# No Settled Answers On State Medicaid Waivers

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Sylvia Brown, an associate in the Vorys Columbus office and a member of the health care group, authored a column titled "No Settled Answers On State Medicaid Waivers," which appeared in the March 31, 2014 edition of *Health Law360*. The full text of the column is included below.

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## No Settled Answers On State Medicaid Waivers

Arkansas, Iowa and Michigan recently received approval by the Centers for Medicare and Medicaid Services to expand Medicaid through the use of waivers. A recent article raised the following question: "Is One Brand of Medicaid Expansion Waiver Better than Another?"

The article concluded there is no settled answer — only a fresh opportunity to consider how states provide services, effect positive outcomes and attempt to keep health care costs down. As we consider those issues, it also is worth taking a look at the policy approaches included in the Section 1115 demonstration waivers that Arkansas, Iowa and Michigan are using to expand Medicaid.

The vast majority of states that opted to expand Medicaid did so by providing coverage to low-income adults without dependent children, who earn up to 138 percent of the federal poverty level through the state's Medicaid State Plan in a fashion similar to that being provided to those traditionally eligible for Medicaid. Some states did not, but individuals in those states are not without options.

If a state has not provided coverage, individuals who are at 100 percent or above the federal poverty level — up to 400 percent — are eligible for cost-sharing subsidies in the health care marketplace as well as premium assistance credits to enable an individual to afford a health care plan in the marketplace.

Arkansas, Iowa and Michigan, on the other hand, chose to expand Medicaid coverage to this population through the use of Section 1115 demonstration waivers.

*Medicaid Expansion Through Waivers*

Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to approve "experimental, pilot, or demonstration" projects which promote the objective of the Medicaid program. The secretary is permitted to waive compliance with certain requirements of the Medicaid program and allow the implementation of these projects. According to the Kaiser Family Foundation, states consistently have used these types of waivers to expand eligibility to individuals who are not otherwise eligible for Medicaid or the Comprehensive Health Investment Project ("CHIP") and to use innovative service delivery systems that are intended to improve care, increase efficiency and reduce costs.

If a state's waiver proposal is approved, the state must test and measure the effect of potential program changes while it implements the Section 1115 demonstration waiver. These waivers are approved for a five-year period and the secretary has the discretion to renew the waiver for a longer period of time, usually for an additional three years.

States had the option to pursue early expansion of Medicaid coverage to this population through a Section 1115 demonstration waiver instead of through the existing Medicaid State Plan, and some states did. Arkansas, Iowa and Michigan, however, requested approval for Section 1115 demonstration waivers with markedly different approaches to expanding Medicaid.

*Innovation in Providing Medicaid Coverage*

In Arkansas, the state received approval to operate the Arkansas Health Care Independence Demonstration, or its "Private Option," in which the state will use premium assistance to purchase qualified health plans ("QHPs") offered in the individual market through the health care marketplace for individuals eligible for coverage in two different categories.

The first category is childless adults ages 19 to 65 with incomes at or below 138 percent of the federal poverty level; the second category is parents between the ages of 19 and 65 with incomes between 17 and 138 percent of the federal poverty level. This waiver is set to expire in late 2016.

CMS approved Iowa's two Section 1115 demonstration waivers, the Iowa Wellness Plan and the Iowa Marketplace Choice Plan. Under the Iowa Wellness Plan, Iowa will provide comprehensive health coverage to individuals ages 19 through 64 with incomes up to and including 100 percent of the federal poverty level. Individuals earning up to and including 138 percent of the federal poverty level who are "medically frail," are Native Americans or Alaska Natives or have access to employer sponsored insurance are also eligible for the Iowa Wellness Plan.

Under the Iowa Marketplace Choice plan, Iowa will use premium assistance to allow uninsured Medicaid eligible childless adults between 19 and 64 years of age with incomes up to and including 138 percent of the federal poverty level to purchase QHP coverage offered in the individual health care marketplace. Both waivers are set to expire in late 2016.

Michigan received approval to implement the Healthy Michigan demonstration that allows the state to require premiums for "new adult" beneficiaries with incomes over 100 percent of the federal poverty level and copayment, where applicable, for all new adult beneficiaries between 0 and 133 percent of the federal poverty level. The waiver is set to expire in late 2018.

Evident in each waiver is an emphasis on the idea of individual obligation through the use of cost-sharing or premium assistance approaches. Michigan's focus on individual obligation is perhaps the most specific about the need to encourage individual responsibility. The state determined its requirement for monthly contributions from individuals would assist in the reduction of the growth of health care costs and increase the efficiency of the health care system because the individuals served will become "more active consumers" of their health care and accountable with making health care decisions that will improve health outcomes.

In Arkansas and Iowa, both states require the covered population to choose a QHP in the marketplace using premium assistance provided by the state. Both states determined this market-based approach to covering low-income residents could improve access to quality health care, discourage over-utilization and improve the continuity of care. The states also require individuals to share in the cost of their health care coverage by paying out-of-pocket costs.

Cost-sharing and premium assistance is permissible for Medicaid enrollees, but the maximum out-of-pocket costs are limited and some categories of the population, such as children and pregnant women, are exempt from most costs. In any case, services cannot be withheld for failure to pay.

Each state will be evaluating the approaches to cost-sharing and premium assistance given these limitations and the requirements of the Medicaid program. However, research has shown that cost-sharing and premiums may act as barriers to accessing and maintaining health coverage. Thus, it is questionable whether substantial positive results will emerge from the use of these approaches if they are not accompanied by efforts to encourage coverage for the uninsured and utilization.