



REALIZING HEALTH REFORM'S POTENTIAL

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How States Are Expanding Medicaid to Low-Income Adults Through Section 1115 Waiver Demonstrations

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Abstract In the wake of the Supreme Court's 2012 decision making state expansion of Medicaid to more adults optional under the Affordable Care Act, several states have received approval to combine such expansion with broader Medicaid reforms. They are doing so under Section 1115 of the Social Security Act, which authorizes Medicaid demonstrations that further program objectives. State demonstrations approved so far combine expanded adult coverage with changes in that coverage and in how the states deliver and pay for health care. These states have focused especially on expanding the use of private health insurance, requiring beneficiaries to pay premiums, and incentivizing them to choose cost-effective care. By enabling states to link wider program reforms to the adult expansion, Section 1115 has allowed them to better align Medicaid with local political conditions while extending insurance to more than 1 million adults who would otherwise lack a pathway to coverage.

OVERVIEW

The Supreme Court's decision allowing states to opt out of the Affordable Care Act's Medicaid expansion for adults has had enormous ramifications for the nation's poorest adults.¹ Under the act, federal subsidies for insurance premiums begin only when people cross the federal poverty level—\$11,670 for an individual in 2014. In states that elect not to expand Medicaid, adults with incomes below that threshold lack a pathway to affordable health insurance. The most recent estimates from the Kaiser Family Foundation suggest that 4 million people fall into the coverage gap created by states' failure to expand Medicaid: 85 percent of these individuals reside in the South, half are African American or Hispanic, and less than half rate their health as very good to excellent.²

As of September 2014, 27 states plus the District of Columbia have expanded Medicaid for poor adults. Another 23 states have chosen

not to do so. Four of the expanding states—Arkansas, Michigan, Iowa, and Pennsylvania—have implemented their expansion as part of a demonstration program authorized under Section 1115 of the Social Security Act. New Hampshire, whose expansion already is under way, has also submitted a demonstration proposal, and a proposal from Indiana to link the adult expansion with a demonstration is pending with the Department of Health and Human Services (HHS).³

Enacted in 1962, Section 1115 allows the secretary of HHS to waive requirements for Social Security Act programs tied to need, enabling states to test innovations.⁴ The secretary can initiate the Section 1115 demonstration process by inviting states to propose such innovations. (The George W. Bush administration did so to interest states in expanding Medicaid eligibility for low-income adults.⁵) States also can submit demonstration proposals on their own initiative.

The HHS secretary must follow certain ground rules in approving Section 1115 demonstrations. First, the demonstrations must further program objectives. Second, they must test hypotheses and be evaluated. Third, both state and federal officials must allow public input before the secretary approves the demonstrations. Finally, the demonstrations must be “budget neutral”: under longstanding policy of the Office of Management and Budget, the federal government must spend no more on benefits and services than it would have spent in the absence of a demonstration.⁶ HHS enforces this “budget neutrality” requirement by estimating what states would have spent on their Medicaid programs over time in the absence of a demonstration and using that estimate to cap federal and state spending on a demonstration.⁷

The federal government and the states have a long tradition of using Section 1115 to reform Medicaid.⁸ Over the decades, they have used it to expand and alter eligibility, encourage the growth of managed care, restructure the design of benefits, improve long-term care, and otherwise test broader changes in the health care system.⁹

Section 1115 demonstrations have sometimes led to permanent changes in the federal Medicaid statute. For example, demonstrations of Medicaid managed care during the 1990s paved the way for amendments allowing states to use such an approach to organize and deliver health care.¹⁰ A Medicaid demonstration program provided a key basis for health reform in Massachusetts.¹¹ Medicaid demonstrations also allowed states to experiment with “benchmark coverage,” the standard that now guides “alternative benefit plans” for adults under expanded state Medicaid programs.¹²

STANDARD MEDICAID VS. STATE DEMONSTRATION PROGRAMS

Medicaid demonstrations for expanding adult coverage have sought to embed reforms that address state lawmakers’ concerns about adding thousands of people to what they perceive as a costly program in need of modernization. Although advocates of expansion have made effective counterarguments to concerns about adding new people to a broken and out-of-control program that exposes states to alarming new costs,¹³ even the best marshaling of facts has not halted political pressure against expansion.

