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# The ACA and Medicaid Expansion Waivers

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## Executive Summary

Under the Affordable Care Act (ACA), Medicaid plays a key role in efforts to reduce the number of uninsured by expanding eligibility to nearly all low income adults with incomes at or below 138% FPL (\$16,242 per year for an individual in 2015); however, the Supreme Court ruling on the ACA's constitutionality effectively made the expansion a state option. As of February 2015, 29 states including DC are implementing the expansion. Nearly all states (24 of 29) are implementing the expansion as set forth by law, but a limited number of states have obtained or are seeking approval through Section 1115 waivers to implement the expansion in ways that extend beyond the flexibility provided by the law. More states are discussing alternative models through waivers as a politically viable way to implement expansion in order to extend coverage and capture federal dollars.

This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA. The brief also highlights key themes in these waivers including implementing the Medicaid expansion through a premium assistance model, charging premiums, eliminating certain required benefits (most notably non-emergency medical transportation), and using healthy behavior incentives as well as provisions that CMS has not approved.

**To date, five states have received approval of a Section 1115 waiver to implement the Medicaid expansion ([Arkansas](#), [Iowa](#), [Michigan](#), [Pennsylvania](#) and most recently [Indiana](#)).** These waivers allow the states to implement the Medicaid expansion in ways that do not meet federal rules and still access enhanced federal matching funds for newly eligible adults. Under the ACA, the federal government will pay 100% of the costs of those newly eligible for 2014-2016 and then the federal share phases down to 90% in 2020 and beyond. While the waivers are each unique, they include some common provisions such as implementing the Medicaid expansion through a premium assistance model, charging premiums, eliminating certain required benefits (most notably non-emergency medical transportation), and using healthy behavior incentives. The Pennsylvania waiver was approved under Governor Corbett, but the current Governor Wolf announced that Pennsylvania will transition to a traditional Medicaid expansion plan and he will not implement the benefit and work changes that the previous Governor had initiated.

**The most recent waiver approval in Indiana includes provisions that had not been approved in other states.** These new provisions include allowing the state not to provide retroactive eligibility; to make coverage effective beginning on the date of the first premium payment, rather than on the date of application; and to bar certain expansion adults from re-enrolling in coverage for six months if they are dis-enrolled for unpaid premiums. In addition, under separate waiver authority (§1916(f)), Indiana received approval to charge

higher cost sharing for non-emergency use of the emergency room than otherwise allowed under federal rules (Table 1).

**Several states have waiver proposals pending or in development.** There is no deadline for states to participate in the Medicaid expansion and moving into the legislative sessions for 2015, other states continue to explore opportunities to implement the Medicaid expansion. Governors in both [Tennessee](#) and [Utah](#) have been negotiating plans with CMS, but these plans also need to be approved by the state legislature. In a special session in early February, the legislature in Tennessee rejected the Governor's expansion plan. In Utah, a legislative taskforce did not endorse the Governor's plan but legislative debate continues. The Wyoming Department of Health published its recommendation for an alternative Medicaid Expansion plan, called the SHARE plan, in November 2014; however, the state Senate voted against the plan in early February 2015. [New Hampshire](#), a state that had implemented the expansion, also has a waiver pending with CMS to continue the expansion through a premium assistance model.

**Table 1: Key Themes in ACA Expansion Waivers and Proposals**

	Premium Assistance	Premiums / Monthly Contributions	Healthy Behavior Incentives	Benefits	Work Referral	Co-Payments*	Waivers of Retroactive Eligibility / Reasonable Promptness
<b>Approved Waivers</b>							
Arkansas <sup>1</sup>	Mandatory for QHPs	X					
Iowa	Optional for QHPs	X	X	X			
Indiana <sup>2</sup>	Optional for ESI	X	X	X		X	X
Michigan		X	X				
Pennsylvania <sup>3</sup>		X	X	X			
<b>Waiver Proposals</b>							
New Hampshire <sup>4</sup>	Mandatory for QHPs				X		X
Tennessee <sup>5</sup>	Optional for ESI	X	X	X		X	X
Utah <sup>5</sup>	Mandatory for QHPs and ESI	X	X	X		X	

\*Cost-sharing waivers were approved in Indiana and are proposed in Tennessee and Utah through §1916(f) not §1115 waiver authority.

