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Updated: August 2017 | Issue Brief

Proposed Medicaid Section 1115 Waivers in Maine and Wisconsin

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While the future of legislation to repeal and replace the Affordable Care Act (ACA) and make fundamental changes to the structure and funding of the Medicaid program is uncertain, states and the Administration may achieve major changes to Medicaid through the use of Section 1115 Medicaid waivers. Section 1115 Medicaid demonstration waivers provide states with an avenue to test new approaches that further the objectives of the Medicaid program in ways that differ from what states can do under current law. On March 14, 2017, the Centers for Medicare and Medicaid Services (CMS) sent a letter to state governors that signaled a willingness to use Section 1115 authority to "support innovative approaches to increase employment and community engagement" and "align Medicaid and private insurance policies for non-disabled adults." Wisconsin submitted a waiver amendment request to CMS in June 2017 and Maine submitted a waiver application to CMS in August 2017.

Unlike previous waivers that encompass the ACA's Medicaid expansion, Wisconsin and Maine are seeking waiver authority to make significant changes to Medicaid that would affect non-expansion Medicaid populations. The proposals seek to impose welfare-like restrictions and make other changes to eligibility and enrollment, premiums and cost-sharing, and benefits to traditional populations that are not allowed under current law. Maine's changes would primarily affect traditional Medicaid adults, such as low-income parents (up to 105% of the federal poverty level, FPL, $20,420/year for a family of 3 in 2017), former foster care youth, those receiving Transitional Medical Assistance, those receiving only family planning services, and people with HIV up to 250% FPL ($30,050/year for an individual in 2017). Wisconsin's changes would affect childless adults up to 100% FPL ($12,060/year for an individual in 2017), who are covered under an existing waiver at the state's regular federal matching rate, rather than through the ACA's Medicaid expansion.

Wisconsin and Maine's proposals include provisions that have not been approved in any state (such as work requirements, drug testing, and time limits). Previously, CMS had not approved state waiver requests to require that Medicaid beneficiaries work as a condition of eligibility, on the basis that such a provision would not further the program's purposes of promoting health coverage and access. Maine and Wisconsin's waiver proposals also include other provisions that have not been approved to date including drug screening and testing (WI), and eligibility time limits (both states).

A number of provisions have never been approved for traditional, non-expansion populations (such as lock-outs for failure to pay premiums). Some policies, such as authority to impose premiums (as well as premium reductions for beneficiaries who participate in healthy behavior programs), eliminate non-

emergency medical transportation, and eliminate retroactive eligibility, have been approved in some Section 1115 Medicaid expansion waiver states. Indiana also has Section 1916 (f) waiver authority to test graduated copayments of $25 for non-emergency use of the emergency room with a control group. However, no Section 1115 waivers approved to date for any Medicaid population include premiums as a condition of eligibility or coverage lock-outs for non-payment for those under 100% FPL.

Several provisions included in Maine and Wisconsin's proposals are being tested and evaluated in other states' waivers, with preliminary data and evidence of negative consequences for beneficiaries and administrative costs and complexities for states, health plans, and providers. Available data about healthy behavior programs in Iowa, Michigan, and Indiana suggest that complicated provisions require extensive administrative resources and beneficiary education to implement. Additionally, Indiana's health accounts, coverage lock-out for premium non-payment, and requirement that individuals pay a premium before coverage starts result in some eligible individuals not accessing or losing coverage. A substantial body of research cites access to care barriers created by premiums and cost-sharing. Some conservative policymakers contend that work requirements are ineffective in the health care context, while others contend that such requirements may be ineffective over the long-term in the TANF program on which the proposals are modeled. An assessment of state drug testing programs in TANF found high administrative costs with few drug users identified.

Both states' waiver proposals estimate less coverage under the waiver. Under its waiver proposal, Wisconsin projects that enrollment will be 5,102 lower under the waiver compared to without waiver estimates in the fifth year of the demonstration. Of this reduction, 4,262 would be disenrolled from the time limit and 840 from the premiums. The state assumed 2-4% reduction in enrollment due to premiums, pointing to research that demonstrates a 5% rate of premium non-payment. A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals, particularly those with incomes below poverty. Maine anticipates that its proposed waiver would cover 55,000 fewer eligible member months but with an increase in per member per month costs from $799 to $815, comparing the "without waiver" estimates to the "with waiver estimates" in the fifth year of the waiver. Maine estimates that the number of covered beneficiaries would decline regardless of waiver implementation but that the decline "may slightly increase over the short-term" due to the waiver provisions. Maine also estimates that costs will increase because the "able-bodied" adults expected to lose eligibility under the waiver have lower costs compared to other coverage groups. Under long-standing policy, CMS has required Section 1115 waivers to be budget neutral to the federal government, meaning that federal costs under the waiver should not exceed what they would have been absent the waiver.

