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Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Summative Evaluation Report

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EXECUTIVE SUMMARY

Following the implementation of the Patient Protection and Affordable Care Act (P.L. 111-148; ACA) in 2014,[1] 39 states have expanded Medicaid coverage to their newly eligible adult population with incomes up to 138 percent of the federal poverty level (FPL).[2] Of the states that expanded Medicaid coverage, while the large majority implemented a traditional Medicaid expansion, several states (including Montana and Indiana) expanded coverage under the ACA and are testing in a demonstration under section 1115 of the Social Security Act, an alternative approach to that coverage, including cost-sharing requirements for Medicaid enrollees in the expansion population.

In November 2015, Montana received approval from the Centers for Medicare & Medicaid Services (CMS) to implement their Medicaid section 1115 demonstration allowing the state's alternative approach to coverage for the Medicaid expansion under the ACA. The demonstration is called the Montana Health and Economic Livelihood Partnership (HELP) Program. Enrollment in HELP started January 1, 2016, and as of January 1, 2020, nearly 85,000 Montanans were enrolled in HELP—8 percent of the state's population.[3] In December 2017, CMS granted a demonstration amendment to HELP that modified two of its components to reduce demonstration costs and administrative burden.[4]

Similar to the ACA Medicaid expansion demonstrations in other states (e.g., Arkansas, Indiana, and Michigan), HELP encourages enrollees to be prudent health care purchasers and take responsibility for their health care through premiums, copayments, and strategies to promote healthy behaviors. HELP also includes provisions that allow Montana to disenroll some newly eligible individuals who do not pay their premiums on a timely basis. To improve continuity of care and reduce the "churn" of individuals losing and then regaining insurance, Montana's demonstration provides 12-month continuous eligibility. Before the 2017 demonstration amendment, HELP included a public-private third party administrator (TPA) plan from which some enrollees received care and a premium credit that applied to these enrollees' cost-sharing obligations. These two components were removed from the demonstration in the 2017 amendment to HELP.

What Did the Evaluation Examine?

In August 2015, CMS awarded a contract to Social & Scientific Systems, Inc. (SSS) and their partner the Urban Institute (henceforth known as the evaluation team) to conduct an evaluation of the HELP demonstration. The federal evaluation has three main goals:

- Understand and document the design, implementation, and ongoing operations of HELP
- Document enrollee understanding of and experiences with HELP
- Estimate the overall effects of HELP on health insurance coverage, health care access and affordability, health behaviors, and health

[1] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

[2] "State Health Facts: Status of State Action on the Medicaid Expansion," Kaiser Family Foundation, no date (accessed January 5, 2021), https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[3] "Montana Medicaid Expansion Dashboard," Montana DPHHS, https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.

[4] "CMS Approved Amendment: HELP Program Demonstration," Centers for Medicare & Medicaid Services, December 20, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

To fully assess the impact of the demonstration and achieve evaluation goals, the evaluation team designed and implemented a comprehensive mixed-methods evaluation of HELP that included:

- A qualitative component with:
    - Site visits conducted in 2017 and 2018 that included semi-structured interviews in Billings, Browning, Bozeman, Butte, Havre, and Helena with HELP stakeholders such as state officials, health care providers and provider association representatives, and consumer advocates
    - Focus groups with HELP enrollees as part of the site visits—four in 2017 and four in 2018
    - Document review of published and gray literature, and program statistics
    - Analysis of HELP administrative data on Medicaid enrollment and disenrollment, provided by Montana Department of Public Health and Human Services (DPHHS), January 2014 through March 2018

- Mixed-mode survey of 2,180 HELP enrollees and 2,187 HELP disenrollees conducted in July of 2017 as well as follow-up surveys[5] in 2018 that asked about HELP enrollees' and disenrollees' experiences with the program including knowledge of the program, cost as a barrier to access, affordability of the program, and satisfaction with the program

- An impact analysis that relied on a quasi-experimental difference-in-differences evaluation design and data from the American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) to compare changes over time for adults in Montana to changes for similar adults in comparison states that did not expand Medicaid (Georgia, North Carolina, and Wyoming), comparison states that expanded Medicaid without a demonstration (Kentucky and North Dakota), and comparison states that expanded Medicaid with a different demonstration (Michigan and New Hampshire)

This summative report is part of the federal evaluation of Montana's HELP demonstration.[6] The evaluation produced an interim evaluation report that provided in-depth qualitative findings from the 2017 and 2018 site visits (including focus groups) and the analysis of the 2017 survey of HELP enrollees and disenrollees as well as impact estimates through 2017 based on the ACS and BRFSS.[7] This report summarizes prior qualitative findings and presents new analyses of HELP administrative data and of the 2018 follow-up survey of HELP enrollees and disenrollees, along with an update of the impact analysis through 2018.

Findings from the Evaluation

Findings from the qualitative and quantitative components of the federal evaluation show that the HELP demonstration has had positive effects on outcomes such as health insurance coverage and health care access, including access to preventive care; although, as with any new program, it faced some

[5] 2,187 enrollees and 1,745 disenrollees were in the survey samples for the follow-up surveys in 2018.

[6] "Evaluation Design Report for Montana HELP Federal Evaluation," Social & Scientific Systems, Inc., (Silver Spring, MD: Centers for Medicare & Medicaid Services, 2017), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/mt/help-program/mt-help-program-fed-state-eval-dsgn-051617.pdf.

[7] "Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Evaluation Report," Social & Scientific Systems, Inc., July 22, 2019, https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf

implementation and operational challenges. Overall, Montana experienced substantial gains in health insurance coverage through Medicaid expansion under ACA in its test of alternative coverage policies under the HELP demonstration. Program enrollees for the most part were very satisfied, and stakeholders said the demonstration has had positive economic impacts by bringing about a decrease in hospital uncompensated care costs and stimulating economic growth in the state.

Allowing Montana to use a section 1115 demonstration resulted in a program that achieved a key goal of both the ACA and the state—a significant expansion in health insurance coverage relative to the comparison states that did not expand Medicaid (Georgia, North Carolina, and Wyoming). As of December 2018, nearly 100,000 Montanans were enrolled in HELP, accounting for about 10 percent of the state's total population. Moreover, based on results from the impact analysis, the expansion in health insurance coverage exceeded the gains that would have been expected relative to the comparison states that expanded Medicaid without a demonstration (Kentucky and North Dakota) or with a different demonstration (Michigan and New Hampshire). Apart from assessing the impacts of the HELP demonstration itself, results from the evaluation may be informative to other states considering implementing a section 1115 Medicaid demonstration.

Generally, findings were consistent with the interim evaluation for both the impact analyses as well as the wave 2 survey. In the follow-up survey, we found an increase in the proportion of respondents reporting satisfaction when compared with wave 1 survey respondents for choice of doctors, how copays work, and cost of premiums. In addition, enrollee respondents demonstrated an improvement in their overall understanding of HELP but continued to demonstrate mixed results in their understanding of program specifics.

Stakeholder interviews reveal:

Strong stakeholder engagement and collaboration with the state expedites system change. While state officials and other interviewees acknowledged that it took time and compromise to pass the ACA Medicaid expansion in Montana, once HELP legislation was enacted the deep collaboration between the state and health care stakeholders in implementing the demonstration created a win-win situation for hospitals, uninsured Montanans, and the state's economy.

Changing patterns of health care use. While findings from stakeholder interviews suggested gaps in enrollee understanding of some program features of HELP, interviewees noted some evidence of changes in health care behaviors by the increase in the share of enrollees obtaining preventive care services over time. Impact estimates from the evaluation support these claims.

Flexibility in program design is important. State officials and other interviewees highlighted the importance of periodically revisiting the HELP demonstration design based on operational experience. For example, to help reduce demonstration costs and administrative complexity, Montana eliminated its private-public TPA plan and the 2 percent premium credit as part of its 2017 amendment. More recently, in 2019 the Montana legislature voted to remove the use of copayments in HELP due to administrative burden on providers.

Focus groups, HELP administrative data, and surveys of HELP enrollees show:

Satisfaction with the HELP program was high among current enrollees. Survey results from both waves show that a majority of enrollees reported being somewhat to very satisfied with individual features of

HELP, such as monthly premiums, the ability to see their doctors as well as the choice of doctors, and coverage of needed health care services. Across both waves of the survey, close to half or more of disenrollee respondents indicated that they would choose to re-enroll in HELP.

HELP enrollees and disenrollees had limited understanding of the individual features of HELP. Enrollees in focus groups expressed confusion about some of the basic components of HELP such as what is covered by the program as well as some of the more complex features of HELP such as copayments. This was consistent with findings from the surveys of HELP enrollees and disenrollees.

Disenrollment from HELP for failing to pay premiums and other reasons has been low. HELP *a*dministrative data show that timely premium payment among HELP enrollees is low (e.g., less than 50 percent in December 2018). Even so, these data also show that for enrollees with incomes above 100 percent FPL who owed premiums and were subject to disenrollment for failing to pay their premium, monthly disenrollment rates have also been low, ranging between 1 to 4 percent in 2017 and 2018. Disenrollment for reasons other than not making timely premium payments has similarly remained low, roughly 2 to 4 percent. Those disenrolled for failing to pay premiums tended to be younger and from larger households than those disenrolled for other reasons. In addition, those disenrolled for failing to pay their premiums were more likely to reenroll within 3 months than those disenrolled for other reasons.

Access to health care improved for many beneficiaries. Focus group with HELP enrollees showed that access to needed health care services was viewed favorably. Survey results indicated that most beneficiaries reported receiving needed services, and cost was a barrier to receiving services for fewer than 20 percent of enrollees. With gains in health insurance coverage, beneficiaries perceived increases in access relative to their prior coverage status. At the same time, even with HELP coverage, access barriers were more prevalent for dental and vision services than for other services, based on both focus group and survey results.

Findings from the impact analyses indicate:

Health insurance coverage increased in Montana. Impact findings revealed strong evidence that Montana's HELP demonstration expanded health insurance coverage for adults beyond what would have been expected if Montana had not expanded Medicaid, a view echoed by site visit interviewees. Health insurance coverage also increased in Montana relative to similar states that expanded Medicaid, without a demonstration or with a different demonstration. These findings held true in both the second and third years (2017 and 2018) after the implementation of HELP.

Evidence suggests that the use of preventive care increased in Montana relative to similar states, regardless of Medicaid expansion status. Findings showed significant increases in Montana in the share of adults with a routine checkup in the previous 12 months relative to not expanding Medicaid, expanding without a demonstration, and to expanding with a different demonstration. There were also increases in the share of adults receiving a flu vaccine in the past 12 months relative to comparison states that did not expand Medicaid or expanded Medicaid without a demonstration.

Montana and its comparison states had similar trends in health behaviors and health status. However, Montana residents were significantly less likely to report that health was not good relative to comparison states.

Policy Implications

Based on results from this evaluation, Montana's HELP program provided coverage and access to care for about 85,000 Montanans enrolled as of January 1, 2020. The program was viewed positively by all interviewees and by most enrollees who participated in focus groups or were surveyed. While the design of the HELP demonstration was intended to encourage enrollees to take responsibility for their health care through premiums, copayments, and strategies to promote healthy behaviors, these components of the program sometimes confused enrollees, or were administratively difficult to implement (such as premium credits). States contemplating implementing the ACA Medicaid expansion or making changes to their Medicaid program more generally may wish to learn from Montana's experiences with specific program features or with their experiences with enrollees' outreach and education. Finally, publicly sponsored programs like HELP are not implemented in a vacuum; general state infrastructure and budget situations will likely affect both implementation and ongoing operations of such public endeavors.

I. Introduction

The Affordable Care Act (ACA) allows states to expand Medicaid eligibility to adults with incomes up to 138 percent of the federal poverty level (FPL). As of February 2020, 37 states had opted to implement the Medicaid expansion as set out in the ACA, while 10 states had expanded coverage using alternate approaches through section 1115 demonstrations.[8] Though long a hallmark of Medicaid, section 1115 demonstrations have gained renewed prominence with the Trump Administration's interest in trying new ways to improve the Medicaid program.[9] Chief among the strategies that the Centers for Medicare & Medicaid Services (CMS) is interested in testing through section 1115 demonstrations are strengthening enrollee engagement in their health care, enhancing the alignment between Medicaid and private health insurance policies, and supporting initiatives that promote upward mobility, greater independence, and improved quality of life for Medicaid enrollees.[10]

Montana received approval to implement the ACA Medicaid expansion through a section 1115 demonstration in November 2015.[11] The state implemented its demonstration, called the Health and Economic Livelihood Partnership or HELP, on January 1, 2016.[12] In December 2017, CMS approved an amendment to Montana's demonstration that is to continue through December 2020. As of January 1, 2020, close to 85,000 Montanans were enrolled in HELP.

In this chapter of the summative report of the federal evaluation of HELP, we first present a summary of the major program features of HELP during 2016 to 2018, followed by a description of the design of the evaluation. We conclude with a discussion of the scope and organization of the report.

Overview of HELP

Like ACA Medicaid expansion demonstrations in other states (e.g., Arkansas, Indiana, and Michigan), HELP is designed to encourage enrollees to be prudent health care purchasers and take responsibility for their health care through premiums, copayments, and provisions that allow Montana to disenroll some demonstration enrollees who do not pay their premiums on time.[13] According to the CMS approved

[8] "Status of State Medicaid Expansion Decisions: Interactive Map. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map//.

[9] "Verma Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program," U.S. Centers for Medicare & Medicaid Services, November 7, 2017, https://www.cms.gov/newsroom/press-releases/verma-outlines-vision-medicaid-announces-historic-steps-taken-improve-program.

[10] "About Section 1115 Demonstrations," Medicaid.gov, no date (accessed May 13, 2019), https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

[11] The legislation that enacted the Medicaid expansion was scheduled to sunset on June 30, 2019. The Montana legislature reauthorized HELP through ratifying House Bill 658, which introduced a new sunset clause of June 30, 2025.

[12] When Montana received approval for HELP, it also received a section 1915(b)(4) Fee-for-Service Selective Contracting Demonstration, which authorized a defined provider network and is associated with the HELP demonstration. The section 1915 demonstration is not covered under the federal evaluation of HELP.

[13] "Special Terms and Conditions: Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," Centers for Medicare and Medicaid Services, approved November 2, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

special terms and conditions (STCs) of Montana's section 1115 demonstration, the HELP demonstration has two central objectives:[14]

- Encourage enrollees to be discerning health care consumers, take personal responsibility for their health care decisions, and develop health-conscious behaviors through the use of premiums and copayments
- Promote continuity of coverage through 12-month continuous eligibility, which allows individuals to stay enrolled in the demonstration for a full year regardless of income changes

To help achieve these objectives, HELP included the following design features when it launched on January 1, 2016:

- Expanded Medicaid eligibility to adults with income up to 138 percent FPL who were not previously eligible for Medicaid in Montana
- Required premiums equal to 2 percent of aggregate household income for HELP enrollees with incomes between 51 and 138 percent FPL who were not otherwise exempt from provisions of the demonstration;[15] enrollees with incomes equal to or less than 50 percent FPL were not subject to premiums
- Operated two health plans to deliver services to HELP enrollees. One was a public-private third party administrator (TPA) plan that provided services to nonexempt enrollees subject to premiums; the other, Montana's Medicaid state plan, delivered services to enrollees exempted from demonstration provisions
- HELP enrollees subject to premiums received a credit toward copayments of up to 2 percent of income
- All HELP enrollees subject to premiums accrue debt owed to the State of Montana for unpaid premiums; enrollees with income above 100 percent of the FPL accrue debt to the State and may also be disenrolled for failing to pay premiums within a 90-day grace period
- All demonstration enrollees had 12-month continuous eligibility in HELP

Although not part of the HELP demonstration's STCs, consistent with Montana's copayment policy in its Medicaid state plan, all HELP enrollees regardless of income were subject to maximum level of cost sharing allowed under federal law. In addition, and not part of HELP's STCs, a voluntary workforce

[14] "Montana Health Economic Livelihood Partnership Plan (HELP) Program Section 1115 Research and Demonstration Waiver Application," Montana Department of Public Health and Human Services (DPHHS), September 15, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/HELP-program/mt-HELP-program-pending-app-09162015.pdf.

[15] In addition to exempting adults with incomes below 50 percent FPL from premiums, when HELP launched Montana also exempted individuals who were medically frail, individuals who the state had determined had exceptional health care needs, individuals who lived in a region where the TPA plan was not able to contract with sufficient providers, individuals who the state determined required continuity of coverage that was unavailable in the TPA plan or could not be effectively delivered through the TPA plan, and individuals otherwise exempted from premiums or copayments by federal Medicaid law (e.g., Native Americans). "Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," Centers for Medicare and Medicaid Services, approved November 2, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

development program called HELP-Link was part of the HELP program.[16] Launched at the same time as the HELP demonstration, HELP-Link aims to reduce reliance on Medicaid for health insurance and strengthen Montana's workforce.[17]

In September 2017, Montana formally submitted a request to CMS to amend the HELP demonstration. Under the amendment request, Montana asked to eliminate the public-private TPA plan and transition HELP enrollees served by the TPA plan to Montana's Medicaid state plan. Montana also asked to eliminate the premium credit that applied to some HELP enrollees' cost-sharing obligations. These changes were designed to help reduce demonstration costs and administrative burden. Other parts of the demonstration remained the same. On December 20, 2017, CMS approved the amendments, which Montana implemented on January 1, 2018.[18]

A more detailed description of HELP and an overview of Montana's Medicaid program before HELP is provided in the interim evaluation report.[19]

Design of the Federal Evaluation

In 2015, Social & Scientific Systems, Inc. (SSS) and the Urban Institute (together referred to in this report as the evaluation team) were awarded a base year and three option years contract (September 2015 to September 2019) to conduct the federal evaluation of Indiana's section 1115 demonstration—Healthy Indiana Plan (HIP) 2.0. The evaluation of Montana's HELP demonstration was added to the contract in 2016. The federal evaluation of HELP has four principal objectives, namely:[20]

- Understand the design, implementation, and administrative costs of HELP
- Document enrollee understanding of and experiences with HELP, including experiences with premiums, copayments, enrollment, and disenrollment
- Estimate the overall effects of HELP on health insurance coverage, access and affordability of health care, health behaviors, and health status
- Provide timely information on HELP that can inform CMS, Montana, and other states as they consider ways to improve the Medicaid program

[16] "Montana Health and Economic Livelihood Partnership (HELP) Act," Montana State Legislature, April 29, 2015, https://leg.mt.gov/bills/2015/sb0499/SB0405_x.pdf; "HELP-Link: The Montana HELP Plan Workforce Program," Montana Department of Labor and Industry, no date (accessed December 2017), https://montanaworks.gov/help-link.

[17] "HELP-Link Program Report," Montana Department of Labor and Industry, July 2018.

[18] "CMS Approved Amendment: HELP Program Demonstration," Centers for Medicare and Medicaid Services, December 20, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

[19] "Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Report," Social & Scientific Systems, Inc., July 22, 2019, https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf.

[20] "Evaluation Design Report for Montana HELP Federal Evaluation," Social & Scientific Systems, Inc., (Silver Spring, MD: Centers for Medicare & Medicaid Services, 2017), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/mt/help-program/mt-help-program-fed-state-eval-dsgn-051617.pdf.

To achieve these objectives, the federal evaluation of HELP has three components that rely on qualitative and quantitative analyses:

- Qualitative analyses entailing document review and two rounds of site visits (September 2017 and September 2018), including conducting informational interviews with HELP stakeholders (such as state officials, health care providers and provider association representatives, and consumer advocates) and focus groups with HELP enrollees; and descriptive analyses using HELP administrative data
- Descriptive analyses also included conducting two surveys (2017 and 2018) of HELP enrollee and disenrollees
- Quantitative analyses using national survey data (through 2018) to estimate the impact of the demonstration on selected outcome measures[21]

The goals of the qualitative analyses were to provide careful documentation of HELP implementation and operations, as well as report on the successes and challenges Montana faced in managing the demonstration. The qualitative analyses were also to provide an in-depth assessment of consumer experiences with HELP through enrollee focus groups and beneficiary surveys. Finally, the qualitative analyses were also designed to inform the evaluation's descriptive analyses using administrative data and survey data, and the impact analyses in two fundamental ways: 1) helping guide the focus of the descriptive and impact analyses components, and 2) providing context for interpreting results from those analyses. The goals of the impact analyses were to assess the extent to which HELP led to changes in health insurance coverage, as well as changes in health care access and affordability, health behaviors, and health status.

Scope and Organization of the Summative Evaluation Report

This summative evaluation report updates the findings from the interim evaluation report,[22] including new results from analyses of HELP administrative data through 2018, analyses of the second wave of HELP beneficiary surveys from 2018, and an update of the impact analysis through 2018.

This report is organized as follows: Chapter II provides a summary of the qualitative assessment of HELP through the fall of 2018 based on site visits and focus groups with demonstration enrollees from the interim evaluation report, along with new analyses of HELP program administrative data. Chapter III presents findings from the HELP beneficiary surveys, including new survey data from 2018. Chapter IV provides an update of findings from the impact analysis from the interim evaluation report based on data through 2018. In Chapter V, we discuss lessons learned from HELP and the demonstration going forward.

[21] Because the national survey data to be used for the impact analysis are released in the fall of the year after the survey is fielded (e.g., data for 2018 are released in fall 2019), the final year of survey data available to the HELP evaluation is 2018.

[22] "Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Report," Social & Scientific Systems, Inc., July 22, 2019, https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf.

II. Qualitative Assessment of HELP

The goal of the qualitative component of the HELP evaluation is to understand and document the implementation and ongoing administration of HELP and evaluate enrollees' experience under Montana's Medicaid expansion. The qualitative assessment relies on document reviews, descriptive analyses of program administrative data, and site visits to Montana in 2017 and 2018, which included 36 key informant interviews and eight focus groups with HELP enrollees. Key informant interviewees included state officials, health care providers and provider association representatives, consumer advocates, and other non-state observers of the demonstration. For the focus groups with HELP enrollees, four were held in 2017 and four in 2018. In 2017, we conducted two focus groups in Helena, one in Havre, and one in Browning.[23] In 2018, we conducted four focus groups in the eastern part of the state--two in Billings, one in Livingston, and one in Forsyth.[24]

The qualitative component of the evaluation is meant to tell the story of HELP from the perspective of a range of stakeholders and HELP enrollees. While this information provides important context for understanding and interpreting the impact findings of HELP presented in Chapter IV of this report, and to corroborate what is being reported by beneficiary survey respondents, qualitative findings presented in this chapter are based on stakeholders' and focus group participants' assessments of HELP and should not be interpreted as providing estimates of the impacts of HELP. The information obtained from interviews and focus groups is self-reported and, therefore, limited by the memory and experience of the individuals with whom we spoke. Finally, while interviewees are designated as representatives of their particular stakeholder type (for example, state officials can speak on behalf of state government, and provider association representatives can speak on behalf of providers they represent), focus group participants are not meant to be representative of all HELP enrollees, but rather offer examples from a range of HELP enrollee perspectives. Further, the focus groups provide rich details on HELP enrollees' perceptions and experiences, but they do not provide full representation of enrollee feedback on the demonstration. This type of information is in Chapter III, which reports on the HELP beneficiary surveys.

The interim evaluation report (Chapter III and Appendix A) and a separate report on the 2017 site visit provided information on the data and methods used for the site visits and focus groups, and a detailed presentation of findings from the qualitative component of the evaluation.[25] This chapter presents a summary of those findings including the addition of an analyses of HELP administrative data. The chapter is organized as follows: We first provide an overview of the development of HELP, which is followed by a discussion on the implementation and ongoing operations of the demonstration and enrollee experiences with HELP. We then present a discussion of stakeholder assessments of HELP.

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[23] Helena is the state capital and, with nearly 30,000 residents, is the sixth largest city in Montana. Havre and Browning are both small towns located in the northern center part of the state.

[24] Billings is the largest city in Montana with nearly 110,000 residents. Livingston and Forsyth are both rural towns, to the west and east of Billings, respectively.

[25] "Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Report," Social & Scientific Systems, Inc., July 22, 2019, https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf;"Federal Evaluation of HELP: Montana Health and Economic Livelihood Partnership Plan- A Look at the Program a Year and a Half into Implementation," the Urban Institute and Social & Scientific Systems, Inc., (Silver Spring, MD: Centers for Medicare & Medicaid Services, 2018), https://www.medicaid.gov/medicaid/downloads/mt-help-focus-group-site-visit-rpt.pdf.

Findings from the Qualitative Analysis

Findings from the qualitative component of the evaluation indicate that Montana was successful in implementing core components of HELP in a timely and effective way. State officials, health care providers, provider associations, consumer advocates, and non-state observer interviewees universally viewed HELP as a major Medicaid expansion that was implemented with just a few glitches and, on an ongoing basis, the demonstration has operated with limited administrative problems. Enrollees who participated in focus groups agreed.

Development of HELP

After failing to pass a traditional ACA Medicaid expansion in 2013, the Montana legislature and the governor worked together to develop a compromise bill to put forward in the 2015 Montana legislative session that called for adopting the expansion through a section 1115 demonstration. Interviewees said that other states' section 1115 demonstrations were reviewed, but HELP was "made in Montana and homegrown." The bill authorizing the expansion of Medicaid, Senate Bill 405, was passed by the Montana legislature in April 2015. Interviewees acknowledged that it took time and compromise to get the Medicaid expansion legislation through the legislature and stressed the importance of compromise among health care stakeholders to reach a consensus on the design of HELP, one that could pass muster in the Montana legislature. Certain program features in the HELP legislation were seen as critical for passage, including requiring enrollees to have some financial responsibility for their health through premiums and copayments, having a public-private TPA plan administer program benefits, and the inclusion of a workforce training program. In addition, stakeholders said that it was important that the legislation provide sufficient flexibility for the state to conduct demonstration negotiations with CMS. Senate Bill 405 also included a "sunset" provision that eliminated the expansion June 30, 2019, unless the legislation was reauthorized by the Montana legislature.[26]

Montana submitted documents to CMS to establish the demonstration on September 15, 2015. After some revisions in the design negotiated between Montana and CMS, the state received approval from CMS on November 2, 2015. HELP was implemented January 1, 2016.

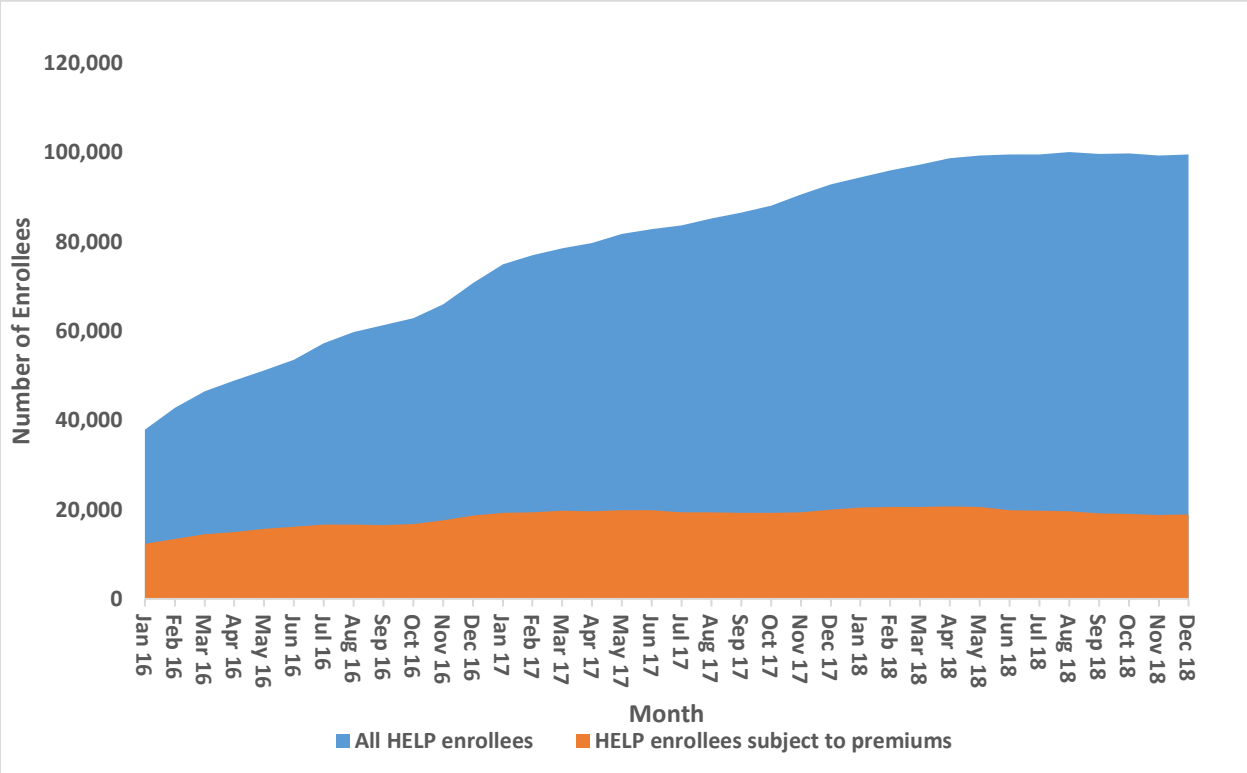
Implementation and Ongoing Operations of HELP

Interviews with key health care stakeholders and focus groups with enrollees revealed that HELP has enjoyed widespread support and appreciation since the demonstration launched. This sentiment carried into 2018 and was expressed by all participants in the focus groups and across all stakeholders with whom we spoke. At the same time, some implementation glitches, and targeted concerns about the ongoing operations of the demonstration were noted by both interviewees and focus group participants.

[26] Although outside the evaluation period, on May 9, 2019, Montana's governor signed the Medicaid Reform and Integrity Act extending the ACA Medicaid expansion on the condition that the Department of Public Health and Human Services (DPHHS) requests federal approval to amend the HELP demonstration to add new conditions of Medicaid eligibility, including community engagement, as well as a new sunset date of June 30, 2025. On August 26, 2019, Montana submitted its demonstration application for amendment and extension to CMS, which introduces new provisions to the program including community engagement requirements, restructured premiums to have a gradual increase of 0.5 percent for non-exempt enrollees who remain on the program more than 2 years, as well as the elimination of copayments.

When Montana implemented HELP in January 2016, a robust and coordinated outreach effort was mounted by the state, community organizations, and providers. A range of strategies were used to publicize HELP, including advertising campaigns and direct one-on-one outreach to prospective enrollees. The initial outreach for HELP was viewed as a success and, reflecting this, enrollment in the demonstration ramped up quickly and reached more than 70,000 within the first year—a number the state had originally projected would take 4 years to achieve (Figure II.1). Though at a slower rate, enrollment continued to grow in 2017 and 2018, reaching nearly 100,000 by December 2018. In December 2018, premium paying enrollees account for 18.9 percent of overall HELP enrollment,[27] a level that has been fairly constant over the course of the demonstration. Given that more than 80 percent of enrollees are not subject to premiums and thus exempt from those demonstration provisions, HELP is similar to a traditional Medicaid expansion for most demonstration enrollees.

Figure II.1: HELP Enrollment Overall and By Premium Payment Status, 2016-2018



Source: Data taken from the State of Montana's Section 1115 Waiver Annual Report for Demonstration Year 1 (2016) and the quarterly reports contained in the Section 1115 Waiver Annual Reports for Demonstration Years 2 and 3 (2017-2018).

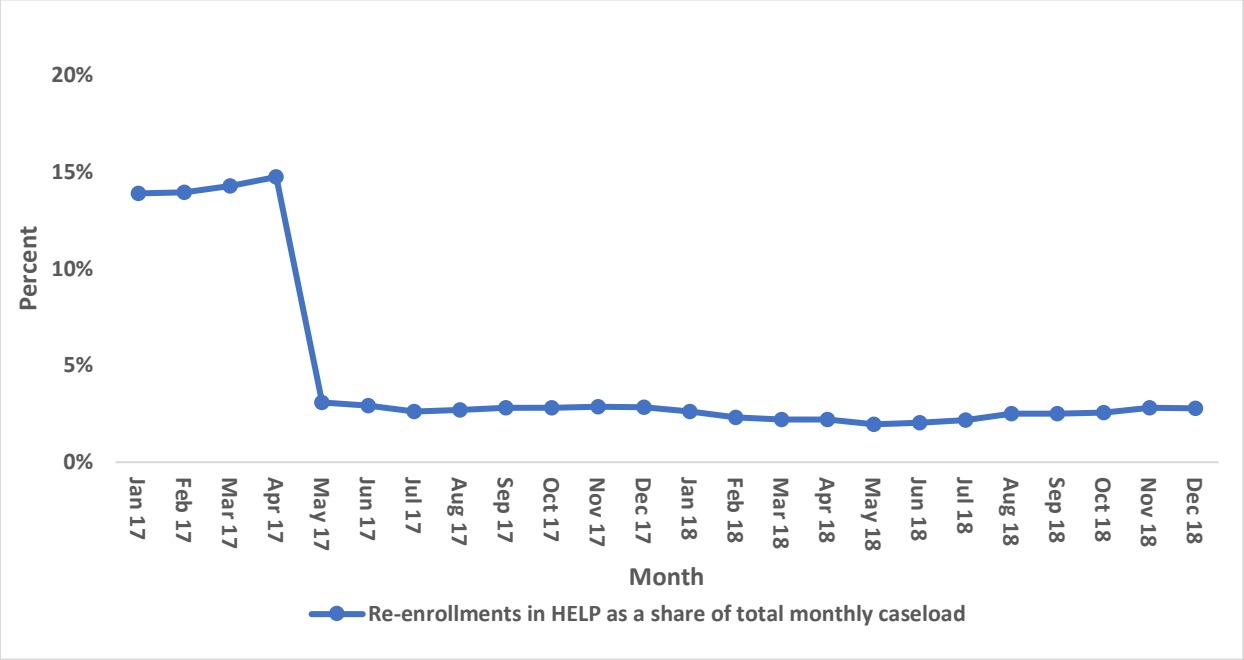
The 12-month continuous eligibility feature provided in the HELP demonstration was universally favorably viewed by stakeholders as having been helpful in stabilizing coverage and improving continuity of care, particularly for preventive care services. As one provider said, "I think that's [12-month continuous eligibility is] super, super helpful… because that in and out of coverage is really difficult to track from our perspective as to maybe I'm scheduled for surgery and maybe it's next month, and I lost my coverage but when I scheduled it I had coverage." State officials said offering 12-month continuous

[27] "HELP Program 1115 Waiver: Quarter 4 Measures December 2018 Data," data produced in the Annual Report for Demonstration Year 3, State of Montana, March 1, 2019, revised October 3, 2019.

eligibility was also seen as way to save on demonstration administrative spending. As one official said, 12-month continuous eligibility has been "cost neutral if not beneficial…Very happy we did continuous eligibility. Frees them [state staff] to do one-time enrollment because you don't have people going on and off."

Figure II.2 shows the share of new HELP enrollees by month who had had Medicaid coverage in the past 3 months as a percent of the total HELP enrollment in that month for the January 2017 to December 2018 period.[28] As can be seen, the share of reenrollees, or those individuals who dropped off of HELP but subsequently reenrolled within 3 months of dropping coverage, decreased substantially over the period. In January 2017, roughly 10,412 individuals reenrolled in HELP within 3 months, accounting for 14 percent of total HELP enrollment.[29] By May 2017, reenrollments in HELP within 3 months dropped sharply to 3.1 percent of overall demonstration enrollment,[30] a level that held steady through December 2018. One possible factor for the high churn observed in early 2017 is that this period was the end of the first 12-month eligibility period for many early HELP enrollees (i.e., individuals who enrolled just after HELP was implemented in January 2016) and, as such, it may reflect issues in the first redetermination period. For example, there could have been confusion about the redetermination process with some enrollees falling off coverage but returning to HELP within 3 months. If that were the case, the data for early 2018 suggests that any issues with redetermination were resolved by 2018.

Figure II.2: Enrollment Churning Under HELP, 2017-2018



Source: Data taken from the quarterly reports contained in the State of Montana's Section 1115 Waiver Annual Reports for Demonstration Years 2 and 3 (2017-2018).

[28] Administrative data used to construct reenrollment measures were not available prior to January 2017.

[29] "HELP Program 1115 Waiver: Quarter 1 Measures January 2017 Data," data produced in the Annual Report for Demonstration Year 2, State of Montana, August 8, 2018.

[30] "HELP Program 1115 Waiver: Quarter 2 Measures May 2017 Data," data produced in the Annual Report for Demonstration Year 2, State of Montana, August 8, 2018.

While enrollment in HELP has been robust since early on and the demonstration enjoys continued widespread support, programmatic issues have surfaced since HELP was implemented in 2016. In some instances, the state responded by making major design changes to the demonstration. Changes to the demonstration were also made to address general state matters—namely, a deterioration in Montana's budget situation that began July 2017. To help reduce demonstration costs and ease administrative burden, in September 2017, Montana submitted a request to CMS to amend HELP asking to make two changes: eliminate the public-private TPA plan and remove the premium credit that applied to some HELP enrollees' cost-sharing obligations. On December 20, 2017, CMS approved the amendments, which Montana implemented on January 1, 2018.[31]

According to focus group participants and interviewees, these changes were implemented without issue. Further, interviewees said the intended goals of reducing demonstration costs and easing administrative burden have been achieved. In particular, interviewees highlighted that consolidating HELP into a single administrating entity simplified the demonstration, both for the state and providers. In addition, state officials characterized the transition of enrollees as a success, evidenced by various program measures, including seeing no real differences or gaps in HELP eligibility and limited program disenrollment. As shown in Figure II.1 earlier, administrative data support this as there was little change in enrollment among premium paying enrollees following the implementation of the amendments in January 2018. Finally, removing the TPA plan from the demonstration has yielded substantial savings on program administrative costs, according to one state official. Eliminating the premium credit was similarly seen as a success. As a Montana state official said in a 2017 interview, the credit was eliminated because it was "amazingly administratively inefficient for not a lot of gain—difficult for clients to understand and for us to administer."

