August 7, 2019

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Amendment to Centennial Care 2.0 Section 1115 Demonstration Waiver

Dear Secretary Azar:

Thank you for the opportunity to submit comments on New Mexico's proposed amendment to Centennial Care 2.0 Section 1115 Demonstration Waiver.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Several 1115 waiver proposals submitted to and approved by the Centers for Medicare and Medicaid Services (CMS) in recent months have jeopardized patients' access to quality and affordable healthcare coverage.[1] As many of our organizations argued in comments to CMS in January 2018, New Mexico's current waiver threatens access to healthcare by creating financial and administrative barriers that could lead patients with serious, acute and chronic conditions to lose their healthcare coverage.[2] The state's own estimates suggested that approximately 700,000 beneficiaries would be impacted by the implementation of premiums and copayments.

Our organizations are committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. Our organizations strongly support the proposals outlined in the

amendment to New Mexico's existing Centennial Care 2.0 Section 1115 demonstration. This coverage will help patients access medications to manage chronic conditions, access preventive services like cancer screenings and receive many other treatments needed to stay healthy.

We commend New Mexico's decision to delay implementation of various provisions and seek changes to the waiver terms to improve and advance healthcare for Medicaid recipients in New Mexico. Our organizations urge HHS to approve the following provisions of New Mexico's 1115 waiver amendment to improve patients' access to quality and affordable healthcare.

Eliminating Premiums

New Mexico's current waiver would allow the state to charge premiums in the Medicaid program and lock individuals out of coverage for three months for failure to pay these premiums, policies that would both increase the number of enrollees who lose Medicaid coverage and discourage eligible people from enrolling in the program.[3] When Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[4] For individuals with serious and chronic conditions, maintaining access to comprehensive coverage is vital to ensure they continue to maintain access to their physicians, medications and other treatments and services they need.

Indiana also implemented premiums in a previous waiver demonstration. The evaluation report[5] from the waiver demonstration found that over half of Medicaid enrollees failed to make at least one payment. The report also found that 29 percent of Medicaid eligible individuals either never enrolled because they did not make a payment or were disenrolled for failure to make payments. Coverage losses on this scale, especially for patients needing access to life-saving and life-sustaining treatment, would be dire. For example, if a patient with cancer had to stop treatment for failure to pay a premium, he or she could face a more advanced disease with potential deadly consequences.

Ultimately, premiums create significant barriers for patients that jeopardize their access to needed care. Our organizations are pleased with New Mexico's decision to eliminate premiums for the adult expansion population and remove the three-month lock-out period. We urge HHS to approve this policy change as part of the amendment request to the Centennial Care 2.0 Section 1115 demonstration.

Eliminating Copayments

The Centennial Care 2.0 1115 waiver currently allows New Mexico to impose cost-sharing on enrollees for non-emergency use of the hospital emergency department and non-preferred prescription drugs. This policy, if implemented, could deter people from seeking necessary care during an emergency or from filling a prescription for a needed medication. Delays in care could have harmful impacts on the short- and long-term health of individuals with serious, acute and chronic diseases.

People should not be financially penalized for seeking lifesaving care for a breathing problem, a heart attack, hyperglycemia, complications from a cancer treatment or any other critical health problem that requires immediate care. When people do experience severe symptoms, they should not try to self-diagnose their condition or worry that they can't afford to seek care. Instead, they must have access to quick diagnosis and treatment in the emergency department.

Evidence suggests cost-sharing may not result in the intended cost savings.[6] Research demonstrates that low-income individuals served by Medicaid are more price sensitive compared to others, more likely to go without needed care, and more likely to experience long-term adverse outcomes. A study of

enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[7] This provides further evidence that copays may lead to inappropriate delays in needed care.

Our organizations support the elimination of the previously approved co-payments for non-exempt Centennial Care beneficiaries to help patients to access care when needed.

Reinstating Retroactive Eligibility

The Centennial Care 2.0 1115 Waiver as previously approved phases out the three-month retroactive eligibility policy for non-pregnant adults over a two-year timeframe. Medicaid enrollment and re-enrollment can be difficult to navigate. Individuals may not be aware that they are eligible for Medicaid until they go to see their doctor, pick up a prescription or experience a health emergency. Retroactive eligibility allows Medicaid to cover patient costs prior to enrollment if patients met eligibility criteria during that time. The three-months of retroactive coverage can prevent patients from going into bankruptcy when diagnosed with a costly illness. For example, when Ohio was considering a change to retroactive coverage in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[8] Patients should not be left to choose between massive medical bills and treating their illness.

Our organizations request that HHS approve the reinstatement of New Mexico's retroactive eligibility for non-pregnant adults. This change will help to ensure access to care for the patients we serve.

Our organizations believe healthcare should be affordable, accessible and adequate. Therefore, we urge HHS to support the proposed amendment to the Centennial Care 2.0 Section 1115 demonstration, as the changes will enhance New Mexico's Medicaid program and provide healthcare to individuals most in need. Thank you for reviewing our comments. Our organizations appreciate the opportunity to provide feedback on this application.

Sincerely,

ALS Association
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Hemophilia Federation of America
Leukemia & Lymphoma Society
March of Dimes
National Alliance on Mental Illness
National Hemophilia Foundation
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

[1] American Lung Association, A Coordinated Attack: Reducing Access to Care in State Medicaid Programs, July 2018. Accessed at http://www.lung.org/assets/documents/become-an-advocate/a-coordinated-attack.pdf.

[2] Health Partner Comments to CMS Re: Centennial Care 2.0 1115 Waiver Renewal Application, January 30, 2018. Accessed at: https://www.lung.org/assets/documents/advocacy-archive/partner-comments-to-cms-re-centennial-care-1115-waiver-renewal.pdf.

[3]Artiga, Samantha, Petry Ubri and Julia Zur. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. Kaiser Family Foundation. June 1, 2017. Accessed at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[4] Id.

[5] The Lewin Group, Health Indiana Plan 2.0: POWER Account Contribution Assessment (March 31, 2017). Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf

[6] See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. J Gen Intern Med. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." Center on Budget and Policy Priorities (July 2005), available at http://www.cbpp.org/5-31-05health2.htm.

[7] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

[8] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

References

AMERICAN LUNG ASSOCIATION®

A COORDINATED ATTACK:

REDUCING PATIENT ACCESS TO CARE IN STATE MEDICAID PROGRAMS

A COORDINATED ATTACK: Reducing Patient Access to Care in State Medicaid Programs

In 2017, high-profile attempts in Congress to compromise patients' access to quality and affordable healthcare by repealing the Affordable Care Act (ACA) dominated the headlines. Now, simultaneously, but with much less public scrutiny, the Administration and many states have been working to enact new and serious barriers to care in state Medicaid programs through the Section 1115 waiver process. This systematic attack on the Medicaid program jeopardizes access to care for hundreds of thousands of low-income patients with serious and chronic health conditions across the country.

Under Section 1115 of the Social Security Act, states can apply to establish a research and demonstration program that waives certain provisions of federal Medicaid law. According to the statute, these demonstrations must be designed to promote the objectives of the Medicaid program.[1] For example, waivers can be used to test new delivery and payment models or improve behavioral health services. Prior to the implementation of the ACA, these waivers were also used to expand coverage to otherwise ineligible populations.

THIS SYSTEMATIC ATTACK ON THE MEDICAID PROGRAM JEOPARDIZES ACCESS TO CARE FOR MILLIONS.

On March 14, 2017, the same day she was sworn in as Administrator of the Center for Medicare & Medicaid Services (CMS), Seema Verma and then Secretary of Health and Human Services (HHS) Tom Price issued a letter to every governor in the country inviting them to pursue changes to their states' Medicaid programs. The letter specifically mentioned a number of proposals that threaten patients' access to care, such as implementing so-called work and community engagement requirements, imposing enforceable premiums, waiving non-emergent transportation benefits, ending retroactive eligibility and charging copays for emergency room visits.[2] In January 2018, CMS issued more detailed guidance for state Medicaid directors specifically encouraging states to consider work and community engagement requirements as a condition of Medicaid coverage.[3] A list of policies that states have proposed through the 1115 waiver process that could have harmful implications for patients is included in the next section.

A major consequence of these proposals is that patients, including those with or at risk of lung disease, who need access to quality and affordable care to manage their medical conditions and stay healthy, will lose their healthcare coverage. Estimates suggest that thousands of individuals will lose coverage under these new

policies. In Kentucky, the state estimated that 95,000 people would lose their healthcare coverage over the demonstration period.[4] Additionally, a group of deans, department chairs, and scholars at leading academic institutions estimated that the coverage loss in Kentucky would actually be between 175,000 and 300,000 individuals.[5] As shown in Table 3, the populations most impacted are often very vulnerable populations that cannot afford a sudden gap in their healthcare coverage. For example, in Alabama, the waiver requesting a work requirement would apply to parents and caregivers making less than 18 percent of the federal poverty level ($312 per month for a family of three).[6]

States Failing to Include Mandated Budget Estimates

Some states have failed to provide the legally required budget neutrality estimates in their 1115 waiver proposals including information about how enrollment would change as a result of the proposals. These estimates inform the public and CMS on issues like the impact of 1115 waivers on coverage in the Medicaid program, which is vital to determine if the proposal will promote the objectives of the Medicaid program. Patient advocacy groups representing individuals facing serious, acute and chronic health conditions have sent letters to state officials in South Dakota and Michigan requesting that these estimates be made public.[7]

These proposals will increase the paperwork and administrative burden on patients, who will have to deal with onerous new reporting requirements. Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health. Even when proposals exempt certain enrollees struggling with health conditions, patients will still have to provide documentation of their illness, creating opportunities for administrative error that could jeopardize coverage. It is already clear that these processes will be difficult for patients despite states' claims to the contrary. In Arkansas, for example, despite over 600,000 Arkansans (23 percent of the population) not having access to wired broadband services, Arkansas only allows hours worked and exemptions to be reported via an online portal.[8] After the first month of this requirement, over 7,000 Medicaid enrollees in Arkansas are in jeopardy of losing their health coverage because they have failed to report 80 hours of work in June via the online portal.[9]

States Spending Millions on Administrative Requirements, Not Patient Care

Administering these requirements will also be expensive for states. States such as Michigan, Pennsylvania, Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track new requirements and to verify exemptions will cost tens of millions of dollars.[10] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

Under this Administration, CMS has approved 1115 waivers or waiver amendments in six states – Arkansas, Indiana, Iowa, Kentucky, New Hampshire and Utah – that contain provisions that threaten patients' access to care. Eleven states have waivers submitted to CMS that are still pending a final decision. This report provides an overview of these proposals, the vulnerable populations that would be impacted, and the number of patients projected to lose coverage as a result of these policies.

Recommendations to Protect Patient Access to Care

To ensure Medicaid patients have access to quality and affordable healthcare, the American Lung Association urges the following:

- CMS should reject any 1115 waiver that would create additional barriers that limit patients' access to care in the Medicaid program, as well as to rescind the guidance inviting states to submit 1115 waivers including work requirements.
- In light of the U.S. District Court for the District of Columbia's recent decision[11] to block implementation of the Kentucky waiver, CMS should also suspend implementation of 1115 waivers containing any provisions that threaten access to healthcare coverage.
- Members of Congress should ask CMS to reject harmful 1115 waivers, protecting people in their states, and use their oversight authority to monitor the impact of these waivers on patients.
- Congress should also ask the Medicaid and CHIP Payment and Access Commission (MACPAC) to monitor monthly Medicaid enrollment among parents, other adults, and children in states implementing these waivers and report to Congress and the public on a quarterly basis.

Barriers Preventing Medicaid Patients' Access to Care – 1115 Waiver Provisions

Medicaid enrollees are a population with unique needs and characteristics. By definition, they are low-income, and in the states that have not expanded Medicaid, the non-disabled adults are very low-income. Policies that might not impact middle class families can have a profoundly negative impact on families that rely on Medicaid to access medical care. For example, research shows that copays as low as one to five dollars lead low-income families to reduce their use of necessary healthcare services.[12]

FACES OF MEDICAID

Standard Medicaid enrollees: Low-income parents and caregivers and low-income patients in long-term care.

Medicaid expansion enrollees: Adults, aged 19-64, with or without children, making less than $1,893/ month for a family of two.

Table 1: Monthly Family Income for Federal Poverty Level (FPL)[13]

Family Size	50%	100%	138%
One	$506	$1,012	$1,396
Two	$686	$1,372	$1,893
Four	$1,046	$2,092	$2,887

States have used 1115 Waivers to propose the following policies that are negatively impacting lung disease patients, patients at risk of lung disease and others who have serious or chronic conditions. Table 2 contains a list of policies proposed and approved by states or CMS.

Emergency Department Copayment

Some states are proposing to impose an additional copay for patients whenever they go to the Emergency Department (ED), or if the patient goes to the ED for a condition that was deemed non-emergent or did not require an admission. These policies discourage patients from seeking needed care. It is often difficult for a lay person to determine if chest pains are a heart attack, indigestion or a panic attack. Patients should not be required to make the judgement calls to determine if a condition is life-threatening or not.

Enrollment Limit

Enrollment limits set a cap on the number of individuals that can be enrolled in a Medicaid program. Some states are proposing to cap enrollment for specific groups of Medicaid eligible individuals. Capping enrollment would limit some patients' access to critical treatment when they need it most. For example, an asthma patient who tries to enroll in Medicaid but is denied coverage because the state has hit an enrollment cap could be unable to get the inhaler she needs to breathe.

Limiting EPSDT Benefits

Children receiving healthcare as part of the Medicaid program have special protections to ensure they get the appropriate treatment. The Early and Periotic Screening, Diagnostic and Treatment (EPSDT) benefit ensures children can access certain screenings, services or treatments that are medically necessary, even if they are not normally covered under a state's Medicaid program for adults. Some states are proposing to limit these benefits to children 18 and under, limiting the benefit for 19- and 20-year-olds. This limitation could reduce older children's access to needed healthcare services at a critical time in their development. For example, a 19-year-old asthma patient could lose access to services like allergen immunotherapy to control his or her asthma.

Limiting Medicaid Expansion Eligibility

Some states that have accepted the enhanced federal matching funds made available for Medicaid expansion under the Affordable Care Act have proposed rolling back Medicaid eligibility to 100 percent of the Federal Poverty Level while retaining the enhanced match. States argue that this population can be served by the

marketplace. While this may be true for some, state experience has shown that many will get lost in the transition.[14] Under any scenario, a rollback of Medicaid eligibility would reduce the number of people with comprehensive healthcare coverage. Some patients might be able to obtain other healthcare coverage, but Medicaid provides important services, such as non-emergency transportation benefits, and limits cost-sharing to help patients adhere to their treatment that coverage on the individual market does not provide. Most importantly, patients could be unable to afford other coverage and become uninsured, as marketplace coverage can still be too expensive for patients at lower incomes even with the advanced premium tax credits.

Monthly Premiums

Many states are using 1115 waivers to request and impose enforceable premiums, in some cases only for populations with incomes above 100 percent of the FPL and in other cases for populations with incomes below 100 percent of the FPL as well. Research is clear that charging premiums to low-income persons will result in a loss of coverage.[15] Patients could risk completely losing coverage or losing access to certain benefits for failure to pay.[16] Ending coverage for lung disease patients who cannot afford their premiums will negatively impact their prognosis and may result in less use of preventive and primary care and more costly treatment in the emergency room. For example, a patient with asthma could lose access to their controller medications or rescue inhaler and end up in the emergency department with an asthma attack.

Prescription Drug Access

Another proposal would change prescription drug coverage in Medicaid. Currently, all the states that chose to provide prescription drug coverage in their Medicaid programs participate in the Drug Rebate Program. This program allows states to take advantage of drug discounts from drug manufacturers, provided they cover all the manufacturers' drugs, with the exception of drugs on the exclusion list. One state, Massachusetts, requested additional authority to have a closed formulary and not cover certain drugs, as well as allow the state or managed care plan to only cover one drug per class, in an attempt to negotiate larger discounts. The state would set up an exceptions process to cover drugs outside of the formulary when medically necessary.[17]

This is incredibly problematic for lung disease patients in the Medicaid program. Unlike individuals who are privately insured, Medicaid enrollees do not have opportunity to shop around for a plan that covers the appropriate medications and treatments. Patients could therefore lose access to lifesaving treatments. For example, lung cancer patients need very individualized treatments based on their tumor type, but the necessary immunotherapy drug might not be covered under this proposal. Additionally, an exceptions process could be extremely difficult for patients, especially patients with low literacy, to navigate, again compromising access to care. On June 27, 2018, CMS rejected Massachusetts's proposal to limit prescription drug coverage in Medicaid.[18] Other states are still publicly contemplating similar requests.[19]

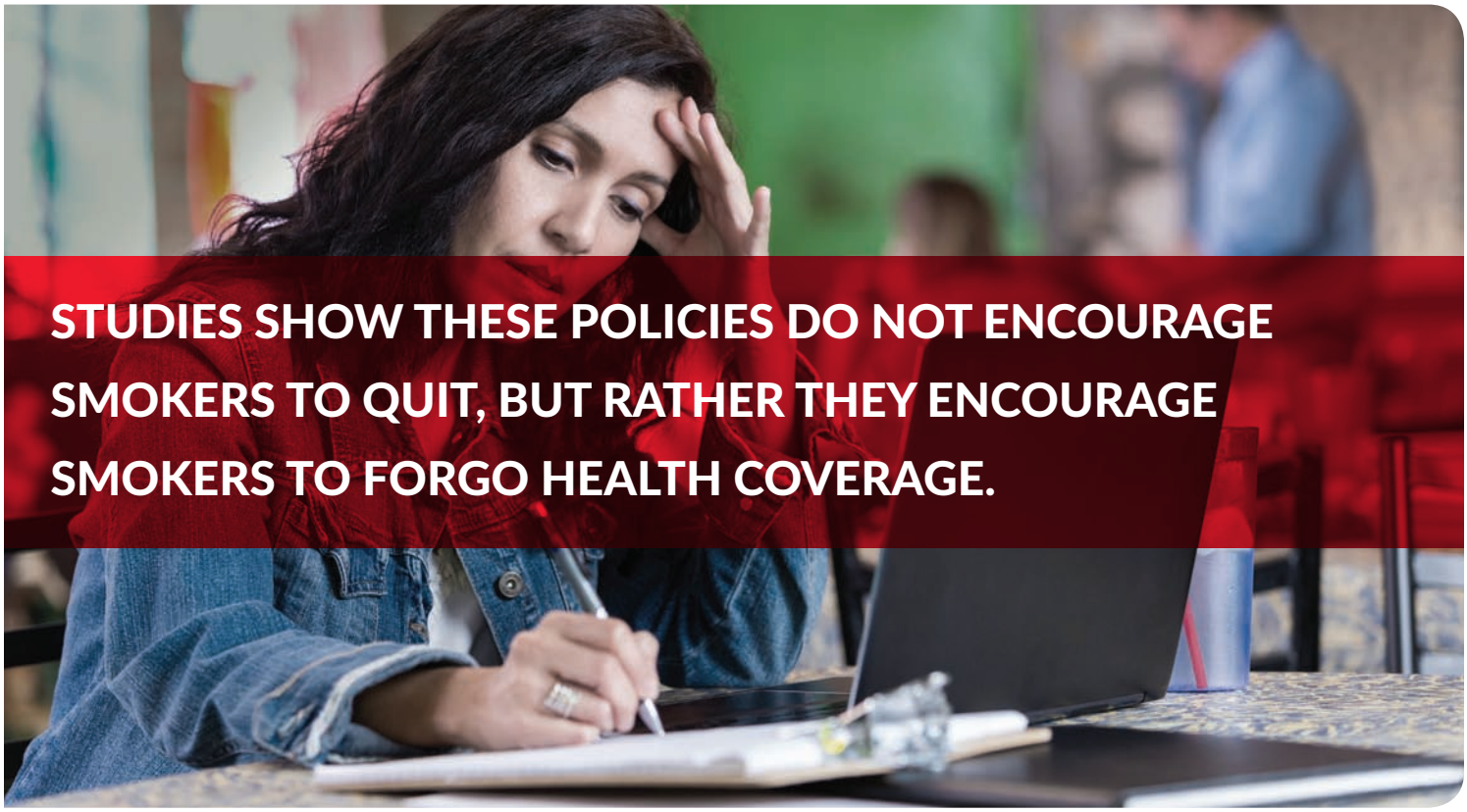
Removal of Non-Emergent Transportation Benefits
Some states are proposing to remove their non-emergent transportation benefits. This benefit helps Medicaid enrollees get transportation to their medical appointments so they can manage their conditions and stay healthy. Without this benefit, enrollees may forgo appointments due to lack of travel funds and delay getting needed care. This delay could also result in patients needing more expensive treatments at the ED in the future.

Removal of Retroactive Coverage
Medicaid programs are required to cover three months of retroactive coverage for Medicaid enrollees. This provision helps protect Medicaid enrollees from medical debt, including those who might have missed a re-enrollment, or those who didn't know they qualified for Medicaid until they got sick. Without this benefit, patients could face unaffordable healthcare bills or delay getting treatment when they need it.

Time Limits on Coverage
Time limit proposals would cap the number of months a person can be enrolled in a state's Medicaid program consecutively or impose a lifetime limit. Lung disease patients need access to continuous coverage, but this proposal could result in patients losing coverage at a critical point in their illness when they need it most. For example, a lung cancer patient could be forced out of the Medicaid program during the middle of chemotherapy and stop treatment because he is unable to obtain other affordable coverage.

Tobacco Surcharge

Quitting smoking is incredibly difficult. It can often take seven or more tries to quit permanently. Some states are proposing and implementing a tobacco surcharge or "non-smoker discount" as part of a broader healthy behavior or wellness program. Both have the same effect on patients – individuals who smoke have to pay more for health coverage than their counterparts who do not. Studies show these policies do not encourage smokers to quit, but rather they encourage smokers to forgo health coverage.[20] This policy would make health coverage too expensive for enrollees who need coverage and help quitting, leading more patients to potentially develop lung disease and other conditions linked to tobacco use and increasing the burden of tobacco-related diseases on the U.S. healthcare system.



Work Requirements

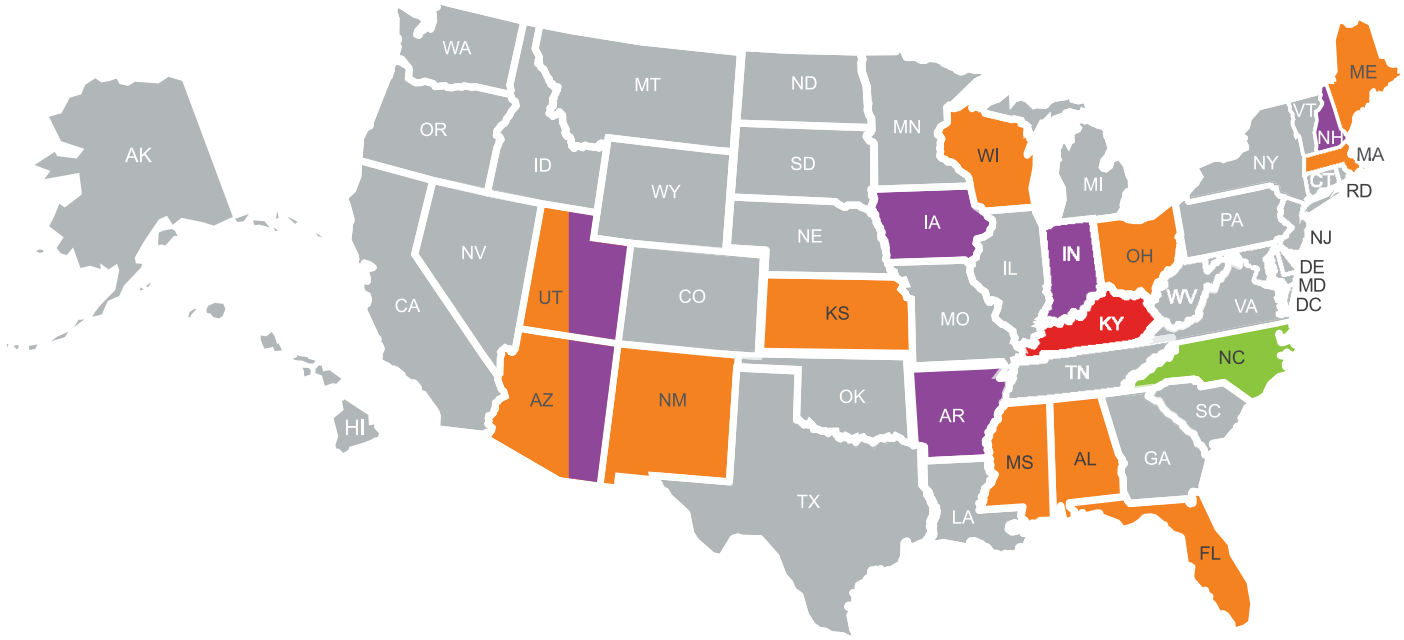
These requirements would end coverage for patients unless they prove that they work or volunteer a certain number of hours per week. These proposals would result in patients losing healthcare coverage. Research shows that expanding (not limiting) healthcare coverage through Medicaid leads to higher employment.[21] Another major consequence of this requirement would be to increase the administrative burden on all enrollees, regardless of whether or not they qualify for an exemption, as well as on state employees. Some states that have not expanded Medicaid are seeking to impose work requirements on very low-income parents. Such a policy targets the very poorest families in these states and could be harmful to children as well, as uninsured parents are more likely to have uninsured children, resulting in less access to care.[22] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Table 2: Barriers to Coverage by State for Waivers Submitted to or Approved by CMS January 2017-June 2018

State	ED Copays	Enrollment Limits	Limited Expansion	Enforceable Premiums	Rx Drug Limits	Eligibility Time Limits	Removing Retroactive Coverage	Removing Non-Emergent Transportation Benefits	Limiting EPSDT	Tobacco Surcharge	Work Requirements
Alabama[23]											Proposed
Arizona[24,25,26]				Approved		Proposed	Proposed				Proposed
Arkansas[27,28]			Not Approved	Approved			Approved				Approved
Florida[29]							Proposed				
Indiana[30]	Approved			Approved			Approved	Approved		Approved	Approved
Iowa[31]	Approved						Approved	Approved			
Kansas[32,33]						Not Approved					Proposed
Kentucky[34]				Approved but currently blocked by U.S. District Court for the District of Columbia			Approved but currently blocked by U.S. District Court for the District of Columbia	Approved but currently blocked by U.S. District Court for the District of Columbia			Approved but currently blocked by U.S. District Court for the District of Columbia
Maine[35]	Proposed			Proposed		Proposed	Proposed				Proposed
Massachusetts[36]			Not Approved		Not Approved						
Mississippi[37]											Proposed
New Hampshire[38,39]							Approved				Approved
New Mexico[40]	Proposed			Proposed			Proposed		Proposed		
North Carolina[41]				Proposed							Proposed
Ohio[42]											Proposed
Utah[43,44]	Proposed	Proposed	Proposed			Proposed	Approved		Proposed		Proposed
Wisconsin[45]	Proposed			Proposed		Proposed				Proposed	Proposed

- Approved
- Proposed
- Not Approved
- Approved but currently blocked by U.S. District Court for the District of Columbia

Figure 1: States with 1115 Waivers that Put Coverage at Risk for Patients



- **States with proposed waivers that would put health coverage at risk for patients**
- **States with proposed waivers that risk patients' health coverage, conditional on expansion of the Medicaid program.**
- **States with an approved waiver that puts patients' health coverage at risk.**
- **States with an approved waiver that puts patients' health coverage at risk, but the waiver has been blocked by the U.S. District Court for the District of Columbia.**

States are only included in this map if they submitted an 1115 Waiver application (including amendments) to CMS or had a waiver application under review by CMS between January 1, 2017 and June 30, 2018.

Table 3: Population Targeted by State*

State	Population Targeted
Alabama Status: Pending	**Work Requirement:** Standard non-disabled Medicaid enrollees under the age of 60 (Parents with a dependent child, making 18 percent FPL or less)[46]
Arizona Status: Approved in Part, Pending in Part	**Work Requirement** (pending)**:** Both standard and Medicaid expansion non-disabled enrollees under the age of 55 **Time Limits** (pending)**:** Both standard and Medicaid expansion non-disabled enrollees **Removal of Retroactive Coverage** (pending)**:** Both standard and Medicaid expansion enrollees **Enforceable Premiums** (approved)**:** Enrollees between 100 and 138 percent FPL[47,48,49]
Arkansas Status: Approved in Part, Denied in Part	**Work Requirement** (approved)**:** Both standard and expansion non-disabled enrollees aged 19 to 49 years old with incomes up to and including 138 percent of FPL **Removal of Retroactive Coverage** (approved)**:** Both standard and Medicaid expansion non-disabled enrollees **Enforceable Premiums** (approved)**:** Enrollees between 100 and 138 percent FPL **Limiting eligibility to 100 percent FPL** (denied)**:** All enrollees[50]
Florida Status: Pending	**Removal of Retroactive Coverage:** All non-pregnant Medicaid enrollees aged 21 and older[51]
Indiana Status: Approved	**Work Requirement:** All members aged 19-59 **Enforceable Premiums:** Medicaid expansion enrollees with incomes over 100 percent of FPL **Tobacco Surcharge:** Medicaid expansion enrollees with incomes over 100 percent of FPL **Removal of Non-Emergent Transportation Benefits:** All non-pregnant, non-medically frail standard and Medicaid expansion enrollees **Co-Pay for Non-Emergent Use of Emergency Department:** All enrollees **Waiving Retroactive Coverage:** All non-pregnant standard and Medicaid expansion enrollees[52]
Iowa Status: Approved	**Co-Pay for Non-Emergent Use of Emergency Department:** All enrollees **Removal of Retroactive Coverage:** All non-pregnant standard and Medicaid expansion enrollees **Removal of Non-Emergent Transportation Benefits:** Medicaid expansion population (New Adult Population)[53]

Table 3: Population Targeted by State*

State	Population Targeted
Kansas Status: Pending (Denied in Part)	**Work Requirements** (pending)**:** Adults under the age of 65 **Lifetime Limits** (denied)**:** Adults under the age of 65[54]
Kentucky Status: Approved	**Work Requirement:** All adult enrollees **Removal of Non-Emergent Transportation Benefits:** Medicaid expansion population (New Adult Population) **Removal of Retroactive Coverage:** All Medicaid enrollees except former foster youth and pregnant women **Enforceable Premiums:** All Medicaid enrollees except medically frail, former foster youth and pregnant women[55]
Maine Status: Pending	**Work Requirement:** All enrollees **Enforceable Premiums:** All enrollees over 50 percent FPL except HIV Waiver enrollees **Removal of Retroactive Coverage:** All enrollees **Enhanced Cost-Sharing for Non-Emergent use of ED:** All enrollees **Lifetime Limits:** All enrollees[56]
Massachusetts Status: Approved in Part, Denied in Part	**Limiting eligibility to 100 percent FPL** (denied)**:** All enrollees **Prescription Drug Limits** (denied)**:** All enrollees[57]
Mississippi Status: Pending	**Work Requirements:** All non-disabled adults[58]
New Hampshire Status: Approved	**Work Requirements:** All non-disabled, non-pregnant adults, aged 19-64 **Retroactive Coverage:** Medicaid expansion population[59]
New Mexico Status: Pending	**Enforceable Premiums:** Medicaid expansion population above 100 percent FPL **Removal of Retroactive Coverage:** Medicaid expansion population above 100 percent FPL **Limiting EPSDT:** Individuals in the adult expansion population and the parent/caregiver categories aged 19 and 20 **Penalty for Non-Emergent use of ED:** All members[60]

Table 3: Population Targeted by State*

State	Population Targeted
North Carolina Status: Pending	**Work Requirement:** All enrollees not caring for a minor child, receiving active treatment, or the medically frail within 100 percent FPL **Premiums:** Enrollees above 50 percent FPL[61]
Ohio Status: Pending	**Work Requirement:** All enrollees under age 50.[62]
Utah Status: Partially Approved, Partially Pending	**Removing Retroactive Eligibility** (approved)**:** Non-disabled members 19-64 years old at or below 100 percent FPL **Work Requirements** (pending)**:** Primary Care Network enrollees under age 60 **Time Limits** (pending)**:** Primary Care Network enrollees and adults without dependent children **Penalty for Non-Emergent use of ED** (pending)**:** Parent/ Caretaker/ Relative Group (current eligibles) **Enrollment Caps** (pending)**:** Adults without dependent children, specifically the chronically homeless; individuals involved in the justice system and needing mental health or substance abuse treatment; and individuals needing substance use or mental health treatment **Limiting eligibility to 100 percent FPL** (pending): All enrollees **Limiting EPSDT** (pending)**:** Individuals aged 19 and 20 without dependent children[63,64]
Wisconsin Status: Pending	**Work Requirements:** Non-pregnant, childless adults, ages 19 to 64 years old, whose income does not exceed 100 percent FPL **Enforceable Premium:** Non-pregnant, childless adults, ages 19 to 64 years old, whose income does not exceed 100 percent FPL **Tobacco Surcharge:** Non-pregnant, childless adults, ages 19 to 64 years old, whose income does not exceed 100 percent FPL **Time Limit:** Non-pregnant, childless adults, ages 19 to 64 years old, whose income does not exceed 100 percent FPL **Penalty for Non-Emergent use of ED:** Non-pregnant, childless adults, ages 19 to 64 years old, whose income does not exceed 100 percent FPL[65]

*Information in the table is only included if a state submitted an 1115 Waiver application (including amendments) to CMS or was under review by CMS between January 1, 2017 and June 30, 2018.
Most states exempt certain subgroups from these requirements, based on age, disability or hardship.

