



Executive Summary

As of April 2016, 31 states and the District of Columbia are implementing the Affordable Care Act's Medicaid expansion.* Most have done so as envisioned by the Act. Six states, however, have expanded coverage through a waiver process that allows them to impose a host of barriers to care—for example, charging premiums and co-pays above current thresholds, limiting when coverage begins, denying coverage to individuals who miss payments, and more.

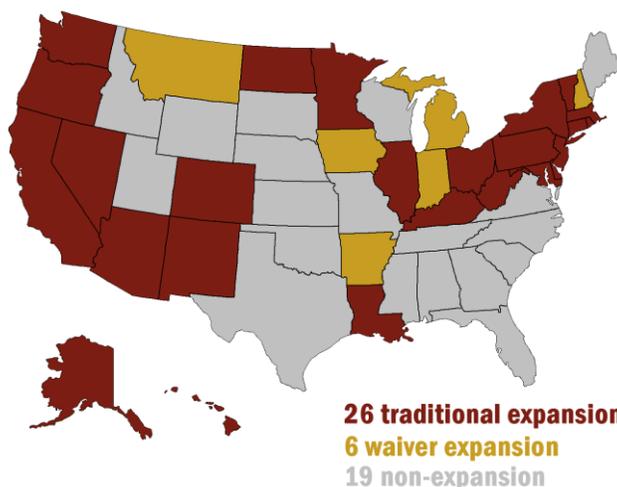
In a number of states, Medicaid expansion is only politically possible through a waiver-based approach that addresses the concerns of conservative lawmakers. And for the six current waiver states, the evidence is clear that they are achieving significant gains in coverage for their most vulnerable residents compared to their non-expansion peers.¹

However, the evidence is also clear that even seemingly small barriers to coverage—for example, small increases in premiums—can limit access to care. Women live in poverty, fall into the Medicaid gap, and lack reliable access to transportation at disproportionately high rates, making them particularly vulnerable to the decisions of policymakers during the waiver process.

Waiver-based expansions are time-limited and must be renewed, and states are free to switch to a waiver-based expansion at any time. *Thus, neither victories nor defeats should be seen as permanent.*

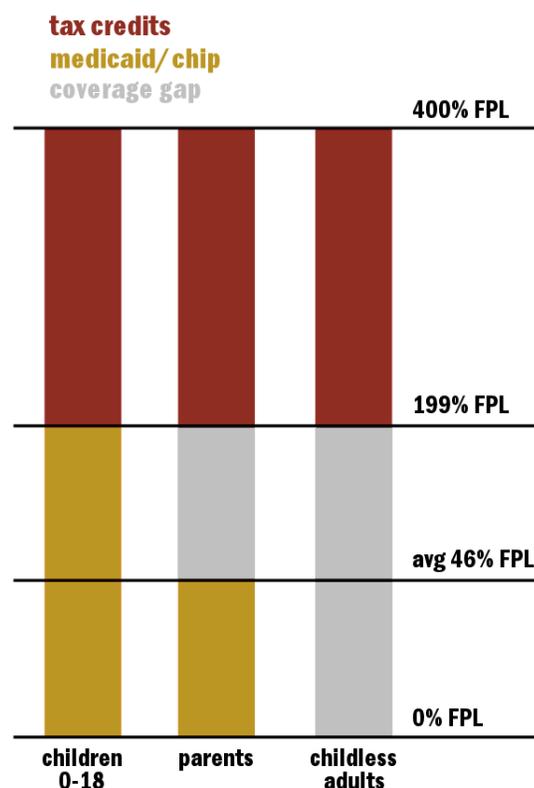
In traditional-expansion states such as Arizona, Kentucky, and Ohio, lawmakers are attempting to roll back progress. In Arkansas and Iowa, where current waivers expire at the end of 2016, advocates are working to ensure that Medicaid expansion stays in place. In Utah and Virginia, where governors are supportive but legislatures are not, advocates continue to push for expansion, recognizing they will have to accept some waiver provisions. And in Louisiana, which expanded Medicaid earlier this year by executive order, the governor has signaled his openness to work with the legislature on a waiver.

This brief examines some of the most common waiver provisions attempted by states and spells out what each means for women as advocates and policymakers work to close the coverage gap.



