Testing New Program Features through Section 1115 Waivers

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 can waive almost any Medicaid state plan requirement under Section 1902 of the Act to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program. States use these waivers for a wide variety of different purposes. This brief focuses on recently adopted state waiver programs that make changes to eligibility and enrollment policies, benefit design, and cost-sharing requirements for low-income adults who are not eligible for Medicaid on the basis of disability. These include additional conditions on eligibility such as work and community engagement requirements, premiums or co-payment requirements that would not normally be permitted under Medicaid rules, limits on certain benefits, and more.

Fourteen states—Arizona, Arkansas, Iowa, Indiana, Kentucky, Maine, Michigan, Montana, New Hampshire, New Mexico, Ohio, South Carolina, Utah, and Wisconsin—have received approval from the Centers for Medicare & Medicaid Services (CMS) to implement these types of Section 1115 waivers. While each of the programs is unique, there are some common themes. This issue brief summarizes the main design features of approved waivers, including covered populations, eligibility and enrollment, benefits, premiums and cost sharing, and the delivery system. (For more details on the waivers, see Table A1 and state-specific fact sheets).

In addition to active state waiver programs, this brief discusses approved programs in eight states where implementation of some or all of the waiver policies is paused or will not move forward.

- Arkansas, Michigan, and New Hampshire's waiver approvals were vacated by the U.S. District Court for the District of Columbia and remanded to CMS for further review in March 2019, July March 2020, and July 2019, respectively.[1] The decisions in Arkansas's and New Hampshire's cases were later upheld by the U.S. Court of Appeals for the District of Columbia Circuit.[2,3] As a result, the future of these states' waiver provisions is in question, and the states are not permitted to enforce them at this time.
- Kentucky's waiver approval was vacated along with Arkansas's in March 2019, and although it initially appealed this ruling, it later chose to terminate the Kentucky HEALTH program (CHFS 2019).[4,5]
- New Mexico amended its waiver to remove provisions affecting low-income adults, including premiums as a condition of eligibility.[6]
- Maine's governor decided not to implement the provisions of the state's waiver.[7]
- Arizona, Indiana, and Utah have each decided to postpone implementation and enforcement of work and community engagement requirements until further notice. [8]

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Populations Covered

In general, only non-disabled, non-elderly, non-pregnant adults are subject to the waiver policies described below. Arizona, Arkansas, Iowa, Indiana, Kentucky, Michigan, Montana, New Hampshire, New Mexico, Ohio, and Utah are states that opted to expand Medicaid to adults with incomes up to 133 percent of the federal poverty level (FPL) under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), and have used Section 1115 waivers to adopt different policies for the expansion population.[9] Four of these states—Indiana, Kentucky, New Mexico, and Utah—also received approval to extend policies to parents and caretaker relatives and transitional medical assistance (TMA) beneficiaries.[10] Two non-expansion states—South Carolina and Wisconsin—have approval to apply the waiver policies to certain covered populations of non-disabled, non-elderly adults in their states.[11,12]In most cases, medically frail beneficiaries are exempt from waiver policies.

Eligibility and Enrollment

Thirteen states—Arizona, Arkansas, Indiana, Iowa, Kentucky, Maine, Michigan, New Hampshire, New Mexico, Ohio, South Carolina, Utah, and Wisconsin—received approval to include policies related to eligibility and enrollment in their waiver programs, including policies affecting the effective date of coverage, redetermination, work and community engagement requirements, and mandatory healthy behavior activities. Two states, South Carolina and Utah, received approval to close enrollment under limited circumstances, although Utah is no longer permitted to do so.[13]

Effective date of coverage

Seven of these states—Arizona, Arkansas, Indiana, Iowa, Kentucky, New Hampshire, and New Mexico—received approved waivers of the statutory requirement to provide three months of retroactive coverage.[14]

- In Arizona and Iowa, coverage begins on the first day of the month of application (the same was true for New Hampshire prior to the court ruling).
- In Arkansas, prior to the court ruling, coverage began 30 days prior to application.
- In Indiana, coverage begins on the first day of the month in which the first premium payment is made. Individuals with income above 100 percent FPL who do not make an initial payment within 60 days will not be enrolled. For those with incomes below 100 percent FPL who do not make an initial payment, coverage begins after the 60-day payment period expires. Individuals can also make an initial prepayment to expedite coverage to begin the first day of the month in which the payment was made. (Prior to the court ruling, Kentucky planned to implement similar policies.)
- Before amending its waiver to remove provisions related to retroactive eligibility, New Mexico began coverage for individuals subject to premiums (those with income over 100 percent FPL) on the first day of the month after receipt of the required premium payment. Coverage for those not subject to premiums began the first day of the month of application.

