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Indiana's Medicaid Expansion Waiver Proposal Needs Significant Revision

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Indiana has proposed to expand Medicaid and extend health coverage to as many as 374,000[1] uninsured Hoosiers through the Healthy Indiana Plan (HIP) 2.0. This is a new demonstration project, or "waiver," that incorporates features from the state's existing Medicaid waiver, which was approved prior to enactment of health reform and offers limited coverage to low-income adults.

Although waivers give states additional flexibility in how they design their Medicaid programs, the Medicaid statute requires that waivers must test new approaches to Medicaid while promoting the program's objective of delivering health care services to vulnerable populations that can't otherwise afford care. As currently designed, however, HIP 2.0 falls short of meeting this standard in several important respects: aspects of the plan would almost certainly result in substantial numbers of low-income people being unable to receive health insurance and access care for significant periods of time. Those aspects of the proposal should be modified to ensure that newly eligible Medicaid beneficiaries can actually enroll in coverage and receive necessary health care services.

The Indiana proposal does drop some problematic features of the state's existing Medicaid waiver, such as a cap on the number of enrollees and annual and lifetime dollar limits on coverage, to comply with changes that the health reform law made to Medicaid. But the state is seeking approval to maintain certain other features of its current waiver that are inconsistent with the Medicaid expansion, such as charging premiums to people with little income. A substantial body of research, including Indiana's own experience under its existing Medicaid waiver, demonstrates that charging premiums to people with low incomes discourages them from enrolling in and maintaining coverage.

Health Reform Has Changed How Low-Income Adults Get Medicaid Coverage

Prior to health reform, Medicaid coverage for parents under age 65 who do not have a disability was usually limited to parents with incomes far below the poverty line, making most working-poor

[1] Genevieve M. Kenney, *et al.*, "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" Urban Institute, August 2012.

parents ineligible. In addition, most states provided no coverage at all to poor non-elderly, non-disabled adults without children.[2]

The handful of states that did provide coverage to low-income adults without children prior to the enactment of health reform did so under section 1115 of the Social Security Act, which allows the Secretary of Health and Human Services (HHS) to approve demonstration projects (also referred to as waivers) to test policies not otherwise permitted under Medicaid by waiving certain provisions of Medicaid law. Such demonstration projects must be "likely to assist in promoting the objectives" of the Medicaid program and must be budget neutral for the federal government (meaning the federal government cannot spend more under a demonstration project than it would have spent if the demonstration hadn't been approved). This requirement has meant that states often have limited their overall waiver costs by imposing enrollment caps and limits on benefits, and in some cases by charging premiums that generally were not otherwise allowed under Medicaid.[3]

While the Supreme Court made health reform's Medicaid expansion a state-by-state decision, an explicit pathway is now available to states through the expansion to provide coverage to all non-elderly adults with incomes below 138 percent of the poverty line. States no longer need to use section 1115 waivers to expand eligibility to these people. The Medicaid expansion under health reform also means that newly eligible adults are now entitled to a standard Medicaid benefit package and the same protections regarding premiums and co-payments as other groups of Medicaid beneficiaries that federal law requires states to cover.

Aspects of HIP 2.0 Are Incompatible with Health Reform's Medicaid Expansion and Would Use Waiver Authority Improperly

While states now have a straightforward pathway to extend coverage to newly eligible low-income adults, several states, such as Indiana, continue to seek section 1115 waivers to gain additional flexibility in how they design and run their Medicaid programs. Because health reform didn't alter the provisions of section 1115, states that request 1115 waivers must continue to show that any policies they propose that aren't otherwise permitted under Medicaid law would further the program's objectives.

