



## How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?

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**Abstract** Section 1115 of the Social Security Act allows the U.S. Department of Health and Human Services and states to test innovations in Medicaid and other public welfare programs without formal legislative action. Six states currently operate their Medicaid expansions as demonstrations and several more are expected to seek permission to do so. While the current Medicaid expansion demonstrations vary, they share a major focus: increasing beneficiaries' financial responsibility for the cost of coverage and care. Demonstrations include requirements that Medicaid beneficiaries pay enrollment fees and cost-sharing that exceed traditional Medicaid limits. Others propose tying beneficiaries' financial responsibility to behavioral changes in health and wellness, while still others impose penalties for nonpayment of enrollment fees. Evaluations must consider the impact of these requirements on access, use of care, and health status, as well as the feasibility of demonstration reforms and their impact on administrative efficiency, providers, and health plans.

### INTRODUCTION

Section 1115 of the Social Security Act allows states to test and evaluate innovations in certain state-administered public programs, including Medicaid. As such, 1115 plays a special role because it allows the federal and state governments to test and study potentially significant policies before they are adopted as legislative reforms. Over the years, 1115 has paved the way for major changes in federal Medicaid policy across a range of areas: eligibility, simplifying the enrollment and renewal process, benefits and coverage, long-term services and supports, and the use of compulsory managed care arrangements.

Currently, six states—Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire—administer their Medicaid expansions as 1115 demonstrations; more states are expected to do so. Ohio and Arizona have proposed 1115 demonstrations and Kentucky's governor has indicated his desire to do so. Louisiana, which expanded Medicaid in January 2016, may also submit a proposal.

State 1115 demonstrations vary, but existing and proposed demonstrations share a key theme: increasing beneficiary financial responsibility, not only at the point of care through increased cost-sharing for certain services but also at the point at which coverage is obtained by requiring people to pay an ongoing, monthly premium or enrollment fee for their coverage. Both changes require demonstration authority under

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1115 because federal Medicaid law currently bars the use of premiums and enrollment fees for beneficiaries with incomes below 150 percent of the federal poverty level—about \$36,500 for a family of four—and limits cost-sharing to nominal amounts<sup>1</sup> based on evidence documenting the impact of financial costs on access to care for low-income individuals.<sup>2</sup>

It is not surprising that testing the impact of increasing financial responsibility for beneficiaries has emerged as a central theme of state Medicaid demonstrations. The new health insurance marketplaces feature premiums and potentially significant cost-sharing for people with household incomes of less than 150 percent of the federal poverty level. In states that have not expanded Medicaid, eligibility for premium tax credits and premium payment responsibilities would begin at 100 percent of the federal poverty level. Arkansas, Indiana, Iowa, Michigan, and Montana have received permission to increase beneficiaries' financial responsibility, and New Hampshire's legislature is considering a similar change. Arizona and Ohio propose to follow suit, and Louisiana and Kentucky have indicated they may request permission to alter normal Medicaid rules to require enrollment fees and additional cost-sharing. Indiana's program offers perhaps the greatest departure from traditional Medicaid. Under its 1115 approval, the state can require even the poorest beneficiaries to pay enrollment fees but also can impose a six-month lockout on beneficiaries with incomes at 100 percent of poverty or higher who fail to pay their premiums. While Indiana's lockout may be the most pronounced penalty, the U.S. Department of Health and Human Services has permitted other state demonstrations to use sanctions that include, among others, treating unpaid fees as debts to the state. An unpaid state debt could trigger other consequences, such as offsets against tax credits otherwise owed by the state, wage garnishment, loss of a driver's license, and denial of student loans.

Since the fundamental purpose of 1115 is to test and evaluate program innovation, it is essential to thoroughly document its outcomes and impact. Evaluations should consider not only the outcomes of the proposed policy change but also whether the change was implemented in an efficient and effective manner. It is also important to test for consequences other than those that were expected to identify unforeseen consequences of the demonstration, such as undue administrative costs or complexities associated with implementation or unintended spillover effects. The immediate impact of the demonstration might be the loss of coverage for certain portions of the population as well as reductions in care, with attendant effects on health. By creating a loss or interruption of insurance coverage for many, the demonstration ultimately might cost significantly more than it saves. Penalties imposed for nonpayment may have separate spillover consequences depending on the types of sanctions used. Health care providers and plans may lose revenues. Finally, there are questions as to whether demonstrations are implemented as designed or if the implementation process reveals basic feasibility problems.

