



# Paying For Medicaid Coverage: An Overview of Monthly Payments in Section 1115 Demonstrations

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## Executive summary

Five states—Arkansas, Indiana, Iowa, Michigan, and Montana—operate section 1115 Medicaid demonstrations that require or encourage monthly payments from Medicaid beneficiaries with incomes up to 133 percent of the federal poverty level.<sup>1</sup> These demonstrations vary in the amount and timing of the required payments, the income levels at which payments are required, and the consequences for nonpayment. In some states, the monthly payments are considered traditional premiums; in others, they are contributions to beneficiary accounts that resemble health savings accounts. We compare the design of monthly payments in the five demonstrations during the 2014–2016 period. We also (1) estimate the number and proportion of potential enrollees in each state who would be subject to monthly payments using data from the American Community Survey and (2) report the proportion of potential enrollees that could be disenrolled for nonpayment to illustrate how broadly nonpayment consequences might apply to demonstration beneficiaries. Overall, we find that the proportion of the demonstration population required or encouraged to make monthly payments ranges from 25 percent in Michigan to 100 percent in Indiana, although in some states beneficiaries may opt out of making payments with few consequences. In Iowa, Indiana, and Montana, about one quarter of the estimated eligible population can be disenrolled for nonpayment. We close by looking

ahead to our continuing observation and evaluation of these demonstrations, including elements of monthly payment design which could be the basis of valid comparisons across states.<sup>2</sup>

## Introduction

Five states—Arkansas, Indiana, Iowa, Michigan, and Montana—operate Medicaid programs that require or encourage certain beneficiaries to pay premiums or make other monthly contributions. Although Title XIX of the Social Security Act normally prohibits states from requiring premiums of Medicaid beneficiaries with family incomes under 150 percent of the federal poverty level (FPL), these states have authority under section 1115 of the Act to waive that prohibition.<sup>3</sup> We use the term “monthly payments” to encompass payments considered to be traditional premiums, as in Iowa and Montana, as well as those that take the form of monthly beneficiary account contributions, as in Indiana and Michigan’s ongoing demonstrations, and in Arkansas’s initial demonstration, the Health Care Independence Program (Arkansas implemented a new monthly payment policy in January 2017, under a new demonstration named Arkansas Works<sup>4</sup>). In this issue brief, we compare the monthly payments policies in the five demonstration states during the 2014–2016 period, including the payment amounts, timing, and consequences of nonpayment, exemptions, and linkages to beneficiary accounts.<sup>5</sup>

## THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some of these new approaches being tested under 1115 authority draw on established practices in commercial health insurance, such as cost-sharing at levels that exceed Medicaid limits and financial incentives for pursuing healthy behaviors. Other new approaches involve partnerships with private-sector entities, such as issuers that offer qualified health plans. However, Medicaid beneficiaries have lower incomes and poorer health status than most privately insured individuals and Medicaid expansion demonstrations have required multiple beneficiary protections, such as limits on total cost-sharing, access to certain mandatory benefits, and rights to fair hearings.

Each of these demonstrations is intended to promote beneficiaries' responsibility for and engagement in their health coverage and care, and as such introduces policies that may affect beneficiary enrollment and coverage continuity. For example, payment amounts and timing of collection may influence whether individuals decide to enroll in Medicaid and how long they remain enrolled. Having to pay for Medicaid coverage could signal that it is valuable, which could encourage people to enroll or to stay enrolled. On the other hand, consequences of nonpayment, such as debt collection policies, may affect take-up and enrollment continuity. Because these demonstrations allow states to apply monthly payment requirements to beneficiaries with lower incomes than previously allowed, the states and CMS are monitoring enrollment patterns at the affected income levels.

## What are the state-by-state differences in monthly payment design?

Table 1 lists the implementation dates for the five states' demonstrations and the dates when payment policies first took effect, and highlights key differences among the five demonstrations in the monthly payment amounts and timing, the consequences of nonpayment, and linkages with beneficiary accounts.

**Monthly payment amounts by income level.** The Iowa design for monthly payment amounts is a fixed amount for each of two different income groups. Iowa requires monthly payments for beneficiaries with incomes above 50 percent of FPL, although the state waives these contributions if beneficiaries engage in