More recently, Montana addressed copayments in HELP, which interviewees and focus group participants reported that providers generally did not bill HELP enrollees for, except for pharmacies. As mentioned above, consistent with Montana's Medicaid state plan, all HELP enrollees regardless of income are charged copayments to the maximum provided under federal law. Given that, following federal policy, HELP has a dual copayment structure, that is, flat copayment fees are imposed on enrollees with income at or under 100 percent FPL and a percentage of the state's reimbursement to the provider for those with incomes above 100 percent FPL. State officials said implementing the variable copayment has been challenging: "An operational nightmare…. [causing] more work and more difficulty," according to one state official. Moreover, Montana providers were reported as generally not billing HELP enrollees for copayments, or only sending bills if the amount owed was above some threshold. As one provider association representative put it, "[HELP] copays are just a pain. They're just symbolic." In 2019, as part of the reauthorization of HELP the Montana legislature eliminated copayments from HELP.[32]

Enrollee Experiences with and Understanding of HELP

Enrollees in our focus groups generally thought HELP was affordable and had enhanced their access to health care. In addition, focus group participants who were paying their premiums said they were happy

[31] "CMS Approved Amendment: HELP Program Demonstration," Centers for Medicare and Medicaid Services, December 20, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

[32] H.B. 658, 66th Leg., Reg. Sess. (Mont. 2019).

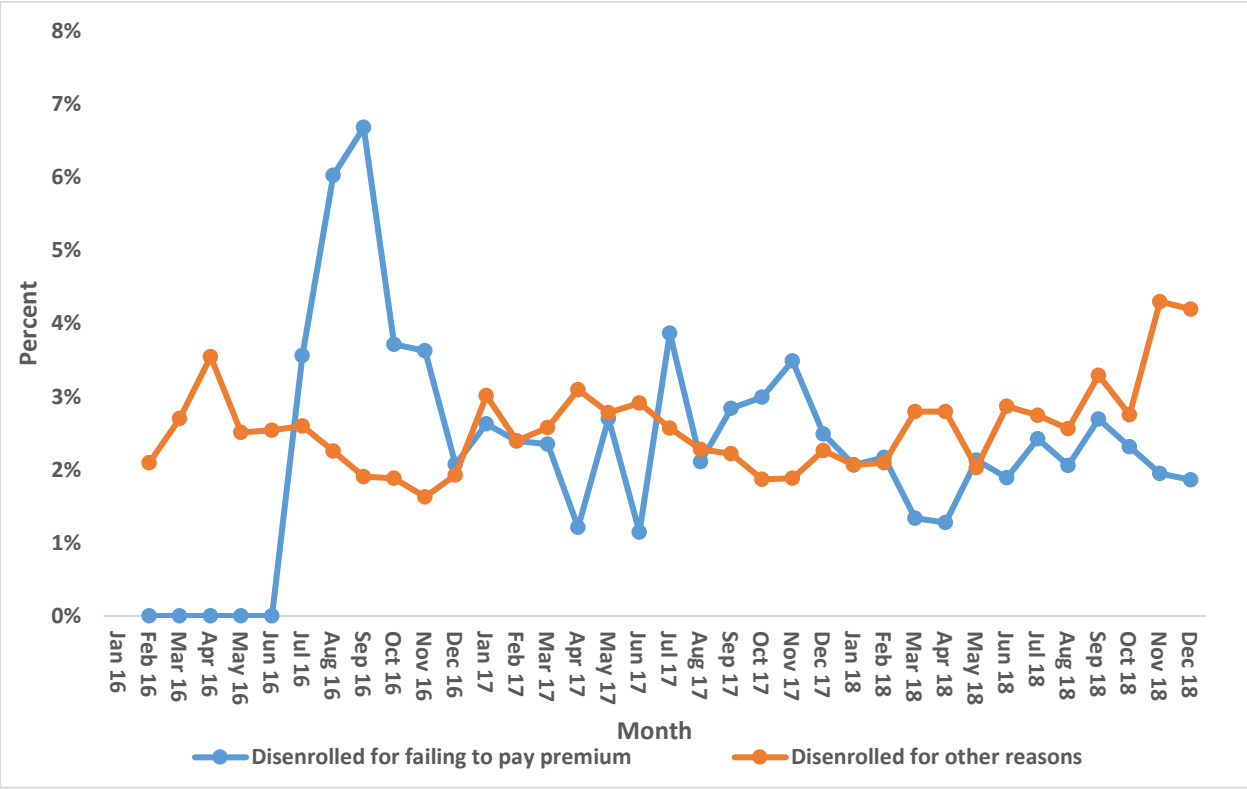
to be contributing. As one participant said, "I felt grateful because I feel like I should be paying something. They could charge me four times as much and it would still be half of what I was paying before." At the same time, some enrollees reported difficulty making their monthly payments. For example, one 2018 focus group participant shared, "I thought a $20 premium was a little high when I was unemployed." Program administrative data suggest that paying monthly premiums is challenging for many HELP enrollees, particularly those with the lowest incomes. In December 2018, for example, HELP data show that of the 18,862 enrollees who owed premiums, only 44.3 percent paid them that month. For enrollees with income between 51 and 100 percent FPL, 40.1 percent paid their premiums for the month, whereas 50.4 percent of those with income above 100 percent FPL paid.[33]

Even though timely premium payment is low among enrollees with incomes above 100 percent FPL who owed premiums and are subject to disenrollment for failing to pay their premium, disenrollment from HELP for failing to pay a premium has also been low (Figure II.3). After a spike in disenrollments for failing to pay premiums of almost 7 percent for a few months during the first year of HELP, such disenrollments fell to 1 to 4 percent of the caseload each month in 2017, and to 1 to 3 percent of the caseload each month in 2018, a level roughly comparable to other ACA waiver expansion states that have disenrollment policies for those who fail to make timely premium payments.[34] Disenrollments for other reasons has remained fairly steady over time for this group, at roughly 2 to 4 percent of the caseload.

[33] "HELP Program 1115 Waiver: Quarter 4 Measures December 2018 Data," data produced in the Annual Report for Demonstration Year 3, State of Montana, March 1, 2019, revised October 3, 2019.

[34] While the specifics for each waiver varies from state to state, among those reporting similar statistics, Montana's level of disenrollment for failure to pay premiums is comparable. In Iowa's demonstration, the Iowa Wellness Plan, among the 11,601 enrollees with incomes between 100 and 133 percent FPL who owed premiums in June 2018, 791 enrollees were disenrolled that month for non-payment of premiums, accounting for 6.8 percent of the monthly caseload. Similarly, in Wisconsin's demonstration, Wisconsin BadgerCare Reform, among the 18,439 Transitional Medical Assistance adults with incomes between 100 and 133 percent FPL, 792 were disenrolled that month for non-payment of premiums. This accounted for 4.2 percent of all disenrollments in December 2018, a rate that was consistent throughout the year. In Indiana's demonstration, the Healthy Indiana Plan (HIP) 2.0, among the 48,121 HIP members disenrolled from the program, 829 members were disenrolled for non-payment of Personal Wellness and Responsibility (POWER) account contributions in 2018, which accounted for 1.8 percent of all HIP disenrollments for the period covering January to March 2019. "Iowa Wellness Plan Quarterly Report 1115 Demonstration Waiver April 01, 2018 - June 30, 2018," Iowa Department of Human Services, May 2, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-apr-jun-2018.pdf; "Wisconsin BadgerCare Reform 1115 Waiver Demonstration Section 1115 Annual Report Demonstration Year 5", Wisconsin Department of Health Services, July, 8, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/Badger-Care-Reform/wi-badgercare-reform-final-annl-rpt-2018.pdf; "Healthy Indiana Plan Interim Evaluation Report, Prepared for the Indiana Family and Social Services Administration, Submitted by the Lewin Group, December 18, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf#page=250.

Figure II.3: Percent of HELP Enrollees with Income Greater than 100% FPL with a Premium Who Were Disenrolled, by Reason for Disenrollment, 2016-2018



Source: Authors' calculation using administrative enrollment data provided by Montana DPHHS.
Notes: FPL - Federal poverty level.

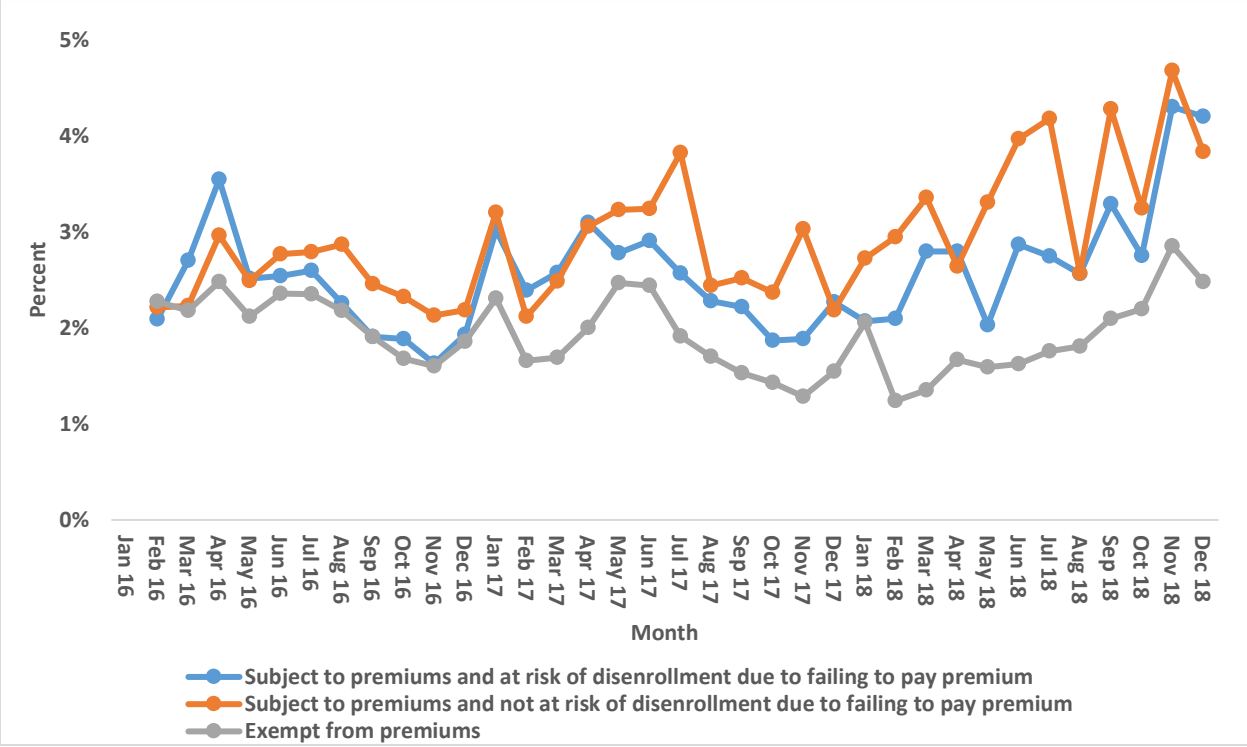
The level of disenrollments for reasons other than failing to pay a premium have tended to be higher for adults who were subject to premiums (regardless of whether or not they were subject to disenrollment for failing to pay their premiums) as compared to enrollees who were exempt from premiums (Figure II.4). While disenrollments for failing to pay premiums have been declining over time, disenrollments for reasons other than failing to pay premiums have been increasing for all three groups in 2018. Due to limitations in the data, however, we are not able to fully parse out reasons for disenrollment beyond failure to pay premiums.[35]

The characteristics of HELP enrollees with incomes above 100 percent FPL who were disenrolled for failing to pay premiums has also been fairly stable over time, especially after the first year of implementation 2016 (Table II.1). By 2017 and 2018, those disenrolled for failing to pay premiums tended to be younger (two-thirds under age 35 years), female, and living with other people. Many of those disenrolled for failing to pay premiums also reenrolled in HELP. Among those disenrolled for failing to pay their premiums in 2016, 15.7 percent had reenrolled by the end of 2016 and more than half had reenrolled by 2018. In both 2017 and 2018, more than 20 percent of those disenrolled for failing to pay

[35] For those who were disenrolled for reasons other than failure to pay premiums, Montana's administrative data include information on three additional reasons—failed living arrangement requirement, individual is incarcerated, and individual is not in the household. Reasons for disenrollment beyond these four are coded as missing, limiting the ability to assess more fully alternative reasons for disenrollment.

their premiums in a year had reenrolled by the end of that year. Among those disenrolled in 2018 for failing to pay premiums, 14.8 percent had reenrolled within 3 months of their first disenrollment in the year (data not shown).[36]

Figure II.4: Percent of HELP Enrollees Disenrolled for Reasons Other Than Failing to Pay Premium, by Month and Disenrollment Risk Status, 2016-2018



Source: Authors' calculations using administrative enrollment data provided by Montana DPHHS.

[36] For those with more than one disenrollment for failing to pay their premiums in 2018, we report on their first disenrollment.

Table II.1: Characteristics of HELP Enrollees with Incomes Above 100% FPL Who Owed Premiums and Were Ever Disenrolled for Failing to Pay Premiums, by Year, 2016-2018

	Disenrolled for Failing to Pay Premiums in 2016	Disenrolled for Failing to Pay Premiums in 2017	Disenrolled for Failing to Pay Premiums in 2018
Age at first month of enrollment (%)			
Less than 36 years	65.2%	66.8%	66.7%
36-50 years	24.9%	24.4%	24.3%
51-64 years	9.9%	8.9%	9.0%
Female (%)	48.8%	52.5%	54.8%
Household size at first month of enrollment (%)			
One person	49.5%	47.1%	45.6%
Two persons	20.6%	21.3%	22.5%
Three or more persons	29.9%	31.6%	31.9%
Whether reenrolled in HELP after *first* disenrollment for failing to pay premiums in year (%)			
By 2016	15.7%	N/A	N/A
By 2017	42.2%	21.8%	N/A
By 2018	50.3%	43.2%	23.2%
Sample size	2,205	2,688	2,220

Source: Authors' calculations using administrative enrollment data provided by Montana DPHHS. **Notes**: FPL = Federal poverty level; NA = Not applicable.

Table II.2 reports characteristics of those with incomes above 100 percent FPL who owed premiums in 2018 and disenrolled for any reason (column 1). It further reports characteristics by those who disenrolled due to not paying their premiums (column 2), and those who disenrolled for only reasons other than failing to pay their premiums (column 3).[37] As shown on the bottom line of Table II.2, among HELP enrollees with incomes above 100 percent FPL and subject to premiums in 2018, about a third (33.9 percent) were disenrolled for failing to pay premiums while two-thirds (66.1 percent) were disenrolled for reasons other than not paying their premiums.

[37] It is possible for an individual to enroll and disenroll more than once per calendar year and, consequently, possible to have more than one reason for disenrollment during the year. Individuals disenrolled multiple times per year, yet disenrolled at least once due to premium payment failure, are included in column 2. Those with only disenrollment reasons other than failure to pay premiums (including unknown reasons) are represented in column 3.

There were some notable differences between those who were disenrolled for failing to pay premiums and those disenrolled for other reasons. Those disenrolled for failing to pay premiums tended to be younger and from larger households than those disenrolled for other reasons. Those disenrolled for failing to pay their premiums were more likely to reenroll within 3 months than those disenrolled for other reasons.

Table II.2: Characteristics of HELP Enrollees with Incomes above 100% FPL Who Owed Premiums in 2018 and Were Disenrolled in 2018

	Disenrolled for Any Reason in 2018 (1)	Disenrolled for Failing to Pay Premiums in 2018 (2)	Disenrolled Only for Other Reasons in 2018 (3)
Age at first month of enrollment (%)			
Less than 36 years	63.6%	66.7%	61.9%
36-50 years	21.3%	24.3%	19.8%
51-64 years	15.2%	9.0%	18.3%
Female (%)	53.9%	54.8%	53.5%
Household size at first month of enrollment (%)			
One person	54.0%	45.6%	58.4%
Two persons	19.5%	22.5%	17.9%
Three or more persons	26.5%	31.9%	23.7%
Reenrolled in HELP within 3 months (%)	11.2%	14.8%	8.7%
Sample size	6,540	2,220	4,320
Percent of total (disenrolled for any reason)	100.0%	33.9%	66.1%

Source: Authors' calculations using administrative enrollment data provided by Montana DPHHS. **Notes:** For those with more than one disenrollment in 2018, we report on their first disenrollment.

While disenrollment for failing to pay premiums has been relatively low, a sizable minority of HELP enrollees has accrued debt owed to the State of Montana because of past due premiums. December 2018 data show that 29.5 percent of HELP enrollees who owed premiums that month also had collectible debt owed to the State of Montana.[38]

[38] "HELP Program 1115 Waiver: Quarter 4 Measures December 2018 Data," data produced in the Annual Report for Demonstration Year 3, State of Montana, March 1, 2019, revised October 3, 2019. Though not exactly comparable to Montana, Iowa's ACA Medicaid expansion waiver, Iowa Wellness Plan (IWP), has a similar debt collection feature and program data

Apart from thinking HELP is affordable and fair, most participants in the focus groups in both 2017 and 2018 said the HELP application process was easy to complete and most commonly enrolled in the program through one of the local state-operated Office of Public Assistance (OPA), a health care provider, or online. Focus group participants found renewing coverage even easier, involving mailing back a form informing the state of any changes to an enrollee's income or other circumstances. Importantly, because our focus groups were comprised of individuals currently enrolled in HELP, we do not know about the coverage renewal experiences of people no longer enrolled in the demonstration. Program data, however, suggest that renewal is a challenge for many: In a typical month in 2017, only about half of HELP enrollees up for redetermination renewed their coverage.[39,40] Enrollees who did not renew on time failed to do so because they either did not complete renewal paperwork in time to renew coverage, did not complete paperwork properly, did not provide required documentation, or were lost to follow-up.[41]

Although the application and renewal process was viewed favorably by enrollees in focus groups, a consistent problem reported in both 2017 and 2018 by focus group participants and health care providers was the length of time it took the state to make an eligibility determination for HELP and for enrollees to get their insurance identification card in the mail. While keeping within the federal required 45-day limit,[42] state officials acknowledged that processing Medicaid applications was taking longer than they preferred. Though a hiring freeze had previously prevented the state from replacing staff who left, one state official in our 2018 site visit told us they had recently received approval to hire more staff, which may speed up HELP application processing.

In our 2018 focus groups, we heard more about enrollment problems among participants who had an issue or a question about enrolling in, maintaining, or reactivating HELP coverage. Some HELP enrollees commented that it had become more difficult to obtain assistance from OPAs because many offices closed due to state budget problems. Participants, for example, described scenarios that prompted them to call or try to meet with OPA staff about HELP coverage or needing help to find out how to pay their premiums. Focus group participants reported that multi-hour hold times, sometimes up to 4 hours, can occur on the OPA-staffed helpline. For example, one focus group participant said, "When I first got

indicate a slightly greater but comparable share of enrollees with collectible debt. Iowa Wellness Plan program data for June 2018, for example, show that among the 11,601 enrollees with incomes above 100 percent FPL who were not exempt from premiums, 4,884 enrollees had premium debt that had been sent to collections, which accounted for 38.7 percent of IWP enrollees who owed premiums in the month of June. "Iowa Wellness Plan Quarterly Report 1115 Demonstration Waiver, April 01, 2018 - June 30, 2018", Iowa Department of Human Services, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-apr-jun-2018.pdf.

[39] "Montana HELP Program 1115 Waiver: Annual Reporting Measures for Second Demonstration Year," data produced in Appendix B of the Annual Report for Demonstration Year 2, State of Montana, August 8, 2018.

[40] Note that the State of Montana has revised the 2018 HELP program data available in Appendix B of the Annual Report for Demonstration Year 3. Accordingly, monthly program data for June 2018 through December 2018 show that only about 2 percent of those enrollees up for redetermination completed the renewal process.

[41] "Montana HELP Program 1115 Waiver: Annual Reporting Measures for Second Demonstration Year," data produced in Appendix B of the Annual Report for Demonstration Year 2, State of Montana, August 8, 2018; "Montana HELP Program 1115 Waiver: Annual Reporting Measures for Third Demonstration Year," data produced in Appendix B of the Annual Report for Demonstration Year 3, State of Montana, March 1, 2019, revised October 3, 2019.

[42] 42 CFR §435.912,

on [HELP], it was easy to get a hold of a person [same] day, within 30 minutes. Then… they changed their phone system… It took me four hours of being on hold and no one talked to me…"[43]

Another issue enrollees in focus groups reported was receiving limited education about how HELP coverage works. Indeed, when asked how HELP could be improved, focus group participants most often mentioned that they wished they had been given more information about the program. This sentiment was echoed by interviewees. One health care provider felt there was "a lot more that can and should be done to help with health insurance literacy," because many people gaining coverage through HELP have never had health insurance before and do not know what words like "copayments" mean. State officials acknowledged the problem and in 2018 were working on ways to improve enrollee education.

Stakeholder Assessment of the Effects of HELP

In our 2018 site visit, several interviewees noted that recently available data and reports suggest that HELP has achieved many goals stated in Montana's 2015 demonstration application, including increasing access to high-quality health care, encouraging Montanans to take greater responsibility for their health, reducing hospital uncompensated care costs, and boosting Montana's economy.

Many interviewees said the biggest achievement of HELP was providing coverage and access to health care to "100,000 lives in a state of a million people," as one state official put it. With the launch of HELP and associated expanded coverage, many interviewees also emphasized the number of enrollees using preventive services. In September 2018, the state reported that more than 85,000 demonstration enrollees had received preventive care since HELP began.[44] Some interviewees highlighted that HELP has been successful in getting enrollees to take responsibility for their health care as evidenced by how much has been collected in premiums and the demonstration's low disenrollment rate. Several participants in our focus groups reported that having HELP coverage and access to health care led to improvements in their health which allowed them to be more productive, such as one focus group participant who said, "It [HELP] has made me healthier and able to work." Other enrollees in the focus groups shared that HELP has allowed them access to needed care that they previously could not afford.

Apart from benefitting HELP enrollees, several interviewees commented that the demonstration has helped health care providers, particularly hospitals. One report states that between 2015 and 2016 hospitals' uncompensated care costs declined 44.9 percent, with further declines in 2017.[45] Federally Qualified Health Centers (FQHCs) have also received a boost from HELP, according to health care providers. "Medicaid expansion has been a [financial] game changer [for us]," as reported by one FQHC

[43] While some of the budget cuts enacted in July 2017 were restored to DPHHS, the State of Montana has not reversed any of the 19 closures of the Office of Public Assistance offices. "State Budgets Partially Restored, But Too Late for Livingston", *The Livingston Enterprise*, October 19, 2018, https://www.livingstonenterprise.com/content/state-budgets-partially-restored-too-late-livingston-0; "Field Offices of Public Assistance", MT DPHHS, no date, accessed on April 14, 2020, https://dphhs.mt.gov/hcsd/officeofpublicassistance.

[44] "Montana Medicaid Expansion Dashboard," MT DPHHS, October 4, 2018, https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard.

[45] "Medicaid Expansion: How It Affects Montana's State Budget, Economy, and Residents," Manatt Health, June 2018.

executive. More broadly, several interviewees mentioned recent studies that highlight how HELP has economically benefitted Montana.[46,47]

Summary of Implementation Findings

Findings from the qualitative component of the evaluation indicate that Montana was successful in implementing the core components of HELP in a timely and effective way. State officials, health care providers, provider associations, consumer advocates and non-state observer interviewees universally viewed HELP as a major Medicaid expansion with just a few glitches. Enrollees in our focus groups agreed. Interviewees stressed the importance of compromise among health care stakeholders to reach a consensus on the design of HELP, one that could pass muster in the Montana legislature.

Initial outreach for HELP was viewed as a success in large measure because of the collaborative relationship established between the state and Montana health care stakeholders. Reflecting this, enrollment in the demonstration ramped up quickly and reached more than 70,000 within the first year—a number the state had originally projected would take 4 years to achieve. As of September 2018, nearly 100,000 Montanans were enrolled in HELP. Interviewees representing all stakeholder categories and focus group enrollees described access to care provided under HELP as being good. Several focus group participants commented how HELP has improved their health and wellbeing. In addition, stakeholders universally viewed HELP premiums as affordable, and enrollees in focus groups agreed that premiums were affordable and fair. However, HELP administrative data indicate that many enrollees do not pay their premiums, suggesting that premiums may be challenging for some. In the meantime, many enrollees have accrued debt owed to the state because of past due premiums.

While on balance interviewees and enrollees in focus groups viewed HELP favorably, they also identified some problems with the demonstration. A consistent issue reported in both 2017 and 2018 by focus group participants and health care providers was the length of time it took the state to make an eligibility determination for HELP and for enrollees to get their insurance identification card in the mail. In part this could reflect the fallout from the state hiring freeze and the closure of several OPAs due to Montana's budget problems that started in 2018. In addition, focus group participants and external stakeholders in both 2017 and 2018 said that the state provides only limited education about how HELP works, with focus group participants often mentioning that they wished they had more information on the program. Though Montana officials in our 2017 site visit maintained that enrollee education was sufficient, by 2018 the state had started working on developing strategies to improve enrollee education.

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[46] "2018 Report to the Governor and Legislative Finance Committee," HELP Act Oversight Committee, submitted August 2018; "Medicaid Expansion: How It Affects Montana's State Budget, Economy, and Residents," Manatt Health, June 2018; "The Economic Impact of Medicaid Expansion in Montana," The Bureau of Business and Economic Research, April 2018, https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf; and "The Economic Impact of Medicaid Expansion in Montana: Updated Findings," The Bureau of Business and Economic Research, January 2019, https://mthcf.org/wp-content/uploads/2019/01/Economic-Impact-of-MedEx-in-MT_1.28.19-FINAL.pdf.

[47] According to the Bureau of Business and Economic Research's 2019 Report, researchers employed a forecasting model to predict the impact of Medicaid expansion on Montana's economy. Based on that forecasting model, HELP is predicted to have brought at least $600 million in new spending to the state each year, which in 2020 is predicted to have generated $350 million in personal income and more than 6,000 new jobs.

Importantly, the work presented here is descriptive and thus does not provide definitive evidence on the impacts of the demonstration, but the qualitative findings suggest that Montana has made headway on some major goals set out for HELP. Most prominently, interviewees across the board report that HELP extended Medicaid coverage and provided stable access to care to nearly 100,000 additional individuals, which is about 10 percent of Montana's total population.

III. Beneficiary Surveys

The purpose of the HELP beneficiary surveys is to enable the evaluation team to answer the following fundamental research questions:

- What are beneficiaries' experiences under HELP, including premiums and copays, and health care access and affordability?
- To what extent do beneficiaries understand how the HELP plan works, including premiums and copays, and nonpayment premium consequences?
- How do experiences vary for HELP enrollees and disenrollees, and for key population subgroups (e.g., based on age, income, health status)?

To fully assess the impact of the program and provide additional context for the impact analyses, SSS designed and implemented surveys of HELP beneficiaries who were nonexempt from the demonstration. Two waves of the survey were conducted. Findings from surveys of HELP current and former enrollees and their knowledge and experiences with the plan for the period January 2016-November 2017 are presented in the Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Evaluation Report referenced earlier. This chapter presents the findings from the second wave of surveys covering the period December 2017–November 2018, and includes a comparison of the results from the second wave with the initial wave of surveys conducted from January 2016-November 2017.

Overview of the Survey Approach

We conducted a mixed-mode (mail and web) survey of individuals who were enrolled in the Montana HELP program as of April 2018, and another mixed-mode (mail and web) survey of individuals who had been previously enrolled but had disenrolled from that program as of April 2018.[48] Survey questions covered five major topic areas, also called domains. Substantive domains reflecting priority policy areas include: *beneficiary understanding*, *beneficiary experience*, *affordability*, *access to care, and satisfaction with HELP*. These topics for evaluation were identified to help assess beneficiary understanding and experience in HELP across both the enrollee and disenrollee versions of the survey.

The sample frames for the enrollee and the disenrollee survey were derived from the State of Montana HELP administrative database. We developed processing rules for the administrative data to best approximate our inclusion/exclusion criteria for the sample frame for the survey using the information available. The enrollee survey sample frame consisted of all individuals aged 19-64 who resided in Montana and were enrolled in the HELP program in April 2018 and had indication of enrollment in each of the prior 5 months. This definition was intended to capture individuals who were currently enrolled and had been enrolled for at least 6 months to have experience with the HELP program.

The disenrollee sample frame consisted of all individuals aged 19-64 who had been enrolled in Montana HELP at some point during the previous 6 months (October 2017 – March 2018) and were listed as

[48] Further details about the survey methodology are presented in Appendix A.

disenrolled from the HELP program as of April 2018. We excluded anyone whose first enrollment in the program occurred more than 12 months prior to the time of sample frame determination (April 2018).

Weighting of the enrollee and disenrollee survey data produced estimates representative of their respective sampling frames. In particular, we compared respondents and non-respondents on available demographic factors of sex, race, age group, urban/rural residence, and FPL category. For each survey, sample weights were developed to account for the probabilities of selection and to adjust for known ineligibility and nonresponse to reduce potential bias. All reported results are from analysis of weighted surveys. More information on survey methodology and design is presented in Appendix A.

Survey Administration

The survey field period began in July 2018 with an initial survey packet mailed to enrollees and disenrollees, and continued for 20 weeks. The survey packet included a cover letter notifying them of survey selection and explaining the purpose of the survey. Also included in the survey packet were an invitation with a URL to the web version of the survey, a printed survey questionnaire, and a stamped pre-addressed return envelope. The survey fieldwork continued with additional mailings and telephone follow-up by trained interviewers through late fall 2018. We concluded the field period on November 30, 2018.

Survey Sample and Response Rates

The sample frames (i.e., the lists of individuals meeting the inclusion criteria, and thus eligible to be sampled) for the enrollee and the disenrollee survey were derived from the State of Montana HELP administrative database. At the time of sample frame creation, we used HELP program participation records from the database for each month during December 2016 – April 2018. Any individual who participated in the HELP program at any time during that period was included in the database.

We randomly sampled 2,187 enrollees and 1,745 disenrollees from the sample frame. A sample size of 2,187 was designed to yield 700 completed surveys; however, the disenrollee sample size was limited to 1,745 due to the low number of eligible individuals in the sample frame. We targeted 700 completed enrollee and disenrollee surveys, since power calculations indicated that it would be necessary to garner this number of completed surveys for the analysis to detect differences between sub-groups within each respondent group. We anticipated that disenrollees would be difficult to reach and/or be less likely to respond, and that the targeted response rate would be challenging to achieve.

A total of 770 individuals (35.2 percent) of the enrollee cohort submitted an enrollee survey form. This response rate is comparable to that seen in other surveys of Medicaid enrollees. For the disenrollee survey, only 152 individuals (8.7 percent) in the sample returned a disenrollee survey. Low response rates have been seen in other surveys targeting subjects with low socioeconomic status. Also, this low response rate may be attributable to a combination of factors including disenrollees being difficult to locate and disenrolled respondents' status changing back to being enrolled during survey field period, thereby excluding them from answering the disenrollee survey. We anticipated that the low response rates might be an indicator of non-response bias. Therefore, we tested for non-response bias that among disenrollees there were no significant differences between the respondents and non-respondents on the demographic factors examined. For the enrollee population, the only statistically significant difference we found on the five observable characteristics between respondents and non-respondents was for age group. Survey responses were weighted to compensate for bias introduced by

these differences between the respondents and non-respondents. For the disenrollees, the impact on the analysis is that the smaller response rate reduced our statistical power to find differences between groups.

Based on our experience with the wave 1 survey, we increased the survey operations team's efforts for the wave 2 survey fielding to reach additional disenrollees, as well as the enrollees. These efforts included calling disconnected and non-working numbers again to determine if the line is connected or working again and accessing directory assistance for those in the survey sample who had a disconnected phone status. We also knew from wave 1 that respondents were not always aware of their enrollment status. We added more probes for the wave 2 telephone interviewers to clarify enrollee/disenrollee eligibility for the HELP survey.

We calculated response rates based on complete survey submissions received through November 30, 2018 where, as long as the respondents answered at least one question in addition to the screening questions, we considered it a response and included all answered questions in the analysis. Considering the low response rate, we saw no reason to discard any information that was provided. Response rates for the primary questions (those not subject to being skipped based on other answers) were generally 90-95 percent.

Sample Characteristics

Table III.1 shows self-reported demographic features of the 770 enrollee and 152 disenrollee survey respondents. Of the HELP enrollees, about 57 percent were female. While over one-third of enrollee respondents were between the ages of 25-34 years, the rest were roughly evenly distributed among the remaining age groups. Over one-third of enrollees were employed full-time, and over 40 percent had at least some high school or had graduated from high school. The vast majority of enrollee respondents were White. With respect to self-reported health status, just over half of enrollee respondents reported being in excellent or very good health.

In the case of the HELP disenrollees, 65 percent were female. Over 40 percent of the disenrollees were between 25 and 34 years of age and more than half were employed full-time, while one-third only had a high school education (or less). Eighty-nine percent of disenrollees were White. A little over one-half of disenrollees reported being in excellent or very good health.

Table III.1: Self-Reported Characteristics of Enrollees and Disenrollees

	Enrollees (N=770)		Disenrollees (N=152)	
	N	Weighted Percent†	N	Weighted Percent†
Sex				
Female	446	57% (1.84)	96	65% (3.91)
Age				
18-24	74	12% (1.26)	23	16% (3.08)
25-34	233	34% (1.79)	63	45% (4.13)
35-44	145	19% (1.45)	26	18% (3.18)
45-54	114	14% (1.21)	17	10% (2.45)
55 and older	192	20% (1.34)	19	8% (1.85)
Employment Status				
Employed, full-time	289	39% (1.81)	76	52% (4.12)
Employed, part-time	187	24% (1.57)	24	16% (2.99)
Self-employed	135	17% (1.37)	14	8% (2.19)
Student or Homemaker*	57	8% (1.00)	5	4% (1.62)
Unable to work for health reasons	33	4% (0.64)	5	2% (0.96)
Unemployed	54	6% (0.88)	24	16% (3.02)
Highest Level of Education Completed				
8th grade or less	29	4% (0.70)	3	2% (1.12)
Some high school/high school graduate or GED	308	41% (1.82)	51	34% (3.91)
Some college or 2-year degree	281	36% (1.76)	56	37% (3.98)
4-year college graduate	97	12% (1.21)	26	18% (3.17)
More than 4-year college degree	43	6% (0.87)	13	8% (2.16)
Self-Reported Health Status				
Excellent	122	16% (1.38)	19	13% (2.77)
Very Good	275	37% (1.79)	60	40% (4.04)
Good	231	29% (1.66)	50	32% (3.84)
Fair	107	13% (1.23)	16	10% (2.48)
Poor	23	3% (0.56)	4	3% (1.42)
Race				
White	721	94% (0.89)	136	89% (2.54)
Other	26	3% (0.65)	10	7% (2.06)

†Percentages may not add to 100 due to missing values.
***Note**: Employment status categories "Student" and "Homemaker" have been combined into one category.
Standard error in parentheses.

Survey Data Analysis

Based on the enrollee and disenrollee data files, the evaluation team developed tabular analyses to assess overall awareness and understanding of the HELP program among enrollees and disenrollees. We also present their responses to questions about their experiences accessing health care while in HELP and after leaving HELP. Weighting of the enrollee and disenrollee survey data produced estimates representative of their respective sampling frames. Analyses consisted of univariate and bivariate statistics on key evaluation questions, complemented by statistical tests where comparison of subgroups were relevant and appropriate.

As sample sizes permitted, we conducted analyses by key demographic features. In addition to sex, subgroups consisted of age, employment status, educational background, urban/rural residence, and FPL. Given the small number of respondents, particularly among disenrollees, we had to consolidate some of these demographic categories to allow subgroup sample sizes large enough to run statistical significance tests. Accordingly, these demographic variables were consolidated to two levels each:

1) Sex (Male; or Female)
2) Age Group (19-44 years; or 45+ years)
3) Educational Attainment (Some high school/high school diploma; or some college/college graduate)
4) Employment status (Any employment; or No employment)
5) Residence (Rural; or Urban)
6) Federal poverty level (>50-100 percent; or >100-133 percent)

Z scores and other tests of significance, as appropriate, were used to determine whether enrollee and disenrollee subgroups differed statistically with respect to the key variables that measure understanding, access, affordability, and satisfaction with the HELP program. Statistical significance was defined as any comparison with $p<0.05$.

In addition, we also looked at key measures within the previously-outlined domains for different subgroups including by age, sex, educational attainment, FPL, and employment status. Because of the small sample size associated with the disenrollee sample, particularly when stratified by demographic subgroups, estimates may appear to be different but are not statistically significantly different due to large standard errors.

Survey Findings

The remainder of this chapter contain the descriptive analyses from the follow-up beneficiary surveys and comparisons between the wave 1 and wave 2 survey results. The chapter ends with a discussion of the survey results and the survey limitations.

For the descriptive analyses, we present key survey findings below separately by enrollees and disenrollees. We report key findings for respondent characteristics and for each of the following survey domains; understanding/awareness of the HELP program; access to care while in HELP and after leaving HELP; affordability of HELP; and satisfaction with the HELP program. At the end of each domain section, we present the key takeaways from the analysis. Because of the differences between enrollees and disenrollees including different inclusion/exclusion criteria for survey participation, the study is not designed for cross-comparisons between the two groups. However, the analysis looks at similar issues

for the two groups including each group's knowledge of and satisfaction with the program, as well as how it affected their access to health care.

