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New Approaches in Medicaid: Work Requirements, Health Savings Accounts, and Health Care Access

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ABSTRACT

Alternative approaches in Medicaid are proliferating under the Trump Administration. Using a novel telephone survey, we assessed views on health savings accounts, work requirements, and private vs. public coverage. Our sample included low-income non-elderly adults (N=2739) in three Midwestern states with different policies: 1) Ohio, which expanded traditional Medicaid; 2) Indiana, which expanded using health savings accounts ("POWER" Accounts); and 3) Kansas, which has not expanded. We found that coverage and access to care in 2017 were significantly higher in expansion states than in Kansas. However, compared to Ohio's traditional expansion, cost-related barriers were more common in Indiana. Among beneficiaries eligible for Indiana's program, 39% had not heard of POWER Accounts, and only 36% were making their required payments, meaning that nearly two-thirds were potentially subject to loss of benefits or coverage. Meanwhile, in Kansas, 77% supported expanding Medicaid, with similar attitudes towards Medicaid or private insurance. 49% of potential Medicaid enrollees in Kansas were already working, 34% were disabled, and only 11% were unemployed and would seek work if required by Medicaid. These findings suggest that current Medicaid innovations may lead to unintended consequences for patient coverage and access.

INTRODUCTION

Medicaid expansion under the Affordable Care Act (ACA) has been associated with significant improvements in coverage, health care access, and quality of care.[1-6] But much of the state-level debate since the 2016 election has shifted away from the question of whether to expand Medicaid to the question of what alternative approaches to take within the program. This paper explores several new approaches (implemented or proposed) in Medicaid, using a novel survey of three Midwestern states.

The Trump Administration has prioritized increased flexibility for state Medicaid programs. This builds on Section 1115 waivers approved under the Obama Administration, including Arkansas's use of private coverage expansion (the "private option") and Indiana's consumer-oriented expansion featuring health savings accounts.[7] Most recently, the Centers for Medicare and Medicaid Services (CMS) approved proposals from Kentucky, Arkansas, and Indiana for the first-ever work requirements in Medicaid, and other states including Ohio have expressed interest in following suit.[8]

While the private option has been well-studied,[2,9,10] less is known about the effects of Indiana's expansion. "Healthy Indiana" was implemented under the leadership of Vice President Mike Pence and CMS administrator Seema Verma (then both Indiana state officials). Featuring premiums, health savings accounts (called "POWER" accounts), and a lock-out period for failure to make required payments, Healthy Indiana's focus on consumer-oriented provisions has been cited by Trump administration officials as a potential exemplar for other states.[11,12]

Preliminary evaluations of Healthy Indiana have been mixed, with one contracted evaluation concluding that the waiver did not result in significant disenrollment in Indiana nor act as a barrier to care,[14] though independent assessments have critiqued the report as

misleading.[15] In contrast, another analysis of the same data found that more than half of enrollees lost some benefits due to a failure to pay premiums,[16] and qualitative interviews suggested that some enrollees did not understand the POWER Accounts.[7] Most recently, CMS announced it was scaling back its own evaluation,[17] which makes the rationale for ongoing independent assessments even more compelling.

Meanwhile, the potential implications of work requirements in Medicaid are of significant interest to policymakers.[18] Previous analyses indicate that most Medicaid beneficiaries are disabled or already working,[18,19] but to our knowledge no studies have explored how many potential enrollees would change their employment behavior (or which demographic groups might be most likely to do so) in response to a work requirement.

This study presents survey data collected in late 2017 from low-income adults in three Midwestern states with different Medicaid policies: Indiana, which expanded coverage in 2015 via Section 1115 waiver; Ohio, which expanded Medicaid without a waiver in 2014; and Kansas, which has not expanded Medicaid after the governor vetoed an expansion bill in early 2017.[20] In Kansas, debate over expansion Medicaid continues, and the state is actively considering work requirements for both the expansion and traditional Medicaid populations.

The objectives of our study were: 1) to assess differences in coverage, access, and heath care satisfaction among low-income adults in these states; 2) to examine low-income adults' experiences with some of the unique features of the Healthy Indiana program; and 3) to explore attitudes towards expansion and the potential effects of Medicaid work requirements in Kansas.

METHODS

Key State Policies & Study Sample

Medicaid policies in our 3 study states are described in Table 1. Ohio has a traditional Medicaid expansion without premiums and with minimal cost-sharing. Kansas has not expanded, and among non-pregnant adults only very poor parents (incomes ≤38% of the Federal Poverty Level, FPL) and disabled adults (≤75% of FPL) are eligible for Medicaid in the state.

Indiana's waiver – called the Healthy Indiana Program 2.0 (HIP 2.0) – built upon an earlier smaller waiver program and features two variations of Medicaid coverage, HIP Plus and HIP Basic. HIP Plus provides more generous prescription drug coverage than HIP Basic, as well as other benefits not covered by HIP Basic including vision and dental services. Upon enrollment in HIP 2.0 and initial payment, all members initially receive benefits provided through HIP Plus. They receive a $2,500 deductible health plan coupled with a state-funded $2,500 POWER Account, similar to a health savings account, that must be used to pay for health care services before the insurance benefit kicks in. Applicants with incomes between 130-138% of FPL who do not make their original POWER contributions within 60 days are never enrolled in the program; those below 100% who never make a contribution are enrolled in HIP Basic.[14]

To maintain enrollment in HIP Plus, members are required to continue making monthly contributions equal to 2% of their income. HIP 2.0 members with incomes ≤100% FPL who fail to make payments for three consecutive months are moved from HIP Plus to HIP Basic. Members with incomes between 100-138% FPL who fail to make payments for three consecutive months are removed from HIP 2.0 and "locked out" for six months. Any unspent POWER funds are rolled over at year's end, reducing the contribution required the following year.

Our sample consists of non-elderly adults with family incomes at or below 138% FPL, the cutoff for the ACA's Medicaid expansion. We oversampled in Indiana and Kansas, given

our intention to ask additional state-specific questions in those states.

