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PAYING MORE FOR LESS

“Healthy Indiana Plan” Would Cost More Than Medicaid While Providing Inferior Coverage

By Judith Solomon

Following requests for federal assistance from states seeking to expand publicly-funded health coverage for the uninsured, the Bush Administration announced its “Affordable Choices” initiative in January 2007. Affordable Choices provides no new federal funds to states. It simply permits states to divert federal funds now being used to support hospitals that care for the uninsured and use those funds instead to help uninsured people purchase “basic private coverage” — that is, coverage provided through private health plans rather than Medicaid.¹

The premise of Affordable Choices is that private coverage will cost less than Medicaid, allowing states to cover more uninsured people.² But in Indiana, the first state with an approved plan under Affordable Choices, “basic private coverage” will actually cost *more* than Medicaid while providing coverage that is far *less* comprehensive.

Indiana received federal approval for its “Healthy Indiana Plan” in December 2007. Also in December, Texas submitted a concept paper for a similar plan to the Centers for Medicare and Medicaid Services (the federal agency that oversees those programs). Both plans would divert uncompensated-care hospital funds to provide private coverage to low-income, uninsured adults. In addition, the Administration is urging Louisiana’s new governor to move forward with a plan based on Affordable Choices that the previous governor rejected.³

In line with Affordable Choices, the plans in these states would provide “basic private coverage” to poor and low-income adults. Most enrollees would have to contribute to the cost of coverage and share the cost of some services.

¹ Judith Solomon, “President’s ‘Affordable Choices’ Initiative Provides Little Support for State Efforts to Expand Health Coverage,” Center on Budget and Policy Priorities, April 3, 2007, <http://www.cbpp.org/4-3-07health2.htm>.

² Remarks of Michael Leavitt, secretary of HHS, at American Enterprise Institute, April 24, 2007, <http://www.hhs.gov/news/speech/2007/sp20070424a.html>.

³ Marsha Shuler, “Transition team talks health care,” *Baton Rouge Advocate*, November 20, 2007.

The Healthy Indiana Plan

Indiana's plan provides coverage to uninsured parents and adults without children who are not eligible for Medicaid and who have incomes below 200 percent of the poverty line (\$34,340 a year for a family of three in 2007). In Indiana, parents are eligible for Medicaid only if their income is less than 22 percent of the poverty line — just \$3,777 a year for a family of three — and they have resources of less than \$1,000.

Participants in the Healthy Indiana Plan (HIP) will have to contribute each month toward a "POWER" account, similar to a health savings account. Individuals' required contributions will vary based on their income, ranging from 2 percent of income for those with incomes below the poverty line to 5 percent of income for some participants with incomes between 150 and 200 percent of the poverty line.⁴ The state will also contribute to the account to bring it up to a \$1,100 annual total, which individuals will then use to pay for health care expenses other than basic preventive care.⁵

Once the POWER account is used up, most participants in the Healthy Indiana Plan will receive coverage through a private health plan. Certain participants with a history of chronic illnesses (such as cancer and HIV/AIDS) and those who have had organ transplants will instead receive coverage through an "Enhanced Services Plan" administered by the entity that operates Indiana's high-risk health insurance pool.

HIP Benefits Are Significantly Weaker Than in Medicaid

The benefits provided under HIP differ are significantly weaker than those provided under Medicaid. In addition to the required monthly contribution, which exists in HIP but not Medicaid, there are other important differences in the ways the two programs are structured and benefits are provided.⁶

- *Limits on benefits.* HIP does not cover certain important services that Medicaid covers, including dental and vision care, non-emergency transportation, and care associated with pregnancy.⁷ HIP also provides other services to a much more limited degree than Medicaid does, particularly skilled nursing care as well as physical, speech, and occupational therapy.⁸ Finally, HIP benefits are capped at \$300,000 each year and \$1 million over a participant's lifetime.⁹

⁴ Parents with income between 150 and 200 percent of the poverty line will have to contribute 4.5 percent of their income; those without children must contribute 5 percent.

⁵ Preventive services up to \$500 are covered by the health plan immediately rather than by the POWER account.

⁶ Information on Indiana Medicaid benefits is from the Medicaid Benefits Online Database at <http://www.kff.org/medicaid/benefits/index.jsp?CFID=22497272&CFTOKEN=51149664>.

⁷ Indiana's Medicaid program provides up to \$600 in dental benefits a year and an eye exam and eyeglasses every two years. If a HIP participant becomes pregnant, she leaves the HIP program and is shifted to Medicaid, which provides coverage for pregnant women with incomes up to 200 percent of the poverty line; the costs are not paid by HIP.

⁸ HIP provides a maximum of 30 days of skilled nursing care; Medicaid does not limit the number of days of skilled nursing care. HIP limits physical, speech, and occupational therapy visits to a total of 25 for each type of therapy over the course of a year; Medicaid provides up to 30 therapy visits per *month*.

⁹ A beneficiary who receives more than \$300,000 in benefits in any year must continue making monthly contributions to his or her POWER account throughout the year but will have no coverage for health care until the next year.

Medicaid benefits, in contrast, are not capped.

- *Limits on eligibility.* HIP coverage is only available to individuals who have been uninsured for at least six months. Medicaid does not have a waiting period.
- *No retroactive coverage.* HIP coverage is not effective until the start of the month following the month in which a participant makes a payment toward his or her POWER account. Medicaid, in contrast, can provide retroactive coverage for health care services provided in the three months prior to the date an individual applies, if he or she was eligible during these prior months.

