

## Comments on HIP 3.0 Waiver Proposal

Sept. 3, 2026

The following public comments are written by Dr. David Craig, an ethicist in the Department of Interdisciplinary Studies, School of Liberal Arts, IU Indianapolis. These comments are based on findings from seven years of research. They represent my views, not those of my university.

I have co-directed two community-university research studies of the Healthy Indiana Plan (HIP). First, in 2019, leaders from two inner-city Indianapolis faith communities and IUPUI researchers conducted a community-engaged study of HIP. We submitted our [final report](#) to Dr. Jennifer Sullivan, FSSA Secretary. Funded by the Indiana Minority Health Coalition, this study provided a snapshot of how HIP 2.0 was operating for members right before the COVID-19 Public Health Emergency. Our report documents how HIP's existing personal responsibility incentives and requirements created many barriers to members' efforts and ability to support their health and wellness. At this time, the high rates of disenrollment and churn made it difficult for many eligible Hoosiers to access health care consistently.

Second, from 2023-2025, I was one of three Co-PIs, with Dr. Elaine Hernandez and Dr. Ivan Douglas Hicks, on a statewide study funded by the Robert Wood Johnson Foundation. This mixed-methods study included quantitative data analysis of Indiana Medicaid enrollment data, in-depth qualitative interviews with 100 HIP members, community listening sessions, and oversight from a Community Leadership Board. In 2025, our team wrote an economic impact report on the [benefits of Medicaid](#) to Indiana's economy. Our June 2026 [article](#) in *Health Services Research* finds evidence that HIP's personal responsibility incentives (e.g., cost-sharing) are associated with substantial and lasting racial disparities between Non-Hispanic Black and Non-Hispanic White HIP members' access to the more comprehensive health benefits in HIP Plus and HIP State Plus plans. As we knew from previous HIP waiver evaluations, these racial disparities existed before the pandemic. This article traces their persistence even after cost-sharing requirements were suspended in April 2020.

Our research teams have listened to people who are firsthand experts on HIP--Hoosiers who have successfully used HIP as well Hoosiers who have lost HIP or struggled to use its benefits. The state's policymakers should also learn from these community experts to understand how HIP works and does not work for the people who depend on it for their health as well as how HIP can strengthen or hurt the economic wellbeing of our state. The most important lesson for the HIP 3.0 waiver proposal is this: The proposal is misguided in continuing to require financial payments from all HIP members regardless of their income level.

Historically, Indiana is the only state that has imposed premiums and copayments on Medicaid members starting at 0% of the Federal Poverty Level. This policy insistence on demanding "personal responsibility" through financial incentives, regardless of people's ability to pay, does not account for people's everyday circumstances or finances. The HIP

3.0 waiver proposal will prevent many eligible Hoosiers from applying for HIP in the first place. It will obstruct enrolled Hoosiers in accessing needed health care and establishing primary care provider relationships and medical homes. It will increase non-emergent use of Emergency Departments by people who go without coverage for which they are eligible. Overall costs to the state and taxpayers will likely rise, contrary to the fiscal prudence claimed in the waiver proposal.

### **Strengths in the Waiver Proposal**

The HIP 3.0 waiver proposal does have several strengths that could help eligible Hoosiers understand how to apply for HIP benefits and navigate their plan:

1. HIP's structure needs simplifying. Our research found that members are confused by the program complexity of having multiple plan tiers and the time-lag of benefits being delayed for two months after new enrollees were downgraded to HIP Basic. The HIP 3.0 proposal reduces the five main tiers (HIP Plus, HIP Basic, HIP State Plan Plus, HIP State Plan Basic, and HIP Maternity) down to one benefit plan. Having one benefit plan for all HIP members is a significant improvement (see below for caveats). The benefits package appears to be the same, including vision and dental benefits for all HIP members.
  - a. The proposal is unclear about whether medically-frail HIP members will be provided additional supports, e.g., care coordination, which should continue to be extended to them.
2. The proposal ends HIP Maternity and shifts qualified women, who are pregnant or up to one-year post-partum, to Hoosier Healthwise. This change is an improvement for two reasons. First, our study participants shared their difficulties in navigating one Medicaid program for their children and a different program for themselves. Second, this shift draws a clear line that ensures qualifying women will not have any copayments during their time on Hoosier Healthwise.
  - a. As this change is being implemented, FSSA will need to ensure pregnant woman can keep their providers when they transition from HIP to Hoosier Healthwise and then back again.
3. A key strength of the proposal is this provision: "Services delivered by a Federally Qualified Health Center (FQHC), Comprehensive Community Behavioral Health Clinic (CCBHC) or Rural Health Center (RHC) are not subject to copayment." (4) The state should encourage HIP members to use these community clinics and assist people in establishing medical homes and relationships with primary care providers (PCPs). Our research finds that these relationships improve HIP members' access to consistent, quality preventive care and chronic disease management.
  - a. The proposal is unclear about the reimbursements that these clinics will receive through HIP. They must include the typical FQHC/RHC bump up for Medicaid members.