Survey Design

We contracted with a survey research firm to conduct a random-digit-dial telephone survey of low-income residents in Indiana, Kansas, and Ohio. The survey instrument was pre-tested in the study population, and then fielded between November 9, 2017, and January 2, 2018. All but 11 surveys (0.4%) were completed in 2017, and excluding 2018 observations has minimal effect on our findings. Inclusion criteria were U.S. citizenship, ages 19 to 64, and family income at or below 138% FPL. The survey was conducted in English or Spanish and via cell phones and landlines. The response rate (AAPOR RR3) was 15% (12% in Indiana, 17% in Kansas, and 14% in Ohio).

Survey respondents in all three states were asked about health insurance, access to care, financial well-being, experiences with the ACA, and perceived quality of care. Respondents in Indiana with Medicaid whose responses indicated they were eligible for the Healthy Indiana Program (i.e. neither pregnant nor eligible for Medicaid due to a disability) were asked about their knowledge, use, and perception of POWER Accounts. Respondents in Kansas were asked about their views of Medicaid expansion, private vs. public insurance, and potential work requirements in Medicaid. All respondents were asked demographic questions. See Appendix Methods for survey questions and additional details.

Outcomes

We measured several outcomes in all three states: source of health insurance; having a personal doctor; delays in care due to its cost in the past 12 months; and needing to borrow money, skip paying medical bills, or skip paying other bills due to medical bills in the past 12

months. The survey asked whether respondents felt they had personally been hurt, helped, or experienced no effect of the ACA, and asked them to rate the quality of their health care over the past six months on a 0-10 scale, a question obtained from a recent Medicaid survey conducted by CMS.[21]

For Indiana, we asked state-specific questions of two coverage groups: 1) Among individuals with Medicaid eligible for Healthy Indiana, we asked about knowledge, use, and perception of POWER Accounts. 2) Among currently uninsured individuals, we assessed their primary reason for not enrolling in the Healthy Indiana Program. For Kansas, state-specific outcomes of interest were whether respondents supported or opposed Medicaid expansion, perceived quality of care with Medicaid coverage compared to private insurance or being uninsured, employment and disability status, and whether the respondent would be more likely to look for work as a condition of Medicaid eligibility.

Statistical Analysis

All responses were weighted to match state-specific population benchmarks in the 2016 American Community Survey for education, race/ethnicity, marital status, geographic region, population density, and cell phone status.

Survey-weighted descriptive statistics were computed for all outcomes. Then, for binary outcomes, we used multivariate logistic regression, and for the only continuous measure (quality of care), we used multivariate linear regression to identify significant predictors of each outcomes. These models included the following covariates: state of residence, age, race/ethnicity, educational attainment, rural vs. urban residence, gender, political party affiliation, marital status, and family income. Analyses of outcomes assessed within a single

state (e.g. work requirements in Kansas, HIP experiences in Indiana) were similar except they did not include the state as a covariate.

All analyses were conducted using Stata 15. We used the "margins command" to generate predicted probabilities from our regression models for ease of interpretation.

Limitations

One important limitation is the response rate (15%). However, our use of population benchmarks for weighting has been shown to reduce the potential non-response bias in random-digit-dial surveys.[22] Additionally, results in previous research using a similar instrument have been validated against two federal government surveys, which demonstrated similar overall patterns of coverage and access to care.[9] More broadly, our response rate compares favorably to other surveys that are frequently used to evaluate the ACA.[23,24]

Our three-state comparisons rely on cross-sectional state differences, which can be biased by numerous unmeasured factors between states, despite multivariate adjustment. However, our results are quite similar to numerous more rigorous quasi-experimental comparisons between expansion and non-expansion states for similar outcomes.[1-5]

Another issue is that many of our state-specific questions, like those related to Indiana's POWER Accounts, have relatively small sample sizes. However, our sample size is similar or larger than that of two prior studies of the Healthy Indiana Program.[7,14]

We asked respondents whether they had heard of or were aware of POWER accounts. It is possible that some individuals did not know the program's name or features, but were still making payments (or receiving third-party assistance with premiums), which would lead us to underestimate participation rates in that part of the program.

Our analysis of employment focuses only on Kansas, based on survey length considerations in each state, but work requirements are clearly also relevant in Indiana (which has been approved to implement them) and Ohio (which has proposed doing so). Moreover, our survey did not assess reasons individuals may not be working, though these issues have been evaluated in other research.[18]

Finally, insurance type is self-reported. Respondents may incorrectly report their coverage, particularly in Indiana's program, in which beneficiary confusion is a major challenge.[7] We tried to mitigate this by including multiple state-specific names in the survey (e.g., Medicaid, HIP 2.0, Healthy Indiana, KanCare). But we cannot exclude the possibility that measurement error may have affected our estimates.

RESULTS

Our sample size was 2739 individuals – 1007 in Indiana, 1000 in Kansas, and 732 in Ohio. Appendix Table 1 presents descriptive statistics. The sample in Ohio had a higher share (33%) of racial/ethnic minorities than the other states (26% in Indiana, 27% in Kansas), while Kansas was disproportionately rural (48%) compared to Indiana (27%) and Ohio (17%).

Three-State Comparisons of Coverage, Access, and Health Care Satisfaction

Figure 1 shows differences in coverage, access to care, attitudes towards the ACA, and overall health care quality across the three states, after adjustment for sociodemographic features. We find significantly higher rates of Medicaid coverage (53.1% vs. 35.9%, $p<0.001$) and lower uninsured rates (14.7% vs. 19.9%, $p=0.06$) in Ohio compared to Kansas, but no significant differences between the two expansion states (Ohio and Indiana). Rates of having a personal

physician were similar in all three states. Rates of delaying care due to cost were higher in Kansas (p=0.04) and Indiana (p=0.06) than Ohio. Meanwhile, respondents in Kansas were less likely to say that the ACA had helped them compared to respondents in Ohio and Indiana, while those in Kansas and Indiana were more likely to say that the ACA had hurt them compared to those in Ohio. Average health care ratings were highest in Ohio and lowest in Kansas (7.3 vs. 6.9, p=0.03), with Indiana in between (7.1, p=0.22 vs. Ohio). Appendix Table 2 shows full regression results for several of these outcomes.