**Table 1. Monthly payment design by state, 2014–2016**

Design element	Arkansas: Health Care Independence Program <sup>a</sup>	Indiana: Healthy Indiana Plan (HIP) 2.0 <sup>b</sup>	Iowa: Iowa Health and Wellness Plan	Michigan: Healthy Michigan Plan	Montana: Health and Economic Livelihood Partnership
Expansion date	January 1, 2014	February 1, 2015	January 1, 2014	April 1, 2014	January 1, 2016
Monthly payments effective	January 1, 2015 Discontinued April 2016	February 1, 2015	January 1, 2015	October 1, 2014	January 1, 2016
Basis for monthly amount	Fixed amounts, as listed below	2% of income for those >5% FPL; \$1 for those at or below 5% FPL	Fixed amounts, as listed below	2% of income for those >100% FPL	2% of income for those at or above 50% FPL
Monthly amounts for income 0–100% FPL	\$0	0–5% FPL: \$1 6–100% FPL: \$1–\$20 <sup>c</sup>	0–49% FPL: \$0 50–100% FPL: \$5	\$0	0–49% FPL: \$0 50–100%: \$10–\$20 <sup>c</sup>
Monthly amounts for income >100% FPL	>100–115% FPL: \$10 116–138% FPL: \$15	>100–133% FPL: \$20–\$27 <sup>c</sup>	>100–133% FPL: \$10	>100–133% FPL: \$20–\$27 <sup>c</sup>	>100–133% FPL: \$20–\$27 <sup>c</sup>
Timing of payments	If paid before the end of the 2nd month after coverage was effective, beneficiary avoided copayments at the point of service	Beneficiaries with income >100% FPL cannot enroll until the first monthly payment is made. For those with income ≤100% who choose not to pay monthly payments, coverage is effective the first day of month in which the 60-day initial grace period expires.	Begins after 12 months of enrollment if incentivized health behaviors are not completed. There is also a 30-day grace period for making the first payment or completing health behaviors.	Begins after 6 months of enrollment	Begins in the first month of enrollment
Consequences of nonpayment	Beneficiaries are exposed to QHP copayments at the point of service	A 60-day grace period is followed by disenrollment for 6 months for beneficiaries with income >100% FPL. Those with income ≤100% remain enrolled, but lose enhanced benefits and are exposed to copayments.	A 90-day grace period is followed by disenrollment for beneficiaries with income >100% FPL, but can re-enroll at any time. Monthly payments can become a collectible debt after 90 days for all beneficiaries.	No beneficiaries are disenrolled for nonpayment, but the state will garnish state tax returns for missed payments in excess of \$50	>100% FPL: disenrollment for nonpayment after a 30-day notice of nonpayment period and a 90-day grace period; may re-enroll upon payment or when debt is assessed  50%–100% FPL: cannot be disenrolled but unpaid payments can become a collectible debt
Beneficiary accounts	Yes	Yes	No	Yes	No

(continued)

Sources: Mathematica analysis of:

Arkansas Special Terms and Conditions, approval period September 27, 2013–December 31, 2016; as amended January 1, 2015.

Iowa Marketplace Choice Plan Special Terms and Conditions, approval period January 1, 2014–December 31, 2016; as amended December 31, 2014.

Indiana Special Terms and Conditions, approval period February 1, 2015–December 31, 2018.

Michigan Special Terms and Conditions, approval period December 30, 2013–December 31, 2018.

Montana Special Terms and Conditions, approval period November 1, 2015–December 31, 2020.

Key informant interviews with Medicaid officials in Arkansas, Indiana, Iowa, Michigan, and Montana.

<sup>a</sup> Arkansas closed the Independence Accounts in June 2016 and subsequently received approval for a new set of demonstration policies for the period 2017 through 2021, under the name Arkansas Works. This issue brief focuses on monthly payment policies during the period when Independence Accounts were in effect.

<sup>b</sup> Payment amounts are for HIP Plus beneficiaries. HIP Basic beneficiaries do not make monthly payments.

<sup>c</sup> Amounts were calculated using the FPL for a household size of one and the 2017 FPL threshold (\$12,060), and are rounded to the nearest whole dollar. Monthly income levels for a household size of one at 50%, 100%, and 133% of the 2017 threshold are \$503, \$1,005, and \$1,387, respectively.

FPL = federal poverty level; QHP = qualified health plan.

certain health behaviors. From January 2015 through April 2016, under the Health Care Independence Program, Arkansas also set fixed amounts for adults with incomes above 100 percent of the FPL.<sup>6</sup> Arkansas initially received section 1115 authority to collect contributions from adults with household incomes between 50 percent and 100 percent FPL, but did not implement this policy.

Indiana, Michigan, and Montana set monthly payments at 2 percent of household income, although beneficiaries in Indiana with incomes of 5 percent of FPL and below have a monthly contribution of \$1 per month, regardless of whether this amount is greater than 2 percent of household income. However, monthly contributions are optional for Indiana beneficiaries with incomes below the poverty line. If beneficiaries in this income range do not make monthly payments, they enroll in HIP Basic rather than HIP Plus. HIP Basic has fewer benefits and exposes beneficiaries to copayments at the point of service. Beneficiaries enrolled in HIP Plus are protected from copayments except for those applied to non-emergency visits to emergency departments. The maximum monthly payment for HIP Plus beneficiaries is \$100. Michigan does not require monthly payments of adults at or below the poverty line, and Montana does not require monthly payments of adults below 50 percent of the FPL. Beneficiaries in Indiana and Michigan can have their contributions reduced if they engage in certain health behaviors.

