

September 6, 2019

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar:

The undersigned organizations appreciate the opportunity to comment on Indiana's request to amend its section 1115 demonstration project, or "waiver," known as the Healthy Indiana Plan (HIP). Many of our organizations submitted comments on earlier HIP proposals, most recently on July 6, 2017. At that time, we opposed Indiana's plan to take coverage away from people who didn't meet a work requirement. We also raised concerns regarding the continued use of premiums that have been shown to depress participation in Medicaid coverage. Earlier comments opposed a premium surcharge for tobacco users, emergency room co-payments, and taking coverage away from people who don't renew their coverage on time, among other things. You have approved all these coverage restrictions, and we still oppose them for the reasons stated in our previous comments, which we would like to incorporate by reference.¹

Indiana's current proposal would make minor changes to the work requirement by exempting members of federally-recognized Tribes and parents of children under age 13, and it would provide a \$1,000 account to pay for health expenses, premiums, and cost-sharing on behalf of enrollees who lose coverage when their earnings increase. These changes do nothing to address the problems that occur when states take coverage away from people who don't meet a work requirement as well as other HIP features that restrict coverage for HIP enrollees, all requirements that would remain unchanged notwithstanding the amendment.

Work requirements can't be fixed. They take coverage away from people who are already working and those who should be exempt. And they do nothing to increase employment among Medicaid beneficiaries.

The proposal attempts to "fix" work requirements by exempting parents with dependent children below age 13, as well members of federally recognized Tribes, but no Medicaid beneficiaries should have their coverage taken away for not meeting a work requirement. Taking coverage away from people who don't meet a work requirement is at odds with Medicaid's "central objective" of providing affordable health coverage to people who wouldn't otherwise have it, which means it's not an allowable use of Medicaid waiver authority under section 1115 of the Social Security Act, as the court found in vacating the Arkansas, Kentucky and New Hampshire waivers.

¹ Comments dated September 21, 2014 at <http://ccf.georgetown.edu/wp-content/uploads/2014/09/IN-HIP-2-0-Waiver-Sign-On-Letter.pdf>; Comments dated March 17, 2017 at <http://ccf.georgetown.edu/wp-content/uploads/2012/03/HIP-2.0-Comments-March-17.pdf>, and comments dated July 6, 2017 at <https://ccf.georgetown.edu/wp-content/uploads/2012/03/IN-Amendment-Comments-7-7-2017.pdf>.

But work requirements also fail on their own terms. Since we submitted our July 2017 comments, there is concrete evidence from Arkansas and New Hampshire showing that work requirements take coverage away from people who are already working and those who should be exempt, and that these unintended consequences can't be avoided. Before being halted by court action, over 18,000 Arkansans lost coverage, making up 23 percent of beneficiaries who were subject to the policy in 2018. A study by Harvard researchers found that the uninsured rate among low-income Arkansans aged 30-49 rose from 10.5 percent in 2016 to 14.5 percent in 2018, after the Medicaid policy took effect.²

Studies estimate that around 3 or 4 percent of those subject to Arkansas' work requirement were not working and did not qualify for exemptions. Yet each month, 8 to 29 percent of those subject to the requirement failed to report sufficient work hours, many of them not reporting any hours. And over 75 percent of those required to report hours — that is, those who were not automatically exempted by the state — failed to do so each month.³ The Harvard researchers' study cited above found no significant increases in employment, number of hours worked, or overall rates of community engagement activities among those subject to the work requirement.

New Hampshire suspended its policy to take Medicaid coverage away from people not meeting work requirements in July, recognizing that it was on pace to end benefits for nearly 17,000 out of roughly 25,000 enrollees subject to the work requirement.⁴ Since then, the policy has been halted by court action. New Hampshire policymakers had said that they would avoid the significant coverage losses that occurred in Arkansas, but the state experienced similar problems communicating with enrollees about the policy. Despite its multiple outreach activities, such as mail notifications, town halls, phone calls, and text messages, the state failed to reach 20,000 out of the 50,000 people potentially subject to the requirement to inform them about the new policy.

The bottom line is that work requirements don't work, and they can't be fixed. All work requirements will have the unintended consequences of taking coverage away from people who are already working or who should be exempt from the requirement based on disability or chronic illness. Moreover, Medicaid work requirements will not increase employment or improve health outcomes, contrary to the Administration's claims. Indiana's work requirement should not be allowed to continue.

Indiana should not be allowed to spend Medicaid funds on short-term plans and other forms of inadequate coverage for people who are no longer eligible for Medicaid.