[1]Centers for Medicare & Medicaid Services, About Section 1115 Demonstrations, Accessed June 19, 2018 at https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.
[2]Department of Health and Human Services, Secretary Price and CMS Administrator Verma Take First Joint Action: Affirm Partnership of HHS, CMS, and States to Improve Medicaid Program, March 14, 2017. Available at https://www.hhs.gov/about/news/2017/03/14/secretary-price-and-cms-administrator-verma-take-first-joint-action.html.
[3]Centers for Medicare & Medicaid Services, CMS Announces New Policy Guidance for States to Test Community Engagement for Able-bodied Adults, Jan. 11, 2018. Available at https://www.cms.gov/Newsroom/Media ReleaseDatabase/Press-releases/2018-Press-releases-items/2018-01-11.html.
[4]Commonwealth of Kentucky Office of the Governor, Kentucky HEALTH 1115 Demonstration Modification Request, July 3, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf.
[5]Stewart et al v. Azar, Brief for Deans, Chairs, and Scholars as Amici Curiae in Support of Plaintiffs, United States District Court for the District of Columbia, April 10, 2018. Available at: https://publichealth.gwu.edu/sites/default/files/downloads/HPM/Kentucky%20Medicaid%20Proposed%20Amici%20Curiae%20Brief.pdf.
[6]State of Alabama, Medicaid Workforce Initiative Section 1115 Demonstration Application, Feb. 27 2018. Available at http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.5_Work_ Requirements/2.7.5_Final_Work_Requirements_Waiver_Bookmarked_2-27-18.pdf.
[7]Letter from Health Groups to William Snyder, Director, Medical Services, South Dakota Department of Social Services, May 23, 2018. Available at http://www.lung.org/assets/documents/advocacy-archive/partners-letter-to-sd-dss-re-1115-proposal.pdf; Letter from Health Groups to Nick Lyon, Director, Michigan Department of Health and Human Services, July 9, 2018. Available at http://www.lung.org/assets/documents/advocacy-archive/partners-letter-to-mi-dhhs-re-1115-waiver.pdf.
[8]Benjamin Hardy, "Medicaid advocate criticizes Arkansas Works' email-only reporting for work requirements," Arkansas Times, April 28, 2018. Available at https://www.arktimes.com/ArkansasBlog/archives/2018/04/28/ medicaid-advocate-criticizes-arkansas-works-email-only-reporting-for-work-requirements; Broadband Now, Broadband Internet Access in Arkansas, Nov. 30, 2017. Available at https://broadbandnow.com/Arkansas.
[9]Dan Goldberg, "More than one quarter of eligible Arkansans didn't comply with Medicaid work requirements," Politico Pro, July 13, 2018. Available at "http://go.politicoemail.com/?qs=5a78155b84772e2456f6be88cf4633b208a989cefdbc940ab68af0f63b195857ad856962ea783ec9bd7899147395d76d" https://subscriber.politicopro.com/health-care/whiteboard/2018/07/more-than-one-quarter-of-eligible-arkansans-fail-to-comply-with-new-work-requirements-1576218.
[10]Senate Fiscal Agency, Bill Analysis for SB 897, March 21, 2018, Available at http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-0897-S.pdf; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018. Available at http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, Feb. 26, 2018. Available at https://www.rollcall.com/news/politics/medicaid-kentucky.
[11]Stewart, et al v. Azar (Civil Action No. 18-152 (JEB)) (United States District Court for the District of Columbia June 29, 2018). Available at: https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74
[12]Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 1, 2017. Available at https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.
[13]Office of the Assistant Secretary for Planning and Evaluation, Poverty Guidelines, Jan. 13, 2018. Available at https://aspe.hhs.gov/poverty-guidelines.
[14]Kate Lewandowski, "Parent Eligibility Roll-Back in Rhode Island: Causes, Effects and Lessons Learned," September 2015. Available at https://www.communitycatalyst.org/resources/publications/document/RI-parent-rollback-081215-KL.pdf?1439834245; Langer, S. et al. Husky Program Coverage for Parents: Most Families Will Feel the Full Impact of Income Eligibility Cut Later In 2016, April 2016, Available at http://www.ctvoices.org/sites/default/files/h16HUSKYIncomeEligibilityCut.pdf; Guy Boulton, "One-third who lost BadgerCare coverage bought plans on federal marketplace," Journal Sentinel, July 16, 2014. Available at http://archive.jsonline.com/business/almost-19000-badgercare-plus-recipients-enrolled-in-obamacare-b99312352z1-267339331.html.
[15]Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 1, 2017. Available at https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.
[16]The Lewin Group, Health Indiana Plan 2.0: POWER Account Contribution Assessment (March 31, 2017). Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf
[17]Commonwealth of Massachusetts Executive Office of Health and Human Services, Massachusetts Section 1115 Demonstration Project, Sept. 8, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-pa3.pdf.
[18]Centers for Medicare & Medicaid Services, Approval for MassHealth, June 27, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf.
[19]Arizona Health Care Cost Containment System, Letter to CMS, November 17, 2017. Available at https://www.azahcccs.gov/shared/Downloads/News/FlexibilitiesLetterFinal_11172017.pdf.
[20]Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540 Accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract.
[21]Arisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, "The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review," Kaiser Family Foundation, June 20, 2016. Available at http://kff.org/ medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/.
[22]Georgetown University Center for Children and Families, Health Coverage for Parents and Caregivers Helps Children, March 2017. Available at https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf.
[23]State of Alabama, Medicaid Workforce Initiative Section 1115 Demonstration Application, Feb. 27 2018. Available at http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.5_Work_

[24]Arizona Health Care Cost Containment System, Arizona Section 1115 Waiver Amendment Request – AHCCCS Works Waiver, Dec. 19, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa6.pdf.
[25]Arizona Health Care Cost Containment System, Arizona Section 1115 Waiver Amendment Request: Proposal to Waive Prior Quarter Coverage, April 6, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa7.pdf.
[26]Centers for Medicare & Medicaid Services, Approval for Arizona Health Care Cost Containment System, Dec. 29, 2017. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf
[27]Arkansas Department of Human Services, Arkansas Works Section 1115 Demonstration, June 30, 2017. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-pa2.pdf.
[28]Centers for Medicare & Medicaid Services, Approval of Arkansas Works, March 5, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf.
[29]State of Florida Agency for Health Care Administration, Florida 1115 Managed Medical Assistance Waiver, May 7, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf.
[30]Centers for Medicare & Medicaid Services, Approval for Healthy Indiana Plan (HIP), Feb. 1, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.
[31]Centers for Medicare & Medicaid Services, Approval for Iowa Wellness Plan Section 1115 Demonstration, October 27, 2017. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf
[32]Kansas Office of the Lieutenant Governor, KanCare 2.0 Program, Dec. 26, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-pa3.pdf.
[33]Centers for Medicare & Medicaid Services, KanCare Medicaid Demonstration, May 7, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-cms-admin-ltr-state-05072018.pdf.
[34]Centers for Medicare & Medicaid Services, Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH), Jan. 12, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.
[35]Maine Department of Health and Human Services, MaineCare 1115 Waiver Application, Aug. 1, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-mainecare-pa.pdf.
[36]Centers for Medicare & Medicaid Services, Approval for MassHealth Medicaid Section 1115 Demonstration, June 27, 2018. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf
[37]Mississippi Division of Medicaid, Medicaid Workforce Training Initiative 1115 Demonstration Waiver Application, Oct. 27, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-workforce-training-initiative-pa.pdf.
[38]State of New Hampshire Office of the Governor, New Hampshire Health Protection Program Premium Assistance 1115 Demonstration, Oct. 24, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa3.pdf.
[39]Centers for Medicare & Medicaid Services, Approval for New Hampshire Health Protection Program Premium Assistance, May 7, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf.
[40]State of New Mexico, Section 1115 Demonstration Waiver Renewal Application for Centennial Care, Dec. 6, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf.
[41]Office of the Governor State of North Carolina, Section 1115 Demonstration Waiver Application, Nov. 20, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-pa2.pdf.
[42]Ohio Department of Medicaid, Group VIII Work Requirement and Community Engagement Section 1115 Demonstration Proposal, April 30, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-community-engagement-pa.pdf.
[43]Utah Department of Health Division of Medicaid and Health Financing, Aug. 15, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa3.pdf.; Utah Department of of Health Division of Medicaid and Health Financing. 1115 Primary Care Network Demonstration Waiver: Adult Expansion Amendment Request. June 22, 2018. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa4.pdf
[44]Centers for Medicare & Medicaid Services, Utah Section 1115 Primary Care Network (PCN) Demonstration Approval, Oct. 31, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf.
[45]State of Wisconsin Department of Health Services, Request to Amend Wisconsin's Section 1115 BadgerCare Reform Demonstration Project, June 7, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-pa.pdf.
[46]State of Alabama, Medicaid Workforce Initiative Section 1115 Demonstration Application, Feb. 27 2018. Available at http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.5_Work_Requirements/2.7.5_Final_Work_Requirements_Waiver_Bookmarked_2-27-18.pdf; State of Alabama, Medicaid Workforce Initiative Section 1115 Demonstration Application, June 29, 2018. Available at http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.5_Work_Requirements/2.7.5_Alabama_Medicaid_Workforce_Initiative_1115_Application_6-29-18.pdf.
[47]Arizona Health Care Cost Containment System, Arizona Section 1115 Waiver Amendment Request – AHCCCS Works Waiver, Dec. 19, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa6.pdf.
[48]Arizona Health Care Cost Containment System, Arizona Section 1115 Waiver Amendment Request: Proposal to Waive Prior Quarter Coverage, April 6, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa7.pdf.
[49]Centers for Medicare & Medicaid Services, Approval for Arizona Health Care Cost Containment System, Dec. 29, 2017. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf
[50]Centers for Medicare & Medicaid Services, Approval of Arkansas Works, March 5, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf.
[51]State of Florida Agency for Health Care Administration, Florida 1115 Managed Medical Assistance Waiver, May 7, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf.

[52]Centers for Medicare & Medicaid Services, Approval for Healthy Indiana Plan (HIP), Feb. 1, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.
[53]Centers for Medicare & Medicaid Services, Approval for Iowa Wellness Plan Section 1115 Demonstration, October 27, 2017. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf
[54]Kansas Office of the Lieutenant Governor, KanCare 2.0 Program, Dec. 26, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-pa3.pdf.
[55]Centers for Medicare & Medicaid Services, Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH), Jan. 12, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.
[56]Maine Department of Health and Human Services, MaineCare 1115 Waiver Application, Aug. 1, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-mainecare-pa.pdf.
[57]Commonwealth of Massachusetts Executive Office of Health and Human Services, Massachusetts Section 1115 Demonstration Project, Sept. 8, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-pa3.pdf.
[58]Mississippi Division of Medicaid, Medicaid Workforce Training Initiative 1115 Demonstration Waiver Application, Oct. 27, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-workforce-training-initiative-pa.pdf.
[59]Centers for Medicare & Medicaid Services, Approval for New Hampshire Health Protection Program Premium Assistance, May 7, 2018. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf.
[60]State of New Mexico, Section 1115 Demonstration Waiver Renewal Application for Centennial Care, Dec. 6, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf.
[61]Office of the Governor State of North Carolina, Section 1115 Demonstration Waiver Application, Nov. 20, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-pa2.pdf.
[62]Ohio Department of Medicaid, Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver Application, April 30, 2018. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-community-engagement-pa.pdf.
[63]Centers for Medicare & Medicaid Services, Utah Section 1115 Primary Care Network (PCN) Demonstration Approval, Oct. 31, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf.
[64]Utah Department of Health Division of Medicaid and Health Financing, Aug. 15, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa3.pdf.; Utah Department of of Health Division of Medicaid and Health Financing. 1115 Primary Care Network Demonstration Waiver: Adult Expansion Amendment Request. June 22, 2018. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa4.pdf
[65]State of Wisconsin Department of Health Services, Request to Amend Wisconsin's Section 1115 BadgerCare Reform Demonstration Project, June 7, 2017. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-pa.pdf.

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January 30, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Centennial Care 2.0 1115 Waiver Renewal Application

Dear Secretary Azar:

Thank you for the opportunity to submit comments on the Centennial Care 2.0 1115 Waiver Renewal application.

The nine undersigned organizations represent millions of patients facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the patients that it serves.

Our organizations are committed to ensuring that Medicaid offers patients **adequate, affordable and accessible health care coverage**. We share the goals New Mexico outlined in its waiver application, however we believe there are some policy proposals included that will harm the patients our organizations represent. We provide the Department of Health and Human Services (HHS) with the following comments and recommendations regarding the New Mexico Medicaid waiver.

<u>Provisions to Advance Health</u>
Our organizations are pleased to see many proposals in this waiver that will advance the health of patients and ease the burden of caretakers, including proposals for coordinated care and integration of physical and behavioral health, which can help patients better manage their disease. Our organizations

are also pleased to see the state incentivizing evidence-based treatments, and maintaining all of the current protections for Native Americans. The inclusion of a pilot home visiting program for prenatal, post-partum and early childhood development services in New Mexico's request demonstrate how state flexibility and innovation can help patients.

Enforceable Premiums

While the Centennial Care 2.0 1115 Waiver seeks to impose premiums on enrollees, our organizations commend the state for thoughtfully considering the feedback received at the state level and limiting the populations impacted by the premiums. However, our organizations believe that the premiums will still be a barrier to get healthcare for the population impacted, including individuals with pre-existing conditions and urge that the enforceable premium proposal be rejected.

The waiver proposal seeks to impose enforceable premiums for the population between 101 percent and 138 percent of the Federal Poverty Level ($12,060 - $16,644 for an individual). These premiums would start at $10 per month and increase to $20 per month. These amounts are substantial for a person or family making this little, potentially making coverage unaffordable for those who need it most.

The enforceable monthly premium would harm all eligible enrollees, but could be particularly harmful to patients with a chronic disease. Many patients can be treated effectively, but only if they participate in continuous treatment, including actively taking medications and using life-saving devices. A gap in coverage could make a treatable disease life-threatening. For patients with cancer, a gap in coverage could be a death sentence. Enforceable premiums could delay or halt care leading to poor health outcomes or even death.

A report prepared for the Indiana Family and Social Services Administration (FSSA) by the Lewin Group found that 29 percent of Indiana's Heathy Indiana Plan (HIP) 2.0 enrollees failed to pay their premiums and were dis-enrolled in the HIP 2.0 program resulting in poorer coverage or no coverage depending on income level.[i] Our organizations are concerned that the proposal put forward by New Mexico could result in a similar situation. New Mexico provided no evidence that the enrollees would be able to pay these premiums and as such, our organizations urge HHS to reject the enforceable premium proposal in the Centennial Care 2.0 waiver.

New Cost Sharing

The Centennial Care 2.0 1115 Waiver requests authority to impose new cost sharing on enrollees. This new cost sharing would impose significant barriers to care for all enrollees, including and especially for patients with chronic and serious health conditions.

New Mexico is requesting to impose a $25 fee for non-emergent use of the emergency department. Even with strong safeguards, patients will be deterred from seeking care at the emergency department when they are in life-threatening situations. For example, a patient experiencing chest pains might be having a heart attack but delay seeking care at the emergency department because of concerns about being charged a co-pay if the condition is less serious. It is important that patients not be deterred from seeking care out of fear of a co-pay. Therefore, we urge HHS not to grant New Mexico the authority to impose this fee.

New Mexico is also seeking the authority to impose "no-show" fees for missed appointments. It is vital for patients, especially those with chronic illnesses, to keep medical appointments, but low-income

patients face a variety of economic and health challenges that may make missing an appointment unavoidable. We ask HHS to not grant the state this new authority.

Removal of Retroactive Eligibility

The Centennial Care 2.0 1115 Waiver proposes to waive the three-month retroactive eligibility policy that allows Medicaid to cover patient costs prior to enrollment if patients met eligibility criteria during that time. Medicaid enrollment and re-enrollment can be difficult to navigate. The three-months of retroactive coverage can prevent patients from going into bankruptcy when diagnosed with a costly illness. The patients represented by our organizations benefit from this eligibility and we urge HHS to keep retroactive eligibility in place.

Our organizations ask HHS to reject these specific policies outlined and work with New Mexico to successfully implement the rest of the Centennial Care 2.0 1115 waiver. Thank you for reviewing our comments. Our organizations appreciate the opportunity to provide feedback on this application.

Sincerely,
American Diabetes Association
American Heart Association
American Lung Association
Arthritis Foundation
Family Voices
Lutheran Services of America
March of Dimes
National Multiple Sclerosis Society
National Organization for Rare Disorders

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

[i] *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment* Prepared by the Lewin Group, Inc. March 31, 2017; https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf

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June 2017 | Issue Brief

The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings

Samantha Artiga, Petry Ubri, and Julia Zur

Key Findings

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. This brief reviews research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. This research has primarily focused on how premiums and cost sharing affect coverage and access to and use of care; some studies also have examined effects on safety net providers and state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts. Together, the research finds:

- **Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.** These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty. Some individuals losing Medicaid or CHIP coverage move to other coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.
- **Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.** Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.
- **State savings from premiums and cost sharing in Medicaid and CHIP are limited.** Research shows that potential revenue gains from premiums and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses. Studies also show that raising premiums and cost sharing in Medicaid and CHIP increases pressures on safety net providers, such as community health centers and hospitals.

Introduction

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. Proponents of increasing premiums and cost sharing in Medicaid indicate that doing so will promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions.[1]

This brief, which updates an earlier brief "*Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*," reviews research on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. It draws on findings from 65 papers published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations. This research has primarily focused on how premiums and cost sharing affect coverage and access to care; some studies also have examined effects on state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts.

Premiums and Cost Sharing in Medicaid and CHIP Today

Currently, states have options to charge premiums and cost sharing in Medicaid and CHIP that vary by income and eligibility group (Box 1). Reflecting these options, premiums and cost sharing in Medicaid and CHIP vary across states and groups. As of January 2017, 30 states charge premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or CHIP.[2] Most of these charges are limited to children in CHIP since the program covers children with higher family incomes than Medicaid and has different premium and cost sharing rules. States generally do not charge premiums for parents in Medicaid, but 39 states charge cost sharing for parents and 23 of the 32 states that implemented the Affordable Care Act (ACA) Medicaid expansion to low-income adults charge cost sharing for expansion adults.[3] Six states have waivers to charge premiums or monthly contributions for adults that are not otherwise allowed.[4]

Box 1: Medicaid and CHIP Premium and Cost Sharing Rules

Medicaid

- States may charge premiums for enrollees with incomes above 150% of the federal poverty level (FPL), including children and adults. Enrollees with incomes below 150% FPL may not be charged premiums.
- States may charge cost sharing up to maximums that vary by income (Table 1). States cannot charge cost sharing for emergency, family planning, pregnancy-related services, preventive services for children, or preventive services defined as essential health benefits in Alternative Benefit Plans in Medicaid. In addition, states generally cannot charge cost sharing to children enrolled through mandatory eligibility categories. The minimum eligibility standard for children is 133% FPL, although some states have higher minimums.
- Overall, premium and cost sharing amounts for family members enrolled in Medicaid may not exceed 5% of household income. This 5% cap is applied on a monthly or quarterly basis.

CHIP

- States have somewhat greater flexibility to charge premiums and cost sharing for children in CHIP, although there are limits on the amounts that states can charge, including an overall cap of 5% of household income.

Table 1: Maximum Allowable Cost Sharing Amounts in Medicaid by Income

	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of state cost	20% of state cost
Non-Emergency use of ER	$8	$8	No limit (subject to overall 5% of household income limit)
Prescription Drugs			
Preferred	$4	$4	$4
Non-Preferred	$8	$8	20% of state cost
Inpatient Services	$75 per stay	10% of state cost	20% of state cost

Notes: Some groups and services are exempt from cost sharing, including children enrolled in Medicaid through mandatory eligibility pathways, emergency services, family planning services, pregnancy related services, and preventive services for children. Maximum allowable amounts are as of FY2014. Beginning October 1, 2015, maximum allowable amounts increase annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

Effects of Premiums (Table 1)

A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals. Studies show that premiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults.[5,6,7,8,9,10] Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid and CHIP.[11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39]

Although some individuals who disenroll from Medicaid or CHIP following premium increases move to other sources of coverage, others become uninsured and face negative effects on their access to care and financial security. Those with lower incomes and those without a worker in the family are more likely to become uninsured compared to those with relatively higher incomes or with a worker in the family, reflecting less availability of employer coverage.[40,41,42,43,44,45,46,47,48,49] Studies also show that those who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens.[50,51,52,53,54] Several studies suggest that these negative effects on health care are largest among individuals with greater health care needs.[55,56]

Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty. Given that most states limit premium charges to children in CHIP, most studies of premium effects have focused on children in CHIP, who generally have incomes above 100% or 150% of the federal poverty level. A range of these studies show that premium effects are larger among children at the lower end of this income range, who have greater disenrollment and increased likelihood of becoming uninsured.[57,58,59,60,61,62,63,64,65] Reflecting the more limited use of premiums among Medicaid enrollees with incomes below poverty, fewer studies have focused on this population. However, studies that have focused on poor Medicaid enrollees found substantial negative effects on enrollment from premiums.[66,67,68,69] For example, in Oregon, nearly half of adults disenrolled from Medicaid after a premium increase with a maximum premium amount of $20, with many becoming uninsured and facing barriers to accessing care, unmet health needs, and increased financial burdens.[70,71,72] Similarly, a more recent study of the Healthy Indiana Plan waiver program for Medicaid expansion adults with incomes below 138% FPL, which requires premiums that range from $1-$100 to enroll in a more comprehensive plan, found that 55% of eligible individuals either did not make their

initial payment or missed a payment.[73] Research also finds that premium effects may vary by other factors beyond income. For example, one study finds larger effects of premiums among families without an offer of employer-sponsored coverage.[74] Some research also suggests that increases in Medicaid and CHIP premiums may have larger effects on coverage for children of color and among children whose families have lower levels of educational attainment.[75,76,77]

Research finds varying implications of premiums for individuals with significant health needs. Overall, individuals with greater health needs are less likely to disenroll from Medicaid or CHIP coverage and are more likely to have longer periods of Medicaid or CHIP coverage compared to those with fewer health needs.[78,79,80,81] However, findings vary regarding how individuals with health needs respond to premium increases. Some studies show that individuals with greater health needs are less sensitive to premium increases compared to those with fewer health needs, reflecting their increased need for services.[82,83] These findings suggest that individuals with greater health needs are more likely than those with less significant health needs to remain enrolled following premium increases, but then face increased financial burdens to maintain their coverage. Other studies find that children with increased health needs are as likely or more likely than those with fewer health needs to disenroll from coverage following premium increases, suggesting premiums may lead to children going without coverage despite ongoing health needs.[84,85]

Effects of Cost Sharing (Table 2)

A wide range of studies find that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services. The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, shows a reduction in use of services after cost sharing increased, regardless of income.[86] Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services,[87] including vaccinations,[88] prescription drugs,[89,90,91,92] mental health visits,[93] preventive and primary care,[94,95,96,97,98] and inpatient and outpatient care,[99,100] and decreased adherence to medications.[101,102,103] In many of these studies, copayment increases as small as $1-$5 can effect use of care. Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals.[104,105] Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room.[106] Two studies have found that copayments do not negatively affect utilization.[107,108] In one case, the authors suggest that increases in provider reimbursement may have negated effects of the copayment increases, particularly if not all copayments were being collected by providers at the point of care.[109]

Research points to varying effects of cost sharing for people with significant health needs. Some studies find that utilization among individuals with chronic conditions or significant health needs is less sensitive to copayments compared to those with fewer health needs. As such, these individuals face increased cost burdens associated with accessing care because of copayment increases.[110,111] Other research finds that even relatively small copayments can reduce utilization among individuals with significant health needs.[112,113,114]

Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families.[115,116,117,118,119,120,121,122] For example, studies have found that increases in cost sharing are associated with increased rates of

uncontrolled hypertension and hypercholesterolemia[123] and reduced treatment for children with asthma.[124] Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small copayments can add up quickly when an individual needs ongoing care or multiple medications.[125,126]

Findings on how cost sharing affects non-emergent use of the emergency room are limited. One study found that these copayments reduce non-urgent visits.[127] Other studies find that these copayments do not affect use of the emergency room.[128,129]

Effects on State Budgets and Providers (Table 3)

Research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited. Studies find that potential increases in revenue from premium and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses.[130,131,132,133,134,135,136] One state study found increased revenues from premiums without significant effects on enrollment, but authors note a range of program-specific factors that may have contributed to this finding, including it being limited to a Medicaid-buy in program for individuals with disabilities with incomes above 150% FPL who may be less price-sensitive to the increase and the state implementing administrative processes designed to minimize disenrollment.[137]

Studies also show that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety net providers, such as community health centers and hospitals. Several studies show that coverage losses following premium increases lead to increases in the share of uninsured patients seen by providers[138,139,140] and increased emergency department use by uninsured individuals.[141,142] One study also found that increases in copayments led to community health centers having to divert resources for medications for uninsured individuals to help people who could not afford copayments and that copayments increased the rate of "no shows" for appointments at community health centers.[143]

Conclusion

Recently, there has been increased interest at the federal and state levels to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. This review of a wide body of research provides insight into the potential effects of increasing premiums and cost sharing for Medicaid enrollees. It shows that premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and that even relatively small levels of cost sharing reduce utilization of services. As such, increases in premiums and cost sharing result in increased barriers to coverage and care, greater unmet health needs, and increased financial burdens for families. Further, the research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited and that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety-net providers.

Endnotes

[1] See Maine Department of Health and Human Services, 1115 Waiver Application, http://www.maine.gov/dhhs/oms/documents/Draft_MaineCare_1115_application.pdf; State of Wisconsin BadgerCare Reform Demonstration Project, Coverage of Adults Without Dependent Children with Income at or Below 100 Percent of the Federal Poverty Level, Draft 1115 Demonstration Waiver Amendment Application, https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-app.pdf; Office of the Governor, Kentucky Health: Helping to Engage and Achieve Long Term Health, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf; and Indiana Family and Social Services Administration, Health Indiana Plan (HIP) Section 1115 Waiver Extension Application, https://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf.

[2] Tricia Brooks, et. al., *Medicaid and HCIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2017: Findings form a 50-State Survey,* (Washington, DC: Kaiser Family Foundation, January 2017), http://kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-introduction/.

[3] Ibid.

[4] Ibid.

[5] Gery P Guy, et. al., "The Role of Public and Private Insurance Expansions and Premiums for Low-Income Parents: Lessons from State Experiences," Medical Care 55, 3 (March 2017):236-243.

[6] Salam Abdus, et. al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, no.8 (August 2014): 1353-1360.

[7] Carole R Gresenz, Sarah E Edgington, Miriam J Laugesen and Jose J Escarce, "Income Eligibility Thresholds, Premium Contributions, and Children's Coverage Outcomes: A Study of CHIP Expansions," *Health Services Research* 48:2, Part II (April 2013):884-902.

[8] Gery P Guy, Jr., E. Kathleen Adams, and Adam Atherly, "Public and Private Health Insurance Premiums: How do they Affect Health Insurance Status of Low-Income Childless Adults?" *Inquiry* 49 (Spring 2012):52-64.

[9] Jack Hadley, et. al., "Insurance Premiums and Insurance Coverage of Near-Poor Children," *Inquiry* 43, 4 (Winter 2006/2007).

[10] Genevieve Kenney, Jack Hadley, and Fredric Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43 (Winter 2006/2007):345-361.

[11] The Lewin Group, Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA), (Washington, DC: Lewin Group, March 2017).

[12] MaryBeth Musumeci, et. al., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, (Washington, DC: Kaiser Family Foundation, January 2017), http://kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/.

[13] James Marton et. al., "Estimating Premium Sensitivity for Children's Public Health Insurance Coverage: Selection but No Death Spiral," *Health Services Research* 50, 2 (April 2015): 579-598.

[14] Laura Dague, "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach," *Journal of Health Economics* 37 (May 2014): 1-12.

[15] Michael Hendryx, et al., "Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program," *Social Work in Public Health*, 27, 7 (2012):671-686.

[16] Michael M Morrisey, et.al., "The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program," *Medicare & Medicaid Research Review* 2,3 (2012):E1-E17.

[17] Bill J Wright, et. al., "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs*, 29, 12 (December 2010):2311-2316.

[18] Michael R Cousineau, Kai-Ya Tsai, and Howard A Kahn, "Two Responses to a Premium Hike in a Program for Uninsured Kids: 4 in 5 Families Stay In as Enrollment Shrinks by a Fifth," *Health Affairs* 31, 2 (February 2012):360-366.

[19] James Marton, Patricia G Ketsche, and Mei Zhou, "SCHIP Premiums, Enrollment, and Expenditures: A Two State, Competing Risk Analysis," *Health Economics* 19 (2010):772-791.

[20] James Marton and Jeffery C Talbert, "CHIP Premiums, Health Status, and the Insurance Coverage of Children," *Inquiry* 47, 3 (Fall 2010):199-214.

[21] Stephen Zuckerman, Dawn M Miller, and Emily Shelton Page, "Missouri's 2005 Medicaid Cuts: How Did they Affect Enrollees and Providers?" *Health Affairs* 28, 2, (2009):w335-w345.

[22] Jill B Herndon, W Bruce Vogel, Richard L Bucciarelli and Elizabeth A Shenkman, "The Effect of Premium Changes on SCHIP Enrollment Duration," Health Services Research 43, 2 (April 2008):458-477.

[23] James Marton, "The Impact of the Introduction of Premiums into a SCHIP Program," *Journal of Policy Analysis and Management* 26 (2007):237-255.

[24] Genevieve Kenney, et. al., "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research* 42, 6 Part 2 (2007):2354-2372.

[25] Gina A Livermore, et. al., "Premium Increases in State Health Insurance Programs: Lessons from a Case Study of the Massachusetts Medicaid Buy-in Program," *Inquiry* 44 (Winter 2007):428-442.

[26] Genevieve Kenney, et. al., "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States," *Inquiry*, 43, 4 (Winter 2006/2007):378-92.

[27] Tricia J Johnson, Mary Rimsza, and William G Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health,* 96, 4 (April 2006):709-715.

[28] Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

[29] Matthew J Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations,* Paper 14 (March 2005).

[30] Rachel Solotaroff, et. al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan," *Chronic Illness* 1, (2005): 191-205.

[31] Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).

[32] Utah Department of Health Center for Health Data, *Utah Primary Care Network Disenrollment Report*, (Salt Lake City, UT: Utah Department of Health Center for Health Data, Office of Health Care Statistics, August 2004).

[33] Mark Gardner and Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*, (Washington, DC: Kaiser Family Foundation, May 2004).

[34] Maryland Department of Health and Mental Hygiene, *Maryland Children's Health Insurance Program: Assessment of the Impact of Premium*s, (Baltimore, MD: Department of Health and Mental Hygiene, April 2004).

[35] John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan*, Prepared for the Office for Oregon Health Policy & Research, (Portland, OR: Oregon Health & Science University, February 2004.

[36] Norma I Gavin, et. al., *Evaluation of the BadgerCare Medicaid Demonstration*, Prepared by RTI International and MayaTech Corp. for the Centers for Medicare & Medicaid Services, (Research Triangle Park, NC: RTI International and MayaTech Corporation, December 2003).

[37] Monette Goodrich, Joan Alker, and Judith Solomon, *Families at Risk: The Impact of Premiums on Children and Parents in Husky A, Policy Brief* (Washington, DC: Georgetown Center for Children and Families, November 2003), http://ccf.georgetown.edu/wp-content/uploads/2012/03/Far%20-%20impact%20of%20premiums.pdf.

[38] Elizabeth Shenkman, et. al., "Disenrollment and Re-Enrollment Patters in a SCHIP Program," *Health Care Financing Review* 23, 3 (Spring 2002):47-63.

[39] Leighton Ku and Teresa A Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36, 4 (Winter 1999/2000).

[40] Gery P Guy, et. al., "The Role of Public and Private Insurance Expansions and Premiums for Low-Income Parents: Lessons from State Experiences," Medical Care 55, 3 (March 2017):236-243.

[41] Salam Abdus, et. al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, no.8 (August 2014): 1353-1360.

[42] Carole R Gresenz, Sarah E Edgington, Miriam J Laugesen and Jose J Escarce, "Income Eligibility Thresholds, Premium Contributions, and Children's Coverage Outcomes: A Study of CHIP Expansions," *Health Services Research* 48:2, Part II (April 2013):884-902.

[43] Bill J Wright, et. al., "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs*, 29, 12 (December 2010):2311-2316.

[44] James Marton, Patricia G Ketsche, and Mei Zhou, "SCHIP Premiums, Enrollment, and Expenditures: A Two State, Competing Risk Analysis," *Health Economics* 19 (2010):772-791.

[45] Genevieve Kenney, et. al., "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research* 42, 6 Part 2 (2007):2354-2372.

[46] Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

[47] Matthew J Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations,* Paper 14 (March 2005).

[48] Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).

[49] Utah Department of Health Center for Health Data, *Utah Primary Care Network Disenrollment Report*, (Salt Lake City, UT: Utah Department of Health Center for Health Data, Office of Health Care Statistics, August 2004).

[50] Michael Hendryx, et al., "Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program," *Social Work in Public Health*, 27, 7 (2012):671-686.

[51] Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

[52] Matthew J Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations,* Paper 14 (March 2005).

[53] Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).

[54] Utah Department of Health Center for Health Data, *Utah Primary Care Network Disenrollment Report*, (Salt Lake City, UT: Utah Department of Health Center for Health Data, Office of Health Care Statistics, August 2004).

[55] Matthew J Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations,* Paper 14 (March 2005).

[56] Rachel Solotaroff, et. al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan," *Chronic Illness* 1, (2005): 191-205.

[57] Gery P Guy, et. al., "The Role of Public and Private Insurance Expansions and Premiums for Low-Income Parents: Lessons from State Experiences," Medical Care 55, 3 (March 2017):236-243.

[58] Genevieve Kenney, Jack Hadley, and Fredric Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43 (Winter 2006/2007):345-361.

[59] Michael M Morrisey, et.al., "The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program," *Medicare & Medicaid Research Review* 2,3 (2012):E1-E17.

[60] Jill B Herndon, W Bruce Vogel, Richard L Bucciarelli and Elizabeth A Shenkman, "The Effect of Premium Changes on SCHIP Enrollment Duration," Health Services Research 43, 2 (April 2008):458-477.

[61] Genevieve Kenney, et. al., "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States," *Inquiry*, 43, 4 (Winter 2006/2007):378-92.

[62] Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

[63] Matthew J Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations,* Paper 14 (March 2005).

[64] Rachel Solotaroff, et. al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan," *Chronic Illness* 1, (2005): 191-205.

[65] John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan*, Prepared for the Office for Oregon Health Policy & Research, (Portland, OR: Oregon Health & Science University, February 2004.

[66] The Lewin Group, Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA), (Washington, DC: Lewin Group, March 2017).

[67] Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

[68] Matthew J Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations,* Paper 14 (March 2005).

[69] Office of the Executive Director, *2003 Utah Public Health Outcome Measures Report,* (Salt Lake City, UT: UT Department of Health, December 2003), http://www.hpm.umn.edu/ ambul_db/db/pdflibrary/ DBfile_49007.pdf

[70] Rachel Solotaroff, et. al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan," *Chronic Illness* 1, (2005): 191-205.

[71] Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).

[72] John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan*, Prepared for the Office for Oregon Health Policy & Research, (Portland, OR: Oregon Health & Science University, February 2004.

[73] The Lewin Group, Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA), (Washington, DC: Lewin Group, March 2017).

[74] Salam Abdus, et. al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, no.8 (August 2014): 1353-1360.

[75] Genevieve Kenney, Jack Hadley, and Fredric Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43 (Winter 2006/2007):345-361.

[76] Michael M Morrisey, et.al., "The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program," *Medicare & Medicaid Research Review* 2,3 (2012):E1-E17.

[77] Genevieve Kenney, et. al., "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States," *Inquiry*, 43, 4 (Winter 2006/2007):378-92.

[78] James Marton et. al., "Estimating Premium Sensitivity for Children's Public Health Insurance Coverage: Selection but No Death Spiral," *Health Services Research* 50, 2 (April 2015): 579-598.

[79] Michael M Morrisey, et.al., "The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program," *Medicare & Medicaid Research Review* 2,3 (2012):E1-E17.

[80] James Marton and Jeffery C Talbert, "CHIP Premiums, Health Status, and the Insurance Coverage of Children," *Inquiry* 47, 3 (Fall 2010):199-214.

