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The ACA and Medicaid Expansion Waivers

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Executive Summary

Under the Affordable Care Act (ACA), Medicaid plays a key role in efforts to reduce the number of uninsured by expanding eligibility to nearly all low income adults with incomes at or below 138% of the federal poverty level (FPL, \$16,242 per year for an individual in 2015) with full federal financing for the first three years, gradually decreasing to 90% federal funding; however, the Supreme Court ruling on the ACA's constitutionality effectively made the expansion a state option. According to CMS guidance, states cannot receive the enhanced federal funding for the ACA expansion unless they cover all newly eligible adults through 138% FPL; enrollment caps also are not permitted. As of November 2015, 31 states including DC have adopted the expansion, and nearly all are implementing the expansion as set forth by the law. A limited number of states have obtained or are seeking approval through Section 1115 waivers to implement the expansion in ways that extend beyond the flexibility provided by the law. In some cases, alternative models to implement expansion through waivers are seen as a politically viable way to extend coverage and capture enhanced federal matching funds for newly eligible adults. This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA and highlights key themes in these waivers as well as highlights provisions that CMS has turned down.

To date, six states are currently implementing or planning to implement the Medicaid expansion through an approved Section 1115 Waiver ([Arkansas](#), [Iowa](#), [Michigan](#), [Indiana](#), [New Hampshire](#), and [Montana](#)). New Hampshire will transition from a state plan amendment to a waiver in January, 2016, and expansion coverage in Montana will be effective in January, 2016. [Pennsylvania](#) had received waiver approval to implement the Medicaid expansion, but transitioned from a waiver to a state plan amendment in mid-2015, so Pennsylvania is not included in the discussion of current and pending waivers.

Two states currently have waiver proposals pending with CMS. Arizona implemented the expansion, but now has a waiver application pending with CMS seeking changes based on state law. Michigan has a pending waiver amendment seeking changes required by state law to continue its expansion after April 2016 (Table 1).

While the waivers are each unique, they include some common provisions. Common provisions approved to date include implementing the Medicaid expansion through a premium assistance model; charging premiums; eliminating non-emergency medical transportation, an otherwise required benefit; and using healthy behavior incentives to reduce premiums and/or co-payments. Indiana's waiver approval included provisions that had not been approved in other states. These include allowing the state to waive retroactive

eligibility (which was also later approved in New Hampshire); to make coverage effective beginning on the date of the first premium payment, rather than on the date of application; and to bar certain expansion adults from re-enrolling in coverage for six months if they are dis-enrolled for unpaid premiums (a lock-out of up to three months for certain expansion adults was later approved in Montana). In addition, under separate waiver authority (§1916(f)), Indiana received approval to charge higher cost-sharing than otherwise allowed under federal rules for non-emergency use of the emergency room. Also unique among the expansion waivers to date, Montana received approval to implement 12-month continuous eligibility for new adults to reduce the effects of churning between Medicaid and Marketplace coverage due to small changes in income (Table 1).

Table 1: Key Themes in Approved and Pending ACA Expansion Waivers

Waiver Provision	Approved Waivers						Pending Waivers	
	AR	IA*	MI	IN*	NH*	MT	MI*	AZ
Premium Assistance	QHP	ESI		ESI	QHP		QHP	
Premiums / Monthly Contributions	X	X	X	X		X	X	X
Healthy Behavior Incentives		X	X	X			X	X
Waive Required Benefits (NEMT)		X		X				X
Reasonable Promptness				X				
Waive Retroactive Eligibility				X	X			
Co-payments Above Statutory Limits				X			X	X
12-Month Continuous Eligibility						X		
Time limit on Coverage							X	X
Work Requirement								X

NOTES: * New Hampshire will transition from a SPA to a waiver in 2016. Cost-sharing waiver approved in IN under Section 1916(f), not Section 1115. IA has approval for mandatory QHP enrollment with premium assistance for new adults from 101-138% FPL but has a waiver amendment pending to instead require mandatory Medicaid managed care due to the loss of both QHPs. MI's pending amendment would apply to beneficiaries from 101-138% FPL after 48 months of coverage; MI's state legislation requires the Medicaid expansion to end on 4/30/16 if the new provisions are not approved by 12/31/15. PA transitioned from a waiver to a SPA in 2015 (so it is not included in the table).

SOURCE: KCMU analysis of waiver proposals.

CMS has denied a number of provisions included in Section 1115 Waiver proposals. CMS has denied waiver authority to include premiums for individuals with incomes under 100% FPL as a condition of eligibility; requirements to omit wrap-around benefits for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and free choice of family planning provider; and work requirements or incentives as a condition of Medicaid eligibility.

Looking ahead, additional states may consider waivers to implement or modify the expansion.

There is no deadline for states to participate in the Medicaid expansion and moving into the legislative sessions for state fiscal year 2017, other states continue to explore opportunities to implement the Medicaid expansion. In addition, states may also consider using the new state innovation waiver authority (Section 1332) available in 2017, which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid and CHIP waivers, although no state has yet released such a proposal.

