

Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion

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INTRODUCTION

What price Medicaid expansion? The Supreme Court's decision in *National Federation of Independent Business (NFIB) v. Sebelius*,¹ sparked intense debate about how the Secretary of Health & Human Services (HHS) would respond to pressure from recalcitrant states. Policy experts and Sunday-morning pundits predicted that Red States would demand Section 1115 waivers of federal Medicaid rules as the quid pro quo for implementing the Affordable Care Act's (ACA) Medicaid expansion that covers adults with incomes up to 133% of the federal poverty level (FPL). They prophesized that the Obama Administration, desperate to move implementation forward, would have little leverage in its negotiations with states.

So far, a handful of states—Arkansas, Iowa, Michigan, Pennsylvania, Indiana and Arizona—have led the way in requesting Section 1115 demonstration waivers that would tie the ACA's Medicaid expansion to Medicaid coverage that offers thinner benefits, higher cost-sharing, premiums, and work requirements. The negotiations have been wild and woolly, but the four states that have obtained Section 1115 waivers—Arkansas, Iowa, Michigan, and Pennsylvania—have won relatively few concessions because the ACA changed the law of Section 1115. The Secretary of HHS has only very limited authority to approve waivers that reduce benefits, and she has no legal authority to approve waivers that increase cost sharing, impose premiums, or implement work rules. HHS simply does not have the leeway to negotiate that some had hoped for—and others feared.

This Essay explores the new legal limits on the Secretary's Section 1115 authority to grant waiver requests for implementation of the ACA Medicaid expansion for adults. Part I describes the Section 1115 waiver process, and explains how provisions in the ACA make this process more transparent, and the federal government more accountable to the law of Section 1115. New notice and comment requirements, and a more robust administrative record for judicial review

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1. 132 S. Ct. 2566 (2012).

require that both states and the Secretary attend more carefully to the legal requirements for Section 1115 waivers.

Part II explains how the ACA amended Section 1902 of the Medicaid Act and broadened the Act's purposes, and, in so doing, constrained the Secretary's authority to grant Section 1115 waivers for benefits, cost-sharing, premiums, and work rules. Part III demonstrates why the Secretary does not have legal authority to grant states' Section 1115 waiver requests for benefit reductions, higher cost-sharing, premiums, and work requirements for those made eligible by the ACA Medicaid expansion.

I conclude by predicting that the bloodiest battleground for Section 1115 waivers will be requests to impose premiums where the Secretary's attempt to accommodate states has resulted in waivers allowing premiums-lite—monthly charges that are not quite full-blown premiums, but still are not authorized by the Medicaid statute or Section 1115.

I. BRINGING SECTION 1115 WAIVERS INTO THE LIGHT: HOW THE ACA CHANGES SECTION 1115

Medicaid is a joint federal-state program that provides federal financial assistance to states operating approved medical-assistance plans. Federal law outlines broad mandatory requirements that state Medicaid programs must follow, but states retain considerable flexibility to cover additional eligibility groups and benefits. States may also seek waivers from the Secretary of HHS to use federal Medicaid funds to cover additional people and services, and to use delivery system models not otherwise authorized by federal law.

Section 1115 of the Social Security Act permits the Secretary to waive provisions in Section 1902 of the Medicaid Act for a limited period of time to allow states to engage in innovative “experimental, pilot, or demonstration” projects that are “likely to assist in promoting the objectives of [the Medicaid Act].”² Although not required by statute or regulations, Section 1115 waivers, under long standing agency policy, are supposed to be budget neutral for the federal government.

Section 1115 began as a limited and targeted tool to test small-scale research hypotheses. However, since the Clinton Administration, the use of Section 1115 Medicaid waivers has skyrocketed. In February 2012, thirty-four states had at least one Section 1115 Medicaid waiver.³

As the size and number of Section 1115 waivers have grown, so have concerns about the lack of transparency in the waiver approval process. Section 1115

2. Social Security Act § 1115(a), 42 U.S.C. § 1315(a)(1) (2012).

3. Kaiser Comm'n on Medicaid and the Uninsured, *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers*, KAISER FAM. FOUND. 2 (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8292.pdf>.

Medicaid waiver requests have typically been negotiated behind closed doors: demonstration goals were often not clearly stated, the terms of the waivers were sometimes vague, and evaluations of demonstrations were often either not done, or not shared with the public or HHS.

The growth in waivers combined with an opaque approval process also raised concerns over the types of waivers that were being granted. Waivers no longer seemed to be about testing new and innovative ideas likely to further the purpose of the Medicaid Act. Instead, waiver approvals seemed to reflect a particular administration's policy preferences: President Clinton's for simply allowing states more flexibility from federal rules to pursue their own priorities and President George W. Bush's for promoting private insurance models with thinner benefits and higher cost-sharing.⁴ Successive federal administrations seemed chronically unconcerned about whether waivers were budget neutral for the federal government. Some waivers have continued for decades with no public evaluation of their impact on Medicaid access, cost, or quality.

In response, the ACA added a new Section 1115(d) providing significant new procedural requirements for Section 1115 waiver requests and renewals. These amendments require public notice, meaningful opportunities for public input, posting of the administrative record online, and evaluations of Section 1115 waiver programs.⁵

Section 1115(d) now requires that states make publicly available a draft waiver request, described in sufficient detail to allow "meaningful input from the public," prior to submission of a waiver to the federal government. Among other things, the draft waiver request must include the demonstration's goals and objectives, the specific waiver and expenditure authorities sought, and the research hypothesis and evaluation parameters.⁶ States must post the draft waiver application on a state website and allow the public to sign up for an email list to be kept apprised of the waiver application process. A 30-day public notice and comment period is required, and the state must also hold at least two public hearings. The final waiver application submitted to the federal government must include similar details to those in the draft waiver proposal, but must also document the public process, including the state's responses to public comments.⁷

4. See, e.g., Samuel R. Bagenstos, *Federalism by Waiver After the Health Care Case*, in *THE HEALTH CARE CASE: THE SUPREME COURT'S DECISION AND ITS IMPLICATIONS* 227 (Nathaniel Persily et al. eds., 2013).

5. Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, § 10201(i), 124 Stat 119, 922 (2010) (codified at 42 U.S.C. § 1315(d) (2012)) (adding a new subsection, Section 1115(d), to the Social Security Act). Implementing regulations are at 42 C.F.R. §§ 431.400–431.428 (2014). These ACA Amendments apply only to Medicaid and CHIP Section 1115 waivers.

