

February 2014 | Issue Brief

The ACA and Recent Section 1115 Medicaid Demonstration 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% FPL (\$16,105 per year for an individual in 2014); however, the Supreme Court ruling on the ACA effectively made the expansion a state option. As of January 2014, 25 states and DC are implementing the expansion in 2014. Under flexibility provided by the ACA's Medicaid expansion, as well as pre-existing federal Medicaid law, the Medicaid expansion will be implemented differently across states in terms of what specific benefits are provided and how those services are delivered. Moreover, 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. Section 1115 Medicaid demonstration waivers provide states with an avenue to test approaches in Medicaid that differ from federal program rules. For many years, these waivers offered the only way for states to cover otherwise ineligible childless adults; now, the ACA provides new state plan authority for states to offer Medicaid to this population without the need for a waiver. While states use Section 1115 waiver authority for a wide range of purposes, this brief focuses on waivers related to implementation of the ACA Medicaid expansion (eligible for ACA enhanced matching funds) or other coverage (not eligible for ACA enhanced matching funds).

Prior to the ACA, states could only cover childless adults and receive federal Medicaid funds by obtaining a Section 1115 waiver. Section 1115 waivers must be budget neutral for the federal government and in the absence of coverage provided through these waivers, childless adults generally did not have any other coverage options through Medicaid. Given these considerations, Section 1115 waivers that expanded coverage to these adults, who otherwise would have been uninsured, often included limited benefit packages, higher cost-sharing and/or enrollment caps designed to limit costs. Since the ACA expands Medicaid to nearly all low-income adults with significant federal funding, the need for and role of waivers to cover adults fundamentally changes.

Using enhanced federal matching funds for those newly eligible for coverage, nearly all states implementing the ACA Medicaid expansion are doing so as set forth by law and will not seek a waiver of federal law. Like the traditional Medicaid program, the law allows states considerable flexibility to implement the expansion. Due to this flexibility, the expansion will look different across states, but the majority of states moving forward are implementing the expansion within federal options and rules, and receiving the associated enhanced federal matching funds by filing a State Plan Amendment (SPA).

A limited number of states are pursuing Section 1115 waivers to implement the ACA Medicaid expansion in ways that do not meet federal rules while still accessing enhanced federal matching funds available for newly eligible adults. To date, the Centers for Medicare and Medicaid Services (CMS) has approved waivers to implement the Medicaid expansion in three states: Arkansas, Iowa and Michigan. In addition, Pennsylvania has a waiver proposal that is in the state comment period. Like before the ACA, waivers must be used to “promote the objectives” of the Medicaid program and they must be budget neutral for the federal government. The newly approved waivers also followed the new rules related to transparency and have allowed for opportunities for public comment in the process. Some of the key themes included in these approved and proposed ACA expansion waivers are highlighted in Table 1.

	Premium Assistance	Premiums	Healthy Behavior Incentives	Benefit Changes	Work Requirements
Arkansas (approved)	✓				
Iowa (approved)	✓	✓	✓	✓	
Michigan (approved)		✓	✓		
Pennsylvania (proposed)	✓	✓	✓	✓	✓

CMS has approved some provisions in the waiver requests, but also denied some provisions.

Examining what CMS has approved and not approved can be instructive for other states that may seek waivers in the future to implement the expansion. As shown in Box ES-1, CMS has approved waivers implementing the ACA’s Medicaid expansion through premium assistance, consistent with earlier guidance; charging premiums for groups at or above 100% FPL; removing certain benefits that are otherwise required, and using healthy behavior incentives. In contrast, CMS has denied requests for premiums for individuals at lower incomes and to impose higher cost sharing. In addition, it has not allowed states to waive the provision of certain benefits. CMS has not yet issued a determination for Pennsylvania’s proposed waiver, which includes work requirement provisions; however, such requirements have never been approved to date.