To find a way forward, lawmakers favoring coverage of poor adults have sought to reframe it as a part of a broader effort to restructure Medicaid to reflect updated approaches to program management. Elements of adult-expansion demonstrations approved so far provide important clues to the direction in which states want to move the program and underscore limits on the authority that Medicaid legislation gives the HHS secretary to approve changes that could move the program in some new directions.

To shed light on how the demonstrations depart from normal Medicaid policy, we will briefly explain how the “standard” Medicaid program is supposed to operate after expansion.

First, under standard Medicaid, states may offer private insurance as a coverage option. For adults eligible for coverage after expansion, the demonstrations anticipate that states will enroll most beneficiaries (other than those considered medically frail or otherwise exempt) in “alternative benefit plans.” This coverage tracks the Affordable Care Act’s “essential health benefit” but has been modified to ensure coverage of all Early and Periodic Screening Diagnosis and Treatment (EPSDT) program services for people under age 21, family planning services from the provider of choice, and nonemergency medical transportation.¹⁴ HHS expects Medicaid managed care plans to provide this coverage, with benchmarks designed by each state. Federal officials expect state benchmark plans to differ from traditional coverage by offering more benefits for preventive care but only limited coverage for long-term care.

Second, standard postexpansion Medicaid bars states from forcing beneficiaries with incomes below 150 percent of the federal poverty level to pay premiums.¹⁵ This provision applies even though people with incomes over 100 percent of the federal poverty level in states that have not expanded Medicaid can pay premiums for coverage through the health insurance exchanges equal to 2 percent of their modified adjusted gross income.

Third, standard Medicaid coverage allows states to ask beneficiaries to share the cost of care, chiefly through copayments at the time of care.

Fourth, standard coverage preserves retroactive eligibility, which begins up to three months before an adult applies for Medicaid.¹⁶ This provision, which dates to the original Medicaid legislation, ensures continuity of care by recognizing that beneficiaries may enroll at a time of great medical need (perhaps the most fundamental difference between Medicaid and private insurance, which operates on traditional risk principles)—and even during a course of treatment. Retroactivity also incentivizes providers to care for indigent people who are sick.

Finally, standard Medicaid does not contain “consumer-driven” elements typical of the private market today, such as value-based cost-sharing, in which beneficiaries who use cost-effective providers and drugs have lower copays, as do beneficiaries who participate in wellness programs. The rationale has been that Medicaid beneficiaries are so indigent that such economic incentives would not be effective.

Section 1115 demonstrations for adult expansion depart from these standard Medicaid elements. Exhibit 1 presents an overview of the four demonstrations approved so far and the two pending proposals, one of which is still under development.¹⁷ This information provides a roadmap to what states are testing or seeking to test in moving away from standard Medicaid, at least for newly eligible adults.

KEY FEATURES OF STATE DEMONSTRATION PROGRAMS FOR ADULTS

One key feature is the expanded use of Medicaid to purchase private insurance, most notably in Arkansas but also in Iowa. New Hampshire and Indiana similarly propose expanded reliance on private insurance to provide coverage to adults. Although Medicaid has always allowed states to offer private insurance as an option, Arkansas and Iowa mandate it for all or some newly eligible adults, with exceptions for those who are more medically vulnerable and perceived as needing Medicaid’s traditional protections. Arkansas is relying heavily on private insurance because the state has no Medicaid

managed care market. New Hampshire, which has similarly lacked such a market, has begun to build one. Michigan and Pennsylvania—and Iowa, for its lowest-income newly eligible adults—plan to continue to rely on a Medicaid managed care market, although the former two have made certain modifications to their managed care programs. The core purpose of modifying Medicaid to emphasize public support for private insurance premiums is to test the impact on churn among low-income adults, who seem to move often between public and private insurance.¹⁸ Another purpose is to test the impact of adding healthy adults to the private health insurance risk pool. Preliminary reports suggest that in doing so, Arkansas has helped hold down rate increases for private insurance in the state.¹⁹

Most of the six states with approved or pending proposals also seek to test the impact of requiring beneficiaries with modified adjusted gross incomes well below Medicaid's standard 150-percent-of-poverty threshold to pay monthly premiums. HHS has not allowed any states to ask beneficiaries to pay more for care than traditional Medicaid standards allow. However, states are expected to expand cost-sharing to more situations, especially nonemergency use of emergency departments, to spur beneficiaries to avoid care that is not cost-effective.