<sup>1</sup> The monthly contributions in AR are in lieu of cost-sharing requirements.

<sup>2</sup> Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid waiver.

<sup>3</sup> The Pennsylvania expansion waiver was approved under Governor Corbett who also had intended to restrict benefits through a SPA and to implement a state-only work-referral program. Governor Wolf (the new governor) announced that PA will transition to a traditional Medicaid expansion plan and will not implement the benefit and work changes.

<sup>4</sup> New Hampshire implemented the Medicaid expansion through a SPA, but has a waiver pending to move to a mandatory Marketplace premium assistance model by 1/2016.

<sup>5</sup> The Governors in Utah and Tennessee have waiver proposals that have not been officially submitted to CMS and are under debate in the state legislatures.

**CMS has denied a number of provisions included in Section 1115 Waiver proposals.** Provisions that CMS had denied waiver authority for include:

- Premiums for individuals with incomes < 100% FPL as a condition of eligibility;
- Requirements to provide wrap-around benefits for EPSDT and free choice of family planning provider to the extent that Marketplace plans do not offer coverage for these services; and
- Work requirements as a condition of Medicaid eligibility.

**To ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their effects.** Waivers are intended to be research and demonstration projects, and federal law requires that they be formally evaluated to measure how well they achieve objectives including the effects on access to care and outcomes for beneficiaries. Particularly as waiver designs become increasingly more complex, the evaluations will help inform policy makers if such policies can be effectively administered and if beneficiaries understand the policies. Ensuring that evaluations are timely and that findings are publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences.

What happens with waivers between 2014 and 2016 also will be important to inform the use of the new state innovation waiver authority (Section 1332) available in 2017, which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid and CHIP waivers. As more states seek waivers to implement the expansion, what we learn from their experiences will help inform the future direction of coverage for low-income adults and families. In addition, in states where Medicaid expansion without a waiver is not politically viable, large numbers of people are likely to remain without coverage. CMS, states, and other stakeholders will continue to navigate the balance between state waiver requests in an effort to reduce the number of uninsured adults while preserving key beneficiary protections and requirements in the Medicaid program.

# Introduction

To date, the majority of states (24 of 29) that have adopted the Medicaid expansion have done so under the existing rules and options provided by the Medicaid program. However, five states have obtained Section 1115 waiver approvals to implement the expansion in ways that extend beyond the flexibility provided by the law, and additional states are considering waiver approaches to adopt the expansion. This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA and key themes in recently approved and proposed coverage expansion waivers. Detailed summaries of approved and proposed waivers are available at [www.kff.org](http://www.kff.org).

## Context for Understanding Expansion Waivers

**Section 1115 Medicaid waivers provide states with an avenue to test new approaches in Medicaid that differ from federal program rules.** These waivers are intended to allow for “experimental, pilot, or demonstration projects” that, in the view of the HHS Secretary, “promote the objectives” of the Medicaid program. Waivers can provide states with additional flexibility in how they operate their programs, beyond the flexibility already available to states under federal law, and can have a considerable impact on program financing. Under long-standing federal policy (not statute), federal spending under a state’s waiver must not exceed projected federal spending without the waiver. Budget neutrality is established using a cap on federal matching funds over the life of the waiver. Federal law requires that waivers be formally evaluated.

**Prior to the enactment of the ACA, a number of states used Section 1115 waivers to expand coverage to childless adults, who could not otherwise be covered under federal rules.** Before the ACA, Medicaid coverage was limited to individuals who met income and other eligibility requirements and fell into one of several specified groups, including children, pregnant women, parents, seniors and people with disabilities. Adults without dependent children, often referred to as childless adults, who did not qualify for Medicaid based on age or disability were ineligible for coverage, and federal law did not authorize federal Medicaid matching funds to cover these adults, regardless of how low their incomes were. The only way a state could extend Medicaid coverage to these adults was through a Section 1115 waiver. Because these waivers must be budget neutral for federal spending, states could not receive additional federal funds to expand coverage to these adults and, as such, needed to redirect existing federal funds or find offsetting program savings to finance such coverage.

