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Planned Parenthood Advocates of Indiana and Kentucky

September 15, 2014

Cindy Mann
Deputy Administrator and Director, Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

VIA ELECTRONIC TRANSMISSION

Dear Ms. Mann:

Planned Parenthood Advocates of Indiana and Kentucky ("Planned Parenthood") is pleased to submit these comments on the Healthy Indiana Plan 2.0 1115 demonstration waiver ("HIP 2.0"). As a trusted women's health care advocate, Planned Parenthood strongly supports the commitment of the Centers for Medicare and Medicaid Services ("Department") to seeking input from a cross section of stakeholders on this unique proposal.

Planned Parenthood Advocates of Indiana and Kentucky serves as the advocacy arm of Planned Parenthood of Indiana and Kentucky which provides high-quality health care to nearly 74,000 men and women each year at our health centers across two states. 94% of our nonprofit's services are preventive in nature and include Pap tests, breast and testicular cancer screenings, birth control, STD testing and treatment, and annual wellness exams. Through the Sara and Albert Reuben Partners in Health Education initiative, PPINK also provides sexuality and reproductive health education programs, equipping people to make responsible decisions so that families thrive in Indiana and Kentucky.

We strongly support expanding Medicaid coverage to individuals with incomes up to 138 percent of the federal poverty level (FPL). Medicaid is a vital part of the health care system and plays a major role in ensuring access to essential primary and preventive care services for women and men. Low-income women, in particular, stand to benefit from the expansion of Medicaid. With greater access to coverage, hardworking women across the state will be able to obtain women's health services that are critical to their health and lives, including birth control, life-saving cancer screenings, and prenatal care.

Planned Parenthood urges the Department to ensure HIP 2.0 meets the unique health needs of women. Specifically, we ask CMS to make certain that HIP 2.0 will provide women comprehensive health care coverage, including family planning and pregnancy-related services, and provide women access to the health providers they trust without delay. Properly implemented, HIP 2.0 will enable women to access the services they need, resulting in better health outcomes for women and their families.

I. The Department Should Ensure All HIP 2.0 Enrollees Have Access to Family Planning Services and Family Planning Providers.

We are pleased that HIP Basic and HIP Plus will provide coverage for family planning services and supplies without cost-sharing, as required under federal law. However, it is concerning that HIP 2.0 proposes not to cover wrap-around services for those enrolled in employer-sponsored insurance via HIP Link. To ensure timely access to family planning care – as well as ensure every aspect of HIP 2.0 complies with federal law – we strongly urge the Department to clarify that all individuals who gain coverage through HIP 2.0, including HIP Link enrollees, will have access to covered family planning services and supplies without cost-sharing.

Federal law is clear that individuals receiving premium assistance, such as HIP Link enrollees, are entitled to all covered benefits and cost-sharing protections.[1] Family planning services and supplies are mandatory covered services[2] that are explicitly exempt from cost-sharing.[3] Therefore, HIP Link enrollees must be able to access Medicaid-covered family planning services at no cost regardless if they receive coverage through their employer.

Explicit protections for contraceptive coverage are particularly important with respect to premium assistance programs like HIP Link. Although the Affordable Care Act (ACA) requires the vast majority of health plans to cover the full range of FDA-approved contraceptive methods without cost-sharing,[4] certain employers and health plans do not have to cover contraception without cost-sharing. Federal law permits certain non-profit religious and religiously-affiliated employers to exclude coverage of contraceptives, and the U.S. Supreme Court recently ruled that for-profit closely held corporations may carve out coverage of contraception on the basis of religious objection.[5] Additionally, grandfathered health plans (typically operated by large employers) do not have to provide coverage of contraception without cost-sharing. It is possible that some HIP Link enrollees may have an employer with a plan that is not legally required to cover contraception, and as a result, could lack access to contraception entirely or experience financial barrier to their needed contraceptive method. According, it is imperative that HIP 2.0 ensure each enrollee's access to family planning services without cost-sharing.

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[1] 42 C.F.R. § 435.1015(a)(2), (b); CMS, *Medicaid and the Affordable Care Act: Premium Assistance* (March 2013), *available at* http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf.

[2] 42 U.S.C. §§ 1396d(a)(4)(C), 42 U.S.C. 1396u-7(b)(7); 42 C.F.R. § 441.20.

