Indiana Medicaid Demonstration Raises Concerns

By: David Machledt

The Affordable Care Act (ACA) provides states funding and authority to extend Medicaid coverage to non-elderly adults with incomes below 138% of the federal poverty level (FPL). States could not previously cover this population without a special waiver. Indiana agreed to accept federal funds to cover these adults through a Medicaid demonstration project, under section 1115 of the Social Security Act. Indiana's demonstration, known as the Healthy Indiana Program, or HIP 2.0, has been held up as a potential model for state Medicaid programs. Champions of the HIP demonstration have painted a rosier picture of the program's success than is supported by published data. Evaluations of the program are decidedly mixed about both the innovativeness and the effectiveness of the HIP approach, and leave many important questions unanswered. One point of contention centers on the relative impact of premiums and enrollment lockouts on program participation and access to care. State and consultant reports conflict on the frequency of disenrollment for nonpayment of premiums – one key feature of the HIP demonstration – and more recently the frequency of disenrollment appears to have spiked. A second debate revolves around the complexity of the demonstration's incentive structure and its effectiveness in shaping enrollee behaviors. This analysis explores both arguments.

Background

Rolled out in 2015 as a revamped version of an earlier demonstration, HIP 2.0 offers enrollees a managed care health plan with a $2500 deductible. There are two types of HIP coverage. "HIP Plus" is for those who pay premiums.[1] These enrollees have no cost sharing to use services except non-emergency use of the emergency department. "HIP Basic" is for enrollees with incomes below FPL who do not pay premiums. Instead, they pay copayments for each service they use, set at the maximum federal Medicaid limits.[2] HIP Basic also offers fewer benefits than HIP Plus, with no vision or dental coverage.

Generally, enrollees above the federal poverty limit (FPL) face disenrollment with a six-month lockout if they fail to pay their monthly premium.[3] Except in a small fraction of cases where providers can

presume eligibility, coverage does not begin until the enrollee makes their initial payment. Enrollees below the FPL do not have to pay premiums, but if they make no payment their coverage does not begin for 60 days and they face per-service copays in the Basic plan.

Prior to reaching the $2500 deductible, both Plus and Basic enrollees pay for their services from a "POWER account" funded almost entirely by the State.[4] Preventive services are not charged to this account. If the enrollee remains eligible for the whole year and retains funds in their POWER account, some of those remaining funds can roll over to the following year and be used to lower the individual's premiums. Plus members who complete preventive services can increase the amount rolled over. Basic members must complete a preventive service during the year to roll over funds.

The Impact of Premiums on HIP Participation Is Likely Understated

Perhaps the most controversial components of Indiana's HIP 2.0 demonstration are the application of premiums, the establishment of a waiting period for those living below the FPL, and the lockout for near-poor enrollees who do not pay premiums on time. Premiums have been repeatedly shown to depress enrollment in other state Medicaid and CHIP programs, including demonstrations covering on non-elderly adults.[5] Lock-outs and waiting periods also create barriers and disrupt continuity of care.

The National Health Law Program reviewed Indiana's program evaluations – including the State's monthly, quarterly, and first annual reports, an interim demonstration evaluation conducted by the Lewin Group. We found numerous inconsistencies in the data, but more broadly we encountered a recurring theme that the reports consistently understate how much these HIP policies impact program participation. For example:

- **Both the State's and Lewin Group's evaluations report disenrollment figures based on enrollees who initiated payments but later stopped paying, which only partially describes who may actually be deterred by premium barriers.** Namely, this does not include another set of individuals who apply and are found eligible, but never make the first payment. None of the available data shows how large this group is. Based on monthly reports, roughly 4,000 to 5,000 individuals with incomes above the FPL are "conditionally eligible" in a given month, but none of the evaluations detail how many never pay.[6] Lewin's evaluation design included a survey of "never members" to track people who miss that first payment, but out of a targeted 121 respondents, the surveyor collected only a single completed survey.[7] This cleaving of a potentially large segment of individuals who never enroll at the front end from enrollees who fail to continue payments creates the impression of a smaller participation barrier due to premiums.