Indiana wants to establish yet another account, the HIP Workforce Bridge Account, through its proposed amendment. These accounts will provide \$1,000 to HIP enrollees who lose coverage due

² Sommers et al., "Medicaid Work Requirements — Results from the First Year in Arkansas," *New England Journal of Medicine*, June 2019, <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772>.

³ Jennifer Wagner, "Commentary: As Predicted, Arkansas' Medicaid Waiver Is Taking Coverage Away From Eligible People," Center on Budget and Policy Priorities, Updated June 28, 2019, <https://www.cbpp.org/health/commentary-as-predicted-arkansas-medicaid-waiver-is-taking-coverage-away-from-eligible-people>.

⁴ New Hampshire Department of Health and Human Services Community Engagement Report, June 2019, <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>.

to increased earnings by using unspent funds from beneficiary POWER Accounts for which the state received 90 percent matching funds. The accounts could be used during the 12 months following HIP disenrollment to pay for unreimbursed health expenses that would be covered if those losing Medicaid were still enrolled as well as premiums, and cost-sharing charges incurred while in “commercial insurance.”

Indiana seeks to make individuals receiving the accounts eligible for Medicaid under the optional coverage group for adults with incomes over 138 percent of the poverty line, which was enacted in the ACA.⁵ But the group Indiana seeks to cover does not meet the criteria for this coverage group, because the state has not—and likely cannot—guarantee that it will not cover higher income individuals without covering lower income individuals and that it will ensure that children of those receiving coverage are enrolled in Medicaid, CHIP, or other minimum essential coverage.

The state proposes to allow funds in the accounts to pay for “commercial insurance” coverage but does not specify that the coverage must be ACA-compliant. We are concerned that these accounts, funded by Medicaid dollars, could be used to pay for premiums and cost-sharing for people who are no longer eligible for Medicaid and who are enrolled in sub-standard health plans.

CMS should not permit Medicaid funds to be used to purchase subpar health coverage such as short-term health plans for ineligible people. Short-term plans don’t have to cover all of the ACA’s essential health benefits, and they often don’t cover such essential benefits as maternity and mental health care, substance use disorder treatment, and prescription drugs.⁶ They can also deny coverage or charge higher prices to people with pre-existing conditions, they typically don’t cover medical services related to a pre-existing condition, and they frequently pay out very little for medical claims compared to what enrollees must pay in premiums.⁷ Such plans are particularly inadequate for low-income people and would put their financial and health security at risk.

The proposed accounts also raise significant program integrity concerns that the state has failed to address. They have to be established and maintained; eligible individuals will have to be notified; provider claims filed with the accounts will have to be “run against allowable services under Medicaid” and, if payable, processed; member requests for reimbursement will have to be reviewed for validity. It’s not clear whether the state will contract out these functions or conduct them in-house, and what the administrative costs will be to the state and federal governments. Indiana also hasn’t specified how it would oversee the accounts to ensure proper disbursement of Medicaid funds.

Moreover, the state’s claim that providing the accounts wouldn’t affect budget neutrality appears to conflict with earlier assertions. In its 2015 proposal to fund \$2,500 accounts for each HIP beneficiary, Indiana’s actuaries stated that amounts left in the accounts would be rolled over to the

⁵ Section 1902(a)(10)(A)(ii)(XX) of the Social Security Act; 42 CFR 435.218.

⁶ Karen Pollitz, Michelle Long, Ashley Semanskee, and Rabah Kamal, “Understanding Short-Term Health Insurance,” Kaiser Family Foundation, April 23, 2018. <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>

⁷ Shelby Livingston, “Short-term plans spend little on medical care,” Modern Healthcare, August 6, 2019. <https://www.modernhealthcare.com/insurance/short-term-health-plans-spend-little-medical-care>

next year and reduce the amount the state would have to spend to fund them the next year.⁸ Now the state is proposing to use the accounts for another purpose, which would appear to increase state expenditures and thereby affect the state's budget neutrality calculations.

In closing, we note that our comments include citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

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

Autistic Self Advocacy Network
Center for Law and Social Policy
Center on Budget and Policy Priorities
Children's Defense Fund
Community Catalyst
Families USA
Family Voices Indiana
First Focus on Children
Georgetown University Center for Children and Families
Guttmacher Institute
Justice in Aging
March of Dimes
National Alliance on Mental Illness
National Association of Pediatric Nurse Practitioners
National Employment Law Project
National Health Care for the Homeless Council
National Multiple Sclerosis Society
Raising Women's Voices for the Health Care We Need
Service Employees International Union

⁸ Milliman, 1115 Waiver – Healthy Indiana Plan Expansion Proposal Budget Neutrality Projections, June 23, 2014, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Expansion-Proposal-06232014.pdf>