Introduction to the Health Discussion

We opened the Faith Community Consultation with a panel on "Health" to recognize the moral teaching common to many religious traditions: We all have shared responsibilities for supporting one another's health and healing.

The three panelists were the Hon. Gregory Porter, an Indiana State Representative, Tracey Hutchings-Goetz, a grassroots organizer with Hoosier Action, and Adam Mueller, a lawyer and the Director of the Indiana Justice Project. They discussed pending legislative threats to nearly 2 million Hoosiers who rely on Indiana's Medicaid programs.

This introduction contextualizes the challenges facing people who are Medicaid-eligible in Indiana's current policy environment. The same legislative goal of curtailing Medicaid eligibility through administrative burdens and cumbersome red-tape is driving national and state-level changes in the United States today.

Legislative Context: Medicaid Matters

At the start of the 2025 legislative session, Indiana Senate Republicans announced Senate Bill 2 (SB 2). Named "Medicaid Matters," this bill proposed major changes to Indiana's Medicaid programs focused on cutting enrollment and curtailing eligibility in the Healthy Indiana Plan (HIP). Among its provisions, SB 2 would:

1. Cap HIP enrollment at 500,000 members—roughly 200,000 below HIP enrollment at the time
2. Institute a 36-month lifetime limit on HIP-eligibility for individual enrollees
3. Make eligibility for HIP contingent on monthly reporting of at least 20 hours worked or volunteered per week
4. Require quarterly (or more frequent) eligibility reviews for beneficiaries in all Indiana Medicaid programs, using back-office checks of state, federal, and other databases

A decade before SB 2, Gov. Mike Pence negotiated an agreement (called a Section 1115 Waiver) with the federal government to expand Medicaid using Indiana's existing HIP program for low-income Hoosiers. After the expansion in Feb. 2015, enrollment in the re-booted HIP 2.0 increased tenfold, growing from 40,000 to 400,000 working-age adults.

Modeled on consumer-driven health plans, HIP was designed to make enrollees navigate "personal responsibility" incentives to get, keep, and use health care coverage. HIP 2.0 maintained HIP's original two-tiered structure of benefit plans:

- When applicants are first approved for HIP, they start in the top-tier **HIP Plus plan**. HIP Plus provides vision and dental coverage, in addition to medical and pharmacy benefits. HIP Plus members have no copayments (except for any non-emergency use of the ER). In exchange for these fairly comprehensive benefits, HIP Plus

members must pay monthly income-based premiums, ranging between $1-$20, with a 50% surcharge for tobacco use.

- HIP members who miss two consecutive months of premiums get downgraded to HIP Basic, if they earn 100% or below of the Federal Poverty Level (FPL), or they lose all HIP coverage, if they earn between 101-138% FPL.

- The **HIP Basic plan** excludes vision and dental coverage and imposes copayments for each health care visit ($4), medication ($4-$8), and inpatient stay ($75). Making copayments on HIP Basic can quickly exceed the cost of monthly premiums on HIP Plus. Research also shows that copayments deter people from seeking care.

In our 2019 study, *Health Equity, Urban Congregations, and HIP* (Craig & Hicks, et al), we found that the different payment requirements and benefits packages of HIP Plus and HIP Basic are already confusing for many members. Adding to program complexity, HIP has three more tiers. Members who are pregnant get re-assigned to **HIP Maternity** up until one-year post-partum. HIP Maternity has no premium or copayment requirements, and members receive additional benefits on top of the HIP Plus package. HIP members with complex medical conditions are re-assigned to separate **HIP State Plus** and **HIP State Basic** plans. These plans provide the same expanded benefits as HIP Maternity but require either premiums (Plus) or copayments (Basic).

HIP's Chutes and Ladders

Our 2019 study provided a snapshot of the Healthy Indiana Plan as it operated right before the Covid-19 Public Health Emergency (PHE). The pandemic took millions of people's lives and drove home the need to keep each person healthy to protect everyone's health. To help people stay healthy, federal legislators and state policy makers changed Medicaid's rules (see Policy Context below). Our interviews and focus groups with 40 people who were enrolled in HIP—or who were eligible for HIP—are important reminders of the many difficulties people experienced while navigating HIP under normal program rules.

