November 19, 2026

The Honorable Robert F. Kennedy
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Healthy Indiana Plan (HIP) 3.0 Waiver Application

Dear Secretary Kennedy:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Indiana's application for a new five-year section 1115 demonstration, the Healthy Indiana Plan (HIP) 3.0, published on October 9, 2026.[1] ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

ACS CAN has serious concerns about policies in this proposal and missing information in the application. We urge the Centers for Medicare and Medicaid Services (CMS) to require the state to re-submit the application with required information and provide stakeholders with adequate opportunity for public comment. Our concerns are detailed below:

Moving Medicaid Expansion to Waiver Authority
Following a legislative mandate, Indiana is seeking waiver authority to remove its Adult Expansion from the Medicaid state plan and cover the Adult Expansion population solely through the HIP 3.0 section 1115 demonstration. Eligibility for the section 1115 demonstration would continue to be adults between the ages of 19-64 with a household income up to 138% of the federal poverty level who are not otherwise eligible for Medicaid.

ACS CAN opposes this change as moving the adult expansion population to section 1115 waiver authority is unnecessary and does not align with the intended use of section 1115 demonstrations. Medicaid expansion was first implemented by Indiana in 2015 and is now a fundamental part of the state's healthcare system, serving over half a million residents in Indiana.[2] Medicaid expansion is a well-established policy, not an experimental one, and is associated with improved health outcomes

[1] Indiana Family and Social Services Administration. Healthy Indiana Plan (HIP) 3.0 Section 1115 Waiver Application. October 9, 2026. Healthy Indiana Plan (HIP) 3.0 — Section 1115 Waiver Application.
[2] Medicaid Expansion Enrollment. KFF. June 2025. Available at: https://www.kff.org/medicaid/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

for patients with chronic disease, greater uptake of preventive care, and lower overall mortality.[3] Moving this population to 1115 waiver authority is unnecessary and goes against recent CMS guidance encouraging reduced reliance on 1115 demonstrations where alternative authorities were available.[4]

Copayments

The Indiana Family and Social Services Administration (heretofore referred to as the Department) seeks to implement cost-sharing through point-of-service copayments as soon as possible. The proposed copayment system is complicated, including an initial amount for individuals entering the program, a reduced amount if/when the individual completes their "healthy behaviors", and a full amount if the individual does not meet the health behavior standard. The completion of healthy behaviors lowers an individual's copayment amount, but does not eliminate the copayment. Cancer-related services that will require a copayment include: outpatient services ($5-15), pharmacy drugs ($1-8), specialist visits ($5-20), urgent care ($10-25) and non-emergent use of the Emergency Department ($35 regardless of healthy behaviors).[5]

ACS CAN strongly opposes instituting cost-sharing for services in Medicaid, as this policy will negatively impact people with cancer, cancer survivors, and individuals being tested for cancer. The list of services that will be subject to the new cost-sharing policy include many services that cancer patients need frequently and must maintain easy access to, including the services listed above. Even after a patient has survived cancer, they must continue to monitor for recurrence, and will likely continue to pay higher cost-sharing for pharmacy drugs, outpatient services, and specialist visits.

ACS CAN is concerned about the potential impact of cost sharing on enrollees facing cancer and other chronic health conditions. Cost sharing can create financial burdens for enrollees, and cause significant disruptions in care, especially for cancer patients and survivors. Imposing copayments or out-of-pocket costs on low-income populations has been shown to decrease the likelihood that they will seek healthcare services, including preventive screenings.[6,7,8] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[9]

Cancer patients undergoing an active course of treatment for a life-threatening health condition need

---

[3] Guth, Madeline and Ammula, Meghana. Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021. KFF. May 6, 2021. Available at: https://www.kff.org/affordable-care-act/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/#f89969af-7af4-45d0-b41c-398865c1d798.

[4] Department of Health and Human Services. SMD # 26-003 RE: Budget Neutrality and Certification by the Chief Actuary of CMS for Section 1115 Medicaid Demonstration Projects. June 11, 2026. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf.

[5] Ibid., pg. 12.

[6] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research.* 2000; 34: 1331-50.

[7] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care.* 2011; 49: 865-71.

[8] Trivedi AN, Rakowsi W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med.* 2008; 358: 375-83.

[9] American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures, 2021-2022*. Atlanta: American Cancer Society; 2021.

uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes. Additionally, recent cancer survivors often require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence,[10] and suffer from multiple comorbidities linked to their cancer treatments.[11,12] Ensuring cancer patients, survivors, and those undergoing testing for cancer receive the care they need is critical to positive health outcomes. ACS CAN encourages CMS to consider the impact of charging cost-sharing for such a wide range of medically necessary services and at amounts that will create hardships – and therefore access barriers – for the low-income Medicaid population. While we recognize that federal law will require some amount and type of cost-sharing being applied by October 1, 2028; we urge CMS to not approve this added cost-sharing earlier than required, or before CMS has given states guidance on this requirement.

The proposed amendment also includes higher cost-sharing for non-emergency use of hospital emergency department (ED). This proposal could also increase costs for cancer patients and deter them from seeking care. 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. One study estimates there are 4 million adult cancer–related ED visits each year in the US.[13] The most frequent reasons cancer patients receive care in the ED are pain, fever, and weakness[14] – symptoms that are understandably alarming for patients undergoing invasive or toxic treatments like chemotherapy. This study also found that 77% of cancer patients did not make the decision to go to the ED alone: healthcare providers (40%, most commonly oncologists) and caregivers (36%) were the other reported decision-makers in these cases.[15] Low-income cancer patients should not be financially penalized for seeking care through the ED, regardless of their eventual diagnosis or how their visit was ultimately coded by the ED. Imposing higher cost-sharing may dissuade an individual from seeking any care from an ED setting – even when it is appropriate for them to go to an ED or they are told to do so by their clinician.

