

Research Insights

■ Medicaid and Personal Responsibility Waivers: Opportunities and Challenges in Evaluating Potential Impacts

Introduction

Initially, after the Supreme Court made the Affordable Care Act (ACA) Medicaid expansions optional to the states, only about half chose to take advantage of the opportunity. But given the opportunity to improve the health of state populations, and to take advantage of generous increases in federal matching funds, many more have since followed suit. By December of 2018, the total number of expanding states had risen to 37. Through Medicaid's waiver process, the states have also enjoyed increased flexibility in how they can manage the program, which some have used to promote what are collectively referred to as "personal responsibility" policies, such as increased cost-sharing, work requirements, and incentives to encourage healthy behavior.

Medicaid and other safety-net programs have a long history with similar initiatives. Work requirements were an essential ingredient of welfare reform in the 1990s, and pre-ACA waivers under Section 1115 of the Medicaid statute allowed experiments with small premiums and other cost sharing features that were otherwise prohibited under the original legislation in 1965.

Until recently, however, work requirements were not permitted in Medicaid, and cost-sharing provisions were tightly limited. But since 2017, with interest in expansion persisting in many initially opt-out states and a conservative Republican administration in the White House, waiver restrictions have been substantially relaxed by the Centers for Medicare and Medicaid Services (CMS).

On September 7, 2018, AcademyHealth convened a conference of about 30 policy analysts and public officials to review and discuss research related to the new Section 1115 expansion waivers and to identify the most pressing research needs going forward. What follows is a synthesis of the presentations and discussions at the meeting, along with relevant background from the gray and peer-reviewed literature. The discussion was off the record, so this brief will review the comments largely in paraphrase, and without attribution. A blog post describing the meeting discussion is also available at <https://www.academyhealth.org/blog/2018-09/experts-examine-evidence-medicaid-and-personal-responsibility-requirements>.

Genesis of this Brief:

This brief is based on a meeting of policymakers and researchers that took place in Washington, D.C., on September 7, 2018. AcademyHealth convened the meeting as part of its Research Insights Project. Funding for the conference was made possible by Grant No. 2R13HS018888-07 from the U.S. Agency for Healthcare Research and Quality (AHRQ). The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the U.S. Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government. The Research Insights Project convenes invitational meetings, holds webinars, and produces reports and issue briefs to foster discussion of existing, relevant research evidence among policy audiences that need to implement health reform and develop new policy. Additional information and publications may be found on the project's website at <http://www.academyhealth.org/about/programs/research-insights>.

Background

Letters from CMS to state officials in early 2017 charged that existing Medicaid rules were “rigid and outdated,” and that the expansion provisions threatened to divert the program from its core mission and drive up state and federal spending.¹ CMS promised a new era, empowering the states with increased freedom to tailor program designs to meet the various states’ unique needs. The letter emphasized new efforts to increase employment among enrollees, incentivize more prudent use of resources by consumers of care, and more fully align Medicaid with private insurance, particularly by increasing the use of cost sharing, high-deductible coverage, and savings accounts.

By October of 2018, five states had received at least initial approval from CMS for their 1115 expansion waiver proposals, and one, in Arkansas, had gone into effect. Implementation of the first approved waiver, in Kentucky, had been blocked in federal court. Approval was pending in ten other states. All varied widely in design details, program goals, and the political circumstances that brought them forth.²

Observers noted substantial challenges in implementing the waiver proposals. They would entail modification of eligibility procedures, new systems to document compliance, outreach efforts to inform potential enrollees of program changes, interfaces with other state and federal program, staff expansions and training, new appeal procedures, and more. Upgrading and retooling information technology (IT) capacity would be needed in all these efforts.³

The CMS guidance letters explicitly cautioned the states about the need to ensure compliance with Medicaid’s overarching legal framework. But in June, a federal district court blocked implementation of Kentucky’s CMS-approved waiver, which entailed a work requirement, on the grounds that it was inconsistent with Medicaid’s statutory purpose of providing medical assistance to the state’s citizens. Shortly thereafter, Arkansas released estimates that nearly 20 percent of otherwise eligible low-income people would lose coverage for failing to document their 80-hour-a-month obligation or prove their exempt status.

