



Medicaid Retroactive Coverage: Stop these Waivers!

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In return for receiving significant federal funding, states must operate Medicaid programs consistent with the rules laid down by Congress. One of these rules requires states to extend retroactive coverage for health services “furnished in or after the third month” before the individual applied for medical assistance (if they would have been eligible at the time they received the services).¹ There is good reason for this law. According to Congress, retroactive coverage is needed to

protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements or because the sudden nature of their illness prevented their applying.²

Congress is right. The need for retroactive coverage often arises because of the sudden onset of a health care crisis—a stroke, an automobile accident, a dangerous communicable disease, a gunshot wound. The impact and recovery can make it impossible for someone to apply for Medicaid until months after the event.³

Another federal law, section 1115 of the Social Security Act, authorizes the Secretary of the Department of Health and Human Services (HHS) to waive requirements set forth in one part of the Medicaid Act, 42 U.S.C. § 1396a. HHS can waive the provisions only to allow a state to implement an “experimental, pilot, or demonstration” project that is “likely to assist in

¹ 42 U.S.C. § 1396a(a)(34), *see also id.* § 1396d(a) (requiring retroactive coverage).

² Staff of S. Comm. on Finance, 92d Cong., Rep. to Accompany H.R. 1 to Amend the Social Security Act, and for other purposes, at 209, H. Rep. No. 92-231, 92d Cong., 2d Sess., reprinted in [1972] U.S. Code Cong. & Ad. News 4989, 5099, <https://bit.ly/2TtPPch>.

³ *See, e.g.,* Alexia Fernandez Campbell, *These 2 Medicaid provisions prevent medical debts from ruining people’s lives*, Vox (July 19, 2017), <https://bit.ly/3D69TnI> (highlighting the story of a man who realized he was eligible for Medicaid after he faced \$500,000 in medical bills and a friend told Medicaid may be able to help).

promoting the objectives” of the Medicaid Act, and the waiver can last only “to the extent and for the period . . . necessary” to enable the state to carry out the experiment.⁴

Thus, HHS’s use of section 1115 is limited to authorizing states to test out time-limited experiments. As one court put it: “As a matter of principle, it is clear that the Secretary would abuse his discretion if he were to approve a project ... which subject[ed] an unreasonably large population to the experiment or continu[ed] it for an unreasonably long period.”⁵ Courts have also noted that section 1115 “was not enacted to enable states to save money or to evade federal requirements but to test out new ideas and ways of dealing with the problems” of program enrollees.⁶ Other courts have reminded HHS that experiments must reflect the objectives of the Medicaid Act—which, according to the Act itself, center on enabling states “to furnish medical assistance,” to the greatest extent practicable, to individuals “whose income and resources are insufficient to meet the costs of necessary medical services.”⁷

Over the years, HHS has frequently used section 1115 to waive the retroactive coverage requirement. Unfortunately, at this point, these waivers are making a sham of section 1115 and continue to harm low-income people.

Waiving retroactive coverage

In the 1990s, the Clinton administration used section 1115 to test novel Medicaid managed care delivery systems in more than a dozen states, and as part of those projects, waived retroactive coverage. HHS’s initial rationale was to facilitate implementation of the managed care programs—managed care companies did not want to be held financially responsible for managing care retroactively.

But here’s the problem: Managed care has long since ceased to be novel. At this point, nearly 70 percent of the Medicaid population nationwide is enrolled in a comprehensive managed care plan.⁸

- In 1997, Congress amended the Medicaid Act to allow states to implement managed care for most enrollees as a state plan option (so a waiver is not needed). At the

⁴ 42 U.S.C. § 1315(a).

⁵ *Cal. Welf. Rts. Org. v. Richardson*, 348 Fed. Supp. 491, 498 (N.D. Cal. 1972).

⁶ *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (internal quotations and citation omitted).

⁷ 42 U.S.C. § 1396-1; *see, e.g., Stewart v. Azar*, 366 F. Supp. 3d 125, 138-40 (D.D.C. 2019) (discussing objectives of the Medicaid Act).

⁸ Elizabeth Hinton et al., Kaiser Fam. Found., *10 Things to Know about Medicaid Managed Care* (Oct 29, 2020), <https://bit.ly/3xVUlin>.

time, Congress *did not* eliminate the retroactive coverage requirement, thus recognizing no incompatibility between the two policies.⁹

- If the 1990s demonstrations had led HHS to conclude that repeal of the retroactive coverage requirement would promote Medicaid's purposes, the proper course would have been for HHS to make that recommendation to Congress. HHS did not.
- Today, a number of states administer comprehensive managed care programs without a waiver of retroactive coverage (*e.g.*, CA, IL, NY, OR).

