Expanding Medicaid to the New Adult Group through Section 1115 Waivers

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) expanded Medicaid coverage to all adults under age 65 not otherwise eligible for Medicaid with incomes at or below 138 percent of the federal poverty level (FPL). After the June 2012 U.S. Supreme Court ruling in NFIB v. Sebelius effectively made Medicaid expansion under the ACA optional for states, a number of states have considered alternative approaches to extending coverage to previously ineligible adults. As of January 2016, 31 states and the District of Columbia, have expanded Medicaid to previously ineligible adults and seven of these states—Arizona, Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire—are currently providing Medicaid to the expansion population through Section 1115 research and demonstration waivers.

Section 1115 waivers allow states to test approaches that are not allowed under traditional Medicaid, such as the imposition of higher premiums for some enrollees and placing limitations on certain mandatory benefits. While each of the waiver programs is unique, there are some common themes. This issue brief summarizes the main design features of expansion waivers currently in operation, including benefits, premiums and cost sharing, premium assistance, and the delivery system. (For more details on the waivers, see Table 1 and state-specific fact sheets.)

Populations Covered

In general, only the new adult group is covered through state Medicaid expansion waiver programs. However, Indiana extends premium and cost sharing requirements to other adults. All states but Michigan exclude people who are medically frail from mandatory enrollment in the waiver program. New Hampshire exempts individuals in the new adult group who are eligible for the state Health Insurance Premium Payment (HIPP) program because they have access to cost-effective employer sponsored insurance.

Benefits

States must use alternative benefit plans (ABPs), to provide coverage to the new adult group. The ABP must include the 10 ACA-required essential health benefits plus the mandatory Medicaid benefits of non-emergency transportation, federally qualified health center or rural health center services, family planning services and supplies, and early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21. Mental health parity rules apply as do all other Medicaid administrative and eligibility rules (42 CFR 440.345 and 42 CFR 440.347, Federal Register 2013). Individuals who are medically frail are exempt from mandatory enrollment in the ABP if it does not include all of the benefits provided under the Medicaid state plan.
Several of the states receiving waivers have sought to exclude certain benefits, although not all of the proposed exclusions were approved. Most of the approved exclusions do not involve a substantial change in benefits. For example, Indiana and Iowa only non-emergency medical transportation (NEMT) has been excluded from the benefits offered. Arkansas requires prior authorization for NEMT. In Arkansas and New Hampshire, which provide coverage through premium assistance (discussed below), Medicaid must provide benefits that are not otherwise available in the plans these states purchase on behalf of Medicaid beneficiaries. For example, these states provide EPSDT services to 19- and 20-year-olds as wrap-around services under their Medicaid fee-for-service delivery systems.

Typically, benefits are covered retroactively for up to 3 months prior to the application, if the individual would have been eligible during that period had he or she applied. Several of the states receiving waivers have also sought to waive the requirement to provide retroactive coverage. Indiana received a waiver of retroactive coverage; New Hampshire has a provisional waiver of retroactive coverage, conditioned upon data demonstrating that the state system ensures that enrollees do not have gaps in coverage of needed services. Arkansas has also received a waiver of retroactive coverage provided that the state comes into compliance with eligibility determination requirements.

**Premiums and Cost Sharing**

Even without a waiver, states can require certain groups of Medicaid enrollees to pay enrollment fees, premiums, copayments, or other cost sharing amounts, although federal guidelines specify who may be charged these fees, the services for which they may be charged, and the allowed amounts. Per-service charges are limited to nominal amounts for individuals with income at or below 100 percent FPL and are prohibited for certain services, such as emergency services. States also may not charge premiums for enrollees with income at or below 150 percent FPL. Total cost sharing (including premiums and per-service charges) is subject to an aggregate limit of five percent of family income (42 CFR 447.50-447.56).

The states with approved waivers sought changes to the premium and cost sharing schedules so that all enrollees pay something, even nominally, toward the cost of coverage. For example, Arkansas, Iowa, and Montana charge monthly premiums. In Montana, premium payments are credited toward the enrollee’s first 2 percent of copayments. Arizona, Indiana, and Michigan use an approach similar to a health savings account in which enrollees make monthly or quarterly contributions toward payment for services. Additionally, most waiver programs require some level of point-of-service cost sharing.

