FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

September 19, 2014

The Honorable Sylvia Matthews Burwell, Secretary
United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

By E-Mail to: Sylvia.Burwell@hhs.gov

Re: Comments on HIP 2.0 1115 Waiver Application

Dear Secretary Burwell:

Families USA is grateful for the opportunity to comment on the state of Indiana's Healthy Indiana HIP 2.0 1115 waiver request to modify and expand eligibility for its existing Medicaid Healthy Indiana Plan (HIP).

We are a national healthcare advocacy organization with the mission of supporting policy changes that will expand access to affordable healthcare for all Americans. We are committed to seeing Indiana expand Medicaid eligibility and we support Indiana's decision to accept federal funding to extend Medicaid coverage to more low-income parents and adults without dependent children.

However, we believe that the program envisioned by Indiana includes components that set extremely troubling precedents for the Medicaid program, and for future Medicaid expansions, including components that are contrary to the program's objectives and that would greatly diminish Medicaid enrollees' ability to access health care.

Our concerns are discussed in greater detail below. We believe that these concerns can, and should, be addressed during the waiver approval process.

The framework for evaluating the waivers requested

In its waiver application, Indiana presents its HIP 2.0 proposal within the context of its existing Healthy Indiana Plan and the accomplishments of that 1115 demonstration. While the achievements of that demonstration are notable and informative, the HIP 2.0 waiver request relates to different sections of Social Security Act than the existing HIP program. The HIP 2.0 waiver request should be evaluated within that context.

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The waivers granted in Indiana's existing HIP program relate to the state's traditional Medicaid plan. The HIP 1.0 demonstration offers coverage to adults not covered under that plan. Coverage and benefits are provided at the state's standard federal matching rate.

In contrast, the HIP 2.0 application relates to the opportunity that states have under the Affordable Care Act to extend Medicaid coverage to all adults under 65 with incomes up to 138 percent of poverty, and to provide that coverage at a significantly higher federal matching rate.[1]

The HIP 2.0 waiver request is not a waiver to extend Medicaid coverage to a new population not covered by the Medicaid program. It is a request to alter Medicaid coverage available under the Affordable Care Act. In weighing whether specific waivers requested in the HIP 2.0 application do or do not meet the requirements of Section 1115 of the Social Security Act and assist in promoting the objectives of Medicaid, we urge that the guide be the legislative objectives for Medicaid within the context of the Affordable Care Act, Section 2001, be the guide.

Eligibility

Referral to employment services should not be a condition of eligibility.
Indiana proposes providing HIP enrollees with a referral to employment services if they work part time or do not work. We do not have concerns with Indiana providing Medicaid enrollees with information about available employment services. We encourage states to let applicants for one social service learn about other services that are available to them. However, we are deeply concerned by the language that Indiana included in section 8.1 of its application, Title XIX Waivers. In that section, Indiana requested that referral to employment services be a condition of eligibility "to the extent necessary." Referral to employment services should not be a condition of Medicaid eligibility under any circumstances. Indiana's open-ended request to include this "to the extent necessary" should not be approved.

HHS did not approve Pennsylvania's request to link premium amounts to work or participation in job search activities. Similarly, it should not give Indiana any flexibility to predicate Medicaid eligibility on receipt of a referral to employment services.

- ***We do not believe that the Secretary has the authority to waive eligibility requirements based on an employment referral.*** Although the Medicaid expansion is optional for states, once a state has made the choice to expand, in order to receive the enhanced federal match, it must cover the expansion population consistent with the requirements of section 1905(y) of the Social Security Act. Section 1115 of the Social Security Act does not give the Secretary authority to waive any of the requirements of section 1905, which requires that a

[1] Patient Protection and Affordable Care Act, Section 2001, Medicaid Coverage for the Lowest Income Populations; populations covered outlined at Social Security Act section 1902(a)(10)(A)(i)(VIII) and the matching rate outlined Social Security Act section 1905 (y).

state cover newly eligible individuals outlined in 1902(a)(10)(A)(i)(VII), without regard to factors other than those outlined in that section. Therefore, we believe that the Secretary does not have the authority to waive eligibility requirements based on whether an individual does or does not receive an employment referral.

