Response to SR 163 of the 2017 Regular Legislative Session

Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Preface

As per Senate Resolution 163 of the 2017 Regular Legislative Session, the Louisiana Department of Health (henceforth "LDH") submits this monthly report on the Medicaid expansion population and the experience of other state Medicaid programs with work requirement and cost sharing initiatives.

Many state Medicaid programs have established various cost sharing mechanisms and some are choosing to engage in work requirements, particularly for the expansion population. Populations that federal regulations allow to be subject to work requirements include nondisabled, nonelderly, non-pregnant Medicaid adults. Excluded groups include:

- Women during pregnancy through the end of the month following 60 days post-delivery;
- Children under 19 years old;
- Individuals who are the only parent or caretaker relative of a child younger than 6 or a child with disabilities;
- Married individuals under 20 years old who are in secondary school or in an educational program directly related to employment.[1]

Cost sharing is a payment mechanism whereby Medicaid recipients are responsible for copayments, coinsurance, deductibles, or similar charges on both inpatient and outpatient services. However, it is subject to certain federal restrictions. It cannot be imposed on emergency services, pregnancy related services (including tobacco cessation), or preventive services for children, and exempted groups include:

- Children under age 18 (or 19, 20, or 21 at the state's option)
- Individuals living in an institution who are required to contribute all of their income (except a minimum amount required for personal needs) toward the cost of their care
- Individuals receiving hospice care or terminally ill individuals
- American Indians and Alaska Natives who have ever received a service from the Indian Health Service, tribal health programs, or under contract health services referral
- Women who are enrolled in Medicaid under the Breast and Cervical Cancer Treatment Program are exempted from Alternative out of pocket costs only.[2]

While services cannot be withheld for failure to pay, enrollees may be held liable for unpaid copayments. The maximum allowable amount for copayments allowed is detailed in the table below.

[1] S.Amdt.586 — 115th Congress (2017-2018). Congressional Record Online, Government Publishing Office. https://www.congress.gov/amendment/115th-congress/senate-amendment/586/text

[2] Accessed July 2017: https://www.medicaid.gov/medicaid/cost-sharing/cost-share-exemp/index.html

Maximum Allowable Copayments For FY 2013

Services and Supplies	Eligible Populations by Family Income		
	100% FPL	101-150% FPL	>150% FPL
Institutional Care (inpatient hospital care, rehab care, etc.)	$75	10% of the cost the agency pays for the entire state	20% of cost the agency pays for the entire state
Non-Institutional Care (physician visits, physical therapy, etc.)	$4.00	10% of costs the agency pays	20% of costs the agency pays
Non-emergency use of the ER	$8.00	$8.00	No limit *within 5% aggregate limit
Drugs Preferred drugs Non-preferred drugs	 $4.00 $8.00	 $4.00 $8.00	 $4.00 20% of cost the agency pays

Source: Medicaid.gov at https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html

A more detailed accounting of the status of those measures and specified utilization data for Louisiana's Medicaid expansion program are enclosed within as per the requirements of the legislation.

Louisiana Medicaid Expansion Population

NUMBER OF INDIVIDUALS ENROLLED IN MEDICAID FOR THE REPORTING PERIOD WHO ARE ELIGIBLE AS PART OF THE EXPANSION POPULATION.

In October 2017, there were 444,176 unduplicated members enrolled in Medicaid under expansion.

NUMBER OF INDIVIDUALS AGE NINETEEN TO FORTY-NINE AND NUMBER OF INDIVIDUALS AGE FIFTY TO SIXTY-FOUR.

Table 1: Expansion enrollment by age cohort, SFY 2018 - October

AGE Group	Unduplicated Recipient Count
Ages 19 to 49	344,297
Ages 50 to 64	99,879

Source: Medicaid Data Warehouse

NUMBER OF INDIVIDUALS IN EACH AGE CATEGORY WITH EARNED INCOME.