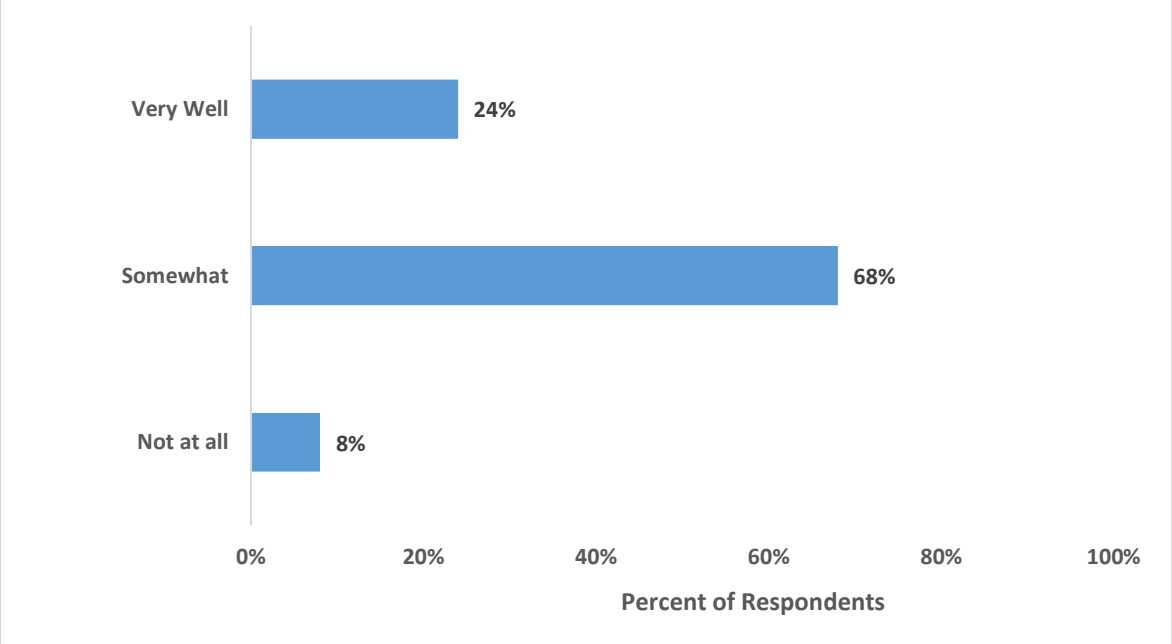
Enrollee Experiences with and Perception of HELP

The enrollee results for this domain about the respondents' experiences and awareness of the HELP program are grouped into three segments: understanding of the HELP program, understanding of premiums and copays by self-reported overall understanding of HELP, and seeking information about HELP. The survey questions in this domain examine how well beneficiaries understand their copays and monthly premiums, and the consequences of premium non-payment, as well as whether or not they tried to access information about HELP that would enable them to understand the various elements of the program.

Understanding of the HELP Program

When asked about their overall understanding of the HELP program, the majority of enrollee respondents said they only understood the program "somewhat well" (Figure III.1). This is consistent with enrollee responses to questions about their understanding of the specific features of the HELP program.

Figure III.1: Overall Understanding of HELP

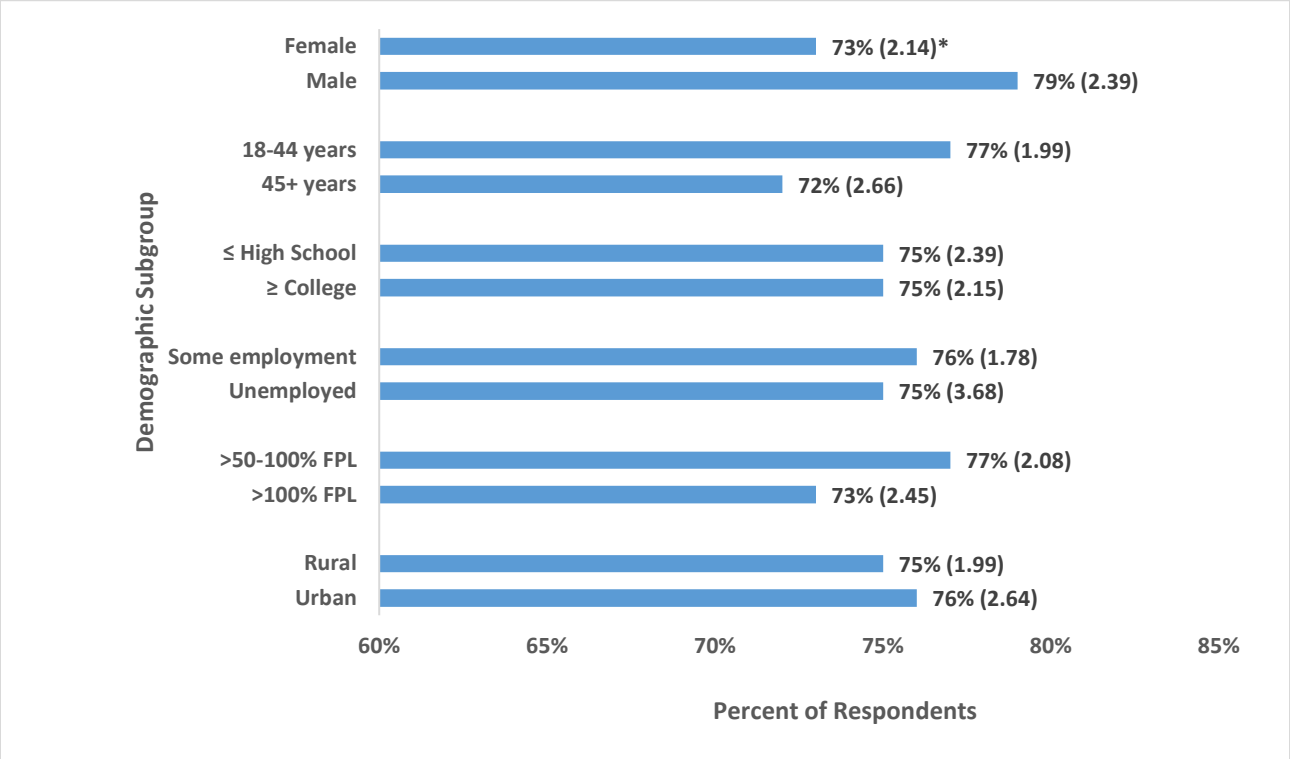


Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Weighted proportions presented in chart.

A significantly smaller proportion of females reported that they only understood HELP somewhat or not at all relative to males (Figure III.2). Respondents did not differ significantly on other demographic characteristics when reporting that they understood the HELP program somewhat/not at all well. Given the minimal variation we note for questions about enrollee "understanding of HELP" when stratified by

subgroups, for the rest of the questions we will present them for enrollees overall, and not by demographic subgroups.

Figure III.2: Understanding of HELP by Demographic Subgroup

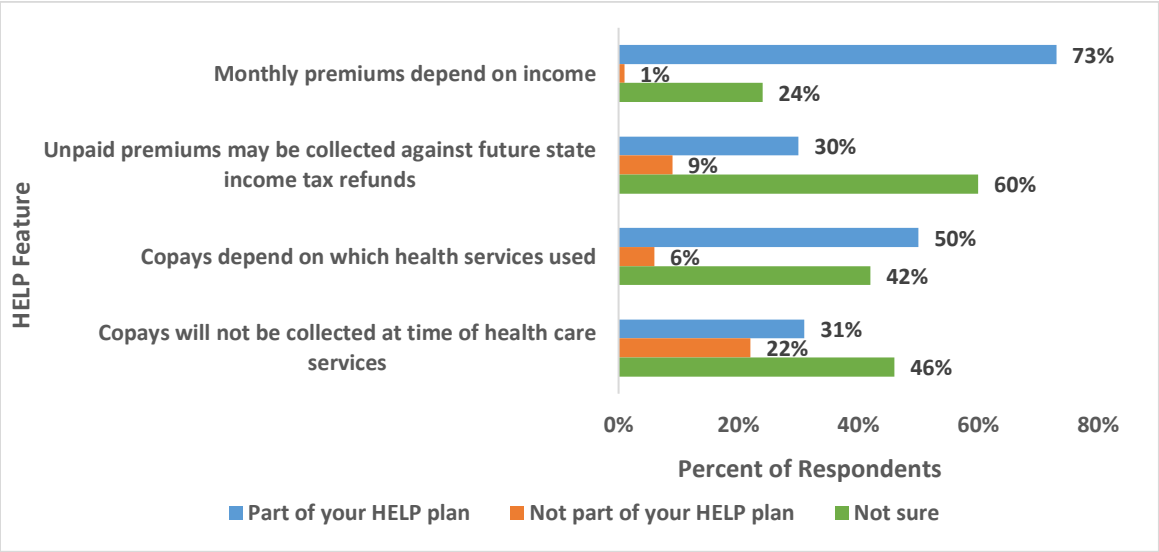


Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Standard errors in parentheses; * indicates statistically significant differences at the p <0.05 level.

Figure III.3 displays respondents' understanding of HELP premium and copay policies. The HELP plan features that enrollees were most familiar with included monthly premiums being a function of income, and copays depending on the particular health care services that are used.

However, far fewer respondents demonstrated awareness of the other features of HELP such as the aspect that copays would not be collected at the time of health care services.

Figure III.3: Understanding of HELP Premiums and Copay Features

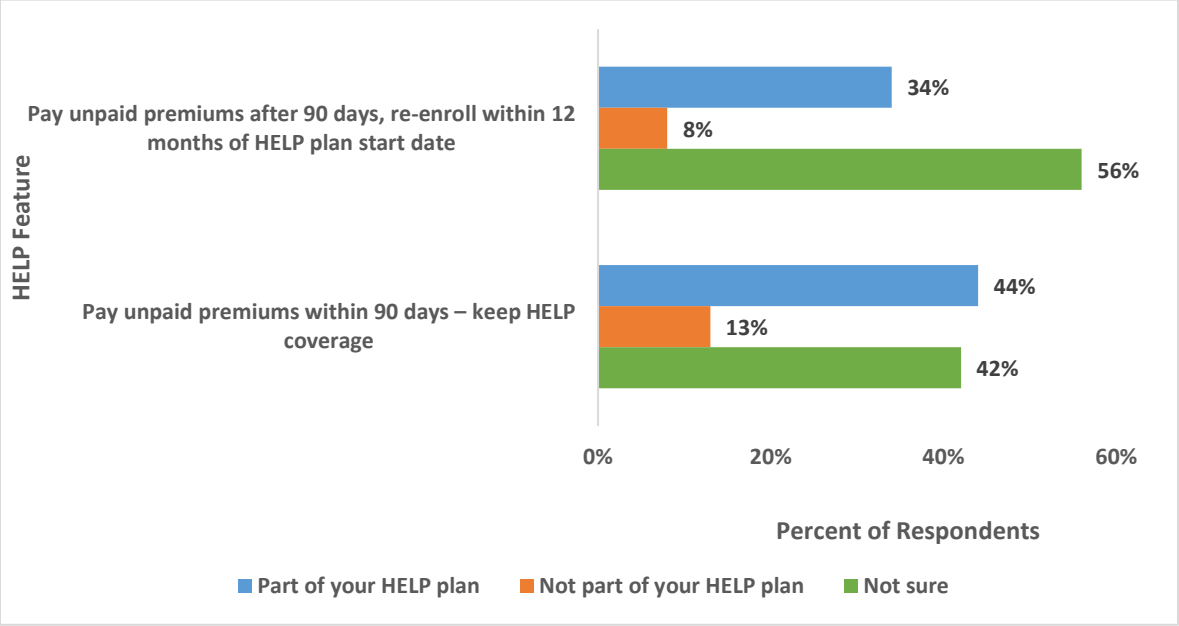


Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.

Figure III.4 examines whether enrollees understood the specificities about the monthly premium payment features of the HELP plan. This question was asked only of enrollees who indicated that they knew their HELP coverage would end as a result of non-payment of premium within 90 days.

Of enrollees who indicated they knew their coverage would end as a result of non-payment of premium within 90 days, less than half were aware that paying unpaid premiums within 90 days would enable them to retain HELP coverage. Of these same enrollees, only about one-third were aware that paying unpaid premiums after 90 days would allow them to re-enroll within 12 months of their HELP plan start date.

Figure III.4: Understanding of the Unpaid Premium Payment Policies and Their Linkage to HELP Coverage



Source: Survey of HELP enrollees covered between December 2016 – April 2018; these questions were asked only of enrollees who reported that HELP coverage would end if premium is not paid within 90 days, **N**=527.
Note: Weighted proportions presented in chart.

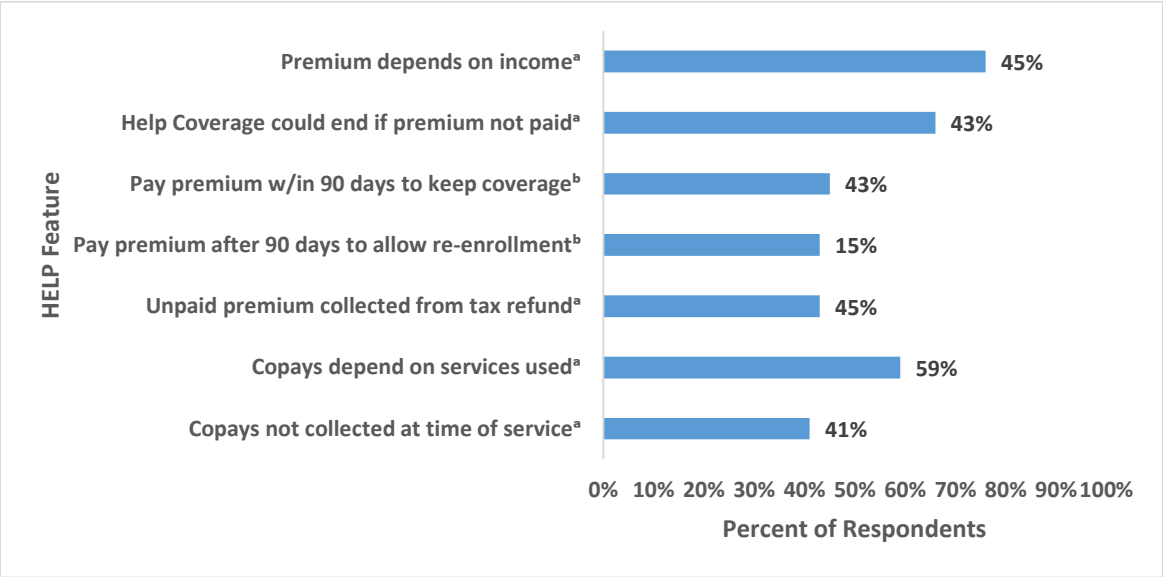
In total, responses to questions about the details of the program indicate that enrollees are either unaware of or do not fully understand the nuances of the program.

Understanding of HELP Premiums and Copays by Self-Reported Overall Understanding of HELP

Several survey questions asked the enrollees about some of the important details of the HELP program. As noted previously, over one-third of enrollee respondents claimed to understand HELP at least "somewhat well," while almost one-quarter claimed to understand HELP very well. We were interested in examining whether this self-assessment about enrollees' overall understanding of HELP was consistent with enrollees' responses to questions about the specific features of the HELP program.

Enrollees' functional understanding of premium payment policies relative to self-reported understanding of HELP is displayed in Figure III.5. In general, self-reported understanding of HELP was positively correlated with functional understanding, although the level of demonstrated understanding differed considerably across topic areas. For example, 66 percent of those who reported understanding "Very well" knew that non-payment of HELP premiums could lead to disenrollment from HELP. Furthermore, only this subgroup of enrollees, who knew HELP coverage could end if monthly premiums are not paid, continued to questions about premium payments within and after 90 days to keep coverage and to allow re-enrollment in HELP, respectively. Figure III.5 shows that for enrollees who reported understanding HELP "Very well" within this subgroup (N=125), less than half of them knew that HELP coverage could be kept if unpaid premiums were paid within 90 days and that re-enrollment would be allowed if premiums were paid after 90 days, 45 percent and 43 percent, respectively.

Figure III.5: Functional Understanding of Premium Payment Policies Relative to Self-Reported Understanding of HELP



Source: Survey of HELP enrollees covered between December 2016 – April 2018; [a] enrollees who self-reported understanding HELP "Very well," **N**=188; [b] enrollees who self-reported understanding HELP "Very well" and who reported that HELP coverage could end if premium not paid, **N**=125. **Note:** Weighted proportions presented in chart.

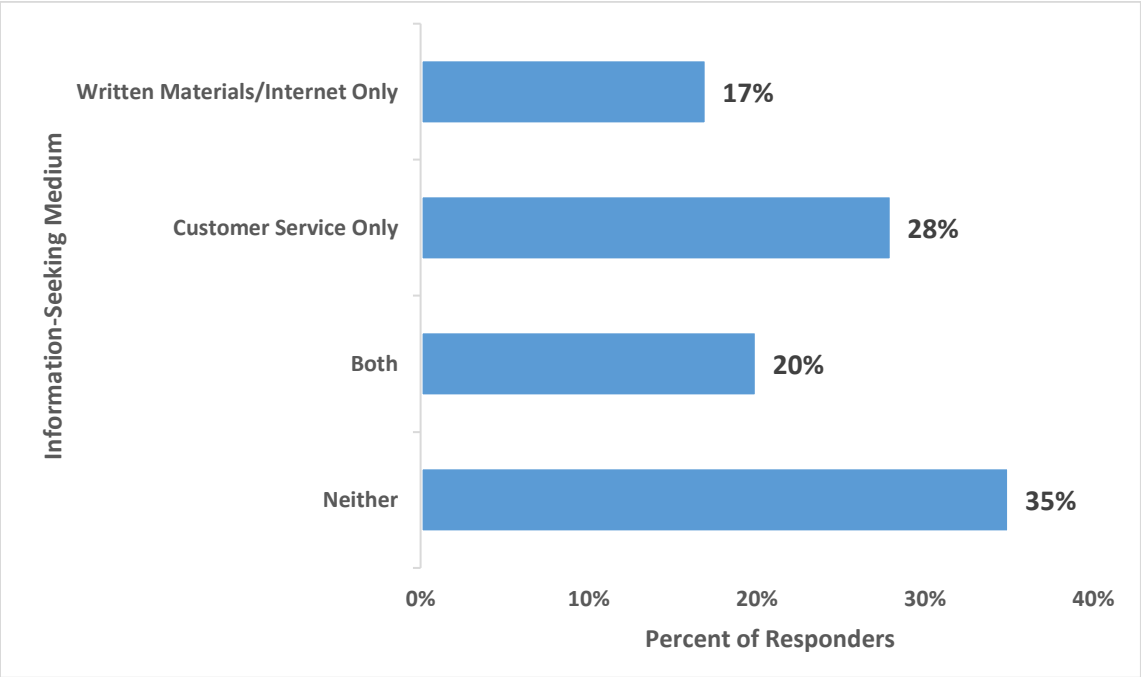
Information-Seeking about HELP

As part of the implementation of HELP, the state of Montana was required to perform an outreach and education campaign to provide information about the program to newly eligible beneficiaries. Since wave 2 of the beneficiary survey was conducted after the state had eliminated the TPA plan, the state was responsible for conducting any outreach to enrollees. In this section, we explore whether respondents sought to avail themselves of the informational materials and services.

Respondents were asked about their information-seeking behavior and whether or not they searched for information in written materials or on the internet about the HELP plan, or if they tried to get information or help from a customer service representative. As the information presented above in Figures III.4 and III.5 show, it appears that functional understanding of HELP was incomplete, at best, among enrollees. This section examines whether enrollees sought assistance in understanding HELP through either internet searches or telephone customer support.

Overall, most enrollees sought some information about the HELP program. About one fifth sought information from both customer service as well as written materials/internet (Figure III.6). About 35 percent of individuals sought no information about HELP. The design of the survey did not include specific questions about the content of the information requests.

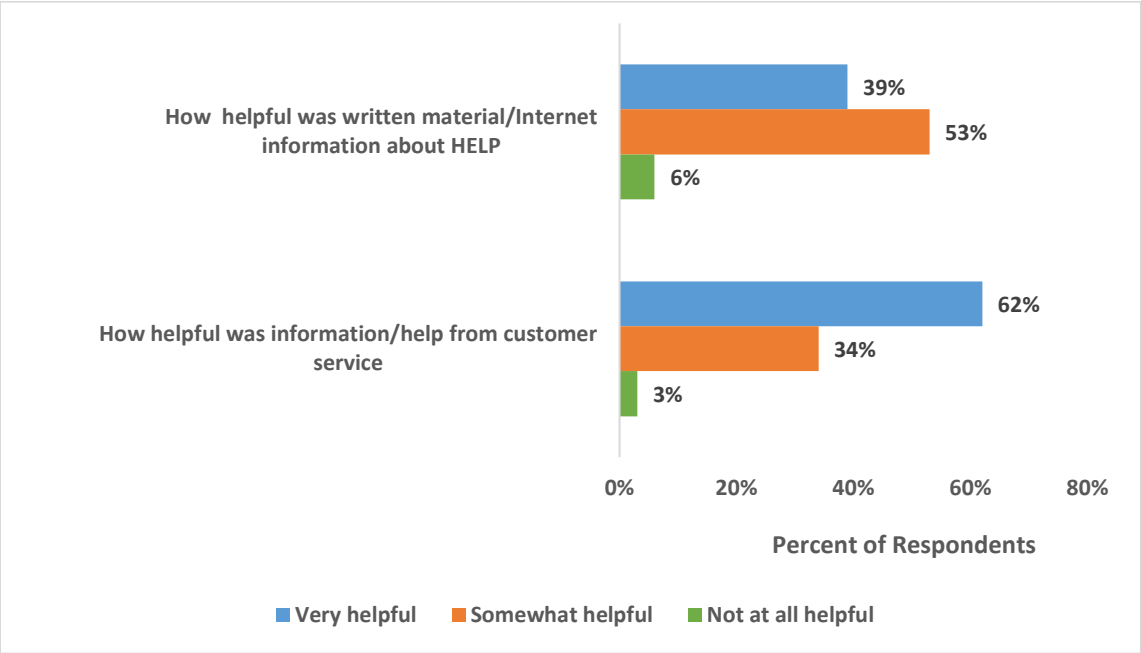
Figure III.6: Information-Seeking About HELP



Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Weighted proportions presented in chart.

A larger proportion of respondents reported information/help received from a customer service representative was very helpful (62 percent) compared to 39 percent who said they found the written materials/internet information about HELP to be very helpful (Figure III.7).

Figure III.7: Helpfulness of Information Regarding HELP Among Those Who Sought Information/Assistance



Source: Survey of HELP enrollees covered between December 2016 – April 2018**;** enrollees who reported looking for written material/internet information, **N**=281; enrollees who reported receiving information/help from customer service, **N**=367.
Note: Weighted proportions presented in chart.

Key Takeaways for Understanding of HELP

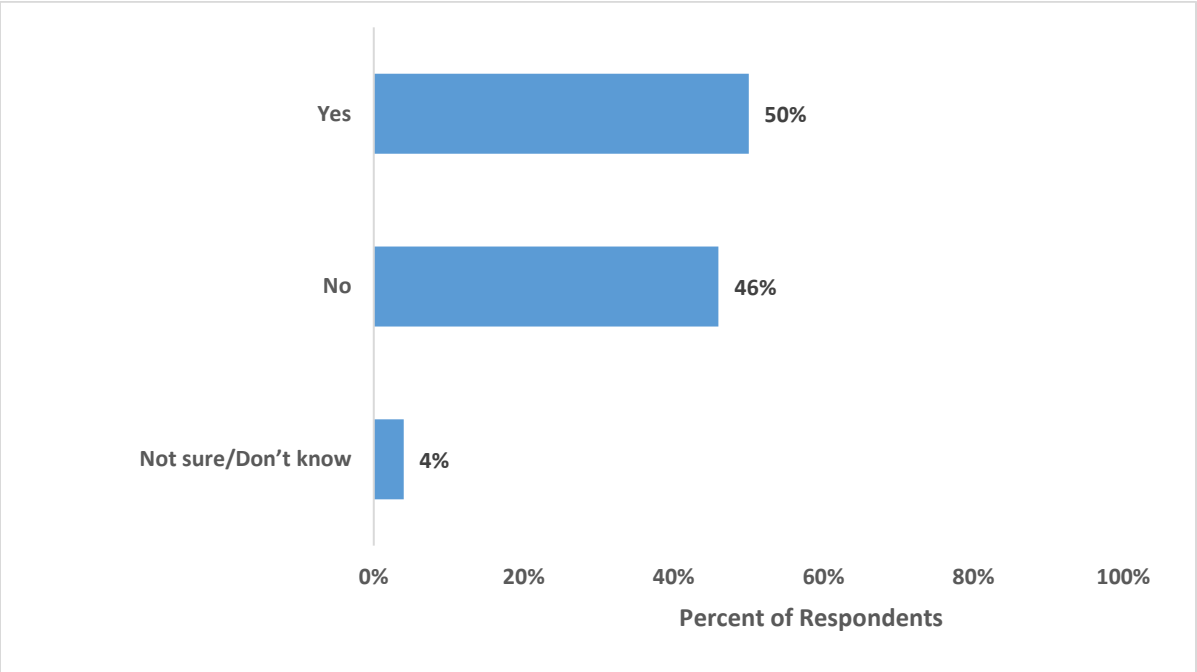
In general, while a large proportion (68 percent) of enrollee respondents reported that they understood "somewhat well" how HELP works overall, their responses to questions on individual program features continued to demonstrate an incomplete understanding of program specifics. In addition, a greater proportion of respondents (44 percent) reported being aware of features such as paying unpaid premiums within 90 days would help them retain HELP coverage. However, we noted that while two-thirds of enrollees had sought information, either via the internet or telephone customer support, about HELP, it appears that enrollees' understanding of the program's nuances was not necessarily improved despite having accessed additional information, or despite an improved understanding they may still be uncertain about program nuances.

Cost as a Barrier to Accessing Care

In this section, we examined whether the premium and copayments features of HELP posed a barrier to access to care for enrollees, including a segment with results by demographic subgroups.

Eighty-eight percent of enrollees said they did not face any cost barriers to accessing care. Only 11 percent mentioned not being able to get health care due to cost considerations in the past 6 months (Table B.8). Of the 11 percent reporting any barriers to access due to cost, 61 percent reported problems accessing dental care and 44 percent reported problems accessing vision care. As shown in Figure III.8 below, about half of enrollees reported having had health insurance prior to enrolling in HELP.

Figure III.8: Had Any Health Insurance in 12 Months Prior to Enrolling in HELP



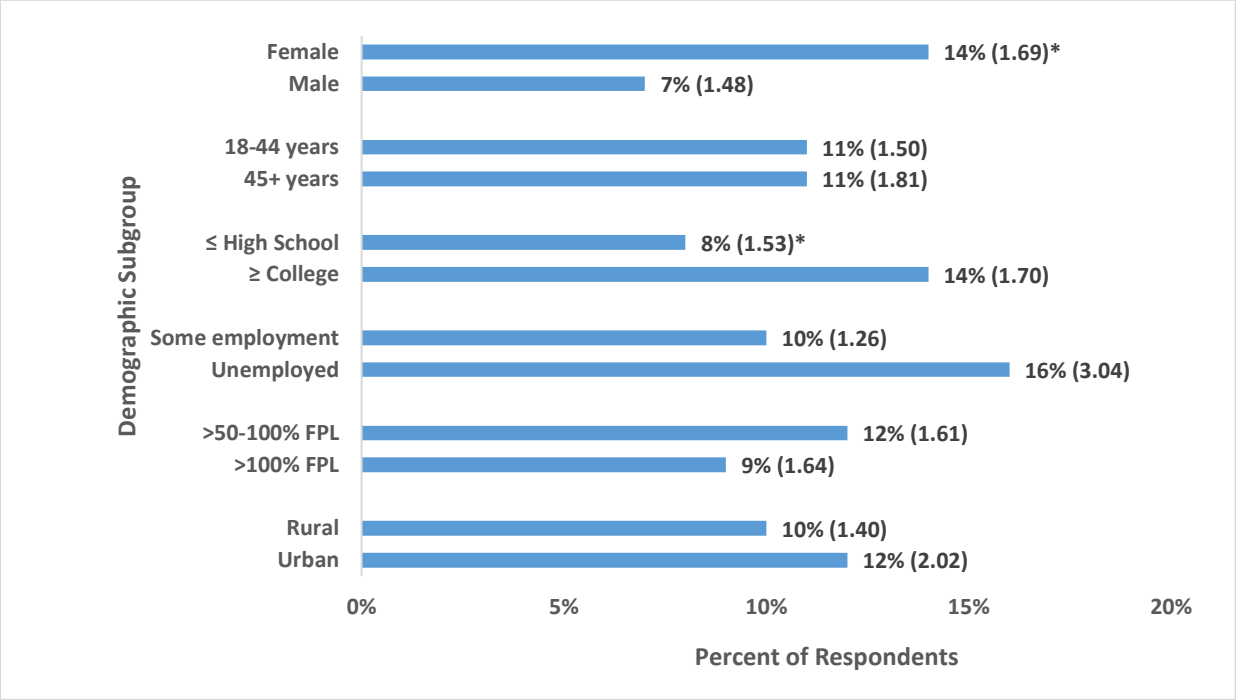
Source: Survey of HELP enrollees covered between December 2016 – April 2018. **N**=770.
Note: Weighted proportions presented in chart.

Of enrollees who had health insurance prior to HELP, 78 percent had health insurance for all 12 months prior to enrollment in HELP, and 60 percent had received some preventive care prior to enrolling in HELP. In addition, we examined whether cost considerations had acted as a barrier to accessing specific types of care after enrollment in HELP, including visits to health professionals, getting a prescription, and preventive care to name a few. We found that 71 percent of enrollees reported having gone to a health professional or getting a prescription in past 6 months.

Cost as a Barrier to Access by Demographic Subgroups

Figure III.9 shows the percentages of enrollees, by demographic groups, who reported that they did not get some needed care due to concerns over cost. Among those who responded that they could not access needed health care in the last 6 months due to cost considerations, significant differences were found in the gender and the level of education subgroups. Females (14 percent) were twice as likely as males (7 percent) to report not being able to access care. Enrollees with at least some college education (14 percent) were also significantly more likely to report cost as a barrier to accessing care than enrollees with a high school graduate education or lower (8 percent).

Figure III.9: Cost as a Barrier to Accessing Needed Care by Demographic Subgroups



Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Standard errors in parentheses; * indicates statistically significant differences at the p <0.05 level; weighted proportions presented in chart.

Key Takeaways on Cost as a Barrier

Among HELP enrollees, cost does not appear to be a barrier to accessing care, as only 11 percent of enrollee respondents mentioned not being able to get health care due to cost considerations in the past 6 months. This is consistent with other nationwide studies that show that Medicaid enrollees in general report low rates of being unable to access medical, specialty, dental/vision care, or prescription drugs due to cost, particularly compared to uninsured adults.[49] For the 11 percent of respondents not able to get health care due to cost, dental and vision care were more problematic, with a large proportion of these enrollee respondents reporting being unable to access dental care (61 percent) and/or vision care (44 percent).

Affordability of the HELP Program

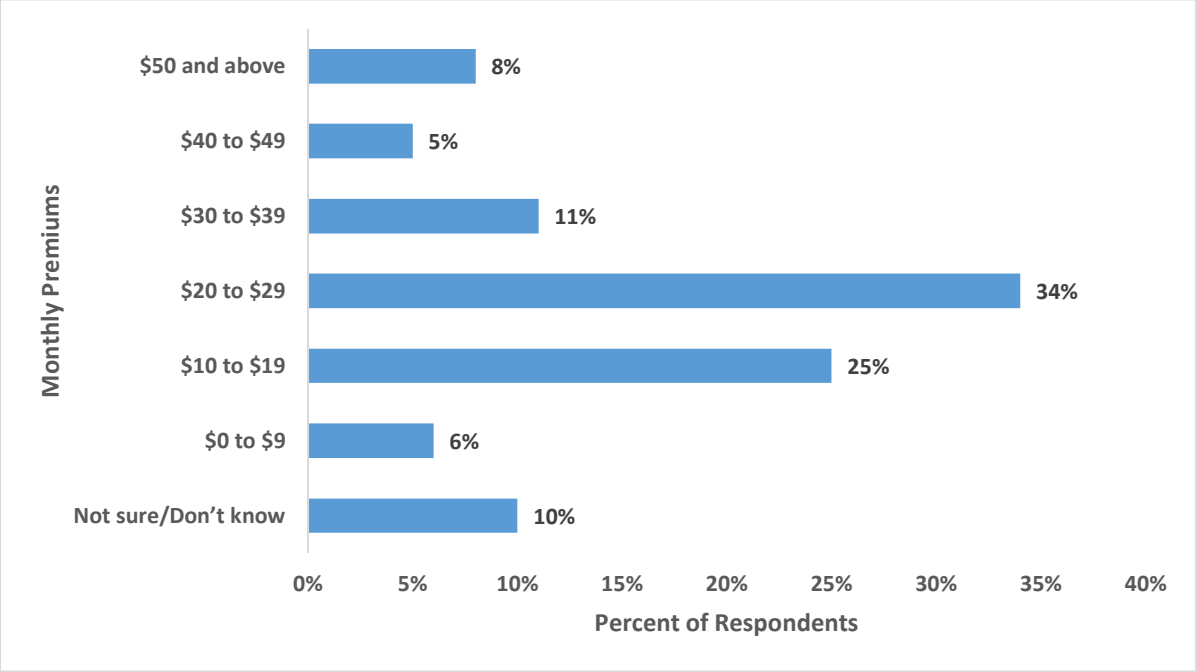
This domain examines whether respondents found their monthly premiums and any copayments for services to be affordable, and whether they had concerns about not being able to make their premium payments. Respondents were queried on their monthly premium payment amounts, how affordable

[49] "Medicaid Access in Brief: Adults' Experiences in Obtaining Medical Care" Medicaid and CHIP Payment and Access Commission, November 2016, retrieved from https://www.macpac.gov/wp-content/uploads/2016/11/Adults-Experiences-in-Obtaining-Medical-Care.pdf.

they found their premium, how worried they were about making their premium payments, and if they self-paid their premiums or if someone other than the respondent paid their premium for them.

Most enrollee respondents had a monthly premium payment between $10 and $39. Only 5 percent reported having monthly premiums between $40 and $49, while about 8 percent reported monthly premium amounts in excess of $50 (Figure III.10). About 12 percent thought the premiums were more than they could afford. Fifty-four percent reported that they were "not at all" worried about being able to make their monthly premium payments.

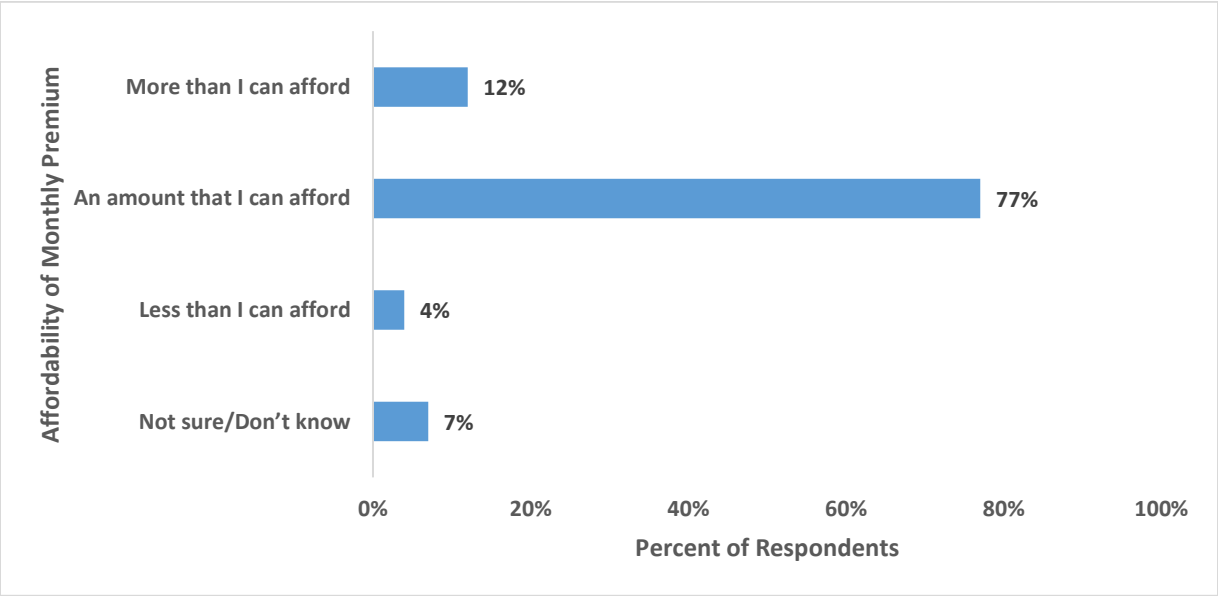
Figure III.10: Monthly Premium Amounts



Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Weighted proportions presented in chart.

Furthermore, as Figure III.11 depicts, a majority of 77 percent felt that the premiums were an amount of they could afford. About 12 percent of enrollees thought the premiums were more than they could afford, while 4 percent of enrollees considered their premiums to be less than they could otherwise afford.

