

STUDY OF THE IMPACT OF THE ACA IMPLEMENTATION IN KENTUCKY

SPECIAL ISSUE BRIEF

Section 1115 Waivers and ACA Medicaid Expansions: A Review of Policies and Evidence from Five States

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INTRODUCTION

Since implementation of the Patient Protection and Affordable Care Act (ACA) in 2014, 32 states have expanded or announced plans to expand the income eligibility of their Medicaid programs as authorized by the law.¹ Twenty-six of these states, including the Commonwealth of Kentucky, have expanded or plan to expand their Medicaid programs through a traditional approach as envisioned by the ACA, and six states currently have expanded Medicaid programs through an alternative approach allowed under Section 1115 of the Social Security Act.²

Kentucky's newly elected Governor Matt Bevin has announced plans to seek an alternative approach to Kentucky's current Medicaid expansion through a waiver from certain federal Medicaid rules, referred to as a Section 1115 waiver. A transition from its traditional expansion to an 1115 waiver-based expansion would make Kentucky somewhat unique. To date, only New Hampshire has transitioned from a traditional to a waiver-based expansion; and unlike Kentucky, that state's traditional expansion was planned as a temporary step until the state implemented a waiver-based expansion. Similar to Kentucky, Arizona and Ohio have announced intentions to transition from traditional to waiver-based expansions, but they have not yet received federal approval.

This brief was written to inform the policy discussion about the specifics of an 1115 waiver in Kentucky by examining the main components of Medicaid expansion waivers from other states. We selected five states with existing Medicaid expansion waivers that most-closely aligned with the policy discussion within Kentucky. Among the study states, their waivers incorporated similar components, although the details vary from state to state. We found mixed results on the potential of the specific waiver activities to impact either access to health coverage and services or costs for newly eligible Medicaid beneficiaries.

BACKGROUND

Section 1115 of the Social Security Act gives the Secretary of the U.S. Department of Health and Human Services (HHS) authority to waive certain federal Medicaid requirements, allowing states the flexibility to modify their Medicaid programs and Children’s Health Insurance Programs (CHIP).^{3,4} Section 1115 waivers are authorized as time-limited demonstration projects designed to test various policy approaches and are typically approved for a period of five years.^{5,6} Historically, states have used Section 1115 waivers to adjust eligibility rules, restructure benefits, modify provider payments, address specific populations or services, or extend coverage during an emergency.⁷

While the Secretary has broad authority for approving these waivers, HHS follows certain ground rules, some of which are set in statute and some of which are based on long-standing administrative policy:

1. The waivers must meet the overall objectives of the Medicaid program to increase access, improve outcomes and increase efficiency.⁶
2. The demonstration must include an evaluation component.⁸
3. Public input and comment must be sought in advance of federal approval.
4. The state must demonstrate that the alternative approach is budget-neutral to the federal government.⁹

Given the Secretary’s broad authority for approving Section 1115 waivers, it can be difficult to determine whether a specific waiver provision proposed by a state will be approved. However, by reviewing approval patterns, some indication of federal restrictions have emerged. Table 1 summarizes some of the more common provisions that have been proposed and subsequently approved or rejected.

Approved Provisions	
✓	Premium assistance
✓	Premiums/HSA contributions
✓	Waiving certain benefits (e.g., non-emergency medical transportation)
✓	Limited penalties for non-payment of premiums (e.g., imposing cost-sharing or reduced benefits for beneficiaries at or below 100% of FPG, disenrolling beneficiaries with incomes above 100% of FPG)
✓	Healthy behavior incentives

Denied Provisions	
✗	Requiring employment or work program referral
✗	Imposing cost-sharing in amounts greater than allowed under federal regulations*
✗	Waiving other benefits (e.g., EPSDT for enrollees under age 21, and free-choice of family planning providers)
✗	Disenrollment penalties for non-payment of premiums by lower-income enrollees (below 100% of FPG)

*States must meet separate cost-sharing waiver requirements under Section 1916(f) authority to impose higher cost-sharing. Indiana received Section 1916(f) approval to charge greater than the \$8 maximum cost-sharing amount allowed for non-emergent emergency room use under federal regulations.