Table 2: Unduplicated expansion enrollment with earned income by health plan, SFY 2018 - October

Health Plan	Age 19 - 49	Age 50 – 64	Total
Aetna	21,635	6,917	**28,552**
ACLA	31,561	6,891	**38,452**
HBL	38,866	8,281	**47,147**
LHCC	66,992	12,721	**79,713**
UHC	71,094	13,699	**84,793**
Total By Age Group	**230,148**	**48,509**	**278,657**

NUMBER OF INDIVIDUALS IN EACH AGE CATEGORY ASSIGNED TO A MEDICAID MANAGED CARE ORGANIZATION (MCO), IDENTIFIED BY EACH INDIVIDUAL MCO.

Table 3: Unduplicated expansion enrollment by health plan, SFY 2018 - October

	Health Plans				
AGE Group	**AETNA**	**ACLA**	**HBL**	**LHCC**	**UHC**
Ages 19 to 49	36,171	48,294	58,723	97,030	104,079
Ages 50 to 64	15,148	14,383	17,067	25,213	28,068

Source: Medicaid Data Warehouse

THE PER-MEMBER PER-MONTH COST PAID TO EACH MCO TO MANAGE THE CARE OF THE INDIVIDUALS ASSIGNED TO THEIR PLAN, IDENTIFIED BY EACH INDIVIDUAL MCO.

Table 4: Expansion per member per month payments by health plan, SFY 2018 - October

Health Plans					
AETNA	**ACLA**	**HBL**	**LHCC**	**UHC**	**Total**
$27,311,117	$31,760,852	$38,290,493	$60,954,831	$66,440,026	**$224,757,319**

Source: Medicaid Data Warehouse

NOTE: Amendment 10 effective October 1, 2017, and associated rate-setting is finishing development. As a result, October PMPMs are paid as a lump sum, which will be followed by capitation rate payments at the member level when the rate-setting is finalized and the lump sums will be recouped.

Medicaid Expansion Utilization

Comparison of individuals age nineteen to forty-nine, age fifty to sixty-four, and those who are covered by Medicaid who are not part of the expansion population utilizing the following services during the reporting period:

- *Emergency department*
- *Prescription drugs*
- *Physician services*
- *Hospital services*
- *Non-emergency medical transportation*

Expenditures associated with each service for individuals age nineteen to forty-nine, age fifty to sixty-four, and those who are covered by Medicaid who are not part of the expansion population during the reporting period.

Total expenditures within these reporting categories alone for the expansion population in September 2017 was $64,393,459 and $102,086,002 for non-expansion populations as detailed in Tables 5 and 6 below.

Table 5: Service expenditures for expansion enrolled individuals, SFY 2018 - October

	Expansion											
	ER		Hospital Inpatient		Hospital Outpatient		NEMT		Pharmacy		Physician	
Age Group	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments
Age 19-49	15,993	$2,467,021	1,160	$4,066,573	31,006	$6,347,999	1,024	$106,781	97,204	$16,486,085	47,906	$5,792,916
Age 50-64	3,785	$640,909	396	$1,687,198	15,085	$4,040,566	902	$76,079	48,579	$9,644,204	20,209	$3,117,684

Table 6: Service expenditures for non-expansion enrolled individuals, SFY 2018 - October

	Regular/Non-Expansion											
	ER		Hospital Inpatient		Hospital Outpatient		NEMT		Pharmacy		Physician	
Age Group	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments	Recip	Payments
Age 0-18	21,841	$2,864,670	1,154	$4,024,452	40,227	$5,199,535	861	$74,116	147,167	$17,589,797	129,745	$12,816,290
Age 19-49	9,293	$1,499,674	1,293	$4,363,957	19,090	$3,821,508	1,537	$123,610	56,548	$13,057,574	30,832	$4,069,907
Age 50-64	2,962	$537,095	485	$2,262,228	9,371	$2,718,972	1,922	$124,259	32,244	$11,346,938	13,891	$2,189,298
Age 65+	48	$10,166	19	$131,658	264	$55,888	662	$28,175	5,569	$378,758	429	$62,645

