Using Section 1115 Waiver Authority to Implement Beneficiary Contribution Programs in Medicaid

Section 1115 waivers allow states to test approaches to coverage that are not allowed under traditional Medicaid. Under Section 1115 of the Social Security Act (the Act), the Secretary of the U.S. Department of Health and Human Services (HHS) can waive almost any Medicaid state plan requirement in Section 1902 of the Act to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program. This brief focuses on recently adopted state waiver programs that authorize policy changes for low-income adults not eligible for Medicaid on the basis of disability that mirror commercial benefit and enrollment design. These include beneficiary contribution requirements such as premiums, which are typically linked to health savings-like accounts or incentives to complete certain healthy behavior activities.[1] Ten states have adopted such policy changes, and several additional states have asked the Centers for Medicare & Medicaid Services (CMS) for permission to implement similar approaches. [2]

States designed these waiver policies with the goal of increasing beneficiary engagement in maintaining health coverage, seeking preventive care, and being cost conscious when making decisions about their health care. While states differ in their specific policy approaches and goals, they cite the following rationales:

- Imposing premiums and disenrollment or lockout penalties for non-payment will increase beneficiary responsibility for maintaining health coverage and prepare them for a transition to private coverage.
- Health savings account-like programs are a tool to educate beneficiaries about the cost and appropriateness of their health care use and incentivize them to consider these factors when seeking care. For example, in Kentucky, deductions are not taken from beneficiary accounts for preventive services and remaining balances can be used to purchase benefits such as dental or vision services.
- Healthy behavior incentives encourage beneficiaries to identify health risks and use preventive health services in order to constrain costs and improve health. For example, Michigan enrollees can reduce cost sharing requirements by completing a health risk assessment.

This brief provides an overview of the policies approved in ten states: Arizona, Arkansas, Indiana, Iowa, Kentucky, Michigan, Maine, Montana, New Mexico, and Wisconsin.[3,4] It describes each state's goals and program policies. For states with well-established programs, the brief discusses the activities and challenges associated with implementation as well as available results from required monitoring reports and interim evaluations.

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This brief also discusses waiver approvals in two states where implementation of beneficiary contribution programs is paused or will not move forward. Kentucky's waiver approval was vacated by the U.S. District Court for the District of Columbia and remanded to CMS for further review in March 2019. [5,6,7] This action leaves the future of Kentucky's waiver provisions in question, as they cannot be enforced at this time. Maine's governor has decided not to implement the provisions of the state's waiver.

Features of Beneficiary Contribution Policies

While all ten states received approval to implement premiums, they include different combinations of incentives and penalties to encourage beneficiaries to continue making premium payments and seek preventive health services (Table A-1). In three states—Arizona, Indiana, and Michigan—monthly premiums serve as contributions to a health savings-like account.[8] In Indiana, and previously, Kentucky, individuals with incomes below 100 percent of the federal poverty level (FPL) can choose to pay either premiums or co-payments.

States have different penalties for non-payment of premiums. In two states—Indiana and Wisconsin—individuals who do not pay premiums are disenrolled and cannot re-enroll in Medicaid for up to six months. Kentucky and Maine's waivers also included this policy. In New Mexico, beneficiaries are disenrolled and cannot re-enroll for three months. In Arizona, Iowa, and Montana, individuals may be disenrolled but can reenroll at any time. In Michigan, individuals can be disenrolled but may reenroll if they pay outstanding premiums. In Arkansas, individuals cannot be disenrolled but may continue to be liable to the state for unpaid premiums. Only Wisconsin is permitted to apply these policies to individuals with income below 100 percent FPL.[9]

In Arizona, Indiana, Iowa, Michigan, and New Mexico, some enrollees can reduce premium payments by completing healthy behavior activities, such as a health risk assessment or preventive care visits. In Arizona, New Mexico, and previously, Kentucky, enrollees can also earn additional benefits through completion of healthy behaviors.[10] For some beneficiaries in Michigan and Wisconsin, participation in healthy behavior activities is required as a condition of eligibility.

Seven states—Arizona, Arkansas, Indiana, Michigan, Montana, New Mexico, and Wisconsin—require co-payments. Kentucky's waiver also included copayments for certain beneficiaries. In two states—Arizona and Michigan—co-payments are billed retrospectively, while in others they are collected at the point of service.