6. 42 C.F.R. § 431.408 (2014).

7. *Id.*

After a waiver application is submitted to the federal government, Section 1115(d) provides for another 30-day comment period. The Centers for Medicare and Medicaid Services (CMS) is required to post the waiver application and supporting documents on its website along with an email address through which the public may comment.⁸ A federal decision on the waiver cannot be made until fifteen days after the close of the public comment period, although the federal government does not need to respond to comments made at the federal or state level.⁹

CMS must post online the administrative record of the waiver process, including, among other things, the waiver application and public comments.¹⁰ For approved waivers, CMS posts the “special terms and conditions” outlining the terms of the approval, a list of the specific sections of the Medicaid Act and applicable regulations being waived or modified, the types of federal expenditures, including the budget neutrality agreement, and requirements for evaluation design and reports.¹¹

States are now required to have a CMS-approved Section 1115 evaluation strategy in place.¹² State evaluations are to be submitted to CMS and shared with the public via online posting by the state and CMS.¹³ The “special terms and conditions” approving the waiver include specific requirements for implementation reviews, evaluation design, quarterly progress reports, and evaluation reports.¹⁴ States are also required to submit an annual report to HHS that includes, among other things, the changes occurring under the demonstrations and their impact on outcomes, quality, and access; beneficiary satisfaction surveys; grievance and appeals data; financial data; audits; and other relevant developments.¹⁵ States are also required to conduct a stakeholder forum within six months of implementation and annually thereafter.¹⁶

The ACA’s new transparency provisions force states and CMS to pay attention to the law of Section 1115. Section 1115 waiver requests and approvals must specify the provisions of Section 1902 to be waived. States must set forth the experimental purpose, specify how this purpose furthers the goals of the Medicaid Act, and describe how the experiment will be evaluated. Budget neutrality assumptions and calculations must be provided.

8. *Id.* § 431.416.

9. *Id.*

10. *Id.* § 431.416(f).

11. *Id.* See also Kaiser Comm’n on Medicaid and the Uninsured, *supra* note 3, at 2 (explaining some of the documents referred to by this rule).

12. 42 C.F.R. § 431.424 (2014).

13. *Id.* § 431.424(e).

14. *Id.* § 431.416.

15. *Id.* § 431.428.

16. *Id.* § 431.420(c).

The new notice and comment provisions have opened up the Section 1115 negotiation process, influencing the development of states' waiver requests and making the process more transparent. Arkansas dropped three of its six original waiver requests in response to comments during the state notice period that HHS did not have Section 1115 authority to grant them.¹⁷ Iowa received comments during its state comment period that the state's proposed reductions in benefits were harmful to patients and not authorized by Section 1115. However, unlike Arkansas, Iowa retained these proposed reductions in its final waiver request, responding to public comments by noting that the state had to seek these waivers because state legislation authorizing the Medicaid expansion directed that they do so.¹⁸

Of course, states and the federal government sometimes try to skirt requirements of federal Medicaid law. Pennsylvania's draft waiver application fell far short of the new requirements for public comment—it did not identify the specific waivers sought, provided no research hypothesis, and was simply too general to allow “meaningful input from the public.”¹⁹ The U.S. Government Accountability Office (GAO) has already called CMS to task for failing to ensure budget neutrality in the Arkansas waiver approval.²⁰ Michigan used a waiver amendment for its ACA Medicaid expansion rather than request a new waiver, skirting Section 1115's public notice and comments rules because waiver amendments are not subject to these new transparency requirements.²¹

Given the states' and CMS's proclivity to try to skirt the law, it is significant

17. *Compare Arkansas Draft 1115 Waiver for Public Comment*, ARK. DEP'T OF HUM. SERVS. 28, http://posting.arktimes.com/images/blogimages/2013/06/24/1372102611-1115_waiver_draft_june_24__2_.pdf with *Arkansas 1115 Waiver Application*, ARK. DEP'T OF HUM. SERVS. 30–31, <https://www.medicaid.state.ar.us/Download/general/comment/FinalHCIWApp.pdf>.

18. *See Iowa Marketplace Choice Plan 1115 Waiver Application*, IA. DEP'T OF HUM. SERVS. 42 (2013), <http://dhs.iowa.gov/sites/default/files/IAMktplaceChoice1115Final.pdf>.

19. *See supra* text accompanying notes 6-7. For Pennsylvania's draft waiver, see *Healthy Pennsylvania: Reforming Medicaid*, PA. DEP'T OF PUB. WELFARE, http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/p_039348.pdf.

20. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-14-689R, *MEDICAID DEMONSTRATIONS: HHS'S APPROVAL PROCESS FOR ARKANSAS'S MEDICAID EXPANSION WAIVER RAISES COSTS CONCERNS, MEDICAID DEMONSTRATIONS: HHS'S APPROVAL PROCESS FOR ARKANSAS'S MEDICAID EXPANSION WAIVER RAISES COSTS CONCERNS* (2014).

21. *See* Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. & State Health Officials, (Apr. 27, 2012), <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-001.pdf> (Re: Revised Review and Approval Process for Section 1115 Demonstrations) (explaining that while Section 1115 amendments are not subject to the new notice and comment requirements, states are encouraged to comply with them, and CMS will provide an opportunity for public comment on amendments). For a sense of the more limited notice and comment provided by Michigan, see *Healthy Michigan Plan Waiver Protocols*, MICH. DEP'T OF CMTY. HEALTH, http://www.michigan.gov/mdch/0,4612,7-132-2943_66797-327655--,00.html (last visited Dec. 9, 2014).

that the ACA's new Section 1115 transparency provisions provide a more meaningful administrative record for purposes of judicial review. The Secretary's grant of a Section 1115 waiver is subject to judicial review pursuant the Administrative Procedure Act,²² and courts will reverse the Secretary's grant of a waiver when it is either contrary to law or "arbitrary and capricious."²³ The question of whether the waiver is for a provision in Section 1902 is a matter of law and is reviewed de novo.²⁴ The administrative record must also demonstrate that the Secretary has examined the record and made a determination that the waiver is for "an [e]xperimental, [p]ilot or [d]emonstration project," is "[l]ikely [t]o [a]ssist in [p]romoting [t]he [o]bjectives [o]f [t]he Act," and has an appropriate "extent and period."²⁵ While courts have not required formal findings, the record must be sufficient to support the agency action, show that the agency considered the relevant factors, and enable the court to review the agency decision.²⁶