TABLE 1. Overview of Approved and Denied Provisions from ACA Medicaid Expansion 1115 Waivers¹⁰

SECTION 1115 AND THE ACA: EXPERIENCES FROM FIVE STATES

To date, 32 states have implemented or announced intentions to implement the Medicaid expansion as set forth by the ACA. Seven of these states have used 1115 waiver authority to implement expansion through an alternative approach, although Pennsylvania has since shifted to a traditional expansion.² This brief focuses on the main components of demonstrations from five states (Arkansas, Indiana, Iowa, Michigan and Montana) that have used 1115 waivers to expand their Medicaid programs with provisions specifically relevant to policy discussions in Kentucky. Key components of the waivers include:

- **Premium Assistance:** Using Medicaid dollars to support the purchase of private health insurance coverage;
- **Enrollee Contributions:** Requiring beneficiaries to pay monthly health insurance “premiums” or contribute to Health Savings Accounts;¹¹

- **Modified Cost-Sharing:** Instituting cost-sharing (e.g., co-pays) in ways that differ from typical Medicaid policies, including cost-sharing that exceeds standard federal limits;
- **Healthy Behavior Incentives:** Offering incentives for beneficiaries to engage in healthy behaviors, such as tobacco-cessation and health risk assessments; and
- **Waive Required Covered Benefits:** Excluding certain benefits that typically are required in Medicaid, specifically non-emergency medical transportation (NEMT).

Table 2 provides information on the key 1115 waiver components by study state and notes when the provisions are specifically designated as mandatory or voluntary for beneficiaries. We then provide more detail on each of the study components, including implementation details, along with relevant research findings, when they are available. A more-detailed comparison of states’ waiver policies is included in Appendix I.

TABLE 2.
Components of
Section 1115
Waivers in
Selected States

Selected States	Premium assistance		Enrollee premiums/ contributions		Higher cost-sharing	Healthy behavior incentive	Excluded benefits
	Marketplace	Employer	Premiums	HSA contributions			
Arkansas	M			M			
Indiana		V		M	M	V	M
Iowa	M ¹	M	M			V	M
Michigan	V ²		M	M		V	
Montana			M				

M-mandatory; V-voluntary

1: While Iowa received approval and implemented Marketplace premium assistance in the first and second years of its waiver, it has since discontinued this component.

2: Michigan does not currently offer Marketplace premium assistance, but the state has received approval to begin offering this option in 2018.

PREMIUM ASSISTANCE

Four of the five study states we examined are using 1115 waivers for premium assistance to support the purchase of private insurance using Medicaid funds, an approach that pre-dates the ACA (e.g., Health Insurance Premium Payment (HIPP) Program).¹² These programs provide premium support for the purchase of either employer-sponsored insurance (ESI), such as in Iowa and Indiana, or Qualified Health Plan (QHP) coverage through Health Insurance Marketplaces (Arkansas, Iowa and Michigan). Table 2 provides information on premium assistance and other waiver provisions by study state, including whether they are mandatory or voluntary.

ESI premium assistance

For ESI premium assistance, states use Medicaid dollars to pay the worker’s share of premiums when Medicaid-eligible individuals are offered health insurance by their employers. Both Iowa and Indiana employ ESI premium assistance, although Iowa makes it mandatory. Potential benefits of this approach are possible cost savings to states by leveraging employer contributions to health insurance coverage, and the enhancement of continuity of care by reducing movement between Medicaid and ESI due to changes in enrollees income and allowing enrollees to continue their existing relationships with providers.¹³

Marketplace premium assistance

Under the Marketplace premium assistance approach, sometimes called the “private option,” states use Medicaid funds to purchase private health insurance for eligible beneficiaries through the Marketplaces created by the Affordable Care Act. This approach has been used in Arkansas, Iowa and Michigan, although

the details of each program vary. For example, Arkansas enrolls newly eligible beneficiaries in Marketplace coverage regardless of income, but Iowa only required premium assistance for those with incomes above 100% of FPG.¹⁴

Arguments in favor

- Potential benefits of ESI premium assistance are possible cost savings to states by leveraging employer contributions to health insurance coverage; the enhancement of continuity of care by reducing movement between Medicaid and ESI due to changes in enrollees income, allowing enrollees to continue their existing relationships with their health care providers and potentially allow families to enroll in the same health plan.¹³ In addition, the higher reimbursement rates offered through private plans may increase access to providers.
- Using Medicaid funds to purchase private coverage on the Health Insurance Marketplace, could potentially increase enrollment in private QHPs. A larger potential pool of enrollees could improve the risk profile and encourage more health plan participation.¹⁵ This in turn could lead to increased competition among health plans, resulting in greater consumer choice and decreased costs within the Marketplaces.
- In addition, the approach of Marketplace premium assistance could improve continuity of care for individuals who “churn” in and out of Medicaid eligibility due to income fluctuations.¹⁵ Enrollees could potentially keep the same Marketplace plans, with premium support through advance premium tax credits and cost-sharing subsidies rather than Medicaid funds.
- If a state’s Marketplace offers enough plans and network options, then Marketplace premium assistance may also offer beneficiaries with more choices of health care providers.¹⁶
- Premium assistance also could help states manage a large increase in enrollees by “relying on the private market,” particularly in cases where states have limited administrative capacity or availability of Medicaid providers.¹⁶

