July 7, 2017

VIA ELECTRONIC SUBMISSION

The Honorable Thomas Price, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Amendment Request to Healthy Indiana Plan (HIP) § 1115 Waiver Extension Application

Dear Secretary Price:

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 under-served people. We commented on a prior version of this extension request on March 17, 2017 and also joined a national group sign-on letter submitted at that time. We incorporate our earlier positions and appreciate the opportunity to provide these additional comments to the amended Healthy Indiana Plan 2.0 (HIP 2.0) extension request.

We support Indiana's decision to accept federal funds to cover low-income adults through Medicaid. We are encouraged that the extension request proposes to increase outreach and education around tobacco cessation and strengthen the benefit package for substance use disorders. Such proposals recognize Medicaid's essential role in addressing these public health problems.

However, NHeLP recommends that HHS not approve the HIP 2.0 extension as requested. This amendment includes new and continuing waiver requests that do not satisfy the 1115 demonstration requirements. We stated our position on existing waivers (premiums, lockouts, waiting periods, nonemergency transportation and emergency department copays, etc.) in prior comments (dated Sept. 9, 2014 and incorporated). The State has yet to provide sufficient evidence showing these components promote Medicaid's objectives, and recent evidence from HIP 2.0 evaluations suggests that several features have created substantial enrollment barriers. We urge HHS to work with Indiana officials to bring the extension proposal into a legally approvable form.

Concurrent comment periods violate 1115 public process regulations

As noted in a separate letter dated July 3, 2017, the comment periods have not complied with the law. State officials submitted this amendment to the extension to CMS shortly after opening the state comment period on it. CMS issued a Letter of Completeness and opened the federal comment period while the State comment period was still open, and without waiting for the State to respond to the comments it received. This process does not comply with 42 C.F.R. §§ 431.408 and 431.416. As requested in our July 3 letter, we are asking that CMS: (1) rescind the Letter of Completeness until such time as the State submits all of the information required by 42 C.F.R. § 431.412(a)(1) and (2) begin the federal comment period required by § 431.416(a) and (b) only after the State submits that information and a new Letter of Completeness is issued.

New Data Shows HIP 2.0 Premiums, Lockouts, and Waiting Periods Create Significant Barriers

We have previously expressed our concern that the premiums included in this waiver have no demonstration value and do not promote the objectives of Medicaid, so they are inappropriate for an 1115 demonstration. Prior studies and literature reviews repeatedly show that premiums create substantial enrollment barriers for low-income populations.[1] The latest data from Lewin, Indiana's chosen evaluator, reinforces this conclusion yet again. That study, released after the comment period closed on Indiana's initial extension application in March, shows that premiums are causing substantial barriers both when enrollees sign up for coverage and later for continuing coverage. Given this new data verifying the chilling effect premiums have on the ability to obtain health coverage and care, CMS should deny a waiver to continue to allow Indiana to charge mandatory premiums in the HIP demonstration.

Nearly three out of ten times a low-income Hoosier faced a barrier due to a required HIP premium payment to start coverage or to remain enrolled, he or she could not overcome the barrier.[2] At least 2,537 Hoosiers were stymied by premiums twice (or more) – once at the front end to begin coverage and again later when they missed a payment.[3] The front-end enrollment barrier presented the bigger obstacle, with nearly one in four (23%) not making the initial payment to start benefits.[4] Although these people could reapply, only

---

[1] See, *e.g.*, Samantha Artiga et al., KAISER FAM. FOUND., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (June 1, 2017), http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/. David Machledt & Jane Perkins, NAT. HEALTH LAW PROGRAM, *Medicaid Premiums & Cost Sharing and Premiums* (March 2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.