Under these standards, courts have overturned the Secretary's approval of some Section 1115 waivers. In *Beno v. Shalala*, the Ninth Circuit held that the Secretary abused her discretion when she granted a waiver to allow benefit cuts for the purpose of saving the state money without any consideration of the research or demonstration value.²⁷ In *Newton-Nations v. Betlach*, the Ninth Circuit held it was an abuse of discretion for the Secretary to approve a waiver allowing copays when the only evidence in the administrative record was public comments submitted on behalf of a public health expert stating that thirty-five years of health policy research had established the detrimental effects of cost-sharing on the poor. The administrative record contained no finding that the waiver had an experimental purpose that would demonstrate anything different.²⁸

The new Medicaid Section 1115 transparency provisions should usher in a

22. *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994); see also *Wood v. Betlach*, 922 F. Supp. 2d 836 (D. Ariz. 2013). The Administrative Procedure Act provides for judicial review of federal agencies' actions. 5 U.S.C. §§ 701-706 (2012). Medicaid beneficiaries may also have a right of action under 42 U.S.C. § 1983 or the Supremacy Clause, U.S. CONST. art. VI, cl. 2. See *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007) (holding that Medicaid beneficiaries have a federal right of action enforceable under § 1983).

23. *Newton-Nations v. Betlach*, 660 F.3d 370, 378 (9th Cir. 2011); see also *Wood*, 922 F. Supp. 2d at 836 (holding that it is an abuse of discretion to approve heightened copays as "experimental" when there is evidence in the administrative record of 35 years of research).

24. *Spry*, 487 F.3d at 1276.

25. *Newton-Nations*, 660 F.3d at 380 (quoting *Beno*, 30 F.3d at 1069).

26. *Id.* at 381.

27. *Beno*, 30 F.3d at 1071. The court noted that under Section 1115, "the Secretary must make some judgment that the project has a research or a demonstration value" and found that "[a] simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy this requirement." *Id.*

28. *Newton-Nations*, 660 F.3d. at 380-82. *But see Wood*, 922 F. Supp. 2d at 836 (approving waiver after remand to the Secretary and development of more robust administrative record about demonstration goals).

new era of transparency and accountability. Instead of the negotiations staying behind closed doors, the details of waiver requests are now available for public comment. For example, Pennsylvania's original waiver application requested twenty-four waivers of fifteen provisions of federal Medicaid law. More than eight hundred comments were filed during the federal comment period.²⁹ After almost a year of protracted negotiations, Pennsylvania's approved waiver authorizes only four waivers of federal Medicaid law, one of which allows the use of Medicaid managed care, something that does not require a waiver because it is already authorized by the Medicaid statute.³⁰

Recalcitrant states are not getting much of what they want from waivers to implement the ACA Medicaid expansion for adults. With a more robust administrative record, CMS seems to be attending more closely to the new, post-ACA law of Section 1115, and courts have shown willingness to enforce this imperative.

II. HOW THE ACA TRANSFORMS SECTION 1902 AND THE MEDICAID ACT

Prior to the ACA, Section 1902 of the Medicaid Act allowed states to extend coverage only to those who fit within the old welfare categories of the worthy poor—children, parents, pregnant women, the elderly, and people with disabilities. States needed a Section 1115 waiver to cover others, like childless adults. The George W. Bush administration encouraged states to use Health Insurance Flexibility and Accountability (HIFA) waivers—a type of Section 1115 waiver—to expand coverage to childless adults, granting states “virtually unlimited flexibility” via these waivers to reduce benefits, impose premiums, and increase cost-sharing.³¹ CMS took the position, and courts agreed, that statutory protections provided outside of Section 1902—and therefore not waivable under Section

29. See *Public Comments: Healthy Pennsylvania Demonstration*, MEDICAID.GOV, <https://public.medicaid.gov/connect.ti/public.comments/view?objectId=1852995> (last visited Dec. 9, 2014).

30. See 42 U.S.C. § 1396u-2 (2012) (authorizing mandatory managed care enrollment for most Medicaid beneficiaries). The waiver application and Pennsylvania's Special Terms and Conditions approving the waiver are both available online. Letter from Tom Corbett, Governor, Commonwealth of Pa., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (Feb. 19, 2014) [hereinafter *Healthy Pennsylvania 1115 Demonstration Application*] (waiver application), http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_071204.pdf; Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Beverly Mackereth, Sec'y, Pa. Dep't of Pub. Welfare (Aug. 28, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf> [hereinafter *Healthy Pennsylvania Special Terms and Conditions*] (waiver approval).

31. Cindy Mann, *The New Medicaid and CHIP Waiver Initiatives*, KAISER FAM. FOUND. 24 (2002), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-new-medicaid-and-chip-waiver-initiatives-background-paper.pdf>.

1115—applied only to those “described” as mandatory categories of eligibility in Section 1902(a)(10) of the Medicaid Act or as optional categories of eligibility in other sections of the Act.³² Since childless adults eligible only through Section 1115 waivers were not “described” in Section 1902(a)(10) or anywhere else in the statute, CMS concluded they were not protected by any of the non-waivable statutory provisions that applied to groups eligible under Section 1902.³³

In light of this history, the ACA added Section 1902(a)(10)(A)(i)(VIII) to the Medicaid Act, creating a new mandatory category of Medicaid eligibility for adults aged 19-64 with incomes up to 133% of the FPL.³⁴ States no longer need a Section 1115 waiver to cover childless adults and others. Furthermore, the statute provides states that opt to cover this group of adults with extremely generous federal funding, covering 100% of the cost of the expansion for 2014-2016, reducing gradually to 90% in 2020 and thereafter. Finally, adults eligible under Section 1902(a)(10)(A)(i)(VIII) are now “described” in the Medicaid Act and entitled to the full range of protections provided by the statute to those eligible under Section 1902(a)(10). As a result, adults covered under the ACA Medicaid expansion are entitled to a higher coverage baseline than under pre-ACA HIFA waivers.