Arguments against

- Premium assistance programs can be administratively complex and potentially difficult to implement because states are “required to provide wrap-around coverage for benefits that are not covered in the private market plan(s), cover the cost of any additional premiums and cost sharing, and complete an assessment of cost effectiveness.”^{16,17,18}
- Another issue adding to the administrative complexity of premium assistance programs is that states must develop and implement a process to identify enrollees who are medically frail and offer them the option of enrolling in traditional Medicaid.¹⁶
- If a state’s Marketplace has limited options in plans and provider networks, this could restrict beneficiaries’ choices.

Relevant evidence

While the premium assistance approach is not new to Medicaid, it has not been adopted by many states, and those that have established programs cover a relatively small number of enrollees.¹⁶ Additionally, there has been limited evaluation research.

- A study of ESI premium assistance in CHIP found that the policy was administratively complex to implement.¹⁹ For example, the state must determine if workers have employer offers of coverage and gather details such as premium amounts and employer contributions.
- Research on an early premium assistance program in New Mexico found that support in paying premiums can increase health insurance enrollment.²⁰

- An analysis of data from the National Health Interview Survey found that lower-income workers are less likely to be offered coverage by their employers, with only 37% who have incomes under 100% of FPG receiving offers in 2014.²¹
- It may be difficult for states to demonstrate budget neutrality to the federal government if the private coverage they purchase is more expensive than traditional Medicaid. One analysis found that premium assistance could cost 20-40% more.²²
- A 2013 study found that Marketplace premium assistance could reduce churn between Medicaid and the Marketplace by nearly two-thirds in states with restrictive Medicaid for adults.²³

REQUIRING ENROLLEE PREMIUMS OR CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS

Enrollee premiums and contributions have been suggested as ways to encourage personal responsibility, and potential benefits include familiarizing beneficiaries with concepts of private insurance and helping them to develop skills in managing health care costs.²⁴ Under federal Medicaid rules, states may impose certain forms of cost-sharing (discussed below), but states are not allowed to impose premiums on newly eligible beneficiaries without a waiver.²⁵ Each of the five states we examined used 1115 waiver authority to impose monthly premiums or require beneficiaries to contribute to health savings accounts. However, the programs vary considerably across the following components:

- Who is expected to pay (e.g., all enrollees, or those with incomes over 100% of FPG)?
- What are the penalties for non-payment (e.g., cancellation of coverage, new or higher cost-sharing, reduced benefits)?
- How are the enrollee contributions structured (e.g., premiums assessments, or contributions to Health Savings Accounts)?

For a more-detailed state-by-state comparison of 1115 waiver components, see Tables 3 and 4. Table 3 shows whether states require premiums or HSA contributions, at what income levels they require these contributions, and Table 4 shows what penalties states impose for non-payment of contributions. For example, all study states consider unpaid enrollee contributions to be a debt to the state, and some levy additional penalties, such as additional cost-sharing or program disenrollment.

Monthly premiums

Three of the states we examined imposed premiums on Medicaid expansion enrollees as part of their 1115 waivers (Iowa, Michigan and Montana). The states target different income groups and require varying amounts. For example, Montana sets premiums at 2% of monthly income for beneficiaries with incomes over 50% of FPG, and Michigan requires premiums of 2% of monthly income for enrollees with incomes over 100% of FPG. In contrast, Iowa charges \$5 per month for enrollees with incomes between 50-100% of FPG, and \$10 per month for those with incomes 101% of FPG or higher. Additionally, the states also address non-payment of premiums in different ways (e.g., disenrollment and allowing beneficiaries to re-enroll vs. disenrollment with a lock-out period). For a summary comparison of these differences, see Tables 3 and 4.

Health Savings Account contributions

Three of the study states require monthly contributions to Health Savings Accounts (HSAs)²⁶ through their 1115 waivers (Arkansas, Indiana and Michigan), with variation in each state's implementation approach (see Tables 3 and 4). For example, Indiana requires contributions of \$1 per month for enrollees with incomes at or below 5% of FPG or 2% of monthly income for those with income more than 5% of FPG. Arkansas requires monthly contributions between \$10-25 per month (depending on income) for enrollees with incomes of

100% of FPG or more. Michigan requires quarterly HSA contributions based on enrollees' use of health care services (effectively cost-sharing paid into HSAs, rather than co-pays made to providers), which are required for enrollees of all incomes.