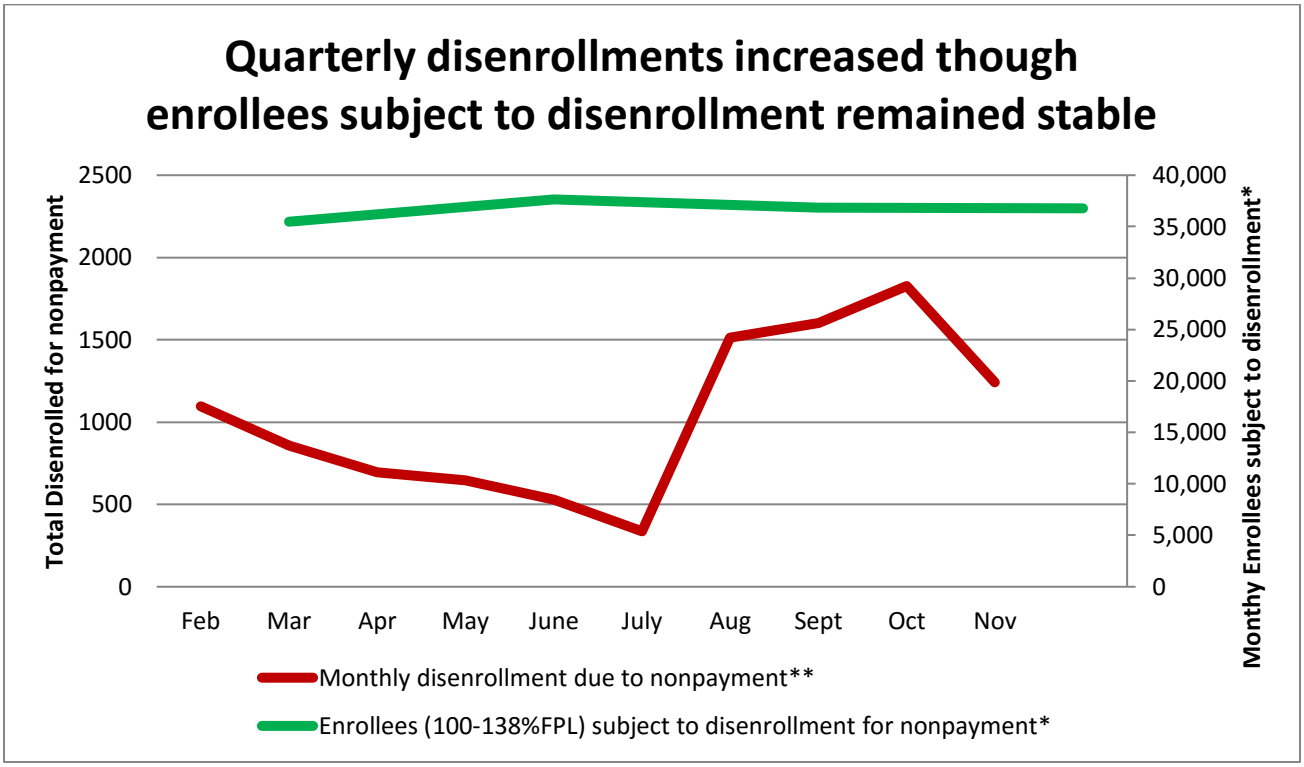
[2] In all, 57,189 of roughly 195,000 who ever faced a required premium were disenrolled or not enrolled due to nonpayment at least once. LEWIN GROUP, *Indiana HIP 2.0: POWER Account Contribution Assessment*, ii (Mar. 31, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[3] *Id*.

[4] *Id*.

about half ever did so successfully.[5] This suggests that HIP's "payment before benefits" provision *alone* kept 11.5% of the otherwise eligible applicants in that income group from ever participating in HIP 2.0. Overall, 55% of Hoosiers who applied and were found eligible for HIP 2.0 missed a premium payment at some point, resulting either in failure to begin coverage, disenrollment, or shift to a plan with higher copays and/or fewer benefits.[6]

The rate of disenrollment for non-payment also clearly accelerated in the second half of 2016 (see chart).[7] Lewin's report offers no explanation for this increase. Of 13,550 disenrolled for nonpayment over the 22-month reporting period, 6,183 (46%) occurred in the final four months. Total HIP enrollment increased only 12% over the course of 2016, and monthly enrollment for enrollees subject to disenrollment for nonpayment remained stable throughout the year.[8] This indicates that Lewin's overall average disenrollment rate (6%) substantially understates current the disenrollment rate due to nonpayment of premiums, suggesting that enrollment barriers may have increased.[9]



*Figures based on monthly enrollment for individuals with incomes 100-138% FPL in HIP Plus Plan. Excludes enrollees with state plan benefits, enrollees with incomes above 138% FPL (likely TMA or on appeal), and

[5] *Id*. at 12.
[6] *Id*. at 8.
[7] *Id*. at 11.
[8] *Id*.; Ind. Fam. Soc. Servs. Admin. ("FSSA"), *Section 1115 Quarterly Report, DY 2: Qtr.1*, 5 (Mar. 31, 2016); *Section 1115 Quarterly Report, DY 2: Qtr.2*, 6 (June 30, 2016); *Section 1115 Quarterly Report, DY 2: Qtr.3*, 4 (Sept. 30, 2016); *Section 1115 Quarterly Report, DY 2: Qtr.4*, 6 (Jan. 31, 2017).
[9] Lewin Group, *supra* n. 2, at ii. These accelerated disenrollment rates have continued through January 2017, based on the State's most recent quarterly report. FSSA, *Section 1115 Quarterly Report, DY2: Qtr. 4*, *supra* n. 8, at 5.

enrollees in Basic plans because these individuals are not subject to disenrollment for nonpayment. Source: Demonstration quarterly reports.
** Source: Lewin Group POWER Accounts report, at 11.

