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Premiums and Section 1115 Waivers: What Cost Medicaid Expansion?

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PREMIUMS AND SECTION 1115 WAIVERS: WHAT COST MEDICAID EXPANSION?

SIDNEY D. WATSON*

ABSTRACT

States reluctant to adopt the Affordable Care Act's Medicaid expansion are demanding that the U.S. Department of Health and Human Services grant them Section 1115 demonstration waivers that allow them to charge poor people premiums.

The U.S. Department of Health and Human Services has yielded to these demands, granting five states waivers of long standing federal statutory protections that limit state discretion to impose premiums for Medicaid. These premium waivers present a fundamental problem of law because the Secretary of the U.S. Department of Health and Human Services has no statutory authority to grant Section 1115 waivers that allow states to impose premiums on Affordable Care Act-eligible adults. The premium waivers the Secretary has granted are not legal and threaten the rule of law in Medicaid by signaling to states that the Secretary is willing to flaunt federal Medicaid law to entice states to implement the Affordable Care Act's Medicaid expansion.

This article provides a detailed look at the premium waivers that the Secretary has granted; a history of the Medicaid Act's treatment of premiums in Medicaid, explaining why the Secretary has no Section 1115 authority to waive premium protections spelled out in the statute for Affordable Care Act-eligible adults; and what is at stake in terms of federalism, the relative roles of the agency and Congress, and people's health and welfare.

The article concludes by calling on the U.S. Department of Health and Human Services to issue sub-regulatory guidance describing the authority the agency claims to have to grant premium waivers and the parameters for such waivers. State legislatures need and deserve such guidance as they debate whether, and how, to expand Medicaid.

* Jane and Bruce Robert Professor of Law, Saint Louis University Center for Health Law Studies. My thanks to the Medicaid Matters workgroup for helpful comments on a very early draft. This article would not be possible without the intrepid work of Kathleen Casey, Assistant Professor of Legal Research who cheerfully tracked down almost fifty years of Medicaid legislative history, leaving no stone unturned. My thanks also to Theresa Condon (J.D./M.H.A. 2017), who read and organized all the history, and Elizabeth Larsen (J.D. 2016), who made sure it is all correctly cited.

What cost Medicaid expansion? The Affordable Care Act (ACA) closed the gaping hole in Medicaid, creating a new category of Medicaid eligibility for adults age eighteen to sixty-four with incomes up to 133% of the federal poverty line (poverty).¹ However, while the ACA provides that its Medicaid expansion for adults is a mandatory category of eligibility,² one that states must cover, the Supreme Court decision in *National Federation of Independent Business (NFIB) v. Sebelius* leaves the choice to the states.³ The Secretary of the United States (U.S.) Department of Health and Human Services (HHS) now has to bring on board reluctant states. What will it take?

As of January 18, 2016, thirty-one states and the District of Columbia (D.C.) have opted to expand Medicaid to include new ACA-eligible adults.⁴ Nearly all these states are implementing the expansion as set forth in federal law. However, six states—Arkansas, Iowa, Michigan, Indiana, New Hampshire, and Montana—have demanded that HHS grant them Section 1115 demonstration waivers that allow the state to implement the expansion in ways that go beyond the flexibility provided by the federal Medicaid statute.⁵

The flash point of these federal-state Section 1115 Medicaid expansion waiver negotiations centers on state demands to require poor people to pay premiums. Five of the six states—Iowa, Michigan, Indiana, Arkansas, and Montana—have obtained Section 1115 waivers that allow them to charge premiums otherwise prohibited by the Medicaid Act.⁶ All five states are

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 2001(a), 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a (2012)) [hereinafter ACA § 2001(a)]. Prior to the ACA, the federal Medicaid statute limited coverage for non-elderly adults to very low-income parents, people with “permanent and total” disabling conditions, and pregnant women. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1901, 79 Stat. 286, 343-44 (1965). The only way states could cover so-called “childless adults” was through a Section 1115 demonstration waiver that had to be budget neutral for the federal government. CINDY MANN, *THE NEW MEDICAID AND CHIP WAIVER INITIATIVES* 11 (2002), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-new-medicaid-and-chip-waiver-initiatives-background-paper.pdf>. The ACA Medicaid expansion for adults adds a new category of eligibility to the Medicaid statute and provides enhanced federal funds to help cover the cost of covering this new category. ACA § 2001(a), *supra* note 1, at 272.

2. ACA § 2001(a), *supra* note 1, at 272.

3. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2608 (2012).

4. *Current Status of State Medicaid Expansion Decisions*, KAISER FAM. FOUND. (Mar. 14, 2016), <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>.

5. For a review of three of these six waivers, see Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 *YALE J. HEALTH POL'Y, L., & ETHICS* 213, 217 (2015) [hereinafter Watson, *Out of the Black Box*]. For a detailed analysis of the Arkansas waiver, see Sidney D. Watson, *Medicaid, Marketplaces, and Premium Assistance: What Is at Stake in Arkansas? The Perils and Pitfalls of Medicaid Expansion Through Marketplace Premium Assistance*, 102 *KY. L.J.* 471, 491-99 (2013-2014).

6. See *infra* text accompanying notes 34-84.

charging premiums for those earning between 100% and 133% of poverty, \$11,880 to \$15,800 a year for a single person.⁷ Iowa and Montana require those earning as little as fifty percent of poverty to pay premiums,⁸ and Indiana even charges premiums to those who are unemployed and have no income.⁹ Montana and Indiana terminate Medicaid coverage for those with incomes between 100% and 133% of poverty who fail to pay their premiums,¹⁰ although no waiver allows a state to terminate people living below poverty for nonpayment.¹¹ Every state ties premium reductions or forgiveness to some sort of incentive including healthy behaviors, Health Savings Accounts (HSA), debit cards, contributions for copays, or participation in work preparedness programs.¹²

The Section 1115 premium demonstration waivers reflect the outcome of a negotiation over a clash between two competing visions of the role of premiums in Medicaid. On one side is the concern reflected in federal Medicaid law that premiums and cost sharing create financial barriers to health insurance and health care for low-income adults and families, and that those earning near or below poverty should be shielded from premiums.¹³ On the

7. Annual Update of the HHA Poverty Guidelines, 81 Fed. Reg. 4,036, 4,036 (Jan. 25, 2016).

8. *See infra* text accompanying notes 46-47, 77-78.

9. *See infra* text accompanying note 64-68.

10. *See infra* text accompanying notes 72, 80.

11. *See infra* text accompanying notes 45, 53, 61, 74, and 84.

12. *See infra* text accompanying notes 44, 50, 59, 69-71, and 83.

13. LEIGHTON KU & VICTORIA WACHINO, CTR. ON BUDGET & POLICY PRIORITIES, THE EFFECT OF INCREASED COST-SHARING IN MEDICAID: A SUMMARY OF RESEARCH FINDINGS 7 (2005), <http://www.cbpp.org/research/the-effect-of-increased-cost-sharing-in-medicaid> (indicating researchers estimate that premiums as low as one percent of income reduce enrollment by fifteen percent for families earning at or below poverty). In 2003, Oregon increased sliding scale premiums for Medicaid beneficiaries with incomes from zero to 100% of poverty. *Id.* at 8 (stating that people with no income were charged six dollars a month and those at the poverty level were charged twenty dollars per month, in turn causing enrollment to drop by about half with about three-quarters of those who dropped out of the Medicaid expansion program becoming uninsured). Research looking at those with incomes between 100-150% also shows that premiums reduce enrollment. *See* Salam Abdus et al., *Children's Health Insurance Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children*, 33 HEALTH AFF. 1353, 1357 (2014) (showing that a ten-dollar increase in monthly Medicaid premiums for families earning between 100 and 150% of poverty resulted in a 6.7% reduction in Medicaid and the Children's Health Insurance Program coverage and a 3.3% increase in the uninsured). Only one study of Kansas children in families earning 151 to 200% of poverty shows no negative impact from premiums. *See* Genevieve Kenney et al., *Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States*, 43 INQUIRY 378, 380 (2006). In Kentucky, where a twenty dollar premium was introduced for children in families from 150 to 200% poverty, there was a thirty percent decrease in enrollment. *Id.* at 380, 386. In New Hampshire, where premiums increased by five dollars per month for children 185 to 300% poverty, there was an eleven percent

other side is the belief espoused by conservative state officials and others that personal responsibility requires that everyone have some financial “skin in the game” and contribute toward the cost of insurance through premiums and the cost of medical care through cost sharing.¹⁴

The premium demonstration waivers also reflect a whiff of interstate competition. States want to be perceived as tough negotiators. Each state expects to be able to negotiate at least as favorable a waiver as the states that came before it. State politics typically demand that states prove their negotiating prowess by obtaining at least one new waiver concession from HHS, something that other states do not have. Section 1115 waivers are supposed to test new and experimental projects, so it makes sense that states should be looking to propose waivers to test different, previously untried Medicaid designs.

The Medicaid expansion waivers also reveal a good bit of state-federal competition: as ever more reluctant states come forward, governors and state legislatures demand more concessions of federal law as the increasing federalism cost for bringing recalcitrant states into the ACA’s Medicaid expansion. State legislatures are imbedding waiver demands in state legislation that authorizes Medicaid expansion, conditioning the expansion on the grant of a waiver and tying state—and federal—negotiators’ hands.¹⁵

decrease. *Id.* at 381, 386. In Kansas, where premiums increased by between twenty dollars and thirty dollars per month for children 151 to 200% poverty, there was no change. *Id.* at 380, 386.

14. See Montana Health Economic Livelihood Partnership (HELP) Act, S.B. 405, 64th Leg., Reg. Sess., at 2 (Mont. 2015), <http://leg.mt.gov/bills/2015/sesslaws/ch0368.pdf> (stating one purpose of the program is to “provide incentives that encourage Montanans to take greater responsibility for their personal health”) [hereinafter Montana HELP Act]; see also CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) PROGRAM DEMONSTRATION 2 (2015) (describing the objectives of the program as “encourag[ing] HELP Program enrollees to be discerning health care purchasers, take personal responsibility for their health care decisions and develop health-conscious behaviors as consumers of health care services”). Grace-Marie Turner, *Indiana’s Innovative Medicaid Expansion Idea Could Chart A Path For Major Reform Going Forward*, FORBES (May 19, 2014), <http://www.forbes.com/sites/gracemarieturner/2014/05/19/indianas-innovation-medicaid-expansion-idea-could-chart-a-path-for-major-reform-going-forward/#4dc2f070c5b2> (noting, “[t]he Healthy Indiana Plan relies on individual responsibility”).