Box ES-1: CMS Decisions on Key Waiver Provisions

Approved

- Premium Assistance: Waivers consistent with CMS guidance, allow for mandatory enrollment in QHPs
- Premiums: For individuals with incomes 100-138%; up to 2% income (= to Marketplace)
- Benefits: Non-emergency transportation (one year waiver in Iowa)
- Healthy Behavior Incentives: Tied to reductions in premiums and cost sharing, protocols must be approved by CMS

Denied

- Premiums: Premiums for individuals with incomes < 100% FPL
- Cost-Sharing: Cost-sharing amounts beyond those allowed under current law
- Benefits: Waivers of requirements to provide wrap-around benefits for EPSDT and free choice of family planning provider to the extent that Marketplace plans do not offer this coverage

Proposed

- Work requirements (never been approved in Medicaid)

Several states have waivers to maintain coverage that was in place prior to the ACA, but this coverage is not eligible for the enhanced ACA matching funds for newly eligible adults. These states generally fall into 2 categories: states implementing the Medicaid expansion but using waivers to provide coverage or assistance to individuals with incomes above 138% FPL (Minnesota and the District of Columbia where waivers are in place and Massachusetts, New York and Vermont where waiver extensions are pending) and states not implementing the Medicaid expansion but primarily maintaining pre-ACA coverage expansions (Wisconsin, Indiana and Oklahoma).

Looking forward, many questions about waivers and the ACA Medicaid expansion remain.

There is no deadline for states to participate in the Medicaid expansion. As states start their legislative sessions for 2015, a number are re-examining decisions about the Medicaid expansion, and additional states may explore the use of waiver authority to implement the expansion. Moreover, states may seek to make changes to existing waivers through waiver amendments so it will be important to monitor how public notice and transparency rules will apply. In addition, as these waivers are implemented, evaluations will be key to understand their impacts on beneficiaries, providers and states to help inform coverage efforts.

INTRODUCTION

Prior to the ACA, one key reason a number of states used Section 1115 waiver authority was to expand Medicaid coverage to low-income adults who could not otherwise be covered under federal rules. The ACA's Medicaid expansion to nearly all low-income adults at or below 138% FPL (\$16,105 per year for an individual in 2014), and the significant federal funding provided to states for this expansion, fundamentally alters the role of Section 1115 waivers in expanding coverage to adults. Through guidance and recent waiver approvals in three states, CMS has identified some of the parameters related to the use of waivers to expand coverage to adults in light of the ACA's Medicaid expansion. This brief provides an overview of the potential role of Section 1115 waivers to expand coverage since the enactment of the ACA and key themes in recently approved and proposed coverage expansion waivers.

BACKGROUND

OVERVIEW OF SECTION 1115 WAIVER AUTHORITY

Section 1115 Medicaid waivers provide states with an avenue to test new approaches in Medicaid that differ from federal program rules. These 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 (See Box 1). Waivers can provide states with additional flexibility in how they operate their programs, beyond the flexibility already available to states under federal law, and can have a considerable impact on program financing. As such, waivers have important implications for beneficiaries, providers, and states. Section 1115 waivers play a notable role in the Medicaid program and have historically been used for a variety of purposes, including expanding coverage to populations who were not otherwise eligible, changing benefits packages, and instituting delivery system reforms.

Box 1: Key Elements of a Section 1115 Waiver

Section 1115 authorizes the HHS Secretary to:

- Waive state compliance with certain federal Medicaid requirements; and
- Provide federal funds for costs that would not otherwise be matched under Medicaid.

Section 1115 waivers are required to be budget neutral for the federal government.

Under long-standing federal policy (not statute) federal spending under a state's waiver must not exceed projected federal spending without the waiver.

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

Waiver approval involves negotiations between a state and HHS and consideration of public comments.

The approval process officially begins when a state submits a waiver application to CMS, which is subject to state and federal public notice and comment requirements.

If a waiver is approved, CMS issues an award letter to the state specifying the sections of the Medicaid Act that are being waived or modified and the types of expenditures allowed as well as the “terms and conditions” of approval with which the state must comply.

Waivers are typically approved for a 5 year period and can be extended, typically for 3 years.

SECTION 1115 COVERAGE EXPANSION WAIVERS FOR ADULTS PRIOR TO THE ACA

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. Before the ACA, Medicaid coverage was limited to individuals who met income and other eligibility requirements and fell into one of several specified groups, including children, pregnant women, parents, seniors and people with disabilities. Adults without dependent children, often referred to as childless adults, who did not qualify for Medicaid based on age or disability were ineligible for coverage, and states could not receive federal Medicaid matching funds to cover these adults, regardless of how low their incomes were. The only way a state could extend coverage to these adults was through a Section 1115 waiver. However, 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.