- **The State reported 67% more disenrollments for nonpayment in HIP 2.0's first year than the Lewin Group.**[8] The Lewin study reported 2,677 disenrollments for failure to pay a premium in the first demonstration year, or roughly 6% of all enrollees who were subject to disenrollment.[9] By contrast, the Indiana HIP 2.0 Annual Report found that 4,486 members were disenrolled for nonpayment over the same time period.[10] The latter number would approach 10% of the 45,607 people ever enrolled who were subject to this policy (and does not include "never enrolled" members described above).[11] Neither Lewin nor the State explained this discrepancy in their reports.

- **Disenrollments appear to have spiked precipitously during 2016.** During the third quarter of 2016, the state report 4,621 disenrollments for failure to pay--approximately 10.5% of the roughly 45,000 monthly enrollees potentially subject to disenrollment for nonpayment.[12] This is an 89% spike from the prior quarter.[13] When compared to Lewin's annual disenrollment figure, it means the State disenrolled 73% more people for nonpayment in the third quarter of 2016 than they did in the entire first year of the HIP demonstration.[14]

- **The State is likely charging lower premiums than its policies say it does, which inflates participation**. Under HIP 2.0, if an individual's income is less than 5% of FPL, then her monthly premium is one dollar. According to the state's data, over half of the individuals enrolled in HIP 2.0 had incomes under 5% of FPL in July 2016.[15] Census data shows that the actual proportion of potentially eligible Indiana adults with incomes that low is around 20%.[16] The state offers no plausible explanation for having so many HIP enrollees with almost no income. Two possible explanations are that the incomes are reported incorrectly or a sizeable chunk of Medicaid-eligible individuals with higher incomes are not signing up, or both. The latter, if true, would suggest Indiana has a substantial under-enrollment problem among the population charged the highest premiums. The former, if true, suggests that many enrollees have lower premiums than their actual income would dictate. While this is good for the enrollees, it artificially inflates participation rates relative to the stated policies in the HIP program. Also, a Kaiser Family Foundation study found that third party payment of premiums is considerably higher than the Lewin evaluation reports.[17] This could also make the barrier of premiums appear smaller.

- **Participation in HIP 2.0 has not met projections.** In early 2015, Milliman's 1115 budget analysis projected that *average* monthly HIP enrollment would be 518,000 in 2016.[18] Earlier, more modest Milliman projections suggested monthly HIP enrollment would reach 421,000 by October 2016.[19] Actual enrollment only reached 389,205 by that month.[20] Until better data is available to compare Indiana's participation rates – particularly for the income range subject to disenrollment – against similar states that have expanded Medicaid with no lockout or prepayment requirement, it is difficult to fully evaluate the extent to which premiums may or may not be inhibiting enrollment.

Enrollee Awareness of HIP Incentives Is Low and Confusion is High

Another major stated goal for HIP 2.0 is to incentivize cost-conscious health care seeking behaviors, including incentivizing preventive care. But this cannot work if enrollees do not understand how the system works. The data paint a picture of considerable confusion, misunderstanding, and administrative complexity. This is not simply an issue of rolling out a new demonstration. HIP 1.0, which had a similar POWER account and rollover structure, was plagued by poor understanding of the incentives even five years after implementation.[21] HIP 2.0 does not appear to have addressed these issues; awareness is actually worse in the new iteration. In short, the available data do not support the conclusion that the State's incentive structure improves health awareness and access to preventive care compared to a standard Medicaid expansion.

One of the criticisms of health accounts tied to high deductible plans is that they add unnecessary complexity that enrollees do not understand. Lewin's HIP 2.0 evaluation found that **more than half** of surveyed HIP enrollees believed they would pay for preventive services from their POWER accounts just like they do other services.[22] Fewer than 10 percent reported (correctly) that preventive services have no impact on their POWER account balance.[23] The finding that a majority of HIP enrollees incorrectly report that free preventive services actually cost them suggests that Indiana's POWER account structure may actually discourage seeking preventive care.