In roughly the order followed at the meeting, this brief will address premiums, health savings accounts (HSAs) and other forms of cost sharing, work requirements, and healthy behavior incentives in Medicaid; and finally cross-cutting issues of implementation and evaluation.

Premiums

The policy rationale for premiums, in both CMS guidance and state waiver proposals, is to offset state spending on services, increase enrollees’ cost consciousness, and help bring Medicaid into closer alignment with private insurance – hopefully smoothing benefi-

ciaries’ transition to private coverage. Not all Medicaid rules are waived. Premiums and other cost sharing can’t exceed five percent of family income. Some groups can’t be charged: poor and near-poor children, pregnant women below 150 percent of the federal poverty level, the medically frail, and some other documentable hardship cases. Income-based sliding scales must be used. But participants at the meeting emphasized also that the reasons for including premiums in many waiver proposals was that “getting to yes” in many state negotiations would have been impossible without them. “We can’t ignore the politics,” said one presenter.

The 1115 proposals vary on multiple dimensions: premium amounts, enrollee income levels, grace periods, lockout provisions – which prevent enrollees who miss payments or other requirements from re-enrolling for a specified period of time. Some states allow premium discounts for healthy behavior or receiving preventive services. A cap of 2 percent of annual income on these obligations is common, as are 60-day grace periods. Non-payment penalties such as lockouts tend to be stiffer for income groups above 100 percent of the federal poverty level (FPL). The variability of state policies will make it difficult to evaluate the net impact of premiums on enrollment, health outcomes, and state budgets.

There is, however, extensive experience with premiums and other forms of cost sharing in Medicaid prior to and outside of 1115 expansion waivers. By 2018, 30 states charged premiums or enrollment fees for children in Medicaid and the Children’s Health Insurance Program (CHIP). While Medicaid prohibits premiums for those with incomes below 150 percent of poverty, eight CHIP programs have waivers to charge premiums or enrollment fees for children from 133 to 150 percent of poverty. Additionally, copays and coinsurance may be charged for some services to patients between 100 and 150 percent of the FPL. Above 150 percent also, there is no limit for non-emergency use of the Emergency Department up to Medicaid’s overall limit of 5 percent of income for those above 150 percent of poverty.⁴

Thus there is a considerable evidence base for evaluating the potential impact of premiums on the new Medicaid expansion waiver programs. Systematic reviews of the research literature on these effects show a consistent downward impact on enrollment when premiums are added or increased. The effects are larger on low-income groups, although the magnitude of effects varies across studies.

Premiums in public programs are also associated with increases in uninsurance and private insurance enrollment, although the magnitude of these effects varies across studies. To date, little evidence is available on the impacts of premiums for adults who are eligible for Medicaid expansion coverage under the Affordable Care Act above and below the federal poverty level. Studies have found that premiums have a negative effect on access to care, but down-

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stream health effects are much more difficult to assess and have yet to be adequately documented. Overall, findings on the negative effect of premiums on enrollment in Medicaid are consistent with the landmark RAND Health Insurance Experiment (HIE) of the 1970s. Also in line with the HIE, a relatively recent study found that “the premium requirement itself, more so than the specific dollar amount, discourages enrollment.”⁵

Administrative costs associated with new premium requirements will be another important concern for state officials and will need careful monitoring and analysis. States can expect to realize savings from anticipated disenrollments. But new information systems will be needed to process payments, whether online, with credit cards, or in cash. Achieving robust enrollment will require investments in outreach and education. New procedures will be needed for non-payment enforcement and associated appeals processes. Similarly, exemption applications have to be managed, as well as appropriate due-process appeals processes.

The net financial effects of premium revenue, disenrollment, and administrative costs will bear close watching. States have estimated that net administrative costs of expansion waivers, including other features such as work requirements and HSAs, may in some cases run into hundreds of millions of dollars.⁶

HSAs and other forms of cost sharing

In addition to premiums, there are a variety of cost-sharing mechanisms among the new waiver-seeking states, including those modeled on HSAs. States experimenting with HSAs tout their value in part as a pathway to familiarizing Medicaid enrollees with how private insurance works. But the accounts, untaxed in private markets, were designed principally for use in conjunction with high-deductible coverage plans that appeal primarily to higher-income consumers.