[81] Jill B Herndon, W Bruce Vogel, Richard L Bucciarelli and Elizabeth A Shenkman, "The Effect of Premium Changes on SCHIP Enrollment Duration," Health Services Research 43, 2 (April 2008):458-477.

[82] Ibid.

[83] Rachel Solotaroff, et. al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan," *Chronic Illness* 1, (2005): 191-205.

[84] James Marton et. al., "Estimating Premium Sensitivity for Children's Public Health Insurance Coverage: Selection but No Death Spiral," *Health Services Research* 50, 2 (April 2015): 579-598.

[85] Michael M Morrisey, et.al., "The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program," *Medicare & Medicaid Research Review* 2,3 (2012):E1-E17.

[86] Joseph P Newhouse and the Insurance Experiment Group, *Free For All? Lessons from the RAND Health Insurance Experiment*, (Arlington, VA, RAND, 1993).

[87] Amitabh Chandra, Jonathan Gruber and Robin McKnight, "The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts," *Journal of Health Economics* 33 (2014): 57-66.

[88] Charles Stoecker, Alexandra M Stewart, and Megan C Lindley, "The Cost of Cost-Sharing: The Impact of Medicaid Benefit Design on Influence Vaccination Uptake," *Vaccines* 5, 8, (March 2017).

[89] Bisakha Sen, et. al., "Can Increases in CHIP Copayments Reduce Program Expenditures on Prescription Drugs?" *Medicare & Medicaid Research Review* 4, 2 (May 2014).

[90] Bisakha Sen, et. al., "Did Copayment Changes Reduce Health Service Utilization among CHIP Enrollees? Evidence from Alabama," *Health Services Research* 47, 4 (September 2012):1303-1620.

[91] Daniel M Hartung, et. al., "Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-service Medicaid Population," *Medical Care* 46, 6 (June 2008):565-572.

[92] Office of the Executive Director, *2003 Utah Public Health Outcome Measures Report,* (Salt Lake City, UT: UT Department of Health, December 2003), http://www.hpm.umn.edu/ ambul_db/db/pdflibrary/ DBfile_49007.pdf

[93] Ibid.

[94] Bisakha Sen, et. al., "Did Copayment Changes Reduce Health Service Utilization among CHIP Enrollees? Evidence from Alabama," *Health Services Research* 47, 4 (September 2012):1303-1620.

[95] Bill J Wright, et. al., "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs*, 29, 12 (December 2010):2311-2316.

[96] Leighton Ku, et. al., *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*, (Washington, DC: Center on Budget and Policy Priorities, November 2004).

[97] Gery P Guy Jr., "The Effects of Cost Sharing on Access to Care among Childless Adults." *Health Services Research,* 45, 6 Pt. 1 (December 2010): 1720-1739.

[98] Vicki Fung, et. al., "Financial Barriers to Care Among Low-Income Children with Asthma: Health Care Reform Implications," *JAMA Pediatrics* 168, 7 (July 2014):649-656.

[99] Office of the Executive Director, *2003 Utah Public Health Outcome Measures Report,* (Salt Lake City, UT: UT Department of Health, December 2003), http://www.hpm.umn.edu/ ambul_db/db/pdflibrary/ DBfile_49007.pdf

[100] Leighton Ku, et. al., *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*, (Washington, DC: Center on Budget and Policy Priorities, November 2004).

[101] Deliana Kostova and Jared Fox, "Chronic Health Outcomes and Prescription Drug Copayments in Medicaid," *Medical Care*, published ahead of print (February 2017).

[102] Marisa Elena Domino, et. al., "Increasing Time Cost and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment," *Health Services Research* 46, 3 (June 2011):900-919.

[103] Joel F Farley, "Medicaid Prescription Cost Containment and Schizophrenia: A Retrospective Examination," *Medical Care* 48, 5 (May 2010): 440-447.

[104] Bisakha Sen, et. al., "Can Increases in CHIP Copayments Reduce Program Expenditures on Prescription Drugs?" *Medicare & Medicaid Research Review* 4, 2 (May 2014).

[105] Michael Chernew, et. al., "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care," *Journal of General Internal Medicine* 23, 8 (August 2008):1131-1136.

[106] Sujha Subramanian, "Impact of Medicaid Copayments on Patients with Cancer," *Medical Care* 49, 9 (September 2011): 842-847.

[107] Office of the Executive Director, *2003 Utah Public Health Outcome Measures Report,* (Salt Lake City, UT: UT Department of Health, December 2003), http://www.hpm.umn.edu/ ambul_db/db/pdflibrary/ DBfile_49007.pdf

[108] James Marton, et. al., "The Effects of Medicaid Policy Changes on Adults' Service Use Patterns in Kentucky and Idaho," *Medicare & Medicaid Research Review* 2, 4 (February 2013).

[109] Ibid.

[110] Bisakha Sen, et. al., "Can Increases in CHIP Copayments Reduce Program Expenditures on Prescription Drugs?" *Medicare & Medicaid Research Review* 4, 2 (May 2014).

[111] Amitabh Chandra, Jonathan Gruber and Robin McKnight, "The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts," *Journal of Health Economics* 33 (2014): 57-66.

[112] Deliana Kostova and Jared Fox, "Chronic Health Outcomes and Prescription Drug Copayments in Medicaid," *Medical Care,* published ahead of print (February 2017).

[113] Sujha Subramanian, "Impact of Medicaid Copayments on Patients with Cancer," *Medical Care* 49, 9 (September 2011): 842-847.

[114] Daniel M Hartung, et. al., "Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-service Medicaid Population," *Medical Care* 46, 6 (June 2008):565-572.

[115] Deliana Kostova and Jared Fox, "Chronic Health Outcomes and Prescription Drug Copayments in Medicaid," *Medical Care,* published ahead of print (February 2017).

[116] Jessica Greene, Rebecca M Sacks, and Sara B McMenamin, "The Impact of Tobacco Dependence Treatment Coverage and Copayments in Medicaid," *American Journal of Preventive Medicine* 46, 4 (April 2014):331-336.

[117] Vicki Fung, et. al., "Financial Barriers to Care Among Low-Income Children with Asthma: Health Care Reform Implications," *JAMA Pediatrics* 168, 7 (July 2014):649-656.

[118] Leah Zallman, et. al., "Affordability of Health Care Under Publicly Subsidized Insurance After Massachusetts Health Care Reform: A Qualitative Study of Safety Net Patients," *International Journal for Equity in Health* 14 (October 2015):112.

[119] Leah Zallman, et.al., "Perceived Affordability of Health Insurance and Medical Financial Burdens Five Years in to Massachusetts Health Reform," *International Journal for Equity in Health* 14 (October 2015):113.

[120] Bill J Wright, et. al., "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs*, 29, 12 (December 2010):2311-2316.

[121] Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).

[122] Office of the Executive Director, *2003 Utah Public Health Outcome Measures Report,* (Salt Lake City, UT: UT Department of Health, December 2003), http://www.hpm.umn.edu/ ambul_db/db/pdflibrary/ DBfile_49007.pdf

[123] Deliana Kostova and Jared Fox, "Chronic Health Outcomes and Prescription Drug Copayments in Medicaid," *Medical Care,* published ahead of print (February 2017).

[124] Vicki Fung, et. al., "Financial Barriers to Care Among Low-Income Children with Asthma: Health Care Reform Implications," *JAMA Pediatrics* 168, 7 (July 2014):649-656.

[125] Peter J Cunningham, *Affording Prescription Drugs: Not Just a Problem for the Elderly,* (Washington, DC: Center for Studying Health System Change, April 2002), http://www.hschange.org/CONTENT/430/430.pdf.

[126] Rachel Solotaroff, et. al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan," *Chronic Illness* 1, (2005): 191-205.

[127] Lindsay M Sabik and Sabina Ohri Gandhi, "Copayments and Emergency Department use Among Adult Medicaid Enrollees," *Health Economics* 25 (May 2016):529-542.

[128] Karoline Mortensen, "Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments," *Health Affairs* 29, 9 (September 2010): 1643-1650.

[129] Mona Siddiqui, Eric T Roberts, and Craig E Pollack, "The Effects of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005," *JAMA Internal Medicine* 175,3 (March 2015):393-398.

[130] Bisakha Sen, et. al., "Health Expenditure Concentration and Characteristics of High-Cost Enrollees in CHIP," *Inquiry* 53 (May 2016):1-9.

[131] Marisa Elena Domino, et. al., "Increasing Time Cost and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment," *Health Services Research* 46, 3 (June 2011):900-919.

[132] Maryland Department of Health and Mental Hygiene, *Estimated Medicaid Savings and Program Impacts of Service Limitations, Copayments, and Premiums,* (Baltimore, MD: Maryland Department of Health and Mental Hygiene, December 2010), https://mmcp.dhmh.maryland.gov/Documents/medicaidsavingsJCRfinal12-10.pdf.

[133] Health Management Associates, *Co-pays for Nonemergent Use of Hospital Emergency Rooms: Cost Effectiveness and Feasibility Analysis*, Prepared for the Texas Health and Human Services Commission, (Austin, TX: Health and Human Services Commission, May 2008).

[134] Neal T Wallace, et. al., "How Effective are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan," *Health Services Research* 43, 3 (April 2008):515-530.

[135] Arizona Health Care Cost Containment System, *Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005,* (Phoenix, AZ: Arizona Health Care Cost Containment System, December 2006), http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf.

[136] Steven Crawford and Garth L Splinter, *It's Health Care, Not Welfare: Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program,* Prepared for the Oklahoma Health Care Authority, (Oklahoma City, OK: Oklahoma Health Care Authority, January 2004).

[137] Gina A Livermore, et. al., "Premium Increases in State Health Insurance Programs: Lessons from a Case Study of the Massachusetts Medicaid Buy-in Program," *Inquiry* 44 (Winter 2007):428-442.

[138] Stephen Zuckerman, Dawn M Miller, and Emily Shelton Page, "Missouri's 2005 Medicaid Cuts: How Did they Affect Enrollees and Providers?," *Health Affairs* 28, 2, (2009):w335-w345.

[139] Mark Gardner and Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*, (Washington, DC: Kaiser Family Foundation, May 2004).

[140] Pamela Hines, et. al., *Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impact in Multnomah and Washington Counties*, Prepared for Office for Oregon Health Policy & Research, (Salem, OR: Office for Oregon Health Policy & Research, December 2003).

[141] Robert A Lowe, et. al. "Impact of Medicaid Cutbacks on Emergency Department Use: The Oregon Experience," *Annals of Emergency Medicine* 52, 6 (December 2008):626-534.

[142] Mark Gardner and Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*, (Washington, DC: Kaiser Family Foundation, May 2004).

[143] Pamela Hines, et. al., *Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impact in Multnomah and Washington Counties*, Prepared for Office for Oregon Health Policy & Research, (Salem, OR: Office for Oregon Health Policy & Research, December 2003).

Healthy Indiana Plan 2.0: POWER Account Contribution Assessment

Prepared for:

Indiana Family and Social Services Administration (FSSA)

Submitted by:

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Executive Summary

The purpose of this report is to assess the Healthy Indiana Plan (HIP) 2.0's POWER Account Contribution (PAC) policy, specifically the affordability of PAC and the effect of the disenrollment-for-non-payment-of-PAC policy on enrollment. Under HIP 2.0, members receive an HSA-like account — called a "Personal Wellness and Responsibility" or "POWER" Account — to pay for services until they meet the deductible on their health plan. Members are encouraged to make monthly contributions to their POWER Accounts. Members who make these monthly contributions are enrolled in HIP Plus, a plan with enhanced benefits — such as dental and vision coverage — that does not require co-payments for services. Members who do not make these contributions are either: 1) moved from HIP Plus into a more limited benefit plan, HIP Basic, if the member's income is at or below 100 percent of the Federal Poverty Level (FPL) or; 2) not enrolled in or disenrolled from HIP 2.0 coverage if the member's income is above 100 percent of the FPL.[1]

Individuals with incomes above 100 percent of the FPL who do not make their *first* PAC are not initially enrolled in HIP coverage, and are referred to as "Never Members" by the Indiana Family and Social Services Administration (FSSA). Individuals with incomes above 100 percent of the FPL who do not make *subsequent* PAC are disenrolled from coverage and are referred to as "Leavers" by Indiana FSSA. Leavers who are enrolled in HIP Plus prior to disenrollment are subject to a six-month disenrollment period; they can submit a new application during this disenrollment period and be considered for other Medicaid programs, but will not be eligible for HIP. Leavers who are enrolled in HIP Basic prior to disenrollment are not subject to a six-month disenrollment period from HIP; they may reapply before six months have passed and be considered eligible for HIP.[2]

Individuals Not Enrolled or Disenrolled Due to Non-payment of PAC

- **Never Members:** Individuals with incomes above 100 percent of the FPL who are not initially enrolled in HIP coverage because they do not make their *first* PAC
- **Leavers:** Individuals with incomes above 100 percent of the FPL who are fully enrolled in HIP but are later disenrolled from HIP coverage because they do not make *subsequent* PAC

This report reflects available data spanning the beginning of the HIP 2.0 demonstration on February 1, 2015 through December 1, 2016. Key findings and the relevant timeframe for each of the six research questions are reported below. The Final Evaluation Report to be submitted to CMS in 2018 will reexamine these issues using data from two and a half years of program experience.

[1] Individuals with incomes at or below 100 percent of the FPL who never make a PAC are never fully enrolled in HIP Plus; they are enrolled in HIP Basic after their payment deadline passes. The following eligibility categories are exempt from disenrollment even if they have incomes above 100 percent of the FPL and do not make PAC: pregnant women, Native Americans, medically frail individuals and Transitional Medical Assistance (TMA) participants.

[2] In general, Basic members cannot be disenrolled due to non-payment because their incomes are at or below 100 percent of the FPL. However, if a Basic member's income increases to above 100 percent of the FPL, he or she is no longer eligible for Basic, and must make a PAC to enroll in Plus coverage. If he or she does not make a PAC, he or she is disenrolled from coverage.

Key Findings

Research Question 1: How many individuals lost HIP Plus coverage due to non-payment of the PAC?

Between February 1, 2015 and November 30, 2016, 9,636 unique individuals with incomes above 100 percent of the FPL were disenrolled from HIP *Plus* coverage due to non-payment of PAC and subject to a six-month disenrollment period. This represents five percent of individuals during the timeframe who could be disenrolled or not enrolled due to non-payment of PAC.[3] An additional 3,914 individuals with incomes above 100 percent of the FPL were disenrolled from HIP *Basic* coverage due to non-payment of PAC, or two percent of individuals during the timeframe who could be disenrolled or not enrolled due to non-payment of PAC. These individuals were no longer eligible for HIP Basic because their incomes increased to above 100 percent of the FPL, and therefore they were required to make a PAC to remain enrolled in HIP. They are not subject to a six-month disenrollment period because they were enrolled in HIP Basic, not HIP Plus, prior to disenrollment. These two groups sum to a total of 13,550 unique individuals disenrolled from HIP coverage for not making PAC, referred to as "Leavers" throughout this report. Leavers represent seven percent of individuals who could be disenrolled or not enrolled due to non-payment.

An additional 46,176 individuals were not initially enrolled in HIP because they did not make their first PAC, referred to as "Never Members." Never Members represent 23 percent of individuals who could be disenrolled or not enrolled due to non-payment during the timeframe.[4]

Together, these counts of Leavers and Never Members sum to 57,189 unique members disenrolled or not enrolled due to non-payment, which represents 29 percent of individuals who could be disenrolled or not enrolled due to non-payment during the timeframe.[5]

Research Question 2: How many individuals requested a waiver from the six-month disenrollment period?

Between February 1, 2015 and December 1, 2016, 230 members requested a waiver from the six-month disenrollment period; 201 (87 percent) of whom received a waiver.

Research Question 3: How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER account contributions?

From January 1, 2016 through September 30, 2016, 5,770 members received help paying their PAC. This represents 1.5 percent of members who ever made a PAC. Fifty-seven of these members received help from an employer (less than one percent of members who ever made a PAC) and 5,713 received help from a non-profit organization (1.5 percent of members who ever made a PAC).

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[3] Individuals can be disenrolled or not enrolled for non-payment if they have incomes above 100 percent of the FPL and are not pregnant, Native American, medically frail or a TMA participant.

[4] 2,537 individuals were both Never Members and Leavers in this time period, meaning that they applied and did not make their first payment, then reenrolled, but then subsequently stopped making payments and were disenrolled as a result (or vice versa).

[5] This figure (29 percent) is less than the sum of the percentages reported previously (30 percent) because some individuals were both Leavers and Never Members during the timeframe.

Research Question 4: How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?

Members enrolled in HIP coverage as of November 2016 (in HIP Plus or HIP Basic) and disenrolled individuals as of November 2016 (Leavers and Never Members) were asked a series of survey questions to gauge their perceptions of PAC affordability.[6]

Plus Members and Leavers were asked how often they were worried about having enough money to pay their PAC.

- Among all HIP Plus Member respondents, 59 percent (n=204) reported that they "rarely" or "never" worried about having enough money to pay PAC.
    - Breaking these results out by income level, this is 60 percent (n=107) of HIP Plus Member respondents with incomes at or below 100 percent of the FPL and 53 percent (n=97) of HIP Plus Member respondents with incomes above 100 percent of the FPL.
- On the other hand, 15 percent (n=59) reported that they "always" or "usually" worried about having enough money to pay PAC.
    - By income level, this is 15 percent (n=26) of HIP Plus Member respondents with incomes at or below 100 percent of the FPL and 18 percent (n=33) of HIP Plus Member respondents with incomes above 100 percent of the FPL.
- Leaver respondents were most likely to report worrying about having enough money to pay PAC, with 38 percent (n=53) reporting that they "rarely" or "never" worried and 41 percent (n=57) indicating that they "always" or "usually" worried.

Basic and Plus Members were also asked about their willingness to pay a small amount each month to remain enrolled. The vast majority of Plus and Basic Member respondents reported that they would be willing to pay $5 to stay enrolled, ranging from 83 percent among Always Basic Member respondents to 92 percent among Previously Plus Basic Member respondents. Among Plus Member respondents, 85 percent of HIP Plus Member respondents with incomes at or below 100 percent of the FPL reported that they would be willing to pay $5 more, compared to 86 percent of HIP Plus Member respondents with incomes above 100 percent of the FPL.

Basic Members, Leavers, and Never Members were also asked the main reason that they did not make – or stopped making – their PAC.

- The most common reason cited for non-payment among Basic and Leaver respondents was that they "could not afford to pay the contribution," with 34 percent and 44 percent citing this reason, respectively.
- Among Never Member respondents, the two most common reasons cited for not making payments were "I could not afford to pay the contribution," (22 percent) and "I was confused about the payment process (I wasn't sure how much to pay, when to pay, where to pay)" (22 percent).

[6] In total, 400 Basic Members, 389 Plus Members, 202 Leavers, and 200 Never Members completed the survey. The survey was administered from December 2016 through January 2017.

Research Question 5: How are individuals accessing health care if they are disenrolled due to non-payment of the PAC?

Both enrolled and disenrolled individuals were asked a series of survey questions about access to care. Respondents were first asked whether they made an appointment for routine care or specialized care, or filled a prescription, in the past six months. Leavers who disenrolled from the program fewer than six months previously were asked about use of services since leaving HIP. Leaver and Never Member respondents were less likely than Plus and Basic Member respondents to report making appointments both for routine and specialty care. Leavers and Never Member respondents were also less likely to report filling a prescription in the past six months or since leaving HIP.

Respondents who indicated that they had made appointments or filled a prescription were asked how often they could get an appointment "as soon as needed" or how often it was easy to fill a prescription.

- For routine care, Leaver respondents were less likely than Plus, Basic, and Never Member respondents to report that they could "always" or "usually" get a routine appointment as soon as needed.
  - Fifty-eight percent (n=43) of Leaver respondents could "always" or "usually" get routine appointments as soon as needed, compared to 73 percent (n=53) of Never Member respondents, 74 percent (n=174) of Basic Member respondents and 76 percent (n=232) of Plus Member respondents.
- For prescriptions, Leaver and Never Member respondents were less likely than Plus and Basic Member respondents to report that it was "always" or "usually" easy to fill a prescription.
  - Sixty-nine percent (n=47) of Leaver respondents and 76 percent (n=58) of Never Member respondents reported that it was "always" or "usually" easy to fill a prescription, compared to 85 percent (n=191) of Basic Member respondents and 92 percent (n=254) of Plus Member respondents.

Disenrolled individuals were also asked whether they had insurance coverage at the time of the survey. Forty-seven percent (n=94) of Leaver respondents and 41 percent (n=82) of Never Member respondents reported that they had insurance coverage. Insurance from their own employer was the most common source of coverage reported among insured Leavers and Never Members, with 59 percent (n=55) of insured Leavers and 56 percent (n=46) of insured Never Members reporting coverage from their employer.

Research Question 6: Was the disenrollment period a deterrent for individuals with incomes over 100 percent FPL to miss a PAC?

In order for the disenrollment period to serve as a deterrent for non-payment of PAC, HIP members must understand that they will be disenrolled for non-payment of PAC. The survey asked respondents if they were aware that they would be disenrolled from HIP if they did not make a PAC.

- Eighty-five percent of HIP Plus Member respondents with incomes above 100 percent of the FPL, i.e., members who are maintaining PAC and could be disenrolled due to non-payment, reported being aware that they could be disenrolled for non-payment of PAC.
- Sixty-seven percent of Leaver respondents and 59 percent of Never Member respondents, i.e., members who did not make PAC and were disenrolled or not enrolled as a result, reported being aware that they could be disenrolled or not enrolled for non-payment of PAC.

I. Introduction and Background

Introduction

The goal of this report - ***Indiana HIP 2.0: POWER Account Contribution Assessment*** - is to assess the Healthy Indiana Plan (HIP) 2.0's POWER Account Contribution (PAC) policy. Per the Special Terms and Conditions (STCs) for Indiana's Section 1115 Demonstration, Indiana must conduct an independent evaluation of the PAC policy that assesses the following (see **Appendix A**):

- The affordability of POWER Account contributions; and
- The effect of the disenrollment-for-non-payment-of-PAC policy on enrollment.

Further, the STCs specify that the evaluation must use the results of a survey of enrolled and disenrolled individuals, including both individuals who are never fully enrolled due to non-payment of PAC and those who are fully enrolled but later disenrolled due to non-payment of PAC, and other available data.

The Indiana Family and Social Services Administration (FSSA) engaged the Lewin Group (Lewin) to conduct this assessment.

Background

HIP 2.0 members are enrolled in a high deductible health plan (HDHP), administered by a Managed Care Entity (MCE). Members receive an HSA-like account — called a "Personal Wellness and Responsibility" or "POWER" Account — to pay for services until they meet the deductible on their health plan.[7]

Members are encouraged to make monthly contributions to their POWER Accounts.[8] These contributions — called POWER Account Contributions or "PAC" — are indexed to two percent of a member's household income, with a minimum contribution of $1 per month and a maximum contribution of $100 per month.[9] Members who make these monthly contributions are enrolled in HIP Plus, a plan with enhanced benefits — such as dental and vision coverage — that does not require co-payments for services.[10] Members who do not make these contributions within 60 days are, depending on the member's income, either transitioned into a more limited benefit plan if the member's income is at or below 100 percent of the Federal Poverty Level (FPL), or not enrolled in

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7 The POWER Account's value is equal to their deductible: $2,500. For members who make a PAC, this amount is a combination of member POWER Account contributions and State contributions. Members contribute two percent of their household income and the State contributes the difference. For members who do not make POWER Account contributions, the POWER Account is fully-funded by the state. After a member has met his/her deductible, services are paid for by the member's MCE. Preventive care services are not paid for using the POWER Account.

8 Members can also make an annual contribution to cover the PAC for the entire year. Native Americans and pregnant women are not eligible to pay PAC.

9 Per federal regulation 42 CFR 447.78, HIP members are not allowed to pay more than five percent of their household income in a given benefit quarter towards HIP cost sharing requirements. This limit is often referred to as the "5 percent threshold" and includes all payments by the member or his/her family members for the following: Monthly contributions, Co-pays, and Children's Health Insurance Program (CHIP) premiums. HIP Plus members who meet the threshold on a quarterly basis have a PAC amount of $1 (the minimum) for the remainder of the quarter.

10 Plus Members are not required to make co-payments for services *except* for non-emergent use of the emergency department.

or disenrolled from coverage if the member's income is above 100 percent of the FPL. More detail on the repercussions of non-payment for each group is provided below.

Transitioned to a more limited benefit plan. Members with incomes *at or below* 100 percent of the FPL who do not make PAC are placed in the more limited benefit plan – HIP Basic – that does not cover some services (e.g. dental and vision) and requires co-payments for most services. These members must wait until their annual redetermination to be eligible for HIP Plus coverage again. For the purposes of this report, we distinguish between two types of Basic Members:

1) *Always Basic Members*: Basic Members who did not make their *first* PAC and therefore were never enrolled in Plus coverage
2) *Previously Plus Basic Members*: Basic Members who made at least one PAC and therefore were enrolled in Plus for at least one month, but subsequently stopped making PAC and were transitioned to Basic

Not enrolled in coverage. Individuals with incomes *above* 100 percent of the FPL who do not make their *first* PAC are not initially enrolled in coverage. This group is referred to as "Never Members" throughout this report.

Never Members are not subject to a six-month disenrollment period; they may reapply for Medicaid before six months have passed and be considered eligible for HIP and other Medicaid programs.

Disenrolled from coverage. Individuals with incomes *above* 100 percent of the FPL who do not make *subsequent* PAC are disenrolled from coverage. This group is referred to as "Leavers" throughout this report.

Leavers who are enrolled in Plus prior to disenrollment are subject to a six-month disenrollment period; they can submit a new application during this disenrollment period and be considered for other Medicaid programs, but will not be eligible for HIP. After six months, they may reenroll in HIP. Leavers who are enrolled in Basic prior to disenrollment are not subject to a six-month disenrollment period from HIP; they may reapply before six months have passed and be considered eligible for HIP.[11]

There are three exceptions to the policies described above: medically frail individuals, Transitional Medical Assistance (TMA) participants, and individuals experiencing certain qualifying events.[12] Medically frail and TMA participants are eligible to pay PAC, however, they are exempt from disenrollment for non-payment even if they have incomes above 100 percent of the FPL. Medically frail individuals with incomes above 100 percent of the FPL who do not make PAC are

[11] In general, Basic members cannot be disenrolled due to non-payment because their incomes are at or below 100 percent of the FPL and therefore they are not required to pay PAC to remain enrolled. However, if a Basic member's income increases to above 100 percent of the FPL, he or she is no longer eligible for Basic, and must make a PAC to enroll in Plus coverage. If he/she does not make a PAC, he/she is disenrolled from coverage.

[12] Medically frail individuals are members with serious physical, mental, and behavioral health conditions. TMA participants are low-income parents/caretaker relatives between 19 – 185 percent of the FPL who would lose Medicaid coverage due to increased earnings, but who, under TMA, continue to receive Medicaid services for up to one year. Some examples of qualifying events include obtaining and then losing private insurance and living in a state-declared disaster area.

transitioned to a special State Plus Plan with co-payments for services.[13] TMA participants with incomes above 100 percent of the FPL who do not to make PAC are transitioned to the State Basic Plan. Individuals who experienced certain qualifying events can be reinstated to HIP prior to the end of the six-month disenrollment period if they file a new application and can provide verification of the qualifying event.

All individuals determined eligible for HIP are encouraged to pay PAC. Individuals are *conditionally* enrolled in HIP Plus, and are given 60 days to make a PAC. However, benefits are not provided during conditional Plus enrollment. In this report, we use the terms 'enrolled in Plus' or 'enrolled in Basic' to refer to members who are *fully* enrolled in Plus or Basic and therefore receiving coverage, not to *conditionally* enrolled individuals.

There are two exceptions to the requirement to pay PAC: pregnant women and Native Americans. Pregnant and Native American members are exempt from all cost-sharing by federal law and therefore are not eligible to pay PAC. Native Americans are enrolled into HIP Plus automatically, without making a PAC.[14] Pregnant women can remain in the plan they were enrolled in before they became pregnant (Basic or Plus), but with no cost-sharing and access to additional benefits – such as non-emergency medical transportation – or they can opt to move to HIP's maternity plan.[15] For a visual depiction of the HIP 2.0 PAC policies, see **Appendix B.**

II. Data Sources

This assessment relies on the following four data sources: surveys of enrolled, disenrolled and not enrolled individuals, FSSA enrollment data, FSSA administrative data, and MCE data.

Surveys of Enrolled, Disenrolled and Not Enrolled Individuals

Brief surveys were administered to four population groups of interest:

1) Current HIP Basic Members
2) Current HIP Plus Members
3) Leavers
4) Never Members

The four surveys were administered via telephone in December 2016 through January 2017. The survey instruments contained a series of close-ended questions pertaining to the affordability of PAC, reasons for non-payment of PAC, awareness of the implications for non-payment of PAC, access to care, and other sources of insurance coverage for disenrolled and not enrolled individuals (see **Appendix C** for the four survey instruments). The questions were modeled after the CMS/Indiana-approved questions used in surveys conducted in December 2015 and January 2016,

[13] HIP 2.0 maintains a traditional Medicaid benefits package, referred to as the "State Plan," for some of HIP's more vulnerable populations, including medically frail individuals, Section 1931 low income parents and caretakers, low income 19 and 20 year olds, and TMA participants. Members who do not qualify for the State Plan (i.e., members not within one of those four groups) are eligible for the Regular Plan.

[14] Native Americans may also opt out of HIP into fee-for-service coverage.

[15] For pregnant women, the exemption from PAC applies during their pregnancy and up to 60 days post-partum.

with minor changes to the survey phrasing and response options based on lessons learned.[16] Consistent with the previous surveys, each survey contained a different set of questions to accommodate differences in circumstances between the four groups, such as whether the member made or was currently making PAC based on their current membership status (Basic, Plus, Leaver, or Never Member).

The samples for the Current HIP Basic and Current HIP Plus surveys were each stratified into two groups to reflect differences in incentives and experience between members. The Basic sample was stratified into: 1) *Always* Basic Members and 2) *Previously Plus* Basic Members. The Plus sample was stratified into: 1) members with incomes above 100 percent of the FPL, i.e. members required to pay PAC to maintain coverage and 2) members with incomes below 100 percent of the FPL, i.e. members eligible for Basic coverage if they do not maintain PAC.[17] Pregnant women and Native Americans were excluded from all samples because they are not eligible to pay PAC. The Plus and Basic Member samples were developed using enrollment data from February 1, 2015 through July 29, 2016, provided by FSSA on December 6, 2016 and enrollment data for November 2016 (as of November 30), provided by FSSA on December 16, 2016. The Leaver and Never Member samples were provided by FSSA on January 10, 2017 and January 6, 2017, respectively, and verified using enrollment data for February 1, 2015 through November 30, 2016, provided by FSSA on January 6, 2017.

Exhibit 1 shows the sample frame and the number of completed surveys for each subgroup. **Appendix D** provides more detail on the sampling strategy.

Exhibit 1: Final Frame Size and Number of Completed Surveys

Group	Final Frame Size	Completed Surveys
Current HIP Basic Members	**146,522**	**400**
Always Basic Members	115,065	327
Previously Plus Basic Members	31,457	73
Current HIP Plus Members	**233,492**	**389**
Plus Members with incomes at or below 100 percent FPL	196,724	195
Plus Members with incomes above 100 percent FPL	36,768	194
Leavers	**5,156**	**202**
Never Members	**11,449**	**200**

Source: FSSA Enrollment Data: November 30, 2016 and February 1, 2015 – July 29, 2016; Basic, Plus, Leaver, and Never Member Survey data: December 2016 – January 2017.

The overall response rate for the four survey groups was 4.8 percent, which is calculated as the number of completed surveys divided by the total number of members called. The Plus Member Survey had the highest response rate at 7.8 percent, while the Never Member Survey had the lowest at 3.0 percent. The incidence rate, which is the number of *completed surveys* out of the total number of members reached, was 74 percent.

[16] For a full description of the prior survey methods and results, see: The Lewin Group. 2016. *Indiana HIP 2.0: Interim Evaluation Report.* Retrieved on February 17, 2017 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf

[17] Medically frail and TMA participants are excluded from the Plus above 100 percent FPL group because they are eligible for Basic coverage (i.e., exempt from disenrollment) even if they have incomes above 100 percent of the FPL.

FSSA Enrollment Data

HIP 2.0 enrollment data for February 1, 2015 through November 30, 2016, provided by FSSA on January 6, 2017, were used to calculate a number of metrics in the report. The enrollment data contained information on members' demographics (e.g., income, gender), enrollment status (open, closed or denied), eligibility categories (e.g., aid category, and whether the member met any special eligibility requirements, such as TMA), reason codes explaining changes in members' coverage status, and whether members who left HIP subsequently enrolled in another Indiana Medicaid program.

For the purposes of this analysis, we included individuals eligible for the following HIP Medical Assistance aid categories: Regular Plus (MARP), Regular Basic (MARB), State Plus (MASP), State Basic (MASB) and State Plus with Co-pays (MAPC).

FSSA Administrative Data

HIP 2.0 data for February 1, 2015 through December 1, 2016, collected by the Indiana Office of Medicaid Policy and Planning (OMPP) and provided to Lewin on December 12, 2016 and December 21, 2016, were used to identify members who applied for and received a waiver from disenrollment due to non-payment of PAC.

Managed Care Entity Data

Data from the three MCEs participating in HIP 2.0 – Anthem, Managed Health Services (MHS), and MDwise – were used to calculate metrics on third party contributions to PAC and Fast Track payments. MCE third party contributions data, provided on December 5, 2016, represents the time period from January 1, 2016 through September 30, 2016. The MCE Fast Track data, received December 7, 2016 from FSSA, represents the time period from February 1, 2015 through September 30, 2016.

III. Methodology

The evaluation design for this report is based on the POWER Account Contributions and Copayments Monitoring Protocol, developed by FSSA and approved by CMS in 2015 (see **Appendix E**). This report is divided into six sections corresponding to the six research questions outlined in the Protocol:

1) How many individuals lost HIP Plus coverage due to non-payment of the PAC?
2) How many individuals requested a waiver from the six-month disenrollment period?
3) How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER Account contributions?
4) How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?
5) How are individuals accessing health care if they are disenrolled due to non-payment of the PAC?
6) Was the disenrollment period a deterrent for individuals with incomes over 100 percent FPL to miss a PAC?

The results are presented by research question.

IV. Results

Research Question 1: How many individuals lost HIP Plus coverage due to non-payment of the PAC?

This Research Question is divided into two sections, each devoted to a type of HIP payment. The first section – POWER Account Contributions – presents data on the number of members making PAC and the number who failed to make a PAC. The second section – Fast Track Payments – presents data on the number of HIP members making another type of payment, called a 'Fast Track' payment, which is applied to a member's first PAC and expedites the start of their coverage.[18]

POWER Account Contributions

This section describes the number of individuals who *made* at least one PAC and the number who *failed to make* at least one PAC during the timeframe. To provide context for the results, the section first introduces data on the number of current HIP members and the number of individuals ever eligible to pay PAC during the timeframe. The section then describes, of those individuals ever eligible to pay PAC, how many paid at least one PAC and how many failed to make at least one PAC. For those who failed to make at least one PAC, we report whether individuals were transitioned to Basic, transitioned to State Plus with Co-pays, disenrolled, or not enrolled as a result of non-payment of PAC. Finally, we report how many disenrolled or not initially enrolled individuals later reenrolled in HIP or another Medicaid program.

