September 21, 2014

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

Dear Secretary Burwell:

We appreciate the opportunity to comment on the proposed Healthy Indiana Plan (HIP) 2.0 demonstration project.

While we support Indiana's decision to accept federal Medicaid funding to provide coverage to newly eligible low-income adults, we have significant concerns regarding the proposal. Our most significant concern is that the proposal includes several features that are outside the scope of what can and should be approved using section 1115 waiver authority.

In deciding whether to approve HIP 2.0 as proposed, it is important to consider the impact of the Affordable Care Act (ACA). Health reform's explicit pathway to coverage for low-income childless adults and parents with incomes up to 138 percent of the poverty line means that they are entitled to the same protections as other mandatory groups of Medicaid beneficiaries, even under a waiver. More broadly, the expansion of coverage in health reform broadened the purposes of Medicaid by making it a critical component of efforts to provide coverage to millions of uninsured Americans. As you continue discussions with Indiana, we hope you can take our concerns into account in your negotiations with the state on a final plan.

Indiana's proposal to impose premiums in the form of POWER account contributions on people with little to no income would significantly limit enrollment of eligible people.

Under Indiana's proposal, individuals enrolled in HIP Plus, regardless of income, would be required to make monthly premiums to obtain *and* maintain coverage. If approved, Indiana's plan would be the first Medicaid demonstration project approved since the creation of a mandatory group of low-income individuals (under section 1902(a)(10)(A)(i)(VII) of the Social Security Act), which would require adults with incomes below 50 percent of the poverty line to pay premiums. Charging premiums to people with very low incomes is not an appropriate use of demonstration authority, because experience already shows that premiums decrease enrollment of very low-income beneficiaries.

In fact, premiums have already been shown to limit enrollment of eligible people in HIP. Currently many HIP enrollees (23 percent as reported in the HIP 2012 evaluation) do not have to pay premiums as they have no income. The 2012 HIP evaluation also showed that 17 percent of those found eligible for HIP were never enrolled because they could not pay their initial premium. The original HIP program covered people with incomes up to 200 percent of the poverty line, but well more than half (69 percent) of those who did not enroll because of non-payment had incomes *below* the poverty line. Finally, of those who *did* enroll,

12 percent lost coverage because they failed to pay premiums, and 58 percent of those losing coverage had incomes below the poverty line.

Indiana's evaluation of its demonstration is not the only study that has demonstrated such results. Evaluations of Medicaid demonstrations in Oregon and Utah and of the state-funded Basic Health program in Washington also show the harmful effect premiums have in decreasing enrollment of otherwise eligible low-income people. Given the abundance of studies on this issue, including those that have evaluated Medicaid waivers with similar program features, Indiana's proposal to "test" how member compliance with required premiums promotes value-based decision making and personal health responsibility does not further the objectives of the Medicaid program, because it would prevent low-income adults from enrolling in or maintaining Medicaid coverage. As noted, the ACA broadened the role of Medicaid to be the pathway to coverage for low-income Americans. Provisions in demonstration projects that would keep people from enrolling in coverage should not be approved.

CMS should not approve Indiana's request to make coverage contingent on payment of an initial premium.

Indiana is requesting two separate waivers that will affect when a beneficiary's coverage becomes effective—one is a waiver of retroactive coverage, which is discussed later in our comments, and the other is a waiver that would allow the state to delay coverage for beneficiaries with incomes above the poverty line until the first day of the month following an individual's first contribution to his or her POWER account and to delay HIP Basic coverage for people with incomes under the poverty line until 60 days "following the date of eligibility." We assume that the intent of the proposal is to give people with incomes below the poverty line 60 days to make a POWER account contribution and only then to enroll them in HIP Basic.

Indiana's proposal requires individuals to remain without Medicaid coverage for up to 60 days until they make a premium payment. For individuals with incomes below the poverty line, this 60-day period of uninsurance makes little sense as they may know when they apply that the HIP 2.0 premiums are unaffordable and that they want to enroll in HIP Basic without waiting 60 days. Moreover, the 60-day requirement could result in a coverage delay of as much as *four* months given the time needed for the state to finalize the individual's application and then to enroll the individual in a health plan.

If coverage does not begin until two to four months after a low-income individual has applied, the individual will not be able to get his or her prescriptions covered in the interim and they may not be able to get other health care services they need. If they do receive care, health-care providers will not be able to receive reimbursement during this period. Delaying coverage in this manner does not further the objectives of the Medicaid program.