During the mid-1990s through the early part of 2000, a number of states obtained waivers to expand coverage to childless adults, and in some cases other groups, including parents at relatively higher incomes. Many of these waivers also implemented broader managed care delivery systems than were permitted under federal Medicaid law at the time. Supported by a strong economy, states used savings from mandatory managed care enrollment or redirected Disproportionate Share Hospital (DSH) funds to finance the expanded coverage.

Between 2001 and 2010, a number of states obtained waivers to expand coverage to adults who were otherwise ineligible, but often provided more limited benefits and/or charged higher cost sharing to these adults. In 2001, the Bush Administration released a new Health Insurance Flexibility and Accountability (HIFA) waiver initiative, which provided a streamlined waiver approval process for waivers that expanded coverage within “current level” resources and offered states increased flexibility to reduce benefits and charge higher cost sharing to help finance these expansions.¹ Reflecting the limited financing available to support these coverage expansions, the waivers typically provided adults with more limited benefits and charged them higher cost sharing than otherwise allowed in Medicaid and often limited the number of adults who could enroll in the program. Moreover, some of these waivers covered adults through a premium assistance model that allowed the state to use Medicaid funds to subsidize the purchase of private insurance that did not meet minimum Medicaid benefit or cost sharing rules without requiring the state to supplement that coverage with wraparound benefits or cost sharing.² While these expansions provided more limited coverage than otherwise allowed under Medicaid, because these adults were otherwise ineligible for Medicaid, the more limited coverage was generally compared to the alternative option of no coverage and these adults remaining uninsured.

THE ACA MEDICAID EXPANSION

The ACA expands Medicaid to nearly all individuals with incomes at or below 138% FPL and provides significant federal funding for the expansion. The expansion eliminates the historic exclusion of adults without dependent children from the program and provides federal statutory authority to make millions of adults newly eligible for the program. The federal government will fund 100% of the cost of covering newly eligible adults for the first three years of the expansion, gradually phasing down to 90% over time. Under the ACA, the Medicaid expansion was intended to occur nationwide. However, the Supreme

Court's ruling on the ACA effectively made the expansion a state option. A total of 26 states (including the District of Columbia) are moving forward with the expansion in 2014.³ There is no deadline for states to adopt the Medicaid expansion. In states expanding Medicaid, individuals with incomes between 139 and 400% FPL (above Medicaid levels) are eligible for tax credits to purchase coverage in the Marketplaces.

In states that do not implement the Medicaid expansion, large gaps in coverage will remain for poor adults, and states will forgo significant amounts of federal financing. In most states that do not implement the expansion, Medicaid eligibility for adults will remain well below the federal poverty level (FPL, \$11,670 per year for an individual in 2014). If a state does not expand Medicaid, uninsured adults in that state with incomes at or below the federal poverty level will not gain a new coverage option and will likely remain uninsured. However, those with incomes above 100% FPL who are ineligible for Medicaid will have access to subsidies to purchase coverage in the new Marketplaces. Recent analysis finds that nearly 5 million uninsured poor adults could fall into this coverage gap due to the states' decisions not to implement the Medicaid expansion. Because these individuals will not gain an affordable coverage option as a result of state decisions not to implement the Medicaid expansion, they are most likely to remain uninsured.⁴ Given the 100% federal matching rate for newly eligible adults under the ACA Medicaid expansion, states moving forward with the expansion can expect large increases in federal funds while states not moving forward will forgo these large increases. Guidance issued by CMS clarified that states can continue to evaluate how and whether to adopt the Medicaid expansion and can adopt the expansion at any time.

