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Protect and Strengthen: Medicaid 1115 Waivers

Each state administers its own Medicaid program, but must meet minimum federal standards. This arrangement affords states a great deal of flexibility in the design and operation of their Medicaid programs. States seeking additional operational flexibility may apply for a Section 1115 demonstration waiver to test new approaches in Medicaid that differ from the standard coverage and benefits required by federal law. Such waivers can be used, for example, to fund Home- and Community-Based Services that allow Medicaid beneficiaries to receive care in their homes rather than in an institution. 1115 Waivers generally reflect priorities identified by states and the Centers for Medicare & Medicaid Services (CMS) as well as changing priorities from one Administration to another.

Importantly, Section 1115 waivers are statutorily required to promote the key objective of the Medicaid program: **to furnish medical assistance to low-income individuals.**

Troublingly, in recent years CMS has approved state waivers that condition eligibility on compliance with burdensome employment and administrative requirements or otherwise restrict Medicaid coverage—seemingly in conflict with the program's aim.

- **Work Requirements:** Increasingly, states are seeking Section 1115 waivers that condition Medicaid eligibility (generally for expansion Medicaid) on compliance with monthly employment and reporting rules. Older adults face particular challenges in meeting work requirements, and the health consequences if they lose Medicaid coverage are likely to be especially severe.[i] In the lone state where these requirements have been implemented, thousands of enrollees have already lost access to Medicaid, many because they were unable to find work or adhere to the state's onerous reporting requirements.[ii]
- **Cost Sharing:** Medicaid rules allow states to impose cost sharing (the amount enrollees pay when they receive a service) within broad federal guidelines. However, these amounts are limited: combined premiums and cost-sharing for all members in a household cannot exceed 5 percent of family income, calculated on a monthly or quarterly basis. However, states can seek waivers to charge enrollees more.[iii] Even small increases can have detrimental effects on an enrollee's ability to keep coverage[iv] and willingness to seek treatment.[v]

Medicaid Waivers: Just the Facts

Arkansas has instituted work requirements via waiver. These requirements have pushed thousands out of Medicaid coverage. A total of 18,164 individuals lost coverage in 2018 due to failure to meet the work and reporting requirements, and few have regained coverage in 2019.

Indiana has instituted premium requirements and disenrollments. These provisions have led to coverage losses. About 25,000 adults were kicked off the Indiana Medicaid rolls, between its start in 2015 and October 2017, for failure to pay their premiums, according to state reports.

Retroactive eligibility was put in place in 1972. The stated Congressional purpose was to "protect persons who are eligible for Medicaid Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying." H.Rep. No. 92-231, 92d Cong., 2d Sess., reprinted in [1972] U.S.Code Cong. & Ad. News 4989, 5099

- Lock-outs and Disenrollment: Currently, if an enrollee loses Medicaid coverage, they can generally reapply and avoid coverage gaps. However, several recent 1115 waivers have included troubling provisions that would lock people out of coverage if they failed to comply with other aspects of the waiver. Enrollees unable to satisfy with the linked requirement—such as paying higher premium amounts—would be disenrolled from Medicaid and not allowed to re-enroll during the lockout period, even if they could subsequently pay their premiums. Such lock-outs create disruptions in care[vi] that lead to poor health outcomes and increased costs for individuals, providers, and state and local governments.[vii]
- Non-Emergency Medical Transportation (NEMT): Medicaid non-emergency medical transportation (NEMT) provides enrollees with transportation to and from scheduled Medicaid-covered services, as required under Medicaid law. Recently, some states have sought 1115 waiver authority to eliminate this benefit. This is extremely problematic, as NEMT is necessary for Medicaid enrollees to get appropriate care at the appropriate time. Lack of transportation is a major barrier to timely access to care.[viii] Many low-income people cannot afford to buy a car or hire a transportation service, and also lack access to affordable and reliable public transit.[ix] Without NEMT, Medicaid enrollees are likely to miss necessary appointments, potentially leading to worse health outcomes and higher health care costs down the road.[x]
- Retroactive Coverage: Upon application, states are required to provide qualifying Medicaid enrollees with three months of retroactive Medicaid coverage. This means enrollees aren't stuck with unaffordable medical bills they incurred before applying for Medicaid, provided they were Medicaid eligible at the time of the charge. It also encourages providers to treat uninsured Medicaid-eligible individuals, because they will be reimbursed for the services once the person is enrolled. Several states have received a waiver of retroactive coverage—exposing Medicaid enrollees to overwhelming medical debt,[xi] reducing provider incentives to provide care, and increasing hospitals uncompensated care burden.[xii]

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[i] Center on Budget and Policy Priorities, "Taking Away Medicaid for Not Meeting Work Requirements Harms Older Americans" (Updated March 14, 2019): https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-older-americans.

[ii] Robin Rudowitz, et al., Kaiser Family Foundation, "February State Data for Medicaid Work Requirements in Arkansas" (March 25, 2019): https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/.

[iii] The Secretary of Health and Human Services can waive cost-sharing rules if the requirements of sections 1916 and 1916A of the Social Security Act are met. In practice, this means state must seek a 1916 waiver (in addition to an 1115 waiver) in order to charge cost sharing above nominal Medicaid amounts set out in Medicaid law. A 1916 waiver has its own set of detailed required protocols and documentation. Few states have approved 1916 waivers for the adult Medicaid population to date.

[iv] Bill J. Wright, et al. Health Affairs, "Raising Premiums and Costs for Oregon Health Plan Enrollees Drove Many to Drop Out" (December 2010): https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0211.

[v] Michael Chernew, et al., NCBI, "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care" (June 14, 2008): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517964/pdf/11606_2008_Article_614.pdf.

[vi] Jacob Dreiher, et al., NCBI, "The association between continuity of care in the community and health outcomes: a population-based study" (May 23, 2012): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3424831/.

[vii] Teresa A. Coughlin, et al., Kaiser Family Foundation, "Uncompensated Care for the Uninsured in 2013: A Detailed Examination" (May 30, 2014): https://www.kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-sources-of-funding-for-uncompensated-care/.

[viii] Paul T. Cheung, Jennifer L. Wiler, Robert A. Lowe & Adit A. Ginde, "National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries," Annals of Emergency Medicine, Volume 60, Issue 1, 4 - 10.e2 (July 2012).

[ix] Gillian B. White, The Atlantic, "Stranded: How America's Failing Public Transportation Increases Inequality" (May 16, 2015): https://www.theatlantic.com/business/archive/2015/05/stranded-how-americas-failing-public-transportation-increases-inequality/393419/.

[x] TRB's Transit Cooperative Research Program, "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation" http://www.trb.org/Publications/Blurbs/156625.aspx.

[xi] David U. Himmelstein, et al., The American Journal of Medicine "Medical Bankruptcy in the United States, 2007: Results of a National Study" (2009): http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

[xii] Amendment to Arkansas Works Section 1115 demonstration, as submitted to HHS Secretary Thomas E. Price on June 30, 2017: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-pa2.pdf.