The Lewin Group also conducted a survey of individuals who never fully enrolled ("never members") or left the program due to nonpayment ("leavers"). Unfortunately, several aspects of the methodology increase the likelihood that the survey results may not accurately reflect the actual experience of people facing these enrollment barriers.[10] Even so, the survey results suggest that, in addition to substantial affordability concerns, many enrollees are confused or face red tape with the payment process for premiums. Fully 30% of never member respondents reported they were confused or unaware of the payment process, while another 22% could not afford the premium.[11] Leavers were more likely to report unaffordability (44%), with another 18% confused or unaware.[12] More than three in four Basic members (who may not be disenrolled) cited unaffordability (34%), confusion (17%), or unawareness (25%) about the premium payment.[13] These numbers suggest significant barriers and poor outreach and notice in HIP 2.0's design and implementation.

Taken together, these new reports suggest that HIP 2.0 premiums are causing substantial access to care barriers for low-income Hoosiers. CMS should not reapprove premiums, required prepayment of premiums, disenrollments and lockouts for this Medicaid expansion population when these aspects of the waiver have hindered access to medical assistance.

Finally, we previously expressed concerns regarding Indiana's emergency department (ED) copayment proposal. Indiana's most recent HIP quarterly report claims that data show a "continued decrease in inappropriate ER usage by HIP members."[14] The tables do show a steady reduction in the proportion of ED visits deemed non-emergency over the prior four quarters.[15] But if the copays were responsible for this reduction, one would also expect an overall reduction in ED visits. But the report indicates that overall ED use has remained stable and has actually increased for Plus members. This must mean that either: (1) there has been a marked increase in emergent visits to the ED for an unexplained reason (delayed care?); or (2) ED providers have been changing their definition of what counts as a non-emergent visit over time. Either way, this evidence should not be interpreted to support the finding that HIP's ED copay is "working."

[10] Lewin Group, *supra* n. 2, at 4 & D-1. The response rates for the survey were extremely low (3 to 8%). The survey does not include demographic information comparing the sample population (respondents) against the overall population that could reveal potential response bias. For example, no evidence suggests accommodations were made for limited English speaking individuals. Also, several errors in the sampling process due to misclassifications affected the final sample.
[11] Lewin Group, *supra* n. 2, at 20.
[12] *Id*.
[13] *Id*. at 19
[14] FSSA, *Section 1115 Quarterly Report, DY 2: Qtr.4*, 8-9 (Jan. 31, 2017).
[15] *Id*.

Work Requirements

The amended extension seeks to impose a mandatory "Gateway to Work" employment program. Once implemented, the work/work search requirements, if not satisfied, would result in suspension of Medicaid coverage. Work search requirements represent an illegal condition of eligibility beyond the Medicaid eligibility criteria.[16]

Conditioning Medicaid eligibility on work requirements will reduce enrollment and does not promote the objectives of the Medicaid program. Medicaid's stated purpose is to provide medical assistance to low-income individuals and to furnish medical assistance and services to help these individuals attain or retain the capacity for independence and self-care.[17] A mandatory work requirement is not medical assistance; it is not a service provided to Medicaid beneficiaries. Work requirements applied to health coverage get it exactly backwards. They block access to necessary care that individuals need to be able to work.

The Medicaid Act establishes the requirements for coverage, and courts have held additional eligibility requirements are illegal.[18] Section 1115 cannot be used to short circuit these protections, because, as CMS has acknowledged when consistently denying previous state requests to impose work requirements through section 1115, conditioning Medicaid eligibility on a work requirement creates barriers to care and does not promote the objectives of the Medicaid program.[19]

Rather than providing medical assistance to low-income populations, this proposal would lead to thousands of low-income adults, including working enrollees, losing eligibility. The State's actuary, Milliman, estimates that 25% of enrollees subject to the requirement would have their eligibility suspended.[20] That does not include thousands more who would lose coverage under this policy due to the red tape required to verify their exemption or work activities. Milliman estimates that students, people with disabilities, and other exempted populations, constitute fully 70% of all HIP 2.0 enrollees, and each would have to document how they fulfill this requirement, often on a monthly basis.[21] This would require new systems to apply different requirements based on length of enrollment, accurate tracking and documentation of employment hours and caregiving hours, and effective screening process for disability and temporary conditions, all on an individual level. In short, this

---

[16] *See generally* SSA § 1902.

