

March 20, 2020

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

Re: Proposed Extension of Healthy Indiana Plan Section 1115 Demonstration Project

Dear Secretary Azar,

The undersigned organizations appreciate the opportunity to comment on Indiana’s proposal for a ten-year extension of its section 1115 demonstration project, called the Healthy Indiana Plan (HIP). Approving a ten-year extension of HIP would exceed your authority, because federal law limits extensions to three years. Moreover, as our comments explain below, the demonstration should not be extended for even three years, because it does not promote the objective of the Medicaid statute to provide affordable coverage. HIP has been in operation in its current form since 2015, and Indiana’s own evaluations show that it has limited participation and services below what they would be absent the demonstration. We request that our comments be read by a Centers for Medicare and Medicaid Services employee.

The Social Security Act Limits Extensions of Section 1115 Demonstration Projects to Three Years

Section 1115 of the Social Security Act (the “Act”) allows the Secretary to approve state demonstration projects that promote the objectives of Medicaid. The statute is silent on the length of initial approvals although demonstrations are generally approved for no more than five years. In contrast, subsections (e) and (f) of section 1115 are clear that initial and subsequent extensions of an approved demonstration are limited to three-year periods.

Despite the clear direction from Congress that extensions be limited to periods no longer than three years, the Centers for Medicare & Medicaid Services (CMS) issued guidance in November 2018, stating that CMS “may approve the extension of routine, successful, non-complex section 1115(a) waiver and expenditure authorities in a state for a period up to 10 years.” Indiana claims a ten-year extension is justified “based on the long-tenure and demonstrated success of HIP.”

Section 1115 clearly prohibits an extension of HIP for longer than three years, so Indiana’s request for a ten-year extension cannot be approved. Absent a statutory prohibition on extensions longer than three years, Indiana’s 10-year extension request would still have to be denied under CMS’ policy, because as shown below it is very far from being a “successful, non-complex” demonstration. Over the course of the demonstration, its features have been shown to limit participation in coverage and make it harder to get care.

HIP Does Not Promote the Objectives of the Medicaid Statute

As noted, section 1115 allows states to implement demonstration projects that promote the objectives of the Medicaid program. The United States Court of Appeals for the District of Columbia recent decision in *Gresham v. Azar* held that the “statute and the case law demonstrate that the primary objective of Medicaid is to provide access to medical care,” rejecting alternative objectives put forward by your agency that related to achieving better health outcomes as lacking textual support in the statute. Among the alternative objectives explicitly rejected by the court was whether the demonstration “would incentivize beneficiaries to engage in their own health care and achieve better health outcomes,” -- the central objective Indiana has claimed for HIP since its inception in 2008. This objective was reinforced by the state when HIP was continued as Indiana’s vehicle to implement Medicaid expansion in 2015.

Indiana lists five goals in its HIP extension request:

- Provide timely and geographically appropriate access to healthcare services;
- Promote appropriate utilization of healthcare by maintaining low, inappropriate use of the emergency department and supporting utilization of needed services from qualified nonemergency providers;
- Promote control of chronic conditions, delivery of needed care, and an increase in member health and wellbeing;
- Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency; and
- Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.

While the first and part of the last goal (reducing the number of uninsured Hoosiers and decreasing gaps in coverage) are consistent with Medicaid’s primary objective, the remaining goals are outside Medicaid’s purposes.

But determining whether a demonstration project promotes the objectives of Medicaid is only the first step. The next question is whether waiving provisions of the Medicaid statute is necessary to carry out the demonstration project. The features of HIP that Indiana wants to extend do not promote the goal of coverage and access to care nor are the waivers the state seeks necessary to insure access to coverage and care. In fact, the key features of HIP, including its premium and copay structure, lockouts for not renewing coverage on time, tobacco surcharge, and work requirements have already been shown to make it less likely that people will receive both coverage and care.

Indiana’s Work Requirement Will Lead to Thousands Losing Coverage and Should Not be Extended

Indiana’s work requirement launched in 2019, but the state suspended implementation after it was challenged in a lawsuit, which is still pending. Given the appeals court decision in *Gresham v. Azar*, finding Arkansas’ work requirement did not promote the objectives of Medicaid, the Indiana plaintiffs’ case is likely to be successful.

