AARP PUBLIC POLICY INSTITUTE JUNE 2019

Research Report

The New Medicaid Waivers: Coverage Losses for Beneficiaries, Higher Costs for States

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Acknowledgments

Manatt Health provided data and technical assistance for this paper. The authors thank Edem Hado, policy research senior analyst, AARP Public Policy Institute, and Molly Evans, fellow, AARP Public Policy Institute, for their assistance in finalizing this report.

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INTRODUCTION

Medicaid plays a central role in the US health system. The program enables millions of people to access essential health care and long-term services and supports, and it has helped drive down the nation's uninsured rates to record lows. A recent wave of proposals, if implemented, could drastically affect the direction of this critical program, potentially leaving many people without health coverage.

Federal law allows states to seek permission to "waive" Medicaid requirements in order to conduct "experimental or demonstration projects," as long as the projects are likely to further Medicaid's primary objective to provide access to health care to low-income individuals.

States are using this discretion to seek waivers—and in some cases have already received federal approval for them—that would place new conditions on receipt of Medicaid—like work and/or premium payment requirements. These and other policies states are seeking to impose could result in significant numbers of people losing Medicaid coverage and result in increased costs for states. Although recent federal court rulings have halted the implementation of work requirements in two states, Arkansas and Kentucky, the Centers for Medicare & Medicaid Services (CMS) continues to approve waivers that include potentially harmful policies—including work requirements.

KEY FINDINGS

- Not all states applying for waivers are complying with the federal requirement to provide estimated enrollment impacts in their proposals.
- Among states with waiver applications that include estimates of enrollment impacts, few provide detailed information to help state and federal officials, or the public, understand the basis for their enrollment projections. Consequently, it is difficult to determine whether states, the public, or the CMS have the information needed to understand the impacts of the proposals on individuals and on state budgets.
- Because many states do not estimate how many people are likely to face challenges complying with requirements (including proving they are exempt from the requirement or are performing the required work activities), their estimates of coverage losses may be inaccurate or understated.
- A review of relevant literature on Medicaid and other public programs affirms that current state estimates of coverage impacts of work requirements and the imposition of premiums in Medicaid are likely understated.
- Administrative costs associated with the new waivers are important to consider. Failure to design, conduct, and adequately fund comprehensive outreach and education strategies for new waiver requirements will likely exacerbate coverage losses.

CONCLUSION

Given the critical importance of Medicaid to millions of vulnerable low-income people, state waiver applications should better account for their effect on the people who rely on Medicaid coverage to meet their health care and long-term services and supports needs. Without this transparency, states risk inflicting unintended harm on individuals, their families, and possibly family caregivers.

Introduction

Medicaid plays a central role in the US health care system, providing health care coverage and assistance with basic life functions (such as eating, dressing, and bathing) to millions of Americans. The program has never been static. Since its inception in 1965, it has evolved to meet the changing needs of the people it serves, the providers who deliver services, states (which directly administer their respective programs), and the federal government (which partners with states to fund and run the program).

One way the program evolved recently was through the Affordable Care Act and a subsequent court decision.[1] Those actions gave states the option to provide Medicaid coverage to previously ineligible adults. To date, 37 states, including the District of Columbia, use this authority to provide Medicaid coverage to millions of uninsured low-income adults.[2] Such coverage provides these individuals with access to needed health and preventive services, while driving down the nation's uninsured rates to record lows and reducing the financial burden of uncompensated care on providers and governments.

Section 1115 of the Social Security Act allows the Secretary of the US Department of Health and Human Services (HHS) to approve experimental projects, or waivers, proposed by a state[3] that promote the objectives of the Medicaid program—that is, to provide access to health care and long-term services and supports to low-income children, families, older adults, and people with disabilities. Historically, states have used Medicaid section 1115 demonstration waivers (waivers) to cover new populations or to implement delivery system reforms for covered populations.

Recently, however, the Centers for Medicare & Medicaid Services (CMS), within HHS, has encouraged states to use waivers for very different purposes—in ways that would result in new eligibility barriers for consumers and new burdens for states. Examples of these barriers include conditioning Medicaid eligibility on satisfying work (or volunteering) requirements, imposing enforceable premiums on people with very low incomes, and locking people out of Medicaid coverage if they are unable to comply with certain requirements.

Among the stated goals of these policies are to promote employment and prepare enrollees for private market insurance, yet the evidence suggests that they could lead to loss of Medicaid coverage for millions of low-income individuals, their families, and their family caregivers[4] who have no other source of health insurance coverage. Such policies could also result in increased administrative costs and complexities for states.

Despite clear evidence about the likelihood of coverage losses, most states that have received waiver approvals or have submitted waiver proposals to implement these types of policies underestimate the impact on beneficiaries. As of February 1, 2019, eight states have federally approved waivers allowing them to impose work requirements on individuals, and 10 states have pending waiver proposals. In Arkansas—the first state to implement work requirements—more than 18,000 people lost coverage between September and December 2018. Although people will be able to reapply for coverage the following year, they continue to face threats to enrollment.

A recent federal court ruling put a stop to the continued implementation of Arkansas's work

1 *National Federation of Independent Business v. Sebelius*, 567 US 519 (2012).

2 Kaiser Family Foundation, "Status of State Medicaid Expansion Decisions: Interactive Map," May 13, 2019, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

3 "About Section 1115 Demonstrations," Medicaid.gov, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

4 Natalie Kean, *Medicaid Work Requirements: The Impact on Family Caregivers and Older Adults* (Washington, DC: Justice in Aging, 2018), http://www.justiceinaging.org/wp-content/uploads/2018/11/The-Impact-of-Medicaid-Work-Requirements-on-Family-Caregivers-and-Older-Adults.pdf.

requirement.[5] In reaching its decision, the court found that such requirements do not further the objective of Medicaid, which is to provide health insurance to low-income individuals who would otherwise not be able to afford such coverage. In a companion decision to the Arkansas case, the same court reiterated its findings from an earlier decision that kept (and continues to keep) Kentucky from implementing its federally approved work requirement.[6] Despite these recent rulings, the federal government is moving forward with its approval of waivers that impose work requirements.[7] More litigation is certain to follow.

This *Research Report* describes emerging section 1115 waiver policies and discusses ways in which these policies—and how they are implemented and administered—can affect Medicaid enrollment. The report also describes how examining the research literature and evaluations of programs that impose similar policies can provide guidance on predicting the coverage and cost impacts of emerging waivers on Medicaid beneficiaries and states.

5 *Gresham v. Azar II*, https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/03/Opinion-Gresham-v-Azar.pdf.

6 *Stewart v. Azar II*, https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/03/Opinion-Stewart-v-Azar.pdf.

7 Kaiser Health News, "CMS Approves Utah Work Requirements Just Two Days After Court Ruled Them Illegal For Kentucky, Arkansas," April 1, 2019, https://khn.org/morning-breakout/cms-approves-utah-work-requirements-just-two-days-after-court-ruled-them-illegal-for-kentucky-arkansas/.

Emerging Waiver Policies

FEDERAL WAIVER REQUIREMENTS RELATED TO PUBLIC REVIEW AND COMMENT

The federal government requires states to solicit public feedback at the state level before submitting waiver applications to the federal government. CMS also solicits public comments at the federal level when it is reviewing state waiver applications.[8] As part of the public comment process, states are required to provide information about the coverage and cost impacts of the proposed waiver (*see* box 1). Despite these requirements, many recently approved waivers and pending proposals provide limited information on coverage and cost impacts. This lack of detailed information could prevent stakeholders from fully understanding the potential for dramatic losses in Medicaid enrollment and the huge uncompensated care costs that could fall to states as a result.

OVERVIEW OF NEW STATE WAIVER POLICIES

The federal government is approving waivers that give states authority to implement a range of new Medicaid policies, many of which could result in loss of coverage for beneficiaries. Among the individuals potentially losing coverage are those who only recently attained such coverage under the authority of the Affordable Care Act.

These new waivers—individually or taken together—add to the complexity of the program and reverse years of progress that significantly

Box 1
Section 1115 Public Notice Requires States to Provide Coverage and Cost Estimates

To ensure that the public has adequate notice about proposed waivers and a meaningful opportunity to comment on them, federal regulations require that states seeking new waivers and extensions of existing waivers include enrollment and expenditure projections as part of the public notice process.*

Many approved demonstration special terms and conditions (STCs) apply these public notice requirements to substantive amendments as well (e.g., those that impact eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, and other comparable program elements).

Before submitting a new waiver application; a waiver extension; or, in many cases, a waiver amendment to CMS, states must provide the public with a comprehensive description of the proposal. The description must include "an estimate of the expected increase or decrease in annual enrollment and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the state in its extension request."** While states are not required to include estimates of administrative costs, the cost implications of changes in enrollment (including those associated with administrative decisions) should be included in waiver applications when posted for public comment and when submitted to CMS for review.

** 42 CFR §431.408(a)(1)(i)(C), https://www.law.cornell.edu/cfr/text/42/431.408.*

*** 42 CFR §431.408(a)(1)(i)(C) sets out public notice requirements for new demonstrations and extensions of existing demonstrations;* see *https://www.law.cornell.edu/cfr/text/42/431.408.*

8 Regulations at 42 CFR § 431.408 set out state public notice process requirements for new demonstrations and extensions of existing demonstrations; many approved demonstration STCs apply these requirements to substantive amendments as well (e.g., those that impact eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, other comparable program elements). Regulations at 42 CFR § 431.412 outline application procedures for new demonstrations and extensions, cross-referencing the requirements at 42 CFR § 431.408, https://www.law.cornell.edu/cfr/text/42/431.408 and https://www.law.cornell.edu/cfr/text/42/431.412. Approved waiver STCs similarly establish parameters for amendment applications.

increased coverage rates for eligible individuals. In addition to loss of needed Medicaid coverage, these complexities add burden for applicants, current beneficiaries, family caregivers, and states. Below, we provide an overview of the most prevalent emerging waiver policies that threaten coverage (*see* table 1 for a more complete description of emerging waiver policies as of February 1, 2019).