Arguments in favor

- Premium and HSA contributions could potentially improve the financial sustainability of public programs while limiting the impact on enrollees by restraining the amount of contributions.²⁷
- Because requiring financial participation is designed to foster personal responsibility and ownership over health care use among low-income individuals, it could potentially better-prepare families to ultimately enroll in private insurance, in which premiums are routine.^{27,24}
- If premiums or HSA contributions and other cost-sharing is required for Medicaid coverage, individuals may be less likely to cancel existing private health insurance to obtain Medicaid coverage.²⁸

Arguments against

- Requiring financial contributions could discourage individuals from enrolling in Medicaid and could increase instability of coverage if enrollees do not pay the required contributions.
- Administering premium or HSA contributions could potentially be costly, considering the large number of enrollees and small number of monthly transactions that would need to be managed.²⁴
- Although states may experience savings from implementing premium or HSA contribution and cost-sharing provisions, these may accrue due to declines in coverage and utilization more than from increases in revenues.²⁹

Relevant evidence

- There is evidence to suggest that low-income individuals are highly sensitive to premiums, and that requiring beneficiaries to pay contributions may reduce enrollment among those in programs such as Medicaid and CHIP.^{24,30,31,32,33,29,34} A study that included Kentucky found decreased enrollment in the commonwealth's KCHIP program when the program instituted premiums for some beneficiaries in 2003.³⁵
- Adding new premiums and strictly enforcing them is associated with larger declines in enrollment and an increase in administrative barriers for individuals wishing to re-enroll.^{27,24}
- In a precursor program to Indiana's waiver, the state's original Healthy Indiana Plan, 12% of enrollees were disenrolled from the program for non-payment to their HSAs—most of whom had incomes at or below 100% of FPG.³⁶ Although, Indiana's current waiver does not disenroll beneficiaries at or below 100% of FPG for non-payment.
- In 2003, after Oregon increased premiums and cost-sharing, and instituted a lock-out penalty for non-payment in one Medicaid Plan, it experienced a decline in enrollment, and a state study found that 72% of those who were disenrolled remained uninsured.³⁷
- Requiring premiums also is associated with a reduced length of Medicaid enrollment for both adults and children, and this may be due to the existence of the premium requirement rather than the amount of the required payment.³⁸
- The revenue collected by premiums often is not enough to offset the administrative costs of collecting fees, tracking payments, sending notices, and imposing non-payment penalties.²⁴
- A 2013 review found that replacing employers' existing plans with a high-deductible plan that included an HSA reduced the plan's total health care spending by 25 percent in the first year, due to lower utilization of services.³⁹ Although, it's not clear how these findings translate to a low-income Medicaid population, or to programs without high deductibles.

TABLE 3.
Comparison of Premium/contribution Components Across 1115 Waivers

Selected States	Enrollee premiums/contributions		Premium/contribution population (income eligibility)		
	Premiums	HSA contributions	0-50% FPG	51-100% FPG	101-138%FPG
Arkansas		X			X ¹
Indiana		X	X	X	X
Iowa	X			X	X
Michigan	X	X	X	X	X ²
Montana	X			X	X

1: Other study states use an income threshold of 101% of FPG, but Arkansas uses 100% of FPG.

2: While Michigan requires HSA contributions for enrollees of all incomes, premiums are only charged for individuals with incomes above 100% of FPG.

TABLE 4.
Comparison of Non-payment Penalties Across 1115 Waivers

Selected States	Debt to state	Reduced benefits	Increased cost-sharing	Disenrollment	Lock-out period	Enrollment begins upon first contribution
Arkansas	X		X			
Indiana	X	X ¹	X ¹	X ²	X ²	X ³
Iowa	X			X		
Michigan	X					
Montana	X			X	X	

1: For beneficiaries with incomes of 100% of FPG or below, Indiana provides a reduced benefit set and requires cost-sharing.

2: For beneficiaries with incomes of 101% of FPG or above, Indiana disenrolls them from the Medicaid program and locks them out of coverage for 6 months.

3: For applicants with incomes of 100% of FPG or below, Indiana enrolls them upon receipt of first premium, or after a 60-day waiting period if they don't make a contribution. For applicants with incomes of 101% of FPG or above, they are not enrolled if they don't make a contribution within 60 days.

MODIFIED COST-SHARING

Under federal rules for the Medicaid program, states can require some cost-sharing from beneficiaries, such as co-pays for provider appointments and prescription medications, which is designed to prevent individuals from overusing or seeking unnecessary health care. However, each of the five states examined in this brief used waiver authority to impose cost-sharing for newly eligible enrollees in ways that depart from typical Medicaid policies. For example, some states have imposed cost-sharing as a penalty for non-payment of premiums or HSA contributions. Additionally, one notable example is found in Indiana, which obtained additional waiver authority under Section 1916(f) to impose cost-sharing that exceeds federal regulations on maximum co-pay amounts.⁴⁰ The state used this provision to adopt a scheme of “graduated” cost-sharing for non-emergency use of emergency department (ED) services, charging beneficiaries \$8 the first time and \$25 for subsequent non-emergency use of the ED.