**Timing of monthly payments.** Iowa's demonstration design has the longest time lapse between enrollment and the first required payment. If beneficiaries do not complete specified health behaviors in the first year of enrollment, including a physical or dental wellness exam and a health risk assessment, they must pay monthly payments beginning in the second year, after a 30-day grace period during which beneficiaries can complete these behaviors and eliminate their payment liability for the second year. Michigan requires the first payment after the first six months of enrollment. Montana requires a payment for the first month that coverage is effective, no matter when in the first month an individual is determined eligible. If beneficiaries enroll early in the first month, the first invoice arrives later that same month and combines payments owed for the first and second months. If beneficiaries enroll after the billing cutoff date in the first month, the first statement arrives in the second month and combines payments owed for the first three months of enrollment. Under

the Health Care Independence Program, Arkansas encouraged beneficiaries to make a first payment by the end of the second month after coverage was effective.

The timing of monthly payments in Indiana is based on section 1115 authority the state has had since 2008 to waive laws governing reasonable promptness and retroactive coverage, setting coverage to begin on the first day of the month in which a beneficiary makes an initial financial contribution.<sup>7</sup> After they are determined eligible, beneficiaries have 60 days to make their first monthly contribution and enroll in HIP Plus. Adults with incomes above the poverty line who do not make a payment do not receive coverage. For those with incomes at or below the poverty line who choose not to make monthly payments, coverage in HIP Basic is effective on the first day of the month in which a 60-day payment period expires. HIP Basic does not cover certain benefits included in HIP Plus, such as vision and dental services and requires point-of-service cost sharing. Beneficiaries can also opt to enroll in coverage right away by making a \$10 contribution at application. The \$10 "fast track" payment is applied to the beneficiary's future monthly payment contribution requirements.

**Consequences of nonpayment.** The three states that have authority to require monthly payments of beneficiaries with incomes below the poverty line (100 percent of the FPL) also apply the most serious consequences for nonpayment. CMS has allowed these three states to disenroll beneficiaries for nonpayment, although these policies apply only to those with incomes above the poverty line. Iowa disenrolls beneficiaries with incomes above the poverty line after a 90-day grace period, but beneficiaries can re-enroll at any time. Montana also disenrolls beneficiaries with incomes above the poverty line for nonpayment after a 30-day notice period and a 90-day grace period. Beneficiaries can re-enroll after payment of past due amounts or after debt assessment by the state.<sup>8</sup> In Indiana, all beneficiaries who make a payment within 60 days of their eligibility determination are enrolled in HIP Plus. After the 60-day grace period passes, HIP Plus beneficiaries with incomes above the poverty line who make at least one monthly contribution but fail to make subsequent payments are disenrolled from the program, and may not re-enroll for six months.

For beneficiaries who owe monthly payments at any income level

in Iowa and Montana, including those below the poverty line, past-due payments can become a collectible debt. In Indiana, those with incomes below the poverty line who do not make monthly payments are automatically enrolled in HIP Basic, a more limited benefit plan. If beneficiaries with incomes at or below the poverty line begin making payments and enroll in HIP Plus, but then stop paying their monthly contributions, they would transition to HIP Basic. They cannot regain access to HIP Plus until their annual coverage renewal date. Beneficiaries with incomes above the poverty line do not have access to HIP Basic.

Michigan asks beneficiaries above the poverty line to make monthly payments and does not disenroll them for nonpayment. Michigan initiates a messaging process for beneficiaries who have missed payments, and will refer beneficiaries who have missed repeated payments and owe more than \$50 to its Department of Treasury to garnish state tax returns or lottery winnings. Likewise, Arkansas asked beneficiaries with incomes above the poverty line to make monthly payments under the Health Care Independence Program, and did not disenroll them for nonpayment. The penalty for nonpayment of monthly payments was that beneficiaries were required to pay copayments at the point of service, and could be denied service if they were not able to do so. Beneficiaries who made monthly payments did not have to make copayments; these beneficiaries therefore traded the unplanned expense of copayments for predictable, uniform monthly contributions.<sup>9</sup> (The state paid copayments for beneficiaries below the poverty line, who were not asked to make monthly payments.)

**Exemptions from monthly payments and nonpayment penalties.** Iowa, Montana, and Indiana exempt certain beneficiaries from monthly payment requirements and/or nonpayment consequences, including those who would otherwise owe monthly payments based on income level. Iowa's monthly payment exemption policy is unique in that individuals who attest to financial hardship are exempt from monthly payment obligations. Individuals can claim financial hardship each month through an option on the payment statement. Medically frail individuals and those enrolled in cost-effective employer-sponsored insurance under the state Health Insurance Premium Payment Program are also exempt from monthly payments in Iowa.