In Medicaid, the savings accounts are designed to help patients meet point-of-service copays, co-insurance, and/or deductibles. They may also represent a way to create incentives for healthy behaviors, such as completing health risk assessments (HRAs), in return for account contributions. A further policy rationale is to promote consumer price sensitivity, although the effectiveness of this strategy is undermined by a pervasive lack of transparency in service pricing. But for low-income Medicaid enrollees, shopping may not matter when expensive specialty services are out of reach at any price.

The accounts entail monthly contributions by enrollees, although requirements may also be met with employer or state contributions. Indiana pioneered the use of HSAs in Medicaid with its Personal Wellness and Accountability (POWER) accounts, as part of a pre-ACA 1115 coverage expansion waiver.

In the first iteration of the Healthy Indiana Plan (HIP), starting in 2008, Medicaid expansion enrollees were required to contribute five percent of their income to POWER accounts to pay for up to the first \$2,500 in care received in a year. Twenty percent of the contributions were subsidized by a state cigarette tax.⁷ Subsequently the state split the plan, with different choices for enrollees in different income groups. Those above 100 percent of the FPL were still required to contribute to their POWER account. Two levels of coverage were offered – HIP Basic and HIP Plus, with the latter including vision and hearing benefits and no point-of-service copays. Those in HIP Plus who miss payments are dropped to the lower level or disenrolled entirely for specified periods.

The complexity of the Indiana program created not only administrative challenges for the state, but barriers for potential Indiana enrollees. In one study, for example, 39 percent of eligible beneficiaries had not heard of POWER accounts, and just 36 percent were making the required contributions. So nearly two-thirds of expansion enrollees were at risk of losing benefits or coverage because of inadequate communications.⁸

Given that many low-wage jobs are temporary or have irregular hours, workers' incomes fluctuate, causing frequent changes in eligibility status. So Indiana workers may often shuttle between HIP Basic, HIP Plus, lockouts, uninsurance, and private coverage in or out of state Marketplace plans. The impact of this churn in coverage status on access to care and health outcomes needs attention, conference participants agreed.

High administrative costs and low participation rates swamped savings in another HSA experiment in Arkansas, and the state shut the program down in 2016. The Healthy Michigan (HM) plan has had better success engaging enrollees with its savings accounts. As elsewhere, Michigan's HSA is embedded in a spectrum of associated cost-sharing mechanisms. Among HM's 600,000 enrollees, those with incomes between 100 and 133 percent pay 2 percent of their income to enroll in one of about a dozen existing, established Medicaid managed care organizations in the state.

Their payments are credited to their MI Health Account, in amounts calculated by income data and family characteristics. Copays at the point of service are then deducted from the accounts and enrollees furnished with a monthly statement of their charges and balance. As part of a CMS-mandated evaluation, a survey of more than 9,000 enrollees reported that 88 percent of respondents said they received a statement and reviewed it carefully, and that it helped them to be aware of the costs of care. Similar shares of respondents agreed that the modest amounts that they paid were fair and affordable.

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On the other hand, fewer than 40 percent said they paid the copays they owe, although only a few were aware that they could not be disenrolled for nonpayment. Slightly fewer than one in four were aware that their payment could be reduced if they completed an HRA, engaged in specified healthy behaviors, or received preventive services.⁹ Best practices identified in the AcademyHealth discussion included frequent and clear communications between providers and enrollees, use of grace periods and other measures to minimize disruptions of access.

The stated goal of some of the expansion waiver provisions is to increase enrollees' familiarity with private insurance, an environment in which cost sharing has been increasing steadily for a decade or more. A few states have been approved to offer premium assistance to Medicaid enrollees who join a qualified health plan in their state Marketplace or from their employer. In general, co-pay limits have drifted upward under expansion waivers, but some states have tried to be strategic with them, waiving cost sharing for preventive services, for example, or increasing them for over-used or low-value services.

