

## Executive Summary

The Center on Budget and Policy Priorities recently published an article by Judith Solomon on Kentucky's Medicaid proposal and Indiana's independent evaluation of the Healthy Indiana Plan (HIP) by the Lewin Group. In several important areas, Solomon's reporting is inaccurate, misleading and incomplete, and this response provides additional critical information that was overtly omitted from the article.

HIP is an innovative program that offers low-income adults a consumer-driven health plan paired with a Personal Wellness and Responsibility (POWER) account, similar to a health savings account. Members make modest monthly financial contributions to the account equal to 2% of income, which encourages value-based healthcare decisions. All members are placed in the HIP Plus benefit package, which provides enhanced healthcare to members who make regular monthly contributions. Those members with income below the federal poverty level, who choose not to make minimum monthly contributions, are placed in the HIP Basic benefit package which provides reduced services and requires copayments.

The initial evaluation of HIP's unique consumer-driven model indicates strong success and individuals who make regular monthly contributions have improved health outcomes compared to individuals choosing not to make contributions. Specifically, the independent evaluation of HIP demonstrated the following:

- Monthly HIP contributions are affordable, resulting in almost 70% of individuals choosing to make contributions into their health savings-like account – and it is important to note that 86% of this group are below the federal poverty line. In fact, a survey of HIP members indicated that almost 90% of HIP Basic and about 80% of HIP Plus members would be willing to pay more to participate in HIP.
- HIP Plus members (those making regular monthly contributions) consistently had better health utilization habits than members choosing to participate in HIP Basic, despite the fact that, on average, they are a less healthy population. Specifically, HIP Plus members have higher rates of primary care visits (31% to 16%) and preventive care visits (64% to 45%), lower emergency room usage (775 to 1,034 visits per 1,000 member years), greater drug adherence rates (84% to 67%), and fewer missed appointments (18% to 23%) than their HIP Basic counterparts.
- HIP's consumer-driven model engages members in their healthcare, as one in four members reported asking their providers about the cost of care, and nearly 40% check the balance of their POWER account at least once a month.
- Ultimately, HIP members understand the program, actively participate in the program, and are very satisfied with HIP. Member satisfaction rates are about 80% overall, and 86% among those making regularly contributions.

Despite the clear evaluation results demonstrating the success of HIP's consumer-driven approach, Solomon attacks all aspects of the Indiana program by reporting inaccurate information and providing only partial truths from the HIP evaluation report to draw erroneous conclusions about the success of the program related to utilization, member contributions, impact of non-payment, program usability, results of the incentive policy, and enrollment. Each of Solomon's invalid conclusions are discussed in more detail below.

## Detailed Response to J. Solomon Article

### *Health Care Utilization*

First, Solomon claims that the evaluation “casts serious doubt” on whether Indiana’s use of health savings accounts, called POWER accounts, encourages preventive care and discourages unnecessary care. This statement is completely false. The HIP evaluation found that members who contributed to their POWER Accounts (versus members who did not contribute) were more likely to obtain primary care (31% to 16%) and preventive care (64% to 45%); were more satisfied with the program (86% to 71%); and had better drug adherence (84% to 67%) than members who did not contribute. The evaluation also found that POWER account contributors relied less on the emergency room for treatment (775 to 1,034 visits per 1,000 member years).

Solomon also states that HIP has prevented low-income people from enrolling and getting the health care they need. This statement is not true. Nearly 90% of HIP members have incomes below the federal poverty level (FPL), and an independent survey of current HIP members found the vast majority were able to obtain routine care (74%) and specialty care (79%) as soon as they needed it. These rates are considerably higher than those observed by a recent evaluation of a patient-centered medical home in Florida (51%) —a model regarded by the National Committee for Quality Assurance (NCQA) as the “gold standard” in primary care delivery.

Solomon further asserts that the results from the HIP evaluation indicate that replicating a similar model in Kentucky would “erode Kentucky’s progress” in promoting health care coverage and access to care. This statement is both inaccurate and misleading. The evaluation found that HIP provided health coverage to nearly 210,000 previously uninsured individuals in its first year. The projected decrease in enrollment is due to individuals transitioning off public assistance and into the private insurance market. The HIP evaluation member survey found that over half (52%) of members who left the program did so because their income increased or because they acquired private insurance, while only 5% of members surveyed reported leaving the program due to affordability.