Work requirements lead to loss of coverage of eligible people who are already working or should be exempt, a result that can't be avoided. In Arkansas, more than 18,000 people — nearly 1 in 4 of those subject to work requirements — lost coverage over the course of just seven months. In New Hampshire, almost 17,000 people, or about 40 percent of those who would have been subject to work requirements, would have lost coverage had state policymakers not put the policy on hold. In Michigan, almost 80,000 people were at risk of losing coverage before a court put its policy on hold, with the state joining in the plaintiff's request.

Indiana appeared to be on a path similar to Arkansas, New Hampshire and Michigan, with small numbers of people reporting work or work-related activities and large numbers of people at risk of losing coverage. According to the interim evaluation, while reporting was still voluntary, only one percent of those who would later be required to report had done so through June 2019.

Based on data in the interim evaluation, 97,000 beneficiaries would be required to complete work activities in order to remain enrolled in coverage. Applying Arkansas' coverage loss ratio of 23% would result in approximately 22,000 people in Indiana losing coverage. The appeals court decision clearly affirmed, "The district court is indisputably correct that the principle objective of Medicaid is providing health care coverage."¹ Indiana's request to extend its work requirement, which will result in the loss of coverage for thousands of beneficiaries, falls well short of promoting the principle objective of Medicaid.

Indiana Shouldn't 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

We provided detailed comments in September 2019 opposing Indiana's request to establish a Bridge Account, which would provide \$1,000 to HIP enrollees who lose coverage due to increased earnings by using unspent funds from beneficiary POWER Accounts (for which the state received 90 percent matching funds). We incorporate those comments here.²

The state proposes that the new 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.³ 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,

¹ *Gresham v. Azar*, United States Court of Appeals for the District of Columbia Court, No. 19-5094, February 14, 2020.

² Our previous comments can be found at https://ccf.georgetown.edu/wp-content/uploads/2019/09/Indiana_SignOn_Letter_FINAL.pdf

³Section 1902(a)(10)(A)(ii)(XX) of the Social Security Act; 42 CFR 435.218.

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, including short-term plans that 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. They can also deny coverage or charge higher prices to people with pre-existing conditions.⁴

Indiana's Evaluation Shows There is Nothing Left to Demonstrate

The state's own evaluation of its current demonstration confirms what previous research has shown: that premiums reduce coverage and that copayments reduce the use of medically necessary services by program beneficiaries. Indiana wants to extend its current demonstration for ten years, but as described below, the evidence is clear that premiums and copayments decrease participation and impede access to care – there is nothing left to demonstrate.

The extension request includes continuing the existing POWER Account structure, which provides two types of coverage: HIP Plus and HIP Basic depending on people's income and whether they pay premiums. People with incomes above the poverty line enroll in Plus and must pay a monthly premium or lose coverage. If people with incomes below the poverty line don't pay their premiums, they are moved from Plus to Basic, which offers fewer benefits and requires copayments for most forms of care.

Premiums Are Decreasing Participation in Coverage

The interim evaluation submitted with Indiana's extension request confirms the findings of previous evaluations showing that HIP's structure has reduced participation, although it omits a key metric—how many people never enroll because they fail to pay a premium.

- The 2016 interim evaluation of HIP found that one-third of individuals who apply for HIP coverage and are found eligible are not enrolled, because they don't make a premium payment.⁵ Despite this alarming finding, the current interim evaluation does not include data on people who never enrolled.
- A separate assessment of the POWER Accounts in 2017 found that 55 percent of eligible individuals either didn't make their initial payment or missed a payment. Of those who missed a payment, 44 percent said they couldn't afford the premium.⁶
- The interim evaluation accompanying Indiana's extension request shows that in 2018, almost 6,000 individuals were disenrolled from coverage for failure to pay initial premiums into HIP Plus, including individuals on HIP Basic whose incomes increased above the poverty line. (This does not include people who were never enrolled for non-payment as noted above.) An

⁴ 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/>.

⁵ The Lewin Group, "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," July 6, 2016, https://www.in.gov/fssa/files/Lewin_IN%20HIP%20202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

⁶ 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>.

additional 5,500 individuals with HIP Plus benefits were disenrolled and locked out of coverage for six months for non-payment.

