Indiana Coalition for Human Services ICHS)

Comments on the Healthy Indiana Plan (HIP) 2.0 Waiver Application (submitted 9/20/14)

Indiana Coalition for Human Services (ICHS) appreciates the opportunity to **support the Administration's Healthy Indiana Plan (HIP) 2.0 1115 Waiver Application and to urge an expedited approval**. ICHS is a coalition of human service advocacy organizations and direct service providers that serve statewide, regional and local constituencies. (See www.ichsonline.org for list of members and their missions.) We advocate that all Hoosiers have quality, affordable, comprehensive healthcare options.

ICHS has helped to lead the Cover Indiana campaign (www.coverindiana.org), a statewide grassroots effort to close the coverage gap. The Cover Indiana campaign consists of consumers, consumer advocacy organizations, religious groups, health care providers, human services, businesses and labor organizations committed to healthcare coverage expansion.

ICHS wants to ensure that all low-income individuals with incomes below 138% of poverty have affordable options for comprehensive healthcare coverage. To this end, ICHS has supported expansion of Medicaid as allowed under the Affordable Care Act.

ICHS has also supported the Healthy Indiana Plan as a means to provide health insurance to low-income adults who have had no other access to coverage. The HIP program has provided tens of thousands of Hoosiers access to quality healthcare. Our members' direct contact with HIP and Medicaid participants offers valuable lessons for the proposed three-tiered plan for HIP 2.0.

ICHS supports the Administration's efforts to expand coverage to uninsured Hoosiers through HIP 2.0. The proposed program design builds on the experience of HIP, while offering a creative response to expand Medicaid under the Affordable Care Act. ICHS has appreciates the responsiveness of Indiana Family Social Services Administration (FSSA) in answering our questions, accepting feedback and even requesting our specific constructive solutions.

ICHS urges the federal Centers for Medicare and Medicaid Services (CMS) to provide an expedited approval of the State of Indiana's HIP 2.0 1115 Waiver Application because the implementation of HIP 2.0 is the best and most expeditious way to provide health care coverage to the hundreds of thousands of hard working, low income Hoosiers who are currently stranded without any coverage. **Please approve HIP 2.0, continuing CMS' appreciation of different circumstances among the states, just as CMS has approved variations to date.** Indiana stakeholders are working with FSSA on the earliest and smoothest implementation in 2015.

In the event that CMS either delays or denies approval of HIP 2.0, ICHS urges continuation of the current HIP program to ensure continuity of care for the tens of thousands of Hoosiers who currently rely on the Healthy Indiana Plan.

In the following pages, we respectfully outline comments, concerns and possible solutions which we have shared with FSSA through the formal comment process and in-person meetings. We are eager to work together to close the coverage gap.

Patients and providers alike appreciate many features of the current HIP program, including:

- Access to preventative care and screenings – This is a proven cost-saving feature to improve the health status of our residents.
- Ability of employers and nonprofits to contribute to POWER account payments – This provision helps ensure continued coverage when an individual encounters financial difficulties.
- Payment rates to providers above the Medicaid rate – This assists in recruiting a robust range of medical provider participation in HIP.

ICHS strongly supports certain changes from the current HIP to HIP 2.0 or features of HIP 2.0, including:

- Elimination of annual and lifetime caps;
- Reduced required POWER account contributions and assurance that all out-of-pocket costs do not exceed 5% of family income;
- Robust menu of covered services, including adult vision and dental in HIP 2.0 Plus; and
- Continuous eligibility for at least HIP Basic if participants fail to make a contribution or have changes in their income or life situation.

Based on the experience of healthcare stakeholders, human service providers and HIP participants, ICHS offers the following **questions, concerns and *recommendations* about HIP 2.0**:

Program design

- **Vision to "bend the cost curve" relative to cost estimates** – ICHS appreciates the vision that HIP may help "bend the cost curve" and appreciates the desire for budget neutrality, as rising healthcare costs are a serious concern for the fiscal health of our families' and our State's budget. Cost estimates from Milliman for the HIP program have ranged from costing more or less than Medicaid expansion. The variance in these estimates shows a level of uncertainty. *ICHS recommends that FSSA track costs and health outcomes according to related underlying assumptions and request modification on certain features, as needed.*
- **Co-pays, POWER accounts and challenge of collections –** ICHS understands the personal responsibility feature of the POWER account and co-pays that are aligned with federal rules. ICHS understands the central focus of financial contribution and does not challenge this part of the program design. However, given the very low incomes of current HIP participants (82% of participants were under 125% FPL and many others are just over), we also recognize that eligible families have very limited resources and often lack the life skills or culture of prioritizing payment for healthcare services. We offer three specific recommendations.
    - Healthcare providers report that it often costs more to collect co-pays than to write them off. Many healthcare providers and nonprofit service providers are currently absorbing these costs to keep families enrolled in coverage. This practice may be impractical to continue for the expected large number of new enrollees. *ICHS recommends that FSSA-OMPP and CMS work with healthcare providers, human service providers and related nonprofit funders to develop a plan to address this issue. The plan*

should minimize administrative burden on all involved—patients, providers and FSSA—and should include strong, ongoing health insurance education for participants, as many of the uninsured do not understand how health insurance works (premiums, deductibles, co-pays, "in-network" vs. "out-of-network," etc.).