Review of these waiver proposals could be on a fast timeline. Wisconsin seeks to amend an existing waiver (with some proposed changes required by state law), while Maine is requesting a new waiver. Wisconsin received 1,043 comments at the state level and made some minor adjustments to the amendment (e.g., to monthly premiums, emergency room copays, and drug screening and testing provisions) before submitting to CMS. Maine received comments from 180 people, over ¾ of which were opposed to the waiver. Before submitting the waiver to CMS, Maine made some changes related to premiums (imposing flat fee premiums for income bands starting at 51% FPL and exempting those enrolled through breast and cervical cancer), the ED copay (lowered from $20 to $10 and provides a list of exempt diagnosis codes), the work requirement (exempts

those with breast and cervical cancer and those caring for an incapacitated adult), removal of the missed appointment assessment and excluding long-term care services from retroactive eligibility waiver. If approved by CMS, Maine estimates it would be ready for implementation six months after receiving approval, while Wisconsin would implement no sooner than one year later. Key proposed waiver provisions in each state are compared in Table 1 below, with more detail about each state's proposal provided in the Appendix.

Table 1: Themes in Non-Expansion States' Proposed Medicaid Section 1115 Waivers

	Maine	Wisconsin
Population(s) Affected	Traditional adults (parents up to 105% FPL, former foster care youth, those receiving Transitional Medical Assistance, medically needy, those receiving family planning services, and those in the HIV waiver)	Adults without dependent children from 0-100% FPL[i]
Eligibility and Enrollment		
Waive Retroactive Eligibility	X (Long-term care excluded)	
Asset Test for Poverty-Related Eligibility Pathways	X	
Eliminate Hospital Presumptive Eligibility	X	
Work Requirement	X	X
Drug Screening and Testing		X
Time Limit on Coverage	X	X
Premiums and Cost-Sharing		
Premiums with Disenrollment for Non-Payment	X (those with HIV excluded from premium requirements)	X
Healthy Behavior Incentives		X
Co-payments Above Statutory Limits	X	X

NOTES: [i] In 2014, Wisconsin implemented a new Section 1115 waiver covering childless adults ages 19 to 64 with income up to 100% FPL ($12,060 for an individual in 2017); those above 100% FPL are covered in the Marketplace. (Wisconsin is the only state opting to cover childless adults without accessing ACA enhanced matching funds.)

Appendix

Appendix Table 1: Key Provisions in Wisconsin's Proposed Amendment to its BadgerCare Reform Section 1115 Medicaid Demonstration Waiver	
Element	**Wisconsin Proposed Waiver Amendment**
Overview:	As directed by state law, seeks to amend existing waiver for childless adults to require monthly premiums for childless adults from 51% to 100% FPL ($8/month per household), with a coverage lock-out of up to 6 months for non-payment; offer premium reductions for completion of a health risk assessment and healthy behavior program; require, as a condition of eligibility, that childless adults complete a drug screening, and if indicated, a drug test at application and renewal; and limit childless adults' eligibility to 48 months followed by a 6 month lock-out. Also seeks authority to charge an $8 copay for emergency department utilization by childless adults; exempt childless adults ages 19 to 49 from the 48 month time limit if working or attending job training 80 hours per month; use Medicaid funds to offer job training as a covered benefit for childless adults; and use Medicaid funds to pay for residential substance use disorder treatment up to 90 days in institutions for mental disease for all Medicaid enrollees.
Duration:	Would amend existing waiver that is in effect through December 31, 2018. State would implement changes no earlier than one year after approval.
Coverage Groups:	Most provisions would apply only to adults without dependent children from 0-100% FPL. Authority to cover 90-day substance use disorder treatment stays in institutions for mental disease would apply to all Medicaid beneficiaries.
Premiums:	Would require childless adults with incomes from 51-100% FPL to pay premiums of $8/month per household. Failure to pay premiums could result in loss of coverage for up to six months unless outstanding premiums are paid. After six months, individuals could re-enroll in coverage without paying past-due amounts. Third parties (including non-profit organizations, hospitals, provider groups, and employers) could make premium payments for enrollees. American Indian and Alaska Natives (AI/AN) would be exempt from paying monthly premiums.
Co-Payments:	Seeks authority (under Section 1916(f)) to charge childless adults who use the emergency department (ED) an $8 co-pay (would be applicable for all ED use not just non-emergency ED use). Providers would be responsible for collecting co-payments but cannot refuse treatment for nonpayment. American Indian and Alaska Natives (AI/AN) would be exempt from paying copays.
Healthy Behavior Incentives:	Would allow childless adults from 51-100% FPL (who are required to pay premiums) to reduce their premium payments by 50 percent if they complete a health risk assessment (HRA) and do not engage in health risk behaviors based on self-attestation. Those who complete the HRA and engage in health risk behaviors but attest to actively managing their behavior and/or to having a condition beyond their control may have premiums