When we spoke to these experts about their experiences with HIP, they described it like a game of Chutes and Ladders. Remember this game from your childhood? The Chutes and Ladders board is a ten-by-ten grid. Players spin a spinner and move the indicated number of squares across the board. At the end of each row, players move up to a higher row and head back the other direction until they reach square #100. The fun of the game is the good luck and bad luck along the way. Players who end their turn in a square at the bottom of a ladder jump up a row or more to a higher square at the top of the ladder. When a turn ends in a square at the top of a chute, the player slides back down a row or more.

The policy makers who designed HIP view its "personal responsibility" incentives as a ladder. New enrollees are approved for the HIP Plus plan with its vision and dental coverage and no copayments. Taking hold of the ladder at this rung gives members the

greater stability and relatively secure health care access of HIP Plus. They hold onto these benefits as long as they pay monthly premiums into their POWER Account (the acronym stands for Personal Wellness and Responsibility), which is similar to a health-savings account. Each year the POWER Account pays for a HIP member's first $2500 in health care costs, using a member's premium contributions, ranging on an income-based scale from $12-$240 per year, with the balance funded by the state.

In theory, these "skin-in-the-game" payments teach HIP members to invest in the personal responsibility of monthly premiums to avoid the copayments and reduced benefits of HIP Basic. Members who miss two consecutive months of payments move down the ladder to Basic coverage if they earn 100% or below of FPL. For HIP's policy makers, losing vision and dental coverage and paying routine copayments are temporary setbacks that incentivize members to manage their health care finances and become smarter consumers of health care. When their redetermination period rolls around the next year, HIP Basic members can opt to move up to HIP Plus. (People earning between 101-138% FPL who miss POWER Account payments are removed from the HIP ladder and must re-apply.)

The HIP program includes other personal responsibility incentives, such as a 50% surcharge on monthly premiums for tobacco use. Wellness visits are free, and members who complete them receive gift cards from the Managed Care Entities that administer their plans. Members can also carry forward any unspent portion of their own POWER Account contributions annually, potentially reducing their premium costs for the next year. On this view of HIP, the personal responsibility ladder does not stop with Medicaid. HIP members are learning to navigate high-deductible commercial health plans as they climb the ladder of economic security. HIP's policy aim is helping members to a higher paying job with full benefits.

Moving from theory to practice, the HIP members we met experienced it as a confusing program that erects a series of hurdles to getting, keeping, and using their health care benefits. Instead of climbing a ladder of economic opportunity, HIP members found themselves navigating unexpected chutes that could drop them down to reduced health care benefits or remove them from HIP health care coverage entirely. Here are some typical examples from our 2019 study of the various chutes confronting HIP members.

Successful HIP applicants received a letter, within 45 days, conditionally approving them for HIP Plus coverage. Their first step was understanding the monthly premium requirement and finding their premium amount in the letter. Then they had to pay it to the right Managed Care Entity (one of four) that manages their plan. For example, for members earning up to $280 per month, the letter would stipulate a payment of $1 to receive full HIP Plus benefits. Without bank accounts or credit cards, some people struggled to pay this first premium within the allowed 30 days, despite options to pay in person at various stores. If members missed that first payment or two subsequent months of premiums, their coverage was downgraded to HIP Basic. Missing the first premium delayed the start of

HIP Basic another two months, leaving new applicants in limbo wondering if they had any coverage at all.