- Many low-wage workers operate in a "cash only" economy and/or do not have access to traditional financial products for making electronic payments. Sending cash through the postal mail does not provide a tracking tool. According to the FDIC, 7.8% of Hoosiers are unbanked (having no access to bank accounts) and an additional 19.1% are underbanked. *ICHS recommends that FSSA find alternatives for these individuals to make payments with cash. Examples might include payments through local BMV offices or major retailers such as grocery stores or pharmacies, as long as there is no additional fee for the participant for making payments with cash.*
- Individuals in the private market have options for prepaying monthly costs, often with a discount if paying in 3-, 6- or 12-month advance payments. Many low-wage workers often have additional funds at certain times of the year, such as with overtime in peak seasons and at tax refund time. Pre-payment aligns with the idea of consumer personal responsibility and planning ahead. *ICHS recommends that FSSA consider options for prepayment of POWER accounts by participants.*

Features of coverage

- **Lockout provisions and disenrollment process** – The proposed plan allows administrative cancellation of coverage for nonpayment for people with incomes over 100% of FPL, and does not allow re-enrollment upon payment for 6 months.
  - This lockout provision may be unnecessarily punitive given instances of payment processing mix-ups and extraordinary healthcare circumstances. This is unlike traditional healthcare programs that allow re-enrollment upon payment. ICHS asserts that disenrollment in HIP has been artificially low (8%) because the population currently enrolled in HIP had a pent up demand for health services and has strong incentives to remain enrolled. We speculate this rate would be much higher with a larger, healthier population.
  - Implementing this lockout and disenrollment process for nonpayment with up to 350,000 Hoosiers during a time of implementation of multiple other changes is simply unrealistic and impractical. *ICHS recommends a provision to allow a clear appeal process with retroactive coverage if deemed to be a processing mix-up or extraordinary circumstances.*
- **Types of coverage and eligible healthcare service providers** – The plan does not include certain coverage that might be needed in special circumstances. Examples of these plan limitations might include exclusion of chiropractic care and non-emergency transportation, and limits on home health and skilled nursing care, limits on physical, speech and occupational therapy and hearing aids. While we understand the desire to control costs, *ICHS encourages offering basic coverage in certain optional services upon referral by a participant's primary care physician. Additionally, ICHS supports a provision that would allow a participant's primary care physician to override the requirement to substitute generics for brand-name drugs, especially for drugs prescribed for mental illness. ICHS recommends that FSSA allow a range of healthcare providers to dispense medications. Finally, ICHS recommends that FSSA include coverage for non-emergency transportation for patients with needs.*

- **Family planning option** -- ICHS appreciates efforts to provide options through either HIP or Medicaid for pregnant women. Healthy pregnancies and health children depend on it. The proposed application does not address whether the state will continue its family planning waiver. ICHS appreciates the options and benefit wrap, but finds the described plan for options unclear in its eligibility and services. *When such options are offered, the process for selection of services should be consumer-friendly, reflect the best option for the individual's needs, subject to change with the patient's situation, and provide continuous coverage during pregnancy and after miscarriage or pregnancy. The services that are covered in the current Medicaid Family Planning State Plan Amendment should continue in HIP 2.0.*

Eligibility issues

- **Multiple types of eligibility and types of coverage within a household** – ICHS strongly supports the intention of family coverage through one carrier starting in 2016, as we know that multiple types of coverage in one household impact their access to and quality of care. Currently, a two-parent family with two children living in a rural county could conceivably access four different types of coverage, i.e. one child on traditional Medicaid, one child on Medicaid managed care for chronic illness, one parent purchasing private insurance via the Federally Facilitated Exchange and one parent on HIP Basic or 2.0. Because some primary care physicians that accept HIP do not also accept Medicaid, this could require multiple primary care physicians in different cities, thwarting policy preferences for assuring a medical home for all consumers. The e*ligibility processes should be consistent and smooth across the healthcare coverage programs accessed by different members of the same family. ICHS urges every effort to streamline application and eligibility verification processes, to maintain policies that support family coverage through one carrier AND to build out robust plan coverage.*
- **Changing incomes of the population throughout the year** – The application describes a how eligibility will be determined based on Modified Adjusted Gross Income (MAGI) with a requirement to provide information on changes in income to FSSA. Low-wage workers often have large fluctuations of income based on the time of year (i.e. seasonal workers, overtime pay) and the economic conditions of that county. *To reduce administrative burden and increase consistency of care, ICHS recommends implementation of continuous eligibility and a clear process for determination. This would also decrease the administrative burden on the State.*
- **Required referral –Gateway to Work program** – ICHS supports the concept of providing referrals and education about employment and training opportunities. However, ICHS also has concerns that the current employment services infrastructure may not have the capacity to serve the potential influx of job-searchers. *ICHS recommends that 1) the Gateway to Work program remain a referral without work participation requirements (we understand work requirements would violate federal rules), and 2) the State invest in and maximize available resources to expand capacity of the employment and training services.*