15. See Montana HELP Act, *supra* note 14, at 6. Typically, premium requirements are included in the state legislation authorizing the ACA Medicaid expansion, and state negotiators are bound by state law requirements that condition the Medicaid expansion on the requirement that new ACA adults pay premiums. See *id.*; see also *Iowa Health and Wellness Plan*, IOWA DEP’T HUM. SERVS. (July 2013), <http://dhs.iowa.gov/sites/default/files/IHAWP%20Overview%20071513.pdf>; Health Care Independence Act of 2013, H.B. 1143, 89th Gen. Assemb., Reg. Sess. (Ark. 2013) (codified as amended at Act 1498), <http://www.arkleg.state.ar.us/assembly/2013/2013R/Bills/HB1143.pdf>; Healthy Michigan Plan, H.B. 4714, Pub. Act No. 107, 97th Leg., Reg. Sess. (Mich. 2013), <http://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2013-PA->

Within this negotiating dynamic, the premium waivers present a fundamental problem of law: as this article explains, the Secretary of HHS has no statutory authority to grant Section 1115 waivers that allow states to impose premiums on ACA-eligible adults. The premium waivers the Secretary has granted are not legal and threaten the rule of law in Medicaid by signaling to states that the Secretary is willing to flaunt federal Medicaid law to entice states to implement the ACA's Medicaid expansion.

Section I provides a detailed look at the premium waivers that the Secretary has granted. Section II provides a history of the Medicaid Act's treatment of premiums in Medicaid, explaining why the Secretary has no Section 1115 authority to waive premium protections spelled out in the statute for ACA-eligible adults. Section III explores what is at stake in terms of federalism, the relative roles of the agency and Congress, and people's health and welfare.

This article concludes by calling on HHS to issue sub-regulatory guidance describing the authority the agency claims to have to grant premium waivers and the parameters for such waivers. Without such guidance, negotiations with the next state to ask for a premium waiver will begin with the slippery slope demand, "give me what everyone else has and one more concession." The Secretary needs to publicly justify her assertion of authority to grant premium waivers and describe the limits she sees on that authority. State legislatures need and deserve such guidance as they debate whether, and how, to expand Medicaid.

I. STATES, ACA MEDICAID EXPANSION, AND PREMIUMS

Medicaid is a joint federal-state entitlement program that provides federal financial assistance to states operating an approved Medicaid State Plan.¹⁶ As a federal-state partnership, each state designs and operates its own Medicaid program within broad federal guidelines.¹⁷ Federal law outlines core mandatory state plan requirements that state Medicaid programs must comply with for eligibility, covered services, and program administration, but states retain considerable flexibility to cover additional optional categories of eligibility and services, and to design delivery systems.¹⁸ States may also seek waivers from the Secretary of HHS to use federal Medicaid funds in ways not authorized by the federal statute and regulations.¹⁹

0107.pdf; Healthy Indiana Plan 2.0, S.B. 165, 119th Gen. Assemb., 2d Reg. Sess. (Ind. 2016), <http://iga.in.gov/static-documents/c/2/5/b/c25b4cac/SB0165.05.ENRH.pdf>.

16. See generally 42 U.S.C. § 1396b (2012).

17. See 42 U.S.C. § 1396a (2012).

18. See *id.* See generally 42 U.S.C. § 1396d (2012).

19. See Social Security Act of 1935, Pub. L. No. 74-271, § 1115, 49 Stat. 620 (codified as amended at 42 U.S.C.A. § 1315(a) (2014)) [hereinafter Section 1115 of the Social Security Act]

Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive provisions in Section 1902 of the Medicaid Act to allow states to operate “experimental, pilot, or demonstration project[s]” that are “likely to assist in promoting the objectives of [the Medicaid Act].”²⁰ Section 1115 waiver experiments are approved for a limited period of time, typically five years.²¹ Although not required by statute or regulations, under long standing agency policy, Section 1115 waivers must be budget neutral for the federal government meaning that federal spending under a waiver must not be more than projected federal spending would have been for that state without the waiver.²²

Prior to the ACA, the only way that states could cover ACA-eligible adults was via a Section 1115 demonstration waiver.²³ Pre-ACA, Section 1902 of the Medicaid Act only allowed states to extend coverage to those who fit within the old welfare categories of the worthy poor—children, parents, pregnant women, the elderly, and people with disabilities.²⁴ States needed a Section 1115 waiver of provisions in Section 1902 to cover childless adults.²⁵ The ACA added Section 1902(a)(10)(A)(i)(VIII) to the Medicaid Act, creating a new categorically needy eligibility group for adults ages nineteen to sixty-four with incomes up to 133% of poverty and extremely generous federal funding, covering 100% of the cost of the expansion for 2014 through 2016, reducing gradually to ninety percent in 2020 and thereafter.²⁶ States no longer need a Section 1115 demonstration waiver to cover these adults who are now entitled

(indicating Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive Medicaid statutory requirements found in Section 1902 of the Social Security Act); *see also* Social Security Act, Pub. L. No. 74–271, § 1915(c), 49 Stat. 620 (codified as amended at 42 U.S.C. § 1396n(c)(1) (2012)) (noting Section 1915(c) of the Social Security Act gives the Secretary authority to waive statutory and regulatory provisions to operate home and community-based long-term care programs); Social Security Act, Pub. L. No. 74–271, § 1915(b), 49 Stat. 620 (codified as amended at 42 U.S.C. § 1396n (2012)) (noting states can also obtain waivers to expand programs under Section 1915(b) waivers).

20. Section 1115 of the Social Security Act, *supra* note 19.

21. *See* SAMANTHA ARTIGA, AN OVERVIEW OF SECTION 1115 MEDICAID DEMONSTRATION WAIVER ACTIVITY 4 (2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8318.pdf>.

22. *Id.*

23. MANN, *supra* note 1, at 15.

24. Watson, *Out of the Black Box*, *supra* note 5, at 219.

25. *Id.*

26. Social Security Act, Pub. L. No. 74–271, § 1902(a)(10)(A)(i)(VIII), 49 Stat. 620 (codified as amended at 42 U.S.C. § 1396a (2012)). 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* Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012).

to the full range of statutory protections for benefits, premiums, and cost sharing.²⁷

While thirty-one states and D.C. have expanded Medicaid using a straight forward State Plan amendment,²⁸ six states have Section 1115 demonstration waivers allowing them to implement the ACA Medicaid expansion in ways that go beyond the flexibility—and protections—provided by the Medicaid statute.²⁹ Arkansas, Iowa, and New Hampshire have waivers that allow them to require ACA-eligible adults to get coverage through private Marketplace plans rather than traditional Medicaid.³⁰ Iowa and Indiana have waivers that exempt them from providing ACA adults with non-emergency transportation to and from care.³¹

On the other hand, HHS has stood firm, refusing waiver requests for other benefit reductions, increased cost sharing, work, and work search requirements.³² The only cost sharing waiver the Secretary has awarded is a special Section 1916 waiver that allows Indiana to impose higher cost sharing than authorized by federal law for repeat use of the emergency room for non-emergency treatment.³³ This waiver is subject to the more rigorous waiver requirements of Section 1916, including that enrollment be voluntary and that there be a control group.³⁴

The toughest state demands and the greatest HHS flexibility have been around premium waivers: five states now have Section 1115 waivers that allow them to charge premiums not authorized by federal Medicaid statute and regulations.³⁵ The Secretary of HHS has granted these states waivers of Sections 1916 and 1916A of the federal Medicaid Act that prohibit premiums for categorically needy enrollees with income below 150% of poverty,

27. Watson, *Out of the Black Box*, *supra* note 5, at 220.

28. *Current Status of State Medicaid Expansion Decisions*, *supra* note 4 (showing thirty-two states including D.C. have expanded Medicaid, and six have done so through approved Section 1115 waivers).

29. MARYBETH MUSUMECI & ROBIN RUDOWITZ, *THE ACA AND MEDICAID EXPANSION WAIVERS* 1 (2015), <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.

30. *Id.* at 6-7; *see also* KAISER COMM'N ON MEDICAID & THE UNINSURED, *MEDICAID EXPANSION IN NEW HAMPSHIRE*, FACT SHEET 1 (2015), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-new-hampshire/>.

31. MUSUMECI & RUDOWITZ, *supra* note 29, at 10.

32. Watson, *Out of the Black Box*, *supra* note 5, at 225-31; *see also* MUSUMECI & RUDOWITZ, *supra* note 29, at 3.

33. CTRS. FOR MEDICARE & MEDICAID SERVS., *INDIANA SPECIAL TERMS AND CONDITIONS* 27 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf> [hereinafter *HEALTHY INDIANA PLAN 2.0*].

34. *Id.* at 28.

35. *See infra* text accompanying notes 37-83.

including the ACA-eligible adults.³⁶ Examining these waivers in chronological order and in detail offers a glimpse into how states’ premium waiver demands have escalated and how federal-state negotiations have evolved.

State (Exp. Date)	Population Subject to Premiums	Premium Amounts	Alternatives to Payments	Penalties for Non-Payment	Co-pays and Other Cost-Sharing
MICHIGAN (12/31/18)	>100%	<ul style="list-style-type: none"> • 2% of income • \$19-25 	<ul style="list-style-type: none"> • Healthy behaviors 	<ul style="list-style-type: none"> • No disenrollment, but “consistently” unpaid premiums may be garnished from lottery winnings and state income tax return 	<ul style="list-style-type: none"> • All enrollees are subject to maximum allowable Medicaid copays
IOWA (12/31/16)	50 - 133%	<ul style="list-style-type: none"> • 50 - 100%: \$5 • >100%: \$10 	<ul style="list-style-type: none"> • Hardship exemptions • Healthy behaviors 	<ul style="list-style-type: none"> • <100% can’t be disenrolled • >100% can be disenrolled but can re-enroll immediately, without a waiting period • Unpaid premiums treated as debt owed to state • Hardship exemption and 90 day grace 	<ul style="list-style-type: none"> • None for people <50% • >50% are subject only to a \$8 copay for non-emergency use of the emergency room

36. 42 U.S.C. §§ 1396o(a), 1396o-1(a) (2012). The statute also caps premiums and cost sharing at five percent of household income, calculated on a monthly or quarterly basis, at the state’s option. *Id.* § 1396o-1(b). Many services are exempt from cost sharing, but where copays are permissible, those with incomes below 100% poverty can only be charged “nominal” copays. *Id.* § 1396o(a)(3). Recently updated regulations define nominal as no more than four dollars for most outpatient services, and seventy-five dollars for inpatient care and provide that those with incomes between 100 and 150% of poverty can be charged up to ten percent of the cost of both inpatient and outpatient services. 42 C.F.R. § 447.52 (2015). Both groups can be charged eight dollars for non-preferred drugs and non-emergency use of the emergency room. 42 C.F.R. §§ 447.53, .54 (2015).