As Justice Roberts noted in *NFIB v. Sebelius*, the ACA does not just expand Medicaid; it also transforms the objectives of Medicaid from a welfare program that only covered some poor people to an inclusive social insurance model.³⁵ In Justice Roberts’ words, the ACA Medicaid expansion was “a shift in kind, not merely in degree,” transforming an old Medicaid program into something new.³⁶ Rather than seeking to exclude people based on categories of eligibility or old notions of worthiness, the ACA re-creates Medicaid as the foundation of a multi-layer insurance system that seeks to offer access to affordable health insurance to *all* Americans and documented immigrants.

A host of ACA provisions seek to create a seamless web of coverage so people do not fall through the cracks and become uninsured when their income fluctuates.

32. *See, e.g.*, *Spry v. Thompson*, 487 F.3d 1272, 1276 (9th Cir. 2007)

33. *Id.* at 1276–77. Moreover, any issue about the Secretary’s Section 1115 authority to waive protections codified outside of Section 1902 was not relevant to these waivers. *Id.*

34. Section 1902(a)(10)(A)(i)(VIII) originally *required* that states extend Medicaid coverage to this group, but the Supreme Court in *NFIB v. Sebelius* made the provision permissive. *See* 132 S. Ct. 2566, 2572 (2012).

35. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2606 (2012) (“[Medicaid] is no longer a program to care for [only] the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage”). The Medicaid Act’s stated purpose, which has been part of the Act since it was enacted in 1965, provides that it is “[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.” 42 U.S.C. § 1396-1 (2012).

36. *Nat’l Fed’n of Indep. Bus.*, 132 S. Ct. at 2575.

These provisions make it easier to qualify for Medicaid, and align Medicaid eligibility rules with those for Marketplace premium tax credits. Both Medicaid and premium tax credit eligibility are determined based on the same “modified adjusted gross income” (MAGI) formula. Income is electronically verified, obviating the need to submit paperwork to the welfare office. Burdensome and intrusive asset tests have been eliminated for Medicaid and do not apply for premium tax credits. People can apply for both Medicaid and premium tax credits via the Marketplace, and state Medicaid applications have been streamlined.

However, the ACA also retains Medicaid’s purpose as a safety net insurer, with a benefit and cost-sharing structure distinct from that offered through new Marketplace premium credits and designed to meet the specific needs of the poor. The ACA did add a provision to Section 1902 to establish an “alternative benefit package” benchmarked to private insurance for adults eligible under the ACA’s Medicaid expansion, but it also provides that these new benefit packages are subject to pre-existing protections under Section 1937(b) of the Medicaid Act.³⁷ The ACA also left in place Sections 1916 and 1916A of the Medicaid Act, which provide special premium and cost-sharing protections for Medicaid eligible individuals “described” in Section 1902(a)(10), and which are more stringent than the financial protections afforded those receiving Marketplace premium tax credits.³⁸

In sum, the ACA transformed the objective of Medicaid to include covering all those with incomes up to 133% of the FPL. At the same time, the ACA maintains Medicaid’s purpose as a safety net insurer, with a unique set of benefits and protections designed to meet the needs of the nation’s poor and to support the nation’s safety net providers.

III. ACA MEDICAID EXPANSION WAIVERS AND THE LIMITS OF LAW

To some extent, states and the public are still catching up with the changes to Section 1115 and the Medicaid Act brought about by the ACA. In the immediate

37. See Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, § 2001(a)(2), 124 Stat 119, 271-72 (2010) (codified at 42 U.S.C. § 1396a(k)(1) (2012)).

38. Social Security Act §§ 1916, 1916A, 42 U.S.C. §§ 1396o, 1396o-1 (2012). In general, these sections prohibit premiums for those with incomes below 150% of the FPL, limit cost-sharing for those at or below FPL to “nominal” amounts, and cap both premiums and out-of-pocket costs at 5% of household income, computed on a quarterly or monthly basis at the state’s option. *Id.* Marketplace premium tax credits are benchmarked at 2% of income for the second lowest cost Silver Plan, with individuals paying more or less depending on the plan they select. Cost-sharing tax credits increase the actuarial value of plans to 94% for those earning between 100-150% of the FPL, which translates into an out-of-pocket cap of \$2,500 for individual coverage and \$4,500 for family coverage. See *Explaining Health Care Reform: Questions about Health Insurance Subsidies*, KAISER FAM. FOUND. (2014), <http://files.kff.org/attachment/explaining-health-care-reform-questions-about-health-insurance-subsidies-issue-brief>.

aftermath of *NFIB v. Sebelius*, some thought that states would be able to obtain Section 1115 expansion waivers resembling pre-ACA HIFA waivers, offering fewer benefits and requiring higher cost-sharing and premiums. But the ACA changed the legal landscape. Post-ACA Medicaid expansion waivers raise different legal issues under Section 1115 than did pre-ACA waivers to cover childless adults. ACA Medicaid expansion adults are now eligible by virtue of Section 1902(a)(10)(A)(i)(VIII), and are therefore entitled to a variety of protections in other parts of the statute that the Secretary has no Section 1115 authority to waive.

A handful of states have taken the lead in requesting Section 1115 waivers as the price for implementing the ACA's Medicaid expansion for adults. Arkansas, Iowa, Michigan, and Pennsylvania have received approved waivers, and expansions are moving forward in those states.³⁹ Indiana and Arizona have waiver requests pending, and Arkansas and Iowa are seeking additional waivers.⁴⁰

39. *Healthy Pennsylvania Special Terms and Conditions*, *supra* note 30; Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Andy Allison, Dir., Ark. Dep't of Human Servs. (Sept. 27, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf> [hereinafter *Arkansas Private Option Special Terms and Conditions*]; Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to Jennifer Vermeer, Medicaid Dir., State of Iowa, Dep't of Human Servs. (May 1, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf> [hereinafter *Iowa Wellness Plan Special Terms and Conditions*] (approving the Iowa Wellness Plan for those earning up to 100% FPL); Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare and Medicaid Servs., to Jennifer Vermeer, Medicaid Dir., State of Iowa, Dep't of Human Servs. (May 1, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf> [hereinafter *Iowa Marketplace Choice Special Terms and Conditions*] (approving Iowa Marketplace Choice for those earning between 100-133% FPL); Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Stephen Fitton, Dir., Mich. Med. Servs. Admin. (Dec. 30, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf> [hereinafter *Healthy Michigan Special Terms and Conditions*]. These and other Section 1115 approved waivers can be viewed and downloaded at Medicaid.gov. *Waivers*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html (last visited Nov. 2, 2014).