**The ACA expands Medicaid to adults with significant federal funding.** The expansion eliminates the historic exclusion of adults without dependent children from the program and provides federal statutory authority to make millions of adults newly eligible for the program. The federal government is funding 100% of the cost of covering newly eligible adults for the first three years of the expansion, gradually phasing down to 90% by 2020 and beyond. The 90% match is significantly higher than the traditional Medicaid matching rate that ranges from a floor of 50% to a high of 73% based on a state’s relative per capita income. Under the ACA, the Medicaid expansion was intended to occur nationwide. However, the Supreme Court’s ruling on the ACA’s constitutionality effectively made the expansion a state option. As of February 2015, a total of 29 states (including the District of Columbia) have implemented the Medicaid expansion, and adoption of the expansion is under discussion in a number of other states.<sup>1</sup> There is no deadline for states to adopt the Medicaid

expansion. In states expanding Medicaid, most individuals with incomes above 138% up to 400% FPL (above Medicaid levels) are eligible for tax credits to purchase coverage in the Marketplaces. In states that do not implement the Medicaid expansion, Medicaid eligibility for adults is quite limited. Because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options. As a result, in states that do not expand Medicaid, many adults will fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits.

**The ACA’s Medicaid expansion eliminates the need for a state to obtain a Section 1115 waiver to cover childless adults, but a small number of states have still used Section 1115 waivers to implement the Medicaid expansion in ways that differ from options provided to states under federal law.** CMS has issued guidance that establishes some parameters for such waivers. Through this guidance, CMS has indicated that states cannot receive the enhanced federal funding available for newly eligible adults unless they implement the full expansion to cover all newly eligible adults through 138% FPL; it also will not approve enrollment caps for the adult expansion group. CMS indicated it will approve a limited number of premium assistance waivers to test the use of Medicaid funds to purchase Marketplace coverage for the Medicaid expansion population, subject to certain requirements.

**Medicaid expansion waivers are subject to new rules about transparency, public input and evaluation.** As a result of longstanding concerns about the lack of public input and transparency in the waiver approval process, the ACA required the Department of Health and Human Services (HHS) to issue regulations designed to ensure that the public has meaningful opportunities to provide input into the Section 1115 waiver approval process. The rules, issued in February 2012, require public notice and comment periods at the state and federal levels before new waivers and extensions of existing waivers are approved by CMS.<sup>2</sup> The transparency regulations also require states to have an approved evaluation strategy in place that is publicly available. States must also submit an annual report to HHS that includes, among other things, a description of the changes occurring and their impact on outcomes, quality, and access; beneficiary satisfaction surveys; grievance and appeals data; financial data; audits; and other relevant developments. A federal contract has been awarded to conduct an evaluation of a number of Section 1115 waivers (related to the ACA Medicaid expansion as well as other demonstration waivers).

# A Look at Medicaid Expansion Waivers Post 2014

To date, a few states have sought Section 1115 waivers to implement the Medicaid expansion, in part because they could not otherwise secure political support to expand coverage. As of February 2015, CMS has approved waivers to implement the Medicaid expansion in five states ([Arkansas](#), [Iowa](#), [Michigan](#), [Pennsylvania](#) and most recently [Indiana](#)). Governors in [Utah](#) and [Tennessee](#) have been negotiating waivers with CMS, but formal waiver applications have not yet been submitted. These plans also need state legislative approval, and Tennessee's legislature recently did not vote a bill authorizing Medicaid expansion out of committee during a special session. [New Hampshire](#) has implemented the Medicaid expansion pursuant to a SPA, but has a pending waiver application to continue its Medicaid expansion through mandatory Marketplace premium assistance beginning in January 2016, as required by state law.<sup>3</sup> The Pennsylvania waiver was approved under Governor Corbett, but the current Governor Wolf announced that Pennsylvania will transition to a traditional Medicaid expansion plan and he will not implement the benefit and work changes that the previous Governor had initiated.

**Each of the approved and proposed expansion waivers is unique, in many cases reflecting variations in the states' underlying Medicaid programs, but there are some common themes across the waivers.** The following sections examine waiver provisions that have been approved and denied by CMS to date.

