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Medicaid: Waivers Are Temporary, Expansion Is Forever

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Introduction

State lawmakers in Michigan, Ohio and numerous other states continue to debate whether to opt–in to an expansion of Medicaid permitted by the Affordable Care Act, popularly known as "Obamacare." In response to serious concerns about the program's lack of flexibility and potential long-term costs for states, proponents of Medicaid expansion are promoting the use of "waivers" that will free states from federal rules and restrictions as they expand Medicaid programs. In other words, these waivers are viewed as a means for states to obtain more federal funds by expanding Medicaid, yet still maintain flexibility over operating their Medicaid programs.

This solution is illusory. Because Medicaid waivers are temporary, subject to the discretion of federal officials and vulnerable to potential judicial reversal, they are unlikely to permit much of the flexibility state policymakers seek. By contrast, Medicaid expansion likely will be difficult to reverse. Accordingly, reliance on waivers as a source of long-term flexibility to reform the operation of Medicaid programs is ill-placed, and trading expansion for waivers is a risky bargain for states.

Background

Medicaid is a federal-state partnership program governed by Title XIX of the Social Security Act of 1965. Each state-based Medicaid program operates under a legal contract between that state's government and the federal government. The basic terms are that the federal government will provide funding to a state if it uses those funds to operate a Medicaid program in accordance with provisions of the legal contract, or "state plan."[1]

Federal Medicaid law sets the allowable scope within which the parties — the U.S. Department of Health and Human Services and the state government — may contract.[2] A state may customize its Medicaid state plan in a number of ways, provided that those customized provisions are within the basic parameters set forth in Title XIX. Any changes to a state plan that are subsequently agreed to by the state and HHS take the form of a "state plan amendment."[3] Thus, a Medicaid state plan amendment is an amendment to the underlying contract and carries the same legal weight as any other provisions of the state plan.

For a state to adopt the Medicaid expansion, it must amend its Medicaid state plan to reflect that action, and HHS must agree to that amendment.[4] Once the state plan has been amended to include the expansion, that agreement becomes part of the legally enforceable state plan contract.[5] A state must be in compliance with its own state plan. The federal government enforces compliance by withholding federal funds.[6] The mere threat of withholding federal dollars can generally ensure compliance.

While Medicaid expansion under the ACA promises states more generous federal funding ("match rates") for the expansion population, it does so by fundamentally transforming Medicaid programs. Instead of a cooperative program in which states were previously only

required to provide coverage for certain categories of needy individuals (the elderly, blind, disabled, pregnant women, children and low-income parents and caretaker relatives with dependent children), the ACA turns Medicaid into a broad-based entitlement program, with participating states required to cover all individuals below age 65 and under 138 percent of the poverty level.[7] Consequently, the new beneficiaries will be able-bodied adults, and the vast majority of them (84 percent in Michigan and 90 percent in Ohio) have no dependent children.[8]

So long as a recipient meets this income criteria, the ACA's expanded Medicaid program does not permit the states flexibility to, for example, limit the duration of benefits or condition the receipt of benefits on meeting work requirements, participating in drug testing programs or paying minimum copayments.[9] This lack of flexibility has been a major concern of Michigan and Ohio policymakers.

Medicaid Expansion is Permanent

The Medicaid expansion decision is particularly important because legal and practical limitations will seriously restrict a state's ability to exit the expansion.[10] The secretary of HHS may withhold the first dollar of Medicaid funding to states that fail to comply with Medicaid requirements.[11] Given that Medicaid accounts for more than 20 percent of an average state's total budget, the decision to withhold federal Medicaid dollars could be crippling for many states, and would likely compel a state to reconsider an attempt to opt out of the expansion.[12]

In the states' challenge to the mandatory nature of Medicaid expansion in *National Federation of Independent Business v. Sebelius* (a challenge in which both Michigan and Ohio sued the federal government), the Supreme Court stated that the federal government cannot condition the first dollar of existing Medicaid funding upon a state's decision to expand Medicaid, but it did not say that the secretary of HHS could not still withhold funds from states that, in the opinion of the secretary, fail to meet the objectives of the Social Security Act. Indeed, by the plain terms of the statute, the secretary maintains this discretion to withhold all Medicaid funds.[13]