Consumer Experience in the Healthy Indiana Program

Among those reporting Medicaid coverage and likely subject to the Healthy Indiana program (i.e. not receiving disability-related income or pregnant), 39% said they had not heard of the POWER Accounts, 26% had heard of the accounts but were not consistently making required payments, and 36% were making regular payments (Table 2). The most common reason for non-payment was affordability (31%), while 22% said they didn't think the additional benefits were worth the money, and 19% were confused about the accounts.

Meanwhile, among those familiar with the POWER Accounts, attitudes were mixed about their impact: 57% agreed or strongly agreed that the POWER Account "helps me think about the health services I really need," while 40% agreed or strongly agreed that the POWER Accounts were hard to understand or made it difficult to obtain necessary care. Meanwhile, 9% of uninsured low-income adults in Indiana reported that they had been locked out of coverage due to premium non-payment.

Appendix Table 3 shows predictors of several of these outcomes. Among Medicaid beneficiaries in Indiana, Latinos (vs. Whites), men (vs. women), and those with less education

were significantly less likely to have heard about the POWER Account. Younger adults were more critical of the POWER Accounts than adults 45 and older.

Attitudes Towards Medicaid Expansion and Work Requirements in Kansas

77% of low-income adults in Kansas support Medicaid expansion in the state, with just 11% opposed (Table 3). A large majority (68%) said they would receive higher quality of care if they had Medicaid than no coverage at all (23% said it would make no difference and 9% said Medicaid was worse than no coverage). Meanwhile, views were evenly split on quality of care with Medicaid vs. private insurance – with 32% preferring Medicaid, 31% preferring private coverage, and 37% saying quality would be similar with either.

Meanwhile, work requirements would potentially impact a fairly small share of the state's potential Medicaid population. Of those with Medicaid currently or without any coverage (who would presumably be eligible if the state expands Medicaid), 49% reported they were currently working and 34% had a disability that kept them from working. 11% were unemployed but said they would be more likely to look for a job if required as a condition of obtaining Medicaid; 6% were unemployed but would not be more likely to look for work even if required. Multivariate analysis (Appendix Table 4) indicates that among unemployed individuals, a Medicaid work requirement would significantly increase rates of job-seeking among single adults, Latinos, and those living in rural areas.

DISCUSSION

With more than a dozen states proposing or already implementing new waivers in Medicaid over the past three years, evaluating low-income adults' experiences in and attitudes

towards these programs is critical. Using a novel survey of more than 2700 low-income adults in three states, we find a mixed picture on the current and potential future effects of several waiver features.

Waiver-Based Medicaid Expansion

Three years into the implementation of the consumer-based Healthy Indiana Program, we find that nearly 40% of beneficiaries likely eligible for the program were unaware of the existence of the required POWER Accounts that serve as one of the state's key innovations. Combined with those who had heard of the accounts but were not paying their premiums regularly, we estimate that as many as two-third of recipients could be at risk for losing benefits such as vision and dental care or being locked out of the program entirely.

In touting HIP's success, officials have said,
"70% of HIP members make POWER account contributions."[25] This appears to refer to the state evaluation by the Lewin Group, which reported a 29% rate of disenrollment from the program among those subject to that penalty (i.e. 100-138% of FPL and not medically frail); however, this is not the same as the overall share of potential HIP enrollees who paid their premiums. This estimate excluded HIP Basic members, most of whom who never made any payments and thus weren't enrolled in HIP Plus in the first place. Elsewhere in the Lewin report, as highlighted by the Kaiser Family Foundation, two broader measures of payment rates were reported: 57% of those with incomes below 100% of FPL were moved to HIP Basic for non-payment, and 51% of those above 100% of FPL determined eligible for HIP did not make premium payments,[16] figures much closer to our estimates. In addition, the Lewin survey had a lower response rate (4.8%) than ours and did not use demographic weighting to reduce non-response bias.[14]

Troublingly, we found that lack of awareness of the program was highest among Latinos and less educated adults, potentially exacerbating disparities compared to traditional Medicaid. Meanwhile, nearly 10% of uninsured respondents in Indiana reported being locked out of Medicaid due to premium non-payment.

These findings are consistent with Medicaid waivers in Iowa and Michigan, where studies indicate that many enrollees do not participate in consumer-directed provisions in their states' Medicaid expansions, often due to confusion or lack of awareness.[7,26] In Michigan, fewer than 20% of members participated in a mandatory health risk assessment,[27] and as of July 2016, more than 100,000 Healthy Michigan enrollees had out-of-pocket payments that were past due.[7] Similar results were seen in Iowa, where just 17% of members completed the program's healthy activities (such as a wellness exam and health risk assessment), and one of the primary drivers of non-participation was a lack of information.[26] Researchers also found that disenrollment (typically for premium non-payment) in Iowa led to financial hardship and barriers to care.[28]

While only a minority of Indiana residents with Medicaid knew about POWER Accounts and were making regular payments, within that smaller population the POWER Accounts were received favorably by many, with 56% of this subgroup reporting the system helped them think about which health care services they need. Increasing cost-based awareness and consumerism in health care was one of the chief arguments made by the program's creators, and for a minority of beneficiaries who understood and paid into the program, that goal was met.[25] However, taking into account the substantial confusion over Indiana's program and higher cost-sharing requirements, it is perhaps not surprising that difficulties affording care were higher in Indiana than in Ohio, which implemented a traditional Medicaid expansion with minimal cost-sharing. While we found similar overall coverage rates in Indiana and Ohio, a recent study using a larger

national dataset found that Indiana's coverage gains lagged behind those of its Midwestern neighbors, perhaps in part due to HIP's cost-sharing requirements.[29]

Interestingly, Indianans were also more likely than Ohioans to report that the ACA had hurt them, though our results do not enable us to determine what led to this disparity in perceptions of the law. While Indiana modified aspects of HIP in its waiver renewal approved by CMS in February 2018 (including the addition of work requirements for 2019), the core features we evaluated here – POWER accounts and premium lock-out periods – remain in effect.

