



March 20, 2020

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

Re: Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver

Dear Secretary Azar:

Thank you for the opportunity to submit comments on Indiana's Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Indiana's Medicaid program provides adequate, affordable and accessible healthcare coverage, and we strongly support Medicaid expansion in Indiana. Over 400,000 low-income adults currently receive healthcare coverage through the state's Medicaid expansion.¹ This means that thousands of enrollees are receiving preventive, early detection and diagnostic services as well as disease management and treatment for their conditions. Research shows an association between Medicaid expansion and early stage cancer diagnosis, when cancer is often more treatable.² Medicaid expansion states have experienced increased utilization of prescription drugs, especially for patients with diabetes and cardiovascular disease.³ This will help patients manage their

conditions and avoid more expensive care in emergency departments and hospital settings. State Medicaid expansions provide continuous care to pregnant women before, during, and after pregnancy, leading to decreases in both maternal deaths and infant mortality.⁴ Another study found that Medicaid expansion was associated with reductions in deaths from opioid overdose, including those involving heroin and synthetic opioids.⁵ Additionally, Medicaid expansion is associated with improvements in quality measures at federally qualified health centers, which are critical healthcare providers for low-income patients.⁶ Medicaid expansion is also playing an important role in addressing health disparities—one recent study found that states that expanded Medicaid under the ACA have nearly eliminated racial disparities in timely treatment for cancer patients.⁷ Medicaid expansion is clearly beneficial for patients with serious and chronic health conditions.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families. Unfortunately, Indiana's application to continue the HIP 2.0 program also includes policies that threaten access to healthcare by creating new financial and administrative barriers that could lead patients to lose their healthcare coverage. Our organizations therefore offer the following comments on Indiana's proposal.

10 Year Waiver

Indiana is requesting their waiver be approved for 10 years as opposed to three years, as is standard per Section 1115(f)(6). While five year extensions have been granted previously and may make sense in certain circumstances, our organizations believe that it is irresponsible to extend the HIP renewal waiver for 10 years. While Indiana has a lengthy interim evaluation report, there are a number of policies the state is asking to continue with limited or no data available. For example, in reference to the work requirement, the proposal states, "*this means that our Gateway to Work program, which started phase-in January 2019, will have almost no real operation experience before we started drafting a renewal.*" In other words, there is no data on how this policy impacts patients and their access to care.

This and many other policies, including the tiered POWER Accounts and the tobacco surcharge, were only approved in February 2018, have been implemented for less than two years and have not proven they furnish medical care to HIP 2.0 enrollees. Our organizations believe some of the policies in the waiver should not be approved and, in the true nature of a demonstration project, a waiver extension should be approved for no more than three years.

Work Requirements

Under the application, individuals between the ages of 19 and 59 are required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.⁸ The U.S. Court of Appeals for the District of Columbia recently reaffirmed that the purpose of the Medicaid program is to provide healthcare coverage and that Arkansas' restrictive waiver, including the work requirement policy, did not meet that objective.⁹

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements for at least eight out of the previous 12

months, their coverage will be suspended for the next calendar year, starting January 1. Coverage will be suspended until members can demonstrate past compliance, enroll in school or training, gain full- or part-time work or qualify for an exemption. For patients with COPD, heart disease or other chronic health conditions, a lapse in coverage can mean a lapse in medication, permanently worsening the patient's prognosis. This is unacceptable for our patients.

Our organizations are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees may have to report their exemption, creating opportunities for administrative error that could jeopardize their coverage. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.¹⁰ No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Ultimately, these requirements do not further the goals of the Medicaid program or help low-income individuals find work. Most people on Medicaid who can work already do so.¹¹ A study published in *JAMA Internal Medicine* looked at the employment status and characteristics of Michigan's Medicaid enrollees.¹² The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. Additionally, a study in *The New England Journal of Medicine* found that Arkansas's work requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment, which negates the state's argument that Medicaid enrollment is down because individuals are finding jobs and gaining other coverage.¹³ The study also estimates that 95 percent of Arkansans subject to the requirements already worked enough hours to meet the requirements or qualified for an exemption, which further confirms that most Medicaid beneficiaries are working if they are able to do so.