While HHS has suggested that it will allow states to withdraw from expansion, these statements, which do not constitute administrative rules, are not legally controlling.[14] The federal statute, which grants the authority to the secretary to withhold funds for failure to meet the requirements of a Medicaid state plan, is what will control the court's inquiry.[15]

Even if there were no legal barrier to exiting expansion, there will undoubtedly be significant political barriers. The decision to curtail what will have become an entitlement program, removing hundreds of thousands of recipients from Medicaid rolls, will necessarily be difficult to execute — even if the federal government has not delivered on a promised or hoped-for waiver.

Section 1115 Waivers

To ameliorate the concerns about the rigidity of Medicaid and the increased long-term costs of expanding it, some contend that even if a state opts for expansion, it can still gain flexibility in how it administers its Medicaid program through special, negotiated "waivers." Ideally, these waivers would help offset higher long- term costs.

A waiver, simply put, allows a state to not comply with underlying federal requirements of the statute. Under the Medicaid waiver provisions in Section 1115 of the Social Security Act, a state may ask for temporary exemptions from federal requirements in order to experiment with pilot programs and other novel methods of delivering Medicaid-funded services. Section 1115 waivers also allow states to spend Medicaid revenues in ways that federal rules would not normally permit.[16]

Although it is not a statutory requirement, the federal government has a long history of requiring Section 1115 demonstration projects to be "budget neutral." That is, the cost of the demonstration project must not exceed the federal government's expense of funding a state's Medicaid program without such a waiver. The federal government enforces budget neutrality by capping the amount of federal funds made available to the state.[17] The state, therefore, is at risk for any costs in excess of the cap.

While a state Medicaid plan (and any amendments thereto) is legally enforceable in federal court, states have no legal authority to compel HHS to grant Medicaid waivers. Thus, waivers are exactly what the term implies — a voluntary suspension of one or more provisions of the contract by one party (in this case, HHS) for the benefit of the other party (in this case, a state government).

Just as it would be imprudent for anyone to enter into a legally enforceable written contract with the expectation that he can later persuade the other party to waive parts of the contract that are no longer preferable, likewise agreeing to expand Medicaid through an amendment to the state plan contract based upon the hopes of procuring future waiver concessions is ill-advised. Moreover, because of the legal and political landscape of expansion (mentioned above), a state's position is unlikely to be made materially better by legislating reserve clauses claiming an ability to exit the expansion if a particular waiver is not granted.

Three Reasons for Caution

Even if waivers are initially granted, there are three reasons why they are not capable of providing sufficient flexibility for long-term Medicaid reform. First, while legal and political considerations are likely to make Medicaid expansion permanent, waivers are designed to be temporary and there is no guarantee that they will be renewed for extended periods. Second, they are highly discretionary and granted by federal officials only for experimental or pilot projects the secretary of HHS deems to be consistent with the goals and objectives of the Social Security Act as modified by the ACA. Finally, despite this broad administrative discretion, waivers granted by HHS will still face unpredictable judicial scrutiny from the federal courts.

Waivers Are Temporary

Section 1115 waivers come with prescribed expiration dates. By law, the secretary of HHS may approve a Medicaid waiver for "the period he finds necessary," which is generally five years.[18] As a waiver's initial experimental period nears its expiration,[19] the state may re-apply for a three- to five-year extension, but recent evidence shows that HHS will not simply rubber-stamp a state's request for renewal.

For instance, HHS denied the state of Oklahoma's waiver extension request for its Insure Oklahoma program in May of this year, because the program used "enrollment caps," which were designed to keep the cost of the program in line with state revenues.[20] In denying the state's request, HHS indicated that any pilot project with enrollment caps will "not be approved under 1115 demonstrations for the new adult group or similar populations," a move that will force Oklahoma to shutter a program created in 2004 and that assists about 30,000 low-income Oklahomans in affording health insurance coverage.[21] Even an eight-year track record of success will not guarantee a waiver extension.