Fluctuating monthly income was another typical challenge for study participants. For HIP Plus members, temporary increases in income can result in higher monthly premiums. When Indiana's Family and Social Services Administration detects an income increase from employment or tax data, it triggers a new notification stipulating a higher payment. With every mailed letter, there is a risk that a member may have moved, a relatively common occurrence for lower-income people. In addition, given the financial challenges of monthly payments, the HIP program allows members to pay a year's worth of premiums at once. For HIP Plus members who may have paid $12 to cover a full year of premiums, a premium increase to only $5 per month will quickly deplete the coverage security they thought they had purchased. Our interviewees reported discovering their new copayments or disrupted coverage when they tried to fill a prescription or visit their doctor.

HIP members reported another frequent challenge of needing to submit new documents to prove eligibility. Sometimes their submitted documents were lost. Many interviewees made it a practice of delivering their forms in person and getting date-stamped copies to prove they had been submitted. On other occasions, the state requests new documents because of a possible change in eligibility. The 13-day turnaround for submitting new documents allows little time to receive and understand the letter, collect the documents, and take time off from work to deliver them to the Division of Family Resources office. Harder cases, such as tracking down a former employer to certify a job has ended, will require even more time.

From the perspective of the HIP members we met, HIP's tiered health plans are not rungs on a ladder, but instead rows on the Chutes and Ladders board. The preceding examples are just some of the chutes arrayed on the HIP Plus row. Any misstep means falling down a chute to the HIP Basic row where the chutes are more frequent and the ladders of personal responsibility get higher.

Here is a scenario that illustrates how chutes pile up from a HIP member's perspective:

The state sends a letter saying (in much more technical language): A data review indicates that you earned more during the last quarter. Now your $1 premium is $10 a month. For some reason, you don't pay this higher charge on time. Perhaps you felt secure in thinking your premiums were paid for the year. Maybe you no longer live at the address where the letter was sent. Perhaps you have no money to pay because your seasonal job ended and you have zero income this month. Whichever chute tripped you up, you now face new ladders when accessing health care in the form of copayments for each health care visit and each medication. Oh, and by the way, you no longer have vision or dental coverage either. Good news, though, you can move up the ladder to HIP Plus next year, if you remember to make this change during your annual redetermination. Be on the lookout for a new letter with that information!

Chutes and Ladders is a fun game, but people's health and health care are not a game.

Policy Context: Going Back on Medicaid

When the Covid-19 Public Health Emergency was declared, the CARES Act authorized an increase in federal funding for Medicaid programs so long as states took steps to keep beneficiaries continuously enrolled. In addition to suspending annual redetermination requirements, Indiana met the moment by voluntarily suspending cost-sharing in all of its Medicaid programs. Monthly premiums for HIP Plus and copayments on HIP Basic were both stopped on April 1, 2020. Indiana hit the pause button on the HIP chutes and ladders game to protect health care access for HIP members and secure a healthier community for all Hoosiers.

Following these changes, newcomers to HIP did not have to worry about making a first payment into their POWER Account or paying premiums in the months ahead. With the threat of coverage downgrades removed, all new HIP members started and stayed on HIP Plus with its comprehensive medical, pharmacy, vision, and dental benefits. As the pandemic's economic fallout took hold, only one group faced the legacy of reduced benefits—those members who had been downgraded to HIP Basic prior to April 2020. More than a year into the PHE, Indiana's FSSA took administrative action in July 2021 and upgraded all HIP Basic members to HIP Plus. Under HIP's rules, these members could have opted to upgrade themselves to HIP Plus during their annual re-enrollment period, but few did. HIP's personal responsibility ladder did not correct the persistent legacy of chutes that make HIP's ladder of opportunity so difficult to climb.

When HIP's rules changed, enrollment grew dramatically. In Jan. 2020, HIP enrollment stood at 390,458 members. When the Medicaid unwind began in April 2023, total enrollment had doubled to 815,890. At this time, Indiana re-started the redetermination process for all Medicaid beneficiaries without re-implementing cost-sharing. As a result, the outsize obstructive effects of HIP's premiums and POWER Accounts became clear. In April 2024, one year into the Medicaid unwind, 702,897 people were enrolled in HIP coverage. Even after the removal of all HIP members who were no longer eligible for the program (along with some HIP-eligible people who lost coverage for procedural reasons), there were 300,000 more Hoosiers on HIP than had been enrolled under the program's cost-sharing "personal responsibility" requirements (Indiana Medicaid Enrollment Dashboard: https://www.in.gov/fssa/ompp/medicaid-enrollment-dashboard/).