<p>ARKANSAS (12/31/16)</p>	<p>50 - 133%</p>	<ul style="list-style-type: none"> • 50 - 100%: \$5 • >100%: \$10-25 	<ul style="list-style-type: none"> • None, but Arkansas has stopped collecting premiums <100% 	<ul style="list-style-type: none"> • No disenrollment • >100% copays must be paid out of pocket, can't use premiums in Independence Account to pay 	<ul style="list-style-type: none"> • None for people <100% • >100% subject to maximum copays • Premiums help pay copays
<p>INDIANA (1/31/18)</p>	<p>0 - 133% (<100% have a choice of plan without premiums)</p>	<ul style="list-style-type: none"> • 2% of income for HIP Plus enrollees • \$1 for HIP Plus enrollees with monthly income under \$50 • \$1-\$37.50 	<ul style="list-style-type: none"> • Healthy Behaviors • 3rd party contributions • Unused funds from HSA can lower future year's monthly premiums 	<ul style="list-style-type: none"> • <100 are moved to HIP Basic, with no dental or vision • >100% disenrolled and locked out of coverage for 6 months, except for medically frail • Unpaid premiums may be treated as debt owed to health plan • Coverage does not begin until 1st day of month in which premium is paid • "Qualifying event" exemption & 60 day grace period 	<ul style="list-style-type: none"> • HIP Plus enrollees subject only to \$8/\$25 copay for non-emergency use of the emergency room <100% in HIP Basic subject to maximum allowable Medicaid copays • Thus enrollees have premiums or co-pays (other than for non-emergency use of the emergency room) but not both

MONTANA (12/31/20)	50 - 133%	<ul style="list-style-type: none"> • 2% of household income, credited to cost-sharing • 19-\$26 or \$45 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • >100% disenrolled and locked out of coverage until arrearage paid or state assesses unpaid premiums as debt, no later than end of calendar quarter. Re-enrollment does not require new application so automatic • <100% no disenrollment, may be treated as debt owed to state • Good cause exemptions & 90 day grace 	<ul style="list-style-type: none"> • All enrollees 50 - 133% are subject to maximum allowable Medicaid copays
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On December 30, 2013, Michigan obtained a Section 1115 waiver to impose premiums on newly eligible ACA adults earning between 101% and 133% of poverty, who are not medically frail.³⁷ Medically frail is a term of art in the Medicaid statute and includes, at a minimum, adults with disabling mental disorders, serious and complex medical conditions, and physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.³⁸ States have the flexibility to include other types of medical conditions in their definitions of medically frail.³⁹

In Michigan, premiums may not exceed two percent of income and, under standards developed by the state, vary by family size for a single person, couple, or family of three and range from nineteen to twenty-five dollars per

37. Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Stephen Fitton, Dir., Mich. Med. Servs. Admin. (Dec. 30, 2013), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-cms-amend-appvl-12302013.pdf>. Also exempt are Native Americans. CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: HEALTHY MICHIGAN SECTION 1115 DEMONSTRATION 54 (2013), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-cms-amend-appvl-12302013.pdf> [hereinafter HEALTHY MICHIGAN 2013].

38. 42 C.F.R. § 440.315(f) (2015). The federal regulations identify additional kinds of medically qualifying conditions for children. 42 C.F.R. § 438.50(d)(3) (2015).

39. 42 C.F.R. § 440.315(f).

month.⁴⁰ Enrollees must also pay the maximum cost sharing allowed by federal law, but total costs for both premiums and cost sharing may not exceed the federal statutory cap of five percent of family income.⁴¹

Michigan enrollees are not charged premiums during their first six months of enrollment,⁴² and those who comply with certain healthy behaviors have their premium charges reduced by half.⁴³ Premiums are deposited into an MI Health Account that is used to pay copays and, under certain circumstances, can be carried over from year to year to reduce future premiums.⁴⁴ People cannot be dis-enrolled for failure to pay premiums, but “consistently” unpaid premiums may be garnished from lottery winnings and state income tax returns.⁴⁵

On December 30, 2014, the Centers for Medicare and Medicaid Services (CMS) also granted Iowa a Section 1115 waiver that allows the state to require premiums for ACA-eligible adults who earn as little as fifty percent of poverty who are not medically frail.⁴⁶ Those earning between 50 and 100% of poverty

40. HEALTHY MICHIGAN 2013, *supra* note 37, at 2; *MI Health Account, How Much Could My Contribution Be?*, HEALTHY MICH. PLAN, http://www.michigan.gov/healthymiplan/0,5668,7-326-67957_69564-336716--,00.html (last visited Mar. 20, 2016).

41. HEALTHY MICHIGAN 2013, *supra* note 37, at 2, 15. The waiver is authorized through December 31, 2018. *Id.* at 1. In December 2015, Michigan was granted a Section 1115 amendment that, effective 2018, allows it to require enrollees who fail to participate in specified healthy behaviors to enroll in Marketplace plans with premiums rather than traditional Medicaid. Letter from Andrew M. Slavitt, Acting Adm’r, Ctrs. for Medicare & Medicaid Servs., to Chris Priest, Dir., Mich. Med. Servs. Admin. (Dec. 17, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf>. The amendment does not change any of the special terms and conditions of the waiver for premium amounts or penalties for non-payment. *Id.*

42. CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: HEALTHY MICHIGAN SECTION 1115 DEMONSTRATION 119 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf> [hereinafter HEALTHY MICHIGAN 2015].

43. *Id.* at 12. Healthy behaviors can also reduce copays by half. *Id.* The healthy behaviors include attending an appointment with a primary care provider, completing a health risk assessment, and agreeing to address or maintain a healthy behavior. *Id.* at 16, 131; MICH. DEP’T OF CMTY. HEALTH, HEALTHY MICHIGAN PLAN QUARTERLY REPORT 11 (2015) (containing information about healthy behavior reductions).

44. HEALTHY MICHIGAN 2015, *supra* note 42, at 12, 37-38.

45. *Id.* at 13-14, 122.

46. Letter from Marilyn Tavenner, Adm’r, Ctrs. for Medicare & Medicaid Servs., to Jennifer Vermeer, Medicaid Dir., State of Iowa, Dep’t of Human Servs. (Dec. 30, 2013), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-amend-appvl-ltr-12302013.pdf>. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: IOWA HEALTH AND WELLNESS PLAN (2014-2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-stc-01012014-12312016.pdf> [hereinafter IOWA HEALTH AND WELLNESS PLAN]; CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL

pay five dollars per month, and those earning between 101 and 133% of poverty pay ten dollars per month.⁴⁷ Premiums are in lieu of copays, except for an eight dollar copay for non-emergency use of the emergency room.⁴⁸

Iowa does not charge premiums for the first continuous twelve months of eligibility.⁴⁹ Premiums are also waived on an annual basis for those who

TERMS AND CONDITIONS: IOWA MARKETPLACE CHOICE PLAN (2014), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Market-Place-Choice-Plan/ia-marketplace-choice-plan-stc-01012014-12312016.pdf>. Native Americans are also exempt from premiums. *Id.* at 9. Iowa's Section 1115 ACA expansion waivers have a convoluted history involving numerous waiver amendments, although the premiums, cost sharing, and healthy behavior provisions discussed in this article have remained unchanged. In December 2013, Iowa was granted two Section 1115 waivers for their ACA Medicaid expansion. *See generally* Letter from Mikki Stier, Medicaid Dir., Iowa Dep't of Human Servs., to Victoria Wachino, Dir., Ctrs. for Medicare & Medicaid Servs. (Sept. 3, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa2.pdf>.

The Iowa Marketplace Choice Demonstration was for newly eligible ACA adults earning between 100 and 133% of poverty and used Medicaid funds to enroll those who were neither medically frail nor eligible in Marketplace plans rather than traditional Medicaid. STATE OF IOWA DEP'T OF HUMAN SERVS., SECTION 1115 DEMONSTRATION AMENDMENT 3 (2015). The Iowa Wellness Plan was for newly eligible ACA adults earning less than 100% of poverty and the medically frail earning between 100 and 133% of poverty, and enrolled them in traditional Medicaid. *Id.* Because one of the two carriers dropped out of Iowa's Marketplace, the Iowa Marketplace Choice Demonstration is no longer enrolling people in Marketplace plans and the Marketplace Choice waiver is now suspended. *See generally* Letter to Victoria Wachino from Mikki Stier, *supra* note 46. Iowa has a waiver amendment request pending that would move Marketplace Choice enrollees with incomes between 100 and 133% of poverty into the Iowa Wellness Plan leaving in place existing premiums, cost sharing, and healthy behavior incentives. *See generally* SECTION 1115 DEMONSTRATION AMENDMENT, *supra* note 46. Citations are to the present versions of the Iowa Wellness Plan and Marketplace Choice waivers: CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: IOWA WELLNESS PLAN (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf> [hereinafter IOWA WELLNESS PLAN]; CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: IOWA MARKETPLACE CHOICE PLAN (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf> [hereinafter IOWA MARKETPLACE CHOICE PLAN]. Readers wishing to confirm that the premium cost sharing and healthy behaviors incentives have not changed may compare the most recent version of the waivers with the December 30, 2013 versions cited earlier in this footnote. The Iowa waiver is set to expire on December 31, 2016.

47. IOWA WELLNESS PLAN, *supra* note 46, at 12; IOWA MARKETPLACE CHOICE PLAN, *supra* note 46, at 48.

48. IOWA WELLNESS PLAN, *supra* note 46, at 12-13; IOWA MARKETPLACE CHOICE PLAN, *supra* note 46, at 17; *see also* 42 C.F.R. § 447.54 (2015).

49. IOWA WELLNESS PLAN, *supra* note 46, at 12, 53; IOWA MARKETPLACE CHOICE PLAN, *supra* note 46, at 16-17.

comply with specified healthy behaviors.⁵⁰ Enrollees can also have premiums waived on a month-to-month basis by checking a box on their premium bill that they have a “financial hardship” and are unable to pay their monthly premium.⁵¹

In Iowa, people earning over poverty can be dis-enrolled for nonpayment after a ninety-day grace period, but must be allowed to re-enroll immediately, without a waiting period.⁵² People earning under poverty cannot be dis-enrolled for nonpayment of premiums and cannot be denied an opportunity to re-enroll because of nonpayment.⁵³ For all enrollees, unpaid premiums may be treated as a debt owed to the state.⁵⁴

One year later, on December 31, 2014, HHS approved an amendment to Arkansas’ Section 1115 ACA expansion waiver, a demonstration that has been operating since January 2014, authorizing the state to charge premiums to ACA-eligible adults earning fifty to 133% of poverty who are not medically frail.⁵⁵ After the 2015 Arkansas General Assembly passed legislation suspending premiums for people earning below poverty, the state submitted an operational protocol to CMS that provides for premiums only for those earning between 100 and 133% of poverty.⁵⁶ The operational protocol authorizes the state to charge premiums of ten to fifteen dollars for those earning 101 to 133% of poverty, but no more than two percent of household income.⁵⁷ Enrollees with income over fifty percent of poverty also pay maximum cost

50. IOWA WELLNESS PLAN, *supra* note 46, at 12; IOWA MARKETPLACE CHOICE PLAN, *supra* note 46, at 17.

51. IOWA WELLNESS PLAN, *supra* note 46, at 12; IOWA MARKETPLACE CHOICE PLAN, *supra* note 46, at 17. The waivers do not define “hardship” and the premium statement reads:

By checking the hardship box you are stating that you have spent or will spend your monthly income on food, housing, utilities, transportation or other health care, and are unable to pay your . . . member contribution for this month. Claiming financial hardship will count for this month only, not amounts due for past months.