Indiana and Montana exempt certain groups from both payment requirements and nonpayment consequences. In Indiana, pregnant women and Native Americans are exempt from monthly payments. Medically frail individuals with incomes above the poverty line cannot be disenrolled for nonpayment. In addition, individuals who are disenrolled for nonpayment can re-enroll before the end of six months if they meet certain criteria, such as gaining and subsequently losing private coverage. In Montana, beneficiaries are exempt from demonstration coverage—and therefore from monthly payment requirements—if they are medically frail (including being pregnant), Native American, or live in an area without sufficient providers.<sup>10</sup> Montana also exempts individuals

from disenrollment for nonpayment if they meet two or more of the following “good cause” criteria: discharge from U.S. military service within the previous 12 months, enrollment in higher education, participation in a workforce program, receipt of care at a Medicaid health home or patient-centered medical home, and participation in specified prevention, treatment, or health care programs. Past-due payments remain a collectible debt for individuals exempted from disenrollment.

Michigan does not specify exemptions from monthly payments other than those individuals already exempt from cost-sharing by law or regulation, such as American Indians/Alaska Natives and pregnant women or those exempt from all demonstration policies.<sup>11</sup> Michigan also excludes individuals with disabilities from the demonstration group. Arkansas excluded medically frail individuals from the Health Care Independence Program. The state allowed American Indians/Alaska Natives and pregnant women to opt in to demonstration coverage, although these groups were exempt from monthly payments.

**Linkage with beneficiary accounts.** Three of the five demonstration states—Indiana, Michigan, and Arkansas—created beneficiary accounts to serve as repositories for monthly payments. To varying degrees, beneficiary accounts resemble health savings accounts (HSAs) in commercial insurance in that their objective is to promote efficient use of health care by building beneficiaries' awareness of the cost of care.<sup>12</sup> Indiana's Personal Wellness and Responsibility (POWER) account is the closest to a commercial HSA, because beneficiaries use POWER account funds to cover the cost of the first \$2,500 of services, with the exception of preventive services, which are paid outside the POWER account. The state contributes the majority of these funds and beneficiaries' contributions fund a pro rata share of claims against the account, depending on their monthly contribution amounts; the full \$2,500 is available to beneficiaries at the beginning of the enrollment year. Beneficiaries may roll over unused funds for use in the next enrollment year, which may result in reduced monthly contributions. As a further incentive, the state doubles the rollover amount for HIP Plus beneficiaries who obtain at least one recommended preventive service for their age and sex. Beneficiaries below 100 percent of the FPL who are enrolled in HIP Basic must receive a recommended preventive service to qualify for any rollover amount, which could reduce their future contributions by up to 50 percent if they opt into HIP Plus at renewal.

Michigan's MI Health Account functions as a \$1,000 deductible; beneficiaries and health plans are jointly responsible for funding the account. Beneficiaries' monthly payments accumulate in their accounts and can be disbursed to health plans to pay for the cost of services received. The health plan pays their portion of the deductible first, and only when that is exhausted are beneficiary contributions to the MI Health account drawn down to pay for services. Beneficiaries with incomes at or under the poverty line

are not required to make payments into the accounts, and the plans are responsible for 100 percent of the payment of all covered services. Beneficiaries in Michigan who agree to complete certain health behaviors and have incomes above the poverty line receive account credits that reduce their monthly payment amounts.

Finally, Arkansas's Independence Accounts were primarily intended to help beneficiaries track their service use and contributions, rather than acting as true HSAs. Beneficiaries in Arkansas who made monthly account contributions could use their account cards to pay point-of-service copayments. The cards drew funds from a master account managed by the state and there was no limit on the total amount of copayments that could be charged to the account cards. Beneficiaries who made six or more contributions to Independence Accounts could use up to \$200 in accumulated account contributions to pay future insurance monthly payments when they left Medicaid. Arkansas closed the Independence Accounts in June 2016, citing concerns about administrative costs.<sup>13</sup>

The other two states, Iowa and Montana, take a more traditional approach to monthly payments and do not track them as account payments.

### **How do beneficiaries learn about their payment obligations and use the collection systems?**

Beneficiaries' understanding of their payment obligations is important contextual information for interpreting observed payment and disenrollment rates. For example, if states' communication materials are unclear or their collection methods are confusing, low payment rates may be caused by a lack of understanding rather than an inability to pay. Alternatively, if there is evidence that beneficiaries do understand the rules and find it easy to enroll, low payment rates may indicate that beneficiaries have difficulty affording their monthly payments.