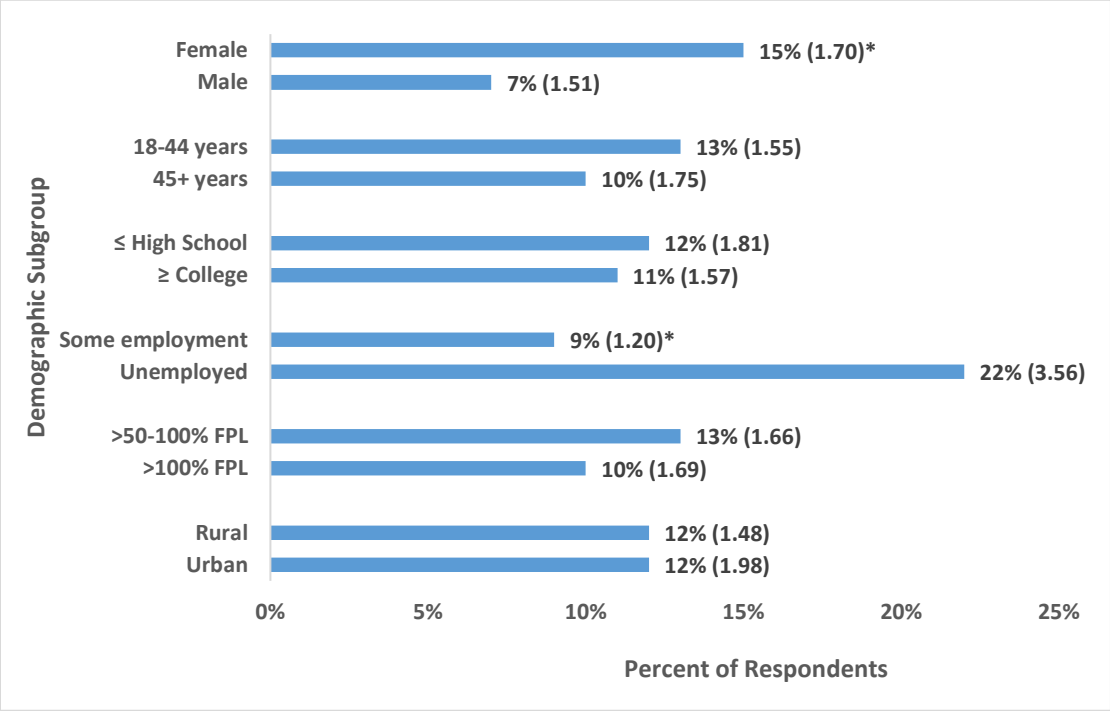
Figure III.11: Affordability of Monthly Premium



Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Weighted proportions presented in chart.

To understand how premium affordability may vary by demographic subgroups, we also looked into the proportion of enrollee respondents who had concerns about HELP premiums being more than they could afford, by demographic subgroup (Figure III.12). Females (15 percent) were twice as likely as males (7 percent) to feel that premiums were more than they could afford. Those who reported being unemployed (22 percent) were also significantly more likely to report feeling that their premiums were more than they could afford when compared to those that reported some employment (9 percent).

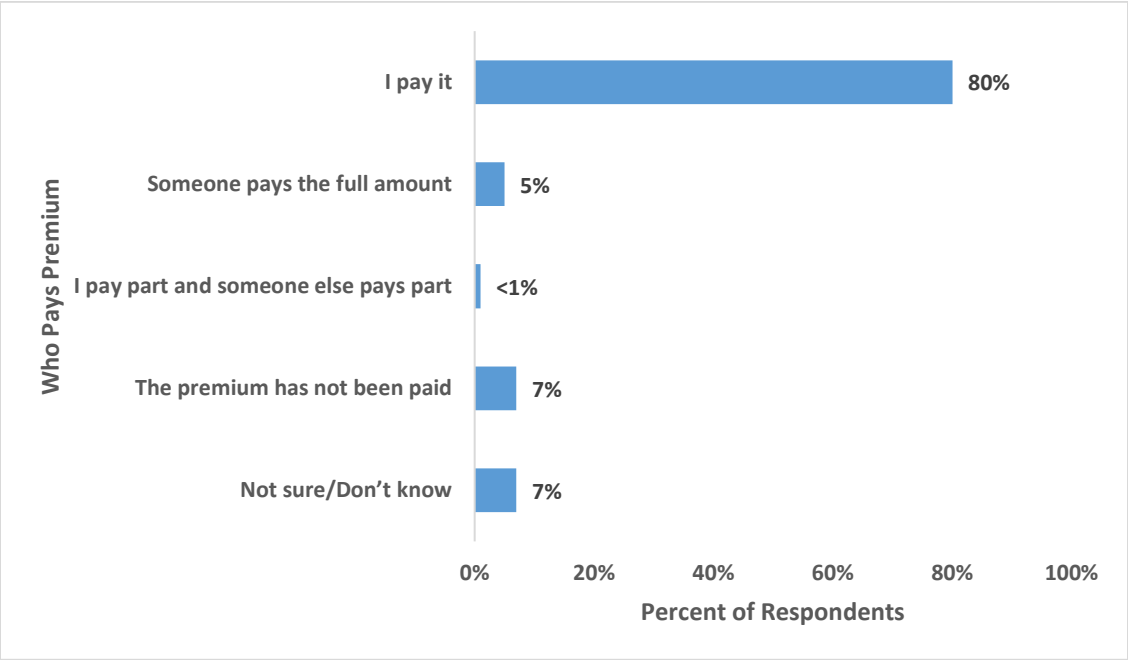
Figure III.12: Affordability of Monthly Premium by Demographic Subgroup



Source: Survey of HELP enrollees covered between December 2016 – April 2018**: N**=770.
Note: Weighted proportions presented in chart; standard errors in parentheses; * indicates statistically significant differences at the p<0.05 level.

To understand to what extent beneficiaries could afford the premiums on their own or required help paying them, a follow-up question asked enrollees who paid their premiums for them— whether they were self-paid or paid by someone else. While 80 percent of enrollees reported paying for their premiums themselves, 5 percent reported that someone else paid the full amount of their premium, and 7 percent said their premium had not been paid (Figure III.13).

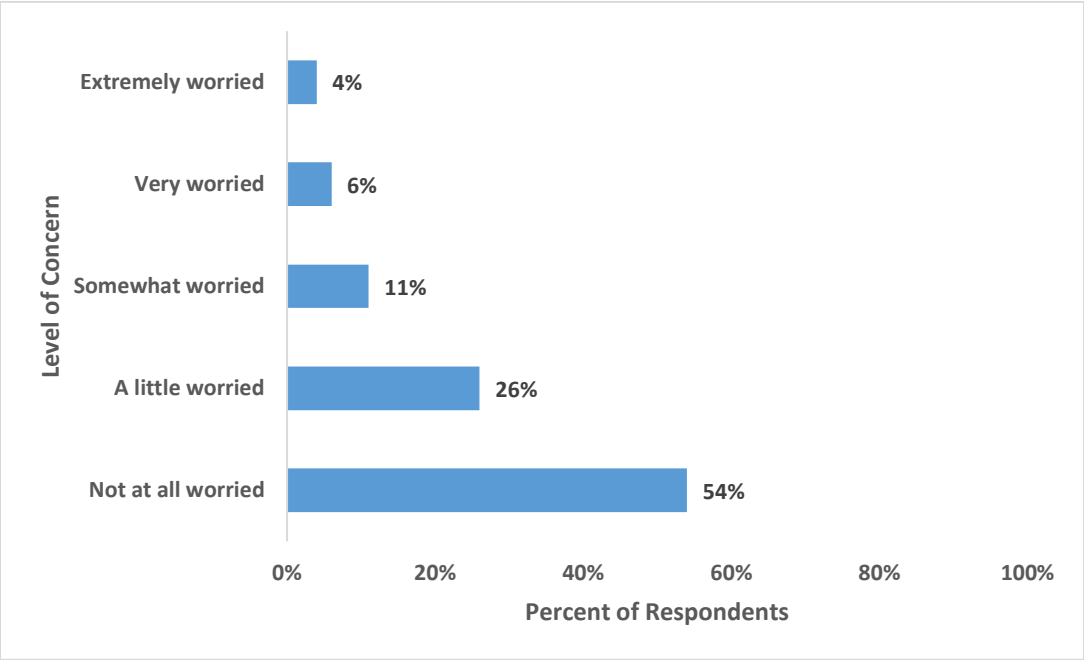
Figure III.13: Who Pays Premium?



Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Weighted proportions presented in chart.

We also examined whether or not respondents were worried about paying their monthly premiums. Almost half of the surveyed enrollees reported some degree of concern about their ability to make the monthly premiums (Figure III.14).

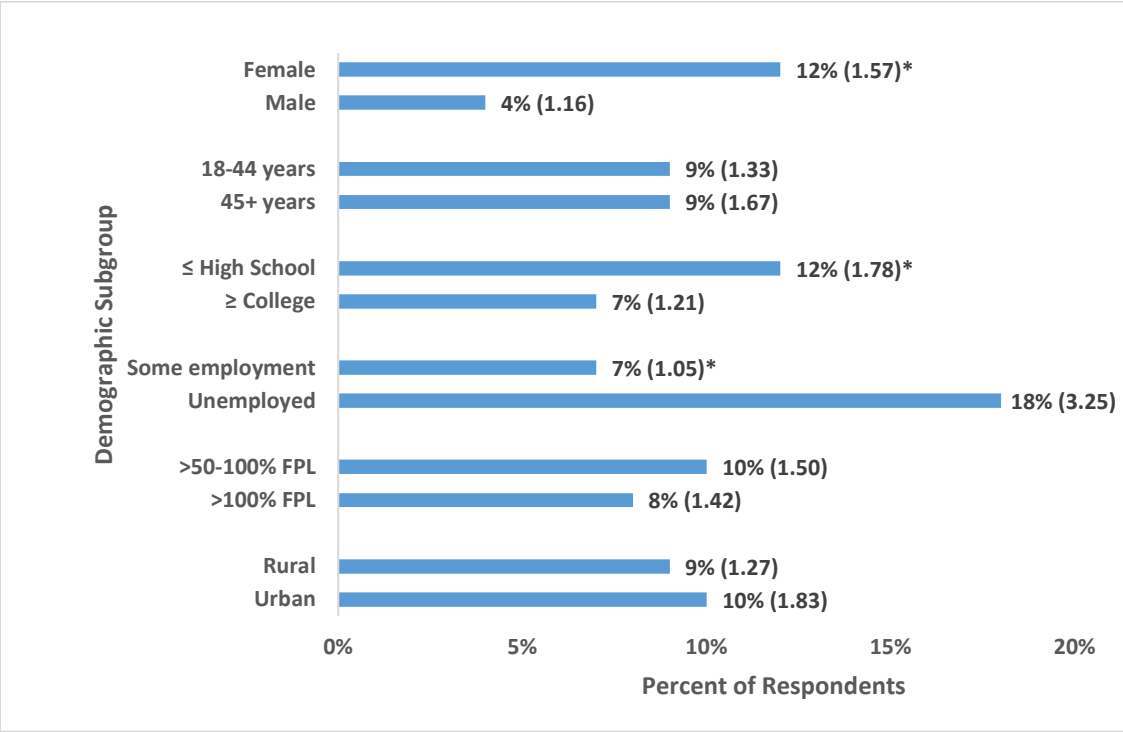
Figure III.14: Concerns About Affordability of Premium



Source: Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Weighted proportions presented in chart.

Only about 44 percent of enrollees reported paying copays in the last 6 months, and of those who did pay the copay, 84 percent said it was an amount they could afford. About 11 percent said it was more than they could afford (Table B.13). Significant differences in how worried enrollees were about being able to pay their premiums were also found along divisions of gender, education, and employment. Females (12 percent) were three times as likely as males (4 percent) to report being very or extremely worried about paying their premiums. Those with a high school education or lower (12 percent) were also more like to express those feelings than those with at last some college education (7 percent). Finally, those who reported being unemployed (18 percent) were more likely than those with at least some reported employment (7 percent) to express similar concerns about paying premiums (Figure III.15).

Figure III.15: Percent of Enrollees that Reported Being "Very" or "Extremely" Worried About Monthly Premium Payments by Demographic Subgroup



Source: Survey of HELP enrollees covered between December 2016 – April 2018**: N**=770.
Note: Weighted proportions presented in chart; standard errors in parentheses; * indicates statistically significant differences at the p<0.05 level.

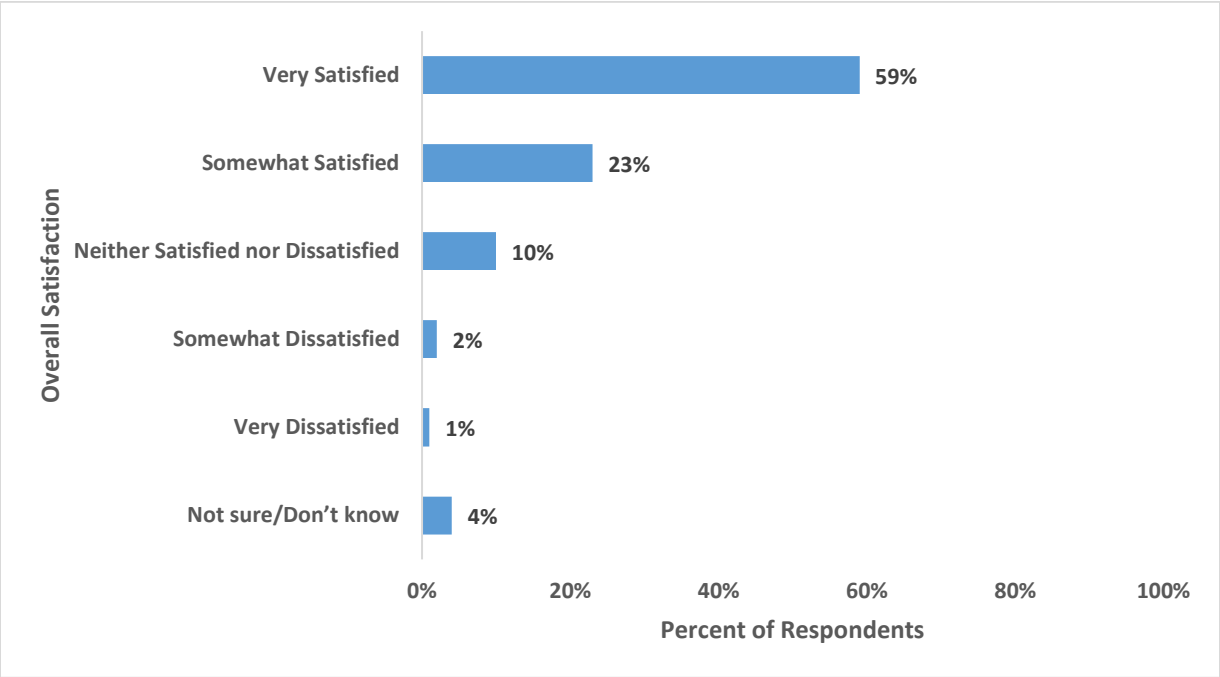
Key Takeaways on Affordability of HELP

The majority (81 percent) of enrollee respondents considered their monthly premiums to be affordable, and more than half of the enrollee respondents reported that they were not at all worried about being able to make their monthly premiums. When asked to compare HELP to their prior health insurance (for those with prior coverage), 74 percent of enrollee respondents found it the same or better than their previous coverage with respect to their ability to afford their plan.

Satisfaction with HELP

Finally, to assess overall enrollee perception about HELP, beneficiaries were asked how satisfied they were with the HELP program overall. Respondents were asked to rate both their overall satisfaction with the HELP program, as well as their satisfaction with key features of the program. Close to 60 percent of the enrollee respondents reported being very satisfied with the program, while about one-quarter were somewhat satisfied (Figure III.16).

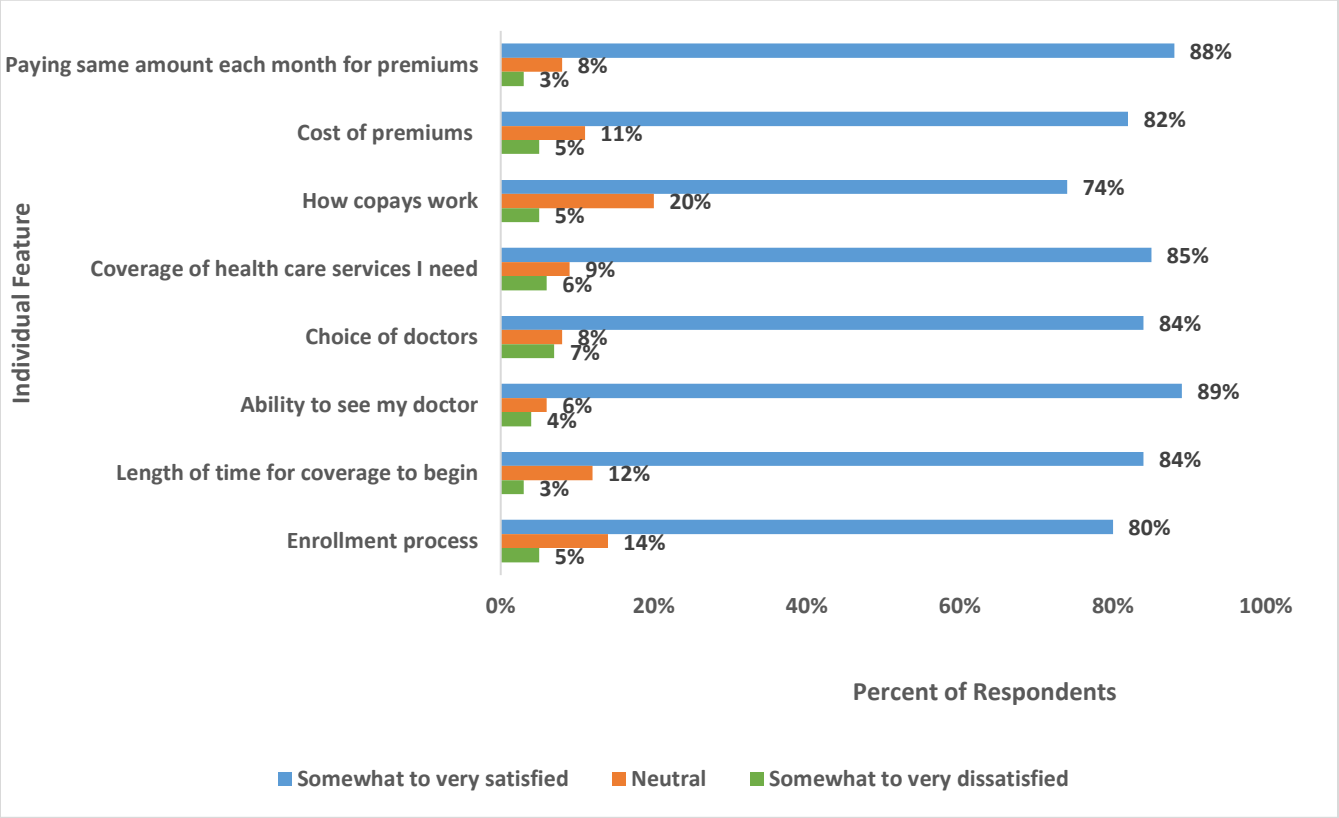
Figure III.16: Overall Satisfaction with HELP



Source*:* Survey of HELP enrollees covered between December 2016 – April 2018; **N**=770.
Note: Weighted proportions presented in chart.

When respondents were asked about their satisfaction with particular features of the HELP program, three quarters or more of respondents reported being somewhat to very satisfied with these various plan elements (Figure III.17). Eighty percent or more of respondents were somewhat to very satisfied with paying the same amount each month for premiums, the length of time it took for their coverage to begin, the ability to see their doctors, the enrollment process, the coverage of health care services they needed, their choice of doctors, and the cost of premiums. Around three quarters of enrollee respondents were somewhat to very satisfied with how copays work.

Figure III.17: Satisfaction with Individual Features of HELP



Source: Survey of HELP enrollees covered between December 2016 – April 2018; enrollees who reported being very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied with their overall experience with HELP, **N**=655.
Note: Weighted proportions presented in chart.

In total, enrollee respondents felt that HELP was as good as, or better than, whatever insurance they previously held (Table III.2). Most enrollee respondents appeared to feel that HELP coverage was the same or better than their coverage under their prior insurance, particularly when it came to their ability to afford the HELP plan coverage.

Table III.2: Comparison of HELP to Prior Health Insurance

Health Insurance Features	Better	Same	Worse	Not sure
Ability to afford plan	55%	19%	9%	11%
Coverage of needed health care services	35%	36%	11%	14%
Ability to see my doctor	26%	53%	8%	8%
Ability to get needed health care services	33%	48%	7%	7%

Source: Survey of HELP enrollees covered between December 2016 – April 2018; enrollees who reported having any health insurance in the 12 months before HELP enrollment, **N**=382.
Note: Weighted proportions presented in table.

Key Takeaways on Satisfaction with HELP

A majority of enrollees were somewhat to very satisfied with individual features of HELP including a consistent monthly premium payment amount and the ability to see their doctors as well as choice of doctors, and coverage of health care services needed. Seventy-four percent of enrollees were somewhat to very satisfied with how copays work in HELP. In general, although there were several features of HELP that many enrollees did not fully understand, they expressed satisfaction with the program and believed it improved their access to care, and ability to see their doctors as well as giving them their choice of doctors.

Disenrollee Experiences with and Perception of HELP

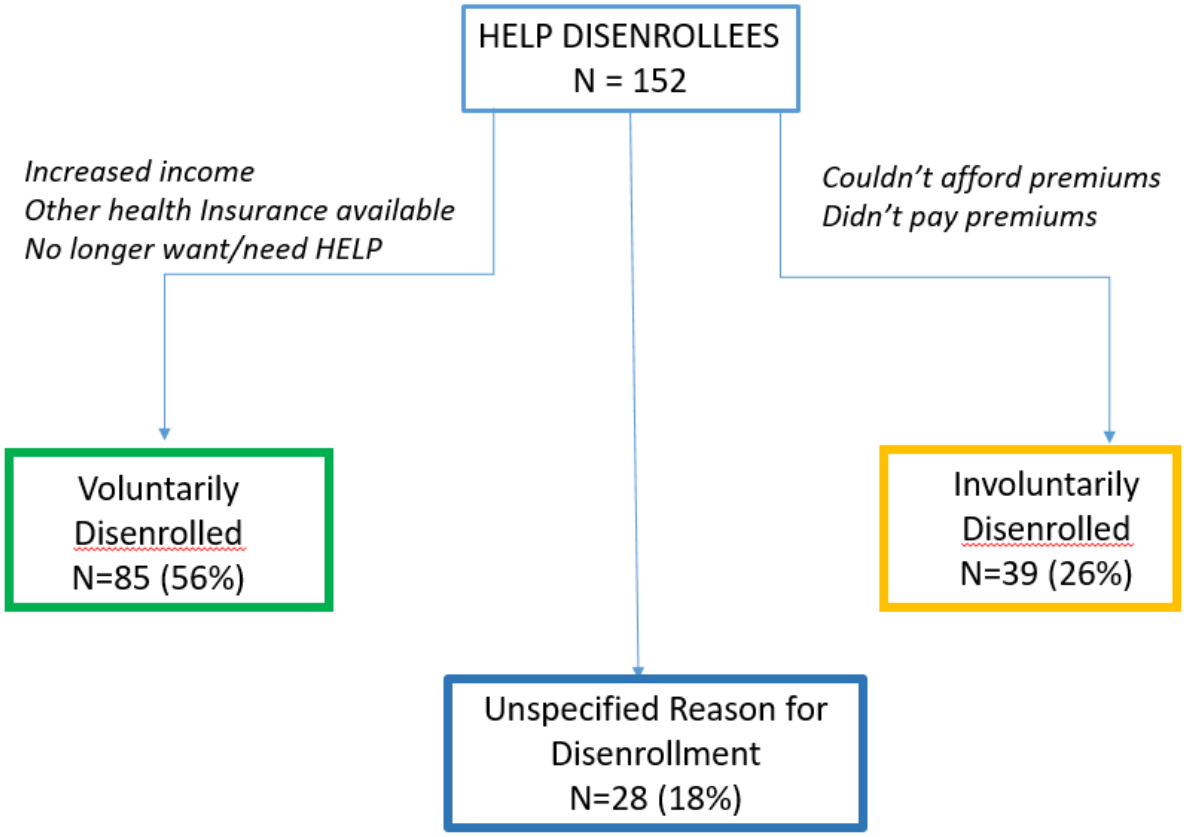
Among the 152 disenrollees responding, we looked to see if there were any patterns in their disenrollment and their perceptions of the HELP program and experiences after leaving HELP. A majority of disenrollees became disenrolled through improvement in their circumstances, hereby referred to in this report as "voluntary disenrollees." A smaller but still sizeable proportion indicated that they were disenrolled due to being unable to afford the premium or because they did not pay the premium. The third category of disenrollees includes individuals who did not select any of the offered reasons for their loss of coverage. Since the response offerings for this group may not have included their specific reason for disenrollment, we assumed their loss of coverage was not related to increased income or availability of other health insurance.

We found it important to examine three groups among disenrollees according to the general reason individuals disenrolled. We expected that responses to many of the questions on the disenrollee survey would differ according to these two sets of circumstances (voluntary vs. involuntary disenrollment). For example, we might expect the first subgroup to have obtained other insurance coverage and therefore to have an easier time getting care after disenrollment than those in the involuntarily enrolled subgroup. As shown in Figure III.18 below, the three groups of disenrollees were:

1) There were 85 (56 percent) disenrollee respondents who reported no longer needing or qualifying for subsidized health coverage either due to increased income or coverage availability from other sources; we refer to these individuals as "voluntary disenrollees;"
2) There were 39 (26 percent) disenrollee respondents who cited inability or failure to pay premiums as a reason for disenrollment; we refer to these individuals as "involuntary disenrollees;" and finally,
3) There were 28 (18 percent) disenrollee respondents who did not provide a reason for disenrollment in their response to the survey; we refer to these individuals as "unspecified disenrollees."

Among respondents who said they did not need/want HELP coverage anymore, 70 percent had some form of other insurance coverage. Among those who said they were disenrolled for non-payment, 55 percent indicated they had some other form of coverage. Of this 55 percent, almost half (47 percent) said they now were covered by standard Medicaid. In contrast, those who said they did not need/want HELP coverage but currently have other insurance coverage, 22 percent were enrolled in standard Medicaid after disenrollment from HELP.

Figure III.18: Disenrollee Groups by Disenrollment Reasons



Because of the small size of the response for disenrollees, we conducted regression analyses using SAS® Proc Surveyreg to test for differences between voluntary and involuntary disenrollees, and voluntary and *unspecified* disenrollees, on select variables of interest across the four key survey domains: understanding/awareness of the HELP program; access to care after leaving HELP; affordability of HELP; and satisfaction with the HELP program.

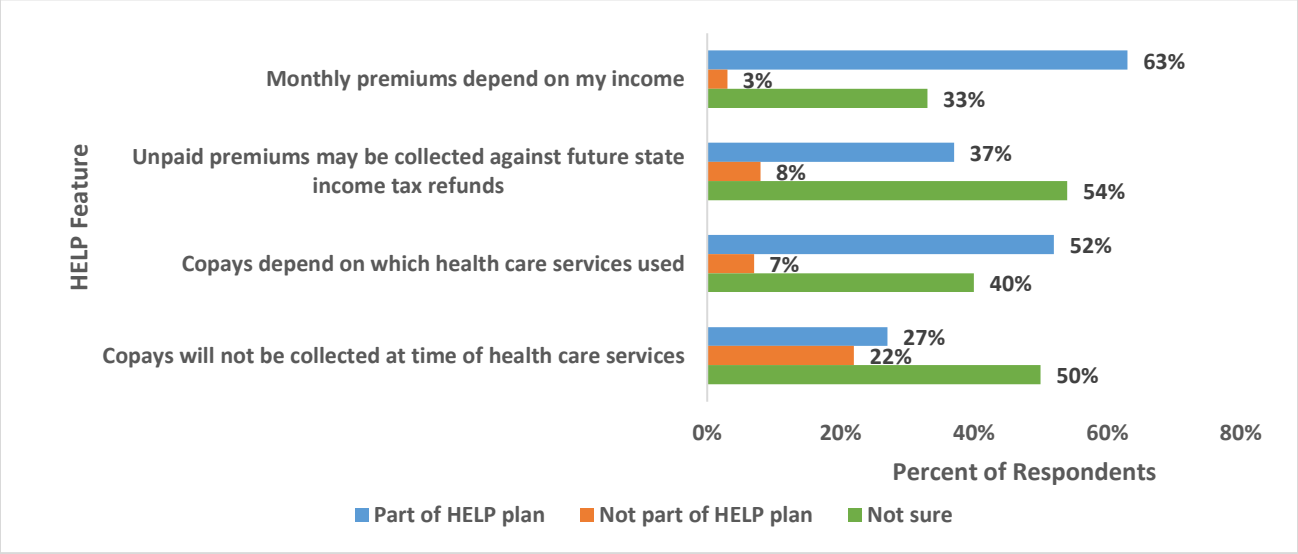
Within each domain section, survey findings are presented for the disenrollees as a whole, followed by a table of differences between the disenrollees by type of disenrollment. At the end of each domain section, we present the key takeaways from the analysis.

Understanding/Awareness of the HELP Program

As with enrollees, we were interested in examining how well disenrollees had understood the specific features of the HELP program during the time that they were enrolled. Responses were solicited across three dimensions—whether the feature was *part of the HELP Plan*, *not part of the HELP plan*, and *not sure*. Overall, as depicted in Figure III.19, while 63 percent of disenrollees knew that monthly premiums depend on income, the proportions of disenrollees who knew that the other features were also part of the HELP plan was much smaller, ranging from 27 percent who knew that copays would not be collected

at the time of receiving health care services, to 52 percent who knew that copays depend on which health care services used.

Figure III.19: Understanding of HELP Premium and Copayment Features



Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018; **N**=152.
Note: Weighted proportions presented in chart.

The pattern for the disenrollees held even when disaggregated by type of disenrollment (Table III.3). Of the HELP premium and copayment features surveyed for understanding, all three types of disenrollees were more likely to indicate that they thought monthly premiums depended on income. However, fewer proportions of all three disenrollee types exhibited understanding of the other features specific to HELP. There were also significant differences found in understanding of several features between voluntary disenrollees and either involuntary or unspecified disenrollees.

Table III.3: Differences Between Disenrollee Groups in Understanding of HELP

Understanding of HELP	**Voluntary**	**Involuntary**	**Unspecified**
Pay unpaid premiums w/in 90 days – keep HELP coverage[a]	50% (6.94)	48% (10.38)	11% (10.24)*
Pay unpaid premiums after 90 days, re-enroll w/in 12 mos. of HELP plan start date[a]	31% (6.39)	35% (10.03)	0%*
Unpaid premium balance may be collected from future state income tax refunds[a]	43% (6.90)	61% (10.01)	11% (10.44)*
Monthly premiums depend on income[b]	70% (5.04)	70% (7.44)	30% (8.68)*
Copays depend on health care services used[b]	64% (5.29)	43% (8.03)*	26% (8.30)*
Copays not collected at time of health care service[b]	30% (5.06)	15% (5.74)*	36% (9.22)

Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018; [a] disenrollees who knew HELP coverage would end if premium was not paid within 90 days, **N**=87; [b] all disenrollees, **N**=152.
Note: *Indicates differences that were significant from voluntary disenrolled at p<0.05 level.

Key Takeaways on Understanding of HELP

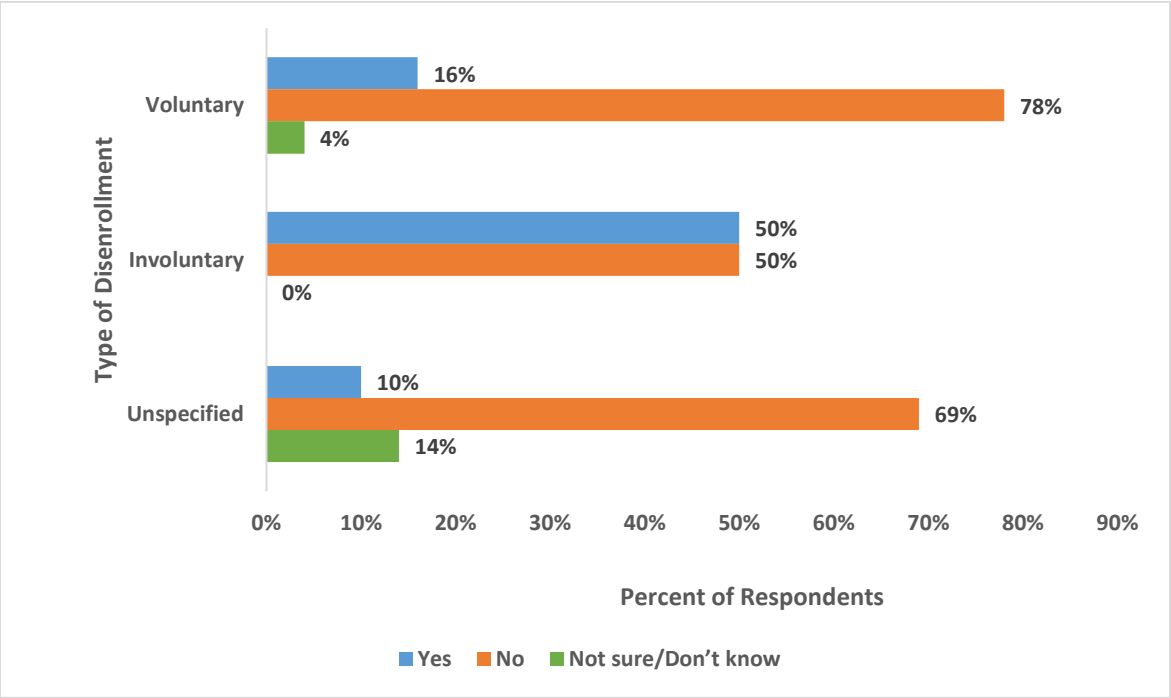
Disenrollee respondents demonstrated an incomplete understanding of individual program features when compared to their self-reported understanding of HELP overall. The feature most understood by a large proportion of disenrollees both overall and by type of disenrollment appear to be monthly premiums being a function of income. Voluntary disenrollees also demonstrated significantly better understanding of almost all HELP features across the board when compared with those with unspecified disenrollment type.

Cost as a Barrier to Accessing Care

For disenrollees we examined whether they reported any barriers to accessing health care due to cost concerns after being disenrolled from HELP. We examined this for disenrollees stratified by type of disenrollment. The questions for disenrollees on whether they reported any barriers to accessing health care due to cost concerns were asked for the period of time since they had been disenrolled from HELP which could cover 1 month to less than a year. This contrasts with the enrollee analysis where we wanted to assess the recent experiences of enrollees and their questions about health care access were limited to the last 6 months *before* they completed the survey. To better understand the disenrollees' experiences with cost as a barrier to accessing health care, we examined this domain for disenrollees stratified by type of disenrollment.

Seventy-six percent of disenrollees reported no barriers to accessing care due to cost concerns after their disenrollment from HELP. As seen in Figure III.20, by disenrollee group, voluntary disenrollees reported fewer barriers to accessing care due to cost concerns after being disenrolled from HELP than involuntary disenrollees.

Figure III.20: Unable to Get Health Care Due to Cost, by Type of Disenrollment



Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018; **N**=152.
Note: Weighted proportions presented in chart.

In addition to looking at the inability to access care due to cost considerations for disenrollees overall, we also stratified disenrollees by disenrollment type and examined specific elements of access to care that they faced challenges with due to cost considerations (Table III.4). Involuntary disenrollees were significantly more likely to be unable to get health care overall than voluntary disenrollees. Unspecified disenrollees were more likely to be unable to access dental care and prescription drugs compared to voluntary disenrollees.

Table III.4: Differences Between Disenrollee Groups in Access to Care

Access to care	**Voluntary**	**Involuntary**	**Unspecified**
Unable to get health care due to cost[a]	16% (4.07)	50% (8.11)*	10% (5.46)
Unable to get visit to doctor[b]	41% (14.02)	49% (11.71)	61% (29.85)
Unable to get preventive care[b]	38% (13.69)	33% (11.10)	22% (21.64)
Unable to get follow up visit/tests[b]	53% (14.11)	57% (11.59)	61% (29.85)
Unable to get dental care[b]	48% (14.14)	73% (10.33)	100%*
Unable to get vision care[b]	39% (13.84)	47% (11.69)	61% (29.85)
Unable to get Rx[b]	48% (14.14)	33% (11.08)	100%*
Unable to get ER care[b]	24% (12.16)	34% (11.20)	39% (29.85)

Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018. [a] all disenrollees, **N**=152; [b] disenrollees who reported that they needed health care but did not get it because of cost, **N**=35. **Note:** *Indicates differences that were significant from voluntary disenrolled at p<0.05 level. Weighted proportions presented in table. Standard error in parentheses.