State Waiver Initiatives

STATES THAT HAVE SUBMITTED WAIVER REQUESTS TO CMS TO IMPLEMENT WORK REQUIREMENTS OR OTHER COMMUNITY ENGAGEMENT INITIATIVES OR ACTIVITIES AS A CONDITION OF ELIGIBILITY FOR ABLE-BODIED MEDICAID RECIPIENTS TO INCLUDE THE NAME OF THE STATE, THE YEAR THE WAIVER WAS SUBMITTED, WHETHER THE WORK REQUIREMENT IS OPTIONAL OR A MANDATORY CONDITION OF ELIGIBILITY, THE POPULATION COVERED, A SHORT SUMMARY OF THE PROPOSAL, AND THE CURRENT STATUS OF THE WAIVER APPLICATION.

Table 7 below reflects summary research performed by the department on the status of waiver requests regarding Medicaid work requirements in other states.

Table 7: Work Requirement Waiver Status by State as of October 2017[3][4][5]

State	Year	Condition of Medicaid Eligibility	Population	Proposal	Status as of 03/2017
Arizona	2015	Yes	Able-bodied expansion and traditional adults	Work, actively seek work, or attend school or job training for 20 hours/week; also proposed voluntary work incentive program for medically frail expansion adults	Denied by CMS
	2017	Yes	Includes able-bodied expansion and traditional adults; excludes full-time high school students, sole caregiver for family member under age 6, receiving temporary or permanent long-term disability benefits, determined physically or mutually unfit for work by health care professional	Work, actively seek work, or attend school or job training for 20 hours/week; requires monthly verification and one year lock-out for making false statement	Submitted to CMS 05/03/2017
Arkansas	2017	Yes	Phased in by age group, ultimately inclusive of enrollees ages 19-49. Exemption criteria: enrollee income is consistent with being	Work requirement	Submitted to CMS 06/30/2017

[3] MaryBeth Musumeci, Medicaid and Work Requirements (The Henry J. Kaiser Family Foundation, March 23, 2017). Accessed August 2017: http://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements/

[4] Montana did not seek § 1115 authority for a work program as part of its Medicaid expansion waiver, but state law creates a state-funded voluntary program.

[5] Additional sources: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/dynamic-list/WA-508.xml

			employed or self-employed at least 80 hours per month, is a student, exempt from SNAP work requirements, receiving TEA Cash Assistance, has short-term incapacitation, caring for an incapacitated person or dependent child under age 6, lives in a home with a minor dependent child age 17 or younger, or is receiving unemployment.		
Indiana	2015	No	Expansion adults	Work referral	Not included as part of waiver approval by CMS – state established separate voluntary state-funded work search and job training program. Managed care entities responsible for creating incentive program to get enrollees to participate in state work search and job training program.
	2017	Yes	All able-bodied, working age adult HIP members who are unemployed or working less than 20 hours per week averaged over eight months of the eligibility period. Exemptions: full or part-time students, employed members working more than 20 hours per week, pregnant women, primary caregivers of dependent child below compulsory education age or disabled dependent, medically frail, certified temporary	Referral to available job training, work search, or employment through the Gateway to Work program (launched as a voluntary participation program in 2015). Will be required to work on average 20 hours per week over eight months during eligibility period, be enrolled in full-time or part-time education, or participate in Gateway to Work. Members who fail to complete the required hours will be suspended from HIP until the member satisfies	Originally submitted 2/14/17, amendment submitted 7/20/2017