Particularly as waiver designs become increasingly more complex, studying and assessing the effects of key waiver provisions will help inform policymakers about whether such policies can be effectively administered and whether beneficiaries understand the policies. Among the issues and waiver provisions to be studied are using Medicaid as premium assistance to purchase Marketplace coverage; imposing premiums and cost-sharing above federal limits; offering healthy behavior incentives; limiting non-emergency medical transportation; and adopting a mix of provisions in different waivers that interrupt, delay or extend effective coverage dates. It will be important to study these provisions for their impact on beneficiary access to care and in comparison to the Marketplace experience that people above poverty would face if their state did not expand Medicaid. The ACA's waiver transparency regulations require states to have a publicly available, approved evaluation strategy, and a federal contract has been awarded to evaluate a number of Section 1115 waivers.

Ensuring that evaluations are timely and that findings are publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences. As more states seek waivers to implement the expansion, what we learn from their experiences will help inform the future direction of coverage for low-income adults and families. CMS, states, and other stakeholders will continue to navigate the balance between state waiver requests in an effort to reduce the number of uninsured adults while preserving key beneficiary protections and requirements in the Medicaid program.

Introduction

To date, the majority of the 31 states (including DC) that have adopted the ACA's Medicaid expansion¹ have done so under the existing rules and options provided by the Medicaid program. However, a small number of states have obtained Section 1115 waiver approvals to implement the expansion in ways that extend beyond the flexibility already provided by federal law,² and additional states are considering waiver approaches to adopt the expansion. This brief provides an overview of the role of Section 1115 waivers in expanding coverage since the enactment of the ACA and key themes in recently approved and proposed coverage expansion waivers. Detailed summaries of approved and proposed waivers are available at www.kff.org.

Context for Understanding Expansion Waivers

Prior to the enactment of the ACA, a number of states used Section 1115 waivers to expand coverage to childless adults, who could not otherwise be covered under federal rules. Because Section 1115 waivers must be budget neutral for federal spending, according to long-standing federal policy,³ states could not receive additional federal funds to expand coverage to these adults and, as such, needed to redirect existing federal funds or find offsetting program savings to finance such coverage.

The ACA eliminates the historic exclusion of adults without dependent children from Medicaid and provides significant federal funding for states to expand coverage. The federal government is funding 100% of the cost of covering newly eligible adults for the first three years of the expansion, gradually phasing down to 90% by 2020 and beyond. The 90% match is significantly higher than the traditional Medicaid matching rate that ranges from a floor of 50% to a high of 73% based on a state's relative per capita income.

In states that do not expand Medicaid, many adults will fall into a “coverage gap” because they have incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits. Because the ACA envisioned low-income people receiving coverage through Medicaid nationwide, it does not provide financial assistance to people below poverty for other coverage options. However, the Supreme Court's ruling on the ACA's constitutionality effectively made the expansion a state option. In states that do not implement the Medicaid expansion, Medicaid eligibility for adults remains quite limited.

The ACA's Medicaid expansion eliminates the need for a state to obtain a Section 1115 waiver to cover childless adults, but a small number of states have still used Section 1115 waivers to implement the Medicaid expansion in ways that differ from options provided to states under federal law. CMS has issued guidance that establishes some parameters for such waivers. Through this guidance, CMS has indicated that states cannot receive the enhanced federal funding available for newly eligible adults unless they implement the full expansion to cover all newly eligible adults through 138% FPL; it also will not approve enrollment caps for the adult expansion group. CMS indicated it will approve a limited number of premium assistance waivers to test the use of Medicaid funds to purchase Marketplace coverage for the Medicaid expansion population, subject to certain requirements.

The ACA makes Medicaid expansion waivers subject to new rules about transparency, public input and evaluation. In February, 2012, the Department of Health and Human Services (HHS) issued new regulations that require public notice and comment periods at the state and federal levels before new Section 1115 waivers and extensions of existing waivers are approved by CMS.⁴ The terms and conditions of Michigan and Montana’s expansion waivers also require public notice and comment for waiver amendments;⁵ this process has been followed for Michigan’s pending amendment request, which seeks significant changes to its demonstration pursuant to state law.

