December 22, 2015

Last week, an article was posted on Forbes' Apothecary website by employees of the Foundation for Government Accountability (FGA) purporting to give a one-year update on the expansion of the Healthy Indiana Plan (HIP) in Indiana.

Obamacare, with its myriad taxes and regulations, restricts the rights of citizens and expands the broken Medicaid program. HIP 2.0 empowers Hoosiers to take control of their own health care, while ending traditional Medicaid for able-bodied adults. These two programs couldn't be more different, and the FGA's inaccurate claims must not be left unchecked.

The expansion of HIP in Indiana was approved on January 27, 2015, and implemented shortly thereafter. The actual one-year anniversary will be marked next month, at which time even more data and information about HIP's implementation will be available. In the meantime, based on current data and operations of the program, and in an effort to safeguard clarity and accuracy, the Indiana Family and Social Services Administration (FSSA) offers the following responses to the claims in the FGA article.

CLAIM 1: "The results so far have been little personal responsibility for enrollees, and higher costs for taxpayers."

FACTS: HIP's consumer-driven model is designed to prepare able-bodied adults for independence from public assistance. The goal is to create an environment that promotes self-sufficiency and to familiarize beneficiaries with how a commercial health insurance program operates. **To this end, all HIP enrollees are required to contribute to their health care.**

HIP has implemented the most far-reaching incentive and disincentive structure in a Medicaid program in the nation. In expanding HIP, Indiana simultaneously ended traditional Medicaid for all but the aged, blind and disabled, transferring 130,000 people from a Medicaid program with no personal responsibility to the consumer-driven HIP.

The early results have demonstrated that HIP creates a strong incentive for individuals to financially contribute to their healthcare:

- *Nearly 70 percent of participants are choosing to make these contributions proactively and the almost 65 percent of individuals below the poverty level are making contributions, which is unheard of in the Medicaid program.*
- *94 percent of individuals who make contributions continue to make their contributions, which shows the personal responsibility enrollees are taking.*

The state costs for expansion of HIP are fully-funded without any tax increases to Hoosiers.

CLAIM 2: "Indiana's expansion to able-bodied adults requires even less cost sharing than traditional Medicaid."

FACTS: Indiana's traditional Medicaid program has some copayments applied for pharmacy and transportation services. However, HIP participants must either pay copayments for all services they receive or make regular monthly contributions equivalent to 2 percent of their income. All HIP participants make copayments for inappropriate use of the ER.

CLAIM 3: "Under HIP 2.0, able-bodied adults have cost sharing capped at 2% of income for nominal monthly premiums to 'POWER Accounts.'"

"As of July 2015, only 10 percent of HIP 2.0 enrollees were above the poverty line, meaning that 90 percent of enrollees weren't obligated to make any required monthly contributions in order to receive taxpayer-funded Medicaid."

FACTS: It is true that individuals are required to make contributions equal to 2 percent of their annual income, but this is far from nominal. For an individual at the poverty level earning $11,770, their monthly contribution would be equal to $235 dollars per year, or $20 per month. Recognizing that even individuals with no reported income should still be empowered to be responsible for their health care, at minimum, these individuals must still pay at least $1.00 per month for coverage. In addition to required monthly contributions, individuals must also pay copayments for inappropriate use of the emergency room, beyond their 2 percent contribution.

Individuals who elect not to make these contributions are penalized, and still must pay if they retain coverage. Similar to the commercial market experience, individuals above the poverty line lose coverage and cannot re-enroll in the program for six months. Although individuals below the poverty line may not be disenrolled from the program, they lose access to supplemental benefits, such as vision and dental coverage. In addition, these individuals are subject to copayments for each service they receive up to the 5 percent federal limit.

CLAIM 4: Indiana's "accounts are supposed to resemble Health Savings Accounts (HSAs), but taxpayers have ended up funding more than 95% of the money in the accounts."

FACTS: In the commercial world, employers make contributions to health savings accounts and occasionally, these contributions total 100 percent. Indiana's contributions to the account are set at a level to ensure that low-income individuals can afford their deductibles.

Similar to commercial HSA's, enrollees can carry-over their contributions from year-to-year and take their contributions with them when they move on from HIP.

CLAIM 5: "Able-bodied adults who fail to pay their monthly contributions can apply for one of many available exemptions."

FACTS: The available exemptions are very limited and require documentation from the member. The non-payment penalty exemptions are limited to the following events: (i) obtained and subsequently lost private insurance coverage; (ii) had a loss of income after a temporary increase income; (iii) moved out of state and returned; (iv) victim of domestic violence; (v) live in a county subject to a natural disaster declaration; or (iv) are medically frail (based on objective evidence based review of claims experience).

CLAIM 6: "Indiana's model is more expensive and generous than traditional Medicaid."

FACTS: FGA failed to finish reading our actuary's report, which notes that over the course of the waiver period, HIP costs less than traditional Medicaid. The initial costs are related to front-loading the health-savings account, but as participants are incentivized to use services prudently, use the emergency room appropriately, etc., the state contributes less to the account each year as funds roll-over to subsequent benefit periods.

CLAIM 7: "Indiana also increased benefits beyond what Obamacare requires for these new enrollees, including optional dental and vision benefits to the standard Medicaid package."

FACTS: Only individuals who regularly make payments to their POWER account are able to access dental and vision benefits, which are provided as part of the overall HIP incentive structure. Those individuals who do not make contributions, lose these benefits. Further, vison and dental services are currently provided in the Medicaid program for the aged, blind and disabled.

CLAIM 8: "Expanded presumptive eligibility only expanded the risk of fraud"

FACTS: The presumptive eligibility (PE) program is a federal requirement. Indiana is only allowing key safety net providers to perform this function, such as federally qualified health centers, rural health centers, local health departments and community mental health centers. These are locations that are serving the neediest and most vulnerable populations. In addition, Indiana's PE rule indicates that if providers fail to meet an 80 percent accuracy standard (applications must be submitted and the individual must be eligible) in the first year, they lose their ability to conduct PE. Beginning in January of 2016, the accuracy standard increases to 95 percent. The numbers that FGA provided do not reflect current data and were taken out of context.

CLAIM 9: "[T]he Governor's team has crisscrossed the country pitching the plan to other states."

FACTS: Our team has not "crisscrossed the country." We have responded only to invitations from other states and policy makers who have asked to learn more about the program.

We have simply provided information on how our program works and its successes. The decision to expand coverage is a local decision and every state needs to determine what is best for its citizens.