CMS should reject HIP 2.0's proposed 6-month lockout period for non-payment of premiums.

Indiana is proposing to impose a 6-month lockout period on individuals with incomes above the poverty line who fail to pay their premiums. Federal regulations at 42 CFR

447.56(b)(5) state that other than terminating eligibility if individuals fail to pay premiums for 60 days, no further consequences can be applied for non-payment. None of the recently approved expansion demonstrations – Arkansas, Iowa, Michigan and Pennsylvania – include a lockout period for non-payment of premiums. We urge you to deny this request, which also does not further the objectives of the Medicaid program.

Very low-income parents should not be shifted to HIP 2.0.

The state proposes to shift parents and caretaker relatives currently eligible as mandatory beneficiaries under section 1931 of the Social Security Act to HIP 2.0 from Hoosier Healthwise, the state's Medicaid program. These beneficiaries would be eligible to enroll in either HIP Basic, which has significant cost-sharing requirements, or HIP Plus, which requires monthly premium payments. Parents and caretaker relatives covered as mandatory beneficiaries in Indiana have incomes below 24 percent of the poverty line under the new Modified Adjusted Gross Income standard. Many in this group are likely to experience very high degrees of instability with housing and other basic needs as well as other forms of deprivation associated with severe poverty. Disrupting their current coverage, which is provided without premiums and significant cost-sharing, would not further the objectives of the Medicaid program. Instead it adds an unnecessary burden on parents living in extreme poverty and as discussed below, adds significant administrative complexity for the state.

The HIP 2.0 proposal does not offer a real "choice" for individuals with income below the poverty line.

Given the longstanding and robust body of evidence showing the negative effects of premiums and cost sharing on low-income beneficiaries, there is no basis to believe that the proposed HIP Basic and HIP Plus programs offer a real "choice" to people with incomes below the poverty line. The "choice" to forgo premiums and enroll in HIP Basic will likely cause barriers to care for some low-income people. As described earlier in this letter, premiums are already known to decrease participation in health coverage for low-income people. Research has also shown that cost sharing deters individuals from seeking care, including necessary care.[1] So for very low-income people the choice is between not enrolling at all or enrolling but not being able to afford necessary health care services.

We urge CMS to consider an alternative pathway to HIP Plus for people with incomes below the poverty line who wish to receive the additional benefits offered in HIP Plus but cannot afford to pay the premiums. One idea would be to require the completion of healthy behavior activities (such as filling out a health assessment form and scheduling an appointment with a primary care physician) within 6 months after being determined eligible. An alternative pathway such as this is consistent with the recent demonstration approvals in Iowa and Pennsylvania.

[1] Kaiser Commission on Medicaid and the Uninsured, "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings," February 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf.

Indiana's request to impose a mandatory $25 copay on people who receive health care services at the emergency room for non-emergencies is outside the scope of section 1115 waiver authority.

Indiana's request to impose a $25 mandatory co-pay on people who use the emergency room in non-emergency situations does not represent an appropriate use of section 1115 waiver authority for several reasons. First and foremost, the Secretary does not have authority under section 1115 to waive the cost-sharing protections specified in section 1916 of the Social Security Act. Waivers of cost-sharing provisions can only be approved under the separate waiver authority in section 1916(f). A state requesting such a waiver must meet the following five criteria:

1. The state's proposal will test a previously untested use of copayments;
2. The waiver period cannot exceed two years;
3. The benefits to the enrollees are reasonably equivalent to the risks;
4. The proposal is based on a reasonable hypothesis to be tested in a methodologically sound manner; and
5. Beneficiary participation in the proposal is voluntary.

Indiana would need to meet these criteria in order to impose the proposed mandatory $25 non-emergent use of the ER co-pay. The state's proposal does not meet several of these criteria – most notably the requirements that participation in the demonstration be voluntary, that the waiver last no more than two years, and that the waiver test a previously untested use of copayments. Several Medicaid waivers that expanded coverage to low-income adults prior to health reform, including the original HIP waiver, imposed non-emergent use of the ER copayments on waiver populations; therefore, Indiana's proposal does not test a previously untested use of such copayments.

Moreover, while the research on this type of co-pay is limited, it is questionable whether such a co-pay would promote the objectives of Medicaid (assuming the Secretary had the proper section 1115 authority to permit Indiana to impose such a co-pay). As with the use of premiums, there is a large body of research – going back to the 1970s – that demonstrates the harmful effects cost sharing has on utilization of care for low-income people, including the impact on appropriate uses of care *and* health outcomes. Cost sharing also poses significant financial strain on individuals that have limited resources. We urge CMS to deny the state's request unless it revises its proposal to comply with the requirements specified in section 1916(f).