Continuous Medicaid coverage can actually help people find and sustain employment. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).¹⁴ That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Suspending individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help people search for and obtain employment. Our organizations urge you to reject Indiana's request to continue its work requirement.

Enforceable Premiums

Indiana's Medicaid program currently charges premiums equal to two percent of modified adjusted gross income to all adults, and individuals with incomes above 100 percent of the federal poverty level (\$1,810 per month for a family of three) can lose their coverage for failing to pay these premiums. Individuals below 100 percent of the federal poverty level move into a lesser benefit plan for failing to pay the premium. The state proposes to keep this policy. In the state's evaluation, the state estimates that over 25,000 individuals have been downgraded to the lesser plan for failure to pay the premium and an additional 5,500 were disenrolled and locked out of coverage for six months due to nonpayment. Lockouts for failure to pay a premium can have significant negative consequences for patients. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of \$20 per month, almost half of enrollees lost coverage.¹⁵ For individuals with chronic health conditions, maintaining access to comprehensive coverage is vital to ensure the necessary treatment. Our

organizations believe that these premiums create significant financial barriers for patients that jeopardize their access to needed care and urge you to reject this request.

Tobacco Surcharge

Indiana's premiums also include an additional surcharge for tobacco users. Research is clear that these surcharges have not been proven effective in helping smokers quit and reducing tobacco use. Recent studies from Health Affairs¹⁶ and the Center for Health and Economics Policy at the Institute for Public Health at Washington University¹⁷ have suggested that tobacco surcharges do not increase tobacco cessation but do lead individuals to forgo health insurance rather than paying the surcharge. Tobacco users often have expensive comorbidities. Charging a tobacco surcharge could cause those enrollees to go without coverage and access to preventive care (including tobacco cessation), allowing comorbid health conditions to worsen and ultimately resulting in more expensive healthcare. Our organizations oppose this surcharge.

POWER Accounts

One of the key features of the HIP program is that it is modeled after a high deductible private health insurance plan. High deductible health plans can be financially challenging for individuals living with a serious or chronic illness, leading to delays in care.¹⁸

The Indiana POWER account is funded by the individual's premiums and then the state, totaling \$2,500 per HIP Plus enrollee. Enrollees use the funds in their accounts to cover the first \$2,500 of care they need. Any additional care is not subject to additional member contributions. If a HIP Plus patient does not use all of the funds in their POWER account, the funds roll over to the next year. This is an unnecessary complicated scheme to provide coverage to low-income patients. Our organizations believe the POWER account structure creates confusion and barriers for patients to access care.

Copayments for Non-Emergent Use of the ED

Indiana's renewal application includes the continuation of the policy to charge all enrollees an eight dollar copayment for non-emergent use of the emergency department (ED). This policy can deter people from seeking necessary care during an emergency. Delays in care could have harmful impacts on the short- and long-term health of individuals with serious, acute and chronic diseases.

People should not be financially penalized for seeking lifesaving care for a breathing problem, symptoms of a stroke, complications from cancer treatment, or any other critical health problem that requires immediate care. When people do experience severe symptoms, they should not try to self-diagnose their condition or worry that they can't afford to seek care. Instead, they must have access to quick diagnosis and treatment in the ED.

Evidence suggests cost-sharing may not result in the intended cost savings.¹⁹ Research demonstrates that low-income individuals served by Medicaid are more price sensitive compared to others, more likely to go without needed care, and more likely to experience long-term adverse outcomes. A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings due to subsequent use of more intensive and expensive services.²⁰ This provides further evidence that copays may lead to inappropriate delays in needed care. Our organizations urge HHS to reject the punitive cost-sharing provision for non-emergent use of the ED.

Future Changes to Premiums and Cost-Sharing

The state also requests the authority to change monthly premium amounts to up to three percent of household income and copayment amounts “within the Medicaid limits” without submitting an amendment to CMS. Our organizations are deeply concerned that Indiana could be allowed to make changes that impact the affordability of coverage for patients without public comment and without review and approval by CMS. This would remove important opportunities for the public to provide feedback on how the cost-sharing structure of Indiana’s Medicaid program impacts key stakeholders before any policies are implemented or continued. Our organizations urge you to reject this request.

