Medicaid Expansion and Section 1115 Waivers

Council of State Governments National Conference

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The goal of the ACA is to make coverage more available, more reliable, and more affordable.

Diagram:

- **Universal Coverage**
  - Medicaid Coverage For Low-Income Individuals
  - Exchanges With Subsidies For Moderate Income Individuals
  - Health Insurance Market Reforms
  - Employer-Sponsored Coverage
  - Individual Mandate
The ACA’s Medicaid expansion fills historic gaps in coverage.

NOTE: The June 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* maintained the Medicaid expansion, but limited the Secretary’s authority to enforce it, effectively making the expansion optional for states. 138% FPL = $16,242 for an individual and $27,724 for a family of three in 2015.
The federal government will pay for the vast majority of costs to cover those newly eligible.

- **Federal Share for Newly Eligible**
- **Traditional FMAP Minimum**

<table>
<thead>
<tr>
<th>Year</th>
<th>Federal Share</th>
<th>Traditional FMAP Minimum</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>100%</td>
<td>50%</td>
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<tr>
<td>2015</td>
<td>100%</td>
<td>50%</td>
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<tr>
<td>2016</td>
<td>100%</td>
<td>50%</td>
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<tr>
<td>2017</td>
<td>95%</td>
<td>50%</td>
</tr>
<tr>
<td>2018</td>
<td>94%</td>
<td>50%</td>
</tr>
<tr>
<td>2019</td>
<td>93%</td>
<td>50%</td>
</tr>
<tr>
<td>2020</td>
<td>90%</td>
<td>50%</td>
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</table>

**NOTE:** The FMAP ranges from a minimum of 50% to a maximum of 73.58% in FY 2015.
The Medicaid expansion has implications beyond the Medicaid program.

- Increased State Economic Activity
- Increased Provider Revenue
- Reduction in the Number of Uninsured
- Increased State Savings
  - ↓ Uncompensated Care Costs
  - ↓ State-funded health programs (e.g. Corrections and Mental health)
- Increased State Economic Activity
  - ↑ Jobs and Revenues
FY 2015 enrollment and total spending growth in expansion states far exceeded non-expansion states; state spending growth was lower.

NOTE: Data show the year over year change in enrollment FY 2014 to FY 2015. Expansion States for FY 2015 include 29 states. Total Medicaid spending includes federal, state and local spending.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.
Medicaid hospital stays up and uninsured stays down in Medicaid expansion states, 2013-2014.

Figure 6

NOTE: Change is measured as change between first two quarters of 2013 and first two quarters of 2014.
NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity.
*AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver will be effective January 1, 2016. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as “adoption under discussion.”
In states that have not expanded Medicaid under the ACA, there are large gaps in coverage available for adults.

**Figure 8**

- **MEDICAID**: Limited to Specific Low Income Groups
  - 0% FPL Childless adults
  - 44% FPL $8,840 for parents in a family of three

- **NO COVERAGE**

- **MARKETPLACE SUBSIDIES**: 100% FPL $11,770 for an individual
  - 400% FPL $47,080 for an individual

**Median Medicaid Eligibility Limits as of November 2015**

- 44% FPL $8,840 for parents in a family of three
- 100% FPL $11,770 for an individual
- 400% FPL $47,080 for an individual
Nationwide, there are 3.1 million low-income adults estimated to fall into the coverage gap.

Distribution By State:
- Texas (TX): 25%
- Florida (FL): 18%
- Georgia (GA): 10%
- North Carolina (NC): 8%
- Other States that Have Not Expanded Medicaid: 39%

Distribution By Geographic Region:
- South: 90%
- Midwest: 6%
- Northeast: < 1%
- West: 3%

Total = 3.1 Million in the Coverage Gap

Note: Totals may not sum to 100% due to rounding.
Adults in the coverage gap vary by race/ethnicity, age, and health status.

**Distribution By Race/Ethnicity:**
- **White:** 44%
- **Hispanic:** 30%
- **Black:** 22%
- **Other:** 4%

**Distribution By Age:**
- **19-24 years:** 24%
- **25-34 years:** 25%
- **35-54 years:** 35%
- **55-64 years:** 17%

**Distribution By Health Status:**
- **Excellent or Very Good:** 49%
- **Good:** 32%
- **Fair or Poor:** 19%
- **Excellent or Very Good:** 49%

Total = 3.1 Million in the Coverage Gap

Note: Totals may not sum to 100% due to rounding.
Over 60 percent of adults in the coverage gap are working.

Family work status:
- Full-time worker: 40%
- No worker: 39%
- Part-time worker: 21%

Total = 3.1 Million in the Coverage Gap

Firm size and industry among those working:
- <50 employees:
  - Agriculture/Service: 47%
  - Professional/Public Admin: 14%
  - Education/Health: 17%
  - Manufacturing/Infrastructure: 8%
  - Other: 6%

Total = 1.5 Million Workers in the Coverage Gap

Notes: Industry classifications: Agriculture/Service includes agriculture, construction, leisure and hospitality services, wholesale and retail trade. Education/Health includes education and health services. Professional/Public Admin includes finance, professional and business services, information, and public administration. Manufacturing/Infrastructure includes mining, manufacturing, utilities, and transportation. Totals may not sum to 100% due to rounding.

