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March 16, 2017

The Honorable Tom Price, Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

**Re: HIP 2.0 1115 Demonstration Waiver Extension**

Dear Secretary Price:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Indiana's proposal to extend and modify the Healthy Indiana Plan (HIP) 2.0 demonstration waiver. We value the transparent process the Centers for Medicare and Medicaid Services (CMS) utilizes to seek input and comments on 1115 demonstration waiver proposals. An open and transparent process provides organizations like ours an opportunity to share our views on the impact of waiver proposals on people with chronic conditions, like cancer. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

We support Indiana's decision to preserve low-income Hoosier's access to health care coverage through HIP 2.0, but we are concerned with many of the proposed modifications. Over 36,000 Hoosiers are expected to be diagnosed with cancer this year – many of whom are receiving health care coverage through the HIP program.[1] We urge CMS to consider our comments as it weighs Indiana's proposed waiver modifications to ensure that low-income Hoosiers have access to quality, affordable, and comprehensive health insurance.

Our comments build on previous communications with the state and CMS. ACS CAN wants to ensure that cancer patients and survivors in Indiana will have adequate access and coverage under the HIP program, and that specific requirements do not have the effect of creating barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer.

Following are our specific comments on the state's HIP 2.0 waiver extension application.

**Tobacco Use Surcharge**

In the current waiver, all HIP members are required to pay a two percent monthly contribution to their Personal Wellness and Responsibility (POWER) account in order to maintain access to the enhanced HIP

[1] American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta, GA: American Cancer Society; 2017.

Plus plan. In the waiver renewal, the Family and Social Services Administration (FSSA) seeks to require members who are known tobacco users to pay a monthly tobacco use surcharge equal to three percent of income after their first year of enrollment in HIP – in hopes of encouraging participation in the proposed voluntary tobacco cessation incentive initiative. We appreciate and share the FSSA's goal to disincentive tobacco use and improve participation in tobacco cessation services, but a surcharge on HIP members who use tobacco is not the most effective way to discourage tobacco use or encourage participation in the expanded voluntary tobacco cessation incentive initiative proposed in this waiver. Research has shown that penalizing smokers with higher insurance costs will result in a reduced likelihood of being able to afford coverage with no significant benefits for smoking cessation.[2,3] Additionally, it is well-documented that cost is a major barrier to individuals obtaining health insurance coverage and prevention services.[4] Tobacco users are disproportionately low-income[5] and at higher risk for chronic diseases associated with tobacco addiction, including lung cancer;[6] therefore, preserving access to affordable health care for these individuals is particularly important.

An increase in premiums, even of one percent, may price HIP members – who are by definition low-income – out of the very coverage they need to help them quit, and to the screening services needed to detect cancer early and save lives. However, modest financial incentives to individuals not tied to cost sharing can be effective at increasing participation in prevention services.[7] For example, employers who offer employees money for completing a smoking cessation program have seen quit rates significantly higher than in cessation programs without such incentives.[8] Ultimately, HIP 2.0 should ensure access to in-person individual, in-person group, and telephone counseling and all forms of tobacco cessation medications approved by the U.S. Food and Drug Administration (FDA), without any barriers to access such as copayments, step therapy, or prior authorization.

Tobacco dependence often requires multiple interventions and attempts to quit.[9] Research shows that the most effective way to help people quit is to provide access to both cessation counseling and FDA-

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[2] Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540. Accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract

[3] Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

[4] Kaiser Family Foundation. *Preventive Services Covered by Private Health Plans Under the Affordable Care Act*. Aug. 4, 2015. Available at http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/.

[5] Centers for Disease Control and Prevention: Current Cigarette Smoking Among Adults—United States, 2005–2015. *Morbidity and Mortality Weekly Report.* 2016;65(44):1205–11.

[6] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General,* 2014. Available at https://www.surgeongeneral.gov/library/reports/50-years-of-progress/.

[7] Cahill K, Hartmann-Boyce J, Perera R. Incentives for Smoking Cessation. *Cochrane Database Syst Rev.* 2015. doi: 10.1002/14651858.CD004307.pub5.

[8] Halpern S, French B, Small DS, et al. Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation. *N Engl J Med.* 2015; 372: 2108-2117.

[9] U.S. Department of Health and Human Services. Public Health Service. *Treating Tobacco Use and Dependence: 2008 Update*. Available at https://www.ncbi.nlm.nih.gov/books/NBK63952/.

approved medications.[10,11] According to the U.S. Public Health Service Guide to Treating Tobacco Use and Dependence and the U.S. Preventive Services Task Force, individual, group and telephone cessation counseling and seven FDA-approved medications have been shown to be effective in increasing quitting. Combinations of medications and counseling are more effective than each intervention alone.[12,13]

ACS CAN believes increasing premiums for tobacco users goes against the intent of Indiana's hope to improve Hoosiers' health by decreasing tobacco use amongst its HIP Medicaid enrollees. Therefore, ACS CAN urges CMS to deny the proposed tobacco surcharge, as it will only create more barriers to low-income Hoosiers to quit smoking, preventing them from achieving and maintaining good health.

**Healthy Incentive Initiative**

We support the goal of the healthy incentive initiative, but the use of outcomes-based incentive programs, such as penalizing enrollees for non-compliance or failing to reach care or disease management goals, will not likely generate cost savings or improve the health of low-income Hoosiers. As an alternative, we would support a participatory healthy incentive program, as evidence shows that unhealthy behaviors can be changed or modified by incentives, as long as they are combined with adequate medical services and health promotion programs.[14] Outcomes-based programs could unfairly penalize individuals managing complex, chronic diseases like cancer. For example, the treatment used to treat an individual's cancer may result in long-term physical side effects that may hinder mobility and physical activity, preventing them from easily contributing to their POWER accounts.

