

Correcting Recent Misinformed Claims about HIP 2.0

HIP Response to NCPA Article

A recent [article](#) by the Dallas-based think tank, the National Center for Policy Analysis (NCPA), claimed that the State of Indiana's HIP 2.0 proposal is not truly consumer-driven. This was surprising, given that organization's scholars had on previous occasions ([here](#) and [here](#)) written that the current HIP program was a consumer-driven model fit for emulation.

1. Claim: "HIP has little in common with consumer-directed health care models."

Members cannot shop for care and are limited to a single managed care provider. Individual accounts are prefunded by the state, and the low monthly contributions to the account by the individuals means that they have very little of their own money at risk. Further, premium payments were waived for about 23% of members.

Response:

This charge against HIP is surprising, as it is written by the same author who in 2011 cited HIP as an example of a consumer-directed Medicaid reform. The HIP 2.0 proposal builds upon and in some ways enhances the current HIP program, previously described as a consumer-directed plan. Specifically, HIP 2.0 keeps intact many of the original HIP design elements, including the POWER accounts, (Health Savings like Account) roll-over incentive, and ER copayments. Members have a choice of three health plans. The POWER account is not fully pre-funded, rather the State makes its share of the contribution to the account in one upfront payment, leaving the member responsible for funding the remaining deductible amount. Historically, there are 23% of members that do not make contributions to their POWER account. The State does not "waive" these contributions. Instead, these members either report no income, or pay Medicaid or Children's Health Insurance Program (CHIP) cost-sharing for other members of their household, and a required contribution would put them over the five percent (5%) maximum income contribution threshold.

2. Claim: "The claims that HIP reduced emergency room usage are open to question."

While HIP members did use the ER at lower rates compared to traditional Indiana Medicaid recipients, there is evidence suggesting that only 28% of the copays are actually collected. Therefore the difference in utilization may be to other program differences. Further, HIP 2.0 attenuates the ER utilization disincentive by waiving it if a patient has first contacted a nurses' hotline, as well as changed the copayment amount to a graduated scale of \$8 for the first visit and \$25 for subsequent visits.

Response:

The HIP 2.0 proposal is actually stronger on ER copay policy than the current HIP program that the author previously praised. Under the current HIP program, non-caretakers must pay a \$25 copay for inappropriate ER utilization, while caretakers must

pay only a \$3 copay. Although the non-caretaker population experiences a higher degree of morbidity and chronic disease burden than the caretaker population, their rate of inappropriate ER utilization has decreased significantly over the course of the demonstration compared to the HIP caretaker population. Based on the comparative data, the larger co-payment for non-caretakers appears to deter members from inappropriate utilization of the ED, which is why the State is seeking a waiver to apply higher copayments to all HIP members, rather than just non-caretakers.

3. **Claim: “HIP 2.0 requires more copayments.”** *Mathematica researchers wrote that the original HIP plan was designed with a deductible and POWER account rather than copays because “evidence available to the state suggested that small copayments do not influence utilization patterns.”*

Response:

HIP 2.0 continues to promote the deductible and POWER account structure of the original HIP plan design. All participants will have a required contribution to their POWER account. Individuals below 100% FPL that do not make contributions will be defaulted into the Basic plan, where instead of making POWER account contributions they will make copayments. Copayments will be more expensive than the POWER account contributions. Therefore, the design of the program creates a value proposition for participants to contribute to their POWER account.

4. **Claim: “[Roll-over] is a weak incentive, especially for people who have chronic medical conditions that routinely use all of their POWER account funding.”** *Generally, consumer-directed plans are successful in controlling costs because members spend their own money, and are financially rewarded for cost savings. In HIP, the only reward for reduced spending is the potential to roll-over funds to offset future program costs.*

Response:

Currently, given the high level of chronic disease among the HIP population, relatively few members (just over one-third) who are eligible for a rollover had any funds remaining in their POWER account at the end of the eligibility period to carry forward. HIP 2.0 proposes to increase the amount in the POWER account to increase the number of members with account balances remaining at the end of the year, which will provide a greater incentive for these members to obtain preventive care and judiciously manage their accounts.

5. **Claim: “HIP 2.0 further weakens individual incentives to reduce spending by lowering required monthly payments.”** *In 2012, HIP monthly payments ranged from \$7.94 a month for people below 22% FPL to \$17.77 a month for individuals earning up to 100% FPL. HIP 2.0 reduces the payments for these income levels to \$3.00 a month and \$15.00 a month.*

Response:

HIP 2.0 maintains the required contributions under the original HIP program. The requested change moves member contributions to a tiered flat rate based on income, as opposed to a percentage of income. The flat rate amounts were developed to create administrative efficiencies and were based on average contribution amounts that are currently being made by participants today. The contribution levels were determined based on data indicating the contributions amounts that individuals at different poverty levels will be most successful in meeting.

6. **Claim: “HIP 2.0 plans to discipline nonpayers with incomes below the federal poverty line with a demotion from the HIP Plus plan to the HIP Basic plan.”** *HIP stressed individual responsibility by kicking people who did not pay out of the program. HIP 2.0 will only kick people out of the program for 6 months who are above 100%, and will transfer those below 100% FPL to the Basic Plan.*

Response:

HIP 2.0 ensures that all members have “skin in the game” by imposing penalties and consequences against all members who fail to pay required monthly contributions. As part of the commitment to the principles of the original HIP, the Basic plan requires individuals to pay copayments for all services which will actually result in increased cost-sharing as compared to the monthly contributions required under the HIP Plus plan. The reduction in the lock-out period for those above 100% FPL is due in part to the changing realities of federal law and CMS policies following the ACA. While Governor Pence continues to support the full repeal of the ACA and the block granting of Medicaid to the states, HIP 2.0 represents the most conservative approach offered to date within the limits of federal laws and regulations.

7. **Claim: “In general, higher preventive care utilization rates increase overall expenditures. There is little evidence that this translate into better health or lower expenditures.”**

Response:

The HIP program is intended to encourage individuals to take responsibility for their health. The incentive for preventive services cannot be taken alone but in a larger context of incentivizing overall health and personal responsibility.

8. **Claim: “Because HIP and HIP 2.0 have so few real incentives to encourage people to make wise health care decisions, their emphasis on tracking small payments and individual accounts may unnecessarily increase administrative overhead.”**

Response:

The HIP program has been operational for six years and its legislation requires that administrative costs are limited to those limits that exist in the commercial market today, known as medical loss ratio (MLR).