HIP 2.0 also included an incentive intended to make members more cost conscious and to reward healthy behaviors like obtaining preventive care. The incentive allows enrollees to roll over some of their remaining POWER account funds to reduce their premiums in the second year, provided they stay enrolled for well over 12 months. Early evidence suggests very poor understanding of the rollover program, which was also poorly understood in the original HIP program. Nearly 53 percent of HIP Plus members (65 percent of Basic) reported they had never heard of or did not have a POWER account Another 20 percent of Plus members (13 percent of Basic) never checked their account at all (See chart).[24] With so few enrollees aware of the basic structure of Indiana's system, it is hard to imagine that the rollover, with its delayed reward, is positively influencing healthy behaviors. Basic members responded to a true/false question on the structure of the rollover in nearly equal proportions for each answer – no better than random guessing. Plus members had slightly higher awareness that getting preventive services allows them to double rollover, but still only 52% found the statement true.[25]

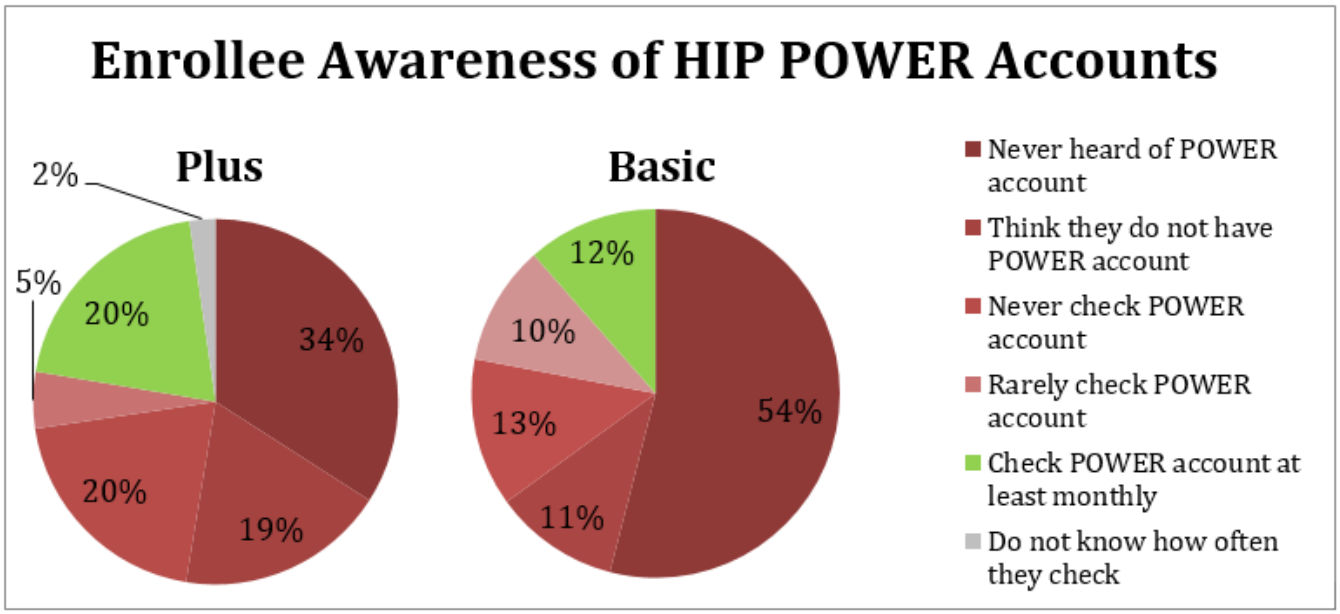

Chart based on data from Lewin Interim Evaluation, at 66.