Further, educating, encouraging, and raising HIP members' awareness of the benefits, services and incentive programs will significantly contribute to the program goal of improving health outcomes for all members. Unfortunately, according to the HIP 2.0 Interim Evaluation Report, over 50 percent of members did not know that they could utilize their preventive services benefit at no cost, two-thirds did not know about the preventive services incentive program or the rollover option, and more than one-third of HIP Basic enrollees did not know they could reduce their monthly contributions (premiums) if they received recommended preventive services.[15] Educating people about the program, and encouraging appropriate utilization of health benefits, specifically primary and preventive care services, will help to reduce the state's cancer burden and associated costs.

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[10] U.S. Preventive Services Task Force. *Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions.* Published September 2015. https://www.uspreventiveservicestaskforce.org/ Page/ Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1.

[11] U.S. Department of Health and Human Services. Public Health Service. *Treating Tobacco Use and Dependence: 2008 Update*. Available at https://www.ncbi.nlm.nih.gov/books/NBK63952/.

[12] Ibid.

[13] U.S. Preventive Services Task Force. *Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions.* Published September 2015. https://www.uspreventiveservicestaskforce.org/ Page/ Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1.

[14] Consensus statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society Cancer Action network, American Diabetes Association, and American Heart Association. Guidance for a reasonably designed, employer-sponsored wellness program using outcomes-based incentives. *JOEM.* 2012; 54(7): 889-96.

[15] The Lewin Group, Inc. *Indiana health Indiana plan 2.0: interim evaluation report*. Published July 6, 2016. Accessed January 2017. http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20 Evaluation%20Report_FINAL.pdf.

**Open Enrollment and Six Month Lock-Out Period**
We are deeply concerned about the proposed 6-month lock-out period for those individuals who do not comply with the redetermination process. While individuals who are medically frail would be exempted from the lock-out, we urge CMS to require FSSA to include an option for a non-medically frail individual to apply for an exemption to the 6-month lock-out. Subjecting enrollees to the lock-out without exception could have overwhelming effects on individuals and families, especially those facing a new cancer diagnosis or a cancer reoccurrence. Being denied access to one's cancer care team for 6-months could be a matter of life or death for a cancer patient and the financial toll that the lock-out would have on individuals and their families could be devastating.

**Copayments for Non-Emergent Emergency Department Use**
We are concerned about the FSSA's request to gain additional approval for graduated copayments for inappropriate emergency department (ED) use through January 31, 2018 and the impact that graduated copayments could have on cancer patients. Imposing graduated copayments may dissuade an individual from seeking care from an ED setting – even if the case is medically warranted. Cancer patients undergoing chemotherapy and/or radiation often have adverse drug reactions or other related health problems that require immediate care during evenings or weekends. If primary care settings and other facilities are not available, these patients are often directed to the ED.

When reviewing the current independent evaluation of this cost sharing requirement, we request that CMS scrutinize the impact the requirement has on patients with complex chronic conditions, such as cancer. If the graduated copayments are impacting cancer patients and others managing complex chronic conditions, we should have access to this information and would hope that we could work with CMS and FFSA to address the access and affordability issues that HIP enrollees experience as a result of the requirement.

**Non-Emergency Medical Transportation (NEMT)**
We continue to oppose Indiana's request to continue waiving NEMT service for members who are not medically frail. We are concerned the continued use of the NEMT waiver will create barriers to HIP members accessing primary care and preventive services, such as cancer screenings and diagnostic testing services. NEMT is used by individuals to access preventive services and cancer screenings – especially colon cancer screenings and mammograms. Early detection of cancer through preventive services generally results in less expensive treatments and better health outcomes.[16] For example, colorectal and cervical cancer screenings can prevent cancer by detecting and removing pre-cancerous lesions.

As indicated in the NEMT Evaluation Report, transportation challenges were reported as the main reason HIP members missed appointments, particularly for those below 100 percent FPL. According to the report "missing appointments impacts patients' preventive care and overall quality of care, with the open ended questions indicating a negative impact."[17] Community health centers and beneficiary

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[16] American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2015-2016. 2016 Update. Atlanta: American Cancer Society; 2016.
[17] The Lewin Group, Inc. *Indiana HIP 2.0: evaluation of non-emergency medical transportation (NEMT) waiver*. Published February 26, 2016. Accessed January 2017. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-

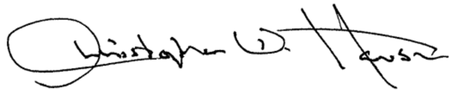
advocates indicate that a lack of access to transportation through the Medicaid program results in patients missing appointments. Therefore, we strongly urge CMS to deny Indiana's request to continue waiving NEMT to non-medically frail Indiana HIP enrollees.

**Conclusion**

We appreciate the opportunity to provide comments on Indiana's HIP 2.0 waiver extension application. Upon further consideration of the policies that will be included in the final waiver extension application, we ask CMS to weigh the impact such policies may have on access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the Administration to ensure that all Americans are positioned to win the fight against cancer. If you have any questions, please feel free to contact me or have your staff contact Michelle DelFavero of our policy team at Michelle.DelFavero@cancer.org or 202-585-3266.

Sincerely,



Christopher W. Hansen
President
American Cancer Society Cancer Action Network

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Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-eval-nonemerg-med-transport-02262016.pdf.