Many questions remained about the use of premiums, copays, HSAs and other cost-sharing mechanisms for participants in the September meeting. Some surveys suggest that some low-income enrollees would be willing to pay at least a little more to keep their coverage, but it is unclear whether this signals a rational economic calculation about the value of care. The net effect of complicated waiver programs on state budgets is also uncertain, since some enrollee contributions come in small increments, which entail disproportionately high administrative costs. Premiums and enrollment fees tend to reduce enrollment, but the strength of this effect varies.

Discussants suggested that state policymakers sometimes seem to be unaware of disconnections between the design details of their 1115 programs and the professed goals of expanding coverage while increasing personal responsibility, as when administrative costs exceed savings, or some forms of cost sharing produce sharp drops in enrollment. The role of research in pinpointing such disconnects and clarifying choices for policymakers was an explicit takeaway from the discussion.

Work requirements

The biggest and most controversial change in expansion waivers after January 2017 has been CMS approval of several state proposals to include a work requirement for Medicaid enrollees, a feature that all previous administrations had rejected. At least five states want work conditions for the new category of enrollees, and a few others want them for their traditional populations. Most proposals require a documented 80 hours a month of employment, training, or job seeking. Some enrollees are exempt due to disability, care-giving, or other priorities.

Similar requirements have been common since the passage of welfare reform in 1996, for example in the Temporary Assistance for Needy Families (TANF) program and the Supplemental Nutrition Assistance Program (SNAP). In both cases, various outcomes of work requirement programs have been analyzed, so some of their general effects are understood. Evaluations of the TANF welfare-to-work experience have shown modest positive effects on employment that may last up to about five years, along with some gains in employer-sponsored health coverage.¹⁰ Reductions in the receipt of welfare benefits tend to be substantial, so the net effect on family income appears to be negligible. Effects have varied widely across states.

In a discussion of labor market factors, participants agreed that the concept of personal responsibility needed to be reconciled with the reality that enrollees have no control over demand for labor, but such provisions would penalize enrollees when employment opportunities are limited. Currently, with five work requirement waivers at least initially approved and more pending, the labor market environment appears to be favorable, with 50-year lows in unemployment reported in September 2018. But the national average masks local variation, particularly in poor communities where receipt of Medicaid is concentrated. And many of the jobs contributing to the current trend are of the low-wage, temporary, and part-time variety that may be difficult to fit with the typical 1115 requirement of 80 documented hours per month.¹¹

Over the first summer of the Arkansas Works 1115 waiver program, more than 4,350 of 26,000 Medicaid enrollees subject to the new requirements failed to meet them and lost coverage. In Arkansas, as elsewhere, many eligible enrollees are employed, but often in temporary or part-time jobs, and many others are exempt for various reasons.¹² Arkansas requires monthly documentation of compliance to be filed online, although about a fourth of those affected are estimated to lack Internet access, with much higher rates in some localities.¹³ Members of a federal oversight panel expressed alarm.¹⁴

In Kentucky, the first state to receive CMS approval for a work requirement, a federal judge blocked implementation of the proposal after state officials estimated that 95,000 low-income people would lose their Medicaid coverage if the state's plan went into effect. The judge found that federal officials who approved the plan had not seriously considered its potential impact on the state's provision of health services for eligible residents as Medicaid law requires.

Work requirements in Indiana, New Hampshire, and Wisconsin have been approved and are due to start in 2019. Ten more states have work requirement proposals pending, including six in non-expansion states. The Arkansas plan has also been challenged in court, with a focus on the adequacy of the state's online system

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for processing enrollees' monthly compliance information. As of September 2018, the Arkansas application also lacked an approved evaluation plan as required by law.¹⁵

Crucially, Medicaid does not offer dollars to support employment efforts, for such needs as childcare and job training, in contrast to work requirement programs in TANF and SNAP. State resources for funding such supports vary, but are often quite limited.