This brief considers the issues that can arise in demonstrations that are aimed at increasing costs of care for the poor. It also examines what is known about evaluations that have been proposed or are under way.

## FINANCIAL RESPONSIBILITY PROVISIONS OF MEDICAID DEMONSTRATIONS

All current demonstration states—along with Ohio and Arizona, which have proposed to move to demonstration status—have seen significant growth in their Medicaid populations as a result of expansion, in both absolute terms and as a percentage increase. Table 1 shows enrollment growth as

**Table 1. Eligibility and Enrollment in Approved and Pending Section 1115 Medicaid Expansion States**

	Enrollment launch date	Total number enrolled in Medicaid and CHIP (January 2016)	Percent change, September 2013–January 2016
Arkansas	October 2013	850,426	52.72%
Iowa	October 2013	605,467	22.68%
Indiana	January 2015	1,443,494	28.81%
Michigan	April 2014	2,339,419	22.35%
Montana	November 2015	208,754	40.13%
New Hampshire	May 2014	186,603	46.84%
Arizona*	<i>Application pending</i>	1,670,422	39.00%
Ohio*	<i>Draft proposal</i>	2,907,193	24.16%

\* Numbers reported for Arizona and Ohio reflect Medicaid enrollment without the effect of Section 1115. Ohio expanded Medicaid under the Affordable Care Act (ACA) in 2014, but is now considering converting expansion to an 1115 demonstration program, which could decrease total enrollment. Arizona expanded its Medicaid program prior to the ACA expansion through a 1115 waiver to include working parents up to 106% of the federal poverty level (FPL) and nonworking parents and childless adults up to 100% FPL, but capped enrollment for childless adults in 2011. Arizona implemented the ACA's Medicaid expansion as of January 2014 to cover adults up to 138% of the federal poverty level.

Source: Centers for Medicare and Medicaid Services, *Medicaid & CHIP: January 2016 Monthly Applications, Eligibility Determinations and Enrollment Report* (CMS, April 13, 2016).

high as 52.7 percent in Arkansas, with the lowest growth rate exceeding 22 percent. Coverage and care for millions of people are subject to the terms of the demonstrations.

No two approved Medicaid expansion demonstrations are alike. Arkansas and, to a lesser extent, New Hampshire are testing the viability of marketplace coverage in lieu of traditional Medicaid managed care. Iowa's demonstration initially included such a component, which was terminated by the state in 2015 and converted to Medicaid managed care.<sup>3</sup> Several demonstrations also test the impact of altering or reducing benefits, such as eliminating Medicaid coverage for nonemergency medical transportation.<sup>4</sup> All demonstrations, other than New Hampshire, which is expected to follow suit, either test or propose to test increasing the cost of care for expansion to beneficiaries (Table 2). In Indiana, Iowa, and Montana, enrollment and coverage is conditional on payment of a monthly fee for beneficiaries with incomes at or above 100 percent of the poverty level. Arkansas, Indiana, Iowa, and Montana require enrollment fees from individuals with below-poverty incomes. Pending 1115 proposals from Arizona and Ohio would increase beneficiaries' financial responsibility, applying enrollment fee obligations on people with incomes below the marketplace threshold.

Indiana and Michigan increase cost-sharing beyond levels traditionally permitted under Medicaid. Indiana imposes a graduated copayment schedule for nonemergency use of the emergency department of \$8 for the first visit and \$25 for subsequent visits in the same year. These payments could exceed the traditional \$8 copayment limit under Medicaid.<sup>5</sup> Arizona would adopt a \$25 emergency department copayment for people who live within 20 miles of a community health center.