1. Current HIP Members (as of November 2016)

In November 2016, 409,935 unique individuals were enrolled in HIP. Of these, 254,229 unique individuals were enrolled in HIP Plus (62 percent) and 155,706 unique individuals were enrolled in HIP Basic (38 percent). Of those enrolled in HIP Plus, 81 percent (n=205,947) had incomes at or below 100 percent of the FPL and 19 percent (n=48,282) had incomes above 100 percent of the FPL.

2. Individuals Ever Eligible to Pay PAC (February 2015 through November 2016)

For the full timeframe from February 2015 through November 2016, there were 590,315 unique individuals determined eligible for HIP who were ever eligible to pay PAC.[19] In the subsequent sections, we report on the percentage of these members who made at least one PAC, and those who did *not* make a PAC and were either transitioned to Basic, transitioned to State Plus with Co-pays, disenrolled, or not initially enrolled as a result of non-payment.

During this timeframe, there were an additional 4,649 unique members who were pregnant or Native American throughout their HIP enrollment, and therefore were never eligible to pay PAC.

[18] Applicants who are likely eligible for another Medicaid program other than HIP – such as members who indicated they were pregnant, disabled, a former foster care child or on Medicare when they applied – are not eligible to make Fast Track payments.

[19] As noted above, all HIP members except pregnant women and Native Americans are required to make PAC to enroll in HIP Plus. As such, only members who were Native American or pregnant in every month in the data are considered not eligible to pay PAC and thus are excluded from the count of members ever eligible to pay PAC.

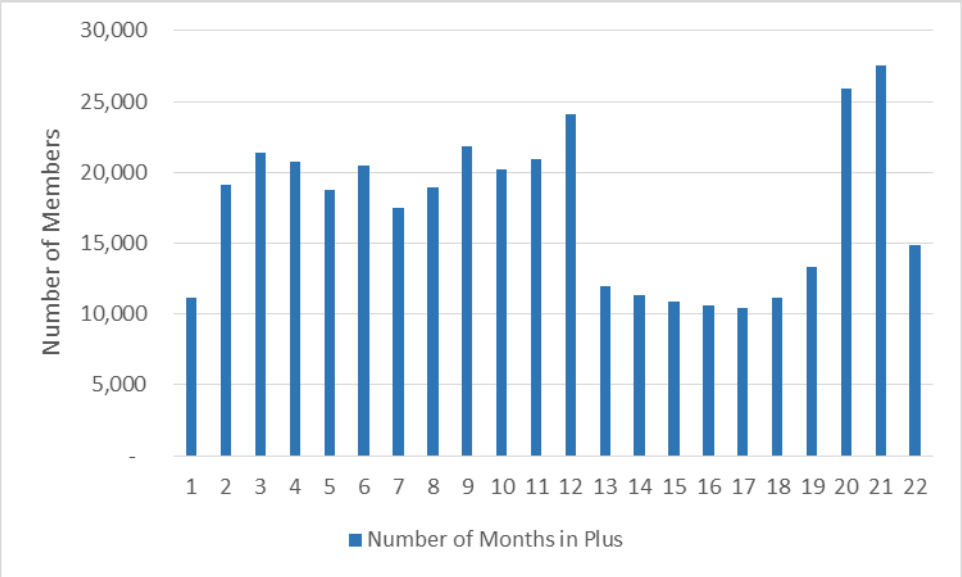
These members are excluded from the counts reported below because they are not eligible to pay PAC.

a. Individuals who Made a PAC

Of the 590,315 unique individuals ever eligible to pay PAC, 383,127 (approximately 65 percent) were fully enrolled in Plus for at least one month (i.e., *Ever* Plus), which indicates that they made at least one PAC.[20]

Exhibit 2 below shows a distribution of the number of months *Ever* Plus Members were enrolled in Plus from February 2015 through November 2016. This includes members who continued to make their PAC and remained enrolled in Plus, as well as those who stopped making PAC and were transitioned to Basic or State Plus with Co-pays, or disenrolled. Note, this includes members who enrolled at any point during the timeframe from February 2015 through November 2016. As such, some members represented in **Exhibit 2** had the opportunity to pay for up to 22 months if they first enrolled in February 2015, whereas others only had the opportunity to pay for one month if they first enrolled in November 2016.

Exhibit 2: Duration of Plus Enrollment for *Ever* Plus Members as of November 2016 (n=383,127)



Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

Almost 40 percent of *Ever* Plus Members had been enrolled in Plus for over a year as of November 2016.

[20] This count includes only those who were fully enrolled in Plus, i.e., receiving benefits; it does not include members who were conditionally enrolled in HIP Plus pending a PAC or the expiration of the 60 day payment period. It also excludes members who were pregnant or Native American during their Plus enrollment because they can be enrolled in Plus without having to make a PAC.

b. Individuals who Did Not Make a PAC

Of the 590,315 unique individuals ever eligible to pay PAC, 324,840 (55 percent) did not make a PAC at some point in time during their enrollment. This includes 286,914 individuals who were enrolled in Basic as a result of non-payment (88 percent of the individuals who did not make a payment), 1,431 individuals who were enrolled in State Plus with Co-pays as a result of non-payment (less than one percent of the individuals who did not make a payment), 13,550 individuals who were disenrolled as a result of non-payment (four percent of individuals who did not make a payment), and 46,176 individuals who were not initially enrolled as a result of non-payment (14 percent of individuals who did not make a payment).[21] Some of these individuals made a PAC but then stopped making payments, while others never made a payment. Each group is described in more detail below.

The rate of non-payment was higher among individuals with incomes at or below 100 percent of the FPL. Among individuals with incomes at or below 100 percent of the FPL ever eligible to pay PAC, 57 percent did not make at least one payment.[22] Among individuals with incomes above 100 percent of the FPL ever eligible to pay PAC, 51 percent did not make at least one payment.[23]

i. Individuals Transitioned to Basic Due to Non-payment of PAC

Individuals with incomes *at or below* 100 percent of the FPL and TMA participants at all income levels who do not make PAC are enrolled in HIP Basic.

During the timeframe of February 2015 through November 2016, 286,914 individuals were fully enrolled in Basic for at least one month, meaning that they did not make a PAC. Among those individuals, 40,756 or 14 percent made a payment (i.e., were enrolled in Plus for at least one month) but subsequently stopped making payments and were transitioned into Basic.[24] **Exhibit 3** displays a distribution of the number of months of Plus membership for members who transitioned into Basic. Note, some members may have transitioned from Plus to Basic more than once during the timeframe. The data in **Exhibit 3** reflect the first time a member transitioned.

About 60 percent of members who transitioned into Basic made the transition after six months or more of Plus enrollment.

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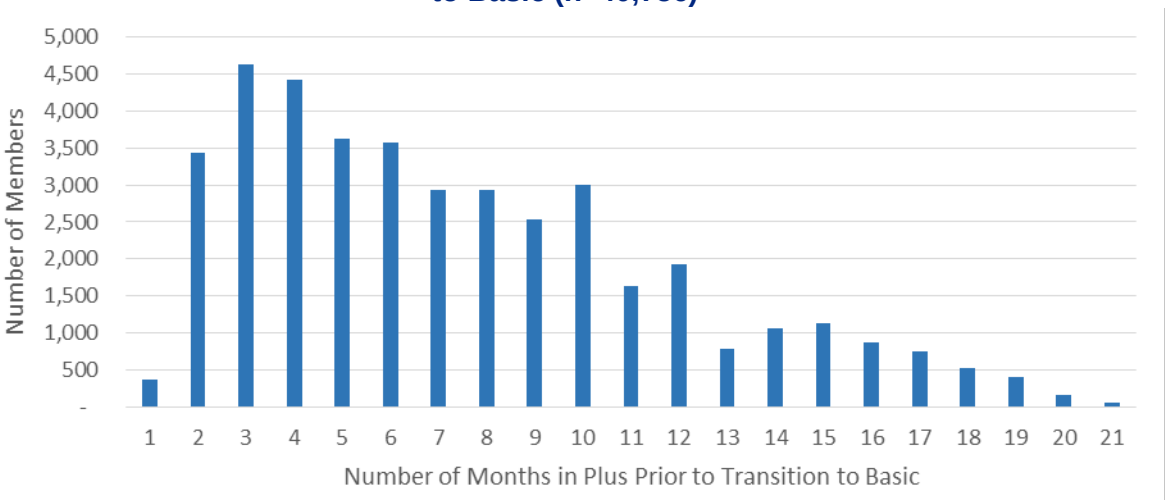
[21] The percentages reported here are out of all individuals who were eligible to pay PAC but did not make a PAC (324,840), including individuals who are exempt from disenrollment for failure to pay PAC (i.e., individuals with incomes at or below 100 percent FPL, medically frail and TMA participants). The percentages do not sum to 100 because individuals may be in multiple groups during the timeframe if they failed to make multiple payments, however the 324,840 count represents *unique* individuals who did not make at least one payment.

[22] This includes members with income *never* above 100 percent of the FPL *at any point during their enrollment*, in other words, their income was always at or below 100 percent of the FPL. Specifically, the numerator for this calculation includes individuals with incomes always at or below 100 percent of the FPL who did not make a payment (Basic members with income always at or below 100 percent of the FPL) and the denominator includes those in the numerator plus members who were always enrolled in Plus (always paid) and always had incomes at or below 100 percent of the FPL.

[23] This includes members with income above 100 percent of the FPL at any point during their enrollment. Specifically, the numerator for this calculation includes individuals with incomes ever above 100 percent of the FPL who did not make a payment (Leavers, Never Members, members in Basic with income above 100 percent of the FPL, and MAPC members) and the denominator includes those in the numerator plus members who were always enrolled in Plus (i.e., always paid) with income ever above 100 percent of the FPL.

[24] This count includes only those individuals who transitioned immediately from HIP Plus coverage to HIP Basic coverage following non-payment. Individuals with gaps between their Plus and Basic coverage, or who moved to Plus *after* being enrolled in Basic, e.g., at their redetermination, are not included in this count.

Exhibit 3: Duration of Plus Enrollment *Prior to Transition* for Members who Transitioned to Basic (n=40,756)



Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

Exhibit 4 displays the first month of Basic enrollment for members who transitioned into Basic. The months with the highest number of transitions were July 2015 and January 2016.

Exhibit 4: First Month of Basic Enrollment for Members who Transitioned to Basic (n=40,756)

First Month in Basic After Transition	Count	Percent
April 2015	9	<1%
May 2015	27	<1%
June 2015	28	<1%
July 2015	7,400	18%
August 2015	212	1%
September 2015	2,507	6%
October 2015	1,905	5%
November 2015	1,116	3%
December 2015	841	2%
January 2016	4,761	12%
February 2016	1,307	3%
March 2016	2,794	7%
April 2016	1,663	4%
May 2016	789	2%
June 2016	1,814	4%
July 2016	2,105	5%
August 2016	2,925	7%
September 2016	2,981	7%
October 2016	3,312	8%
November 2016	2,260	6%

Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

ii. Individuals Transitioned to State Plus with Co-pays Due to Non-payment of PAC

Medically frail members with incomes above 100 percent of the FPL who do not make PAC are enrolled in State Plus with Co-pays (MAPC). From February 1, 2015 through November 30, 2016, 1,431 individuals were fully enrolled in MAPC for at least one month, meaning that they did not make a PAC.

iii. Individuals Disenrolled Due to Non-payment of PAC

Individuals with incomes *above* 100 percent of the FPL are disenrolled from coverage for not making PAC. During the studied timeframe, February 1, 2015 through November 30, 2016, 13,550 unique individuals were enrolled in HIP at least one month but did not make a payment and were disenrolled as a result, referred to as "Leavers." This includes 3,914 unique individuals who were enrolled in HIP Basic prior to disenrollment and 9,636 individuals enrolled in Plus prior to disenrollment.

The 3,914 individuals enrolled in Basic prior to disenrollment are not subject to a six-month disenrollment period. These members likely experienced a change that made them ineligible for Basic, for example an increase in income above 100 percent of the FPL.[25] In other words, these members failed to make their first PAC, and were transitioned to Basic as a result, but then became ineligible for Basic due to an income increase and therefore were required to pay PAC to remain enrolled. When these members did not make PAC, they were disenrolled from HIP Basic. This group represents two percent of individuals during the timeframe who could be disenrolled or not enrolled due to non-payment of PAC.[26]

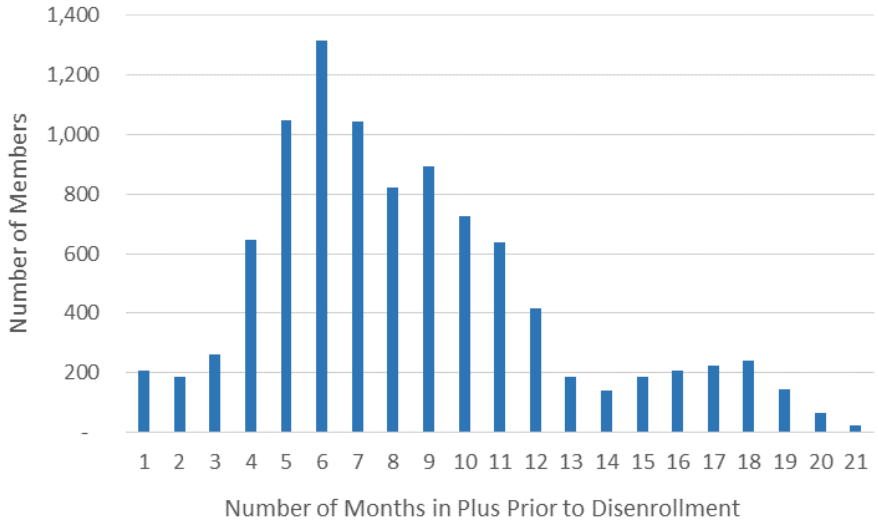
The 9,636 individuals enrolled in Plus prior to disenrollment were subject to the six-month disenrollment period.[27] This group represents five percent of individuals during the timeframe who could be disenrolled or not enrolled due to non-payment of PAC. **Exhibit 5** displays a distribution of the number of months of Plus membership prior to non-payment for Leavers enrolled in Plus at least one month, i.e., who made at least one PAC. Among Leavers who made at least one PAC, about 62 percent were enrolled in Plus for more than six months before being disenrolled from the program due to non-payment.

[25] Members with incomes above 100 percent of the FPL could also have experienced a loss of TMA status, which would also make them ineligible for Basic.

[26] Individuals can be disenrolled or not enrolled for non-payment if they have incomes above 100 percent of the FPL and are not pregnant, Native American, medically frail or a TMA participant.

[27] Some of these members may have subsequently received a waiver from the six-month disenrollment period. As reported in Research Question Two below, 201 members received a waiver from the six-month disenrollment period during the timeframe.

Exhibit 5: Duration of Plus Enrollment for Leavers Ever Enrolled in Plus (n=9,636)



Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

Exhibit 6 displays the last month of enrollment for members who were disenrolled due to non-payment. The months with the highest number of disenrollments were August through October 2016.

Exhibit 6: Last Month of Enrollment for Leavers (n=13,550)

Last Month Before Disenrollment	Count	Percent
March 2015	27	<1%
April 2015	21	<1%
May 2015	3	<1%
June 2015	296	2%
July 2015	1	<1%
August 2015	440	3%
September 2015	625	5%
October 2015	273	2%
November 2015	374	3%
December 2015	8	<1%
January 2016	1,136	8%
February 2016	1,095	8%
March 2016	859	6%
April 2016	695	5%
May 2016	647	5%
June 2016	530	4%
July 2016	337	2%
August 2016	1,513	11%
September 2016	1,602	12%
October 2016	1,827	13%
November 2016	1,241	9%

Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

iv. Individuals Not Enrolled Due to Non-payment of PAC

An additional 46,176 individuals were not initially enrolled in HIP because they did not make their first PAC, referred to as "Never Members."[28] This represents 23 percent of individuals who could be disenrolled or not enrolled as a result of non-payment.

c. Disenrolled or Not Enrolled Individuals who Re-Enrolled in HIP or other Medicaid Programs

As mentioned previously, Leavers who are enrolled in Plus prior to disenrollment are subject to a six-month disenrollment period. However, they can submit a new application during this disenrollment period and be considered for other Medicaid categories aside from HIP. After six months have passed, they may also reapply for HIP.

Never Members and Leavers who were in Basic prior to disenrollment are not subject to this six-month HIP disenrollment period; they may reapply and be reconsidered eligible for HIP before six months have passed.

Eleven percent (1,496) of the Leavers and 53 percent (24,424) of the Never Members reenrolled in HIP or another Medicaid program as of November 2016.

Fast Track Payments

Under HIP 2.0, HIP Plus coverage begins the first day of the month in which an individual makes their POWER Account contribution. In April 2015, HIP 2.0 established a means for eligible HIP members to expedite the start of their coverage called "Fast Track." Fast Track allows individuals to make a $10 payment at the time of application, after applying, or while the application is being processed, as a mechanism to expedite the start of HIP Plus coverage. The $10 payment is applied towards the member's first POWER Account contribution.[29] If a member makes a Fast Track payment and is determined eligible for HIP, his or her HIP Plus coverage begins the first of the month in which he or she made the Fast Track payment. [30]

Exhibit 7 describes the number of members – by income category – who made Fast Track payments, based on data provided by the MCEs. Across all three MCEs, 116,000 unique members made a Fast Track payment. This represents 20 percent of the ever-enrolled HIP 2.0 members.[31]

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[28] 2,537 individuals were both Never Members and Leavers during the timeframe, meaning that they applied and did not make their first payment, then reenrolled, but then subsequently stopped making payments (or vice versa).

[29] If the individual is not found eligible for HIP, the state will refund the payment. If the member's POWER Account contribution amount is less than $10 per month, the $10 payment is applied to their first coverage month, with the remaining amount applied to future months.

[30] Applicants who are likely eligible for another Medicaid program other than HIP – such as members who indicated they were pregnant, disabled, a former foster care child or on Medicare when they applied – are not eligible to make Fast Track payments.

[31] The denominator for this calculation is the total number of members ever enrolled in MARB, MASB, MARP, or MASP from February 1, 2015 through November 30, 2016.

Exhibit 7: Number of Members Making a Fast Track Payment, by Member Income Level

Income Level	Number of Members Making Fast Track Payments
All Income Levels	116,000
Less than or equal to 100 percent FPL	95,554
Greater than 100 percent FPL	20,446

Source: MCE data: February 1, 2015 – September 30, 2016
Notes: 14 records were dropped because they had payment dates prior to the implementation of the Fast Track program (i.e., before 4/1/2015). Income from the first month of enrollment was used.

Individuals can make Fast Track payments online via credit card any time during the application process: at the time of application, after applying, or while the application is being processed. Individuals who do not apply online (or choose not to make a Fast Track payment when applying) are sent a Fast Track invoice from their MCE. As shown in **Exhibit 8**, the majority of members making a Fast Track payment made the payment after receiving a Fast Track invoice from their MCE.

Exhibit 8: Timing of Fast Track Payment Submission

Timing of Payment Submission	Percentage of All Members Making Fast Track Payments
Made Fast Track payment at the time of application	11%
Made Fast Track payment after submitting an application but before receiving an invoice from their MCE	3%
Made Fast Track payment after receiving an invoice from their MCE	87%

Source: MCE data: February 1, 2015 – September 30, 2016

Research Question 2: How many individuals requested a waiver from the six-month disenrollment?

As noted above, members with incomes above 100 percent of the FPL who do not make subsequent PAC are disenrolled from HIP and are not allowed to return for six months.[32] However, members may apply for a waiver from the six-month disenrollment period. Specifically, individuals may be reinstated to HIP prior to the end of the six-month disenrollment period if they file a new application and can provide verification that they experienced one of the following qualifying events:[33]

- Obtained and subsequently lost private insurance coverage;
- Had a loss of income after disqualification due to increased income;
- Took up residence in another state and later returned;
- Were a victim of domestic violence; or

[32] Medically frail and TMA participants are exempt from disenrollment.
[33] Indiana HIP 2.0 Special Terms and Conditions, Section VII, Paragraph 12, Section D.

- Were residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty (60) calendar days prior to date of member termination for non-payment.

Exhibit 9 describes the number of members who applied for and were granted a waiver from the six-month disenrollment period. In total, 201 members received a waiver from the disenrollment period in the first 21 months of HIP 2.0. Some of these members may be included in the count of Leavers subject to the six-month disenrollment period reported above (9,636) if they experienced a gap of at least one month in coverage, however this cannot be confirmed at this time.

Exhibit 9: Number of Disenrollment Waivers and Exemptions

HIP Members Applied for Waiver/Exemption	Granted Waiver/Exemption	Denied
230	201	29

Source: Administrative data from the Indiana Family and Social Services Administration's Office of Medicaid Policy and Planning: February 1, 2015 – December 1, 2016

Research Question 3: How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER account contributions?

HIP 2.0 enrollees can have all or a portion of their PAC paid for by employers or non-profit organizations.

Exhibit 10 presents information on the number of employers and non-profit organizations making contributions on behalf of HIP members from January 1, 2016 through September 30, 2016.

Exhibit 10: Employer and Non-Profit Organization Contributions

Entity	Metric	2016 YTD Total
Employer Contributions	Number of Employers Participating	40
	Number of Members on Whose Behalf an Employer Makes a Contribution	57
	Total Amount of Employer Contributions	$2,528.51
	Average Amount of Employer Contributions Per Member	$44.36
Non-profit Contributions	Number of Non-Profit Organizations Participating	138
	Number of Members on Whose Behalf a Non-Profit Makes a Contribution	5,713
	Total Amount of Non-Profit Contributions	$66,142.52
	Average Amount of Non-Profit Contributions Per Member	$11.58

Source: MCE data: January 1, 2016 – September 30, 2016

From January 1, 2016 through September 30, 2016, 5,770 members received help paying their PAC. This represents 1.5 percent of members who ever made a PAC. Participation from non-profit organizations was higher than employer participation, with 138 non-profit organizations making contributions on behalf of 5,713 members (1.5 percent of members who ever made a PAC),

compared to 40 employers making contributions on behalf of 57 members (less than one percent of members who ever made a PAC).[34]

Plus Member survey results provide additional information on the extent of third party assistance with PAC. Plus Members were first asked whether they made a monthly or annual contribution to be in HIP. Of the 389 Plus Members who completed the survey, 361 responded that they made a contribution. These members were then asked whether they received help with the cost of making contributions from someone else such as a family member, friend, employer, health care provider or charity. About 24 percent of HIP Plus Member respondents (n=76) indicated that they received help from a third party.[35]

Those who reported receiving help were asked about the source(s) of their help. Individuals could indicate more than one source of assistance. **Exhibit 11** shows the most common responses.

Exhibit 11: Help with POWER Account Contribution

Source of Assistance	Number of Members	Percentage
Help from a Family Member	66	87%
Help from a Friend	17	24%

Source: Plus Member Survey data: December 2016 – January 2017, weighted percentages reported. Other options for which there were five or fewer responses include a charity or religious organization, a health care provider such as a doctor's office or hospital, an employer, and some other source.

Plus Members were most likely to report receiving help from a family member (87 percent) or a friend (24 percent). Very few members reported receiving help from an employer (n=3) or a charity or religious organization (n=5), which is consistent with the low participation reported by MCEs, shown in **Exhibit 10** above.

Research Question 4: How do HIP 2.0 enrollees perceive the affordability of PAC and non-payment penalties?

Survey data from individuals enrolled in HIP coverage as of November 2016 (in HIP Plus or HIP Basic) and disenrolled or not enrolled individuals as of November 2016 (Leavers and Never Members) were used to assess member perceptions of the affordability of PAC and their self-reported reasons for not making PAC.

Perceptions of PAC affordability

1. Members' Frequency of Worrying about Ability to Pay PAC

Current HIP Plus Members and Leavers were asked a series of questions to gauge their perceptions of PAC affordability. Respondents were first asked, "Did you make a monthly or annual contribution when you were in HIP?" Respondents who reported that they made a monthly or

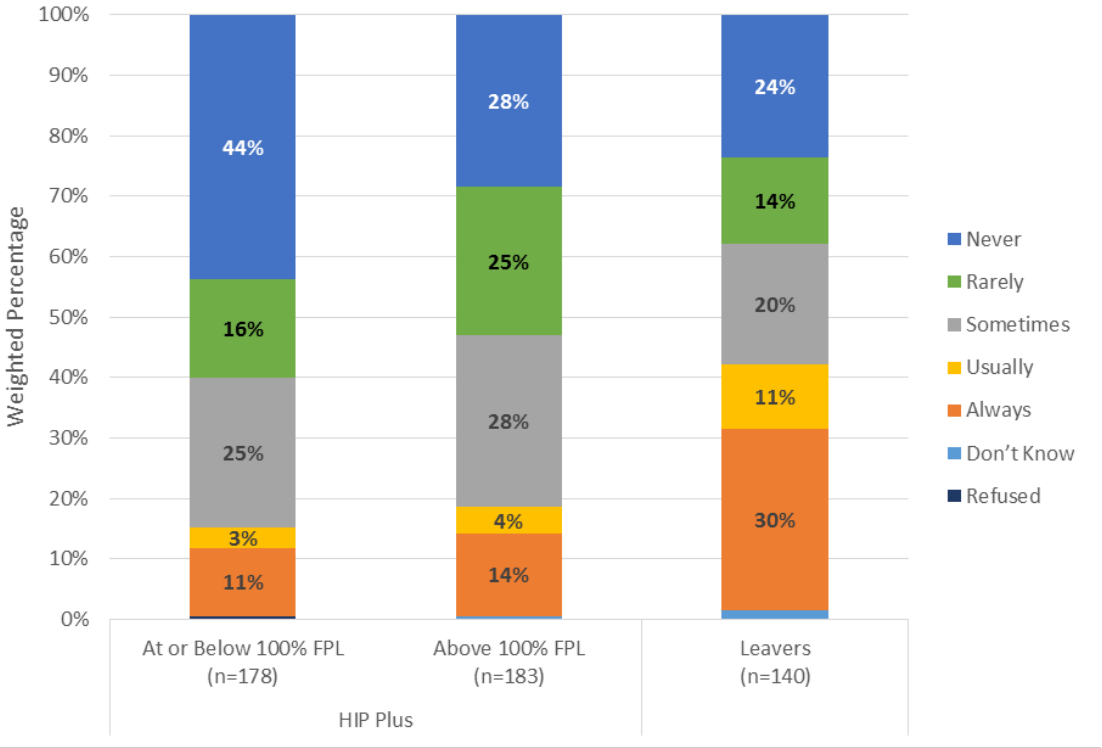
[34] HIP Employer Link – HIP's contribution premium assistance program designed to support individuals wishing to purchase their employer's sponsored health insurance – began in June 2015.

[35] One member responded "Don't Know," one "Refused."

annual contribution (n=361 for Plus Members, n=140 for Leavers) were then asked a series of questions on their perceptions of PAC affordability and their reasons for non-payment.[36]

Respondents were first asked how often they worried about having enough money to pay their contribution. As shown in **Exhibit 12**, less than 20 percent of HIP Plus Member respondents reported that they "always" or "usually" worried about having enough money to pay PAC.

Exhibit 12: Members' Frequency of Worrying about Ability to Pay PAC, by Member Type



Source: Plus Member and Leaver Survey data: December 2016 – January 2017, weighted percentages reported

HIP Plus Member respondents with incomes at or below 100 percent of the FPL were least likely to report worrying about having enough money to pay PAC, with 15 percent (n=26) reporting that they "always" or "usually" worried. Among Plus Members with incomes above 100 percent of the FPL, 18 percent (n=33) reported that they "always" or "usually" worried.[37] Leavers were most likely to worry about their ability to pay PAC, with 41 percent (n=57) reporting that they "always" or "usually" worried.

2. Members' Willingness to Pay More

To further explore members' perceptions of the affordability of PAC, HIP Plus and HIP Basic Members were asked about their willingness to pay to remain enrolled in HIP. Basic Members were asked if they would be willing to pay $5, and then $10 each month to remain enrolled. HIP

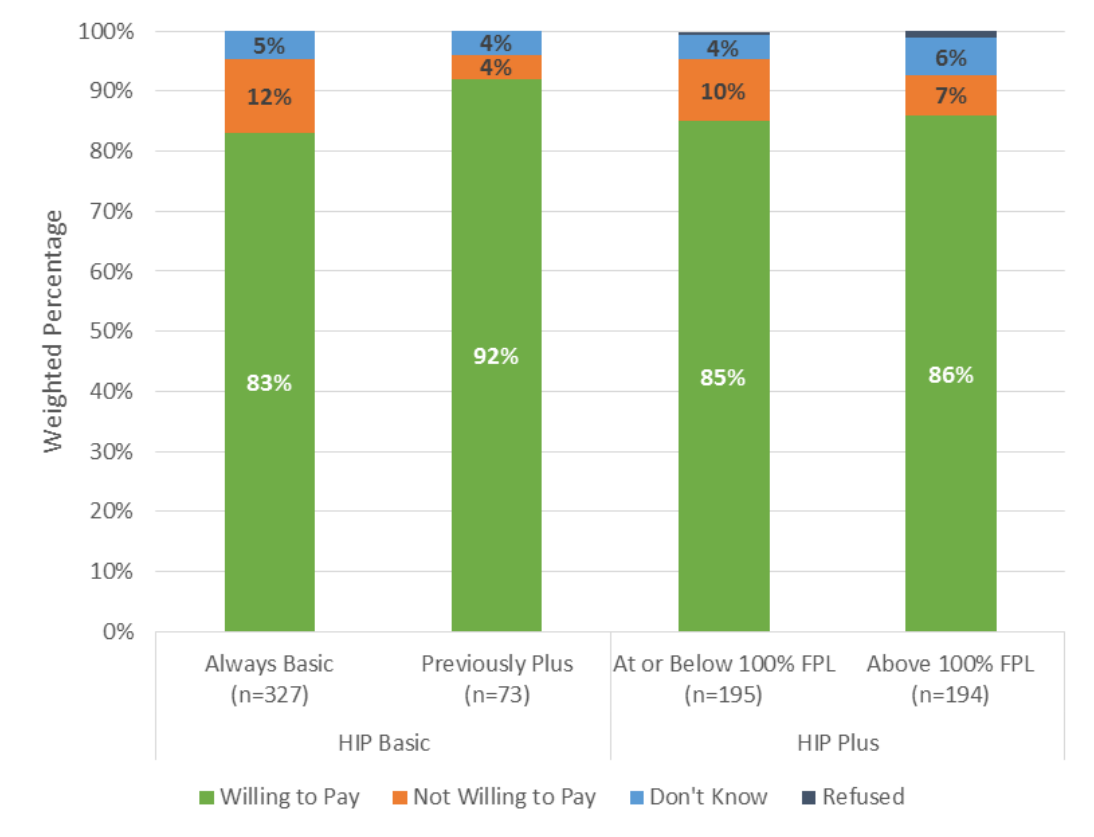
[36] Twenty-eight Plus members and 62 Leavers responded that they "did not make a monthly or annual contribution to be in HIP," or selected "Don't know" or "Refused."

[37] One Plus member and two Leavers responded "Don't Know" to this survey question. One Plus member "Refused."

Plus Members were asked if they would be willing to pay $5 *more*, and then $10 *more* each month to remain enrolled.

As shown in **Exhibit 13**, the majority of HIP 2.0 Basic and Plus Members were willing to pay $5 or $5 more each month to remain enrolled in HIP 2.0.

Exhibit 13: Members' Willingness to Pay $5 (Basic) or $5 More (Plus) to Remain Enrolled, by Member Type

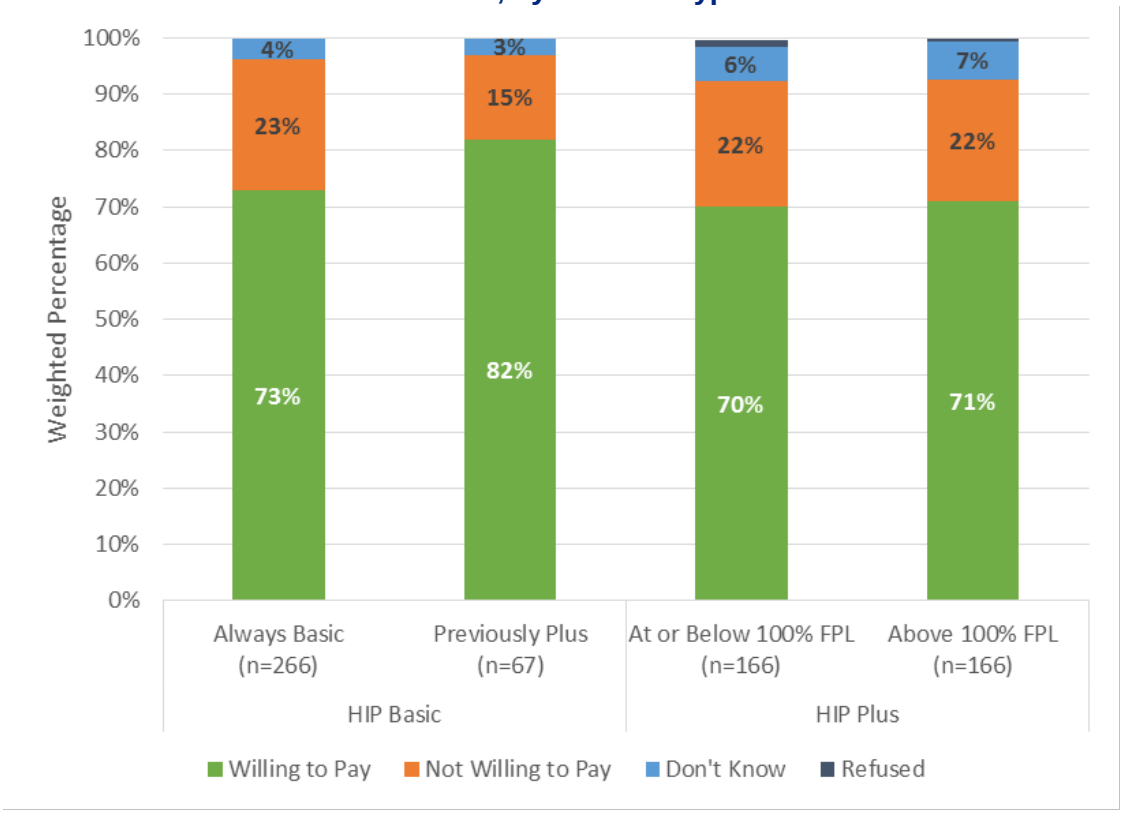


Source: Basic and Plus Member Survey data: December 2016 – January 2017, weighted percentages reported

Among members who were not making monthly contributions (Basic Members), 83 percent (n=266) of *Always* Basic Member respondents and 92 percent (n=67) of *Previously Plus* Basic Member respondents reported that they would be willing to pay $5 each month to remain enrolled. Among those who were already making monthly contributions (Plus Members), approximately 85 percent (n=166) of Plus Member respondents with incomes at or below 100 percent of the FPL and 86 percent (n=166) of Plus Member respondents with incomes above 100 percent of the FPL reported that they were willing to pay $5 more each month to remain enrolled.

