



A Guide to Policy Compromises in Recent Section 1115 Waivers

To date, 29 states including the District of Columbia have chosen to close the coverage gap created in their states after the Supreme Court of the United States made the Affordable Care Act's (ACA) Medicaid expansion optional.¹ Five of these states have closed the coverage gap through demonstration waivers authorized by Section 1115 of the Social Security Act which allow states to close the coverage gap in ways that extend outside the traditional Medicaid program.

Because Medicaid expansion is a highly politicized issue, a waiver that allows a state to put its own stamp on Medicaid expansion might be the only politically feasible path to expansion in some states. On the other hand, some waivers have the potential to undo important consumer protections and even undermine the goal of providing coverage to low-income adults by creating financial and other barriers to coverage and care.

It is important to note that there are limits to the flexibility provided in Section 1115 waivers. For example, the waiver must promote the objectives of the Medicaid program, which is to provide health insurance to qualifying low-income people. For more information about the rules governing 1115 waivers, see the Center on Budget and Policy Priority's "[Approved Demonstrations Offer Lessons for States Seeking to Expand Medicaid through Waivers.](#)"

This guide is meant to help prepare advocates for policy compromises that may emerge in their states by providing an overview of notable trends that have appeared thus far in waivers. Trends in state waivers discussed in this guide include:

- Premium Assistance
- Benefit Changes
- Premiums and Cost Sharing
- Healthy Behavior Incentives
- Work-Search Requirements

¹ The Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision*, retrieved from, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

Premium Assistance

Some states are using public funds through Medicaid to help consumers, who would normally be eligible for Medicaid, purchase insurance plans in the Marketplace. A state that chooses a premium assistance model must provide “wrap-around” cost sharing and benefits so that premium assistance beneficiaries have the same benefits and cost-sharing obligations that they would if they were covered directly through Medicaid.²

What can a state do with premium assistance?

Using a waiver a state could make premium assistance mandatory for most individuals with the exception of certain populations, such as people with disabilities or those who are medically frail, who must have the option to enroll in the state’s Medicaid program. However, the Department of Health and Human Services (HHS) has indicated a preference for states focusing premium assistance on the population above 100 percent FPL.³ A state can implement premium assistance without a waiver by electing this option in their Medicaid state plan using a state plan amendment. However, under a state plan amendment, the state must give enrollees a choice between private coverage and coverage through the state’s Medicaid program.

Where has HHS drawn the line?

So far, HHS has approved three premium assistance waivers – two for nearly all newly-eligible individuals, and one focused on newly-eligible individuals above 100 percent FPL. The Centers for Medicare and Medicaid Services (CMS) has stated it will only consider premium assistance proposals that are time-limited through the end of 2016, and that treat enrollees as Medicaid beneficiaries with the same benefit and cost sharing protections.

States Examples

Arkansas: HHS approved premium assistance enrollment for all newly eligible childless adults between 0 percent -138 percent FPL and parents between 17 percent -138 percent FPL, excluding exempt populations.

Iowa: HHS approved premium assistance enrollment for newly eligible adults between 100 percent -138 percent FPL, excluding exempt populations.

New Hampshire: HHS approved premium assistance enrollment for all newly eligible adults between 0 percent -138 percent FPL, excluding exempt populations.

² *Medicaid Expansion Through Marketplace Premium Assistance*, The Kaiser Commission on Medicaid and the Uninsured, September 2013, retrieved from: <http://kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/>

³ *Medicaid and the Affordable Care Act: Premium Assistance*, March 2013 FAQ, retrieved from <http://www.medicare.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>

Impact on Consumers

In theory, individuals enrolled through premium assistance remain Medicaid enrollees and are entitled to all of the benefits and protections that come with a state's Medicaid program. In practice, how well this is enforced will vary from state-to-state based on the design and implementation of their premium assistance program, as well as whether the state applies for a waiver from other important Medicaid protections in its premium assistance program.

For example, how easily can consumers access their wrap-around benefits? Do premium assistance enrollees still have access to the Medicaid appeals process and three months' retroactive coverage from their date of application, or is the state applying to waive those protections? Without proper protections in place, the increased use of premium assistance could turn Medicaid into merely a funding stream for private insurance.⁴

One possible benefit of premium assistance is that it could reduce coverage gaps or "churning" when enrollees switch between Medicaid and the Marketplace. Also, it might simplify coverage for families who have family members in Medicaid as well as the Marketplace by allowing them to enroll in the same plan. A possible drawback is the potential for increased costs to the state because historically Medicaid coverage is less expensive than private coverage.⁵

Benefit Changes

Generally, federal law requires states to provide Medicaid enrollees certain mandatory benefits and allows states to offer other optional benefits. However, the ACA provides states even more flexibility in determining benefits for the newly eligible by requiring individuals in the expansion population to be covered by an Alternative Benefit Plan (ABP), except for exempt populations who must have the option of enrolling in a traditional Medicaid plan. ABPs must include the ACA's 10 essential health benefits, certain mandatory Medicaid services and mental health parity.⁶

What can a state do with benefit changes?