Key Takeaways on Cost as a Barrier to Accessing Needed Care

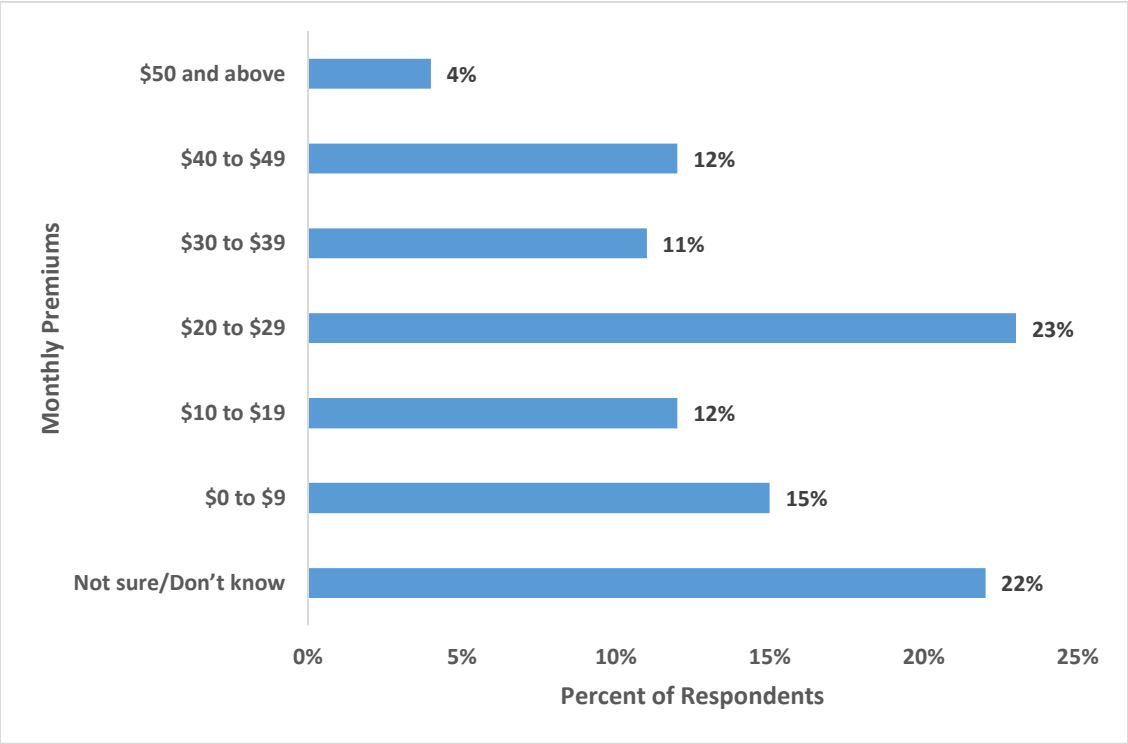
In general, cost did not appear to be a barrier to accessing care for disenrollees after leaving HELP. By type of disenrollment, involuntary disenrollees were more likely to report that they faced barriers to accessing care due to cost. For access to dental care and prescription drugs, unspecified disenrollees were more likely to report cost barriers compared to voluntary disenrollees.

Affordability of the HELP Program

Because affordability of premiums and copayments or the lack thereof might be a factor in respondents no longer being enrolled in HELP, we examined the affordability of HELP overall as well as stratified by type of disenrollment.

We note that only about 4 percent of disenrollee respondents indicated that they paid a premium of $50 or more monthly. A little less than one quarter of respondents said their monthly premium was between $20-$29, and almost one quarter of the respondents were unsure about or did not know their premium payment amount (Figure III.21).

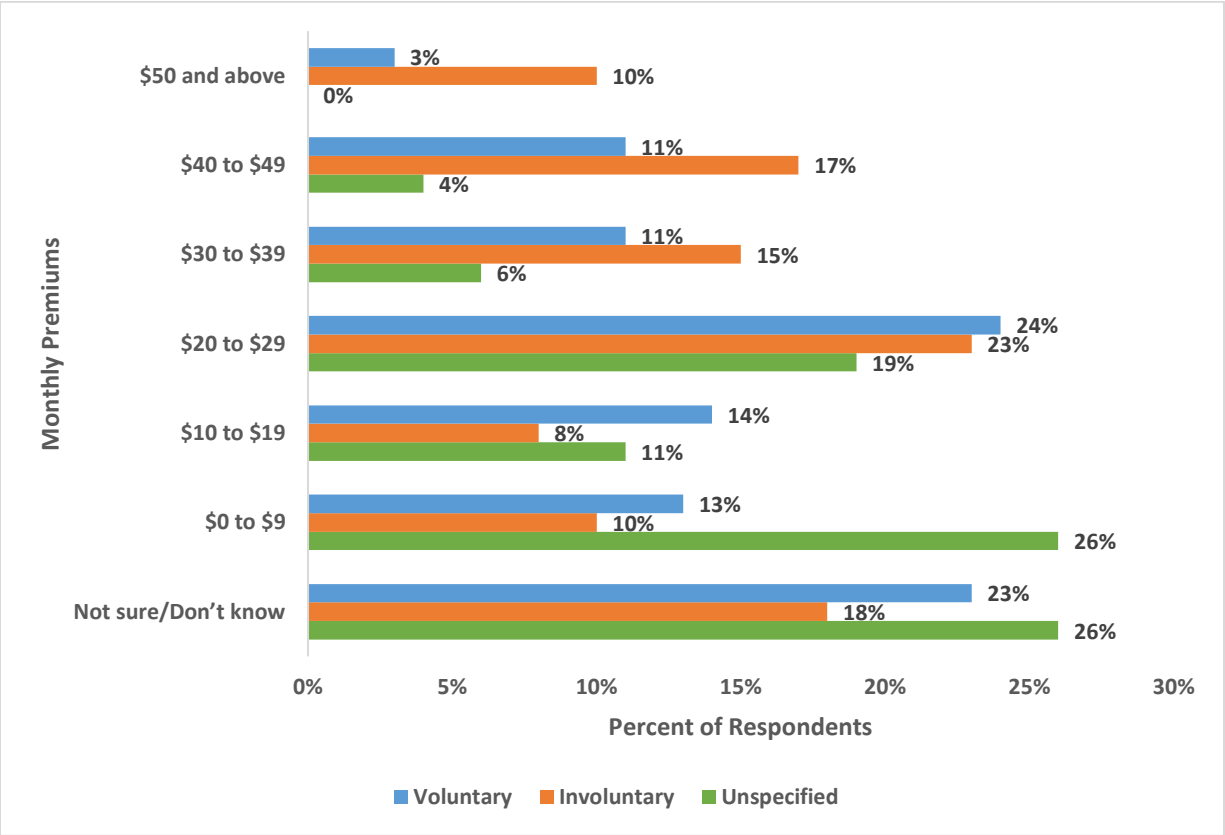
Figure III.21: Premium Amounts for Disenrollees as a Whole



Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018; **N**=152.
Note: Weighted proportions presented in chart.

Figure III.22 shows the distribution of premium amounts by type of disenrollment. Involuntary disenrollees were more likely to have premiums greater than the $20-$29 average range compared to other disenrollees.

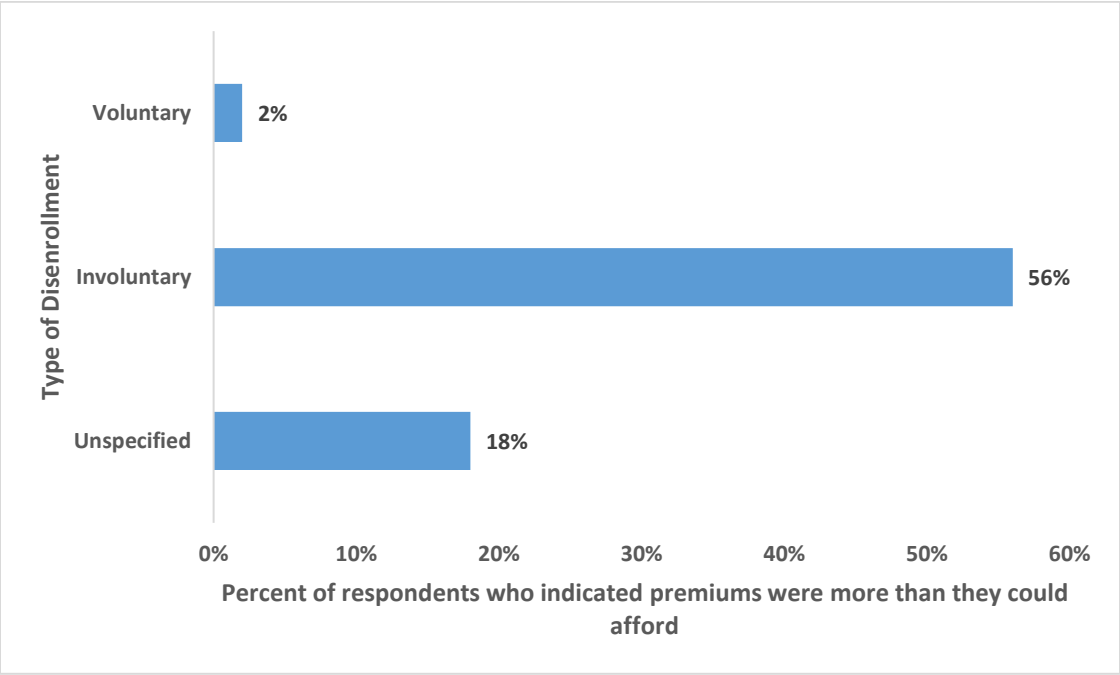
Figure III.22: Premium Amounts, by Type of Disenrollment



Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018; **N**=152.
Note: Weighted proportions presented in chart.

We then examined what disenrollees perceived about premiums being more than they could afford, broken out by type of disenrollment, because we were interested in seeing whether the type of disenrollment was related to perceptions of affordability. A larger proportion of involuntary and unspecified disenrollees reported finding their premiums to be more than they could afford, when compared to voluntary disenrollees (Figure III.23).

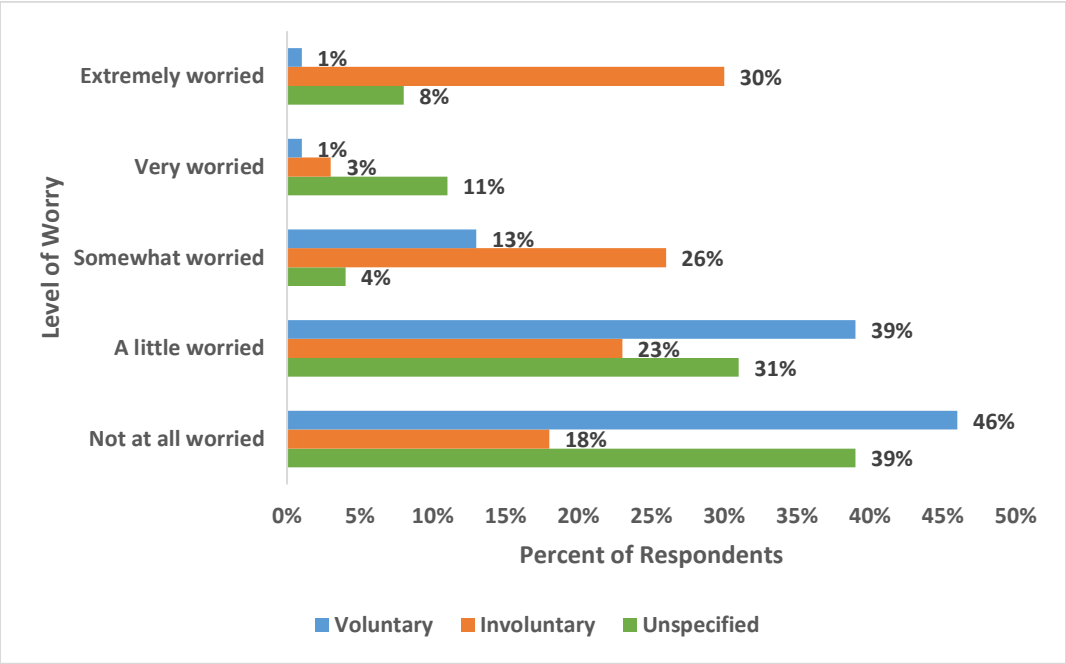
Figure III.23: Premium Affordability, by Type of Disenrollment



Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018; **N**=152.
Note: Weighted proportions presented in chart.

We also looked into disenrollees' concerns about their premium payments by type of disenrollment, to see if there was a larger proportion of involuntary disenrollees who reported being worried about making their payments (Figure III.24).

Figure III.24: Worried About Making Premiums, by Type of Disenrollment



Source*:* Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018; **N**=152.
Note: Weighted proportions presented in chart.

As Figure III.24 depicts, involuntary disenrollees and those disenrolled for unspecified reasons were more likely to respond that they were somewhat to extremely worried about paying their premiums, compared to voluntary disenrollees.

In addition, we examined differences between disenrollee groups in their perceptions of the affordability of HELP premiums and copays (Table III.5).

Table III.5: Differences Between Disenrollee Groups in Affordability of HELP

Affordability of HELP	**Voluntary**	**Involuntary**	**Unspecified**
Paid any copays[a]	22% (4.53)	32% (7.54)	22% (7.98)
Affordability of copays (Copays more than I can afford)[b]	9% (6.27)	47% (14.26)*	34% (19.90)
Affordability of monthly premium (Premiums more than I can afford)[a]	2% (1.59)	56% (8.01)*	18% (7.55)*
Very/Extremely worried about monthly premium[a]	2% (1.59)	33% (7.70)*	18% (7.43)*

Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018**;** [a] all disenrollees, **N**=152; [b] disenrollees who reported paying copays, **N**=38. **Note:** *Indicates differences that were significant from voluntary disenrolled at p<0.05 level. Standard error in parenthesis.

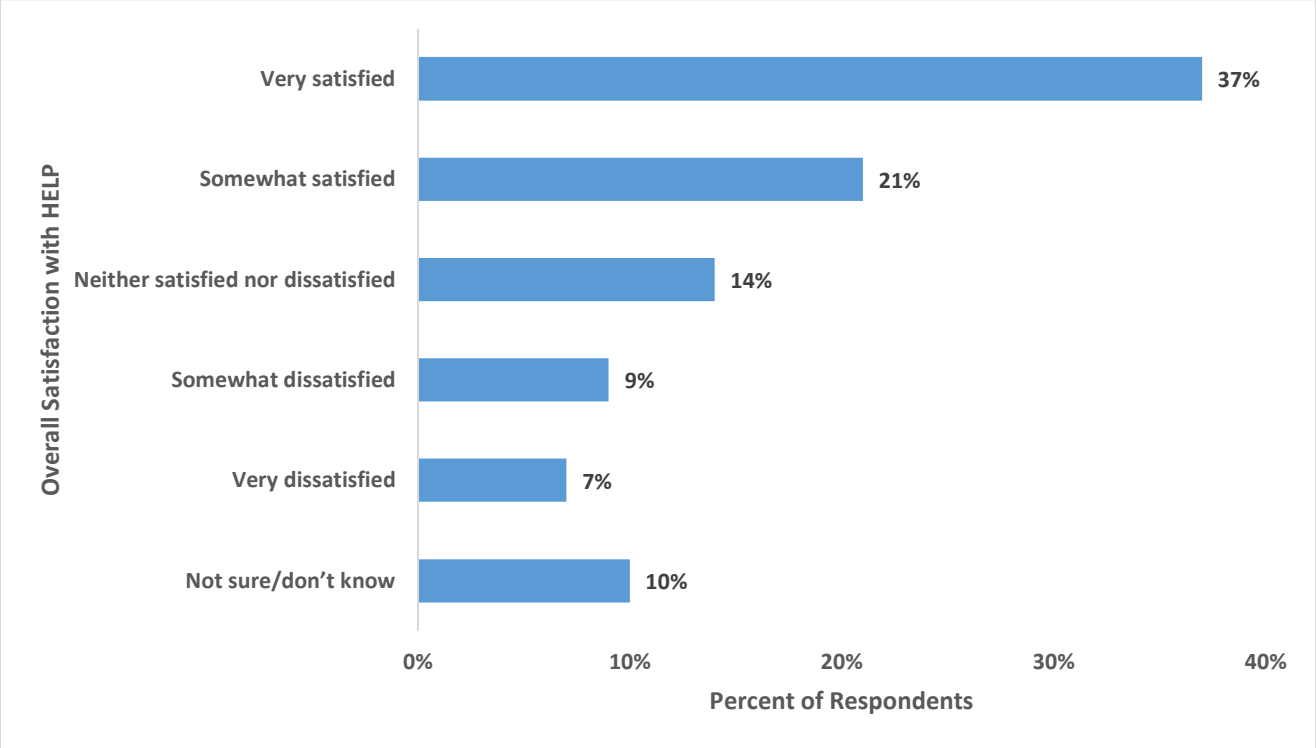
Key Takeaways on Affordability of HELP

More than half of disenrollee respondents considered premium payments to be affordable. Involuntary and unspecified reason disenrollees were significantly more likely than voluntary disenrollees to respond that they were very to extremely worried about their premiums. The proportion of disenrollees who paid copayments did not differ significantly by type of disenrollment. However, of the disenrollees who paid copays, involuntary disenrollees were more likely to indicate that the copays were more than they could afford compared to voluntary disenrollees.

Satisfaction with the HELP Program

We examined disenrollees satisfaction with the HELP program overall, as well as with specific program features, and for all disenrollees along with stratification by disenrollee groups based on type of disenrollment. For disenrollee respondents as a whole, we found that almost 40 percent reported being very satisfied with the program, and another 21 percent reported being somewhat satisfied. Only 16 percent reported being either somewhat or very dissatisfied (Figure III.25).

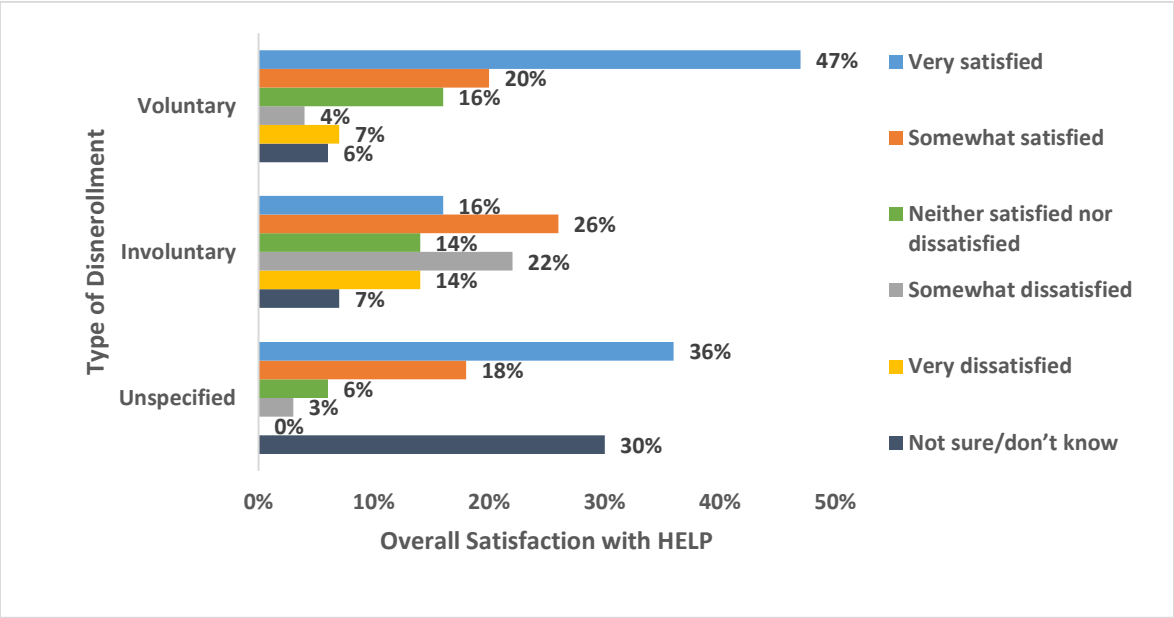
Figure III.25: Overall Satisfaction with HELP



Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018**; N**=152.
Note: Weighted proportions presented in chart.

When asked about their overall level of satisfaction with the HELP program, those disenrolled voluntarily reported the most satisfaction, while involuntary disenrollees appeared to be the least satisfied (Figure III.26).

Figure III.26: Overall Satisfaction with HELP by Type of Disenrollment



Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018**; N**=152.
Note: Weighted proportions presented in chart.

After examining overall satisfaction for disenrollees as a whole and by disenrollment type, we also stratified disenrollees by type of disenrollment and examined their satisfaction with specific elements of HELP. Consistent with how the different disenrollee types responded to questions about their overall satisfaction with the different elements of HELP—in general those disenrolled voluntarily were the most satisfied with specific HELP features, followed by those with unspecified reasons, while the involuntary disenrollees reported the least satisfaction (Table III.6). The proportion of involuntary disenrollees who reported being somewhat to very satisfied overall was significantly lower than voluntary disenrollees. The individual features of HELP that seemed to drive this significance the most were paying the same amount each month for premiums and cost of premiums.

Table III.6: Differences Between Disenrollee Groups in Satisfaction with HELP

Overall Satisfaction with HELP	**Voluntary**	**Involuntary**	**Unspecified**
Somewhat to very satisfied[a]	67% (5.19)	42% (7.98)*	54% (9.60)
Satisfaction with specific HELP features (Somewhat to very satisfied)[b]			
How copays work	67% (5.92)	42% (9.09)	71% (11.43)
Paying same amount each month for premiums	80% (5.03)	51% (9.24)*	79% (9.74)
Length of time for coverage to begin	74% (5.55)	56% (9.20)	88% (8.24)
Cost of premiums	74% (5.55)	44% (9.12)*	76% (10.64)
Enrollment process	63% (6.07)	42% (9.09)	64% (12.17)
Ability to see my doctor	75% (5.47)	63% (8.97)	77% (10.44)
Choice of docs	76% (5.39)	56% (9.20)	81% (10.00)
Coverage of health care services respondent needed	75% (5.42)	56% (9.20)	68% (11.99)

Source: Survey of HELP disenrollees who were disenrolled between December 2016 – April 2018. [a] all disenrollees, **N**=152; [b] disenrollees who reported being very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied with their overall experience with HELP, **N**=112. **Note:** Weighted proportions presented in chart.

Key Takeaways on Satisfaction with HELP

Based on their recall of the HELP program, close to 60 percent of disenrolled respondents reported being somewhat to very satisfied with the program when enrolled in it. Respondents who were disenrolled because they had obtained other insurance coverage (i.e., voluntarily disenrolled) reported higher satisfaction levels with HELP compared to those who were disenrolled for non-payment of premiums.

Comparisons Between Wave 1 and Wave 2

This section presents a comparison of key survey findings between the wave 1 and wave 2 surveys. The initial wave of enrollee and disenrollee surveys covered the period January 2016-November 2017 which reflect the respondents' experiences with the HELP program in the first year and a half into implementation. The follow-up round of surveys covered the period December 2017-November 2018 and reveal the knowledge and experiences of the beneficiaries with HELP *post-maturation* of the program. Differences and similarities in the results between survey waves are noted below for specific survey questions of interest within the various survey domains, separately for enrollees and disenrollees.

These comparisons of two independent, cross sectional samples (waves 1 and 2) primarily distinguished by the time of their responses, resulted in a complex design requiring careful analytic adjustment. We

used the SAS® SurveyFreq procedure to perform a series of Rao-Scott likelihood ratio chi-square tests.[50,51] This test, which compares ratios of expected to observed frequencies, adjusts for complex survey designs

Though in most respects the results obtained from wave 1 and wave 2 surveys were similar, there were a few key differences between the two subsets of enrollees and disenrollees. Demographically, there were no substantial differences between either enrollees or disenrollees, with wave 2 being comprised of more enrollees (n=770 vs. n=655), and slightly fewer disenrollees (n=152 vs. n=178) compared to wave 1. Tables of results from wave 1 and wave 2, including statistically significant differences between waves, are displayed in Tables B.1-B.35 in Appendix B.

Enrollees

A larger proportion of enrollees in wave 2 self-reported better overall understanding of HELP, with 24 percent saying they understood the plan "very well" compared to 20 percent in wave 1. Correspondingly, the proportion of the population that reported they understood their plan somewhat or not at all decreased between waves 1 and 2.

Despite self-reported understanding improving between waves, enrollees continued to demonstrate mixed results when asked about individual policies. While there was no statistically significant difference between enrollees in waves 1 and 2 on their understanding that HELP coverage would end if premiums weren't paid, of those who reported knowing that their HELP coverage would end due to non-payment - wave 2 enrollees were significantly more likely to be aware that payment of the premium within 90 days would help maintain coverage, or that they could re-enroll within 12 months if premiums were paid after 90 days. They were also significantly more likely to be aware that unpaid premiums could be collected from state income taxes (Table B.4). Enrollees in wave 2 demonstrated a significantly greater understanding of how copays work (Table B.5).

In terms of information-seeking behavior, wave 2 enrollees indicated a lower rate of seeking information about the HELP program, with 37 percent responding that they had done so compared to 41 percent in wave 1. The medium by which enrollees sought information did not vary greatly between waves, nor did how helpful enrollees found said information. None of these differences approached statistical significance.

Respondents in both waves reported similar rates of insurance in the 12 months prior to enrolling in HELP. In general, enrollees in wave 2 reported fewer issues with getting care related to cost than enrollees in wave 1 but again, the differences were not statistically significant.

Both waves had similar proportions of respondents who felt similarly, regarding how affordable they perceived their monthly premiums to be, although wave 2 enrollees were generally less concerned about how affordable their premiums were when compared to wave 1 enrollees. Respondents in the

[50] Rao, J.N.K., and Scott, A.J. (1981). "The Analysis of Categorical Data from Complex Surveys: Chi-Squared Tests for Goodness of Fit and Independence in Two-Way Tables." *Journal of the American Statistical Association* 76:221-230.

[51] Rao, J.N.K., and Scott, A.J. (1984). "On Chi-Square for Multiway Contingency Tables with Cell Properties Estimated from Survey Data." *Annals of Statistics* 12:46-60.

second wave were significantly less likely to say that their monthly premium was more than what they could afford and were significantly less likely to be worried about having money to make payments.

In general, enrollees in wave 2 also reported significantly greater satisfaction with HELP, with 59 percent of enrollees reporting that they were very satisfied when compared to 48 percent in wave 1. Among individual features of HELP, enrollees in wave 2 reported being significantly more satisfied with the enrollment process, choice of doctors, how copays work, and cost of premiums as well as the consistency of monthly premiums.

Respondents in both waves reported similar rates of insurance in the 12 months prior to enrolling in HELP. In general, enrollees in wave 2 reported fewer issues with getting care related to cost than enrollees in wave 1.

Cost of monthly premiums was also reported similarly by respondents in both waves, although a higher proportion of enrollees in wave 2 (10 percent) reported being unsure of how much they were paying each month than the enrollees in wave 1 (6 percent). Both waves had similar proportions of respondents who felt similarly, regarding how affordable they perceived their monthly premiums to be, although wave 2 enrollees were generally less concerned about how affordable their premiums were when compared to wave 1 enrollees.

In general, enrollees in wave 2 also reported greater satisfaction with HELP, with 59 percent of enrollees reporting that they were very satisfied when compared to 48 percent in wave 1. Among individual features of HELP, enrollees in wave 2 reported a larger increase in satisfaction when compared with wave 1 respondents for choice of doctors, how copays work, and cost of premiums as well as the consistency of monthly premiums.

Disenrollees

When examining differences between survey waves 1 and 2 for disenrollee respondents, we looked at disenrollee responses overall and not by involuntary and voluntary disenrollees. Despite weighting the responses, because of the low response rate it is possible that certain observations could have a disproportionately large effect on the survey results, and this is particularly true when the small disenrollee sample is split further into involuntary and voluntary disenrollees. To avoid this, we restricted the comparison to the overall disenrollee respondents in waves 1 and 2.

When asked about their understanding of their HELP plan, disenrollees in wave 2 were more likely to say that they were aware that copays would not be collected at the time of service, and that copays depended on which healthcare services were used, as well as that unpaid premiums would be collected against future state income tax refunds. However, wave 2 disenrollees were less likely to be aware that monthly premiums depended on income (Table B.20).

With respect to affordability, the proportion of wave 2 disenrollees reporting that their monthly premium was more than they could afford decreased by 10 percentage points, while correspondingly there was an increase in the proportion of those reporting that their monthly premium was an amount they could afford (Table B.26). However, wave 2 respondents were significantly more likely to report being worried about being able to afford their monthly premium (Table B.27).

A larger proportion of wave 2 respondents reported being "very satisfied" overall with their HELP plan when compared to wave 1, but this did not approach statistical significance. However, when we examined satisfaction with individual features of HELP, wave 2 respondents were significantly more likely to be satisfied with their choice of doctors compared to wave 1.

Key Takeaways from Comparison of Wave 1 and Wave 2

There appears to be increased overall understanding among enrollees about HELP as the program matured, although results continued to be mixed when enrollees were asked about their understanding of individual features of the program. A smaller proportion of enrollees also sought information about the program as time went by. In addition, enrollees across both waves expressed positive sentiments about the affordability of their monthly premium payments as well as high levels of satisfaction with the program.

Among disenrollees, a similar pattern held as with enrollees—with disenrollees demonstrating an improved understanding of HELP overall in wave 2, as well as increased satisfaction overall with the program.

Discussion on Beneficiary Survey Analysis

As part of the federal evaluation of HELP and to examine HELP enrollee and disenrollee experiences post the maturation of the program, the evaluation team conducted a follow-up round of surveys with enrolled and disenrolled HELP beneficiaries in the late summer/ fall of 2018. Respondents were surveyed about their understanding of and experiences with HELP, as well as on other domains including affordability of HELP, and for those disenrolled from the program, experiences after leaving HELP.

Although most HELP enrollees and disenrollees claim to understand the overall HELP program well or somewhat well, HELP enrollees' and disenrollees' in the follow-up surveys continued to display an incomplete understanding of the individual features of HELP. Close to 40 percent of enrollee respondents appear to have sought assistance with understanding HELP either via the internet or through contacting customer support. This was particularly true for some of the more complex features, such as collection of unpaid premiums against future state income tax refunds, or regarding copayments and method of collection. This is consistent with findings from earlier focus groups with HELP enrollees as well as interviews with HELP stakeholders.

While both enrollees and disenrollees generally thought their premiums were an amount they could afford, a larger proportion of disenrollees thought their premium amounts were more than they could afford compared to enrollees (19 percent compared to 12 percent). Few enrollee respondents had been subject to copays in the 6 months prior to answering the survey, but of those that reported paying copays, 86 percent indicated that the copays were affordable.

In general, HELP enrollees and disenrollees did not appear to have experienced barriers to accessing care, particularly with respect to cost. Over two-thirds of enrollees reported visiting a health professional in the last 6 months or getting prescription drugs. Only 11 percent of enrollee respondents mentioned not being able to get health care due to cost considerations in the past 6 months, and for 44-61 percent of these individuals, it was dental and/or vision care that proved challenging to obtain. The majority of disenrollees reported that they did not have trouble accessing care after being disenrolled

from HELP—potentially because many of them were voluntarily disenrolled and obtained other insurance coverage post-disenrollment from HELP.

Satisfaction with the HELP program was high among current enrollees, but somewhat less so among those disenrolled from the program. A majority of enrollees were somewhat to very satisfied with individual features of HELP including monthly premiums, the ability to see their doctors as well as choice of doctors, and coverage of health care services needed by these enrollee respondents. A smaller proportion expressed satisfaction with how copays work, which could be attributable to their lack of understanding about copays in HELP. Among the disenrollee respondents, as is to be expected, those who voluntarily disenrolled from the program appeared to be more satisfied than those who were disenrolled from the program for non-payment of premiums. However, nearly 55 percent of disenrollee respondents did indicate that they would choose to re-enroll in HELP, a slight increase from 50 percent of disenrollees during the first wave of surveys.

Other evaluations that surveyed Medicaid expansion enrollees have reported similar findings. For instance, a survey of members enrolled in the Healthy Indiana Plan (HIP) 2.0 found that overall 58 percent of enrollees reported being very satisfied with the program, while an additional 22 percent reported being somewhat satisfied.[52] Consistent with our findings on the affordability of HELP, the majority of enrollees in the Healthy Michigan Plan (HMP) who completed a survey strongly agreed or agreed that the amount they have to pay for HMP overall seems fair (85.8%) and the amount they pay for HMP is affordable (86.5%).[53] HMP enrollees also generally reported a good overall understanding of HMP's covered benefits, similar to HELP enrollees.

Limitations of the Beneficiary Survey Analysis

As with the first wave of the survey, response rates continued to be low. Our sample non-response analysis found disproportionate response rates by age group among enrollees, and no significant differences between disenrollee respondents and non-respondents on demographic factors. However, differences in responses between the differing demographic groups were quite modest, thus minimizing concern about a demographic bias in survey results.

[52] https://www.in.gov/fssa/hip/files/IN_HIP_Interim_Evaluation_Report_Final.pdf
[53] https://www.michigan.gov/documents/mdhhs/2018_HMV_2nd_Follow-Up_Survey_Report_-_Final_684779_7.pdf

IV. Assessment of the Impacts of HELP Through 2018

The qualitative analysis of Chapter II and the beneficiary survey results from Chapter III established that Montana was successful at implementing the core components of HELP, including launching a major Medicaid coverage expansion. The goal of the impact analysis is to assess the extent to which HELP has caused the changes in enrollee outcomes that were intended under the demonstration. Specifically, the impact analysis assesses whether HELP led to gains in health insurance coverage, health care access and affordability, health behaviors, and health status relative to what would have been expected under the other policy choices available to Montana--not expanding Medicaid, expanding Medicaid without a demonstration, and expanding Medicaid with a different demonstration. We would expect the changes introduced under HELP to first affect health insurance coverage, with any gains in coverage translating into improvements in health care access and affordability over time, followed later still by improvements in health behaviors and health status as access improves. We would also expect the impacts on the latter outcomes to be smaller than any impacts on health insurance coverage as uninsured individuals generally have some access to health care, including, in some cases, low-cost health care. Finally, we would expect the impacts of HELP relative to the states that did not expand Medicaid to be larger than the impacts relative to states that expanded Medicaid (without a demonstration or with a different demonstration).

In assessing HELP, the impact analysis relied on a quasi-experimental difference-in-differences evaluation design and data over time from the American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) that compares changes over time for adults in Montana to changes for similar adults in similar comparison states. The interim evaluation report (see footnote 6) provided estimates of the impacts of HELP through 2017. As detailed in that report, HELP led to a significant increase in health insurance coverage in Montana in 2016-17 relative to not expanding Medicaid, expanding Medicaid without a demonstration, or expanding Medicaid with a different demonstration. There was also some early evidence of gains in receipt of flu vaccines and in having a routine checkup in the previous 12 months in 2016-17 compared to all three groups of comparison states but little evidence of gains in health care affordability or health status. This summative report updates the impact estimates for changes through 2018, which is the third year of HELP operations.

To preview our findings on the impacts of HELP through 2018, HELP led to a significant increase in health insurance coverage in Montana. Between 2011-13 and 2017-18, health insurance coverage for adults increased significantly more in Montana than what would have been expected if Montana had not expanded Medicaid, had expanded Medicaid without a demonstration, or had expanded Medicaid with a different demonstration such as the demonstrations in Michigan and New Hampshire. We also found evidence that HELP increased health care access, as measured by having a routine check-up in the past 12 months, relative to states that did not expand Medicaid and those that expanded Medicaid, without a demonstration or with different demonstrations.

While these findings point to successes under HELP, the impact analysis has several limitations. Most importantly, we rely on quasi-experimental methods, which compare changes over time between Montana and similar states that provide the counterfactual for what would have happened in Montana in the absence of HELP. Because it is not possible to identify states that match Montana across all dimensions (e.g., demographic, social, economic, health, and political context), any differences identified in the comparisons between Montana and the comparison states will reflect differences in those factors as well as differences in Medicaid expansion strategies. In addition, the impact analysis is

limited to national survey data from the ACS (for health insurance coverage) and the BRFSS (for the remaining outcomes), which means the impact analysis focuses on the overall impacts of HELP for the outcomes available in those surveys. We do not have the data needed to disentangle the impacts of different components of HELP nor do we have the data to look at outcomes beyond those available in the ACS and BRFSS, including more detailed measures of health care access (e.g., additional measures of preventive care use and emergency department visits). In general, we have more confidence in the estimates for health insurance coverage, which are based on the ACS, than the estimates for health care access and affordability, health behaviors, and health status, which are based on the smaller samples of the BRFSS. Further, because of limitations in the income data available in the BRFSS, we have more confidence in the BRFSS estimates for all adults than in the BRFSS estimates for low-income adults. Finally, the impact estimates reported here are based on data through 2018, which is early in the post-implementation period for Montana, particularly given the fiscal challenges faced by Montana in 2017 and the changes to HELP introduced under the December 2017 demonstration amendments.

In the remainder of this chapter, we present the research questions that motivate the impact analysis, followed by a brief discussion of our data and methods, and the limitations of our data and methods. We then present the results from the assessment of the impacts of HELP. More detailed information about the data and methods are available from the evaluation design report (see footnote 5) and the interim evaluation report (see footnote 6).

Research Questions

The impact analysis is organized around three research questions:

1. What are the impacts of Montana's Medicaid expansion demonstration compared with not expanding Medicaid?
2. What are the impacts of Montana's Medicaid expansion demonstration compared with expanding Medicaid without a demonstration?
3. What are the impacts of Montana's Medicaid expansion demonstration compared with expanding Medicaid with a different demonstration?

We hypothesize that Montana's alternative Medicaid expansion demonstration will lead to gains in health insurance coverage and other outcomes relative to not expanding Medicaid. Given Montana's focus on encouraging preventive care, we would expect the state to see gains in preventive care use over time relative to non-expansion states. We have no *a priori* expectations regarding the impacts of Montana's expansion demonstration relative to other strategies for expanding Medicaid, including expanding without a demonstration and expanding with a different type of demonstration than Montana HELP.

As noted above, we expect the changes introduced under the HELP demonstration to first affect health insurance coverage and the mix of public and private health insurance coverage in the state, with any gains in coverage translating into improvements in health care access and affordability over time, followed later still by improvements in health behaviors and health status as access improves. We would also expect the impacts on the latter outcomes to be smaller than any impacts on health insurance coverage as uninsured individuals generally have access to some health care.

Overview of Data, Methods, and Limitations

We provide a brief overview of data, methods, and limitations here. More detailed information is available in the evaluation design report (see footnote 5) and the interim evaluation report (see footnote 6).