Table 1: Key Themes in ACA Expansion Waivers and Proposals

	Premium Assistance	Premiums / Monthly Contributions	Healthy Behavior Incentives	Benefit Changes	Work Referral	Co-Payments*	Waivers of Retroactive Eligibility / Reasonable Promptness
Approved Waivers							
Arkansas <sup>1</sup>	Mandatory for QHPs	X					
Iowa	Optional for QHPs	X	X	X			
Indiana <sup>2</sup>	Optional for ESI	X	X	X		X	X
Michigan		X	X				
Pennsylvania <sup>3</sup>		X	X	X			
Waiver Proposals							
New Hampshire <sup>4</sup>	Mandatory for QHPs				X		X
Tennessee <sup>5</sup>	Optional for ESI	X	X	X		X	X
Utah <sup>5</sup>	Mandatory for QHPs and ESI	X	X	X		X	

\*Cost-sharing waivers were approved in Indiana and are proposed in Tennessee and Utah through §1916(f) not §1115 waiver authority.

<sup>1</sup>The monthly contributions in AR are in lieu of cost-sharing requirements.

<sup>2</sup>Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid waiver.

<sup>3</sup> The Pennsylvania expansion waiver was approved under Governor Corbett who also had intended to restrict benefits through a SPA and to implement a state-only work-referral program. Governor Wolf (the new governor) announced that PA will transition to a traditional Medicaid expansion plan and will not implement the benefit and work changes.

<sup>4</sup> New Hampshire implemented the Medicaid expansion through a SPA, but has a waiver pending to move to a mandatory Marketplace premium assistance model by 1/2016.

<sup>5</sup>The Governors in Utah and Tennessee have waiver proposals that have not been officially submitted to CMS and are under debate in the state legislatures.



## WAIVER PROVISIONS APPROVED BY CMS

### PREMIUM ASSISTANCE

**Two states have received approval to implement the Medicaid expansion through a premium assistance model using mandatory enrollment in private coverage through Marketplace plans (Arkansas and Iowa).** According to guidance released by CMS, it will approve a limited number of waivers to allow state to use Medicaid funds to purchase coverage for some or all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs) as a “private approach” to expansion. States can implement premium assistance programs without a waiver, subject to certain rules. Arkansas and Iowa received waivers to allow them to mandatorily enroll beneficiaries in premium assistance. In Arkansas all newly eligible adults, including childless adults between 0-138% FPL and parents between 17-138% FPL, are enrolled in premium assistance. In Iowa, only newly eligible adults with incomes above 100% up to 138% FPL were enrolled in premium assistance.<sup>4</sup> With the loss of one of the two Marketplace QHPs serving Medicaid beneficiaries in Iowa, beneficiaries instead are enrolled in Medicaid managed care as of December 2014, with the option to choose Marketplace premium assistance as an alternative (instead of imposing mandatory premium assistance) .

These states indicate that they are using premium assistance to test how private coverage works for Medicaid beneficiaries and whether enrolling beneficiaries in Marketplace coverage will increase provider access and reduce churn between Medicaid and Marketplace coverage due to income fluctuations. How premium assistance affects continuity of care, the impact on access to benefits, how well wrap-around coverage will work, how states will exempt people who are medically frail from their demonstrations, what the impact of premiums and cost sharing will be, and whether the demonstrations will be cost effective are key issues to monitor and are included in the evaluation requirements of these waivers.<sup>5</sup> Consistent with CMS guidance, the premium assistance waivers in Arkansas and Iowa were approved through 2016.<sup>6</sup>

**The waiver proposals in New Hampshire and Utah would also provide premium assistance for Marketplace coverage to some Medicaid expansion enrollees.** The New Hampshire proposal includes mandatory enrollment in Marketplace QHPs for Medicaid expansion adults beginning January 1, 2016. Utah’s proposal similarly would require most newly eligible adults to enroll in Marketplace QHPs. Expansion adults who have access to employer-sponsored insurance (ESI) in Utah would receive premium assistance for enrollment in their ESI.