Waiver Implementation

States are at various stages of the implementation process. For example, while programs in New Mexico and Wisconsin were approved in late 2018 and are not yet operational, Iowa's waiver has been operating since 2014. MACPAC gathered information on program implementation and outcomes for Arkansas, Indiana, Iowa, and Michigan, finding that policies were complex and resource intensive to administer. Engaging beneficiaries was challenging. However, states reported greater numbers of people covered and

greater use of preventive services than prior to waiver implementation[11] For more details on waiver implementation and challenges, see MACPAC's contractor report, *Section 1115 Medicaid Expansion Waivers: Implementation Experiences*.

Implementation activities

All four states devoted significant staff time or relied heavily on contractors to implement their waivers. These efforts required intensive communication and coordination efforts across different entities responsible for implementation, and set-up and maintenance of IT systems. For example, states designed systems for determining required contribution amounts, established procedures for communicating with beneficiaries about their responsibilities and options for paying or reducing them, and applying payments or healthy behavior credits to beneficiary accounts (Table 1).

TABLE 1. Implementation Steps for Beneficiary Contribution Programs

Implementation activities
Enrollee contribution requirements
• establish systems and processes to determine enrollees' required contribution based on their income level and—in Michigan—service use • design invoice statements to convey premium requirements and other program features to beneficiaries • collect and reconcile payments with enrollee accounts • set up processes to take appropriate action when enrollees do not pay their premiums
Health savings accounts
• set up procedures for communicating with and educating beneficiaries on their responsibilities regarding the accounts • establish ways for beneficiaries to view their account balances (e.g., through account statements, web or mobile application portals) • establish a process for reconciling information about beneficiary information, contributions, and completion of healthy behaviors, etc. between the state and its vendors, including managed care organizations
Healthy behavior incentives
• establish a process for beneficiaries to complete a health risk assessment tool • provide outreach and education to beneficiaries about healthy behaviors • set up procedures for tracking healthy behaviors and participation in qualifying activities • institute reconciliation processes to account for qualifying preventive services, healthy behaviors, and resulting account balances • provide incentives to beneficiaries for the completion of a healthy behavior • monitor health plans (in Indiana and Michigan) to ensure account reductions are applied appropriately when someone has earned a healthy behavior

Source. Zylla et al. 2018.

Implementation challenges

States faced a variety of challenges in implementing their waivers, including those related to basic set-up of IT systems, strategies for communicating with enrollees, procedures for coordinating between plans

and the state Medicaid agency, and complexity of the waiver policies. Overall, states with a history of using similar policies in their Medicaid programs or that had longstanding relationships with managed care organizations and other entities responsible for implementation experienced fewer, less complex challenges than states starting from scratch. Examples of specific challenges states faced included:

Calculating and collecting premiums. Iowa and Michigan—states that were not using widespread premiums in their Medicaid program prior to waiver implementation—experienced technical challenges collecting and applying premium payments. Indiana's managed care plans already had this capability, but had to regularly recalculate beneficiary premiums of 2 percent of income due to even small changes in income. Indiana switched to a tiered premium structure to alleviate this burden on plans and beneficiaries.

Establishing and attracting members to health savings accounts. Arkansas spent $9 million to set up and operate IT systems for its health savings account feature, but was unable to attract significant participation; only 7,000 to 8,000 Medicaid enrollees participated out of 40,000 who were eligible. Costs per enrollee became so high that the state terminated the program. Indiana, which already had a health savings-like account in place for Medicaid enrollees, built on existing systems and strategies for encouraging participation.

Crediting beneficiaries for healthy behavior activities. Iowa and Indiana experienced technical and operational difficulties with reconciling claims systems and systems used to credit beneficiaries for adopting healthy behaviors. Michigan, which uses paper-based health risk assessments, initially experienced a backlog of health risk assessments because doctors had difficulty identifying which plan to send them to (Zylla et al. 2018).

All states and health plans struggled with educating beneficiaries about their responsibilities and incentives under the policies and engaging them to participate. They noted challenges in conveying the concepts of premiums, account contributions, and cost-sharing to beneficiaries, especially how these concepts related to one another; for example, that enrollees could reduce their monthly contributions by completing healthy behavior activities (Zylla et al. 2018). These challenges are reflected in the evaluation findings, which indicate limited understanding of many of the complex program features from the beneficiary perspective.