[17] *See* 42 U.S.C. §§1396-1, 1396d(a).

[18] E.*g.*, *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).

[19] *See*, *e.g.*, Ctrs. for Medicare & Medicaid Servs., AHCCCS 1115 Demonstration Extension (Sept. 30, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf.; Letter from Vikki Wachino, Dir., CMS, to Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Human Servs. (Nov. 1, 2016); *see* Kaiser Fam. Found., *Medicaid Expansion in Pennsylvania: Transition from Waiver to Traditional Coverage* (Aug 3, 2015), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/#footnote-159781-6.

[20] Rober M. Damler et al., MILLIMAN, *1115 Waiver – Healthy Indiana Plan*, 4 (May 24, 2017), attached to HIP 2.0 application.

[21] *Id*.

would require tremendous investment of resources and administrative costs and, as CMS has previously concluded, would create dangerous barriers to enrollment and care.

The sheer number of exemptions in Indiana's proposal is a tacit acknowledgment that most low-income enrollees who are not already working have a good reason not to be working.[22] A work requirement would only add to their considerable burdens by requiring verification of their exemption or compliance. Studies of TANF have shown that work-related sanctions and regulations are often unevenly applied and fail to distinguish between procedural/administrative issues, like missing an appointment, and actual noncompliance.[23]

Work requirements have been widely tested in other safety net programs and have not been very effective. The Temporary Assistance for Needy Families (TANF) program is the most widely known example of the application of work requirements to public safety net programs. TANF, created in 1996, was initially credited with temporarily helping increase employment rates for low-income mothers and reduce caseloads for cash assistance, but the magnitude of that effect is difficult to tease from a booming economy, a minimum wage increase (1997), and other contemporaneous changes to the safety net, including expansions of the Earned Income Tax Credit (mid-1990s) and the CHIP program (1997).[24] More recent research suggests that the effects of TANF's work requirement were modest and faded over time, and that time limits and work requirements may increase the incidence of extreme poverty when families have neither employment income nor cash assistance.[25] At any rate, it is not clear what Indiana is proposing to demonstrate that has not already been assessed through the TANF work waivers and requirements.

The Gateways to Work program would be extremely expensive and burdensome to implement, but also likely does not offer enough support to actually improve employment. Indiana says its work search program would cost $90/month to administer and run per enrolled member.[26] This would represent a huge shift of funds away from providing health care and into a new bureaucracy designed to require work or stop coverage. Medicaid's purpose is not to fund job training, but to provide medical assistance. The with-waiver estimated monthly cost to cover an adult in the new adult group is $567 in

---

[22] The State claims in its proposal that 244,000 HIP enrollees are unemployed, but it provides no citation to show where that number comes from. FSSA, *Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application*, 7 (May 24, 2017).

[23] Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines."* 82 SOC. SERVS. REV. 199 (2008); Andrew Cherlin et al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings* 76 SOC. SERV. REVIEW 387 (2002).

[24] Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 *J. Policy Analysis & Management* 231 (2016); Younghee Lim, *The Mid-1990s Earned Income Tax Credit Expansion: EITC and Welfare Caseloads*, 32 SOC. WORK RES. 46 (2008).

[25] Sandra K. Danziger et al., *supra* n. 24, at 234; Ladonna Pavetti, CTR. ON BUDGET & POL'Y PRIORITIES, *Work Requirements Don't Cut Poverty, Evidence Shows* (June 7, 2016), http://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf. Pamela Loprest & Austin Nichols, URBAN INSTIT., *The Dynamics of Being Disconnected from Work & TANF* (2011), http://www.urban.org/research/publication/dynamics-being-disconnected-work-and-tanf.

[26] Robert Damler et al., *supra* n. 20, at 4. It is not clear if this statement refers to $90 per member enrolled in the Gateway program or per member enrolled in HIP 2.0.

Demonstration year 5, meaning the work search would constitute close to 16% of the coverage cost for enrolled members.[27] The State does not specify how much would be spent on training and employment supports relative to the cost of administering and enforcing the requirement. Both would require enormous investments likely in excess of Milliman's estimates.

The proposal presents no evidence that the Gateway to Work program has the capacity to effectively scale up to enrollment of at least 75,000. The current voluntary program received fewer than 3300 calls and conducted only 550 orientations in HIP's first year.[28] This anemic participation, despite some 300,000 letters sent to enrollees, suggests that the program offers too few actual supports to be of real value to enrollees. And the HIP evaluations provide no documentation that those who have participated have had any more success finding and sustaining work than enrollees who did not participate. Without evidence of prior success or metrics to ensure the program is delivering a quality service, the risk and potential harm of ramping up such a small program so quickly would be astronomical.