*In January, Louisiana became the 31st state. In March, the Utah legislature voted to expand Medicaid to 16,000 uninsured residents, but rejected a full expansion that would have covered tens of thousands more, making the state ineligible for the higher match formula offered under the ACA. Therefore, Utah is not included as an expansion state for the purposes of this memo.

Coverage gap in non-expansion states



Background

Prior to enactment of the Affordable Care Act (ACA) in 2010, most parents with dependent children were eligible for Medicaid only if they had incomes well below the poverty line and most adults without dependent children (often shortened to “childless adults”) weren’t eligible at all—although the rules varied state to state. As a result—and contrary to popular belief—millions of even the poorest Americans weren’t eligible for coverage.

Congress’s remedy, enacted as part of the ACA, was to extend Medicaid eligibility to individuals with incomes between 0% and 138% of the federal poverty level (FPL) regardless of whether they fit into an existing eligibility category. Individuals with incomes between 100% and 400% FPL were made eligible for subsidies to help them purchase coverage in the newly-created state and federal healthcare marketplaces (also called exchanges).[†] And individuals with incomes over 400% FPL who didn’t have access to employer-provided coverage were made eligible to purchase coverage in the exchanges, but without federal subsidies. The states that have expanded Medicaid follow this coverage model.

In 2012, the Supreme Court upheld the constitutionality of the ACA but made the Medicaid expansion optional for states. The Supreme Court’s decision created a coverage gap in states that refused to expand Medicaid eligibility. This coverage gap left millions of Americans without access to any coverage at all because they are too poor to qualify for federal subsidies on the exchange and ineligible under the old Medicaid rules.[‡]

While the majority of states expanding Medicaid have done so as envisioned by the ACA, seven states have been granted exemptions by the Centers for Medicare and Medicaid Services (CMS) from certain coverage rules through a waiver process. Of those seven, one (Pennsylvania) transitioned to a traditional expansion after the governor who negotiated the waiver was defeated, while Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire are currently operating as waiver states. With each new waiver approval, other states have adapted their strategies in order to win greater and greater concessions from CMS.

[†] The practical result of the overlap between tax credit and Medicaid eligibility is that in states that have expanded Medicaid, families are eligible for tax credits once their incomes reach 138% FPL while in states that have not expanded Medicaid, families are eligible for tax credits once their incomes reach 100% FPL. However, some families in the 100-138 FPL tier can’t afford coverage through the exchanges even with federal subsidies, and thus still fall into the coverage gap.

[‡] Note that lawfully-present non-citizens are subject to lengthy waiting periods before they can access Medicaid and the Children’s Health Insurance Program (CHIP) while undocumented residents are not eligible at all. Even if all 50 states expand Medicaid, 4.9 million people will still be ineligible for coverage due to their immigration status.

Several states have used more than one kind of waiver to build the Medicaid program best suited to their state’s politics, but the bulk of new provisions have come in the form of Section 1115 waivers. These are intended to be short-lived research and demonstration projects, and federal law requires that they be formally evaluated to measure how well they achieve their objectives, the effects on access to care, and the outcomes for beneficiaries. As such, all of the states with waiver-based expansions will be forced in the next few years to re-fight the battle, which creates the opportunity to either improve or undermine access to care.

Section 1115 Waivers	Approval	Effective	Expiration
Arkansas Health Care Independence Program	9/27/2013	10/1/2013	12/31/2016
Healthy Indiana Plan 2.0	1/27/2015	2/1/2015	1/31/2018
Iowa Wellness Plan	12/10/2013	1/1/2014	12/31/2016
Healthy Michigan	12/30/2013	4/1/2014	12/31/2018
Montana Health and Economic Livelihood Partnership (HELP) Program	11/2/2015	1/1/2016	12/31/2020
New Hampshire Health Protection Program	3/4/2015	1/1/2016	12/31/2018

Impact on Women

Women live in poverty at higher rates than men do and are much less likely than men to have employer-provided insurance in their own names.² Thus, even women with insurance are at greater risk than men of losing it following changes in their relationship status or in the family coverage offered by their spouse’s employer. Unsurprisingly, women are more likely to fall into the Medicaid gap than men, and women of color are particularly vulnerable. In 2013, prior to expansion, a quarter of Black women and a third of Latina women were uninsured.³ Since then, the total number of uninsured women of color nationwide has fallen but their *share* of the uninsured population has grown following the failure of several southern states with large Black populations to expand Medicaid.⁴

At the same time, women are more likely to face non-cost barriers to care. More than one in four low-income women (26%) delayed getting needed health care or skipped it altogether because they couldn't get time off of work, while one in five women with children (19%) did so because they couldn't find child care.⁵ These factors make women more vulnerable to policy decisions made by state legislators during the waiver process.