SECTION 1115 WAIVERS AND THE MEDICAID EXPANSION

Since the ACA expands Medicaid to adults with significant federal funding, the need for and role of waivers in expanding coverage to childless adults fundamentally changes. The ACA Medicaid expansion eliminates the need for a state to obtain a Section 1115 waiver to cover adults and makes substantial federal funding available to cover these adults. However, a small number of states have still expressed interest in using Section 1115 waivers to implement the Medicaid expansion in ways that differ from federal law. To date, 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 covering all newly eligible adults through 138% FPL; it will not approve enrollment caps for the adult expansion group; and 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 (Box 2). CMS has also provided guidance related to how it will determine which adults will qualify for the enhanced federal matching rate for newly eligible adults in states that already expanded coverage to adults prior to the ACA and offered states streamlined waiver approval for several strategies that facilitate enrollment in the Medicaid expansion.⁵

Box 2: Key CMS Guidance About the Use of Section 1115 Waivers for Coverage Expansions Post-ACA⁶

Partial Coverage Expansions

- States cannot receive the enhanced 100% federal matching rate for partial Medicaid coverage expansions that do not extend up to 138% FPL (e.g., an expansion only to 100% FPL).
- CMS will consider partial expansion demonstration waivers at a state's regular Medicaid matching rate if the Secretary determines that the proposal would further the purposes of the program.
- In 2017, when the 100% federal funding for newly eligible enrollees begins to reduce, further demonstration opportunities will become available to states under the ACA's new State Innovation Waiver authority, provided that waivers offer comparable coverage that is comprehensive and affordable at no additional cost to the federal government.

Enrollment Limits

- HHS will not authorize enrollment caps through Section 1115 demonstrations for the new adult group or similar populations (the Secretary has determined that these policies do not further the objectives of the Medicaid program).

Premium Assistance

HHS will consider approving a limited number of Section 1115 demonstrations to test using Medicaid funds to purchase Marketplace coverage for the Medicaid expansion population, provided that:

- States ensure wrap-around coverage for benefits and cost sharing to the extent that Marketplace plans differ from Medicaid requirements;
- Beneficiaries have a choice of at least two Marketplace plans;
- Demonstrations include only enrollees eligible for benefits that are closely aligned with Marketplace benefits packages (e.g., not medically frail); and
- Demonstrations end by December 31, 2016.

RECENT WAIVER APPROVALS AND PROPOSALS

The majority of the 25 states and DC moving forward with the Medicaid expansion in 2014 are implementing the expansion consistent with the new authority created by the ACA by filing a State Plan Amendment (SPA). In these cases, the state is implementing the expansion under the allowable federal rules and options. Within these options and rules, states have significant flexibility in terms of the benefits they provide and how services are delivered to newly eligible adults. To date, 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. CMS has approved waivers to implement the Medicaid expansion in three states, but also denied some of the provisions included in these states' waiver proposals. The following sections review which provisions CMS has approved and denied and those that have been proposed, providing insight into the types of waiver requests CMS is likely to approve in the future and certain limits on the flexibility it is willing to grant through waivers.

APPROVED PROVISIONS IN EXPANSION WAIVERS

Consistent with the guidance indicating that CMS will approve some expansion waivers to test premium assistance, two states have received approval to implement the Medicaid expansion through a premium assistance model (Arkansas⁷ and Iowa⁸). Pennsylvania has a waiver proposal to use premium assistance.⁹ Under this approach, states use Medicaid funds to purchase coverage for some or all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs). States can implement premium assistance programs without a waiver, subject to certain rules. However, Arkansas and Iowa received waivers to allow them to mandatorily enroll beneficiaries in premium assistance. In Arkansas all newly eligible adults, which include childless adults between 0-138% FPL and parents between 17-138% FPL are enrolled in premium assistance. In Iowa, only newly eligible adults with incomes between 100-138% FPL are enrolled in premium assistance. Like Arkansas, the proposed waiver in Pennsylvania would enroll all newly eligible adults in premium assistance (parents between 33-138% FPL and childless adults between 0-138% FPL). Also consistent with the earlier guidance released by CMS related to premium assistance waivers, the Arkansas and Iowa waivers were approved only through 2016.