Expansion vs. Non-Expansion

Meanwhile, in Kansas, which has yet to expand coverage, we find very strong support for Medicaid expansion among low-income adults. This is consistent with public opinion in prior national and single-state studies.[30,31] While most respondents agreed that having Medicaid was better than being uninsured, views on Medicaid vs. private coverage showed that there was no clear preference for one over the other.

Our cross-state comparisons demonstrate that the uninsured rate, cost-related barriers to care, health care ratings, and trouble with medical bills were all significantly worse among low-income adults in Kansas, compared to Ohio's traditional Medicaid expansion. While these findings are only cross-sectional (albeit adjusted for sociodemographic factors), the basic pattern is consistent with quasi-experimental studies of expansion vs. non-expansion states that have shown significant gains in coverage, access, and affordability of care after Medicaid expansion.[2-5]

Work Requirements

Our results in Kansas also shed light on the push for Medicaid work requirements in several states. Consistent with prior analyses, we find that most potential Medicaid beneficiaries are either already working or disabled.[18,19,32] We add to this literature with the new finding that only 11% of potential Medicaid beneficiaries reported that a work requirement would have any effect on their likelihood of looking for a job, though this did represent more than half of the 17% who were not working and were not disabled. Notably, this potential effect was disproportionately reported by rural adults – which raises questions as to the availability of employment for these individuals, given the paucity of new jobs in rural areas over the past decade.[33]

Advocates of work requirements have pointed to the positive association between employment and health to argue that the policy could improve Medicaid beneficiaries' health outcomes by inducing more of them to work[34] (though the causality of this relationship is unclear). Our findings suggests that work requirements would likely produce modest impacts on job-searching behavior in this population – inducing some to look for jobs, but not changing the likelihood of employment for the vast majority (nearly 90%) of people who might enroll in Medicaid. This builds on prior evidence that the ACA's Medicaid expansion to date has had no detectable impact on employment decisions among low-income adults.[35,36]

Administrative Costs

While our findings do not shed direct light on the costs of administering these programs, this is another consideration for Indiana's POWER Accounts and potential work requirements in Kansas or any other state. Implementing these alternative approaches requires additional resources. Even though the POWER Accounts in Indiana built upon the previous incarnation of

this program ("HIP 1.0"), the expansion's new enrollment substantially increased per-beneficiary administrative requirements. One study indicated that Indiana's Medicaid managed care organizations had to increase staffing ratios and devote more administrative time to meets the state's requirements for coordination of the POWER Accounts.[37] While Indiana officials have not released estimates on the program's administrative cost, officials in Arkansas estimated that administrative costs for its HSA accounts in Medicaid were over $1,100 per participating beneficiary per year.[37]

These costs to states of HSAs may outweigh the relatively modest benefits noted among some Indiana respondents in our survey. Similarly, a work requirement that changes behavior for only 10% of the population but requires verification of employment and/or hardship exemptions for the vast majority of beneficiaries also raises concerns about administrative efficiency.[18]

Of course, these administrative costs may ultimately be outweighed in the Medicaid budget if total enrollment falls substantially as a result of these requirements, which may be another reason that states are considering these changes. While some people losing coverage will do so because they choose not to cooperate with the new requirements (e.g. look for work, or contribute to an HSA / make premium payments), others may be dissuaded from applying or get removed from the Medicaid rolls due to the added administrative difficulty of applying or re-enrolling, even though they may meet the program's requirements.[8]

Conclusion

Among low-income adults in three Midwestern states, we find that coverage rates and access to care were significantly higher in the expansion states than the non-expansion state, but

with some evidence that Indiana's waiver program led to less affordable care than Ohio's traditional expansion. Consumer confusion about the Healthy Indiana Program and difficulty paying premiums may have offset benefits among the subset of enrollees who perceived the health savings accounts to be helpful. Meanwhile, low-income Kansans strongly support Medicaid expansion, while a work requirement would have effects on job-seeking behavior for approximately 10% of the potential Medicaid population. These findings suggest that current Medicaid innovations may lead to unintended consequences for patient coverage and access, and ongoing independent monitoring of their effects is essential.

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Table 1: Comparison of Medicaid Program Features in Indiana, Ohio, and Kansas

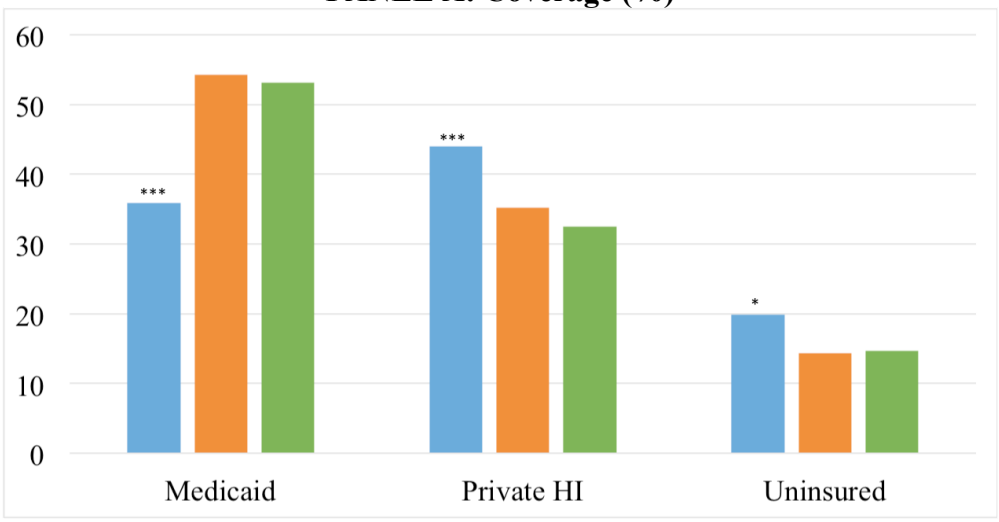
Medicaid Features	Indiana		Ohio	Kansas
	HIP 2.0 Basic	HIP 2.0 Plus		
Eligibility	Medicaid expansion: Family income at or below 138% of the Federal Poverty Level (FPL)		Medicaid expansion: Family income at or below 138% of FPL	Non-expansion: –Parents below 38% of FPL –Disabled adults below 75% of FPL –Childless adults not eligible
Premiums	2% of income, or $1 / month for those between 0-5% FPL		None	None
Co-payments	Graduated payments for non-emergent use of ED: $8 for first visit, $25 for subsequent visits in same year. Co-payments for other services are based on state plan.	None	Based on state plan co-payment amounts. –1931 parents: $3 for non-urgent ED visits for, $2 for preferred brand drug prescriptions, and $3 for non-preferred brand drugs. –Expansion adults: $3 for non-preferred brand drugs.	None
Health Savings Accounts	State places an initial $2,500 into HSA-like POWER Account, which must be exhausted before other plan benefits become effective. Enrollees who make premium payments on time can roll over unused portion and use for premiums the following year		None	None
Penalty for Failure to Make Payments	–Individuals between 100-138% FPL: Disenrolled and locked out of the program for 6 months –Individuals ≤ 100% of FPL: Moved from HIP Plus to HIP Basic, with higher cost-sharing and fewer benefits		N/A	N/A
Benefits	Standard state plan benefits, which do not include vision or dental services	Standard benefits plus vision and dental benefits, and a more generous prescription drug benefit	Standard state plan benefits, which include vision and dental services	Standard state plan benefits; some managed care plans cover vision and dental services