Selected Waiver Provisions Approved by CMS

Regardless of whether a state chooses traditional Medicaid expansion or a waiver, federal law requires that essential health benefits, mental health parity requirements, and certain other services must be covered. Nonetheless, CMS has approved a range of waiver provisions even when existing research suggests they will be administratively complex or pose barriers to care. In each of these cases, the benefits of expansion must be weighed against the potential harms. Also at stake is the danger of setting a bad precedent that other states will then copy.

1- Premiums and Copays

A number of studies dating back to the 1970s have clearly documented the impact of even small premiums and “cost-sharing” requirements such as co-pays on access to care among low-income populations.

As a result, federal law limits what states can charge Medicaid beneficiaries, capping co-pay amounts and preventing beneficiaries with incomes below 150% FPL from being charged premiums. However, Iowa,

Indiana, Michigan, and Montana have used their Section 1115 waivers to charge monthly contributions or premiums.

Thus, a woman in Indiana, Michigan, or Montana working full-time at minimum wage must pay \$25 every month in premiums. That is, \$300 per year on top of her food, housing, and transportation costs and in addition to the co-pays she is charged under the traditional Medicaid program, which range from \$4 – \$8 for routine care. And in the case of Indiana, failure to pay means she can be locked out of the program for six months.

To put that figure in context, a 2004 study of Utah’s pre-ACA Medicaid waiver program found that requiring individuals below 150% FPL to pay a yearly fee of \$50 forced roughly one out of every 12 participants to drop out of the program after one year.⁶ Although the Utah study did not break out affordability concerns by gender, women made up a disproportionate share of the total disenrolled population (55%).

State	Income	Monthly Premium	Disenrollment for Failure to Pay?
Indiana	0 – 138% FPL	2% of income OR \$1 whichever is greater	YES. Households between 101-138% FPL face disenrollment and a 6-month lock-out period.
Iowa	50 – 100% FPL 101 – 138% FPL	\$5 \$10	YES. Households between 101-138% FPL face disenrollment but can re-enroll at any time.
Michigan	101 – 138% FPL	2% of income	NO.
Montana	51 – 138% FPL	2% of income	YES. Households between 101-138% FPL face disenrollment; re-enrollment upon payment of back premiums

While Section 1115 does not authorize states to change co-payment structures under Medicaid, a state seeking to impose co-pays above current caps can also apply for a Section 1916(f) waiver. Indiana is the only state to be granted this authority thus far, allowing it to impose co-pays up to \$25 per non-emergency visit to the emergency room.

Indiana has done more than any other state to shift costs onto beneficiaries. For example, coverage in Indiana is effective on the date of the first premium payment, not on the date of application. Similarly, Indiana does not provide the three months of retroactive coverage that traditional Medicaid does, even though retroactive coverage helps reduce uncompensated care costs for hospitals and helps prevent medical debt from swamping low-income families.

And, as noted, Indianans with incomes between 100 – 138% FPL who fail to pay their premiums within 60 days can be locked out of the program and lose their health insurance altogether for six months. Meanwhile, Indianans below 100% FPL are given a stingier benefits package unless they pay up to 2% of their income in premiums each month. As a result, the Indiana program ensures that those who are the least able to afford premiums and are most likely to be chronically ill are also those with skimpier coverage.

While none of the other waiver states currently follow the Indiana model, it has set a precedent that several governors have declared their intention to follow. These cost-shifting provisions are often framed as “skin in the game” by proponents: a way to prevent beneficiaries from getting care they don’t really need. But this population already faces significant non-cost barriers to care that force them to delay or skip treatment. Cost-shifting is not only a solution in search of a problem for this population, its practical effect is to prevent low-income households from accessing the care they really do need, turning

manageable health problems into costly emergencies. A 2003 review of relevant literature found that even small premium increases led to dramatic drops in enrollment and that cost-sharing resulted in foregone treatment and greater hospitalization and emergency care.⁷

These costs are felt even more strongly by women—who earn less, have fewer financial resources, and are more likely to be taking care of family members. Not surprisingly, then, significantly more women than men are forced to forgo care when costs increase.⁸

Indiana’s accomplishment in reducing its uninsured rate from 15.3% in 2013 to 10.8% in 2015 should not be dismissed. But the evidence suggests that strict premium requirements are preventing women from accessing much-needed care, and ultimately imposing higher costs on society in the future.