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 churning between Medicaid and Marketplace coverage due to income fluctuations. How premium assistance affects continuity of care, the impact on access to benefits, how well wrap-around coverage will work, how states will exempt people who are medically frail from their demonstrations, what the impact of premiums and cost sharing will be, and whether the demonstrations will be cost effective are key issues to consider when evaluating the impact of these waivers.¹⁰

CMS has approved waivers that allow premiums for adults between 100 and 138% FPL. Under federal law and regulations released in July 2013, Medicaid beneficiaries with incomes below 150% FPL (\$17,505 per year for an individual in 2014) cannot be charged premiums. Premiums in the Medicaid program are limited given that a large body of research shows that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for low-income groups.¹¹

The recently approved waivers in Michigan¹² and Iowa allow those states to charge monthly premiums equal to 2% of income for newly eligible beneficiaries with incomes between 101-138% FPL. These premiums are 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. In both Iowa and Michigan, premiums will not be imposed immediately (Iowa waives premiums in the first year of its demonstration and Michigan will not charge premiums for at least the first six months following the April 1, 2014 implementation of its expansion). Both states would also allow individuals to have premiums waived or reduced based on compliance with healthy behavior incentives. In Iowa, healthy behavior incentives include completing a health risk assessment and obtaining a wellness examination. In addition, beneficiaries in Iowa have a 90 day grace period to pay past-due premiums in full before termination of Medicaid coverage, and the state must waive premiums for beneficiaries who self-attest to financial hardship in paying the premiums. The Michigan waiver terms and conditions specify that individuals may not lose coverage for failure to pay premiums (or other copayments).

CMS has approved the use of healthy behavior incentives but requires further approval of specific protocols to implement these incentive programs. The recently approved waivers in Iowa and Michigan and the proposed waiver in Pennsylvania¹³ all include healthy behavior programs. In Iowa and Michigan, individuals who complete specified healthy behaviors will have their premiums and cost sharing waived or reduced.

In Iowa, in order to implement its healthy behavior program, after the first year of waiver implementation, the state must submit for CMS approval a protocol for the program and document through data and on-going monitoring that enrollees have adequate access to providers. Any changes to the healthy behaviors protocol must be approved by CMS. For Michigan, there is little detail in the waiver approval about the healthy behavior provisions. These aspects of Michigan's demonstration will be governed by protocols that the state must submit to CMS for approval at least 90 days prior to implementation. The protocols are required to: specify the types of healthy behaviors (such as health risk assessments); 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"; engage stakeholders and the public in developing the healthy behavior standards, show how healthy behaviors will be tracked and monitored at the enrollee and provider level, include a beneficiary and provider education strategy, and include the methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

Under the Pennsylvania proposal, premiums would be reduced by 25% if beneficiaries engage in healthy behavior activities. In the first year of the waiver, these would include completing a health risk self-assessment, paying premiums on time and having a physical exam. The waiver application seeks authority to change or expand the list of healthy behaviors in the future. For example, after three years, the state would evaluate health risk assessment data and determine "broader healthy behaviors" such as cholesterol testing.

CMS has approved limited waivers related to otherwise required Medicaid benefits. 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. However, 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." This coverage may be a state's current Medicaid benefits package for adults. The approved waiver in Iowa allows a benefit package change beyond that allowed under these federal options. Specifically, under the waiver, the state does not have to provide non-emergency transportation to newly eligible adults for one year. After one year, CMS will evaluate the impact on access to care.

States and CMS have complied with new rules about transparency and public input as part of the waiver approval process. As a result of longstanding concerns about the lack of public input and transparency in the waiver approval process, the ACA required the Department of Health and Human Services to issue regulations designed to ensure that the public has meaningful opportunities to provide input into the Section 1115 waiver approval process. The rules, issued in February 2012, require public notice and comment periods at the state and federal levels before waivers are approved by CMS. The rules apply to new Section 1115 waivers and extensions of existing waivers.¹⁴ To date, the waivers in Arkansas, Iowa and Michigan followed

these transparency rules. However, these rules do not apply to waiver amendments, which can result in significant changes to waiver programs. For example, Arkansas indicates that they may seek to include additional populations in premium assistance, add health savings accounts and cost-sharing for populations with incomes between 50-100% in future demonstration years. Consequently, it will be important to monitor how states and CMS apply these rules to waiver amendments going forward. It appears that as part of the waiver approval in Michigan, the state must comply with public notice and comment requirements for any amendments to the waiver.