If members responded that they were willing to contribute $5 (or $5 *more*, in the case of Plus Members), they were then asked if they were willing to contribute $10 (or $10 *more* for Plus Members). **Exhibit 14** shows that the majority of members who reported that they were willing to pay $5 (or $5 more) also reported that they were willing to pay $10 (or $10 more) to remain enrolled.

Exhibit 14: Members' Willingness to Pay $10 (Basic) or $10 More (Plus) to Remain Enrolled, by Member Type



Source: Basic and Plus Member Survey data: December 2016 – January 2017, weighted percentages reported

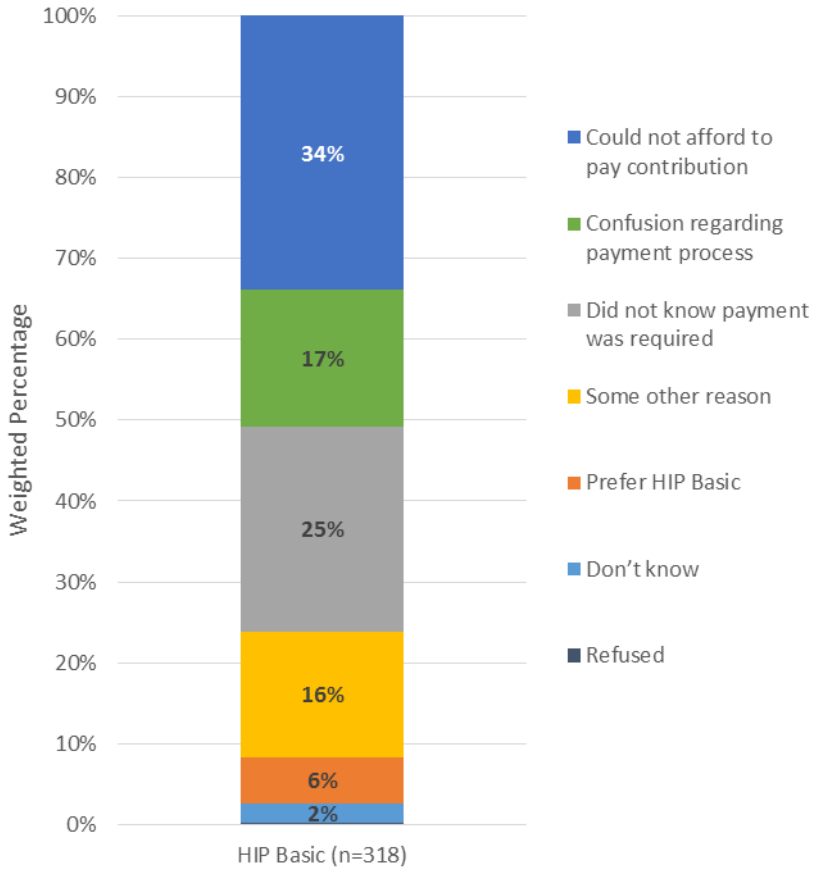
Reasons for non-payment of PAC

To understand why Basic Members, Leavers, and Never Members did not pay their PAC, respondents were first asked to confirm that they did not make or had stopped making a contribution to be in HIP. Three-hundred and eighteen Basic Members (78 percent) confirmed that they were not currently making a contribution to be in HIP, 124 Leavers (61 percent) confirmed that they had stopped making contributions, and 168 Never Members (84 percent) confirmed that they did not make their first contribution to be in HIP.

Individuals who confirmed their payment status were then asked why they did not make – or stopped making – payments. The surveys allowed for response choices that were relevant for each specific group. For example, for the Leaver and Never Member surveys, response options included events that would render an individual ineligible for HIP coverage, such as moving out of Indiana or an increase in income. For Basic Members, these response options were not included because they do not apply to Basic Members, given that they are still enrolled in and eligible for HIP.

Exhibit 15 displays Basic Member respondents' reported reasons for non-payment.

Exhibit 15: Reasons for Non-Payment of PAC, Basic Member Respondents

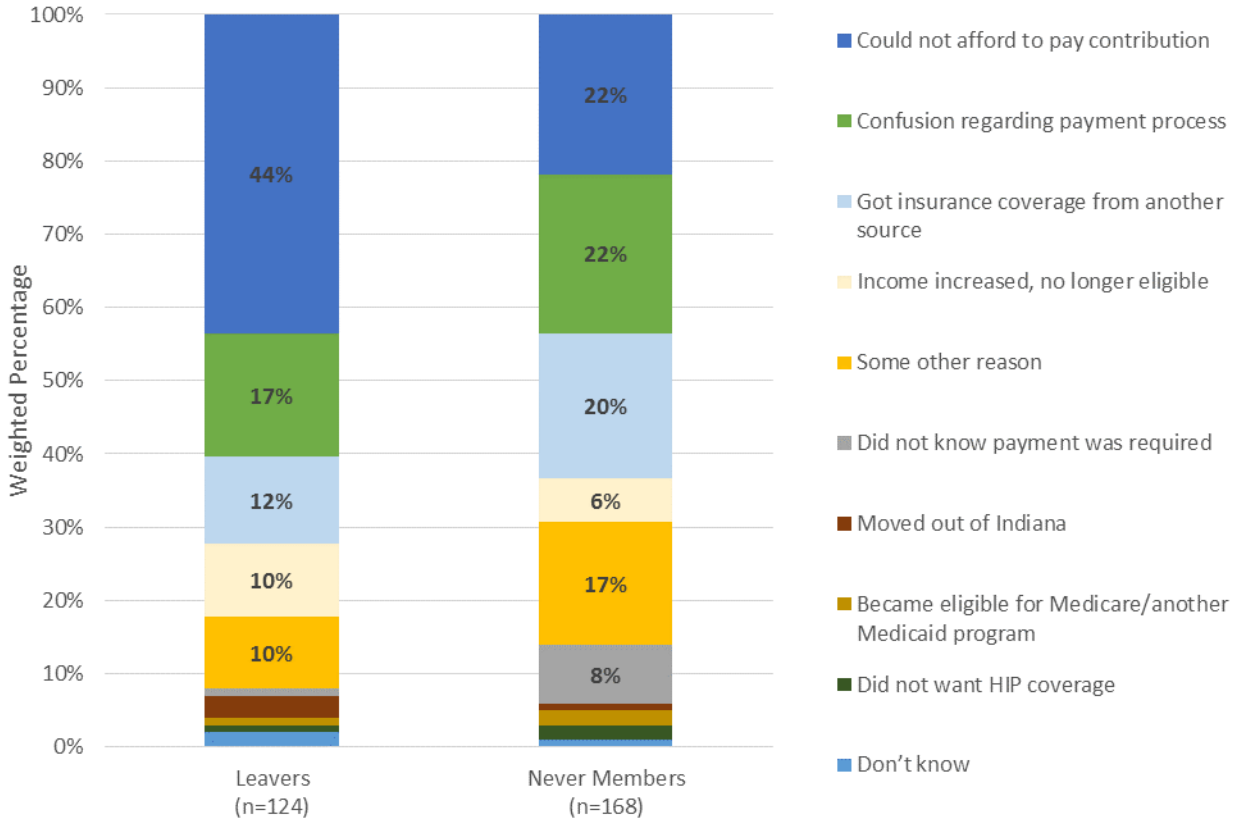


Source: Basic Member Survey data: December 2016 – January 2017, weighted percentages reported

The most common reason cited for Basic Member respondents not making payments was "I could not afford to pay the contribution," with 34 percent (n=109) of Basic Member respondents citing this as the main reason for not making PAC. Previously Plus Basic Member respondents were slightly more likely to choose "I could not afford to pay the contribution," as their main reason for non-payment, with 42 percent (n=20) of Previously Plus Basic Member respondents choosing this reason, compared to 32 percent (n=89) of Always Basic Member respondents.

Among Leaver and Never Member respondents, "I could not afford to pay the contribution" was also a common reason cited for non-payment of PAC, as illustrated in **Exhibit 16**. Approximately 44 percent (n=54) of Leaver respondents reported that they could not afford to pay the contribution. Among Never Member respondents, the two most common reasons cited for not making payments were "I could not afford to pay the contribution," (n=37; 22 percent) and "I was confused about the payment process (I wasn't sure how much to pay, when to pay, where to pay)" (n=37; 22 percent).

Exhibit 16: Reasons for Non-Payment of PAC, Leaver and Never Member Respondents



Source: Leaver and Never Member Survey data: December 2016 – January 2017, weighted percentages reported

Research Question 5: How are individuals accessing health care if they are disenrolled due to non-payment of PAC?

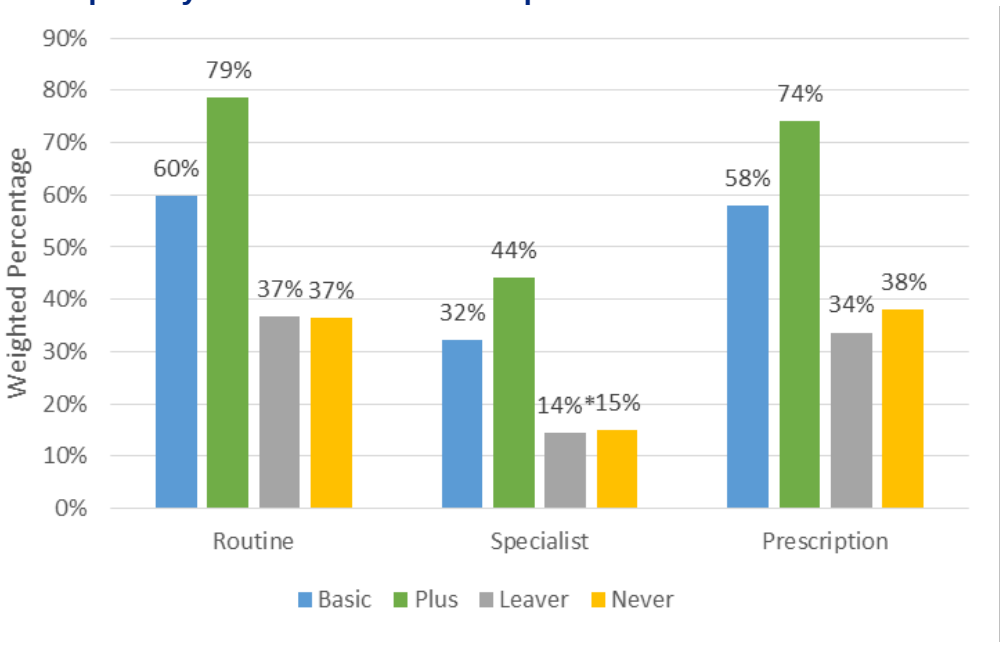
Access to Care

The Basic, Plus, Leaver, and Never Member surveys included a series of questions about whether respondents made appointments for health care services in the past six months, or since leaving HIP for Leavers who disenrolled from HIP fewer than six months previously. Specifically, the surveys asked whether members had:

1) Made any appointments for a routine check-up at a doctor's office or clinic;
2) Made any appointments to see a specialist; or
3) Filled a prescription.

Exhibit 17 shows the percentages of Basic, Plus, Leaver, and Never Member respondents who reported making appointments for routine or specialized care or filling a prescription.

Exhibit 17: Percentages of Survey Respondents who Made an Appointment for Routine or Specialty Care and Filled Prescriptions in the Past Six Months



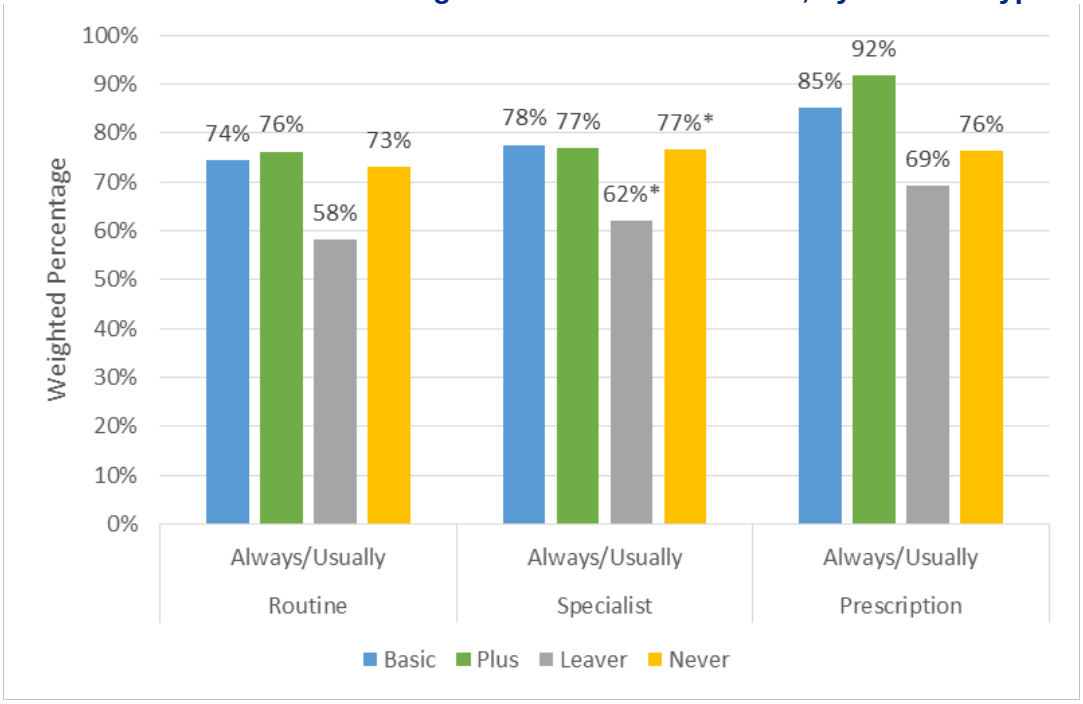
Source: Basic, Plus, Leaver, and Never Member Survey data: December 2016 – January 2017, weighted percentages reported.
Note: Asterisks next to the percentage represent instances where the sample size is fewer than 30 respondents, which indicates reduced confidence in the findings.

Leaver and Never Member respondents were less likely than Plus and Basic Member respondents to report making appointments both for routine and specialty care. Leavers and Never Member respondents were also less likely to report filling a prescription in the past six months or since leaving HIP.

Respondents who reported that they had made an appointment or filled a prescription were then asked about their access to these services, specifically whether, for routine or specialty care, they could get an appointment "as soon as you needed," and for prescriptions, "how often was it easy to get your prescription medicine from your health plan." Respondents could select "never," "sometimes," "usually," or "always."[38] **Exhibit 18** shows the percentage of respondents indicating that they could "always" or "usually" access care as soon as needed.

[38] Respondents could also select "Don't know" or "Refused."

Exhibit 18: Ease of Accessing Care as Soon as Needed, by Member Type



Source: Basic, Plus, Leaver, and Never Member Survey data: December 2016 – January 2017, weighted percentages reported.
Note: Asterisks next to the percentage represent instances where the sample size is fewer than 30 respondents, which indicates reduced confidence in the findings.

A majority of respondents in every member group reported that they "always" or "usually" could access care as soon as needed, as opposed to "never" or "sometimes." For routine appointments, Leaver respondents were less likely than Plus, Basic and Never Member respondents to report that they could "always" or "usually" get an appointment as soon as needed, with 58 percent (n=43) of Leaver respondents selecting "always" or "usually," compared to 73 percent (n=53) of Never Member respondents, 74 percent (n=174) of Basic Member respondents and 76 percent (n=232) of Plus Member respondents. With respect to prescriptions, Leavers and Never Member respondents were less likely than Plus and Basic Member respondents to report that it was "always" or "usually" easy to fill a prescription, with 69 percent (n=47) of Leaver respondents and 76 percent (n=58) of Never Member respondents selecting these options, compared to 85 percent (n=191) of Basic Member respondents and 92 percent (n=254) of Plus Member respondents.

Access to Other Insurance Coverage after Leaving HIP

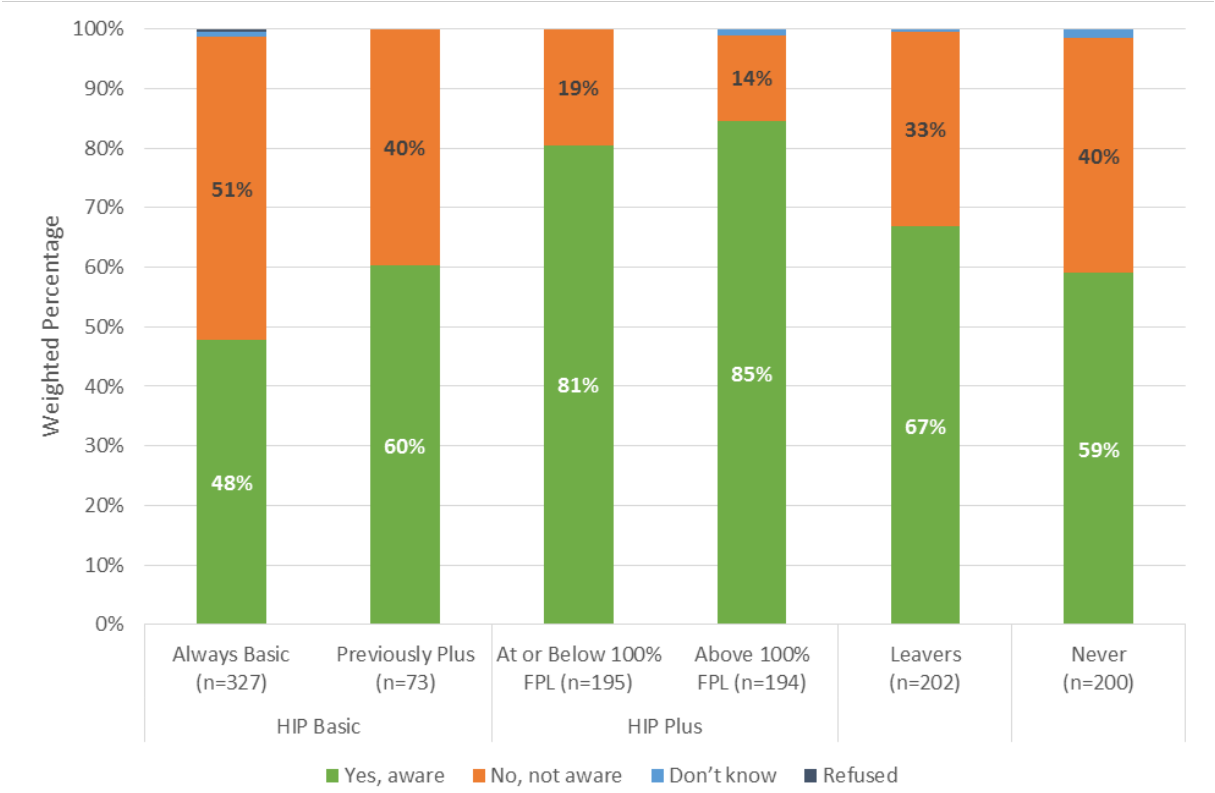
The Leaver and Never Member surveys also asked respondents whether they had health insurance coverage after leaving HIP. Forty-seven percent (n=94) of Leaver respondents and 41 percent (n=82) of Never Member respondents reported that they had insurance coverage at the time of the survey. Insurance from their own employer was the most common source of coverage reported among both Leaver and Never Member respondents, with 59 percent (n=55) of Leaver respondents with insurance and 56 percent (n=46) of Never Member respondents with insurance reporting

coverage from this source.[39] An additional nine percent (n=8) of Leavers with insurance and 12 percent (n=10) of Never Members with insurance reported coverage from their spouse's employer.

Research Question 6: Was the disenrollment period a deterrent for individuals with incomes over 100 percent of the FPL to miss a PAC?

The four surveys also included a series of questions to gauge enrolled, disenrolled and not enrolled members' understanding of the repercussions of non-payment: disenrollment or no enrollment for individuals with incomes over 100 percent of the FPL and transition to Basic for members with incomes under 100 percent of the FPL.[40] These questions were not analyzed to assess causality, but rather members' understanding of the effects of non-payment. **Exhibit 19** shows the survey responses for each member group.

Exhibit 19: HIP Member Understanding of the Repercussions of Non-payment, by Member Group



Source: Basic, Plus, Leaver, and Never Member Survey data: December 2016 – January 2017, weighted percentages reported.

[39] Respondents who reported that they did not have insurance coverage were not asked the source of their insurance coverage. As such, the percentages reported here are out of the Leaver and Never Members respondents *who reported that they had insurance.*

[40] As noted above, TMA participants and medically-frail were excluded from the sample of Plus Members with incomes above 100 percent of the FPL because they are exempt from disenrollment.

Among all of the groups, HIP Plus Member respondents, particularly HIP Plus Member respondents with incomes above 100 percent of the FPL, reported the greatest understanding of the repercussions of non-payment. Eighty-five percent (n=164) of HIP Plus Member respondents with incomes above 100 percent of the FPL, i.e., members who are maintaining PAC and could be disenrolled due to non-payment, reported being aware that they could be disenrolled for non-payment of PAC.

Sixty-seven percent of Leaver respondents (n=135) and 59 percent of Never Member respondents (n=118), i.e., members who did not make PAC and were disenrolled or not enrolled as a result, reported being aware that they could be disenrolled or not enrolled for non-payment of PAC. Always Basic Member respondents, i.e., members who had never made a PAC, were least aware of the repercussions of non-payment, with 48 percent (n=154) reporting that they were aware that members are transitioned to Basic for non-payment of PAC.

V. Limitations

Surveys have some inherent limitations which may affect this analysis. First, individuals who were not able to be contacted or who did not complete the survey could have different responses than individuals who did complete the survey. Additionally, respondents may introduce errors if they do not accurately recall events, for example making an appointment in the past six months. To minimize recall bias, the survey look-back timeframe for questions related to access was limited to the past six months, or in the months since they left HIP, for Leavers who left HIP fewer than six months previously. In addition, the survey questions assessing access to care asked about whether respondents *made* appointments. It may be possible that a member needed health care but did not make an appointment because he or she did not think it would be possible to get the appointment. Thus, asking about scheduled appointments may underreport potential access issues.

In addition, some eligibility variables received from FSSA, namely the reason codes, may lead to a biased estimate of the number of individuals disenrolled or not enrolled for missing a PAC. Reason codes were used to identify individuals disenrolled or not enrolled due to non-payment of PAC, specifically the reason code 276. Individuals with 1) an enrollment status of closed or denied in a given month, 2) a 276 reason code and no other reason code in that month, and 3) without full coverage in the month prior to the closure/denial (for Never Members) or without coverage in the month following the closure/denial (for Leavers) were counted as individuals disenrolled or not enrolled due to non-payment.[41] The 276 code is system-generated, meaning that if a member fails to make a PAC, the code is automatically applied to the member's record. Individuals could have other reasons for not making a PAC, for example gaining access to employer-sponsored coverage, which may not be documented in the reason code enrollment data. Such issues with the reason code data could result in overreporting or underreporting of the number of individuals disenrolled or not enrolled due to non-payment.

[41] Individuals with a 276 in the month *before* they were disenrolled were also considered disenrolled due to non-payment to account for lags in processing. Also, members with a 276 reason code in November 2016 were considered Leavers even though due to the data timeframe, it could not be verified that these members did not have coverage in December 2016. For Leavers, we also verified that members had a fully enrolled month *prior* to being disenrolled.

VI. Appendices

Appendix A: Relevant Special Terms and Conditions

Relevant text from the Special Terms and Conditions (STCs) is included below. The requirements from Section XIII, STC 5 pertain to this evaluation; Section VIII, STC 5 pertains to the Monitoring Protocol in **Appendix E**.

a. Section XIII, STC 5

5. HIP Plus POWER Account Contribution Evaluation. Indiana must use the results of the contribution monitoring data—including the survey of enrolled and unenrolled individuals—described in Section VIII STC 4—as well as other available data to conduct an independent evaluation that examines POWER Account contributions policy for HIP Plus beneficiaries.

a) As part of this evaluation, the state shall survey statistically significant groups of individuals who:
   i) are income eligible but do not enroll in HIP;
   ii) have been disenrolled for non-payment of POWER account contribution; and
   iii) are in HIP Basic.
b) The survey shall include questions about the affordability of HIP POWER account contributions.
c) The interim evaluation report must be submitted within 60 days after DY 2, include hypotheses, and address the effect of the lockout policy on enrollment and reenrollment for HIP Plus beneficiaries broken down by income level and questions including:
   i) How many individuals were disenrolled by income level?
   ii) What are the reasons beneficiaries did not make contributions?
   iii) What health care needs did individuals have while they were in the lockout period and how did they address those needs?
d) Information provided in this interim evaluation report must also be addressed in the evaluation design, interim evaluation report as described in paragraph 8 of this section, and final evaluation report as described in paragraph 9 of this section. A delay in submitting this report could subject the state to penalties described in paragraph 16 of section III.

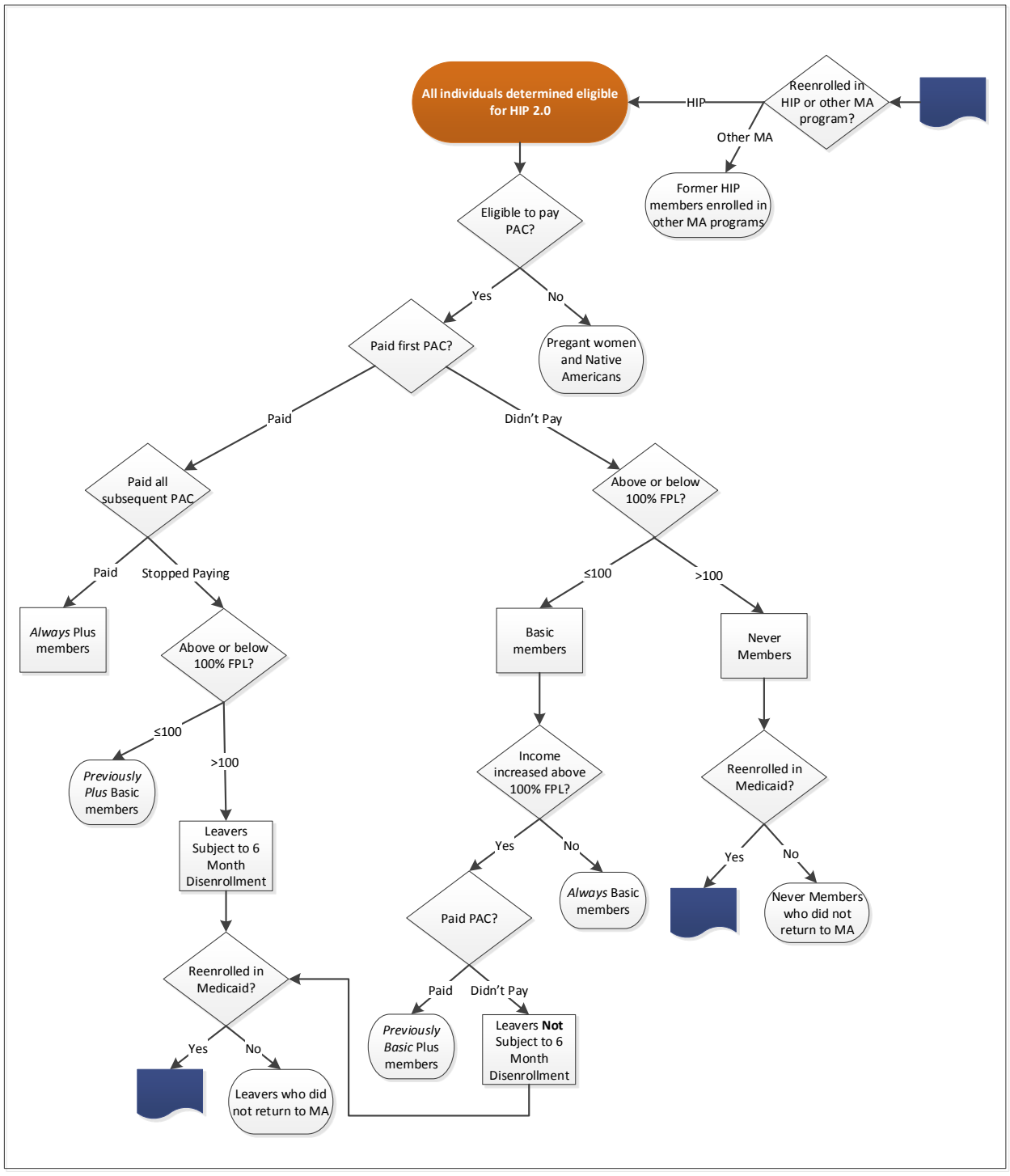
b. Section VIII STC 5

5. Power Account Contributions and Copayments Monitoring Protocol. Within 180 days after approval of this demonstration, the state must submit criteria by which the state shall monitor required beneficiary contributions (both POWER account contributions and copayments). As part of monitoring, the state shall engage an independent entity to, each year, survey individuals enrolled in HIP 2.0, individuals who are eligible but not enrolled, and individuals who have disenrolled for nonpayment of contributions. The state must include a list of the data it will report to CMS in quarterly reports and actual data where it is available. Such data must include but is not limited to the number of:

a) Individuals subject to POWER account contributions and copayment requirements;
b) Individuals whose required POWER account contributions have been reduced or have benefited from the roll-over incentive due to preventive care;
c) The number of individuals who received POWER account contributions from employers and not-for-profit entities and the average total amounts by income level;

d) Individuals with overdue POWER account contributions including those with POWER account contributions past due less than and greater than 60 days;
e) The number of beneficiaries subjected to a 6-month lockout, number exempted and meeting qualifying event criteria, and the reasons for non-payment as reported in the survey;
f) Information about the MCO's collection activities including the number of beneficiaries subject to collection, amounts due, and amounts paid;
g) The number of individuals who are obligated to make POWER account contributions, POWER account debts;
h) The number of individuals who have reached the 5 percent threshold on a monthly or quarterly basis;
i) The number of individuals in the differing co-payment structures for nonemergency use of the ER;
j) The number of individuals who have called the nurse hotline and the number who subsequently visited the ER;
k) The number of individuals charged the $8 non-emergency use of the ER copayment; and
l) The number of individuals charged the $25 non-emergency use of the ER copayment.

Appendix B: Diagram of HIP 2.0 POWER Account Contribution Policies



Note: MA refers to Medical Assistance (i.e., Medicaid). The blue shapes signify a break in the flow: members who reenroll in Medicaid and therefore may reenter the process from the beginning.

Appendix C: Survey Instruments

Basic Member Survey

Survey of Current Healthy Indiana Plan (HIP) Members – BASIC

DESCRIPTION: This survey applies to individuals currently enrolled in HIP BASIC, per eligibility data.

INTERVIEWER INITIALS:				LEWIN ID:								

INTRODUCTION: Hello my name is _____calling from Opinion Access Corporation on behalf of the new Healthy Indiana Plan, also known as HIP or HIP 2.0. May I please speak with (INSERT NAME FROM SAMPLE)?

(OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY)
Today we're talking with HIP members to get their opinions about the services they receive. We're interested in your opinions about the plan.
IF NEEDED: You may know this by the name of your Medicaid health plan such as Anthem, MDwise or MHS. You may know HIP as your Medicaid health insurance.
IF NEEDED: Please remember that the answer that you provide today will NOT affect your benefits and all responses will remain anonymous.
IF NEEDED: Your name was picked from a list of all people who receive health care through HIP. By sharing your opinions you can help HIP improve services for everyone.

Q1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (or HIP) for Hoosiers age 19 to 64. Are you enrolled in the "Healthy Indiana Plan" or "HIP" at this time?

- ☐ YES → **CONTINUE WITH THE SURVEY, GO TO Q3**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q2**
- ☐ REFUSED

Q2. Sorry, but just to confirm, based on the information we have from HIP, it looks like you are currently enrolled in the "Healthy Indiana Plan" or "HIP." Is this correct?

- ☐ YES → **CONTINUE WITH THE SURVEY, GO TO Q3**
- ☐ NO
- ☐ DON'T KNOW → **GO TO CLOSE**
- ☐ REFUSED

Q3. How long have you been enrolled in the "Healthy Indiana Plan" or "HIP?"

- ☐ LESS THAN 3 MONTHS
- ☐ 3 MONTHS TO LESS THAN 6 MONTHS
- ☐ 6 – 12 MONTHS
- ☐ MORE THAN 12 MONTHS
- ☐ DON'T KNOW
- ☐ REFUSED

Next, please think about how you have received health care such as doctors'

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appointments in the past 6 months.

Q4. In the last 6 months, while enrolled in HIP, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ☐ YES → **GO TO Q5**
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q6**

Q5. In the last 6 months, while enrolled in HIP, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

Q6. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, while enrolled in HIP, did you make any appointments to see a specialist?

- ☐ YES → **GO TO Q7**
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q8**

Q7. In the last 6 months, while enrolled in HIP, how often did you get an appointment to see a specialist as soon as you needed?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

Q8. In the last 6 months, while enrolled in HIP, did you get any new prescription medicines or refill a prescription?

- ☐ YES → **GO TO Q9**
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q10**

Q9. In the last 6 months, while enrolled in HIP, how often was it easy to get your prescription medicine from your health plan?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

AWARENESS

Q10. Were you aware that if you did not make a monthly or annual contribution, you would be moved from HIP Plus to HIP Basic?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service. HIP Basic is the fallback option for members who don't make their POWER account contributions. Unlike HIP Plus, HIP Basic does not cover vision or dental services and members are required to make copayments for most services.)

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

AFFORDABILITY

Q11. If HIP required you to pay $5 each month, would you continue to stay enrolled?

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q13**

Q12. What about $10? Would you continue to stay enrolled if HIP required you to pay $10 each month?

- ☐ YES
- ☐ NO

- ☐ DON'T KNOW
- ☐ REFUSED

REASONS FOR NON-PAYMENT

Q13. According to information from HIP, you are not currently making a contribution to be in HIP. Is this correct?
(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service.)

- ☐ YES, I AM CURRENTLY **NOT** MAKING A CONTRIBUTION → **GO TO Q14**
- ☐ NO, I AM CURRENTLY MAKING A CONTRIBUTION
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO CLOSE**

Q14. What is the main reason you are not making the contribution?

I'm going to read a few statements. Please tell me which one of these statements best describes your reason. (NOTE TO INTERVIEWERS: If respondent thinks more than one applies, redirect them to choose the main reason.)