Healthy Incentive Initiative

Indiana proposes a healthy behaviors incentive, where members who complete at least three specified healthy behaviors within a benefit period can receive a reduced copayment fee for the remainder of the benefit period and the following benefit period. Healthy behaviors include

[10] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed August 2021. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.

[11] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[12] Xiao Y, Wang H, Tang Y, et al. Increased risk of diabetes in cancer survivors: a pooled analysis of 13 population-based cohort studies. ESMO Open. 2021;6(4):100218. doi:10.1016/j.esmoop.2021.100218.

[13] Rivera DR, Gallicchio L, Brown J, Liu B, Kyriacou DN, Shelburne N. Trends in Adult Cancer–Related Emergency Department Utilization: An Analysis of Data From the Nationwide Emergency Department Sample. JAMA Oncol. 2017;3(10):e172450. doi:10.1001/jamaoncol.2017.2450.

[14] Lash RS, Bell JF, Reed SC, et al. A Systematic Review of Emergency Department Use Among Cancer Patients. Cancer Nurs. 2017;40(2):135-144. doi:10.1097/NCC.0000000000000360.

[15] Ibid.

preventive care services, such as annual wellness exams, lab testing, cancer screenings, and vaccines, and chronic disease management services. Completion of healthy behaviors will be verified by claims data.

While ACS CAN shares the Department's goal of increasing Medicaid enrollees' use of preventive care and chronic disease management services, we note that the HIP is structured so that enrollees who are not able to complete three of the services are punished by being charged higher cost-sharing for medically necessary services.

Research indicates that penalizing enrollees for non-compliance with state-dictated healthy behaviors will not likely generate cost savings or improve the health of low-income Medicaid enrollees.[16] We are also concerned about the way this initiative is structured: enrollees will not have their cost-sharing reduced to the smaller amounts until they complete three of the specified services. Many of these services require a clinician visit, which must be scheduled based on the clinician's schedule and requires the enrollee to overcome access barriers to attend (such as transportation, child care, etc.). Additionally, many of the services on the list, including cancer screenings and vaccines, are given on a specific schedule and would likely not all occur when the enrollee needs to have them in order to quickly "earn" their lower cost-sharing. Even an enrollee who was fully engaged and incredibly motivated to complete their services would have to take some amount of time to earn their lower cost-sharing amounts. Additionally, there are likely to be lags in the claims data that the Department plans to use to confirm compliance. While the enrollee is waiting for their appointments, attempting to access care, or waiting for the data systems to catch up; they are paying higher cost-sharing for doctor's visits and monthly prescriptions. It is unclear whether the enrollee would be reimbursed for higher cost-sharing they paid while completing the requirements or waiting for data confirmation – but even if they are, this reimbursement will not prevent higher cost-sharing at point-of-service from impacting these low income enrollees.

We believe state residents would be better served by a comprehensive, evidence-based participatory wellness initiative based on incentives that provides adequate and comprehensive coverage of preventive services (including tobacco cessation, weight loss, and cancer screenings) and that emphasize evidence-based interventions to educate, promote, and encourage patients to participate in prevention, early detection, and wellness. Evidence shows that unhealthy behaviors can be changed or modified by modest incentives, rather than penalties, as long as they are combined with adequate medical services and health promotion programs.[17] Providing enrollees incentives could lead to a change in behavior whereas penalties do little to improve health and would reduce access to necessary healthcare services.

Enrollment Cap or Termination of the Program

Indiana is seeking explicit confirmation from CMS that the state may either end HIP expansion coverage or seek amendment of the demonstration to limit enrollment (i.e. impose an enrollment

[16] 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.

[17] Ibid.

cap) if funding is not sufficient.

ACS CAN urges CMS to reject this request, as we would strongly oppose the termination of the Medicaid expansion program or the institution of enrollment caps. If the state has a specific request to limit enrollment in the future, it must submit a formal waiver request subject to public comment periods and formal consideration.

Limiting HIP enrollment does not promote the objectives of Medicaid. Capping Medicaid enrollment is an arbitrary, harmful policy that limits coverage based on who hears about the program first and files their application the fastest. And with implementation of P.L. 119-21-mandated work reporting requirements, an individual may be enrolled in HIP, lose coverage as a result of being deemed non-compliant with the work reporting requirement, and then, due to the enrollment cap, be unable to return to coverage despite being in compliance. For patients in active treatment for a serious condition, being forced to wait for coverage and lifesaving treatment can have devastating health consequences.

Lack of Detail

The state's waiver lacks several key details, leaving stakeholders unable to assess its impact on Indianans. The state intends to implement copayments that exceed the current legal limits, but does not include this request in the state's Requested Waivers list, which makes it unclear which authorities are being requested to be waived. In addition, while Indiana proposes to transition to 1115 authority, the waiver list does not have a list of requested expenditure authorities. Indiana should be required to repost an application with this information for public comment following proper notice.

Conclusion

The goal of the Medicaid program is to provide health coverage and access to care for people who need it. This proposal does not meet this goal and therefore we oppose it. Because the state has not provided a list of requested expenditure authorities or a request to implement higher copayments, we urge CMS to require the state to repost this proposal with the missing information, providing stakeholders adequate opportunity to comment on these features. If you have any questions, please feel free to contact Jennifer Hoque, Policy Director – Access to Care, at jennifer.hoque@cancer.org.

Sincerely,



Anna Schwamlein Howard
Vice President, Public Policy Advocacy
American Cancer Society Cancer Action Network