Data

We used data from the ACS and BRFSS from 2011 to 2018. We define the pre-HELP period as 2011 to 2013.[54] This provides a 3-year baseline period before implementation of ACA's Medicaid expansion and Marketplace provisions began in 2014. In this report, we exclude 2014 to 2016 from the study period as transition years associated with the Marketplace rollout and Medicaid expansions in many states (2014) and the rollout of HELP in Montana (2016). In the interim evaluation report, we reported on the impacts of HELP in 2016-17, which were early estimates of the impacts of HELP. In this report, we focus on the impacts of HELP in 2017-18, which are the second and third years of HELP operations. We treat 2017-18 as the postperiod rather than 2018 alone to maximize the available sample size for the most recent postperiod. We provide impact estimates for the 2017 and 2018 postperiods in Appendix C. In general, the impact estimates for the 2017 and 2018 postperiods are similar to the estimates for the 2017-18 postperiod, although, as would be expected with the smaller sample sizes for 2017 and 2018 alone, there are some differences in statistical significance.

We also provide estimates in Appendix C that define the postperiod based on the timing of the implementation of the Medicaid expansion in Montana and the comparison states rather than calendar years. Specifically, we compare the second and third years after the implementation of the Medicaid expansion, which is 2017-18 for Montana and 2015-16 for the comparison states. In general, the impact estimates based on the second and third years after implementation as the postperiod are similar to the estimates based on the 2017-18 calendar year postperiod.

We focus on the impacts of HELP for adults 19 to 64. We also provide estimates for the low-income population targeted by the Medicaid expansion: adults with family income at or below 138 percent of FPL. However, identifying those income groups in the BRFSS involves some degree of measurement error and sample sizes for the low-income population in the BRFSS are often small, rendering those impact estimates less precise than estimates based on the ACS. Issues with the BRFSS income measure are discussed in the interim evaluation report (see footnote 6).

We focus on measures of health insurance coverage from the ACS and measures of health care access and affordability, health behaviors, and health status from the BRFSS. The outcome measures include:

[54] We explored two alternate pre-HELP periods. First, given the potential for spillover effects on Medicaid enrollment from the first Marketplace open enrollment period in 2013, we also considered a pre-HELP period of 2011-12. Second, because 2011 was the first year of a major redesign of the BRFSS, a key data source for the evaluation, we considered a pre-HELP period of 2012-13. As reported in the interim evaluation report, the choice of preperiod had little effect on the findings.

- Health insurance coverage at the time of the survey, including type of health insurance coverage (Medicaid or other public coverage, employer-sponsored insurance, or direct purchase or other coverage)[55]
- Health care access and affordability
    - Had a personal doctor at the time of the survey
    - Had a routine check-up in the past 12 months
    - Had a flu vaccine in the past 12 months
    - No unmet need for doctor care due to costs in the past 12 months[56]
- Health behaviors and health status
    - Smoker at the time of the survey
    - Smoker who did not try to quit in the past 12 months
    - Health status was fair or poor at the time of the survey
    - Physical health was not good in the past 30 days (defined as not good for at least 1 day)
    - Mental health was not good in the past 30 days (defined as not good for at least 1 day)
    - Had an activity limitation due to health issues at the time of the survey

Although we report on type of health insurance coverage, evidence suggests that respondents misreport their coverage type in surveys, particularly between Medicaid or other public coverage and direct purchase.[57, 58, 59]

Because the ACS and BRFSS are both fielded continuously over the year (with one-twelfth of the sample interviewed in each month), the estimates for outcomes measured at the time of the survey (e.g., a respondent's health insurance coverage, whether he or she has a personal doctor, and his or her health status) are averages for the calendar year. By contrast, the estimates for outcomes that have a 12-month look-back period (e.g., whether the respondent had a routine check-up in the past 12 months and whether the respondent received a flu vaccine in the past 12 months) will include periods from the previous calendar year. For adults interviewed in July 2017, for example, the past 12 months would include August through December 2016 and January through July 2017, where 2016 is the implementation year for HELP. Consequently, the look-back period in the BRFSS for those measures exacerbates the lag between the likely impacts of HELP on health care access and affordability and health outcomes (which are expected to be on a slower path than any impacts on health insurance

[55] Because some respondents report multiple types of health insurance coverage, we impose a hierarchy on coverage type in presenting the results based on Medicaid or other public coverage first, employer-sponsored insurance second, and direct purchase or other coverage third.

[56] We frame this as a "positive" outcome so that higher values indicated better access and affordability across all the measures examined.

[57] Call, KT., ME Davern, JA Klerman, V Lynch. "Comparing Errors in Medicaid Reporting across Surveys: Evidence to Date." *Health Services Research* 48(2pt1) (2013): 652-664.

[58] Boudreaux, MH, KT Call, J Turner, B Fried, B O'Hara. "Measurement Error in Public Health Insurance Reporting in the American Community Survey: Evidence from Record Linkage." *Health Services Research* 50 (6) (2015): 1973-1995.

[59] Noon, JM, LE Fernandez, SR Porter. "Response Error and the Medicaid Undercount in the Current Population Survey." *Health Services Research* 54(1) (2016): 34-43.

coverage) and the ability to detect those lagged impacts with the available data, which are limited to 2018 in this report.

Finally, while the BRFSS design calls for continuous fielding of the survey over the year, in conducting the analysis of the 2017-18 data we discovered that a number of comparison states have gaps in the months in which the survey was fielded, with the gaps more frequent in 2017-18 than in earlier years.[60] While the gaps in fielding are not expected to have a significant effect on most measures, they can have an impact on seasonal measures, including receipt of a flu vaccine. We would expect states with gaps in data collection in winter months to underestimate receipt of flu vaccines (by surveying more of their sample in the summer when they are less likely to remember having had a flu vaccine in the prior year), while states with gaps in data collection in summer months would tend to overestimate receipt of flu vaccine (by surveying more of their sample in the winter when they are more likely to have had a recent flu vaccine). Because of this data limitation, the analysis of the receipt of flu vaccine was limited to the states that had no gaps or only a single month gap in fielding over any of the study years.

Methods

The impacts of Montana's Medicaid expansion demonstration are estimated using a quasi-experimental difference-in-differences (DD) framework, meaning changes over time in Montana are compared with changes over time in comparison groups. The comparison groups provide an estimate of the counterfactual for what would have happened in Montana absent HELP. The empirical model for the DD analysis can be written as

$$Y_{ist} = \beta_1 MONTANA_s + \beta_2 POST_t + \beta_3 (MONTANA_s * POST_t) + \boldsymbol{X}_i \beta_4 + \varepsilon_{ist}$$

Where Y is the outcome of interest for individual i in state s and time t; MONTANA takes the value one for individuals from Montana and zero for individuals in the comparison group; POST is a dummy for the post-HELP period relative to the pre-HELP period; and X is a vector of individual and family characteristics. β_3, the coefficient on the interaction term between MONTANA and POST, provides the DD estimate of the relative impact of Montana's Medicaid expansion on the outcome in the post-HELP period.

Defining the comparison groups. As noted, we consider three counterfactuals for Montana's Medicaid expansion demonstration: (1) not expanding Medicaid, (2) expanding Medicaid without a demonstration, and (3) expanding Medicaid with a different demonstration. We describe in detail the process to select the states to be included in each comparison group in the interim evaluation report (see footnote 6, Chapter V and Appendix E). Table IV.1 identifies the group of best comparison states for adults and the single-best comparison state from among each group of best comparison states. We focus on impact estimates using the group of best comparison states, but also report on impact estimates based on the single-best comparison state, as well as each of the comparison states within the group of best comparison states, since there is not a definitive approach for identifying an appropriate counterfactual to estimate the impacts of HELP. Given our inability to control for all the potential differences between Montana and the comparison states that could confound the impact estimates, we

[60] For example, four of the comparison states in Table IV.1 had gaps in fielding in 2011-2013, two had gaps in 2016, and four had gaps in 2017-18. Altogether, six of the comparison states had gaps of a month or more over the study period. For information on the gaps in 2018, see, Centers for Disease Control and Prevention. "The Behavioral Risk Factor Surveillance System: Comparability of Data BRFSS 2018." (2019).

have more confidence in estimates that are consistent across multiple comparison states and groups of comparison states.

Table IV.1: Comparison States for Adults Ages 19 to 64 in Montana

	Group of Best Comparison States	Single-best Comparison State
Similar states that did not expand Medicaid	GA, NC, WY	WY
Similar states that expanded Medicaid without a demonstration	KY, ND	ND
Similar states that expanded Medicaid with a different demonstration	MI, NH	MI

As shown in Table IV.1, the group of best comparison states include three states that did not expand Medicaid, two states that expanded Medicaid without a demonstration, and two states that expanded Medicaid with a different demonstration. The two states in that last group are New Hampshire, which focused on expanding private coverage through the Marketplace using premium assistance, and Michigan, which required premium contributions through a version of a health savings account and a wellness program.

We created the comparison groups for adults in the group of best comparison states, the single-best comparison state and for each of the remaining states in the group of best comparison states using propensity score weighting, as discussed in the interim evaluation report (see footnote 6, Chapter V and Appendix E). Propensity score models identify the adults in each comparison state (or group of comparison states) who are most similar to the adults in Montana. By using the propensity scores to create inverse probability weights, adults in the comparison states who were more similar to adults in Montana received larger weights while those who were less similar to Montana adults received lower weights.

Estimation approach. All the outcomes examined here are binary outcomes—which means their value can be either one or zero. For simplicity in comparing across the outcomes, we estimated the DD models using linear probability models,[61] controlling for the individual and family characteristics from the propensity score models as an additional adjustment for differences between adults in Montana and the comparison states. For the BRFSS, where we have additional data on elements of survey design, we also controlled for survey month and whether the respondent was a member of the cell phone sample in the BRFSS.[62] The analyses using the ACS and BRFSS were conducted using Stata version 15.1.[63] All estimates using the BRFSS and ACS were weighted and used Stata's "svy" command to control for the

[61] Linear probability models generally provide reliable estimates over average effects. See JD Angrist and JS Pischke, *Mostly Harmless Econometrics: An Empiricist's Companion* (Princeton, NJ: Princeton University Press, 2008).

[62] As noted above, the BRFSS conducts interviews with individuals drawn from landline and cell phone samples. Because there are differences across the two samples in how the respondent is selected (the landline sample selects a random adult from among all adults in the household while the cell phone sample respondent is the individual who answers the cell phone) and in some of the questions asked of the respondents, we controlled for the survey sample in the analysis.

[63] StataCorp, *Stata Statistical Software: Release 15* (College Station, TX: StataCorp LLC, 2017).

complex designs of the surveys. As reported in the interim evaluation report, we assessed the robustness of our findings to an alternate weighting (using ebalance rather than propensity score weighting) and alternative estimation strategies (using logit and probit regression rather than linear probability models). Since the alternate approach to propensity score reweighting and the alternate estimation methods had little effect on the DD estimates, we focus on the results based on the linear probability models using propensity score reweighting in this report.

The estimates from the DD models are based on two-tailed hypothesis tests in which we reject the null hypothesis of no difference between Montana and the comparison groups if the likelihood of the observed data under the null hypotheses is low. We report on statistical significance at the 10, 5 and 1 percent levels. When multiple hypotheses are tested (as is the case here), the likelihood of incorrectly rejecting a null hypothesis of no difference between Montana and the comparison group (i.e., making a Type I error) increases. To address this issue, we are cautious about interpreting isolated findings of significance (e.g., a single-significant estimate on access to care among multiple access outcomes) as evidence of an impact, particularly when the statistical significance level is relatively low. We have more confidence when our findings are consistent (e.g., all positive or all negative and statistically significant across several related measures and/or comparison groups).

Limitations

The impact analysis has several limitations. These include an inability to disentangle the impacts of different components of HELP. In addition, because we rely on quasi-experimental methods, our impact estimates likely incorporate some omitted variable bias because, absent random assignment, the potential for unmeasured differences between Montana and the comparison groups persists. To reduce the potential for omitted variable bias, we include a rich array of measures in both the propensity score reweighting and in the DD models. We also test the sensitivity of our estimates of HELP impacts using multiple comparison groups.

Further, the federal surveys, like all surveys, are subject to measurement error, including reporting error by respondents. This is particularly true for the household income measure in the BRFSS relative to the income measures in the ACS. Thus, we have more confidence in the measures of family income relative to FPL in the ACS than in the BRFSS. We also have more confidence in the estimates from the ACS because it provides larger sample sizes than the BRFSS. Because of the ACS's larger samples, we are better able to detect small changes in Montana relative to the comparison groups for measures of health insurance coverage than for the remaining outcomes examined.

As noted above, gaps in the fielding of the BRFSS in some states introduced measurement error in the measure for receipt of a flu vaccine, which is a seasonal measure. Thus, we have more confidence in estimates based on states that do not have gaps in the fielding of the BRFSS in any of the study years. The states without gaps include Montana, one of the three comparison states that did not expand Medicaid (Georgia), and one of the two comparison states that expanded Medicaid with a different demonstration (Michigan). Both states that expanded Medicaid without a demonstration had gaps in the fielding of the BRFSS over the study period; however, Kentucky had only a single month gap in November 2017. We focus on these comparison states in estimating the impacts of HELP on the receipt of flu vaccines over the past 12 months.

Finally, as noted, these estimates are based on data through 2018, which is relatively early in the Montana demonstration and thus may not capture the ultimate effects of HELP, particularly any changes

that reflect the effects of that state's fiscal difficulties in 2017 and the modifications to HELP that were made as part of the December 2017 demonstration amendments. This is particularly true for effects on health care access and affordability, health behaviors, and health status, which will likely take longer to be influenced by HELP than changes in health insurance coverage. The delay in impacts on those outcomes is further complicated because many of them rely on variables with a 12-month look-back period in the BRFSS.

Results

Simple Differences over Time

Table IV.2 provides simple differences in the study outcomes for adults ages 19 to 64 in Montana between 2011-13 (preperiod) and 2017-18 (postperiod). As shown, we see significant gains in health insurance coverage for Montana adults in 2017-18 relative to the preperiod, as well as significant gains in health care access and affordability. We also see improvements in health behaviors and health, with significantly fewer smokers, smokers who had not tried to quit, and individuals reporting poor physical health.

In the remainder of this section, we present DD models to assess the changes over time for adults under Montana's HELP *relative* to states that did not expand Medicaid, expanded Medicaid without a demonstration, and expanded Medicaid with a different demonstration, respectively. Unlike the simple differences in study outcomes over time, the DD models provide estimates of changes in the study outcomes that were likely caused by the HELP demonstration.

Table IV.2: Changes in Health Insurance Coverage, Health Care Access and Affordability, and Health Behaviors and Health Status for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod)

	2011-13	2017-18	Difference	
Health insurance coverage (%)				
Had health insurance coverage at the time of the survey	75.6	88.0	12.5	***
Type of coverage				
Medicaid or other public coverage	9.2	17.3	8.1	***
Employer-sponsored insurance	56.8	59.5	2.7	***
Direct purchase or other coverage	9.6	11.3	1.6	***
Sample size	16,604	10,860		
Health care access and affordability (%)				
Had a personal doctor at the time of the survey	68.2	68.4	0.3	
Had a routine checkup in past 12 months	54.5	65.4	10.9	***
Received flu vaccine in past 12 months	31.6	32.8	1.2	
No unmet need for doctor care due to costs in past 12 months	85.2	88.3	3.1	***
Sample size	18,997	6,830		
Health behaviors and health status (%)				
Smoker at the time of the survey	21.8	18.0	-3.8	***
Smoker who did not try to quit in past 12 months	9.9	8.7	-1.2	**
Health status was fair or poor at the time of the survey	12.2	11.4	-0.8	
Physical health was not good in past 30 days	34.2	31.6	-2.6	***
Mental health was not good in past 30 days	35.1	37.0	1.8	*
Had an activity limitation due to health at the time of the survey	20.9	21.3	0.3	
Sample size	18,997	6,830		

Source: Health insurance coverage: 2011-13 and 2017-18 American Community Survey (ACS); Health care access and affordability, health behaviors, and health: 2011-13 and 2017-18 Behavioral Risk Factor Surveillance System (BRFSS). ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Difference-in-Differences Estimates of Changes in Health Insurance Coverage

Adults in Montana experienced significant gains in health insurance coverage between 2011-13 and 2017-18 relative to the changes for adults in similar states that did not expand Medicaid (Table IV.3). Under HELP, health insurance coverage for all adults increased 6.4 percentage points (p<.01) relative to similar adults in the group of best comparison states that did not expand Medicaid. As would be expected given HELP's focus on low-income adults, the relative gains in coverage under HELP were larger for low-income adults (defined as adults with family income at or below 138 percent of FPL), at 11.4 percentage points (p<.01). Similar patterns are observed if we focus on 2017 alone (Appendix Table C.1) and 2018 alone (Appendix Table C.2) as the postperiod for the impact estimates.

When compared with similar states that expanded Medicaid, whether without a demonstration or with a different demonstration, there were also significant gains in health insurance coverage in Montana between 2011-13 and 2017-18. Health insurance coverage increased by 3.4 percentage points (p<.01) for all adults and 3.2 percentage points (p<.05) for low-income adults in Montana relative to states that expanded Medicaid without a demonstration. Relative to states that expanded with a different demonstration, health insurance coverage increased by 3.3 percentage points (p<.01) for all adults and 4.7 percentage points (p<.01) for low-income adults in Montana.

Thus, the gains in health insurance coverage under HELP tended to be larger than the gains that would have been expected had Montana pursued other Medicaid expansion strategies. Similar patterns are observed if we focus on 2017 alone (Appendix Table C.1) or 2018 alone (Appendix Table C.2) as the postperiod for the impact estimates or if we define the postperiod based on the second and third years after implementation of the Medicaid expansion (which is 2017-18 for Montana and 2015-16 for the comparison states) rather than calendar year (Appendix Table C.3).

State-specific impact estimates. As a check on the impact estimates for health insurance coverage based on the groups of best comparison states, we also estimated the impacts of Montana's demonstration relative to the single-best comparison state and each of the remaining states in the groups of best comparison states. Table IV.4 summarizes the results from that analysis, with the detailed results underlying the summary provided in Appendix Table C.4.

As shown in Table IV.4, there were significantly larger coverage gains in Montana relative to each of the comparison states, regardless of whether they did not expand Medicaid, expanded Medicaid without a demonstration, or expanded Medicaid with a different demonstration. In all the comparison states except Kentucky, those gains can be attributed to significantly larger gains in Medicaid coverage in Montana relative to the comparison state. These patterns are also observed when we compare Montana and the comparison states based on the second and third years after implementation of the Medicaid expansion rather than calendar year (Appendix Table C.5). Thus, the relative impact of Montana's section 1115 demonstration on health insurance coverage tended to be larger than the impacts of similar states that expanded Medicaid.

Table IV.3: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had health insurance coverage at the time of the survey	6.4	***	4.9, 7.9	11.4	***	8.3, 14.5
Type of coverage						
Medicaid or other public coverage	7.0	***	5.9, 8.2	16.6	***	13.6, 19.6
Employer-sponsored insurance	-0.3		-2.0, 1.5	-2.2		-5.4, 1.0
Direct purchase or other coverage	-0.4		-1.6, 0.8	-3.0	***	-5.2,-0.7
Sample size	712,585			209,151		
Compared to Expanding Medicaid without a Demonstration						
Had health insurance coverage at the time of the survey	3.4	***	1.9, 4.9	3.2	**	0.0, 6.4
Type of coverage						
Medicaid or other public coverage	1.1	*	-0.1, 2.3	1.8		-1.4, 5.0
Employer-sponsored insurance	0.3		-1.6, 2.1	0.4		-3.0, 3.7
Direct purchase or other coverage	2.1	***	0.8, 3.4	1.1		-1.4, 3.5
Sample size	207,196			58,971		
Compared to Expanding Medicaid with a Different Demonstration						
Had health insurance coverage at the time of the survey	3.3	***	1.9, 4.8	4.7	***	1.8, 7.7
Type of coverage						
Medicaid or other public coverage	1.9	***	0.8, 3.1	4.3	***	1.3, 7.3
Employer-sponsored insurance	1.3		-0.3, 3.0	1.2		-1.9, 4.3
Direct purchase or other coverage	0.1		-1.0, 1.2	-0.8		-2.9, 1.4
Sample size	412,732			112,040		

Source: 2011-13 and 2017-18 American Community Survey (ACS).
Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Table IV.4: Summary of Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod) for Each of the Best Comparison States

	Group of Best Comparison States that Did Not Expand Medicaid			Group of Best Comparison States that Expanded Medicaid Without a Demonstration		Group of Best Comparison States that Expanded Medicaid with a Different Demonstration	
	WY^	**GA**	**NC**	**ND^**	**KY**	**MI^**	**NH**
Health insurance coverage at the time of the survey	+***	+***	+***	+***	+**	+***	+**
Type of coverage							
Medicaid or other public coverage	+***	+***	+***	+***	-	+***	+**
Employer-sponsored insurance	-	+	-	-	+	+	+
Direct purchase or other coverage	-	-	-	+	+	-	-

Source: 2011-13 and 2017-18 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: ^ indicates the single-best comparison state within group of best comparison states; + indicates positive impact estimate relative to comparison state; - indicates negative impact estimate relative to comparison state. The detailed findings that underlie this table are provided in Appendix Table C.4. For sample sizes, see Appendix Table C.16. ***/**/***** Impact estimate is significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Difference-in-Differences Estimates of Changes in Health Care Access and Affordability

As discussed, we would expect a lag between any changes in health insurance coverage under HELP and any subsequent effects on health care access and affordability. This lag is further compounded because of the 12-month look-back period for many of the health care access and affordability measures in the BRFSS. Given those data limitations, we would not necessarily expect to see robust changes in health care access and affordability in Montana between 2011-13 and 2017-18 relative to the comparison states. Nonetheless, we do see significant increases in Montana in the share of adults with a routine checkup in the past 12 months relative to not expanding Medicaid, to expanding Medicaid without a demonstration, and to expanding Medicaid with a different demonstration (Table IV.5). Similar patterns are observed if we focus on 2017 alone (Appendix Table C.6) or 2018 alone (Appendix Table C.7) as the postperiod for the impact estimates or if we define the postperiod based on the second and third years after implementation of the Medicaid expansion rather than calendar year (Appendix Table C.8). Similarly, we find increases in the share of adults receiving a flu vaccine in the past 12 months relative to not expanding Medicaid and expanding without a demonstration. As with the finding for routine checkups, the increase in flu vaccines is robust to alternate postperiods of 2018 alone (Appendix Table C.7) and the second and third implementation years (Appendix Table C.8). However, we do not find evidence of increased receipt of flu vaccines based on the 2017 postperiod (Appendix Table C.6).

State-specific impact estimates. We also estimated the impacts of Montana's demonstration relative to the single-best comparison state and each of the remaining states in the groups of best comparison states as a check on the impact estimates based on the groups of best comparison states for measures of health care access and affordability. Table IV.6 summarizes the results from that analysis, with the detailed results underlying the summary provided in Appendix Table C.9. As shown in Table IV.6, there were significant gains in receipt of routine checkups over the past 12 months in Montana relative to all the comparison states, regardless of Medicaid expansion status.[64] These patterns are also observed when we compare Montana and the comparison states based on the second and third years after implementation of the Medicaid expansion rather than calendar year (Appendix Table C.10).

[64] The findings reported here for receipt of a flu vaccine are also consistent with Table IV.5, however, that is because Table IV.5 is limited to a single comparison state within each group of best comparison states.

Table IV.5: Difference-in-Differences Estimates for Changes in Health Care Access and Affordability for Adults and Low-income Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had a personal doctor at the time of the survey	1.6		-0.5, 3.6	3.2		-2.4, 8.7
Had a routine checkup in past 12 months	6.8	***	4.5, 9.0	6.6	***	2.3,11.0
Received flu vaccine in past 12 months [a]	4.0	***	1.4, 6.6	4.3		-1.8,10.5
No unmet need for doctor care due to costs in past 12 months	0.8		-0.7, 2.3	4.4	**	0.2, 8.7
Sample size	98,526			14,059		
Compared to Expanding Medicaid Without a Demonstration						
Had a personal doctor at the time of the survey	1.5		-0.6, 3.6	0.1		-6.7, 6.9
Had a routine checkup in past 12 months	6.1	***	3.9, 8.3	4.9	**	0.2, 9.5
Received flu vaccine in past 12 months [a]	3.2	**	0.8, 5.7	-0.5		-7.5, 6.4
No unmet need for doctor care due to costs in past 12 months	-0.1		-1.6, 1.4	-0.3		-4.5, 3.9
Sample size	79,229			11,225		
Compared to Expanding Medicaid with a Different Demonstration						
Had a personal doctor at the time of the survey	0.3		-1.7, 2.4	-0.6		-6.3, 5.1
Had a routine checkup in past 12 months	3.6	***	1.4, 5.9	1.1		-3.5, 5.6
Received flu vaccine in past 12 months [a]	0.7		-1.5, 3.0	-0.6		-6.3, 5.1
No unmet need for doctor care due to costs in past 12 months	-1.3	*	-2.8, 0.2	-1.3		-5.2, 2.7
Sample size	82,279			10,201		

Source: 2011-13 and 2017-18 Behavioral Risk Factor Surveillance System (BRFSS).

Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. [a] Because of measurement error due to gaps in survey fielding in some states, the comparison groups for the analysis of the receipt of a flu vaccine are limited to GA for the comparison to not expanding Medicaid, limited to KY for the comparison to expanding Medicaid without a demonstration, and limited to MI for the comparison to expanding Medicaid with a different demonstration. For sample sizes, for the flu shot estimates, see Appendix Table C.16. */**/*** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Table IV.6: Summary of Difference-in-Differences Estimates of Changes in Health Care Access and Affordability for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod) for Each of the Best Comparison States

	Group of Best Comparison States that Did Not Expand Medicaid			Group of Best Comparison States that Expanded Medicaid Without a Demonstration		Group of Best Comparison States that Expanded Medicaid with a Different Demonstration	
	WY^	**GA**	**NC**	**ND^**	**KY**	**MI^**	**NH**
Had a personal doctor at the time of the survey	+	+***	-	+**	+	-	+
Had a routine checkup in past 12 months	+**	+***	+***	+***	+***	+**	+***
Received flu vaccine in past 12 months [a]	NA	+***	NA	NA	+**	+	NA
No unmet need for doctor care due to costs in past 12 months	+	+	-	+***	-**	-	-

Source: 2011-13 and 2017-18 Behavioral Risk Factor Surveillance System (BRFSS).

Notes: ^ Indicates single-best comparison state within group of best comparison states; + Indicates positive impact estimate relative to comparison state; - Indicates negative impact estimate relative to comparison state; NA is estimate not available. The detailed findings that underlie this table are provided in Appendix Table C.9. [a] Because of measurement error due to gaps in survey fielding in some states, the comparison groups for the analysis of the receipt of a flu vaccine are limited to GA for the comparison to not expanding Medicaid, limited to KY for the comparison to expanding Medicaid without a demonstration, and limited to MI for the comparison to expanding Medicaid with a different demonstration. For sample sizes, see Appendix Table C.16. */**/*** Impact estimate is significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Difference-in-Differences Estimates of Changes in Health Behaviors and Health Status

As with the expected lag in any impacts of Montana's Medicaid expansion demonstration on health care access and affordability, we would not necessarily expect to see robust changes in health behaviors and health status in Montana relative to the comparison states between 2011-13 and 2017-18. Consistent with that expectation, we find few significant differences in changes in health behaviors or health status in Montana relative to the comparison states, regardless of Medicaid expansion status (Table IV.7). However, Montana residents were significantly less likely to report that their physical health was not good in the past 30 days relative to each group of comparison states, although the level of statistical significance is low ($p<.10$) for the comparison to not expanding Medicaid and expanding Medicaid without a demonstration. Similar patterns are observed if we define the postperiod based on the second and third years after implementation of the Medicaid expansion rather than calendar year (Appendix Table C.13) or using the 2017 postperiod alone (Appendix Table C.11). However, when we define the postperiod as 2018 alone (Appendix Table C.12), the estimates relative to not expanding Medicaid and expanding without a demonstration are no longer statistically significant.

State-specific impact estimates. We also estimated the impacts of Montana's demonstration relative to the single-best comparison state and each of the remaining comparison states in the groups of best comparison states as check on the impact estimates based on the groups of best comparison states for health behaviors and health status. As would be expected given the findings for the groups of best comparison states, we find few statistically significant differences in changes in health behaviors and health status between Montana and the different comparison states. Table IV.8 summarizes the results from that analysis, with the detailed results underlying the summary provided in Appendix Table C.14. We observe the same pattern when we compare Montana and the comparison states based on the second and third years after implementation rather than calendar year (Appendix Table C.15).

Table IV.7: Difference-in-Differences Estimates for Changes in Health Behaviors and Health Status for Adults and Low-income Adults Ages 19 to 64 in Montana between 2011-13 (preperiod) and 2017-18 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Smoker at the time of the survey	0.0		-1.8, 1.7	0.7		-3.5, 4.9
Smoker who did not try to quit in past 12 months	0.2		-1.2, 1.5	0.5		-3.1, 4.1
Health status was fair or poor at the time of the survey	-0.4		-1.8, 0.9	-0.5		-3.6, 2.5
Physical health was not good in past 30 days	-1.9	*	-4.0, 0.2	-1.5		-5.8, 2.8
Mental health was not good in past 30 days	0.4		-1.7, 2.6	1.1		-6.2, 8.3
Had an activity limitation due to health at the time of the survey	-0.2		-2.0, 1.6	0.8		-3.7, 5.4
Sample size	98,526			14,059		
Compared to Expanding Medicaid Without a Demonstration						
Smoker at the time of the survey	0.4		-1.4, 2.1	0.2		-4.5, 4.9
Smoker who did not try to quit in past 12 months	1.3	*	0.0, 2.7	2.0		-2.0, 6.0
Health status was fair or poor at the time of the survey	-0.9		-2.3, 0.4	-0.5		-3.9, 2.8
Physical health was not good in past 30 days	-2.0	*	-4.1, 0.2	-2.1		-6.5, 2.4
Mental health was not good in past 30 days	-0.6		-2.8, 1.6	-0.1		-5.8, 5.5
Had an activity limitation due to health at the time of the survey	-0.2		-2.0, 1.7	2.0		-2.4, 6.4
Sample size	79,229			11,225		
Compared to Expanding Medicaid with a Different Demonstration						
Smoker at the time of the survey	-0.4		-2.1, 1.4	0.0		-4.2, 4.2
Smoker who did not try to quit in past 12 months	0.0		-1.3, 1.3	0.4		-2.9, 3.8
Health status was fair or poor at the time of the survey	-1.0		-2.4, 0.3	-1.4		-5.0, 2.2
Physical health was not good in past 30 days	-3.4	***	-5.6, -1.3	-4.5	*	-9.2, 0.2
Mental health was not good in past 30 days	-0.7		-3.0, 1.5	-0.6		-8.2, 7.0
Had an activity limitation due to health at the time of the survey	-1.4		-3.3, 0.4	-0.8		-5.5, 3.9
Sample size	82,279			10,201		

Source: 2011-13 and 2017-18 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH.
/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Table IV.8: Summary of Difference-in-Differences Estimates of Changes in Health Behaviors and Health Status for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod) for Each of the Best Comparison States

	Group of Best Comparison States that Did Not Expand Medicaid			Group of Best Comparison States that Expanded Medicaid Without a Demonstration		Group of Best Comparison States that Expanded Medicaid with a Different Demonstration	
	WY^	GA	NC	ND^	KY	MI^	NH
Smoker at the time of the survey	-	-	+	+	+	-	-
Smoker who did not try to quit in past 12 months	+	+	-	+	+*	-	+
Health status was fair or poor at the time of the survey	-	-	-	-	-	-*	-
Physical health was not good in past 30 days	-	-**	-	-	-*	-***	-
Mental health was not good in past 30 days	+**	-	-	-	+	-	+
Had an activity limitation due to health at the time of the survey	+	-	+	-	-	-*	-

Source: 2011-13 and 2017-18 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: ^ indicates single-best comparison state within group of best comparison states; + indicates positive impact estimate relative to comparison state; - indicates negative impact estimate relative to comparison state. The detailed findings that underlie this table are provided in Appendix Table C.14. For sample sizes, see Appendix Table C.16. ***/**/***** Impact estimate is significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Summary of Impact Analysis

Between 2011-13 (the period just before the ACA's Medicaid expansion and the launch of the Marketplace) and 2017-18 (the second and third years after the implementation of Montana's section 1115 HELP demonstration), health insurance coverage in Montana was significantly higher than what would have been expected if Montana had not expanded Medicaid. Specifically, the change in health insurance coverage in Montana was 6.4 percentage points ($p<.01$) higher for all adults and 11.4 percentage points ($p<.01$) higher for low-income adults relative to the group of best comparison states (Georgia, North Carolina, and Wyoming) that did not expand Medicaid.

Beyond simply examining the impact of HELP relative to no Medicaid expansion, an equally important question is how the impact of HELP on health insurance coverage compared to the impacts of alternate

strategies for Medicaid expansions, such as expanding without a section 1115 demonstration or expanding with a different demonstration. We find that the gains in health insurance coverage for adults under HELP were significantly larger than those achieved by either the group of best comparison states (Kentucky and North Dakota) that expanded Medicaid without a demonstration or the group of best comparison states (Michigan and New Hampshire) that expanded Medicaid with a different demonstration.

V. Lessons Learned from HELP

The years following the implementation of HELP in Montana have seen marked progress in improving health care coverage for Montana's adult population, as well as gains in health behavior and health status, as shown by the federal evaluation of the demonstration. This evaluation followed HELP for 3 years post-implementation while exploring stakeholder as well as beneficiary views on the Montana HELP demonstration and assessing the impact of the demonstration on health insurance coverage and access to care. Findings from all three components of this HELP evaluation show that the program had significant and positive effects. However, as with any program, implementation and administration of the demonstration were not without problems. Overall, however, health insurance coverage increased substantially; beneficiaries were largely satisfied with the program, and stakeholders believed it had positive economic impacts by reducing hospital uncompensated care and bolstering the state's overall economy.

One of the principal lessons from Montana's section 1115 demonstration is that allowing Montana to use a section 1115 demonstration to test alternative approaches to Medicaid coverage resulted in a program that achieved a key goal of both the ACA and the state—a significant expansion in health insurance coverage. As of January 1, 2020, nearly 85,000 Montanans were enrolled in HELP—8 percent of the state's population. Moreover, the expansion in health insurance coverage exceeded the gains that would have been expected if the state had expanded Medicaid without a demonstration or with a demonstration more similar to those of Michigan or New Hampshire.

Apart from increases in health insurance coverage, the three components of the federal evaluation of HELP provide a number of additional insights, which other states considering designing and implementing section 1115 Medicaid demonstrations or undertaking programmatic changes to their Medicaid program more generally may find beneficial to take into account:

- **Satisfaction with the HELP program was high among current enrollees, but somewhat less so among those disenrolled from the program.** A majority of enrollees were somewhat to very satisfied with individual features of HELP including monthly premiums, the ability to see their doctors as well as choice of doctors, and coverage of health care services needed by these enrollee respondents. Among the disenrollee respondents, as is to be expected, those who voluntarily disenrolled from the program appeared to be more satisfied than those who were disenrolled from the program for non-payment of premiums. However, 3 years post-implementation, a little over 50 percent of disenrollee respondents did indicate that they would choose to re-enroll in HELP.
- **HELP enrollees' and disenrollees' understanding of the individual features of HELP appears to be incomplete.** Focus groups and survey results show issues with beneficiary outreach and assistance, which could reduce beneficiary, and in some cases provider, confusion about who is eligible, what is covered, and what copayments are required. In fact, focus group participants expressed a desire for better education and information regarding the provisions of HELP.
- **Access to health care improved for many beneficiaries. Focus groups and stakeholder interviews showed that access was viewed favorably by both beneficiaries and stakeholders.** With gains in health insurance coverage, enrollees in focus groups said their access to care had improved relative to their access before being covered under HELP. Access barriers were more prevalent for dental and vision services than for other services, even with HELP coverage. The impact analysis also provides evidence of gains in health care access and affordability, as well as

gains in health behaviors and health status in Montana relative to states that did not expand Medicaid and those that expanded Medicaid with or without a demonstration. However, given that the results are based on the first 3 years under HELP, a longer follow-up period is needed to more fully assess the impacts of HELP on health care access and affordability, health behaviors, and health status.

- **Strong stakeholder engagement and collaboration with the state expedites system change.** While state officials and stakeholders acknowledged that it took time and compromise to pass the Medicaid expansion in Montana, once HELP legislation was enacted, the deep collaboration between the state and stakeholders in implementing HELP created a win-win situation for hospitals, the broader health care system, and the uninsured in Montana.
- **Changing patterns of health care use is hard and requires a long-term commitment.** One of HELP's goals is to promote personal health responsibility. State officials and other interviewees noted that changing health care behaviors takes time as enrollees, especially enrollees who may never have had health insurance, learn how health insurance works and gain experience with the health care system. While state officials, other interviewees, and focus group participants reported continued gaps in enrollee understanding of HELP, they also noted evidence of changes in health care behaviors in response to the program as more enrollees were reported to be obtaining preventive care over time, a finding that our early impact estimates appear to support.
- **Flexibility in program design is important. State officials and other interviewees highlighted the importance of periodically revisiting the HELP demonstration design based on actual program experience.** For example, the administrative complexity of the original design of the 2 percent premium credit was difficult for the TPA plan to track and was a source of confusion for enrollees. As a result, Montana eliminated the premium credit as part of its 2017 demonstration amendments. Similarly, owing to administrative concerns and after conducting several cost-benefit analyses, the state decided not to implement copayments for non-emergent use of the emergency room.
- **Broader state contextual issues have important implications. Montana experienced a significant budget crisis in 2017.** In a cost saving measure, Montana as part of its 2017 demonstration amendments eliminated the TPA plan and brought all HELP enrollees into the state's traditional Medicaid plan, thereby removing the public-private partnership feature of HELP. Montana's budget crisis also affected the state hiring which caused Medicaid eligibility and enrollment problems, both for the general Medicaid program and for the HELP demonstration enrollees.