Indiana's experience is consistent with extensive research (including research from Medicaid demonstration projects conducted prior to the enactment of the Affordable Care Act (ACA)) showing that premiums significantly reduce low-income people's participation in health coverage programs. These studies show that the lower a person's income, the less likely they are to enroll and the more likely they are to drop coverage due to premium obligations. People who lose coverage most often end up uninsured and unable to obtain needed health care services.⁷

Indiana's premiums appear to be affecting overall enrollment, according to a study in *Health Affairs*.⁸ Indiana's coverage gains under the ACA were smaller than in neighboring states like Illinois, Kentucky, Michigan, and Ohio, which also expanded Medicaid, but do not terminate coverage for people who fail to make premium payments or impose a waiting period before enrollment.

Moreover, Indiana's experiment is having a disparate impact on African Americans who, according to the current interim evaluation, are more likely to lose coverage than other participants. They also had a higher likelihood of moving from Plus to Basic coverage and were more likely to be enrolled in Basic, which as explained below likely led to lower utilization of care. Despite the evaluation's findings, the new application does nothing to address the negative effects the demonstration has had on African American beneficiaries.

The impact of Indiana's premiums will likely be exacerbated by the tobacco surcharge premium imposed on people who smoke. According to the evaluation, only one percent of people have had to pay the premium surcharge so far, because it is imposed after people self-identify as tobacco users over a 12-month period of enrollment with the same managed care organization. That number is likely to increase and likely lead to decreased participation in coverage and decreased use of care as people end up leaving HIP Plus for Basic.

As we wrote in earlier comments, the tobacco surcharge is not likely to have the desired effect of encouraging people to quit.⁹ Evidence shows that a tobacco surcharge does not reduce tobacco use; rather, it has negative side effects like reduced insurance take-up.¹⁰

HIP Copayments Reduce Use of Necessary Care

People enrolled in HIP Basic must pay copayments for physician's visits, prescription drugs and other services. Extensive research shows that even relatively low co-payments (\$1 to \$5 range) are

⁷ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings," The Kaiser Family Foundation, June 2017, <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

⁸ Seth Freedman, Lilliard Richardson, and Kosali Simon, "Learning From Waiver States: Coverage Effects Under Indiana's HIP Medicaid Expansion," Health Affairs, June 2018, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1596>.

⁹ Our earlier comments can be found at <https://ccf.georgetown.edu/wp-content/uploads/2012/03/HIP-2.0-Comments-March-17.pdf>.

¹⁰ Abigail Friedman, *et al.*, "Evidence Suggests That the ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation," *Health Affairs*, July 2016, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1540>.

associated with reduced use of care, including necessary care.¹¹ The HIP experience and the state's own evaluation confirms the findings of previous research. The current interim evaluation, like the previous evaluation, found HIP Plus members were more likely to use primary, specialty, preventive and urgent care than Basic members. Indiana acknowledged that HIP Basic members “found the copayments a disincentive to seeking appropriate care, particularly in filling prescriptions and getting primary care,” and expressed concern for “the potential that HIP Basic copayments are contributing to this difference.” Yet the state is maintaining the current design of HIP in its 10-year extension request.

While HIP Plus members had higher utilization of preventive, primary and specialty care, this didn't translate to lower utilization of the emergency room for non-emergency reasons. Rates of utilization for non-emergency reasons were similar for Basic and Plus in 2018 (20.5 percent in Basic and 19.6 percent in Plus) and also for visits for emergencies that would be treatable in a primary care setting (25.7 percent in Basic and 25.6 percent in Plus). The high rates of emergency room use suggest that there are barriers to care even for Plus members. This is confirmed by a study comparing Indiana with neighboring expansion state Ohio, where survey respondents reported more difficulties affording care.¹²

Conclusion

Our comments include numerous 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 need additional information, please contact Judith Solomon (solomon@cbpp.org) or Joan Alker (jca25@georgetown.edu).

Autistic Self Advocacy Network
Center on Budget and Policy Priorities
Children's Defense Fund
Community Catalyst
Epilepsy Foundation
Families USA
Family Voices Indiana
First Focus on Children
Georgetown University Center for Children and Families
HIV Medicine Association
Justice in Aging

¹¹ Artiga, *et al.*

¹² Benjamin D. Sommers, *et al.*, “New Approaches in Medicaid: Work Requirements, Health Savings Accounts, and Health Care Access,” *Health Affairs*, July 2018, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0331>.

National Alliance on Mental Illness
National Employment Law Project
National Health Care for the Homeless Council
National Multiple Sclerosis Society
Professor Pamela Herd, Professor of Public Policy, Georgetown University
Raising Women's Voices for the Health Care We Need
United Way Worldwide