Program Outcomes

Results of the waiver programs with consumer engagement initiatives are limited, and formal evaluations are available only for Indiana, Iowa, and Michigan. However, a large body of research on the effect of premiums and cost sharing indicates that premiums lead to decreased enrollment, and that broadly applied cost sharing leads people to reduce use of both effective and less effective services. Thus far, no study has demonstrated a level of cost sharing that encourages prudent use of services without impeding access to necessary care (Artiga et al. 2017, MACPAC 2015). Research also has shown that state savings from premiums and cost sharing are limited (Zylla et al. 2018, Artiga et al. 2017).

Findings from state evaluations focused on the relationship between premium and cost-sharing structure to beneficiary plan choices, health care use, and engagement with health savings-like accounts. They also looked at affordability and other barriers beneficiaries face in making premium payments. Overall, waiver enrollees generally reported being able to afford premiums and cost sharing and that they received high levels of preventive services. While they understood premiums and the consequences of not making payments, they were less aware of more complex features such as healthy behavior incentives, health savings accounts, and how the different features interact.

In addition to state-based evaluations, CMS initiated a multi-state evaluation to look at the effects of enrollee contribution programs (among other waiver program features) across states. The interim evaluation has not yet been released, but will examine the extent to which required monthly premiums affect enrollment patterns, including continuity of coverage; the strategies states are using to educate beneficiaries about healthy behavior incentives; the effect of healthy behavior incentives on access to and use of care; and population-level effects such as preventive service receipt and smoking cessation (Colby et al. 2017).

In March 2019, CMS issued evaluation and monitoring guidance to states, designed to strengthen expectations for states implementing certain types of demonstrations, including those that implement premiums and non-eligibility (or lockout) periods. The guidance includes a monitoring report template outlining the specific quantitative and coverage monitoring metrics states are expected to report as well as evaluation design guidance that includes the key hypotheses, evaluation questions, measures, and methodologies that states are expected to include in their evaluations.

Premiums

State evaluations, annual and quarterly reports, and other studies for Indiana, Iowa, and Michigan examined the extent to which beneficiaries have been disenrolled or locked out of coverage for non-payment.

- In its first demonstration year, February 2015 through January 2016, Indiana disenrolled 4,486 people with incomes over 100 percent FPL due to non-payment of premiums, or 6.3 percent of Healthy Indiana Plan (HIP) 2.0 members (i.e., enrollees included in the demonstration program) in this income group. This number has grown in subsequent demonstration years, with the state disenrolling about 12,000 individuals with income over 100 percent FPL in each year, or about 20 percent of HIP 2.0 members in this income group (Indiana FSSA 2018). Between February 2015 and November 2016, an additional 46,176 people were determined eligible for coverage but never enrolled because they did not make their initial premium payments (The Lewin Group 2017).
- In Iowa, between 500 and 1,200 members per month with incomes over 100 percent FPL were disenrolled for failure to pay premiums in 2017 (IDHS 2018, 2017a–c).
- In Michigan, 217,203 beneficiaries had past due premium contributions or co-payments as of June 2018, and 93,978 of them were categorized as consistently failing to pay and their debts were recoverable by the state (MDHHS 2018).[12]

Some studies have also examined the reasons why beneficiaries fail to make premium payments. Most beneficiaries in Iowa and Indiana reported being aware that they could be disenrolled for non-payment. Most beneficiaries in all three states reported feeling that their contribution requirements are fair and many feel they are affordable. However, affordability was consistently the most common reason for non-payment. For example, a survey of beneficiaries in Indiana found that among those who reported they were not making regular premium payments, 31 percent cited affordability (Sommers et al. 2018). Additionally, in interviews of disenrolled members in Iowa, most individuals reported affordability as the primary reason they did not pay, and only one respondent knew that premiums could be waived for reaching of healthy behavior targets (Askelson et al. 2017).

Beneficiaries also experienced non-financial barriers to payment. Stakeholders in Michigan have cited members' inability to make payments by credit card, and noted that that the cost of a money order to pay balances is often greater than the balances themselves (Musumeci et al. 2017). Additionally, confusion about how premium payments were tied to health savings accounts presented a barrier in Indiana; about 20 percent of HIP-eligible survey respondents reported not paying premiums because they were confused about the program's Personal Wellness and Responsibility (POWER) accounts. Confusion was highest among individuals who identified as Latino or who had less education (Sommers et al. 2018).