**Indiana and Tennessee include optional premium assistance programs for beneficiaries with access to ESI.** The Tennessee proposal would offer newly eligible adults with access to ESI the option of receiving premium assistance to enroll in their ESI plan in the form of a defined contribution from the state. Under this Volunteer Plan, costs and benefits not covered by the defined contribution would be the responsibility of the beneficiary.<sup>7</sup>

## MONTHLY CONTRIBUTIONS AND PREMIUMS

**CMS has approved waivers that allow states to charge premiums or monthly contributions primarily for expansion adults between 100 and 138% FPL.** Under federal law, Medicaid beneficiaries with incomes below 150% FPL (\$17,655 per year for an individual in 2015) cannot be charged premiums. Premiums in the Medicaid program are limited because a large body of research shows that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for people with low-incomes.<sup>8</sup> Each of the five approved expansion waivers allows the states to impose premiums or monthly contributions for newly eligible beneficiaries with incomes between 101-138% FPL. These premiums (equal to about 2% of income) are about the same level as those allowed for individuals at these incomes who are eligible for tax credits to purchase coverage through the Marketplace in states not expanding Medicaid.

**The consequences of non-payment of premiums for adults with incomes above poverty vary across states, but only Indiana includes a six month lock-out for beneficiaries dis-enrolled due to unpaid premiums.** In Michigan, payment of premiums is not a condition of eligibility. In Iowa, beneficiaries have a 90 day grace period to pay past-due premiums in full before they are dis-enrolled from Medicaid, and the state must waive premiums for beneficiaries who self-attest to financial hardship. Individuals can re-enroll at any time. Similarly, in the approved Pennsylvania waiver, there is a 90-day grace period before disenrollment for unpaid premiums, and beneficiaries may re-enroll without a lock-out period. Indiana's waiver is different than others approved to date in that it allows the state to impose a six month lock-out period for non-medically frail individuals above poverty who are dis-enrolled due to unpaid premiums after a 60 day grace period. Individuals who never make their initial premium payment are not subject to the 6 month lock-out.

**In Arkansas, Iowa and Indiana, the waivers allow the states to charge monthly contributions for individuals below poverty; however, failure to pay these charges cannot result in the termination of Medicaid coverage.** Arkansas received approval through a waiver amendment to require monthly income-based contributions to health savings accounts, ranging from \$5 to \$25 per month, for beneficiaries with incomes between 50-138% FPL to be used for co-payments and co-insurance. In Arkansas, those with incomes below poverty cannot be denied services for failure to pay. In Iowa, the waiver allows the state to impose monthly contributions of \$5 per month for beneficiaries with incomes between 50-100% FPL beginning in year two; however, premiums can be waived by completing healthy behavior activities and Medicaid eligibility cannot be terminated for non-payment of premiums for beneficiaries at or below 100% FPL.

The waiver in Indiana imposes monthly contributions to a Personal Wellness and Responsibility (POWER) health savings account for most newly eligible adults with incomes between 0-138% FPL. Those with incomes between 0-5% FPL (up to \$589 per year for an individual in 2015) must pay \$1.00 per month. If individuals with incomes at or below poverty do not pay the monthly POWER account contributions, they receive a less generous benefit package.

**In Indiana, the waiver allows the state not to begin coverage until the first premium is paid.** Under the Indiana waiver, beneficiaries who pay premiums will be eligible for an HIP Plus benefit package, which includes expanded benefits and co-payments only for non-emergency use of the ER. Coverage in HIP



Plus begins the first day of the month in which a beneficiary pays a premium, instead of the date of Medicaid application. To allow coverage to begin on the first day of the month in which a beneficiary pays a premium, instead of the date of Medicaid application, the state needed waivers of reasonable promptness and retroactive eligibility. Under federal law, Medicaid benefits must be provided with “reasonable promptness” to eligible beneficiaries, and coverage extends to bills incurred retroactively for three months prior to the month of application, if the individual would have been eligible during the retroactive period.<sup>9</sup> Indiana’s waiver also includes FQHCs, RHCs, CMHCs, and health department sites in an expanded presumptive eligibility program. Presumptive eligibility enables applicants to receive Medicaid-covered services as of the date that a qualified provider entity preliminarily determines that the applicant eligible for Medicaid, while the final determination is pending. To maintain the reasonable promptness waiver, the state must make final eligibility determinations for a certain percentage of presumptively eligible applicants (out of eligibility determinations made on all types of applications).

