July 6, 2017

The Honorable Thomas Price, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, DC 20201

Dear Secretary Price:

The undersigned organizations appreciate the opportunity to comment on Indiana's request to amend its proposal to extend the Healthy Indiana Plan (HIP) 2.0 demonstration project. As expressed in our March comments on Indiana's original extension request, we support Indiana's decision to continue to accept federal Medicaid funding to provide coverage to low-income adults as well as the state's proposal to expand substance use disorder treatment. However, as outlined below, we have concerns with specific aspects of the state's request to amend its extension, which should be addressed during the approval process.

CMS Should Not Extend Power Account Contributions without More Evaluation

As we expressed in our earlier comments on the HIP 2.0 extension request, we continue to have significant concerns with several provisions in the HIP 2.0 demonstration that the state seeks to extend. Findings in several reports, including the HIP 2.0 interim evaluation report and Power Account Contribution Assessment, which was issued after we submitted our comments in March, show that POWER account contributions are affecting participation in the program and making it harder for people to obtain care.

Indiana is proposing to continue requiring HIP 2.0 enrollees to make monthly contributions to their POWER accounts. The amendment to its proposal for an extension of HIP 2.0 would change how these monthly contributions are calculated. Instead of setting them at 2 percent of an individual's income (or $1 a month for those with little or no income), Indiana is now proposing to use a tiered contribution structure based on income. These monthly contributions are premiums under section 1916(a)(1) of the Social Security Act, and Indiana is seeking to waive that section that prohibits imposing premiums on people with incomes below 150 percent of the poverty line.

A recent report looked at research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income people enrolled in Medicaid and CHIP. The authors concluded from this review of the literature that premiums are a barrier to obtaining Medicaid and CHIP coverage, with the largest effect among those with incomes below poverty. The research shows that while some individuals losing Medicaid or CHIP coverage move to other coverage, others become uninsured. Those with lower income are most likely to become uninsured. Once uninsured, people face increased barriers to accessing care, greater unmet health needs and increased financial burdens.[1]

Moreover, the research shows that state savings from premiums are limited. Studies find that potential increases in revenue from premiums are offset by increased disenrollment, use of more

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[1] Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, http://www.kff.org/medicaid/issue-

expensive services, such as emergency room care, costs in other areas, such as resources for uninsured individuals, and administrative expenses.[2] For example, a recent study looking at Arkansas' Independence Accounts, which are similar to Indiana's POWER accounts, found that they were not cost effective to implement. The state collected $426,457 from eligible enrollees, but spent $595,135 in co-payment protections.[3] In addition to spending more than it collected, the state spent $9 million to contract with a vendor to manage the accounts.[4]

Evidence from the HIP 2.0 Power Account Contribution shows that 55 percent of eligible individuals either did not make their initial payment or missed a payment. Affordability of premiums is a key reason for this — 44 percent of HIP 2.0 members who missed a payment and 22 percent of those who never made an initial payment said it was because they could not afford the contribution. Affordability is still an issue for those who are enrolled and make their payments — 29 percent of HIP 2.0 members with incomes below poverty, and 46 percent of those above poverty, said that they "sometimes," "usually," or "always" worry about their ability to pay.[5]

Findings from the Power Account Contribution Assessment are consistent with the evidence from the HIP 2.0 interim evaluation, which suggests that monthly premiums are deterring people from enrolling in the program. Specifically, about one-third of individuals who apply for Medicaid coverage under HIP 2.0 and are found eligible are not enrolled, because they don't make a premium payment.[6] According to the evaluation, in any given month, as many as 30,000 people are in a "conditional eligibility status" — i.e., have been found eligible within the past 60 days but are not enrolled because they haven't made premium payments. Of those, only two-thirds enroll by the end of their 60-day payment period.

On top of that, Indiana's non-payment of premium policy is denying coverage as well as important benefits to individuals. In HIP 2.0's first year, 2,677 individuals with incomes above the poverty line who had been enrolled in HIP Plus — that is, 5.9 percent of such individuals — had their coverage terminated for falling behind for 60 days on their premiums and were then locked out of coverage for six months. In addition, 21,445 HIP-Plus enrollees with incomes below the poverty line (8 percent of such individuals) were moved to the more-limited HIP Basic due to non-payment of premiums.

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[2] *Ibid.*

[3] By making monthly contributions to their accounts, enrollees were "protected," or not required to pay co-payments for services rendered in the subsequent. The $595,135 represents state spending to offset the enrollee's co-payment obligation.

[4] Joseph Thompson, *et al.,* "Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population," Arkanasa Center for Health Improvement, June 27, 2017, https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18272.

[5] The Lewin Group, "Healthy Indiana Plan 2.0: POWER Account Contribution Assessment," March 31, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[6] The Lewin Group, "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," July 6, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt- 07062016.pdf.

Until more evaluation data is available, we recommend CMS not extend Indiana's authority to charge premiums and lock individuals out of coverage for non-payment of premiums. Current data suggests that these policies are denying individuals coverage, which doesn't further the objectives of the Medicaid. Moreover, the state has failed to demonstrate any positive impact on enrollees from charging premiums. Indiana claims that people paying premiums get more care, but there is no evidence that paying premiums is a causal factor. It's just as likely that people who don't pay premiums get less care, because they can't pay the copayments required in the Basic plan. As we said in our earlier comments, CMS should not allow Indiana to continue penalizing people who can't pay premiums, because it is keeping them from getting the care they need. This is not a proper use of demonstration authority.