- b. The state should also invest resources to ensure that there are enough of these health centers with sufficient capacity to serve as medical homes for growing numbers of Hoosiers, especially in rural areas and especially for community mental health centers across the state.

### **Problems in the Waiver Proposal**

1. The proposed copayment schedule is a misguided step backward from HIP's longstanding prioritization of personal wellness as a key policy value. Extensive research finds that copayments create barriers to people seeking needed health care, particularly at lower incomes. The proposed copayments are intolerably expensive for low-income people who struggle to pay for their family's needs and often end up short. Charging \$15 for an outpatient primary care visit to people with extremely tight personal and family budgets will not lead to more HIP members seeking primary care or establishing a medical home. The proposed copayments are much higher than the old HIP Basic copayments, which members already could not afford (see the opening story in our 2019 report, p. 8).
2. HIP members with incomes 100% FPL or below should not face any copayments, with the one possible exception of non-emergent use of Emergency Departments. The HIP 3.0 waiver proposal implies that the copayment schedule is mandated by federal law, but it is not. The 2025 federal budget reconciliation (aka One Big Beautiful Bill Act) does not mandate cost-sharing for Medicaid expansion adults earning between 0-100% FPL. Neither should Indiana. HIP Basic should simply be eliminated, not replaced with a benefits package that secures vision and dental coverage for all HIP members (a real improvement), while significantly increasing copayments at all income levels.
3. The 5% cap on out-of-pocket expenses represents a major increase in the cost of health care for HIP members who had HIP Plus. POWER Account premiums were capped at 2% income tiers. This 2% cap on cost-sharing should be maintained for Hoosiers earning between 101-138% FPL so that they can continue to meet cost-sharing obligations by spending no more than 2% of their annual income, as they could under HIP Plus.
4. The HIP 3.0 waiver proposal has the right goal of encouraging HIP members to get preventive care, complete preventive screenings, and participate in various wellness activities. But the proposed means to this goal puts personal responsibility barriers in the way of the goal of wellness. *Reducing* copayments *after* people complete three wellness activities/behaviors is misguided both in the rewards and the timing. The wellness incentives in other states, for example, Iowa, help their expansion plan members get established with PCPs and engage in wellness activities for one year before facing copayments. If members complete wellness activities/behaviors one year, then they avoid copayments the next. The HIP 3.0 proposal hits new members

with high copayments from the very start and reduces them only after members complete wellness activities/behaviors. Further, members still face copayments afterward, which even with the wellness reduction, are generally more expensive than the old HIP Basic schedule. Indiana should follow other states' lead in making any copayments start after one year only if members do not complete wellness activities/behaviors.

5. The proposed HIP 3.0 evaluation metrics will prejudice the demonstration project by omitting important data and critical questions about the waiver proposal's impact. The data is limited to enrolled HIP members. It ignores the experiences of Hoosiers who would meet HIP's eligibility criteria but remain uncovered--or discontinue their coverage--because of the financial burdens of copayments or other administrative burdens. Key questions should be added to the waiver evaluation plan:
  - a. How many HIP-eligible Hoosiers do not apply for benefits due to the burdens of copayments or the complexity of HIP's administrative burdens?
  - b. How many HIP enrollees do not renew their benefits due to high copayment fees or other burdens despite remaining eligible?
  - c. How many enrolled HIP members do not use their benefits for needed health care (wellness, primary, specialty, etc.) due to the copayment structure?
  - d. How many HIP enrollees lose coverage due to delayed reviews of their redetermination information and documents?
  - e. How many HIP-eligible Hoosiers are cut from the rolls as a result to "budget-neutral" enrollment caps?

Indiana's current woeful record with reviewing all Medicaid members' redetermination information and paperwork and Indiana's shockingly high procedural disenrollment rate underscore how administrative burdens thwart Medicaid-eligible Hoosiers' continuity of coverage and access to needed care. FSSA has not finalized the procedures for the new work/community engagement reporting by HIP members or the process for requesting an exemption from this requirement, even though members' reporting obligations start within weeks. Before requesting a HIP 3.0 waiver, the state should streamline renewal review procedures, increase *ex parte* and pre-filled form renewals, and demonstrate the capacity to ensure that HIP members who meet the requirements get the Medicaid coverage and the office support that they deserve. This is not the time for an overhaul of the HIP program.