## HEALTHY BEHAVIOR INCENTIVES

**CMS has approved the use of healthy behavior incentives to reduce or eliminate beneficiaries’ out-of-pocket expenses.** The approved waivers in Iowa, Michigan, Pennsylvania and Indiana all include healthy behavior programs. Under these four waivers, individuals who complete specified healthy behaviors will have their premiums and cost sharing waived or reduced. Separate protocols must be approved by CMS to implement these health behavior programs. The protocols are required to: (1) specify the types of healthy behaviors (such as health risk assessments); (2) include a diverse set of behaviors as well as a strategy to measure access to providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives; (3) engage stakeholders and the public in developing the healthy behavior standards; (4) show how healthy behaviors will be tracked and monitored at the enrollee and provider level; (5) include a beneficiary and provider education strategy; and (6) include the methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

In Iowa, beneficiary premiums were waived for the first year of enrollment. In subsequent years, premiums are waived if beneficiaries complete specified healthy behavior activities. In the first year of the healthy behavior program, these include completing an online health risk assessment and obtaining a wellness examination. Iowa has retroactively broadened the definition of a qualifying wellness exam to allow providers to choose a routine medical exam in lieu of a more comprehensive annual physical, depending on the beneficiary’s individual needs.

In Michigan, demonstration beneficiaries have cost-sharing obligations based on their prior six months of copays. Cost-sharing will be paid into health accounts and can be reduced through compliance with healthy behaviors. The cost-sharing amounts are based on the state plan amounts and not changed from what would have been collected without the waiver. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays or premiums. Similarly, under the approved waiver in Pennsylvania, beginning in demonstration year 2, beneficiaries can reduce their premiums or copayments by completing healthy behaviors including an annual wellness exam.

## WAIVERS OF REQUIRED BENEFITS

**CMS has approved limited waivers of required Medicaid benefits that allow states not to cover non-emergency medical transportation (NEMT).** In implementing the ACA, states have considerable flexibility in determining benefits packages for those newly eligible for coverage by the ACA's Medicaid expansion. States must cover the ten ACA-required Essential Health Benefits (EHBs) along with certain other mandatory Medicaid services. States also must meet mental health parity requirements. Beyond these requirements, states have flexibility to choose a benchmark plan for coverage that may include one of several specified private insurance options or "Secretary-Approved Coverage" which can include a state's current Medicaid benefits package for adults. However, some states have sought waiver approval for greater flexibility in the provision of benefits.

Iowa was the first state to receive approval to waive NEMT for newly eligible adults. The original NEMT waiver applied through December 31, 2014, and extension is conditioned on an evaluation of the waiver's impact on beneficiary access to care. In December 2014, CMS approved a waiver amendment extending the NEMT waiver through July 1, 2015, while noting that Iowa had submitted preliminary data that "raised concerns about beneficiary access[,] particularly for those with incomes below 100 percent of the FPL." CMS will consider additional data collected by the state as of May 31, 2015 in determining whether to further extend the NEMT waiver. Iowa provides NEMT to beneficiaries who are medically frail and those under age 21.

Following the original approval in Iowa, Pennsylvania was authorized to waive NEMT for newly eligible adults in 2015, with this benefit to be provided beginning in 2016. Most recently, Indiana was also allowed to waive NEMT for most newly eligible adults for one year, to be extended based on the results of an evaluation assessing the impact on access to care. Arkansas also sought waiver authority to limit NEMT to 8 trip legs per year for non-medically frail beneficiaries. Instead, the state will establish a prior authorization process for NEMT for newly eligible adults (a change that does not require waiver authority).

**The Indiana plan allows for different benefit packages for individuals below poverty who do not pay premiums.** Under the Indiana waiver, newly eligible adults 0-138% FPL who pay monthly POWER account contributions receive HIP Plus, which includes the ACA's essential health benefits and covers more services than the HIP Basic benefit package. Newly eligible adults at or below 100% FPL who do not pay premiums receive HIP Basic, an ABP that includes the ACA's essential health benefits but with fewer covered services (no vision or dental coverage) compared to HIP Plus. HIP Basic includes all EPSDT services for 19 and 20 year olds, consistent with federal law.