Enrollment cap

CMS has granted approval to implement enrollment caps in limited circumstances. South Carolina used a Section 1115 waiver to expand coverage to certain groups of non-disabled adults experiencing chronic homelessness, involved with the criminal justice system, or in need of substance use disorder treatment (SUD) who would otherwise be ineligible for Medicaid. The state is permitted to close enrollment in these eligibility groups once enrollment reaches a specified number.

Redetermination

Indiana is permitted to disenroll members who do not submit information requested for their annual redetermination and prevent them from re-enrolling for three months. Kentucky planned to implement a similar policy, prohibiting individuals from re-enrolling for six months.

Work and community engagement requirements

Arizona, Arkansas, Indiana, Kentucky, Maine, Michigan, New Hampshire, Ohio, South Carolina, Utah, and Wisconsin received approval to implement community engagement and employment requirements as a condition of eligibility for certain non-disabled adults. As noted previously, Kentucky and Maine will not implement these programs. Arizona, Indiana, and Utah will delay implementation and enforcement until further notice, and—due to the court rulings—Arkansas, Michigan, and New Hampshire may not enforce requirements at this time.[15] These requirements are similar in many respects, but vary with regard to:

- which populations are required to participate in work or community engagement as a condition of eligibility;
- which individuals qualify for an exemption to the requirement;
- activities that qualify as work or community engagement;
- the number of hours beneficiaries must complete; and
- penalties for non-compliance.

Generally, unless enrollees meet an exemption, they are required to work or participate in an authorized activity for 80 hours per month (100 hours per month in New Hampshire). In some cases, compliance is not tied to working a set number of hours; rather, beneficiaries need to participate in certain job search activities. For example, prior to suspending enforcement of its requirement, Utah required beneficiaries to participate in a set of employment training and search activities once per 12-month eligibility period. Beneficiaries who failed to comply with the requirements would have had their eligibility suspended until they complied or be disenrolled for a specified time period. For more detail on individual state work and community engagement requirement policies and related guidance from CMS, see *Medicaid Work and Community Engagement Requirements.*

Benefits

Most of the approved exclusions do not involve a substantial change in benefits. For example, in Indiana and Iowa, only non-emergency medical transportation (NEMT) was approved for exclusion from the

benefits offered.[16] In Arkansas, which provides coverage through premium assistance (discussed below), Medicaid must provide benefits that are not otherwise available in the plans these states purchase on behalf of Medicaid beneficiaries.[17]

Premiums and Cost Sharing

Even without a waiver, states can require certain groups of Medicaid enrollees to pay enrollment fees, premiums, co-payments, or other cost-sharing amounts, although federal guidelines specify who may be charged these fees, the services for which they may be charged, and the allowed amounts. Per-service charges are limited to nominal amounts for individuals with income at or below 100 percent FPL and are prohibited for certain services, such as emergency services. States also may not charge premiums for enrollees with income at or below 150 percent FPL. Total cost sharing (including premiums and per-service charges) is subject to an aggregate limit of five percent of family income (42 CFR 447.50-447.56).