Arguments in favor

- Cost-sharing is intended to reduce overuse or unnecessary use of health care services, leading to reductions in program expenditures and potential cost-savings to the Medicaid program.
- Introducing cost-sharing in Medicaid programs may provide enrollees with experience with concepts found in private health insurance, which could ease the transition from public to private coverage.

Arguments against

- Implementing cost-sharing may increase the risk of enrollees avoiding or delaying needed medical care, which could increase their need for services and require higher-cost care later.^{29,16}
- Similar to provisions for premiums and HSA contributions, cost-sharing requires administrative systems for imposing and collecting payments from enrollees.²⁴

Relevant evidence

- Studies focusing specifically on Medicaid programs have found that cost-sharing can discourage beneficiaries from obtaining necessary health services, and that cost-sharing is associated with higher unmet needs for health care and greater financial strain.^{41,42}
- However, the RAND Corporation health insurance experiment found that cost-sharing for those with private health insurance coverage had little or no effect on health outcomes, except for the lowest-income individuals, and it found that beneficiary satisfaction is similar between plans with and without cost-sharing.⁴³
- In 2003, the Oregon Health Plan experienced a dramatic decline in enrollment after premiums and cost-sharing were increased. Medicaid administrative data showed a 46% enrollment decline in the 10 months after the change was implemented, with 44% of those who left the program naming cost-sharing as the main reason they left.⁴⁴
- Studies have shown that cost sharing reduces the use of both effective and ineffective medical care similarly.^{43,29}

HEALTHY BEHAVIOR INCENTIVES

Healthy behavior incentives are intended to encourage individuals to take certain actions —such as quitting smoking and obtaining preventive health care services—that are aimed at improving their health and potentially reducing health care costs.⁴⁵ As part of their Medicaid expansion waivers, three of the study states (Indiana, Iowa and Michigan) adopted incentives to encourage beneficiaries to engage in healthy behaviors.⁴⁶ In these states, beneficiaries may receive reductions in or exemptions from premiums/HSA contributions for participating in certain behaviors, such as quitting smoking or completing a health risk assessment (see Appendix I).

Arguments in favor

- These programs are designed to improve the health status of Medicaid enrollees through improved identification of health care needs, and encouragement of healthy behaviors and the use of prevention services.
- These programs have the potential to incentivize beneficiaries to take an active role in their health and health care by engaging in certain health-related behaviors.⁴⁷
- Health assessments upon enrollment can be used to identify and target high-risk individuals who may benefit from care coordination and case management.

Arguments against

- The development and implementation of incentive programs will have administrative costs, especially when programs aim to track enrollee adherence and outcomes.
- It may be challenging to determine the most-effective incentive level to encourage beneficiaries to participate in desired behaviors.

Relevant evidence

Although they have gained in popularity in both private employer-based insurance plans and Medicaid programs, evidence on the effects of healthy behavior incentives is currently limited.

- Healthy behavior incentives can be effective for simple interventions, such as doctor visits, vaccinations, and screenings; but it is more challenging to develop and administer programs to modify more-complex lifestyle behaviors, which have a greater potential for savings to Medicaid programs.⁴⁸
- Having a regular source of physician care was found to be related to increased participation in healthy behavior incentive programs.²⁷
- Health risk assessments can be used upon enrollment to identify high-need Medicaid members for targeted interventions and care coordination services.⁴⁹
- A 2013 study of healthy behavior incentives in three states' Medicaid programs found mixed results. For example, Idaho operated two wellness programs: One program provided discounted CHIP premiums for children who received well-child visits, which was associated with a more than doubling of adherence (from 23 to 49 percent).⁵⁰ The other program, which offered rewards to Medicaid enrollees who participated in tobacco cessation or weight-loss programs, saw relatively small participation—approximately 1,400 out of 185,000 eligible beneficiaries over two years.⁵⁰

EXCLUDED BENEFITS

Some study states have excluded certain benefits typically required in Medicaid programs, potentially to make Medicaid coverage more similar to private coverage.⁵¹ Under the ACA, states are required to provide Medicaid expansion enrollees with a set of benefits based on the 10 essential health benefits that the law requires of private health insurance,⁵² as well as unique Medicaid benefits. While the study states have proposed excluding other Medicaid benefits, such as early and periodic screening, diagnostic and treatment (EPSDT) benefits for enrollees under age 21, HHS has only provided authority to exclude non-emergency medical transportation (NEMT), which provides transportation to and from health care visits. Two of the states described in this brief received authority under Section 1115 to waive NEMT benefits under their Medicaid expansion programs (Iowa and Indiana).

