

## Correcting Recent Misinformed Claims about HIP 2.0

### HIP Response to Forbes Article

A recent opinion [article](#) by the Naples, Florida-based Foundation for Government Accountability and published in Forbes claimed that the State of Indiana was implementing Obamacare's Medicaid expansion through its HIP 2.0 proposal.

- 1. Claim: "Gov. Pence's proposal creates a new entitlement for able-bodied adults without children."** *Although a small number of childless adults previously qualified for the Healthy Indiana Plan, their enrollment was always subject to available funds from other Medicaid savings initiatives. The program capped the number of childless adults who could enroll at 36,500. Gov. Pence's new plan turns that small, limited program into a massive new entitlement for childless adults. More than 284,000 able-bodied childless adults (and 91,000 parents) will become eligible for Medicaid expansion, an increase of nearly 700%. And unlike the Healthy Indiana Plan, there is no cap on enrollment, obligating the state to provide benefits to those individuals regardless of the availability of funds.*

#### **Response:**

Governor Pence's proposal creates a fiscally sustainable program to cover uninsured Hoosiers below 138% FPL. The plan will not increase taxes for Indiana taxpayers at any time and is financed through existing funding sources. Our plan includes the continued support of a trust fund for the program to ensure there are adequate reserves. Further, in keeping with the original program values, the State will automatically terminate the expansion program at any time if the anticipated funding sources are reduced or eliminated.

Additionally, the program is intended to be a "hand-up, not a hand-out". Our program requires individuals to be referred to job training and search programs designed to create incentives for them transition off of public assistance to stable employment. In addition, the infusion of market principles into the program works to educate members and prepare them to participate in the private market when they are able to transition off the program.

- 2. Claim: "Gov. Pence's proposal increases Medicaid eligibility under ObamaCare."** *Currently, the Healthy Indiana Plan only serves individuals earning below the federal poverty level, though it once served individuals with higher incomes. Gov. Pence's ObamaCare expansion proposal not only lifted the enrollment cap, it also increased the eligibility threshold from 100% to 138% FPL. Individuals earning more than 100% FPL are currently eligible for subsidies through the ObamaCare exchange. They would be forced out of the exchange and into Medicaid under Gov. Pence's proposal.*

**Response:**

ObamaCare does not allow individuals who are Medicaid-eligible to receive premium tax credits on the Marketplace. Therefore, individuals between 100% FPL and 138% FPL who have Marketplace plans will be subject to the full plan cost. However, these individuals will now have the option to enroll in HIP Plus, which offers a benefit package similar to Marketplace plans at an affordable cost. Every one of HIP's private health insurance carriers also offers plans on the Marketplace, so individuals transitioning from the Marketplace to HIP may choose to stay with their current health insurance carrier.

Further, while Governor Pence's proposal increases HIP eligibility, the plan actually eliminates traditional Medicaid in the State for all non-disabled adults.

- 3. Claim: "Gov. Pence's proposal reduces skin-in-the-game and incentivizes costly ER use." *The Healthy Indiana Plan requires contributions ranging from 2% to 5% of income, with a minimum contribution of \$160 per year. The plan also attempts to incentivize childless adult patients to avoid using ERs for non-urgent needs by imposing a \$25 copayment. These contribution and incentive provisions have long been celebrated by Healthy Indiana Plan advocates. Gov. Pence's plan, however, greatly reduces the required contributions, giving enrollees less skin-in-the-game. In fact, these monthly contributions are completely eliminated for three-quarters of the expansion population if they choose the "Basic" plan option and are as low as \$3 per month for plans that include extra benefits like dental and vision coverage. Pence's plan also reduces some copayments for unnecessary ER use to just \$8, though it attempts to keep the \$25 copay in some situations. Based on what CMS has denied in the past, the final deal will likely replace the \$25 copayment altogether, imposing only the nominal \$8 copayment currently allowed by Medicaid rules. After all, if CMS rejected Iowa's proposal to increase this copayment to \$10, it is unlikely Pence's plan would be able to keep the \$25 copayment whatsoever. Reducing this copayment to nominal amounts will surely incentivize enrollees to make unnecessary ER visits more than they would under the Healthy Indiana Plan's initial design.***

**Response:**

HIP 2.0 maintains the required contributions under the original HIP program. The requested change moves member contributions to a flat rate based on income, as opposed to a percentage of income. The flat rate amounts were developed using data on the average contribution amounts that are currently being made by participants today, and do not represent a decrease in required contributions, but rather creates program efficiencies.