The waiver transparency regulations also require states to have a publicly available, approved evaluation strategy and to submit an annual report to HHS that includes, among other things, a description of the changes occurring and their impact on outcomes, quality, and access; beneficiary satisfaction surveys; grievance and appeals data; financial data; and audits. A federal contract has been awarded to evaluate a number of Section 1115 waivers (related to the ACA Medicaid expansion as well as other demonstration waivers). CMS released its first report to Congress as required under the ACA outlining how it has complied with the transparency rules in its review and approval of Section 1115 waivers.⁶

A Look at Medicaid Expansion Waivers Post 2014

A few states have sought Section 1115 waivers to implement the Medicaid expansion, in part because they could not otherwise secure political support to expand coverage. To date, CMS has approved waivers to implement the Medicaid expansion in seven states ([Arkansas](#), [Iowa](#), [Michigan](#), [Pennsylvania](#), [Indiana](#), [New Hampshire](#), and [Montana](#)). Arkansas, Iowa, Michigan, and Indiana are currently operating their expansions through a Section 1115 waiver. New Hampshire will transition from state plan authority to a waiver as of January, 2016. Montana’s expansion coverage will take effect in January, 2016. Pennsylvania had a waiver approved but transitioned to state plan authority in mid-2015, and is not included in the discussion of current and pending waivers.

Two states have waivers pending with CMS (Arizona and Michigan). Arizona implemented the expansion in 2014, but now has a waiver application seeking changes to its expansion required by state law.⁷ Michigan has a waiver amendment pending with CMS seeking changes for new adults from 101-138% FPL after 48 months of coverage, and state law requires approval to continue the expansion beyond April 2016. Governors in [Utah](#) and [Tennessee](#) negotiated expansion waiver proposals with CMS, but waiver applications have not yet been submitted and plans were not approved by state legislatures. In a special session in early February, 2015, the legislature in Tennessee rejected the Governor’s expansion plan. In Utah, the UtahAccess+ plan only was able to garner seven of 63 House Republicans’ votes to support the plan in mid-October, 2015. However, a legislative committee continues to debate expansion.

Each of the approved and pending expansion waivers is unique, but there are some common themes across the waivers. The following sections examine waiver provisions that have been approved and denied by CMS to date. Table 1 summarizes the key provisions in the approved and pending waivers.

Table 1: Key Themes in Approved and Pending ACA Expansion Waivers

Waiver Provision	Approved Waivers						Pending Waivers	
	AR	IA*	MI	IN*	NH*	MT	MI*	AZ
Premium Assistance	QHP	ESI		ESI	QHP		QHP	
Premiums / Monthly Contributions	X	X	X	X		X	X	X
Healthy Behavior Incentives		X	X	X			X	X
Waive Required Benefits (NEMT)		X		X				X
Reasonable Promptness				X				
Waive Retroactive Eligibility				X	X			
Co-payments Above Statutory Limits				X			X	X
12-Month Continuous Eligibility						X		
Time Limit on Coverage							X	X
Work Requirement								X

NOTES: * New Hampshire will transition from a SPA to a waiver in 2016. Cost-sharing waiver approved in IN under Section 1916(f), not Section 1115. IA has approval for mandatory QHP enrollment with premium assistance for new adults from 101-138% FPL but has a waiver amendment pending to instead require mandatory Medicaid managed care due to the loss of both QHPs. MI’s pending amendment would apply to beneficiaries from 101-138% FPL after 48 months of coverage; MI’s state legislation requires the Medicaid expansion to end on 4/30/16 if the new provisions are not approved by 12/31/15. PA transitioned from a waiver to a SPA in 2015 (so is not included in the table).

SOURCE: KCMU analysis of waiver proposals.

WAIVER PROVISIONS APPROVED BY CMS

PREMIUM ASSISTANCE

Three states have received approval to implement the Medicaid expansion through a premium assistance model using mandatory enrollment in private coverage through Marketplace plans (Arkansas, Iowa, and New Hampshire). According to guidance released by CMS, it will approve a limited number of waivers to allow states to use Medicaid funds to purchase coverage for some or all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs) as a “private approach” to expansion. States can implement premium assistance programs without a waiver, subject to certain rules. Arkansas, Iowa, and New Hampshire received waivers to allow them to mandatorily enroll beneficiaries in premium assistance. In Arkansas, all newly eligible adults are enrolled in premium assistance,⁸ and as of January, 2016, all newly eligible adults in New Hampshire will be enrolled in Marketplace premium assistance.⁹ In Iowa, only newly eligible adults with incomes from 101 to 138% FPL were enrolled in premium assistance; however, due to the loss of both Marketplace QHPs, Iowa is transitioning these beneficiaries from Marketplace premium assistance to mandatory capitated Medicaid managed care organizations.¹⁰ These states indicate that they are using

premium assistance to test how private coverage works for Medicaid beneficiaries and whether enrolling beneficiaries in Marketplace coverage will increase provider access and reduce churn between Medicaid and Marketplace coverage due to income fluctuations.

Some states also have included premium assistance for beneficiaries with access to employer-sponsored insurance (ESI). ESI premium assistance is required in Iowa and optional in Indiana.