Indiana's proposal to refer some HIP beneficiaries to work search programs is unnecessary and outside the scope of a Medicaid demonstration project

Indiana proposes to condition eligibility for non-disabled adults on a referral to the state's work search and training programs. This request is confusing since the state does not need a waiver to refer an individual to a job search program so long as participation is not a condition of eligibility.

CMS has rejected proposals from other states to make work or participation in a work search program a condition of eligibility. Pennsylvania proposed making work search a condition of eligibility for many adults working fewer than 20 hours a week, and then modified the proposal to charge different premiums to beneficiaries based on whether they are working or actively looking for work. Despite this modification, CMS rightly rejected Pennsylvania's request to charge different premiums to beneficiaries based on whether they are working or actively looking for work.

The Pennsylvania request was rejected because it is outside the scope of the Secretary's authority to approve demonstration projects under section 1115 of the Social Security Act. That is because demonstration projects must assist in promoting the objectives of the Medicaid program, which is to provide health care services to low-income and vulnerable people who can't afford the costs of the health care services they need. Programs aimed at connecting people to employment, however laudable, have no connection to the purposes of the Medicaid program.

Indiana's proposal should be rejected because it serves no demonstration purpose and is in no way connected to helping people access and maintain health coverage.

CMS should not waive the non-emergency transportation benefit (NEMT).

The state seeks to waive the requirement to offer non-emergency transportation benefits for the newly eligible in both HIP Basic and HIP Plus. We believe that waiving NEMT is short-sighted, because NEMT provides transportation to primary, specialty and preventive services for beneficiaries – thus enabling them to manage their health conditions before they worsen.

If CMS permits Indiana to limit this benefit in some way, we urge you to adopt language similar to the recent Pennsylvania Section 1115 Demonstration approval which sunsets the limitation after one year, and requires the state to "undertake efforts to ensure that PCO beneficiaries shall have the ability to utilize non-emergency transportation."

CMS should deny the state's request to waive retroactive eligibility.

As noted, Indiana requests a waiver to delay coverage for months after the determination of eligibility. The state is also requesting a waiver of retroactive coverage—the Medicaid requirement that coverage be provided for health care services provided up to three months prior to the individual's eligibility determination if the individual was eligible during the retroactive period. Indiana's request to waive retroactive eligibility for the newly eligible low-income adults puts newly eligible beneficiaries at risk of medical debt and providers at risk for bad debt. None of the recently approved expansion demonstrations – Arkansas, Iowa, Michigan and Pennsylvania – include such a provision, and we urge you to deny this request.

The complexity of benefit packages and benefit plans in HIP 2.0 will adversely affect enrollment and ability of beneficiaries to access care.

The extraordinary complexity of the HIP 2.0 proposal will make it difficult for beneficiaries, providers, plans and eligibility workers to navigate the program. In evaluating proposals like HIP 2.0, we urge the Secretary to ensure that proposals are consistent with section 1902(a)(19) of the Social Security Act, which provides that state plans must include:

> *" such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."*

HIP 2.0 categorizes persons newly eligible for Medicaid with incomes below 138 percent of the poverty line into five different groups based on their income and/or health status (i.e. medically frail or pregnant) and then assigns them three different benefit plan options. Low-income adults face categorization into a bewildering array of benefit plans and options that shift based on benefit category, premium payment history and other factors. As described further below, women becoming pregnant face a particularly confusing structure under HIP 2.0.

The three different benefit packages are assigned to the five different adult eligibility groups as follows:

1. An adult with income below the poverty line who pays premiums gets the enhanced HIP Plus benefit package If she does not pay premiums, she gets the HIP Basic benefit package.

2. An adult with income over the poverty line must pay premiums, and he receives the HIP Plus benefit package.

3. Pregnant women have a choice of HIP 2.0 or the Hoosier Healthwise program. If they choose HIP 2.0, they receive traditional state plan benefits and have their cost-sharing suspended.

4. Medically frail individuals with complex medical management and health needs with incomes at or below 138 percent of the poverty line will enroll in HIP Plus or HIP Basic depending on their income and payment of premiums, but they will receive traditional state plan benefits.

