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Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved

By Judith Solomon

Kentucky has made impressive progress in extending health coverage to its residents under health reform, cutting in half the share who are uninsured and covering over 400,000 newly eligible Kentuckians. Governor Matt Bevin is now proposing changes to the state's Medicaid program, some of which would make it harder for Kentuckians to keep their coverage and obtain health care, and he has threatened to cancel the state's Medicaid expansion if the federal government doesn't approve his plan. Evidence from the few other states that have instituted similar changes, however — most notably Indiana — shows why Kentucky's proposal is highly problematic and does not merit approval.

Gov. Bevin has modeled his proposal on Indiana's Medicaid expansion program, called the Healthy Indiana Plan 2.0 (HIP 2.0).[1] HIP 2.0 is a demonstration project (or "waiver") under section 1115 of the Social Security Act. Under federal law, waivers must promote Medicaid's objective of delivering health care services to vulnerable populations who cannot otherwise afford them and must be evaluated to determine if they meet their goals.

An evaluation[2] of HIP 2.0's first year shows it has not worked as the state intended in some important respects, likely due in part to its complexity. For example, the evaluation casts serious doubt on whether Indiana's use of accounts similar to health savings accounts, which Kentucky seeks to replicate, meets the state's goal to "promote the efficient use of healthcare, including encouraging preventive care and discouraging unnecessary care."[3] Moreover, key features of HIP

[1] "Proposed Changes to Medicaid Expansion in Kentucky," Kaiser Commission on Medicaid and the Uninsured, July 2016, http://files.kff.org/attachment/fact-sheet-Proposed-Changes-to-Medicaid-Expansion-in-Kentucky.

[2] The Lewin Group, "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," July 6, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf. The terms and conditions of the demonstration project require this interim evaluation as well as a final evaluation at the end of the three-year demonstration project.

[3] Letter from Marilyn Tavenner, Administrator of the Centers for Medicare & Medicaid Services, to Joseph Moser, Indiana Medicaid Director, approving HIP 2.0, January 27, 2015, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.

2.0 appear to be keeping some eligible low-income people from enrolling and keeping some who have enrolled from getting health care that they need.

The Department of Health and Human Services (HHS) considers whether waiver proposals hold promise for strengthening coverage or health outcomes for low-income individuals, increasing access to providers, or otherwise increasing the efficiency and quality of care provided to Medicaid beneficiaries and other low-income people. HHS has made clear that it will not approve waiver proposals that would impose premiums or cost-sharing charges that would keep low-income individuals from obtaining coverage and care.[4] Results from Indiana's first-year evaluation indicate that replicating HIP 2.0 would almost certainly erode Kentucky's progress in increasing the number of people with health coverage and improving their access to health care services.[5]

Indiana's HIP 2.0 Differs From Traditional Medicaid

Indiana expanded Medicaid in February 2015 following federal approval of Healthy Indiana Plan (HIP) 2.0.[6] Key features of HIP 2.0 make the program considerably more complicated than traditional Medicaid expansions, such as Kentucky's current expansion.

- The key feature of HIP 2.0 is a Personal Wellness and Responsibility (POWER) account, modeled on health savings accounts (HSAs). HIP 2.0 enrollees have $2,500 POWER Accounts, which are funded annually by a combination of deposits by the state and premiums that enrollees pay into the accounts. The accounts are coupled with a high-deductible health plan that covers health care costs when the POWER Account is spent.
- HIP 2.0 includes two types of coverage: HIP Plus and HIP Basic. People with incomes between 100 and 138 percent of the poverty line must pay premiums and enroll in HIP Plus. Enrollees with incomes below the poverty line either pay premiums and enroll in HIP Plus *or* don't pay premiums and enroll in HIP Basic. HIP Basic has significantly narrower benefit coverage — for example, it excludes dental and vision care — and charges co-pays for most services. (HIP Plus has co-payments only for non-emergency use of the emergency room.)
- Coverage in HIP Plus isn't effective until enrollees pay their first premium. If premiums aren't paid within 60 days, applicants with incomes below the poverty line are instead enrolled in the more-limited HIP Basic, while those with incomes above the poverty line are not enrolled at all.
- People below the poverty line who enroll in HIP Plus but fall behind on their premiums are moved to HIP Basic if they don't pay the premiums within 60 days. Those with incomes

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[4] Ryland Barton, "Federal Government Starting to Question Bevin's Medicaid Proposal," WKMS, July 1, 2016, http://wkms.org/post/federal-government-starting-question-bevin-s-medicaid-proposal#stream/0.