- ***Even if the Secretary had the authority to waive eligibility for certain individuals in the expansion population, the link between employment and the purpose of the Medicaid program is insufficient to meet the requirements of Section 1115***. In its waiver application, Indiana cites research noting that employed individuals are healthier mentally and physically. The cited research may be true, but it is not relevant for purposes of making a determination of whether or not to grant the waiver request.

  The mere presence of a link between an activity, in this case employment, and health does not create a sufficient connection for the activity to promote the objectives of the Medicaid program, which is to provide medical assistance to low-income Americans.[2] Starting down the path of linking elements of the Medicaid program to activities or conditions unrelated to Medicaid's purpose sets a precedent that could ultimately undermine the program's effectiveness in meeting its objective of providing medical assistance to low-income people.

- ***There are many reasons an individual may not receive a "referral" to employment that are outside of an applicant's control and should have no bearing on eligibility.*** In addition, the request to condition eligibility on a referral to employment services "to the extent necessary" is inappropriate. Receipt of a referral to services is an administrative function. While it is unclear how referrals will be provided, we assume that it will be either through online or in person applications. There are many reasons an applicant might not receive a referral that are outside of the applicant's control, from an oversight on the part of the person processing the application to a computer glitch. Requiring applicants to have to correct foreseeable errors of this type before being considered eligible is an inappropriate barrier to care.

Premiums and Non-Payment Penalties

CMS should consider Indiana's proposed POWER Account contributions to be premiums for purposes of evaluating the state's waiver requests.

Indiana proposes charging monthly fees that will be placed into individual POWER Accounts, which are akin to Health Savings Accounts. Payments into those accounts will be used to help individuals meet HIP 2.0's deductible.

[2] Employment is among many things that are associated with improved health but are unrelated to the Medicaid program. Other examples include things as diverse as housing quality and educational attainment.

As monthly payments that must be made, regardless of services used, to retain coverage (or, for individuals under 100 percent of poverty, to retain benefits of HIP Plus), POWER Account contributions function as premiums. CMS should consider these payments to be premiums for purposes of evaluating the state's associated waiver requests. We will be referring to the payments as premiums throughout the remainder of our comments.

Premiums should not be part of Medicaid expansion 1115 waiver approvals. Ample evidence exists to show that premiums are a barrier to coverage.

There is ample evidence that imposing premiums on Medicaid beneficiaries limits both initial enrollment and enrollees' ability to retain coverage. There is little demonstration value in adding premiums to Medicaid expansion programs.

- ***Premiums negatively affect coverage retention even among higher income Medicaid enrollees.*** In July 2012, Wisconsin added or increased premiums for some adults enrolled in its Medicaid program, BadgerCare. Enrollees with incomes between 133% and 150% of poverty who had previously had no premium costs were required to pay three percent of their income in premiums. Preliminary analysis showed that premium payments had a negative effect on the ability of these low-income enrollees to maintain coverage. From July through September 2012, there was a 24 percent enrollment reduction due to non-payment of premiums for those in the 133 to 150 percent of poverty income group. [3] Wisconsin's premium payment was a comparable percent of income to the premium levels proposed in the Indiana application.[4] However, Indiana is proposing to impose these premiums on a much lower income population (0 to 138 percent of poverty). The premiums proposed in Indiana would be a significant financial burden relative to income, inevitably resulting in program drop-out and depressed enrollment.

- ***Premiums negatively affect enrollment***. A study of multiple Medicaid programs in which premiums were imposed found that for low-income families, premiums as low as one

[3] For analyses of the BadgerCare results see: "State of Wisconsin Department of Health Services Wisconsin Medicaid Premium Reforms: Preliminary Price Impact Findings," available online at: http://www.dhs.wisconsin.gov/MAreform/report12.11.12.pdf Wisconsin Council on Children and Families, "Evaluation of Last Year's BadgerCare Changes Makes Strong Case Against New Waiver," September 4, 2013, available online at: http://wccf.org/pdf/BadgerCare_changes_evaluation.pdf.

[4] Indiana's proposed premiums are a flat rate based on income bands, not a consistent percent of income. While the percent of income varies, it frequently exceeds 2% of income. For example, while the premiums proposed would be 1.9% of income for a single individual at 138% of poverty, they would be 2.5% of income for someone at 101% of poverty, 3% of income for someone at 51% of poverty, and 3.6% of income for someone at 23% of poverty.

percent of income are associated with decreased enrollment.[5] The premiums proposed in HIP 2.0 would exceed 2 percent of income for many enrollees (see footnote 4).