Arguments in favor

- Aligning Medicaid benefits with benefits found in private health insurance can help familiarize enrollees with private coverage and ease transitions from public to private coverage when their incomes change.

Arguments against

- The specific benefit that study states have excluded, non-emergency medical transportation, is typically included in Medicaid to improve access to health care services. It is possible that excluding this benefit could decrease enrollees' access to health care services.

Relevant evidence

- Each of these states initially received approval to exclude these benefits for one year, but the Centers for Medicare & Medicaid Services provided both states with extensions for further study after initial research found small or no impacts on unmet need for transportation and whether individuals missed medical appointments due to a lack of transportation.^{53,54,55,56}
- Indiana's evaluation also examined whether the exclusion of NEMT benefits had different impacts for rural and urban enrollees, finding that a similar percentage of enrollees reported missing appointments, regardless of whether or not they had access to NEMT and whether they lived in rural or urban counties.⁵⁶

DISCUSSION

The five states examined in this brief used similar approaches in their 1115 waivers to promote personal responsibility in obtaining, maintaining and using health insurance coverage. In many ways, these states have used waiver authority to make Medicaid coverage operate more similarly to private coverage, through such provisions as imposing monthly insurance premiums and copayments, incorporating health savings accounts, excluding Medicaid benefits that typically are not included in private health insurance, and in some cases purchasing private coverage for Medicaid beneficiaries.

Because these states' 1115 Medicaid expansion waivers are relatively new, their impacts have not yet been fully evaluated. In some instances, related research suggests that certain provisions of these waivers may reduce Medicaid beneficiaries' access to health coverage and services, but in other cases, early evidence suggests some provisions of the waivers may have limited or no significant impacts on beneficiaries. As states continue to experiment with their Medicaid programs, it will be important to monitor the findings from 1115 waiver evaluations that are mandated by the ACA.

In contemplating the potential impacts of 1115 waiver provisions in Kentucky, it is worth considering the ways in which the commonwealth is similar or dissimilar to the study states examined in this brief. For example, with 42% of Kentuckians living in rural areas, Kentucky more closely resembles Arkansas, Iowa and Montana than the more urban populations of Michigan and Indiana.⁵⁷ This presents challenges in access to health care services because rural areas tend to have fewer health care providers.⁵⁸ It also is important to note that some of the evidence related to 1115 waiver provisions comes from populations that differ from Medicaid enrollees. For example, much of the research on HSAs focuses on employer-sponsored insurance programs, but it is unclear how findings from these studies relate to lower-income Medicaid beneficiaries, since ESI coverage is more likely among individuals with higher incomes.⁵⁹

Additionally, unlike Kentucky, the study states in this brief used 1115 waiver authority as a means to implement their ACA Medicaid expansions from the beginning, rather than modify an existing traditional expansion. Because Kentucky is one of the first states to pursue an 1115 waiver to change an established traditional expansion, it currently is unclear whether and how HHS may consider the state's existing program as a potential benchmark in the federal approval process (e.g., requiring the state to attain similar enrollment compared to the existing expansion).

¹ The ACA sets eligibility for expanded Medicaid to reach 133 percent of FPG. However, that threshold is based on modified adjusted gross income (MAGI), which provides a 5 percentage point income disregard, effectively increasing the income-eligibility threshold to 138 percent of FPG. Because FPG is calculated according to income and household size, the exact income for eligibility varies (e.g., 138% of FPG is \$16,394 for a single person, or \$33,534 for a family of four). More information is available at <http://www.shadac.org/news/aca-note-when-133-equals-138-fpl-calculations-affordable-care-act>.

² As of May 2016, 31 states (including the District of Columbia) have expanded their Medicaid programs. Additionally, Louisiana has announced plans to expand its program in July 2016. Currently, 25 states operate under traditional expansions (Louisiana also plans a traditional expansion) and six operate under 1115 waivers. In some cases, states have changed their Medicaid expansion approaches. For example, Pennsylvania began its expansion with and 1115 waiver and transitioned to a traditional approach. Additionally, New Hampshire has implemented a planned transition from an initial traditional expansion to a waiver-based expansion.

³ Section 1115 waivers pre-date the Affordable Care Act (ACA), but this brief focuses on how these waivers have been used to implement the ACA's Medicaid program expansions. The major provisions of Section 1115 did not change with the passage of the Affordable Care Act (ACA) but, the ACA did establish new transparency rules requiring periods of public notice and public comment at the state and federal level before new waivers and waiver extensions can receive federal approval.