5. Parents and caretaker relatives who are mandatory beneficiaries under section 1931 of the Social Security Act will enroll in HIP Plus or HIP Basic depending on their income and payment of premiums and will receive traditional state plan benefits.

Thus, potential enrollees in HIP 2.0 will be sorted into five categories and receive three different benefit packages. Many beneficiaries will move between the categories and change benefit packages after enrollment based on changes in income, pregnancy status, and their medical conditions. The multitude of different benefit packages and plans will cause

confusion for beneficiaries and providers regarding what benefits are covered. This confusion will likely lead beneficiaries to have problems accessing necessary care and will unduly complicate eligibility determinations both at initial application and when changes occur.

The proposed healthy behaviors program further complicates the demonstration project.

CMS has allowed Iowa, Michigan, and Pennsylvania to pursue programs that provide incentives for healthy behaviors through reduced premiums and cost-sharing. Indiana proposes to implement a program in which beneficiaries who consistently contribute to their POWER accounts during the coverage year will be able to roll-over unused funds into the next coverage year. The proposal includes complex methodologies to calculate the roll-over amount – one methodology will be used for HIP Basic enrollees and a separate methodology will be used for HIP Plus enrollees. Regardless of which methodology is used, beneficiaries that have received all recommended preventive care services during the coverage year will be eligible to have their unused POWER account doubled. Depending on the size of the unused POWER account balance, a beneficiary could have their monthly premiums in the upcoming coverage year reduced or completely paid for.

Indiana's proposed roll-over incentive further complicates an already complex structure that includes two separate programs – HIP Basic and HIP Plus. Moreover, the roll-over incentive will likely discriminate against individuals with significant health care needs such as diabetes, hypertension, and serious mental illness as these individuals will have a smaller unused portion of their POWER accounts available to roll-over than individuals with low health care needs. It is these individuals – those with high health care needs – that would benefit most from a reduced, or zero, monthly premium. There is a real danger individuals will forgo needed medical care simply to keep a higher unused POWER account balance available to roll-over in order to reduce, or eliminate their monthly premiums.

Future premium assistance programs should not be established without meaningful public notice and comment.

Section 4.1.3 of the state's application describes an "Optional Defined Premium Assistance Program" the state intends to establish in 2016 pursuant to state law. The state makes clear that it will seek additional waiver authority (such as the ability to limit the provision of benefits and cost-sharing "wraparound" services) in Year 2 of the demonstration to establish this program known as "HIP Link." The state also intends to establish a premium assistance program for children pursuant to authority under the Children's Health Insurance Program Reauthorization Act of 2009, which would not require an amendment to the waiver, because participation would be voluntary.

While we understand that this issue is outside the scope of this waiver application, we are concerned that HIP Link would likely be proposed as a waiver amendment not subject to public process requirements specified in 42 CFR §§431.408 and 431.416. Given that the state has stated that it intends to limit benefits for those participating in the program, we believe that any such amendment should be subject to public notice and comment. Moreover, as we

have stated in the past, we urge CMS to apply public process protections to section 1115 waiver amendments making significant changes in approved demonstration projects.

Approval of the current proposal without ensuring public notice and comment for significant amendments that the state clearly intends to pursue at a later date violates the spirit of the notice and comment provisions in Subpart G of 42 CFR Section 431.

Additionally we are concerned that the state intends to establish a voluntary premium assistance program for children and families, including for children eligible for Medicaid, through state plan options that would allow them to elect Marketplace or employer coverage without any transparency or opportunity for public comment.

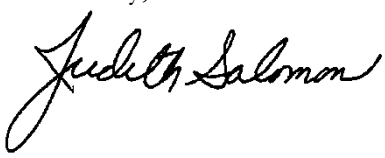
Our concerns about the direction Indiana is likely to take are compounded by the Governor's statements that he views traditional Medicaid is a "broken program." These statements raise questions as to whether choices beneficiaries will have between traditional public coverage and private coverage options in a "voluntary" premium assistance program will be presented in a fair and impartial manner.

Informed and impartial choice is critical when important benefits and cost-sharing provisions are at stake, particularly when states intend to potentially affect a child's entitlement to benefits available through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. The ESPDT program is not well understood by insurers and families alike, nor is it clear that providing wrap around services to ensure the receipt of EPSDT services works well.

Conclusion

Thank you for the opportunity to share our views. Please contact Judith Solomon at the Center on Budget and Policy Priorities or Joan Alker at the Georgetown University Center for Children and Families if you would like additional information.

Yours truly,



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