[3] 42 U.S.C. § 1396o(a)(20(D), 1396o(b)(2)(D), 1396o-1(b)(3)(B)(vii); 42 C.F.R. § 447.53(b)(5); 78 Fed. Reg. 42160, 42311 (Jul. 15, 2013) (to be codified at 42 C.F.R. § 447.56(a)(2)(ii)). Additionally, Medicaid benchmark coverage and benchmark-equivalent coverage (which is provided to the newly eligible population) must include the Essential Health Benefits, which provides coverage for certain women's preventive health services without cost-sharing such as the full range of FDA-approved contraceptives, contraceptive counseling, and an annual exam. ACA § 2001(c) (adding 42 U.S.C. § 1396u-7(b)(5)); 78 Fed. Reg. at 42307; 78 Fed. Reg. 12834, 12843 (Feb. 25, 2013) ("a plan does not provide EHB unless it meets the standards in 45 C.F.R. § 147.130") (to be codified at 45 C.F.R. § 156.115(a)(4)); 45 C.F.R. § 147.130(a)(iv) (specifying coverage of the women's preventive health services).

[4] Public Health Service Act § 2713(a)(4) (added by ACA § 1001); Human Resources and Services Administration, *Women's Preventive Services Guidelines*, http://www.hrsa.gov/womensguidelines/.

[5] 78 Fed. Reg. 39870 et seq. (to be codified at 45 C.F.R. §§ 147.131) (religious employers (e.g., churches) are exempt from the contraceptive coverage requirement entirely, and religiously-affiliated non-profit employers (e.g., religiously-affiliated hospital) may receive an accommodation that enables the employer plan to exclude coverage of contraception but requires the health issuer of the employer plan to provide separate payments for contraceptive services); *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. ___ (2014).

We are also concerned that HIP 2.0 does not explicitly maintain freedom of choice for family planning providers in its proposal to waive freedom of choice broadly under 42 U.S.C. § 1396a(a)(23). While we assume this was an oversight, we urge the Department to clarify that all HIP 2.0 enrollees, including HIP Link enrollees, will retain freedom of choice for family planning providers. As the Department is aware already, existing federal law and policy unequivocally protects an enrollee's ability to receive family planning services from any qualified Medicaid provider, even if the enrollee is enrolled in a manage care plan.[6] Indeed, the Department has rightly enforced the "family planning freedom of choice" protection with 1115 demonstration waivers, including recent 1115 demonstration waivers to expand Medicaid coverage,[7] and we urge the Department to reinforce this critical provision again when approving HIP 2.0.

II. The Department Should Ensure HIP 2.0 has Sufficient Mechanisms in Place to Ensure Women's Access to Pregnancy-Related Care in a Timely Manner.

We support the proposal to provide women who become pregnant after enrolling in HIP 2.0 coverage to remain in that coverage or transfer to Hoosier Healthwise. In addition, we are pleased the HIP 2.0 proposal explicitly stipulates that wrap-around pregnancy-related care and that pregnancy-related care will be available without cost-sharing. To make these policy proposals a reality, however, the HIP 2.0 system must have sufficient mechanisms in place to recognize when a woman becomes pregnant so that she can access the coverage she needs without cost barriers.

In particular, it is critical that HIP 2.0 ensure the pregnancy coverage mechanisms reach HIP Link enrollees. HIP Link-participating employer plans may not cover as many pregnancy-related services as the state provides to pregnant women – especially since the HIP 2.0 proposal does not require large employer plans to cover the essential health benefits, which includes maternity coverage. Likewise, employer plans may impose cost-sharing for certain pregnancy benefits such as labor and delivery, which are available without cost-sharing under HIP 2.0. Implementing sufficient protocols will help ensure pregnant HIP Link enrollees receive the care they need, at no cost, in a timely manner.

III. The Department Should Ensure Retroactive Coverage for HIP 2.0 Enrollees.

We urge the Department to clarify that HIP 2.0 must follow federal eligibility rules, including the provisions on retroactive coverage. As this Department is likely aware, the Social Security Act requires states to pay for covered services provided to individuals during the three month period prior to the date of application if the

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[6] 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(a)(4); CMS, State Medicaid Manual § 2088.5. ("recipient may obtain family planning services and supplies from outside of the HMO without an HMO referral, even if the HMO contracts with Medicaid to provide the same services").

[7] CMS, *Special Terms and Conditions Iowa Marketplace Choice Plan* (2013) ("The state Medicaid program will ensure payment at state plan rates of family planning services that the QHP considers to be out-of-network, subject to all third party liability rules"); CMS, *Letter to Billy Millwee, Deputy Executive Commissioner of the Texas Health and Human Services Commission* (Dec. 12, 2011) (notifying the State of Texas that CMS will not renew the 1115 family planning demonstration waiver because Texas sought to waive freedom of choice of family planning providers); *see also* CMS, *Informational Bulletin* (Jun. 1, 2011) (reiterating the federal requirement that states must provide Medicaid enrollees freedom of choice of family planning providers); U.S. Statement of Interest at 4, 8-9, *Planned Parenthood of Indiana v. Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012) (cert denied) (asserting that freedom of choice is a longstanding provision, and that a State may not exclude certain providers from the Medicaid program because of a provider's scope of practice).

applicant would have been eligible at the date of the application.[8] This provision safeguards enrollees' access to care when there are delays in determining eligibility, which is likely to happen as the state rolls out HIP 2.0.