Solomon later acknowledges that, although HIP Plus members exhibited better cost-conscious behavior regarding non-emergency use of the emergency room, the higher rate of non-emergency utilization displayed by HIP Basic members “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.” This statement is unfounded and is a direct contradiction to the findings of the evaluation which state: **“Cost did not appear to be a major barrier to care in data available for this evaluation... About one percent of Plus members and two percent of Basic members reported missing appointments due to cost.”**

### *Monthly Contributions*

Solomon claims, “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.” First, it is unclear whether the research she refers to assesses able-bodied populations, which is the target group of HIP. In any case, however, Indiana’s research contradicts this assertion. Second, the HIP evaluation found of the two-thirds (65%) of HIP members that elected to make premium contributions, the vast majority (86%) had incomes below the federal poverty level, which means these members made an **active choice** to make premium payments, as members with incomes below the poverty level have the option to not make premium payments without losing HIP coverage. The overwhelming majority of members below (92%) and above (94%) the federal poverty

level maintained consistent premium payments. Third, almost 90% of HIP Basic and about 80% of HIP Plus members surveyed said they would be willing to pay more to stay in the program, while over half of members (52%) report “rarely” or “never” worrying about premium payments. Fourth, only 5% of members who left the program reported affordability as their reason for leaving. These four facts, combined with the aforementioned findings that contribution-paying HIP members have higher rates of primary and preventive care, prescription drug adherence, and overall program satisfaction, utterly and completely dispel the notion that premiums “significantly reduce low-income people’s participation in health coverage programs.” On the contrary, the HIP evaluation demonstrates definitively that premium payments **improve** low-income people’s access to health care, their active participation, and their satisfaction with health coverage programs.

In addition, Solomon also uses a dubious probe of census data to argue that “HIP 2.0’s premiums are deterring significant numbers of eligible low-income people from enrolling”, and there “is strong evidence that the program’s high degree of complexity is negatively affecting participation and the ability of people to obtain health care.” This statement reflects bias, particularly when considered alongside some of the key self-reported findings from the HIP evaluation regarding members who make premium payments. Among these members, 86% are satisfied with the program, 80% would pay more to stay in the program, and 95% would try to re-enroll in the program if they left and became eligible again.

Later in the article, Solomon returns to the affordability argument, this time claiming premium payments are **too** affordable. Solomon notes that “Premiums are only \$1 a month for enrollees in this extremely low-income bracket,” referring to premium payment amounts for HIP members with income below 5% of the federal poverty level. Solomon uses her analysis of census data to claim that in essence, there cannot be **that many** poor people in Indiana, while insinuating these individuals should be required to pay higher premium amounts. Thus, she has now argued not only that HIP premium payments are prohibitive to acquiring health care, but also that the premiums need to be higher to enable successful evaluation of the program.

### ***Non-Payment & Disenrollment***

Solomon states that 2,677 individuals (5.9% of all HIP members) were disenrolled from the program for choosing not to contribute to their POWER accounts; however, she fails to mention that nearly all (94%) of the members who applied for a waiver or exemption from disenrollment had their enrollment reinstated. As stated previously, Solomon also fails to mention that the majority of members who leave HIP (52%) report increased income or acquiring private health insurance as their reason for leaving, while 16% of members leave because they no longer qualify (e.g., they moved out of state); and 15% leave for “other” reasons outside of affordability, which as stated previously, accounts for only 5% of members’ reported reason for leaving. To summarize, most people who leave HIP do so for reasons unrelated to affordability.

Solomon correctly confirms that affordability is not a barrier to premium payments in HIP: “Of interest, only 16 percent of those moved from Plus to Basic cited affordability as the reason for non-payment of premiums.” This finding is consistent with the results throughout the HIP evaluation; specifically, that most members **do not worry** about premium payments and would **pay more** to stay in the program, which demonstrates that premium payments are affordable and are not prohibitive to member care. However, Solomon states, “The biggest reason [for non-payment of premiums] 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.” Unfortunately she fails to mention that “forgetting to pay” (13%) was reported almost as often as “affordability” (16%) as a reason for non-payment.

### ***Member Usability***

Solomon calls the HIP program “considerably more complicated” than other Medicaid expansions; a statement that insults the intelligence of Medicaid members and conflicts with the state’s independent evaluation that demonstrated that members had strong knowledge of the program. For example, while the survey was conducted only after 10 months after the program started and many of the members only enrolled for a few months, nearly all (97%) of HIP members surveyed with income above the federal poverty level indicated they were aware of the program’s penalties for non-payment. Moreover, the vast majority (78%) of HIP members with income below the federal poverty level reported awareness of the disenrollment penalty for non-payment, even though these particular members were not required to make premium payments and could not be disenrolled for non-payment. Similarly, 65% of HIP Plus members and 57% of HIP Basic members reported being aware of the rollover policy, (which allows members to “rollover” part of their unused savings account funds to reduce future premium payments), even though these members would not be eligible to receive the rollover benefit until they are enrolled in HIP for one year. When members were asked: “If you get preventive services suggested by your plan every year and have money left in your POWER account, will part of that money be rolled over to your account for next year? Also, could this result in lower payments in the next year?” Two-thirds (65%) of HIP Plus members correctly responded “yes.” So, at less than 10 months of enrollment, most HIP members understand the key concepts of the program.