The states with approved waivers sought changes to the premium and cost-sharing schedules so that all enrollees pay something, even nominally, toward the cost of coverage.[18] For example, Arkansas, Iowa, , Michigan, Montana, and Wisconsin charge monthly premiums to some enrollees, as did Kentucky prior to the court ruling and New Mexico prior to removing this provision.[19,20] In Montana, premium payments are credited toward the enrollee's first 2 percent of co-payments. Additionally, Arizona, Indiana, and Michigan use an approach similar to a health savings account in which enrollees make monthly or quarterly contributions toward payment for services. Most waiver programs also require some level of point-of-service cost sharing. Several states, including, Indiana, Iowa, Michigan (and previously, Kentucky and New Mexico) also provide credits or discounts on premiums, co-payments, or health savings account contributions based on the completion of certain healthy behavior requirements, such as getting a risk assessment or annual wellness exam (see below).[21]

In general, enrollees remain protected by the Medicaid rule limiting aggregate out-of-pocket spending on premiums and cost sharing to 5 percent of income.[22] Arizona, Indiana, Iowa, Michigan, Montana, (and previously, New Mexico) are permitted to disenroll individuals with incomes over 100 percent FPL for nonpayment of premiums. Wisconsin and Maine (as approved) are permitted to disenroll individuals with incomes below 100 percent FPL. Each state has different policies for allowing beneficiaries to re-enroll.

- In Arizona and Iowa, individuals who are disenrolled for nonpayment of premiums can re-enroll at any time regardless of any outstanding unpaid premiums.
- In Indiana they are denied re-enrollment for six months.
- In Wisconsin, they are denied re-enrollment for up to six months but can re-enroll early by meeting certain conditions. (Prior to the court ruling, Kentucky planned to implement a similar policy.)
- In New Mexico they were able to re-enroll after a three-month lockout period and payment of all overdue premiums and in Maine they were to be denied re-enrollment for 90 days or until outstanding payments were made, whichever was sooner.
- In Michigan they are able to re-enroll once they pay outstanding premiums.
- In Montana, they are able to re-enroll once they pay overdue premiums or their premium debt is assessed against their state taxes.

Healthy Behaviors

Two states, Michigan and Wisconsin, require certain beneficiaries to complete a health risk assessment (HRA) as a condition of eligibility. In Michigan, only beneficiaries with income over 100 percent FPL with more than 48 cumulative months of enrollment are subject to this requirement, and they may also fulfil it by completing a state-approved healthy behavior activity. Enrollees who fail to complete the full HRA or a healthy behavior activity prior to redetermination will be disenrolled and may only re-enroll upon completion.

Additionally, six states—Arizona, Indiana, Iowa, Kentucky, Michigan, and New Mexico—have implemented optional incentive programs to encourage beneficiaries to complete healthy behavior activities. Arizona, Indiana, Iowa, Michigan, (and New Mexico, before removing premium requirements) allow beneficiaries to reduce their financial contributions by completing health risk assessments, healthy behavior targets, or other state defined activities.[23] In Kentucky, beneficiaries can accrue rewards based on meeting healthy behavior targets and use them to purchase additional benefits or services. New Mexico is still permitted operate an optional healthy behavior incentive program, allowing beneficiaries to use rewards to purchase additional services. Kentucky is permitted to operate an optional healthy behavior incentive program in the absence of an approved waiver; however, the state is currently required to provide vision and dental services consistent with the state plan, rather than requiring beneficiaries to use healthy behavior rewards to purchase these services.

Premium Assistance

Premium assistance is the state purchase of private market coverage on behalf of Medicaid enrollees, such as employer-sponsored insurance or qualified health plans on the exchange. Four of the waiver states are currently using some type of premium assistance in their expansions. In Arkansas, members of the new adult group are enrolled in exchange plans. This portion of the waiver, approved in December 2016, was not affected by the March 2019 action by the U.S. District Court, which dealt with a waiver amendment approved in March 2018. In New Hampshire and Kentucky, new adult group enrollees may be enrolled in cost-effective employer-sponsored coverage in premium assistance arrangements. [24, 25] Utah's waiver requires beneficiaries with an offer of employer-sponsored insurance to enroll in premium assistance.

Delivery System

In general, states offer Medicaid benefits on a fee-for-service (FFS) basis, through Medicaid managed care plans, or through some combination of the two. Under the FFS model, the state pays providers directly for each covered service provided to a Medicaid enrollee. Under managed care, the state pays a monthly premium to a managed care plan for each person enrolled in the plan. The Arizona, Indiana, Iowa, Kentucky, Michigan, New Hampshire, New Mexico, Utah, and Wisconsin waivers provide services to most non-disabled adult enrollees through managed care plans. In their waiver programs, Arkansas, Kentucky, New Hampshire, and Utah use some form of premium assistance to provide benefits to covered

populations through exchange or employer-sponsored plans with the Medicaid fee-for-service program providing wrap-around benefits. Montana has a contract with a third-party administrator for the fee-for-service coverage of health care services for most adults in the new group with incomes between 50 and 138 percent FPL.

