Medicaid Waivers

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Filling the need for trusted information on national health issues.
The HHS Secretary can waive certain Medicaid provisions to implement “experimental, pilot or demonstration projects” that are “likely to assist in promoting the objectives of the Medicaid program”

- Budget neutral to the federal government and subject to state and federal public notice and comment periods

The Trump Administration has issued waiver guidance in November 2017 (waiver approval criteria) and January 2018 (work / community engagement)

Each Administration has some discretion over which waivers to approve and encourage; however, that discretion is not unlimited.

- DC federal district court invalidated Secretary’s approval of Kentucky’s waiver in June, 2018, citing failure to consider impact on providing affordable coverage. AR litigation in progress
- Other provisions not approved include: partial expansion (MA and AR); closed formulary (MA); not approved in MA; time limits on coverage (KS)
- Issues raised about approval of work requirements in non-expansion states
Figure 2
Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, September 24, 2018

NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page. “MLTSS” = Managed long-term services and supports. On June 29, 2018, the DC federal district court issued a decision in Stewart v. Azar. The court invalidated the waiver approval and sent it back to HHS to reconsider the Kentucky HEALTH Section 1115 waiver program. The separate “institution for mental disease” substance use disorder payment waiver continues.
Figure 3

Key considerations in implementing a waiver:

- What are the goals and what provisions of law need to be waived?
- What are the key policy provisions? What do we know from other states or research about effects?
- What populations will be part of the demonstration?
- What is necessary to implement the waiver? (systems, staff, coordination across agencies, beneficiary / plan and provider education)
- How will the demonstration be evaluated?
- What are the estimated effects of the demonstration on coverage and costs?
Over ½ of states have an approved or pending Section 1115 waiver related to behavioral health, as of September 27, 2018.

NOTES: Some states have both approved and pending waivers. Waivers may contain initiatives in more than one area. IMD = Institution for Mental Disease. State IMD waiver requests include substance use and/or mental health services. Delivery system reform includes physical/behavioral health integration, alternative payment models, and workforce development initiatives.

SOURCE: KFF analysis of approved and pending waiver applications posted on Medicaid.gov.
Waiver provisions to impose eligibility restrictions not allowed under current law have been approved or are pending at CMS.

- Premiums / monthly contributions
  - Waivers for reasonable promptness (so coverage is not effective until premiums are paid)
- Waivers for retroactive eligibility
- Coverage lock-outs
  - Failure to pay premiums
  - Timely renew coverage
  - Report changes in income
- Drug screening and testing
The Kentucky HEALTH waiver included coverage lock-outs for different reasons.

- Failure to Meet Work Requirements
- Non-Payment of Premiums if >100% FPL
- Failure to Complete Timely Renewals
- Failure to Report Changes in Circumstances
Research shows negative effects of premiums and cost-sharing policies for low-income populations.

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

- Even small levels ($1-$5) decrease use of 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

Data from Indiana show confusion about the payment process was the second top reason for failure to pay premiums.

**Reasons for Premium Non-Payment:**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Never Members (n=124)</th>
<th>Leavers (n=168)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could not afford to pay, 22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confusion about payment process, 22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not know payment required, 20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Reason, 36%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59% of Never Members surveyed as of Nov. 2016 were uninsured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confusion about payment process, 17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not know payment required, 12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Reason, 27%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53% of Leavers surveyed as of Nov. 2016 were uninsured</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTES: Weighted percentages reported. “Confusion about payment process” includes unsure how much to pay, when to pay, where to pay. “Another reason” includes got insurance from another source, income increase resulted in ineligibility, some other reason, moved out of state, became eligible for Medicare or another Medicaid coverage group, did not want HIP coverage, don’t know. Survey data from individuals disenrolled or not enrolled as of Nov. 2016. SOURCE: Lewin, Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Leaver and Never Member Survey data for Dec. 2016-Jan. 2017 (March 31, 2017).
Literature on the work/health relationship suggests Medicaid work requirements may not benefit and could harm health.

- Poor health is associated with increased risk of job loss, while access to affordable health insurance supports obtaining and maintaining employment.

- Evidence that employment improves health is limited:
  - Some studies show benefits, others show no relationship or isolated effects.
  - Job availability and quality are important; transition from unemployment to poor quality or unstable employment options can be detrimental to health.

- Caveats to the literature and implications for Medicaid work requirements:
  - Limited job availability or poor job quality may moderate or reverse any positive effects of work.
  - Work or volunteering to fulfill a requirement may produce different health effects than work or volunteer activities studied in existing literature.
  - Loss of Medicaid under work requirements could negatively impact health care access and outcomes, as well as exacerbate existing health disparities.

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

- **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.**
  - TANF spending on work activities and supports is critiqued by some as too low, but 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 eligible people could lose coverage.

Most Medicaid adults are working or face barriers to work.