Estimates of the overall cost of implementation of work requirements vary, but are substantial:

- Alaska, \$79 million over six years
- Kentucky, \$186 million
- Michigan, \$15 million to \$30 million annually
- Minnesota, \$163 million in 2021
- Ohio, \$378 million over five years
- Pennsylvania, \$600 million
- Tennessee, \$34 million a year
- Virginia, a range from \$200 million a year with “high touch” case management, and \$7 million without it.¹⁶

The states, of course, can expect that some of their increased administrative costs will be offset by declines in enrollment and thus also in spending on benefits. The net effect of these budgetary impacts then needs to be measured against the potential harms to the affected population and local providers and to factor in other offsetting government spending related to rising uncompensated care burdens. The level of risk in turn depends on the details of each states' plans and policies, and details of its implementation practices.

Enforcement of penalties for non-compliance and procedures for establishing exemptions were cited at the AcademyHealth meeting as particularly critical factors for determining enrollment effects. IT capacity is another. Economic stress, low education levels and literacy, limited transportation and internet access, and cultural barriers often confront the communities that rely on Medicaid, leaving them vulnerable to coverage losses where strict disenrollment and lock out policies and practices are implemented. Transportation, documentation standards, lockout policies, and grace periods will also interact to affect net enrollment changes.

The states' experiences with supported welfare-to-work programs, primarily for mothers, may have only limited value as a template for Medicaid's complicated requirements, the conferees agreed. “It's a really different world,” said one. Concerns of special importance to the research community are the design, rigor, and data requirements of the states' evaluation plans. Political considerations have figured prominently in the waiver process, highlighting decision makers' need for relevant and reliable research on program outcomes.

Healthy behavior incentives

Healthy behavior incentives are a feature of several expansion waiver proposals that fit under the rubric of personal responsibility. They have a long history in workplace wellness programs and a more recent history in Medicaid. But changing behavior is a notoriously difficult endeavor, and evidence about the effectiveness of these efforts in saving money and promoting health is mixed. Programs vary widely, data collection is not standardized, and outcomes may take many years to show up. Attributing causality to any single factor is inevitably confounded by multiple co-factors. Clear-cut evidence of the effectiveness and cost-effectiveness of healthy behavior incentives is limited to tightly targeted programs with measurable outcomes built in.

Research on workplace wellness has yielded many useful insights into behavioral psychology and economics. Especially after the advent of self-funded employee health coverage in the 1970s and 1980s, employers saw an opportunity to reduce their health care spending by promoting healthy behavior and preventive care. They offered incentives for workers to enlist in weight-loss and smoking-cessation programs; to receive preventive services such as mammograms, and cholesterol and blood pressure screenings; and to monitor and manage chronic conditions like diabetes and hypertension with regular testing and provider visits. Incentives might include cash payments, reductions in employees' premium shares, perks like gym memberships or parking privileges, or simply tokens of recognition.

The effectiveness of these different incentives was found to vary widely. Cash rewards – the larger the better – worked better than in-kind perks. Quick disbursement – monthly, say, rather than quarterly or annually – improved effectiveness. Ease of use, as with electronic communication tools, made a difference. Overall, education, engagement, and communication, along with clarity and simplicity, emerged as essential. Several factors distinguish workplace programs from Medicaid, including that the workplace constitutes a contained environment, providing multiple channels and opportunities for managers to facilitate program participation.

Prior to the ACA, CMS had approved at least a dozen healthy behavior programs, dating back as far as 2006. The Medicaid Incentives for Prevention of Chronic Disease program gave ten states a total of \$85 million, starting in 2011. Six programs targeted smoking, another six diabetes, five obesity, four hypertension, and three high cholesterol. All the programs had rigorous evaluation components incorporated in their design. Overall results were mixed. Some increased use of preventive services was found in three diabetes programs. In three smoking projects, calls to quit lines and cessation counseling increased. Minimal effects on body weight were observed, and few changes in hospital use were seen. Three programs registered net savings, but two others showed losses.

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Seven states incorporated healthy behavior components in their 1115 expansion waivers, including Kentucky's suspended program. Use of negative incentives increased. In Iowa, for example, enrollees could be charged premiums for dental benefits if they failed to complete an HRA. A lack of awareness about the programs among providers and beneficiaries was found in several instances. In Michigan, fewer than 30 percent of eligible enrollees knew that they could receive premium and copay reductions for completing an HRA in a 2016 survey.¹⁷ In Kentucky's proposal, an extensive range of healthy behaviors could be rewarded with cash contributions to an enrollee account for dental or vision care. But the accounts could be debited for non-emergency ED use or nonpayment of premiums. In programs that have been evaluated thus far, program complexity tended to depress participation.

