Health Advocate

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Medicaid Expansion Waivers Update

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Key Resources

NHeLP Comments to Healthy Indiana Plan Renewal and Healthy Indiana Plan 2.0 Section 1115 Demonstration Applications

NHeLP Comments on Amendments to Arkansas' Health Care Independence Program

Earlier Access to Care for Uninsured Women Living with HIV: The Affordable Care Act's Medicaid Expansion and 1115 Demonstration Projects

Key Takeaways for Medicaid Health Expense Accounts

Coming in May's *Health Advocate*:

Home and Community Based Services

Although the Affordable Care Act (ACA) includes a provision making Medicaid expansion mandatory, the Supreme Court's Medicaid expansion decision in 2012 resulted in effectively giving every state the choice of whether to expand. To date, 29 states (including DC) have expanded Medicaid. The first 23 states did so exactly as authorized by the law. However, the next 6 states expanded using the Social Security Act's section 1115 demonstration authority – an authority to pilot innovative Medicaid experiments. The states proposed, and HHS approved, alternate versions of the Medicaid expansions, which include "waivers" of long-standing Medicaid protections – meaning that HHS has waived an otherwise mandatory Medicaid Act provision to allow the state to implement the experimental project.

While these approvals mean that benefits will be available to previously uninsured individuals, they could raise serious concerns for the integrity of the Medicaid program in the future.

The Waivers Begin

Arkansas was the first state to pursue Medicaid expansion through a section 1115 waiver, and was approved in September 2013 to conduct Medicaid expansion (starting January 2014) using premium assistance. Under the premium assistance demonstration, Arkansas uses Medicaid expansion money to pay the premiums for a Qualified Health Plan (QHP) for enrollees. QHPs are the plans sold on the Arkansas Marketplace.

Although these Medicaid enrollees are enrolled into a Marketplace product, they remain Medicaid enrollees, meaning they must receive the scope of benefits, affordability protections and all other applicable rights and protections that are contained in the Medicaid Act. Therefore, it is the state's responsibility to provide for covered benefits if the QHP fails to provide them.

One potential advantage of premium assistance is that it will facilitate transitions between Medicaid and Marketplaces, since the same QHPs might be used for both. As of yet, there is no evidence confirming or disproving this hypothesis. One of the most important reasons Arkansas is committed to Medicaid premium assistance is the impact it has outside of Medicaid. The QHP enrollees covered through Medicaid premium assistance make up 80 percent of the *entire* QHP Marketplace. In other words, non-Medicaid enrollees make up only 20 percent of the Arkansas Marketplace, and as such, the Medicaid expansion is essentially stabilizing the state's private insurance market.

To date, however, the Arkansas model has received mixed reviews. Serious questions have been raised about the model's cost-effectiveness compared to normal Medicaid expansion. It has also been unclear whether the state has been ensuring coverage of benefits that are not covered by the QHP, particularly for 19- and 20-year-olds who should have important Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. There have also been problems with the federal Marketplace conducting eligibility and enrollment for the Medicaid QHP population and challenges for consumer advocates getting information from the Medicaid agency about QHPs as compared to traditional Medicaid health plans.

Since Arkansas' approval, two other states (Iowa and New Hampshire, discussed later), have also implemented premium assistance models. As mentioned above, there are concerns; however, the premium assistance model is relatively untested in this context and thus there are some experimental benefits. Therefore, it is reasonable to have a limited number of these section 1115 demonstrations to determine whether are not they are a viable means of providing health coverage to the Medicaid populations.

More Waivers

Subsequent to the Arkansas approval, various states became interested in pursuing Medicaid expansion through the section 1115 demonstration authority and began negotiations with HHS. States frequently made aggressive requests to waive numerous Medicaid Act provisions, testing the limits of how much HHS might concede in exchange for securing another Medicaid expansion state. The states ultimately approved so far include Iowa (December 2013), Michigan (December 2013), Pennsylvania (August 2014), Indiana (January 2015) and New Hampshire (March 2015).

The sheer number of waiver requests (*i.e.*, requests to ignore otherwise mandatory Medicaid Act provisions) from these states makes it impossible to list out all of their requests. However, there are some consistent themes of great concern. Most notably, all of these states received section 1115 waiver approvals that raise at least two broad issues.

First, many of the waivers serve only to *reduce* access to Medicaid coverage for vulnerable Medicaid enrollees as compared to what Congress intended with the Medicaid expansion. For example, despite Medicaid law's common-sense prohibition of premiums on individuals below 150 percent of the Federal Poverty Level (FPL), HHS approved the use of mandatory premiums above 100 percent FPL (IA, PA, IN; optional in MI) and optional premiums below 100 percent FPL (AR, IA, IN). With mandatory premiums, an individual just above the poverty line who fails to pay is terminated from Medicaid. HHS also approved waivers allowing states to stop providing transportation assistance for low-income individuals to attend their medical appointments (IA, PA, IN). In the most extreme case, HHS also approved a state's waiver requests to implement a waiting period delaying access to Medicaid coverage after application, and a lock-out barring individuals from re-applying for 6 months if they failed to make premium payments (IN). In each of these cases, Medicaid waivers were proposed by states and approved by HHS at the expense of access to care for impoverished and needy Medicaid enrollees.

Second, many of the waivers fail to comply with the legal requirements of section 1115 authority. Section 1115 requires demonstrations to actually demonstrate something. For example, with respect to the demonstrations allowing premiums, there is already ample evidence in research literature establishing that premiums sharply reduce coverage for low-income populations, meaning there is no valid experiment being tested in the waivers of the Medicaid Act's premium protections. Section 1115 also requires demonstrations to "promote the objectives" of the Medicaid program, which is to "furnish medical assistance" to enrollees, yet HHS's waivers of medical transportation and waivers to allow waiting periods and lock-outs clearly will not help furnish care to enrollees. These specific waivers not only fail to comply with the requirements of section 1115 demonstrations, they also create dangerous precedent for the section 1115 authority to be used without restraint to dismantle core Medicaid protections.

Back to the Future?

Another problematic consequence of these waiver approvals is that each new approval undercutting Medicaid's legal requirements sets a new and lower baseline that the next state will use to start negotiations. For example, the most recent flexibilities granted in Indiana have become features of new proposals now being developed in other states (such as FL, MT, and TN). Moreover, these waivers can impact all states – even states that have *already* expanded may pursue these new flexibilities as a condition of preserving their *existing* Medicaid expansions. In fact, Arkansas, the first state to expand through section 1115, actually went back to HHS after their waiver had been approved, to request additional waivers (*e.g.,* premiums) that other states had subsequently received. The provision of these waivers, therefore, destabilizes the Medicaid expansion for all states, those that have expanded and those that have yet to expand.

The outlook is of concern for the Medicaid program. Medicaid's careful design makes the coverage affordable and accessible for low-income enrollees who have special health care needs and who experience barriers to obtaining needed care. As these core Medicaid protections are traded away, enrollees risk being left with low-value health insurance that fails to provide real access to care.

This is additionally troubling because, given the extremely generous federal funding provided by the Medicaid expansion, it is only a matter of time until all states choose to participate. Twenty-nine states have already expanded. By comparison, when Medicaid was established in 1965, only 26 states chose to participate in the first year. Five years into Medicaid, 49 states were participating, and even the two holdouts had joined the program by 1982 (AK 1972, AZ 1982). The lesson from Medicaid's history is clear: dismantling Medicaid's core protections to entice states is unnecessary given the incredible value Medicaid provides states.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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