How to Read Your Statement, IOWA DEP’T HUM. SERVS., http://dhs.iowa.gov/sites/default/files/IHAWP_how_to_read_your_statement_FINAL_0.pdf (last visited Mar. 18, 2016).

52. IOWA MARKETPLACE CHOICE PLAN, *supra* note 46, at 17, 49.

53. IOWA WELLNESS PLAN, *supra* note 46, at 12.

54. IOWA WELLNESS PLAN, *supra* note 46, at 12; IOWA MARKETPLACE CHOICE PLAN, *supra* note 46, at 49. For those with income under 100% poverty, unpaid premiums debt is forgiven if at the time of annual re-enrollment the individual does not apply or is not eligible. *Id.*

55. Letter from Marilyn Tavenner, Adm’r, Ctrs. for Medicare & Medicaid Servs., to John Selig, Dir., Ark. Dep’t of Human Servs. (Dec. 31, 2014), <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf>. The Arkansas waiver runs through December 31, 2016. CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS AND CONDITIONS: ARKANSAS HEALTH CARE INDEPENDENCE PROGRAM (PRIVATE OPTION) 1 (2015) [hereinafter ARKANSAS SPECIAL TERMS AND CONDITIONS]. Native Americans are also exempt from premiums. *Id.* at 9-10.

56. ARKANSAS SPECIAL TERMS AND CONDITIONS, *supra* note 55, at Attachment C.

57. *Id.* at 16, Attachment C, at 5.

sharing allowed by federal law with a five percent cap on premiums and cost sharing.⁵⁸

Arkansas deposits premiums into an Independence Account that can be used to pay copays.⁵⁹ Those who make at least six monthly premium contributions are eligible to receive credits to offset future Medicaid, employer, or Medicare premiums.⁶⁰

In Arkansas, no one can be dis-enrolled or denied eligibility for nonpayment of premiums.⁶¹ However, those earning over 100% of poverty who fail to pay premiums have their Independence Accounts frozen the next month, must pay copays out of their own pockets, and may be denied medical services if they do not pay copayments.⁶²

Less than a month after Arkansas obtained its waiver amendment, but after months of protracted negotiations, on January 27, 2015, Indiana secured a Section 1115 waiver that allows the state to charge premiums to new ACA eligible adults and low income parents with income from 0 to 133% of poverty.⁶³ Unlike Michigan, Iowa, and Arkansas, Indiana requires the medically frail as well as healthier individuals to pay premiums.⁶⁴ Indiana is also the only state that has a waiver to impose premiums on an eligibility category other than the new ACA adults.

Indiana premiums are equal to two percent of income, ranging from one dollar per month for those earning below five percent of poverty to \$37.50 for a couple at the top of the income scale.⁶⁵ Premiums are assessed instead of cost sharing, except for an eight dollar copay for non-emergency use of the

58. *Id.* at 15.

59. *Id.* at 17, Attachment B.

60. *Id.* at 17. The credits are capped at \$200 and have to be used within two years. *Id.* This credit is good only as long as the individual resides in Arkansas. *Id.*

61. ARKANSAS SPECIAL TERMS AND CONDITIONS, *supra* note 55, at 18. This includes both those over 100% of poverty and those under 100% of poverty, should that part of the waiver be re-instated. *Id.*

62. *Id.* at 18, Attachment C. People below 100% are billed for copays but cannot be denied services for failure to pay. *Id.* at 18.

63. Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Joseph Moser, Medicaid Dir., Ind. Family & Soc. Servs. Admin. (Jan. 27, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf>; HEALTHY INDIANA PLAN 2.0, *supra* note 33, at 9. The Indiana waiver is approved through January 31, 2018. *Id.* at 1. Native Americans are exempt from premiums. *Id.* at 9.

64. HEALTHY INDIANA PLAN 2.0, *supra* note 33, at 9, 17-18.

65. *Id.* at 1, 17; *see* IND. FAMILY & SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN 2.0: INTRODUCTION, PLAN OPTIONS, COST SHARING, AND BENEFITS, http://www.in.gov/fssa/hip/files/HIP_2_0_General.pdf (last visited Apr. 3, 2016).

emergency room.⁶⁶ Coverage does not begin until the month in which the premium is paid.⁶⁷ Third parties, including employers and foundations can pay the premium.⁶⁸

Indiana deposits premiums into a POWER Account, similar to a HSA and to which the state also contributes, which is used to pay the first \$2,500 in covered services.⁶⁹ Enrollees with a POWER Account balance at the end of the year may have a portion of their premium contribution carried forward to reduce or eliminate the enrollee's monthly contribution the next year.⁷⁰ The rollover amount is doubled as the reward for the healthy behavior of getting preventive care, but cannot exceed the next year's premium contribution.⁷¹

In Indiana, those with incomes between 100 and 133% of poverty who are not medically frail, who fail to pay premiums for sixty days, and who do not have a "qualifying event" are dis-enrolled and locked out of coverage for six months.⁷² Qualifying events that avoid dis-enrollment include having a loss of income after an increase in income that disqualified one from Medicaid, being a domestic violence victim, living in a disaster area, obtaining private insurance, moving to another state and coming back, and other circumstances to be identified by the state.⁷³ Those earning below poverty, low income parents, and the medically frail who fail to pay premiums for sixty days do not lose coverage, but are moved to a less generous Medicaid plan that does not cover dental or vision care and that requires the maximum copays allowed by federal law.⁷⁴ Unpaid premiums or copays do not have to be repaid to retain or regain coverage, but are treated as a debt owed to the enrollees managed care plan and the state.⁷⁵ The managed care company may attempt to collect the debt, but may not report it to a credit reporting agency, place a lien on a home,

66. HEALTHY INDIANA PLAN 2.0, *supra* note 33, at 27. The state has a special 1916 waiver that allows it to test whether the use of a twenty-five dollar copay for recurring use of the emergency room for non-emergent needs reduces unnecessary emergency room use without harming beneficiary health. *Id.* at 27.

67. *Id.* at 10.

68. *Id.* at 21.

69. *Id.* at 22.

70. *Id.*

71. HEALTHY INDIANA PLAN 2.0, *supra* note 33, at 22.

72. *Id.* at 24.

73. *Id.* at 25-26. Medically frail individuals with incomes over 100% of poverty who fail to pay premiums are re-enrolled in a plan with few benefits and the maximum cost sharing allowed by federal law. *Id.* at 18, 25.

74. *Id.* at 17, 25; HEALTHY IND. PLAN, POWER ACCOUNT CONTRIBUTIONS AND COPAYMENTS INFRASTRUCTURE OPERATIONAL PROTOCOL 11, 12 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Pwr-acct-copay-prtcl-02262015.pdf>.

75. HEALTHY INDIANA PLAN 2.0, *supra* note 33, at 20-21, 24.

refer the case to a debt collector, file suit, seek a court garnishment, or sell the debt to a third party.⁷⁶

On November 2, 2015, Montana became the most recent state to receive a waiver allowing it to charge premiums for new ACA adults with income from fifty to 133% of poverty who are not medically frail or who the state determines have exceptional medical needs.⁷⁷ The waiver authorizes premiums of two percent of household income, ranging from nineteen to twenty-six dollars for a single person and up to forty-five dollars for a family of three earning 133% of poverty.⁷⁸ Enrollees are also charged maximum copays allowed by federal law with premiums credited against copay obligations.⁷⁹

In Montana, those earning above poverty who fail to pay premiums for ninety days may be dis-enrolled and locked out of coverage for up to three months.⁸⁰ Re-enrollment at the end of the lock out period is automatic and does not require a new Medicaid application.⁸¹ People who have “good cause” are not subject to dis-enrollment.⁸² Good cause is not defined in the waiver, but under the Montana statute authorizing the Medicaid expansion waiver, good cause to avoid dis-enrollment requires meeting two of four criteria: (1) discharge from the U.S. military in the last twelve months; (2) enrollment in a Montana university, tribal college, or an accredited Montana college offering at least an associate’s degree; (3) participation in, but not completion of, a state workforce program; or (4) participation in one of nine identified healthy behavior programs.⁸³

In Montana, those earning under poverty cannot be dis-enrolled for failure to pay premiums, but unpaid premiums become a debt owed to the state and

76. *Id.* at 21.

77. CTRS. FOR MEDICARE & MEDICAID SERVS., WAIVER LIST: MONTANA HEALTH & ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) PROGRAM DEMONSTRATION 1 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf> [hereinafter MONTANA WAIVER LIST]; CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL TERMS & CONDITIONS: MONTANA HEALTH & ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) PROGRAM DEMONSTRATION 9 (2015) [hereinafter MONTANA HELP PROGRAM]. The waiver is effective through December 31, 2020. *Id.*

78. MONTANA HELP PROGRAM, *supra* note 77, at 10. *See also* BLUECROSS BLUESHIELD OF MONT., MONTANA HELP PLAN PARTICIPANT GUIDE 6 (2016), <https://www.bcbsmt.com/mthelp/plan/pdf/participant-guide-mt.pdf> (premium amount for a family earning \$27,000).

79. MONTANA HELP PLAN PARTICIPANT GUIDE, *supra* note 78, at 2, 11, 29-30.

80. *Id.* at 2, 10. The lock out lasts until the arrearage is paid or the state assesses the unpaid premiums as a debt, which must take place no later than the end of the calendar quarter. *Id.*

81. *Id.* at 10. “Unless the person states the intent not to reenroll, the department may reenroll the person in the HELP Program when the Department of Revenue assesses the unpaid premium through the participant’s income tax.” MONT. CODE ANN. § 53-6-131(3)(c) (2015).

82. MONTANA HELP PROGRAM, *supra* note 77, at 10.

83. MONT. CODE ANN. § 53-6-1307(6) (2015).

can be collected from future tax refunds.⁸⁴ The state may attempt to collect unpaid premiums, but may not report the debt to credit agencies, place liens on homes, refer to debt collectors, file a lawsuit, garnish wages, or sell the debt to third parties.⁸⁵

The sheer complexity of these premium waivers raises a number of policy concerns. First, they add administrative burdens and administrative costs to Medicaid. Individualized premium statements must be prepared and mailed monthly, and premium payments collected and correctly credited. In Iowa, Michigan, and Montana, the state must track not only monthly premium payments, but also healthy behaviors, good cause, and hardship exemptions that reduce premium obligations. Indiana has to move some people who fail to pay premium payments from one health plan to a different one, and make sure providers and consumers are aware of the change in covered benefits. Indiana, Michigan and Arkansas are using debit cards and must contract with a third party administrator to create and maintain the accounts, including making payments to providers for cost sharing and determining whether enrollees have funds that can carry over from year to year.