Evaluation and Monitoring

Because Section 1115 waivers are experiments, pilots, or demonstration programs, they require evaluation. Evaluations of these varied approaches to coverage for the new adult group may provide data on the effect of changes in benefits and cost sharing on enrollment, access to care, and service use, which can inform future policy. Evaluation results will not be available on the full extent of the waivers for several years.

States are also required to submit quarterly monitoring reports that describe implementation progress and report on qualitative and quantitative metrics, though specific monitoring requirements vary by state and demonstration feature (Table A1).

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 test new approaches for covering low-income adults. 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 evaluation.

Endnotes

[1] *Young v. Azar* 1:19-cv-03526 (D.D.C. 2020), *Philbreck v. Azar 1*9-773-JEB (D.D.C. 2019), *Gresham v. Azar* 1:18-cv-01900-JEB (D.D.C. 2019).

[2] *Gresham v. Azar* 1:18-cv-01900 (D.C. Cir. 2020).

[3] New Hampshire's appeal is currently pending.

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

[5] The decision to terminate the Kentucky HEALTH program was made following a change in state administration: Governor Andy Beshear announced this action soon after taking office in December 2019 (CHFS 2019). Kentucky received initial approval for a demonstration of work and community engagement requirements in January 2018, which had been scheduled to take effect on July 1, 2018 (CMS 2018a). 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 (CMS 2018b).

[6] The decision to remove these provisions was made following a change in state administration. Soon after taking office, New Mexico Governor Michelle Lujan Grisham signaled her intention to do so, and the state submitted a request to amend the demonstration (Lujan Grisham 2019, NMHSD 2019). The amendment was approved on February 7, 2020 (CMS 2020).

[7] 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).

[8] Citing ongoing litigation on these requirements and other factors in the national landscape, Arizona's Medicaid director notified CMS in October 2019 that it will delay implementation of its work and community engagement requirements indefinitely (AHCCCS 2019). Indiana made a similar announcement in October 2019 (FSSA 2019). Additionally, in April 2020, Utah announced that it would suspend work requirements temporarily in response to the COVID-19 pandemic (Meyer 2020). These states are continuing other programs approved through these waivers, including premiums and healthy behavior incentives.

[9] The ACA set a single income eligibility disregard equal to 5 percentage points of the FPL. For this reason, eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[10] Arizona applies retroactive eligibility changes (but no other waiver polices) to most Medicaid populations in the state.

[11] Two additional states, Maine and Utah, received approval for such waivers before they adopted the full Medicaid expansion. Prior to implementation of its Medicaid expansion, Utah received approval to adopt a partial expansion to adults with income up to 95 percent FPL and apply waiver policies to that newly eligible population (CMS 2019a). Maine received approval to apply waiver policies to its pre-expansion adult population, including parents and low-income caretakers with income up to95 percent FPL, former foster care youth, and transitional medical assistance (TMA) beneficiaries (CMS 2018c). However, Maine governor Janet Mills chose not to move forward with implementation (Mills 2019). (These income eligibility thresholds are effectively 100 percent FPL due to the five percent disregard.)

[12] South Carolina applies waiver policies to parents and caretaker relatives, who are covered up to 95 percent FPL, beneficiaries receiving TMA, and certain other targeted, non-disabled adults (CMS 2019b, c). Wisconsin applies waiver policies to non-elderly, non-disabled, non-pregnant adults up to 95 percent FPL (CMS 2018d).

[13] Before Utah adopted the full Medicaid expansion, it used its Section 1115 waiver to expand coverage to non-disabled adults with income up to 95 percent FPL and received approval to close new enrollment for the waiver population if projected costs exceed state appropriations (CMS 2019a). However, because Utah has now adopted the full Medicaid expansion, it can no longer cap enrollment.

[14] Retroactive coverage is still provided to other populations, including pregnant women in Indiana and New Hampshire.

