Emily Spitzer
Executive Director

June 12, 2014

VIA ELECTRONIC SUBMISSION

Indiana Office of Medicaid Policy and Planning
Attn: Steven Holt
402 W. Washington Street Rm W374
Indianapolis, IN 46204

Re: Healthy Indiana Plan Renewal and Healthy Indiana Plan 2.0 Section 1115 Demonstration Applications

Dear Mr. Holt:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to both of the Indiana Family and Social Services Administration's (FSSA) proposed § 1115 demonstration applications: the Healthy Indiana Plan 2.0 (HIP 2.0) and the contingent Healthy Indiana Plan (HIP) renewal.

General Comments

We appreciate FSSA's proposal to expand access to Medicaid to cover many uncovered Hoosiers through the HIP 2.0 plan. We believe that implementing Medicaid expansion is the right choice for vulnerable Hoosiers, the health care infrastructure, and the state budget. However, the HIP 2.0 plan, as currently proposed, fails to comply with numerous statutory requirements. In addition, the proposed HIP 2.0 program would create serious access problems for the low- income beneficiaries that Medicaid is designed to serve. The proposed alternative to Medicaid expansion, the HIP plan, is also not approvable.

These individuals and the State would be better served by FSSA implementing a standard Medicaid expansion, as has occurred in the majority of other states. While Medicaid has become a political football, it has also proven to be a health coverage work horse, able to cover thousands of low-income, vulnerable individuals at a much lower administrative cost that other insurers. At any rate, if

the State is going to continue to pursue a § 1115 project, then both proposals should be modified so that they comply with the law.

By way of background, we note that prior HHS approvals of Healthy Indiana plans were based on specific circumstances. These approvals were implemented prior to the January 2014 effective date of the Affordable Care Act's (ACA) Medicaid expansion. Prior to the ACA, some of the HIP and HIP 2.0 eligible populations below 138% FPL were not described in the Medicaid Act (for example, childless non-disabled, non-pregnant, non-elderly adults). As a result, HHS used its "expenditure authority" under § 1115 of the Social Security Act to allow Indiana to provide coverage to this non-Medicaid, expansion population. However, starting 2014, individuals below 138% of FPL are a Medicaid state plan population and, thus, can no longer be considered expansion populations. As a result, FSSA can no longer rely on the expenditure authority to ignore certain Medicaid requirements. Rather, the State must either fully comply with all Medicaid requirements or obtain a waiver that meets all of the requirements of § 1115 for experimental/demonstration projects, and in the case of cost-sharing, § 1916(f). (This applies not only to HIP 2.0 and HIP proposals but also to any extension of the *temporary* Healthy Indiana extension that HHS authorized for transitional purposes for calendar year 2014.)

Many features of the HIP 2.0 and HIP proposals, described below, do not meet the § 1115 requirements, as currently proposed.

Specific Comments to the HIP 2.0 and HIP

A. Cost-sharing and Premiums Generally

Section 1115 of the Social Security Act (SSA) explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.[1] Provisions outside of § 1902 may not legally be waived through the § 1115 demonstration process. The HIP 2.0 and HIP proposals include waiver requests for provisions outside of § 1902, in particular §§ 1916 and 1916A – impacting premiums and cost-sharing. FSSA should comply fully with §§ 1916 and 1916A, which provide extensive flexibility to implement premiums and cost-sharing. This includes complying with the cost-sharing waiver process described at § 1916(f).

B. Required and Optional Contributions

Both HIP 2.0 and HIP are premised on monthly contribution systems. FSSA requests these monthly contributions to implement health savings account (HSA) models. There is no provision in the Medicaid Act that authorizes the use of HSAs, and it specifically prohibits some of the essential HSA features that FSSA requests. Moreover, the State cannot suggest HSAs as a novel, experimental Medicaid concept because the Medicaid Act already included provisions for the Secretary of HHS to establish demonstration projects under which states could use HSAs, called "health opportunity accounts" in the statute. See § 1938. Therefore, as designed, the proposal is not approvable by HHS.

[1] Social Security Act ("SSA") § 1115(a)(1).