Sources: Musumeci et al. 2017.[7]
Zylla E, Planalp C, Lukanen E, Blewett L. Section 1115 Medicaid Expansion Waivers: Implementation Experiences. Washington, DC: Medicaid and CHIP Payment and Access Commission (MACPAC); 2018.

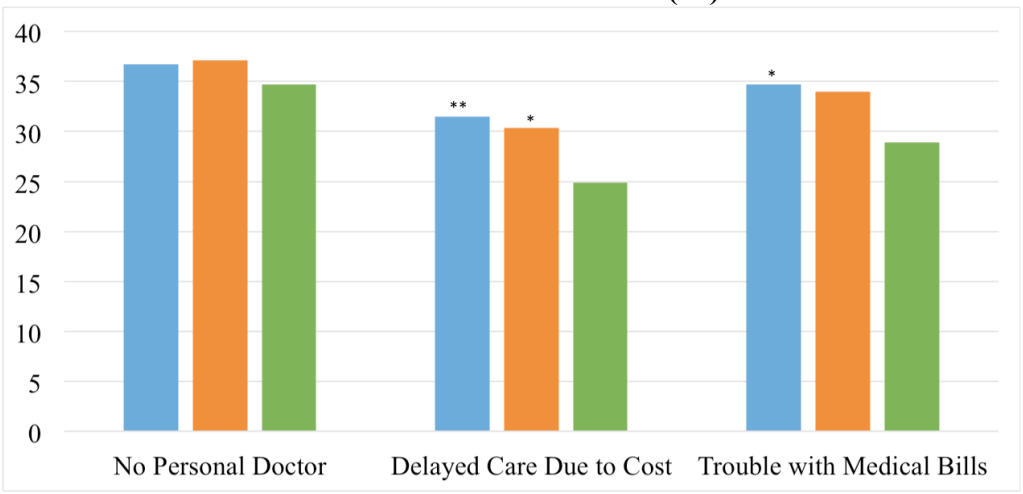
Brooks T, Wagnerman K, Artiga S, Cornachione E, Ubri P. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2017: Findings from a 50-State Survey. Washington, D.C.: Kaiser Family Foundation; 2017.
Medicaid financial eligibility: primary pathways for the elderly and people with disabilities. Washington, D.C.: Kaiser Family Foundation; 2010

Figure 1: Coverage, Access, and Health Care Experiences Among Low-Income Adults

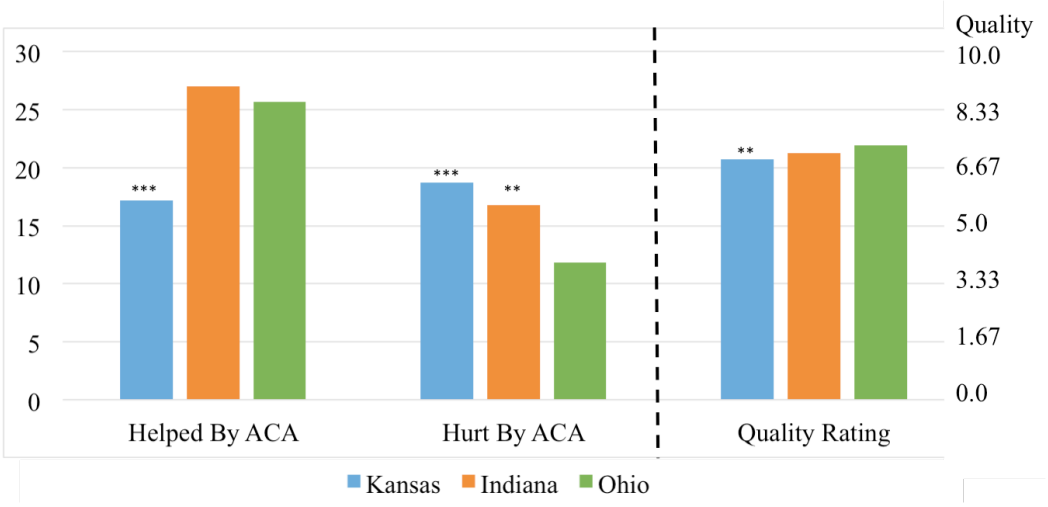
PANEL A: Coverage (%)



PANEL B: Access to Care (%)



PANEL C: Attitudes Towards ACA (%) and Overall Health Care Quality (0-10)



Source: Authors' analysis of 2,739 survey responses of US citizens with incomes below 138% FPL between the ages of 19-64 living in Indiana, Kansas, and Ohio.
Notes: Results are regression-adjusted for age, race, ethnicity, political identification, marital status, educational attainment, gender, family income, and rurality.
All p-values refer to comparisons with Ohio as the reference group: * $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$