In addition to imposing financial obligations, four of six demonstration states propose to test methods that tie beneficiaries' financial responsibility to behavioral changes in health and wellness. For example, Indiana provides a reward program for beneficiaries in the form of additional contributions to health savings accounts for specified healthy behaviors; these contributions can be used to reduce (but not eliminate) monthly required payments by up to 50 percent. The demonstrations vary in how they introduce their wellness plans, which might be through reduced cost-sharing, reduced or waived enrollment fees, or a combination thereof.

**Table 2. Beneficiaries' Financial Responsibility Under Approved and Proposed State Medicaid Section 1115 Expansion Demonstrations**

	Is increased financial responsibility part of the demonstration?				
	<i>Enrollment fees: beneficiaries with incomes between 100%–138% of poverty</i>	<i>Enrollment fees: beneficiaries with incomes &lt;100% of poverty</i>	<i>Cost-sharing beyond traditional levels</i>	Do beneficiaries have an opportunity to reduce their financial liability?	Are there penalties for nonpayment of premiums or enrollment fees?
Arkansas	YES: monthly contribution of \$10 to \$25 to “health independence accounts”; may be used to pay cost-sharing owed	YES: for people at 50%–100% of poverty, monthly contribution to “health independence accounts” of \$5; may be used to pay cost-sharing owed	NO	NO	Yes: tighter enforcement of cost-sharing and debt to state incurred
Iowa	YES: monthly \$10 payments beginning in year 2 of enrollment	YES: for people at 50%–100% of poverty; monthly contribution of \$5 beginning in year 2 of enrollment	NO	YES: through the use of health and wellness initiatives	YES: nonpayment by people with incomes between 100%–138% of poverty will result in disenrollment after 90-day grace period, with opportunity to reapply at any time  All unpaid premiums are considered state-owed debt
Indiana	YES: monthly contribution equaling 2% of income or \$1/month to Personal Wellness and Responsibility (POWER) health savings account	YES: monthly contribution equaling 2% of income or \$1/month to POWER account; people with incomes <5% of poverty contribute \$1/month	YES: copayments for nonemergency use of the emergency department increase to \$25/visit after first visit	YES: Health Incentive Program rewards healthy behaviors to offset monthly contributions	YES: nonpayment by people with incomes between 100%–138% of poverty will result in disenrollment after 60-day grace period, with six-month lockout  People with incomes <100% of poverty receive more limited benefits and higher cost-sharing as a result of nonpayment
Michigan	YES: monthly payments equaling 2% of income; premiums rise to 3.5% of income after 48 cumulative months of continuous enrollment, thereby exceeding marketplace premium levels	NO	YES: for people with incomes between 100%–138% of poverty; after 48 cumulative months of coverage, total allowable cost-sharing increases to 7% of income	YES: compliance with healthy behavior incentives can reduce cost-sharing	NO
Montana	YES: monthly payments equaling 2% of income for people with incomes between 100%–138% of poverty	YES: monthly payments equaling 2% of income for people with incomes between 51%–100% of poverty	NO	NO	YES: nonpayment by people with incomes between 100%–138% of poverty will result in disenrollment after notice and 90-day grace period, with opportunity to reenroll upon payment
New Hampshire*	NO	NO	NO	NO	NO
Arizona**	YES: monthly contribution equaling the lesser of 2% of income or \$25/month to health savings account	YES: monthly contribution equaling the lesser of 2% of income or \$25/month to health savings account	YES: copayments for nonemergency use of the emergency department up to \$25/visit if within 20 miles of health center; higher rates for subsequent ED use if no admission on first visit  For a missed appointment, all enrollees pay copayment that would otherwise have been due for the service	YES: through the use of health and wellness initiatives	YES: nonpayment by people with incomes between 100%–138% of poverty will result in disenrollment, with six-month lockout  Unpaid premiums for people <100% of poverty are considered state-owed debt
Ohio***	YES: annual contribution equaling the lesser of 2% of income or \$99/year to health savings account	YES: annual contribution equaling the lesser of 2% of income or \$99/year to health savings account	NO	YES: through the use of health and wellness initiatives and preventive care utilization	YES: nonpayment will result in disenrollment after 60-day grace period, with opportunity to reenroll upon payment

\* New Hampshire is expected to submit a proposal to increase financial responsibility later in 2016.