Assessing beneficiaries' understanding of their financial obligations is important in monitoring and evaluating demonstrations, because teaching beneficiaries about their obligation to make health insurance payments is a primary policy goal for several states. For example, Arkansas designed Independence Accounts primarily as a teaching tool to communicate the advantages of making steady monthly payments. For each monthly payment beneficiaries made, they were protected from copayments in the following month. Beneficiaries received quarterly Independence Account statements that showed their health service use and the costs they would have paid at the point of service if they had not made monthly account payments (or, conversely, costs they did pay at the point of service if they skipped the monthly payments).

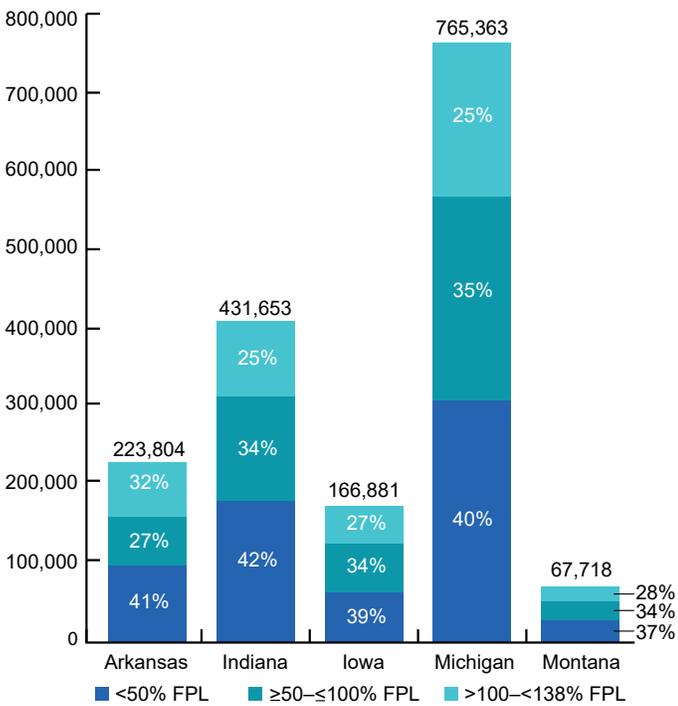
Indiana, Iowa, and Michigan also use payment statements to educate beneficiaries on how to navigate their insurance coverage. Michigan's payment statement includes information about monthly payment and copayment reductions available to anyone who completes certain health behaviors. In Indiana, different health plans have different statements, but all provide the same general information: monthly payments and copayments due, providers visited, services received, and basic medical information. As in Arkansas, these statements also highlight the copayments that beneficiaries avoided by making their POWER account contributions.<sup>12</sup>

All five states designed their collection methods to include personal checks and at least one more method of payment. Montana accepts payments by money order and electronic payments. Michigan also accepts electronic payments. Under the Health Care Independence Program, Arkansas allowed payments by credit card, automated draft, and money order. In the future, Indiana will give beneficiaries the option of making payments at MoneyGram and Walmart. Indiana, Michigan, and Montana also allow third parties, such as employers, providers, or community-based organizations, to contribute to monthly payments on behalf of beneficiaries. Given the state's earlier experience with HIP 1.0, Indiana Medicaid officials predict that some employers will pay monthly payments on their employees' behalf. Arkansas also allowed third-party payments under the Health Care Independence Program.

### **How many individuals could be subject to monthly payments in these demonstrations?**

We used data from the American Community Survey to estimate the number of eligible adults for each demonstration, setting the upper income threshold at 138 percent of FPL to account for the income disregard established by the Affordable Care Act (see Methods and Data Sources box at the end).<sup>14</sup> These estimates provide important context for the national evaluation, highlighting whether key design features are likely to affect a large or small proportion of likely enrollees. Michigan has the greatest number of likely eligible adults with incomes up to 138 percent of FPL (765,363), and Montana has the fewest (67,718; Figure 1). These standardized estimates of the number of eligible adults are based on a single data source and a uniform methodology, which facilitates comparison across the states. Each state has also developed its own estimate of the size of the eligible population, but these estimates are not necessarily comparable across states because each state uses its own approach to constructing an estimate in the year they apply for a demonstration, and because the methodology used is not always publicly available.