Health savings accounts

State evaluations and studies of health savings accounts examined the extent to which beneficiaries understood and managed their accounts. While many beneficiaries knew they had accounts, they had mixed awareness of how the accounts worked, and were not necessarily connecting them with behavior change.

- In Indiana, 60 percent of waiver enrollees reported having heard of a POWER health savings account; of those, about 75 percent reported having one. Of members who reported having a POWER account, only about 40 percent reported checking the balance regularly. About half (52 percent) incorrectly believed that the cost of preventive services were deducted from the account (The Lewin Group 2016b). However, a later survey of HIP 2.0 beneficiaries found that of those who reported being familiar with POWER accounts, about 60 percent agreed that the accounts helped them think about proper service use (Sommers et al. 2018).
- In Michigan, 75 percent of respondents reported receiving an MI Health health savings account statement; less than half reported changing decisions about health care use based on this information (Goold et al. 2016).

Healthy behavior incentives

Interim evaluations in Indiana and Iowa and beneficiary surveys in Michigan looked at beneficiary knowledge of and engagement with healthy behavior incentive programs, and the effect of incentives on outcomes and beneficiary choices about service use. Additionally, quarterly and annual reports from each state show the healthy behavior incentive completion rates among beneficiaries.

- In 2017, Indiana's health plans reported that between 34 and 50 percent of HIP 2.0 members received preventive examinations qualifying for a healthy behavior incentive, an increase over the previous year, but below Indiana's goal of 85 percent (Indiana FSSA 2018). Only about half of HIP 2.0 members were able to correctly explain how receiving preventive services would allow them to roll over any remaining funds in their POWER accounts at the end of the year and reduce their required premiums (The Lewin Group 2016b).
- In Iowa, the highest participation rate for healthy behavior activities was 25 percent (Askelson et al. 2016).[13] In 2014, rates did not exceed 17 percent; lack of knowledge among members and clinic staff hindered progress toward program goals and led to members being disenrolled unnecessarily for non-payment of premiums (Askelson et al. 2017).
- In Michigan, as of December 2017, 18 percent of members enrolled for at least six months completed the health risk assessment process and were eligible to receive a healthy behavior incentive credit (MDHHS 2017).

Evaluations showed high use of preventive services (including those that qualified for healthy behavior incentives), but it was not clear that behavior was motivated by the incentive program given low awareness and understanding of the program. For example, a U.S. Government Accountability Office report noted that this lack of knowledge made it difficult to evaluate these programs' ability to change behavior (GAO 2018). Additionally, federal evaluators noted that because health plans often offer additional incentives for healthy behaviors that are separate from the demonstration, it was difficult to isolate the effect of the demonstration itself (Colby et al. 2017).

For further details on other healthy behavior incentives in Medicaid and their outcomes, see the MACPAC issue brief, *The Use of Healthy Behaviors in Medicaid*.

Endnotes

[1] Waivers often include other changes, such as the elimination of retroactive eligibility and coverage of certain benefits, requirements for work and community engagement participation as a condition of eligibility, and the use of premium assistance. However, these issues are beyond the scope of this brief.

[2] Even without a waiver, states can require certain groups of Medicaid enrollees to pay enrollment fees, premiums, copayments, or other cost sharing amounts. However, federal guidelines generally do not allow states to charge premiums for enrollees with incomes at or below 150 percent FPL and total cost sharing (including premiums and per-service charges) is subject to an aggregate limit of 5 percent of family income (42 CFR 447.50–447.56).

[3] After becoming governor in January 2019, Maine governor Janet Mills formally notified CMS that the state is rejecting the terms and conditions of the waiver and will not move forward with implementation (Mills 2019). Similarly, after assuming office in 2019, New Mexico Governor Michelle Lujan Grisham signaled her intention to revise policies approved in New Mexico's waiver, but has not yet submitted a request to amend the demonstration (Cash 2019, Lujan Grisham 2019).