The state claims evidence of success in promoting preventive services with the rather banal "finding" that the longer people are enrolled, the more likely they are to receive preventive services.[26] HIP proponents have also pointed out that more Plus members received preventive and primary care services compared to Basic members. But Plus members are much older and generally sicker overall, making this an apples-to-oranges comparison.[27] And as the Lewin study points out: "It would be expected that sicker members be more active users of preventive and primary care services."[28] It would also be consistent with prior research that Basic members are less inclined to seek care or adhere to medications due to the $4 copay they are charged for most services and the widespread misunderstanding about no-cost preventive services.[29]

Finally, the HIP 2.0 evaluations reveal a number of insights about the effects of administrative complexity on program participation. Two of the top five reasons for a HIP 2.0 closure during the first year related to such administrative issues.[30] In Lewin's small survey of individuals who left HIP 2.0, 9% left due to affordability or nonpayment, but an additional 9% experienced problems with administration or processing.[31] A different sample of Basic members found that two-thirds attributed their non-payment of premiums to confusion about payments, plan type or some other administrative issue.[32] These data all suggest that the bifurcation of plan types in HIP 2.0 is creating unnecessary red tape rather than a functional incentive to promote cost conscious decision-making.

Conclusion

Any 1115 demonstration is judged on how well it promotes the objectives of the Medicaid program, which is to furnish medical assistance to individuals who otherwise cannot afford to pay for necessary services.[33] Most importantly, it is critical to remember that this demonstration should be judged against a standard adult expansion that does not include premiums and lockouts, not against an alternative where expansion did not happen at all. If it is the better model proponents hold it up to be, then it should perform well in such a comparison. But that evaluation has not yet been performed.

Based on available evaluations, HIP 2.0 has raised more questions than answers. Far from being a model to emulate, Indiana's Medicaid demonstration has generated widespread confusion. To date, it has not been shown to improve healthy behaviors or cost-conscious health care seeking. Rather, it appears that premiums have likely hindered participation, disenrollments have spiked, and cost sharing may be creating counterproductive barriers to care. These concerns, until addressed, cast shadows on the effectiveness of the HIP model over a straightforward Medicaid expansion.

ENDNOTES

[1] Premiums are set at 2% of household income with a minimum of $1/month.
[2] HIP copayments are $4 for most services and prescriptions, $8 for nonemergency use of the emergency department, and $75 for a hospitalization.
[3] Some HIP members with incomes above the FPL, such as the medically frail, 19- and 20 year old adults, pregnant women, and people on Transitional Medical Assistance (TMA), are not subject to disenrollment for nonpayment.
[4] HIP Plus member fund a small share of the Personal Wellness and Responsibility (POWER) account with their premiums.
[5] Laura Snyder & Robin Rudowitz, KAISER FAMILY FOUND., *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (2013); Brendan Saloner et al., *Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 PEDIATRICS e20152440 (2016)
[6] IND. FAMILY & SOC. SERVS. ADMIN. ("FSSA"), *HIP CMS Metrics* (July 19, 2016), http://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-july-2016-07202016.pdf.
[7] LEWIN GROUP, *Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report*, 16 (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. Presumably, the survey will be included in the final evaluation, but that will not come for several years.
[8] Author's calculations based on Lewin and FSSA reports.
[9] LEWIN GROUP, *supra* note 7, at 63.
[10] FSSA, *Healthy Indiana Plan Annual Report*, 22 (Apr. 29, 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-annl-rpt-feb-jan-2016-04292016.pdf. The state claims that this is only 6.3% of the ever-enrolled over 100% of FPL, but the state's total includes the medically frail, Native Americans, pregnant women and individuals on transitional Medicaid who were not subject to disenrollment.
[11] LEWIN GROUP, *supra* note 7, at 63.