**Figure 1. Estimated eligible adults, by income level**



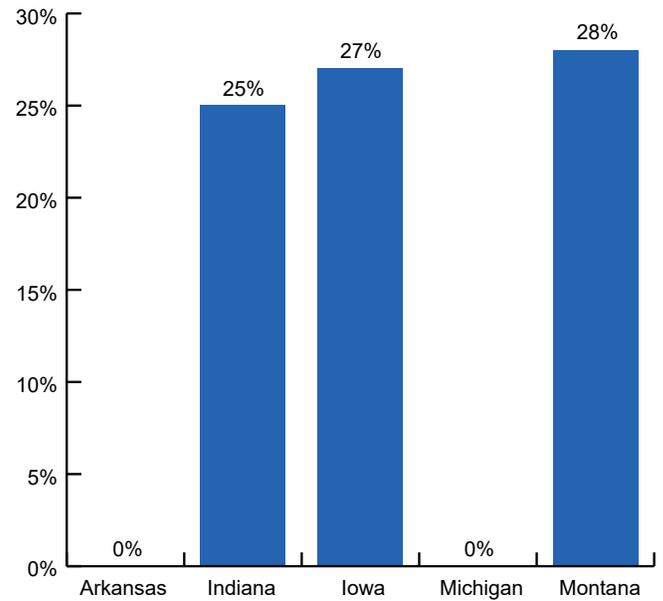
Source: Mathematica estimates of the likely eligible population for each demonstration; based on the Integrated Public Use Microdata Sample for 2015, the most recent data available.

Note: Estimates do not account for the exemptions described in the section on state-by-state differences in monthly payment design.

Figure 1 also illustrates how eligible adults are distributed across the different income groups. In Arkansas and Michigan, the beneficiaries subject to monthly payment policies are those above the poverty line (this is also true of Arkansas’s current demonstration, approved for the 2017–2021 period). This group, indicated by the top segment of the bars, represents 32 percent of the total eligible population in Arkansas and 25 percent in Michigan. In Iowa and Montana, adults with incomes above 49 percent of FPL are subject to monthly payments, indicated by the middle and top sections of the bar. The group subject to monthly payments represents 61 percent of the total eligible population in Iowa and 62 percent in Montana. Finally, in Indiana, the entire demonstration population is subject to monthly payments. However, the monthly payments are essentially optional for those at or below the poverty line—76 percent of the eligible population—because nonpayment results in a transfer to the HIP Basic plan rather than disenrollment.

Figure 2 shows the proportion of the likely eligible population in each state that can be disenrolled for nonpayment. Arkansas did not have a disenrollment policy under the Health Care Independence Program and Michigan also does not disenroll beneficiaries for nonpayment. In Iowa, Indiana, and Montana, about one quarter of the estimated eligible population can be disenrolled for nonpayment. In all states, only adults with household incomes above the poverty line can be disenrolled.

**Figure 2. Proportion of potential enrollees that can be disenrolled for non-payment of monthly payments, by state**



Source: Mathematica estimates of the likely eligible population; based on the Integrated Public Use Microdata Sample for 2015, the most recent data available.

Note: Estimates do not account for the exemptions described in the section on state-by-state differences in monthly payment design.

### What implications do monthly payments have for evaluations of section 1115 demonstrations?

All five demonstrations represent policy experiments that will produce valuable evidence about the effect of monthly payments on Medicaid beneficiaries with incomes up to 133 percent of FPL. Varying demonstration policies provide a unique opportunity to evaluate the effects of specific design elements. For example, because the states apply monthly payments to different income groups, including adults at or below the poverty line in Iowa and Montana and below 50 percent of FPL in Indiana, the national evaluation of section 1115 demonstrations can compare the effect of monthly payments on adults at different income levels. Similarly, cross-state comparisons, using beneficiaries in certain demonstration states as treatment groups and those in other demonstration states as comparison groups, will also facilitate evaluations of the effect of different payment incentives and different consequences of nonpayment. Table 2 lists the treatment and comparison states that feature these and other design elements.

The five demonstrations also have the potential to produce valuable evidence when examined individually. Anticipating that many Medicaid beneficiaries will transition to commercial coverage one day—either through the Marketplace or through an employer—states have designed their payment requirements to help teach Medicaid beneficiaries about the value of

**Table 2. Cross-state comparisons among demonstration states for evaluating selected elements of monthly payment design**

Policy	Indicator	Treatment states	Comparison states
Monthly payments for beneficiaries with incomes under 100% FPL	Take-up rates	Iowa, Indiana, Montana	Arkansas, Michigan
Monthly payment amounts above \$15	Take-up rates; payment rates	Indiana, Michigan, Montana	Arkansas, Iowa
Disenrollment for non-payment	Mid-year disenrollments	Indiana, Iowa, Montana	Arkansas, Michigan
Immediate re-enrollment allowed after disenrollment for non-payment	Length of coverage spells/churn	Iowa	Indiana, which also disenrolls for nonpayment but does not allow immediate re-enrollment. Montana, which allows re-enrollment if past-due premiums are paid or assessed by the state.
Upfront payment required for coverage to take effect	Take-up rates	Indiana	Montana, which requires premiums upon enrollment but provides a 90-day grace period
Monthly payments waived or reduced for completion of (or commitment to) health behaviors	Rewards earned; renewal rates by whether rewards were earned	Indiana, Iowa, Michigan	Arkansas, Montana

Note: The take-up rate is the proportion of the likely eligible population that enrolls.

health insurance, the importance of participating actively in their own coverage, and the typical payment requirements in commercial coverage. States should carefully assess whether the required payments and payment rates are understood by beneficiaries and whether the demonstrations are meeting their educational goals before interpreting the results of these programs. As noted, lack of beneficiary understanding may drive low payment rates. However, if there is evidence that beneficiaries understand payment rules, low payment rates may indicate that beneficiaries have difficulty affording their monthly payments.<sup>15</sup> The upcoming national evaluation will include an assessment of states' educational materials and of beneficiary understanding of premium requirements (Irvin et al. 2015). The national evaluation will also examine beneficiaries' understanding and use of accounts, as well as rates of completion of incentivized health behaviors that can reduce monthly payment liability.