PREMIUMS AND/OR MONTHLY CONTRIBUTIONS

CMS has approved waivers that allow states to charge premiums or require monthly contributions primarily for expansion adults with incomes from 101-138% FPL. Under federal law, Medicaid beneficiaries with incomes below 150% FPL (\$17,655 per year for an individual in 2015) cannot be charged premiums. Premiums in the Medicaid program are limited because a large body of research shows that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for people with low incomes.¹¹ Five of the approved expansion waivers (Arkansas, Iowa, Michigan, Indiana, and Montana) allow the states to impose premiums and/or monthly contributions for newly eligible beneficiaries with incomes between 101-138% FPL. These premiums (equal to about 2% of income) are about the same level as those allowed for individuals at these incomes who are eligible for tax credits to purchase coverage through the Marketplace in states not expanding Medicaid.

Arkansas received waiver approval to require certain non-medically frail beneficiaries to make monthly income-based contributions to health savings accounts (HSAs) to be used for co-payments and co-insurance in lieu of paying at the point of service and is currently implementing this provision for those from 101-138% FPL. Co-payment rates are at state plan amounts.

Michigan's waiver provides for monthly premiums of 2% of income for beneficiaries from 101-138% FPL as well as monthly payments into HSAs based on their prior six months of co-payments for services used. The co-payments are based on state plan amounts and not changed from what would have been collected without the waiver.

Iowa has waiver authority to impose premiums of \$10 per month for non-medically frail beneficiaries from 101-138% FPL beginning in the second year of enrollment. Iowa beneficiaries only incur co-payments for non-emergency use of the emergency room (at state plan amounts). In Indiana, monthly premiums of 2% of income are paid into HSAs, and individuals who make these payments do not face point of service co-payments (other than for non-emergency use of the ER, discussed below).

In Montana, beneficiaries are subject to monthly premiums of 2% of income. Beneficiaries receive a credit in the amount of their premiums toward co-payments incurred so that they effectively only have to pay co-payments that exceed 2% of income.

Among states with waiver applications pending with CMS, Arizona proposes monthly premiums of 2% of income or \$25, whichever is less, for all new adults. In addition, Arizona proposes co-payments at state plan amounts up to 3% of income, which would be paid monthly into HSAs for services already used instead of at

point of service.¹² Arizona also seeks waiver authority to impose co-payments in excess of federal limits for non-emergency use of the emergency room and missed appointments, discussed below.

Michigan's pending waiver amendment creates two options for beneficiaries from 101-138% FPL who have been enrolled in waiver coverage for 48 cumulative months: transfer to Marketplace QHP coverage with Medicaid premium assistance and cost-sharing subsidies, or continue to receive coverage through Medicaid managed care but with premiums increased to 3.5% of income, which exceeds the 2% Marketplace premiums for people at that income level, and total cost-sharing (including premiums and co-payments) increased to 7% of income, which exceeds the federal Medicaid limit of 5% of income.

The consequences of non-payment of premiums for adults with incomes above poverty vary across states, but two states (Indiana and Montana) have approval to impose a lock-out for beneficiaries dis-enrolled due to unpaid premiums. Indiana's waiver allows the state to impose a six month lock-out period for non-medically frail individuals above poverty who are dis-enrolled due to unpaid premiums after a 60-day grace period. Individuals who never make their initial premium payment are not subject to the 6-month lock-out. In Montana, beneficiaries above poverty can be dis-enrolled for non-payment of premiums after notice and a 90-day grace period and can re-enroll upon payment of arrears or after the debt is assessed against their state income taxes, no later than the end of the calendar quarter. Re-enrollment in Montana does not require a new application, and the state must establish a process to exempt beneficiaries from dis-enrollment for good cause.

In Arkansas and Michigan, payment of premiums or monthly contributions is not a condition of eligibility. In Arkansas, beneficiaries from 101-138% FPL who fail to make monthly HSA contributions are responsible for Medicaid state plan level co-payments and co-insurance at the point of service, and providers can deny services for failure to pay cost-sharing. Arkansas beneficiaries will incur a debt to the state but can self-attest to financial hardship if their accounts have insufficient funds to cover co-payments for services used. Michigan beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay co-payments or premiums. In Iowa, beneficiaries have a 90-day grace period to pay past-due premiums in full before they are dis-enrolled from Medicaid, and the state must waive premiums for beneficiaries who self-attest to financial hardship; in addition, individuals in Iowa can re-enroll at any time.

Among states with pending waivers, Arizona has proposed a provision similar to Indiana's, where beneficiaries from 101-138% FPL would be dis-enrolled and locked out of Medicaid eligibility for 6 months for non-payment of monthly premiums and co-payments.

In Arkansas, Iowa, Indiana, and Montana, the waivers allow the states to collect monthly contributions from individuals below poverty; however, failure to pay these amounts cannot result in the termination of Medicaid coverage. Arkansas's waiver authority for monthly HSA contributions in lieu of co-payments at the point of service extends down to 50% FPL, but Arkansas currently is not implementing this provision for those with incomes below poverty. In Iowa, the waiver allows the state to impose monthly contributions of \$5 per month for non-medically frail beneficiaries with incomes between 50-

100% FPL beginning in year two; however, Medicaid eligibility cannot be terminated for non-payment of premiums for beneficiaries at or below 100% FPL.

