HEALTH CARE

No, Mike Pence, Obamacare's Medicaid Expansion Isn't Conservative

There's no such thing.

Indiana Governor Mike Pence announced today his state is expanding its Medicaid program using the Healthy Indiana Plan, styling it an "alternative" to Medicaid expansion under Obamacare. "There are two futures in health care—government-directed health care or consumer-driven health care," Gov. Pence said in a statement. Indiana has presumably chosen the latter, but the governor's plan isn't consumer-driven in any meaningful sense. It is merely the latest iteration of full Obamacare Medicaid expansion thinly disguised as a conservative entitlement reform.

Indiana joins Michigan and a handful of other Republican-controlled states that are pursuing Medicaid expansion under the guise of a negotiating a "conservative" expansion of Medicaid with the Obama administration. But there is really nothing all that conservative about the state-specific plans to capture federal dollars earmarked for Medicaid expansion. To understand why, we have to take a step back.

When the Supreme Court ruled in 2012 that the federal government could not force states to expand Medicaid under Obamacare, many Republican governors vowed not to go along with the scheme. Red-state leaders knew all too well that Medicaid was a fraught program that produced poor health outcomes, and that Medicaid spending was already straining their budgets. A wholesale expansion would only exacerbate a very real problem.

But gradually, some started to cave. With billions of federal dollars on the table,

Republican governors and legislators came under tremendous pressure to expand Medicaid—especially since the feds would pick up the entire cost of expansion for the first three years, shielding states from the need to appropriate significant state funds at the outset. Some Republican-controlled states followed the lead of Arkansas, of all places, which pursued a "private option," expanding Medicaid coverage by funneling new enrollees into the federal ACA exchange.

The Arkansas plan has turned out to be expensive and somewhat disastrous. Josh Archambault at *Forbes* reported yesterday that cost overruns could be as high as $45 million this year and Arkansas officials are considering whether to ask Washington, D.C. for a bailout. (Because Arkansas' deal with HHS capped federal funding for the expansion, any overruns must be covered by Arkansas taxpayers.) The state's Medicaid director, an architect of the "private option," has abruptly resigned.

Close observers predicted this would happen with the Arkansas plan, but that didn't stop some states from pushing ahead with various waiver schemes to expand Medicaid. According to an analysis by Avalere Health, waivers "are important politically," because they allow Republican governors and lawmakers to "remain critical of the ACA while pursuing Medicaid waivers they view as beneficial for their states." That is, they provide political cover.

Now comes Indiana's plan to expand Medicaid through the Healthy Indiana Plan, or HIP. Simply put, HIP is a Medicaid expansion program from 2008 modeled after private consumer-driven health plans. The waiver for HIP went even further than Obamacare, expanding Medicaid eligibility to 200 percent of the federal poverty level (at the time, about $44,000 a year for a family of four) versus the ACA's 133 percent FPL (or $31,000). Then-Governor Mitch Daniels paid for the expansion with a 126 percent tax hike on cigarettes.

Indiana officials negotiated a waiver extension with CMS last year that decreased HIP eligibility from 200 to 100 percent FPL, effective April 30 (because those earning more than 100 percent FPL are eligible for subsidized coverage on the exchanges). Governor Pence's expansion, dubbed "HIP 2.0," would extend the

program to all non-disabled adults in the state age 19 to 64 who earn less than 138 percent FPL, “and concurrently eliminate traditional Medicaid in Indiana.”

Supporters of HIP claim this is a conservative alternative to Medicaid because it’s modeled after consumer-driven health plans that pair a high deductible with a health savings account. Under the old HIP program, Medicaid patients had meet a $1,100 deductible before coverage kicked in, and had to keep contributing to their health savings account (called a POWER account) on a sliding income scale—no more than 2 percent of income for enrollees below 100 percent FPL. If an enrollee stopped contributing, they were kicked out of the program for a year.