[4] Additional states, including Kansas and Virginia, have asked CMS for permission to adopt similar policies through Section 1115 waivers. Kansas would establish an optional health savings-like account for transitional medical assistance (TMA) beneficiaries, available to members for certain services or items after they transition out of the TMA program. Virginia would

implement healthy behavior incentives and tiered income based premiums for members with income between 100 and 138 percent FPL.

[5] *Stewart v. Azar* 313 F. Supp. 3d 237 (D.D.C. 2018).

[6] Kentucky received initial approval for its demonstration in January 2018, which had been scheduled to take effect on July 1, 2018. The June 2018 ruling in *Stewart v. Azar* vacated the approval, remanding it to CMS for further review. CMS issued a reapproval for Kentucky's demonstration program on November 20, 2018, which was again vacated in March 2019.

[7] Approval of Arkansas's Section 1115 Medicaid demonstration waiver amendment adding work and community engagement requirements and a shortened retroactive eligibility period was also vacated in *Gresham v. Azar* 1:18-cv-01900-JEB (D.D.C. 2019). However, other components of Arkansas' waiver were not subject to the lawsuit, including beneficiary contribution requirements.

[8] Arkansas also used this approach initially but terminated its health savings account program because of low participation and high administrative costs (Zylla et al. 2018).

[9] Maine also received approval to implement this policy, but will not proceed.

[10] Under Kentucky's approved waiver, beneficiaries would have been required to use healthy behavior credits to purchase dental and vision services and would have been charged copayments.

[11] We advise caution in interpreting these early evaluation results from expansion waiver programs. Limitations include the early stage of implementation, methodological challenges typically associated with health services research, and insufficient data. Because most states with such waivers were not previously covering the new adult group, there is no appropriate comparison group to assess access, outcomes, affordability, or health care use. It is also difficult to attribute changes to the waivers themselves as many results are due to expansion of coverage itself rather than specific design features of the expansion program. In addition, multiple other initiatives were underway at the plan, state, and federal levels (Sommers et al. 2016a and 2016b).

[12] In Michigan, "consistently failing to pay" means that beneficiaries' premiums and cost sharing obligations were unpaid for three consecutive months.

[13] Exact rates varied based on the data source (ranging from 6.6 percent of Wellness Plan and 1.3 percent of Marketplace Choice enrollees as reported in the claims data to 25 percent of Wellness Plan and 12 percent of Marketplace Choice enrollees as reported by the Iowa Department of Human Services).

References

Artiga, S., P. Ubri, and J. Zur. 2017. *The effects of premiums and cost sharing on low-income populations: Updated review of research findings.*Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

Askelson, N., B. Wright, S. Bentler, et al. 2017. *In-depth interviews with Iowa Health and Wellness Plan members who were recently disenrolled for failure to pay required premiums*. Iowa City, IA: University of Iowa Public Policy Center. http://ppc.uiowa.edu/sites/default/files/ihawp_disenrollee_report.pdf

Askelson, N., B. Wright, S. Bentler, et al. 2016. *Health behaviors incentive program evaluation interim report.* Iowa City, IA: University of Iowa Public Policy Center. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-bhvrs-int-rpt-mar-2016.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Section 1115 of the Social Security Act Medicaid demonstration: Arizona Health Care Cost Containment System. January 18, 2019. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. Section 1115 of the Social Security Act Medicaid demonstration: MaineCare. December 21, 2018. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-mainecare-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. Section 1115 of the Social Security Act Medicaid demonstration extension and amendment: Healthy Michigan Plan. December 21, 2018. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018c. Section 1115 of the Social Security Act Medicaid demonstration: New Hampshire Granite Advantage Health Care Program. November 30, 2018. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-granite-advantage-health-care-program-ca.pdf.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2018d. Section 1115 of the Social Security Act Medicaid demonstration: Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH). November 20, 2018. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018e. Section 1115 of the Social Security Act Medicaid demonstration: Wisconsin BadgerCare Reform. October 31, 2018. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018f. Section 1115 of the Social Security Act Medicaid demonstration extension: Healthy Indiana plan 2.0. February 1, 2018. Baltimore, MD: CMS. 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.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2018g. Section 1115 of the Social Security Act Medicaid demonstration: Kentucky helping to engage and achieve long-term health (KY HEALTH). January 12. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Section 1115 of the Social Security Act Medicaid demonstration application: KanCare. December 20, 2017. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-pa3.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Section 1115 of the Social Security Act Medicaid demonstration: Arkansas Works Section 1115 Demonstration. December 8. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf .

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Section 1115 of the Social Security Act Medicaid demonstration: Montana Health and Economic Livelihood Partnership (HELP) program.

November 2, 2015. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Section 1115 of the Social Security Act Medicaid demonstration: Amendment to the Iowa Marketplace Choice Plan. December 30. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf.

Colby, M., K. Bradley, K. Contreary, B. Natzke. 2017. *Medicaid 1115 demonstration evaluation design plan supplement: Premium assistance, monthly payments, and beneficiary engagement.* Princeton, NJ: Mathematica Policy Research. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/eval-plan-beneficiary-engagement-programs.pdf.

Damiano, P., E. Momany, S. Bentler, et al. 2015. *Iowa Health and Wellness Plan Evaluation interim report.* Iowa City, IA: University of Iowa Public Policy Center. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-interim-rpt-2015-2016.pdf.

Goold, S. D., J. Kullgren, S. Clark, C. Mrukowicz. 2016. *Healthy Michigan voices beneficiary survey interim report.* Ann Arbor, MI: Institute for Healthcare Policy & Innovation. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-benef-survey-interim-report-09212016.pdf.

Indiana Family and Social Services Administration (FSSA). 2018. Section 1115 annual report: Year 3. Indianapolis, IN: Indiana FSSA. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2018-043018.pdf.

Iowa Department of Human Services (IDHS). 2018. Iowa Wellness Plan annual report: 1115 demonstration waiver, January 1, 2017–December 31, 2017. Des Moines, IA: IDHS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-annl-rpt-2017.pdf.

Iowa Department of Human Services (IDHS). 2017a Iowa Wellness Plan quarterly report: 1115 demonstration waiver, July 1, 2017–September 30, 2017. Des Moines, IA: IDHS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-jul-sep-2017.pdf.

Iowa Department of Human Services (IDHS). 2017b. Iowa Wellness Plan quarterly report: 1115 demonstration waiver, April 1, 2017–June 30, 2017. Des Moines, IA: IDHS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-apr-jun-2017.pdf.

Iowa Department of Human Services (IDHS). 2017c. Iowa Wellness Plan quarterly report: 1115 demonstration waiver, January 1, 2017–March 31, 2017. Des Moines, IA: IDHS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-jan-mar-2017.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. *The use of healthy behavior incentives in Medicaid.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2016/08/The-Use-of-Healthy-Behavior-Incentives-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. *The effect of premiums and cost sharing on access and outcomes for low-income children.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/07/Effect-of-Cost-Sharing-on-Low-Income-Children.pdf.

Michigan Department of Health and Human Services (MDHHS). 2017. Healthy Michigan Plan—Health risk assessment report. Lansing, MI: MDHHS. http://www.michigan.gov/documents/mdch/HMP_HRA_Report_FINAL_468616_7.pdf.

Michigan Department of Health and Human Services (MDHHS). 2018. Healthy Michigan demonstration: Section 1115 quarterly report. Lansing, MI: MDHHS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-qtrly-rpt-jul-sept-2018.pdf.

Musumeci, M., R, Rudowitz, P. Ubri, E. Hinton. 2017. *An early look at Medicaid expansion waiver implementation in Michigan and Indiana.* Washington, DC: Kaiser Family Foundation. http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Medicaid-Expansion-Waiver-Implementation-in-Michigan-and-Indiana.

Sommers, B., C. E. Fry, R. J. Blendon, and A. Epstein. 2018. New approaches in Medicaid: Work requirements, health savings accounts, and health care access. *Health Affairs* 37, no 7: 1099–1108. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.0331.

Sommers, B., R. Blendon, E. J. Orav. 2016a. Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance. *JAMA Intern Med.* 176, no. 10: 1501–1509. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420

Sommers, B., R. Blendon, and E. J. Orav. 2016b. Both the "Private option" and traditional Medicaid expansions improved access to care for low-income adults. *Health Affairs* 36, no. 4: 96–105. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0917

The Lewin Group. 2017. *Healthy Indiana Plan 2.0: POWER account contribution assessment.* Falls Church, VA: The Lewin Group. 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.