The waiver in Indiana imposes monthly contributions at 2% of income to a HSA for most eligible (new eligible as well as parents who were eligible before the ACA with an exception for the medically frail) with incomes between 0-138% FPL. Those with incomes between 0-5% FPL (up to \$589 per year for an individual in 2015) must pay \$1.00 per month. If individuals with incomes at or below poverty do not pay the monthly HSA contributions, they receive a less generous benefit package and must pay co-payments at point of service. Montana has waiver authority to charge premiums at 2% of income down to 50% FPL. These beneficiaries cannot be dis-enrolled for non-payment of premiums and receive a credit toward incurred co-payments so that they effectively only pay out-of-pocket for co-payments that exceed 2% of income.

In Arizona's pending waiver, beneficiaries from 0-100% FPL would not lose Medicaid eligibility for non-payment of premiums and co-payments but would have any unpaid amounts counted as a debt to the state.

In Indiana, the waiver allows the state not to begin coverage until the first premium is paid.

Coverage in Indiana begins the first day of the month in which a beneficiary pays a premium, instead of the date of Medicaid application, which required a waiver of the state's obligation to provide Medicaid benefits with "reasonable promptness."¹³ Individuals from 101-138% FPL who do not make a premium payment are not enrolled in coverage. Those from 0-100% FPL who do not make a premium payment within 60 days are enrolled in a more limited benefit package and subject to co-payments at the point of service (the medically frail below poverty would not move to a more limited benefit package but would be subject to co-payments at point of service). Indiana's waiver also includes Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Community Mental Health Centers (CMHCs), and health department sites in an expanded presumptive eligibility program. Presumptive eligibility enables applicants to receive Medicaid-covered services as of the date that a qualified provider entity preliminarily determines that the applicant is eligible for Medicaid, while the final determination is pending. To maintain the reasonable promptness waiver, the state must make final eligibility determinations for a certain percentage of presumptively eligible applicants (out of eligibility determinations made on all types of applications).

HEALTHY BEHAVIOR INCENTIVES

CMS has approved the use of healthy behavior incentives to reduce or eliminate beneficiaries' out-of-pocket expenses. The waivers in Iowa, Michigan, and Indiana all include healthy behavior programs. Under these waivers, individuals who complete specified healthy behaviors will have their premiums and cost sharing waived or reduced. Separate protocols must be approved by CMS to implement these healthy behavior programs. The protocols are required to: (1) specify the types of healthy behaviors (such as health risk assessments); (2) include a diverse set of behaviors as well as a strategy to measure access to providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives; (3) engage stakeholders and the public in developing the healthy behavior standards; (4) show how healthy behaviors will be tracked and monitored at the enrollee and provider level; (5) include a beneficiary and provider education strategy; and (6) include the methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

In Iowa, beneficiary premiums are not charged for the first year of enrollment. In subsequent years, premiums are not charged if beneficiaries complete specified healthy behavior activities. In the first year of Iowa's healthy behavior program, these include completing an online health risk assessment and obtaining a wellness examination. Iowa has retroactively broadened the definition of a qualifying wellness exam to allow providers to choose a routine medical exam in lieu of a more comprehensive annual physical, depending on the beneficiary's individual needs. Iowa also offers enhanced dental benefits if beneficiaries have periodic dental exams. In 2015, Iowa determined that it needed to conduct additional research before submitting a protocol to CMS to implement its year two healthy behavior program.

In Michigan, demonstration beneficiaries can have monthly cost-sharing payments that exceed 2% of income reduced through compliance with healthy behaviors. Michigan's waiver amendment proposes increasing this threshold to 3% of income. Indiana beneficiaries can reduce their premiums to 1% of income if they make timely payments and comply with healthy behaviors.

Arkansas does not have a healthy behavior program but if six HSA payments are made in a year, beneficiaries will be awarded account credits for future QHP, ESI, or Medicare premiums after they are no longer eligible for Medicaid.

Arizona proposes that beneficiaries from 101-138% FPL could reduce monthly payments if they comply with healthy behaviors and work incentives and make timely payments; Arizona beneficiaries also could use their HSA payments to fund specific non-covered services.

WAIVERS OF BENEFITS

CMS has approved limited waivers of non-emergency medical transportation (NEMT), an otherwise required Medicaid benefit. In implementing the ACA, states have considerable flexibility in determining benefits packages for those newly eligible for coverage by the ACA's Medicaid expansion. States must cover the ten ACA-required Essential Health Benefits (EHBs) along with certain other mandatory Medicaid services. States also must meet mental health parity requirements. Beyond these requirements, states have flexibility to choose a benchmark plan for coverage that may include one of several specified private insurance options or "Secretary-approved coverage," which can include a state's current Medicaid benefit package for adults. However, some states have sought waiver approval for greater flexibility in the provision of benefits.