Thus, a person who enrolls in Medicaid after a serious illness or accident *would* have coverage for all health care expenses that arose from the illness or accident, but a person who enrolls in HIP would only be covered for health care expenses that were incurred well after the accident occurred or the illness began. This is a particularly important omission, because low-wage workers (the group targeted by HIP) rarely have the resources to cover the cost of an illness or injury and can suffer years of financial hardship while trying to repay large costs incurred for treatment of an injury or serious illness for which they had no insurance.

HIP's "Basic Coverage" Costs More Than Medicaid

As noted, the stated premise of Affordable Choices is that coverage through commercial health plans will be cheaper than Medicaid and thus will allow states to cover more people. Yet Indiana's experience shows that this is not the case: HIP actually costs more than Medicaid.

According to the approved terms and conditions of the Indiana Medicaid waiver, covering parents in Medicaid will cost the state \$330.69 per person a month in 2008, while HIP coverage for parents will cost the state \$312.59 per month. But the cost of HIP also includes the amount contributed by participants. A participant with income at the poverty line would contribute 2 percent of family income; for a parent in a three-person household, this would amount to \$28.62 a month, bringing HIP's total cost to \$341.21 a month. This is over \$10 a month per person *more* than the cost of Medicaid. Even though HIP benefits are far less generous than Medicaid, they are more costly.

The fact that Medicaid coverage for Indiana parents costs less than HIP coverage for parents is consistent with research comparing the costs of private coverage and Medicaid. A study by researchers at the Urban Institute found that Medicaid costs less than private coverage for comparable beneficiaries. The study found that if the average person enrolled in Medicaid were enrolled in private insurance instead, annual costs would increase by \$1,265 per beneficiary.¹⁰

¹⁰ Per capita expenditures for non-disabled adult Medicaid beneficiaries totaled \$3,415, while coverage for these same individuals under private insurance would have cost \$4,410. (These figures are in 2001 dollars.) Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, Vol. 40, No. 4, Winter 2003/2004.

Why Does Private Coverage Cost More to Provide Less?

There are three reasons why HIP provides much less comprehensive coverage than Medicaid at a higher cost.

- Administrative costs are much higher in private plans than in Medicaid. In 2003, administrative costs in Medicaid were 6.9 percent of total spending, compared to 13.6 percent for private coverage.¹¹
- Under HIP, payments to health care providers will equal those in *Medicare*, which are higher than provider payments in *Medicaid*.¹²
- Private insurers demand a higher premium for covering individuals through HIP because of the risk of “adverse selection” — that is, the risk that these individuals will be sicker, on average, than a similar group of people not insured through HIP.

The third point requires some explanation. As noted, even very low-income people will have to make a monthly contribution before they can gain coverage through HIP. These contributions will be burdensome for many. (Research in a number of states has shown that even relatively modest premiums cause a significant drop in Medicaid and SCHIP participation.¹³) Given the difficulty of making the monthly contributions, it is likely that those with the greatest need for health care services (i.e., people with the most serious health problems) will be the individuals most likely to enroll. Moreover, only people who have been uninsured for at least six months can enroll in HIP, so individuals are more likely to have a pent-up demand for health care when they enroll.

The potential that people with a greater need for health care services will enroll in HIP, as well as uncertainties about how many people will actually participate, will drive up the price that private insurers charge. These factors, combined with the fact that private coverage is already more expensive than Medicaid, forced Indiana to put significant limits on the benefits offered in HIP in order to lower the cost of coverage.¹⁴ Thus, even though HIP provides coverage that is far less comprehensive than what Medicaid and most private insurance plans provide, HIP still costs more per beneficiary than Medicaid.

¹¹ John Holahan and Mindy Cohen, “Understanding the Recent Growth in Medicaid Spending and Enrollment Growth Between 2000-2004,” Kaiser Commission on Medicaid and the Uninsured, May 2006.

¹² Results of a survey conducted in 13 states showed that although Medicaid payments to providers tend to be low, Medicaid beneficiaries have access to providers comparable to the access that low-income people enrolled in private insurance have, taking into account geographic factors and differences in individual health status. Teresa Coughlin *et al.*, “Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States,” *Health Affairs*, Vol. 24, No. 4, July/August 2005.

¹³ For citations to these studies, see “Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy,” Kaiser Commission on Medicaid and the Uninsured, November 2006.

¹⁴ These factors also cause insurers to demand policies that will limit their risk. In HIP, such policies include the annual and lifetime caps on benefits, the shift of people with some chronic conditions to a state-funded program, and limits on services like speech and physical therapy.

Conclusion

Paying more for less represents poor stewardship of taxpayer dollars. There is no need for a complicated new structure like HIP (and similar plans being developed under Affordable Choices) to provide health insurance to very low-income uninsured parents and adults, since Medicaid can provide superior coverage at less cost. Affordable Choices appears to be an unfortunate example of ideology — in this case, the desire to promote private over public health coverage — triumphing over efficiency.¹⁵

¹⁵ Moreover, most Medicaid beneficiaries, including most beneficiaries in Indiana, are already enrolled in private managed care plans. The HIP approach is not necessary to ensure that Medicaid enrollees are served through private plans. Centers for Medicare and Medicaid Services, 2006 Medicaid Managed Care Enrollment Report at <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcp06.pdf>. Judith Solomon, “The False ‘Public Versus Private’ Choice for Children’s Health Coverage,” Center on Budget and Policy Priorities, June 21, 2007.