DENIED AND OTHER PROPOSED PROVISIONS IN RECENT EXPANSION WAIVERS

CMS has not approved waiver requests proposing premiums for individuals with incomes below 100% FPL. In its waiver proposal, Iowa had also sought to charge premiums for beneficiaries with incomes between 50% and 100% FPL (\$5,835 to \$11,670 per year for an individual in 2014). As noted above, a large body of research shows that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for low-income groups.¹⁵ In its waiver proposal, Pennsylvania is seeking to charge premiums for beneficiaries with incomes between 50 and 138% FPL. Under this proposal, premiums could be reduced by 25% for engaging in healthy behavior activities and by another 25% for engaging in required work or work search activities. Pennsylvania would terminate Medicaid coverage for non-payment of premiums after three consecutive months.

CMS has denied requests to waive certain Medicaid benefits. In its waiver proposal, Iowa also requested additional changes in benefits that were not approved. Specifically, CMS denied the state's request to waive the provision of EPSDT services to 19 and 20 year olds and to provide free choice of family planning providers for newly eligible adults (these are services that are required for all Medicaid beneficiaries). The Pennsylvania waiver proposal seeks to waive the federal requirements to cover all family planning providers. It also seeks to waive the requirement to wrap-around benefits for those enrolled in premium assistance including non-emergency medical transportation. In addition, under Pennsylvania's proposal, currently eligible beneficiaries would be screened and enrolled in one of two adult benefits packages: one for "low risk" beneficiaries and one for "high risk beneficiaries." Enrollment would be based on health screening during online application.

CMS has not approved waivers for states to impose cost sharing in amounts greater than those allowed under federal law. The July 2013 final rules that streamlined and simplified existing regulations around premiums and cost-sharing 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.¹⁶ In order to impose higher cost sharing than otherwise allowed under federal law, a state needs to meet the 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 copayments and limiting the demonstration to no longer than two years.

A few of the recent ACA expansion waivers include cost sharing provisions. However, they do not increase beneficiary cost sharing amounts beyond what is allowed under current law. Iowa is imposing and Pennsylvania proposes to impose copayments for beneficiaries for non-emergency use of the emergency room

(for current and newly eligible beneficiaries). In Arkansas, beneficiaries between 100-138% FPL have cost-sharing consistent with existing Medicaid state plan and Marketplace QHP rules. Arkansas intends to seek authority to add cost-sharing for beneficiaries between 50-100% FPL in 2015 and 2016.

In Michigan, after six months, all beneficiaries will have cost-sharing obligations based on their prior six months of copays, billed at the end of each quarter. Cost-sharing will be paid into health savings accounts and can be reduced through compliance with certain healthy behaviors. However, the cost-sharing amounts are the same as what the state would have been able to collect without a waiver. The Michigan waiver terms and conditions specify that 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 copays or premiums.

The Pennsylvania waiver proposal includes work search requirements which have never been approved by CMS. Under Pennsylvania's proposal, all able-bodied adults ages 21-64 would be required to register for work with the state Department of Labor and actively engage in work search or job training activities as a condition of Medicaid eligibility. These beneficiaries would be required to complete 12 approved unspecified work search activities per month during first six months of enrollment to maintain Medicaid eligibility. The proposal would allow exemptions for a crisis, serious medical condition or temporary situation that prevents work search, such as domestic abuse or substance abuse treatment. Failure to comply would result in termination of eligibility; however, beneficiaries who meet certain work requirements could reduce their premium contributions by up to 25%. In the history of waiver approvals, CMS has never approved a waiver that tied Medicaid eligibility to any work requirements.

STATES CONTINUE TO USE SECTION 1115 WAIVERS TO MAINTAIN PRE-ACA COVERAGE

Several states have waivers or waiver proposals to maintain coverage that was in place prior to the ACA, but this coverage is not eligible for the enhanced ACA matching funds for newly eligible adults. These states generally fall into two categories: states implementing the Medicaid expansion and using waivers to provide full Medicaid coverage or other assistance to individuals with incomes above 138% FPL (Minnesota, the District of Columbia and Massachusetts), and states not implementing the Medicaid expansion but using waivers to maintain pre-ACA coverage levels (Wisconsin, Indiana and Oklahoma).