Iowa was the first state to receive approval to waive NEMT for newly eligible adults. The original NEMT waiver applied through December 31, 2014, and extension is conditioned on an evaluation of the waiver's impact on beneficiary access to care. In December 2014, CMS approved a waiver amendment extending the NEMT waiver through July 1, 2015, while noting that Iowa had submitted preliminary data that "raised concerns about beneficiary access[,] particularly for those with incomes below 100 percent of the FPL."¹⁴ In July, 2015, CMS extended the NEMT waiver through March, 2016, although data from a fall 2014 beneficiary survey show that beneficiaries without NEMT are more likely than those with NEMT to need assistance to travel to a health care visit. CMS has directed Iowa to collect additional data if it seeks a further extension of this waiver. Iowa provides NEMT to beneficiaries who are medically frail and those under age 21.

Indiana was also allowed to waive NEMT for most newly eligible adults for one year, to be extended based on the results of an evaluation assessing the impact on access to care. Arkansas had sought waiver authority to limit NEMT to 8 trip legs per year for non-medically frail beneficiaries, but instead, the state established a prior authorization process for NEMT for newly eligible adults (a change that does not require waiver authority). Arizona's pending application seeks a one year waiver of NEMT for those from 101-138% FPL.

The Indiana waiver allows for different benefit packages for individuals below poverty who do not pay premiums. Under the Indiana waiver, newly eligible adults from 0-138% FPL who pay monthly premiums receive an expanded benefit package, which includes the ACA's essential health benefits and adult dental and vision benefits. Newly eligible adults at or below 100% FPL who do not pay premiums receive a more limited benefit package, which includes the ACA's essential health benefits but no vision or dental coverage. The more limited benefit package includes all EPSDT services for 19- and 20-year-olds, consistent with federal law.

WAIVERS OF COVERAGE PERIODS

Two states have been granted time-limited waivers of retroactive eligibility, which limit the period during which beneficiaries otherwise would be eligible for Medicaid under federal law. Federal law extends coverage to medical bills incurred for three months prior to the month of application, if the individual would have been eligible during the retroactive period.¹⁵ Indiana was granted a one-year waiver of retroactive eligibility, and New Hampshire has a conditional one-year waiver of retroactive eligibility after CMS reviews state data to determine that there are no gaps in coverage.

In a different vein, Montana has waiver authority to provide 12-month continuous eligibility for all newly eligible adults, which seeks to stabilize coverage over time.¹⁶ Under the ACA, all states must conduct Medicaid eligibility renewals once every 12 months. States can further support stable coverage and reduce churn resulting from small fluctuations in income by opting to provide 12-month continuous eligibility, which allows beneficiaries to remain enrolled for a full year regardless of changes in circumstances. This policy is available as a state plan option for children, and as of January, 2015, 23 states have implemented this option in their Medicaid programs.¹⁷ Waiver authority is required to adopt 12-month continuous eligibility for adults. New York has an approved Section 1115 waiver to test the effects of 12-month continuous eligibility for adults on stability and continuity of coverage and care.¹⁸

COST-SHARING WAIVERS

Indiana has received approval to impose cost-sharing in amounts greater than those allowed under federal law under separate Section 1916(f) authority. Section 1115 waiver authority does not extend to Medicaid cost-sharing requirements. In order to impose higher cost-sharing than otherwise allowed under federal law, a state needs to meet separate cost-sharing waiver requirements under Section 1916(f). Section 1916(f) permits a state to seek a demonstration waiver to charge cost-sharing above otherwise allowable amounts if the state meets specific requirements and criteria, including testing a unique and previously untested use of co-payments and limiting the demonstration to no longer than two years.

In July 2013, final regulations were released that streamlined and simplified existing rules around premiums and cost-sharing in Medicaid, increased the nominal rate for cost-sharing, and increased allowable cost-

sharing amounts for non-preferred drugs and non-emergency use of the emergency room. Indiana received Section 1916(f) waiver authority to charge cost-sharing that exceeds the \$8 maximum allowed for non-emergency use of the emergency room under these federal rules. This waiver allows the state to implement a two-year demonstration (until Jan. 31, 2017) to test whether graduated co-payments (\$8 for first visit and \$25 for subsequent visits in the same year) discourage non-emergency use of the emergency room. This authority applies to both newly eligible adults and previously eligible parents. On May 1, 2015, the state submitted a protocol to CMS that includes the methodology for establishing a control group with a minimum of 5,000 beneficiaries who will not be subject to the increased co-payments.

Two states have pending waiver proposals involving cost-sharing above federal limits. Arizona seeks Section 1916(f) waiver authority to impose a \$25 co-payment for non-emergency use of the ER if beneficiaries live within 20 miles of a community health center, rural health center, or urgent care center; otherwise, Arizona proposes \$8 and then \$25 for those under 100% FPL and \$25 for all visits for those over 100% FPL. Arizona also seeks to require co-payments for missed appointments. Michigan's pending waiver amendment would require cost-sharing up to 7% of income, above the Medicaid limit of 5%, for those from 101-138% FPL after 48 months of coverage if these beneficiaries did not move to Marketplace premium assistance (discussed above).

