



How Common Medicaid Waiver Provisions Impact People and State Budgets

Expanding coverage to low-income Americans is a core objective of the Affordable Care Act (ACA). States that have accepted federal dollars to expand Medicaid, or “close the coverage gap” have yielded significant benefits to people and state budgets. To date 30 states and the District of Columbia have closed the coverage gap. Most of the remaining, largely conservative, states have yet to do so because of political barriers. For these states, a Medicaid waiver that allows flexibility around covering newly eligible adults may be the only feasible path to expansion.

On the other hand, certain waiver elements have the potential to undermine the goal of providing coverage to low-income adults by undoing important consumer protections and creating financial and other barriers to coverage. By pitting important priorities against one another – closing the coverage gap and preserving Medicaid consumer protections – these waivers put consumer advocates in a difficult position. While some compromise on these issues may be necessary to achieve coverage expansion, advocates should be equipped during waiver negotiations with a thorough understanding of the impacts of commonly proposed waiver provisions.

This paper explores the evidence to date of how beneficiaries and state budgets are impacted by: 1. Premium assistance; 2. Monthly contributions (including Health Savings Accounts); 3. Lockout periods for nonpayment of premiums; 4. Healthy behavior incentives; and 5. Waiving non-emergency medical transportation. For more information on what CMS has approved in the context of Medicaid expansion waivers, see [our companion paper](#). Additionally, [here is the 1-page summary](#) of this paper.

1. Premium Assistance

Premium assistance allows states to use Medicaid funds to purchase private coverage for certain newly eligible Medicaid beneficiaries. States are required to fill in the gaps in benefits and excess cost-sharing between a private plan and Medicaid. Prior to the ACA, premium assistance helped Medicaid enrollees and families with Children's Health Insurance Program (CHIP) beneficiaries purchase coverage. In the context of Medicaid expansion, waivers allow states to enroll many newly eligible adult beneficiaries in premium assistance through Qualified Health Plans (QHPs).¹

Premium assistance’s cost-effectiveness compared to direct Medicaid is uncertain^a

- CMS requires that premium assistance be cost-effective relative to direct Medicaid coverage.² In practice, CMS has permitted states to look at a wide range of the benefits as

^a Costs to the state are difficult to measure because the state share of expansion does not start until 2017 (although initial estimates show that the savings and revenues of expansion often exceed costs). Ultimately, costs will play out differently depending on the state and their marketplace dynamics.

well as the costs of private coverage to measure cost-effectiveness. That is, the “cost-effectiveness” analysis is not just a simple measure of whether the program would cost more money using premium assistance compared with direct Medicaid coverage.³

- Premium assistance is projected to cost 20 to 40 percent more than traditional Medicaid programs.⁴ In Arkansas, even though premium assistance costs per capita remained below projections in 2015,⁵ a lack of available data makes it difficult to compare to the costs of traditional Medicaid expansion.
- Data from the Government Accountability Office on state premium assistance before the ACA showed that only 12 out of 38 premium assistance programs were more cost-effective than direct Medicaid.^b And 13 out of 39 state Medicaid officials cited difficulty in meeting premium assistance cost-effectiveness standards.⁶

Premium assistance’s impact on enrollment and access to care compared to traditional Medicaid has yet to be seen

- Premium assistance’s use of QHPs is speculated to reduce discontinuity of care stemming from churn between the Marketplace and Medicaid by allowing enrollees to keep their plan and providers if they switch between systems.
- Despite a lack of conclusive evidence, higher reimbursement rates through private plans is thought to support increased access to providers.

Private market fluctuations can destabilize premium assistance

CMS requires that at least two QHPs be available in premium assistance. In Iowa, an insurance carrier providing premium assistance pulled out, leaving only one carrier for 2015. Iowa now has transitioned away from premium assistance by allowing beneficiaries 100-138 percent FPL to choose between the remaining silver-level QHP or standard Medicaid managed care.⁷

2. Monthly Contributions

While traditional Medicaid prohibits charging premiums to beneficiaries below 150 percent FPL,⁸ expansion waivers have allowed monthly contributions from individuals as low as 0 percent FPL.^c In some states, monthly contributions are put into Health Savings Accounts (HSAs), which are intended to cover copayments and coinsurance of health care services.