- ***Indiana's own evaluation of its HIP program confirms that premiums are a barrier to enrollment, particularly for the lowest income enrollees***. A 2012 HIP evaluation found that 17 percent of those found eligible for HIP were never enrolled because they could not pay their first month's premium. This evaluation shows that premiums payments are a hardship even at higher income levels—a the time of the evaluation, HIP eligibility was up to 200 percent of poverty—but impose a particular hardship at lower income levels. More than half of enrollees (69 percent) of people who did not enroll were below the poverty line. Of the population that did enroll, 12 percent lost coverage because of failure to pay premiums and over 50 percent of these enrollees were below the poverty line.[6]

Indiana's request to impose premiums at all income levels should not be approved.
If premiums are approved, they should not be approved for the lowest income enrollees, as Indiana requests.

- ***If premiums are approved for HIP 2.0, they should not apply to individuals with incomes below 100 percent of poverty.*** While we believe that premiums should not be approved as part of Medicaid expansion waivers, if they are, they should be limited to individuals with incomes above the poverty level. Even though Indiana is not proposing a disenrollment penalty for non-payment for individuals with incomes below 100 percent of poverty, the mere presence of premiums will discourage enrollment, as is shown by Indiana's own program data on enrollment and program drop-out among this group.

- ***Premiums should absolutely not be approved for individuals with incomes below 50 percent of poverty.*** Premiums for individuals with incomes below 50 percent of poverty are completely contrary to the goals of the Medicaid program. If premiums are approved below that level, this would be the first such approval since the creation of a mandatory low-income adult group under section 1902(a) (10)(A)(i)(VII) of the Social Security Act. As outlined above, there is little demonstration value in imposing premiums on any low-income Medicaid beneficiaries, but this is particularly true for the lowest income individuals. Imposing premiums on individuals below 50 percent of poverty serves no demonstration function and is an inappropriate use of waiver authority.

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[5] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 2005, available online at http://www.cbpp.org/files/5-31-05health2.pdf.

[6] Healthy Indiana Plan Demonstration, Section 1115 Annual Report, Demonstration Year 5 (1/1/12-12/31/12) http://www.in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf

- ***If premiums are included below 100 percent of poverty, the program should include a hardship exemption with self-attestation.*** At the least, individuals with incomes below poverty should have easy access to a hardship exemption. Preferably, such an exemption would be available at all income levels.

Premium amounts requested are too high and should not be approved at the level requested. If premiums are approved, the amounts requested are too high. Any amounts approved should be consistent with prior Medicaid expansion waiver approvals.

- ***For individuals with incomes above the poverty level, premium amounts should not be greater than what those individuals would pay in the Marketplace and should be consistent with what CMS has already approved.*** If premiums are imposed for enrollees with incomes over 100 percent of poverty, the flat rate proposed in HIP 2.0 is too high. For example, at the lowest income level (101 percent of poverty), the proposed flat rate is 2.5 percent of income for a single individual. This is higher than premium costs for individuals with comparable incomes in the Marketplace, where the maximum premium for individuals with incomes at 100 percent of poverty is 2 percent of income. That level is also consistent with other expansion waiver approvals that include premiums payments.

- ***Premium amounts requested for individuals with incomes below poverty are too high.*** If premiums are approved for individuals with incomes below poverty—and again, we strongly urge they not be—the amounts requested are far too high. If premiums are approved for individuals with incomes below poverty, they should be significantly less than 2 percent of income, consistent with the graduated premium structure of the Marketplace, where premiums are a lower percent of income as income declines. Between 50 and 100 percent of poverty, Indiana proposes two flat rates, one for people between 51-75 percent of poverty and another for people between 76-100 percent of poverty. At the lowest end of the range, both proposed flat rates are more than two percent of income (at 51% percent of poverty, premiums are over 3 percent and at 76% of poverty premiums are over 2.5%). This amount is much too high for this very low-income group.

- ***Premiums should not be approved for any individuals with incomes below 50 percent of poverty.*** These extremely low-income people cannot afford even very low premiums and any premium amount represents a financial hardship.