[15] Indiana's work and community engagement requirements have also been challenged; the case is pending in the same court that vacated waivers for Arkansas, Kentucky, Michigan, and New Hampshire. However, court proceedings were paused in April 2020, as the Secretary and plaintiffs agreed to a hiatus in light of the COVID-19 pandemic and Indiana's prior decision to voluntarily suspend enforcement of the requirements.

[16] Initially in Indiana and Iowa's demonstrations, NEMT was waived for the first year. Both states have received extensions of this authority and currently are not providing NEMT to the new adult group (CMS 2016, 2017).

[17] The premium assistance component of Arkansas's waiver can continue because it was approved separately from the amendment authorizing work and community engagement requirements and it was not subject to the lawsuit.

[18] Under Section 1115 authority, the Secretary can waive premium requirements; however, Section 1916(f) of the Act sets limits on changes that can be made to cost-sharing provisions through a waiver.

[19] After the first year of the demonstration in New Mexico, the state was permitted to increase premiums annually in increments up to a maximum of 2 percent of household income (capped at $20 per month).

[20] The premiums in Arkansas's waiver can continue because they were approved separately from the amendment authorizing work and community engagement requirements and were not subject to the lawsuit.

[21] The Arkansas and Montana waivers also mention the use of healthy behavior incentives, but no further details are available.

[22] In Kentucky, prior to the court ruling, once individuals' household out-of-pocket spending reached 5 percent of income, they paid the minimum monthly premium requirement of $1 for the remaining quarter.

[23] Michigan does not allow enrollees with incomes above 100 percent FPL through 138 percent FPL and more than 48 months of cumulative eligibility to receive cost sharing reductions related to healthy behavior objectives.

[24] Cost-effectiveness for premium assistance means that the total cost of purchasing premium assistance coverage, including administrative expenditures, coverage of excess cost sharing charges, and the costs of providing wrap-around benefits, must be comparable to the cost of providing traditional coverage under the state plan (42 CFR 435.1015(a)(4)).

[25] New Hampshire previously used Medicaid-funded exchange plan premium assistance to provide coverage to expansion waiver enrollees (CMS 2018e). However, the state terminated this program on January 1, 2019, transitioning beneficiaries to Medicaid managed care. Iowa previously provided coverage through exchange plan premium assistance to enrollees with incomes over 100 percent FPL but discontinued the program in 2016 because to plans were dropping participation (CMS 2017). Indiana previously used an employer-sponsored insurance premium assistance program but discontinued it in 2018 citing low participation (CMS 2015).

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Appendix

TABLE A1. Summary of Key Provisions in Approved Section 1115 Waivers

State	Eligibility and enrollment	Benefits	Premiums and cost sharing	Premium assistance	Delivery system
Arizona (work and community engagement provisions postponed indefinitely)	retroactive coverage waived; work and community engagement requirement for non-disabled adults age 19–64; eligibility suspended for non-compliance with work requirement;	no waived benefits	premiums for enrollees with income > 100 percent FPL; premiums waived for healthy behaviors; disenrollment for non-payment; copayments ranging from $4 to $10 required for select services for enrollees with income > 100 percent FPL	no premium assistance program	Medicaid managed care
Arkansas (approval vacated for eligibility and enrollment provisions)	retroactive coverage waived; work and community engagement requirement for new adult group age 19–49; disenrollment and lockout for non-compliance with work requirement	no waived benefits	premiums and copayments for enrollees with income > 100 percent FPL	exchange plans	commercial exchange coverage with FFS wrap
Indiana (work and community engagement provisions postponed indefinitely)	retroactive coverage waived; work and community engagement requirement for non-disabled adults age 19–64; eligibility suspended for non-compliance with work requirement; disenrollment and lockout for failure to submit information necessary for redetermination	NEMT	premiums for all enrollees; disenrollment and lock-out for those with income > 100 percent FPL who don't contribute; copayments for those with income ≤100 percent FPL who don't contribute; credits for healthy behaviors	no premium assistance program	Medicaid managed care

TABLE A1. (continued)

