Indiana Medicaid plan under Pence seen as model for attack on health care

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In the wake of the Supreme Court's 2012 ruling that made the Medicaid expansion provisions of the Affordable Care Act (ACA) optional, many states with Republican governors refused to implement an expansion. Under the ACA, better known as Obamacare, the eligibility cutoff for the government health insurance program for the poor was raised to an income of up to 138 percent of the federal poverty line.

In Indiana under then-governor and now Vice President Mike Pence, the state took a different route, developing an expansion plan that is today serving as a model for state and federal efforts to privatize Medicaid, the federal program which currently provides health coverage to one-sixth of insured Americans, some 70 million people.

In 2015 the state of Indiana introduced a Medicaid expansion plan, the Healthy Indiana Plan 2.0 (HIP 2.0), which converts the entitlement program into a fee-based insurance program. It requires the state's poorest residents to pay a monthly income-based fee into the program or face a reduction or potential loss in coverage. It also introduces a tiered system of coverage, with those patients who wish to have dental and vision coverage required to pay more.

Under the HIP 2.0 plan, Indiana residents with incomes between 105 percent to 138 percent of the federal poverty level must pay a monthly premium of two percent of their income into a health savings account, dubbed a POWER account (Personal Wellness and Responsibility). This qualifies them for the HIP plus plan, which includes dental and vision coverage. For an individual making $16,394 (138 percent of the federal poverty line) per year, this works out to $27 per month and $55 for a family of four with an income of $33,500. Those residents with incomes between 0-105 percent of the poverty line pay a fee of $1 per month.

Those residents above the poverty line who fail to pay the monthly fees lose their coverage and are locked out of access to the plan for six months.

Those residents below the poverty line who cannot pay the monthly fee are downgraded to the HIP basic plan. This plan excludes dental and vision care and requires co-payments for a range of services, including a $75 copay for inpatient services, including hospital stays.

According to figures released by the state of Indiana, roughly half of the program's enrollees make less than $600.00 per year.

An assessment carried out by The Lewin group on behalf of the Indiana Family and Social Services Administration that was published in March concludes that of the 590,315 Indianans eligible for Medicaid, 13,550 people lost their coverage between February 1, 2015, to November 30th, 2016 due to nonpayment of the monthly fee. An additional 46,176 people eligible for the program never enrolled because they did not or could not make the initial payment. A further 287,000 Indianans were bumped from the HIP Plus to the HIP basic plan for nonpayment.

The HIP 2.0 plan was introduced after two years of negotiations with the Obama administration concluded with the state being granted a waiver to implement its right-wing scheme. In order to increase support amongst doctors and hospitals for the plan the state increased compensation for participating hospitals by approximately 20 percent and doctors' pay by some 25 percent.

The state sought to impose work requirements as a precondition for access, but was denied by the Obama administration. Many believe the Trump administration will override that decision when the state applies for the renewal of its program later this year.

The program's architect, Seema Verma, worked as a health care consultant at the time and has since been appointed by President Trump as the new administrator for the Centers for Medicare and Medicaid Services. In this capacity, she now has the authority to grant waivers to other states to supplant traditional Medicaid with a fee-based system similar to Indiana's. In March, Verma sent a letter to governors cosigned by Health and Human Services director Tom Price encouraging states to develop alternatives to Medicaid, stating "We wish to empower all states to advance the next wave of innovative solutions to Medicaid's challenges."

Verma has made a career out of helping state governments subvert Medicaid. As the founder of SVC, a health care consulting firm now known as HMA Medicaid Marketing Solutions, Verma was the architect of the original Healthy Indiana Plan, HIP 1.0. Similar to its successor, the original Healthy Indiana Plan was a high deductible plan for the poor that required monthly payments based on the user's income. Those who fell behind on payments were expelled from the program for a year.

On their company web site, HMA describes their activities in reactionary language: "Our colleagues have also been instrumental in the design and development of several pioneering Medicaid waiver initiatives, many modeled on the Healthy Indiana Plan (HIP), the nation's first consumer directed Medicaid program. These waivers include elements of personal responsibility, price- and quality-conscious healthcare consumption, and a focus on healthy lifestyles".

For her efforts in advancing the privatization of health care, Verma has been richly rewarded by those companies which have benefitted from it. A 2014 article in the *Indianapolis Star* describes how Verma, whose company at that time had received $3.5 million in state contracts, was at the same time working for a division of Hewlett-Packard, which is one of the state's primary Medicaid vendors. The article states that Verma was paid over $1 million by the company, which subsequently secured more than $500 million in state contracts.

In addition to their work in Indiana, Verma's company also worked with the states of Kentucky and Ohio in crafting Medicaid alternatives using the section 1115 waiver, the provision of the Affordable Care Act which allows states to design their own Medicaid programs.

Thus far ten states have applied for section 1115 waivers (Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, New Hampshire, Kentucky, Pennsylvania, and Wisconsin). Seven of those had been previously approved. Amongst those states, several are seeking to make additional changes that will further reduce the level of coverage of enrollees.

In Kentucky, which had implemented Medicaid expansion under its previous governor, the new Republican governor, Matt Bevin, is seeking a waiver to make substantial changes to the state's program. This includes work requirements that would compel those enrolled in the program to work 20 hours a week to remain eligible. It would also require users to either pay a premium for Medicaid or pay a fee for every doctor's visit.

In Wisconsin, Republican Governor Scott Walker has applied to alter the state's Medicaid program, known as BadgerCare, along similar right-wing lines. Walker's plan would require participants to pay a monthly premium based on income as well as a co-pay for emergency room visits beginning at $8 dollars for initial visits and $25 for all subsequent visits. The plan also imposes a 48-month limit on BadgerCare coverage, after which participants would lose benefits for six months.

Walker is also seeking the right to drug test applicants prior to approval. Those who fail the test would be required to complete a rehabilitation program, while those who refuse to take the test would be declared ineligible for six months. Walker has also sent a letter to President Trump requesting permission to drug test applicants for the state's FoodShare program, commonly referred to as food stamps.

In Arkansas, Republican Governor Asa Hutchinson is seeking to roll back the expansion of Medicaid his state had previously implemented. If granted, the state's waiver would scale back eligibility from 138 percent above the federal poverty line to 100 percent. This alone would cause an estimated 60,000 Arkansans to lose coverage. Participants would be required to work 80 hours per month or attend school or job training. Those who fail to comply would become ineligible for the remainder of the calendar year.

Hutchinson used familiar language in the waiver application, stating that the proposed changes in the health law "seek to test innovative approaches to promoting personal responsibility and work, encouraging movement up the economic ladder, and facilitating transitions to employer-sponsored insurance and marketplace coverage."

Beneath the hypocritical rhetoric about "personal responsibility" lies the reality of a concerted drive to dismantle the social programs upon which millions of Americans rely and which were extracted from the ruling class in the course of decades of struggle by the working class. This process has accelerated under the Trump administration, but the Democrats have spearheaded cuts to both Medicaid and Medicare, the federal health insurance program for the elderly; Obamacare includes a $700 billion cut in Medicare funding.