Removing Retroactive Coverage

Indiana has also requested to extend its current waiver limiting retroactive coverage for most populations to 30 days. Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days (or quarter of the year) prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. With a shorter period of retroactive eligibility, Medicaid enrollees could face substantial costs at their doctor’s office or pharmacy. When Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.²¹ Patients should not be left to choose between massive medical bills and treating their illness. Our organizations encourage HHS to not approve the continuance of limiting retroactive coverage.

Eliminating Non-Emergency Medical Transportation

Indiana has also requested to extend its waiver to eliminate Non-Emergency Medical Transportation (NEMT) benefits. Low-income patients may not own a car and may lack access to reliable public transportation, especially in rural areas. Removing this benefit will therefore harm patients who need to attend regular visits with their providers to manage their medications and treatments. For example, one study found patients with asthma, hypertension or heart disease who needed multiple visits to a medical professional more likely to keep their appointments if they had NEMT.²² Our organizations ask HHS to reject the waiver extension request and encourage Indiana to reinstate the NEMT benefit so that patients in HIP 2.0 are able to keep appointments to manage their conditions and stay healthy.

Our organizations support the continuation of Medicaid expansion in Indiana; however, there are many policies that limit the potential benefits of this coverage and do not further the delivering of medical services to enrollees. Our undersigned organizations urge HHS to reject certain components of the waiver renewal request. Thank you for the opportunity to submit comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Arthritis Foundation

Crohn's & Colitis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
Mended Little Hearts
Muscular Dystrophy Association
National Hemophilia Foundation
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
United Way Worldwide

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

¹ Kaiser Family Foundation, Medicaid Expansion Enrollment, Available at; <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

² Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", *American Journal of Public Health* 108, no. 2 (February 1, 2018): pp. 216-218. Available at <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304166>.

³ Ghosh, Ausmita, Simon, Kosali and Sommers, Benjamin D., (2017), The Effect of State Medicaid Expansions on Prescription Drug Use: Evidence from the Affordable Care Act, No 23044, NBER Working Papers, National Bureau of Economic Research, Inc, <https://EconPapers.repec.org/RePEc:nbr:nberwo:23044>

⁴ Adam Searing and Donna Cohen Ross. "Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies," (May 2019). Georgetown University Health Policy Institute, Center for Children and Families. Accessed at: <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>.

⁵ Kravitz-Wirtz N, Davis CS, Ponicki WR, et al. Association of Medicaid Expansion With Opioid Overdose Mortality in the United States. *JAMA Netw Open*. 2020;3(1):e1919066. doi:10.1001/jamanetworkopen.2019.19066. Accessed at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476>.

⁶ Megan B. Cole, Omar Galárraga, Ira B. Wilson, Brad Wright, and Amal N. Trivedi. "At Federally Funded Health Centers, Medicaid Expansion Was Associated With Improved Quality Of Care," *Health Affairs* 36, no. 1 (January 2017): pp. 40-48. Available at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0804>.

⁷ American Society of Clinical Oncology, "Racial Disparities in Access to Timely Cancer Treatment Nearly Eliminated in States with Medicaid Expansion." American Society of Clinical Oncology Annual Meeting. June 2, 2019. Access at: <https://www.asco.org/about-asco/press-center/news-releases/racial-disparities-access-timely-cancer-treatment-nearly>

⁸ Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/>; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

⁹ US Court of Appeals for the District of Columbia Circuit, *Gresham v. Azar*, Feb. 14, 2020. Available at: <https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.pdf>.

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- ¹³ Benjamin D. Sommers, MD, et al. “Medicaid Work Requirements—Results from the First Year in Arkansas,” *New England Journal of Medicine*. Published online June 18, 2019, https://cdf.nejm.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B
- ¹⁴ Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf>.
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- ¹⁶ Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA’s Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. *Health Aff* 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540 accessed at: <http://content.healthaffairs.org/content/35/7/1176.abstract>
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- ¹⁹ See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. *J Gen Intern Med*. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings.” Center on Budget and Policy Priorities (July 2005), available at <http://www.cbpp.org/5-31-05health2.htm>.
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- ²² Michael Adelberg and Marsha Simon, “Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?” *Health Affairs*, September 20, 2017. Accessed at: <https://www.healthaffairs.org/doi/10.1377/hblog20170920.062063/full/>