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	reduced by 50 percent. Health risk behaviors include alcohol consumption, body weight, illicit drug use, seatbelt use, and tobacco use. State would use target measures set by national organizations such as the CDC to determine the threshold for when a behavior becomes a risk. Enrollees would complete the HRA and self-attest to any changed health risk behavior at annual eligibility renewal.
Benefits:	Would use Medicaid funds to cover stays up to 90-days for residential substance use disorder treatment services in "institutions for mental disease" for all Medicaid beneficiaries ages 21-64 (in MCOs and FFS).
Drug Screening and Testing:	Would require as a condition of eligibility that childless adults complete a drug screening questionnaire about current and prior substance use and, if indicated, a drug test at application and renewal. Individuals who indicate they are ready to enter treatment on the drug screening questionnaire may forego the drug test and enter treatment. For individuals who test positive for a controlled substance without evidence of a valid prescription, eligibility will be conditioned on completing a substance abuse treatment program. If treatment is not immediately available, Medicaid eligibility continues. Refusal to participate in treatment would result in Medicaid ineligibility but individuals may reapply (at any time) when they are willing to consent to treatment.
Work Requirement:	Would require childless adults ages 19 to 49 to work or participate in job training for 80 hours per month. Enrollees would be exempt from the work requirement if diagnosed with a mental illness; receiving Social Security Disability; serving as primary caregiver for a person who cannot care for him/herself; physically or mentally unable to work; receiving or applied for unemployment insurance; taking part in alcohol or drug abuse treatment program; enrolled in an institution of higher learning at least half-time; or attending high school at least halftime. DHS will consider comments to add performing community service and actively seeking work as qualified activities in discussions with CMS and when developing an operational protocol. Also would use Medicaid funds to pay for costs associated with job training as a covered benefit for childless adults.
Time Limit on Eligibility:	Would limit Medicaid enrollment for childless adults to 48 months (beginning the first month the policy goes into effect or upon initial program enrollment). After 48 months, enrollees would be ineligible for Medicaid for six months, but the 48-month time limit would re-start if an individual re-enrolls after the six-month period. Enrollees over age 49 and those that meet the work requirement (described above) would not be subject to the 48-month eligibility limit (the time limit clock would stop during the time a beneficiary works and/or receives job training for at least 80 hours per month). Individuals exempt from the work requirement would also be exempt from the 48-month time limit on eligibility.

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Next Steps:	State submitted its waiver amendment to CMS on June 7, 2017. The federal public comment period will be open from June 15, 2017 to July 15, 2017.
SOURCE: BadgerCare Reform Demonstration Project Section 1115 Demonstration Waiver Amendment Application, submitted June 7, 2017 and certified as complete on June 15, 2017.	