⁴ Rudowitz, R., and Musumeci, M. “The ACA and Medicaid Expansion Waivers.” Kaiser Family Foundation. 2014. Available at: <http://kff.org/report-section/the-aca-and-medicaid-expansion-waivers-issue-brief/>

⁵ While 1115 waivers are time-limited, they may be extended upon approval by the Secretary.

⁶ Centers for Medicare and Medicaid Services. “Section 1115 Demonstrations.” Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

⁷ Kaiser Family Foundation. “Medicaid and the Uninsured: Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers.” 2011. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf>

⁸ Rudowitz, R., Musumeci, M., and Gates, A. “Medicaid Expansion Waivers: What Will We Learn?” Kaiser Family Foundation. 2016. Available at: <http://kff.org/medicaid/issue-brief/medicaid-expansion-waivers-what-will-we-learn/>

⁹ While HHS requires budget neutrality for 1115 demonstrations, the U.S. Government Accountability Office (GAO) has voiced long-standing concern about HHS’s approval process for assessing and ensuring budget neutrality. According to the GAO, “these concerns have centered around how HHS allows states to use questionable methods and assumptions when developing cost projections that serve as the basis for demonstration spending limits, without providing adequate documentation to support these projections.” If costs exceed expected federal expenditures, states must either request to adjust budget neutrality calculations due to changes in circumstance through an amendment or bear the costs themselves. More information is available at <http://www.gao.gov/assets/670/665265.pdf>.

¹⁰ Refer to the following links for examples of how states have amended their waiver proposals to align with federal review. **Arkansas:** <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-tech-crrctns-req-07142015.pdf> **Iowa:** <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Iowa-Family-Planning/ia-family-planning-network-pending-app-09032015.pdf> **Indiana:** <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Waiver-Applica> **Montana:** <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-basic-medicaid-pa.pdf>

¹¹ The components of premium assistance and monthly premiums operate independently; a state could employ both, one or neither of the components.

¹² Mitchell, J., and Osber, D. “Using Medicaid/SCHIP to Insure Working Families: The Massachusetts Experience.” 2002. Health Care Financing Review. 23(3); 35-45. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/02springpg35.pdf>

¹³ Medicaid and CHIP Learning Collaboratives. “Coverage Expansion Learning Collaborative: Medicaid Premium Assistance in the Employer Sponsored Insurance Market.” 2015. Available at: <https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/learning-collaborative-state-toolbox/downloads/coverage-expansion-learning-collaborative.pdf>

¹⁴ While Iowa received approval and implemented mandatory Marketplace premium assistance for beneficiaries with incomes over 100% of FPG in the first year of its waiver, the state made this voluntary in 2015 and discontinued it in 2016.

¹⁵ Arkansas Department of Human Services. “Arkansas 1115 Waiver Application.” 2013. Available at: <http://humanservices.arkansas.gov/dms/Documents/Final%201115%20Waiver%20Materials%20for%20Submission.pdf>

¹⁶ Medicaid and CHIP Payment and Access Commission (MACPAC). “Chapter 5: Premium Assistance: Medicaid’s Expanding Roll in the Private Health Insurance Market.” March 2015 Report to Congress on Medicaid and CHIP. Available at: <https://www.macpac.gov/wp-content/uploads/2015/03/Premium-Assistance-Medicaid%E2%80%99s-Expanding-Role-in-the-Private-Insurance-Market.pdf>

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- ⁵² The ACA requires that all non-grandfathered health insurance plans in the individual and small-group markets include benefits in 10 categories: 1) outpatient services, 2) emergency services, 3) inpatient services, 4) maternity and newborn care, 5) mental health and substance use disorder services, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services.
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APPENDIX I