Unfortunately, several important aspects of Indiana's proposal do not further Medicaid's objectives. HIP 2.0 erects various barriers to coverage because it maintains certain features of the state's existing Medicaid waiver, including premiums and a related "lock-out" period that are impermissible under Medicaid law for enrollees who make up a "mandatory coverage group" (i.e., a group of individuals or families whom states are required to cover).[4]

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[2] To be eligible for Medicaid in the typical state prior to health reform, a working parent had to earn less than 61 percent of the poverty line (about $12,100 for a family of three in 2014), and an unemployed parent had to have an income below 37 percent of the poverty line (about $7,300). Most states did not provide coverage to low-income, non-disabled adults without dependent children *at any income level*. Under the Medicaid expansion, adults with income below 138 percent of poverty (about $16,100 for an individual and $27,300 for a family of three) become eligible.

[3] For more information on the role of section 1115 demonstration projects in providing coverage to low-income adults before health reform and as a vehicle for expanding Medicaid coverage, see Jesse Cross-Call and Judith Solomon, "Approved Demonstrations Offer Lessons for States Seeking to Expand Medicaid through Waivers," Center on Budget and Policy Priorities, August 20, 2014, http://www.cbpp.org/cms/index.cfm?fa=view&id=4190.

[4] Indiana is seeking to have its waiver approved as a Medicaid expansion that qualifies for the substantially enhanced federal matching rates provided for the expansion under the Affordable Care Act. The beneficiaries who would be

This is an important issue: there is good reason that Medicaid does not permit imposing premium charges on such individuals. A substantial body of research shows that charging premiums to people with low incomes results in many eligible people forgoing or delaying coverage and remaining uninsured. That outcome does not promote, and is not consistent with, Medicaid's goal of providing medical assistance to low-income and vulnerable populations.

As explained below, Indiana would permit people with incomes below the poverty line to receive coverage through an alternative program that does not charge premiums. But it appears that these individuals could be forced to wait several months for that coverage to start. (In addition, the coverage would be more limited, lacking coverage for vision and dental care and charging co-payments for prescriptions and doctors' visits.)

Moreover, people with incomes as low as 101 percent of the poverty line ($11,787 for an individual) who missed a monthly premium payment and didn't make it up within 60 days would be removed from Medicaid for six months. They would be locked out of the program for this duration and, in most cases, effectively forced to be uninsured. For people with very low wages who face a constant struggle to make ends meet and can face various financial crises — such as the need to pay for a major car repair so they can continue to get to work and avoid losing their job — this is harsh punishment.

How HIP 2.0 Would Work

HIP 2.0 is based on the "Healthy Indiana Plan," or HIP, Indiana's existing section 1115 Medicaid waiver, which the state has operated since 2008. HIP covers about 40,000 low-income adults and is designed to be a Medicaid version of a high-deductible health plan paired with a health savings account (HSA).

HIP participants are enrolled in a managed care plan and must pay a monthly premium that can't be more than 2 percent of their income. The premium is paid into the individual's "Personal Wellness and Responsibility" account — known as a POWER account — which is modeled on an HSA. If the individual's premium payments amount to less than $1,100 a year, as they generally do, the state contributes the difference so that each individual's POWER account has $1,100 in it each year. This amount matches the managed care plan's deductible, which is also set at $1,100.[5]

The HIP waiver is now expiring; it was initially set to expire at the end of 2012, and HHS granted extensions through 2014 so the state could consider replacing it with options for expanding Medicaid as part of health reform. Indiana is proposing a new waiver, HIP 2.0, which is a variant of the original HIP plan.

Under the new proposal, the state would operate two distinct programs for adults (other than those who are elderly or have disabilities) — HIP Plus and HIP Basic. Adults whose incomes are *below* 100 percent of the poverty line could enroll in either HIP Plus or HIP Basic. Adults with income *between* 100 percent and 138 percent of the poverty line could enroll only in HIP Plus.

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affected by the Indiana waiver proposal constitute a mandatory coverage group in states that take the expansion and qualify for the enhanced federal matching rates.

[5] Preventive health services of up to $500 annually are not subject to the deductible.