A waiver with benefit changes could allow a state to change benefits beyond what is allowed by the law – for example, to leave out a mandated Medicaid service like non-emergency transportation.⁷ The trend among states seeking waivers from required benefits so far has been in

⁴ *Medicaid Expansion Update: Premium Assistance and Demonstrations*, Health Advocate E-Newsletter of the National Health Law Program, March 2014, retrieved from: <http://www.healthlaw.org/issues/medicaid/medicaid-expansion-toolbox/issues-a-advocacy/health-advocate-march-2014#.U6HX-Ba4ISU>

⁵ Arkansas, in its waiver application, justified the budget neutrality of its premium assistance program based on the claim that the provider rate of reimbursement needed to achieve sufficient access for the new population is equivalent regardless of whether the payer is public or private. However, The Government Accountability Office recently raised cost concerns about Arkansas's premium assistance plan. (<http://www.gao.gov/assets/670/665265.pdf>)

⁶ Herz, Elicia J., *Medicaid: A Primer*, Congressional Research Service, July 2012, retrieved from: http://assets.opencrs.com/rpts/RL33202_20120718.pdf

⁷ *Medicaid Alternative Benefit Plans: What States Should Consider When Designing Coverage for the Expansion Population and the Role for Advocates*, Families USA, November 2013, retrieved from: http://familiesusa.org/sites/default/files/product_documents/alternative-benefit-plans.pdf

the context of premium assistance to circumvent providing services that aren't typically covered by private plans. Because Marketplace plans must cover all EHBs, states are asking for exemptions from the Medicaid-mandated services to avoid providing wrap-around coverage.

Where has HHS drawn the line?

So far, HHS has only approved one-year waivers from providing non-emergency transportation to newly eligible enrollees, with the option for extension. Waivers for other mandatory Medicaid services, such as retroactive coverage and EPSDT have been denied.

State Examples:

Iowa: HHS initially approved a one-year waiver from non-emergency transportation to newly eligible adults, and recently approved an extension of this waiver through July 31, 2015. However, HHS stated that the current data raises concerns about access to care and any subsequent extensions will be based on Iowa's ability to submit data to HHS that demonstrates the waiver does not impact access to care, especially for individuals below 100 percent FPL. HHS denied a waiver from providing early periodic screening, diagnostic and treatment services (EPSDT) to newly eligible 19 and 20 year olds, as well as a waiver from providing free choice of family planning providers.

Indiana: HHS approved a one-year waiver from non-emergency transportation services to newly eligible adults. However, HHS denied Indiana's request to waive EPSDT for 10 and 20 year-olds who failed to make the required contributions to their POWER accounts.

Pennsylvania: HHS denied Pennsylvania's proposal that sought to waive all wrap around benefits, and only approved a one-year waiver from non-emergency transportation to newly eligible adults.

Arkansas: Arkansas sought waiver authority to limit non-emergency transportation to eight trip legs per year for non-medically frail individuals. HHS denied this waiver so Arkansas will instead establish a prior authorization process for newly eligible adults, which does not require waiver authority.

Impact on Consumers

This will be an important area for consumer advocates to watch because any waiver from a required benefit sets a precedent for other states to follow. For example, after HHS approved Iowa's waiver from non-emergency transportation services, HHS approved two more one-year waivers, and Pennsylvania tried to push the line even further by waiving all wrap around benefits. Fortunately, HHS has drawn the line at a one-year waiver with an option for extension, but waiving one benefit opens the doors for other benefits to be tested in future waivers.

As states seek extensions to benefit waivers it's important for advocates to pay particular attention to any evaluation of the effects of waived benefits on consumers. For example, Iowa's evaluation of their first-year waiver from non-emergency transportation shows that there is an unmet need for transportation that affects access to care in Iowa. In Iowa's waiver amendment request it cites that 50 percent of enrollees in the Iowa Wellness program and 37 percent of enrollees in the Medicaid program expressed some level of concern about their ability to pay for transportation to access health care.⁸

Premiums and Cost Sharing

States can impose nominal cost sharing on non-exempt populations for most benefits.⁹ With regard to premiums, states have the flexibility to impose premiums for beneficiaries with incomes above 150 percent FPL, but they are generally prohibited from charging premiums to Medicaid beneficiaries with incomes below 150 percent FPL. For all Medicaid beneficiaries, total premiums and cost-sharing for a family cannot exceed 5 percent of the family's income calculated on either a quarterly or monthly basis.¹⁰

What can a state do with premiums and cost-sharing?