[5] The Centers for Medicare & Medicaid Services (CMS) plans to do its own evaluation of HIP 2.0, but the state has not provided the data that CMS needs to carry it out. John Russell, "State, feds battle over review of HIP 2.0," *Indianapolis Business Journal,* http://www.ibj.com/articles/59336-state-feds-battle-over-review-of-hip-20.

[6] HIP 2.0 is the successor to Indiana's pre-health reform waiver, referred to as HIP 1.0, which enrolled about 40,000 low-income adults. Indiana had to modify HIP 1.0 to comply with health reform by, for example, removing its enrollment cap and offering a more comprehensive benefit package. For more on the differences between HIP 1.0 and HIP 2.0, see Jessica Schubel and Jesse Cross-Call, "Indiana's Medicaid Expansion Waiver Proposal Needs Significant Revision," Center on Budget and Policy Priorities, October 17, 2014, http://www.cbpp.org/research/indianas-medicaid-expansion-waiver-proposal-needs-significant-revision.

above the poverty line who fall behind for 60 days lose coverage altogether — and are barred from reenrolling for six months.

- After 12 months, enrollees in HIP Plus can roll over a portion of any funds that remain in their POWER Account and use those funds to reduce their premiums for the following year. The amount they're permitted to roll over is doubled if they get preventive care services that are recommended for their age and gender. Similarly, enrollees in HIP Basic who get preventive care can roll over a portion of any funds that remain in their POWER Account, which they can use to reduce their premiums if they move to HIP Plus.

Governor Bevin's Proposal Modeled on HIP 2.0

The evidence on Kentucky's current Medicaid expansion is very positive. In addition to a very large drop in the number of uninsured, the data show that many fewer low-income people in Kentucky are now skipping medications because of cost or having trouble paying their medical bills.[7] Nevertheless, Governor Bevin is proposing a major overhaul, known as Kentucky HEALTH (Helping to Engage and Achieve Long Term Health). Like Indiana's HIP 2.0, it would include accounts linked to a health plan and premiums linked to benefits, with penalties for non-payment. As explained below, these elements of the plan are likely to reduce health coverage and access to care among low-income Kentuckians.[8]

- Under the Bevin proposal, enrollees would be placed in a health plan that carries a $1,000 deductible (unlike regular Medicaid, which has no deductible) and that *lacks* coverage for dental and vision care and non-emergency medical transportation that Kentucky's current Medicaid program covers. Enrollees also would get a "My Rewards Account" into which the state would make deposits if they participated in "health, community engagement and job training activities." The rewards account could be used to help pay for vision and dental care, over-the-counter drugs, and the like. Half of any balance that remained in an enrollee's regular account at the end of the year would be shifted to the individual's rewards account. If an enrollee went to the emergency room for non-emergency care, funds would be deducted from the rewards account.
- Adults would be charged premiums that range from $1 to $15 a month, depending on their income. After two years in the program, monthly premiums would rise by $7.50 each year for people between 100 and 138 percent of the poverty line until they reach $37.50 a month ($450 on an annual basis) in the fifth year of participation.
- Enrollment would not be effective until payment of the premium. People with incomes below the poverty line who didn't pay the premium would, after 60 days, be enrolled in a plan without premiums but with co-payment charges and would not have a rewards account.

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[7] "Medicaid Expansion Report: 2014," Deloitte, February 2015, http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf; "What's At Stake in the Future of the Kentucky Medicaid Expansion," Kaiser Commission on Medicaid and the Uninsured, July 2016, http://files.kff.org/attachment/fact-sheet-Whats-At-Stake-in-the-Future-of-the-Kentucky-Medicaid-Expansion.