Indiana faced similar difficulties in its attempts over the past several years to renew its Healthy Indiana Plan. HIP establishes medical savings accounts for those who qualify, but requires recipients to contribute between 2 and 5 percent of their gross family income toward the benefits they receive, which include a high-deductible insurance policy and up to $1,100 in contributions to a "POWER Account" (similar to a health savings account).[22] Failure to meet this copay obligation would bar the recipient from coverage for one year — giving teeth to the requirement and providing a limited but more effective cost-control mechanism for the state.[23] A CQ HealthBeat report described HIP as a Medicaid program "that covers thousands of previously uninsured residents in the state while charging them premiums in an effort to promote personal responsibility."[24]

HHS denied Indiana's request for a multi-year extension of the program in 2012,[25] but Indiana has continued to negotiate with HHS in effort to save HIP before its waiver expires in December of this year.[26]

Waiver denials are not just a "red state" problem, either. Connecticut requested a Section 1115 waiver for the state's "Medicaid Low-Income Adult Coverage Demonstration" to raise the total asset test limit for eligibility and save the state about $50 million.[27] The changes would have reduced coverage for 13,381 individuals for one year.[28] HHS rejected Connecticut's request because such restrictions and ineligibility periods are "not consistent with the general statutory objective to extend coverage to low-income populations."[29]

Other Section 1115 waiver requests have also been denied recently, including Arizona's cost-sharing increases for children and pregnant women, California's request to charge copayments, and Florida's proposal "to charge a $10 monthly premium and $100 copayment for non-emergent use of the emergency room for most Medicaid beneficiaries."[30]

Enrollment caps and copayment policies may not be the only types of pilot projects to be denied waivers or extensions. For example, HHS warned in April of 2013 that reforms which include a

"period of ineligibility" are inconsistent with the goals of the Medicaid expansion, and — as Oklahoma discovered — the agency will deny any waiver application that contains one:

> [Enrollment caps and periods of ineligibility] policies do not further the objectives of the Medicaid program, which is the statutory requirement for allowing section 1115 demonstrations. As such, we do not anticipate that we would authorize enrollment caps or similar policies through section 1115 demonstrations for the new adult group or similar populations.[31]

State policymakers should be aware that HHS does and will deny Section 1115 waivers and extensions of these waivers based on "periods of ineligibility," "enrollment caps" or similar policies — the very policies that many states are considering using to make their expanded Medicaid programs more cost-effective and flexible.

Waivers Are Subject to the Discretion of Federal Bureaucrats

The secretary of HHS has fairly broad discretion in granting waivers. Section 1115 authorizes the secretary to approve exemptions for "any experimental, pilot, or demonstration project which, *in the judgment of the Secretary*, is likely to assist in promoting the objectives" of the Social Security Act.[32] Such broad discretion only adds to the uncertainty as states consider whether and how to execute Medicaid expansion.

The secretary's discretion, though broad, is not unlimited. By the very terms of the statute, the secretary may not approve Section 1115 waivers that are inconsistent with the goals and objectives of the Social Security Act, which includes the modifications to this act made by the ACA.[33] It is difficult to imagine, therefore, that the secretary will approve waivers for any pilot or demonstration programs that effectively limits or affects mandatory Medicaid populations — which would include the population targeted by expansion — insofar as such restrictions would not promote the law's objectives. In other words, such programs may simply be beyond the secretary's statutory authority to approve.

Finally, the secretary's Section 1115 Medicaid waiver authority only applies to the requirements of Section 1902 of the Social Security Act. The secretary has no authority, for example, to approve waivers for pilot programs modifying the federal match rates.

Waivers Face Legal Barriers

Waivers and state pilot programs that are approved by the secretary of HHS face one more potential hurdle — judicial review. And the judiciary has recently shown itself willing to overturn the secretary's Section 1115 waiver decisions.