Medicaid monthly contribution requirements reduce coverage and access to care

- In Oregon in 2003, nearly half of the state’s Medicaid beneficiaries below poverty lost coverage when the state increased premiums from \$6 to \$20 per month, imposed cost-

^b Most of the individuals in these programs had family incomes at or below 200 percent FPL. Fewer individuals had family incomes above 200 percent FPL. These programs were mandatory at state option – fewer than half of the premium assistance programs mandated enrollment for eligible individuals. Mandatory enrollment required eligible individuals to enroll in premium assistance if they had access to private health insurance. Individuals who chose not to enroll in premium assistance would not be eligible for direct coverage from the state.

^c Indiana’s expansion waiver allows the state to collect premiums from enrollees as low as 0 percent FPL. Enrollees below 100 percent FPL who do not pay the monthly contribution in Indiana move in to a plan with lesser benefits and higher cost-sharing that does not include a premium.

sharing and created lockout periods for failure to pay. One-third of those who disenrolled remained uninsured 18 months after having lost coverage.⁹

- In 2002, Utah's Medicaid waiver that extended primary care coverage to adults below 150 percent FPL saw a 27 percent drop in enrollment soon after enacting an annual \$50 fee. Of this group, 29 percent of those who disenrolled cited financial barriers to reenrolling in the program. An August 2004 survey revealed that nearly two-thirds of disenrollees remained uninsured.¹⁰
- In Washington, 36 percent of the people in a free, state-funded health insurance program lost coverage after premiums were imposed in 2002. Premiums varied from \$10-\$158 per person for people up to 200 percent FPL.¹¹
- Between 2008-2011, the first Healthy Indiana Plan required enrollees below 200 percent FPL to pay premiums of \$13.33 to \$48 per month per individual (or 2-4 percent of income). 17 percent of those eligible could not pay their initial premium (69 percent of these had incomes below the poverty line), while 12 percent were disenrolled over the course of time for failing to pay the monthly contributions.¹²

Medicaid monthly contributions can be especially punitive if paired with lockout periods for failure to pay, which we explore in the next section.

Medicaid premiums and HSAs are neither cost-effective nor popular among consumers

- For every \$1 raised in cost-sharing in Medicaid, states will spend more in administrative expenses (\$2.77 in Arizona¹³ and \$1.39 in Virginia).¹⁴ Arizona's Medicaid agency's fiscal impact study showed that it would cost the state about \$15.8 million to collect proposed premiums and cost-sharing charges while raising only about \$2.9 million in premiums and \$2.7 million in co-pays.¹⁵
- Because of the high administrative cost to maintain tens of thousands of individual HSAs with very small contributions, Arkansas decided to eliminate the HSA requirement for enrollees below poverty. Doing so saved \$6 million.¹⁶
- A report in Arkansas found that of the HSAs that were kept in place for enrollees above 100 percent FPL, only one in four of the accounts had been activated by June 2015.¹⁷

3. Lockout periods for failure to pay

States that charge monthly contributions for Medicaid must offer a 60-day grace period before cancelling coverage for beneficiaries who do not make a payment. In traditional Medicaid, states cannot lock beneficiaries out of coverage for failure to pay past the grace period nor can they require repayment of outstanding amounts in order to re-enroll.^d However, Medicaid waivers permit use of lockout periods, barring reenrollment in Medicaid for a specified period of time as a penalty for missed payment during the grace period (triggered upon the first missed payment). To date, only one state that has closed the coverage gap through a waiver is using a lockout period for enrollees above poverty level.

Lockout periods cause enrollees to lose coverage and experience unmet medical needs

^d Traditional Medicaid programs that require monthly contributions prohibit states from locking beneficiaries out of coverage or making them repay outstanding amounts in order to re-enroll. See 42 CFR 447.80. <https://www.law.cornell.edu/cfr/text/42/447.80>

- In the first Healthy Indiana Plan, 12 percent of enrollees who failed to pay premiums were locked out and became uninsured over the entire five year demonstration (they never reenrolled or found other sources of coverage). Most were below poverty level.¹⁸
- In 2003, Oregon introduced stricter payment policies and a six-month lockout period for enrollees up to 100 percent FPL that caused 72 percent of enrollees who lost coverage to remain uninsured and experience unmet needs for medical care.¹⁹
- In 2002, when Rhode Island imposed premiums and lock-out periods for the state's Medicaid program for low-income children, parents, and pregnant women, the end result was that within three months 18 percent of families subject to premiums were locked out of the program for non-payment. Half of those locked-out became uninsured indefinitely after losing coverage.²⁰