Work Requirements

Work requirements condition Medicaid eligibility on participation in employment or volunteer community activities or demonstration of a satisfactory exemption from the requirement. Although work requirements are new to the Medicaid program, lessons from other programs like the Supplemental Nutrition Assistance Program (SNAP)—formerly known as the food stamp program—and evidence from Arkansas's recent implementation of a work requirement suggest that this policy will cause large numbers of people to lose coverage. Several factors could drive likely coverage losses. These include lack of awareness of the work requirement or a qualified exemption from the requirement; fluctuating work hours; lack of supportive services (such as transportation or childcare); lack of awareness of reporting requirements and/or how to comply with reporting requirements; and lack of access to the technology (e.g., computers or smartphones) needed to comply with requirements. These factors will likely be especially problematic for people with health problems, language barriers, and other challenges.

Lockouts

Some states are implementing or proposing lockout policies—loss of coverage for a specified length of time—as a penalty for failing to timely renew Medicaid eligibility or timely report changes in income, or failing to comply with work requirements. This policy would deny people access to needed coverage, and possibly needed services, for a specified length of time even if they meet requirements before the lockout period expires.

Eliminating Retroactive Eligibility

Eliminating retroactive eligibility undermines current policy that allows the effective date of coverage to go back three months prior to the month a Medicaid application was initially filed.[9] The goal of this policy is to ensure that people receive the care they need (including long-term services and supports)—when they need it—without incurring crushing medical debt. The policy also ensures that health care providers receive payment for services delivered during the three-month look-back period. Retroactive eligibility is vital for people living on the financial margins who have an acute medical event that leaves them in need of expensive hospital or nursing home care. Eliminating retroactive coverage puts patients and providers at risk. The policy could result in people not getting the care they need because of provider concerns about not being paid for delivered services. The policy also exposes low-income beneficiaries to potentially high medical bills if they do receive care.

Premiums

The federal government also is approving proposals that impose premiums on Medicaid beneficiaries in larger amounts or for lower-income individuals than is allowed under current law and under prior administrations' waivers. Imposing burdensome premiums on low-income people and conditioning Medicaid eligibility on payment of those premiums will likely result in many people becoming uninsured. Studies clearly demonstrate that imposing relatively small premiums and cost sharing on low-income individuals can cause them to become uninsured, leading to unmet health needs—like increased rates of uncontrolled high blood pressure—and increased use of costly emergency room care. Studies also show that revenue gains associated with increasing premiums on low-income individuals are illusory.[10]

9 Retroactive eligibility provides for Medicaid coverage of medical costs incurred in the three months prior to an individual's application. Hospital presumptive eligibility allows individuals to receive a temporary period of coverage if they are determined eligible by a qualified hospital provider. Prompt enrollment refers to a requirement that Medicaid eligibility must take effect no later than the date of application or, at state option, the first day of the month of application.

10 Samantha Artiga, Petry Ubri, and Julia Zur, *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (Washington, DC: Kaiser Family Foundation, 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/print/.

Other Policy Proposals

In addition to the more prevalent policies discussed above, states are advancing other waiver policies. These policies may also restrict Medicaid eligibility and/or negatively impact enrollment. Examples of these policies include requiring people to complete health risk assessments, eliminating hospital authority to assess individuals for presumptive Medicaid eligibility, delaying effective dates for Medicaid enrollment, imposing time limits on coverage, imposing more restrictive asset transfer policies, creating additional citizenship and residency requirements, capping Medicaid enrollment for expansion adults, and eliminating transitional Medicaid for parents (*see* table 1).

Table 1

States with Recently Approved or Proposed Waivers to Condition or Limit Medicaid Eligibility, as of February 1, 2019

Policy	Approved States	Proposed States
Work requirements*	AR, AZ, IN, KY, ME, MI, NH, WI	AL, KS,** MS, OH, OK, SC, SD, TN, UT,** VA
Premiums*	AZ, IN, IA, KY, ME, MI, MT, NM, WI	VA
Assessment or completion of health behaviors	MI, WI	None
Timely renewal*	IN, KY	None
Timely reporting of changes in circumstances*	KY	None
Eliminating or reducing retroactive eligibility	AR, AZ, IA, IN, KY, ME, NH, NM, OK, UT	FL
Eliminating requirement for hospitals to determine presumptive eligibility**	None	ME, UT
Delaying the effective date of enrollment	IN, KY, NM	VA
Time limits on coverage***	None	AZ, KS, UT
Other	Restriction on asset transfers: ME	Asset test: ME**
		Asset test, additional requirements to document citizenship and residency: NH**
		Enrollment cap for expansion adults: UT**
		Elimination of transitional Medicaid for parents: NM**

Notes: *Excludes policies that do not have an impact on eligibility (e.g., premiums for which there is no disenrollment consequence for nonpayment, voluntary work referral programs) and those that would allow a partial expansion with enhanced federal funding (which thus far have not been acted on by HHS). States may appear in both the approved and proposed columns for a given policy if they have sought waiver modifications. Incoming governors in both New Mexico and Maine have indicated that they do not intend to implement all approved authorities.*

** Lockout policy applies as a consequence for the following: work requirements proposed or approved in Arizona, Arkansas, Indiana, South Dakota, and Wisconsin; premiums approved or proposed in Indiana, Kentucky, Maine, Michigan, New Mexico, Virginia, and Wisconsin; timely renewal reporting approved in Indiana and Kentucky; timely change in circumstance reporting approved in Kentucky.*

*** CMS recently approved several states' waivers without approving or specifically denying certain proposals, including requests to eliminate transitional Medical assistance coverage (New Mexico); eliminate hospital presumptive eligibility (Maine and Utah); impose asset tests (Maine and New Hampshire; federal law expressly limits CMS's ability to allow asset tests for certain populations); impose time limits (Utah; as noted below, Arizona and Kansas time limit provisions were denied); impose work requirements (Kansas, which requested that CMS defer consideration of the provision, and Utah); or require additional citizenship/residency documentation (New Hampshire).*

**** Arizona initially included a time limit in its proposal but subsequently requested to exclude it from discussions in order to expedite negotiations with CMS; the provision ultimately did not receive approval. The Kansas proposal also received a denial by CMS. Utah's most recent waiver received approval without reference to this provision and several others.*

Waiver Policy Decisions: Estimating Impacts on Coverage

The public and key decision makers need thoughtful and comprehensive estimates of the coverage impacts of waiver proposals—that is, the number of people who will gain or lose Medicaid coverage—as they consider whether a waiver represents sound public policy and furthers the objectives of the Medicaid program. State policy makers should review waiver applications with, among other considerations, an eye toward impacts on their constituents. In addition, the public should receive enough information to determine whether the impacts on beneficiaries promote the goals of Medicaid.

Projecting coverage impacts can be difficult because so many aspects of a proposed policy—including outreach, education, and implementation plans—can affect coverage gains or losses. Policy makers should consider a range of factors when constructing estimates of coverage impacts, including the following:

- Targeted and exempt groups
- Work requirement policies
- Cost-sharing Policies
- Consumer outreach, education, and supports
- Administrative processes
- Noncompliance

Following is an examination of how each of these factors could affect coverage and why states should consider them when they develop estimates of the impact of state waiver policy choices on Medicaid enrollment.

IMPACT OF TARGETED AND EXEMPT GROUPS ON COVERAGE

The number of people in groups subject to waiver requirements (e.g., the *target* group)—for example, all nondisabled adults versus *expansion* adults—and the number of people expected to qualify for exemptions within a target group (e.g., *family caregivers*)—help determine the baseline number of people affected by a waiver policy. Federal guidance relating to work requirements requires states to exempt some groups, but states are generally free to set their own criteria beyond the federal minimums (*see* boxes 2 and 3).[11]

Decisions about targeted *and* exempt groups can play a large role in determining coverage impacts on Medicaid enrollees. For example, some, but not

Box 2
Populations That Must Be Exempted from Medicaid Work Requirements*

- Children, pregnant women, adults ages 65 or older, and individuals eligible for Medicaid based on a disability
- Individuals determined by the state to be "medically frail"
- Individuals with "acute medical conditions" validated by a medical professional that would prevent them from complying with the requirements
- Individuals who are complying with or exempt from SNAP and Temporary Assistance for Needy Families (TANF) work requirements

* *Letter from Centers for Medicare & Medicaid Services (CMS) to State Medicaid Directors,* Opportunities to Promote Work and Community Engagement among Medicaid Beneficiaries *(Baltimore, MD: CMS, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.*

11 The federal government may also deny an exclusion or exemption sought by states. For example, it is currently unclear whether and under what circumstances an exclusion of Native Americans from work requirements would be allowed. Dan Diamond, "Trump Readies New Round of Controversial Medicaid Changes," *Politico*, August 16, 2018, https://www.politico.com/story/2018/08/16/medicaid-changes-trump-work-drug-use-741890.

Box 3
Populations That May Be Exempted from Medicaid Work Requirements

- Primary caregivers of dependents, individuals with disabilities or health-related barriers to employment, individuals participating in tribal work programs, victims of domestic violence, other populations with extenuating circumstances, and full-time students
- Individuals with opioid addiction and other substance use disorders who are participating in intensive medical treatment
- Individuals who meet good cause exemptions used in SNAP/TANF
- Individuals who meet good cause exemptions that reflect market forces and structural barriers
- Other exemptions as determined by the state

* *Gary Koenig, Lori Trawinski, and Sara Rix,* The Long Road Back: Struggling to Find Work after Unemployment *(Washington, DC: AARP Public Policy Institute, 2015), https://www.aarp.org/content/dam/aarp/ppi/2015-03/The%20Long%20Road%20Back_INSIGHT-new.pdf.*

all, states exempt people ages 50 and older from work requirements; others do not. Older adults face significant barriers to workforce reentry like employer reluctance to hire the long-term unemployed and age discrimination in hiring practices.[12]

States that impose work requirements on older adults may experience a higher need to provide affected adults with job training, volunteer opportunities, or other activities that will satisfy the work requirement. States that lack resources to accommodate these needs may experience higher disenrollment rates.

IMPACT OF WORK REQUIREMENT POLICIES ON COVERAGE

The potential coverage impacts of work requirement policies depend on a state's waiver design choices. Decisions related to how work and/or volunteer activities are defined (e.g., what constitutes work, how many hours are required, whether hours may be averaged over time) impact coverage. States that may see higher numbers of people losing coverage are those that narrowly define the types of activities that meet work and/or volunteer requirements, impose large numbers of work and/or volunteer hours, or do not accommodate fluctuations in income by allowing people to average their work and/or volunteer hours over a period of time.

It is also important for states to consider economic conditions and the availability of jobs in wage sectors in which low-income individuals are most likely to seek employment. If employment conditions in a state will not support the number of people impacted by a work requirement, the state will need to increase the availability of volunteer opportunities or other acceptable alternatives. States unable to respond to the demand for employment or acceptable alternatives will likely experience decreases in Medicaid enrollment, as people will have no feasible option to comply with the waiver requirement.

It is critical for states to consider how policy decisions related to work requirements and acceptable alternatives can impact coverage and to develop estimates that consider their policy choices.

IMPACT OF COST-SHARING POLICIES ON COVERAGE

Decisions about who will incur new premium obligations, the amount of the premiums, and the consequences for nonpayment will all impact

12 Gary Koenig, Lori Trawinski, and Sara Rix, *The Long Road Back: Struggling to Find Work after Unemployment* (Washington, DC: AARP Public Policy Institute, 2015), https://www.aarp.org/content/dam/aarp/ppi/2015-03/The%20Long%20Road%20Back_INSIGHT-new.pdf.

coverage. States seeking waiver authority to impose premiums vary in terms of the amount of the premium, the ways in which people can pay their premiums, and the penalty for failure to pay.

These decisions will influence how many people are likely to comply and, thus, how many could lose coverage. For example, Arizona has authority to charge monthly premiums of up to $25 for enrollees with incomes above 100 percent of the federal poverty level (FPL)—just over $12,000 a year for an individual in 2018—but does not disenroll people who do not pay.

In contrast, Wisconsin recently became the first state to receive federal approval to disenroll people below the poverty line, with income as low as 50 percent of poverty—approximately $6,245 a year for an individual in 2019—for not paying a premium.

States that impose burdensome premiums on very low-income individuals and/or their families and disenroll them for nonpayment will likely see significant losses of coverage among those who arguably need health coverage the most. It is critical that waiver proposals provide realistic estimates of the impact of policy choices related to premiums *and* the underlying methodology used to determine these estimates.

IMPACT OF CONSUMER OUTREACH, EDUCATION, AND SUPPORTS ON COVERAGE

As states implement waiver requirements, it is vital to make outreach, education, and ongoing support available to all consumers living in those states. Outreach and education strategies must be statewide, culturally and linguistically competent, and accessible to people with disabilities.

In addition, a range of supportive services should be available to help individuals successfully comply with certain requirements, in particular those related to work or volunteering. Examples include help securing job training, conducting job search activities, obtaining childcare, finding transportation, and complying with reporting requirements.

Even if states conduct robust education and outreach as well as provide adequate supportive services, which generally require state funding, these actions will not necessarily avert coverage losses. While these activities go far to inform beneficiary impacts and state costs, they may not necessarily meet the needs of special populations—like those with cognitive limitations, low literacy levels, or serious health conditions, or those experiencing homelessness.

IMPACT OF ADMINISTRATIVE PROCESSES ON COVERAGE

The administrative processes states establish to report work, report exempt status, or pay premiums can significantly impact enrollment over time. For example, the process for obtaining an exemption from waiver requirements and for complying with state requirements for periodically documenting exempt status could affect coverage as much as (or even more than) the actual policy choice to exempt certain individuals from a work or premium payment policy.

Arkansas provides a useful illustration of the consequences resulting from state decisions about administrative process. Arkansas uses data matching—electronically matching individual Medicaid data with SNAP data—to identify beneficiaries who are exempt from the work requirement and to identify beneficiaries who meet the work requirements by virtue of meeting the SNAP work requirement. Data matching decreases barriers for individuals whose data matched through such systems. It does nothing for those who are not in the electronic system.

Initially, Arkansas required individuals whose status was unable to be determined through electronic systems to prove their exempt status or report compliance using an online reporting portal available between 7 a.m. and 9 p.m.[13] This proved to be a significant barrier. Between 25 percent and 31 percent of nonexempt adults who were potentially subject to the state's work requirement lacked Internet access at home.[14] This problem is not unique to Arkansas (*see* box 4).

13 Anuj Gangopadhyaya et al., *Medicaid Work Requirements in Arkansas* (Washington, DC: Urban Institute, 2018), https://www.urban.org/sites/default/files/publication/98483/2001846_2018.05.23_arkansas_medicaid_finalized.pdf.

14 Ibid.

As an alternative to online reporting, Arkansas established a helpline that is accessible during the same hours as the online portal and allows people to report by phone. The state added the helpline to respond to concerns about online reporting.[15] However, it is unclear how many beneficiaries are aware of the new reporting option (*see* Outreach and Education section, above).

Similarly, in states with waivers that impose premium requirements, making payments may require individuals without bank accounts to purchase money orders that may have fees equaling or exceeding the premium in some cases.[16] These fees, on top of required premiums, are likely prohibitively expensive for many low-income individuals and/or families and could cause them to lose coverage for nonpayment. Accurate and transparent estimates of coverage impacts must reflect these types of real-world considerations.

Box 4
Broadband Subscription Rates Are Lowest Among Low-Income Households

An analysis of American Community Survey data found that many states with pending or approved waivers to impose work requirements have broadband subscription rates lower than the national average, with the lowest rates found among low-income households. This finding suggests that online reporting requirements will present a significant barrier to compliance in many waiver states.*

* *Camille Ryan,* Computer and Internet Use in the United States: 2016 *(Washington, DC: US Census, 2018), Report Number ACS 39, https://www.census.gov/library/publications/2018/acs/acs-39.html.*

IMPACT OF NONCOMPLIANCE POLICIES ON COVERAGE

The consequences for not meeting state requirements related to the implementation of new waiver policies vary among states; they can limit coverage losses or exacerbate them. For example, in some states, work requirement and premium payment policies provide a one- or two-month grace period that gives people who have not satisfied requirements the opportunity to become compliant. Other states are not so lenient, imposing lockout periods that immediately terminate coverage for those who fall into noncompliance.

Some states allow a certain amount of time before applying penalties (including disenrollment) for not meeting waiver requirements and/or not fulfilling reporting requirements. These reprieves give people more time to become informed about work requirements and reporting procedures and may help them avoid disenrollment. Other states disenroll people immediately for noncompliance.

In states with *lockout policies*—barring people from receiving Medicaid for a certain period of time if they fail to comply with a new waiver and/or reporting requirement—people are prevented from receiving Medicaid coverage for a specified period, even if they demonstrate compliance or the ability to comply before the period has expired. Arkansas has a lockout for one to nine months, depending on in which month the lockout begins. Indiana and Kentucky include lockouts for nontimely renewal reporting, but the states have 90-day grace periods that will

15 Arkansas Department of Human Services, "DHS Expanding Phone Reporting, Outreach for Arkansas Works Enrollees," December 12, 2018, https://humanservices.arkansas.gov/newsroom/details/dhs-expanding-phone-reporting-outreach-for-arkansas-works-enrollees.

16 MaryBeth Musumeci et al., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana* (Washington, DC: Kaiser Family Foundation, 2017), http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Medicaid-Expansion-Waiver-Implementation-in-Michigan-and-Indiana.

likely help mitigate coverage losses.[17] Some states require people to pay all previously owed premiums before the end of a lockout period in order to reenroll.

Lockout policies and grace periods have a direct influence on Medicaid coverage, and state estimates should reflect their impacts. This information helps policy makers and the public determine how harsher penalties could cause large numbers of people to lose Medicaid coverage.

SUMMARY OF COVERAGE AND COST IMPACTS

States should consider all of the above factors when estimating the impact of waiver policy decisions. The analysis of state coverage impacts presented in table 2 shows that state estimates vary widely—ranging from one state that would impose work requirements on most expansion adults projecting no material impact on enrollment to a non-expansion state proposing work requirements for its eligible parent population projecting a 20 percent reduction in enrollment for this population.

Evaluating the coverage impacts of new waiver proposals (or in some cases the lack of such estimates, among those reviewed for this report) raises concerns. First, most of the waiver proposals considered in this report do not provide comprehensive projections of coverage impacts. In addition, the absence of underlying assumptions to support state estimates is troublesome because there is no basis for determining how these estimates were determined. Without more information, policy makers and the public do not know whether state estimates have considered the wide range of variables described above that can significantly affect the estimates.

17 Indiana indicates its prior experience suggests that 6 percent of renewal cases result in closure due to nonresponse within 90 days; half of these cases are estimated to be individuals who remain eligible. Under the new policy, the state assumes that 2 percent of renewal cases will result in closure due to non-timely reporting among eligible individuals (a reduction of 1 percentage point relative to current policy); these individuals will be subject to a lock-out but given that the lock-out lasts only half the year the impact on average monthly enrollment is estimated at 1 percent. Letter from State of Indiana Office of the Governor to US Department of Health and Human Services, *Health Indiana Plan Section 1115 Demonstration Waiver Amendment to Extension (Project No. 11-W-00296/5)* (Indianapolis: State of Indiana Office of the Governor, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa5.pdf.

Evidence from Prior Research and Program Evaluations

Evidence from research and evaluations that has considered coverage losses associated with previous waiver policies can inform coverage and cost impacts of current wavier policies. Examples of impacts of the same types of policies imposed in other low-income programs are also useful to inform current waiver policies. The following discussion illustrates how considering prior research and program evaluations can inform state estimates.

INCREASED ADMINISTRATIVE BARRIERS AND COVERAGE IMPACTS: THE EVIDENCE

Many of the new waiver policies discussed in this paper impose new reporting and administrative requirements on applicants, current beneficiaries (and possibly their families), and administrating agencies. These requirements are bound to have a negative impact on Medicaid coverage over time.

Studies show that disenrollment rates due to administrative burdens like beneficiary reporting and other administrative requirements in Medicaid or the Children's Health Insurance Program range from 5 percent to 30 percent of enrollees who otherwise meet eligibility criteria, depending on the specific policies and populations impacted by the policy.[18] Evidence also suggests that reporting requirements can drive down enrollment even when people comply with the actual requirements but fail to successfully report their activities to the state.[19]

Possible reasons for not meeting paperwork and other administrative requirements may include a lack of knowledge about the requirements, inability to understand requirements, confusion about how to meet reporting requirements, not having access to the technology needed to comply, and difficulty navigating the systems and processes required to meet them.[20] People could also be experiencing significant health problems, homelessness, or literacy barriers that prevent them from meeting administrative requirements.

- In Arkansas, in addition to the lack of Internet access described above, beneficiaries may face challenges with literacy and comprehension. Among Arkansas Medicaid enrollees potentially subject to the work requirement who are currently unemployed, 23 percent did not have a high school diploma and 18 percent reported cognitive limitations such as difficulty concentrating, remembering, or making decisions.[21]
- Early survey results of Iowa Medicaid enrollees subject to a premium requirement under the state's waiver found that 90 percent did not know the state waives premiums for individuals who meet a healthy behavior requirement.[22]
- A recent evaluation of Indiana's waiver found that one-third of individuals who were disenrolled for nonpayment of premiums were

18 Rachel Garfield, Robin Rudowitz, and MaryBeth Musumeci, *Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses* (Washington, DC: Kaiser Family Foundation, 2018), https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/.

19 Ibid.

20 Letter from National Health Law Program to US Department of Health and Human Services, *Kentucky HEALTH Project* (Washington, DC: National Health Law Program, 2018), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/NHeLP-comments-8.18.18-FINAL.pdf.

21 Gangopadhyaya et al., *Medicaid Work Requirements in Arkansas*. These and other issues have been confirmed in qualitative interviews with program enrollees: Jessica Greene, *Medicaid Recipients' Early Experience with the Arkansas Medicaid Work Requirement* (Washington, DC: Health Affairs Blog, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

22 Natoshia M. Askelson et al., *Health Behaviors Incentive Program Evaluation Interim Report* (Iowa City: University of Iowa Public Policy Center, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-bhvrs-int-rpt-mar-2016.pdf.

not aware that they could lose coverage for this reason.[23]

INCREASED COVERAGE LOSS AS A RESULT OF IMPLEMENTING WORK REQUIREMENTS: THE EVIDENCE

Although work requirements are new to the Medicaid program, findings from Arkansas (the first state to implement such a requirement in Medicaid) suggest that the coverage impact of this policy choice can be substantial. In Arkansas, even with considerable automation of exemption and compliance determinations, 23 percent of expansion adults subject to the policy in 2018 lost their Medicaid coverage for noncompliance (*see* box 5).

While it is difficult to draw comparisons across states due to differences in policies and populations, Arkansas has experienced disenrollment rates in excess of 20 percent despite having a high degree of automation in its determination of exemptions and compliance. In states with lower levels of automation, disenrollment rates could be even higher than those in Arkansas.

When considering the likely impact of work requirements, past experience with SNAP—

Box 5
Recent Arkansas Experience with Medicaid Work Requirements*

In June 2018, Arkansas became the first state to implement a work requirement in Medicaid. The requirement affects expansion adults, with an exemption for those ages 50 or older.

- Because the state makes extensive use of existing data to determine compliance and exemptions, not all individuals have a reporting obligation. For example, before the state began disenrolling beneficiaries, only one-third of those who were subject to the work/community engagement requirement were obligated to report.** Among those who were required to report work/CE activities in 2018, a large share—75 percent—were disenrolled.*** In January 2019, 86 percent of those required to report activities did not do so, indicating that coverage losses would have likely continued had a federal court not halted implementation of the state's work requirement. In total, 23 percent of beneficiaries subject to the work/CE requirement in 2018—more than 18,000 out of 79,000—were disenrolled.† Fewer than 300 individuals reported noncompliant activities in any given month, meaning that nearly all of the 18,000 lost coverage because they did not meet the reporting requirement.
- At a Senate hearing on the subject, the HHS secretary suggested that those who lost coverage likely found employment. Data from the state's New Hire Database do not support this claim.‡

** Analysis of ARWorks Monthly Reports, "Reports, Toolkits & Infographics,"* Arkansas Department of Human Services, *https://humanservices.arkansas.gov/newsroom/toolkits*.

*** Based on data for August 2018. The percentage in later months is higher as people with administrative determinations remained enrolled while many of those with a reporting requirement were disenrolled.*

**** The number required to report work/CE activities reflects those who had a reporting obligation and no exemption in December 2018, plus the cumulative number disenrolled.*

† Based on cumulative disenrollment as a share of beneficiaries who were enrolled in December 2018, plus those who were disenrolled.

‡ Jennifer Wagner, New Arkansas Data Contradict Claims That Most Who Lost Medicaid Found Jobs *(Washington, DC: Center on Budget and Policy Priorities, March 2019), https://www.cbpp.org/blog/new-arkansas-data-contradict-claims-that-most-who-lost-medicaid-found-jobs*.

23 The Lewin Group, *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment* (Falls Church, VA: Indiana Family and Social Services Administration, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

formally known as the food stamp program—and TANF may be instructive.

During the recession from 2009 to 2015, many states waived SNAP work requirements in areas where unemployment was high. As the economy recovered and waivers expired, SNAP participation among nondisabled adults without dependents dropped by 50 percent to 85 percent among studied states.[24]

For example, after Kansas reinstated its SNAP work requirement, enrollment of those subject to the requirement was 75 percent lower than before the waiver period. Similarly, in Maine, 80 percent of those subject to the SNAP work requirement were dropped from the program within three months of reinstatement of the work requirement following the waiver period. Although improved economies may account for some of the decline, these data still suggest that work requirements may have significant, detrimental effects on enrollment.[25]

Research on the TANF program also illustrates that work requirements could adversely impact Medicaid enrollees—especially those who are most vulnerable.[26] For example, over two-thirds (41 percent) of unemployed TANF beneficiaries who lost their benefit had poor mental or physical health.[27] Other research found that those penalized for not meeting TANF work requirements were more likely to have a disability compared with those who were not subject to a penalty.[28]

Taken together, research on SNAP and TANF work requirements have implications for work requirements in Medicaid. Findings from the two programs suggest that Medicaid enrollment is likely to experience significant declines in states that adopt—and vigorously enforce—work requirements.

IMPOSING PREMIUMS ON LOW-INCOME INDIVIDUALS: THE EVIDENCE

While premiums are a common feature of commercial insurance, research shows that when imposed on low-income people they have a negative impact on coverage.[29] As a result, Medicaid generally prohibits the imposition of premiums on those with incomes under 150 percent of the FPL (approximately $18,735 for an individual in 2019) and does not allow states to deny coverage for failure to pay premiums.[30] Studies—including foundational work conducted years ago by the RAND Corporation—have consistently found that premiums, even modest ones, significantly reduce participation in health coverage programs among low-income people.[31]

Early evidence from states with recently approved Medicaid waivers suggests that premiums (and copayments) have resulted in low-income Medicaid enrollees accumulating debt[32] and a significant number of people losing Medicaid

24 Erin Brantley and Leighton Ku, "Work Requirements: SNAP Data Show Medicaid Losses Could Be Much Faster and Deeper than Projected," *Health Affairs Blog*, April 12, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180412.310199/full/.

25 Ibid.

26 MaryBeth Musumeci and Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience* (Washington, DC: Kaiser Family Foundation, 2017), https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/.

27 Ibid.

28 Musumeci and Zur, *Medicaid Enrollees and Work Requirements*.

29 Artiga et al., *Effects of Premiums and Cost Sharing*.

30 Similarly, low-income Medicare beneficiaries have premium protections under federal law, with Medicare Part B premiums paid by Medicaid for those with incomes up to 135 percent FPL and Part D premiums subsidized by the federal government for those with incomes up to 150 percent FPL.

31 Artiga et al., *Effects of Premiums and Cost Sharing*.

32 Letter from Michigan Department of Health and Human Services to Centers for Medicare & Medicaid Services (CMS), *Michigan Adult Coverage Demonstration Section 1115 Quarterly Report* (Lansing, MI: Michigan Department of Health and Human Services, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-qtrly-rpt-jul-sept-2015-02082016.pdf.

enrollment[33] or never enrolling.[34] A recent evaluation found that more than half of adults with income above 100 percent of the FPL who were determined eligible for Indiana's Medicaid program and were required to pay premiums did not do so.[35]

These studies and evaluations suggest that imposing premiums on people with very low incomes will likely result in substantial coverage losses, particularly in states that allow few exemptions from premium payments and that lock people out of coverage for a number of months as the penalty for nonpayment.

DELAYED EFFECTIVE DATES FOR COVERAGE: THE EVIDENCE

Several policies included in recent waivers—those that end or limit retroactive eligibility, hospital presumptive eligibility, and prompt enrollment requirements—shorten the period during which individuals could receive Medicaid coverage. Even in cases in which the impact on total monthly enrollment is small, the impact on individuals may be large if delayed coverage impedes their access to care or saddles them with medical debt they cannot afford to pay.

When low-income individuals lack a source of payment for their medical care or long-term services and supports needs, providers are likely to feel the impact. In the case of safety-net hospitals, one study estimated that a full elimination of retroactive eligibility would reduce hospital Medicaid revenues nationwide by more than $13 billion,[36] creating a significant financial incentive for them to avoid serving low-income people who present with non–life threatening conditions.

Although retroactive coverage waivers have not been evaluated extensively, research does show the extent to which eliminating retroactive coverage could impact coverage as well as people's financial well-being. Data from Indiana indicated that 13.9 percent of affected beneficiaries had incurred costs during the retroactive eligibility period, averaging $1,561 per person.[37] Similarly, data from New Hampshire revealed that between August 2014 and November 2015, 4,657 individuals in the Medicaid expansion population (potentially about 10 percent) benefited from retroactive coverage, which paid for more than $5 million in medical expenses.[38]

THE IMPACT OF ADMINISTRATIVE COST AND COMPLEXITY ON STATES: THE EVIDENCE

Implementing and administering new waiver policies that impact Medicaid eligibility require

33 Iowa Department of Human Services, *Premium Monitoring Report-4th Quarter 2015* (Ankeny, IA: HIS, 2015), https://dhs.iowa.gov/sites/default/files/Attachment7-PremiumMonitoringReport.pdf.

34 The Lewin Group, *Healthy Indiana Plan 2.0*.

35 Robin Rudowitz, MaryBeth Musumeci, and Elizabeth Hinton, *Digging into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums* (Washington, DC: Kaiser Family Foundation, 2018), https://www.kff.org/medicaid/issue-brief/digging-into-the-data-what-can-we-learn-from-the-state-evaluation-of-healthy-indiana-hip-2-0-premiums/.

36 Allen Dobson, Joan DaVanzo, and Randy Haught, *The Financial Impact of the American Health Care Act's Medicaid Provisions on Safety-Net Hospitals* (Washington, DC: The Commonwealth Fund, 2017), https://www.commonwealthfund.org/publications/fund-reports/2017/jun/financial-impact-american-health-care-acts-medicaid-provisions.

37 The findings here reflect a prior claims payment program that CMS required in Indiana to safeguard against unpaid medical bills for traditional populations subject to its retroactive coverage waiver. Indiana was required to reimburse providers for services received up to 90 days prior to the effective Medicaid coverage date for low-income parents who were not determined presumptively eligible. MaryBeth Musumeci and Robin Rudowitz, *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States* (Washington, DC: Kaiser Family Foundation, 2017), https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/; Letter from Centers for Medicare & Medicaid Services (CMS) to State of Indiana Office of the Governor; *Healthy Indiana Plan 2* (Baltimore, MD: CMS, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

38 Average monthly enrollment of expansion adults since June 2015 has been approximately 43,000 and average monthly retroactive coverage has been less than 400. While the number ever enrolled in expansion between August 2014 and November 2015 may be slightly higher than 43,000, it is likely that the nearly 4,700 individuals ever benefiting from retroactive coverage is approximately 10 percent of the total. Letter from New Hampshire Department of Health & Human Services (DHHS) to Centers for Medicare & Medicaid Services (CMS), *New Hampshire's Conditionally Approved Waiver of Retroactive Coverage Submitted to the Centers for Medicare & Medicaid Services* (Concord, NH: DHHS, 2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf.

sizeable state investment. This is because—at a minimum—such policies require states to change their eligibility and enrollment systems, update beneficiary notices, develop new call center capacity, and review compliance or requests for good cause exemptions (*see* box 6).

Federal law does not require states to include estimates of administrative costs in waiver proposals. Consequently, waiver requests generally do not include information about the cost of new processes required to implement and administer waivers, but the costs could be high.

Information about the magnitude of state spending is emerging.

Kentucky[39]—which is barred from implementing its waiver by a federal court ruling—had plans to spend close to $374 million over two years to implement its waiver, which includes work requirements and a range of other eligibility and coverage changes.[40] Financial analysts reported

Box 6
Administrative Decisions Influence Coverage Impact

- **Information Technology.** States implementing work requirements are building new platforms to enable beneficiaries to report, and the state to track, work participation as well as identify, verify, or validate the numerous exemptions that may apply to beneficiaries and then appropriately suspend or terminate eligibility when appropriate. Systems need to undergo extensive recoding to enable them to identify exempt individuals based on available information in Medicaid and other state data systems, necessitating additional investments to build interfaces with other state systems.
- **Staffing.** Some states, like Arkansas and Kentucky, are primarily relying on technology solutions to implement their new work requirements and project few new staff resources are needed. Even implementation plans that are heavily reliant on technology are likely to have some staffing needs for tasks including increased call center staffing, processing exemptions and verifying compliance, processing case closures, and reviewing appeals and conducting hearings.
- **Case Management.** States can leverage federal matching funds to support case management costs, or costs associated with helping people navigate the new requirements.* States' case management costs could vary greatly depending on the extent of assistance that states plan to provide.
- **Beneficiary Supports.** CMS guidance prohibits states from using federal Medicaid funds to underwrite the cost of beneficiary supports, such as childcare, transportation, education, and training to help beneficiaries meet work requirements.** Some states explicitly indicate that they will invest state-only dollars for these purposes.

** Most states that opt to cover this benefit target it to specific populations.* See *Social Security Act sections 1905(a)(19) and 1915(g) and 42 CFR 440.169 and 42 CFR 441.18. The regulations and required state plan template include prescriptive elements that states must satisfy to receive approval to offer this optional benefit. Medicaid also reimburses for care coordination by managed care organizations (MCOs), and states may be able to leverage MCO contracts to cover screening and assessment related to work requirements.* See *42 CFR 438.208. Care management is not a Medicaid benefit but rather a plan function, and states must build sufficient administrative funds into their capitation rates to cover care management activities.*

*** Letter from Centers for Medicare & Medicaid Services (CMS) to State Medicaid Directors,* Opportunities to Promote Work and Community Engagement.

39 Kentucky was the first state to receive approval for its work requirements waiver. In the context of Kentucky's waiver, a federal district court held that because providing coverage is central to the objectives of the program, federal officials must carefully consider the implications on coverage before approving a waiver. The court found that HHS had failed to consider these impacts and invalidated the Kentucky waiver approval; after an additional public comment period, CMS reapproved Kentucky's waiver in November 2018 and plaintiffs are challenging the reapproval.

40 Deborah Yetter, "Bevin's Medicaid Changes Actually Mean Kentucky will Pay More to Provide Health Care," *Louisville Courier Journal*, February 14, 2018, https://www.courier-journal.com/story/news/politics/2018/02/14/kentucky-medicaid-changes-bevin-work-requriements/319384002/.

that Kentucky would have seen its Medicaid administrative costs rise more than 40 percent in 2018 partly because of the work requirements.[41] The majority of those costs would likely have been attributable to development of information technology infrastructure and workforce services administration.[42] Administrative costs could be even higher in states where the waivers are the subject of lawsuits because systems in those states are likely to experience starts, stops, and revisions depending on the results of the litigation.

SUMMARY OF THE EVIDENCE

There is ample evidence from research and evaluations that the number of people who lose Medicaid coverage is likely to be significant in the current waiver environment. Behind these numbers are people who rely on Medicaid to keep them healthy or to treat chronic illnesses, and those who typically will not have any other source of coverage or the means to pay for the health care they need. The result will be increased burdens on providers and governments, which will likely see significant increases in uncompensated care costs. When developing the coverage and cost impact of new waivers, policy makers should consider prior research and evaluations in the process.

41 Fitch Ratings, "Fitch: Medicaid Waiver Actions Limit US States' Cost Controls," *Fitch Group*, July 17, 2018, https://www.fitchratings.com/site/pr/10038515; Bruce Japsen, "Trump's Medicaid Work Rules Hit States with Costs and Bureaucracy," *Forbes*, July 22, 2018, https://www.forbes.com/sites/brucejapsen/2018/07/22/trumps-medicaid-work-rules-hit-states-with-costs-and-bureaucracy/#7e0cdd966f5e.

42 Benjamin Hardy, "Despite Exemptions, Medicaid Work Requirements May Cause Coverage Losses," *Kark.com*, June 14, 2018, https://www.kark.com/news/health/dMJj/1239347531.

Moving Forward

Given the high stakes to individuals—in terms of loss of Medicaid coverage and access to needed health care—thorough, evidence-based projections of waiver impacts on coverage is essential. The aim should be to avoid harm to current and potential beneficiaries. Waiver applications must provide detailed information about enrollment impacts, informed by program experience and relevant research, in order for stakeholders (including the public) to meaningfully evaluate the impact of new waiver policies. Without this transparency, states risk inflicting unintended harm on low-income individuals, their families, and, possibly, family caregivers. In addition, providers, including safety-net providers, risk increased uncompensated care costs.

Table 2

State Estimates of Enrollment Impacts for Medicaid Waivers Containing Conditions or Limits on Medicaid Eligibility, as of February 1, 2019

State*	Policy Type	Affected Groups, with Age and Income Exemptions Noted**	Enrollment Impact Estimated by State***
APPROVED WAIVERS			
AZ[1,2]	Premiums	• Expansion adults above 100% FPL	• With and without waiver expenditures are provided in application, but enrollment is only provided for without waiver estimates[3]
	Work[4]	• Expansion adults under age 55	• Enrollees in affected groups: 398,519 expansion adults as of October 2017 • Enrollees projected to lose coverage: No change in enrollment projected;[5] application includes an estimate that at least 129,012[6] would be exempt
	Retro[7]	• All groups, other than individuals who would have been eligible as pregnant women or those within 60 days postpartum, infants under age 1, or children under age 19	• Enrollees in affected groups: 1,845,478 as of March 2018[8] • Enrollees projected to lose coverage: Not provided[9]
AR[10]	Work	• Expansion adults under age 50	• Not provided
	Retro	• Expansion adults	
IN[11]	Work	• Expansion adults; parents; TMA	• Enrollees in affected groups: 260,047 expansion, 117,911 parents in 2020 • Enrollees projected to lose coverage: 9,323 (4%) expansion, 1,969 (2%) parents[12]
	Premiums	• Expansion adults, with only those above 100% FPL subject to disenrollment; TMA	• No change in enrollment projected in 2014 waiver application[13]
	Prompt enrollment	• Expansion adults; parents; TMA	
	Retro	• Expansion adults; parents; TMA; excludes pregnant women	
	Timely renewal reporting	• Expansion adults; TMA	• Enrollees in affected groups: 260,047 expansion, 117,911 parents in Calendar Year 2020 • Enrollees projected to lose coverage: 3,716 (1%) expansion, 1,969 (2%) parents[14]
IA[15]	Premiums	• Expansion adults above 51% FPL, with only those above 100% FPL subject to disenrollment	• Not provided, but waiver application notes possibility that imposition of premiums could lead to disenrollment[16]
	Retro	• All groups, other than pregnant women and infants under age	• Enrollees in affected groups: Not provided • Enrollees projected to lose coverage: 3,344[17]

State*	Policy Type	Affected Groups, with Age and Income Exemptions Noted**	Enrollment Impact Estimated by State***
KY[18]	Work	• Expansion adults; parents; TMA	• Enrollees in affected groups: 514,443 expansion, 140,027 non-expansion adults in 2021 • Enrollees projected to lose coverage: 76,922 (15%) expansion, 19,765 (14%) non-expansion[19]
	Premiums	• Expansion adults, with disenrollment limited to those above 100% FPL; parents; TMA	
	Prompt enrollment	• Expansion adults; parents; TMA	
	Retro	• Expansion adults; parents; TMA; excludes pregnant women and former foster youth	
	Timely renewal reporting	• Expansion adults; parents; TMA	
	Timely change in circumstance reporting	• Expansion adults; parents; TMA	
ME[20–21]	Work	• Adults	• Enrollees in affected groups: Not provided; enrollment in Medicaid overall estimated at 229,263 in 2022 • Enrollees projected to lose coverage: 4,585 (share of affected groups not provided; 2.0% of overall Medicaid)[22]
	Premiums	• Adults above 50% FPL	
	Retro	• All groups, other than individuals who would have been eligible as pregnant women or those within 60 days postpartum, infants under age 1, children under age 19, or individuals applying for a long-term care determination	
	Asset transfer limits	• Long-term care enrollees	
MI[23]	Work	• Expansion adults under age 63	• Enrollees in affected groups: 655,000 at time of waiver application;[24] 680,000 at time of subsequent letter from Governor Gretchen Whitmer[25] • Enrollees projected to lose coverage: Not provided; application indicated that approximately 400,000 beneficiaries could be impacted by waiver changes; subsequent letter cites an estimate of up to 183,000 (27%) losing coverage due to the work requirement
	Premiums	• Expansion adults above 100% FPL, after 48 months of cumulative expansion enrollment	
	Health risk assessment or healthy behaviors	• Expansion adults above 100% FPL, after 48 months of cumulative expansion enrollment	
MT[26]	Premiums	• Expansion adults, with only those above 100% FPL subject to disenrollment	• Not provided, but waiver application acknowledges potential for coverage impact[27]
	Continuous eligibility	• Expansion adults	• Not provided, but waiver approval notes CMS anticipation that states adopting continuous eligibility for adults would experience a 2% increase in enrollment

State*	Policy Type	Affected Groups, with Age and Income Exemptions Noted**	Enrollment Impact Estimated by State***
NH[28,29]	Work	• Expansion adults	• Enrollees in affected groups: 53,000 expansion adults currently covered • Enrollees projected to lose coverage: Waiver application notes that the state "estimates that enrollment . . . will not change materially over the course of the five-year extension period, with enrollment remaining near current levels"; however, it also notes that "enrollment could decline as more beneficiaries seek and find employment and leave the program as their earnings increase"[30]
	Retro	• Expansion adults, other than individuals who would have been eligible as pregnant women or those within 60 days postpartum, infants under age 1, or parents/caretaker relatives, or as individuals in aged, blind, or disability groups (including those who are applying for a long-term care determination)	• Enrollees in affected groups: 53,000 expansion adults currently covered • Enrollees projected to lose coverage: Not provided, but data submitted for 2015 conditionally approved waiver indicated 452 (1%) or less out of approximately 43,000 expansion adults at that time[31]
NM[32,33]	Premiums	• Expansion adults, with disenrollment limited to those above 100% FPL	• Enrollees in affected groups: 304,762 expansion adults in 2023 • Enrollees projected to lose coverage: None; with and without waiver enrollment estimates do not differ[34]
	Prompt enrollment	• Expansion adults, with disenrollment limited to those above 100% FPL	
	Retro	• All groups, other than those not covered under the state's managed care demonstration, those eligible under institutional care categories, pregnant women or those within 60 days postpartum, infants under age 1, and individuals under age 19	• Enrollees in affected groups: Not provided • Enrollees projected to lose coverage: Not provided, but waiver application notes that 10,000 (1% of the Medicaid population) requested retroactive coverage in CY 2016[35]
OK[36]	Retro	• All groups under the waiver, other than pregnant women and those within 60 days postpartum; infants under age 1; children under 19; and aged, blind, and disabled populations (including Tax Equity and Fiscal Responsibility Act (TEFRA children)	• Not readily available[37]
UT[38]	Retro	• Nonelderly adults who receive limited benefits or premium assistance coverage under waiver	• Not readily available[39]

State*	Policy Type	Affected Groups, with Age and Income Exemptions Noted**	Enrollment Impact Estimated by State***
WI[40]	Work	• Childless adults under age 50	• Enrollees in affected groups: 151,963 in 2023 • Enrollees projected to lose coverage: 4,262 (2.8%)[41]
	Premiums	• Childless adults above 50% FPL	• Enrollees in affected groups: 151,963 in 2023 • Enrollees projected to lose coverage: 840 (0.6%)[42]
	Assessment of drug use and other health risk behaviors	• Childless adults	
PROPOSED WAIVERS			
AL[43]	Work	• Parents under age 60	• Enrollees in affected groups: 82,260 parents in 2023 • Enrollees projected to lose coverage: 16,041 (20%)
	Extended TMA	• TMA	• Enrollees in affected groups: 2,648 TMA enrollees in 2023 • Enrollees projected to lose coverage: None; 1,324 expected to gain (50%)
AZ[44,45]	Time limit	• Expansion adults	• Enrollees in affected groups: 398,519 expansion adults as of October 2017 • Enrollees projected to lose coverage: None during waiver cycle through 2021
FL[46]	Retro	• Adults above age 21	• Enrollees in affected groups: Not provided • Enrollees projected to lose coverage: 39,000 (less than 1%) based on SFY 2016 data
KS[47]	Work[48]	• Adults	• Enrollees in affected groups: 50,965 • Enrollees projected to lose coverage: State indicated that it does not anticipate a significant change in enrollment
	Time limit[49]	• Adults	
ME[50, 51]	Asset test Hospital PE	• All eligibility groups currently without asset test • Most nonelderly, non-disabled	• Enrollees in affected groups: Not provided; enrollment in Medicaid overall estimated at 229,263 in 2022 • Enrollees projected to lose coverage: 4,585 (share of affected groups not provided; 2.0% of overall Medicaid)[52]
MS[53]	Work	• Parents	• Enrollees in affected groups: 40,237 in 2023 • Enrollees projected to lose coverage: 3,226 (8%)
	Extended TMA	• TMA	
NH[54]	Asset test Citizenship documentation requirements	• Expansion adults • Expansion adults	• Enrollees in affected groups: 53,000 expansion adults currently covered • Enrollees projected to lose coverage: Waiver application notes that NH "estimates that enrollment . . . will not change materially over the course of the five-year extension period, with enrollment remaining near current levels"; potential impact of asset test and citizenship/residency documentation provisions not specifically referenced[55]

State*	Policy Type	Affected Groups, with Age and Income Exemptions Noted**	Enrollment Impact Estimated by State***
NM[56,57]	Eliminate TMA	• TMA	• Enrollees in affected groups: 2,000 TMA individuals in 2017 • Enrollees projected to lose coverage: 2,000 (100%)
OH	Work	• Expansion adults under age 50	• Enrollees in affected groups: 708,371 expansion adults in 2023 • Enrollees projected to lose coverage: 18,018 (2.5%)
OK[58]	Work	• Adults under age 50	• Enrollees in affected groups: 101,914 parent/caretaker relatives ages 19–50 in SFY 2017[59] • Enrollees projected to lose coverage: Not provided; state estimated in October 2018 version of the proposal that 6,193 enrollees ages 19–50 will be subject to work requirements after exemptions;[60] December 2018 version submitted to CMS indicates that state is continuing its analyses to determine how many would be exempt or are already furnishing documentation of meeting the requirement[61]
SC[62]	Work	• Parents • TMA	• Enrollees in affected groups: 337,176 in 2023 • Enrollees projected to lose coverage: 3,020 (1%)
SD[63]	Work	• Parents under age 60 in two counties	• Enrollees in affected groups: Not provided; state estimates that 1,300 nonexempt individuals will meet criteria for program • Enrollees projected to lose coverage: 15% of participants annually
	Premium assistance when TMA exhausted	• TMA	• Not provided
TN[64]	Work	• Parents	• Enrollees in affected groups: Not provided • Enrollees projected to lose coverage: Not provided; the state notes in its waiver application that some number of individuals may transition off but that it is not possible to reliably project the magnitude at this time

State*	Policy Type	Affected Groups, with Age and Income Exemptions Noted**	Enrollment Impact Estimated by State***
UT	Work	• Nonelderly adults under age 60 who receive limited benefits or premium assistance coverage under waiver[65] • Expansion adults up to 100% FPL (population not yet approved) who are under age 60[66]	• State currently caps or is proposing to cap enrollment for affected groups; impacts of other policies not provided
	Hospital PE[67]	• Certain adults up to 5% FPL • Parents	
	Time limit[68]	• Nonelderly adults who receive limited benefits or premium assistance coverage under waiver • Certain adults up to 5% FPL	
	Partial expansion with enrollment cap[69]	• Expansion adults up to 100% FPL (population not yet approved)	• Projected enrollment of 70,000–90,000; includes some who would transition from current groups covered under waiver; ability to cap enrollment based on available appropriations is proposed
VA[70]	Work Prompt enrollment Premiums	• Nonelderly adults • Nonelderly adults at or above 100% FPL, other than those exempt from work requirement • Nonelderly adults at or above 100% FPL, other than those exempt from work requirement	• Enrollees in affected groups: 307,570 expansion, 122,451 non-expansion adults in 2023 • Enrollees projected to lose coverage: 26,108 (8%) expansion, 1,183 (1%) non-expansion

Notes: *CE is community engagement (or volunteering opportunities); PE is presumptive eligibility. For states that have proposed waivers, the most recent policies are reflected in the table; in some cases, states had included policies to condition or limit eligibility in their initial proposals but subsequently revised them. Excludes policies that do not have an impact on eligibility (e.g., premiums for which there is no disenrollment consequence for nonpayment, voluntary work referral programs) and those that would allow a partial expansion with enhanced federal funding (which thus far have not been permitted by HHS).*

** States may appear in both the approved and proposed sections of the table if waiver modifications have been sought.*

*** Parent group includes caretaker relatives; TMA reflects parents and caretaker relatives receiving transitional medical assistance for a limited period following an increase in work hours/income that leaves them otherwise ineligible for Medicaid. Exemptions noted are generally limited to those based on income or age, but others may apply. In the case of work/CE waivers, federal guidance requires states to exempt people who are under age 19 or ages 65 or older, pregnant, eligible based on a disability, medically frail, or exempt from SNAP/TANF work requirements, or have an acute medical condition validated by a medical professional that would prevent them from complying with the requirements.*

**** Unless noted otherwise, the number of enrollees in affected groups reflects the overall population (e.g., expansion adults) without any age, income, or other exemptions or exclusions applied. Figures are average monthly enrollment for the last waiver projection year unless noted otherwise and are typically calculated from member months provided in state waiver documents. Although additional estimates may be provided in other state documents, information shown is generally limited to waiver applications or approvals posted on the CMS website.*

1 Letter from Centers for Medicare & Medicaid Services (CMS) to Arizona Health Care Cost Containment System, *Arizona Medicaid Section 1115 Demonstration* (Washington, DC: CMS, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf.

2 Arizona initially included a time limit on coverage in its proposal but subsequently requested to exclude it from discussions in order to expedite negotiations with CMS. The time limit was not approved by CMS. Letter from Arizona Health Care Cost

Containment System to Centers for Medicare & Medicaid Services (CMS), *Arizona Section 1115 Waiver Amendment Request-AHCCCS Works Waiver* (Phoenix, AZ: Arizona Health Care Cost Containment System, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa6.pdf.

3 Arizona Health Care Cost Containment System, *Arizona's Application for a New Section 1115 Demonstration* (Phoenix, AZ: Arizona Health Care Cost Containment System, 2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-ext-app-10152015.pdf.

4 Letter from Arizona Health Care Cost Containment System to Centers for Medicare & Medicaid Services (CMS), *Arizona Section 1115 Waiver Amendment Request*.

5 CMS notes in its approval letter that "The full state public notice included budget neutrality worksheets with enrollment projections reflecting the estimated number of covered beneficiary member months for each year of the demonstration through 2021. The state estimated that enrollment in the new adult group would be the same with or without the demonstration and was unable to estimate the extent to which individuals might lose coverage due to noncompliance with the community engagement requirement."

6 CMS indicates in its approval letter that the figure is 137,755; however, this double counts individuals falling into more than one exemption category. The state's waiver application indicated that 269,507 out of 398,519 individuals do not fall into one of the identified exemption categories, leaving 129,012 who do.

7 Arizona Health Care Cost Containment System, *Arizona's Application*.

8 Includes groups that were ultimately excluded from the provision in the approved waiver.

9 Although the number of affected enrollees was not provided, the state's waiver application indicated expected savings of $39 million in SFY 2019 based on historical expenditures.

10 Letter from Centers for Medicare & Medicaid Services (CMS) to Arkansas Department of Human Services, *Arkansas Works Section 1115 Demonstration* (Washington, DC: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf.

11 Letter from Centers for Medicare & Medicaid Services (CMS) to Indiana Family and Social Services Administration, *Healthy Indiana Plan* (Washington, DC: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.

12 Letter from State of Indiana Office of the Governor to US Department of Health and Human Services, *Amendment Request to Healthy Indiana Plan (HIP): Section 1115 Waiver Extension Application (Project Number 11-W-00296/5)* (Indianapolis, IN: State of Indiana Family and Social Services Administration, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa5.pdf.

13 Letter from State of Indiana Office of the Governor to US Department of Health and Human Services, *HIP 2.0 1115 Waiver Application* (Indianapolis, IN: State of Indiana Office of the Governor, 2014), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-exp-app-07022014.pdf; Milliman Inc., *1115 Waiver–Healthy Indiana Plan Expansion Proposal* (Indianapolis, IN: Milliman, 2014), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Expansion-Proposal-06232014.pdf.

14 Letter from State of Indiana Office of the Governor to US Department of Health and Human Services, *Amendment Request to Healthy Indiana Plan (HIP)*.

15 Letter from Centers for Medicare & Medicaid Services (CMS) to Iowa Department of Human Services, Iowa Wellness *Plan Section 1115 Demonstration* (Baltimore, MD: CMS, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf.

16 Iowa Department of Human Services, *Iowa Wellness Plan 1115 Waiver Application* (Des Moines, IA: Iowa Department of Human Services, 2013), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-waiver-app-082013.pdf.

17 Letter from Iowa Department of Human Services to Centers for Medicare & Medicaid Services (CMS), *Iowa Health and Wellness Plan Section 1115 Demonstration Amendment* (Des Moines, IA: State of Iowa Department of Human Services, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa4.pdf.

18 Letter from Centers for Medicare & Medicaid Services (CMS) to Kentucky Cabinet for Health and Family Services, *Kentucky HEALTH Section 1115 Demonstration* (Washington, DC: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.

19 Letter from Commonwealth of Kentucky Office of the Governor to Centers for Medicare & Medicaid Services (CMS), *Kentucky HEALTH Section 1115 Demonstration Modification Request* (Frankfort, KY: Commonwealth of Kentucky Office

of the Governor, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf.

20 Letter from Centers for Medicare & Medicaid Services (CMS) to Maine Department of Health and Human Services, *MaineCare Section 1115 Demonstration* (Washington, DC: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/mainecare/me-mainecare-request-approval-12212018.pdf.

21 At the direction of Governor Janet T. Mills, the state did not accept the waiver terms and will not be implementing changes in the waiver. Letter from State of Maine Office of the Governor to Centers for Medicare & Medicaid Services (CMS), *MaineCare Approval Response* (Augusta, ME: State of Maine Office of the Governor, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/mainecare/me-mainecare-approval-reponse-ltr-01222019.pdf.

22 Includes asset test and presumptive eligibility provisions that are not referenced in the approved waiver. Letter from State of Maine Office of the Governor to Centers for Medicare & Medicaid Services (CMS).

23 Letter from Centers for Medicare & Medicaid Services (CMS) to the Governor of Michigan, *Healthy Michigan Plan Section 1115 Demonstration* (Washington, DC: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf.

24 Letter from State of Michigan Executive Office to US Department of Health and Human Services, *Section 1115 Demonstration Application: Healthy Michigan Plan Project No. 11-W-00245/5* (Lansing, MI: State of Michigan Executive Office, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf.