A waiver could allow a state to charge premiums to individuals with incomes below 150 percent FPL. In order to impose higher cost sharing than otherwise allowed under federal law a state must meet separate requirements under a Section 1916(f) waiver. Indiana is the first and only state to receive approval using a 1916(f) waiver to charge higher-than-allowable cost-sharing in the context of a Medicaid expansion waiver.

Where has HHS Drawn the line?

HHS has approved premiums up to 2 percent of an individuals' income for nearly all eligible adults up to 138 percent FPL, as long as beneficiaries below 100 percent FPL do not lose coverage if they fail to pay.

State Examples:

Arkansas: In December 2014, HHS approved a waiver amendment allowing Arkansas to require newly eligible individuals between 50 percent – 138 percent FPL to contribute between \$5 and \$25 monthly into a Health Independence Account to cover copayments and coinsurance. However, individuals below 100 percent FPL cannot be denied services

⁸ *State of Iowa NEMT Waiver Amendment Draft*, Medicaid.gov, retrieved from: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa.pdf>

⁹ *Cost Sharing Out of Pocket Costs*, Medicaid.gov, retrieved from: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Out-of-Pocket-Costs.html>

¹⁰ *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, The Kaiser Commission on Medicaid and the Uninsured, February 2014, retrieved from: <http://kaiserfamilyfoundation.files.wordpress.com/2014/02/8551-the-aca-and-recent-section-1115-medicaid-demonstration-waivers1.pdf>

for failure to pay this contribution.¹¹ In addition, the state recently suspended the practice of collecting contributions from adults with incomes between 50-99 percent FPL.¹²

Iowa: HHS approved a waiver to charge Medicaid managed care enrollees premiums of \$5 per month (50 percent - 100 percent FPL), and premium assistance enrollees \$10 per month (100 percent -138 percent FPL) beginning in 2015. Failure to pay will not result in lost coverage for anyone, and enrollees can apply for a hardship waiver to be exempt from the required premiums. HHS initially approved Iowa's request to terminate coverage for nonpayment for those between 100 percent -138 percent FPL. However, Iowa later amended the terms and conditions of their waiver, so no one will lose coverage for nonpayment of premiums.

Indiana: The approved waiver includes a HIP Plus plan requiring people up to 138 percent FPL to make a monthly payment equal to 2 percent of their income to a "POWER" account, which is an HSA-like account that the state funds beyond the individual's contribution. Individuals between 0 and 5 percent FPL (up to \$589 per year for an individual in 2015) are required to pay \$1.00 per month, and all other newly eligible adults up to 138 percent FPL must contribute 2 percent of their monthly income. For people with incomes above 100 percent FPL failure to make the monthly payment, within a 60-day grace period, results in disenrollment for 6 months. People below 100 percent FPL retain coverage but are switched to the HIP Basic plan. HIP Basic is an option for anyone below 100 percent FPL, which doesn't require monthly payments, but it offers more limited benefits and requires co-pays on all services. Certain exempt populations, such as the medically frail, will not be dis-enrolled or locked out of coverage for failure to make a monthly payment.

Indiana's approved waiver also requires a co-pay of \$25 for non-emergency use of the ER (in both HIP Plus and HIP Basic). Section 1916(f) requires, among other things, that Indiana set up a control group to test the impact of this co-pay.

Michigan: The approved waiver includes monthly premiums up to 2 percent of income¹³ for newly eligible people earning between 100 percent and 138 percent FPL (this is consistent with what they would be required to pay in the Marketplace if the state didn't expand Medicaid). HHS approved a unique co-pay structure here that essentially averages out co-pays for use of services every six months amounting to a monthly payment. Co-pays and premiums are paid through a health savings account, and failure to pay does not result in lost coverage or denied services.

¹¹ *The ACA and Medicaid Expansion Waivers*, The Kaiser Commission on Medicaid and the Uninsured, February 15, 2015, retrieved from: <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.

¹² Arkansas passed legislation to eliminate cost sharing and the Health Independence Account requirements for individuals between 50-99 percent FPL. Ramsey, David, *Hutchinson's Private Option Plan Would Nix Cost-Sharing and Savings Accounts Below Poverty Line*, Arkansas Times, January 2015, retrieved from: <http://www.arktimes.com/ArkansasBlog/archives/2015/01/23/hutchinsons-private-option-plan-would-nix-cost-sharing-and-savings-accounts-below-poverty-line>. See also Jessica Schubel and Judith Solomon; *States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility*, Center on Budget and Policy Priorities, April 9, 2015, retrieved from: <http://www.cbpp.org/files/4-9-15health.pdf>.