2- Premium Assistance, AKA “the Private Option”

Waivers approved in Arkansas, Iowa, Michigan, and New Hampshire allow those states to use Medicaid funds to purchase private coverage through qualified health plans (QHPs) for their expansion populations. This model is popular among conservative legislators and can provide some real benefits to Medicaid beneficiaries. For example, families with incomes near 138% FPL may go back and forth between eligibility for Medicaid and tax credits when they have even minor income fluctuations. Having a Medicaid-funded QHP in the marketplace may lessen disruption by allowing them to stay within their same provider network even if they ‘churn’ out of Medicaid. Likewise, in some areas there may be more providers for private marketplace plans than for Medicaid. However, there are also significant potential downsides, including the challenges many women face in accessing “wrap-around” benefits.

CMS requires states providing premium assistance to provide “wrap-around” coverage to fill the gaps between the benefits that Medicaid provides and the smaller package of 10 essential health benefits that qualified health plans are required to cover under the ACA. Wrap-around benefits include non-emergency medical transportation (discussed more below), early periodic screening diagnostic and treatment (EPSDT) for children up to age 21, family planning services from Medicaid providers outside of the QHP network, and more.⁹

Prior to the ACA, a number of states offered or required certain subgroups to use premium assistance in lieu of Medicaid. Most of these states were notoriously deficient at tracking how well wrap-around coverage worked in practice and researchers found wide variation in the quality of information that states shared with beneficiaries. Anecdotal evidence suggests that many beneficiaries may not know they have a right to wrap-around coverage or understand how to use it.¹⁰

While little research has been done directly on the impact of premium assistance programs on women, there is reason to suspect that the administrative challenges of wrap-around coverage may be higher for women than men. As noted by the US Department of Labor, “women make approximately 80% of health care decisions for their families and are more likely to be the care givers when a family member falls ill.”¹¹ Thus, state failures to provide seamless coverage of required benefits such as screening and treatment for children (EPSDT) and family planning are likely to fall heavier on women. Additionally, coverage for pregnant women is often better in state Medicaid programs than in QHPs; women who should have been eligible for labor and delivery without cost-sharing may discover too late that their QHP in-network provider does not accept Medicaid reimbursement for this wrap-around benefit.¹²

3- Non-Emergency Transportation

Traditional Medicaid covers the costs of non-emergency transportation to Medicaid-covered services, for example, covering the costs of a shuttle to a doctor’s appointment or a taxi cab to kidney dialysis. Researchers have found that providing this benefit is highly cost-effective over the long-run, ensuring that

patients are able to access the kinds of routine and preventive services that mitigate the need for more expensive emergency care and hospitalization.¹³

While the authors of the ACA intended for this benefit to apply to the expansion population, CMS has approved waivers allowing the states of Iowa, Indiana, and Pennsylvania to suspend this benefit—though Pennsylvania has since transitioned to a traditional expansion.

In keeping with the gender disparity in overall poverty rates, a 2005 study by the National Academies of Sciences, Engineering, and Medicine found that the “transportation-disadvantaged” population was “disproportionately female (62.8% female versus 51.9%).”¹⁴ And in a study conducted in 2013 prior to Medicaid expansion, the Kaiser Family Foundation found that nearly one in five low-income women nationwide (18%) cited transportation problems as a reason for forgoing medical care.¹⁵ Of the 19 states that have not yet expanded Medicaid, all are geographically-large states with low-income residents who lack reliable, affordable public and private transportation options.

While research has not yet been completed in Indiana and Iowa, the data released thus far raises significant concerns.¹⁶ Initial results, combined with earlier research, suggest that women will be particularly harmed by these provisions, forced to forgo or delay care they need.