[8] Kentucky also proposes to impose a work requirement that HHS has said cannot be approved. See Jesse Cross-Call, "No Precedent for Kentucky's Proposed Medicaid Work Requirement," Center on Budget and Policy Priorities, July 25, 2016, http://www.cbpp.org/blog/no-precedent-for-kentuckys-proposed-medicaid-work-requirement.

Those with incomes above the poverty line who fall 60 days behind on their premium payments would be locked out of coverage for six months. (They could re-enroll if they paid their past-due premiums and took a financial or health literacy course.)

Kentucky claims its proposal would save $2.2 billion over five years. It appears the savings would result from *significantly fewer people having health coverage* and more people consequently being uninsured. The state projects that it will cover almost 18,000 fewer people in the first year under the plan — and almost 86,000 fewer people by the fifth year.[9]

How Premiums Are Affecting Enrollment in HIP 2.0

Kentucky's proposal makes a look at the evidence on Indiana's waiver particularly important. Extensive research (including research from Medicaid demonstration projects conducted prior to health reform) shows that premiums significantly reduce low-income people's participation in health coverage programs.[10] This appears to be occurring in Indiana. Premiums and the complexity of HIP 2.0 appear to be decreasing enrollment below what it otherwise would be.

At the time that HIP 2.0 was approved, Indiana estimated it would cover 350,000 then-uninsured Hoosiers.[11] At the end of January 2016, although total enrollment was about 346,000, some 40 percent of those enrolled had been transferred from HIP 1.0 (HIP 2.0's predecessor) or from an Indiana coverage program for low-income parents, leaving about 207,000 who were newly insured — well below Indiana's estimate. In addition, Indiana assumed in its waiver proposal that total enrollment, including enrollees transferred from other programs, would exceed 404,000 in May 2016.[12] The most recent data show enrollment for May 2016 was 352,000, over 50,000 people short of the 404,000 expected.[13]

Strong additional evidence of the premiums' negative impact on enrollment in HIP 2.0 is that about one-third of individuals who apply and are found eligible *are not enrolled*, because they don't make a premium payment**.** According to the evaluation, in any given month, as many as 30,000 people are in a "conditional eligibility status" — i.e., have been found eligible within the past 60 days but are not enrolled because they haven't made premium payments. Of those, only two-thirds enroll by the end of their 60-day payment period. This indicates that HIP 2.0's premiums are deterring significant numbers of eligible low-income people from enrolling.

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[9] Jason Bailey, "Waiver Proposal Says Cost Savings Come from Covering Fewer People," Kentucky Center for Economic Policy, June 23, 2016, http://kypolicy.org/waiver-proposal-says-cost-savings-come-covering-fewer-people/

[10] Laura Snyder and Robin Rudowitz, "Premiums and Cost-Sharing in Medicaid," Kaiser Commission on Medicaid and the Uninsured, February 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf.

[11] "Fact Sheet: HIP 2.0 By the Numbers," http://www.in.gov/fssa/hip/files/HIP_By_The_Numbers.pdf.

[12] Healthy Indiana Plan Budget Neutrality Projections, Milliman, June 23, 2014, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Expansion-Proposal-06232014.pdf.

[13] HIP CMS Metrics, May 19, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-monthly-rpt-may-2016-06012016.pdf.

On top of that, in HIP 2.0's first year, 2,677 individuals with incomes above the poverty line who had been enrolled in HIP Plus — that is, 5.9 percent of such individuals — had their coverage terminated for falling behind for 60 days on their premiums and were then locked out of coverage for six months. In addition, 21,445 HIP-Plus enrollees with incomes *below* the poverty line (8 percent of such individuals) were moved to the more-limited HIP Basic due to non-payment of premiums.[14]

Of interest, only 16 percent of those moved from Plus to Basic cited affordability as the reason for non-payment of premiums. The biggest reason was confusion about the payment process or the plan in which they were enrolled. This is strong evidence that the program's high degree of complexity is negatively affecting participation and the ability of people to obtain health care.