	Arkansas	Indiana	Iowa	Michigan	Montana
Premium assistance					
Marketplace	Mandatory enrollment of beneficiaries in private Marketplace plans	N/A	Originally, mandatory enrollment of beneficiaries with incomes above 100% of FPG in private Marketplace plans; in subsequent years, made this optional in 2015 and discontinued in 2016.	Voluntary enrollment of beneficiaries in private Marketplace plans, starting in 2018	N/A
ESI	N/A	Voluntary enrollment in premium assistance for beneficiaries with an employer offer of insurance	Mandatory enrollment in premium assistance for beneficiaries with an employer offer of insurance	N/A	N/A
Premiums/ contributions					
Premiums	N/A	N/A	Based on income: 50% to 100% FPG - \$5/month More than 100% FPG - \$10/month	Based on income: More than 100% FPG - 2% of monthly income	Based on income: More than 50% FPG - 2% of monthly income
Required HSA contributions	Based on income: More than 99% FPG - \$10-25/month, depending on income	Based on income: 5% or less FPG - \$1/month More than 5% FPG - 2% of monthly income	N/A	Quarterly HSA contributions based on utilization of health care services, regardless of income	N/A
Non-payment penalty ¹	Enrollees become responsible for co-pays at the traditional Medicaid state plan level (see cost-sharing)	Based on income: 100% FPG or less - beneficiary is given reduced benefits (no dental or vision) with co-pays at the traditional Medicaid state plan level (see cost-sharing) More than 100% FPG - beneficiary is disenrolled in program and locked out for 6 months	Based on income: More than 100% FPG - beneficiary is disenrolled from the program but may re-enroll without a lock-out period	N/A	Based on income: More than 100% FPG - beneficiary is disenrolled from the program (after a grace period of 90 days) and locked out until premiums are paid or they are assessed to their state taxes (which the state will perform by end of the quarter)
Restrictions on coverage start date	N/A	No retroactive eligibility: Enrollees are not eligible for 90 days of retroactive coverage, typically offered through Medicaid Enrollment date: Enrollment begins the first day of the month when beneficiaries pay their first contribution. Non-payment penalty based on income: 100% FPG or less - enrolled first day of the month after a 60-day waiting period More than 100% FPG - beneficiary is not enrolled	N/A	N/A	N/A

	Arkansas	Indiana	Iowa	Michigan	Montana
Cost-sharing	Based on income: More than 99% FPG - Co-pays as a penalty for non-payment of monthly contributions	Non-emergency use of emergency department: Graduated co-pay — \$8 co-pay for the first time and \$25 for subsequent times. ² Co-pays as penalty: 100% FPG or less - Co-pays as a penalty for non-payment of monthly contributions	Co-pays for non-emergency use of the emergency department (\$8 per use, the maximum under federal regulations), regardless of income	Tracks beneficiaries' utilization of health care services and bills them quarterly for their cost-sharing, which is placed in beneficiaries' HSAs, regardless of income This approach differs from other states, which employ point-of-service co-pays.	Imposes the maximum co-pays allowed under federal regulations on enrollees, regardless of income. ³ Certain services are exempted from co-pays (e.g., preventive, emergency, family-planning, pregnancy services). See footnote for full list of exempt services. ⁴
Healthy behavior incentives	N/A	Enrollee can reduce their HSA contributions by engaging in certain healthy behaviors. ⁵ See footnote for list of behaviors. ⁶	Enrollees are exempted from monthly premiums if they complete a health risk assessment (HRA) and receive an annual wellness or dental exam	Enrollee can reduce premiums and HSA contributions by completing an HRA and engaging in certain healthy behaviors. ⁷	N/A
Excluded benefits	N/A	Received authority to exclude non-emergency transportation benefits for one year (extended so the state can study the impacts).	Received authority to exclude non-emergency transportation benefits for one year (extended so the state can study the impacts).	N/A	N/A

¹ Each of the states in this brief make unpaid premiums/HSA contributions a debt owed to the state.

² Because Section 1115 waivers do not allow authority to exceed federal regulations on maximum cost-sharing, Indiana obtained Section 1916(f) authority to impose a \$25 co-pay.

³ The maximum cost-sharing allowable under federal regulations varies by individuals' income and by the type of service. Accessible at: <https://www.medic-aid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing-out-of-pocket-costs.html>

⁴ Individuals exempt from copayments include pregnant women and those age 20 and under. Services exempt from copayments include preventive health screenings, family planning, eyeglasses, transportation, emergencies in the emergency room, immunizations, and medically necessary health screenings ordered by a health care provider. More information is available at: <http://dphhs.mt.gov/helpplan>

⁵ Indiana effectively allows enrollees to reduce their HSA contributions by providing increased state matching funds when HSA dollars roll over into the next year, if enrollees complete certain healthy behaviors.

⁶ Individuals can receive healthy behavior incentives for appropriately utilizing the following preventive care services: annual physical, cholesterol testing, blood glucose screening, tetanus-diphtheria screening, and flu shot. For women, these preventive care services also include mammogram and pap smear. Accessible at: <http://www.mhsindiana.com/files/2011/08/POWERAccount-Brochure-EN.pdf>

⁷ In addition to an HRA, beneficiaries in Michigan's Medicaid expansion may engage in other healthy behaviors for incentives. Accessible at: <http://enroll-michigan.com/wp-content/uploads/2014/02/healthy-michigan-plan-handbook-2.pdf>