\*\* Arizona proposal pending with the Centers for Medicare and Medicaid Services as of April 2016.

\*\*\* Ohio proposal pending with the Centers for Medicare and Medicaid Services as of April 2016.

Source: George Washington University review of pending and approved Section 1115 state demonstration proposals.

With respect to penalties, the states also vary considerably. Indiana, Iowa, and Montana will impose penalties for nonpayment of enrollment fees. Indiana and Iowa both proposed to disenroll beneficiaries with incomes at 100 percent of poverty or greater for nonpayment of premiums. Iowa would allow individuals to reapply at any time. In contrast, Indiana imposes a six-month lockout period. Montana would condition reenrollment on repayment of sums owed or debt collection by the state. Indiana would reduce but not eliminate coverage for people with incomes below poverty who fail to pay enrollment fees, while Ohio's proposal would subject beneficiaries at all income levels to disenrollment for nonpayment.<sup>6</sup>

Michigan imposes a 48-month cumulative time limit on Medicaid enrollment for individuals with incomes that exceed the marketplace subsidy eligibility threshold of 100 percent of poverty. At the end of the time limit, beneficiaries would have a choice of either paying up to 7 percent of their incomes toward continued Medicaid or moving into the marketplace, where their financial exposure could not exceed permissible marketplace levels.

### RAISING AND ANSWERING QUESTIONS

Increasing the cost of health care for the poor raises a host of issues. Does Indiana's lockout result in greater compliance than Iowa's approach of disenrollment for nonpayment and then allowing reenrollment? Do health consequences differ? What are the consequences of different state approaches to treating unpaid fees as debts? Does the fact that Montana will pursue repayment of sums owed have a greater impact on timely payment than Indiana's lockout?

Early reports from demonstration states are raising questions and issues for future research and program evaluations.<sup>7</sup> For example, in reality, few people may be paying premiums because some states are not actually enforcing their requirements. Conversely, for people who are required to pay, disenrollment may be widespread. Premium revenue may be well below the cost of instituting premium programs and the loss of eligibility may be having an adverse financial effect on health care providers that serve large numbers of low-income patients and receive state and local support for indigent care. Additional questions for evaluations could include:

- Do beneficiaries actually pay? Or do third parties like health care providers or health foundations pay the fees?
- If third parties stop paying fees, do beneficiaries assume the cost or drop out?
- How do implementation costs compare to revenues collected?
- How much do costs shift onto state and local indigent care programs in the event that eligibility is lost?
- What are the health, employment, and family characteristics of people unable to make payments?
- If parents owe premiums while other family members, like children, do not, does confusion over who owes a premium cause parents to discontinue coverage for their children out of concern they will be unable to pay the cost of enrollment?
- Are beneficiaries able to pay the higher copayments that may be required under a demonstration, or are these additional costs ultimately shifted to providers?

- Is the care that beneficiaries forgo because of cost-sharing necessary and appropriate?
- Do wellness programs result in changes in behavior? Are the financial incentives offered sufficient to promote participation? How are programs implemented? What is the burden on providers?

## EVALUATING DEMONSTRATIONS

It is both legally required and critical to evaluate 1115 demonstrations, especially the impact of proposals that can result in the reduction or elimination of Medicaid coverage given the potential harm that may come to people who lose eligibility and benefits. In addition, 1115 demonstrations are exempt from the Common Rule, which regulates human subject research conducted or funded by the federal government.<sup>8</sup> Such an exemption only increases the need for robust and impartial evaluation of how proposals that can reduce coverage are implemented in practice and their impact on access, use, health outcomes, and provider participation before the components of these demonstrations become broad public policy.

The Centers for Medicare and Medicaid Services (CMS) has begun preliminary work to carry out comparison evaluations, but designing such comparative research is complex and results are years away. CMS also is conducting an independent evaluation of Indiana's nonemergency transportation waiver. However, CMS' plan focuses on selected outcomes and effects such as enrollment rates and coverage utilization rather than more broadly at implementation and costs.<sup>9</sup> It is not clear how the CMS plan will capture certain aspects of states' proposals: if premiums are collected, if copayments are paid (or instead waived), and if wellness programs produce changes in health.