Implementation

- **Scalability** – ICHS is concerned about FSSA's capacity to implement HIP 2.0 from the current HIP program enrollment of 45,000 individuals to possibly 350,000 individuals. Currently, as we understand, the Medicaid and HIP systems do not share information. Therefore, a family may report an income change in one or two eligibility programs and erroneously believe that their information is being updated in another program (i.e., SNAP, Medicaid and HIP). *ICHS*

recommends aligning application and eligibility verification across as many benefit programs as possible, with Medicaid, HIP and the Federally Facilitated Marketplace at a minimum, and working with stakeholders very closely for a feedback loop for rapid-response adaptations as issues arise.

- **Categorical and presumptive eligibility** – ICHS understands there are opportunities to implement categorical eligibility across eligibility programs and presumptive eligibility in the healthcare settings--which benefit the consumer, healthcare providers and the State. *ICHS urges that FSSA maximize opportunities to increase services through categorical and presumptive eligibility, and thus to decrease administrative duplication and gaps in coverage.*
- **Streamlining of forms and processes** – Physical and mental health care providers report challenges of managing separate forms for credentialing and prior authorizations with managed care organizations and health insurance plans, despite that most require the same information. *ICHS urges use that FSSA, IN Dept. of Insurance and providers work to use standardized forms and processes or a central repository when possible.*
- **Outreach and marketing** – The first year of HIP was accompanied by strong investments in professional marketing and outreach. Participants will be confused about options and processes, especially if application for HIP 2.0 lies outside of the Federally Facilitated Marketplace and during a time period outside of open enrollment in employer-based or Marketplace plans. *ICHS urges a collaborative approach with health and human service providers and investments in a marketing plan. ICHS urges that the marketing plan begin in advance of the enrollment start. Ideally, the initial marketing and consumer education messages will be available in November, 2014, to align with the open enrollment of the Marketplace. ICHS is eager to work with FSSA on outreach and consumer education.*
- **Enrollment assistance** – Participants will need help with making initial and renewal applications, and with understanding eligibility, application follow-up inquiries and their coverage. Many nonprofit health and human service providers already play this role. Some are reimbursed; most are not. The current requirements for Indiana Navigators imposed by state law and the Indiana Department of Insurance create barriers for some organizations to assisting participants with information or enrollment. *ICHS recommends that FSSA provide human service organizations—even if they are not official assisters or navigators—regular communications and protocols to access client information for the purpose of assisting them. This could be similar to the process allowed in other eligibility programs. 2-1-1 will likely play a role in helping clients with information and referrals to appropriate programs. Where available, funding should help these organizations serving as formal Navigators or informal assisters. Where possible, barriers to organizations providing enrollment assistance should be addressed.*
- **Stakeholder input** – ICHS and the Cover Indiana campaign include a diverse range of healthcare, human service and consumer organizations that serve every county in Indiana. *ICHS respectfully requests the Administration work directly with us to assure the best implementation possible. Any advisory committees involved with implementing and administering HIP 2.0 should include human service professionals who understand poverty and the ways programs actually work in local communities.*
- **Ongoing health insurance education –** As the three tiers of HIP 2.0 are implemented, education about how to use insurance is critical. Many of the uninsured do not understand preventative care, co-pays, deductibles, incentives and best ways to access services. For example, HIP 2.0 rewards participants for full access of preventative care services in a year or

for use of a nurse triage line prior to emergency room use. *ICHS recommends that FSSA work with stakeholders and plans to ensure appropriate consumer education about health insurance and healthcare delivery. Education should be delivered in culturally and linguistically appropriate methods.*

Thank you for the opportunity to provide comments and constructive ideas for a smooth implementation. **ICHS urges expedited approval of HIP 2.0 by CMS.** Indiana Coalition for Human Services is eager to work with State and Federal agencies to implement HIP 2.0.

For follow-up to these comments or implementation considerations, you may contact:
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