Arizona, Indiana, Iowa, and Michigan also provide credits or discounts on premiums or health savings account contributions based on the completion of certain healthy behavior requirements, such as getting a risk assessment or annual wellness exam.

In all of these waiver programs, enrollees remain protected by the Medicaid rule limiting aggregate out-of-pocket spending on premiums and cost sharing to 5 percent of income. Additionally, while premiums may be charged to enrollees with incomes below 100 percent FPL, they are not at risk of losing their Medicaid coverage for nonpayment. Through their waiver programs, however, Arizona, Indiana, Iowa, and Montana are permitted to disenroll individuals with incomes over 100 percent FPL for nonpayment of premiums. In
Arizona and Iowa, individuals who are disenrolled for nonpayment of premiums can re-enroll at any time regardless of any outstanding unpaid premiums. In Indiana, they are denied reenrollment for six months, and in Montana, they are able to re-enroll once they pay overdue premiums or their premium debt is assessed against their state taxes.

**Premium Assistance**

Premium assistance is the state purchase of private market coverage, such as employer-sponsored insurance or qualified health plans on the exchange, on behalf of Medicaid enrollees. Four of the waiver states use some type of premium assistance in their expansions. In Arkansas and New Hampshire, adults are enrolled in exchange plans. Beginning in 2018, individuals in Michigan will have the choice of enrolling in Medicaid or an exchange plan. In Arkansas, Indiana, and New Hampshire, new adult group enrollees also may be enrolled in cost-effective employer-sponsored coverage in premium assistance arrangements.

**Delivery System**

In general, states either offer Medicaid benefits on a fee-for-service (FFS) basis, through Medicaid managed care plans, or through some combination of the two. Under the FFS model, the state pays providers directly for each covered service provided to a Medicaid enrollee. Under managed care, the state pays a monthly premium to a managed care plan for each person enrolled in the plan. Arizona, Indiana, Iowa, and Michigan waivers provide services to new adult enrollees through managed care plans. In their waiver programs, Arkansas and New Hampshire use premium assistance to provide benefits to covered populations through exchange or employer-sponsored plans with the Medicaid fee-for-service program providing wrap-around benefits. Montana has a contract with a third-party administrator for the fee-for-service coverage of health care services for most adults in the new group with incomes between 50 and 138 percent FPL.

**Conclusion**

Seven states are currently operating Section 1115 waivers to implement Medicaid expansion. While the terms of each state’s waiver vary, the waivers generally do not involve a substantial change in benefits compared to those offered in Medicaid. Although all states are charging some level of cost sharing, it is still subject to the five percent of income cap. Enrollment of individuals with incomes below 100 percent FPL cannot be contingent on payment of premiums. Four states are using some sort of premium assistance.

Because Section 1115 waivers are experiments, pilots, or demonstration programs, they require evaluation. As such, each of these varied approaches to coverage for the new adult group may provide data on the effect of changes in benefits and cost sharing on enrollment, access to care, and service use, which can inform future policy. However, data will not be available on the full extent of the waivers for several years.
### TABLE 1. Summary of Key Provisions in Approved Section 1115 Medicaid Expansion Waivers