An important insight from prior experience is the value of efforts to inform and engage beneficiaries, which implies a need for "high touch" approaches that necessarily entail higher costs. The effectiveness of larger rewards also puts upward pressure on costs, highlighting the problem of capturing long-term health benefits and savings in research evaluations. Much remains to be learned about the tradeoffs between positive and negative incentives – carrots and sticks. Informing and involving providers in healthy behavior programs appears to be a largely unexplored frontier, especially for those with fewer Medicaid patients; and incentives for provider engagement are lacking. Improvements could be made in program design to better the chances of obtaining meaningful evaluation results.

Monitoring and evaluation

Crosscutting issues addressed at the meeting included two levels of thinking about evaluation. One was its importance as a tool for focusing attention on the details of policy and program execution, with the need for vigorous data collection as a corollary and an expectation that the states have the will and the ability to make mid-course corrections when indicated. A broader standard for weighing outcomes was also considered, which was to judge results on macro effects, or how well the programs meet Medicaid's overall statutory goal.

In the latter respect, concerns were expressed about potential harms to beneficiaries from the cumulative and longitudinal effects of the coverage disruptions that various provisions of the waivers seem likely to entail, on the basis of the research at hand. Coverage interruptions multiply as incomes fluctuate, documentation problems arise, life situations change, and new policies ripple through the state infrastructure. Gaps in coverage are likely to be compounded over time, compromising care and outcomes.

Should otherwise eligible recipients be locked out of coverage for six months or a year because they can't find a pay stub, or lack Internet access, or have poor reading skills? Further, because of the concentration of poverty in neighborhood pockets, aggregate coverage gaps are likely to have community-wide effects on local economies and social conditions. The negative effect of reduced coverage on provider capacity has also been documented. Community health centers are particularly vulnerable. Routine program evaluations are unlikely to measure these broader impacts.

Procedures necessary for managing the programs create many challenges. Notice and appeal processes must meet statutory standards. Even without federal help, states must provide beneficiary supports that satisfy the Americans with Disabilities Act. Exempt populations must be protected. As noted previously, IT investments will be substantial and entail design challenges for interfaces with other state agencies, the state Marketplace and its plans, and actual state residents seeking coverage. As much or more of a burden will be staffing needs to implement the new version of Medicaid, with some waiver provisions also being extended to previously covered populations in several states.¹⁸

As in welfare-to-work programs, case management is essential to successful transitions. Between hiring and training new workers, Ohio expects to spend \$378 million over five years to support case management. Tennessee's budget for these needs is \$22 million in the first year of its proposed work requirement. There, as elsewhere, budget pressures are often reducing case management to bare bones levels. Moreover, many state health and human service departments are already understaffed and face high vacancy rates, so that new responsibilities are likely to detract from ongoing projects, such as developing improved payment systems to promote integration and better care. Work previously underway on simplifying and streamlining enrollment processes will be fundamentally disrupted. CMS resources may also be stretched.

Evaluation challenges are also testing the states' mettle, from formulating the right questions to capturing program performance to gathering the data needed to answer them. Provisions must be made for special populations and the most vulnerable. Those seeking exemptions from work requirements are the most likely to face obstacles. Comparison groups have to be constructed to measure program impacts and may require tracking outcomes for populations in non-expansion states. Care and coverage outcomes for those who lose eligibility need to be tracked. Adequate evaluations are difficult and expensive to conduct.

Conclusion

The new waiver programs have not been in operation long enough for much to be known yet about their outcomes and impacts, but eventually evaluations will have a critical role to play. Some conference participants emphasized that these programs operate under CMS's demonstration authority, which means that benefits and harms from their implementation have to be monitored and measured. Evidence presented and discussed at the conference shows that both kinds of outcomes are possible.

The shape of Medicaid's future depends on how well these tasks are performed.

About the author

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Endnotes

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