CMS does require that states evaluate their own demonstrations. However, states' evaluation plans are similarly limited and do not appear to include a detailed assessment of implementation (see box). Furthermore, states' self-evaluations raise potential for conflict of interest, which further underscores the importance of a nationwide impartial evaluation.

### EVALUATION PLANS FOR DEMONSTRATION STATES

**Arkansas:** Measures the impact of marketplace enrollment on access, quality, and health.

**Iowa:** Measures the impact of the state's wellness plan on access to health care, the impact of copayments for inappropriate emergency department use on health care access, and the impact of healthy behavior monitoring on beneficiaries' health.

**Indiana:** Measures the impact of savings account contributions on access to care. No separate evaluation of the impact of lockout, because the state assumes that the lockout will have a negligible impact. Also examines beneficiary compliance with coverage requirements, and the ability to manage savings accounts. In addition, evaluates extent to which greater cost-sharing results in more cost-conscious health care behavior with respect to primary, specialty, and pharmacy service utilization without harming beneficiaries' health.

**Michigan:** Measures the impact of cost-sharing on use of care, mix of health care, use of high-value and low-value health care (e.g., nonurgent emergency department use and low-priority office visits), and total costs over time following initial year of enrollment. Compares impact of higher cost-sharing on health care access compared to the traditional Medicaid population.

Note: Evaluation designs for Indiana and New Hampshire are in a revise and resubmit phase.

Sources: [Arkansas Department of Human Services](#); [Iowa Department of Human Services](#); [Indiana Family and Social Services Administration](#); and [Michigan Medical Services Administration](#).

## CONCLUSION

Section 1115 is designed to test and evaluate significant policy reforms. In the context of Medicaid expansion, 1115 has been used to move expansion forward in ways that normally are impermissible under federal law. Changes in benefits and service delivery have been built into several of the demonstrations; above all, the demonstrations seek to alter financial responsibility rules for low-income beneficiaries. It will be important to comprehensively and impartially evaluate the programs, given that several propose to withhold or reduce coverage for nonpayment and that beneficiary participation is not voluntary. In addition, CMS has been willing to grant renewals of demonstration, meaning that in some states, the Medicaid coverage landscape for beneficiaries may be changing permanently.

## NOTES

- <sup>1</sup> Sections 1916 and 1916a of the Social Security Act.
- <sup>2</sup> R. A. Brook, E. B. Keeler, K. N. Lohr et al., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* (RAND Corporation, 2006).
- <sup>3</sup> Notice of Iowa Department of Human Services Public Comment Period for Changes to Medicaid Waivers, [https://dhs.iowa.gov/sites/default/files/IHQHCI\\_FullPublicNotice\\_07202015.pdf](https://dhs.iowa.gov/sites/default/files/IHQHCI_FullPublicNotice_07202015.pdf). See R. Pradhan, “Iowa Medicaid Expansion Dropping Exchange Coverage,” *Politico ProHealth*, July 16, 2015.
- <sup>4</sup> S. Rosenbaum and C. Hurt, *How States Are Expanding Medicaid to Low-Income Adults Through Section 1115 Waiver Demonstrations* (The Commonwealth Fund, Dec. 2014).
- <sup>5</sup> Indiana was granted §1916(f) waiver authority to carry out a two-year demonstration (until Jan. 31, 2017) to test whether graduated copayments discourage nonemergency use of the emergency department. This authority applies to all demonstration populations.
- <sup>6</sup> Enrollment fees would not apply to pregnant women and disenrollment would not apply to either pregnant women or beneficiaries with no income.
- <sup>7</sup> A. Callow, *Charging Medicaid Premiums Hurts Patients and State Budgets* (Families USA, April 2016).
- <sup>8</sup> 45 C.F.R. §46.101(b)(5).
- <sup>9</sup> C. V. Irvin, J. Heeringa, D. Lipson et al., *Medicaid Section 1115 Evaluation Demonstration Design Plan* (Mathematica Policy Research, July 2015).



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