			illness or incapacity, active substance use disorder treatment, members over the age of 60, former foster children under age 26, chronically homeless individuals, TANF recipients, recently incarcerated.	the Gateway to Work participation requirements for one full month.	
Kansas	2017	Yes	Able-bodied adults, excludes members receiving long-term care, those enrolled in HCBS waiver programs (autism, serious emotional disturbance, technology assisted, frail elderly, traumatic brain injury, intellectual and developmental disabilities, and physical disability), children, pregnant women, members receiving SSI for disabilities, caretakers for dependent children under six or those caring for a household member with a disability, Medicaid beneficiaries with a retroactive eligibility period, members enrolled in MediKan, persons whose only coverage is under a Medicare Savings Program, members enrolled in PACE, and members with TBI, HIV, or in the Breast and Cervical Cancer Program.	Align KanCare work requirements with TANF program requirements. Min 20-30 hrs/week in one-adult household, 35-55 hrs/week in two-adult household, max requirement is 40 hrs/week. Work includes unsubsidized employment, subsidized public employment, subsidized private employment, work experience, on-the-job-training, supervised community service, vocational education, job search/job readiness, job readiness case management, job skills training directly related to employment, education related to employment, secondary school attendance. Those who do not meet work requirements can have max KanCare coverage of 3 months out of 36 month period. Members who meet work requirements can enroll in KanCare for 36 months.	Not yet submitted, posted to kancare.ks.gov 10/27/2017
Kentucky	2016	Yes-benefits suspended for failure to comply and not reinstated until compliance for full month	Includes all able-bodied working age adults; excludes children, pregnant women, medically frail, students, and primary caregivers of dependents	Volunteer work, employment, job search, job training, education, or caring for non-dependent relative or person with disabling chronic condition for 5 hours/week in year one and 20 hours/week in year two	Waiver application pending with CMS - modifications proposed 07/03/2017

Maine	2017	Members deemed "required to work" may receive up to three months of MaineCare coverage in a 36 month period without meeting the community engagement and work requirements. MaineCare may authorize additional months of eligibility in exceptional circumstances.	Includes individuals between ages 19 and 64. Exemptions: institutionalized, residential substance use or rehabilitation program recipients, members caring for dependent child under age six, providing caregiver services for an incapacitated adult, pregnant, physically or mentally unable to work more than 20 hours/week, or receiving temporary or permanent disability benefits.	Compliance includes at least one of the following activities: work in paid employment at least 20 hours/week; if self-employed, earnings must equal 20 hours/week at minimum wage rate; participate in and comply with approved work program for at least 20 hours/week, workfare or volunteer community service 24 hours/month; individual or group job search and job readiness assistance; student enrollment; combination of employment and education 20 hours/week; receiving unemployment benefits; or complying with work requirements for SNAP or TANF.	Waiver application pending with CMS - submitted 08/04/2017
New Hampshire	2015	No	Expansion adults	Referral to state job counseling service if unemployed	Not included as part of waiver approval by CMS
	2017	Yes	Newly eligible, able-bodied adults. Excludes: temporarily unable to participate due to illness, person participating in state-certified drug court program, parent or caretaker where care is considered necessary by health professional, parent or caretaker of dependent child under 6 years of age.	Must engage in one or more of the following activities: unsubsidized employment, subsidized private sector employment, subsidized public sector employment, work experience, on-the-job training, job search and job readiness assistance, vocational education training, job skills training, education directly related to employment, satisfactory attendance at secondary school. Hours required increase from 20 – 30 hrs/week depending on number of months receiving benefits.	Submitted to CMS 10/24/2017