Under HIP 2.0, however, the deal is much better. Enrollees who contribute a nominal amount to their Medicaid-funded HSA will also get vision and dental coverage. Those who don’t contribute won’t be kicked out of the program, they’ll simply be put into a “HIP basic” plan, which requires nominal co-pays for accessing care in various setting ($4 for outpatient services, only $25 for non-emergent visit to the ER), but again, paid out of the HSA account, which will be funded by Medicaid. The deductible for these accounts will increase to $2,500, but the difference will be covered entirely by taxpayer dollars.

The expansion thus provides strong incentives for enrollees to stay on Medicaid—especially because if they leave HIP, they lose the account.

These provisions are supposed to give patients “skin in the game,” which conservative health policy wonks have long argued is an indispensable tool for controlling costs and improving health outcomes. It’s true that HSAs can be a powerful tool to accumulate wealth and cut health care costs, but an incentive to save only works if the money saved is your own. In the case of HIP 2.0, these HSA-type accounts will be almost entirely taxpayer-funded, partly from Medicaid and partly from a tax on hospitals. The expansion thus provides strong incentives for enrollees to stay on Medicaid—especially because if they leave HIP, they lose the account. Enrollees can spend funds on any provider they choose, and whatever is unspent will roll over at the end of the year.

What's more, HIP 2.0 contains an employer option that allows enrollees to pay for an employer-sponsored plan using their taxpayer-funded HSA account. In fact, the employer provision in HIP 2.0 will likely lead to crowd out—a migration of workers away from private employer coverage into Medicaid. This would quickly swell costs for Indiana taxpayers, especially if federal funding ever drops off.

According to Indiana's proposal, if federal support is ever reduced the HIP 2.0 expansion "will automatically terminate." This has become a common gesture in state expansion schemes. It is meant to mollify conservative skeptics, but the problem is that such a condition is simply not possible under federal Medicaid rules. In order to expand Medicaid a state must apply for a waiver and amend its state plan, and CMS must approve the amendment. Once that happens, the expansion becomes part of the state plan (really, a contract between the state and the federal government), and the feds have the authority to enforce that plan and withhold federal funding if the state does not comply with it.

Indiana officials estimate the expansion will amount to about 350,000 new enrollees. Given the much more attractive deal that HIP 2.0 offers, enrollment will likely surpass these projections, as will costs (HIP 2.0 increases Medicaid provider rates to 75 percent of Medicare, which presumably was a tradeoff for increasing taxes on hospitals.)

This is already happening in expansion states. In California, expansion enrollment has already exceeded projections by 1.2 million—one-third of the state, about 11.5 million people, will be on Medicaid by next year—and officials are now saying that it will cost $1.2 billion more than expected. As Cato's Michael Cannon noted back in 2011, "If [then-Governor] Daniels wanted to demonstrate that HSAs are superior to old Medicaid as we know it, he should have put existing enrollees into HSAs, rather than expand Medicaid up to 200 FPL to make his point."

It's worth mentioning that Indiana isn't some outlier among Republican-controlled states. Michigan recently trotted out a version of HIP (dubbed the "Healthy Michigan Plan") that expands Medicaid by giving every enrollee a "MI Health Account," which is essentially an HSA. Under the Michigan plan only the

expansion population—non-disabled adults earning between 100 and 138 percent of federal poverty—will contribute to this account. But, like HIP, you can't get kicked out of the program for not contributing. Why? Because federal law doesn't allow states to kick someone out of Medicaid for not paying. That's why they call it an entitlement.

Vox recently quoted Michigan's Medicaid director saying that states always want more freedom than the federal government will afford them, calling this "a natural law of some kind." In a sense that's correct. Those tasked with running programs according to rules they haven't written and can't change will always want more freedom.

But if Indiana officials think that's what they're getting, they're sorely mistaken. At the end of the day, Medicaid is a federal program and the feds are calling the shots. You can dress up an entitlement health care program to look like a private, consumer-driven plan and call it whatever you want, but they are not and never will be the same.

It's a shame that it will now cost the people of Indiana—and Michigan and Arkansas and all the other expansion states—tens of millions in cost overruns to figure this out.

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