

September 19, 2014

**VIA ELECTRONIC SUBMISSION**

**Re: The Healthy Indiana Plan (HIP) 2.0 Section 1115 Demonstration Application**

To Whom It May Concern:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to submit comments regarding the proposed expansion of the Healthy Indiana Plan (HIP)—called HIP 2.0—under a Section 1115 demonstration waiver.<sup>1</sup> PhRMA is a voluntary nonprofit organization representing the country’s leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives.

The HIP 2.0 Demonstration Application asserts that it aims to increase access and lower costs of care for Medicaid beneficiaries by encouraging “responsible consumer-driven health care.” The proposal would expand access to Medicaid by enrolling approximately 559,000 uninsured, non-disabled, non-medically frail adults (aged 19 years through 64 years) with income up to 138% of the federal poverty level (FPL) using a modified version of Indiana’s existing HIP program. Under HIP 2.0, the State would contract with health plans to offer three commercial-plan like Alternative Benefit Plans (ABPs) that are consistent with the federal “essential health benefits” (EHB) requirements: (1) HIP Plus, which would be benchmarked to a “comprehensive commercial EHB” and also will include the State Plan’s adult vision and dental benefit; (2) HIP Basic, based on a “basic commercial EHB” benchmark, Indiana’s largest health maintenance organization (HMO) plan, which would offer reduced benefit coverage and a more limited pharmacy benefit and would require co-payments for most beneficiaries for all services except preventive services; and (3) a plan that would be available to medically frail beneficiaries and would provide full coverage of the benefits described in the Indiana State Plan. All three ABPs would combine a high deductible health plan with a deductible of \$2500 with a Personal Wellness and Responsibility (POWER) account that operates like a Health Savings Account and would be pre-funded by the State up to the level of the deductible. Each beneficiary would receive a debit card that could only be used for covered services through network providers. To encourage prudent choices, beneficiaries would receive monthly statements showing the services purchased and the balance remaining in the account.

Individuals who consistently make required monthly contributions to the POWER account, which are fixed dollar amounts scaled based on income, would maintain access to the HIP Plus plan. Enrollees have a 60-day grace period to make the required monthly contribution. If an enrollee with income between 100 and 138% FPL does not make the monthly contribution within that time, he or she would lose eligibility and would be “locked out” from re-enrolling for a period of six months. If an individual with income of less than 100% FPL does not make the monthly contribution, he or she would be switched to the HIP Basic plan and would not be permitted to re-enroll in HIP Plus until the next annual Medicaid eligibility redetermination period. The HIP Basic plan requires copayments for all services, except for preventive services, in lieu of contributions to the POWER account. The funds in the POWER account could not be used for these co-payments, but rather would be used to cover the remaining plan

---

<sup>1</sup> Indiana Family and Social Services Administration, Healthy Indiana Plan (HIP 2.0) 1115 Waiver Application (July 2014), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2.0/in-healthy-indiana-plan-support-20-pa.pdf>.

deductible. If a HIP Basic enrollee obtains preventive services and has a balance remaining in his or her POWER account at the time of the next annual redetermination of Medicaid eligibility, the enrollee may choose to enroll in HIP Plus and make monthly contributions to the POWER account.

In addition, in 2016, HIP 2.0 will also roll out HIP Link, an optional defined contribution premium assistance program designed to encourage private market coverage as an alternative to HIP for individuals with access to employer sponsored insurance.

In considering the waiver, PhRMA respectfully suggests that the Centers for Medicare & Medicaid Services (CMS) take steps to ensure the proposed consumer-driven features of the Demonstration are appropriately balanced against the need to increase access to quality, affordable health care. Two examples of modifications that we believe would be critical are described in greater detail below.

### **CMS Should Limit the Use of the Lock-Out Period**

PhRMA appreciates Indiana's recognition that requiring the payment of small monthly contributions as a condition for Medicaid eligibility could pose a significant barrier to low-income individuals. The 1115 Waiver Application appropriately responds to data gathered from the existing HIP program and establishes scaled flat monthly contribution amounts for individuals that are lower than those required under the existing HIP.<sup>2</sup> PhRMA also appreciates that under HIP 2.0, individuals with incomes below 100 % FPL who are not able to make the monthly contributions to their POWER accounts will, at a minimum, have access to the EHB through the HIP Basic plan.<sup>3</sup>

Nevertheless, PhRMA remains concerned that the imposition of a monthly contribution—even only \$3—could discourage the lowest-income individuals from enrolling in Medicaid. PhRMA is also concerned that Indiana's proposal to terminate Medicaid coverage for individuals with incomes between 100 and 138 % FPL who are unable to pay the monthly contribution amount within 60 days and to prevent that beneficiary from re-enrolling for six months is especially detrimental to continuity of care. PhRMA is similarly concerned that individuals with incomes below 100% of FPL would not be permitted to re-enroll in HIP Plus until the next annual determination of Medicaid eligibility, which likewise could significantly disrupt a beneficiary's care. Although PhRMA recognizes that requiring monthly contributions to a POWER account is not perfectly analogous to requiring monthly premiums as a condition of Medicaid eligibility, we note that in the federal regulations establishing the limits on premiums for Medicaid beneficiaries, CMS allowed for the termination of individuals who do not pay premiums past due for 60 days or more but indicated that "no further consequences can be applied for non-payment of Medicaid premiums, including 'lock-out' periods."<sup>4</sup> For this reason, PhRMA urges CMS to, at a minimum, condition approval of the waiver on agreement that Indiana will conduct regular assessments as to whether the required POWER account contributions discourage initial Medicaid enrollment by the affected populations. CMS also should closely monitor the numbers of individuals whose coverage is terminated or who are moved from HIP Plus to HIP Basic for failure to make their monthly contributions.

### **CMS Should Carefully Examine SPAs to Ensure Plan Compliance with Federal Requirements**

---

<sup>2</sup> HIP 2.0 1115 Waiver Application, *supra* note 1, at 29 & Table 4.4.1.

<sup>3</sup> *Id.* at 29–30.

<sup>4</sup> 78 Fed. Reg. 42,2160, 42,280 (July 15, 2013); *see also* 42 C.F.R. § 447.55(b)(5).

PhRMA also urges CMS to carefully evaluate the State Plan Amendments for the HIP Plus and HIP Basic ABPs to ensure that they are entirely consistent with all applicable Medicaid and EHB requirements and to ensure that individuals enrolled in either plan will continue to receive comprehensive prescription drug coverage in accordance with the Medicaid statute. In particular, PhRMA requests that CMS examine the “more limited pharmacy benefit” that is available under the HIP Basic plan,<sup>5</sup> to verify that it is consistent with the Medicaid statute and the federal EHB anti-discrimination requirement, as some plan benefit designs may discriminate against individuals whose health conditions and quality of life depend on access to specific medications.

\* \* \* \* \*

We thank you for your consideration of these comments on the HIP 2.0 1115 Waiver Application based on our initial assessment. We look forward to the opportunity to continue working with CMS as additional information about HIP 2.0 becomes available, as our analysis continues, and as implementation proceeds. Please contact me if you have any questions regarding these comments. Thank you again for your attention to these important issues.

Respectfully submitted,

Tara C.F. Ryan  
Vice President, State Policy

---

<sup>5</sup> *Id.* at 5.