Ohio	2016	No	Expansion and traditional adults 18 and older	Referral to work development agency if not working 20 hours/week	Waiver application denied in its entirety by CMS
Pennsylvania	2014	Yes beginning in year two, would lose eligibility for 3 months, then 6 months, then 9 months for continued noncompliance	Expansion and traditional adults, ages 21 to 64; exemption for those experiencing crisis, serious medical condition, or temporary condition that prevents work search such as domestic violence or substance use treatment. Excluded: seniors, children under 21, pregnant women, SSI beneficiaries, those in institutions, dual eligible, & full and part-time students must register but do not have to complete work activities	20 hours/week of work or complete 12 job training and employment-related activities/month; those working more than 20 hours/week could have premiums or cost-sharing reduced or other incentives beginning in year two	Not included as part of waiver approval by CMS; previous administration planned to offer incentives for Medicaid beneficiaries who chose to participate in state-funded job training and work activity (current gubernatorial administration did not pursue this program)
Utah	2014	No, although state was considering sanctions related to benefits under other state programs for noncompliance	Able-bodied expansion adults	Automatic enrollment in work program with access to online assessment, job training, and job postings upon Medicaid application	Not seeking waiver authority for work proposal and overall waiver was ultimately never submitted to CMS
	2017	Yes - failure to comply will result in loss of eligibility, eligibility restores upon completing all required activities or meeting an exemption.	All non-exempt enrollees; exemptions include: enrollees over age 60, mentally or physically unfit for employment, parents or members of households with responsibility of dependent child under age six, responsible for care of incapacitated person, receiving unemployment, participating regularly in drug and alcohol treatment program, enrolled student, participating in refugee employment services, Family Employment Program recipients, or working at least 30 hours/week.	Eligible members must participate in online job search/training within the first three months of being notified that they have been enrolled in the program. Once they've met the requirement, they will be eligible for the remainder of their eligibility period (12 months).	Waiver application pending with CMS - submitted 8/16/2017

Wisconsin	2017	No	Members ages 19 through 49 years old. Exemptions: mental illness diagnosis, SSDI, primary caregiver for a person who cannot care for themselves, physically or mentally unable to work, receiving or applied for unemployment insurance, taking part in an alcohol or other drug abuse program, enrolled in institution of higher learning at least half-time, high school student age 19 or older attending high school at least half-time.	Medicaid benefits are limited to 48 months; however, those who meet specified work requirements for at least 80 hours per month while receiving Medicaid benefits will not accrue time in their 48 month eligibility time limit (i.e. those who work can receive benefits for longer than those who do not).	Waiver application pending with CMS - submitted 6/15/2017

NOTE: Montana did not seek § 1115 authority for a work program as part of its Medicaid expansion waiver, but state law creates a state-funded voluntary program.

STATES THAT HAVE SUBMITTED WAIVER REQUESTS TO CMS WITH COST-SHARING PROVISIONS SUCH AS PREDICTABLE MONTHLY PREMIUM PAYMENTS, COPAYMENTS, HEALTH SAVINGS ACCOUNTS, REWARDS ACCOUNTS, OR OTHER COST COMPONENTS FOR ABLE-BODIED MEDICAID RECIPIENTS CONSISTENT WITH COMMERCIAL INSURANCE TO INCLUDE THE NAME OF THE STATE, THE YEAR THE WAIVER WAS SUBMITTED, WHETHER THE COST-SHARING IS OPTIONAL OR A MANDATORY CONDITION OF SERVICE RECEIPT, THE POPULATION COVERED, A SHORT SUMMARY OF THE PROPOSAL, AND THE CURRENT STATUS OF THE WAIVER APPLICATION.

Table 8 below reflects summary research performed by the department on cost sharing waiver requests and implementation in other states.

Table 8: Cost Sharing Waiver Status by State as of October 2017[67]

State	Year submitted	Population covered	Cost-sharing optional	Summary of proposal	Current status of waiver
Arkansas	Original: 2013 Renewal request: 2016 Amendment: 2017	Childless adults from 0-138% FPL Adult parents from 17-138% FPL Exemptions: Dual eligibles, individuals who are medically frail/have exceptional medical needs who do not have access to cost effective ESI, individuals who are medically frail/have exceptional medical needs who have access to cost-effective ESI through a participating employer and choose to receive standard Medicaid coverage under the State Plan	No	Enrollees with incomes above 100% FPL will be subject to premiums of up to 2% of household income. Failure to pay premium within a 90-day grace period will incur a debt to the state. Incentive benefit (e.g., dental services) for new adult population available to those who make timely premium payments and achieve healthy behavior standards. All beneficiaries will receive information on referrals to work and work training opportunities.	Initial application approved 09/2013, renewal approved 01/2017, amendment approval pending with CMS – submitted 6/30/17