Moreover, while labelling the payments "monthly contributions," they meet the federal definition of a premium or similar charge. Thus, FSSA should modify its proposal to eliminate monthly contributions for all individuals below 150% FPL, as required by Medicaid law.[2] We note that under Medicaid law, "any enrollment fee or similar charges" are illegal for this very-low-income population, whether they are called monthly fees, assessments, contributions, or premiums.[3] Since monthly contributions are not permitted for this population below 150% FPL, *termination* for non-payment of contributions should also never be approved. Even if, contrary to the law, HHS considered a waiver of the premium prohibition, it should still not be approvable because, given the well-established studies on the impact of premiums on low-income people, there is no experimental value to premiums nor do they promote the objectives of the Medicaid program, as required by §1115(a).[4] The impact of any premiums on low-income people is clearly visible from FSSA's own data, showing that even a premium below $5 a month causes lower income individuals to disenroll from health coverage. Premiums for those living on incomes below 100% FPL are especially concerning, since they contradict the structure of the ACA and numerous Medicaid cost-sharing protections set at 100% FPL. We note that, under the law, premiums are equally impermissible for individuals below 150% FPL whether they are mandatory or optional.

FSSA's proposal is also problematic because of the consequences for failure to pay the premiums. There is no authority in the Medicaid Act for "lockouts" after termination. FSSA should eliminate the termination lockout provisions to reduce the harm inflicted by the illegal premiums. These provisions will unnecessarily increase the number of uninsured, and thus contradict any effort to promote continuity of care and will harm the provider infrastructure in Indiana (as providers will continue to treat uninsured patients). We also urge the state to clarify in both the HIP 2.0 and HIP renewal applications that it will also refrain from using lockouts for anyone who fails to submit redetermination materials. Redetermination lockouts are one of the most problematic features of the current HIP program, and state advocates hear regularly from uninsured consumers who are locked out of coverage, sometimes in cases where the individual submitted redetermination materials which she reasonably believed were complete. If FSSA intends to attempt to continue the harmful practice of lockouts (for failure to pay premiums or file redeterminations), the state will need to provide HHS with evidence about the impacts of the current lockout demonstration, including the data collected, the methodologies used to evaluate that data, and the state lessons learned from this experiment.

In sum, we urge Indiana to amend its proposal to impose premiums only on those with incomes above 150% of FPL and to abandon its proposal to lock individuals out of coverage and health care access.

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[2] *See* SSA §§ 1916(c), 1916A(b)(1)(A). There are very limited exceptions to this rule, for certain populations, that are not broadly applicable to the Medicaid expansion population. *See, e.g.*, § 1916(d).

[3] 42 U.S.C. § 1916A(a)(3)(A).

[4] For example, in 2003, Oregon experimented with charging sliding scale premiums ($6-$20) and higher copays on some groups in an already existing § 1115 demonstration for families and childless adults below poverty. Nearly *half* the affected demonstration enrollees dropped out within the first nine months after the changes. Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 Health Affairs 1106, 1110 (2005).

C. Copays for Non-emergent ER Use

Under Medicaid regulations, in general, states can charge individuals with income below 150% a copayment up to $8 copayment for non-emergent ER use.[5] FSSA's requested copay amounts in HIP 2.0 and HIP of $25 are therefore significantly above the legal limit. We note that both Arkansas and Iowa requested § 1115 authority for non-emergent ER copays of $10, and neither was approved. Furthermore, the State would need to comply with the stringent waiver requirements of § 1916(f) to implement copays above $8.

While we understand the drafters' desire for enrollees to have "skin in the game," this can be accomplished with copayments set at the lower amounts that are authorized by the Medicaid Act. As a percentage of income, the notion of paying an $8 copayment should readily discourage inappropriate use of the ER. We also want to underscore that ER copayments have been repeatedly studied and the research indicates that: (1) Medicaid enrollees use the ER at comparable rates to private pay patients if you factor in their health status, and are no more likely to use the ER for non-urgent visits; and (2) contrary to some of the suggestions in the demonstration applications, the only two peer-reviewed evaluations of nonemergency ER copays in Medicaid show no demonstrated impact on reducing non-urgent ER use.[6]

D. Annual Application of 5% Aggregate Cost-sharing Cap

Indiana apparently seeks to continue to allow annual calculation of the 5% aggregate cap on Medicaid premiums and cost sharing.[7] While Medicaid law does provide states the flexibility to tabulate the aggregate cap on a monthly or quarterly basis, it does not allow the aggregate limit to be applied *annually*.[8] As described above, the requirements of § 1916 and § 1916A cannot be ignored or waived for the populations subject to the demonstration (as they are state plan populations described in the Medicaid Act). HHS can only approve this change to the aggregate cap if the proposal complies with the additional requirements at § 1916(f).