[12] In October 2016, fewer than 45,081 individuals were potentially subject to disenrollment due to non-payment. Individuals in Basic (not subject to disenrollment) and individuals with incomes above 138% FPL, who are likely in TMA, are not subject to disenrollment. Some of the 45,081 Plus members are likely medically frail, or pregnant or young adults under 21 who are also not subject to disenrollment, so the share closed for nonpayment likely exceeds 10.5% of average enrollment. FSSA, *Healthy Indiana Plan Demonstration Quarterly Report, Demonstration Yr 2, Qtr. 3*, 4 (Dec. 30, 2016). The state did not publish an ever-enrolled figure for the third quarter.
[13] The state corrected its quarter 2 total down to 2,442 closures. FSSA, *Healthy Indiana Plan Demonstration Section 1115 Quarterly Report Demonstration Yr. 1, Qtr. 4*, 8 (Mar. 31, 2016).
[14] Percentages based on author's calculations using state data.
[15] FSSA, *supra* note 6.
[16] Judith Solomon, CENTER ON BUDGET & POL'Y PRIORITIES, *Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved*, http://www.cbpp.org/research/health/indiana-medicaid-waiver-evaluation-shows-why-kentuckys-medicaid-proposal-shouldnt-be (Last visited Feb. 14, 2017).
[17] MaryBeth Musumeci, et al., KAISER FAMILY FOUND., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, 12 (Jan. 2017).
[18] MILLIMAN, *1115 Waiver – Healthy Indiana Plan Expansion Proposal: Budget Neutrality Projections*, 1 (June 23, 2014). This budget neutrality analysis uses total member months, but assumes that 518,000 individuals would be enrolled in each of the 12 months.
[19] MILLIMAN, *1115 Waiver – Healthy Indiana Plan Expansion Proposal: Budget Neutrality Projections – 3 Year*, 5 (Feb. 27, 2015).
[20] FSSA, *supra* note 12, at 4.
[21] In demonstration year 5 of the original HIP, more members were aware of POWER accounts (76.5%), but fully 72% believed incorrectly that preventive screenings were deducted from their accounts. Sixty percent were not sure or did not know the connection between preventive services and rollover. FSSA, *Healthy Indiana Plan 2013 Annual Report & Interim Evaluation Report*, 58, 61-62 (October 2014). Note: Lewin cited this rollover connection data in their evaluation, contending that awareness has improved in HIP 2.0, but the question on the prior survey was structured differently, making a direct comparison problematic. LEWIN GROUP, supra note 7, at 68.
[22] LEWIN GROUP, *supra* note 7, at 66.
[23] Id.
[24] Author's calculations based on results in Lewin evaluation. After weighting for the relative share of HIP Plus and Basic members at the time of the survey, the combined figures for all HIP members would be: 40% not aware of the POWER account, 16% did not know or thought they did not have a POWER account, 18% knew about but never checked their POWER account, 7% rarely checked their POWER account, 17% checked their account at least monthly, and 2% did not know how often they checked it. *See* id, at 66, and at Table G1 of Appendix G.
[25] Id. at 67.
[26] FSSA, *Response to Center on Budget and Policy Priorities Article*, 4 (Sept. 2, 2016), https://www.in.gov/fssa/hip/files/Solomon%20Response%209-2-16.pdf
[27] State data shows that in January 2016, 46% of Basic members were under 30, while only 8% were 50+. Twenty-seven percent of Plus members were under 30, while 25% were 50+. FSSA, *supra* note 10, at 28.
[28] LEWIN GROUP, *supra* note 7, at 104.
[29] For a review of research linking higher cost-sharing with reduced medication adherence, see Jane Perkins and David Machledt, NAT'L HEALTH LAW PROGRAM, *Medicaid Premiums & Cost Sharing* (Mar. 2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.
[30] LEWIN GROUP, *supra* note 7, at 21.
[31] LEWIN GROUP, *supra* note 7, at 25.
[32] An additional 16% cited affordability issues. LEWIN GROUP, *supra* note 7, at 45.
[33] 42 U.S.C. 1396.