Research is also needed on the achievement of preventive care goals and on enrollment outcomes. Having to pay for Medicaid coverage could signal that it is valuable, which could encourage some people to enroll or to stay enrolled. On the other hand, monthly payment requirements could have an unintended effect on Medicaid-eligible adults by discouraging them from enrolling or staying enrolled in the program. Where payments are required, or beneficiaries do not understand that payment is voluntary, monthly payments may deter low-income adults from enrolling in Medicaid because they may believe they cannot afford to do so. In states that disenroll beneficiaries for nonpayment, it may be more difficult for beneficiaries to stay on Medicaid, or to re-enroll after a gap in coverage. Investigating enrollment outcomes where there are payments is a key goal of the national evaluation (Irvin et al. 2015).

Due to the potential for both positive outcomes and harms to beneficiaries that may result from monthly payment

demonstrations, the national evaluation will maximize the opportunity to compare these demonstrations to each other and to states with traditional Medicaid programs (Irvin et al. 2015). As the five states monitor and refine their demonstrations, and as other states consider adopting similar policies, indications that monthly payments are adversely affecting coverage may signal the need for changes in CMS policy to protect beneficiaries. Conversely, if adverse outcomes are not observed, state and federal officials may consider allowing a range of monthly payment designs that meet state policy goals.

### ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports will inform an interim outcomes evaluation in 2017 and a final evaluation report in 2019.

## METHODS AND DATA SOURCES

Descriptive information about section 1115 demonstrations is based on Mathematica's analysis of the Special Terms and Conditions listed below, as well as approved operational protocols. Operational protocols are included as attachments to the Special Terms and Conditions or as standalone documents on [www.Medicaid.gov](http://www.Medicaid.gov), depending on the state.

- Arkansas Special Terms and Conditions, approval period September 27, 2013–December 31, 2016; as amended January 1, 2015.
- Indiana Special Terms and Conditions, approval period February 1, 2015–December 31, 2018.
- Iowa Wellness Plan Special Terms and Conditions, approval period January 1, 2014–December 31, 2016; as amended December 31, 2014.
- Michigan Special Terms and Conditions, approval period December 30, 2013–December 31, 2018.
- Montana Special Terms and Conditions, approval period November 1, 2015–December 31, 2020.

We also conducted key informant interviews with Medicaid officials in Arkansas, Indiana, Iowa, and Michigan in 2015 and 2016, and with Montana officials in 2017. We designed interview protocols to clarify information in the Special Terms and Conditions and operational protocols for each demonstration and to assess the implementation of demonstration policies. Each interview included a lead interviewer and a note taker.

To construct estimates of the size of the eligible population, the number of enrollees who could be subject to premiums and the number that could be disenrolled for nonpayment in each state, we used the 2015 Integrated Public Use Microdata Sample (IPUMS) data, prepared by the University of Minnesota Population Center (Ruggles et al. 2015). These were the most recent data available at the time of our analysis. IPUMS is generated from the American Community Survey and facilitates construction of family relationships. We used SAS (version 9.4) to apply sample weights to all estimates.

To estimate the eligible population, we identified individuals who:

- Were between the ages of 19 and 64.
- Reported that they were a citizen or became naturalized citizens.
- Did not report receiving Supplemental Security Income (SSI), as these individuals would already have been Medicaid-eligible on the basis of disability.
- Met state-specific income eligibility thresholds for the demonstration. Modified adjusted gross income was estimated by excluding household welfare payments received through SSI, Aid to Families with Dependent Children, or General Assistance. The American Community Survey gathers information on income received over the last 12 months. Thus, income data reflect earnings in 2014.
- Did not report having any type of health insurance coverage at the time of the survey, which means our estimates reflect the number of uninsured at a point in time.
- Met other state-specific inclusion and exclusion criteria:
  - Indiana, Iowa, Michigan, and Montana transitioned adults that were previously eligible for Medicaid into the new demonstrations. In addition to adults who reported being uninsured, our estimates include adults who reported enrollment in “Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability” and who met the income eligibility requirements of the 1115 demonstration in these three states.
  - Arkansas's demonstration did not include adults previously eligible for Medicaid, so we excluded employed parents with incomes below 17 percent of the FPL and unemployed parents with incomes below 14 percent of the FPL.