## COST SHARING WAIVERS

**Indiana has received approval to impose cost sharing in amounts greater than those allowed under federal law under separate Section 1916(f) authority.** Section 1115 waiver authority does not extend to Medicaid cost-sharing requirements. In order to impose higher cost sharing than otherwise allowed under federal law, a state needs to meet separate cost sharing waiver requirements under Section 1916(f). Section 1916(f) permits a state to seek a demonstration waiver to charge cost sharing above otherwise allowable amounts if the state meets specific requirements and criteria, including testing a unique and previously untested use of copayments and limiting the demonstration to no longer than two years.

In July 2013, final regulations were released that streamlined and simplified existing rules around premiums and cost-sharing in Medicaid, increased the nominal rate for cost-sharing, and increased allowable cost-sharing amounts for non-preferred drugs and non-emergency use of the emergency room. Indiana received Section 1916(f) waiver authority to charge cost sharing that exceeds the \$8 maximum allowed for non-emergency use of the emergency room under these federal rules. This waiver allows the state to implement a two-year demonstration (until Jan. 31, 2017) to test whether graduated co-payments (\$8 for first visit and \$25 for subsequent visits in the same year) discourage non-emergency use of the emergency room. This authority applies to both newly eligible adults and previously eligible parents. By May 1, 2015, the state must establish a control group with a minimum of 5,000 beneficiaries who will not be subject to the increased co-payments; selection of the control group will be detailed in the state's protocol submitted to CMS.

A few of the other recent ACA expansion waivers include cost sharing provisions. However, they do not increase beneficiary cost sharing amounts beyond what is allowed under current law. In Arkansas, beneficiaries between 50-138% FPL have cost-sharing consistent with existing Medicaid state plan and Marketplace QHP rules (as discussed above, monthly contributions are paid into an account used to pay for co-payments and co-insurance). In Michigan, after six months, all beneficiaries will have cost-sharing obligations based on their prior six months of copays, billed at the end of each quarter. Cost-sharing will be paid into health savings accounts and can be reduced through compliance with certain healthy behaviors. However, the cost-sharing amounts are the same as what the state would have been able to collect without a waiver. The Michigan waiver terms and conditions specify that beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays or premiums.

## WAIVER PROVISIONS DENIED BY CMS

**CMS has not approved waiver requests proposing premiums for individuals with incomes below 100% FPL where payment is a condition of eligibility.** As noted above, Arkansas, Iowa and Indiana do impose monthly contributions for individuals with incomes below poverty; however, for Medicaid eligibility cannot be terminated for non-payment.

**CMS has denied requests to waive certain Medicaid benefits.** In their waiver proposals, some states requested additional changes in benefits that were not approved. Specifically, CMS denied Iowa and Indiana's requests to waive the provision of EPSDT services for newly eligible 19 and 20 year olds and requests from Iowa and Pennsylvania to waive the provision of free choice of family planning providers for newly eligible adults. Pennsylvania's original waiver proposal also sought benefits package changes for current and newly eligible beneficiaries, seeking to replace current state plan benefits with a "high risk" package for people who are medically frail and a "low risk" package for other beneficiaries. These changes are not included in the waiver approval and the state instead submitted a SPA to implement these changes. The state's new governor subsequently withdrew the pending SPA seeking a reduced benefit package.

**CMS has denied waivers for states seeking to impose cost sharing in amounts greater than those allowed under federal law.** While Indiana recently received waiver authority to impose higher than statutory cost-sharing under Section 1916(f), CMS did not approve a § 1916(f) waiver request to allow Arizona to impose a \$200 co-pay for non-emergency use of the emergency room.<sup>10</sup> Pennsylvania was also denied a

waiver request to impose higher than statutorily allowed cost sharing amounts for non-emergency use of the ER.

