**Study Background**

**Section 1115 Waivers**
- Eight states are currently using Section 1115 waiver authority to expand Medicaid to the new adult group
  - Arizona, Arkansas, Indiana, Iowa, Kentucky, Michigan, Montana, and New Hampshire
- Goals of Expansion Waivers include
  - Burden changes to mirror commercial benefit and enrollment design
  - Create incentives for enrollees to use resources more efficiently

**Study Purpose**
The Medicaid and CHIP Payment and Access Commission (MACPAC) was interested in understanding how the states of Arkansas, Indiana, Iowa, and Michigan have approached the development, implementation, and management of innovative Section 1115 waiver policies that expand Medicaid.

**1115 Waivers in Study States**

### Arkansas
- Arkansas Health Care Independence Program (aka Private Option)
  - Exchange plan premium assistance
  - Health independence accounts (partially implemented, then discontinued in 2016)
  - Mindy Cards
  - Tiered based on income, with copayment exemption for making payments
  - 50–100% FPL — $5 per month
  - 101–115% FPL — $10 per month
  - 116–129% FPL — $17.50 per month
  - 130–138% FPL — $25 per month

### Indiana
- Healthy Indiana Plan (HIP 2.0)
  - Personal Wellness and Responsibility (POWER) Accounts
    - 0–5% FPL — $1 per month
    - 6–138% FPL — 2% of income
  - Healthy Behavior Incentives

### Copayments for non-emergency use of ED
- $58 copay for first non-emergency visit, $25 copay for subsequent non-emergency visits

### Iowa
- Health and Wellness Plan
  - Beneficiaries with incomes 0–100% FPL enrolled (initially)
    - Premiums tiered based on income
      - 0–49% FPL — none
      - 50–100% FPL — $5 per month
      - 101–138% FPL — $10 per month
  - Healthy Behavior Incentives

### Marketplace Choice Plan
- Beneficiaries with incomes 101–138% FPL enrolled
- Dis-enrolled for non-payment of premiums
- Discontinued in 2016, sole remaining plan exited the market

**Study Approach**
- Structured interviews with 33 individuals
- Current and former state agency staff, health plan staff

**Key Program Provisions Examined**
- Exchange plan premium assistance
- Enrollee contribution requirements
- Health savings accounts
- Healthy behavior incentives
- Graduated copayments for non-emergency use of the emergency department (ED)

**Policy Questions**
- What administrative elements were needed?
- What challenges arose, and how did states respond?
- What are important considerations for CMS and other states?

**Results**

### Administrative Capacity Needs
- Staff time needed for program implementation was considerable, even when some responsibilities were delegated to contractors.
- Necessary coordination and communication across different entities that have implementation responsibilities, and with beneficiaries, was significant and ongoing.
- Systems, processes, and IT infrastructure workloads were variable depending on existing capacity.
- Very little information is available on total costs for program administration.

### Exchange Plan Premium Assistance (AR & IA)
- Health plans were unwilling to offer products for Medicaid beneficiaries in Iowa.
- Health plans in both Iowa and Arkansas did not have previous experience serving low-income adults, so pricing the population was difficult.
- In Arkansas, coordinating between Medicaid, the Department of insurance, and exchange plans was difficult and time-consuming.

### Enrollee Contributions (IA & MI)
- Calculating, collecting, and processing beneficiary contributions was time-intensive and administratively burdensome.
- Setting up systems and coordination needed to collect unpaid contributions required more administrative work than originally anticipated, and in some cases it is not yet occurring.

### Health Savings Accounts (AR & IN)
- Michigan experienced processing delays in its paper-based HSAs.
- Educating and engaging beneficiaries about their HSAs was difficult.
- Engaging beneficiaries on healthy behavior incentives was difficult.

### Graduated Copayments for Non-Emergency Use of the ED (IN)
- Neither the state nor health plans in Indiana reported significant challenges.
- In Indiana, it was difficult to reconcile information about payments like account balance amount and member enrollment status across plans, the state, and the fiscal agent at the end of the benefit period.

### Healthy Behavior Incentives (IN, IA, & MI)
- Engaging beneficiaries on healthy behavior incentives was difficult.
- Michigan experienced processing delays in its paper-based health risk assessment screeners.
- In Indiana and Iowa, it was difficult reconciling claims systems with the payment system used for crediting beneficiaries.

### Discussion Themes
- **Invoking operational staff in waiver design process as early as possible may help to ensure policy goals are achievable.**
  - If there’s any way that you could have the opportunity or luxury of developing the operational protocol first, and then develop the policy, you’re better off. If you develop your policy first and try to wrap your operations around it, that’s where you get in trouble.
- **Building off of existing capacity and infrastructure made implementation manageable under short timelines, but it was not necessarily efficient.**
  - It’s building the plane as we were flying it... we had to have something workable, out the door, so that we could send the first bill out within six months of signing.
- **Significant administrative resources were needed to implement and support ongoing operations of these new programs.**
  - We’ve worked on this system for two years and we’ve still got little things left to do to it. There is still overhead consistently with the system. Not to mention the size of the database that’s just growing at a significant rate.
- **Considerable IT system redesign was required to develop and maintain programs.**
  - We definitely had plenty of education and collateral materials which were distributed and communications, there was a user guide that was created. It seemed like a pretty good educational tool. I think you just have to wonder if this type of program really is worth all the work that is going into this income population.
- **Despite a need for substantial communication and negotiation with states, health plans generally felt equipped to take on additional implementation responsibilities.**
  - We’ve talked a lot about communication, and the states have really been clear about what they wanted.

**Discussion Themes**
- **Involving operational staff in waiver design process as early as possible may help to ensure policy goals are achievable.**
- **Building off of existing capacity and infrastructure made implementation manageable under short timelines, but it was not necessarily efficient.**
- **Significant administrative resources were needed to implement and support ongoing operations of these new programs.**
- **Considerable IT system redesign was required to develop and maintain programs.**
- **Despite a need for substantial communication and negotiation with states, health plans generally felt equipped to take on additional implementation responsibilities.**

**Conclusions**
- **Implementation involved major administrative efforts, requiring significant coordination among multiple stakeholders, sophisticated IT systems, and ongoing education of beneficiaries.**
- **The total costs of the program implementation and administration were unclear.**
- **Interviewees felt that the overall value in the waiver approach was in carrying out policy differently, not necessarily in saving the state money.**
- **Waiver programs were ultimately worthwhile because they led to increased health care coverage for a population that would not otherwise have been covered.**