[6] MaryBeth Musumeci and Robin Rudowitz, The ACA and Medicaid Expansion Waivers, (The Henry J. Kaiser Family Foundation, updated November 2015). Accessed August 2017: http://www.kff.org/report-section/the-aca-and-medicaid-expansion-waivers-issue-brief/

[7] Additional sources: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/dynamic-list/WA-508.xml https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html

Arizona	2016	All Medicaid expansion adults from 0-138% FPL	No	Monthly premium of 2% of income or $25 (whichever is less) and copayments up to 3% of income which would be paid monthly into HSAs for services already used instead of at point of service. Enrollees from 101-138% FPL would be disenrolled and locked out of Medicaid eligibility for six months for non-payment of premiums and co-payments. Also proposed imposing co-payments in excess of federal limits for non-emergency use of ER and missed appointments. Beneficiaries below 100% FPL would not lose Medicaid eligibility for failure to pay, but would have unpaid amounts counted as a debt to the state. Monthly payments for beneficiaries from 101-138% FPL could reduce monthly payments for complying with healthy behaviors and work incentives.	Approved
Indiana	06/2014, extension request 08/2016	Working parents from 24-138% FPL Jobless parents from 18-138% FPL Childless adults from 0-138% FPL	No	Premiums are 2% of income for all waiver beneficiaries (including some traditional Medicaid enrollees such as parents). This with income 0-5% FPL (up to $50/month in 2016) pay a flat $1.00/month. Premiums are paid into a Personal Wellness and Responsibility (POWER) health account. Adults with income from 100-138% FPL must pay a premium to effectuate coverage, those who fail to pay premiums within 60 days are dis-enrolled and locked out of coverage for six months. Coverage for expansion adults from 0-100% FPL who fail to pay premiums within 60 days are moved to a more limited benefit package (HIP Basic, without dental and vision benefits and with more limited prescription coverage) and incur point-of-service copayments. Traditional Medicaid enrollees who do not pay premiums are guaranteed state plan benefits. Graduate copayments ($8 for first visit and $25 for second visit) for non-emergency use of ER. Health plans provider care after exhausting the	Approved 01/2015, temporary extension 11/2016

				$2,500 POWER account deductible (funded by the state and beneficiary premiums).	
	2017	Adult enrollees with income less than 138% FPL	Yes	Premium: Adult enrollees with income less than 138% FPL have the option to pay a monthly contribution to Personal Wellness and Responsibility Health Accounts to receive a better benefit package and no cost sharing (except for copayments for non-emergency use of the emergency department); request to increase premium to up to 3% of income for smokers.	Pending
Iowa	2013, amendment in 2015	Adults ages 19-64 from 101-138% FPL	No	After first year of enrollment, beneficiaries with income from 50-100% FPL pay $5/month premium. Cannot be disenrolled for non-payment. Beneficiaries with income from 101 - 138% FPL pay $10/month premium. Can be disenrolled for non-payment. State must waive premium for beneficiaries who self-attest to financial hardship. Unpaid premiums will be considered debt to state, which will be forgiven if the beneficiary does not re-apply or is no longer Medicaid-eligible at renewal. Premiums can be waived if beneficiaries complete specified healthy behavior activities. Cost sharing limited to 5% of quarterly income, including premiums. Co-pay required for non-emergency use of the ER beginning in year two of enrollment.	Approved 12/2013, Extended 11/2016
		Adults ages 19-64 from 50-100% FPL	Yes		
		Exempt: Adults age 19-64 with income below 50% FPL, those who are medically frail, and American Indians/Alaska Natives			
Kentucky	2017	All adult enrollees except pregnant women, children, section 1931 parents, and the medically frail.	No	Monthly premium payments of $1-$15/month for enrollees from 0-138% of FPL. Third-parties may assist members with monthly contributions. Failure to pay for those above 100% FPL will result in disenrollment from Kentucky HEALTH, with a waiting period of six months to re-enroll. Those at or below 100% FPL will be required to pay copayments for all services, $25 will be deducted from My Rewards Account or suspension of My Rewards Account.	Pending