Nevertheless, HHS has repeatedly reauthorized states' retroactive coverage waivers, and it continues to dole out new waivers to states upon request. As of 2021, nearly half of the states have been granted a retroactive coverage waiver at some point. Over this time, these waivers have *not* been treated as experiments, much less time limited ones. The Medicaid and CHIP Payment and Access Commission reports that, of states with these waivers, "none have conducted a formal evaluation of the effects of these policies."¹⁰

Even without the formal study that should accompany any valid experiment, nearly 30 years of experience with these waivers has confirmed that they inevitably produce the following three results:

1. These waivers subvert, rather than promote, the objectives of Medicaid because "restricting retroactive eligibility will, by definition, reduce coverage for those not currently on Medicaid rolls."¹¹
2. These waivers saddle low-income people with medical expenses and debt, undermining the Biden administration's commitment to protecting the financial security of American families.¹² Anyone who qualifies for Medicaid does so because their income is insufficient to meet the costs of medical care, and they certainly cannot afford to meet the costs of unanticipated medical emergencies. Data from New Hampshire show that, in one 16-month period, 4,657 individuals in the Medicaid expansion population benefited from retroactive coverage, which paid for

⁹ 42 U.S.C. § 1396u-2.

¹⁰ Medicaid and CHIP Payment & Access Comm'n, *Medicaid Retroactive Eligibility: Changes under Section 1115 Waivers 2* (Aug. 2019), <https://bit.ly/3sxLJqT>; see also U.S. Gov't Accountability Office, *GAO-18-220, Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures* (2018), <https://www.gao.gov/assets/gao-18-220.pdf>.

¹¹ *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019) (emphasis in original).

¹² The White House, *Fact Sheet: The American Families Plan* (Apr. 28, 2021), <https://bit.ly/3k5F0XA> (recognizing the need to make it "easier for American families to break into the middle class, and easier to stay in the middle class").

more than \$5 million for their medical expenses.¹³ When Indiana received permission to waive retroactive coverage in 2015, HHS required the State to continue to provide some retroactive coverage to parents and caretakers relatives. The State reported that nearly 14% of this group needed retroactive coverage, with the incurred costs averaging \$1,561 per person.¹⁴ This amount of medical debt leaves even those *at the top* of the income cut-off for Medicaid expansion coverage (approximately \$1480/month in 2021) with hard decisions to make when balancing how they will pay for basic necessities and medical bills. Given that nearly three in ten U.S. households have less than \$1,000 in savings and four in ten adults do not have enough savings to cover a \$400 emergency, thousands of dollars' of unexpected costs are simply unaffordable.¹⁵

3. These waivers increase financial burdens for hospitals and other providers who care for low-income people. An Ohio report estimated that waiving retroactive coverage would result in roughly \$2.5 billion more in uncompensated costs for Ohio hospitals over five years, with annual totals of "350,000 to 380,000 [uncompensated] medical claims, adding up to \$470 million to \$510 million a year in lost revenue for providers."¹⁶ Sixteen percent of providers in Indiana experienced increases in the provision of uncompensated care after retroactive coverage was waived.¹⁷ The Iowa Hospital Association noted that a waiver would "place a significant financial burden on hospitals and safety-net providers and reduce their ability to serve Medicaid patients[,] ... and will affect the financial stability of Iowa's hospitals, especially in rural communities."¹⁸

¹³ N. H. Dep't of Health & Human Servs., *Conditionally Approved Waiver of Retroactive Coverage* (Dec. 21, 2015), <https://bit.ly/3ASn5KL>.

¹⁴ Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., to Tyler Ann McGuffee, Insurance & Healthcare Policy Dir., Office of Governor Michael R. Pence (July 29, 2016), <https://bit.ly/3yUYJQ2>.

¹⁵ Natalie Kean, Justice in Aging, *Medicaid Retroactive Coverage: What's at Stake for Older Adults When States Eliminate the Protection?*9 (Sept. 2019), <https://bit.ly/3xX4POz>.

¹⁶ Virgil Dickson, *Ohio Medicaid Waiver Could Cost Hospitals \$2.5 Billion*, Modern Healthcare (Apr. 22, 2016), <http://www.modernhealthcare.com/article/20160422/NEWS/160429965>.

¹⁷ Harris Meyer, *New Medicaid Barrier: Waivers ending retrospective eligibility shift costs to providers, patients*, Modern Healthcare (Feb. 9, 2019), [modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients](http://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients).

¹⁸ Virgil Dickson, *Hospitals Balk at Iowa's Proposed \$37 Million Medicaid Cuts*, Modern Healthcare (Aug. 8, 2017), <http://www.modernhealthcare.com/article/20170808/NEWS/170809906>.