Under *HIP Plus*, enrollees would be required to pay monthly premiums that would be deposited in their POWER accounts, as under the current HIP program, though the amount that must be placed in the account and the size of the deductible would rise from $1,100 to $2,500. The premium charges would vary by income, and employers or charities would be permitted to contribute to an individual's POWER account (i.e., to pay part of the premium contributions for an individual). Monthly premium charges would range from $3 to $20 for people with incomes below the poverty line and be set at $25 for people with incomes between 100 and 138 percent of the poverty line. Thus, for parents in a family of four with incomes just above the poverty line, the premium charges would be $50 per month — $600 on an annual basis — which is more than such a family would be expected to contribute for coverage in the Marketplace. Coverage would not begin until an individual made his or her first premium payment.

If an enrollee with income between 100 and 138 percent of the poverty line missed a premium payment and didn't make it up in 60 days (in addition to paying his or her current premiums for the ensuing months), the individual would be disenrolled and barred from re-enrolling for six months. If an enrollee whose income is below 100 percent of the poverty line missed a premium payment (including his or her initial premium payment), the individual would be allowed to enroll in HIP Basic, but as noted below, it appears there could be a gap in coverage during which the person would be uninsured.

HIP Basic would have both similarities to, and differences from, HIP Plus. Enrollees would still have a POWER account paired with a health plan with a $2,500 deductible, but the state would place the full $2,500 into the account. Hence, HIP Basic would not charge premiums.

At the same time, HIP Basic would provide more limited coverage. It would charge its enrollees co-payments for doctors' visits, prescription drugs, and most other health services. (HIP Plus would not charge co-payments except for use of the emergency room in non-emergency situations; see Box 2, below.) In addition, while HIP Plus and HIP Basic would both cover the "essential health benefits" required for newly eligible Medicaid enrollees under health reform, only HIP Plus would provide vision and dental coverage.

From the proposal Indiana has submitted, it also appears that people with incomes below the poverty line would initially be enrolled in HIP Plus, and would be allowed to receive coverage through HIP Basic only after a period of 60 days had passed without their having made a premium payment to HIP Plus. It then could take additional time for the state to switch these people to HIP Basic and enroll them in a managed care plan. As a result, people living in poverty apparently could go without coverage for at least two months and possibly longer. (Note: this aspect of Indiana's HIP 2.0 waiver application is unclear, but it gives no indication that people below the poverty line would be allowed to elect to enroll from the outset in HIP Basic and thereby avoid a period without coverage.)

Furthermore, unlike under normal Medicaid rules — where Medicaid coverage is available for covered health care expenses incurred during the three months prior to Medicaid enrollment for people who were eligible during this time period — coverage would be denied under both HIP Plus and HIP Basic for the three-month period before the month of enrollment.

Aspects of HIP 2.0 Not Compatible With Objectives of the Medicaid Program

Several elements of the HIP 2.0 proposal are not compatible with the objectives of the Medicaid program and do not represent a proper use of section 1115 waiver authority.

- **Coverage in HIP Plus is contingent on payment of monthly premiums.** Mandatory premiums generally are not permitted in Medicaid.[6] A longstanding and robust body of research shows that premiums create a barrier to coverage for low-income individuals, especially those living below the poverty line. A 1999 study, based on data on the impact sliding-scale premiums had on low-income people in four states, developed a model to forecast the effect that premium increases would have on whether uninsured low-income individuals enroll in coverage. The model estimates that raising premiums from 1 percent to 3 percent of family income will cause the share of eligible, uninsured low-income people who enroll in coverage to fall substantially, from 57 percent to 35 percent.[7] Similarly, a recent study published in *Health Affairs* found that in the nine states imposing premiums in the Children's Health Insurance Program (CHIP) in 2013 on children with family incomes between 101 and 150 percent of the poverty line,[8] a $10 increase in the monthly premium resulted in a 6.7 percentage-point drop in CHIP enrollment (and a 3.3 percentage-point increase in the share of children who were uninsured).[9]