Implausible Number of Enrollees with Little or No Income

Indiana's hypothesis, as stated in its waiver proposal, that its POWER Account contributions "are affordable and do not create a barrier to health care access" can't be fairly tested if the state isn't actually charging premiums based on beneficiaries' incomes. Indiana appears to be failing to faithfully implement its own plan — it is classifying an implausibly large share of enrollees as having little or no income, which makes their premium amounts simpler to calculate and easier to collect.

The state reports that *slightly over half* of all enrollees in HIP 2.0 have annual incomes *below 5 percent of the poverty line*. This simply cannot be correct. Census data from 2010 to 2014 show only about *one-fifth* of uninsured people in Indiana with incomes below the Medicaid expansion's income limit of 138 percent of the poverty line had income below 5 percent of the poverty line. It defies credulity that a *majority* of HIP 2.0 enrollees could have incomes below 5 percent of the poverty line.

This discrepancy is important for assessing HIP 2.0. Premiums are only $1 a month for enrollees in this extremely low-income bracket (as compared to 2 percent of income for people with incomes above 5 percent of the poverty line). If large numbers of beneficiaries are being charged $1 a month rather than the higher amount they actually should owe under HIP 2.0 based on their income, then participation in HIP 2.0 is higher than it would be if the state had truly implemented its plan. As a result, Indiana's experience *may not provide an accurate test of how its design affects enrollment*. Other states — including Kentucky — could see a much greater negative impact of premiums on participation if they implemented premiums in a way that is accurately tied to enrollees' incomes.

The Indiana evaluation acknowledges this discrepancy; it notes that "there are differences between the state-reported number of enrolled individuals below 25 percent of the poverty level and estimates of the total number of Indiana residents under 25 percent of the poverty level using national survey data." The only explanation that the state has provided for this discrepancy is that eligibility for Medicaid is based on "Modified Adjusted Gross Income" (or MAGI), a tax-based definition that excludes some types of income, such as child support and welfare payments that are counted as income in Census Bureau estimates. But this cannot explain much of the gross discrepancy, as the impact of using MAGI is small. Only 23 percent of uninsured people in Indiana with incomes below 138 percent of the poverty line have income below 5 percent of the poverty line if income is measured by MAGI, compared to 19 percent of such people under a traditional

[14] Individuals who are deemed medically frail with incomes above the poverty line are moved to HIP Basic, so some of those who moved to Basic may actually have had incomes above the poverty line.

definition of income. It remains virtually impossible for over *50 percent* of HIP Plus enrollees to have incomes below *5 percent* of the poverty line.

Many Enrollees Are Unaware of Incentives for Preventive Care

A key test for HIP 2.0 is whether it is meeting its goal of promoting personal responsibility for healthy behaviors and for more efficient health care spending through the use of the personal accounts (i.e., the POWER accounts). Enrollees in both HIP Basic and HIP Plus who receive preventive care can, after the first year, secure reductions in their premiums for future years, by virtue of being allowed to roll over funds that remain in their POWER Accounts. The evaluation indicates, however, that the rollover does not appear to be working as an incentive for a large share of enrollees, because they lack basic knowledge about the accounts and how they work.

Only 60 percent of respondents to a survey conducted as part of the evaluation said they had heard of the POWER Accounts, even though every enrollee has such an account. Those who said they'd heard of the accounts were asked whether they have one, and only about three-quarters of those who had heard of the accounts said they did. This means that fewer than half of *all* enrollees (three-quarters of the 60 percent who had heard of the accounts) even knew they had an account. Large shares of respondents also showed a lack of understanding when answering a series of true-false questions about their POWER Accounts. Without enrollee knowledge about the account, the rollover can't act as an effective incentive.