Selected Waiver Provisions Denied by CMS

1- Asset Limits

Traditional Medicaid operates less like a single program and more like a group of affiliated programs with different eligibility and implementation rules. For example, individuals who qualify for Medicaid’s long-term care coverage (such as nursing home care) are currently subject to certain restrictions on the assets (homes, cars, savings, and so on) that they can retain or pass on to their heirs. But for the majority of individuals covered by Medicaid—including those in the expansion group—the ACA eliminated asset limits. As a result, individuals are eligible for Medicaid based on their incomes and can’t be excluded from the program simply for having an extra old car or a modest savings account.

Numerous studies have shown that asset limits are both costly to administer in the short-term and counterproductive over the long-term, denying families the kinds of savings they need to break the cycle of poverty and making them *more dependent* on the safety net.¹⁷ Nevertheless, conservative lawmakers have continued to include asset limits in their waiver applications. For example, Arkansas included an asset limit in its 2016 renewal application. Montana, meanwhile, did not request an asset limit for *eligibility*, but did enact a fee on households with assets above a certain threshold—an approach that allowed them to circumvent CMS approval.¹⁸ The specific components of the Montana law will likely result in very few households there ever paying the fee. But if CMS continues to deny asset limits on eligibility, states may look to the Montana model. A more punitive fee than Montana’s could prevent women from accumulating the savings they need to escape poverty.

2- Work Requirements

A number of states have sought to use the waiver process to link work requirements to Medicaid eligibility, benefits, or cost-sharing—even though such requirements would do little to increase employment.

Currently, 60% of the nearly 3 million adults in the coverage gap are already working. Among those not working, the vast majority are students, care-takers, those too ill to work, and those already actively looking for work.

From a public health perspective, it makes little sense to deny coverage that helps prevent the spread of disease, allows the mentally ill to access care, and ensures that family members are able to care for individuals who might otherwise require more costly services like nursing homes.

But the consequences for women and people of color would be particularly severe. While women and men have had roughly equivalent unemployment rates post-recession, women are far more likely to work part-time, making them vulnerable to the kinds of hourly requirements legislators have proposed. In 2014, for example, women accounted for 66% of the part-time work force and only 41% of the full-time workforce.¹⁹ Likewise, since the 1940s, the unemployment rate among African Americans has been consistently double that of white Americans.²⁰

CMS has denied all work requirements, making it clear that “while states may promote employment through state programs operated outside of the demonstration, this is not permitted under the Medicaid program.”²¹ Nevertheless, as with asset limits, governors and state legislators continue to probe for ways to implement work requirements that won’t require CMS approval.

Looking Ahead

The challenging political climate in both expansion and non-expansion states ensures that closing the coverage gap—and keeping it closed—will depend on waiver-based approaches that address the concerns of conservative lawmakers. States have begun to release preliminary data about the effectiveness of various waiver provisions, but no states have yet completed a comprehensive evaluation, and final results from CMS’s cross-state evaluation will not be available until 2019.

Nonetheless, these provisions remain ideologically appealing to many lawmakers, and many more states—including states that have already expanded Medicaid—are likely to seek waivers before their full impact is known.

In the interim, the evidence from a broad array of earlier studies strongly suggests that women will be particularly impacted by these provisions, forced to forgo or delay care they need, or forced out of coverage altogether. This, in turn, will have a ripple effect on families, state economies, and state budgets.

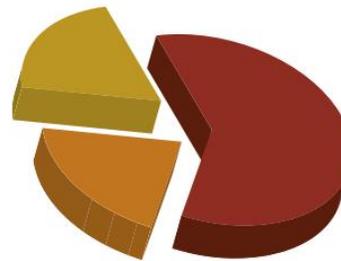
Additional Resources

Map, state by state overview, and advice for advocates when evaluating various waiver provisions from Families USA

- <http://familiesusa.org/medicaid-expansion-waivers-states>

Detailed fact sheets from the Kaiser Family Foundation on the waiver provisions approved or proposed in a number of states, including:

3 million people in this country are in the “Coverage Gap”



60% are workers
20% are spouses, disabled and students
20% are unemployed

- <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/>
- <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/>
- <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/>
- <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/>
- <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-montana/>
- <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-new-hampshire/>
- <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/>

Real-time tracking sites with state legislative activity and gubernatorial proposals for Medicaid expansion from State Reform and The Advisory Board Company

- <https://www.statereform.org/Medicaid-Expansion-Decisions-Map>
- <https://www.advisory.com/daily-briefing/resources/primers/medicaidmap>