While this federal evaluation will not continue to track HELP as it moves forward, there is more that can be learned from Montana's section 1115 demonstration beyond the first few years of implementation. This is especially true for HELP given that on May 8, 2019, the Montana legislature reauthorized HELP as part of the Medicaid Reform and Integrity Act, which calls for several program changes including introducing community engagement requirements for some HELP enrollees, eliminating copayments, and increasing premiums for those enrollees who remain on the program more than 2 years. These programmatic changes were contained in the state's demonstration application for amendment and extension, which was submitted to CMS on August 8, 2019. Considering that the proposed changes to the HELP demonstration are currently under federal review, it will be critical to monitor the continued implementation and management of the demonstration as it evolves. Should the proposed changes go into effect, further research on how community engagement requirements affect HELP enrollment,

coupled with how a restructured premium schedule affects timely premium payment and disenrollment levels will be important to examine.

Appendix A: Methodological Approach for the HELP Beneficiary Surveys

Survey Sample and Response Rates

As with wave 1 of the survey, the sample frames (i.e., the lists of individuals meeting the inclusion criteria, and thus eligible to be sampled) for the enrollee and the disenrollee surveys were derived from the State of Montana HELP administrative database. At the time of sample frame creation, we used HELP program participation records from the database for each month during December 2016 – April 2018. Any individual who participated in the HELP program at any time during that period was included in the database.

Once included in the database, HELP enrollees had at least one record for each calendar month indicating current status (enrolled/disenrolled), reason for enrollment/disenrollment, income category relative to the federal poverty level, and demographic/residential information including zip codes which were then used to classify individuals as living in urban/rural areas.[65] In the event of a change in any component of an individual's status or demographics in a given month, the individual would have an additional record.

We devised processing rules for the administrative data to best approximate our inclusion/exclusion criteria for the sample frame for the survey using the information available. The enrollee survey sample frame consisted of all individuals aged 19-64 who resided in Montana and were enrolled in the HELP program in April 2018 and had indication of enrollment in each of the prior 5 months. "Unequivocal enrollment" was defined as having a record for April 2018 in which the "Eligibility_Indicator" field had an entry of "1" with no indication of failure to pay premium, and no separate record for that month indicating ineligibility. This definition was intended to capture individuals who were currently enrolled, and had been enrolled for sufficient time (at least 6 months) to have experience with the aspects of the program examined in this survey.

The disenrollee sample frame consisted of all individuals aged 19-64 who had been enrolled in Montana HELP at some point during the previous 6 months, but were unequivocally listed as disenrolled from the HELP program as of April 2018. "Unequivocal disenrollment" was defined as having a record for April 2018 in which the "Eligibility Indicator" field had an entry of "0", and no separate record for that month indicating eligibility. We excluded anyone whose first enrollment in the program occurred more than 12 months prior to the time of sample frame determination (April 2018).

We randomly sampled 2,187 enrollees and 1,745 disenrollees from the sample frames of 20,867 records and 1,745 records, respectively. A sample size of 2,187 aimed to yield 700 completed surveys; however, the disenrollee sample size was limited to 1,745 due to the low number of eligible individuals in the sample frame. We calculated response rates based on complete survey submissions received through November 30, 2018, where as long as the respondents answered at least one question in addition to the screening questions, we considered it a response, and included all answered questions in the analysis. Particularly considering the low response rate, we saw no reason to discard any information that was provided. Response rates for the primary questions (those not subject to being skipped based on other answers) was generally 90-95 percent. A total of 770 individuals (35.2 percent) of the enrollee cohort submitted an enrollee survey form. This response rate is comparable to that seen in other surveys of Medicaid enrollees (Barnett & Sommers, 2017). For the disenrollee survey, only 152 individuals (8.7

[65] Urban/rural was defined by mapping respondent zip codes to their corresponding county FIPS, and then using the county FIPs codes to classify them into core-based statistical areas (CBSAs). If a county fell in a CBSA it was considered urban. Counties that did not meet the definition of a CBSA were assigned as rural.

percent) in the sample returned a disenrollee survey. This low response rate is comparable to that seen in other surveys targeting subjects within this particular socioeconomic group.

We anticipated that between the date of survey subject selection and the date of subject response, some individuals in the samples would change status from enrollee to disenrollee, or vice versa. For those selected for the disenrollee survey, 235 (13.5 percent) of the disenrollee sample reported that they were currently enrolled by the time the survey was fielded and were administered the enrollee survey. Forty-five (2.1 percent) of those selected for the enrollee sample reported that they were not currently enrolled or unsure if they were currently enrolled in HELP and were administered the disenrollee survey.

Sample Non-Response Analysis

We conducted a non-response analysis to examine whether survey respondents and non-respondents differed on demographic factors by which program experiences or opinions might conceivably differ. In particular, we compared respondents and non-respondents on available demographic factors of sex, race, age group, urban/rural residence, and FPL category. Tables A.2 and A.3 below show percentage distributions of sex, race, urban/rural, FPL, and age group for the two sample populations, separately for those who responded and those who did not. Note that the information source for these tables is the Montana administrative file, so that non-respondent information can be included and fairly compared to respondent information. For all other tables with demographic variables, the information comes from survey responses. Hence, the demographics in Tables A.2 and A.3 may vary slightly from what is shown in other tables.

Among disenrollees there were no significant differences between the respondents and non-respondents on the demographic factors examined. For the enrollee population, the only statistically significant difference we found on the five observable characteristics between respondents and non-respondents was for age group, with only 53 percent of respondents being in the 19-39 age group, compared to 67 percent among non-respondents. The sample survey data are weighted to compensate for bias introduced by these differences between the respondents and non-respondents.

Sample Weights

For each survey, sample weights were developed in three steps to account for the probabilities of selection and to adjust for known ineligibility and nonresponse to reduce potential bias. The initial weight for each person in the sampling frame was calculated as the reciprocal of a given record's probability of selection from the sampling frame. To create the base weight, the initial weight was further adjusted by multiplying it by the number of records each person had in the sampling frame to compensate for unequal probabilities of selection.

The adjustment for ineligibility and nonresponse involved the creation of strata defined by demographic characteristics related to response. For the enrollees, the variables used for the adjustment strata were age (19-29 years, 30-39 years, 40-59 years, and 60+ years), race (nonwhite and white), gender, and residential location (urban and rural). Age (19-34 years, 35-49 years, and 50+ years) and residential location (urban and rural) were used for the adjustment strata for the disenrollees. Within these strata, adjustment factors for ineligibility and nonresponse were computed and applied to the base weights of the samples.

The eligibility weight is calculated using the ratio of the sum of the weights for the survey respondents, nonrespondents and known ineligible participants to the sum of the weights for the respondents and

nonrespondents. The base weight is multiplied by the ineligibility-adjusted ratio for respondents and nonrespondents to yield the eligibility weight.

The final weight accounts for differential non-response by demographic groups. The nonresponse adjustment factor is calculated as the ratio of the sum of eligible respondents plus eligible nonrespondents over eligible respondents. The nonresponse adjusted weight is calculated as the product of the eligibility weight and the nonresponse adjustment factor for survey respondents to derive the final sampling weight.

Appendix Table A.1: Survey domains and questions by respondent group

Appendix Table A.1 below presents the survey data elements that are specific to the enrollee and disenrollee surveys, as well as those that overlap across both surveys. Areas of overlap included the eligibility screening questions for the survey that asked about current enrollment in the program, demographic questions, and the domains on access to care, affordability of HELP, and satisfaction with HELP.

A. About Your HELP Enrollment

	Enrollee Survey	Disenrollee Survey
Are you currently enrolled in the "Montana Health and Economic Livelihood Partnership Plan" (also called "HELP")?	✓	✓
How long have you been enrolled in HELP?	✓	
Since you enrolled in HELP, was there ever a time you lost your coverage or were disenrolled from HELP?	✓	
About how long were you disenrolled from HELP?	✓	
Have you ever been enrolled in HELP?		✓
Were you enrolled in HELP within the last 12 months?		✓
How long ago did your HELP enrollment end?		✓
Why did your HELP enrollment end? *(I got an increase in my income and was no longer eligible for HELP; I had other health insurance available to me; I could not afford my monthly HELP premiums; I no longer wanted HELP coverage; I did not pay my premium within 90 days)*		✓
Would you try to re-enroll in HELP if you could?		✓

B. Before You Enrolled in HELP

	Enrollee Survey	Disenrollee Survey
In the 12 months before you enrolled in HELP, did you have any health insurance?	✓	
How long did you have that health insurance?	✓	
What type of health insurance did you have?	✓	
In the 12 months before you enrolled in HELP, did you get any preventive care (such as a routine checkup, blood pressure check, flu shot, family planning services, prenatal services, cholesterol or cancer screening)?	✓	

C. About Your HELP Plan

	Enrollee Survey	Disenrollee Survey
How well do you think you understand how your HELP plan works?	✓	
When you enrolled in HELP, did you look for any information in written materials or on the Internet about the HELP plan?	✓	
How helpful was the information about the HELP plan?	✓	
When you enrolled in HELP, did you get information or help from a customer service representative?	✓	
How helpful was the information you got?	✓	
From the time you submitted your application until your HELP coverage started, how much time did it take?	✓	

D. Experiences After Leaving HELP

	Enrollee Survey	Disenrollee Survey
After you were no longer enrolled in HELP, was there any time you needed health care but did not get it because of cost?		✓
After you were no longer enrolled in HELP, what types of health care were you unable to get because of cost?		✓
After you were no longer enrolled in HELP, did you go to a doctor, nurse, or any other health professional or get prescription drugs?		✓
After you were no longer enrolled in HELP, were any of your health care visits for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.		✓
Do you have any health insurance coverage right now?		✓
What type of health insurance do you have?		✓
How long have you had your current health insurance?		✓
After you were no longer enrolled in HELP, how long did it take you to get your current health insurance?		✓

E. Premiums and Copayments

	Enrollee Survey	Disenrollee Survey
How much is/was your monthly HELP premium?	✓	✓
How is/was that monthly premium paid, if at all?	✓	✓
Which of the following groups help/helped pay for monthly premium?	✓	✓
Would you say the amount of your monthly premium is/was: *(more than I can afford, an amount that I can afford, less than I can afford, not sure/don't know)*	✓	✓
In the last 6 months/while you were in help, how worried were you about not having enough money to pay your monthly premium?	✓	✓
What do you think will happen/would happen, if anything, if your monthly premium is not paid within 90 days?	✓	✓
Please tell us whether each of the following are/were a part of your HELP Plan: *(payment of any unpaid premiums within 90 days will allow me to keep my HELP coverage; payment of any unpaid premiums after 90 days will allow me to re-enroll in HELP within 12 months of my HELP plan start date; any unpaid premium balance may be collected from my future state income tax refunds)*	✓	✓
In the last 6 months/while you were in HELP, have you paid any copays?	✓	✓
In the last 6 months/while you were in HELP, would you say the amount you were required to pay for copays was: ***(****more than I can afford, an amount that I can afford, less than I can afford, not sure/don't know)*	✓	✓
The last time you received a bill for a copay, how was that copay paid, if at all?	✓	
How easy or hard was it to understand how HELP copays work?	✓	✓
For each of the following statements about HELP premiums, and copays, please tell us whether each of the following are/were a part of your HELP Plan: *(monthly premiums depend on my income; copays depend on which health care service(s) I use; copays will not be collected at the time of my health care service(s); unpaid premiums may be collected against my future state income tax refunds)*	✓	✓

F. Access to Care

	Enrollee Survey	Disenrollee Survey
In the last 6 months, did you go to a doctor, nurse, or any other health professional or get prescription drugs?	✓	
In the last 6 months, were any of your health care visits for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.	✓	
In the last 6 months, was there any time you needed health care but did not get it because of cost?	✓	
In the last 6 months, what types of health care were you unable to get because of cost? *(a visit to the doctor when I was sick; preventive care; a follow up visit to get tests or care recommended by my doctor; dental care; vision (eye) care; prescription drugs; emergency room care)*	✓	
As part of your HELP plan, is/was there an $8 copay for going to the emergency room for a non-emergency condition?	✓	✓
In the last 6 months/while you were in HELP, was there a time you thought about going to the emergency room when you needed care?	✓	✓
In the last 6 months/while you were in HELP, when you needed care did you go to the emergency room?	✓	✓
What was the main reason you did not go to the emergency room for care?	✓	✓

G. Satisfaction with HELP

	Enrollee Survey	Disenrollee Survey
Thinking about your overall experience with HELP, would you say you are: *(very satisfied, somewhat satisfied, neither satisfied nor dissatisfied, somewhat dissatisfied, very dissatisfied, not sure/don't know)*	✓	✓
Please tell us how satisfied or dissatisfied are you with each HELP item below: *(enrollment process; length of time for coverage to begin; ability to see my doctor; choice of doctors; coverage of health care services that I need; how copays work; cost of premiums; paying the same amount each month for premiums)*	✓	✓
For each of the following items, how does your current HELP plan compare to your previous health insurance plan? *(ability to afford my plan; coverage of health care services that I need; ability to see my doctor; ability to get health care services that I need)*	✓	

H. About You

	Enrollee Survey	Disenrollee Survey
Would you say that in general your health is: *(excellent, very good, good, fair, poor)*	✓	✓
What is the highest grade or level of school that you have completed?	✓	✓
What best describes your employment status?	✓	✓
What is your age?	✓	✓
Are you male or female?	✓	✓
Are you of Hispanic, Latino/a, or Spanish origin?	✓	✓
What is your race?	✓	✓
Please circle the number of people in your family (including yourself) that live in your household. Mark only one answer that best describes your family's total income over the last year before taxes and other deductions. Your best estimate is fine.	✓	✓
Did someone help you complete this survey?	✓	✓
How did that person help you?	✓	✓

Appendix Table A.2: Demographic Features of Respondents, Non-respondents, and Sample Pools

Enrollee Sample

	Respondents (N=770)	Non-Respondents (N=1,322)
Sex		
Female	57%	58%
Male	43%	42%
Race		
White	82%	84%
Other/Unspecified	18%	16%
Age Group*		
19-39	53%	67%
40-59	34%	28%
60+	13%	5%
FPL		
0 - <= 50%	-	-
>50% - <=100%	55%	55%
>100% - 133%	45%	45%
Residence		
Urban	36%	38%
Rural	64%	62%

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Appendix Table A.3: Demographic Features of Respondents, Non-respondents, and Sample Pools
Disenrollee Sample

	Respondents (N=152)	Non-Respondents (N=1,198)
Sex		
Female	64%	57%
Male	36%	43%
Race		
White	81%	78%
Other/Unspecified	19%	22%
Age Group		
19-34	59%	60%
35-49	24%	27%
50+	17%	13%
FPL		
0 - <= 50%	88%	84%
>50% - <=100%	5%	8%
>100% - 133%	7%	9%
Residence		
Urban	43%	40%
Rural	57%	60%

No statistically significant differences found.

Appendix B: Results from the HELP Beneficiary Surveys

This appendix provides supplemental tables to support the survey analysis reported in Chapter III

Results from the Enrollee Surveys

Understanding of and Information-Seeking About HELP

Table B.1: Enrollee – How well do you think you understand how your HELP plan works?

How well do you think you understand how your HELP plan works?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Very well	20%	1.62	24%	1.58
Somewhat	70%	1.96	68%	1.73
Not at all	9%	1.28	8%	0.98

Table B.2: Enrollee – When you enrolled in HELP, did you look for any information in written materials or on the Internet about the HELP plan?

When you enrolled in HELP, did you look for any information in written materials or on the Internet about the HELP plan?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	41%	2.10	37%	1.79
No	57%	2.13	62%	1.79
{If Yes} How helpful was the information about the HELP plan?				
Very helpful	35%	3.13	39%	2.97
Somewhat helpful	59%	3.23	53%	3.04
Not at all helpful	5%	1.26	6%	1.47

Table B.3: Enrollee – When you enrolled in HELP, did you get information or help from a customer service representative?

When you enrolled in HELP, did you get information or help from a customer service representative?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	47%	2.14	47%	1.84
No	51%	2.15	52%	1.84
{If Yes} How helpful was the information you got?				
Very helpful	61%	3.10	62%	2.59
Somewhat helpful	33%	2.90	34%	2.53
Not at all helpful	4%	1.94	3%	0.88

Table B.4: Enrollee – What do you think will happen, if anything, if your monthly premium is not paid within 90 days?

What do you think will happen, if anything, if your monthly premium is not paid within 90 days?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Nothing will happen	2%	0.61	3%	0.64
My HELP coverage could end	71%	1.93	68%	1.73
Not sure/Don't know	25%	1.83	28%	1.67
{If response=My HELP coverage could end} Please tell us whether each of the following are a part of your HELP Plan				
Payment of any unpaid premiums within 90 days will allow me to keep my HELP coverage				
Part of your HELP plan	43%	2.52	44%*	2.21
Not part of your HELP plan	8%	1.30	13%	1.49
Not sure	48%	2.56	42%	2.19
Payment of any unpaid premiums after 90 days will allow me to re-enroll in HELP within 12 months of my HELP plan start date				
Part of your HELP plan	26%	2.23	34%*	2.13
Not part of your HELP plan	7%	1.25	8%	1.17
Not sure	67%	2.40	56%	2.21
Any unpaid premium balance may be collected from my future state income tax refunds				
Part of your HELP plan	30%	2.28	34%*	2.12
Not part of your HELP plan	5%	0.94	8%	1.23
Not sure	65%	2.38	56%	2.21

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Table B.5: Enrollee – How easy or hard was it to understand how HELP copays work?

How easy or hard was it to understand how HELP copays work?*	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Very easy	24%	3.58	38%*	2.68
Somewhat easy	36%	4.00	33%	2.59
Neither easy nor hard	21%	3.64	16%	2.04
Somewhat hard	9%	2.22	11%	1.69
Very hard	7%	2.39	2%	0.76

*Only answered by respondents who said they had paid copays in the last 6 months.

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Table B.6: Enrollee – Please tell us whether each of the following are a part of your HELP plan

Please tell us whether each of the following are a part of your HELP Plan	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Monthly premiums depend on my income				
Part of your HELP plan	75%	1.90	73%	1.65
Not part of your HELP plan	3%	0.72	1%	0.45
Not sure	20%	1.76	24%	1.59
Copays depend on which health care services(s) I use				
Part of your HELP plan	44%	2.15	50%	1.84
Not part of your HELP plan	6%	1.00	6%	0.88
Not sure	48%	2.15	42%	1.82
Copays will not be collected at the time of my health care service(s)				
Part of your HELP plan	23%	1.79	31%*	1.69
Not part of your HELP plan	19%	1.74	22%	1.52
Not sure	57%	2.14	46%	1.84
Unpaid premiums may be collected against my future state income tax refunds				
Part of your HELP plan	28%	1.91	30%*	1.70
Not part of your HELP plan	4%	0.71	9%	1.03
Not sure	67%	2.01	60%	1.81

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Table B.7: Enrollee – As part of your HELP plan, is there an $8 copay for going to the emergency room for a non-emergency condition?

As part of your HELP plan, is there an $8 copay for going to the emergency room for a non-emergency condition?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	5%	0.98	5%	0.82
No	10%	1.49	15%	1.30
Not sure/Don't know	82%	1.78	79%	1.50

Access to Care

Table B.8: Enrollee – In the last 6 months, did you go to a doctor, nurse, or any other health professional or get prescription drugs?

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
In the last 6 months, did you go to a doctor, nurse, or any other health professional or get prescription drugs?				
Yes	71%	2.01	71%	1.69
No	26%	1.94	26%	1.65
Not sure/Don't know	1%	0.54	2%	0.46
{If Yes} In the last 6 months, were any of your health care visits for a routine checkup?				
Yes	47%	2.50	51%	2.17
No	50%	2.51	46%	2.16
Not sure/Don't know	2%	0.57	2%	0.63
In the last 6 months, was there any time you needed health care but did not get it because of cost?				
Yes	14%	1.49	11%	1.15
No	85%	1.58	88%	1.20
{If Yes} What types of health care were you unable to get because of cost?				
A visit to the doctor when I was sick				
Yes	25%	5.22	32%	5.26
No	55%	5.95	49%	5.56
N/A	17%	4.79	17%	4.05

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Preventive care				
Yes	33%	5.79	26%	4.88
No	51%	5.96	57%	5.48
N/A	13%	4.41	14%	3.75
A follow up visit to get tests or care recommended by my doctor				
Yes	34%	5.61	40%	5.48
No	49%	5.96	46%	5.53
N/A	14%	3.61	12%	3.51
Dental care				
Yes	59%	5.93	61%	5.36
No	30%	5.43	30%	5.03
N/A	8%	4.04	6%	2.50
Vision (eye) care				
Yes	45%	5.85	44%	5.49
No	42%	5.90	44%	5.55
N/A	10%	4.20	9%	3.20
Prescription drugs				
Yes	31%	5.55	23%	4.73
No	56%	5.86	63%	5.34
N/A	10%	3.05	12%	3.35
Emergency room care				
Yes	14%	3.84	14%	3.88
No	66%	5.36	64%	5.35
N/A	17%	4.04	20%	4.43

Table B.9: Enrollee – In the last 6 months, was there a time you thought about going to the emergency room when you needed care?

In the last 6 months, was there a time you thought about going to the emergency room when you needed care?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	23%	1.85	21%	1.51
No	75%	1.90	78%	1.54
{If Yes} In the last 6 months, when you needed care did you go to the emergency room?				
Yes	62%	4.64	57%	4.01
No	38%	4.64	43%	4.01
{If No} What was the main reason you did not go to the emergency room for care?				
Did not have a way to get there or could not afford to get there	13%	9.06	5%	2.63
Went to my doctor's office or clinic instead	29%	6.93	33%	5.86
Did not want to pay a copay	3%	2.30	3%	2.22
Waited to see if I would get better on my own	42%	7.84	46%	6.20
Some other reason	11%	4.24	10%	3.70

Affordability of HELP

Table B.10: Enrollee – How much is your monthly HELP premium?

	Wave 1		Wave 2	
	Weighted Percent	**Standard Error of Weighted Percent**	**Weighted Percent**	**Standard Error of Weighted Percent**
How much is your monthly HELP premium?				
$0 to $9	2%	0.96	6%	0.91
$10 to $19	26%	1.87	25%	1.59
$20 to $29	36%	2.01	34%	1.74
$30 to $39	15%	1.48	11%	1.17
$40 to $49	6%	0.94	5%	0.80
$50 and above	7%	1.29	8%	1.02
Not sure/Don't know	6%	1.11	10%	1.12

Table B.11: Enrollee – How is that monthly premium paid, if at all?

	Wave 1		Wave 2	
How is that monthly premium paid, if at all?	**Weighted Percent**	**Standard Error of Weighted Percent**	**Weighted Percent**	**Standard Error of Weighted Percent**
I pay it	83%	1.83	80%	1.49
Someone pays the full amount for me	3%	0.80	5%	0.87
I pay part and someone else pays part	0%	0.23	0%	0.17
The premium has not been paid	8%	1.38	7%	0.94
Not sure/Don't know	4%	0.93	7%	0.94
{If response= "Someone pays the full amount for me" or "I pay part and someone else pays part"}				
Which of the following groups help pay for monthly premium?*				
Family or friends	78%	10.08	53%	8.03
Other (includes community or non-profit organization, health services organizations, health care provider, employer, and other)	22%	10.08	47%	8.02

***Respondents could pick more than one category of the above.

Table B.12: Enrollee – Would you say the amount of your monthly premium is:

Would you say the amount of your monthly premium is:	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
More than I can afford	15%	1.65	12%*	1.19
An amount that I can afford	76%	1.91	77%	1.56
Less than I can afford	3%	0.64	4%	0.69
Not sure/Don't know	4%	0.89	7%	0.95
In the last 6 months, how worried were you about not having enough money to pay your monthly premium?				
Not at all worried	50%	2.15	54%*	1.84
A little worried	21%	1.66	26%	1.62
Somewhat worried	13%	1.39	11%	1.11
Very worried	7%	1.12	6%	0.82
Extremely worried	7%	1.36	4%	0.68

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Table B.13: Enrollee – In the last 6 months, have you paid any copays?

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
In the last 6 months, have you paid any copays?				
Yes	24%	1.79	44%	1.83
No	65%	2.04	48%	1.84
Not sure/Don't know	9%	1.25	8%	0.98
{If Yes} **In the last 6 months, would you say the amount you were required to pay for copays was:**				
More than I could afford	25%	3.70	11%	1.74
An amount that I could afford	69%	4.07	84%	2.04
Less than I could afford	3%	2.21	2%	0.80

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Not sure/Don't know	1%	1.03	2%	0.87
The last time you received a bill for a copay, how was that copay paid, if at all?				
I paid it	77%	3.79	85%	2.01
Someone paid it for me	5%	2.44	5%	1.21
The copay has not been paid	10%	2.71	7%	1.38
Not sure/Don't know	5%	1.71	3%	0.92

Satisfaction with HELP

Table B.14: Enrollee – Thinking about your overall experience with HELP, would you say you are:

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Thinking about your overall experience with HELP, would you say you are:				
Very Satisfied	48%	2.14	59%*	1.82
Somewhat Satisfied	25%	1.83	23%	1.56
Neither Satisfied nor Dissatisfied	15%	1.72	10%	1.12
Somewhat Dissatisfied	5%	1.03	2%	0.60
Very Dissatisfied	1%	0.45	1%	0.34
Not sure/Don't know	5%	0.94	4%	0.71
{If response= "Very/Somewhat Satisfied" or "Very/Somewhat Dissatisfied} **How satisfied or dissatisfied are you with:**				
Enrollment Process				
Very Satisfied	57%	2.33	58%	1.98
Somewhat Satisfied	25%	2.07	22%	1.66
Neutral	12%	1.58	14%	1.41
Somewhat Dissatisfied	4%	0.84	4%	0.75

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Very Dissatisfied	2%	0.61	1%	0.45
Length of time for coverage to begin				
Very Satisfied	63%	2.26	67%*	1.90
Somewhat Satisfied	23%	1.97	18%	1.56
Neutral	10%	1.42	12%	1.31
Somewhat Dissatisfied	3%	0.80	1%	0.42
Very Dissatisfied	1%	0.38	1%	0.47
Ability to see my doctor				
Very Satisfied	69%	2.17	74%	1.76
Somewhat Satisfied	16%	1.74	15%	1.44
Neutral	10%	1.41	6%	0.95
Somewhat Dissatisfied	2%	0.77	3%	0.65
Very Dissatisfied	2%	0.58	1%	0.47
Choice of doctors				
Very Satisfied	60%	2.27	67%*	1.88
Somewhat Satisfied	17%	1.69	17%	1.50
Neutral	15%	1.63	8%	1.09
Somewhat Dissatisfied	5%	1.10	5%	0.84
Very Dissatisfied	2%	0.59	3%	0.64
Coverage of health care services that I need				
Very Satisfied	58%	2.32	64%	1.92
Somewhat Satisfied	26%	2.06	20%	1.62
Neutral	10%	1.42	9%	1.14
Somewhat Dissatisfied	4%	0.92	3%	0.71
Very Dissatisfied	2%	0.61	3%	0.65
How copays work				
Very Satisfied	41%	2.29	53%*	2.00

	Wave 1		Wave 2	
	Weighted Percent	**Standard Error of Weighted Percent**	**Weighted Percent**	**Standard Error of Weighted Percent**
Somewhat Satisfied	19%	1.89	21%	1.64
Neutral	33%	2.20	20%	1.61
Somewhat Dissatisfied	3%	0.78	3%	0.67
Very Dissatisfied	2%	0.69	2%	0.54
Cost of premiums				
Very Satisfied	61%	2.29	67%*	1.89
Somewhat Satisfied	14%	1.56	15%	1.46
Neutral	18%	1.86	11%	1.29
Somewhat Dissatisfied	4%	0.91	3%	0.67
Very Dissatisfied	3%	0.79	2%	0.57
Paying the same amount each month for premiums				
Very Satisfied	75%	2.06	79%*	1.63
Somewhat Satisfied	14%	1.65	9%	1.13
Neutral	7%	1.24	8%	1.11
Somewhat Dissatisfied	2%	0.78	2%	0.59
Very Dissatisfied	1%	0.45	1%	0.32

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Before Enrolled in HELP and HELP Coverage

Table B.15: Enrollee – In the 12 months before you enrolled in HELP, did you have any health insurance?

	Wave 1		Wave 2	
	Weighted Percent	**Standard Error of Weighted Percent**	**Weighted Percent**	**Standard Error of Weighted Percent**
In the 12 months before you enrolled in HELP, did you have any health insurance?				
Yes	53%	2.15	50%	1.84
No	44%	2.14	46%	1.84
Not sure/Don't know	2%	0.68	4%	0.72
{If Yes} How long did you have that health insurance?				
All 12 months	77%	2.50	78%	2.19
6 to 11 months	14%	2.00	13%	1.84
Less than 6 months	7%	1.70	6%	1.30
What type of health insurance did you have?*				
Medicaid	20%	2.32	24%	2.23
Private	54%	2.87	56%	2.60
Other (including TRICARE, Indian Health Service, and other)	22%	2.40	17%	1.92
Not Sure/Don't Know	3%	0.93	6%	1.29
For each of the following items, how does your current HELP plan compare to your previous health insurance plan?				
Ability to afford my plan				
Better	63%	2.81	55%	2.62
The same	14%	2.05	19%	2.08
Worse	13%	1.96	9%	1.53
Not sure	5%	1.31	11%	1.72
Coverage of health care services that I need				
Better	35%	2.75	35%	2.49

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
The same	38%	2.82	36%	2.52
Worse	10%	1.66	11%	1.62
Not sure	12%	1.86	14%	1.83
Ability to see my doctor				
Better	25%	2.52	26%	2.31
The same	54%	2.88	53%	2.62
Worse	7%	1.48	8%	1.40
Not sure	9%	1.64	8%	1.42
Ability to get health care services that I need				
Better	31%	2.71	33%	2.46
The same	46%	2.87	48%	2.63
Worse	10%	1.74	7%	1.32
Not sure	8%	1.50	7%	1.35

*****Respondents could pick more than one category of the above.

Table B.16: Enrollee – In the 12 months before you enrolled in HELP, did you get any preventive care?

In the 12 months before you enrolled in HELP, did you get any preventive care (such as a routine checkup, blood pressure check, flu shot, family planning services, prenatal services, cholesterol or cancer screening)?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	61%	2.84	60%	2.59
No	30%	2.65	33%	2.48
Not sure/Don't know	8%	1.62	6%	1.34

*Only answered by respondents who said they had health insurance before they enrolled in HELP.

Table B.17: Enrollee – From the time you submitted your application until your HELP coverage started, how much time did it take?

From the time you submitted your application until your HELP coverage started, how much time did it take?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Less than a month	40%	2.08	49%	1.84
1 to 3 months	33%	2.04	26%	1.61
More than 3 months	4%	0.79	4%	0.68
Not sure/Don't know	21%	1.81	22%	1.51

Table B.18: Enrollee – How long have you been enrolled in HELP?

How long have you been enrolled in HELP?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
1 to 3 months	3%	0.78	3%	0.64
4 to 6 months	16%	1.75	11%	1.16
7 to 12 months	31%	1.94	23%	1.55
More than 12 months	49%	2.15	64%	1.78
Since you enrolled in HELP, was there ever a time you lost your coverage or were disenrolled from HELP?				
Yes	10%	1.50	11%	1.17
No	83%	1.84	80%	1.50
Not sure/Don't know	7%	1.16	9%	1.07
{If Yes} About how long were you disenrolled from HELP?				
Less than 1 month	30%	8.49	32%	5.41
1 to 3 months	44%	7.97	36%	5.45
More than 3 months	12%	5.30	16%	4.25
Not sure/Don't know	14%	5.70	16%	4.18

Results from the Disenrollee Surveys

Understanding of HELP

Table B.19: Disenrollee – While you were in HELP, what did you think would happen, if anything, if your monthly premium was not paid within 90 days?

While you were in HELP, what did you think would happen, if anything, if your monthly premium was not paid within 90 days?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Nothing would change	6%	1.87	5%	1.79
My HELP coverage would end	66%	3.66	58%	4.08
Not sure/Don't know	26%	3.37	35%	3.95
{If response=My HELP coverage would end} Please indicate whether you thought the following features were part of your HELP Plan				
Payment of any unpaid premiums within 90 days would have allowed me to keep my HELP coverage				
Part of your HELP plan	31%	4.34	45%	5.44
Not part of your HELP plan	13%	3.17	11%	3.40
Not sure	54%	4.71	44%	5.41
Payment of any unpaid premiums after 90 days would have allowed me to re-enroll in HELP within 12 months of my HELP plan start date				
Part of your HELP plan	18%	3.54	29%	4.95
Not part of your HELP plan	11%	2.98	17%	4.14
Not sure	69%	4.33	54%	5.44
Any unpaid premium balance may be collected from my future state income tax refunds				
Part of your HELP plan	37%	4.56	45%	5.44
Not part of your HELP plan	4%	1.89	11%	3.44
Not sure	57%	4.69	44%	5.40

Table B.20: Disenrollee – Please indicate whether you thought the following features were part of your HELP plan

Please indicate whether you thought the following features were part of your HELP Plan	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Monthly premiums depend on my income				
Part of your HELP plan	67%	3.62	63%	3.99
Not part of your HELP plan	4%	1.42	3%	1.50
Not sure	28%	3.47	33%	3.86
Copays depend on which health care service(s) I use				
Part of your HELP plan	43%	3.83	52%	4.13
Not part of your HELP plan	7%	2.14	7%	2.09
Not sure	48%	3.86	40%	4.04
Copays will not be collected at the time of my health care service(s)				
Part of your HELP plan	17%	2.93	27%	3.66
Not part of your HELP plan	25%	3.37	22%	3.41
Not sure	57%	3.84	50%	4.13
Unpaid premiums may be collected against my future state income tax refunds				
Part of your HELP plan	33%	3.64	37%	4.00
Not part of your HELP plan	5%	1.69	8%	2.20
Not sure	61%	3.77	54%	4.12

Table B.21: Disenrollee – As part of your HELP plan, was there an $8 copay for going to the emergency room for a non-emergency condition?

As part of your HELP plan, was there an $8 copay for going to the emergency room for a non-emergency condition?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	4%	1.48	3%	1.30
No	18%	2.98	35%	3.94
Not sure/Don't know	76%	3.29	59%	4.04

Table B.22: Disenrollee – How easy or hard was it to understand how HELP copays work?

How easy or hard was it to understand how HELP copays work?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Very easy	33%	6.73	27%	7.27
Somewhat easy	21%	5.77	42%	8.29
Neither easy nor hard	27%	6.06	12%	5.56
Somewhat hard	15%	5.15	11%	4.77
Very hard	3%	2.41	9%	4.93

Access to Care

Table B.23: Disenrollee – After you were no longer enrolled in HELP, was there any time you needed health care but did not get it because of cost?

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
After you were no longer enrolled in HELP, was there any time you needed health care but did not get it because of cost?				
Yes	21%	3.19	24%	3.52
No	75%	3.37	69%	3.82
Not sure/Don't know	3%	1.30	5%	1.80

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
{If Yes} What types of health care were you unable to get because of cost?				
A visit to the doctor when I was sick				
Yes	57%	8.59	47%	8.64
No	37%	8.33	41%	8.45
N/A	6%	4.07	12%	5.59
Preventive Care				
Yes	49%	8.77	34%	8.19
No	45%	8.68	51%	8.64
N/A	6%	4.07	15%	6.25
A follow up visit to get tests or care recommended by my doctor				
Yes	60%	8.48	56%	8.59
No	34%	8.08	38%	8.39
N/A	6%	4.44	6%	4.19
Dental care				
Yes	66%	8.32	66%	8.18
No	25%	7.57	34%	8.18
N/A	9%	5.14	0%	
Vision (eye) care				
Yes	46%	8.75	45%	8.60
No	47%	8.74	52%	8.63
N/A	6%	4.44	3%	2.85
Prescription drugs				
Yes	52%	8.77	43%	8.58
No	41%	8.65	45%	8.59
N/A	7%	4.85	12%	5.59

	Wave 1		Wave 2	
	Weighted Percent	**Standard Error of Weighted Percent**	**Weighted Percent**	**Standard Error of Weighted Percent**
Emergency room care				
Yes	33%	8.25	30%	8.05
No	56%	8.71	61%	8.50
N/A	11%	5.62	9%	4.96
While you were in HELP, was there a time you thought about going to the emergency room when you needed care?				
Yes	23%	3.32	22%	3.40
No	75%	3.36	77%	3.48
{If Yes} While you were in HELP, when you needed care, did you go to the emergency room?				
Yes	63%	8.06	49%	8.84
No	34%	7.99	51%	8.84
{If No} What was the main reason you did not go to the emergency room for care?				
Did not have a way to get there or could not afford to get there	16%	10.97	17%	9.48
Went to my doctor's office or clinic instead	15%	10.64	6%	6.03
Did not want to pay a copay	16%	10.97	7%	6.66
Waited to see if I would get better on my own	23%	12.35	51%	12.69
Some other reason	20%	13.01	19%	10.10

Table B.24: Disenrollee – After you were no longer enrolled in HELP, did you go to a doctor, nurse, or any other health professional or get prescription drugs?

After you were no longer enrolled in HELP, did you go to a doctor, nurse, or any other health professional or get prescription drugs?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	64%	3.70	47%	4.12
No	35%	3.67	45%	4.11
Not sure/Don't know	1%	0.53	6%	2.05
{If Yes} After you were no longer enrolled in HELP, were any of your health care visits for a routine checkup?				
Yes	45%	4.86	44%	5.92
No	46%	4.86	48%	5.96
Not sure/Don't know	7%	2.31	4%	2.53

Affordability of HELP

Table B.25: Disenrollee – How much was your monthly HELP premium?