Lockout periods created barriers to preventive care and lead to downstream costs

- People who lost coverage on Oregon Medicaid in 2003 because of increased premiums and strict lockout policies were three times as likely to lack a usual source of care, more likely to skip filling a prescription and four to five times more likely to use the ER as a usual source of care than people who remained enrolled.²¹

4. Waiving Non-emergency Medical Transportation

Medicaid provides a mandatory non-emergency medical transportation (NEMT) benefit that pays for the least costly and most appropriate way of getting people to their appointments. Several states have received one-year waivers from covering NEMT for the expansion population.

Transportation barriers lead to delayed or missed care and medication use

- An evaluation of Iowa's first year of waiving NEMT showed that 28 percent of enrollees reported that cost of transportation to a health care visit was somewhat or a great deal concerning. Also, 20 percent of enrollees reported not being able to access transportation to or from a health care visit.^{22, 23}
- Limits put on Indiana's NEMT program in 1994 correlated with a 16 percent decline in primary care visits and an 18 percent fall in medication refills.²⁴
- Several studies on Medicaid and non-Medicaid populations cite transportation barriers as a reason for missed or rescheduled appointments.²⁵ For instance, two studies found that 25 percent of lower-income patients have missed or rescheduled their appointments due to lack of transportation.

NEMT could help individuals avoid costly ambulance trips or ER visits

- Cutting NEMT may not save as much money as policymakers expect, because more patients may miss important preventive care, increasing costs elsewhere in the health care system. In fact, NEMT has been shown to be either cost-effective or cost-saving²⁶ among beneficiaries with one or more of 12 major health conditions.²⁷
- While NEMT makes up less than 1 percent of total Medicaid expenditures, emergency room visits are 15 times the cost of routine transportation.²⁸ Another estimate calculates \$11 saved for up to each dollar spent on NEMT if 1 percent of total medical trips resulted in avoiding an emergency room visit.²⁹

5. Healthy Behavior Incentives

Healthy behavior incentives largely aim to target individual behaviors with a goal to improve health and hold down health care costs. These incentive programs have had a transient presence in state Medicaid programs over the years. Some states are using Medicaid expansion waivers to reduce or eliminate cost-sharing and/or premiums for beneficiaries who participate in certain wellness programs, such as a health risk assessment or wellness examination.

The effects of healthy behavior incentives are limited

- In general, healthy behavior incentives can be effective for simple interventions, including doctor visits, vaccinations, screenings and prevention services. Incentives targeting more complex and long-term lifestyle behaviors such as smoking and weight management can help motivate initial positive behaviors, but these effects diminish over time.³⁰
- In Idaho, a 2007 preventive health incentive program significantly improved the proportion of children in CHIP who were up-to-date with well-child visits. At about the same time, a healthy behavior program targeting weight management and tobacco cessation yielded little impact – only 1,422 of about 185,000 beneficiaries participated after two years.³¹

Beneficiaries generally have low levels of awareness of healthy behavior programs

- In Iowa's first year of expansion, less than 30 percent of enrollees were aware of the physical exam incentive.³²
- In 2004, an incentive program in California Medicaid managed care for wellness visits showed that only 3,000 of 145,000 adolescents and 2,000 of 56,000 parents who qualified redeemed rewards. Managed care plans reported that beneficiaries did not know about or understand the incentives and that the incentive program was labor intensive.³³
- In 2006, Florida's Medicaid program offered rewards to purchase health related products produced a low return rate. In two months, 57,000 beneficiaries earned \$2.3 million in credits, but only 2,000 beneficiaries collected \$50,000 of these credits. The state spent over \$1.1 million to administer the program.³⁴

Conclusion

While the full effects of current Medicaid expansion waiver demonstrations has yet to be evaluated, examining similar Medicaid waiver elements throughout the years can illuminate how they impact people and state budgets. While a waiver with some of these compromises may be the only politically feasible path to closing the gap, advocates can weigh in during the waiver process to minimize any barriers to coverage and care.

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