Some states are exploring alternative approaches to implementing the Medicaid expansion.

- Most states implementing the Medicaid expansion through a State Plan Amendment (SPA) using flexibility provided in the law
- A limited number of states are seeking waivers for alternative approaches to implement Medicaid expansion
- Section 1115 waiver authority is for demonstrations that promote the objectives of the Medicaid program
  - Authorizes the HHS Secretary to waive certain federal Medicaid requirements and provide federal matching funds for costs that would not otherwise be matched
  - Section 1115 waivers are required to be budget neutral to the federal government
  - Waiver approval involves negotiations between a state and HHS
  - The ACA requires transparency and meaningful opportunities for public input in the Section 1115 waiver process
Before 2014, there was no federal statutory authority to cover childless adults under Medicaid. The only way for states to expand coverage was to use § 1115 demonstrations to redirect existing federal funds or find offsetting program savings.

Given the limited federal financing available, pre-2014 coverage expansion demonstrations often offered more limited benefits and/or higher cost-sharing than otherwise allowable under federal Medicaid law.

Under the ACA, states can receive federal Medicaid funds to cover previously ineligible adults as of 2014.

Post-2014 expansion waivers are made possible by the ACA’s Medicaid expansion and enhanced federal funding.
State expansion waiver designs vary based on the features of their pre-ACA Medicaid programs.

- For example,
  - Arkansas did not have Medicaid managed care in place prior to 2014, and instead uses Medicaid premium assistance to cover newly eligible adults in Marketplace plans.
  - Michigan relies on its existing capitated Medicaid managed care delivery system to cover newly eligible adults.
  - Montana already used a third party administrator for CHIP and is expanding this model for its managed fee-for-service Medicaid expansion.
  - Indiana had a pre-ACA waiver in place that expanded coverage to some adults and used a health savings account model; the state’s expansion waiver modifies this model and covers all newly eligible adults.
A limited number of states have approved waivers for Medicaid expansion.

<table>
<thead>
<tr>
<th>Waiver Provision</th>
<th>AR</th>
<th>IA</th>
<th>MI</th>
<th>IN</th>
<th>NH*</th>
<th>MI*</th>
<th>MT</th>
<th>AZ</th>
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<tr>
<td>Implement Premium Assistance</td>
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<tr>
<td>Implement Healthy Behavior Incentives</td>
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<td>X</td>
<td>X</td>
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<td>Waive Benefits (NEMT)</td>
<td>X</td>
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<td>X</td>
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<td>Waive Reasonable Promptness</td>
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<td>Waive Retroactive Eligibility</td>
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<td>X</td>
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<td>Impose Co-payments Above Statutory Limits</td>
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<td>Implement 12-Month Continuous Eligibility</td>
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<td>Propose Time limit on Coverage</td>
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<td>Propose Work Requirement</td>
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NOTES: *New Hampshire will transition from a SPA to a waiver in 2016. MI’s pending amendment would apply to beneficiaries from 101-138% FPL after 48 months of coverage; MI’s state legislation requires that the Medicaid expansion will 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 mid-2015 and is omitted from the table.
CMS has denied some waiver requests.

- Premiums as a condition of eligibility for beneficiaries with incomes below the federal poverty level
- Provision of Early Periodic Screening Diagnosis and Treatment benefits for 19 and 20 year olds
- Provision of free choice of family planning provider (for Marketplace premium assistance)
- Work requirements
States continue to adjust their demonstrations based on their experience with implementation.

- Example: Iowa
  - Moving newly eligible adults with income from 101-138% FPL from Marketplace premium assistance to Medicaid managed care plans
  - Conducting additional research before continuing to implement healthy behavior program

- Example: Arkansas
  - Phasing in monthly health savings account payments for newly eligible adults (implemented for those from 101-138% FPL but not for those from 50-100% FPL)
  - Decided not to seek non-emergency medical transportation waiver; found that administering transportation benefit through brokerage model was cost-effective
What to look for going forward:

- How many additional states will seek expansion waivers? How will CMS respond to new and pending state waiver requests? Will CMS approve waiver requests that could make beneficiaries worse off compared to their current status?

- How will the Medicaid expansion affect program enrollment and spending? The uninsured rate? State revenues, employment, and other fiscal indicators?

- What will evaluation plans show about states’ experiences with current expansion waivers? Will CMS grant waivers to additional states to test similar hypotheses or wait for evaluation results from states with existing waivers?

- How will states manage the complexity and costs of administering waiver provisions that involve tracking income, premiums, co-payments, and other elements?

- Will beneficiaries understand program features such as healthy behavior incentive programs? What impact will expansion waivers have on beneficiary access to care and health outcomes?