40. *Arizona Section 1115 Waiver Amendment Request: Cost Sharing for Arizona's Expansion Population* (Jan. 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa-cost-sharing-request.pdf>; *HIP 2.0: Healthy Indiana Plan*, IND. FAM. & SOC. SERVS. ADMIN. 27-29 (July 2, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2.0/in-healthy-indiana-plan-support-20-pa.pdf>; Iowa Dep't of Human Servs., *Health and Wellness Plan: NEMT Waiver Amendment Request*, ST. OF IOWA (Sept. 4, 2014), http://dhs.iowa.gov/sites/default/files/IA_NEMT_WaiverAmendment090414.pdf; Letter from Dawn Stehle, Dir. Div. of Med. Servs., Ark. Dep't of Human Servs., to Sylvia Mathews Burwell, Sec'y, U.S. Dep't of Health & Human Servs. (Sept. 15, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-pa.pdf>.

This Part provides a survey of waiver requests from these path-breaking states—requests that seek to reduce benefits, impose premiums and work requirements, and increase cost-sharing. This analysis is made possible by new transparency requirements in Section 1115(d). Waiver requests and approvals must now expressly address each Section 1115 waiver requirement, demonstrating that the waiver is (1) of a provision in Section 1902, (2) for a limited period of time, (3) for an experimental, pilot, or demonstration purpose, (4) likely to assist in promoting the purposes of the Medicaid Act, and (5) budget neutral for the federal government. This analysis draws heavily on the public comments and administrative record posted by the states and HHS in compliance with these new requirements.

A. “Private Option” via Marketplace Premium Assistance: Benefits, Cost-Sharing and Premiums

Arkansas was the first state to request a Section 1115 waiver as a condition for implementing the ACA's Medicaid expansion for adults. Arkansas asked HHS for a waiver that would allow it to use premium assistance to purchase Marketplace plans for adults newly eligible for Medicaid under the ACA's expansion. This proposal, dubbed the “Private Option,” caught the public and policy wonks by surprise. Many saw it as a “son of HIFA waiver” designed to provide Medicaid coverage that looked like private insurance with fewer benefits and higher costs for the beneficiary.⁴¹ However, a few months before Arkansas and HHS reached an agreement for a waiver, CMS issued proposed regulations that identified Section 1905(a)(29) of the Medicaid Act as the statutory authority for a new option that would allow states to give Medicaid beneficiaries the choice between premium assistance to purchase individual plans, including plans sold on the new Health Insurance Marketplaces, or traditional Medicaid coverage.⁴² The now-final regulations specify that Section 1905(a)(29) Marketplace premium assistance enrollees are entitled to all Medicaid benefits and cost-sharing protections, and states must assure that wrap-around services are available to the extent that Marketplace plans offer fewer benefits or require greater cost-sharing than the state

41. See, e.g., Avik Roy, *Should Arkansas Take the Obamacare Medicaid Deal? Probably Not*, FORBES: THE APOTHECARY (Apr. 3, 2013, 12:01 AM), <http://www.forbes.com/sites/theapothecary/2013/04/03/should-arkansas-take-the-obamacare-medicaid-deal-probably-not/>.

42. Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 4594, 4624 (proposed Jan. 22, 2013).

Medicaid plan.⁴³

Both Arkansas and Iowa have Section 1115 waivers that allow them to require some ACA expansion adults to obtain their Medicaid coverage via Marketplace plans. Arkansas uses its “Private Option” for all those who are not medically frail with incomes up to 133% FPL. Iowa uses its “Marketplace Choice” only for those who are not medically frail with incomes between 100-133% FPL.

The Secretary authorized this mandatory use of Marketplace premium assistance by waiving Section 1902(a)(23)(A) which guarantees Medicaid beneficiaries “freedom of choice” among all Medicaid participating providers. The waiver allows the states to limit Medicaid enrollees’ choice of providers to only those that participate in the networks of their Marketplace plans.⁴⁴ These freedom of choice waivers are very similar to early, and some ongoing, Medicaid managed care waivers that allow mandatory enrollment in HMOs.

The Section 1115 waivers authorizing Arkansas’ “Private Option” and Iowa’s “Marketplace Choice” demonstrations do not—and cannot—waive regulations promulgated pursuant to Section 1905(a) that guarantee premium assistance enrollees all Medicaid benefits and cost-sharing protections. Marketplace premium assistance waivers do not—and cannot—change the benefit package or cost-sharing rules that are codified in sections other than Section 1902 of the Medicaid Act.

While Marketplace premium assistance waivers have not been vehicles for benefit reductions or cost increases, policy experts remain interested in Marketplace demonstration projects to learn how well this new option may work in terms of access, quality, and cost for Medicaid beneficiaries. Pilots offering Marketplace coverage to Medicaid beneficiaries seem to further the objectives Medicaid Act because they may improve continuity of provider networks for those who move from Medicaid eligibility into new Marketplace premium tax credits. In addition, they may offer access to a better network of providers, depending upon

43. 42 C.F.R. § 435.1015 (2014); *see also* Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 42,160, 42,184-86 (July 15, 2013) (explaining that individuals who get premium assistance via the Section 1905(a) option remain Medicaid beneficiaries entitled to the full range of statutory protections).

44. *Arkansas Private Option Special Terms and Conditions*, *supra* note 39, at 1; *Iowa Marketplace Choice Special Terms and Conditions*, *supra* note 39, at 2. Iowa’s waiver also waives Section 1902(a)(10)(A)(i)(VIII) to the extent necessary to provide that enrolling in a Marketplace plan is a condition of eligibility for those eligible pursuant to the ACA Medicaid expansion. *Id.* at 1. Both waivers also waive the Section 1902 comparability requirement to allow the states to provide different benefits for different groups, a frequently waived provision in Section 1115 waivers. The waivers also allow the states to reimburse primary care providers in Marketplace plans at market rates.

how Marketplace plans develop.