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
How much was your monthly HELP premium?				
$0 to $9	13%	2.62	15%	2.92
$10 to $19	15%	2.71	12%	2.68
$20 to $29	23%	3.29	23%	3.46
$30 to $39	12%	2.51	11%	2.63
$40 to $49	6%	1.77	12%	2.71
$50 and above	10%	2.34	4%	1.58
Not sure/Don't know	21%	3.11	22%	3.40

	Wave 1		Wave 2	
	Weighted Percent	**Standard Error of Weighted Percent**	**Weighted Percent**	**Standard Error of Weighted Percent**
How was that monthly premium paid, if at all?				
I paid it	44%	3.83	61%	4.03
Someone paid the full amount for me	4%	1.65	3%	1.52
I paid part and someone else paid part	1%	0.53	2%	1.25
The premium has not been paid	26%	3.41	15%	2.94
Not sure/Don't know	24%	3.30	16%	3.04
{If response= "Someone paid the full amount for me" or "I paid part and someone else paid part"} **Which of the following groups helped pay for monthly premium?***				
Family or friends	50%	19.11	74%	16.74
Other (includes community or non-profit organization, health services organizations, health care provider, employer, and other)	39%	18.75	39%	18.69

*Respondents could pick more than one category of the above.

Table B.26: Disenrollee – While you were in HELP, would you say the amount of your monthly premium was:

	Wave 1		Wave 2	
While you were in HELP, would you say the amount of your monthly premium was:	**Weighted Percent**	**Standard Error of Weighted Percent**	**Weighted Percent**	**Standard Error of Weighted Percent**
More than I could afford	29%	3.53	19%	3.30
An amount that I could afford	51%	3.86	64%	3.98
Less than I could afford	4%	1.43	2%	1.25
Not sure/Don't know	14%	2.64	13%	2.76

Table B.27: Disenrollee – While you were in HELP, how worried were you about not having enough money to pay your monthly premium?

While you were in HELP, how worried were you about not having enough money to pay your monthly premium?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Not at all worried	48%	3.86	38%*	3.98
A little worried	15%	2.79	34%	3.91
Somewhat worried	16%	2.82	14%	2.91
Very worried	9%	2.20	3%	1.52
Extremely worried	9%	2.26	10%	2.48

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Table B.28: Disenrollee – While you were in HELP, did you pay any copays?

While you were in HELP, did you pay any copays? Copays are payments owed by you to your health care provider for health care services that you receive. You are responsible for paying the provider after the claim has been processed.	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	31%	3.57	25%	3.54
No	57%	3.82	59%	4.05
Not sure/Don't know	12%	2.37	15%	2.94

Table B.29: Disenrollee – While you were in HELP, would you say the amount you were required to pay for copays was:

While you were in HELP, would you say the amount you were required to pay for copays was:	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
More than I could afford	26%	6.22	26%	7.32
An amount that I could afford	71%	6.45	61%	8.17
Less than I could afford	2%	2.21	6%	4.03
Not sure/Don't know	1%	1.28	7%	4.34

Satisfaction with HELP

Table B.30: Disenrollee – Thinking about your overall experience with HELP, would you say you are:

Thinking about your overall experience with HELP, would you say you are:	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Very Satisfied	26%	3.38	37%*	3.97
Somewhat Satisfied	22%	3.14	21%	3.40
Neither Satisfied nor Dissatisfied	26%	3.46	14%	2.88
Somewhat Dissatisfied	9%	2.28	9%	2.33
Very Dissatisfied	9%	2.22	7%	2.21
Not sure/Don't know	7%	1.81	10%	2.45

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Table B.31: Disenrollee – Please tell us how satisfied or dissatisfied you are with each HELP item below

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Please tell us how satisfied or dissatisfied you are with each HELP item below.				
Enrollment process				
Very Satisfied	37%	4.58	43%	4.76
Somewhat Satisfied	21%	3.87	14%	3.33
Neutral	25%	4.18	20%	3.92
Somewhat Dissatisfied	8%	2.72	11%	3.00
Very Dissatisfied	8%	2.64	8%	2.73
Length of time for coverage to begin				
Very Satisfied	43%	4.71	53%	4.80
Somewhat Satisfied	21%	3.85	18%	3.70
Neutral	28%	4.28	18%	3.72
Somewhat Dissatisfied	3%	1.67	1%	0.53
Very Dissatisfied	5%	2.09	8%	2.66

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Ability to see my doctor				
Very Satisfied	48%	4.77	59%	4.73
Somewhat Satisfied	20%	3.71	13%	3.21
Neutral	21%	3.92	19%	3.75
Somewhat Dissatisfied	5%	2.15	3%	1.75
Very Dissatisfied	5%	2.25	4%	1.95
Choice of doctors				
Very Satisfied	41%	4.68	51%*	4.81
Somewhat Satisfied	19%	3.60	20%	3.81
Neutral	30%	4.47	16%	3.52
Somewhat Dissatisfied	7%	2.44	5%	2.09
Very Dissatisfied	2%	1.13	6%	2.39
Coverage of health care services that I need				
Very Satisfied	41%	4.66	53%	4.80
Somewhat Satisfied	21%	3.83	16%	3.52
Neutral	19%	3.81	19%	3.79
Somewhat Dissatisfied	10%	2.89	3%	1.54
Very Dissatisfied	8%	2.66	7%	2.42
How copays work				
Very Satisfied	30%	4.35	44%	4.77
Somewhat Satisfied	18%	3.61	17%	3.56
Neutral	39%	4.67	25%	4.18
Somewhat Dissatisfied	7%	2.48	6%	2.12
Very Dissatisfied	6%	2.24	7%	2.52
Cost of premiums				
Very Satisfied	45%	4.73	52%	4.81
Somewhat Satisfied	12%	3.19	14%	3.36

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Neutral	21%	3.93	17%	3.60
Somewhat Dissatisfied	9%	2.83	5%	2.00
Very Dissatisfied	10%	2.84	11%	3.08
Paying the same amount each month for premiums				
Very Satisfied	51%	4.77	60%	4.73
Somewhat Satisfied	13%	3.21	12%	3.21
Neutral	24%	4.09	17%	3.60
Somewhat Dissatisfied	4%	1.99	2%	1.45
Very Dissatisfied	7%	2.44	7%	2.49

/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

End of HELP Enrollment

Table B.32: Disenrollee – How long ago did your HELP enrollment end?

	Wave 1		Wave 2	
How long ago did your HELP enrollment end?	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Less than 3 months	16%	2.83	14%	2.87
3 to 6 months	27%	3.35	28%	3.68
More than 6 months	50%	3.86	38%	4.03
Not sure/Don't know	8%	2.05	20%	3.28

Table B.33: Disenrollee – Why did your HELP enrollment end?

Why did your HELP enrollment end?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
I got an increase in my income and was no longer eligible for HELP				
Yes	22%	3.23	27%	3.63
No	55%	3.84	47%	4.13
Not Sure	19%	3.03	24%	3.49
I had other health insurance available to me				
Yes	53%	3.85	43%	4.08
No	30%	3.56	42%	4.08
Not Sure	14%	2.63	13%	2.81
I could not afford my monthly HELP premiums				
Yes	25%	3.34	18%	3.14
No	52%	3.86	60%	4.03
Not Sure	21%	3.08	19%	3.24
I no longer wanted HELP coverage				
Yes	17%	2.85	17%	3.16
No	57%	3.81	64%	3.94
Not Sure	23%	3.25	16%	2.93
I did not pay my premium within 90 days				
Yes	16%	2.85	18%	3.21
No	57%	3.82	61%	4.01
Not Sure	24%	3.30	18%	3.12

Table B.34: Disenrollee – Would you try to re-enroll in HELP if you could?

Would you try to re-enroll in HELP if you could?	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Yes	50%	3.86	55%	4.11
No	30%	3.53	21%	3.37
Not sure/Don't know	20%	3.03	22%	3.41

Health Insurance Coverage after HELP

Table B.35: Disenrollee – Do you have any health insurance coverage right now?

	Wave 1		Wave 2	
	Weighted Percent	Standard Error of Weighted Percent	Weighted Percent	Standard Error of Weighted Percent
Do you have any health insurance coverage right now?				
Yes	83%	2.88	63%	3.99
No	15%	2.78	31%	3.80
Not sure/Don't know	1%	0.65	5%	1.87
{If Yes} What type of health insurance do you have?*				
Private	41%	4.18	49%	5.23
Medicaid	47%	4.23	33%	4.90
Other (includes TRICARE or other military health care, Medicare, Indian Health Service, and other)	18%	3.10	16%	3.82
Not Sure/Don’t Know	0%		3%	1.99
How long have you had your current health insurance?				
Less than one month	4%	1.67	10%	3.13
Between 1 and 6 months	40%	4.14	37%	5.08
More than 6 months	56%	4.20	52%	5.23

	Wave 1		Wave 2	
	Weighted Percent	**Standard Error of Weighted Percent**	**Weighted Percent**	**Standard Error of Weighted Percent**
How long did it take you to get your current health insurance?				
Less than one month	75%	3.66	73%	4.64
Between 1 and 6 months	18%	3.29	18%	4.03
More than 6 months	6%	1.97	3%	1.93

*Respondents could pick more than one category of the above.

Appendix C: Supplemental Tables for Chapter IV

This appendix provides supplemental tables to support the impact analysis reported in Chapter IV.

Appendix Table C.1: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had health insurance coverage at the time of the survey	6.1	***	4.2, 8.1	13.1	***	9.1,17.1
Type of coverage						
Medicaid or other public coverage	6.2	***	4.6, 7.9	13.9	***	9.5,18.3
Employer-sponsored insurance	-0.2		-2.7, 2.3	1.0		-3.4, 5.5
Direct purchase or other coverage	0.1		-1.6, 1.8	-1.8		-4.9, 1.2
Sample size	473,777			144,178		
Compared to Expanding Medicaid Without a Demonstration						
Had health insurance coverage at the time of the survey	2.8	***	0.8, 4.8	4.1	**	0.0, 8.1
Type of coverage						
Medicaid or other public coverage	0.8		-1.0, 2.6	0.7		-3.8, 5.3
Employer-sponsored insurance	-0.2		-2.8, 2.4	2.0		-2.7, 6.7
Direct purchase or other coverage	2.2	**	0.4, 4.0	1.3		-2.0, 4.6
Sample size	138,355			40,336		
Compared to Expanding Medicaid with a Different Demonstration						
Had health insurance coverage at the time of the survey	2.5	***	0.7, 4.3	3.9	**	0.2, 7.7
Type of coverage						
Medicaid or other public coverage	1.6	*	-0.0, 3.3	2.6		-1.7, 7.0
Employer-sponsored insurance	0.6		-1.7, 3.0	2.0		-2.3, 6.4
Direct purchase or other coverage	0.2		-1.4, 1.8	-0.7		-3.6, 2.2
Sample size	276,821			77,659		

Source: 2011-13 and 2017 American Community Survey (ACS).
Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.2: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2018 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had health insurance coverage at the time of the survey	5.8	***	4.2, 7.4	13.1	***	9.8, 16.4
Type of coverage						
Medicaid or other public coverage	7.8	***	6.5, 9.1	18.0	***	14.5, 21.4
Employer-sponsored insurance	-0.1		-2.1, 1.8	-1.2		-4.8, 2.3
Direct purchase or other coverage	-2.0	***	-3.3, -0.6	-3.7	***	-6.1, -1.2
Sample size	589,668			178,962		
Compared to Expanding Medicaid Without a Demonstration						
Had health insurance coverage at the time of the survey	3.4	***	1.8, 5.1	5.0	***	1.6, 8.5
Type of coverage						
Medicaid or other public coverage	2.4	***	1.0, 3.8	3.4	*	-0.3, 7.1
Employer-sponsored insurance	0.2		-1.8, 2.2	1.1		-2.7, 4.8
Direct purchase or other coverage	0.8		-0.6, 2.3	0.5		-2.2, 3.2
Sample size	172,639			50,101		
Compared to Expanding Medicaid with a Different Demonstration						
Had health insurance coverage at the time of the survey	4.1	***	2.6, 5.7	7.8	***	4.6, 11.0
Type of coverage						
Medicaid or other public coverage	4.0	***	2.7, 5.3	8.4	***	5.0, 11.8
Employer-sponsored insurance	1.0		-0.9, 2.8	0.6		-2.8, 4.1
Direct purchase or other coverage	-0.8		-2.1, 0.4	-1.3		-3.6, 1.1
Sample size	344,427			96,736		

Source: 2011-13 and 2018 American Community Survey (ACS).

Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.3: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and Second and Third Years Following Implementation of the Medicaid Expansion (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Expanding Medicaid Without a Demonstration						
Had health insurance coverage at the time of the survey	3.4	***	1.8, 5.1	5.0	***	1.6, 8.5
Type of coverage						
Medicaid or other public coverage	2.4	***	1.0, 3.8	3.4	*	-0.3, 7.1
Employer-sponsored insurance	0.2		-1.8, 2.2	1.1		-2.7, 4.8
Direct purchase or other coverage	0.8		-0.6, 2.3	0.5		-2.2, 3.2
Sample size	172,639			50,101		
Compared to Expanding Medicaid with a Different Demonstration						
Had health insurance coverage at the time of the survey	4.1	***	2.6, 5.7	7.8	***	4.6, 11.0
Type of coverage						
Medicaid or other public coverage	4.0	***	2.7, 5.3	8.4	***	5.0, 11.8
Employer-sponsored insurance	1.0		-0.9, 2.8	0.6		-2.8, 4.1
Direct purchase or other coverage	-0.8		-2.1, 0.4	-1.3		-3.6, 1.1
Sample size	344,427			96,736		

Source: 2011-13 and 2015-18 American Community Survey (ACS).
Notes: The postperiod is 2017-18 for Montana and 2015-16 for the comparison states. Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.4: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod) for Each of the Best Comparison States

	Group of Best Comparison States that Did Not Expand Medicaid						Group of Best Comparison States that Expanded Medicaid Without a Demonstration				Group of Best Comparison States that Expanded Medicaid with a Different Demonstration			
	WY^		GA		NC		ND^		KY		MI^		NH	
Health insurance coverage at the time of the survey	6.2	***	7.9	***	7.2	***	7.5	***	2.0	**	4.2	***	3.0	**
Type of coverage														
Medicaid or other public coverage	9.9	***	8.2	***	8.2	***	6.1	***	-0.2		3.2	***	2.5	**
Employer-sponsored insurance	-2.6		0.1		-0.7		-0.3		1.4		1.4		1.2	
Direct purchase or other coverage	-1.1		-0.4		-0.4		1.8		0.9		-0.3		-0.7	

Source: 2011-13 and 2017-18 American Community Survey (ACS).
Notes: ^ indicates single-best comparison state within group of best comparison states. For sample sizes, see Appendix Table C.16. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.5: Difference-in-Differences Estimates of Changes in Health Insurance Coverage for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and Second and Third Years Following Implementation of the Medicaid Expansion (postperiod) for Each of the Best Comparison States

	Group of Best Comparison States that Expanded Medicaid Without a Demonstration				Group of Best Comparison States that Expanded Medicaid with a Different Demonstration			
	ND^		KY		MI^		NH	
Health insurance coverage at the time of the survey	6.3	***	1.4	*	3.8	***	4.7	***
Type of coverage								
Medicaid or other public coverage	6.0	***	-0.4		3.5	***	4.7	***
Employer-sponsored insurance	-0.6		1.3		0.7		1.5	
Direct purchase or other coverage	1.0		0.4		-0.4		-1.5	*

Source: 2011-13 and 2015-18 American Community Survey (ACS). **Notes:** The postperiod is 2017-18 for Montana and 2015-16 for the comparison states. ^ indicates single-best comparison state within group of best comparison states. For sample sizes, see Appendix Table C.16. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.6: Difference-in-Differences Estimates for Changes in Health Care Access and Affordability for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had a personal doctor at the time of the survey	0.6		-2.1, 3.2	0.5		-6.7, 7.6
Had a routine checkup in past 12 months	6.4	***	3.5, 9.3	6.0	*	-0.1,12.1
Received flu vaccine in past 12 months [a]	2.8		-0.8, 6.4	4.9		-6.3,16.2
No unmet need for doctor care due to costs in past 12 months	1.2		-0.8, 3.2	4.6	*	-0.9,10.1
Sample size	83,262			12,178		
Compared to Expanding Medicaid Without a Demonstration						
Had a personal doctor at the time of the survey	1.1		-1.5, 3.8	-1.9		-10.9, 7.2
Had a routine checkup in past 12 months	6.2	***	3.3, 9.1	2.1		-4.9, 9.1
Received flu vaccine in past 12 months [a]	2.3		-1.0, 5.5	-0.7		-10.3, 8.9
No unmet need for doctor care due to costs in past 12 months	-0.7		-2.7, 1.2	-1.8		-6.8, 3.1
Sample size	67,255			9,754		
Compared to Expanding Medicaid with a Different Demonstration						
Had a personal doctor at the time of the survey	-0.2		-2.8, 2.4	-2.3		-9.3, 4.8
Had a routine checkup in past 12 months	3.2	**	0.3, 6.1	-0.6		-6.7, 5.5
Received flu vaccine in past 12 months [a]	0.4		-2.5, 3.3	-0.2		-7.2, 6.8
No unmet need for doctor care due to costs in past 12 months	-1.7	*	-3.6, 0.3	-1.8		-7.0, 3.3
Sample size	68,925			8,807		

Source: 2011-13 and 2017 Behavioral Risk Factor Surveillance System (BRFSS).

Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH.

[a] Because of measurement error due to gaps in survey fielding in some states, the comparison groups for the analysis of the receipt of a flu vaccine are limited to GA for the comparison to not expanding Medicaid, limited to KY for the comparison to expanding Medicaid without a demonstration, and limited to MI for the comparison to expanding Medicaid with a different demonstration. For sample sizes for the flu shot estimates, see Appendix Table C.16. */**/*** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.7: Difference-in-Differences Estimates for Changes in Health Care Access and Affordability for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2018 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Had a personal doctor at the time of the survey	2.6	*	-0.1, 5.4	6.3	*	-0.4, 13.0
Had a routine checkup in past 12 months	7.3	***	4.4, 10.1	7.3	**	1.1, 13.5
Received flu vaccine in past 12 months [a]	5.1	***	2.0, 8.2	3.6		-3.5, 10.8
No unmet need for doctor care due to costs in past 12 months	0.3		-1.7, 2.3	4.4	*	-0.7, 9.5
Sample size	84,766			12,250		
Compared to Expanding Medicaid Without a Demonstration						
Had a personal doctor at the time of the survey	2.0		-0.8, 4.8	2.5		-4.9, 10.0
Had a routine checkup in past 12 months	6.3	***	3.4, 9.2	8.2	**	1.4, 15.1
Received flu vaccine in past 12 months [a]	4.2	**	1.0, 7.4	-0.5		-7.5, 6.4
No unmet need for doctor care due to costs in past 12 months	0.7		-1.3, 2.7	1.6		-3.8, 6.9
Sample size	65,489			9,472		
Compared to Expanding Medicaid with a Different Demonstration						
Had a personal doctor at the time of the survey	0.9		-1.8, 3.6	1.5		-5.1, 8.1
Had a routine checkup in past 12 months	4.5	***	1.6, 7.3	3.1		-3.5, 9.7
Received flu vaccine in past 12 months [a]	1.2		-1.6, 4.1	-1.0		-8.7, 6.7
No unmet need for doctor care due to costs in past 12 months	-0.9		-2.9, 1.1	-0.4		-5.4, 4.5
Sample size	68,299			8,608		

Source: 2011-13 and 2018 Behavioral Risk Factor Surveillance System (BRFSS).

Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH. [a] Because of measurement error due to gaps in survey fielding in some states, the comparison groups for the analysis of the receipt of a flu vaccine are limited to GA for the comparison to not expanding Medicaid, limited to KY for the comparison to expanding Medicaid without a demonstration, and limited to MI for the comparison to expanding Medicaid with a different demonstration. For sample sizes for the flu shot estimates, see Appendix Table C.16. */**/*** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.8: Difference-in-Differences Estimates for Changes in Health Care Access and Affordability for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and Second and Third Years Following Implementation of the Medicaid Expansion (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Expanding Medicaid Without a Demonstration						
Had a personal doctor at the time of the survey	1.3		-0.8, 3.4	-1.4		-6.1, 3.3
Had a routine checkup in past 12 months	6.2	***	4.0, 8.5	3.9		-0.8, 8.6
Received flu vaccine in past 12 months [a]	3.4	***	0.9, 5.8	-0.7		-5.3, 3.9
No unmet need for doctor care due to costs in past 12 months	-0.1		-1.6, 1.4	-0.5		-4.3, 3.3
Sample size	79,236			11,206		
Compared to Expanding Medicaid with a Different Demonstration						
Had a personal doctor at the time of the survey	0.1		-1.9, 2.1	-1.4		-6.2, 3.5
Had a routine checkup in past 12 months	3.6	***	1.4, 5.9	0.6		-3.8, 5.0
Received flu vaccine in past 12 months [a]	1.0		-1.2, 3.2	-0.2		-5.3, 4.9
No unmet need for doctor care due to costs in past 12 months	-1.2		-2.8, 0.3	-1.7		-5.6, 2.1
Sample size	82,283			10,174		

Source: 2011-13 and 2015-18 Behavioral Risk Factor Surveillance System (BRFSS).

Notes: The postperiod is 2017-18 for Montana and 2015-16 for the comparison states. Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH.

[a] Because of measurement error due to gaps in survey fielding in some states, the comparison groups for the analysis of the receipt of a flu vaccine are limited to GA for the comparison to not expanding Medicaid, limited to KY for the comparison to expanding Medicaid without a demonstration, and limited to MI for the comparison to expanding Medicaid with a different demonstration. For sample sizes for the flu shot estimates, see Appendix Table C.16. */**/*** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.9 Difference-in-Differences Estimates of Changes in Health Care Access and Affordability for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod) for Each of the Best Comparison States

	Group of Best Comparison States that Did Not Expand Medicaid			Group of Best Comparison States that Expanded Medicaid Without a Demonstration		Group of Best Comparison States that Expanded Medicaid with a Different Demonstration	
	WY^	GA	NC	ND^	KY	MI^	NH
Had a personal doctor at the time of the survey	2.2	4.5***	-1.7	3.1**	0.5	-0.3	1.6
Had a routine checkup in past 12 months	3.6**	9.0***	7.7***	6.4***	5.5***	2.5**	4.9***
Received flu vaccine in past 12 months [a]	NA	4.0***	NA	NA	3.2**	0.7	NA
No unmet need for doctor care due to costs in past 12 months	1.6	1.1	-0.7	3.2***	-1.8**	-1.3	-0.9

Source: 2011-13 and 2017-18 Behavioral Risk Factor Surveillance System (BRFSS).

Notes: ^ indicates single-best comparison state within group of best comparison states. NA is estimate not available.

[a] Because of measurement error due to gaps in survey fielding in some states, the comparison groups for the analysis of the receipt of a flu vaccine are limited to GA for the comparison to not expanding Medicaid, limited to KY for the comparison to expanding Medicaid without a demonstration, and limited to MI for the comparison to expanding Medicaid with a different demonstration. For sample sizes, see Appendix Table C.16. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.10: Difference-in-Differences Estimates of Changes in Health Care Access and Affordability for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and Second and Third Years Following Implementation of the Medicaid Expansion (postperiod) for Each of the Best Comparison States

	Group of Best Comparison States that Expanded Medicaid Without a Demonstration				Group of Best Comparison States that Expanded Medicaid with a Different Demonstration			
	ND^		KY		MI^		NH	
Had a personal doctor at the time of the survey	2.8	**	0.2		-0.7		1.3	
Had a routine checkup in past 12 months	6.5	***	5.5	***	2.4	**	4.9	***
Received flu vaccine in past 12 months [a]	NA		3.4	***	1.0		NA	
No unmet need for doctor care due to costs in past 12 months	3.2	***	-2.0	**	-1.3		-1.0	

Source: 2011-13 and 2015-18 Behavioral Risk Factor Surveillance System (BRFSS).

Notes: The postperiod is 2017-18 for Montana and 2015-16 for the comparison states. ^ indicates single-best comparison state within group of best comparison states. NA is estimate not available. [a] Because of measurement error due to gaps in survey fielding in some states, the comparison groups for the analysis of the receipt of a flu vaccine are limited to GA for the comparison to not expanding Medicaid, limited to KY for the comparison to expanding Medicaid without a demonstration, and limited to MI for the comparison to expanding Medicaid with a different demonstration. For sample sizes, see Appendix Table C.16. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.11: Difference-in-Differences Estimates for Changes in Health Behaviors and Health Status for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Smoker at the time of the survey	-0.6		-2.8, 1.6	0.5		-4.9, 6.0
Smoker who did not try to quit in past 12 months	-0.4		-2.0, 1.3	-0.1		-4.3, 4.2
Health status was fair or poor at the time of the survey	0.1		-1.7, 1.9	0.8		-3.3, 4.9
Physical health was not good in past 30 days	-2.6	*	-5.3, 0.2	-1.8		-7.9, 4.2
Mental health was not good in past 30 days	-1.1		-3.9, 1.7	0.1		-8.6, 8.7
Had an activity limitation due to health at the time of the survey	-0.4		-2.8, 1.9	-0.3		-5.8, 5.3
Sample size	83,262			12,178		
Compared to Expanding Medicaid Without a Demonstration						
Smoker at the time of the survey	-0.1		-2.3, 2.1	1.2		-5.3, 7.7
Smoker who did not try to quit in past 12 months	0.8		-0.8, 2.5	2.7		-1.8, 7.1
Health status was fair or poor at the time of the survey	-1.3		-3.1, 0.6	-0.8		-5.0, 3.5
Physical health was not good in past 30 days	-3.0	**	-5.8,-0.3	-3.2		-10.1,3.7
Mental health was not good in past 30 days	-2.0		-4.8, 0.8	-1.2		-8.2, 5.9
Had an activity limitation due to health at the time of the survey	-0.7		-3.1, 1.6	0.4		-5.0, 5.8
Sample size	67,255			9,754		
Compared to Expanding Medicaid with a Different Demonstration						
Smoker at the time of the survey	-1.2		-3.4, 1.1	0.8		-4.7, 6.4
Smoker who did not try to quit in past 12 months	-0.9		-2.5, 0.8	0.0		-4.2, 4.2
Health status was fair or poor at the time of the survey	-0.4		-2.2, 1.4	-0.7		-4.9, 3.6
Physical health was not good in past 30 days	-4.6	***	-7.4,-1.9	-6.0		-13.3,1.3
Mental health was not good in past 30 days	-2.3		-5.2, 0.5	-2.1		-11.0,6.7
Had an activity limitation due to health at the time of the survey	-2.2	*	-4.6, 0.2	-2.2		-7.6, 3.2
Sample size	68,925			8,807		

Source: 2011-13 and 2017 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH.
/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.12: Difference-in-Differences Estimates for Changes in Health Behaviors and Health Status for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2018 (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Not Expanding Medicaid						
Smoker at the time of the survey	0.8		-1.6, 3.1	1.0		-4.2, 6.2
Smoker who did not try to quit in past 12 months	0.8		-1.0, 2.5	1.2		-3.4, 5.7
Health status was fair or poor at the time of the survey	-1.0		-2.6, 0.7	-2.2		-6.2, 1.8
Physical health was not good in past 30 days	-1.1		-3.9, 1.7	-0.9		-6.9, 5.0
Mental health was not good in past 30 days	2.3		-0.6, 5.2	2.4		-6.8, 11.7
Had an activity limitation due to health at the time of the survey	0.2		-2.2, 2.6	2.0		-4.4, 8.4
Sample size	84,766			12,250		
Compared to Expanding Medicaid without a Demonstration						
Smoker at the time of the survey	1.0		-1.5, 3.4	-0.9		-6.5, 4.6
Smoker who did not try to quit in past 12 months	1.9	**	0.1, 3.8	1.1		-4.0, 6.3
Health status was fair or poor at the time of the survey	-0.6		-2.4, 1.1	-0.4		-5.1, 4.4
Physical health was not good in past 30 days	-0.7		-3.5, 2.2	-0.5		-7.6, 6.6
Mental health was not good in past 30 days	1.1		-1.9, 4.1	1.1		-5.4, 7.7
Had an activity limitation due to health at the time of the survey	0.6		-1.9, 3.1	3.9		-3.4, 11.2
Sample size	65,489			9,472		
Compared to Expanding Medicaid with a Different Demonstration						
Smoker at the time of the survey	0.7		-1.6, 3.0	-1.0		-7.1, 5.2
Smoker who did not try to quit in past 12 months	1.0		-0.8, 2.8	1.0		-3.1, 5.0
Health status was fair or poor at the time of the survey	-1.7	*	-3.5, 0.0	-2.5		-7.6, 2.5
Physical health was not good in past 30 days	-2.0		-4.9, 0.8	-2.3		-9.2, 4.5
Mental health was not good in past 30 days	1.2		-1.7, 4.2	1.2		-7.3, 9.7
Had an activity limitation due to health at the time of the survey	-0.5		-3.0, 1.9	0.8		-5.9, 7.6
Sample size	68,299			8,608		

Source: 2011-13 and 2018 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. Best comparison states for not expanding Medicaid are GA, NC, and WY. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH.
/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.13: Difference-in-Differences Estimates for Changes in Health Behaviors and Health Status for Adults and Low-income Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and Second and Third Years Following Implementation of the Medicaid Expansion (postperiod) Using the Group of Best Comparison States

	All Adults			Low-income Adults		
	Estimate		95% confidence Interval	Estimate		95% confidence Interval
Compared to Expanding Medicaid Without a Demonstration						
Smoker at the time of the survey	0.3		-1.5, 2.1	0.8		-3.6, 5.3
Smoker who did not try to quit in past 12 months	1.3	*	-0.1, 2.6	2.0		-1.2, 5.3
Health status was fair or poor at the time of the survey	-1.0		-2.4, 0.4	-0.5		-4.2, 3.3
Physical health was not good in past 30 days	-2.0	*	-4.1, 0.1	-4.0		-9.0, 1.0
Mental health was not good in past 30 days	-0.5		-2.7, 1.8	-1.4		-6.7, 4.0
Had an activity limitation due to health at the time of the survey	-0.2		-2.1, 1.6	0.1		-4.2, 4.4
Sample size	79,236			11,206		
Compared to Expanding Medicaid with a Different Demonstration						
Smoker at the time of the survey	-0.5		-2.2, 1.3	0.1		-4.9, 5.0
Smoker who did not try to quit in past 12 months	-0.1		-1.4, 1.2	-0.4		-3.4, 2.6
Health status was fair or poor at the time of the survey	-1.1		-2.4, 0.3	-0.8		-3.9, 2.3
Physical health was not good in past 30 days	-3.5	***	-5.6, -1.3	-6.7	***	-11.4, -2.1
Mental health was not good in past 30 days	-0.6		-2.8, 1.6	-1.7		-6.6, 3.2
Had an activity limitation due to health at the time of the survey	-1.3		-3.2, 0.5	-2.5		-6.5, 1.4
Sample size	82,283			10,174		

Source: 2011-13 and 2015-18 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: The postperiod is 2017-18 for Montana and 2015-16 for the comparison states. Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. Best comparison states for expanding without a demonstration are KY and ND. Best comparison states for expanding with a different demonstration are MI and NH.
/**/** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test.

Appendix Table C.14 Difference-in-Differences Estimates of Changes in Health Behaviors and Health Status for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and 2017-18 (postperiod) for Each of the Best Comparison State

	Group of Comparison States that Did Not Best Expand Medicaid						Group of Best Comparison States that Expanded Medicaid Without a Demonstration				Group of Best Comparison States that Expanded Medicaid with a Different Demonstration			
	WY^		GA		NC		ND^		KY		MI^		NH	
Smoker at the time of the survey	-0.2		-1.0		1.0		0.5		0.3		-0.4		-0.6	
Smoker who did not try to quit in past 12 months	0.9		0.1		-0.4		1.1		1.5	*	-0.3		0.4	
Health status was fair or poor at the time of the survey	-0.1		-1.0		-0.7		-0.4		-1.2		-1.2	*	-1.4	
Physical health was not good in past 30 days	-1.4		-3.2	**	-1.4		-1.8		-2.1	*	-4.2	***	-2.2	
Mental health was not good in past 30 days	3.2	**	-0.7		-1.5		-1.4		0.3		-1.3		0.6	
Had an activity limitation due to health at the time of the survey	1.0		-1.9		0.3		-0.4		-0.1		-1.8	*	-1.1	

Source: 2011-13 and 2017-18 Behavioral Risk Factor Surveillance System (BRFSS).

Notes: ^ indicates single-best comparison state within group of best comparison states. For sample sizes, see Appendix Table C.16.

Appendix Table C.15: Difference-in-Differences Estimates of Changes in Health Behaviors and Health Status for Adults Ages 19 to 64 in Montana Between 2011-13 (preperiod) and Second and Third Years Following Implementation of the Medicaid Expansion (postperiod) for Each of the Best Comparison States

	Group of Best Comparison States that Expanded Medicaid Without a Demonstration				Group of Best Comparison States that Expanded Medicaid with a Different Demonstration			
	ND^		KY		MI^		NH	
Smoker at the time of the survey	0.4		0.1		-0.5		-0.7	
Smoker who did not try to quit in past 12 months	1.0		1.3	*	-0.3		0.3	
Health status was fair or poor at the time of the survey	-0.4		-1.3		-1.3	*	-1.5	
Physical health was not good in past 30 days	-1.8		-2.0	*	-4.3	***	-2.3	*
Mental health was not good in past 30 days	-1.2		0.4		-1.0		0.6	
Had an activity limitation due to health at the time of the survey	-0.4		-0.2		-1.7	*	-1.1	

Source: 2011-13 and 2015-18 Behavioral Risk Factor Surveillance System (BRFSS).
Notes: The postperiod is 2017-18 for Montana and 2015-16 for the comparison states. ^ indicates single-best comparison state within group of best comparison states. For sample sizes, see Appendix Table C.16. ***/**/***** Significantly different from zero at the .10/.05/.01 level, using a two-tailed test

Appendix Table C.16: Sample Sizes for 2011-13 and Alternate Postperiods for Adults and Low-income Adults Ages 19 to 64 in Montana and the Groups of Best Comparison States

	American Community Survey		Behavioral Risk Factor Surveillance System	
	All adults	Low-income adults	All adults	Low-income adults
Montana				
Postperiod is 2017-18	27,464	7,161	25,827	8,229
Postperiod is 2018	21,971	5,772	22,179	7,018
Postperiod is 2017	22,097	5,886	22,645	7,241
Montana and Comparison States that Did Not Expand Medicaid				
Postperiod is 2017-18	594,274	175,776	98,526	31,291
Postperiod is 2018	473,912	142,996	84,766	26,758
Postperiod is 2017	473,777	144,178	83,262	26,274
Postperiod is 2017-18, flu shot sample [a]	-	-	52,603	7,748
Postperiod is 2018, flu shot sample [a]	-	-	45,024	6,666
Postperiod is 2017, flu shot sample [a]			43,136	6,497

	American Community Survey		Behavioral Risk Factor Surveillance System	
	All adults	Low-income adults	All adults	Low-income adults
Montana and Comparison States that Expanded Medicaid without a Demonstration				
Postperiod is 2017-18	172,825	49,477	79,229	23,835
Postperiod is 2018	138,314	40,065	65,489	19,840
Postperiod is 2017	138,355	40,336	67,255	20,310
Postperiod is 2nd and 3rd post-implementation years	172,661	50,113	79,736	24,121
Postperiod is 2017-18, flu shot sample [a]	-	-	59,586	9,784
Postperiod is 2018, flu shot sample [a]	-	-	50,179	8,358
Postperiod is 2017, flu shot sample [a]			50,813	8,523
Postperiod is 2nd and 3rd post-implementation years, flu shot sample [a]	-	-	59,583	9,761
Montana and Comparison States that Expanded Medicaid with a Different Demonstration				
Postperiod is 2017-18	344,262	94,141	82,279	24,091
Postperiod is 2018	275,906	76,986	68,299	19,983
Postperiod is 2017	276,821	77,659	68,925	20,262
Postperiod is 2nd and 3rd post-implementation years	344,417	96,736	83,753	24,623
Postperiod is 2017-18, flu shot sample [a]	-	-	62,189	8,374
Postperiod is 2018, flu shot sample [a]	-	-	51,608	7,051
Postperiod is 2017, flu shot sample [a]			52,128	7,239
Postperiod is 2nd and 3rd post-implementation years, flu shot sample [a]	-	-	62,190	8,353
Montana and Each Comparison State for 2017-18				
WY	43,802	10,663	43,619	12,217
GA	303,167	92,232	52,601	17,452
NC	302,233	87,203	53,960	18,054
ND	47,859	10,785	45,464	11,879
KY	152,430	45,853	59,592	20,185
MI	305,445	87,113	62,185	19,589
NH	66,281	14,189	45,921	12,731

Source: 2011-13 and 2015-18 American Community Survey (ACS) and Behavioral Risk Factor Surveillance System (BRFSS).
Notes: Low-income is defined as family income at or below 138% of the Federal Poverty Level (FPL). Low-income is imputed in the BRFSS. [a] Because of measurement error due to gaps in survey fielding in some states, the comparison groups for the analysis of the receipt of a flu vaccine are limited to GA for the comparison to not expanding Medicaid, limited to KY for the comparison to expanding Medicaid without a demonstration, and limited to MI for the comparison to expanding Medicaid with a different demonstration.