Health Advocate

E-Newsletter of the National Health Law Program

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Key Resources

NHeLP Comments: Arkansas Works 1115 Demonstration

NHeLP Comments: Healthy Ohio Program Section 1115 Demonstration

Coming in September *Health Advocate*: States Expanding Coverage of Contraception

Medicaid Expansion Section 1115 Demonstrations Update

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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, 32 states (including DC) have expanded Medicaid. The first 23 states did so as authorized by the law. However, eight of the next nine 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, waivers of core Medicaid protections lead to reduced access to care for the enrollees and raise serious concerns for the integrity of the Medicaid program in the future.

Everything-but-the-Kitchen-Sink Demonstrations

As a matter of law and policy, demonstration waivers that *reduce* access to care for enrollees should never be approved. Under the law, section 1115 demonstrations can only be approved if they promote the objective of the Medicaid program (which is to furnish care for enrollees) and have a useful experimental purpose. As a matter of policy, many waivers requested by the states – such as to allow them to charge premiums on individuals in poverty – result in increased rates of uninsurance, worse health outcomes, and financial strains on the health care system. While even one such waiver is too many, the worst demonstrations are the ones that attempt to "throw in everything but the kitchen sink." Instead of thoughtful, targeted waivers, such states simply ask for exceptions to almost every rule they can think of.

The first state to be approved for such an approach was Indiana. Indiana was approved for waivers to:

- Charge premiums to all individuals in poverty;
- "Lockout" individuals (from 100-138% of the federal poverty level) who are terminated for failure to pay premiums, meaning they are barred from reapplying for a time period;
- Provide fewer benefits to individuals who do not pay premiums;
- Create a waiting period for enrollment;
- Charge higher cost-sharing to individuals who do not pay premiums;
- Charge extra-high copayments for non-emergent Emergency Room use;

- Cease providing non-emergent transportation assistance; and
- Exclude required retroactive coverage.

With each of these waivers Indiana has effectively skirted a Medicaid requirement designed to protect low-income health care consumers. It should be noted that although HHS approved these problematic features, HHS also denied several other harmful requests, such as work requirements.

Unfortunately, two other states are now proposing similar "kitchen sink" proposals. Ohio and Kentucky each have Indiana-style applications that include most of the waivers requested by Indiana. Both states request waivers for premiums, waiting periods, lockouts after termination, and retroactive coverage. Kentucky also adds waiver requests for a work requirement, a lockout for failure to complete redetermination papers, and ending non-emergent transportation for some enrollees. These proposals, if approved, would result in expansions that do not achieve the promise of coverage that provides meaningful access for consumers and will only encourage more states to erect barriers to care.

One of the lessons from HHS's past approval decisions is that an approval of waivers in one state will quickly lead other states to request the same exceptions, to the detriment of care for enrollees. Perhaps most alarming, in requesting waiting periods and lockouts, Ohio and Kentucky request waivers of some of the most sacred core provisions of Medicaid: these waivers attack the basic requirement that states must promptly enroll all eligible individuals. The potential repercussions of waiving this foundational requirement are staggering. What does it mean for individuals to be eligible for Medicaid if the state does not have to enroll them?

Regression Instead of Expansion

Another important lesson from past approvals is readily apparent in the recent Medicaid expansion activity. The states with section 1115 Medicaid expansion proposals currently in process are Ohio, Kentucky, Arkansas, New Hampshire, and Iowa. All five of these states are states that *already* expanded Medicaid and some have been held out as national models for expansion. Despite the indisputable success of their expansions, the states now are trying to add the exceptions granted to subsequent states (such as Indiana), which would result in worsening care for existing enrollees. In other words, HHS's granting of waivers to entice more states may be resulting in more steps backwards in expanded states than forwards in unexpanded states, a *regression* rather than *expansion* in coverage.

The issue is challenging for HHS because in some cases the states have threatened to abandon their expansions if they do not receive the concessions they have requested. If HHS concedes to these demands, however, it will only perpetuate the cycle by setting new precedents for yet more states to make demands. Ultimately, NHeLP has recommended that HHS set a clear standard that it will not approve demonstrations that worsen coverage for individuals who are *already* enrolled, in order to protect those individuals and avoid regression in the future.

Micro-Expansions: Coming Trend?

A newer and challenging issue being considered in a few states is a proposal to implement a quasi-expansion to a small subset of the full expansion population, which some refer to as a "micro-expansion." In a micro-expansion, instead of covering the full range of adults normally eligible under Medicaid expansion (all uninsured adults under 138% of the federal poverty level), the state proposes to expand coverage to only *some* of those individuals. For example, Utah is currently developing a proposal to cover only a few subpopulations, including some low-income parents, individuals who are homeless, individuals interacting with the criminal justice system, and individuals with mental illness. Micro-expansions present legal and policy challenges.

Legally, there is no authority in Medicaid law to cover only part of a mandatory eligibility category and such approaches could violate civil rights and disability act laws. Under the statute, the Medicaid expansion group remains a mandatory eligibility category, and therefore states must cover all individuals in the category, and they cannot pick and choose within the category. A waiver allowing a micro-expansion would be highly problematic, since there is no reason the precedent might not invite a state to request a waiver to cover only *some* individuals in another mandatory eligibility category, such as mandatorily-eligible pregnant women. As such, micro-expansions could lead to a massive degradation of Medicaid eligibility standards. One significant fact, however, is that HHS has signaled it will not provide states with enhanced Medicaid expansion matching funds for a micro-expansion, so at the very least states will retain that strong incentive to fully expand.

As a matter of policy, the analysis is more nuanced. A micro-expansion would, of course, benefit the subpopulation that got coverage – such as some homeless individuals under the Utah proposal. At the same time, if a state can cover the high-interest populations through micro-expansion, it would reduce the incentive to pursue a full expansion covering the other “less sympathetic” subpopulations. Ultimately, using cost-benefit analysis, NHeLP has recommended that HHS not approve micro-expansions and instead concentrate on encouraging states to fully expand. The risks of micro-expansion are great: setting grave Medicaid precedents and decreasing incentives to fully expand for *millions* of Medicaid enrollees. The benefits, while important to the individuals who would receive coverage, are by definition much smaller since only a subpopulation gains coverage. For example, under Utah’s proposal draft, *only 10,000* people (or less) would gain coverage. The better alternative – full Medicaid expansion – will cover those 10,000 and over one-hundred thousand more individuals.

Conclusion

NHeLP will continuing working with state advocates and advocating with HHS until full Medicaid expansion has been achieved in all 50 states and DC. At the same time, NHeLP will continue to work to ensure that core Medicaid protections are not degraded in the process, to ultimately ensure that Medicaid continues to provide coverage that works for the low-income and underserved enrollees who depend on it.

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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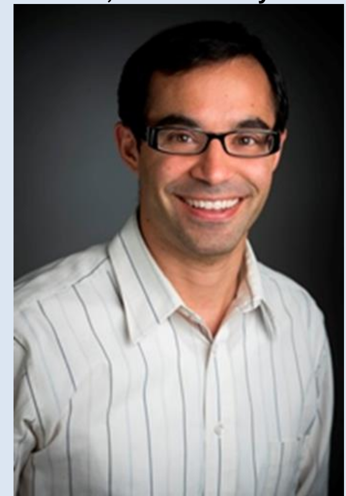

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