However, the biggest Section 1115 hurdle for Marketplace premium assistance waivers is cost neutrality for the federal government. HHS has played fast and loose with the budget neutrality requirement, allowing Arkansas and Iowa to use cost assumptions with little to no basis in fact. The GAO has already raised red flags about the potential cost to the federal government from Section 1115 waivers allowing Marketplace premium assistance.⁴⁵

B. Benefit Reductions

While Marketplace premium assistance waivers have not been vehicles for benefit reductions, a number of states have requested other waivers to reduce benefits. Pennsylvania sought a wholesale reduction in Medicaid benefits for existing beneficiaries as well as ACA expansion adults.⁴⁶ Iowa sought to eliminate Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits for those aged 19–21 who are part of the ACA expansion group, only leaving such coverage in place for younger adolescents and children.⁴⁷ Iowa and Pennsylvania both sought to exclude from coverage some federally qualified health centers, rural health centers, and family planning providers, and to eliminate coverage for non-emergency medical transportation for patients to get to and from care.⁴⁸

Except for non-emergency transportation, these requests to reduce benefits implicate statutory provisions in Section 1937, and are therefore outside the Secretary's Section 1115 authority to waive provisions in Section 1902. The ACA provides that Medicaid expansion adults are to receive an alternative benefit package benchmarked to private insurance as described in Section 1937(b)(1) or equivalent coverage as described in Section 1937(b)(2), and subject to all other requirements of Section 1937.⁴⁹ EPSDT benefits are required by Section 1937(1)(A)(ii), coverage of all rural health and federally qualified health clinics is required by Section 1937(b)(4), and coverage of all family planning providers is required by Section 1937(b)(7). The Secretary has no Section 1115 authority to waive any of the provisions in Section 1937.

By contrast, the statutory authority for non-emergency transportation is

45. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 20.

46. *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30.

47. *Iowa Wellness Plan 1115 Waiver Application*, IA. DEP'T OF HUM. SERVS. (Aug. 2013), http://dhs.iowa.gov/sites/default/files/IAWellnessPlan1115_Final.pdf; *Iowa Marketplace Choice Plan 1115 Waiver Application*, *supra* note 18.

48. *Iowa Wellness Plan 1115 Waiver Application*, *supra* note 46; *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30. Arkansas had included similar requests in its draft waiver request but deleted them in response to public comments that they were not authorized by law.

49. See Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, § 2001(a)(2), 124 Stat 119, 271-72 (2010) (codified at 42 U.S.C. § 1396a(k)(1) (2012)).

Section 1902(a)(4). Non-emergency transportation is not listed in Section 1937 as a basic benchmark or benchmark-equivalent service, nor is it mentioned anywhere else in Section 1937 as a service that states must provide. The Secretary has Section 1115 authority to waive Section 1902(a)(4), and she used this authority to allow both Iowa and Pennsylvania a one-year waiver of the requirement to provide non-emergency transportation.⁵⁰

Even though the Secretary has Section 1115 authority to waive the Section 1902(a)(4) non-emergency transportation requirement, it is arguably an abuse of discretion for the Secretary to find that such a waiver comports with other elements of Section 1115. The waiver must also further an “experimental, pilot, or demonstration” purpose and be “likely to assist in promoting the objectives of [the Medicaid Act].” Lack of transportation has been consistently identified in the research literature as a key barrier to care for low-income individuals and families.⁵¹ The research has been done and there is no need for a pilot or demonstration. Moreover, creating barriers to care flies directly in the face of Medicaid’s purpose to provide access to medical care. Medicaid, unlike private insurance, has covered non-emergency transportation since the program was created in 1965. Coverage for non-emergency medical transportation is one of the unique benefits that Medicaid covers because it is the country’s safety net insurer.

On the other hand, the waivers for non-emergency transportation are limited to a one-year period, allowing the states and CMS to quickly determine whether the lack of transportation is creating barriers. Pursuant to new Section 1115(d) requirements, the states must submit and make public an evaluation of these transportation demonstrations. Iowa’s data after the first six months of its waiver show that 20% of those earning below poverty, and 10% of those earning between 100-133% FPL, were unable to get transportation to or from medical care.⁵² Iowa has filed a request to extend its waiver for non-emergency transportation for a second year.⁵³ It will be interesting to see how CMS responds to this and other states’ requests for additional waivers of coverage for non-emergency transportation in light of Iowa’s early experience demonstrating that such waivers create barriers to care.

50. *Iowa Wellness Plan Special Terms and Conditions*, *supra* note 39, at 1; *Iowa Marketplace Choice Special Terms and Conditions*, *supra* note 39, at 1; *Healthy Pennsylvania Special Terms and Conditions*, *supra* note 30, at 1.

51. Richard Wallace et al., *Access to Health Care and Non-Emergency Medical Transportation: Two Missing Links*, TRANSP. RES. REC. no. 1924, 76 (2005); Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. COMMUNITY HEALTH 976 (2013).

52. Iowa Dep’t of Human Servs., *supra* note 40, at 2-3.

53. *Id.*

C. Work Requirements

A number of states have expressed interest in attaching work incentives, work requirements, and work referrals to Medicaid. Pennsylvania requested a Section 1115 waiver to impose a work requirement on adults aged 21-64 as a condition of Medicaid eligibility.⁵⁴ Those who failed to comply would be banned from Medicaid for nine months. After several months of unsuccessful negotiations with CMS, the state changed its request to instead seek a waiver to use a work incentive to “positively encourage” these adults to work by charging those who were neither working nor searching for work higher premiums and cost-sharing.⁵⁵ In the end, neither waiver was approved.

The Secretary has no Section 1115 authority to allow a work requirement or work incentive. Section 1115 only gives the Secretary authority to *waive* federal rules contained in Section 1902. It does not give the Secretary authority to allow states to impose new conditions on Medicaid eligibility beyond those already authorized by Section 1902.⁵⁶

Moreover, work requirements and incentives are not “likely to assist in promoting the objectives” of the Medicaid program, particularly post-ACA. Pennsylvania argued that studies have shown that people who work are healthier than those who do not, and thus, incentivizing people to work furthers the objectives of the Medicaid Act because it is likely to make them healthier.⁵⁷ However, these studies do not establish a causal relationship between work and health. It may be that people who are healthier are able to get and maintain jobs, rather than work causing people to be healthier.