Disenrollment for non-payment, particularly with lockout periods, should not be approved. Indiana proposes disenrollment penalties, with a 6-month lockout period, for individuals over 100 percent of poverty who fail to make their premium payments. We do not believe that disenrollment penalties should be approved. However, if they are, they should not include lockout periods. None of the recently approved expansion waivers that included premiums—Iowa, Michigan or

Pennsylvania—have included a lockout period for premium non-payment. We urge you to deny this request. Lockout periods do nothing to further the objectives of the Medicaid program.

The non-payment grace period is too short.
Indiana is requesting approval to disenroll individuals with incomes above poverty if they do not pay premiums for 60 days. This grace period is too short. If disenrollment is allowed, the grace period should be at least as long as the Marketplace grace period of 90 days. CMS has not approved requests for shorter grace periods in other states' expansion waiver requests and should not do so here.

CMS should reject Indiana's proposal to require premium payment before providing coverage.
Indiana's proposal requires individuals to make a premium payment before coverage can begin. If an enrollee under 100 percent of poverty FPL fails to pay their premium, they will remain uninsured for 60 days, at which time they will be enrolled in premium-free HIP Basic. Individuals above 100 percent of poverty will remain uninsured until they make their first premium payment.

- ***For the lowest income enrollees, this requirement will be comparable to a waiting period.*** It is completely predictable that many of the applicants with incomes below poverty will not be able to make their first premium payment. For them, the proposed delay in coverage will create what is essentially a 60-day waiting period. An enrollment waiting period is in direct conflict with the requirements of 42 CFR 435.914. The requirements of this section should not be waived as this 60 day waiting period poses a barrier to coverage that does not further the objectives of the Medicaid program.

- ***For higher income applicants, this requirement will be comparable to a lockout.*** Individuals over 100 percent of poverty who are unable to afford premiums will not be able to enroll in Medicaid coverage to which they are entitled at all. The requirement of premium payment before enrollment presents an impermissible access barrier akin to a lockout period for non-payment of premiums. CMS rejected Pennsylvania's proposal to impose premium non-payment lockout periods and should apply the same logic to Indiana's request that a first premium payment be mandatory before coverage can begin.

- ***Premium prepayment requirements will predictably discourage many from initially applying.*** In its wavier application, Indiana cites an evaluation of its existing HIP program that shows that most people who are "conditionally eligible" make their first POWER Account payment. However, that is not entirely relevant. The HIP program has limited enrollment and eligibility restrictions, such as an unemployment requirement, that further limits the pool of applicants. HIP 2.0 will not have such restrictions. It is difficult to generalize from the target population of HIP to the target population of HIP 2.0. Additionally, it is unclear how many potential applicants did not attempt to enroll because

of HIP's pre-payment requirement. For HIP 2.0, with its larger eligibility base, a pre-payment requirement will likely keep many from applying.

- ***Required pre-payments will likely discourage healthier individuals from enrolling.*** Furthermore, it is likely that the pre-payment requirement would result in adverse selection, with younger and healthier individuals not enrolling until they become sick. In fact, there is some evidence of adverse selection in the current HIP program. In that program, enrollment for individuals under 30 is comparatively low.[7] Establishing a system that will predictably result in adverse selection is not consistent with Medicaid's objectives or the stated objectives of HIP 2.0.

Retroactive Eligibility

CMS should reject Indiana's request to waive mandatory three-month retroactive eligibility. Indiana's request to waive Section 1902(a)(34) of the Social Security Act, which requires three months retroactive coverage for newly eligible individuals, does not provide any demonstrative value and the state provides no justification for its request. It is difficult to ascertain how a waiver of retroactive eligibility would further the purposes of the Medicaid program, especially in light of application and denial of this provision in Iowa and Pennsylvania. The waiver of retroactive eligibility puts newly eligible beneficiaries at risk for medical debt and providers at risk for bad debt and represents a potentially serious hardship to both groups. A request to waive retroactive eligibility was denied in Iowa and Pennsylvania and should likewise be denied in Indiana.

Benefits

The structure of the HIP Plus and HIP Basic benefits does not further the objectives of the Medicaid program. Indiana is proposing a benefit structure in which individuals with incomes below poverty who cannot pay premiums are placed in a plan, HIP Basic, with lesser benefits. While that is preferable to disenrollment, the structure does not offer the lowest income enrollees a true choice. It is predictable that many will not be able to make premium payments and will be transferred into the Basic program.