Indiana would not need annual caps to accomplish the objectives of this demonstration; quarterly caps would not be a barrier towards the State's goals. Furthermore, considering that low-income individuals have little disposable income and the impacts of cost sharing on this population are well known, applying the aggregate cap on a yearly basis would not be consistent with the objectives of Medicaid or serve any demonstration purpose.[9] We also note that Indiana's inclusion of CHIP expenses in its

[5] 42 C.F.R. § 447.54.
[6] *See* David Machledt & Jane Perkins, National Health Law Program, *Medicaid Premiums and Cost Sharing* (March 2014) available at http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.U5cW-ij3Ijw.
[7] Healthy Indian Plan 2.0 proposal, at 29.
[8] SSA §§ 1916A(b)(1)(B)(ii), (b)(2)(A).
[9] To be clear, we would like to provide an example as to why an annual cap would be so detrimental. An individual at 60% FPL would earn $6,894 per year. Her 5% aggregate cost-sharing cap would be $29 per month or $86 per quarter. If she used minimal health care during the year, but had one health crisis month with high-utilization (ex. multiple ED trips), she is protected by a limit of $29 for that month or $86

annual aggregate cap is practically meaningless, because any children of adults eligible under this proposal would be eligible for full Medicaid, not CHIP.

E. Basic package copays

The HIP 2.0 proposal suggests that individuals below 100% FPL who make monthly contributions will receive a superior "Plus" package, while those who do not will receive the lower "Basic" package with copayments. As a demonstration involving copayments, this proposal needs to comply with the requirements of 1916(f) and the waiver proposal needs to be amended to address the 1916(f) factors. We are concerned that providing different benefits based on cost-sharing methodology has no experimental value and does not promote the objectives of the Medicaid Act, as required by § 1115.[10]

As an aside, we acknowledge that, Medicaid law allows states flexibility to create different benefits packages in the context of alternative benefits plans for different groups who are "identified by characteristics of individuals."[11] However, we question the legality of a state providing different benefits packages based on an arbitrary factor such as whether an individual was able to pay a monthly premium.

F. EPSDT

The requests in HIP 2.0 and HIP to eliminate EPSDT services for a subset of 19- and 20-year olds would be illegal because EPSDT is specifically required in § 1937 for ABPs (a provision which is not waivable under § 1115, since is lies outside of § 1902) and because EPSDT coverage is a primary objective of the Medicaid Act.[12]

Congress designed Medicaid with clear requirement to cover EPSDT for children and youth under age 21. These statutory provisions have been repeatedly amended and strengthened over the years, as research repeatedly documents that poverty-level children and youth need a range of enabling and developmental interventions. Young people are one of the core populations of the Medicaid program and to diminish EPSDT – the most essential and enduring feature of coverage for children and youth – is clearly inconsistent with the objectives of the Medicaid program.[13]

G. Work Search Requirements

We ask FSSA to eliminate all work search requirements from its HIP 2.0 and HIP proposals. Work search requirements are an illegal condition of eligibility in excess of the Medicaid eligibility criteria clearly enumerated in Federal law.[14] Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act

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for that quarter, and that might be her total cost-sharing responsibility for the full year. If an annual limit was used, however, she could pay as much as $345. This would be the equivalent of what she would pay if they if she had the same crisis *every* quarter. Put another way, under the law, her cost for *one event* is limited to 5% of the cost of a quarter, but under an annual cap, her cost is 5% of her annual income.

[10] SSA § 1115(a)(1).

[11] 42 C.F.R. § 440.305(a).

[12] SSA § 1937(a)(1)(A)(ii).

[13] SSA § 1115(a).

[14] *See generally* SSA § 1902.

requires that they provide assistance to all individuals who qualify under federal law,[15] and courts have held additional eligibility requirements to be illegal.[16] Section 1115 cannot be used to short circuit the Medicaid protections, because work search requirements can in no way promote the objectives of the Medicaid Act or demonstrate anything.

H. Non-Emergent Medical Transportation (NEMT)

Medicaid requires coverage of NEMT.[17] This is a core Medicaid requirement, applicable to all state plan enrollees. HHS cannot approve the waivers of NEMT requested in HIP 2.0 and HIP under § 1115 authority. As mentioned earlier, as of January 1, 2014, individuals below 138% FPL are a state plan population. Thus, for HIP 2.0 or HIP renewal, FSSA would need a waiver, and such waivers can only be approved if they have a valid experimental purpose and promote the objectives of the Medicaid Act. There is no valid experimental purpose to <u>not</u> providing transportation – it is clear that beneficiaries will lose access to care. Furthermore, reducing access to care for poor beneficiaries, including ones in isolated rural communities that lack any public transportation, clearly contradicts the objectives of the Medicaid Act.