Appendix Table 2: Key Provisions in Maine's Proposed Section 1115 Medicaid Demonstration Waiver	
Element	**Maine Proposed Waiver**
Overview:	State seeks waiver to require premiums and work for most traditional adults ages 19-64 (such as parents up to 105% FPL, former foster care youth, those receiving Transitional Medical Assistance, medically needy parent/caretakers, and those eligible for family planning services only) as conditions of eligibility. Work also would be required for those eligible based on HIV status. Failure to pay premiums could result in disenrollment for 90 days or until payment of unpaid premiums. Noncompliance with work requirements for more than three months in a 36-month period would result in disenrollment. State also seeks waiver to apply a $5,000 asset test to all households eligible based solely on low income; impose limits on Medicaid-compliant annuities for long-term care eligibility determinations; eliminate hospitals' ability to make presumptive eligibility determinations; waive retroactive eligibility, and impose a $10 copay for ER use that does not result in an admission.
Duration:	Seeks 5-year waiver (Jan. 1, 2018 through Dec. 31, 2022). Would implement changes 6 months following CMS approval (estimated start: January 1, 2018); however, premiums would be required 6 months later (estimated start: July 1, 2018).
Coverage Groups:	Proposed work and premium requirements (starting at 51% FPL) would apply to traditional adults, ages 19-64, at *all income levels*,[i] such as: -parents from 0-105% FPL (up to $20,420/year for a family of 3 in 2017); -young adults who have aged out of foster care up to age 26; -those eligible for family planning services (up to 209% FPL, $42,678/year for a family of 3 in 2017); -those receiving Transitional Medical Assistance (TMA, eligible for up to one year after leaving cash assistance due to earnings – premiums apply for 1st 6 months); and -people with HIV up to 250% FPL ($30,150/year for an individual in 2017) Individual exemptions discussed under "work requirement" section below apply to both work and premium requirements except that premiums do not apply to HIV group. All other proposed provisions would apply to all applicants or beneficiaries (as applicable per provision).
Asset Test:	Seeks authority to apply a $5,000 asset test to all coverage groups that currently do not have an asset test (there is no asset test under current law for coverage groups based solely on low income (vs. old age/disability)).
Limits on Annuities:	Seeks authority to impose a transfer penalty for the purchase of Medicaid-compliant annuities for long-term care eligibility determinations and to set a minimum pay out period at 80% of the annuitant's life.
Presumptive Eligibility:	Seeks to remove requirement for hospitals to make presumptive eligibility determinations.

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Retroactive Coverage:	Seeks waiver of retroactive eligibility so that coverage would begin no earlier than 1st day of month of application. Individuals applying for long-term care would be eligible for retroactive eligibility.
Premiums:	Would require monthly premiums for traditional adults (such as parents, former foster care youth, those receiving TMA, medically needy, those receiving family planning services) calculated using 2% of the lowest income in the bracket for an individual as follows: 51-100% FPL ($513-1,005/month for a family of 3 in 2017) = $10 101%-150% FPL ($1,015-$1,508/month) = $20 151%-200% ($1,518-$2,010/month) = $30 201% FPL and above ($2,020 / month) = $40 Premium payments must be made by the last day of the final enrollment month (for a 12 month enrollment period) or beneficiaries will be disenrolled for 90 days or until unpaid premiums are paid. The same exemptions that apply to the work requirement (described below) apply to premiums except people eligible based on HIV status and American Indians and Alaska Natives who are members of federally-recognized tribes are exempt from premiums.
Co-Payments:	Beneficiaries would continue to be subject to point-of-service cost sharing at state plan amounts up to 5% of quarterly household income. All beneficiaries (except for dual eligible beneficiaries who do not receive full Medicaid benefits, those residing in institutions, and American Indian/Alaska Natives) would be subject to $10 copayment for emergency department claims with "an applicable diagnosis code" detailed in the waiver. The state would collect these payments after periodic claims reviews; payments to providers would not be decreased.
Work Requirement:	Would require traditional adults (such as parents, former foster care youth, those receiving TMA, medically needy, those eligible for family planning services only, and people with HIV) ages 19-64 to meet a work requirement. Compliance would include 20 hours (averaged monthly) of the following: paid employment; approved work program; enrollment at an academic institution at least half time or some combination of employment and education. Compliance also includes volunteer work at least 24 hours per month, job search, receipt of unemployment benefits, or compliance with SNAP or TANF work requirements. Beneficiaries would be exempt from the work requirement if they reside in an institutional or residential facility; reside in a residential substance abuse treatment and rehabilitation program; provide care for an incapacitated adult *or* dependent under age six; are pregnant; are physically or mentally unable to work 20 or more hours per week; women

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	in the breast and cervical cancer treatment program, or are receiving temporary or permanent public or private disability benefits.
Time Limit on Eligibility:	Coverage for traditional adults (such as parents, former foster care youth, those receiving TMA, people with HIV, those receiving family planning services) would be limited to no more than 3 months in a 36-month period unless beneficiaries comply with work requirement (described above). Coverage for an additional month (beyond the three months) may be authorized in exceptional circumstances and the state may provide additional exemptions with a determination of good cause.
Next Steps:	Waiver submitted to CMS on August 1, 2017.

NOTE: [i] Eligibility groups that would be affected by proposed work requirements and premiums include the following mandatory categorically needy groups: low income families, parents/caretaker relatives, transitional medical assistance (TMA), , former foster care children AND the following optional categorically needy groups:, individuals eligible for family planning services, reasonable classifications of individuals under age 21, medically needy individuals age 18 through 20, medically needy parents and other caretaker relatives, and special benefits waiver (HIV waiver) (no premium requirement for this group).

SOURCE: 1115 Waiver Application Department of Health and Human Services State of Maine.