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⁵ Salganicoff A, Ranji U, Beamesderfer A, Kurani N, "Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey," Kaiser Family Foundation, May 2014, <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf>

⁶ "Utah Primary Care Network Disenrollment Report," Office of Health Care Statistics, Utah Department of Health, 2004, <http://health.utah.gov/hda/reports/PCN%20Disenrollment.pdf>

⁷ "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Family Foundation, March 30, 2003, <http://kff.org/medicaid/issue-brief/health-insurance-premiums-and-cost-sharing-findings/>

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⁹ For example, wraparound coverage in New Hampshire includes emergency dental extractions and eyeglasses. "230.09 NHHPP/NHHPP-M: Marketplace Premium Assistance Program (PAP)," New Hampshire Department of Health and Human Services, January 2016, http://www.dhhs.nh.gov/mam_hm/230_09_nhpp_nhpp_m_marketplace_premium_assistance_program_pap_and_the_bridge_program.htm

¹⁰ "Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act," Kaiser Family Foundation, March 2013, <http://ccf.georgetown.edu/wp-content/uploads/2013/03/premium-assistance.pdf>

¹¹ "General Facts on Women and Job Based Health," U.S. Department of Labor Employee Benefits Security Administration, December 2013, <http://www.dol.gov/ebsa/newsroom/fshlth5.html>

¹² The National Health Law Program notes, "Medicaid law prohibits states from charging deductibles, copayments, or similar charges for services that are related to pregnancy or conditions that might complicate pregnancy, regardless of the Medicaid category in which the woman is enrolled. ... [P]regnant women in the Marketplace could have cost-sharing for other pregnancy-related services, such as labor and delivery services and post-partum care. It is unclear at this time whether some insurers may also designate some services as not included in prenatal care and therefore impose cost-sharing." Singh D, "Q&A on Pregnant Women's Coverage under Medicaid and the ACA," November 08, 2013, <http://www.healthlaw.org/publications/browse-all-publications/QA-Pregnant-Women-Coverage-Medicaid-and-ACA#.VsfqkkrKJA>.

The Kaiser Family Foundation notes, "States have different policies for administering wrap-around cost-sharing protections, with most protecting beneficiaries from paying excess cost-sharing upfront. However, wrap-around cost sharing protections in examined states are available only if beneficiaries receive services from a provider who is both in their private insurance plan network and also accepts Medicaid. Beneficiaries may not be aware of this limitation, and it may further restrict provider options rather than expanding them." Alker J, Miskell S, Musumeci M, Rudowitz R, "Medicaid Premium Assistance Programs: What Information is Available About Benefit and Cost-Sharing Wrap-Around Coverage?" Kaiser Family Foundation, December 2015, <http://files.kff.org/attachment/issue-brief-medicaid-premium-assistance-programs-what-information-is-available-about-benefit-and-cost-sharing-wrap-around-coverage>

¹³ "Cost Benefit Analysis of Providing Non-Emergency Medical Transportation," Transportation Research Board of the National Academies, October 2005, http://onlinepubs.trb.org/Onlinepubs/tcrp/tcrp_webdoc_29.pdf

¹⁴ Ibid.

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¹⁶ Georgetown University Center for Children and Families et al, Letter to Secretary Burwell, June 22, 2015, <http://ccf.georgetown.edu/wp-content/uploads/2015/07/Comments-on-IA-NEMT-July-2015.pdf>

¹⁷ Cramer R, O'Brien R, Cooper D, Luengo-Prado M, "A Penny Saved is Mobility Earned: Advancing Economic Mobility Through Savings," The Economic Mobility Project at The Pew Charitable Trusts, November 2009, http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2009/empsavingsreportpdf.pdf

¹⁸ "Medicaid Expansion in Montana," Kaiser Family Foundation, November 20, 2015, <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-montana/>

¹⁹ "Latest Annual Data," United States Department of Labor, 2014, http://www.dol.gov/wb/stats/latest_annual_data.htm

²⁰ Desilver D, "Black unemployment rate is consistently twice that of whites," Pew Research Center, August 21, 2013, <http://www.pewresearch.org/fact-tank/2013/08/21/through-good-times-and-bad-black-unemployment-is-consistently-double-that-of-whites/>

²¹ "CMS and Indiana Agree on Medicaid Expansion," CMS.gov, January 27, 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-01-27.html>