A few states are using waivers to maintain coverage or provide assistance for individuals with incomes above 138% FPL. Minnesota, DC, Massachusetts, New York and Vermont have approved waivers or pending waiver proposals to provide coverage or assistance to individuals with incomes above 138% FPL. Prior to the ACA, a number of other states provided Medicaid coverage to adults above 138% FPL but transitioned coverage of this population to the Marketplaces as of 2014 instead of maintaining Medicaid coverage.¹⁷ Both Minnesota and DC may transition this coverage to a new Basic Health Plan (BHP) once final rules are set for that program. Under the ACA, the BHP is intended to reduce churning between Medicaid and Marketplace coverage by allowing states to use federal funding to offer subsidized health insurance to adults with incomes between 139 and 200% FPL (\$16,221 to \$23,340 per year for an individual in 2014) who would otherwise be eligible to purchase subsidized coverage through the Marketplaces. Federal regulations implementing the BHP were delayed so states cannot officially set up a BHP until 2015.

In a pending waiver extension request, Massachusetts has requested approval to continue to provide assistance to individuals with incomes between 139 and 300% FPL by paying the premiums and cost sharing these individuals would otherwise have to pay for Marketplace coverage. Under its existing waiver, the state uses Medicaid funds to cover individuals with incomes up to 300% FPL through its Commonwealth Care program. Massachusetts is the first state to request approval to assist individuals above 138% FPL with purchasing Marketplace coverage. New York and Vermont also have waiver proposals for similar approaches.¹⁸

A small number of states are using waivers to maintain pre-ACA coverage expansions without adopting the full Medicaid expansion. Wisconsin, Indiana and Oklahoma had waivers to provide coverage to otherwise ineligible adults prior to the ACA. To prevent disruptions in coverage, CMS granted a one year waiver extension for these waivers in Indiana and Oklahoma. In both of these states, the waiver coverage will continue, but coverage will be limited to individuals with incomes below 100% FPL. However, because this coverage is limited (in terms of eligibility and benefits) these states cannot receive the enhanced Medicaid financing available under the ACA Medicaid expansion for new coverage and there will still be large gaps in coverage in Indiana and Oklahoma without implementing the ACA's Medicaid expansion.¹⁹ An estimated 181,930 people in Indiana and 144,480 in Oklahoma will fall into the coverage gap which represents about 9 out of 10 poor uninsured in these states.²⁰ Individuals with incomes above 100% FPL will be eligible for subsidies to purchase coverage in the new Marketplaces.

Wisconsin received waiver approval to cover childless adults with incomes up to 100% FPL as of 2014. As in other states not implementing the Medicaid expansion, individuals with incomes above 100% FPL in Wisconsin will be eligible to receive tax credits to purchase coverage in the Marketplace. As such, there will be

no coverage gap in Wisconsin. Compared to the prior coverage expansion waiver in Wisconsin, Medicaid eligibility for childless adults is reduced from 200% to 100% FPL, but there is no cap on enrollment.²¹ Like Indiana and Oklahoma, Wisconsin is ineligible for the enhanced federal funding associated with the Medicaid expansion because it is not extending Medicaid to the entire population up to 138% FPL.

LOOKING AHEAD

To date, just over half of the states are implementing the ACA Medicaid expansion in 2014. The large majority of these states will implement its expansion as set forth in the law; however, because of the flexibility that exists under federal Medicaid law to allow states to tailor their benefit packages and decide how best to deliver services, the expansion will look different across these states. To date, CMS has issued guidance and approved waivers to implement the Medicaid expansion in three states. Specifically, CMS has approved waiver requests to implement the Medicaid expansion using premium assistance with mandatory enrollment in Marketplace QHPs (in compliance with other guidance issued) and to impose premiums up to 2% of income (similar to what individuals with similar incomes would face in the Marketplace in states not implementing the Medicaid expansion) for individuals with incomes from 100-138% FPL. CMS has also approved the concept of healthy behavior programs (tied to reducing premiums and cost sharing) and limited changes in benefits packages.