Table 2: Knowledge of and Experiences with the Healthy Indiana Program (HIP) Among Low-Income Adults in Indiana

Variable	Percent
Adults with Medicaid: Eligibility for HIP 2.0 *(N = 578)*	
SSI/SSDI	36.2
Pregnant	1.6
Likely Eligible for HIP 2.0	62.2
Among HIP 2.0 Eligible: Heard of POWER Account and/or making regular premium payments† *(N=296)*	
No	39.0
Yes – Not making regular payments	25.5
Yes – Making regular payments	35.6
Reasons for Non-Payment *(N = 56)*	
Forgot	2.5
Could not afford payments	30.6
Confused by POWER Account	19.1
Did not think benefits were worth payment	21.6
Other	26.2
Among those who have heard of POWER Accounts: "The POWER Account helps me think about the health services I really need." *(N = 196)*	
Strongly Agree	25.1
Agree	32.0
Neutral/Don't Know	17.1
Disagree	14.5
Strongly Disagree	11.3
Among those who have heard of POWER Account: "The POWER Account is hard to understand or has made it more difficult for me to get the health care I need. *(N = 196)*	
Strongly Agree	18.9
Agree	20.9
Neutral/Don't Know	12.7
Disagree	18.5
Strongly Disagree	29.1
Among uninsured adults: Reasons not enrolled in HIP 2.0 (N = 122)	
Unaffordable	29.6
Do not think I qualify	20.3
Too complicated	17.3
'Locked out' for POWER non-payment	8.6
Don't Know	24.3

Source: Authors' analyses of survey responses of US citizens with incomes below 138% FPL between the ages of 19-64 living in Indiana.
Notes: All responses are survey weighted to produce representative estimates.
† Exact question wording was, "Do you pay a premium or put money into your POWER Account on a regular basis?"

Table 3: Views Towards Coverage Expansion and Work Requirements Among Low-Income Adults in Kansas

Variable	Percent
Support for Medicaid Expansion in Kansas	
Favor	77.0
Oppose	11.3
Don't Know	11.4
Perceived Quality of Care on Medicaid vs. Being Uninsured	
Medicaid Better	67.9
Same	23.1
Being Uninsured Better	9.0
Perceived Quality of Care on Medicaid vs. Private Insurance	
Medicaid Better	31.8
Same	37.0
Private Insurance Better	31.3
Work Status – All Respondents	
Employed	60.2
Disabled	25.9
Unemployed – would look for work required	8.8
Unemployed – would not look for work if required	5.2
Work Status – Medicaid and Uninsured Respondents (N = 586)	
Employed	48.7
Disabled	34.1
Unemployed – would look for work if required	11.1
Unemployed – would not look for work if required	6.0

Source: Authors' analyses of survey data from US citizens with incomes below 138% FPL between the ages of 19-64 living in Kansas (N=1,000 minus item non-response, except where otherwise indicated).
Notes: All responses are survey weighted to produce representative estimates.

Appendix Table 1: Demographics of Survey Respondents by State

	Indiana (%)	Kansas (%)	Ohio (%)
Age Groups			
19-34 years old	43.9	49.7	42.3
35-44 years old	18.7	16.8	19.5
45-54 years old	15.0	11.2	14.7
55-64 years old	22.4	22.3	23.4
Race/Ethnicity			
Latino	5.6	9.5	4.2
Black, Not Latino	14.5	11.8	21.8
Other, Not Latino	6.3	6.0	6.6
White, Not Latino	73.7	72.7	67.4
Political Affiliation			
Democrat	23.5	19.2	28.9
Independent/Other	59.4	63.2	56.7
Republican	17.1	17.5	14.5
Educational Attainment			
No High School Degree	19.8	14.0	17.9
High School Graduate or GED	36.2	34.7	39.4
Some College or College Graduate	44.0	51.3	42.7
Household Income			
Less than 50% FPL	27.9	30.6	31.6
50-100% FPL	38.7	36.8	37.6
100-138% FPL	25.1	25.4	21.4
Missing / Not Reported	8.3	7.3	9.5
Other Characteristics			
Female (vs. Male)	55.2	54.2	54.1
Live in Rural Area (vs. Urban)	26.8	47.9	17.3
Married / Partnered (vs. Not Married)	34.3	32.9	36.4
N	1,007	1,000	732

Source: Authors' analyses of survey data from US citizens with incomes below 138% FPL between the ages of 19-64 living in Indiana, Kansas, Ohio.
Notes: Responses are survey-weighted to reflect state demographics. Figures may not sum to 100% due to rounding.

Appendix Table 2: State and Demographic Predictors of Being Uninsured And Experiencing Cost-Related Care Delays

Variable	Uninsured		Delay Care Due to Cost	
	Odds Ratio	Predicted Probability (%)	Odds Ratio	Predicted Probability (%)
State				
Kansas	1.49*	19.9	1.40**	31.5
Indiana	0.96	14.3	1.33*	30.4
Ohio	1.00 (Ref)	14.7	1.00 (Ref)	24.9
Age Group				
19-34 years old	2.26***	18.1	1.31	29.8
35-44 years old	1.89**	15.8	1.11	26.6
45-54 years old	1.70*	14.6	1.05	25.5
55-64 years old	1.00 (Ref)	9.4	1.00 (Ref)	24.7
Race/Ethnicity				
Latino	1.10	16.2	1.33	32.1
Black, Not Latino	0.86	13.4	1.18	29.6
Other, Not Latino	1.51	20.4	1.14	28.9
White, Not Latino	1.00 (Ref)	15.0	1.00 (Ref)	26.4
Political Affiliation				
Democrat	0.69	9.4	0.96	24.9
Independent/Other	1.52	18.0	1.21	29.1
Republican	1.00 (Ref)	12.9	1.00 (Ref)	25.5
Educational Attainment				
No High School Degree	1.63*	17.6	0.63**	21.2
High School Graduate or GED	1.65**	17.8	0.91	27.7
Some College or College Graduate	1.00 (Ref)	12.0	1.00 (Ref)	29.6
Household Income				
Missing/Not Reported	0.68	12.8	0.44**	15.7
Below 50% FPL	1.06	18.1	0.72	23.3
50-100% FPL	0.63	12.1	1.12	32.0
100-138% FPL	1.00 (Ref)	17.3	1.00 (Ref)	29.6
Other Characteristics				
Female (vs. Male)	0.32***	8.8	0.88	26.3
Live in Rural Area (vs. Urban)	0.73	12.5	0.91	26.0
Married / Partnered (vs. Not Married)	0.85	14.0	1.28	30.6
N	**2,739**		**2,722**	

Source: Authors' analyses of survey responses of US citizens with incomes below 138% FPL between the ages of 19-64 living in Kansas, Indiana, and Ohio (N=2,739, minus item non-response).
Notes: Responses are survey-weighted to reflect state demographics. *p*-values: * $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$. "Ref" = Reference Group. Predicted probabilities were obtained using the Stata "margins" command.