Second, these premium waivers are so complex, they are likely to generate consumer confusion that creates barriers to enrollment. All of these demonstrations say that one of the goals of the premium waivers is to help people make the transition to using private insurance. But private insurance does not operate like these Section 1115 waivers. People with employer-sponsored insurance have their premium contributions automatically deducted from their paychecks. Medicare beneficiaries have their premiums automatically deducted from their Social Security checks. Yes, people with Marketplace plans and other individual insurance have to pay monthly premiums, but they generally have higher and more stable incomes than these Medicaid beneficiaries, particularly those with income below poverty.

Third, the complexity of these premium waivers makes it difficult, and maybe impossible, to evaluate the impact of the premiums on enrollment and dis-enrollment, family finances, access to care, and health status. It may be impossible to untangle the impact of premium costs when they are imbedded in a whole array of other experiments including HSAs, healthy behaviors, and consumer preference for copays versus premiums.⁸⁶

84. MONTANA HELP PROGRAM, *supra* note 77, at 2, 10; *see also* MONTANA HELP PLAN PARTICIPANT GUIDE, *supra* note 78, at 6.

85. MONTANA HELP PROGRAM, *supra* note 77, at 11.

86. *See generally* MATHEMATICA POLICY RESEARCH, MEDICAID 1115 DEMONSTRATION EVALUATION DESIGN PLAN (2015), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf> (plan for a national, cross-state evaluation of several different types of Section 1115 demonstrations, including premium waivers).

As each state wants a premium waiver that is a little different or goes a little further, it is also unclear how far the Secretary of HHS will go. HHS has approved premiums for ACA adults and low-income parents, and for the medically frail as well as the relatively healthy. It has authorized premiums for the poorest of the poor, including those who have no income. HHS has authorized both terminations of coverage and lock outs from coverage as the non-payment penalty for those earning at and just above poverty, between 100 and 133% of poverty.

What's next: will HHS allow states to impose premiums on children, elderly, or people who qualify based upon disability with incomes under 150% of poverty? Will HHS authorize states to terminate beneficiaries with income under 100% of poverty who fail to pay premiums? Will the Secretary waive the statutory maximum that limits out of pocket spending to five percent of household income?

Section 1115 only permits the Secretary to waive provisions in Section 1902 of the Medicaid Act for "experimental, pilot, or demonstration project[s]" that are likely to promote the objectives of the Medicaid Act.⁸⁷ Consumer advocates object that the premium waivers are neither experimental nor likely to promote the objectives of the Act.⁸⁸ They point to decades of research that show premiums create substantial barriers to enrollment and argue that these waivers really test nothing new or experimental.⁸⁹ Advocates predict that the complexity and bureaucracy the premium waivers add will deter enrollment, undermining, rather than promoting, the objectives of the Medicaid Act.⁹⁰ Yet these are matters that are within the Secretary's discretion. They have not constrained HHS so far, and it is certainly unclear where the line is likely to be drawn.

The firmest limit on the Secretary's Section 1115 authority is that she may only grant waivers of provisions contained in Section 1902 of the Medicaid Act. The next section explores how the Secretary may have already exceeded her statutory authority in granting Section 1115 premium waivers.

II. CONGRESS, MEDICAID, AND PREMIUMS

The federal Medicaid statute has always limited state discretion to impose cost sharing and, since 1972, premiums too. While the premium and cost sharing provisions have been amended numerous times, the most important statutory development occurred in 1982 when Congress moved the premium

87. 42 U.S.C.A. § 1315 (2014).

88. See, e.g., Letter from Elizabeth G. Taylor, Exec. Dir., Nat'l Health Law Program, to Ctrs. for Medicare & Medicaid Servs. 2 (Oct. 17, 2014) (commenting on Amendments to Arkansas's Health Care Independence Program).

89. See Watson, *Out of the Black Box*, *supra* note 5, at 231.

90. For more of the objectives of the Medicaid Act in a post-ACA world, see generally *id.*

and cost sharing protections from Section 1902(a)(14) of the Social Security Act to a new Section 1916 to curtail the Secretary of HHS's ability to grant Section 1115 waivers for premium and cost sharing demonstrations.⁹¹

In 1965, when Medicaid was enacted, Section 1902(a)(14), rather surprisingly, allowed states to impose premiums for all Medicaid enrollees and cost sharing for almost all services.⁹² States were explicitly allowed to charge an "enrollment fee, premium, or similar charge" and a "deduction, cost sharing, or similar charge" as long as they were "reasonably related" to the beneficiary's income and resources, in accordance with standards developed by the Secretary, and included in the State Plan.⁹³ The only limit on cost sharing was that states were prohibited from imposing a deduction, cost-sharing, or other charge for inpatient hospital care, a prohibition included not because of concern about the impact of cost sharing on low-income enrollees, but because of concern about the impact uncollectable deductibles and cost sharing would have on hospitals' bottom-lines.⁹⁴

In 1967, as part of an array of amendments prompted by concerns over higher than anticipated costs for the early Medicaid program, Congress amended Section 1902(a)(14) to give states new authority to impose deductibles and cost sharing for hospital care for the relatively few enrollees who qualify as "medically needy" while still protecting the "categorically needy" from such charges.⁹⁵ The categorically needy are people who qualify

91. Social Security Act, Pub. L. No. 74-271, § 1902(a)(14), 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. § 1396a(14) (2012)); Social Security Act, § 1916 (codified as amended at 42 U.S.C. § 1396o (2012)).

92. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1902(a)(14), 79 Stat. 286, 346 (1965) (codified as amended at 42 U.S.C. § 1396a(14) (1965)).

93. *Id.* The 1965 Amendments,

[P]rovide that (A) no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to inpatient hospital services furnished him under the plan, and (B) any deduction, cost sharing, or similar charge imposed under the plan with respect to any other medical assistance furnished him thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, shall be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or his income and resources.

Id.

94. *Social Security Amendments of 1967, Hearing on H.R. 12080 Before the S. Comm. on Fin.*, 90th Cong. 2018 (statements in response to questions submitted to the Department of Health, Education, and Welfare). *See* Social Security Amendments of 1967, Pub. L. No. 90-248, § 1902(a)(14), 81 Stat. 821, 821 (1968) (codified as amended at 42 U.S.C. § 1396a(14) (1967)) (removing this prohibition).

95. *See* Odin W. Anderson, *Review of Welfare Medicine in America: A Case Study of Medicaid*, 42 U. CHI. L. REV. 393, 393, 396-97 (1974); Social Security Amendments of 1967, Pub. L. No. 90-248, § 1902(a)(14), 81 Stat. 821, 821 (1967) (codified as amended at 42 U.S.C. § 1396a(14)(1968)). Section 1902(a)(14) amends Section 1396a(14) to:

for Medicaid through one of the categories of eligibility in the Medicaid Act: children, parents, seniors, people with permanent and disabling conditions, and, after the ACA, adults with incomes up to 133% of poverty.⁹⁶ Some categorically needy groups are mandatory and others are optional for states.⁹⁷ The medically needy are an optional category of coverage for people who would be eligible for a categorically needy coverage group, but whose income or assets are too high.⁹⁸ These people qualify for medically needy Medicaid by “spending down” their excess income on medical expenses until they reach the medically needy income level.⁹⁹ Congress apparently assumed the medically needy were better able to pay cost sharing charges. However, the 1967 amendment impacted only a tiny portion of Medicaid enrollees. Even today, only thirty-four states cover the medically needy: they make up only five percent of Medicaid beneficiaries and account for only eleven percent of Medicaid spending.¹⁰⁰

In 1972, Congress once again amended Section 1902(a)(14), for the first time, ratcheting back state authority to charge premiums, prohibiting states from imposing premiums on the categorically needy.¹⁰¹ States now only had

[P]rovide that (A) in the case of individuals receiving aid or assistance under State plans approved under subchapters I, X, XIV, XVI, and part A of subchapter IV of this chapter, no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to inpatient hospital services furnished him under the plan, and (B) any deduction, cost sharing, or similar charge imposed under the plan with respect to inpatient hospital services or any other medical assistance furnished to an individual thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, shall be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient’s income or his income and resources.

Id. See S. COMM. ON FIN. & H. COMM. ON WAYS & MEANS, 90TH CONG., SUMMARY OF SECURITY AMENDMENTS OF 1967 23 (Comm. Print 1967).

Under present law, States may not impose any deductibles or cost sharing provisions with respect to hospital care under the medicaid [sic] program. Under the amendments, the costs of hospital care received by the medically needy will be subject to deductibles or other cost sharing if a State desired to have such provisions in its program. No such deductible or cost sharing could be imposed with respect to money payment recipients, as under existing law.

Id.; see also 90 CONG. REC. 36361, 3675 (1967); 42 U.S.C. § 1396a(a)(14) (1967).

96. See JANE PERKINS & SARAH SOMERS, THE ADVOCATE’S GUIDE TO THE MEDICAID PROGRAM, 4.3-4.5 (2011) (providing a complete list of categorically needy groups). Federal law mandates that states cover some categorically needy groups and others are optional. *Id.*

97. *Id.* (providing a list of both mandatory and optional categorically needy groups).

98. *Id.*

99. *Id.* at 3.17-3.18 (providing a complete list and explanation medically needy eligibility).

100. KAISER FAMILY FOUND., THE MEDICAID MEDICALLY NEEDED PROGRAM: SPENDING AND ENROLLMENT UPDATE 1, 6 (2012).

101. Social Security Amendments of 1972, Pub. L. No. 92-603, § 208(a)(14)(A), 86 Stat. 1329, 1381 (1973) (codified at 42 U.S.C. § 1381 (1974)). Section 1902(a)(14) amends Section 1381 of the U.S. Code to read, with respect to the categorically needy:

discretion to impose premiums on the five percent of enrollees who qualified through the optional category of medically needy.¹⁰² The amendment also narrowed states' ability to impose cost sharing, prohibiting cost sharing for mandatory services for the categorically needy and limiting cost sharing for optional services for the categorically needy to "nominal" amounts.¹⁰³ States continued to be able to charge the medically needy nominal cost sharing for both mandatory and optional services.¹⁰⁴

Over the next decade, the substance of the premium and cost sharing provisions of Section 1902(a)(14) remained unchanged even as states pushed for greater authority to impose cost sharing.¹⁰⁵ In Alabama, federal district courts repeatedly struck down state attempts to impose copays for mandatory physician services provided to categorically needy enrollees.¹⁰⁶ Georgia obtained a Section 1115 waiver to impose copays on mandatory services for the categorically needy to avoid the Section 1902(a)(14) prohibition.¹⁰⁷

In 1982, Congress overhauled the premium and cost sharing provisions of Medicaid, as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the most significant budget reduction initiative of President Ronald Reagan's first term.¹⁰⁸ States had long wanted more flexibility to impose cost

[N]o enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to care and services [that are mandatory services] . . . (ii) any deduction, cost sharing or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and (B) with respect to [the medically needy] . . . (i) there shall be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and (ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal.