  In addition, an evaluation that Mathematica conducted in 2012 of Indiana's existing HIP waiver showed that the required POWER account contributions (that is, the premiums under HIP) effectively restrict HIP enrollment. The evaluation found that over a five-year period from 2008 to 2012, some 17 percent of those found eligible for the program — or over 21,000 people — never enrolled because they didn't pay the initial premium. Moreover, at the time of the evaluation, HIP covered people with incomes up to 200 percent of the poverty line, but 69 percent of those who didn't enroll because of non-payment of the initial premium had incomes below 100 percent of the poverty line. And of those who *did* enroll, 12 percent subsequently lost coverage because they failed to pay premiums, with 58 percent of those being people with incomes below the poverty line.[10]

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[6] The statute allows states to impose premiums only on Medicaid beneficiaries with incomes above 150 percent of the poverty line.

[7] Leighton Ku and Teresa Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* Vol. 36(4), Winter 1999/2000: 471-480.

[8] States have flexibility in determining the structure of their CHIP programs. States can run their CHIP program as a stand-alone program, can use CHIP funds to expand Medicaid eligibility for children, or can run a combined CHIP and Medicaid program. While premiums are generally prohibited in Medicaid for people with income below 150 percent of the poverty line, such a prohibition does not apply in states that operate a stand-alone CHIP program.

[9] Salam Abdus, Julie Hudson, Steven Hill, and Thomas Selden, "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, No. 8 (2014): 1353-1360. Some 22 percent of children in CHIP who have incomes between 101 and 150 percent of the poverty line faced premiums in 2009-10; for those who did, the premiums averaged between $5 and $6 per month.

[10] Mathematica, "Healthy Indiana Plan Demonstration, Section 1115 Annual Report," Centers for Medicare and Medicaid Services, 2013, http://in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf.

Box 1: An Idea to Help Shortcomings of HIP 2.0

A modification could be made to HIP Plus to provide an alternative pathway to HIP Plus for people below the poverty line who wish to receive the coverage that HIP Plus offers but cannot afford the premiums. One such approach would be to require these individuals to complete activities that encourage the use of preventive services, such as filling out a health assessment form and scheduling and keeping an appointment with a primary care physician within six months of being determined eligible. If the enrollee has not completed such activities during this time period, they could be disenrolled and moved to HIP Basic. Such an alternative pathway would be consistent with the recently approved Medicaid demonstration projects in Iowa and Pennsylvania.

Similar results have been found in other states. For example, Oregon received HHS approval in 2003 to increase the premiums it charged participants in its Medicaid waiver program and also to impose a six-month lock-out period for non-payment of premiums, both of which are similar to Indiana's proposal. A study in 2004 found that following these changes, enrollment in Oregon's waiver program dropped *by almost half*.[11] Another study found that two-thirds of those who lost coverage remained uninsured at the end of the study period in February 2004.[12]

Utah and Washington had similar experiences. Under its Medicaid waiver, Utah requires individuals below 150 percent of the poverty line to pay an annual $50 enrollment fee (payable both at initial enrollment and each subsequent year when the individual re-enrolls).[13] A study conducted in 2004 found that of those who lost coverage at the time of re-enrollment, nearly one-third cited financial barriers as the primary reason they did not re-enroll. A substantial majority of that group said they could not afford the $50 enrollment fee.[14]

In Washington, in 2002, the state transitioned approximately 25,000 individuals who weren't eligible for Medicaid to its state-funded Basic Health Plan from other state-funded health insurance programs.[15] Some 36 percent of the people being transitioned were disenrolled and lost their coverage because they didn't pay the new monthly premiums, which ranged from $10 to $158 a month based on the individual's income.[16]

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[11] John McConnell and Neal Wallace, "Impact of Premium Changes in the Oregon Health Plan," The Office for Oregon Health Policy and Research, February 2004, http://www.statecoverage.org/files/Impact%20of%20Premium%20Changes%20in%20the%20Oregon%20Health%20Plan.pdf.

[12] Matthew Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access and Utilization in the Oregon Health Plan Standard Population," The Office for Oregon Health Policy and Research, March 2005, http://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1012&context=soc_fac.

[13] While this is a fee imposed annually rather than monthly, HHS treats enrollment fees as premiums because they are similar in purpose.