For example, in *Newton-Nations v. Betlach*, the Ninth Circuit Court of Appeals held that the secretary acted "arbitrarily and capriciously" when she approved waivers for copayment

increases for recipients of Medicaid benefits under Arizona's Medicaid demonstration project.[34] The court reviewed the secretary's decision to determine if the project met the definitional requirement of a Section 1115 waiver, promoted the objects of the Social Security Act and was of appropriate extent and length.[35] Despite the secretary's conclusion (a conclusion that closely mirrors the arguments of states currently contemplating waivers) that Arizona's demonstration project "will continue to ensure wider health benefit coverage to low-income populations," the court found that "[t]here is no evidence that the Secretary made 'some judgment that the project has a research or a demonstration value.'"[36] The court found that the secretary had failed to consider whether Arizona's project would "actually demonstrate something different than the last 35-years' worth of health policy research" and voided the secretary's waiver.[37]

This line of judicial review, of course, is not limited to copayment cases, and virtually any waivers for programs aimed at Medicaid eligibility, duration limitations, personal responsibility or enrollment procedures could face similar judicial scrutiny. Legal challenges of this sort are inherently unpredictable, adding uncertainty and leaving important state reform initiatives in a kind of perpetual limbo.

Conclusion

Expanding Medicaid under the ACA can have potentially permanent consequences for states and their residents. Policymakers should resist the temptation to go along on the attenuated hope that Washington will allow them latitude in designing long-term cost-saving and delivery measures. Seeking special dispensations from federal agencies every few years is no way to achieve sustainable reform.

Section 1115 waivers were effective tools for states to use in their policy laboratories in the past as states experimented with expanding eligibility into optional populations and reforming the service delivery system. But what were optional populations in the past become mandatory populations in expansion, which carry the full mantle of entitlement. The record of the past five years demonstrates greater federal control over the Medicaid program in every area (including the very process for obtaining a waiver). It is simply wishful thinking that the current administration will suddenly reverse course entirely and weaken the entitlement status.

Any waiver obtained is likely to be far too limited — given HHS imposed restrictions which foreclose work and other personal responsibility requirements — and far too precarious — given the short duration and need for discretionary re-approval — to offer states a viable long-term solution. Any decision to accept the Medicaid expansion today should not be based on the illusory promise of a federal waiver tomorrow.

Endnotes

1 42 U.S.C. § 1396-1.

2 42 U.S.C. § 1396a.

3 Ibid. For examples of state plan amendments, see: "Medicaid State Plan Amendments," (Centers for Medicare & Medicaid Services), http://goo.gl/C3oagI (accessed Aug. 23, 2013).

4 Ibid.

5 Ibid.

6 42 U.S.C. § 1396c.

7 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Note that the law requires states to cover all individuals under 133 percent of the federal poverty level, but the ACA also requires states to disregard 5 percent of an individual's income, making the effective threshold 138 percent of the federal poverty level. For more information, see: "Quick Take: Who Benefits from the ACA Medicaid Expansion?," (The Henry J. Kaiser Family Foundation, 2012), http://goo.gl/xI0nxW (accessed Aug. 23, 2013).

8 Genevieve M. Kenney et al., "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?,"(Urban Institute, 2012), 47, http://goo.gl/stZ4eR (accessed Aug. 23, 2013).

9 "Affordable Care Act: State Resources FAQ," (Centers for Medicare & Medicaid Services), 9, http://goo.gl/NL2J9r (accessed Aug. 23, 2013); Department of Health and Human Services Acting Administrator Marilyn Tavenner, letter correspondence with Connecticut Department of Social Services Commissioner Roderick Bremby, March 1, 2013.

10 Robert Alt and Dan Greenberg, "Can Arkansas Escape From Medicaid Expansion if the Federal Government Breaks its Commitments?,"(Advance Arkansas Institute, 2013), http://goo.gl/23qnpc (accessed Aug. 21, 2013).

11 42 U.S.C. § 1396c(2).

12 "State Expenditure Report: Examining Fiscal 2010-2012 State Spending," (National Association of State Budget Officers, 2012), 47, http://goo.gl/ZsKlR7 (accessed Aug. 23, 2013).