In fact, the proposal is not very clear what Gateway to Work actually purports to do. One description states the program will "connect unemployed and under-employed HIP members to available job training, work search, and employment programs," which suggests that those programs are not actually part of (funded by) Gateway to Work.[29] The FSSA website description suggests that the program provides job search assistance, such as case management, job skills training, job search assistance, and in limited cases, some training or educational supports.[30] The proposal fails to mention key components of any successful employment program, such as child care supports and opportunities for supported employment for people with disabilities. By comparison, a training voucher provided through workforce development programs averages approximately $3,500 or more.[31] Support for affordable child care – vital for many working families – would also far exceed $90 per month.

Rather than condition eligibility on participation in a work program that is destined to serve as a benefit cut, Indiana should invest in meaningful job training and affordable child care for HIP participants. We wholeheartedly support efforts by Indiana and other states to create well-funded, independent and voluntary employment supports for lower income individuals. Accessible employment supports are services that our clients have sought and been denied for decades.

Premium Tiering

---

[27] *Id*. at 15.

[28] FSSA, *Healthy Indiana Plan Demonstration Annual Report*, 23 (April 20, 2016).

[29] FSSA, *Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application* 5 (May 24, 2017).

[30] *Gateway to Work*, FSSA, http://www.in.gov/fssa/hip/2466.htm (last visited July 1, 2017).

[31] Sheena McConnell et al., MATHEMATICA, *Providing Public Workforce Services to Job Seekers: 15-Month Impact Findings on the WIA Adult and Dislocated Worker Programs* (May 2016), https://www.mathematica-mpr.com/our-publications-and-findings/publications/providing-public-workforce-services-to-job-seekers-15-month-impact-findings-on-the-wia-adult.

In the same proposal that would vastly increase the red tape and administrative burden of the HIP 2.0 program by instituting a work requirement, the State simultaneously proposes changes to simplify the premium structure to "ease administrative burden on the State."[32]

Tiering premiums may make the system easier to operate for plans or Medicaid administrators, but tiers neither cure the harm that premiums represent nor address the problems with their legality. And while the State bills this proposal as a simplification, it includes several changes that will expose enrollees to higher costs and increase their risk of losing coverage:

- **The proposal would charge 50% more for parents and two-person households.** In the face of clear evidence from its own evaluator that premiums are causing enrollment barriers, Indiana proposes a 50% spousal surcharge on premiums, a departure from current approved terms and conditions that limit total household premiums to 2% of monthly income, including all eligible members. This change would increase overall premiums for some households above the 2% monthly threshold, in the face of clear evidence from the State's own evaluator that premiums cause enrollment barriers at current amounts (see above). For example, a couple making just over the Federal Poverty Level would be charged $30/month under this new proposal, versus just over $27 under current policy. CMS should not approve any premiums, let alone an increase in premiums on some enrollees.

- **Restricting access to Transitional Medical Assistance will expose more parents and families to lesser coverage and disenrollment for non-payment.** The State proposes a "technical revision" to its program, but this technical revision has negative policy effects for parents. TMA provides parents transitional coverage when their income increases or other changes cause them to lose eligibility for the traditional § 1931 Parents/Caretakers group (income threshold roughly 18% FPL).[33] The State now proposes that parents whose income increase does not exceed 138% FPL (the Medicaid expansion limit) would no longer qualify for TMA and would instead be covered under regular HIP 2.0 coverage. Parents currently in TMA receive full state plan benefits (including dental, vision and non-emergency Medical transportation) regardless of whether they pay monthly HIP 2.0 premiums and cannot be disenrolled from the program for nonpayment of premiums. If this change were approved, parents whose income rises only slightly (to between 19% FPL and 138% FPL), *would* lose services if they cannot not afford premiums, and those whose income rose to 100-138% FPL would be subject to disenrollment for nonpayment. Furthermore, two-parent households would be subject to the spousal surcharge described above.

[32] FSSA, *Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application* (May 24, 2017).

[33] CMS, Medicaid and CHIP Eligibility Levels, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/ (last visited June 29, 2017).

Conclusion

Thank you for consideration of our comments. If you have any questions, please contact David Machledt, Sr. Policy Analyst (machledt@healthlaw.org) or Jane Perkins, Legal Director (perkins@healthlaw.org).

Sincerely,

Jane Perkins
Legal Director