement 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 limitations, 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 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, even under a waiver. As a result, states can no longer implement provisions of certain waivers approved prior to health reform that treated this population as outside Medicaid's protections;[4] for example, HHS will not approve continuation of provisions included in waivers prior to health reform like enrollment caps, limits on mandatory benefits, and excessive premiums for individuals with very low incomes.

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

Most states that elected to expand Medicaid after the 2012 Supreme Court decision that made the Medicaid expansion optional simply amended their Medicaid state plans to extend coverage to the new adult eligibility group. In February 2013, however, Arkansas introduced a new expansion

---

[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," The 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," The 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 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).

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 that beneficiaries enroll in QHPs, rather than giving them a choice between coverage through a QHP or regular Medicaid, which Medicaid premium assistance rules require.

Prior to and in the course of negotiations with Arkansas state officials, HHS set forth limits on the use of waivers and other possible variations in taking up the Medicaid expansion:

- **Expansions must fully extend Medicaid to adults 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 required to enroll in QHPs remain Medicaid beneficiaries.** As such, states must fully "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 the objectives of the Medicaid program, as with section 1115 waivers granted prior to health reform.** In Arkansas' case, the purpose of the expansion waiver is to evaluate whether enrollment in QHPs eases individuals' transition between marketplace and Medicaid coverage due to changes in income, and whether enrolling more individuals in QHP coverage can reduce premiums in the marketplace.[8]

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

Since Arkansas' expansion waiver was approved, two other states — Iowa and Michigan — have had expansion waivers approved by HHS. In addition, Pennsylvania and Indiana have waiver

---

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

applications pending, and New Hampshire likely will soon submit a waiver request. (See Appendix for a summary of approved and pending expansion waivers.) As additional states consider expanding Medicaid through waivers, state policymakers should consider how HHS has responded to such waivers so far:

- **People with incomes below the poverty line may not be disenrolled for non-payment of premiums.** Under Iowa's approved waiver, starting in 2015 the state can charge beneficiaries with incomes between 100 and 138 percent of the poverty line a premium up to $10 a month, and those with incomes between 50 and 100 percent of the poverty line a premium up to $5 a month. For both groups, the state will waive premiums for individuals who either complete a health risk assessment and a 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.[9]
- **Individuals may not be required to pay cost-sharing charges above what is allowed under Medicaid rules.** Medicaid cost-sharing rules provide states with significant flexibility while providing significant protections for beneficiaries that are intended to minimize barriers to necessary health care services. The rules include special protections barring cost-sharing for 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, and providers cannot deny services to people with incomes below the poverty line who cannot afford to pay. These cost-sharing protections are *not* among the provisions that states can waive using section 1115 authority.
- **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, however, did grant Iowa a one-year waiver 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, this provision of the waiver will be evaluated to determine the impact on beneficiaries' access to care.[10]
- **Medicaid eligibility cannot be conditioned on employment or participation in work search activities.** 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

[9] 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 on account of non-payment of premiums.

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

activities per month to remain eligible for Medicaid coverage. Those judged not to be in compliance would have their health coverage revoked. Governor Corbett subsequently submitted a revised proposal to HHS in February 2014 that would charge beneficiaries differential premiums based on whether they are working or engaged in work search activities. (Utah's governor and the Missouri legislature have also expressed interest in tying eligibility for coverage under the expansion to work.

In response to Pennsylvania's proposal, HHS has indicated that it is unlikely to approve waivers that condition either Medicaid eligibility or premium amounts on compliance with work search or other work-related activities**.** In contrast, a provision likely to be part of New Hampshire's forthcoming waiver proposal requiring that Medicaid beneficiaries who are unemployed be referred to job search and job training programs is more likely to be approved. The referral to job search, which was part of the New Hampshire legislation authorizing the state to expand Medicaid, wouldn't *condition* a person's health coverage on whether they are working or searching for work.

- **Premium assistance waivers are available only for three years.** HHS approved Arkansas' and Iowa's premium assistance waivers through 2016.[11] In guidance, HHS limited the duration of premium assistance waivers to three years so that 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."[12] Under the health reform law, states may apply to the federal government to waive certain provisions of the law, including those related to the marketplaces and to market reforms applying to the individual and small group markets, so long as the state's alternative covers as many people, is as least as comprehensive and affordable, and does not increase federal costs relative to what they would have been under the health reform law.[13] 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 the Medicaid program and cannot include provisions that 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 in compliance with work requirements.

[11] Michigan's waiver was approved through 2018 because it does not use premium assistance.

[12] For more information about waivers for state innovation, see Jesse Cross-Call, "Understanding Health Reform's Waivers for State Innovation," Center on Budget and Policy Priorities, April 18, 2011, http://www.cbpp.org/cms/?fa=view&id=3475.

Appendix A:
Approved 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 because 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 that limits be placed on Medicaid's non-emergency transportation benefit.)

Iowa

Iowa expanded Medicaid through two waivers. Taken together, the state gives eligible individuals with incomes between 100 and 138 percent of the poverty line premium assistance to purchase coverage in a QHP. Starting in 2015, the state will charge individuals in this income range who do not complete a wellness protocol or attest to financial hardship up to a $10 monthly premium. Beneficiaries with incomes between 50 and 100 percent of the poverty line are not enrolled in coverage through a QHP, but they still pay up to $5 in monthly premiums. For both groups, coverage cannot be terminated for non-payment of premiums.

Michigan

Michigan is not using premium assistance to purchase coverage in QHPs, but similar to Iowa, it gained approval to charge premiums to individuals with incomes between 100 and 138 percent of the poverty line. Michigan's waiver sets up "MI Health Accounts." Beneficiaries with incomes between 100 and 138 percent of poverty will be required to pay a monthly premium into their account equal to no more than 2 percent of their income, and they will be responsible for a copayment amount 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, the amount of the contributions for copayments cannot exceed those allowed under Medicaid rules.

Appendix B:
Proposed State Medicaid Expansion Waivers

Indiana

In July 2014, Governor Mike Pence submitted a proposal that would charge premiums to all newly eligible beneficiaries, even those with no income. The premium amounts would be on a sliding scale, from $3 a month for those with incomes below 22 percent of the poverty line (about $214 a month), to $25 a month for those with incomes between 100 and 138 percent of the poverty line. Individuals with incomes above the poverty line who do not make premium payments for 60 days would 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 will not be disenrolled from coverage, but they will receive a less-generous benefit package.

An enrollee's premiums would be deposited into a "POWER" account, which has been the trademark of the state's pre-health reform waiver that provided coverage to childless adults and low-income parents not eligible for Medicaid.

New Hampshire

In March, 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 were allowed to enroll in Medicaid through the state's managed care program, with coverage effective beginning August 15. The legislation requires the state to seek HHS approval for a waiver by March 31, 2015. Under the waiver, starting January 1, 2016, newly eligible individuals would use premium assistance to purchase coverage in a QHP in the state's marketplace.

Pennsylvania

Governor Tom Corbett has submitted a waiver proposal that, like Arkansas', would give all newly eligible adults premium assistance to purchase coverage. But the Pennsylvania proposal includes several additional provisions that would make it difficult for some individuals to gain and maintain coverage. These provisions would require individuals with incomes as low as 50 percent of the poverty line ($5,835 a year) to pay premiums and would condition the amount of a person's premium liability on whether they work or engage in work search activities.