- ☐ I WAS CONFUSED ABOUT THE PAYMENT PROCESS (I WASN'T SURE HOW MUCH TO PAY, WHEN TO PAY, WHERE TO PAY)
- ☐ I DIDN'T KNOW A PAYMENT WAS REQUIRED TO BE IN HIP PLUS
- ☐ I COULD NOT AFFORD TO PAY THE CONTRIBUTION
- ☐ I PREFER HIP BASIC COVERAGE (I PREFER TO PAY FOR EVERY SERVICE I USE, I DON'T USE A LOT OF SERVICES)
- ☐ SOME OTHER REASON
- ☐ DON'T KNOW
- ☐ REFUSED

CLOSE: Those are all of our questions. On behalf of the Healthy Indiana Plan, we thank you for participating in this survey. Your answers will help improve the program.

Plus Member Survey

Survey of Current Enrollees in the Healthy Indiana Plan (HIP) PLUS

DESCRIPTION: This survey applies to individuals currently enrolled in HIP PLUS, identified with eligibility data.

INTERVIEWER INITIALS:				LEWIN ID:								

INTRODUCTION: Hello my name is _____calling from Opinion Access Corporation on behalf of the new Healthy Indiana Plan, also known as HIP or HIP 2.0. May I please speak with (INSERT NAME FROM SAMPLE)?

(OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY)
Today we're talking with HIP members to get their opinions about the services they receive. We're interested in your opinions about the plan.
IF NEEDED: You may know this by the name of your Medicaid health plan such as Anthem, MDwise or MHS. You may know HIP as your Medicaid health insurance.
IF NEEDED: Please remember that the answer that you provide today will NOT affect your benefits and all responses will remain anonymous.
IF NEEDED: Your name was picked from a list of all people who receive health care through HIP. By sharing your opinions you can help HIP improve services for everyone.

Q1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (or HIP) for Hoosiers age 19 to 64. Are you enrolled in the "Healthy Indiana Plan" or "HIP" at this time?

- ☐ YES → **CONTINUE WITH THE SURVEY, GO TO Q3**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q2**
- ☐ REFUSED

Q2. Sorry, but just to confirm, based on the information we have from HIP, it looks like you are currently enrolled in the "Healthy Indiana Plan" or "HIP." Is this correct?

- ☐ YES → **CONTINUE WITH THE SURVEY, GO TO Q3**
- ☐ NO
- ☐ DON'T KNOW → **GO TO CLOSE**
- ☐ REFUSED

Q3. How long have you been enrolled in the "Healthy Indiana Plan" or "HIP?"

- ☐ LESS THAN 3 MONTHS
- ☐ 3 MONTHS TO LESS THAN 6 MONTHS
- ☐ 6 – 12 MONTHS
- ☐ MORE THAN 12 MONTHS
- ☐ DON'T KNOW
- ☐ REFUSED

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Next, please think about how you have received health care such as doctors' appointments in the past 6 months.

Q4. In the last 6 months, while enrolled in HIP, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ☐ YES → **GO TO Q5**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q6**
- ☐ REFUSED

Q5. In the last 6 months, while enrolled in HIP, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

Q6. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, while enrolled in HIP, did you make any appointments to see a specialist?

- ☐ YES → **GO TO Q7**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q8**
- ☐ REFUSED

Q7. In the last 6 months, while enrolled in HIP, how often did you get an appointment to see a specialist as soon as you needed?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

Q8. In the last 6 months, while enrolled in HIP, did you get any new prescription medicines or refill a prescription?

- ☐ YES → **GO TO Q9**
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q10 OR Q11, AS APPROPRIATE**

Q9. In the last 6 months, while enrolled in HIP, how often was it easy to get your prescription medicine from your health plan?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

AWARENESS

Q10. (ONLY ASK OF THOSE WHO ARE AT OR BELOW 100% FPL) Are you aware that if you do not make a monthly or annual contribution, you will be moved from HIP Plus to HIP Basic?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service. HIP Basic is the fallback option for members who don't make their POWER account contributions. Unlike HIP Plus, HIP Basic does not cover vision or dental services and members are required to make copayments for most services.)

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

Q11. (ONLY ASK OF THOSE WHO ARE ABOVE 100% FPL) Are you aware that if you do not make a contribution you can be disenrolled from HIP and not allowed to return for 6 months?

(IF NEEDED: Disenrolled means you would no longer have coverage.)

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

AFFORDABILITY

Q12. Did you make a monthly or annual contribution when you were in HIP?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.')

- ☐ NO, I DID NOT MAKE A MONTHLY OR ANNUAL CONTRIBUTION IN HIP → **GO TO Q18**
- ☐ YES, MONTHLY CONTRIBUTION→ **GO TO Q13**
- ☐ YES, ANNUAL CONTRIBUTION→ **GO TO Q14**
- ☐ DON'T KNOW → **GO TO Q18**
- ☐ REFUSED → **GO TO Q18**

Q13. When you were enrolled in HIP, how much money did you pay each month? (NOTE TO INTERVIEWERS: Enter a value between 1 and 9,999)

$ |___|,___|___|___|

- ☐ DON'T KNOW
- ☐ REFUSED

Q14. When you were enrolled in HIP, how much money did you pay each year or annually? (NOTE TO INTERVIEWERS: Enter a value between 1 and 9,999)

$ |___|,___|___|___|

- ☐ DON'T KNOW
- ☐ REFUSED

Q15. In the past 6 months, how often were you worried about having enough money to pay your contribution?

- ☐ NEVER
- ☐ RARELY
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

Q16. When you paid your contribution, did you get any help with the cost from someone else such as a family member, friend, employer, healthcare provider or charity?

- ☐ YES → **GO TO Q17**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q18**
- ☐ REFUSED

Q17. Please tell me yes or no if you received help in making contributions from each of these sources:

- ☐ FAMILY MEMBER
- ☐ FRIEND
- ☐ CHARITY OR RELIGIOUS ORGANIZATION
- ☐ A HEALTHCARE PROVIDER SUCH AS A DOCTOR'S OFFICE OR HOSPITAL
- ☐ EMPLOYER
- ☐ SOME OTHER SOURCE

Q18. If HIP required you to pay $5 more each month, would you continue to stay enrolled?

- ☐ YES → **GO TO Q19**
- ☐ NO
- ☐ DON'T KNOW → **GO TO CLOSE**
- ☐ REFUSED

Q19. What about $10 more? Would you continue to stay enrolled if HIP required you to pay $10 each month?

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

CLOSE: Thank you for answering these questions. On behalf of the Healthy Indiana Plan, we thank you for participating in this survey. Your answers will help improve the program.

Leaver Survey

Survey of Healthy Indiana Plan (HIP) Previous HIP Plus Members (Income Above 100 Percent of the Federal Poverty Level)

DESCRIPTION: This survey applies to previous HIP Plus members with income over 100% FPL who were disenrolled from the program due to non-payment of the POWER Account Contribution (PAC).

INTERVIEWER INITIALS:				LEWIN ID:								

INTRODUCTION: Hello my name is _____calling from Opinion Access Corporation on behalf of the new Healthy Indiana Plan, also known as HIP or HIP 2.0. May I please speak with (INSERT NAME FROM SAMPLE)?

(OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY)

Today we're talking with Hoosiers who previously had HIP insurance but no longer have it. We're interested in your opinions about the plan.

Q1. In February 2015, the State of Indiana introduced a new Medicaid program called HIP, sometimes called the "Healthy Indiana Plan." Information from HIP shows that you had coverage through HIP, but are no longer enrolled in the program. Is this correct?
(IF NEEDED: 'No longer enrolled' means you currently do not have coverage through HIP.)

- ☐ YES → **GO TO Q3**
- ☐ NO, I NEVER HAD COVERAGE THROUGH HIP → **GO TO Q2**
- ☐ NO, I AM CURENTLY ENROLLED IN HIP → **GO TO Q2**
- ☐ DON'T KNOW → **GO TO Q2**
- ☐ REFUSED→ **GO TO Q2**

Q2. Sorry, but just to confirm, based on the information we have from HIP, it looks like you had coverage through HIP but are not currently enrolled at this time. Is that correct?

- ☐ YES → **GO TO Q3**
- ☐ NO, I NEVER HAD COVERAGE THROUGH HIP → **GO TO CLOSE**
- ☐ NO, I AM CURENTLY ENROLLED IN HIP → **GO TO CLOSE**
- ☐ DON'T KNOW → **GO TO CLOSE**
- ☐ REFUSED → **GO TO CLOSE**

Q3. How long were you enrolled in HIP?

- ☐ LESS THAN 3 MONTHS
- ☐ 3 MONTHS TO LESS THAN 6 MONTHS
- ☐ 6 – 12 MONTHS
- ☐ MORE THAN 12 MONTHS
- ☐ DON'T KNOW
- ☐ REFUSED

ACCESS

Next, please think about how you have received health care such as doctors' appointments in the past 6 months since you left HIP or if you have been off of HIP for less time, think about that time.

Q4. In the last 6 months, since you left HIP, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ☐ YES → **GO TO Q5**
- ☐ NO →
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q6**

Q5. In the last 6 months, since you left HIP, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

Q6. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, since you left HIP, did you make any appointments to see a specialist?

- ☐ YES → **GO TO Q7**
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q8**

Q7. In the last 6 months, since you left HIP, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q8. In the last 6 months, since you left HIP, did you get any new prescription medicines or refill a prescription?

- YES → **GO TO Q9**
- NO
- DON'T KNOW
- REFUSED

→ **GO TO Q10**

Q9. In the last 6 months, since you left HIP, how often was it easy to get your prescription medicine?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

AWARENESS

Q10. Were you aware that, in HIP, if you did not make a monthly or annual contribution, you would be disenrolled from the program and not allowed to return for 6 months?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' 'Disenrolled' means you no longer have coverage.)

- YES
- NO
- DON'T KNOW
- REFUSED

AFFORDABILITY

Q11. Did you make a monthly or annual contribution when you were in HIP?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.')

- NO, I DID NOT MAKE A MONTHLY OR ANNUAL CONTRIBUTION IN HIP → **GO TO Q17**
- YES, MONTHLY CONTRIBUTION→ **GO TO Q12**

- ☐ YES, ANNUAL CONTRIBUTION→ **GO TO Q13**
- ☐ DON'T KNOW → **GO TO Q17**
- ☐ REFUSED → **GO TO Q17**

Q12. When you were enrolled in HIP, how much money did you pay each month? (NOTE TO INTERVIEWERS: Enter a value between 1 and 9,999)

$ |___|,___|___|___|

- ☐ DON'T KNOW
- ☐ REFUSED

Q13. When you were enrolled in HIP, how much money did you pay each year or annually? (NOTE TO INTERVIEWERS: Enter a value between 1 and 9,999)

$ |___|,___|___|___|

- ☐ DON'T KNOW
- ☐ REFUSED

Q14. When you were enrolled in HIP, how often were you worried about having enough money to pay your contribution?

- ☐ NEVER
- ☐ RARELY
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

REASONS FOR NON-PAYMENT

Q15. According to information from HIP, you stopped making your contributions. Is this correct?
(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service.)

- ☐ YES, I STOPPED MAKING CONTRIBUTIONS → **GO TO Q16**
- ☐ NO, I DID NOT STOP MAKING CONTRIBUTIONS
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q17**

Q16. What is the main reason you stopped making the contribution?

I'm going to read a few statements. Please tell me which one of these statements best describes your reason. (NOTE TO INTERVIEWERS: If respondent thinks more than one applies, redirect them to choose the main reason.)

- ☐ I WAS CONFUSED ABOUT THE PAYMENT PROCESS (I WASN'T SURE HOW MUCH TO PAY, WHEN TO PAY, WHERE TO PAY)
- ☐ I DIDN'T KNOW A PAYMENT WAS REQUIRED
- ☐ I COULD NOT AFFORD TO PAY THE CONTRIBUTION
- ☐ I DIDN'T WANT HIP COVERAGE
- ☐ MY INCOME INCREASED; SO I WAS NO LONGER ELIGIBLE
- ☐ I MOVED OUT OF INDIANA
- ☐ I GOT INSURANCE COVERAGE FROM ANOTHER SOURCE, SUCH AS MY EMPLOYER OR MY SPOUSE'S EMPLOYER
- ☐ I BECAME ELIGIBLE FOR COVERAGE THROUGH MEDICARE OR ANOTHER MEDICAID PROGRAM
- ☐ SOME OTHE REASON
- ☐ DON'T KNOW
- ☐ REFUSED

OTHER COVERAGE

Q17. Do you have any health insurance coverage right now?

- ☐ YES → **GO TO Q18**
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO CLOSE**

Q18. What is your primary source of insurance coverage?

I'm going to read some sources of insurance coverage. Please tell me which ONE of these is your primary source of insurance coverage.

(IF NEEDED: If you have more than one source, then tell me which one is the main source of coverage)

- ☐ THROUGH YOUR OWN EMPLOYER
- ☐ THROUGH YOUR SPOUSE'S OR PARTNER'S EMPLOYER
- ☐ MEDICARE
- ☐ MEDICAID OR HOOSIER HEALTHWISE, OR HOOSIER CARE CONNECT
- ☐ TRICARE
- ☐ VETERAN'S ADMINISTRATION (VA)
- ☐ AN INDIVIDUAL POLICY
- ☐ MARKETPLACE
- ☐ SOME OTHER SOURCE
- ☐ DON'T KNOW
- ☐ REFUSED

CLOSE:	**Those are all of our questions. On behalf of the Healthy Indiana Plan, we thank you for participating in this survey. Your answers will help improve the program.**

Never Member Survey

Survey of Individuals Never Enrolled in the Healthy Indiana Plan (HIP) 2.0 – Did Not Make the Initial PAC

DESCRIPTION: This survey applies to individuals **NOT** currently enrolled in HIP who applied for HIP coverage but did not make their first Power Account Contribution (PAC). At the time of the application these individuals were over 100% of the FPL. Individuals in this population were identified using eligibility data.

INTERVIEWER INITIALS:				**LEWIN ID:**								

INTRODUCTION: Hello my name is _____calling from Opinion Access Corporation on behalf of the new Healthy Indiana Plan, also known as HIP or HIP 2.0. May I please speak with (INSERT NAME FROM SAMPLE)?

(OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY)

Today we're talking with Hoosiers who applied for HIP insurance but did not enroll in the program. We're interested in your opinions about the plan.

Q1. In February 2015, the State of Indiana introduced a new Medicaid program called HIP, sometimes called the "Healthy Indiana Plan." Information from HIP shows that you applied for coverage through HIP but that you never enrolled in the program. Is this correct?

(IF NEEDED: 'Never enrolled' means you never had coverage through HIP.)

- ☐ YES → **GO TO Q3**
- ☐ NO, I NEVER APPLIED FOR HIP COVERAGE → **GO TO Q2**
- ☐ NO, I HAD OR CURRENTLY HAVE COVERAGE THROUGH HIP → **GO TO Q2**
- ☐ DON'T KNOW → **GO TO Q2**
- ☐ REFUSED → **GO TO Q2**

Q2. Sorry, but just to confirm, based on the information we have from HIP, it looks like you applied for coverage through HIP but that you never enrolled in the program. Is that correct?

- ☐ YES → **GO TO Q3**
- ☐ NO, I NEVER APPLIED FOR HIP COVERAGE → **GO TO CLOSE**
- ☐ NO, I HAD OR CURRENTLY HAVE COVERAGE THROUGH HIP → **GO TO CLOSE**
- ☐ DON'T KNOW → **GO TO CLOSE**
- ☐ REFUSED → **GO TO CLOSE**

ACCESS

Next, please think about how you have received health care such as doctors' appointments in the past 6 months.

Q3. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ☐ YES → **GO TO Q4**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q5**
- ☐ REFUSED

Q4. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

Q5. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

- ☐ YES → **GO TO Q6**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q7**
- ☐ REFUSED

Q6. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

Q7. In the last 6 months, did you get any new prescription medicines or refill a prescription?

- ☐ YES → **GO TO Q8**
- ☐ NO
- ☐ DON'T KNOW → **GO TO Q9**
- ☐ REFUSED

Q8. In the last 6 months, how often was it easy to get your prescription medicine?

- ☐ NEVER
- ☐ SOMETIMES
- ☐ USUALLY
- ☐ ALWAYS
- ☐ DON'T KNOW
- ☐ REFUSED

AWARENESS

Q9. This question is about contributions to HIP, the Healthy Indiana Program for which you applied but did not enroll. Were you aware that if you did not make your first contribution, that you would not be enrolled in HIP?
(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' 'Not enrolled in HIP' means you didn't have coverage through HIP.)

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED

REASONS FOR NON-PAYMENT

Q10. According to information from HIP, you did not make your first contribution to enroll in HIP coverage. Is this correct?
(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service.)

- ☐ YES, I DID NOT MAKE A CONTRIBUTION → **GO TO Q11**
- ☐ NO, I MADE A CONTRIBUTION
- ☐ DON'T KNOW
- ☐ REFUSED

→ **GO TO Q12**

Q11. What is the main reason you did not make the contribution?

I'm going to read a few statements. Please tell me which one of these statements best describes your reason. (NOTE TO INTERVIEWERS: If respondent thinks more than one applies, redirect them to choose the main reason.)

- ☐ I WAS CONFUSED ABOUT THE PAYMENT PROCESS (I WASN'T SURE HOW MUCH TO PAY, WHEN TO PAY, WHERE TO PAY)
- ☐ I DID NOT REALIZE A PAYMENT WAS REQUIRED

- ☐ I COULD NOT AFFORD TO PAY THE CONTRIBUTION
- ☐ I DIDN'T WANT HIP COVERAGE
- ☐ MY INCOME INCREASED; SO I WAS NO LONGER ELIGIBLE
- ☐ I MOVED OUT OF INDIANA
- ☐ I GOT INSURANCE COVERAGE FROM ANOTHER SOURCE, SUCH AS MY EMPLOYER OR MY SPOUSE'S EMPLOYER
- ☐ I BECAME ELIGIBLE FOR COVERAGE THROUGH MEDICARE OR ANOTHER MEDICAID PROGRAM
- ☐ SOME OTHER REASON
- ☐ DON'T KNOW
- ☐ REFUSED

OTHER COVERAGE

Q12. Do you have any health insurance coverage right now?

- ☐ YES → **GO TO Q13**
- ☐ NO
- ☐ DON'T KNOW → **GO TO CLOSE**
- ☐ REFUSED

Q13. What is your primary source of insurance coverage?

I'm going to read some sources of insurance coverage. Please tell me which ONE of these is your primary source of insurance coverage.

(IF NEEDED: If you have more than one source, then tell me which one is the main source of coverage)

- ☐ THROUGH YOUR OWN EMPLOYER
- ☐ THROUGH YOUR SPOUSE'S OR PARTNER'S EMPLOYER
- ☐ MEDICARE
- ☐ MEDICAID OR HOOSIER HEALTHWISE, OR HOOSIER CARE CONNECT
- ☐ TRICARE
- ☐ VETERAN'S ADMINISTRATION (VA)
- ☐ AN INDIVIDUAL POLICY
- ☐ MARKETPLACE
- ☐ SOME OTHER SOURCE
- ☐ DON'T KNOW
- ☐ REFUSED

CLOSE: Those are all of our questions. On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve the program.

Appendix D: Survey Sampling Strategy

A. Survey Sampling Strategy

A simple sampling method was used to draw the samples for this study. Frames were obtained for each of six population groups:

1) *Always* Basic Members
2) *Previously Plus* Basic Members
3) Plus members *at or below* 100 percent of the FPL
4) Plus members *above* 100 percent of the FPL
5) Leavers
6) Never Members

The Plus and Basic Member samples were developed using enrollment data for November 30, 2016, provided by FSSA on December 16, 2016, and enrollment data from February 1, 2015 through July 29, 2016, provided by FSSA on December 6, 2016. The Leaver and Never Member samples were provided by FSSA on January 10, 2017 and January 6, 2017, respectively. Lewin verified the Leaver and Never Member samples using enrollment data for February 1, 2015 through November 30, 2016, provided by FSSA on January 6, 2017. Members were removed from the samples if they 1) were not present in the enrollment data in any month, 2) were currently enrolled in HIP or another Medicaid program according to the data, or 3) were exempt from disenrollment (i.e., if they met any of the following criteria in their last month of enrollment: income at or below 100 percent of the FPL, Native American, pregnant, medically frail or TMA).[1] For the Leaver sample, members who were not enrolled at least one month in HIP were also excluded. For the Never Member sample, members who had been enrolled in HIP for one month or more were excluded.[2]

A simple random sample size of 5,000 for each Basic and Plus subgroup was drawn from each of the Basic and Plus frames after removing members who were pregnant or Native American, or had obviously non-working phone numbers, including missing phone numbers and phone numbers equal to zero or 999-999-9999. The list of sampled members was then turned over to a sampling subcontractor who called individuals in the sample until a goal sample size was reached.[3] For Leavers and Never Members, the survey subcontractor was provided the full universes of Leavers and Never Members (after removing members with obviously non-working numbers) because non-

[1] Individuals who were currently enrolled in HIP as of November 2016 were excluded from the samples to ensure that Leaver and Never Member results reflected the experience of members who were not currently enrolled in HIP.

[2] Never Members ever enrolled in HIP as of November 2016 were excluded from the Never Member sample to ensure that Never Member results reflected the experience of members who had never been enrolled in HIP.

[3] AIRvan Consulting served as the survey contractor on this project. They provide services in market research, communication programs, and qualitative and quantitative research. The company abides by professional standards of the Council of American Research Organizations (CASRO), the Marketing Research Association, the Public Relations Society of America, the American Marketing Association, and the International Association of Business Communicators. The call center, Opinion Access Corp. (OAC), is comprised of recognized industry experts who have worked in the field of marketing research quantitative data collection for over two decades. OAC uses state-of-the-art CATI interviewing with quality controls and monitoring and supervisor-to-interviewer ratios that meet or exceed standards set by the Marketing Research Association. They are a CAHPS certified research facility.

response was expected to be very high. The goal sample size was nominally 150 in each of the groups.

The final frame and sample sizes obtained are shown in ***Exhibit D-1***.

Exhibit D-1: Final Frame and Sample Sizes Obtained

Group	Final Frame Size*	Final Sample Size
Current HIP Basic Members	146,522	400
Always Basic Members	115,065	327
Previously Plus Basic Members	31,457	73
Current HIP Plus Members	233,492	389
Plus members at or are below 100 percent of the FPL	196,724	195
Plus members above 100 percent of the FPL	36,768	194
Leavers	5,156	202
Never Members	11,449	200

*Data Source: FSSA Enrollment Data: November 30, 2016 and February 1, 2015 – July 29, 2016. These represent counts after removing 1) members with obviously non-working phone numbers, 2) Native Americans and 3) pregnant women from all frames. TMA participants and medically-frail individuals were also removed from the frames for Plus members above 100 percent of the FPL, Leavers and Never Members. Individuals with incomes at or below 100 percent FPL in their last month of enrollment were also removed from the Leaver and Never Member frames.[4]

As can be seen from the table, target sample sizes were more or less obtained. The quotas for each subgroup actually increased from 150 to 200 during surveying because the deadline for survey completion was extended. In some instances, the survey firm completed a few additional interviews above the 200 target. This occurs because if multiple interviewers are on the line with multiple respondents when the quota is reached, the interviewers continue the interviews in progress even though the quota has already been reached.

In some instances, the survey firm obtained less than 200 interviews for each subgroup. This arose as it was discovered after sampling was completed that some members were mistakenly considered *fully* enrolled in Basic or Plus, but had actually only been *conditionally* enrolled in Basic or Plus. This issue most affected the Basic samples, leading to a much greater sample size of Always Basic Members than Previously Plus Basic Members. Within the Basic frame, 65,438 members were incorrectly categorized as *Previously Plus* rather than *Always* Basic because they had been *conditionally* enrolled in the Plus plan. This led to 127 sampled members making the shift from Previously Plus to Always Basic. Similarly, the issue led 13 Plus members to be dropped from the results because these members were not fully enrolled in Plus according to the enrollment data, only conditionally enrolled in Plus.

Because the sampling was done according to a simple random sampling scheme, the weighting is correspondingly simple. Subgroup analyses were not planned and thus no oversampling was done of any population groups. Thus, each individual group in the survey was simply weighted up to the appropriate frame. The only exception was the Always Basic group, where the original sample was weighted up to the original frame (from which it was actually sampled), while the additional 127 members were weighted up to 65,438, the portion of the original Previously Plus frame that shifted

[4] The final frame sizes for Leavers and Never Members differ from the total counts of Leavers and Never Members during the timeframe (13,550 and 46,176 respectively) because the samples provided by Indiana FSSA only included Leavers and Never Members as of July 2016 who had not returned to HIP or other Medicaid programs as of November 2016. Also, the final frames did not include members with obviously non-working phone numbers or who were exempt from disenrollment.

to Always Basic. Any analyses of the data should be performed using these weights to be representative of the population at hand.

B. Survey protocol

The survey firm used computer-assisted telephone interviewing (CATI) to collect data. This telephone methodology provides for interviewer assistance with complicated skip patterns, unaided responses, and consistency in evaluation and limitations of sample bias. Additionally, it provides for expedient collection of the data, allows for better sample control, and can provide more complete data than other types of data collection methodologies.

The CATI first removed any duplicate phone numbers from the sample such that one record for each phone number was randomly selected to be preserved within the sample.[5] After removing duplicates, the survey team set quotas for each sample group. To comply with Telephone Consumer Protection Act (TCPA) guidelines, phone numbers were then separated into two buckets for each group: 1) Cell phones and 2) Landlines by running the lists against national databases. Quotas were then set for each of the six subgroups with the goal of reaching a cell phone versus landline proportion that was within about 10 percent of the proportion in the sample.

The CATI algorithm then randomly identified participants in each of the buckets to be loaded for dialing. When the quota (i.e., total number of interviews) was reached in a category, no additional attempts to reach individuals were made in that category. The CATI system pulled a random selection from the sample for each quota group. Any phone numbers found inactive (i.e., instances where it would not be possible to call again) were flagged and were not included in additional contact attempts during the survey period. Inactive phone numbers include: disconnected numbers, wrong numbers, fax numbers, a response of "no such person lives here," those who refused to start the survey, and those who started but were "qualified refusals." Qualified refusals were those who stayed on the phone long enough to answer the qualifying questions, but refused or dropped off at some point and did not complete the survey. All "live" numbers such as those at which a busy signal or answering device was reached would be eligible to be called again until the quota for each membership category was filled.

Calling took place between 5 pm and 9 pm on weekdays, and 11:30 am to 9 pm on weekends. Any individual who was interested in taking the survey, but who could not participate at the time he or she was initially reached, was given the option of a callback at a specific time. The CATI system would then initiate a call at the scheduled time. If the person was available, the interview would be conducted. If there was no answer, the number would be placed in the "live" category with the potential to be called back.

Due to a data error, the Basic and Plus samples initially provided by Indiana FSSA included members not enrolled in HIP. The issue was not discovered until the incorrect samples had been loaded into the CATI and the survey firm had begun calling. When the correct samples for the Basic and Plus groups were obtained, the correct samples were run against the previous incorrect samples, and any numbers that were in the first incorrect sample were marked as duplicates, and thus removed from the new sample universes available for dialing. As a result, 110 members present in both samples were inadvertently removed from the samples. We do not expect this to bias the results significantly.

[5] Theoretically we expect some phone numbers to *correctly* appear multiple times in the sample if members selected into the sample are in the same household or live in a group home. However, this deduplication was part of the standard CATI procedures, and therefore was a required step in the process. In sum, 418 members were marked as duplicates and removed from the sample, though their phone numbers still had the opportunity to be called (because one of each duplicate phone number was preserved in the sample).

Appendix E: POWER Account Contributions and Copayments Monitoring Protocol

POWER Account Contributions and Copayments Monitoring Protocol

7/30/2015

POWER Account and Copayments Infrastructure Monitoring Protocol describes the process to be used to monitor POWER account contributions and copayments from beneficiaries in order to report required metrics to the Centers for Medicare and Medicaid (CMS).

Table of Contents

Background

POWER Account and Copayment

a) ***A description of POWER accounts and copayments, focusing on the differences between the two***

Indiana's HIP 2.0 POWER account is similar to a health savings account arrangement under a consumer-directed health plan. The POWER account holds state and beneficiary contributions (including beneficiary contributions donated by employers or other entities). POWER account funds are used to pay for the first $2,500 in claims; claims beyond the initial $2,500 are fully covered through capitation payments or other payments made by the state. POWER accounts may not be used to pay for beneficiary copayments. However, for those who elect HIP Link enrollment, POWER account funds are used to pay premium and cost sharing amounts.

Beneficiaries with income at or below 100 percent of the FPL, medically frail beneficiaries, and section 1931 parents and caregivers, and low-income 19 and 20 year old dependent beneficiaries who do not pay their monthly POWER account contributions (PAC) within the sixty (60) day grace period are enrolled in HIP Basic and subject to co-payments. Those above 100 percent of the FPL who are not in an exempted category may be disenrolled for a period of six months for not paying PAC. Exempted members are those who are pregnant, American Indians/Alaska Natives, medically frail, or those with out-of-pocket expenses that exceed 5 percent of income.

Data Collection

b) ***A description of how the state will collect data from the plans regarding the amount of POWER account contributions and copayments due.***

The member's income, as requested and verified through the Indiana Application for Health Coverage, determines an individual's POWER account contribution or their eligibility for HIP Basic, if they do not make their POWER account contribution. The state sends MCEs the initial POWER account contributions; subsequent contributions are collected by the MCEs directly from each enrollee. The state sends the MCEs data regarding the amount of POWER account contributions; it is never calculated or changed by the MCE.

POWER account contributions are indexed to 2 percent of household income. For example, a HIP plus member whose annual countable income is $9,800 will have a required annual contribution of $196. This is divided by 12 to determine a predictable monthly PAC of $16.33. The maximum monthly POWER account contribution is $100 and the minimum contribution for all HIP Plus members is $1.

Individuals who i) elect to not make their POWER account contribution; ii) have income over 100 percent FPL; and iii) are not in one of the exempted groups described above (medically frail, pregnant, American Indian, or have out-of-pocket expenses that exceed 5% of income), are disenrolled from HIP and may not re-enroll for six months. Those with income under 100 percent FPL and who are not in an exempted group will default to HIP Basic which does not offer optional benefits, including dental, eye coverage, enhanced pharmacy, bariatric surgery, lower service limits, and no copayments for all medical and pharmacy services, other than emergency

department visits. Individuals in HIP Basic have a copayment, which is collected at the point of service. Copayment amounts are as follows:

- No copayment is required for preventive care, maternity services or family planning services
- Four dollar ($4.00) copayment for outpatient services
- Seventy-five dollar ($75.00) copayment for inpatient services
- Four dollar ($4.00) copayment for preferred drugs
- Eight dollar ($8.00) copayment for non-preferred drugs
- Up to a twenty-five dollar ($25.00) copayment for a non-emergency ER visit

Members may not pay copayments out of POWER accounts. The state sends any updated POWER account contribution requirements or copayment requirements to the MCEs, which are required to regularly report information regarding member POWER accounts. The details and frequency of the regular reports provided by MCEs are described in the POWER account excerpt of the HIP Reporting Manual included in Enclosure 1.

Tracking

c) ***The state's operational plan ensures that POWER account contributions and copayment liability (on a per visit basis) will be accurately tracked, as well as monthly statements will be provided to the beneficiary.***

The member invoices sent from the health plan contain information that includes the current monthly POWER account contribution owed, POWER account contributions that are past due and POWER account contributions paid to date. Similar to an explanation of benefits (EOB), the member is kept aware of the amounts they have paid into their POWER account and the amount and cost of services they have received while enrolled in the program.

Per the State's contract with MCEs, each must mail POWER account statements to members on a monthly basis. The statements are required to contain information on the account balance, the member's annual and monthly contribution amounts, and the State's annual contribution amount. In addition, the contract specifically allows the MCE to combine the POWER account statements with the Explanation of Benefit (EOB) information also required under the contract. One MCE combines the information, while the other two send POWER account balances separately from EOBs. The comprehensive statements include (i) POWER account balances showing all withdraws and deposits; (ii) comprehensive contribution activity; (iii) all claims activity for the period; and (iv) status towards the member's preventive service target.

MCEs are contractually obligated to track member cost-sharing and provide regular and ad hoc reports to the state.

Monitoring

d) ***As part of HIP 2.0, Indiana and the Centers for Medicare and Medicaid (CMS) have agreed upon a series of measures that will be used to test the state's hypothesis that POWER accounts will provide incentives to actively manage account funds in order to maintain benefits that are not offered in HIP Basic, thereby encouraging more cost-conscious healthcare consumption behavior***

By monitoring these populations' use of POWER accounts and copayments, and taking member surveys into account, the state will determine their impact on three of Indiana's HIP 2.0 goals:

1. Reduce the number of uninsured low income Indiana residents and increase access to health care services
2. Promote value-based decision making and personal health responsibility
3. Promote disease prevention and health promotion to achieve better health outcomes

Specifically, by using member survey data, in conjunction with eligibility, enrollment and health plan data, Indiana will report metrics to test the state's hypotheses.

Design

e) ***To address the key questions identified above, CMS requires Indiana to monitor and report on 12 unique measures. In the section below, we describe each measure and its corresponding hypothesis in detail.***

Methodology

f) ***For each of the agreed upon metrics, the following methodology will be used for collecting, analyzing and reporting the findings, as described below. The methodology is consistent with the draft evaluation plan submitted to CMS.***

Tracking and Reporting Key Metrics

In this section, we describe each of the required metrics and their relationship to each of the five research questions. We also provide detail for each metric, including:

- Data sources
- Reports where the measure appears
- How the measure is calculated
- An example of how the results will be displayed

1. How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER account contributions?

HIP 2.0 permits employers and third party organizations to help enrollees pay their POWER account contributions.

Measures that support this research question include:

- # of individuals receiving POWER account contributions (PAC) from employers and/or not-for-profit entities (by entity type)
- Average amount paid by employer and/or not-for-profit (by member income level)

The evaluation plan uses MCE reports with measures that are reported to CMS on a quarterly and annual basis. The MCE reports are created monthly and also provide year to date totals. The State will use the year-to-date totals in each report to avoid double counting unique individuals and employers by summarizing monthly data.

Figure 1. Number of Members receiving POWER account contributions (PAC) from Third Parties by FPL (Example)

# of Members	# of individuals receiving POWER account contributions (PAC) from employers	# of individuals receiving POWER account contributions (PAC) from non-profit organizations
Average amount paid by FPL		
0 – 4%		
5 – 10%		
11 – 22%		
23 – 50%		
51 - 75%		
76 – 100%		
101 – 137%		
138%		

1. How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?

The State will conduct a survey about the perceived affordability and reasons for non-payment to explain why members do or do not make monthly contributions. Survey questions will build on the HIP 1.0 survey that Mathematica developed for a consistent comparison of perceptions in HIP 1.0 and 2.0.

Measures that support this research question include *(Note: relevant survey questions are under development):*

- Reasons for non-payment of PAC
- Perception of ability to make POWER account contribution
- Member aware of non-payment penalties?
- Perceived affordability of the PAC, by income level

- Reasons individual did not make contribution, by income level

These measures will be populated using member and leaver data from a sample drawn from the POWER account contribution data. The survey sample will be drawn in such a way to allow more detailed understanding of specific program features. It will include persons at a range of poverty levels, both persons who made and did not make contributions and will differentiate between people who did not make their first payment versus those who did then later decided not to make subsequent payments. Comparison between those who made payments and those who did not allows us to show differences in perceptions of affordability. Differentiating between those who made their initial payment and then stopped versus those who did not may yield further information about reasons for non-payment.