CMS Should Not Approve Indiana's Request to Condition Medicaid Eligibility on Employment

We have significant concerns with the state's proposal to condition Medicaid eligibility by requiring HIP 2.0 members to either:

1. Work on average 20 hours per week over eight months during their eligibility period;
2. Be enrolled in full-time or part-time education; or
3. Participate in Gateway to Work, the state's job training program.

Work requirements are not permitted in Medicaid. Federal Medicaid law defines the broad criteria for Medicaid eligibility and does not include a requirement for the individual to be working or seeking work as a condition of qualifying for Medicaid coverage. A number of courts have recognized that states may not "add additional requirements for Medicaid eligibility" that are not set forth in the Medicaid Act. Congress has acted to include work requirements in other public benefit programs, including the Temporary Assistance for Needy Families (TANF), and has chosen not to include such an option in Medicaid. Absent new authorization in federal Medicaid law, states cannot implement work requirements unless there is some other statutory authority.[7]

A work requirement has never been allowed in Medicaid because it is contrary to the goal of the program: to offer health coverage to those without access to care. The state's proposal seeks to solve a problem that does not exist. Even the state's actuary noted in its budget neutrality narrative that only 30 percent of HIP 2.0 members would be subject to this mandatory work requirement. This is consistent with what we know about Medicaid — most people on Medicaid who can work, do so, and for people who face major obstacles to employment, harsh requirements won't help to overcome them. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.[8]

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[7] Jane Perkins, "Medicaid Work Requirements: Legally Suspect," National Health Law Program, March 2017.

[8] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

The amendment would harm those individuals who are unable to work. While the proposal does allow some individuals to be excluded from the work requirement,[9] it can be difficult and burdensome for people with disabilities, family care responsibilities, or other significant problems or limitations to prove to a state bureaucracy their inability to meet a work requirement that has been imposed on them. State TANF programs have failed to implement successful systems exempting eligible individuals from these requirements, with studies showing that TANF recipients who are sanctioned for not meeting a work requirement have significantly higher rates of disability than those who are not sanctioned.[10] The TANF work requirements also failed to increase long-term employment or reduce poverty among those sanctioned; the same result would be likely in Medicaid.[11]

If the loss of coverage resulting from a work requirements leads to a deterioration in health for some people, as it well could, *a work requirement could make it harder for some of the affected low-income adults to become or remain employed.* Many people not working have health conditions that could worsen without access to health coverage, such as opioid addiction. For some of these individuals, access to health services could be the primary pathway to employment; if blocked from Medicaid coverage, they could find it much more difficult to find and hold a job.

There have been recent reports showing that Medicaid can reduce health barriers to finding or holding a job for beneficiaries who are not working. Ohio's Department of Medicaid found that three-quarters of beneficiaries who received care under the state's Medicaid expansion and who were looking for work reported that Medicaid made it easier to do so. For those who were currently working, more than half said that Medicaid made it easier to keep their jobs.[12] Michigan experienced similar findings — 55 percent of those who were out of work said Medicaid coverage made them better able to look for a job while 69 percent of those who had jobs said they did better at work once they got covered.[13]

We recommend that CMS not approve Indiana's work requirement request creates barriers to care and does not further the objectives of the Medicaid program, a requirement for section 1115 demonstration projects.

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[9] The following populations are exempt: pregnant women, HIP members who are a primary caregiver of a dependent child below the compulsory education age or a disabled dependent, members identified as medically frail, member with a certified temporary illness or incapacity or who are in active substance use disorder treatment, members over the age of 60 and those recently incarcerated.

[10] LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, "Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments," Mathematica Policy Research, Inc., February 2008.

[11] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016.

[12] Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[13] Kara Gavin, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan Health Lab, June 27, 2017, http://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches.

CMS Should Uphold its Commitment to the Public Notice Process

In addition to the policies outlined above, we are particularly concerned with the public transparency process associated with Indiana's extension amendment request as it does not comply with the requirements for extension request set forth in 42 CFR 431.412(c) and 431.416. Our concerns are twofold: (1) CMS determined, after regular business hours on Friday, June 9, 2017, that Indiana's extension amendment request was complete; and (2) it opened the federal comment period while the state comment period was still underway.

The state did not meet the notice and comment requirements for extension requests as specified in 42 CFR 431.412(c)(2)(vii), which requires states to complete the public notice process outlined in 42 CFR 431.408. Indiana submitted its request to CMS before its 30-day public comment ended, and it did not include a report of the issues raised by the public and how the state addressed them. Moreover, CMS did not adhere to the federal public notice process specified in 42 CFR 431.416(a), as it determined the state's request to be complete despite the fact that Indiana had not completed its 30-day public notice or included its report addressing the comments it received during the state process in its submission to CMS.

There are weaker notice and comment rules for amendments, but CMS has always applied the regulatory requirements to amendments. Moreover, even if CMS planned to change its policy on amendments, Indiana's request should not be considered an amendment to an ongoing waiver. It is a very significant change in its proposal for an extension, adding a brand new work requirement. Notice and comment rules clearly apply to extensions, and states shouldn't be able to skirt these rules by submitting major changes to their extension requests *after* submitting their extension proposals.

To ensure proper consideration of Indiana's request, we recommend that CMS extend the federal public comment for an additional 30-day period in order for the state to complete its public notice process, make changes as appropriate, and include a report on the issues — and how the state addressed them — in a revised amendment request.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (Solomon@cbpp.org).

CC: Seema Verma, Brian Neale, Judith Cash

American Congress of Obstetricians and Gynecologists
American Heart Association/American Stroke Association
American Lung Association
Center on Budget and Policy Priorities
Community Catalyst
First Focus
Georgetown University Center for Children and Families
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
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National Health Care for the Homeless Council

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