<table>
<thead>
<tr>
<th>State</th>
<th>Benefits</th>
<th>Premiums and cost sharing</th>
<th>Premium assistance</th>
<th>Delivery system</th>
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</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>No waived benefits</td>
<td>Individual accounts with monthly contributions for enrollees &gt;100% FPL; premiums waived for healthy behaviors; disenrollment for non-payment; co-pays for select services for enrollees &gt;100% FPL</td>
<td>None</td>
<td>Medicaid managed care</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Retroactive coverage waived</td>
<td>Premiums and co-pays for enrollees &gt;100 percent FPL</td>
<td>Employer-sponsored insurance and exchange plans</td>
<td>Commercial coverage with FFS wrap</td>
</tr>
<tr>
<td>Indiana</td>
<td>Non-emergency medical transportation (NEMT) and retroactive coverage waived</td>
<td>Individual accounts with monthly contributions for all enrollees; disenrollment and lock-out for those &gt;100% who don’t contribute; co-pays for those ≤100% FPL who don’t contribute; credits for healthy behaviors; graduated co-pays for non-emergency use of the ED</td>
<td>Employer-sponsored insurance</td>
<td>Commercial coverage with FFS wrap and Medicaid managed care</td>
</tr>
<tr>
<td>Iowa</td>
<td>NEMT waived for the duration of the demonstration</td>
<td>Premiums for enrollees &gt;50% FPL; premiums waived in the first year and for healthy behaviors thereafter; disenrollment for non-payment of premiums for enrollees &gt;100% FPL; co-pays for non-emergency use of the ED</td>
<td>None</td>
<td>Medicaid managed care</td>
</tr>
<tr>
<td>Michigan</td>
<td>No waived benefits</td>
<td>All enrollees subject to co-pays; premiums for enrollees &gt;100% FPL; payments go toward a health account; credits for healthy behaviors</td>
<td>Exchange plans (beginning in April 2018)</td>
<td>Medicaid managed care</td>
</tr>
<tr>
<td>Montana</td>
<td>No waived benefits</td>
<td>Monthly premiums for enrollees &gt;50% FPL that are credited toward co-payments; disenrollment for those &gt;100% for non-payment of premiums</td>
<td>None</td>
<td>FFS</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Retroactive coverage waived</td>
<td>Co-pays for enrollees &gt;100% FPL</td>
<td>Exchange plans; employer-sponsored insurance premium assistance offered through a separate state program</td>
<td>Exchange or employer-sponsored plans with FFS wrap</td>
</tr>
</tbody>
</table>

Source: MACPAC 2017 analysis of Section 1115 Medicaid expansion waivers.

Notes: ED is emergency department. FFS is fee for service. Arkansas’ waiver of retroactive coverage is conditional upon the state coming into compliance with eligibility determination requirements, completing the Arkansas MAGi Backlog Mitigation Plan, and
implementing the ACA’s provision on presumptive eligibility determinations. Approval of New Hampshire’s waiver of retroactive coverage is pending state submission of data and analysis to CMS.

Endnotes


2 A Section 1115 waiver gives broad authority to the Secretary of Health and Human Services to authorize an experimental, pilot, or demonstration project that is likely to assist in promoting the objectives of a state’s Medicaid program. Section 1115 waivers allow the Secretary to waive certain provisions of the Medicaid statutes related to state program design, and are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state.

Pennsylvania received approval for a five-year waiver called Healthy Pennsylvania, which began enrolling individuals on January 1, 2015. Healthy Pennsylvania provided coverage to enrollees through Medicaid managed care. Outside of the demonstration, the state planned to encourage employment through job training and work-related activities. However, a new governor was elected in November 2014 who took action to end the waiver and transition the state to a traditional Medicaid expansion, halting the implementation of some waiver activities that were to begin in the second year of the waiver and rolling back waiver activities that had already begun. The transition was fully implemented on September 1, 2015 (Office of Governor Tom Wolf 2015).

3 Cost effectiveness for premium assistance means that the total cost of purchasing premium assistance coverage including administrative expenditures, coverage of excess cost sharing charges, and the costs of providing wrap-around benefits, must be comparable to the cost of providing traditional coverage under the state plan (42 CFR 435.1015(a)(4)).

4 An alternative benefit plan (ABP) offers an option to states to provide alternative benefits specifically tailored to meet the needs of certain Medicaid population groups or provide services through specific delivery systems, instead of following the traditional Medicaid benefit plan. All states that expand Medicaid are required to submit an ABP to denote any differences in benefit coverage between the base population and expansion population, or to note that they are offering the same benefit coverage to all enrollees in the base and expansion populations.

5 Most other exempt individuals may be eligible for coverage under another eligibility pathway (e.g., disability-related coverage); because medically frail individuals do not become eligible for Medicaid through a separate pathway, they are most likely to be enrolled in the new adult group. The federal definition of medically frail includes individuals with disabling mental health disorders, chronic substance use, serious and complex medical conditions, a physical or mental disability that significantly impairs their ability to perform one or more activities of daily living, or other special medical needs (42 CFR 440.315(f)).

6 Initially in these states’ demonstration, NEMT was waived for the first year. Both states have received extensions of this authority and are currently not providing NEMT.

7 Under Section 1115 authority, the Secretary can waive premium requirements; however Section 1916(f) sets limits on changes that can be made to cost-sharing provisions through a waiver.

8 Both Arkansas’ and Montana’s waiver also mention the use of healthy behavior incentives, but no further details are provided.

References

Medicaid and CHIP Payment and Access Commission
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