On the other hand, CMS has denied requests to impose premiums on individuals with incomes below 100% FPL, waive the requirement to provide wrap around coverage and other benefits in premium assistance models, or impose cost sharing higher than amounts allowed under current law. Some waiver requests, like the ability to impose work requirements, are still outstanding, although CMS has not approved such requests in the past. These decisions shed light on limits for other states to consider when applying for waivers. A limited number of states also continue to use waivers primarily to maintain their pre-ACA expanded coverage levels, but this coverage is not eligible for enhanced ACA matching funds.

Looking forward, additional states may decide to implement the Medicaid expansion and possibly apply for waivers to do so. How CMS decides on future waiver proposals will continue to shape how waivers will be used for coverage post-ACA. It will also be important to understand evaluations of current waiver and determine if the waivers helped states to achieve goals and objectives they were supposed to be testing. What happens with waivers between 2014-2016 will be important to inform the use of the new state innovation waiver authority available in 2017 which will allow states to waive Marketplace coverage provisions and combine those waivers with Medicaid, CHIP and other waivers.

¹ Samantha Artiga and Cindy Mann. *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Kaiser Commission on Medicaid and the Uninsured, 2005), <http://www.kff.org/medicaid/issue-brief/new-directions-for-medicaid-section-1115-waivers/>.

² All HIFA waivers required to include at least a feasibility study of premium assistance.

³ Status of State Action on the Medicaid Expansion Decision, 2014. (Kaiser Family Foundation). <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

⁴ State Profiles: How Will the Uninsured Fare Under the Affordable Care Act? <http://www.kff.org/state-profiles-uninsured-under-aca/>

⁵ Martha Heberlein, Tricia Brooks, Samantha Artiga and Jessica Stephens. *Getting into Gear for 2014: Shifting New Medicaid Eligibility and Enrollment Policies into Drive* (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, November 2013) <http://kff.org/medicaid/report/getting-into-gear-for-2014-shifting-new-medicaid-eligibility-and-enrollment-policies-into-drive/>

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¹¹ Laura Snyder and Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*. (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 Michigan Department of Community Health, Healthy Michigan § 1115 Demonstration Application (November 8, 2013) Michigan Department of Community Health, Healthy Michigan § 1115 Demonstration (December 30, 2013), available at http://www.michigan.gov/documents/mdch/Healthy_Michigan_Plan_1115_Demonstration_Approval_443686_7.pdf

¹³ Pennsylvania Dep't of Public Welfare, Draft Healthy Pennsylvania 1115 Demonstration Application (Dec. 2013), available at http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_039654.pdf.

¹⁴ *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers*. (Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2012) <http://kff.org/health-reform/fact-sheet/the-new-review-and-approval-process-rule/>

¹⁵ Laura Snyder and Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*. (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/>

¹⁶ Federal Register Vol. 78, No. 135, July 15, 2013, pp. 42307-42310.

¹⁷ The ACA has an optional state plan category for people above 138% at 42 CFR 435.218. States would receive the traditional Medicaid match for this population, not the ACA enhanced match for those newly eligible.

¹⁸ New York Department of Health, *3ADM-03 - Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010*, (Albany, NY: New York Department of Health,) September 2013. http://www.health.ny.gov/health_care/medicaid/publications/adm/13adm3.htm.

Vermont Agency of Human Services, Vermont Global Commitment 1115 Demonstration Extension Request Submitted to CMS. (Montpelier, VT: Vermont Agency of Human Services,) revised May 13, 2013. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-pa.pdf>.

¹⁹ Indiana will maintain its enrollment cap and other core components of its waiver, which requires higher cost-sharing contributions and provides more limited benefits than the state's traditional Medicaid state plan benefits package. Oklahoma will continue to provide limited subsidized coverage under the Insure Oklahoma waiver. See: *Healthy Indiana Plan and the Affordable Care Act. Waivers* (Kaiser Commission on Medicaid and the Uninsured, December 2013) <http://kff.org/medicaid/fact-sheet/healthy-indiana-plan-and-the-affordable-care-act/>

²⁰ *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*. (Kaiser Commission on Medicaid and the Uninsured, October 2013). <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>

²¹ Wisconsin Department of Health Services. *BadgerCare+ Reform Project Waiver* (December 31, 2013), <http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm>.