- Working Full Time: 43%
- Working Part-Time: 19%
- Not Working Due to Caregiving: 11%
- Not Working Due to School Attendance: 6%
- In Fair/Poor Health or Not Working Due to Illness or Disability: 15%
- Not Working for Other Reason: 6%

Total = 23.5 million

Notes: “Not Working for Other Reason” includes retired, could not find work, or other reason. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one-job.
Figure 12

Occupations with largest number of workers covered by Medicaid are low paying jobs without benefits.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of Workers with Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cashiers</td>
<td>647,000</td>
</tr>
<tr>
<td>Nursing, psychiatric, and home health aides</td>
<td>397,000</td>
</tr>
<tr>
<td>Personal care aides</td>
<td>374,000</td>
</tr>
<tr>
<td>Cooks</td>
<td>368,000</td>
</tr>
<tr>
<td>Waiters and waitresses</td>
<td>362,000</td>
</tr>
<tr>
<td>Retail salespersons</td>
<td>359,000</td>
</tr>
<tr>
<td>Janitors and building cleaners</td>
<td>347,000</td>
</tr>
<tr>
<td>Maids and housekeeping cleaners</td>
<td>327,000</td>
</tr>
<tr>
<td>Driver/sales workers and truck drivers</td>
<td>319,000</td>
</tr>
<tr>
<td>Customer service representatives</td>
<td>296,000</td>
</tr>
</tbody>
</table>

Figure 13

3 in 10 Medicaid adults never use a computer which could have implications for finding a job and reporting work status.

*Share who say they:*

- **Never Use Computer:**
  - All Medicaid Adults: 30%
  - Medicaid Workers: 28%
  - Medicaid Non-Workers: 36%

- **Do Not Use Internet:**
  - All Medicaid Adults: 28%
  - Medicaid Workers: 23%
  - Medicaid Non-Workers: 32%

- **Do Not Use Email:**
  - All Medicaid Adults: 41%
  - Medicaid Workers: 32%
  - Medicaid Non-Workers: 49%

**NOTE:** Includes non-elderly adults with Medicaid coverage who do not receive Supplemental Security Income (SSI). All differences between workers and non-workers significantly different at p<0.05 level.

**SOURCE:** Kaiser Family Foundation analysis of 2016 National Health Interview Survey.
Complex policies in recent waivers run counter to simplified ACA eligibility and enrollment rules.

**Pre-ACA**
- Apply in person
- Paperwork and asset test requirements
- Wait for eligibility determination
- Frequent renewals requiring paperwork and documentation

**Post-ACA**
- Multiple options to apply
- Electronic verification and no asset tests
- Real-time determination
- Annual automated renewals

**Future?**
- More documentation (e.g. work)
- Premiums
- Frequent reporting and documentation
- Lock-out periods
Under all scenarios, the majority of those who could be disenrolled from work requirements are related to reporting.

Assumed Disenrollment Rate:
- **Already Working or Exempt**
  - Low (5%)
  - Low (25%)
  - High (50%)

- **Subject to Work Requirement**
  - Low (5%)
  - High (15%)
  - High (50%)

**Total Number Losing Coverage**
- 1.4 M
- 1.7 M
- 3.7 M
- 4.0 M

Note: Components may not sum to totals due to rounding.

Source: Kaiser Family Foundation analysis
Over 4,300 AR Works enrollees lost Medicaid coverage for failure to meet work and reporting requirements for 3 months.

Number of Enrollees Who Did Not Meet Work and Reporting Requirements for 1, 2 and 3 months as of September 9, 2018:

- **1 Month Non-Compliance**: 6,174
- **2 Months Non-Compliance**: 5,076
- **3 Months Non-Compliance (cases closed)**: 4,353

27% of AR Works enrollees did not report 80 hours of qualifying work activities in August 2018.

Total of 60,012 People Subject to Work and Reporting Requirements in August 2018*

- Did Not Report 80 Hours of Qualifying Work Activities: 16,357 (27%)
- Reported an Exemption: 2,247 (4%)
- Reported 80 Hours of Qualifying Work Activities: 1,218 (2%)
- Exempt from Reporting: 40,190 (67%)

NOTE: *Work requirement is being phased in for those ages 30-49 from June-September, 2018. **Includes those identified as already working >80 hours or meeting an exemption from the work requirement.

SOURCE: Arkansas Works Program, State Data from the Arkansas Department of Human Services for August 2018, Released September 12, 2018.
Arkansas coverage losses far exceed enrollees who are meeting work and reporting requirements outside of SNAP requirements.

Complex waivers could increase administrative costs for states and counties.

- **State Costs**
  - Kentucky plans to spend $186 million in state fiscal year 2018 and an additional $187 million in 2019 to implement its approved waiver.
  - Alaska projects that its proposed work requirement would cost the state $78.8 million over six years, including about $14 million per year in annual ongoing costs.
  - A Pennsylvania state official testified that a proposed work requirement would cost $600 million and require 300 additional staff to administer.

- **County Costs**
  - In Minnesota, counties would have to spend an estimated $121 million in 2020 and $163 million in 2021 to implement proposed work requirements.
    - Counties estimate that it will take on average 53 minutes to process each exemption, 22 minutes to refer a client to employment and training services, and 84 minutes to verify non-compliance and suspend Medicaid benefits.

Figure 20

Key Questions Looking Ahead:

• What will happen with Medicaid work requirement waivers?
  – What will the recent ruling in *Stewart v. Azar* mean for states seeking or with approved waivers for work requirements?
  – Will non-expansion states be granted waivers to impose work requirements on traditional populations?
  – What effect will new these policies have on enrollment? Will work requirements help people find jobs and “rise out of poverty”? Will eligible people lose coverage due to administrative hurdles?

• Will states continue to pursue waivers to implement delivery system reforms or address social determinants of health?

• What effect will IMD waivers have on access to SUD treatment? Will states expand community-based SUD services and pursue delivery system reforms?

• What will we learn about administrative costs to implement complex requirements?

• Will waiver evaluations be timely and adequate? What data and reporting will be available prior to the completion of formal evaluations?