More importantly, an unemployment exclusion directly contravenes the objectives of the Medicaid Act in the post-ACA world. The ACA transformed Medicaid for working age adults from a welfare program that sought to exclude

54. See *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30. Under the “Encouraging Employment” prong of the proposed waiver, adults with disabilities would be exempt but others would have to prove they are working or searching for work to be eligible to obtain and keep Medicaid. *Id.*

55. See Letter from Tom Corbett, Governor, Commonwealth of Pa., to Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs. (Mar. 5, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-submit-ltr-encourage-03052014.pdf>.

56. When states have tried to impose additional conditions of eligibility, like wellness checkups, school attendance, and refraining from substance abuse, courts have struck down such “extra” eligibility requirements as inconsistent with, and thus preempted by, federal law. See, e.g., *Camacho v. Texas Workforce Comm’n*, 408 F.3d 229 (5th Cir. 2005). See generally *Carleson v. Remillard*, 406 U.S. 598 (1972) (invalidating state law that denied Aid to Families with Dependent Children (AFDC) benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).

57. *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30.

the “undeserving poor”—i.e. childless adults who might be able to work—into part of a new social health insurance system that seeks to offer coverage to all Americans. Work requirements and incentives contradict the ACA’s new inclusive social insurance system. They seek to exclude or penalize those deemed unworthy because they are not working enough. They reinforce the old welfare stigma that paints all those not in the paid work force as lazy and shiftless, and seek to withhold support services so as not to make people “dependent” on government services.

The rationales used to justify work rules also ignore that there are many reasons that people are not in the paid work force, and thus need to be covered by the safety net building block of the ACA’s new social insurance system. Some people are out of the workforce because of a recent layoff, short-term illness, or the need to be a caretaker for a family member. Others, like those with severe mental illness, substance abuse, or physical health problems, need health insurance as a way to get the care that will help them become healthy enough to work.

D. Premiums and Cost-Sharing

Requests to impose higher cost-sharing and premiums are a recurring theme in states’ post-ACA Medicaid expansion waiver requests. Federal Medicaid law provides that Medicaid enrollees with incomes below 150% FPL cannot be charged premiums or deductibles, and provides that many groups and services are exempt from other cost-sharing requirements. Where co-pays are permissible, those with incomes under 100% FPL can only be charged “nominal” co-pays of no more than \$4 for most outpatient services, and \$75 for inpatient care. Those with incomes between 100–150% FPL can be charged up to 10% of the cost of both inpatient and outpatient services. Both groups can be charged up to \$8 for non-preferred drugs and non-emergency use of the emergency room. Federal rules also cap out-of-pocket costs from both premiums and cost-sharing at 5% of household income, calculated on a monthly or quarterly basis, at the state’s option.⁵⁸

Both Iowa and Pennsylvania requested waivers to increase co-pays for non-emergency use of the emergency room from \$8 to \$10, and to impose an annual, rather than monthly or quarterly, cap on cost-sharing.⁵⁹ Arizona has a pending waiver application that requests permission to impose a \$200 copay for non-emergency use of the emergency room for expansion adults with incomes between 100-133% FPL.⁶⁰

58. Premium and cost-sharing rules are codified at 42 U.S.C. §§ 1396o, 1396o-1 (2012). Regulations are at 42 C.F.R. 447.52–.54 (2014).

59. *Iowa Wellness Plan 1115 Waiver Application*, *supra* note 46, at 22; *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30, at 56-57.

60. *Arizona Section 1115 Waiver Amendment Request*, *supra* note 40.

While the Secretary has not yet authorized any waivers to impose higher cost-sharing, she has granted Iowa, Michigan, and Pennsylvania waivers that allow them to impose premiums on ACA-eligible adults.⁶¹ These premiums are tied to wellness incentives—they are not charged during the first year of eligibility and are only imposed if the individual fails to complete prescribed “healthy behavior” incentives, like getting a wellness checkup. In Michigan, those who fail to pay premiums do not lose their Medicaid. In Iowa, those with incomes below 100% of the FPL cannot be terminated for failure to pay premiums, but those with incomes between 100-133% of the FPL can be, although they can file for a hardship waiver to avoid losing coverage.⁶² In Pennsylvania, those with incomes over 100% of the FPL can lose their Medicaid for failure to pay premiums, but, as in Iowa, they may reapply immediately to avoid any gap in coverage.⁶³

The problem with these premium waivers is that the Secretary has no Section 1115 authority to grant waivers for premiums or cost-sharing, because statutory protections against premiums and cost-sharing are found in Sections 1916 and 1916A of the Medicaid Act, not Section 1902.⁶⁴ These protections reside outside of the Secretary’s Section 1115 authority due to express Congressional action. In the early 1980s, the Secretary granted several Section 1115 waivers allowing states to impose higher cost-sharing than authorized by federal law. In response, Congress enacted new premium and cost-sharing protections, moving the substantive provisions out of Section 1902 into a new Section 1916 to put them outside the Secretary’s Section 1115 waiver authority.⁶⁵ In 2005, Congress enacted a second provision, Section 1916A, giving states increased options and flexibility to impose premiums and higher cost-sharing—but again chose to place the

61. See *Iowa Wellness Plan Special Terms and Conditions*, *supra* note 39, at 2; *Iowa Marketplace Choice Special Terms and Conditions*, *supra* note 39, at 1; *Healthy Michigan Special Terms and Conditions*, *supra* note 39, at 1; *Healthy Pennsylvania Special Terms and Conditions*, *supra* note 30, at 1.

62. Compare *Iowa Wellness Plan Special Terms and Conditions*, *supra* note 39, at 12, with *Iowa Marketplace Choice Special Terms and Conditions*, *supra* note 39, at 16-19. For more details on premiums in Iowa, see Dep’t of Human Servs., *Iowa Medicaid Healthy Behaviors Program and Premium Monitoring Protocols*, STATE OF IOWA 13-15, <http://dhs.iowa.gov/sites/default/files/FINALHealthyBehaviorsProgramProtocolYear1.pdf> (last visited Dec. 9, 2014).

63. *Healthy Pennsylvania Special Terms and Conditions*, *supra* note 30, at 10.

64. Section 1902(a)(14) specifies that “enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916.” 42 U.S.C. § 1396a(a)(14) (2012).