Requiring the state to provide enrollees with retroactive coverage will also help ensure the success of HIP 2.0. Retroactive eligibility guarantees providers reimbursement for care, which in turn, reduces uncompensated care costs and alleviates financial burdens on health care providers. When providers are reimbursed adequately for their services (and not forced to absorb losses in revenue for Medicaid patients), they are more likely to participate in the Medicaid program and accept new Medicaid patients. Sufficient provider participation is essential to the implementation of HIP 2.0; indeed, health care coverage is meaningless if patients are unable to receive care from quality providers in a timely manner.

IV. The Department Should Adjust the Proposed POWER Account Contribution and Cost-Sharing Structure to Comply with Federal Law.

We urge the Department to revise the POWER account contributions and cost-sharing requirements to align with federal standards. Specifically, the Department should clarify that individuals maintain coverage regardless of their ability to contribute to their coverage and that cost-sharing amounts not apply to individual with incomes below 100 percent FPL or exceed federal limits.

HIP 2.0 seeks to terminate coverage for certain individuals. In the proposal, individuals with incomes above 100 percent FPL who fail to make their POWER account contributions on time will be terminated from the program and will have a six month lock-out period before they can re-enroll in coverage. Individuals with incomes at or below 100 percent FPL who enroll in HIP Plus and fail to make POWER account contributions will be moved to HIP Basic but not terminated from coverage. However, it is unclear whether individuals can or will be terminated from HIP Basic if they fail to make cost-sharing payments. We urge the Department to explicitly disallow the state from terminating an individual's coverage and/or imposing barrier to re-enrollment, if an individual is terminated from coverage. All individuals eligible for HIP 2.0 coverage (as well as other Medicaid coverage options) should be able to access and maintain coverage – regardless of their ability to pay.

It is also troubling that the HIP 2.0 proposal seeks to require individuals with household incomes below 100 percent FPL to make contributions to their POWER accounts. HIP 2.0's proposed POWER account contribution is no different than a premium. Like a premium payment, enrollees will be unable to access their coverage until they make their first POWER account contribution, and as noted above, enrollees may lose coverage if they fail to make future contributions on time. Imposing premiums on coverage for lower-income individuals and families may make coverage cost-prohibitive, even if the contribution is no more than two percent of family income, undermining the intent of Medicaid expansion to ensure all low-income families and individuals receive affordable, quality coverage.

In addition, HIP 2.0 seeks to impose cost-sharing requirements that exceed what is allowable under federal law. Specifically, federal law limits inpatient care to 10 or 20 percent of what the agency pays (but no more

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[8] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914.

than $75)[9] and non-emergency use of the emergency room to $8.[10] Accordingly, at a minimum, the Department should clarify that HIP 2.0 will require a co-pay for inpatient care that is the lesser of what is required under federal law, and that the co-pay for non-emergency use of the emergency room should be no more than $8.

V. The Department Should Require the State to Receive Input from Stakeholders in Developing the Health Incentive Program and Clarify that all HIP 2.0 Enrollees are Eligible for the Health Incentive Program.

HIP 2.0 proposes to implement a "rewards program" that would reduce monthly contributions by to 50 percent if they complete specified healthy behaviors. The proposal does not detail what behaviors will count as an incentive; rather, the state indicates that it will "work with health plans to develop the list of approved incentives." We support the incentive for healthy behaviors (and tying the incentive to a reduced POWER account contribution), but without more specific information, it is hard to determine if this program will actually meet the needs of women and their families. In addition, we are concerned that the program inadvertently excludes a large number of enrollees since some individuals will be in HIP Basic, which has cost-sharing in lieu of POWER account contributions.

We request that the Department clarify that participation results in a reduction of POWER account contributions or other cost-sharing obligations. In addition, we ask that the state collaborate with stakeholders, as well as plans, to develop the list of healthy behaviors. Stakeholder input is critical to ensure that the program meets the diverse needs of low-income individuals and families across Indiana. In particular, to ensure women have robust participation in the health incentive program, the state should consult with women's health providers and advocates to make sure the list of approved healthy behaviors reflects the unique ways women access the health care system and integrates women's health care services.

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We thank the Department for the opportunity to submit these comments. If you have any questions, please do not hesitate to contact me at 317-637-4348 or pstauffer@ppin.org.

Sincerely,

Patricia A Stauffer
Vice President, Public Policy

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[9] 42 C.F.R. § 447.52(b).

[10] 42 C.F.R. § 447.54. The $8 limit applies to individuals with household incomes at or below 150 percent FPL, which would apply to HIP 2.0 enrollees.