### ***Member Incentives***

Although Solomon correctly describes the preventive service rollover policy, which allows members to further reduce their future POWER account contributions if they obtain preventive health care services, she incorrectly asserts that: “The evaluation indicates, however, that the rollover does not appear to be working as an incentive for a large share of enrollees ... Without enrollee knowledge about the account, the rollover can’t act as an effective incentive.” Solomon fails to report that the likelihood members will qualify for this reduction increases with the amount of time members remain in the program. Specifically, by 12 months of enrollment, 87% of HIP members making contributions completed their required preventive services.

Solomon later states that, even when HIP members know about the policy, greater member awareness of rollover incentives are unlikely to change member behavior. This statement is not consistent with the evidence from the HIP evaluation, which shows that the percentage of members who obtain preventive health care services continues to increase with the amount of time members are enrolled in HIP. Specifically, less than 10% of HIP Basic and Plus members have obtained preventive services after one month of enrollment. By 12 months of enrollment, those numbers increase to 62% and 86% respectively. Solomon, indicates that this population cannot understand the concept of a basic reward-system, and that even if they manage to understand it, they are unlikely to change their behaviors unless they will receive “immediate gratification.” Indiana’s data contradicts this assertion and instead shows that the consumer directed model is effective at empowering individuals to improve their health.

## Enrollment

Next, Solomon asserts, “premiums and the complexity of HIP 2.0 appear to be decreasing enrollment below what it otherwise would be,” stating, “the most recent data show enrollment for May 2016 was 352,000, over 50,000 people short of the 404,000 expected.” This statement is misleading. The HIP evaluation indicates that 407,746 Indiana residents were enrolled in HIP 2.0 for at least one month, which exceeds the expected projection of 404,000. Health insurance projections are understandably difficult to make, as evidenced by the recent projection change for Obamacare health insurance exchange enrollment from 21 million to 13 million in 2016, made by the non-partisan Congressional Budget Office. However, HIP projections have been incredibly accurate.

The July enrollment projections listed in the document Solomon cited state HIP will enroll 410,962 members by July 2016. The July enrollment counts for HIP indicate that 394,876 members are enrolled in the program, which does not include the 12,229 members eligible through presumptive eligibility (PE), which would bring the total to 407,175. Thus, Solomon’s assertion that HIP is failing to meet member projections is unfair, if not biased and irresponsible.

Further, Solomon states that coverage in HIP Plus does not become effective until members make their first premium payment. This statement is misleading. Members may obtain coverage through Indiana’s presumptive eligibility (PE) process, which grants immediate coverage for 60 days based on self-reported income. The PE program is targeted to individuals facing an acute health care crisis, although anyone can apply. The HIP evaluation found that nearly 27,000 members enrolled in HIP through PE. In addition, all HIP members can obtain expedited coverage that begins on their application date, by making a “fast-track” payment of \$10. The HIP evaluation found that nearly 31,000 members made fast track payments to start their coverage faster.

Another inaccurate statement from Solomon that demonstrates a lack of knowledge about how the HIP program works is: “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.” In reality, members who apply for HIP are deemed “conditionally eligible” until they make their first premium payment. Most members make a payment within 60 days; however, members may be given additional time to make payments to help them become enrolled. In other words, just because a member is **not enrolled** within 60 days, does not mean the member is **never enrolled**. In addition, Solomon fails to report that members with income below the federal poverty level are not required to make a premium payment within 60 days, and are moved to Basic. Thus, Solomon’s statement: “This indicates that HIP 2.0’s premiums are deterring significant numbers of eligible low-income people from enrolling” is unfounded conjecture at best, and at worst, is an attempt to discredit the summary statement from the independent HIP evaluation, which reads, “Thus, it appears that POWER Account contributions do not constitute a barrier to enrollment in the HIP program.”

## Conclusion

Ultimately, Solomon has created an inaccurate, incomplete, and misleading description of the results of the HIP evaluation that she uses to discourage duplication of the HIP 2.0. However, had Solomon given an objective review of the results of the Lewin Study, her conclusion would have to be that HIP 2.0 is outperforming traditional Medicaid on many levels and is a model for reform.