I. Retroactive and Point-in-time Eligibility

Under the law, FSSA must provide point-in-time eligibility and up to three months retroactive coverage for enrollees.[18] FSSA requests waivers of these requirements in HIP 2.0 and HIP. However, HHS cannot approve a § 1115 demonstration to waive these requirements because there is no *demonstrative* value to such a waiver. The entirely predictable results will be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers – especially safety net hospitals – incurring losses; and (3) more individuals experiencing gaps in coverage due to providers refusing to treat them because providers realize they will not be paid retroactively by Medicaid. We ask FSSA to reconsider this request, especially considering that such coverage is fully federally funded until 2017. We note that Iowa requested a similar waiver of the retroactive and point-in-time requirements and was not approved.

J. ABPs must cover Medicaid FPSS, and the EHB preventive services requirements.

Both the HIP 2.0 and HIP renewal applications should clarify that the proposed benefits packages will comply with the legal minimums for family planning services and supplies. The coverage packages proposed under both demonstrations are Medicaid "alternative

[15] *Id.* §§ 1902(a)(10)(A), (B).
[16] *Camacho v. Texas Workforce Comm'n,* 408 F.3d 229, 235 (5th Cir. 2005), ***aff'g***, 326 F. Supp. 2d 803 (W.D. Tex. 2004) (finding that Texas could not "add additional requirements for Medicaid eligibility"). *See generally Carleson v. Remillard,* 406 U.S. 598 (1972) (invalidating state law that denied AFDC benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).
[17] *See* 42 C.F.R. § 431.53; CTRS. MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 2113.
[18] 42 U.S.C. § 1902(a)(34); 42 C.F.R. § 435.914 (redesignated at §435.915 in 77 Fed. Reg. 17143 (Mar. 23, 2012)).

benefits plans" (ABP) which have two clear and independent requirements under § 1937. First, all ABP coverage must comply with the essential health benefits requirements, which have their own standards for preventive services, including coverage of all FDA-approved contraceptive methods.[19] Second, all ABPs must include family planning services and supplies as per the Medicaid requirements at § 1905(a)(4)(C) .[20] There may be circumstances under which one of these family planning standards is more robust and less restrictive than the other. Therefore, the HIP 2.0 and HIP demonstrations can only be legally approved if they comply with *both* requirements. In the case of HIP 2.0, the description of benefits appears to ignore the § 1905(a)(4)(C) requirement, stating that it is "[l]imited to ACA required preventive services."[21] In the case of the HIP renewal, the description of benefits ignores the essential health benefits requirement, stating that "the State seeks approval for the current HIP benefit package … to continue to be designated Secretary-approved coverage."[22] Both proposals must be amended to indicate compliance with *both* the § 1905(a)(4)(C) and essential health benefit requirements.

Additionally, although the HIP renewal application clarifies that abortion is not covered as a "family planning service," we remind the State of its legal obligation to cover abortion services in the circumstances required by law.

K. Freedom of Choice for Family Planning Services and Supplies

Both the HIP 2.0 and HIP renewal applications include broadly worded requests for waiver of freedom of choice. While freedom of choice may be waived for many services, freedom of choice for family planning services and supplies cannot be waived under the law. HHS and a number of district and federal circuit courts of appeal have consistently made clear that states must cover family planning services and supplies provided by any qualified provider, including out-of-network providers.[23] Therefore, the freedom of choice waiver requests in HIP 2.0 and HIP should be amended to clarify that for family planning services and supplies, individuals are entitled to go out-of-network regardless of whether there are available in-network family planning providers.

L. Coverage for Pregnant Women

We support the provisions in the HIP 2.0 proposal that would allow pregnant women to elect to maintain their ABP coverage and receive all additional benefits and cost-sharing protections to which pregnant women are entitled under the state plan. However, the state should clarify that a pregnant woman remains eligible for these enhanced benefits and cost-sharing protections not only for the duration of pregnancy, but through the month in which the 60-day post-partum period ends, even if she has a change in income otherwise making her ineligible.[24]

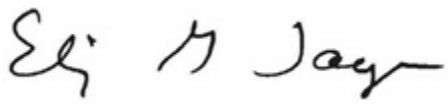
[19] § 1937(b)(5).
[20] § 1937(b)(7).
[21] Healthy Indiana Plan 2.0 proposal, page 25.
[22] Healthy Indiana Plan renewal proposal, page 8.
[23] *See* CMS, State Medicaid Manual, § 2088.5.
[24] 42 U.S.C. § 1396a(e)(6).

Further, women eligible for pregnancy-related Medicaid coverage may also be eligible for advance premium tax credits to purchase coverage through the Marketplace. Indiana must ensure that all pregnant women – whether covered under Hoosier Healthwise or HIP 2.0 – have timely and appropriate information about all of their coverage options so they may elect the coverage option(s) that best meet their needs.

Conclusion

In summary, we urge the State to move forward with an approvable Medicaid expansion. If you have questions, please contact Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,



Elizabeth G. Taylor,
Executive Director