Most of the demonstration programs also eliminate retroactive eligibility. However, states that have done so retain Medicaid's core provision allowing eligible adults to enroll at any time—a feature that the HHS secretary most likely lacks the power to waive, because restricting eligibility would run counter to Medicaid's safety net purpose. One testable question is whether there is any link between elimination of retroactive eligibility and earlier enrollment by beneficiaries.

States have not usually sought to relax Medicaid's benefit and coverage rules further, with two notable exceptions. The first is coverage of medical transportation for nonemergencies, which the HHS secretary waived for three demonstrations. The second is EPSDT benefits for Medicaid-eligible adults under 21, waived in Michigan. In effect, Michigan has sought to align its Medicaid coverage with health plans available through the federally run health insurance marketplace, which cease mandatory coverage of vision and dental care at age 18.

Finally, three of the four states with approved demonstrations are using or plan to use insurance coverage to incentivize healthy behavior. Indiana and New Hampshire use consumer-driven incentives. Arkansas is considering a similar approach, using health savings accounts to encourage healthy behaviors by allowing consumers to keep the money they save when they use less health care.

HHS did not approve Pennsylvania's proposal to condition adult eligibility for Medicaid on job search. Indiana has made a similar proposal. Because Medicaid's objective is to expand access to coverage, the secretary likely does not have the power to restrict eligibility in this fashion.

Exhibit 1. Provisions of Demonstration Programs for Adult Medicaid Expansion, as of September 2014

	Arkansas	Iowa	Michigan	Pennsylvania	Indiana (proposed)	New Hampshire (proposed)
Model	Enrolls newly eligible adults in private health plans, except for adults who are medically frail.	Enrolls newly eligible adults with incomes of 100%–138% of federal poverty level (FPL) in private health plans. Includes behavioral interventions and standard Medicaid managed care for newly eligible adults with incomes <100% FPL.	Requires newly eligible adults to pay premiums and have health savings accounts. Provides behavioral interventions and standard Medicaid managed care to newly eligible adults with incomes <100% FPL.	Relies on a “private coverage option” (PCO): private insurance plans modified to meet Medicaid managed care requirements. Newly eligible adults pay premiums and receive behavioral interventions.	Will eliminate enrollment caps now in effect under Healthy Indiana and reform the health care delivery system.	Extended Medicaid to low-income adults in August 2014. Expansion beyond 2016 contingent on approval of demonstration proposal. Temporarily uses Medicaid managed care; transitioning in 2016 to premium support for qualified health plans purchased in the marketplace. Includes reform of delivery system.
Premiums	None. State is considering requiring beneficiaries to have a health savings account.	No premium for first year. Adults with incomes 50%–100% of FPL or more pay premiums. Capped at \$5/month for adults with incomes 50%–100% of FPL, and 2% of income for adults at 100%–133% of FPL.	No premium for first six months. Monthly premiums capped at 2% of household income for adults with incomes 100%–138% of FPL.	No premium for first year. Monthly premium capped at 2% of household income for adults with incomes 100%–138% of FPL.	No premium for first year. Optional defined contribution up to 5% of family monthly income into employer-sponsored insurance plans or individual coverage.	Two temporary programs: Mandatory Health Insurance Premium Program to help workers earning up to 138% of FPL pay employee premiums. Voluntary Bridge to Marketplace subsidizes managed care coverage for newly eligible adults.
Benefits	No changes to standard Medicaid alternative benefit plan.	Standard alternative benefit plan for managed care enrollees. Marketplace standard for beneficiaries enrolled in qualified health plans.	Standard alternative benefit plan for Medicaid managed care enrollees. Marketplace standard for beneficiaries enrolled in qualified health plans.	Standard alternative benefit plan for PCO enrollees. Additional benefits for newly eligible individuals with complex health needs.	Standard alternative benefit plan. Enrollees under 100% of FPL can choose between Basic or Plus plans.	Alternative benefit plan for individuals enrolling in the Bridge to Marketplace program.
Cost-sharing	Follows Medicaid requirements.	Follows Medicaid requirements.	Follows Medicaid requirements.	Follows Medicaid requirements.	Follows Medicaid requirements but will add health savings accounts and increase beneficiary cost-sharing for nonemergency use of emergency departments.	Not yet determined.
Retroactive eligibility	Waived for newly eligible adults.	Not waived.	Waived for newly eligible adults.	Waived for newly eligible adults.	Waived for newly eligible adults.	Not addressed.
Health and wellness plans	None.	Health and wellness initiative for beneficiaries with incomes <100% FPL, incentivized through reductions in cost-sharing and waived premiums.	Beneficiaries who attain benchmarks for healthy behaviors contribute less to their MI Health Account.	Beneficiaries who attain benchmarks for healthy behaviors see reductions in cost-sharing.	Managed care organizations may allow enrollees to earn funds for their POWER accounts if they attain benchmarks for healthy behavior.	Expanding programs under the New Hampshire Medicaid Wellness Incentive Program (InSHAPE).
Work search requirement	None.	None.	None.	Voluntary participation in Encouraging Employment program. Health coverage not contingent on participation.	Will require non-disabled adults unemployed or working fewer than 20 hours a week to search for work.	Not addressed.
Wraparound benefits	Provides all wraparound benefits required under Medicaid alternative benefit plan.	Eliminates nonemergency medical transportation for one year.	Eliminates nonemergency medical transportation. Waives EPSDT dental, vision, and hearing benefits for newly eligible 19-to-21-year-olds.	Eliminates nonemergency medical transportation for one year.	Eliminates nonemergency medical transportation for one year.	Provides all wraparound benefits for Bridge to Marketplace Program, including nonemergency medical transportation and EPSDT benefits.