Appendix Table 3: Demographic Predictors of Knowledge, Participation in, and Perception of Indiana's POWER Account

Variable	*Indiana Medicaid & HIP Eligible:* Aware of POWER Account		*Indiana Medicaid & Heard of POWER Account:* Paying Premiums Regularly†		*Indiana Medicaid & Heard of POWER Account:* POWER Helps Me Think about Healthcare Services I Need		*Indiana Medicaid & Heard of POWER Account:* POWER Makes Getting Healthcare More Difficult	
	Odds Ratio	Predicted Probability (%)	Odds Ratio	Predicted Probability (%)	Odds Ratio	Predicted Probability (%)	Odds Ratio	Predicted Probability (%)
Age Group								
19-34 years old	0.97	56.8	0.60	57.5	0.22***	48.4	1.76	39.1
35-44 years old	3.82**	79.4	0.76	62.6	0.30**	55.7	2.14	43.5
45-54 years old	1.20	60.6	0.29**	41.9	0.89	77.9	2.04	43.4
55-64 years old	1.00 (Ref)	57.3	1.00 (Ref)	68.0	1.00 (Ref)	79.7	1.00 (Ref)	27.5
Race/Ethnicity								
Latino	0.15**	31.2	1.05	59.5	5.11	86.1	2.87	60.9
Black, Not Latino	1.02	65.1	0.84	54.9	0.99	56.8	1.65	48.5
Other, Not Latino	0.84	61.7	1.34	64.6	0.44	38.5	0.81	33.0
White, Not Latino	1.00 (Ref)	64.8	1.00 (Ref)	58.5	1.00 (Ref)	57.1	1.00 (Ref)	37.4
Political Affiliation								
Democrat	0.35*	52.5	2.43	73.8	1.34	58.2	1.03	36.5
Independent/Other	0.68	64.3	0.87	52.6	1.37	58.7	1.37	42.8
Republican	1.00 (Ref)	70.6	1.00 (Ref)	55.8	1.00 (Ref)	51.7	1.00 (Ref)	35.9
Educational Attainment								
No High School Degree	0.21***	43.3	2.50	69.2	1.08	60.8	0.73	39.3
High School Graduate or GED	0.48*	58.5	2.91**	72.1	0.69	51.1	0.38*	25.9
Some College or College Graduate	1.00 (Ref)	71.6	1.00 (Ref)	49.4	1.00 (Ref)	59.2	1.00 (Ref)	46.5
Household Income								
Missing/Not Reported	1.95	63.4	1.76	62.4	1.96	61.8	2.23	58.8
Below 50% FPL	1.60	59.8	1.14	53.0	1.63	57.8	0.88	38.0
50-100% FPL	2.40**	70.3	2.13	66.3	1.83	60.4	0.92	38.0
100-138% FPL	1.00 (Ref)	51.2	1.00 (Ref)	50.1	1.00 (Ref)	46.7	1.00 (Ref)	40.8
Other Characteristics								
Female (vs. Male)	4.34***	73.3	1.11	58.9	0.99	57.0	1.80	43.2
Rural (vs. Urban)	0.75	58.6	0.79	54.9	1.48	63.2	0.79	36.2
Married / Partnered (vs. Not Married)	2.77**	73.6	1.50	62.8	0.77	54.0	1.33	43.2
N	**300**		**193**		**196**		**196**	

Source: Authors' analyses of survey responses of US citizens with incomes below 138% FPL between the ages of 19-64 living in Kansas, Indiana, and Ohio.
Notes: Responses are survey-weighted to reflect state demographics. *p*-values: * $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$. REF = Reference Group.
† Exact question wording was, "Do you pay a premium or put money into your POWER Account on a regular basis?"

Appendix Table 4: Demographic Predictors of Support for Medicaid Expansion and Work Inducement in Kansas

Variable	*Kansas - All Respondents:* Support Medicaid Expansion		*Kansas - Medicaid & Uninsured, Unemployed but Not Disabled:* Would Look for Work if Required	
	Odds Ratio	Predicted Probability (%)	Odds Ratio	Predicted Probability (%)
Age Group				
19-34 years old	0.69	76.5	0.88	64.7
35-44 years old	0.48*	70.5	1.72	74.3
45-54 years old	0.84	79.3	0.16	38.5
55-64 years old	1.00 (Ref)	81.8	1.00 (Ref)	66.6
Race/Ethnicity				
Latino	1.57	82.6	14.89**	90.6
Black, Not Latino	0.79	72.2	4.99	80.1
Other, Not Latino	1.78	84.2	0.09	21.8
White, Not Latino	1.00 (Ref)	76.2	1.00 (Ref)	56.9
Political Ideology				
Democrat	5.30***	88.9	2.94	67.2
Independent/Other	2.17***	77.6	3.07	67.8
Republican	1.00 (Ref)	63.3	1.00 (Ref)	50.2
Educational Attainment				
No High School Degree	3.13**	87.8	1.13	62.2
High School Graduate or GED	1.72**	80.6	2.01	70.9
Some College or College Graduate	1.00 (Ref)	71.9	1.00 (Ref)	60.3
Household Income				
Missing / Not Reported	0.72	65.3	0.37	60.6
Below 50% FPL	1.66	79.8	0.36	60.5
50-100% FPL	1.82*	81.1	0.70	70.3
100-138% FPL	1.00 (Ref)	71.6	1.00 (Ref)	75.1
Other Characteristics				
Female (vs. Male)	2.25***	82.8	0.49	60.6
Live in Rural Area (vs. Urban)	0.64*	73.5	6.95**	83.1
Married / Partnered (vs. Not Married)	0.83	75.1	0.08***	37.5
N	**1,000**		**83**	

Source: Authors' analyses of survey responses of US citizens with incomes below 138% FPL between the ages of 19-64 living in Kansas, Indiana, and Ohio.
Notes: Responses are survey-weighted to reflect state demographics. *p*-values: * $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$. REF = Reference Group.