Rather than setting up a benefit structure that invariably will punish the lowest income enrollees simply because they are poor and unable to make monthly premium payments, there are other ways to structure the HIP Plus and HIP Basic programs that would instead provide enrollees with

[7] Healthy Indiana Plan Demonstration, Section 1115 Annual Report, Demonstration Year 5 (1/1/12-12/31/12) http://www.in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf . HIP enrollment data by age shows that enrollment is generally lower among those under age 30, with the exception of the over 60 age group, and for that group, lower enrollment is to be expected given availability of Medicare at age 65.

incentives to engage in healthy behaviors. Such a structure would be more consistent with the objectives of the Medicaid program and a more appropriate use of 1115 waiver authority.

For example, the program could be structured to immediately enroll all individuals in HIP Plus. HIP Plus benefits would only continue if an individual completes wellness requirements within a set period of time. If an individual does not, he or she would be moved to HIP Basic, but would have an opportunity to move back to HIP Plus if the wellness program requirements were met at some point in the future.

Requests to Waive Certain Benefits

Indiana's request to waive non-emergency transportation coverage should not be granted.
The request to waive non-emergency transportation coverage for HIP Plus and HIP Basic enrollees should not be approved.

- ***The Medicaid Alternative Benefit Package outlined in the Affordable Care Act is designed to meet the needs of a low-income population***. Congress specifically designating this benefit package—which includes services, such as non-emergency transportation, that are in addition to the Essential Health Benefits package—because they recognized the special needs of the low-income individuals who would be gaining coverage through a Medicaid expansion. Indiana does not offer any health justification that would warrant excluding non-emergency transportation. The request appears to be primarily for the convenience of extending current policies under the existing HIP waiver. That is not an appropriate rationale for a demonstration waiver. Absent a justification related to patient care or health outcomes, this request should not be approved.

- ***Omitting non-emergency transportation will make it harder for enrollees to meet preventive care requirements***. Indiana has proposed a cost sharing and premium scheme in which enrollees' financial obligations are reduced through state payments into POWER Accounts if they have certain preventive services during the year. For low-income individuals to be able to receive the recommended preventive services, it is critical to mitigate as many barriers to care as possible. Covering non-emergency transportation will lessen one barrier to care. Providing this coverage will make it easier for individuals to get to health care providers so that they can receive the services that will allow them to get a premium reduction. It is incongruous to omit non-emergency transportation benefits and financially penalize individuals for not meeting preventive care requirements.

- ***Any approval of this request should be on a limited one-year basis, consistent with what has been approved in similar 1115 waivers in Iowa and Pennsylvania.*** As in Pennsylvania, any approval should include a requirement that the state develop a plan for adding non-

emergency transportation in waiver year two.

The request to waive vision and dental services for 19 and 20 year olds in HIP Basic should be denied. Indiana's request to omit vision and dental services for 19 and 20 year olds enrolled in HIP Basic should be denied. It is predictable that many individuals in this age group will not be able to meet premium payments and will be assigned to HIP Basic. Vision and dental services are important components of Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits. Those benefits are required benefits under the Alternative Benefit Package. No patient care justification is given for omitting this benefit. The request should not be approved and suggests that 19 and 20 year olds should not be included in this demonstration.

Cost Sharing

The request to charge $25 for non-emergency use of the emergency room should be denied. We share Indiana's goal of encouraging appropriate use of emergency room services. We do not have issues with imposition of higher cost sharing for inappropriate emergency room use, if coupled with a strong education component and a program to connect patients with the appropriate providers. However, charging $25 for each non-emergency use of emergency room services after the fist visit is excessive. For the covered population, this is an exceedingly high copayment. It is foreseeable that cost sharing at this level will lead some HIP enrollees to forego appropriate emergency care for fear of incurring such an onerous charge.

The $8 allowed under current regulation attempts to set a balance—high enough to discourage inappropriate emergency room use, but not so high as to discourage appropriate emergency room use. Requests to charge higher copayments for non-emergency use of emergency rooms were denied in Iowa and Pennsylvania and should likewise be denied here.

We are grateful for the opportunity to submit comments on Indiana's HIP 2.0 waiver request. As we noted at the outset, we believe that the concerns that we have raised can and should be addressed during the approval process. If you have any questions, please feel free to contact us.

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