What is more, HHS has implicitly acknowledged the harmful effects of these waivers by requiring states to exempt some populations. For example, the Tennessee waiver approved by HHS on January 8, 2021, replaces a blanket waiver of retroactive coverage with a partial waiver—children and youth under age 21 and pregnant women now have retroactive coverage. This is no reason to applaud. Such approvals breathe new life into tired concepts of worthy and unworthy poor, allowing HHS and willing states to pick and choose which populations are not worthy. It also has serious health equity implications. In Tennessee’s case, for instance, the partial waiver leaves adults with disabilities and chronic conditions exposed, and these are the very people who are likely to have major medical expenses.¹⁹

HHS’s recent justifications for waiving retroactive coverage do not get around these fundamental problems.

Justification #1: Waiving retroactive coverage will align Medicaid coverage with commercial coverage, which does not include retroactive coverage, better preparing individuals for their eventual transition to private coverage. However:

Preparing low-income individuals for commercial coverage is not an objective of the Medicaid program. Congress created Medicaid as a safety-net program that would meet the specific needs of low-income individuals who, right now, cannot afford health care coverage.

Justification #2: Waiving retroactive coverage will incentivize individuals to enroll in Medicaid before the need for care arises, increasing the use of preventive services, and ultimately improving health outcomes. However:

There is no evidence suggesting that low-income individuals decide not to enroll in Medicaid because they are healthy and do not need care. To the contrary, there is evidence suggesting that individuals do not know about Medicaid coverage or how to enroll.²⁰ Since the 1990s, when many of the retroactive coverage waivers were initially approved, Congress has taken a very different approach to incentivizing

¹⁹ Partial waivers modify the wording of section 1396a(a)(34), which on its face extends to all Medicaid enrollees. While some other waiver authorities authorize HHS to “waive or modify” Medicaid Act provisions, section 1115 only authorizes the Secretary to waive them. *Cf.* 42 U.S.C. § 1320b-5 (section 1135 “waive or modify” authority during a national emergency) *with id.* § 1315 (section 1115 “waiver” authority for a time-limited experiment).

²⁰ *See, e.g.,* Jennifer M. Haley & Erik Wengle, Urban Inst., *Many Uninsured Adults Have Not Tried to Enroll in Medicaid or Marketplace Coverage* (Jan. 2021), <https://urbn.is/3yYuAQ0> (noting problems with lack of awareness or understanding of public programs); Julie L. Judson & Asako S. Moriya, *Medicaid Expansion for Adults had Measurable ‘Welcome Mat’ Effects for Their Children*, Health Aff., Sept. 2017, <https://bit.ly/37SadYG> (noting significant increases in Medicaid coverage for previously eligible but not enrolled children).

early enrollment and preventive care. Leaving the retroactive coverage requirement alone, Congress has enacted a variety of measures to encourage prompt Medicaid enrollment—*e.g.*, streamlining eligibility and enrollment and providing additional funding for outreach and enrollment assistance.

Justification #3: Waiving retroactive coverage will enhance fiscal predictability. However:

This rationale boils down to allowing the state to save money by cutting services to low-income people. Florida, for example, predicted that eliminating retroactive eligibility would affect 11,500 Floridians while saving \$104 million in state and federal funds.²¹ As noted, courts have already said that section 1115 is abused when it is used to save money instead of to experiment.

Justification #4: Retroactive coverage should be waived because not many people use it. However:

The estimate from Florida, as well as the highlighted data from New Hampshire and Indiana, show the importance of retroactive coverage for thousands of low-income individuals.

Next Steps

HHS needs to reverse course and stop approving waivers of retroactive coverage. *First*, there are serious questions about whether retroactive coverage is ever waivable under section 1115. Congress established the coverage requirement in two different parts of the Medicaid Act—one of them within the provisions of section 1396a and the other in a provision outside of section 1396a. HHS cannot waive the provision outside of section 1396a, so it should stop letting states ignore it.

Second, even assuming that HHS has the authority to waive retroactive coverage, these waivers do not meet the requirements of section 1115. States are not conducting a genuine experiment that is likely to yield new information and that promotes Medicaid's objectives – namely, furnishing medical assistance (*i.e.*, promoting coverage).

Third, should HHS nevertheless decide that it will not immediately put an end to these sham waivers, then it should commit to phasing them out by refusing to approve any more first-time retroactive coverage waivers (on grounds discussed above) and by limiting a state's request to extend an existing waiver to a one-time extension of no longer than two years to allow a phase-out period. To receive a time-limited extension, the state's waiver extension application and design would, at minimum, need to take steps to minimize and document the coverage loss/harm that will occur by:

²¹ Medicaid and CHIP Payment & Access Comm'n, *supra* note 10.

- announcing the end date for the experiment and making it clear that the waiver will not be renewed;
- establishing baseline data on retroactive coverage and specific data points to be measured and reported on a monthly basis;
- identifying inequities in health status and access among covered populations and articulating how the state will measure the effect of the waiver on inequities—with routine reporting—over the course of the retroactive coverage waiver;
- surveying beneficiaries for quarterly reporting on their experiences during the retroactive coverage waiver; and
- stipulating that the retroactive waiver will automatically be revoked if the state fails to comply with any of these requirements.