APPENDIX METHODS: Survey Instrument

Details on our survey approach have been published previously.[9,30] As with prior analyses, we omitted from the sample for each analysis any observation with missing response for that outcome. For covariates, we treated item-non response as follows: missing race/ethnicity (2.0%) was treated as "other." Missing income was treated as its own category in regression analyses, given its much higher prevalence (8.9%) than other categories of missing data – though note that all respondents had already indicated that their family incomes were below 138% of FPL; this only applied to which subcategory of income within the 0-138% range a person had. Other covariates in Appendix Table 1 with missing values were imputed based on age, education, race/ethnicity, gender, income, marital status, family size, urban/rural location, cell phone usage, and political affiliation. This resulted in regression-based imputation for 0.7% of the weighted sample for missing age, 1.1% for education, and 1.1% for marital status.

Question wording for our study outcomes is as follows:

1) Health Insurance

		Marketplace Name	Medicaid Program
OH	Ohio	The Healthcare.gov website	Medicaid
KS	Kansas	The Healthcare.gov website	Medicaid or KanCare
IN	Indiana	The HealthCare.gov website	Medicaid, Healthy Indiana, or HIP 2.0

I am going to read a few common types of health insurance. For each one, please tell me 'yes' if you currently have it and 'no' if you don't. You can answer 'yes' more than once.

a. [State Medicaid Plan Name] (INTERVIEWER NOTE: Clarify, if needed, "Medical Assistance or government-assistance plan for those with low incomes or a disability")
b. Medicare (INTERVIEWER NOTE: Clarify, if needed, "for people 65 and older, or people with certain disabilities")
c. A military health care plan, such as TRI-CARE, CHAMPUS, or CHAMP-VA
d. A health plan you got through an employer or union (INTERVIEWER NOTE: This also includes through a spouse's employer or union)
e. A health insurance plan that you signed up for through [State Marketplace Name] or a health insurance Marketplace created by the national health reform law. (INTERVIEWER

NOTE: If respondent says "do you mean Obamacare or ACA," then say: "The national health reform law is sometimes referred to as Obamacare or the Affordable Care Act")

f. A health plan that you bought directly from an insurance company, not through an employer or union, and not through a health insurance Marketplace
g. Some other kind of health insurance I haven't already mentioned

If no to all:

h. Does this mean you have no health insurance of any kind?

2) Do you have one person you think of as your personal doctor or health care provider?

3) Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all the health care in the last 6 months?

4) At any time in the last year, have you waited to seek medical care or chosen not to seek medical care for an illness, injury, or condition because you couldn't afford it?

5) Under the national health reform law, sometimes referred to as Obamacare or the Affordable Care Act, many Americans have new choices for obtaining health insurance. The law created health insurance Marketplaces, called [State Marketplace Name] in your state, where people can buy insurance, and some may be eligible for subsidies to help pay for coverage. Also, some states have expanded Medicaid. So far, would you say the health care law has directly (helped) you, directly (hurt) you, or has it not had a direct impact?

6) In the past year, have you either had to borrow money, or skip paying medical bills, or skip paying other bills as a result of medical costs?

7) Are you currently employed?

<u>Indiana-Specific Questions for Medicaid Sample</u>

8) Do you personally receive any disability payments from Social Security or the state, sometimes called SSI? Do not include payments made to other members of your family.

9) Are you currently pregnant?

10) *If NO to 8 and 9*: In Indiana's Medicaid program, called the Healthy Indiana program, the first $2,500 of medical expenses for covered services are paid through a special savings account called a Personal Wellness and Responsibility or POWER Account. Have you ever read or heard about the POWER Account?

11) Do you pay a premium or put money into your POWER Account on a regular basis?

12) *If NO to 11:* Which of the following is the **main** reason you have missed payments or not put money into your POWER Account?

A) I forgot
B) I could not afford it
C) I was confused about how POWER Account works
D) I didn't think it was worth it

13) For each of the following, please tell me which best describes your feelings and experiences.

1 Strongly agree
2 Somewhat agree
3 Neither agree nor disagree
4 Somewhat disagree
5 Strongly disagree

a. "The POWER Account helps me think about the health services I really need."
b. "The POWER Account is hard to understand or has made it more difficult for me to get the health care I need."

14) *If uninsured:* You told us earlier you do not have any health insurance. Which of the following is the **main** reason that you are not enrolled in the Healthy Indiana Program?

1 I don't think I would qualify/ I make too much money
2 I don't think I can afford it
3 I haven't heard of the program
4 I got kicked out of the program for not paying my premiums
5 I tried to sign up but it was too complicated
6 I heard the program was being eliminated

<u>Kansas-Specific Questions</u>

15) Do you have a disability that prevents you from working?

16) If you were required to work or look for a job in order to be eligible for Medicaid or KanCare, would this make you more likely to work or look for a job?

17) Under the national health reform law, states may choose to make Medicaid, also called KanCare in Kansas, available to cover more of their low-income residents. Medicaid is a health insurance program that covers services such as hospital care, doctor visits, and prescription drugs. Do you favor or oppose Kansas making Medicaid available to more people under the health reform law?

18) Do you think the quality of healthcare you (get/would get) on Medicaid or KanCare is better, the same, or worse than if you had no insurance?

19) Do you think the quality of healthcare you (get/would get) on Medicaid or KanCare is better, the same or worse than if you had private insurance?