¹³ For an individual at 100% FPL (an annual income of \$11,670), 2% of income would amount to \$233.40. A family of four at 100% FPL (an annual income of 23,850) 2% of income would amount to \$477.

Pennsylvania: After the first year, Pennsylvania was approved to charge people above 100 percent FPL premiums up to 2 percent of income.

Impact on Consumers

Research shows that premiums and cost sharing adversely affect low-income and vulnerable populations because they act as a barrier to obtaining and maintaining coverage, particularly for people with significant health care needs.¹⁴ States might use premiums and cost sharing to attempt to lower state Medicaid spending, but any savings will likely be offset by adverse health outcomes that result from barriers to care.¹⁵ Additionally, processing the premiums and cost sharing results is an increased administrative burden on the state. In fact, after Arkansas suspended the practice of collecting cost-sharing charges from adults between 50-99 percent FPL, the state Medicaid agency projected that the administrative costs of the waiver program would be cut in half – from \$12 to \$6 million.¹⁶

The negative impact on consumers could partially be mitigated by factors including the amount of money charged, the impacted population, and how the requirements are enforced. For example, a waiver that provides a hardship exemption from required payments and doesn't result in lost coverage for failure to pay may mitigate some of the negative impact. Alternatively, the foreseeable negative consequences that stem from a 6-month lockout period as in Indiana's waiver have the potential to be catastrophic for people with low incomes.

Healthy Behavior Incentives

Healthy behavior incentives or rewards programs can be used in different ways, but in the context of recent waivers to close the coverage gap healthy behavior is rewarded by reducing or waiving premiums and cost sharing.

State Examples

Indiana: Indiana's approved waiver allows HIP Plus enrollees to rollover unused contributions in their account to apply towards the next year's required contributions, and if the enrollee completes "age and gender appropriate preventive services" the state will double the rollover amount. If HIP Basic enrollees complete the same set of preventative services, then they have the option to rollover up to 50 percent of their unused contributions to offset the next year's required contribution.

¹⁴ The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research and Findings, Center on Budget and Policy Priorities, July 2005, retrieved from: <http://www.cbpp.org/files/5-31-05health2.pdf>

¹⁵ Medicaid Premiums and Cost Sharing, National Health Law Program, March 2014, retrieved from: http://www.nationaldisabilitynavigator.org/wp-content/uploads/resources-links/NHeLP_IssueBriefMedicaidCostSharing_03262014.pdf

¹⁶ Jessica Schubel and Judith Solomon; *States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility*, Center on Budget and Policy Priorities, April 9, 2015, retrieved from: <http://www.cbpp.org/files/4-9-15health.pdf>.

Iowa: Iowa's Healthy Behavior program waives premiums after an annual wellness exam and a health risk assessment. Iowa is currently developing a financial rewards plan for 2015 to further incentivize enrollees to participate in healthy behaviors. These rewards are intended for those who have already received a waiver from premiums to offer rewards such as vouchers or payments for fresh foods, gym memberships, or over the counter medications.

Michigan: The Healthy Michigan Plan reduces co-pays and premiums for an individual after completing a health assessment and annual physical, and co-pays will not be required for certain services that help an individual get or stay healthy, like services that help to manage a chronic condition.

Pennsylvania: The approved waiver offers premium reductions for enrollees above 100 percent FPL who engage in healthy behavior activities. In the first year of the waiver, activities include completing a health risk self-assessment, paying premiums on time, and having a physical exam. The proposal seeks authority to change or expand the list of healthy behaviors in the future.

Impact on Consumers

A substantial body of research shows that financial barriers make it more difficult for low-income individuals to access care, but there is very little evidence that proves rewards or incentives lead consumers to using more preventative services.¹⁷ Factors such as healthy weight or smoking status can be outside of an enrollees' control. Therefore, it is in the consumer's best interest if healthy behavior incentives are tied to process or participation in preventive measures or services, and not rewards or punishments for health improvements.

Recently, Iowa released some early data with respect to their healthy behavior program.¹⁸ According to the state, approximately 15 percent of eligible enrollees completed the wellness exam and the health risk assessment requirements that would absolve them from paying premiums in 2015. Because it was the first year of this program, and because the state didn't begin its outreach about these incentives until midway through the year, it's too early to say if this program will result in better health outcomes for Iowans.