Exhibit 2. Number and Share of Adults Gaining Coverage Through State Medicaid Demonstrations

	Arkansas	Iowa	Michigan	Pennsylvania	Indiana (proposed)	New Hampshire (proposed)
Number of uninsured adults	510,400	301,500	1,110,500	1,426,900	801,600	158,500
Number of adults gaining coverage under Section 1115 waivers	200,000	150,000	300,000–500,000	500,000	334,000–598,334	50,000
Share of uninsured adults	39.20%	49.80%	27.0%–45.0%	35.00%	41.67%–74.6%	31.50%

Sources: <http://www.in.gov/fssa/hip/2445.htm#impact>; <http://www.commonwealthfund.org/-/media/images/blog/2014/mar/exhibit-1.jpg>; <http://www.nhfp.org/new-hampshire-health-protection-program>; and <http://kff.org/other/state-indicator/nonelderly-0-64/>.

Notes: In some cases, these estimates vary among the sources. Commonwealth Fund estimates obtained from Section 1115 demonstration waivers, supplemented with state data where numbers were missing.

Overall, the impact of a Section 1115 demonstration program on a state's uninsured population is considerable. Medicaid-eligible adults account for nearly one-third or more of the uninsured adults in each of the six states (Exhibit 2).

CONCLUSION: EVALUATING ADULT COVERAGE THROUGH SECTION 1115

For decades, Section 1115 has enabled states to evolve their Medicaid programs outside the federal legislative process, and in ways that address the program's uncommonly complex politics. Analysis of approved and pending demonstrations shows common movement toward private insurance, premium payments by even the poorest adults, more limited benefits, and an emphasis on Medicaid as subsidized health insurance for healthy adults rather than as a safety net for the sick.

Given that additional states, including Utah, Wyoming, and Tennessee, have come forward with their own preliminary plans to use Section 1115 to create Medicaid expansion alternatives, robust evaluation will be essential to answer these key questions: What is the impact of required premium payments on the poorest beneficiaries? Does reliance on private health plans sold in the marketplace work as well as a separate Medicaid managed care market? Is care equally accessible, and is beneficiary satisfaction comparable? What is the effect of subsidized premiums on the market for health insurance for individuals? How does eliminating retroactive eligibility affect hospitals and other safety net providers? What is the effect of eliminating vision and dental care for the poorest young adults? Can consumer-driven elements change health behaviors among low-income adults?