13 *National Federation of Independent Business v. Sebelius,* 132 S.Ct. 2566, 2607 (2012); "A Guide to the Supreme Court's Affordable Care Act Decision," (The Henry J. Kaiser Family Foundation, 2012), 7, http://goo.gl/dBCjhz (accessed Aug. 23, 2013).

14 "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid," (U.S. Department of Health and Human Services, 2012), 11-12, http://goo.gl/suF6VB (accessed Aug. 23, 2013). Kathleen Sebelius, (testimony before the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, April 25, 2013), http://goo.gl/dPFYSl (accessed Aug. 23, 2013).

15 *Pennhurst State Sch. & Hosp. v. Halderman,* 451 U.S. 1, 17-18 (1981).

16 "An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity," (The Henry J. Kaiser Family Foundation, 2012), http://goo.gl/FFmQq3 (accessed Aug. 20, 2013).

17 "Section 1115 Demonstrations," (Centers for Medicare & Medicaid Services), http://goo.gl/DS013P (accessed Aug. 23, 2013).

18 42 U.S.C. § 1315(a)(1).

19 42 U.S.C. § 1315(e)(2)

20 Wayne Greene, "Insure Oklahoma to lose federal funding unless it conforms to 'Obamacare'," Tulsa World, May 9, 2013, http://goo.gl/cCjRWv (accessed Aug. 20, 2013).

21 Center for Medicare and Medicaid Services Deputy Aministrator Director Cindy Mann, letter correspondence with Oklahoma Health Care Authority Chief Executive Officer Joel Nico Gomez, May 7, 2013, 2013.

22 "Healthy Indiana Plan Frequently Asked Questions,"), 3-4, http://goo.gl/CVQua9 (accessed Aug. 21, 2013).

23 ibid., 4.

24 John Reichard, "CMS Tries to Let Indiana Down Gently on Bush Era Coverage Expansion," CQ HealthBeat, Aug. 17, 2012, http://goo.gl/Wfl99y (accessed Aug. 20, 2013).

25 HHS approved an extension of the program through 2013, but Indiana applied for a renewal that would have extended the program through 2015. Center for Medicare and Medicaid Services Deputy Administrator Director Cindy Mann, letter correspondence with Indiana Family and Social Services Administration Secretary Michael Gargano, July 31, 2012, 2012; "Healthy Indiana Plan Waiver Renewal Notice of Public Hearing 1," (Indiana Family and Social Services Administration, 2011), http://goo.gl/M4TBwp (accessed Aug. 20, 2013).

26 For example, see: "Healthy Indiana Plan 1115 Waiver Extension Application," (Indiana Family and Social Services Administration, 2013), http://goo.gl/9kSSFh (accessed Aug. 21, 2013).

27 Specifically, this would have increased the total asset limit to $10,000 from $6,144 and counted parental assets for 19- to 25-year-olds who live with their parents or are listed as a tax dependent by one of their parents. Acting Administrator Marilyn Tavenner, letter correspondence with Commissioner Roderick Bremby, March 1, 2013; Josh Archambault, "Connecticut Feels the Burden of Medicaid Expansion & Exchange Regs: CMS Plays Control Card," 2013, http://goo.gl/Tt4xFG (accessed Aug. 21, 2013).

28 Acting Administrator Marilyn Tavenner, letter correspondence with Commissioner Roderick Bremby, March 1, 2013.

29 Ibid.

30 "An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity," (The Henry J. Kaiser Family Foundation, 2012), http://goo.gl/FFmQq3 (accessed Aug. 20, 2013).

31 "Affordable Care Act: State Resources FAQ," (Centers for Medicare & Medicaid Services), 9, http://goo.gl/NL2J9r (accessed Aug. 23, 2013).

32 42 U.S.C. § 1315(a) (emphasis added).

33 42 U.S.C. § 1315(a).

34 *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (citing Beno v. Shalala, 30 F.3d 1057 (9th Cir. 1994)).

35 Ibid. at 380 (internal citations omitted).

36 Ibid. at 381 (internal citations omitted).

37 Ibid. Arizona's program expired naturally before all appeals were exhausted, so the case was dropped for mootness without being overturned.

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