Id.

102. *Id.* (codified at 42 U.S.C. § 1396a(14) (1974)).

103. *See id.*

104. *See id.*

105. *See id.* at 1460 (codified at 42 U.S.C. §§ 1396(a)(14), 1396d(a) (1981) (including nurse midwife services among mandatory services). Congress passed technical amendments in updating the mandatory services exempt from copays for the categorically eligible to reflect a statutory amendment adding nurse midwife services as a mandatory service. *Id.* Otherwise the statute remained unchanged.

106. *See Potter v. James*, 499 F. Supp. 607, 609-610, 613 (M.D. Ala. 1980) (striking down two dollar copays and citing *Moody v. Holzworth*, Civil Action No 76-349-N, striking down a similar statute requiring a one dollar copay). The court allowed cost sharing of fifty cents to three dollars for optional prescription drugs holding that such amounts were "nominal in amount" and thus allowed by Section 1902(a)(14). *Id.* at 608.

107. *Crane v. Mathews*, 417 F. Supp. 532, 537 (N.D. Ga. 1976).

108. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324 (codified as amended at 42 U.S.C. § 1396o (2012)) [hereinafter Pub. L. No. 97-248]; *see, e.g.*, JENNIFER O'SULLIVAN & GLENN MARKUS, 82-173 EPW, MEDICARE AND MEDICAID

sharing, and the budget process created the momentum and the legislative vehicle to give states expanded statutory authority. The Medicaid cost sharing increases authorized by the legislation were estimated to save the federal government \$151 million over three years, about fifteen percent of the total Medicaid cost reductions authorized by the Act.¹⁰⁹

TEFRA's premium and cost sharing provisions, like many budget resolutions and maybe most bills, took an unorthodox path through Congress.¹¹⁰ TEFRA's Medicaid provisions began as H.R. 4961, a bill drafted by and reported out of the Senate Finance Committee, and passed by the Senate.¹¹¹ A House-Senate Conference Committee took up H.R. 4961 before the House passed a budget bill that contained Medicaid provisions.¹¹² In lieu of a House-passed bill, the conferees agreed to consider provisions in H.R. 6877, a bill introduced by Representative Dingell but not yet passed by the House Energy and Commerce Committee, as the House version of TEFRA for Medicaid budget cuts.¹¹³ The bill that ultimately passed both houses and became TEFRA 1982 was H.R. 4961, as amended and passed by the Conference Committee.¹¹⁴

As the Conference Committee convened, the House and Senate bills offered similar, yet different, amendments to Section 1902(a)(14): both bills continued to prohibit premiums for the categorically eligible, while expanding state discretion to impose cost sharing by giving states authority to impose nominal cost sharing on all beneficiaries for all services with certain exceptions.¹¹⁵ It was the exceptions from cost sharing that set the bills apart: the bills differed significantly in the eligibility groups and covered services they would exempt from cost sharing.¹¹⁶

PROVISIONS OF THE "TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982" (P.L. 97-248) 1 (1982) [hereinafter CRS Report].

109. See CRS Report, *supra* note 108, at 66.

110. See Abbe R. Gluck et al., *Unorthodox Lawmaking, Unorthodox Rulemaking*, 115 COLUM. L. REV. 1789, 1792-93 (2015).

111. Tax Equity and Fiscal Responsibility Act of 1982, H.R. 4961, 97th Cong. (1982) [hereinafter H.R. 4961]; see CRS Report, *supra* note 108, at 11.

112. CRS Report, *supra* note 108, at 13.

113. *Id.* at 13; see also H.R. REP. NO., 97-757, PT. 1, AT 1 (1982) [hereinafter H.R. 6877].

114. Pub. L. No. 97-248, *supra* note 108, at 384.

115. Compare H.R. 4961, *supra* note 111, with H.R. 6877, *supra* note 113.

116. H.R. 4961, *supra* note 111, at 4. H.R. 4961 precluded copays for mandatory services provided to categorically needy children, pregnancy related services provided to pregnant women, all services provided to nursing home residents, and emergency services provided to the categorically needy. *Id.* It also allowed states to exempt copays for medically needy children and pregnant women, and all Health Maintenance Organization (HMO) enrollees. *Id.* H.R. 6877 precluded copays for all services provided to all children and pregnant women, and categorically eligible nursing home inpatients and HMO enrollees. H.R. 6877, *supra* note 113, at 1; H.R. REP. NO. 97-760, pt. 3, at 47 (Conf. Rep.) (summarizing the provisions of both bills) [hereinafter H.R.

The compromise bill that emerged from the Conference Committee and became TEFRA 1982 took a dramatic and legally significant turn: instead of amending the premium and cost sharing provisions of Section 1902(a)(14), the Conference Committee bill removed premiums and cost sharing from Section 1902(a)(14) and put them into a new Section 1906.¹¹⁷ Section 1902(a)(14) was amended to say “that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916.”¹¹⁸

The new Section 1916 that emerged from the conference process still prohibited premiums for everyone except the medically needy, but the cost sharing provisions reflected a compromise between the House and Senate bills.¹¹⁹ States were given new discretion to impose nominal copays on all beneficiaries for all services with the exception of children up to age eighteen, pregnancy-related services, nursing home residents, categorically needy health maintenance organization (HMO) enrollees, family planning services, and emergency services.¹²⁰ States were permitted, but not required, to exclude children eighteen to twenty-one, all services for pregnant women, and medically needy HMO enrollees from copays.¹²¹ Providers were prohibited from denying Medicaid services because of a patient’s inability to pay cost sharing amounts.¹²²

By moving the premium and cost sharing provisions to Section 1916, the Conference Committee explicitly and purposely removed the Secretary’s authority to grant Section 1115 waivers for premium and cost sharing

REP. NO. 97-760]. It also precluded copays for all emergency and family planning services. *Id.* The Senate left in place the existing statutory requirement that copays for the categorically needy be “nominal” while the House bill specified a one dollar maximum allowable nominal copay for hospital, physician, outpatient, and clinic services for the categorically needy and four dollars for non-emergency services in an emergency room. H.R. 6877, *supra* note 113, at 1-2. The House also added a provision specifying that providers could not deny Medicaid services because of a patient’s inability to pay cost sharing amounts. *Id.* at 2.

117. Pub. L. No. 97-248, *supra* note 108, at 367 (TEFRA as passed by both Houses).

118. *Id.*

119. *Id.* at 368.

120. *Id.*; *see also* H.R. REP. NO. 97-760, *supra* note 116, at 47 (summarizing the provisions of both bills).

121. Pub. L. No. 97-248, *supra* note 108, at 368-69; *see also* H.R. REP. NO. 97-760, *supra* note 116, at 48. The bill also amended Section 1902(a)(10), the Medicaid Act’s comparability provision, to specifically provide that states could impose premiums on those not exempt under Section 1916 without having to also impose premiums on those exempted by Section 1916. Pub. L. No. 97-248, *supra* note 108, at 369-70.

122. Pub. L. No. 97-248, *supra* note 108, at 369; *see also* H.R. REP. NO. 97-760, *supra* note 116, at 48. Congress also froze the definition of “nominal” cost sharing, requiring CMS to abide by the existing regulatory definition of the term or follow a specified rule making process. Pub. L. No. 97-248, *supra* note 108, at 369; *see also* H.R. REP. NO. 97-760, *supra* note 116, at 48.

experiments. The Secretary of HHS has Section 1115 authority only to waive provisions in Section 1902(a) of the Medicaid Act.¹²³ The Secretary may not use Section 1115 to allow states to avoid other provisions in the Medicaid Act.¹²⁴

The conferees were aware that “a large number of states” had sought Section 1115 waivers to impose cost sharing otherwise prohibited by Section 1902(a)(14).¹²⁵ Representative Dingell ordered a House Committee Report on H.R. 6877 to be printed on August 17, 1982, the day the Conference Committee bill was reported out.¹²⁶ Referring to the original House bill, the report says,

The Committee notes that a large number of States have sought waivers of current law relating to the imposition of cost-sharing under demonstration authority at section 1115 of the Act. The Committee believes that this bill gives the States sufficient flexibility in this regard to make further exercise of the Secretary’s demonstration authority unnecessary.¹²⁷

As the House and Senate conferees negotiated over how much additional discretion states should have to impose cost sharing, they also considered whether the Secretary should be able to authorize Section 1115 waivers to give states even more flexibility. In the end, the bill that emerged resolved the issue by removing premiums and cost sharing from the Secretary’s Section 1115 waiver authority.¹²⁸

In lieu of Section 1115 waiver authority, Section 1916 contains two more “tightly limited” waiver provisions that allow cost sharing but not premium demonstrations.¹²⁹ Section 1916(a)(3) gives the Secretary authority to grant a waiver to allow states to impose cost sharing of up to twice the nominal amount for non-emergency care in an emergency room where the state has established that an alternative source of non-emergency care is actually

123. See Section 1115 of the Social Security Act, *supra* note 19 (subpart (a)) (codified at 42 U.S.C.A. § 1315(a)(1) (2014)).

124. See *id.*

125. See H.R. 6877, *supra* note 113. (“The [House] Committee notes that a large number of States have sought waivers of current law relating to the imposition of cost-sharing under demonstration authority at section 1115 of the Act.”).

126. See *id.* (H.R. REP. NO. 4691 reported by House-Senate conference committee on August 17, 1982).

127. H.R. 6877, *supra* note 113, at 6. Medicaid and Medicare Part B Budget Reconciliation Amendments of 1982, H.R. REP. NO. 97-757, pt. 1, at 6 (1982).

128. See H.R. REP. NO. 97-760, *supra* note 116.

129. Social Security Act, Pub. L. No. 74-271, § 1916, 49 Stat. 620 (codified as amended at 42 U.S.C. § 1396o (2012)). The “nominality” requirement cannot be waived except for demonstration under tightly limited circumstances, with one exception. *Id.*

available and accessible.¹³⁰ Section 1916(d) provides that the Secretary may waive the cost sharing provisions of Section 1916 only if, after notice and public comment, she finds that a demonstration meets five criteria: (1) tests a “unique and previously untested use of co[pays],” (2) is limited to two years, (3) the benefits to Medicaid enrollees are equivalent to the risks, (4) the demonstration includes a control group, and (5) participation is voluntary or the state assumes liability for preventable damage resulting from involuntary participation.¹³¹

Section 1916 contains no provision for premium waivers.¹³² The Conference Committee debate over the differences between the House and Senate bills focused on how much more statutory authority states should have to impose cost sharing.¹³³ Increased state authority to impose premiums was not part of the TEFRA discussion. The states and HHS seemed content with the long-standing premium restrictions in the statute. The Conference Committee would not have perceived any need to provide for even limited premium demonstration authority under Section 1916.