Work-Search Requirements

Work-search requirements tied to Medicaid expansion are not yet a trend in waivers, but the topic has received a lot of attention as states have tried to include such requirements in their waivers.

Where has HHS drawn the line?

HHS has never approved work related requirements for determining eligibility for Medicaid benefits.

¹⁷ *Can Incentives for Health Behavior Improve Health and Hold Down Medicaid Costs?*, Center on Budget and Policy Priorities, June 2007, retrieved from: <http://www.cbpp.org/files/6-1-07health.pdf>

¹⁸ *Iowa Health and Wellness Plan*, Iowa Department of Human Services, February 2015, retrieved from: <https://www.legis.iowa.gov/docs/publications/SD/632296.pdf>

State Examples

Indiana: Indiana's proposal required HIP enrollees who are unemployed or working less than 20 hours per week be referred to the state's workforce training programs and work search resources to connect enrollees with potential employers. HHS did not approve this request, and instead stated that Indiana will make the workforce training programs available to interested individuals. There is no impact on consumers who do not follow up on the state's referral to these programs or resources.

Pennsylvania: Pennsylvania proposed a one-year pilot that would lower cost-sharing obligations and premiums for those who engage in job training and work search opportunities. However, in the final approved waiver, the state is pursuing incentives for job training and work-search through a voluntary program that is separate from Medicaid.

Impact on Consumers

Work-search requirements would act as a barrier to care for low-income individuals for whom the ACA explicitly intended to increase coverage. HHS has never approved a work requirement in Medicaid, and it stated that it doesn't anticipate approving any waiver that bars enrollment of otherwise eligible individuals. Federal law requires states to provide coverage to all eligible individuals, and therefore a state is prohibited from adding restrictions on eligibility, such as a work requirement.

Indiana's work-search referral requirement does not impact the consumer's eligibility or financial obligations, and might be a good middle ground for states where tying work-search activities to Medicaid might help more conservative lawmakers close the coverage gap.¹⁹

Putting the Waiver Pieces Together

It is important for advocates to analyze the individual issues of a state's waiver proposal, and to think about their potential impact on consumers as we have done above. However, it's equally as important to step back and think about the state's waiver application as a whole. For example, advocates should think about the combined impact of a premium assistance model and benefit changes such as a waiver from non-emergency transportation. How will the waiver application as a whole affect things such as participation in the program, access to care, and provider participation? A detailed understanding of the individual issues as well as the impact of the waiver application as a whole will ensure that advocates are in the best position to make informed decisions about their advocacy efforts.

Conclusion

Expanding Medicaid through a waiver can pit two important objectives against one another—closing the coverage gap and preserving important Medicaid protections. This puts consumer advocates in states attempting to close the coverage gap through a waiver in a difficult position. Understanding where HHS has drawn the line in the four waivers that have been approved as

¹⁹ *Medicaid Expansion Work Requirements*, National Health Law Program, October 2013, retrieved from: <http://www.healthlaw.org/issues/medicaid/medicaid-expansion-toolbox/Medicaid-expansion-work#.U6Ng3ha4ISU>

well as keeping a watchful eye on the waivers awaiting approval will help inform your advocacy efforts in your state if closing the gap through a waiver becomes a viable option.

For more information about working with your coalition through waiver compromises, please see [A Guide to Policy Compromises: Preparing Your Coalition to Close the Gap](#).

State-by-State Waiver Status and Trends

	Arkansas <i>(Approved)</i>	Indiana <i>(Approved)</i>	Iowa <i>(Approved)</i>	Michigan <i>(Approved)</i>	New Hampshire <i>(Approved)</i>	Pennsylvania <i>(Approved)</i>
Premium Assistance	✓		✓		✓	
Benefit Changes ²⁰	✓	✓	✓			✓
Premiums ²¹	✓	✓	✓	✓		✓
Healthy Behavior Incentives		✓	✓	✓		✓
Work-Search Requirements ²²						

Authored By,

ASHLEY BLACKBURN, POLICY ANALYST

²⁰ Arkansas and Iowa have both applied for benefit changes through amendments to their approved waivers, but CMS has not yet approved the amendments.

²¹ In this context we are talking about premiums in excess of what federal Medicaid law ordinarily allows. Also, Arkansas has filed an amendment to charge premiums that has not yet been approved by CMS.

²² Indiana's work-search requirement only requires a referral to work-search related services with no impact on eligibility.

Community Catalyst works to ensure consumer interests are represented wherever important decisions about health and the health system are made: in communities, courtrooms, statehouses and on Capitol Hill.

www.communitycatalyst.org