WAIVER PROVISIONS DENIED BY CMS

CMS has not approved waiver requests proposing premiums for individuals with incomes below 100% FPL where payment is a condition of eligibility. As noted above, Arkansas, Iowa, Indiana, and Montana do have authority to impose monthly contributions for individuals with incomes below poverty; however, Medicaid eligibility cannot be terminated for non-payment.

CMS has denied requests to waive certain Medicaid benefits. In their waiver proposals, some states requested additional changes in benefits that were not approved. Specifically, CMS denied Iowa and Indiana's requests to waive the provision of EPSDT services for newly eligible 19- and 20-year-olds and requests from Iowa and Pennsylvania to waive the provision of free choice of family planning providers for newly eligible adults.

CMS has denied most waivers for states seeking to impose cost-sharing in amounts greater than those allowed under federal law. While Indiana recently received waiver authority to impose higher than statutory cost-sharing under Section 1916(f), CMS did not approve an earlier waiver request to allow Arizona to impose a \$200 co-pay for non-emergency use of the emergency room.¹⁹

CMS has not approved a waiver to include a work requirement or referral as a condition of Medicaid eligibility. Pennsylvania initially sought a work requirement as a condition of Medicaid eligibility (later amended to a voluntary work search program) for current and newly eligible beneficiaries as part of its waiver application, but none of these elements were included as part of the demonstration approved by CMS.²⁰ Indiana sought waiver authority to require a work referral as a condition of eligibility, which was not approved by CMS. Instead, Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid expansion demonstration.²¹ New Hampshire's waiver proposal included a referral

to state job counseling services for unemployed applicants but such a program was not included as part of CMS's waiver approval.

In Arizona's pending waiver application, the state seeks to include a voluntary work incentive program for newly eligible adults. The state would provide beneficiary education about the program, and beneficiaries in the expansion population would comply with the work incentive program by connecting to a state employment supports program, attending a job fair, enrolling in job seekers' assistance, taking a class, or other similar goals. Medicaid eligibility is not conditioned on participation in the work incentive program, and medically frail beneficiaries are exempt. However, in compliance with state legislative requirements, the Arizona waiver also would require that all able-bodied adult Medicaid beneficiaries must work, actively seek work as verified by the state, or attend school or a job training program at least 20 hours/week to be eligible for coverage. Beneficiaries must verify compliance and any change in family income monthly, and the state must verify changes in income and re-determine eligibility. In addition, the state may ban beneficiaries from enrollment for one year due to knowingly failing to report a change in family income or making a false statement about work program compliance.

OTHER WAIVER PROVISIONS PENDING WITH CMS

Two states have pending waiver proposals involving time limits, neither of which has been previously approved by CMS. As noted earlier, Michigan's state legislation requires certain changes in the delivery system (option for Marketplace premium assistance) and/or cost-sharing (above federal limits if remain in Medicaid managed care) for beneficiaries from 101-138% FPL after 48 months of coverage in order for Michigan's expansion to continue beyond April 2016. Arizona's state legislation requires it to seek waiver approval for a five year lifetime limit on Medicaid coverage for all able-bodied adults.

Key Issues Looking Forward

To date, 31 states (including DC) have adopted the ACA's Medicaid expansion including a small number of states that are implementing the expansion under waiver authority. Examining what provisions CMS has approved and denied in recent waiver approvals can help inform states considering waivers moving forward. Other states debating moving forward with the expansion are considering implementing the expansion through a waiver, including Tennessee and Utah.

Particularly as waiver designs become increasingly more complex, studying and assessing the effects of key waiver provisions will help inform policymakers about whether such policies can be effectively administered and whether beneficiaries understand the policies. Among the issues and waiver provisions to be studied are using Medicaid as premium assistance to purchase Marketplace coverage;²² imposing premiums and cost-sharing above federal limits; offering healthy behavior incentives; limiting non-emergency medical transportation; and adopting a mix of provisions in different waivers that interrupt, delay or extend effective coverage dates. It will be important to study these provisions for their impact on beneficiary access to care and in comparison to the Marketplace experience that people above poverty would face if their state did not expand Medicaid. The ACA's waiver transparency regulations require states to have a publicly available, approved evaluation strategy, and a federal contract has been awarded to evaluate a number of Section 1115 waivers.

Ensuring that evaluations are timely and that findings are publicly available will be important for enabling researchers, policymakers, and other stakeholders to identify and examine lessons learned from these waiver experiences. As more states seek waivers to implement the expansion, what we learn from their experiences will help inform the future direction of coverage for low-income adults and families. CMS, states, and other stakeholders will continue to navigate the balance between state waiver requests in an effort to reduce the number of uninsured adults while preserving key beneficiary protections and requirements in the Medicaid program.