State	Eligibility and enrollment	Benefits	Premiums and cost sharing	Premium assistance	Delivery system
Iowa	retroactive coverage waived	NEMT	premiums for enrollees with income > 50 percent FPL; premiums waived in the first year and for healthy behaviors thereafter; disenrollment for non-payment of premiums for enrollees with income > 100 percent FPL; copayment for non-emergency use of the ED	no premium assistance program	Medicaid managed care
Kentucky (approval vacated)	retroactive coverage waived; work and community engagement requirement for non-disabled adults age 19–64; eligibility suspended for non-compliance with work requirement and disenrollment and lockout for failure to submit information necessary for redetermination	NEMT	premiums between $1 and 4 percent of income; disenrollment and lockout for those with income > 100 percent FPL for nonpayment; copayments for those with income ≤ 100 percent FPL	employer-sponsored insurance	Medicaid managed care and employer sponsored insurance with FFS wrap
Maine (as approved—Maine rejected its waiver in January 2019.)	retroactive coverage waived; work and community engagement requirement for non-disabled adults age 19–64; disenrollment for non-compliance with work requirement	no waived benefits	monthly premiums of 5 percent income for enrollees with income > 50 percent FPL; disenrollment and lockout for non-payment	no premium assistance program	FFS
Michigan (approval vacated for work and community engagement requirements)	no waived requirements	no waived benefits	copayments for enrollees < 100 percent FPL or < 48 months cumulative eligibility; premiums for enrollees with income > 100 percent FPL; credits for healthy behaviors for beneficiaries with income < 100 percent FPL or < 48 months cumulative eligibility	no premium assistance program	Medicaid managed care

TABLE A1. (continued)

State	Eligibility and enrollment	Benefits	Premiums and cost sharing	Premium assistance	Delivery system
Montana	no waived requirements	no waived benefits	monthly premiums for enrollees > 50 percent FPL that are credited toward copayments; disenrollment for those with income > 100 percent FPL for non-payment of premiums	no premium assistance program	FFS
New Hampshire (approval vacated for eligibility and enrollment provisions)	retroactive coverage waived, work and community engagement requirement for new adult; eligibility suspended for non-compliance with work requirement	no waived benefits	no waived requirements	Medicaid managed care; employer-sponsored insurance premium assistance offered through a separate state program	exchange or employer-sponsored coverage with FFS wrap; beginning January 1, 2019, managed care replaces exchange plan premium assistance
New Mexico (as approved in December 2018; New Mexico amended its waiver to remove these provisions in February 2020)	retroactive coverage waived	no waived benefits	monthly premiums up to 1 percent of income for those with income > 100 percent FPL; disenrollment and lockout for non-payment of premiums; credits for healthy behaviors	no premium assistance program	Medicaid managed care

TABLE A1. (continued)

State	Eligibility and enrollment	Benefits	Premiums and cost sharing	Premium assistance	Delivery system
Ohio	work and community engagement requirements for new adult group; disenrollment for non-compliance	no waived benefits	no waived requirements	no premium assistance program	Medicaid managed care
Utah (work and community engagement requirements postponed indefinitely)	work and community engagement requirements for non-disabled adults age 19–59; disenrollment for non-compliance	no waived benefits	no waived requirements	mandatory employer-sponsored insurance premium assistance for those with qualifying offers	Medicaid managed care
South Carolina	work and community engagement requirements for certain targeted adults, including parents and caretaker relatives and TMA beneficiaries; disenrollment or eligibility denial for non-compliance; enrollment cap for certain targeted adults	no waived benefits	no waived requirements	no premium assistance program	FFS or Medicaid managed care
Wisconsin	work and community engagement requirement for non-disabled adults age 19–49; disenrollment and lockout for non-compliance with work requirement; HRA requirement; disenrollment for non-compliance with HRA	family planning, pregnancy-related, and tuberculosis-related services	monthly premiums for enrollees between 50 and 100 percent FPL; disenrollment and lockout for non-payment of premiums	no premium assistance program	Medicaid managed care

Notes: FPL is federal poverty level. FFS is fee for service. NEMT is non-emergency medical transportation. TMA is transitional medical assistance.

Sources: MACPAC analysis of CMS 2020; 2019 a–f; 2018a–j; 2017; 2015.