To answer questions about affordability, the survey will ask members about their perceptions of the amount of the PAC as too high or too low, and if the amount impacts their decision to remain

Example 1.

If HIP required you to pay $10 more each month, would you continue to stay enrolled?
1. YES
2. NO
- DON'T KNOW
- REFUSED

What about $5 more? Would you continue to stay enrolled if HIP required you to pay $5 each month?
1. YES
2. NO
- DON'T KNOW
- REFUSED

Example 2.

Would you say the amount you contribute each month is:
1. Way too much
2. A little too much
3. The right amount
4. Below the right amount, or
5. Way below the right amount
6. DON'T KNOW
7. REFUSED

Example 3.

How do you prefer to pay for your health care? Do you prefer to pay…
1. Up front with a fixed amount every month, and the money that is not spent for care would be returned to you when you leave the program
2. Or would you prefer to pay for every time you go to a health professional, the pharmacy, the ER, or hospital?
- DON'T KNOW
- REFUSED

in the program. Where appropriate, the survey will include questions employed in the HIP 1.0 survey instrument. Following are examples of such questions:

The data to answer this hypothesis would come from survey data and POWER account data, as well as an extract report from the MCEs identifying members and their monthly POWER account status. This file will be structured as one row per member per month and would include the member identifier, month/year, and an indicator showing the POWER contribution status (paid yes or no). It would also include an identifier on each row to exclude persons not required to make a PAC payment, such as those who are pregnant or Alaska Native/American Indian. The survey sample would then be drawn from this data. Data displays would be structured as follows:

Figure 2. Perceptions of Affordability (Example)

Reasons for non-payment by FPL	Members who make ongoing payments	Members who did not make first payment	Members who made first payment but not subsequent payments
Number of Members			
0 – 4%			
5 – 10%			
11 – 22%			
23 – 50%			
51 - 75%			
76 – 100%			
101 – 137%			
138%			

Figure 3. Reasons for Non-Payment Summary (Example)

Reasons for non-payment by FPL	Members who did not make first payment	Members who made first but not subsequent payments
Number of Members		
0 – 4%		
5 – 10%		
11 – 22%		
23 – 50%		
51 - 75%		
76 – 100%		
101 – 137%		
138%		

Figure 4. Member Awareness of Non-Payment Penalty

	Member aware of non-payment penalty
Yes	
No	

2. ***How many individuals lost HIP Plus coverage due to non-payment of the PAC?***

individuals eligible for PAC (by income level)

individuals exempted from PAC

individuals meeting qualifying event[6] criteria

individuals in HIP Basic

of months PAC paid, average per member

individuals approved for HIP and over 100% FPL who do not pay first PAC

individuals with overdue PAC (less than and greater than 60 days)

Rate of non-payment of PAC, by FPL

Rate of disenrollment for failure to pay PAC

# of individuals making fast-track payments, by FPL

Timing of fast-track payment submission

Timing of eligibility change due to non-payment (transition to Basic or lockout), by # of months paid and by month in the year

Figure 5. Counts of Individuals with Regard to PAC

[6] Qualifying events are:

- Obtained and lost private coverage
- Lost income after disqualification due to increased income
- Took up residence in another state then returned
- Is a victim of domestic violence
- Was in a county subject to a disaster declaration
- Is medically frail

Income Level	# of individuals subject to PAC	# of individuals exempted from PAC	# of individuals meeting qualifying event	# of individuals in HIP Basic
0 – 4%				
5 – 10%				
11 – 22%				
23 – 50%				
51 - 75%				
76 – 100%				
101 – 137%				
138%				

Figure 6. Statistics Relating to PAC Participation

Income Level	Average # of months PAC paid per member	# of individuals approved for HIP who do not pay first PAC	# of individuals with overdue PAC	Rate of non-payment of PAC	Disenrollment Rate for failure to pay PAC
0 – 4%					
5 – 10%					
11 – 22%					
23 – 50%					
51 - 75%					
76 – 100%					
101 – 137%					
138%					

*3. **How many individuals requested a waiver from the six month lockout**?*

HIP 2.0 includes provisions that allow members to request a waiver of the six month lockout. Members who are disenrolled may reenroll prior to the end of the 6 month period by obtaining an exception from the state if the member:

i. Obtained and subsequently lost private insurance coverage;

ii. Had a loss of income after disqualification due to increased income;

iii. Took up residence in another state and later returned;

iv. Is a victim of domestic violence;

v. Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty (60) calendar days prior to date of member termination for non-payment; or

vi. Is medically frail.

Measures that support this research question include:

- # individuals subjected to 6 month lockout, by FPL
- # individuals requesting waiver of lockout
- # individuals granted waiver of lockout

Figure 7. Counts of Individuals Affected by Lockout

Income Level	# of individuals subject to 6 month lockout	# of individuals requesting waiver of lockout	# of individuals granted waiver of lockout
0 – 4%			
5 – 10%			
11 – 22%			
23 – 50%			
51 - 75%			
76 – 100%			
101 – 137%			
138%			

4. ***How are individuals accessing healthcare if they are locked out due to non-payment of the PAC*?**

Measures that support this research question include:

- Individual health care needs during lockout period, by income level
- How health care needs are addressed during lockout period, by income level

Data for these measures would be sourced from the member survey. Depending on needed sample sizes, the member survey may need to oversample members who are locked out. Member demographic information can be extracted from the EDW.

Figure 8. Distribution of Health Services Received During Lockout

	Individuals with incomes greater than 100% of FPL

Doctor visits	
Emergency room visits	
Prescriptions	

5. Was the lockout period a deterrent for individuals over 100% FPL to miss a PAC?

To answer this research question, the survey will ask members above 100% FPL how much of a factor the lockout period was in their decision to maintain PAC. This can be done with the following metrics:

- # of members reporting that the lockout period was a major factor, minor factor, or not a factor at all in maintaining PAC

A similar question about the role of the lockout period can also be asked of members who made their initial PAC but subsequently missed a PAC and were locked out.

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THE EFFECT OF INCREASED COST-SHARING IN MEDICAID:
A Summary of Research Findings

By Leighton Ku and Victoria Wachino

Recent policy discussions concerning ways to change Medicaid often include the idea of letting states increase the amounts that low-income beneficiaries are charged in the form of cost-sharing (i.e., in premiums, deductibles, co-insurance, and co-payments). Proponents of increased cost-sharing maintain it would make Medicaid more like private health insurance and promote "personal responsibility," by making people accountable for a larger share of the cost of their care. (A text box on page 2 describes recent recommendations of the National Governors Association.)

Medicaid already permits cost-sharing on a limited basis. Those who advocate increased cost-sharing generally seek flexibility to raise the amounts that can be charged and to apply cost-sharing to groups of beneficiaries that currently are exempted. Changes in Medicaid's cost-sharing rules could mean charging higher copayments when a patient sees a doctor or picks up a prescription or charging monthly premiums to participate in Medicaid. This analysis highlights key research about the impact of cost-sharing on low-income families and individuals, including recent evidence about how cost-sharing has affected low-income Medicaid beneficiaries in states that have increased their cost-sharing levels.[1]

States have asked that the federal government avoid shifting Medicaid costs to them. Both state and federal policymakers should exercise caution before shifting costs on to low-income beneficiaries, whom research shows to be the people least able to shoulder additional costs.

Executive Summary

Cost-sharing would, by definition, shift a share of Medicaid costs from states and the federal government to Medicaid beneficiaries. Most Medicaid beneficiaries have incomes below the poverty line. Research shows that higher copayments tend to cause low-income people to decrease their use of essential as well as other health care,

[1] This paper summarizes and updates a more detailed report, Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 7, 2003. Another useful synthesis is by Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured, May 2005.

and can trigger the subsequent use of more expensive forms of care such as emergency room care or hospitalization.

The research indicates that higher copayments can make it harder for people covered by Medicaid to afford medical services they need, while premiums can make it more difficult for low-income people to enroll and maintain coverage. Low-income people with chronic health conditions are the most vulnerable to harm from cost-sharing, as they use the most health care services. (Cost-sharing may also have adverse consequences for health care providers, who may experience a loss of revenue because of reduced utilization of health care or because some beneficiaries cannot afford their copayments or lose eligibility when they cannot pay premiums and seek uncompensated care.)

It is for these reasons that cost-sharing has been limited in Medicaid. Children and pregnant women are exempt from Medicaid copayments by federal law, because they are in a critical developmental stage of life and copayments could create barriers to preventive and primary health care, with long-lasting adverse health consequences. People in nursing homes are exempt because there are other Medicaid mechanisms that ensure they are subject to extensive cost-sharing: *all* of the income of these people is used to pay for their care, except for a small allowance they are allowed to keep for personal needs (e.g., $30 per month) and an allowance to support a spouse (if there is one) who still resides in the community. For other types of Medicaid beneficiaries, i.e., non-pregnant, non-institutionalized adults, senior citizens and people with disabilities, copayments can be charged but may not exceed "nominal" levels such as $3 per service or prescription.

Within the allowable limits, cost-sharing is very widely used. As of 2003, some 43 states charged copayments to some or all adult, elderly or disabled Medicaid beneficiaries, according to the Government Accountability Office (GAO). Copayments are most frequently charged for prescription drugs but also are often charged for physician, outpatient, inpatient, dental care or other services.[2]

In recent years, many states have increased copayments within the federal limits, and some have received waivers to exceed those limits.

- In 2003, 17 states increased Medicaid copayments;
- 20 states raised them in 2004; and
- Nine states plan to do so in 2005, according to the Kaiser Commission on Medicaid and the Uninsured.[3]

Some have argued that copayments should be increased further because Medicaid beneficiaries pay little or nothing for care and do not bear financial responsibility for it. And it has been noted that the federal limits on allowable co-payment charges, such as $3 per service, have not been raised since the 1980's.

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[2] U.S. General Accounting Office, "Medicaid and SCHIP: States Premium and Cost-Sharing Requirements for Beneficiaries," March 2004. This report provides a detailed explanation of federal Medicaid cost-sharing rules and state cost-sharing levels.

[3] Vernon Smith, et al. "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005," Kaiser Commission on Medicaid and the Uninsured, October 2004.

Governors Promote Significantly Higher Medicaid Cost-Sharing

On June 15, the National Governors Association released preliminary policy recommendations on Medicaid reform. Among other things, the NGA recommended a substantial restructuring of current federal cost-sharing rules for Medicaid. NGA's proposed cost-sharing policy would let states "establish any form of premium, deductible or co-pay" in Medicaid for all populations and all services.

This would give states substantial new discretion to increase cost sharing. The only upper bound on the cost-sharing charges that could be imposed would be a rule that beneficiaries' total cost-sharing expenses could not exceed 5 percent of family income for people with incomes *below* 150 percent of the poverty line, and could not exceed 7.5 percent of income (almost one-twelfth of a family's annual income, or nearly one month's worth of income) for people with incomes above that level.

The NGA recommendation would permit cost-sharing for the first time for Medicaid beneficiaries such as poor pregnant women and children and also for services such as emergency care. Medicaid currently exempts pregnant women and children from cost-sharing charges to ensure that cost-sharing does not deter the use of primary and preventive care during these key developmental periods of life. Medicaid also exempts services like family planning from copayments to ensure that important preventive services are readily accessible. Most of Medicaid's low-income beneficiaries, except the "medically needy" and those in Medicaid waiver programs, also are shielded from monthly premiums; premiums have been found to deter enrollment in health insurance by people of limited means. NGA's proposal appears to erase all of these longstanding protections.

Medicaid already permits small copayments to be charged to poor senior citizens, people with permanent disabilities and other adults. The NGA proposal would allow the amounts of these co-payments to rise rather dramatically. Current Medicaid policy establishes caps of between 50 cents and $3 per service on copayments for most services, in recognition of the fact that most Medicaid beneficiaries live in poverty. The NGA recommendation would let states increase copayments to, for example, $10, $20, or more for each service — and also allow states to charge sizeable monthly premiums to all Medicaid beneficiaries — as long as the aggregate amount that a family was required to pay did not exceed 5 percent or 7.5 percent of its income. An extensive body of research, some of which is summarized in this paper, shows that imposing significant cost sharing on low-income households has been found to have pronounced adverse effects.

In defending NGA's recommendations in this area, some governors have correctly noted that the Medicaid copayment limits of 50 cents to $3 per service have not changed for many years, while prices have risen. The NGA proposal, however, would permit increases in cost-sharing that vastly exceed the erosion of the current co-payment limits by inflation. In addition, as a recent Center analysis demonstrates, the average out-of-pocket costs that Medicaid beneficiaries bear already are significantly higher as a percentage of income — and have been growing faster in recent years — than the out-of-pocket costs that middle-income people with private health insurance pay.[1]

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[1] Leighton Ku and Matt Broaddus, Out of Pocket Expenses for Medicaid Beneficiaries are Substantial and Growing, May 31, 2005.

The NGA has said its Medicaid cost-sharing recommendations are modeled on current SCHIP policy. The policies that apply in SCHIP, however, are not necessarily appropriate for Medicaid since Medicaid serves a significantly poorer population than SCHIP does, and in any case, the increases in cost-sharing that the NGA is proposing go well beyond what SCHIP policy permits. Medicaid primarily serves people with incomes *below* the poverty live. SCHIP, by contrast, serves children in families with incomes *above* 100 percent or 133 percent of the poverty line. In addition, a large proportion of those on Medicaid are pregnant women, senior citizens, or people with disabilities or chronic diseases, who often require substantially more medical care than children typically do — and for whom the burdens posed by having to make sizeable co-payments each time a health service is used would accordingly be much greater. In short, the NGA's proposed increases in cost-sharing could impose substantial hardships on Medicaid beneficiaries, who tend to be both poorer and sicker than SCHIP enrollees.

It also should be noted that the NGA recommendations do not include key beneficiary protections that SCHIP provides. Under SCHIP, children in families with incomes below 150 percent of poverty may *not* be charged copayments that exceed $5 per service or premiums that exceed $19 per month. The NGA proposal appears to contain no such limitations on the charges that could be imposed on Medicaid beneficiaries with incomes below 150 percent of poverty. In addition, SCHIP prohibits charging copayments or deductibles for preventive health care, while the NGA proposal would permit such charges. Similarly, under SCHIP, cost-sharing may never exceed 5 percent of a family's income even for those *above* 150 percent of the poverty line, while the NGA would raise this ceiling to 7.5 percent of income for Medicaid beneficiaries in this income range, thereby setting the ceiling 50 percent higher than the maximum charges that SCHIP allows.

In making these recommendations, the NGA added a caveat that these policies should be monitored and evaluated, and if the evidence shows that access to appropriate health care is being compromised, the policies should be revised. As the review of the research literature presented in this report substantiates, however, this matter already has been extensively studied. There already is compelling evidence that imposing higher copayments on people with low incomes reduces their access to essential health care, with adverse consequences for their health status, and that imposing premiums on low-income people lowers enrollment in public health insurance programs and increases the ranks of the uninsured.

A new analysis finds, however, that out-of-pocket medical expenses have been rising rapidly for Medicaid beneficiaries — more rapidly, in fact, than for other Americans — and that poor Medicaid beneficiaries actually spend a considerably *larger* share of their incomes on out-of-pocket medical expenses than do middle-class people with private health insurance.

- For poor adults on Medicaid who are not elderly or disabled, out-of-pocket medical costs rose an average of *nine percent per year* between 1997 and 2002, roughly twice as fast as their incomes. (2002 is the latest year for which these data are available.) For privately-insured non-elderly adults who do *not* have low incomes, (i.e., for those with incomes above twice the poverty line), out-of-pocket expenses increased an average of six percent per year over this period.

  Out-of-pocket costs have been rising rapidly for Medicaid beneficiaries despite the lack of adjustment in the federal co-payment limits, as a result both of increases in cost-sharing charges by state Medicaid programs (both by states that are operating within the federal cost-sharing limits and to a lesser extent by states that have received waivers to exceed those limits) and

increases in the cost of health care services that Medicaid does not cover. (Actions by some states to scale back the services Medicaid covers are a factor here.)[4]

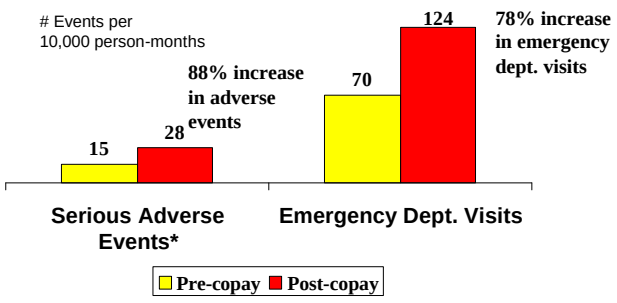
- Poor Medicaid beneficiaries aged 19-64 who are not disabled spent an average of 2.4 percent of their incomes on out-of-pocket medical costs in 2002. In contrast, non-elderly adults who have private health insurance and are not low income spent 0.7 percent of their incomes on such costs in 2002, less than one-third as much.

The Effects of Copayments

Higher copayments tend to make it harder for low-income patients to access medical care or fill prescriptions. Reductions in medical care or use of medications can, in turn, have adverse consequences, including poorer health and greater subsequent use of high-cost services such as emergency rooms. This is documented by a substantial body of research.

One research study, published in the *Journal of the American Medical Association*, studied the consequences of a policy change in Quebec that imposed copayments for prescription drugs on adults receiving welfare. The researchers found that after prescription drug copayments were added, the low-income adults filled fewer prescriptions for essential medications. The copayments led to an 88 percent increase in the occurrence of adverse events, including death, hospitalization and nursing home admissions, apparently because the reduction in the use of essential medications led to poorer health. The copayments also led to a 78 percent increase in emergency room use (see Figure 1).[5] Another peer-reviewed study conducted in the United States found that copayments for substance-abuse services led to initial reductions in treatment costs but ultimately led to higher rates of relapse that required more treatment and drove up long-term costs.[6]

Figure 1.
Drug Copayments Reduced Use of Essential Medications and Led to Serious Problems



*Includes hospitalizations, institutionalizations, and deaths

Source: R. Tamblyn et al., JAMA 285(4):421-9, 2001.

[4] Leighton Ku and Matt Broaddus, "Out-Of-Pocket Medical Expenses For Medicaid Beneficiaries Are Substantial and Growing," Center on Budget and Policy Priorities, May 31, 2005.

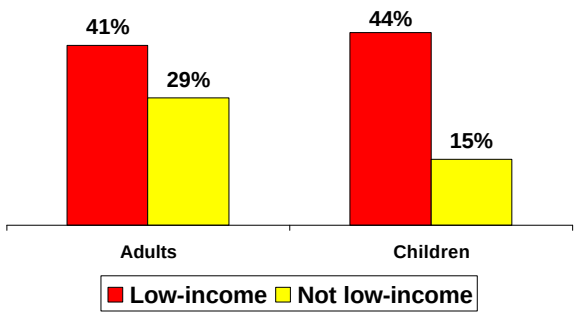
[5] Robyn Tamblyn, et al., "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons," *Journal of the American Medical Association*, 285(4): 421-429, January 2001. In this study, the low-income people were adults who were on welfare.

[6] Anthony LoSasso and John Lyons, "The Effects of Copayments on Substance Abuse Treatment Expenditures and Treatment Reoccurrence," *Psychiatric Services*, 55(12):1605-11, December 2002.

A recent small survey in Minnesota had similar findings. Physicians at Minneapolis' main public hospital surveyed patients attending medical clinics in mid-2004.[7] Of 62 patients covered by Medicaid or medical assistance, more than half (32) reported that they had been unable to get their prescriptions at least once in the last six months because of copayments of $3 for brand name drugs or $1 for generic drugs. Eleven of the patients who failed to get their medications had 27 subsequent emergency room visits and hospital admissions for related disorders. For example, patients with high blood pressure, diabetes or asthma who could not get their medications experienced strokes, asthma attacks and complications due to diabetes. The inability to afford copayments had serious health consequences and led to the use of more expensive forms of medical care.

Those with low incomes are more vulnerable to adverse consequences from cost-sharing than higher-income people are, because they have less disposable income and must use much of their limited incomes to meet other basic needs such as food and shelter. This has been documented by rigorous research. The RAND Health Insurance Experiment, considered the definitive study this issue, found that copayments led to a much larger reduction in the use of medical care by low-income adults and children than by those with higher incomes, as seen in Figure 2. Contrary to those who may assume that cost-sharing simply causes people to eliminate "unnecessary" care, the RAND study found that copayments led to reductions in medical care that the researchers rated as being "effective," as well as in care viewed as being "less effective."

Figure 2.
Low-income Patients More Vulnerable to Copayments



Source: J. Newhouse, *Free for All,* 1996 (RAND Health Ins.Expt)

The RAND study found that copayments did not significantly harm the health of middle- and upper-income people but did lead to poorer health for those with low incomes. The study found that among low-income adults and children, health status was considerably worse for those who had to make copayments than for those who did not. (In the RAND study, low income was defined as the lowest third of the income distribution, which is roughly equivalent to being below 200 percent of the poverty line.) For example, copayments increased the risk of dying by about 10 percent for low-income adults at risk of heart disease.[8]

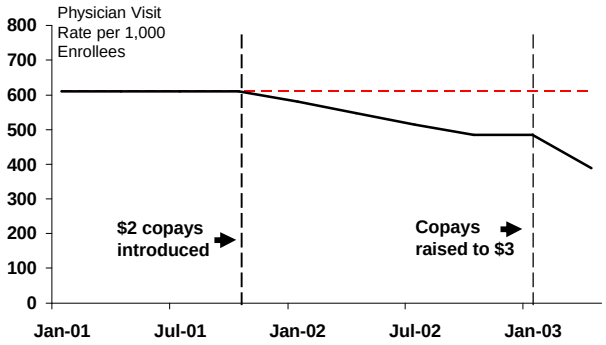
Copayments are particularly challenging for those who have serious or chronic health conditions such as diabetes, cancer, heart conditions or mental illness. Because people with chronic conditions

[7] Melody Mendiola, Kevin Larsen, et al. "Medicaid Patients Perceive Copays as a Barrier to Medication Compliance," Hennepin County Medical Center, Minneapolis, MN, presented at the Society of General Internal Medicine national conference, May 2005 and American College of Physicians Minnesota chapter conference, Nov. 2004.

[8] Joseph Newhouse, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996. The risk of dying was estimated using an index of clinical measures that are correlated with cardiovascular mortality, such as blood pressure and blood cholesterol levels.

require more medical care and more medications, they must make more copayments.[9] A person who requires five prescription drugs per month must pay five times as much in copayments as someone who has one prescription. Because these individuals also tend to be in fragile health, the consequences of going without a needed service or medication can be severe.

Figure 3.
$2 & $3 Copays Affected Physician Visits in Utah Medicaid



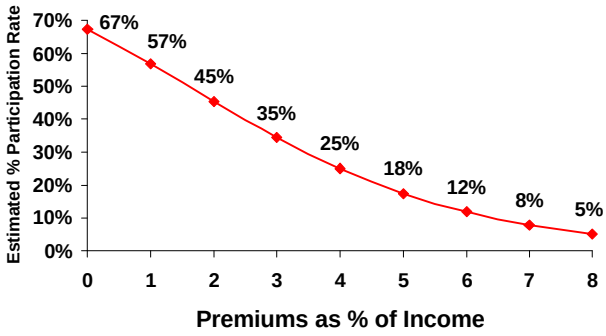
Source: Ku, Deschamps and Hilman, CBPP 2004

Research has found that when Utah imposed small copayments ($2 or $3 per service or prescription) on Medicaid beneficiaries with incomes below the poverty line, the copayments led to a significant reduction in health care access and utilization (Figure 3). Even though copayments of this size are considered "nominal," four of ten affected Utahans reported the copayment increases caused "serious" financial hardships.[10] For impoverished individuals and families, copayments as small as $2 or $3 per service evidently can create barriers to accessing some necessary services. To cope with increased health care expenses, about two-fifths of the affected Utahans in the survey reported that they had to resort to coping strategies such as reducing the amount they spent on food or housing or "stretching out" their prescriptions (i.e., taking medications less often than prescribed). Larger copayments would impose greater hardships.

The Effect of Premiums

Several states charge monthly premiums to low-income Medicaid or SCHIP beneficiaries. Evidence indicates that premiums reduce Medicaid participation and make it harder for individuals to maintain stable and continuous enrollment. One multi-state study of health insurance programs for low-income people examined participation rates among people who faced premiums of differing levels and found that higher premiums were associated with lower participation. As seen in Figure 4, premiums set as low as 1 percent of a family's income were estimated to lead to a 15 percent reduction

Figure 4.
As Premiums Rise, Fewer Low-income Uninsured People Participate



Source: L. Ku and T. Coughlin, Inquiry, 1999/2000

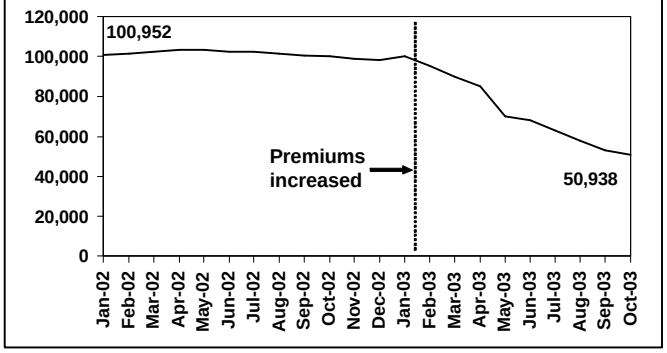
[9] Bruce Stuart and Christopher Zacker, "Who Bears the Burden of Medicaid Drug Copayment Policies?" *Health Affairs*, 18(2):201-12, 1999.

[10] Leighton Ku, Elaine Deschamps and Judi Hilman "The Effects Of Copayments in the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," Center on Budget and Policy Priorities, November 24, 2004.

in enrollment. (For example, if 67,000 people are enrolled without premiums, a 1 percent premium would lead to estimated enrollment of 57,000, which is a 15 percent reduction.) Premiums of 3 percent were estimated to reduce enrollment by as much half.[11]

Oregon's experience is instructive. The state obtained permission through a waiver to increase premiums for its Medicaid expansion program (known as Oregon Health Plan Standard, or OHP). Enrollees included people with incomes below the poverty line. After the state tightened the premium policies, about half of those enrolled — approximately 50,000 people — lost coverage (Figure 5).

Figure 5.
Changes in Oregon Health Plan Standard Enrollment



Oregon raised premiums to levels ranging from $6 per month for those without any income to $20 per month for people at the poverty line. The state also eliminated the exemption from premiums that it previously had in place for people with no income, and denied enrollment for a period of six months if a person missed or was late in making a single premium payment. The state reduced covered benefits as well, but state researchers concluded that most of the enrollment reduction was caused by the changes in the premiums. About three-quarters of those who dropped from the program became uninsured.[12]

The Oregon experience also provides evidence of the impacts that such a loss of Medicaid coverage can have. Those who disenrolled in Oregon were four to five times more likely to report the emergency room to be their usual source of care than people who remained enrolled.[13] Emergency room use in Oregon's largest metropolitan hospital increased 17 percent after these changes, although researchers could not isolate the effects of the loss of OHP coverage from the effects of the loss of private insurance that some other Oregonians experienced during the same period.[14] One recent report concluded, however, that there is "strong evidence" that taken together,

[11] Leighton Ku and Teresa Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36: 471-480 (Winter 1999-2000). In this study, the low-income criteria varied for each state's program.

[12] Oregon Health Research and Evaluation Collaborative, "Research Brief: Changes in Enrollment of OHP Standard Clients," January 2004, and "Research Brief: The Impact of Program Changes in Health Care for the Oregon Health Plan Standard Population: Early Results from a Population Cohort Study," March 2004.

[13] Matthew Carlson and Bill Wright, "The Impact of Program Changes on Health Care for the Oregon Health Plan Standard Population: Early Results from a Prospective Cohort Study," Office of Oregon Health Policy and Research, March 2004.

[14] Robert Lowe, et al. "Changes in Access to Primary Health Care for the Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report Based on Oregon Health and Science University Emergency Department Data," Office of Oregon Health Policy and Research, April 2003.

the OHP changes "resulted in loss of coverage, unmet health care and medication needs, and increased emergency department utilization for the most vulnerable Oregonians."[15]

In fact, concerns about the adverse consequences of premiums on Medicaid or SCHIP enrollment, along with the administrative costs involved, have led a number of states to reconsider and change their policies regarding premiums. Virginia initially imposed premiums on children with family incomes above 150 percent of the poverty line. Upon learning in late 2001 that coverage for approximately 3,000 children would be terminated due to non-payment of premiums, however, then-Governor James Gilmore established a moratorium to keep the children from losing coverage. In 2002, newly elected Governor Mark Warner went a step further and cancelled the premiums, explaining that "Our premiums were actually costing more to administer than the dollars we were receiving, so the team made the case to me that [eliminating the premiums] was both the morally right and the fiscally right thing to do."[16]

Similarly, Maryland imposed premiums on thousands of children in its SCHIP program, and enrollment declined significantly. In response, the state discontinued the premiums after one year. In addition, Connecticut planned to increase premiums substantially for Medicaid beneficiaries but reversed course and repealed these requirements before they were implemented, after analysis indicated that tens of thousands of people would lose coverage.[17] Finally, Washington state obtained a federal waiver to increase the premiums it charges for children's insurance, but after more analysis and debate, the state delayed implementation and eventually dropped the premium increases.

Does Cost-sharing Encourage Responsible Use of Health Services?

Proponents of increased cost-sharing often contend that if Medicaid beneficiaries faced greater cost-sharing like people with private insurance do, they would become more "responsible" and consume less unnecessary care. This argument implies that Medicaid beneficiaries are using unnecessary services at greater rates than people with private insurance. Research shows, however, that Medicaid beneficiaries use approximately the same amount of services as people with private insurance. Two recent studies by Urban Institute researchers found that after controlling for health characteristics, people on Medicaid used the same average amount of care as similar people with private insurance. One study found no statistically significant differences in the number of doctor visits, emergency room visits, hospital stays or dental visits.[18]

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[15] Matthew Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Office of Oregon Health Policy and Research, March 2, 2005.

[16] Presentation by Gov. Warner at a briefing on children's health insurance coverage, sponsored by the Kaiser Commission on Medicaid and the Uninsured, Washington, DC, July 29, 2003.

[17] Joan Alker and Judith Solomon, "Families at Risk: The Impact of Premiums on Children and Families in Husky A," Connecticut Health Foundation policy brief, November 2003.

[18] Sharon Long, Teresa Coughlin and Jennifer King," "How Well Does Medicaid Work in Improving Access to Care?" *Health Services Research*, 40(1): 39-59, Feb. 2005. Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, 40 (2003/2004): 323-42.

In certain situations, Medicaid beneficiaries use more care than privately insured people, but this is a desirable difference. Research indicates that children enrolled in Medicaid are more likely to receive preventive health care, such as well-child visits, than children with private insurance.[19] The American Academy of Pediatrics recommends periodic preventive health visits to monitor children's health and development and to prevent longer-term illnesses. One likely reason for the beneficial use of preventive services by children enrolled in Medicaid is that children are exempt from copayments under Medicaid. This policy was designed to help ensure that children faced as few barriers as possible to the use of preventive health care. Copayments almost certainly would reduce the extent to which children on Medicaid receive preventive health visits.

Other research has found that while copayments lead people to reduce their use of medical care, copayments do not necessarily make people "smarter" health care consumers. When higher copayments are imposed, patients reduce their use of both essential and less-essential services.[20] For example, a recent study of tiered drug copayments in the private sector (in which copayments are set higher for some medications than for others) found that higher copayments led diabetics to reduce their use of diabetes medications.[21] Another study found that increased copayments led to reductions in patients' use of drugs for high blood pressure (ACE inhibitors) and cholesterol reduction (statins).[22] When patients reduce their use of important chronic-disease medications because of higher copayments, their diseases can progress and lead to more severe consequences such as heart attacks.

Charging patients higher copayments also may be ineffective in motivating consumers to choose less expensive drugs since it is physicians, not consumers, who select the medications to prescribe. When they are writing prescriptions, physicians often do not know which insurance plans patients have or which drugs have higher or lower copayments under each insurance plan. They often lack the knowledge and financial incentive to prescribe a drug with a lower copayment. If a physician prescribes a medication with a higher copayment, the patient may have little choice but to pay the higher price or do without the medication. For low-income patients, the consequences are more serious because they are less able to afford copayments.

Conclusions

Some states have sought to increase cost-sharing limits in Medicaid. At the same time, states have urged the federal government to avoid reducing federal Medicaid expenditures by shifting costs to states. State officials may want to consider whether it is appropriate to shift costs to low-income beneficiaries by significantly raising cost-sharing charges or limiting covered benefits. That would

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[19] Lisa Dubay and Genevieve M. Kenney, "Health Care Access and Use Among Low-income Children: Who Fares Best?" *Health Affairs* 20(1)(2001): 112-21.

[20] Joseph Newhouse, *op cit.*

[21] Dana Goldman, et al. "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *Journal of the American Medical Association,* 291: 2344-50, May 19, 2003.

[22] H.A. Huskamp, "The Effects of Incentive-Based Formularies on Prescription Drug Utilization and Expenditures," *New England Journal of Medicine,* December 4, 2003: 2224-32.

not only place heavier financial burdens on poor families and individuals but could jeopardize the ability of such people to access health services and risk ultimately impairing their health.

The problems created by higher cost-sharing may extend beyond beneficiaries to other parts of the health system. To the extent that premiums cause low-income people to lose Medicaid coverage and become uninsured, or that copayments cause patients to avoid obtaining medical care or filling prescriptions, this could lead to increased use of emergency rooms or safety-net clinics. In addition, when Medicaid patients can not afford their copayments, this can create a revenue loss for health care providers, including pharmacies.

It is important to encourage efficient and cost-effective care in Medicaid. Cost-sharing, however, is a blunt tool that can discourage essential and appropriate care and can create barriers to health care for those in need. It is important to remember that the current cost-sharing protections in Medicaid exist precisely because the program's beneficiaries generally have incomes well below the poverty line and a substantial proportion of them have health conditions that could be compromised by excessive cost-sharing.

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RESEARCH ARTICLE

How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan

Neal T. Wallace, K. John McConnell, Charles A. Gallia, and Jeanene A. Smith

Objectives. To determine the impact of introducing copayments on medical care use and expenditures for low-income, adult Medicaid beneficiaries.

Data Sources/Study Setting. The Oregon Health Plan (OHP) implemented copayments and other benefit changes for some adult beneficiaries in February 2003.

Study Design. Copayment effects were measured as the "difference-in-difference" in average monthly service use and expenditures among cohorts of OHP Standard (intervention) and Plus (comparison) beneficiaries.