Endnotes

¹ Kaiser Family Foundation State Health Facts, *Status of State Action on the Medicaid Expansion Decision*. Data Source: KCMU tracking and analysis of state executive activity (Nov. 2, 2015), <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

² Section 1115 waivers are intended to allow for “experimental, pilot, or demonstration projects” that, in the view of the HHS Secretary, “promote the objectives” of the Medicaid program. 42 U.S.C. § 1315(a).

³ Budget neutrality is established using a cap on federal matching funds over the life of the waiver.

⁴ *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2012) <http://kff.org/health-reform/fact-sheet/the-new-review-and-approval-process-rule/>.

⁵ Centers for Medicare and Medicaid Services, Healthy Michigan Section 1115 Demonstration, Special Terms and Conditions at p. 5, section III.7.a (Dec. 30, 2013), http://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf; Centers for Medicare and Medicaid Services, *Montana Health and Economic Livelihood Partnership Program Demonstration, Special Terms and Conditions at p. 7-8, section III.14 (Nov. 2, 2015)*, available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf>.

⁶ Report to Congress. The US Department of Health and Human Services’ First Report on Section 1115(a) Demonstrations: Transparency in the Review and Approval of Medicaid and Children’s Health Insurance Program (CHIP) Section 1115 Demonstrations, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/1115-transparency-rtc.pdf>.

⁷ Arizona administers its entire Medicaid program through a long-standing Section 1115 demonstration waiver, dating back to 1989, that enables Arizona to deliver Medicaid through capitated managed care. Arizona’s present waiver incorporates the ACA’s Medicaid expansion population but does not include any waiver authorities related to the ACA expansion specifically.

⁸ Newly eligible adults in Arkansas include childless adults between 0-138% FPL and parents between 17-138% FPL.

⁹ Newly eligible adults in New Hampshire include non-working parents from 38-138% FPL, working parents from 47-138% FPL, and childless adults from 0-138% FPL.

¹⁰ As of October, 2014, Iowa beneficiaries from 101-138% FPL were no longer required to enroll in Marketplace premium assistance as a condition of eligibility because one of the two QHPs covering Medicaid beneficiaries was no longer participating. Instead, these beneficiaries could choose to receive coverage through the state’s Medicaid managed care delivery system or enroll in the remaining QHP with premium assistance. Subsequently, the other QHP informed Iowa that it would no longer accept new members. In September, 2015, Iowa submitted a waiver amendment request seeking to require all beneficiaries from 101-138% FPL to enroll in capitated Medicaid managed care as of January, 2016. Iowa also submitted a Section 1915(b) waiver request to expand its capitated managed care system statewide.

¹¹ Laura Snyder and Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2013), <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/>.

¹² Arizona proposes not charging co-payments for preventive or wellness services, services to manage chronic illness, any services (well or sick visit) at PCP or OB/GYN office, specialist services with PCP referral, behavioral health services/people with serious mental illness, or prescription drugs (except for opioids other than for people with cancer or who are terminally ill and brand name drugs unless doctor has determined that generic is ineffective).

¹³ 42 U.S.C. § 1396a(a)(8).

¹⁴ Letter from Cindy Mann, Director, CMCS, CMS to Julie Lovelady, Interim Medicaid Director, State of Iowa (Dec. 30, 2014), <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf>.

¹⁵ 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914.

¹⁶ Montana also is expected to amend its other Section 1115 demonstration waiver to implement 12-month continuous eligibility for other populations.

¹⁷ Kaiser Commission on Medicaid and the Uninsured, *Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Jan. 2015), available at <http://kff.org/report-section/modern-era-medicaid-enrollment-and-renewal-processes/>.

¹⁸ CMS Special Terms and Conditions, *New York Partnership Plan Medicaid Section 1115 Demonstration*, No. 11-W-00114/2, at 10 (§ IV. 4) (Sept. 30, 2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-partnership-plan-ca.pdf>.

¹⁹ Letter from Cindy Mann to Thomas Betlach, December 15, 2014. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf>

²⁰ Letter from Marilyn Tavenner, CMS Administrator, to Secretary Beverly Mackereth (Aug. 28, 2014), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf>.

²¹ Press release: CMS and Indiana Agree on Medicaid Expansion (Jan. 27, 2015), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-01-27.html>; see also Letter from CMS Administrator Marilyn Tavenner to Medicaid Director Joseph Moser (Jan. 27, 2015), http://www.in.gov/fssa/hip/files/IN_HIP_2.0_CMS_Approval_Ltr_1_27_15.pdf.

²² Kaiser Commission on Medicaid and the Uninsured, *A Look at the Private Option in Arkansas* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Aug. 2015), <http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/>; MaryBeth Musumeci. *Medicaid Expansion Through Marketplace Premium Assistance* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Sept. 2013), <http://www.kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/>.