[14] Office of Health Care Statistics, "Utah Primary Care Network Disenrollment Report, July – August 2003," Utah Department of Health, August 2004, http://health.utah.gov/hda/reports/PCN%20Disenrollment.pdf.

[15] Before 2002, Washington provided health insurance to these individuals through a Medicaid look-alike program that did not have premiums.

[16] Mark Gardner and Janet Varon, "Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations," Kaiser Commission on Medicaid and the Uninsured, May 2004, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/moving-immigrants-from-a-medicaid-look-alike-program-to-basic-health-in-washington-state-early-observations.pdf.

Finally, individuals in Wisconsin with incomes modestly above the poverty line experienced similar effects. In July 2012, the state received approval through Medicaid waivers to impose premiums on adults (including adults without children, parents, and caretaker relatives) with incomes between 133 and 200 percent of the poverty line. The premiums ranged from 3 percent of income for people at 133 percent of poverty to 6.3 percent of income for those at 200 percent of poverty. Data from the Wisconsin Department of Health Services' preliminary evaluation show that 24 percent of those with incomes between 133 and 150 percent of the poverty line (and 18 percent of those with incomes between 150 and 200 percent of the poverty line) were dropped from the state's Medicaid waiver program and lost their health coverage because they didn't make the required premium payments.[17]

- **Delays in coverage.** Indiana's proposal also would result in significant delays in coverage for many newly eligible beneficiaries. Medicaid requires that coverage be provided for up to three months prior to the date of an individual's application if the individual was eligible during that period. (This retroactive coverage reduces the likelihood that people who were eligible for Medicaid prior to applying, especially those who are sick or have medical conditions, will have unpaid medical expenses; it also reduces uncompensated care for health care providers.)

  Indiana's proposal not only lacks this feature, but also would require individuals to go without coverage — and thus to incur more medical debt if they are sick — until an initial HIP Plus premium payment is made (or until 60 days have passed, at which time people below the poverty line could enroll in HIP Basic). Moreover, as noted above, if beneficiaries modestly above the poverty line missed an HIP Plus premium payment and didn't promptly make it up, they would be locked out of coverage for six months.

[17] State of Wisconsin Department of Health Services, "Wisconsin Medicaid Premium Reforms: Preliminary Price Impact Findings," http://www.dhs.wisconsin.gov/publications/P0/P00447.pdf

Box 2: Indiana's Proposal for Mandatory Co-payment for Non-emergency Use of the Emergency Room

Under HIP Plus, people would be required to pay a $25 co-payment for non-emergency use of the emergency room (ER). While this may sound reasonable at first blush, a careful reading of the Indiana proposal reveals problems here.

In 2006, Congress and President George W. Bush significantly expanded states' flexibility to require such co-payments, through provisions of the Deficit Reduction Act (DRA). The DRA effectively doubled the amount of cost-sharing that states can impose on Medicaid beneficiaries for non-emergency services provided in the ER, as long as certain basic, eminently reasonable conditions are met. The DRA requires that a state imposing such a co-payment ensure that alternative non-emergency providers are available and accessible to the Medicaid beneficiary seeking care and that before non-emergency care is provided at the ER, the beneficiary is informed of the co-payment and the availability of alternative care providers. Indiana's request *fail*s to include these basic conditions.

In addition, the $25 charge that Indiana seeks to impose exceeds what the DRA allows, and the waiver authority under section 1115 of the Social Security Act does not extend to Medicaid cost-sharing rules. Those rules can legally be waived only under strict criteria set forth in section 1916(f) of the Social Security Act, which Indiana's co-payment proposal does not meet.

Conclusion

Indiana's interest in expanding Medicaid coverage to those currently without coverage is commendable. Several features of the state's proposed HIP 2.0 waiver, however, would create barriers to coverage for low-income individuals and cause substantial numbers of people to remain uninsured. Indiana should modify its proposal to ensure that all newly eligible adults are actually able to participate and receive necessary health care services on a timely basis.