**CMS has not approved a waiver to include a work requirement or referral as a condition of Medicaid eligibility.** Pennsylvania initially sought a work requirement as a condition of Medicaid eligibility (later amended to a voluntary work search program) for current and newly eligible beneficiaries as part of its waiver application, but none of these elements were included as part of the demonstration approved by CMS. Indiana sought waiver authority to require a work referral as a condition of eligibility, which was not approved by CMS. Instead, Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid expansion demonstration. Utah's proposal includes a provision to automatically enroll able-bodied adults in a concurrent work program when newly eligible beneficiaries apply for Medicaid. The work program would include an online assessment and access to training opportunities and job postings. Utah is exploring possible sanctions related to benefits available under other state programs for non-compliance with the work program but is not proposing that work program participation be a condition of Medicaid eligibility and is not seeking federal waiver authority for the work program. New Hampshire's waiver proposal includes a referral to state job counseling services for unemployed applicants.

## Key Issues Looking Forward

To date, 29 states (including DC) are implementing the ACA's Medicaid expansion including five states that are implementing the expansion under waiver authority. Examining what provisions CMS has approved and denied in recent waiver approvals can shed light on what may be approved for other states considering waivers moving forward. A number of states currently debating moving forward with the expansion are considering implementing the expansion through a waiver.

To ensure Section 1115 waivers fulfill their purpose as research and demonstrations projects, it will be important to evaluate their effects. Waivers are intended to be research and demonstration projects, and federal law requires that they be formally evaluated to measure how well they achieve objectives and the effects on access to care and outcomes for beneficiaries. Particularly as waiver designs become increasingly more complex, the evaluations will help inform policy makers if such policies can be effectively administered and if beneficiaries understand the policies. Ensuring that evaluations are timely and that findings are publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences.

What happens with waivers between 2014 and 2016 also will be important to inform the use of the new state innovation waiver authority (Section 1332) available in 2017, which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid and CHIP waivers. As more states seek waivers to implement the expansion, what we learn from their experiences will help inform the future direction of coverage for low-income adults and families. In addition, in states where Medicaid expansion without a waiver is not politically viable, large numbers of people are likely to remain without coverage. CMS, states, and other stakeholders will continue to navigate the balance between state waiver requests in an effort to reduce the number of uninsured adults while preserving key beneficiary protections and requirements in the Medicaid program.

# Endnotes

<sup>1</sup> Status of State Action on the Medicaid Expansion Decision, Jan. 27, 2015. (Kaiser Family Foundation). <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

<sup>2</sup> *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers*. (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2012) <http://kff.org/health-reform/fact-sheet/the-new-review-and-approval-process-rule/>

<sup>3</sup> See N.H. Sen. Bill 413, available at <http://www.gencourt.state.nh.us/legislation/2014/SB0413.pdf>.

<sup>4</sup> As of December 1, 2015, Iowa beneficiaries from 101-138% FPL are no longer required to enroll in Marketplace premium assistance as a condition of eligibility because one of the two QHPs covering Medicaid beneficiaries is no longer participating. Instead, these beneficiaries can choose to receive coverage through the state's Medicaid managed care delivery system or enroll in the remaining QHP with premium assistance. As of January 1, 2015, beneficiaries from 101-138% FPL are enrolled in Medicaid managed care unless they opt to enroll in the remaining QHP. The state is submitting a waiver amendment about this program change to CMS after the required public notice and comment periods.

<sup>5</sup> MaryBeth Musumeci. *Medicaid Expansion Through Marketplace Premium Assistance* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2013), <http://www.kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/>.

<sup>6</sup> The shorter approval periods were designed to allow CMS use states' experience in these models to inform the new §1332 Marketplace innovation waiver authority available to states beginning in 2017.

<sup>7</sup> Instead of utilizing premium assistance models, approved waivers in Michigan, Pennsylvania, Indiana and Iowa for beneficiaries below 100% FPL, rely on Medicaid managed care organizations (MCOs) to delivery care to those newly eligible for coverage. Some of these states had considered premium assistance, but instead relied on existing delivery systems and MCOs to delivery care to the new population.

<sup>8</sup> Laura Snyder and Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*. (Kaiser Commission on Medicaid and the Uninsured, February 2013). <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/>

9 42 U.S.C. § 1396a(a)(8), 1396a(a)(34); 42 C.F.R. § 435.914.

<sup>10</sup> Letter from Cindy Mann to Thomas Betlach, December 15, 2014. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf>