WHAT'S AT STAKE

Medicaid 1115 Waivers

Over time, policy ideas gain and lose popularity, including several that threaten the effectiveness of major health care programs like Medicare, Medicaid, and the Affordable Care Act (ACA). In this series—What's at Stake—we explore some of these reform ideas and how they could affect coverage, care, and outcomes for older adults and people with disabilities.

Many states have expanded Medicaid coverage and care through 1115 waivers, but some have attempted to use them to limit eligibility or restrict coverage.[1]

Background

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

Section 1115 waivers are statutorily required to promote the key objective of the Medicaid program: to furnish medical assistance to low-income individuals. Troublingly, under some administrations, CMS has approved state waivers that condition eligibility on compliance with employment and administrative requirements or otherwise restrict Medicaid coverage—seemingly in conflict with the program's aim. The Biden-Harris administration has denied

[1] KFF, "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State" (last visited March 5, 2024), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

waiver applications that include some of the most aggressive eligibility requirements, but future administrations could change course entirely.

- **Work Requirements**:[2] Many states have sought Section 1115 waivers that condition Medicaid eligibility (generally for expansion Medicaid) on compliance with monthly employment and reporting requirements. People over 50 face particular challenges in meeting work requirements, and the health consequences if they lose Medicaid coverage are likely to be especially severe.[3] In the lone state where work requirements have ever been fully implemented, thousands of enrollees lost access to Medicaid, many because they were unable to find work or adhere to the state's onerous reporting requirements.[4]

- **Cost Sharing**: Medicaid rules allow states to impose cost sharing (the amount enrollees pay when they receive a service) within broad federal guidelines. However, these amounts are limited, as combined premiums and cost-sharing for all members in a household cannot exceed 5% of family income, calculated on a monthly or quarterly basis. However, states can seek waivers to charge enrollees cost sharing above these nominal amounts.[5] Even small increases in cost sharing can have detrimental effects on an enrollee's ability to keep coverage[6] and willingness to seek treatment,[7] and these effects are likely to be more pronounced for consumers with more health conditions who need more extensive care more often.

- **Lockouts and Disenrollment**: Currently, if an enrollee loses Medicaid coverage, they can generally reapply and avoid coverage gaps. Several 1115 waivers have included troubling lock-out provisions that would be used to enforce other problematic changes—such reporting or work requirements, or higher premiums as described above. Enrollees unable to comply with the linked requirement would be disenrolled from Medicaid and not allowed to re-enroll during the lockout period, even if they can

[2] For more on work requirements, see our companion fact sheet focused on that issue.
[3] Center on Budget and Policy Priorities, "Taking Away Medicaid for Not Meeting Work Requirements Harms Older Americans" (March 14, 2019), https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-older-americans.
[4] Robin Rudowitz, et al., Kaiser Family Foundation, "February State Data for Medicaid Work Requirements in Arkansas" (March 25, 2019), https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/.
[5] The Secretary of Health and Human Services can waive cost-sharing rules if the requirements of sections 1916 and 1916A of the Social Security Act are met. In practice, this means state must seek a 1916 waiver (in addition to an 1115 waiver) in order to charge cost sharing above nominal Medicaid amounts set out in Medicaid law. A 1916 waiver has its own set of detailed required protocols and documentation. Few states have approved 1916 waivers for the adult Medicaid population to date.
[6] Bill J. Wright, et al., "Raising Premiums and Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," Health Affairs (December 2010), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0211.
[7] Michael Chernew, et al., "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care," NCBI (June 14, 2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517964/pdf/11606_2008_Article_614.pdf.

subsequently pay their premiums or meet their work requirements. Such lockouts are unnecessary and punitive and create disruptions in care[8] that lead to poor health outcomes and increased costs for individuals, providers, and state and local governments.[9]

- **Eliminating Non-Emergency Medical Transportation (NEMT)**: Medicaid non-emergency medical transportation (NEMT) provides enrollees with transportation to and from scheduled Medicaid-covered services, as required under Medicaid law. Some states have sought 1115 waiver authority to eliminate this benefit. This is extremely problematic, as NEMT is necessary for Medicaid enrollees to get appropriate care at the appropriate time. Lack of transportation is a major barrier to timely access to care.[10] Many low-income people simply cannot afford to buy a car or hire a transportation service, and some lack access to affordable and reliable public transit.[11] Without NEMT, Medicaid enrollees are likely to miss necessary appointments, potentially leading to worse health outcomes and higher health care costs down the road.[12]

- **Eliminating Retroactive Coverage**: States must provide qualifying enrollees with three months of retroactive Medicaid coverage when they apply. This means enrollees aren't stuck with unaffordable medical bills they incurred before applying for Medicaid, provided they were Medicaid eligible at the time. It also encourages providers to treat uninsured Medicaid-eligible individuals, because they will be reimbursed for the services they provided once the person is enrolled. Several states have received a waiver of retroactive coverage—exposing Medicaid enrollees to overwhelming medical debt,[13] reducing provider incentives to provide care, and increasing hospitals uncompensated care burden.[14]

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

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

[10] Paul T. Cheung, et al., "National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries," Annals of Emergency Medicine (July 2012), https://www.annemergmed.com/article/S0196-0644(12)00125-4/fulltext.

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

[12] TRB's Transit Cooperative Research Program, "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation" (March 23, 2016), http://www.trb.org/Publications/Blurbs/156625.aspx.

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

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