The Lewin Group. 2016a. *Indiana HIP 2.0: Evaluation of non-emergency medical transportation (NEMT) waiver.* Falls Church, VA: The Lewin Group. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-final-evl-rpt-11022016.pdf.

The Lewin Group. 2016b. *Healthy Indiana Plan 2.0: Interim evaluation report.* Falls Church, VA: The Lewin Group. 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.

U.S. Government Accountability Office (GAO). 2018. *Evaluations yielded limited results, underscoring need for changes to federal policies and procedures,* GAO-18-220. Washington, DC: GAO. https://www.gao.gov/products/GAO-18-220.

Zylla, E., C. Planalp, E. Lukanen, and L. Blewett. 2018. *Section 1115 Medicaid expansion waivers: Implementation experiences.* Minneapolis, MN: State Health Access Data Assistance Center. https://www.macpac.gov/wp-content/uploads/2018/02/SECTION-1115-MEDICAID-EXPANSION-WAIVERS_-IMPLEMENTATION-EXPERIENCES.pdf.

APPENDIX

TABLE A-1. Features of Beneficiary Contribution Policies by State

State	Monthly contributions			Co-payments	Healthy behavior incentives
	Premiums	Accounts	Non-payment penalty		
Arizona	Serve as account contributions	Monthly contributions are the lesser of 2 percent of income or $25. For beneficiaries who complete a healthy behavior target, funds can be used to purchase approved health care-related items.	Disenrollment for enrollees with incomes over 100 percent FPL; co-payments for enrollees with incomes below 100 percent FPL	Enrollees are subject to quarterly retrospective cost sharing for selected services, including opioid prescriptions or refills, non-emergency use of the ED, specialist services without a PCP referral, and brand name drugs when a generic is available.	Beneficiaries who meet a healthy behavior target are temporarily exempt from premiums and co-payments. They may also use accrued health account funds for health care-related items.
Arkansas (approval vacated)	Premiums for enrollees with incomes over 100 percent FPL not to exceed 2 percent of income.	None	Unpaid premiums can become debt to the state.	Enrollees with income over 100 percent FPL are subject to co-payments consistent with traditional Medicaid	None

TABLE A-1. (continued)

State	Monthly contributions			Co-payments	Healthy behavior incentives
	Premiums	Accounts	Non-payment penalty		
Indiana	Serve as account contributions	Tiered monthly account contributions based on household income: • $1 per enrollee with income up to 22 percent FPL; • $5 per enrollee with income 23–50 percent FPL; • $10 per enrollee with income 51–-75 percent FPL; • $15 per enrollee with income 76–100 percent FPL; • $20 per enrollee with income above 100 percent FPL 50 percent surcharge for enrollees who use tobacco products; accounts used for first $2,500 of claims for non-preventive services	Disenrollment and six-month lockout for enrollees with income over 100 percent FPL; enrollees with income below 100 percent FPL will be transitioned to the HIP Basic Plan and are subject to copayments	Enrollees with income under 100 percent FPL who do not pay premiums are subject to co-payments; all enrollees subject to $8 co-payment for non-emergency use of the ED.	Enrollees can reduce their required premiums by receiving certain preventive health services.
Iowa	$5 for enrollees with income over 50 percent FPL; $10 for enrollees with income over 100 percent FPL	None	Disenrollment for individuals with income over 100 percent FPL; unpaid premiums become debt to the state	None	Premiums waived if beneficiaries complete a wellness exam and health risk assessment

TABLE A-1. (continued)

State	Monthly contributions			Co-payments	Healthy behavior incentives
	Premiums	Accounts	Non-payment penalty		
Kentucky (approval vacated)	Premiums up to 4 percent of income	State-funded deductible account used for first $1,000 of claims for non-preventive services; up to 50 percent of the deductible account balance at the end of a 12-month benefit period can be transferred to the rewards account	Disenrollment and six-month lockout period for enrollees with income over 100 percent FPL; co-payments for enrollees with income below 100 percent FPL	Enrollees with income under 100 percent FPL who do not pay premiums are subject to co-payments	All enrollees have a rewards account that accrues based on meeting healthy behavior targets and other state-defined activities, which can be used to purchase additional benefits
Maine (approved but will not be implemented)	Tiered monthly premiums based on household income: • $10 per household for enrollees with income 50-100 percent FPL; • $20 per household for those with income 100-150 percent FPL; • $30 per household for those with income 150-200 percent FPL; • $40 per household for those with income above 200 percent FPL	None	Disenrollment and lockout of 90 days or until payment of outstanding premiums	None	None