Since 1982, Congress has periodically amended Section 1916 to give states additional flexibility to charge premiums and cost sharing for higher income Medicaid beneficiaries, confirming that Congressional action is needed to vary Section 1916 premium and cost sharing protections. In 1987, Congress gave states permission to impose premiums on all infants and pregnant women with incomes over 150% of poverty.¹³⁴ In 1989, Congress authorized premiums for certain qualified disabled and working individuals with incomes over 150% of poverty.¹³⁵ In 1999, Congress created a new eligibility “Ticket to Work” program for people with disabilities and amended Section 1916 to allow premiums or cost sharing and, in some situations, require states to impose premiums on these workers.¹³⁶ In 2009, Congress amended Section 1916 to restrict state authority to impose premiums, prohibiting premiums for Native Americans.¹³⁷

130. Pub. L. No. 97-248, *supra* note 108, at 368 (discussing 1916 (a)(3)). This provision was later moved to 42 U.S.C. § 1396o (2012).

131. *Id.* at 369. This provision was later moved to 42 U.S.C. § 1396o (2012).

132. *Id.* at 367-69. This provision was later moved to 42 U.S.C. § 1396o (2012).

133. See CRS Report, *supra* note 108, at 9, 12. See generally H.R. REP. No. 97-760, *supra* note 116.

134. Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, § 4101(d)(1)(B), 101 Stat. 1330-39 (1987).

135. Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, §§ 6408(d)(3)(B), 6408(d)(3)(C), 103 Stat. 2106, 2269 (1989) (codified at 42 U.S.C. § 1396o(d) (2012)).

136. Ticket to Work and Work Incentives Act of 1999, Pub. L. 106-170, § 201(a)(3)(B), 113 Stat. 1860, 1893 (codified at 42 U.S.C. § 1396o(g)).

137. American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, § 5006(a)(1)(B), 123 Stat. 115, 505 (codified at 42 U.S.C. § 1396o(j) (2012)).

For almost twenty years, HHS did not grant a Section 1115 waiver that allowed premiums or copays prohibited by Section 1906.¹³⁸ It was settled law that Section 1916 premium and copay protections were not subject to the Secretary's 1115 authority.

However, in 2001 during President George W. Bush's first year in office, HHS announced the Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA), clouding the waters around premium and cost sharing protections.¹³⁹ HIFA invited states to propose statewide Section 1115 demonstration waivers to cover uninsured people with incomes up to 200% of poverty who were otherwise not eligible for Medicaid because of federal statutory requirements.¹⁴⁰ HIFA guidelines gave states virtually unfettered freedom to design benefit packages and cost sharing for this expansion group, a population that could only be covered by a waiver.¹⁴¹ HIFA also encouraged states to reduce statutorily mandated benefits and impose "cost sharing for optional Medicaid populations" to fund these eligibility expansions, an offer it did not have statutory authority to make.¹⁴²

Ultimately, HHS never granted a HIFA demonstration that waived Section 1916 premium or cost sharing protections for the categorically needy or medically needy,¹⁴³ although sloppy language in the HIFA guidance continues

138. See Jonathan R. Bolton, *The Case of the Disappearing Statute: A Legal and Policy Critique of the Use of Section 1115 Waivers to Restructure the Medicaid Program*, 37 COLUM. J. L. & SOC. PROBS. 91, 145 (2003) (identifying no Section 1115 premium or co-pay waivers prior to 2001). Outside of HIFA, HHS may have approved Section 1115 waivers for Arizona and Vermont that allowed premiums and enrollment fees for optional categorically eligible groups. *Id.* Vermont was allowed to charge a ten dollar to twenty dollar per month premium to families with incomes over 185% of poverty. *Id.* Arizona was allowed to charge co-pays of one dollar per doctor visit to most beneficiaries, five dollars for non-emergency surgery, and five dollars for emergency use of the emergency room. *Id.* at 145, 145 n.300, 147.

139. *Id.* at 110; CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION INITIATIVE 1 (2015) [hereinafter HIFA DEMONSTRATION INITIATIVE]; CTRS. FOR MEDICARE & MEDICAID SERVS., APPLICATION TEMPLATE FOR HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) § 1115 DEMONSTRATION PROPOSAL [hereinafter HIFA APPLICATION TEMPLATE].

140. HIFA DEMONSTRATION INITIATIVE, *supra* note 139, at 5; HIFA APPLICATION TEMPLATE, *supra* note 139.

141. MANN, *supra* note 1, at 19, 24.

142. HIFA DEMONSTRATION INITIATIVE, *supra* note 139, at 4; HIFA APPLICATION TEMPLATE, *supra* note 139. HIFA also specifically instructed that waivers would not be granted that reduced benefits or increased cost sharing for the mandatory categories of eligibility. Bolton, *supra* note 138, at 102-05. HHS provided states with a HIFA Application Template to streamline the application process, promising to expedite and quickly approve requests that followed the template. *Id.* at 105. HIFA also "strongly encourage[d] states to use . . . premium assistance programs, where Medicaid funds are used to subsidize the purchase of private insurance," as part of their HIFA waivers. *Id.* at 102.

143. Bolton, *supra* note 138, at 145.

to muddy court opinions, law review articles, and blogs. The HIFA guidance encouraged states to impose higher cost sharing not authorized by Section 1916 on optional, but not mandatory categories of eligibility.¹⁴⁴ This has, at times, left courts and some commentators confused, equating the categorically needy with mandatory eligibility and the medically needy with optional eligibility.¹⁴⁵ In fact, Medicaid has three types of eligibility: (1) mandatory categorical needy, (2) optional categorically needy, and (3) optional medically needy.¹⁴⁶ Section 1916 provides one set of protections to all categorically needy, both optional and mandatory, and a different set of protections to the medically needy.¹⁴⁷

However, HHS did approve a number of HIFA waivers and other Section 1115 waivers allowing states to impose premiums and cost sharing for expansion populations.¹⁴⁸ HHS concluded, and the courts agreed, that Section 1916 statutory protections apply only to the categorically needy and medically needy who could be eligible for Medicaid via a State Plan amendment and not to expansion groups who could only be eligible via a Section 1115 waiver.¹⁴⁹ HHS granted dozens of Section 1115 expansion waivers that included premiums and copays for the expansion group that are statutorily prohibited for the categorically needy and medically needy.¹⁵⁰

In the Deficit Reduction Act of 2005 (DRA), Congress again amended the premium and cost sharing provisions of the Medicaid Act, this time adding a new Section 1916A, giving states more statutory flexibility to use premiums and cost sharing for both categorically needy and medically needy Medicaid beneficiaries with incomes over 150% of poverty.¹⁵¹ Section 1916A leaves in place Section 1916's prohibition on premiums for the categorically needy with

144. HIFA DEMONSTRATION INITIATIVE, *supra* note 139, at 3; HIFA APPLICATION TEMPLATE, *supra* note 139, at 18.

145. *See, e.g.*, *Spry v. Thompson*, 487 F.3d 1272, 1274 (9th Cir. 2007). In dicta, the court confused the categorically needy with groups that are mandatory categories of eligibility. The court does not seem to realize that there are (1) mandatory categorically needy, (2) optional categorically needy, and (3) optional medically needy. *See id.*

146. *See supra* text accompanying notes 95-104.

147. 42 U.S.C. § 1396o (2012).

148. *MANN*, *supra* note 1, at 23-24. By August 2003, HHS had approved eight HIFA waivers and three more were in the pipeline. *Id.*

149. *Spry*, 487 F.3d at 1276; *see also* *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011) (dispute over whether certain people subject to copays pursuant to a waiver were an expansion group or medically needy for purposes of entitlement to Section 1916 protections and thus outside the reach of the Secretary's waiver authority).

150. *See* *Bolton*, *supra* note 138, at 100.

151. Deficit Reduction Act of 2005, Pub. L. No. 109-171, title VI, §§ 6041(a), 6042(a), 6043(a), 120 Stat. 6, 81, 85, 86 (2006); Social Security Act, 42 U.S.C. § 1396o-1 (2012). Section 1916A drops the distinctions between categorically needy and medically needy and instead refers to all those eligible through a "State plan amendment" rather than only via a waiver. *Id.*

incomes below 100% of poverty and adds a prohibition on premiums for all those with incomes between 100 and 150% of poverty.¹⁵² It also prohibits premiums for most children under age eighteen, pregnant women, terminally ill receiving hospice, certain inpatients of nursing homes, women eligible because of breast cancer, and certain Native Americans.¹⁵³ Section 1916A specifically allows premiums for all others with incomes above 150% of poverty, but limits total premium and cost sharing charges to no more than five percent of family income on a quarterly or monthly basis as specified by the state.¹⁵⁴

When Congress passed the DRA adding Section 1916A, it was aware of the HIFA initiative and that Section 1916 prevented HHS from granting Section 1115 waivers to allow premiums and cost sharing for the categorically needy and medically needy.¹⁵⁵ Congress recognized that states wanted additional statutory authority to be able to charge premiums and cost sharing for higher income Medicaid beneficiaries.¹⁵⁶ Congress also recognized that this flexibility had to come via statutory amendment because premium and cost sharing protections were outside Section 1902 and not within the Secretary's Section 1115 authority.¹⁵⁷ Section 1916A gave states additional flexibility to charge premiums for most individuals over 150% of poverty, including both categorical needy and medically needy, while expanding premium protections for those with incomes below 150% of poverty.¹⁵⁸

In 2010, when Congress passed the ACA, Medicaid law on premiums and cost sharing was clear and settled. The categorically needy have premium and cost sharing protections set forth in Sections 1916 and 1916A, and these protections cannot be waived via a Section 1115 waiver. HHS did not grant Section 1115 waivers of Section 1916 or 1916A premium and cost sharing protections for the categorically or medically needy.¹⁵⁹

152. 42 U.S.C. §§ 1396o-1(a), 1396o-1(b)(1) (2012).

153. *Id.* § 1396o-1(b)(3)(A).

154. *Id.* § 1396o-1(b)(2).

155. *Spry v. Thompson*, a Ninth Circuit case which held that Section 1916 protections applied only to categorically and medically needy and not to expansion populations was submitted and argued on November 17, 2005. *See Spry v. Thompson*, 487 F.3d 1272, 1272, 1277 (9th Cir. 2007). The DRA was considered by Congress from October 2005 to February 2006. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 6, 184 (2005). Congress and states were well aware of HHS position vis-à-vis Section 1916 and Section 1115 waiver. *Id.*

156. 151 CONG. REC. 167, S142010 (Dec. 21, 2005) (statement of Sen. Grassley); *See Sara Rosenbaum, Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 33-34, 45-46 (2006).