It turns out that dropping monthly premiums makes HIP a very different program. Ending premiums helps HIP members keep their benefits, which was Indiana's goal in suspending cost-sharing at the start of the pandemic. When Indiana made this investment in people's health care, it helped people stay healthy. When Indiana removed the barrier of premiums and simplified HIP's program complexity, members could navigate the system more easily.

The U.S. District Court for the District of Columbia reached a similar conclusion in *Rose v. Becerra* (released on June 27, 2024). Using pre-pandemic data, the Court observed how HIP's monthly premium requirements have contributed to members either losing specific health care benefits or losing health care coverage, contrary to the legislative purpose of the 1965 Medicaid Act to "furnish healthcare coverage" (p. 34). The Court cited evidence that "Black recipients" were more likely to have their HIP benefits reduced or removed due to premium requirements (p. 35). As a result of this ruling, Indiana could not reinstate cost-sharing in HIP as had been planned for July 1, 2024.

HIP's cost-sharing requirements remain suspended through a preliminary injunction while pending legal challenges proceed. (Cost-sharing has returned to Indiana's other Medicaid programs where premiums and copayments affect members earning above 150% FPL.) Our research is cited in the amicus curiae brief, included in this Panoply, submitted as part of the ongoing legal case.

The significance of community-valued research on Medicaid was clear during the legislative debates and public testimony over SB 2. Citing our research at times, a coalition of advocacy groups, HIP members, and community leaders succeeded in getting Indiana legislators to remove two restrictions: 1) capping HIP enrollment at 500,000 members and 2) restricting HIP-eligibility to a 36-month lifetime limit.

However, the provision to conduct quarterly (or more frequent) eligibility reviews was passed and signed into law. Now, all participants in all Indiana Medicaid programs face the prospect of notifications requiring new document submissions within very tight turnaround times. Research finds that "people with lower incomes are more likely to experience frequent income fluctuations compared to higher income populations. One study of low and moderate-income households found that they experienced an average of 2.5 months each year in which income fell by more than 25 percent, and 2.6 months in which income increased by 25 percent" (Sugar et al, p. 3). Seasonal workers and self-employed workers with variable monthly incomes are most likely to experience continual scrutiny and bureaucratic hurdles to maintaining their eligibility.

Indiana legislators also passed SB 2's work requirement. Following panelist Tracey Hutchings-Goetz, we call it a "work *reporting* requirement" because the majority of HIP members are working already. Although the state typically has this employment information, members will need to report it anyway. Other members are students or caregivers who have exemptions under the new law. Nationally, 90% of people covered by Medicaid Expansion plans have jobs, attend school, or are caregivers (Tolbert et al, 2025). Prior to the PHE, Arkansas implemented a work requirement. Research shows that busy workers often forgot to report their monthly work hours. Low-income HIP members may lack technology access for reporting (Hinton et al., 2025). In Indiana, certified caregivers may have to reapply for caregiver status if the system loses track of their prior approvals. Extrapolating from the experiences of HIP members in our 2019 study, administrative errors will lead to eligible people losing coverage, as new data floods into the state and

technical glitches occur. Then, notifications will be sent out requesting new documents, and people who are Medicaid-eligible will fall down chutes and lose their health care coverage.

It is difficult to anticipate how many eligible people will lose Medicaid coverage due to these policy changes. We know that the increase in HIP enrollment from Jan. 2020 to April 2024 was over 300,000 members. That 75% jump remained one year after the redetermination requirements re-started, which removed people who were no longer eligible for the program.

Our shared moral responsibility for supporting one another's health and healing calls us to watch the numbers closely, listen to our neighbors, and offer support as they navigate the chutes and ladders of HIP and other Medicaid programs.