HIP 2.0 proposes a novel concept regarding ER copayments. The first inappropriate emergency department visit would require an \$8 co-payment; and subsequent inappropriate emergency department utilization would require a \$25 co-payment. Unlike Iowa, the state is requesting the authority to impose these copayments under Section 1916(f) which allows for waiver to test "unique and previously untested use of

copayments”. Again, due to the nature of the federal Medicaid program, the State must work within the limitations of the current program, which is why Governor Pence continues to support the block granting of Medicaid to the states.

4. **Claim: “Gov. Pence’s proposal crowds out private insurance.”** *Under the original design of the Healthy Indiana Plan, individuals could only become eligible if they had been uninsured for at least six months and without access to employer-sponsored insurance. These requirements are nowhere to be found in Gov. Pence’s proposal, ensuring that taxpayers will be forced to pick up the cost of people who drop private insurance to enroll in taxpayer-paid Medicaid, as has happened in other states that have expanded Medicaid eligibility. Gov. Pence’s proposal also shifts individuals who qualify for subsidies in the ObamaCare exchange into Indiana’s Medicaid program, increasing crowd-out even further.*

**Response:**

Governor Pence’s plan promotes private employer-sponsored health insurance over public options by allowing uninsured individuals to use a defined contribution POWER account (or HSA-like account) to pay for an employer plan as an alternative to Medicaid.

The effects of crowd-out on this population are overstated. Individuals below 138% FPL that earn less than \$33,000 for a family of four cannot likely afford health plans that cost upwards of \$13,000 a year for family coverage, decreasing the likelihood that the program would actually lead to significant crowd out. In fact, it has been observed in the course of healthcare reform analysis for employers that less than 5% of low-income (under 138% FPL) full-time employees in the service industry choose to participate in the health plans for which they are eligible.

5. **Claim: “Gov. Pence’s proposal replaces a limited benefit package with ObamaCare benefits.”** *The Healthy Indiana Plan’s benefit package had previously been approved by the federal government and is limited in nature. It does not meet ObamaCare’s standard of “benchmark equivalent” coverage and does not offer all the benefits as traditional Medicaid, including maternity coverage and non-emergency medical transportation. Additionally, the Healthy Indiana Plan has annual and lifetime limits on benefits. Gov. Pence’s proposal replaces this limited benefit package with more robust ObamaCare benefits, losing the design flexibility Indiana had previously secured. In fact, Pence’s “Plus” plan covers additional benefits not even required by ObamaCare, such as vision and dental.*

**Response:**

HIP does not include certain of the “Cadillac” Medicaid benefits, such as chiropractic services, and instead, provides benefits comparable to those offered in the commercial market. In fact, the State continues to seek a waiver of the non-emergency medical transportation benefit. In addition, while the HIP 2.0 proposal adds maternity coverage,

this service was already provided to pregnant HIP members by the State under the Hoosier Healthwise program. HIP members who become pregnant are currently transferred from HIP to HHW in order to obtain maternity coverage- an administratively burdensome process for providers and the State.

The addition of limited vision and dental coverage conforms not only to the original HIP legislation, but also aligns with the original HIP principles by encouraging participation in the HIP Plus plan. The HIP Plus plan offers a commercial market benefit plan to further encourage members to take personal responsibility for their health by making required monthly contributions.

**6. Claim: “Gov. Pence’s proposal turns required contributions into mere suggestions.”**

*Under the Healthy Indiana Plan, enrollees who failed to make their required contributions into so-called “POWER Accounts” were automatically disenrolled from the program and barred from enrolling again for at least 12 months. Those individuals also forfeited 25% of the remaining funds they had contributed to their accounts. Gov. Pence’s proposal eliminates the ability to disenroll those below the poverty line by eliminating any required contributions. For those above the poverty line, Pence’s plan cuts the lock-out period in half to just six months. But even this six-month lockout period is likely to be denied by CMS, if its approved waiver agreement with Iowa is any indication.*

**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. For those HIP 2.0 participants over 100% FPL, failure to make required POWER account contributions will result in disenrollment from the program and a six-month lockout period. For individuals below 100% FPL, failure to make required POWER account contributions will result in a transfer of the member to the HIP Basic plan, a plan characterized by copayments and fewer offered benefits. As part of the commitment to the principles of 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.

Governor Pence continues to support the full repeal of ObamaCare and the block granting of Medicaid to the states. HIP 2.0, which is a waiver from Medicaid’s rules, and represents the type of state-based innovation we can look forward to if states are given the ability to run their own Medicaid programs free from excessive federal involvement. However, under the current system, the proposals in HIP 2.0 represent the most conservative approach offered to date within the existing Medicaid structure. While there are certainly program elements in HIP 2.0 that would be different if Indiana had full flexibility, HIP 2.0 is the best available alternative to support the State’s uninsured citizens until the Medicaid program can be fixed on the federal level.