65. See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §133, 96 Stat. 324, 373-74 (adding 42 U.S.C. § 1396o). The House of Representatives’ Committee on Energy and Commerce noted: “[A] large number of States have sought waivers of current law relating to the imposition of cost sharing under the demonstration authority at §1115 of the Act. The Committee believes that this bill gives the Secretary sufficient flexibility in this regard to make further exercise of the Secretary’s demonstration authority unnecessary.” H.R. REP. NO. 97-757, at 6 (1982).

provisions outside the Secretary's Section 1115 authority.⁶⁶ Not only did Congress move the premium and cost-sharing protections to Section 1916 and 1916A, but it also created a special waiver for cost-sharing demonstrations with even more stringent requirements than Section 1115.⁶⁷ Section 1916 provides no mechanism for waivers of its premium protections.

Prior to the ACA, the Secretary approved HIFA waivers that allowed states to impose premiums and cost-sharing on childless adults and others in amounts above those authorized by Section 1916 and 1916A. These sections provide protections to "individuals described in" Section 1902(a)(10) and other sections of the Medicaid Act. Because childless adults and others not listed in Section 1902 were eligible only because of a waiver, they were not subject to the protections of Section 1916 and 1916A.⁶⁸ However, post-ACA, expansion adults are described in Section 1902(a)(10)(A)(i)(VII). They are entitled to the cost-sharing and premium protections in Section 1916 and 1916A. The Secretary therefore has no authority to grant waivers authorizing higher cost-sharing or premiums.

As a practical matter, it may be that premiums have become the price for Medicaid expansion. HHS may be trying to circumvent Section 1115 by allowing states to impose something that is called a premium, but that does not function like a traditional premium, which must be paid in advance, and for which non-payment results in loss of coverage. In Iowa, Michigan, and Pennsylvania, "premiums" are only imposed after a year of eligibility, and only on those who fail to comply with "healthy behavior" incentives. In Iowa and Pennsylvania, those earning under 100% FPL do not lose their Medicaid for non-payment. In Michigan, even those with incomes between 100-133% cannot lose coverage for failure to pay.

These charges might be better characterized as "premiums lite," because even though they are paid monthly (like premiums), they do not have to be paid in advance to obtain coverage and do not result in a loss of insurance if not paid. However, Sections 1916 and 1916A forbid not only premiums but also any "enrollment fee" or "similar charge." Moreover, both CMS and the states are calling these charges premiums, prompting a public perception that they are traditional premiums.

66. See Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6041(a), 120 Stat. 4, 81-84 (adding 42 U.S.C. § 1396o-1).

67. See 42 U.S.C. § 1396o-1 (2012). Pursuant to Section 1916A, any waiver for a "deduction, cost sharing or similar charge" may only be granted if the Secretary finds (1) it will test a unique and previously untested use of copayments; (2) it is limited to no more than two years; (3) the benefits to enrollees can reasonably be expected to equal or exceed the risks; (4) it is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar Medicaid enrollees; and (5) it is voluntary or provides for payments for preventable damage to the health of Medicaid enrollees resulting from involuntary participation.

68. See *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007).

In addition to the Section 1902 issues, premiums raise other Section 1115 concerns. State waiver applications assert that using premiums as an incentive to engage in healthy behaviors (or a punishment for failing to do so, depending on your viewpoint) is an innovative experiment that deserves to be tested via a waiver. However, decades of research show that premiums create substantial barriers to enrollment for low-income adults and children.⁶⁹ These healthy behavior premiums are likely to create similar obstacles to coverage, undermining the objectives of the Medicaid Act in a post-ACA world. Instead of reducing barriers to enrollment and streamlining the process, healthy behavior premiums add layers of complexity and bureaucracy that are likely to deter enrollment.

CONCLUSION

What price Medicaid expansion? The Secretary does not have much legal room to maneuver in response to state requests to reduce benefits, impose work rules, increase cost-sharing, and impose premiums. Section 1115(d)'s new notice and public comment requirements make the law of Section 1115 more transparent and more central to the waiver approval process. The ACA's changes to Medicaid, amending Section 1902 to add a new eligibility category of low-income adults and transforming it from a welfare program to a social insurance model, have created new substantive limits on the Secretary's Section 1115 authority.

Premiums have become the flash point for waiver requests because the Secretary has opened the door by acting contrary to law and beyond her legal authority. Section 1115 provides HHS with a clear legal limit: Section 1916 and 1916A prohibit premium charges on those earning below 150% FPL, and connecting the premiums to healthy behavior incentives does not change the nature of the charges. The Secretary has no Section 1115 authority to grant waivers that impose premiums as part of healthy behavior incentives or otherwise.

But now that the Secretary has stepped across this legal line, how far will HHS go in allowing states to impose premiums on Medicaid recipients? What leverage does HHS have as recalcitrant states demand larger premiums and more punitive sanctions for failure to pay?

Arizona recently filed a waiver amendment requesting permission to impose traditional premiums of 2% of income on newly eligible adults with incomes between 100-133%.⁷⁰ Indiana is requesting a waiver to impose traditional premiums on expansion adults, with payments required prior to coverage

69. See David Machledt & Jane Perkins, *Medicaid Premiums and Cost Sharing*, NAT'L HEALTH LAW PROGRAM (Mar. 26, 2014), <http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing> (reviewing research literature on cost-sharing and premiums for low income populations).

70. *Arizona Section 1115 Waiver Amendment Request*, *supra* note 40, at 1.

beginning. For those with incomes between 100-133% FPL non-payment would result not just in loss of coverage, but disqualification from Medicaid for six months. Those with incomes below 100% FPL who fail to pay premiums would not lose coverage, but would have their benefits cut and their cost-sharing increased.⁷¹ Arkansas is also asking for an additional waiver to impose premiums on expansion adults with incomes over 50% FPL.⁷² Premiums would be \$5 per month for those earning below 100% FPL, and \$10-25 per month for those earning 100-133% FPL. The penalty for nonpayment for those earning 100-133% FPL would be a requirement that they pay higher Marketplace cost-sharing rather than being protected by Medicaid rules.

The law of Section 1115 is clear. Will the courts be asked to step in and review the Secretary's actions to determine if they are contrary to the law, or arbitrary and capricious? With the benefit of the more fulsome administrative record now required by Section 1115(d), courts are now in a more informed position to review the Secretary's Section 1115 decisions.

71. *HIP 2.0: Healthy Indiana Plan*, *supra* note 40, at 27-29.

72. Letter from Dawn Stehle, *supra* note 40.