

September 16, 2014

Secretary Sylvia Matthews Burwell  
Department of Health and Human Services  
330 Independence Avenue SW  
Washington, DC 20201

Dear Secretary Burwell,

On behalf of the over 29 million Americans living with diabetes and the 86 million more with prediabetes, the American Diabetes Association (Association) provides the following comments and recommendations regarding the Indiana Family and Social Services Administration *HIP 2.0 Section 1115 Demonstration Waiver Application*.

According to the Centers for Disease Control and Prevention, 462,000 adults in Indiana have diabetes and another 272,000 are at risk for developing diabetes. Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. When people are not able to afford the tools and services necessary to manage their diabetes, they scale back or forego the care they need, potentially leading to costly complications and even death.

Adults with diabetes are disproportionately covered by Medicaid.<sup>i</sup> In Indiana, the diabetes prevalence for individuals with annual household incomes of less than \$15,000 is 15.3%, compared to 6.8% for those with annual household incomes of \$50,000 or higher.<sup>ii</sup> For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions. For example, a recent study conducted in California found “amputation rates varied tenfold between the highest- and lowest-income neighborhoods in the state.”<sup>iii</sup> Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing these disparities. As such, the Association strongly supports Indiana’s decision to accept federal Medicaid funding to extend eligibility for the program. We do, however, have concerns regarding some of the provisions of Indiana’s proposal, and provide the following comments and recommendations to help ensure the needs of low-income individuals with diabetes are met by the state’s Medicaid program.

### **The HIP 2.0 Program “Incentives” are Detrimental to Enrollees with Diabetes**

According to the *HIP 2.0 Section 1115 Waiver Application*, the state is proposing to “replace traditional Medicaid for all non-disabled adults ages 19-64 and expand HIP to those who fall below 138% of the federal poverty level (FPL).” The state will divide HIP 2.0 enrollees between “HIP Basic” and “HIP Plus” depending on income and/or whether the enrollee makes required monthly payments. Enrollees in the HIP Basic program will be required to make co-payments for all services (except certain preventive services) and will have a “reduced” benefits package. Enrollees in the HIP Plus program will have access to an “enhanced” benefit package, and will be required to make monthly contributions into their “POWER” account (defined by the state as an “HSA-like account”) with no additional cost-sharing, except for inappropriate use of the emergency department. All HIP 2.0 enrollees will have a POWER account to cover the plan’s deductible. In addition, all HIP 2.0 enrollees are “incentivized” to manage their POWER accounts “judiciously.” If they have a balance remaining in their POWER accounts at the end of the year, they can reduce their contributions in the following year. In addition, if enrollees receive all recommended preventive services during the year, they may be able to further reduce their contributions in the following year.

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#### **Diabetes Information**

Call 1-800-DIABETES (1-800-342-2383)  
Online: [www.diabetes.org](http://www.diabetes.org)  
The Association gratefully accepts gifts through your will.

#### **The Mission** of the American

Diabetes Association is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

The Association is very concerned the financial “incentive” scheme in the HIP 2.0 program will be detrimental to enrollees diagnosed with diabetes. Diabetes is a complex, chronic illness requiring continuous medical care with multifactorial risk reduction strategies beyond glycemic control. Ongoing patient self-management education and support are critical to preventing acute complications and reducing the risk of long-term complications. The Association, including its scientific and medical experts, believes essential benefits for the management, prevention, and care of diabetes include:

- Diabetes screening for individuals at high risk;
- Services as determined by a treating health care provider;
- Prescription medications;
- Durable medical equipment, such as blood glucose testing equipment and supplies, and insulin pumps and associated supplies;
- Services related to pregnancy, including screening for diabetes; monitoring and treatment for women with pre-existing diabetes and gestational diabetes; and postnatal screening;
- A yearly dilated eye exam by an eye-care professional with appropriate follow-up care as medically needed;
- Podiatric services;
- Diabetes education, including diabetes outpatient self-management training services; and
- Medical nutrition therapy services.

Providing a HIP 2.0 enrollee with diabetes a financial incentive to *not* use medical services—and therefore have a remaining balance in the POWER account at the end of the year—is inappropriate, and could result in increased costs for state and federal healthcare programs in the long-term. For example, studies show intensive diabetes management can delay the onset and progression of diabetic nephropathy, which is the leading cause of end stage renal disease.<sup>iv</sup> When people are not able to afford the tools and care necessary to manage their diabetes, they scale back or forego the care they need. If a low-income individual with diabetes is enrolled in the HIP 2.0 program, the financial incentive offered by the program may dissuade him from obtaining the medical care, supplies and medications he needs to manage his diabetes.