157. *See Spry*, 487 F.3d at 1276-77 (discussing the legislative intent of the DRA via the Secretary of HHS's interpretation of the statute).

158. 42 U.S.C. § 1396o-1 (2012).

159. *See* Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., to Michael Hales, State Medicaid Dir., Utah Dep't of Health 2 (Feb. 6, 2012) ("Given that Utah's cost sharing

The ACA created a new categorically needy eligibility group for adults ages nineteen to sixty-four with incomes up to 133% of poverty. This new categorically needy group, typically described in short-hand as “ACA-eligible adults” is entitled to the premium protections in Section 1916 and 1916A. HHS has no Section 1115 authority to waive these statutory protections.

III. WHAT IS AT STAKE?

Yet the Secretary has granted Section 1115 waivers that allow states to impose premiums on ACA eligible adults that are prohibited by Sections 1916 and 1916A. What must HHS be thinking? Regrettably, HHS has not offered policy guidance explaining this shift in long-standing policy. However, based upon the waiver approvals and prior litigation positions, one can speculate as to HHS’s possible, and flawed, rationales.

Each Section 1115 waiver contains a list of the statutory provisions that HHS is waiving for purposes of the demonstration.¹⁶⁰ In the ACA expansion waivers, HHS has consistently said that premiums are waived pursuant to “Section 1902(a)(14) and Section 1916” or “Section 1902(a)(14) as it incorporates Section 1916 and 1916A.”¹⁶¹ The Secretary seems to be claiming that since Section 1902(a)(14) refers to Section 1916, this gives her authority to reach outside of Section 1902 and waive Sections 1916 and 1916A.¹⁶²

proposal affects the lowest income State plan populations, section 1115 authority to increase cost sharing above the nominal amounts permitted under statute is constrained by section 1916(f) of the Act, and the State has not shown that its request is consistent with that provision.”).

160. CTRS. FOR MEDICARE & MEDICAID SERVS., WAIVER LIST: HEALTHY MICHIGAN SECTION 1115 DEMONSTRATION 1 (2013-2018) (“Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A”); CTRS. FOR MEDICARE & MEDICAID SERVS., WAIVER LIST: IOWA WELLNESS PLAN SECTION 1115 DEMONSTRATION 1 (2014-2016) (“Section 1902(a)(14) and Section 1916”); CTRS. FOR MEDICARE & MEDICAID SERVS., WAIVER LIST: ARKANSAS HEALTH CARE INDEPENDENCE PROGRAM (PRIVATE OPTION) SECTION 1115 DEMONSTRATION 1-2 (2013-2016) (“Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A”); CTRS. FOR MEDICARE & MEDICAID SERVS., WAIVER LIST: HEALTHY INDIANA PLAN (HIP) 2.0 1 (2015-2018) (“Section 1902(a)(14) and Section 1916”); MONTANA WAIVER LIST, *supra* note 77, at 1 (“Section 1902(a)(14) and Section 1916”) [hereinafter, *collectively*, WAIVERS AND DEMONSTRATIONS].

161. WAIVERS AND DEMONSTRATIONS, *supra* note 160.

162. HHS does not appear to be asserting that Section 1115 gives the Secretary a separate and independent “expenditure authority” which is not tied to provisions in Section 1902. In two cases involving HIFA waivers, HHS asserted that Section 1115(a)(2) allegedly creates an “expenditure authority” that grants the Secretary authority to approve Section 1115 demonstrations not tied to waivers of provisions in Section 1902. *Spry*, 487 F.3d at 1275-76; *Newton-Nations v. Betlach*, 660 F.3d 370, 377 (9th Cir. 2011). However, this argument ignores the text of Section 1115. Section 1115(a)(1) and Section 1115(a)(2) are connected by an “and” not an “or.”

(1) the Secretary may waive compliance with any of the requirements of section. . . 1902 . . . to the extent and for the period he finds necessary to enable such State or States to carry out such project, and (2)(A) costs of such project which would not otherwise be

But this claim does not comport with history: the statutory history of Section 1916 makes clear that Section 1902(a)(14) is not meant to incorporate Sections 1916 and 1916A into Section 1902(a)(14).¹⁶³ Congress purposely moved premiums and cost sharing out of Section 1902(a)(14) to put them outside of the Secretary's Section 1115 waiver authority. Congress left Section 1902(a)(14) in place only to avoid having to renumber all the later sub-sections of Section 1902.

Congressional intent to move premiums out of Section 1902(a)(14) and into Section 1916 is reflected in the text of Section 1902(a)(14). Section 1902(a)(14) provides that premiums and cost sharing are allowed "*only* as provided in §1916" (emphasis added).¹⁶⁴ Section 1902(a)(14) is the *only* place in Section 1902 that uses the phrase "only as provided in," while the phrase "as provided in" is used more than twenty times.¹⁶⁵ Congress meant what it said: premiums and cost sharing are only allowed as provided in Section 1916 and are beyond the Secretary's Section 1115 authority.

The Secretary may also be claiming that because Section 1916 contains its own special waiver provision for cost sharing but contains no such provision for premiums, that the Secretary retains Section 1115 waiver authority for premiums. This position is consistent with her repeated refusal to grant Section 1115 waivers for cost sharing and the Section 1916 waiver she granted Indiana to charge higher cost sharing for non-emergency use of the emergency room.

However, this position also ignores the structure of the statute and the history of the enactment of Section 1916. The debate over Section 1916 centered on the cost sharing provisions. The premium provisions seemed well-settled and an area where Section 1115 authority was not needed. Congressional action since passage of Section 1916 confirms that Congress has repeatedly stepped in to enact statutory premium amendments as the need arose, a clear indication that the Secretary did not have Section 1115 authority to allow premium waivers.

included as expenditures under section. . .1903. . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title . . .

Section 1115 of the Social Security Act, *supra* note 19 (codified at 42 U.S.C.A. §§ 1315(a)(1), 1315(a)(2)(A) (2014)).

Section 1115(a)(1) gives the Secretary authority to waive provisions in Section 1902 "and" then Section 1115(a)(2) gives the Secretary authority to use federal money to fund the demonstration. *Id.* The "expenditure authority" argument would give the Secretary virtually unlimited authority to use Section 1115 to allow states to ignore federal statutory limits on the use of federal Medicaid funds. The Medicaid statute would become practically meaningless, and the Secretary's discretionary authority practically boundless.

163. *See supra* text accompanying notes 93-125.

164. 42 U.S.C. § 1396a(14) (2012).

165. *See id.* § 1396a.

What if the Secretary is correct and she has Section 1115 authority to waive the premium provisions even though her authority is more constrained for cost sharing waivers because of the special demonstration provisions in Section 1916? So far, all of the waivers but Indiana's limit premiums to the ACA adult group. So far, all the waivers, but one, prohibit premiums on those earning below fifty percent of poverty. So far, all the waivers prohibit terminations of coverage for those earning under 100% of poverty.

If the Secretary has Section 1115 authority to waive premium protections for new ACA adults under the theories laid out above, she also has authority to waive all premium protections in Section 1916 and Section 1916A. The Secretary could impose premiums on children, pregnant women, the elderly, and people with disabilities no matter how poor. She could allow terminations and lock outs as the penalty for premium nonpayment for even the poorest Americans.

But the stakes may be even higher if the Secretary has no Section 1115 authority to waive premiums for new ACA-eligible individuals, but is willing to grant waivers anyway. If the Secretary is willing to ignore the statutory constraints on her authority to grant premium waivers, she may also be willing to ignore other statutory constraints on her Section 1115 authority and discretion. Is the Secretary willing to ignore the statutory constraints that prevent her from granting a waiver with work requirements? Is the Secretary willing to ignore the statutory constraints that prevent her from giving a state an enhanced federal match for covering ACA adults but only up to 100% of poverty rather than 133%? Is she willing to ignore statutory constraints on benefits and cost sharing?

IV. A WAY FORWARD

Much is at stake with the ACA's Medicaid expansion. Nearly three million poor adults remain uninsured because their state has not expanded Medicaid.¹⁶⁶

Much is also at stake with the ACA expansion waivers that allow states to impose premiums not authorized by federal law. This area is where HHS's waiver authority is least clear. It is also the area where states have pushed the hardest for waiver authority. HHS needs to send a clearer message about how the Section 1115 premium waivers comport with federal law and where the limits lie for premium waivers.

HHS should issue sub-regulatory guidance describing the authority the agency claims to have to grant premium waivers and the parameters for such waivers. In March 2013, a few months after Arkansas announced an agreement

166. RACHEL GARFIELD & ANTHONY DAMICO, *THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID – AN UPDATE 2* (2016), <https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8659-04-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid.pdf>.

in principle on the use of Medicaid funds to provide premium assistance to enroll ACA adults in Marketplace plans, HHS released a set of Frequently Asked Questions (FAQs) that outlined the standards it intended to use to evaluate applications for Section 1115 demonstration waivers that included such mandatory enrollment in Marketplace plans.¹⁶⁷ The Premium Assistance FAQs advised states about the types of waivers HHS would consider granting and which proposals were off the table.¹⁶⁸ The FAQs provided guidance that has helped states craft successful premium assistance waivers, but also saved both state and federal officials from haggling over ideas that HHS is not willing to entertain.

HHS has repeatedly used such sub-regulatory guidance to assist states in navigating the Section 1115 waiver process. A letter from HHS to Utah written in 2012 sets forth clearly and unequivocally that HHS does not consider itself to have authority to grant waivers to allow a community service requirement as a condition of Medicaid eligibility.¹⁶⁹ In 2012, then-Secretary Kathleen Sebelius used a blog post to clearly and publicly explain that she did not have legal authority to grant Section 1115 state waivers to obtain the higher federal match for ACA adults if they only implemented a partial expansion for adults living below poverty.¹⁷⁰

HHS should issue similar sub-regulatory guidance on Section 1115 premium waivers. Without such guidance, negotiations with the next state to ask for a premium waiver will begin with “give me what everyone else has and one more concession,” which is a slippery slope. The Secretary needs to publicly justify her assertion of authority to grant premium waivers and describe the limits she sees on that authority. State legislatures need and deserve such guidance as they debate whether, and how, to expand Medicaid.

167. Ctrs. for Medicare & Medicaid Servs., *Medicaid and the Affordable Care Act: Premium Assistance*, MEDICAID.GOV (Mar. 2013), <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

168. *Id.*

169. Letter from Marilyn Tavenner, Adm’r, Ctrs. for Medicare & Medicaid Servs., to Michael Hales, State Medicaid Dir., Utah Dep’t of Health (Apr. 6, 2012).

170. See Kathleen Sebelius, *Progress Continues in Setting up Health Insurance Marketplaces*, HEALTHCARE.GOV (Dec. 12, 2012), http://ifawebnews.com/wp-content/uploads/2012/12/ALL_sebelius-blog-for-six-states-approve_TO.pdf.