25 Letter from State of Michigan Office of the Governor to Centers for Medicare & Medicaid Services regarding the state's request for an extension and amendment of its Section 1115 "Healthy Michigan" waiver (Lansing, MI: State of Michigan Office of the Governor, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-state-acceptance-ltr-20190608.pdf.

26 Letter from Centers for Medicare & Medicaid Services (CMS) to Montana Department of Public Health and Human Services, *Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration* (Baltimore, MD: CMS, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

27 Letter from State of Montana Office of the Governor to US Department of Health and Human Services, *Montana Section 1115 Health and Economic Livelihood Partnership Program Waiver* (Helena, MT: State of Montana Office of the Governor, 2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/HELP-program/mt-HELP-program-pending-app-09162015.pdf.

28 Letter from Centers for Medicare & Medicaid Services (CMS) to New Hampshire Department of Health and Human Services, *New Hampshire Granite Advantage Health Care Program 1115 Demonstration* (Baltimore, MD: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-granite-advantage-health-care-program-ca.pdf.

29 The state also requested approval to implement an asset test and additional citizenship/residency verification but the waiver was approved without reference to these provisions.

30 Letter from State of New Hampshire Office of the Governor to US Department of Health and Human Services, *Granite Advantage 1115 Waiver Amendment and Extension Application* (Concord, NH: New Hampshire Department of Health and Human Services, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa4.pdf.

31 New Hampshire Department of Health & Human Services, *New Hampshire's Conditionally Approved Waiver of Retroactive Coverage Submitted to the Centers for Medicare & Medicaid Services* (Concord, NH: New Hampshire Department of Health & Human Services, 2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf.

32 Letter from Centers for Medicare & Medicaid Services (CMS) to New Mexico Department of Human Services, *Centennial Care 2.0 1115 Medicaid Demonstration* (Washington, DC: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf.

33 At the direction of Governor Lujan Grisham, the state is requesting approval to reverse certain policies included in the state's waiver, including premiums and limits on retroactive eligibility. Office of the Governor, *Gov. Lujan Grisham Announces Plan to Reverse Medicaid Policies that Create Barriers to Accessing Coverage* (Santa Fe, NM: Office of the Governor, 2019), https://www.governor.state.nm.us/2019/02/13/gov-lujan-grisham-announces-plan-to-reverse-medicaid-policies-that-create-barriers-to-accessing-coverage/.

34 Letter from State of New Mexico Office of the Governor to US Department of Health and Human Services, *Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0* (Santa Fe, NM: State of New Mexico Human Services Department, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf.

35 Ibid.

36 Letter from Centers for Medicare & Medicaid Services (CMS) to Oklahoma Health Care Authority, *SoonerCare* (Baltimore, MD: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/ok-soonercare-ca.pdf.

37 The state's waiver of retroactive eligibility has been in place since at least 2010 (the earliest documents available on the CMS website) and was only updated recently to exclude pregnant women and children.

38 Letter from Centers for Medicare & Medicaid Services (CMS) to Utah Department of Health, *Primary Care Network* (Washington, DC: CMS, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf.

39 The state's waiver of retroactive eligibility has been in place since at least 2010 (the earliest documents available on the CMS website).

40 Letter from Centers for Medicare & Medicaid Services (CMS) to Wisconsin Department of Health Services, *Wisconsin BadgerCare Reform* (Washington, DC: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf.

41 Letter from State of Wisconsin Department of Health Services to Centers for Medicare & Medicaid Services (CMS), *Request to Amend Wisconsin's Section 1115 BadgerCare Reform Demonstration Project* (Madison, WI: State of Wisconsin Department of Health Services, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-pa.pdf.

42 Ibid.

43 State of Alabama Medicaid Workforce Initiative, *Section 1115 Demonstration Application* (Montgomery, AL: State of Alabama, 2018), http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.5_Work_Requirements/2.7.5_Alabama_Medicaid_Workforce_Initiative_1115_Application_6-29-18.pdf.

44 Letter from Arizona Health Care Cost Containment System to Centers for Medicare & Medicaid Services (CMS), *Arizona Section 1115 Waiver Amendment Request*.

45 Arizona initially included a time limit on coverage in its proposal but subsequently requested to exclude it from discussions in order to expedite negotiations with CMS. The time limit was not approved by CMS. *See here* for the approved waiver: Letter from Centers for Medicare & Medicaid Services (CMS) to Arizona Health Care Cost Containment System, *Arizona Medicaid Section 1115 Demonstration*.

46 Letter from Florida Agency for Health Care Administration to Centers for Medicare & Medicaid Services (CMS), *Amendment Request–Low-Income Pool and Retroactive Eligibility* (Tallahassee, FL: Florida Agency for Health Care Administration, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf.

47 Letter from Kansas Office of the Lieutenant Governor to US Department of Health and Human Services, *KanCare 2.0: Section 1115 Demonstration Renewal Application* (Topeka, KS: KanCare, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-pa3.pdf.

48 The state's most recent waiver approval indicates that state has asked CMS to defer consideration of this provision and several others. Letter from Centers for Medicare & Medicaid Services (CMS) to Kansas Department of Health and Environment, *KanCare* (Baltimore, MD: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-ca.pdf.

49 Letter from Centers for Medicare & Medicaid Services (CMS) to Kansas Department of Health and Environment denying the state's proposal to extend KanCare (Washington, DC: CMS, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-cms-admin-ltr-state-05072018.pdf.

50 Letter from Maine Department of Health and Human Services to US Department of Health and Human Services, *MaineCare 1115 Demonstration Project Application* (Augusta, ME: Maine Department of Health and Human Services, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-mainecare-pa.pdf.

51 As noted above, the state's waiver was approved without reference to these provisions, which are unlikely to be pursued. At the direction of Governor Mills, the state did not accept the waiver terms and will not be implementing changes in the waiver. Letter from State of Maine Office of the Governor to Centers for Medicare & Medicaid Services (Augusta, ME: State of Maine Office of the Governor, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/mainecare/me-mainecare-approval-reponse-ltr-01222019.pdf.

52 Letter from Maine Department of Health and Human Services to US Department of Health and Human Services, *MaineCare 1115 Demonstration Project Application*.

53 Memorandum from State of Mississippi Medicaid Reform Demonstration Project to Mississippi Office of the Governor, *Medicaid Workforce Training Initiative 1115 Demonstration Waiver Application* (Jackson, MI: Mississippi Division of Medicaid, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-workforce-training-initiative-pa3.pdf.

54 As noted above, the state's waiver was approved without reference to these provisions. State of New Hampshire Office of the Governor to US Department of Health and Human Services, *Granite Advantage 1115 Waiver Amendment*.

55 In contrast, the state did reference the potential for work requirement and retroactive eligibility impacts. State of New Hampshire Office of the Governor to US Department of Health and Human Services, *Granite Advantage 1115 Waiver Amendment*.

56 Letter from State of New Mexico Office of the Governor to US Department of Health and Human Services, *Application for Renewal*.

57 As noted above, the state's waiver was approved without the elimination of TMA, which is unlikely to be pursued. At the direction of Governor Lujan Grisham, the state is requesting approval to reverse certain policies included in the state's waiver, including premiums and limits on retroactive eligibility. Office of the Governor, *Gov. Lujan Grisham Announces Plan*.

58 Oklahoma Health Care Authority, *SoonerCare 1115(a) Research and Demonstration Waiver Amendment Request* (Oklahoma City, OK: Oklahoma Health Care Authority, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/ok-soonercare-pa6.pdf.

59 Ibid.

60 Oklahoma Health Care Authority, *SoonerCare 1115(a)*.

61 Oklahoma Health Care Authority, *SoonerCare 1115(a)*.

62 South Carolina Department of Health and Human Services (SCDHHS), *Community Engagement Section 1115 Demonstration Waiver Application* (Columbia, SC: SCDHHS, 2018), https://msp.scdhhs.gov/cew/sites/default/files/CE%20Waiver%20Application%20Nov%202018.pdf.

63 Letter from South Dakota Department of Social Services to Centers for Medicare & Medicaid Services (CMS), *Career Connector: A South Dakota 1115 Demonstration Proposal* (Pierre, SD: South Dakota Department of Social Services, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sd/sd-career-connector-pa.pdf.

64 Letter from Division of TennCare to Centers for Medicare & Medicaid Services (CMS), *TennCare II Demonstration* (Nashville, TN: Division of TennCare, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa6.pdf.

65 Letter from Utah Department of Health to Centers for Medicare & Medicaid Services (CMS), *Utah 1115 PCN Demonstration Waiver Amendment # 20* (Salt Lake City, UT: Utah Department of Health, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa3.pdf.

66 Utah Department of Health Medicaid, *State of Utah 1115 Primary Care Network Demonstration Waiver: Adult Expansion Amendment Request* (Salt Lake City, UT: Utah Department of Health Medicaid, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa4.pdf.

67 Letter from Utah Department of Health to Centers for Medicare & Medicaid Services (CMS), *Utah 1115 PCN*.

68 Letter from Utah Department of Health to Centers for Medicare & Medicaid Services (CMS), *Utah 1115 PCN*.

69 Utah Department of Health Medicaid, *State of Utah 1115 Primary Care Network*.

70 Virginia COMPASS, *Virginia Department of Medical Assistance Services 1115 Demonstration Extension Application* (Richmond, VA: Virginia COMPASS, 2018), http://www.dmas.virginia.gov/files/links/1803/Virginia%201115%20Waiver%20Application%209.19.2018%20final%20for%20comment%20v2.pdf.

Research Report 2019-12, June 2019

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https://doi.org/10.26419/ppi.00066.001

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