TABLE A-1. (continued)

State	Monthly contributions			Co-payments	Healthy behavior incentives
	Premiums	Accounts	Non-payment penalty		
Michigan	Serve as account contributions	Premiums, co-payments, or combination of both (depending on enrollee category) serve as account contributions. Individuals with income over 100 percent FPL are subject to monthly premiums; premiums may not exceed 2 percent of income for those with fewer than 48 cumulative months of enrollment, or 5 percent of income for those with more than 48 months. Individuals with incomes at or below 100 percent FPL or with fewer than 48 cumulative months of enrollment are subject to copayments billed through quarterly account statements and calculated as a monthly average based on service use during prior six months.	For individuals with income over 100 percent FPL who have been enrolled for a cumulative 48 months or more, disenrollment and lockout until payment of outstanding premiums; for all beneficiaries, unpaid premiums and cost sharing can become debt to the state.	Serve as account contributions	Enrollees with incomes at or below 100 percent FPL or with fewer than 48 cumulative months of enrollment who complete a healthy behavior activity receive up to a 50 percent reduction in any cost sharing or monthly contributions requirements above 2 percent of income. Enrollees with incomes above 100 percent FPL and at least 48 cumulative months of enrollment must complete an HRA or an approved healthy behavior activity as a condition of eligibility.
Montana	Monthly premiums for enrollees with income over 50 percent FPL that are credited toward co-payments	None	Disenrollment for individuals with income over 100 percent FPL; unpaid premiums can become debt to the state	Enrollees may be subject to co-payments if co-payment amounts exceed 2 percent of income	None

TABLE A-1. (continued)

State	Monthly contributions			Co-payments	Healthy behavior incentives
	Premiums	Accounts	Non-payment penalty		
New Mexico	Premiums up to 1 percent of household income in first demonstration year for individuals with income over 100 percent FPL; annual premium adjustments are allowed in subsequent years, up to a maximum of 2 percent of household income	See healthy behavior incentives	Disenrollment and three-month lockout for individuals with income over 100 percent FPL	Enrollees are subject to co-payments as specified in the state plan	All enrollees have the option of a rewards account that accrues based on completing state-defined healthy behavior activities, which can be used to offset premiums or purchase additional health related items or services.
Wisconsin	Monthly premiums of $8 per household for individuals with incomes between 50 and 100 percent FPL	None	Disenrollment and six-month lockout for enrollees with incomes between 50 and 100 percent FPL	Enrollees are subject to an $8 copayment for non-emergent use of the emergency room.	Enrollees must complete an HRA as a condition of eligibility; enrollees will be disenrolled for non-compliance with the HRA requirement

Notes. ED is emergency department. FPL is federal poverty level. HRA is health risk assessment. PCP is primary care provider. Medically frail enrollees and pregnant women are not required to pay premiums. The Medicaid aggregate cap on out-of-pocket spending at 5 percent of income applies, although prior to the court ruling, Kentucky was permitted to exceed it under certain circumstances. New Mexico is permitted to increase premiums annually, up to 2 percent of household income. Arkansas received approval to implement health savings accounts for all waiver enrollees and require contributions for all enrollees over 50 percent FPL. However, it only went into effect for enrollees over 100 percent FPL and was discontinued for all groups in 2016 due to high administrative costs and low participation. Prior to 2018, Indiana was testing graduated co-payments for non-emergency use of the ED (i.e., charging some enrollees $8 for the first non-emergency visit and $25 for subsequent visits), but discontinued this program in the latest waiver extension. After becoming governor in January 2019, Maine governor Janet Mills formally notified CMS that the state is rejecting the terms and conditions of the waiver and will not move forward with implementation. Similarly, after assuming office in 2019, New Mexico Governor Michelle Lujan Grisham signaled her intention to revise policies approved in New Mexico's waiver, but has not yet submitted a request to amend the demonstration.

Source. MACPAC 2019 analysis of CMS 2019, 2018a–g, 2016, 2015, 2014.