According to the *HIP 2.0 Section 1115 Waiver Application*, Indiana’s evaluation of the current HIP program demonstrates its success. However, while some diabetic complications, such as diabetic ketoacidosis, can be acute, other complications, such as retinopathy, neuropathy and nephropathy, are a result of elevated blood glucose over a long period of time. Considering the long-term nature of many diabetes complications combined with the amount of turnover within the Medicaid program, Indiana is likely unable to measure any long-term health impacts the program may have on enrollees with diabetes. Offering a financial incentive to not obtain needed medical care, supplies and medications is counter-intuitive and could potentially be harmful in the long-term to HIP 2.0 program enrollees with diabetes.

### **The HIP 2.0 Program “Incentives” Discriminate Against Enrollees with Diabetes**

In addition to the potential long-term clinical impacts which could result from the inappropriate incentives offered through the HIP 2.0 program, the Association is also concerned the HIP 2.0 program does not meet the requirements of the ACA as it relates to the new adult eligibility group. We are particularly concerned the HIP 2.0 incentive scheme violates Section 1302 of the ACA which says that in defining the Essential Health Benefits (EHB) the Secretary of the Department of Health and Human Services shall “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.”<sup>v</sup> Section 2001 of the ACA requires states to provide beneficiaries in the new adult group benchmark or benchmark

equivalent coverage (called an alternative benefit plan or ABP), as outlined in Section 1937 of the Social Security Act.<sup>vi</sup> The ACA also modified the requirements of Section 1937 to require benchmark benefits to, at a minimum, include EHB.<sup>vii</sup> Therefore, individuals in the new adult eligibility group must receive Section 1937 ABP coverage which includes EHB.

While it appears the benefits package options for the new adult eligibility group outlined in the *HIP 2.0 Section 1115 Waiver Application* may meet the Section 1937 requirement of covering benefits in the ten EHB categories, the incentive program discriminates against individuals with disabilities—including those with diabetes—in violation of Section 1302 of the ACA. Even if program enrollees who have diabetes make all of the required monthly payments and meet the healthy behavior requirements, their need for regular medical care to treat and manage their diabetes puts them at a great disadvantage in achieving the offered incentive compared to program enrollees who do not have diabetes.

As such, the Association recommends CMS require the state to provide *all* HIP 2.0 eligible enrollees with diabetes and other chronic conditions—not just those in the new adult eligibility group—a coverage option which encourages and supports the use of necessary medical care, supplies and medications.

### **The Options for Individuals Exempt from Mandatory ABP Enrollment are Inadequate**

As discussed above, individuals in the new adult eligibility group are to receive Section 1937 ABP coverage.<sup>viii</sup> However, certain individuals in the new adult eligibility group “must be given the option of an ABP that includes all benefits available under the approved State plan.”<sup>ix</sup> This exemption includes individuals who are deemed “medically frail” by the state, the definition of which must at least include individuals with “serious and complex medical conditions.”<sup>x</sup> Since the state is proposing two different benefit packages for individuals in the new adult eligibility group depending on household income, it appears the state is proposing to use two different ABPs for the new adult eligibility group. The state is proposing to give those exempt from mandatory enrollment in the ABP the choice between the HIP Basic ABP with co-payments, and the HIP Plus ABP with POWER account contributions. While the medical services and supplies covered under each option will include “all State Plan services” in the form of a benefit wrap for those exempt from mandatory ABP enrollment, the cost-sharing requirements will not be the same as the State Plan.

Under this proposal, an individual with a serious and complex medical condition will be faced with the dilemma of choosing a plan under which he has to pay a co-payment for each medical service, supply and medication he needs to manage his disease, or a plan under which he must pay a portion of his income each month while being told if he is “judicious” with the medical care he uses, he can pay less next year. As discussed above, diabetes is a complex, chronic illness requiring continuous medical care. As such, neither of the options offered to those exempt from mandatory enrollment in the ABP is appropriate for someone with a serious and complex medical condition, such as diabetes. Since the “choice” proposed by the *HIP 2.0 Section 1115 Waiver Application* does not include a benefit option which contains the same benefits and cost-sharing as the approved State Plan, the Association strongly urges CMS to require the state to allow those exempt from mandatory enrollment in the ABP to choose between the HIP program, and a non-HIP State Plan benefit package.