## References

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## Endnotes

- <sup>1</sup> The Affordable Care Act established a 5 percent income disregard that increases the effective income limit from 133 to 138 percent of the federal poverty level.
- <sup>2</sup> For more information on the national evaluation, the design plan is available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf>.
- <sup>3</sup> See section 1916A(b)(1)(A) of the Social Security Act. Certain eligibility groups constitute exceptions, such as working people with disabilities eligible under the Ticket to Work and Work Incentives Improvement Act and children with disabilities eligible under the Family Opportunity Act. States may also require premiums of certain parents eligible for transitional medical assistance.

<sup>4</sup> Under Arkansas Works, the state requires monthly payments of 2 percent of household income for beneficiaries with incomes above 100 percent of the FPL. The policies and implementation experience described in this brief were in effect during Arkansas's initial demonstration.

<sup>5</sup> See Byrd, Colby, and Bradley (2017), a companion issue brief, for more detail on payment rewards and incentives.

<sup>6</sup> Arkansas stopped accepting monthly payments just prior to closing its beneficiary accounts in June 2016, citing the administrative costs of operating the accounts. Dates are based on information gathered from key informant interviews with state officials on July 8, 2015 and on August 16, 2016.

<sup>7</sup> Section 1902(a)(8) of the Social Security Act establishes the reasonable promptness rule. The Act states: [A state plan for medical assistance must] "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals."

Section 1092(a)(34) of the Social Security Act establishes the retroactivity rule. The Act states: [A state plan for medical assistance must] "provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (...)"

<sup>8</sup> Beneficiaries who are disenrolled for nonpayment in Montana remain eligible but no longer receive benefits, consistent with the state's 12-month continuous eligibility policy. Disenrolled individuals may re-enroll after repayment of debt or debt assessment without reapplying for Medicaid if they are within the 12-month continuous eligibility period.

<sup>9</sup> Arkansas has a premium assistance demonstration, in which adults newly eligible for Medicaid under the Affordable Care Act enroll in Qualified Health Plans (QHPs) in the Marketplace. The state pays qualified health plan (QHP) copayments on behalf of premium assistance beneficiaries. Enrollment in QHPs is mandatory if beneficiaries are not medically frail and have a choice of QHPs from two or more issuers. Iowa also has a premium assistance demonstration in 2014 and 2015. Iowa's premium assistance demonstration effectively closed on December 31, 2015, although the state retained its authority to operate the program through December 2016. One of Iowa's two participating QHP carriers became insolvent in late 2014 and the other stopped accepting new Medicaid beneficiaries in 2015. The state received approval in January 2016 to modify eligibility for its other 1115 demonstration, the Iowa Wellness Plan, to include the population formerly enrolled in premium assistance.

<sup>10</sup> As of June 2017, there were no areas with insufficient providers contracted to the third-party administrator (TPA) for the demonstration. Montana also exempts those needing continuity of care that would not be available or cost-effective

through arrangements with the TPA. This exemption primarily applies to Native Americans and Alaska Natives receiving care from Indian Health Services.

<sup>11</sup> See federal regulations set forth in 42 CFR § 447.56(a)(1) for a list of groups exempt from premiums and cost-sharing.

<sup>12</sup> See Miller and Contreary (2017) for a full description of beneficiary health accounts in Arkansas, Indiana, and Michigan, including account functions, the role of states and plans in account administration, and the contents of account statements distributed to beneficiaries.

<sup>13</sup> As described by state Medicaid officials in a key informant interview on August 16, 2016.

<sup>14</sup> The ACS has a large sample size, and its approach to creating annual average estimates of health insurance coverage is considered to be more accurate than the approach used for the Current Population Survey, which produces annual point-in-time estimates for each state. The U.S. Census Bureau constructs survey weights for the ACS that account for seasonal

fluctuations in population and other sources of potential bias (Spielman, Folch, and Nagle 2014). Analyses in this report incorporate survey weights. People who respond to the ACS (or other surveys) do not always report their coverage status accurately. We do not know the exact extent of this response error, although it is estimated to be in line with that of other national surveys. One recent study estimated the pre-expansion Medicaid undercount in the ACS at 27 percent for adults (Boudreaux, Call, and Turner et al. 2013). It is not possible to remedy this problem by using a different federal survey because the Current Population Survey, National Health Interview Survey, and Medical Expenditure Panel Survey all undercount the Medicaid population to a comparable or greater degree.

<sup>15</sup> See Miller, Maurer, and Bradley (2017) for preliminary information on beneficiary understanding of demonstration policies. This issue brief synthesizes evidence from interim state-based demonstration evaluation reports in Indiana, Iowa, and Michigan.