Section 1115 has enabled four states to find a pathway to coverage for more than 1 million low-income adults who otherwise would be left without one. Given that record and the likelihood that more states will follow this path, it is crucial that these questions be answered.

NOTES

- ¹ *National Federation of Independent Businesses v Sebelius*, 132 S. Ct. 2566 (2012).
- ² R. Garfield, A. Damico, J. Stephens, and S. Rouhani, *The Coverage Gap: The Uninsured Poor in States that Do Not Expand Medicaid* (Washington D.C.: Kaiser Family Foundation, Nov. 12, 2014), <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.
- ³ New Hampshire expanded adult Medicaid coverage in August 2014, before HHS approved the state's demonstration proposal. Continuation of the expansion beyond 2016 is conditioned on approval.
- ⁴ Title I, Pub. L. 87-543 (87th Cong. 2d sess.). See B. Vladeck, "Medicaid Section 1115 Demonstrations: Progress Through Partnership," *Health Affairs*, Feb. 1995 14(1):217–20.
- ⁵ See N. Owcharenko, *How States Can Expand Private Coverage with HIFA Waivers*, executive memorandum no. 846 (Washington, D.C.: Heritage Foundation), <http://www.heritage.org/research/reports/2002/12/how-states-can-expand-private-coverage-with-hifa-waivers>.
- ⁶ A recent study by the Government Accountability Office (GAO) found that Arkansas's Medicaid demonstration, which subsidizes insurance premiums for low-income adults, is expected to exceed the state's spending, absent the demonstration, by as much as \$778 million, chiefly because the Centers for Medicare & Medicaid Services (CMS) allowed the state to make unsubstantiated assumptions about what it otherwise would have spent. According to the GAO, HHS has also allowed other states to exceed budget neutrality. See *Medicaid Demonstrations: HHS' Approval Process for Arkansas' Medicaid Expansion Waiver Raises Cost Concerns* (Washington, D.C.: GAO, September 2014), <http://www.gao.gov/assets/670/665265.pdf>.
- ⁷ R. Rudowitz, S. Artiga, and M. Musumeci, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers* (Washington, D.C.: Kaiser Family Foundation, Feb. 2014), <http://kff.org/medicaid/issue-brief/the-aca-and-recent-section-1115-medicaid-demonstration-waivers/>.
- ⁸ See J. Holahan et al., "Insuring the Poor Through Section 1115 Demonstration Waivers," *Health Affairs*, Feb. 1995 14(1):195–216.
- ⁹ Vladeck, "Progress Through Partnership," 1995.
- ¹⁰ Balanced Budget Act of 1997, Pub. L. 105-33 (105th Cong., 1st sess.).
- ¹¹ For a discussion of why the Oregon Medicaid demonstration failed to serve as a basis for broader health system reform while the Massachusetts demonstration succeeded, see J. Oberlander, "Health Reform Interrupted: The Unraveling of the Oregon Health Plan," *Health Affairs*, Jan. 2007 26(1):w95-w105.
- ¹² Kaiser Family Foundation, *The Deficit Reduction Act of 2005: Implications for Medicaid* (Washington, D.C.: KFF), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7465.pdf>. See also 42 U.S.C. §1396u-7 and 1396o-1.
- ¹³ See, for example, S. Dorn, M. McGrath, and J. Holahan, *What Is the Result of States Not Expanding Medicaid?* (Washington, D.C.: Urban Institute, Aug. 2014), <http://www.urban.org/publications/413192.html>.
- ¹⁴ 42 U.S.C. §1397u-7.
- ¹⁵ 42 U.S.C. §1396o(c)(2).
- ¹⁶ 42 U.S.C. §1396a(a)(34).

- ¹⁷ Agreements between states and HHS describe in detail how a state can modify the standard Medicaid approach. CMS has no single website with details on all approved and pending Medicaid demonstrations of adult expansion. An online search usually reveals CMS approval letters for such programs.
- ¹⁸ See B. Sommers and S. Rosenbaum, “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges,” *Health Affairs*, Feb. 2011 30:228–36.
- ¹⁹ Health Insurance Marketplace Premiums Projected to Drop Two Percent in Arkansas in 2015, http://governor.arkansas.gov/newsroom/index.php?do:newsDetail=1&news_id=4592

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