### **The Cost-Sharing Requirements of HIP 2.0 Deter Enrollment and Use of Services**

The Association is concerned by the amount of cost-sharing and monthly contributions enrollees will be required to pay as outlined in the *HIP 2.0 Section 1115 Waiver Application*. In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a recent study conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of \$10 per month is associated with a decrease in public coverage of children in families with incomes above 150% of the federal poverty level (FPL), with a greater decrease in coverage

for those below 150% FPL.<sup>xi</sup> In addition, a Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that “[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes.”<sup>xii</sup> The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150% FPL.<sup>xiii</sup>

Yet, in the *HIP 2.0 Section 1115 Waiver Application*, the state is proposing monthly contributions ranging from \$3 for those enrolled in HIP Plus who have incomes under 22% of the Federal Poverty Level (FPL) to \$25 for those earning between 101% and 138%. Not only are the proposed monthly POWER Account contribution amounts very likely to deter individuals from obtaining Medicaid coverage—negating the benefits of extending eligibility to the new adult group—they do not comply with federal Medicaid regulations. Therefore, the Association strongly urges CMS to prohibit monthly payment requirements under HIP 2.0, and ensure the co-payment requirements meet all federal rules.

### Summary

The Association is pleased Indiana has decided to accept federal Medicaid funding to extend eligibility for its Medicaid program. However, the program outlined in the *HIP 2.0 Section 1115 Waiver Application* is not “likely to assist in promoting the objectives” of the Medicaid program as required in Section 1115 of the Social Security Act.<sup>xiv</sup> The proposed incentives are potentially detrimental to the health of HIP 2.0 program enrollees with chronic health conditions, such as diabetes. Further, the HIP 2.0 incentive program discriminates against individuals with diabetes. In addition, neither the HIP Basic nor the HIP Plus programs are adequate for individuals in the new adult eligibility group who are exempt from mandatory enrollment in the ABP. Finally, the cost-sharing requirements in HIP 2.0 are likely to deter individuals from obtaining Medicaid coverage and from accessing necessary care. As such, the Association urges CMS to carefully consider which components to approve within the *HIP 2.0 Section 1115 Waiver Application*.

We appreciate the opportunity to provide comments on Indiana’s *HIP 2.0 Section 1115 Waiver Application*. If you have any questions, please contact Dr. LaShawn McIver at [lmciver@diabetes.org](mailto:lmciver@diabetes.org) or (703) 299-5528.

Sincerely,



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Managing Director, Public Policy & Strategic Alliances  
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American Diabetes Association

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<sup>i</sup> Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid for People with Diabetes*, November 2012. Available at [http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383\\_d.pdf](http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf).

<sup>ii</sup> Indiana State Department of Health, *Burden of Diabetes in Indiana*, 2011. Available at [http://www.in.gov/isdh/files/BR\\_Diabetes-2011.pdf](http://www.in.gov/isdh/files/BR_Diabetes-2011.pdf).

<sup>iii</sup> Stevens CD, Schriger DL, Raffetto B, et. al, *Geographic Clustering of Diabetic Lower-Extremity Amputations in Low-Income Regions of California*, 8 *Health Affairs* 33, August 2014.

<sup>iv</sup> American Diabetes Association, *Standards of Medical Care in Diabetes—2014*, *Diabetes Care*, S43, January 2014. Available at [http://care.diabetesjournals.org/content/37/Supplement\\_1/S14.extract](http://care.diabetesjournals.org/content/37/Supplement_1/S14.extract)

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<sup>v</sup> Patient Protection and Affordable Care Act, Public Law 111-148, §1302(b)(4)(B), March 23, 2010. Note: Through rulemaking the Secretary allowed states to define EHB through a benchmark plan process.

<sup>vi</sup> Id. at § 2001(a)(2)(A).

<sup>vii</sup> Id. at § 2001(c)(3).

<sup>viii</sup> Id. at § 2001(a)(2)(A).

<sup>ix</sup> 42 C.F.R. § 440.315.

<sup>x</sup> Id. at § 440.315(f).

<sup>xi</sup> Abdus S, Hudson J, Hill SC, Selden TM, Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

<sup>xii</sup> Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013.

<sup>xiii</sup> 42 C.F.R. § 447.52(e)(1) and § 447.55(a).

<sup>xiv</sup> 42 U.S.C. § 1315(a).