Data Collection/Extraction Methods. There were 10,176 OHP Standard and 10,319 Plus propensity score-matched subjects enrolled during November 2001–October 2002 and May 2003–April 2004 that were selected and assigned to 59 primary care-based service areas with aggregate outcomes calculated in six month intervals yielding 472 observations.

Results. Total expenditures per person remained unchanged (+2.2 percent, $p = .47$) despite reductions in use (− 2.7 percent, $p < .001$). Use and expenditures per person decreased for pharmacy (− 2.2 percent, $p < .001$; − 10.5 percent, $p < .001$) but increased for inpatient (+27.3 percent, $p < .001$; +20.1 percent, $p = .03$) and hospital outpatient services (+13.5 percent, $p < .001$; +19.7 percent, $p < .001$). Ambulatory professional (− 7.7 percent, $p < .001$) and emergency department (− 7.9 percent, $p = .03$) use decreased, yet expenditures remained unchanged (− 1.5 percent, $p = .75$; − 2.0 percent, $p = .68$, respectively) as expenditures per service user rose (+6.6 percent, $p = .13$; +7.9 percent, $p = .03$, respectively).

Conclusions. In the Oregon Medicaid program applying copayments shifted treatment patterns but did not provide expected savings. Policy makers should use caution in applying copayments to low-income Medicaid beneficiaries.

Key Words. Medicaid, cost-sharing, medical expenditures

Cost sharing has been an increasing theme as states' have renewed an emphasis on redesigning Medicaid programs to obtain cost-savings (Ku 2003). These changes include the introduction of substantial copayments for medical services. One impetus for cost sharing is the potential to provide Medicaid services at a lower cost per individual, allowing more individuals to be covered at any level of total expenditures. This concept has been central to legislation that has provided expanded Medicaid cost-sharing opportunities to states, including the 2001 Health Insurance Flexibility Act (HIFA) and the more recent 2005 Deficit Reduction Act, and is implicitly based on the assumption that cost-sharing will deliver the desired savings (National Governor's Association 2001; The Kaiser Commission on Medicaid and the Uninsured 2006). There is, however, very limited research to guide policy makers on the effectiveness of cost-sharing policies in reducing Medicaid expenditures. In 2003, the state of Oregon implemented changes to its Medicaid program, the Oregon Health Plan (OHP), incorporating comprehensive and substantial copayments for some of its adult beneficiaries. This study uses this natural experiment to investigate the impact of copayments on the use and expenditures of OHP members.

The seminal work on health care copayments is the Rand Health Insurance Experiment, which found that copayments could significantly reduce health care use and expenditures without, on the whole, reducing health outcomes (Manning et al. 1987; Newhouse 1993). Analyses of persons with low-incomes or chronic conditions did find some decrements in the use of effective care attributable to copayments (Keeler et al. 1985; Lohr et al. 1986; Lurie et al. 1989). This effect was additive for low-income, chronic condition individuals, which could be a point of concern regarding Medicaid populations where these joint conditions are quite prevalent. These negative effects were only found on the benefit side. Expenditures were proportionally reduced for these groups compared with others, and there was not a "cost-offset" effect, i.e., changes in health care use under copays that led to more expensive care than would have occurred without them (Gruber 2006).

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A potential limitation of the HIE results for low-income individuals is that income effects were mitigated by design (to focus on price effects) through mechanisms such as limiting the maximum amount of copayments to a percentage of income. Such income-based protections are not evident in emerging Medicaid rules or policies, including Oregon's policy. This raises the potential for unintended supply or demand effects due to the inability to pay that could incur cost-offsets. Consumers may avoid care until they are more ill, potentially incurring greater loss of health status and/or greater health care expenditures. Providers, anticipating lower expected reimbursement, may limit access or shift use to providers more willing to absorb potential losses from unpaid copays.

There is also a growing body of literature focused on copayments or caps applied to pharmacy benefits indicating that cost-offsets can occur. Several of these studies apply to low-income individuals in public insurance settings (Helms, Newhouse, and Phelps 1978; Soumerai et al. 1991, 1994; Tamblyn et al. 2001), and also extend to higher income individuals and private insurance settings (Huskamp et al. 2003; Anis et al. 2005; Rosen et al. 2005; Hsu et al. 2006b). Newhouse (2006) summarizes this body of research and notes their consistency with recent economic findings that some individuals may discount future benefits so significantly that they will forgo current activities, such as taking medication, which would prevent future losses in health status and/or health expenditures.

Overall, copayments provide significant opportunities and risks, the balance of which is likely dependent upon the specific design and context of their application. In this paper, we analyze changes in use and expenditures for low-income adult OHP members before and after implementation of substantial copayments and in comparison with other low-income adults who did not experience this change to assess the extent of cost-savings and any changes in specific treatment patterns that may inform the overall change and the issues raised above.

METHODS

Setting

Beginning in February of 2003, the state fundamentally changed its Medicaid program, the OHP, creating two levels of Medicaid coverage. Approximately 300,000 adults and children categorically eligible under the Social Security Act became "OHP Plus" members, retaining existing coverage. The remaining 100,000 enrollees, ages 18–64 years with incomes under 100 percent of the

Federal Poverty Level (FPL) who did not fall under any of the traditional Medicaid eligibility categories, but who were eligible under Oregon's Medicaid waiver, became "OHP Standard" members.

The new OHP Standard benefit package eliminated coverage for outpatient mental health and substance abuse treatment services, dental, vision, hearing, durable medical equipment (DME), and nonemergent transportation and copayments were applied to the remaining covered benefits. Some existing monthly premiums were increased and a stricter premium payment policy implemented that penalized a missed monthly payment with disenrollment and a 6-month re-enrollment "lock-out." Table 1 outlines the copayment structure and lists the benefits eliminated. In contrast to prevailing federal statutes for categorical populations, providers could refuse services if OHP Standard beneficiaries did not pay their copayments, and there were no limits on aggregate copayment expenditures.

Design Overview

We use a retrospective propensity score-matched cohort design to estimate the effects of the copay policy. The policy effects are identified as the difference-

Table 1: Copayments and Excluded Services under the Standard Benefit Package

	Copayment Schedule
Service	*Copayment Amount(s) and Conditions*
Inpatient	$250 per admission
Hospital outpatient	$20 surgery, $5 other
Emergency department	$50, waived if admitted
Physician	$5, waived for vaccine or preventative services
Lab and radiology	$3 each
Pharmacy	$2 preferred brand, $3 generic, $15 other brand
Emergency transportation	$50
Home health and other therapists	$5
Services excluded from the Standard benefit package	Outpatient mental health
	Outpatient substance abuse (including Methadone)
	Durable Medical Equipment
	Dental services
	Vision services and supplies
	Hearing services and supplies
	Nonemergency transportation

There was no limit on the aggregate amount of copayments charged to Standard enrollees and providers could refuse services for inability to pay.

in-difference between a fixed cohort of OHP standard enrollees before and after the benefit change in comparison with a fixed cohort OHP Plus enrollees whose benefits were unaffected by this policy. We estimate rates of change in the average monthly percentage of enrollees using a service type; average monthly expenditures per service user; and their product, expenditures per enrollee per month. These measures are assessed across and within the services covered under the postpolicy Standard benefit package.

There are two main threats to our research design: (1) the elimination of specific benefits, which may incur substitution to the remaining benefits, concurrent with copay implementation; and (2) differences in OHP Plus and Standard enrollees that determined their Medicaid eligibility that may not be captured entirely by the propensity score matching process. We address these issues through data selection (e.g., eliminate any mental health or substance abuse inpatient stays) and sensitivity testing as described in detail below.

Study Subjects

Our analysis used annual periods before and after the policy change: November 2001 through October 2002 and May 2003 through April 2004. We excluded 3 months before and after the February 2003 policy change in order to avoid short-term implementation effects. Study subjects were first selected on the following criteria: age 18–64 years, enrolled at least 3 months in each half year within the two annual study periods, consistently enrolled as Plus (Temporary Aid to Needy Families, Blind or Disabled eligible only) or Standard after the policy change, not diagnosed with schizophrenia or giving birth during the study period, and with complete utilization data.

The age restriction follows Standard eligibility criteria and the enrollment criteria are designed to balance inclusiveness and measurement of longer-term effects of the policy. The exclusion of those diagnosed with schizophrenia and giving birth reflects the lack of representation within the Standard population of these conditions as they provide options for categorical eligibility. As noted below, pharmacy data for some managed care organizations were incomplete or missing within the study period requiring exclusion of some individuals solely due to data availability. These criteria identified 10,381 OHP Standard enrollees and 15,140 OHP Plus enrollees.

We then used a propensity score matching process to obtain cohorts comparable on a set of demographic and health condition indicators with covariate balance and proportional representation across the propensity score distribution (D'Agostino 1998; Dehejia and Wahba 2002). Propensity scores

were based on age, gender, race, ethnicity, presence of a chronic physical illness, and prepolicy use of the outpatient mental health or chemical dependency benefit and their interactions. This yielded a final sample of 10,176 OHP Standard and 10,319 OHP Plus beneficiaries.

Data Sources

We used Oregon Medicaid eligibility files, fee-for-service claims, and managed care organization encounter data. Claims and encounter data were aggregated into service categories based on a protocol developed by the state's actuaries for managed care rate setting that delineated the categories for copayments and benefit elimination. We excluded data for the services eliminated under the policy, as well as transportation, which was not well suited for aggregation into the other broader designations. We also removed all nonpharmacy claims within the remaining benefits with primary mental health or substance abuse diagnoses (290.00–316.99), and all drug claims within the two therapeutic drug classes comprising psychotropic drugs. Some managed care organizations did not report pharmacy data during some months in the study period leading to the exclusion of some potential subjects as noted above.

Use and Expenditures

We measured use and expenditures for services covered under the Standard benefit in total; (outpatient) pharmacy and all other medical services; and nonpharmacy services by inpatient, (ambulatory) emergency department, (ambulatory) lab and radiology, hospital outpatient and all other ambulatory professional services. Professional service records were attributed to the facility-based service categories for all of the nonpharmacy categories except hospital outpatient, where we could not consistently match professional and facility-based data. We calculated expenditures based on the average fee-for-service rates paid by the state over the entire study period to eliminate price change effects. These rates were not discounted for the copayments in the postpolicy period in order to measure the change in total expenditure value. We provide separate, direct estimates of the percentage savings to the state from shifting expenses to consumers through the copayments as well as the percentage savings from the eliminated benefits.

To allow for simple, direct, and efficient estimation of our outcome measures, we calculated aggregate monthly averages by service region in each of four 6-month study periods for the three interrelated dependent measures. We first calculated monthly averages for each subject in each 6-month period.

Subjects were then assigned by zip code to one of 130 primary care service areas defined by the Oregon Office of Rural Health. Geographically contiguous primary care service areas with similar general characteristics (e.g., rural) were further aggregated to service regions with an approximate minimum of 50 subjects to assure stable, representative aggregates with nonzero values. This resulted in 59 service regions averaging 174 subjects (range: 45–640) for a total of 472 observations across the four time periods and two beneficiary categories.

Statistical Analysis

We estimate a weighted, fixed effects model incorporating a standard difference-in-difference specification, which includes a dummy variable for the postpolicy observations, a dummy variable for the intervention group (Standard), and their interaction that captures the "difference-in-difference" or any differences in Standard group treatment trends from the Plus group after adjusting for initial differences. To efficiently capture initial differences across the aggregate observations due to either variations in subject characteristics or local treatment supply, we also included dummy variables for each service region and beneficiary group.

The dependent variables are log transformed to allow estimation of the relative rate of change in use and expenditures. We test for heteroskedasticity to assure that the regression coefficients reflect rates of change in the mean of the untransformed dependent measures (Manning 1998). Using the White test, we fail to reject the hypothesis of constant variance within groups over time (White 1980). For each dependent measure and service type, we present the postpolicy net percentage change derived from our estimates for the Plus subjects alone, the Standard subjects alone and then the difference-in-difference. Because the difference-in-difference is measured as a rate of change, it is derived from the ratio of full percentage changes in each group from their initial levels, and is not the additive sum of the net percentage changes for each group. We footnote the results tables accordingly to avoid this potential misinterpretation.

Observations are weighted in the regression analyses by the number of subjects in each regional aggregate to account for underlying differences in the variance of the aggregate measures based on different subject numbers. We also used Huber/White/sandwich estimates of the standard errors to adjust for heteroskedasticity generally and specifically for the repeated observations in the pre- and postpolicy periods (Huber 1967; White 1980).

Sensitivity Testing

We ran our models using a variety of different sampling schemes to test the sensitivity of results in regard to the two main threats previously identified: the appropriateness of the OHP Plus members as a comparison group and the potential impact of benefit elimination concurrent with copay introduction. To test the comparison group effects, we split the comparison group into those eligible for Temporary Assistance for Needy Families (TANF) and those eligible by disability status and ran independent comparisons with the Standard group. To test the impact of benefit elimination, we focused on the mental health/chemical dependency (MH/CD) and DME benefits as the most likely areas for cross-benefit effects. In comparison with the results presented, which exclude claims within the continuously covered services that had mental health or substance abuse diagnoses, we ran our model excluding all prepolicy users of the MH/CD benefit, anyone who received a service with a primary mental health of substance abuse-related diagnosis pre- or postpolicy, and excluding all prepolicy users of the DME benefit.

RESULTS

Characteristics of the Enrollees

Table 2 provides descriptive data on the enrollees in the Plus and Standard samples. Consistent with the propensity score matching on these measures, only very small and statistically insignificant differences are evident. The use and expenditure measures indicate consistently higher rates of use and expenditures among the Plus sample. This reflects the differences in these populations inherent in their OHP eligibility characteristics and underscores the fact that this is a nonequivalent comparison group. The sample selection criteria result in samples from both groups that are older and have a higher prevalence of chronic illness and behavioral health service use than the underlying population.

Use and Expenditures Changes

Total, Pharmacy, and All Other Medical Care. Table 3 provides estimates of the percentage change across the three dependent measures for all services covered in the Standard benefit package after the policy change, as well as for outpatient pharmacy services and all other medical services separately. For the total of services covered, there was a reduction in use for the Standard group relative to the Plus comparison group, but no discernible reduction in

Table 2: Characteristics of the Study Population

Characteristic	*Standard (Intervention) Group (N= 10,176)*	*Plus (Comparison) Group (N= 10,319)*	*p Value*
Male gender (%)	39.9	39.3	.37
Non-Caucasian race/ethnicity (%)	13.6	13.5	.87
Age (%)			
18–4 years	25.5	26.1	.32
35–9 years	44.6	44.1	.42
50–4 years	29.8	29.8	.93
Chronic medical condition (%)	73.8	74.3	.47
Used outpatient mental health or substance abuse benefit (%)	17.6	17.8	.73
Average monthly use and expenditures			
Probability of use (%)	62.7	71.2	<.001
Expenditures per user ($)	397	547	<.001
Expenditures per person ($)	249	390	<.001

Chronic medical conditions were identified using primary diagnoses from the claims and encounter data. The list of conditions used is available from the author. Use and expenditure statistics are based on the twelve month pre-policy study period.

Table 3: Pre- to Post-Policy Percentage Change in Average Monthly Use and Expenditure for All Covered Services, Pharmacy, and All Other Medical Services

Service Type	*Probability of Use*	*p Value*	*Expenditures per User*	*p Value*	*Expenditures per Person*	*p Value*
All covered services						
Plus	0.3	.410	− 1.0	.58	− 0.7	.69
Standard	− 2.4	<.001	4.0	.10	1.4	.54
Difference-in-difference	− 2.7	<.001	5.0	.10	2.2	.47
Pharmacy						
Plus	− 1.9	.01	0.6	.72	− 1.3	.47
Standard	− 4.1	<.001	− 10.0	<.001	− 13.7	<.001
Difference-in-difference	− 2.2	.03	− 10.5	<.001	− 12.5	<.001
All other medical services						
Plus	1.0	.47	− 2.3	.28	− 1.3	.64
Standard	− 3.7	<.001	12.2	<.001	8.1	.007
Difference-in-difference	− 4.7	.002	14.9	<.001	9.5	.02

The (net) percentage changes presented are calculated directly from the coefficients of the regression equations with logged dependent variables (exponent of coefficient minus one). The difference-in-difference, which represents the net percentage change in the Standard group relative to the Plus group, is equal to the ratio of Standard to Plus full percentage changes (net percentage plus one). It is not equal to the difference between the Standard and Plus net percentage changes shown in the tables.

expenditures per person. Reduction in the likelihood of filling at least one prescription or using any other medical service in a month is also evident for the Standard group, yet expenditures diverge dramatically. Pharmacy expenditures per user decreased for the Standard group and, combined with the decrease in use, led to large reductions in expenditures per person. Alternatively, expenditures per user increased for all other medical services at almost three times the rate that use declined, resulting in a large increase in expenditures per person for the Standard group. The initial finding of no overall expenditure decrease reflects the weighted average of these opposing results by relative expenditure level.

All Other Medical Care (Nonpharmacy) by Service Type. Table 4 presents use and expenditure change for the five service categories other than pharmacy: inpatient, ambulatory (nonadmitted) emergency department, hospital outpatient, lab and radiology, and all other ambulatory care. Use and expenditures per person for inpatient care and hospital outpatient services by the Standard group increased relative to the Plus cohort. Alternatively, rates of use for emergency department services among Standard enrollees declined relative to the Plus enrollees. The reduction in emergency department use was met with increases in expenditures per user that resulted in no difference in expenditures per person.

Utilization and expenditures for all other ambulatory care followed a pattern similar to emergency department services, but the positive increase in expenditures per user was not statistically significant. Lab and radiology was the only service category in which there were no statistically significant differences in Standard and Plus use and expenditures.

Sensitivity Testing. The study results were found to be robust in comparison with the sensitivity testing results both in regard to benefit elimination and the comparison group tests. From a qualitative perspective, that is, based on the signs and significance of individual effects, identical conclusions would be drawn under all the alternative sampling schemes. We also conducted direct tests of the differences in the magnitude of effects relative to our main analysis. Among the 504 individual differences among coefficients through the seven sensitivity tests, 13 were found to be statistically significant at the 5 percent level, and two involved difference-in-difference coefficients. We conclude from these results that the study findings represent the effects of the

Table 4: Pre- to Post-Policy Percentage Change in Average Monthly Use and Expenditure for All Other (Nonpharmacy) Services by Service Type

Service Type	*Probability of Use*	*p Value*	*Expenditures per User*	*p Value*	*Expenditures per Person*	*p Value*
Inpatient						
Plus	−12.5	<.001	0.4	.92	−12.2	.02
Standard	11.4	.03	−5.4	.21	5.4	.44
Difference-in-difference	27.3	<.001	−5.7	.31	20.1	.03
Emergency department						
Plus	1.8	.51	6.3	.009	9.8	.008
Standard	−6.2	.01	14.7	<.001	7.6	.03
Difference-in-difference	−7.9	.03	7.9	.03	−2.0	.68
Hospital outpatient						
Plus	−9.6	<.001	2.6	.43	−7.3	.04
Standard	2.6	.06	8.2	.03	11.1	.002
Difference-in-difference	13.5	<.001	5.5	.27	19.7	<.001
Lab and radiology						
Plus	−6.2	<.001	11.9	<.001	5.0	.03
Standard	−3.0	<.001	8.7	<.001	5.4	.04
Difference-in-difference	3.3	.32	−2.9	.28	0.3	.92
All other ambulatory professional						
Plus	2.7	.14	10.0	<.001	13.0	<.001
Standard	−5.2	<.001	17.3	<.001	11.2	.01
Difference-in-difference	−7.7	<.001	6.6	.13	−1.5	.75

The (net) percentage changes presented are calculated directly from the coefficients of the regression equations with logged dependent variables (exponent of coefficient minus one). The difference-in-difference, which represents the net percentage change in the Standard group relative to the Plus group, is equal to the ratio of Standard to Plus full percentage changes (net percentage plus one). It is not equal to the difference between the Standard and Plus net percentage changes shown in the tables.

copayments and that any benefit elimination effects that may exist are likely focused within specific subpopulations.

DISCUSSION

Our results indicate that copayments for low-income adults in the OHP did not reduce expenditures for the remaining covered benefits as intended. The policy did reduce overall use of services, but in some cases shifted treatment patterns, such as the relative increase in inpatient care, in ways that are not inherently aligned with more cost-efficient or effective care. Overall, the study results suggest that both intended and unintended effects of copayments were

at play, and at the level of total expenditures canceled each other out. Effects within and among the specific service types are consistent with both unintended demand and supply-side effects.

The opposing effects of reduced use and expenditure for pharmacy and increased expenditures for all other medical care are strongly consistent with previously cited findings for drug copayments applied to welfare recipients in Quebec (Tamblyn et al. 2001), among Medicaid and Medicare recipients with capped drug benefits (Soumerai et al. 1991, 1994; Hsu et al. 2006b), among Canadians with drug cost-sharing generally (Anis et al. 2005), and for Medicaid copayments applied in California during the late 1970s (Helms, Newhouse, and Phelps 1978). Alternatively, reductions in use and expenditures have been generally found in prescription drug cost-sharing studies, regardless of whether offsets in other medical care have been measured or found (Gibson, Ozminkowski, and Goetzel 2005). Thus, a combination of intended and unintended effects of the drug copays is likely to have occurred. In particular, the copayment schedule for drugs by Oregon follows a "three tier" approach that provides incentives to choose less expensive preferred brands or generics. This approach has been found to generally reduce use and expenditures in its intended manner, as well as with potentially harmful termination of drug treatment occurring where more "aggressive" tiered copayments were applied (Huskamp et al. 2003).

Effects consistent with a counterbalancing of intended and unintended effects of copayments are evident in results for some of the specific service types. For both emergency department and all other ambulatory services significant reductions in use are evident but counterbalanced by increased expenditures per user such that expenditures per person remain unchanged. Research on copayments for emergency department services in commercial insurance environments has found reduced use and expenditures, no evidence of delayed care or other adverse events, and greater reductions in use for less serious conditions (O'Grady, et al. 1985; Selby, Fireman, and Swain 1996; Magid et al. 1997; Hsu et al. 2006a, Reed et al. 2005). A review of procedure codes for 15-, 30-, and 45-minute office visits and emergency services among the Standard enrollees indicates a marked increase in longer duration office visits and higher intensity emergency services after the policy change. A pattern indicating consumers have "selected" proportionally fewer less serious, less intensive, and less expensive emergency department or ambulatory visits are consistent with the intended effects of copayments. Proportional increases in more serious, intensive, and more expensive visits at a rate greater than expected from selection alone are, however, more consistent with unintended effects such as inappropriately delaying care.

Other results suggest the presence of supply or access effects due to the copayments. Hospital outpatient use increases while use of other ambulatory professional care declines. When all hospital-based services are combined (inpatient, emergency department, and hospital outpatient), use and expenditures increase overall. This may signal shifts toward organizations such as hospitals that may be more willing or able to forgo copayments. To the extent that hospital outpatient care is being substituted for nonhospital ambulatory care, the hospital-based care may still be appropriate and equally effective. However, it would not be cost-efficient as hospital outpatient care incurs facility charges in addition to physician fees, making it more expensive than office-based physician care, all else equal.

Our study has several limitations inherent to a natural experiment. Despite our sensitivity analyses, we cannot be sure that the OHP Plus enrollees provide an accurate comparison group. Specifically, we cannot be sure that the Plus group was not affected by the policy change as providers may not have distinguished between Standard and Plus enrollees. The sampling process also yielded subjects that were slightly older, more likely to have chronic physical or behavioral conditions, and had longer durations of enrollment than typical adult OHP Medicaid enrollees. While these members may not be fully representative of a typical Medicaid population, they do represent a disproportionate share of expenditures. Our expenditure measures were based on fee-for-service rates and thus do not reflect actual state expenditure levels, which include managed care organization capitation rates.

There was confusion and instability in the initial months of the policy, including 2 weeks in which the Standard pharmacy benefit was eliminated and then restored. Our findings may include residual implementation effects despite the exclusion of 3 months before and after the policy implementation. Many managed care organizations were wary of the policy expectations and stopped covering Standard beneficiaries. This may have caused disruptions in treatment access beyond the policy change itself. These and other unique aspects of the policy and its environment may limit the ability to generalize from these findings.

Although our study did not find reductions in expenditures for continuously covered benefits expected from applying copayments, the state did save money by directly shifting expenditures to consumers through the copayments on the remaining benefits and by the elimination of benefits itself. The copayments represented approximately 6 percent of expenditures for the Standard study sample in the postpolicy period. Using our study methodology applied to total program expenditures (i.e., expenditures for continuous and

eliminated benefits pre- and postpolicy), we found an expenditure reduction of 17.8 percent.

Copayments on medical services have generally worked well as a cost-saving device in commercially insured populations. If copayments are to be applied successfully in Medicaid programs, there is a clear need for a greater understanding of how they work in this context and greater attention paid to the details of copayment policies. Eliminating drug copayments, if they are more likely to cause cost-offsets, and/or establishing income-based limits on total copayments, might have reduced the unintended effects found in Oregon and allowed for the desired savings to occur. If copayments exacerbate the already endemic problems of treatment access experienced by most Medicaid enrollees, then it may be difficult to obtain savings from more efficient treatment use, regardless of the copayment structure. Without further information, state policy makers seeking to limit the growth of Medicaid expenditures, or seeking savings to expand coverage, should be wary of relying heavily on traditional, demand-side cost sharing, particularly when applied to very low-income beneficiaries.

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REFERENCES

Anis, A. H., D. P. Guh, D. Lacaille, C. A. Mara, A. A. Rashidi, X. Li, and M. Esdaile. 2005. "When Patients Have to Pay a Share of Drug Costs: Effects on Frequency of Physician Visits, Hospital Admissions and Filling Prescriptions." *Canadian Medical Association Journal* 173 (11): 1335–40.

D'Agostino, R. B. Jr. 1998. "Propensity Score Methods for Bias Reduction in the Comparison of Treatment to a Non-Randomized-Control Group." *Statistics in Medicine* 17 (19): 2265–81.

Dehejia, R. H., and S. Wahba. 2002. "Propensity Score-Matching Methods for Nonexperimental Casual Studies." *Review of Economics and Statistics* 84 (1): 151–61.

Gibson, T. B., R. J. Ozminkowski, and R. Z. Goetzel. 2005. "The Effects of Prescription Drug Cost Sharing: A Review of the Evidence." *American Journal of Managed Care* 11 (11): 730–40.

Gruber, J. 2006. "The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond" Henry J. Kaiser Family Foundation [accessed on January 23, 2007]. Available at http://www.kff.org/insurance/7566.cfm

Helms, L. J., J. P. Newhouse, and C. E. Phelps. 1978. "Co-Payments and the Demand for Medical Care: The California Medicaid Experience." *Bell Journal of Economics* 9 (1): 192–209.

Hsu, J., M. Price, R. Brand, G. T. Ray, B. Fireman, J. P. Newhouse, and J. V. Selby. 2006a. "Cost-Sharing for Emergency Care and Unfavorable Clinical Events: Findings from the Safety and Financial Ramifications of ED Copayments Study." *Health Services Research* 41 (5): 1801–20.

Hsu, J., M. Price, J. Huang, R. Brand, V. Fung, R. Hui, B. Fireman, J. P. Newhouse, and J. V. Selby. 2006b. "Unintended Consequences of Caps on Medicare Drug Benefits." *New England Journal of Medicine* 354 (22): 2349–59.

Huber, P. J. 1967. "The Behavior of Maximum Likelihood Estimates under Non-Standard Conditions." In *Proceedings of the Fifth Berkeley Symposium on Mathematical Statistics and Probability*, pp. 221–33. Berkeley, CA: University of California Press.

Huskamp, H. A., P. A. Deverka, A. M. Epstein, R. S. Epstein, K. A. McGuigan, and R. G. Frank. 2003. "The Effect of Incentive Based Formularies on Prescription Drug Utilization and Spending." *New England Journal of Medicine* 349 (23): 2224–32.

The Kaiser Commission on Medicaid and the Uninsured. 2006. *Deficit Reduction Act of 2005: Implications for Medicaid.* Washington, DC: The Henry J. Kaiser Foundation [accessed September 23, 2006]. Available at http://www.kff.org/medicaid/upload/7465.pdf

Keeler, E. B., R. H. Brook, G. A. Goldberg, C. J. Kamberg, and J. P. Newhouse. 1985. "How Free Care Reduced Hypertension in the Health Insurance Experiment." *Journal of the American Medical Association* 254 (14): 1926–31.

Ku, L. 2003. *Charging the Poor More for Health Care: Cost Sharing in Medicaid.* Washington, DC: Center on Budget and Policy Priorities [accessed August 20, 2006]. Available at http://www.cbpp.org/5-7-03health.pdf

Lohr, K. N., R. H. Brook, C. J. Kamberg, G. A. Goldberg, A. Leibowitz, J. Keesey, D. Reboussin, and J. P. Newhouse. 1986. "Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis and Service Specific Analyses in a Randomized Controlled Trial." *Medical Care* 24 (suppl 9): S1–S87.

Lurie, N., C. J. Kamberg, R. H. Brook, E. B. Keeler, and J. P. Newhouse. 1989. "How Free Care Improved Vision in the Health Insurance Experiment." *American Journal of Public Health* 79 (5): 640–2.

Magid, D. J., T. D. Koepsell, N. R. Every, J. S. Martin, D. S. Siscovick, E. H. Wagner, and W. D. Weaver. 1997. "Absence of Association between Insurance Copayments and Delays in Seeking Emergency Care among Patients with Myocardial Infarction." *New England Journal of Medicine* 336 (24): 1722–9.

Manning, W. G. 1998. "The Logged Dependent Variable, Heteroskedasticity, and the Retransformation Problem." *Journal of Health Economics* 17 (3): 283–95.

Manning, W. G., J. P. Newhouse, N. Duan, E. B. Keeler, A. Leibowitz, and M. S. Marquis. 1987. "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment." *American Economic Review* 77: 251–77.

National Governor's Association, Center for Best Practices. 2001. "HIFA: Finding the Flexibility" [accessed on August 20, 2006]. Available at http://www.nga.org/cda/files/102401hifa.pdf

Newhouse, J. P. 2006. "Reconsidering the Moral Hazard-Risk Avoidance Trade-off." *Journal of Health Economics* 25 (5): 1005–14.

Newhouse, J. P. and The Insurance Experiment Group. 1993. *Free for All? Lessons from the Rand Health Insurance Experiment.* Cambridge, MA: Harvard University Press.

O'Grady, K. F., W. G. Manning, J. P. Newhouse, and R. H. Brooks. 1985. "The Impact of Cost Sharing on Emergency Department Use." *New England Journal of Medicine* 313 (8): 484–90.

Reed, M. V., V. Fung, R. Brand, B. H. Fireman, J. P. Newhouse, J. V. Selby, and J. Hsu. 2005. "Care-Seeking Behavior in Response to Emergency Department Copayments." *Medical Care* 43 (8): 810–6.

Rosen, A. B., M. B. Hamel, M. C. Weinstein, D. M. Cutler, A. M. Fendrick, and S. Vijan. 2005. "Cost-Effectiveness of Full Medicare Coverage of Angiotensin-Converting Enzyme Inhibitors for Beneficiaries with Diabetes." *Annals of Internal Medicine* 143 (2): 89–99.

Selby, J. V., B. H. Fireman, and B. E. Swain. 1996. "Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization." *New England Journal of Medicine* 335 (25): 1888–96.

Soumerai, S. B., T. J. Mclaughlin, D. Ross-Degnan, C. S. Casteris, and P. Bollini. 1994. "Effect of a Limit on Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia." *New England Journal of Medicine* 331 (10): 650–5.

Soumerai, S. B., D. Ross-Degnan, J. Avorn, T. McLaughlin, and I. Choodnovskiy. 1991. "Effects of Medicaid Drug-Payment Limits on Admissions to Hospitals and Nursing Homes." *New England Journal of Medicine* 325 (15): 1072–7.

Tamblyn, R., R. Laprise, J. A. Hanley, M. Abrahamowitz, S. Scott, N. Mayo, J. Hurley, R. Grad, E. Latimer, R. Perrault, P. McLeod, A. Huang, P. Larochelle, and L. Mallet. 2001. "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons." *Journal of the American Medical Association* 285 (4): 421–9.

White, H. 1980. "A Heteroskedasticity-Consistent Covariance Matrix Estimator and a Direct Test for Heteroskedasticity." *Econometrica* 48 (4): 817–38.

Modern Healthcare

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Ohio Medicaid waiver could cost hospitals $2.5 billion

VIRGIL DICKSON

A provision of the pending Medicaid waiver request submitted by the administration of Republican Gov. John Kasich would eliminate 90-day retroactive coverage. That could cost hospitals as much as $2.5 billion over the course of the five-year waiver, according to an analysis.

Ohio hospitals could lose billions if the CMS approves a Medicaid waiver requested by Gov. John Kasich's administration.

The Republican governor and presidential candidate wants to **move Ohio to a more conservative approach to Medicaid** expansion, allowing the program to drop adult beneficiaries who don't pay into a health savings account, regardless of their income.

Another controversial provision would eliminate 90-day retroactive coverage for Medicaid beneficiaries. That could be particularly painful for hospitals, according to Cleveland-based Human Arc, a consulting firm that advises hospitals in the state on spending and eligibility issues. The change could cost hospitals as much as $2.5 billion over the course of the five-year waiver, the firm estimated.

Under current Ohio Medicaid rules, eligibility begins the day an application is submitted, assuming the applicant is ultimately deemed to qualify for benefits. Providers can also bill for services provided in the preceding three months, assuming the patient met eligibility rules during that time, said John Corlett, a former Ohio Medicaid director and executive director of the Center for Community Solutions, a not-for-profit, nonpartisan think tank.

Under the Healthy Ohio waiver, eligibility would not begin until an application is actually approved for Medicaid and the person enrolls in a managed-care plan and makes a first payment into a health savings account.

This change would mean the program would not pay an estimated 350,000 to 380,000 medical claims, adding up to $470 million to $510 million a year in lost revenue for providers, according to the Human Arc analysis.

The chances that the CMS will go along with the plan are unclear. The agency approved a similar request for Healthy Indiana Plan 2.0, which is the template for Healthy Ohio. New Hampshire received a conditional one-year waiver to eliminate retroactive eligibility, but the state was required to submit data showing no coverage gap would occur as a result. The state submitted the data in December, but a final decision has not been announced. A spokesperson for New Hampshire's Medicaid agency did not respond to a request for comment.

Arkansas officials have also expressed interest in a retroactive coverage waiver, but HHS Secretary Sylvia Burwell appeared to oppose the idea in a January 2016 letter to the state's Republican governor, Asa Hutchinson.

“Retroactive coverage is especially important when issues with a state's eligibility and enrollment systems lead to unnecessary gaps in coverage,” Burwell said. “We recognize the recent improvements Arkansas has made to its eligibility and enrollment system, but significant additional progress is needed to ensure that all eligible individuals are enrolled in Medicaid in a timely manner.”

Ohio's waiver request is posted for comment. The deadline for responses is May 13. The state wants to launch the new version of Medicaid expansion outlined in the waiver by Jan. 1, 2018.

Inline Play