Indiana's experience is consistent with what has occurred in Iowa and Michigan, two other states with Medicaid expansion waivers that provide incentives for preventive care. Iowa doesn't charge premiums in a beneficiary's first year of eligibility, and it waives premiums the following year for people who complete a health risk assessment and get preventive care during their first year. But only 17 percent of enrollees with incomes below the poverty line and 8 percent of those with incomes above poverty qualified for the premium waiver. "The combination of a general lack of awareness and understanding about the program at the enrollee and provider level have [sic] stunted the program's ability to achieve significant participation" in its first phase, researchers said.[15] In Michigan, only 14.9 percent of beneficiaries enrolled in a health plan for at least six months completed a health risk assessment that could lower their cost-sharing charges. Researchers found that most beneficiaries weren't aware the incentive existed.[16]

Even with greater awareness, the type of incentives being tried in Indiana, Iowa, and Michigan, which reward people long after they engage in the desired behavior, are unlikely to change behaviors significantly. Behavioral economics research finds that individuals are more likely to respond to immediate gratification than to a delayed reward. Rewards awarded soon after completion of the healthy behavior are more likely to be effective.[17]

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[15] Natoshia M. Askelson *et al.,* "Health Behaviors Incentive Program Evaluation Interim Report," March 1, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-bhvrs-int-rpt-mar-2016.pdf.

[16] "Michigan Adult Coverage Demonstration Section 1115 Annual Report,' May 17, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-annual-report-DY6.pdf.

[17] Maia Crawford, "Healthy Behavior Incentives: Opportunities for Medicaid," Center for Health Care Strategies, November 2014.

HIP Basic Enrollees Experiencing Barriers to Care

HIP 2.0 is also testing whether providing better benefits to people who pay premiums will advance the goal of increasing personal responsibility for healthy behaviors and awareness of their health care costs. As of January 2016, some 65 percent of enrollees were paying premiums and enrolled in HIP Plus, while 35 percent were in HIP Basic, a breakdown that has been fairly steady since HIP 2.0's inception. Plus enrollees are more likely to be older and have chronic conditions.

HIP Plus enrollees used more preventive, primary, and specialty care and prescription drugs than enrollees in HIP Basic. Basic enrollees were more likely to use the emergency room, with 1,034 visits per 1,000 members per year compared to 775 visits for Plus enrollees. Basic members were also more likely to visit the emergency room for non-emergency reasons, with 263 visits per 1,000 members per year compared to 183 per 1,000 members for Plus. When coupled with lower rates of primary care use (31 percent of enrollees in Plus but only 16 percent in Basic had at least one primary care visit) and preventive care use (64 percent in Plus and 45 percent in Basic had a visit qualifying them for a rollover of POWER Account payments), the greater reliance on the emergency room for non-emergency care among HIP Basic enrollees suggests that they were more likely to lack adequate access to ordinary health care, likely due in part to the co-pays charged in Basic or other factors.

Basic members also have lower rates of adhering to their prescription drug regimens for certain chronic conditions such as asthma, arthritis, and heart disease. This isn't surprising, because Basic members must refill their prescriptions every month and make a co-payment, while Plus members can obtain a 90-day supply of maintenance medications without a co-pay. This is of particular concern because access to maintenance medications can affect health outcomes. It's also of concern because, compared to other groups, African Americans are more likely to be in the Basic plan; fully half of African Americans enrolled in HIP 2.0 are in Basic rather than Plus.

Evaluation Doesn't Support Extending HIP 2.0 Model to Kentucky

Demonstration proposals are supposed to test better ways of organizing and providing health care. They should be replicated only if they show promise in strengthening coverage or health outcomes for low-income individuals. The HIP 2.0 evaluation suggests that the waiver's design is lowering participation relative to what it would be under a regular Medicaid expansion like Kentucky's. The evaluation also indicates that the hypothesis that the personal accounts would be an effective incentive for healthy behaviors and cost-conscious use of the health system hasn't been borne out. And it appears that some people in Indiana's Basic plan are experiencing more difficulty in obtaining care. Moreover, their lower adherence to maintenance medications could lead to a decline in their health outcomes.

Extending the risky Indiana experiment to Kentucky, which has been highly successful in enrolling people and providing equal access to care for all Medicaid beneficiaries, would thus constitute a significant step backward. It would undo part of the impressive progress that Kentucky has made. And because it likely would have these deleterious effects, it fails to meet the basic criteria that must be satisfied for a waiver request to be approved.