Maine	2017	Able bodied adults ages 19-64 (with same exemptions as community engagement and work requirements)	No	Premium: Able bodied adults ages 19-64; participation in MaineCare will be terminated if payment is not made. Payments must be received by last day of final enrollment month or member will be disenrolled for 90 days or until any unpaid premiums are paid. Payments required: 51-100% FPL = $10/month, 101-150% FPL = $20/month, 151-200% FPL = $30, 201% FPL and above = $40. Copayments: Non-emergency use of the emergency department = $10.	Pending
Michigan	2013, amendment in 2015	Working parents from 64-138% FPL Jobless parents from 37-138% FPL Childless adults from 0-138% FPL	No	Expansion adults with income from 100-138% FPL pay monthly premiums of 2% of income (~$20-$27/month) into health accounts for services used in the previous six months. Failure to pay does not result in loss of Medicaid eligibility, past due premiums can be recouped from state income tax refunds or lottery winnings. Payments are due until six months of enrollment. Compliance with specified healthy behaviors results in a 50% reduction in future premiums for those above poverty and a $50 gift card for those below poverty.	Approved 12/2013, extended 12/2015
Montana	Amendment application submitted 2016	Childless adults from 0-138% FPL and parents from 50-138% FPL	No	State can charge enrollees monthly premiums of 2 percent of aggregate household income for people with incomes 50-138% FPL and childless adults with income 0-138% FPL. Enrollees with income at or below 100% FPL cannot be disenrolled for failure to pay premium. Enrollees above 100% FPL who fail to make a premium payment after a 90-day grace period may be disenrolled, can be re-enrolled upon payment of arrears or when deb is assessed, the state will establish a process to exempt individuals from disenrollment for good cause. Premium payments will be a credit toward copayment obligations so that they shall not accrue out of pocket expenses for copayments until copayments exceed 2 percent of household income. Preventive health services, immunizations, and medically	Amendment approval pending

				necessary health screenings exempt from copayments. [8]	
New Mexico	Pending submission 11/2017	Native Americans exempt from premiums; exempt from copays: Native Americans, ICD-IID individuals, QMB/SLIMB/QI1 individuals, Family Planning-Only, PACE, DD waiver recipients, and people receiving hospice care.	No	Premiums: $10-$50/mo. per household with potential to increase from $50-$100 per household. Copayments: $2 for prescriptions/medical equipment and supplies, $5 for routine doctor visits, $50 for hospital stays and surgeries, $8 for non-preferred drugs and non-emergency ED visits (only copays not subject to 5% annual out of pocket maximum). Retroactive Coverage: eliminate retroactive coverage that pays for three-months of medical expenses if patient is eligible for Medicaid immediately before enrollment. Providers can impose $5 fees on members for three or more missed appointments.	Pending submission 11/2017; posted to: http://www.hsd.state.nm.us/centennial-care-2-0.aspx
Utah	2017	All enrollees	No	$25 co-payment for non-emergent use of the emergency department	Pending
Wisconsin	2017	Childless adult population with household income from 51-100% FPL	No	Premium of at most $8 per household which may vary based on level of income and results of health risk assessment. Limit of 48-months of continuous eligibility, must wait 6 months before re-enrolling. $8 copay for nonemergent use of ED.	Pending

[8] Montana Section 1115 Waiver for Additional Services and Populations (December 5, 2016). Accessed July 2017: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-basic-medicaid-fs.pdf