Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape

Council of State Governments

September 14, 2017
Congress has been considering fundamental changes to Medicaid, which have implications for waivers.

<table>
<thead>
<tr>
<th>American Health Care Act (passed by House)</th>
<th>Better Care Reconciliation Act (failed in Senate)</th>
<th>Obamacare Repeal Reconciliation Act (failed in Senate)</th>
<th>Graham-Cassidy (introduced in Senate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase out Medicaid expansion in 2020</td>
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<td>Eliminate Medicaid expansion in 2020</td>
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<td>Convert Medicaid funding to per capita cap; Growth rate: CPI-M+1% and CPI-M; Block grant option for children and nonexpansion adults</td>
<td>Convert Medicaid funding to per capita cap; Growth rate: CPI-M+1% and CPI-M, then CPI-U starting 2025; Block grant option for expansion adults and nonelderly nondisabled adults</td>
<td>No change to current financing</td>
<td>Convert Medicaid funding to per capita cap; Growth rate: CPI-M+1% and CPI-M, then CPI-U and CPI-M starting 2025; Block grant option for nonelderly nondisabled adults</td>
</tr>
<tr>
<td>Create state option for work requirement</td>
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Graham-Cassidy
(introduced in Senate)

Eliminate Medicaid expansion in 2020; states could use Market-based block grant funds to cover those ineligible for Medicaid and up to 20% to cover Medicaid eligibles.

Convert Medicaid funding to per capita cap; Growth rate: CPI-M+1% and CPI-M, then CPI-U starting 2025; Block grant option for expansion adults and nonelderly nondisabled adults.

No change to current financing.

Create state option for work requirement.

Create state option for work requirement.
Section 1115 of the Social Security Act allows the HHS Secretary to grant waivers of certain Medicaid provisions that are:

- “Experimental, pilot or demonstration projects”
- “Likely to assist in promoting the objectives of the program”
- Budget-neutral to federal government
- Subject to state and federal public notice and comment periods
There are 41 approved waivers in 33 states and 21 pending waivers in 18 states as of September, 2017.

NOTE: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas.

Seven states have approved Section 1115 ACA Medicaid expansion waivers, as of September, 2017.

<table>
<thead>
<tr>
<th>Waiver Provision</th>
<th>AR</th>
<th>AZ</th>
<th>IA</th>
<th>IN</th>
<th>MI</th>
<th>MT</th>
<th>NH</th>
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</thead>
<tbody>
<tr>
<td>Eligibility and Enrollment</td>
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<tr>
<td>Premium Assistance</td>
<td>QHP &amp; ESI</td>
<td>ESI</td>
<td>ESI</td>
<td>QHP⁴</td>
<td>QHP</td>
<td></td>
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<tr>
<td>Premiums / Monthly Contributions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Reasonable Promptness</td>
<td></td>
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<td>X</td>
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<tr>
<td>Retroactive Eligibility</td>
<td>X²</td>
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<td>X⁵</td>
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<tr>
<td>12-Month Continuous Eligibility</td>
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<tr>
<td>Benefit Restrictions, Copays, and Healthy Behaviors</td>
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<tr>
<td>Waive Required Benefits (NEMT)</td>
<td>¹</td>
<td>X</td>
<td>X</td>
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<td>Co-payments Above Statutory Limits</td>
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<td>X³</td>
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<tr>
<td>Healthy Behavior Incentives</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

NOTES: QHP = Marketplace Qualified Health Plan. ESI = Employer-sponsored insurance. NEMT = Non-emergency medical transportation. ¹NEMT waived for individuals covered through ESI who do not demonstrate need for services. ²Contingent on state meeting standards for timely eligibility determinations, offering a reasonable opportunity period for immigration status verifications, and implementing a presumptive eligibility program. ³Approved under § 1916 (f), not § 1115. ⁴Effective April, 2018. ⁵Contingent on state submission of data showing no gaps in coverage.

Both expansion and non-expansion states are seeking provisions that would restrict eligibility and enrollment never before approved by CMS, as of September, 2017.

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<tr>
<th>Waiver Provision</th>
<th>AR</th>
<th>IN</th>
<th>KY</th>
<th>ME</th>
<th>TX*</th>
<th>UT</th>
<th>WI</th>
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</thead>
<tbody>
<tr>
<td>Limit Expansion to 100% FPL w/ Enhanced Match</td>
<td>X</td>
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<tr>
<td>Eliminate Hospital Presumptive Eligibility</td>
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<td>Asset Test for Poverty-Related Pathways</td>
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<td>Waive MAGI Methodology</td>
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<td>Drug Screening and Testing</td>
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<td>Premiums with Disenrollment for Non-Payment for Traditional Medicaid Populations</td>
<td>X</td>
<td>X</td>
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<td>Tobacco Surcharge</td>
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<td>Lock-out for Failure to Timely Renew Eligibility</td>
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<td>Time Limit on Coverage</td>
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<td>X</td>
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<tr>
<td>Work Requirement</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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</tbody>
</table>

NOTES: *TX = Healthy Women family planning waiver. IA has pending waiver request to eliminate retroactive eligibility for all populations.
Six states are seeking waivers to condition Medicaid on work requirements, but most enrollees not working face barriers.

Own Work Status, 24 Million Medicaid Adults

- Not Employed: 41%
- Part-Time: 18%
- Full-time: 41%

Not Employed = 9.8 Million Medicaid Adults

Main Reasons for Not Working

- Ill or disabled: 35%
- Taking care of home or family: 28%
- Going to school: 18%
- Could not find work: 8%
- Other: 3%
- Retired: 8%

The TANF experience with work requirements can provide some lessons for Medicaid.

- Health coverage through Medicaid supports enrollees’ ability to work. Many of the jobs held by enrollees do not offer health insurance.
- Addressing barriers to work requires adequate funding and supports. While TANF spending on work activities and supports is critiqued by some as too low, it exceeds estimates of state Medicaid program spending to implement a work requirement.
- Implementing work requirements can create administrative complexity. States can incur additional costs and demands on staff, and some eligible people could lose coverage.

States also are seeking waivers to impose premiums and cost sharing, but research shows negative effects of these policies on low-income populations.

New/increased premiums

- Decreased enrollment and renewal in coverage
- Largest effects on lowest income
- Many become uninsured and face increased barriers to care and financial burdens

New/increased cost-sharing

- Even small levels ($1-$5) decrease use of services, including needed services
- Increased use of more expensive services (e.g., ER)
- Negative effects on health outcomes
- Increased financial burdens for families

- States savings are limited
- Offset by disenrollment, increased costs in other areas, and administrative expenses

HHS’s March 14, 2017 letter to state governors signals some Section 1115 waiver policy changes and priorities.

- Use “reasonable” public input processes and transparency guidelines
- Establish “fast track” approval of waiver extensions
- Improve “consistency” of incorporating specific waivers and approaches already approved in another state
- Approve waiver provisions related to “increas[ed] employment and community engagement”
- Approve provisions that “align Medicaid and private insurance policies for non-disabled adults”
Looking Ahead: Issues to Watch in Section 1115 Waivers

- What provisions will the Secretary deem “likely to assist in promoting the objectives of the [Medicaid] program”?
- Will CMS authorize joint Section 1115/1332 waivers allowing Medicaid funds to subsidize Marketplace initiatives?
- Will requirements for transparency, public input and budget neutrality be maintained?