DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

December 22, 2023

Cora Steinmetz
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Room W461, MS25
Indianapolis, IN 46204

Dear Director Steinmetz:

On October 26, 2020, the Centers for Medicare & Medicaid Services (CMS) approved an extension of the Healthy Indiana Plan (HIP) section 1115 demonstration for a ten-year period, effective January 1, 2021 through December 31, 2030. Among the policies included in the extension was authority for a premium requirement and associated penalties, and waivers of retroactive eligibility and the assurance to provide non-emergency medical transportation (NEMT).

In a letter to Indiana on June 24, 2021[1], CMS indicated it was reviewing authorities previously approved in the HIP demonstration and that such review remained ongoing. CMS has concluded the review of the authorities approved in the HIP demonstration, including the premium requirement. As explained below, CMS has concerns with premium requirements in section 1115 demonstrations generally based on the large body of evidence suggesting that premiums beyond those authorized under the Medicaid statute reduce access to coverage and care among populations that Medicaid is designed to serve. However, we are not taking any action now on the premium authority, or any other authority, in the approved HIP demonstration because, given the totality of the circumstances, we have concluded that withdrawing those authorities at this time is too disruptive, particularly in the context of the state needing to maintain focus on keeping people covered through Medicaid unwinding and the resumption of Medicaid renewals following the COVID-19 Public Health Emergency (PHE). CMS reserves its authority to take appropriate action in the future, as part of its ongoing oversight and monitoring of the HIP demonstration.

CMS's decision aims to minimize any unintended disruptions for the state's Medicaid beneficiaries. The premium requirement and associated penalties, first effective on January 27, 2015, were halted on March 1, 2020, with the onset of the COVID-19 PHE and have not been reinstated to date. As of December 2023, it is CMS's understanding that the state intends has begun efforts to resume implementation of the premium policy in 2024. Since the state is undertaking its unwinding activities following the PHE, any action by CMS on the HIP

[1] CMS letter to State, June 24, 2021: https://www.medicaid.gov/sites/default/files/2023-12/in-healthy-indiana-plan-cms-withdr-commu-engmnt.pdf

demonstration may inadvertently affect the state's ability to effectively prioritize the unwinding efforts. Specifically, the added complexity from any action to the demonstration's overall operational system may lead to inaccuracies in beneficiary eligibility determinations during unwinding and result in beneficiaries being inadvertently disenrolled and delays to new beneficiary enrollment. For example, the state raised operational concerns with the time and resources of phasing out such policies from eligibility systems and managed care plan contracts, as well as the complexity of providing beneficiary communication on such changes during the unwinding period. However, should the state determine they can terminate the premium requirement from the HIP demonstration without impacting their PHE unwinding efforts consistent with recent CMS guidance, CMS encourages the state to do so. CMS would be available to provide technical assistance on mitigating any operational challenges from such a termination, including charting a path to do so without causing undue beneficiary loss of coverage from errors in eligibility determinations processes.

In general, CMS approves demonstrations for a fixed term. At the same time, when CMS receives information raising serious concerns about the evidentiary basis for demonstration authorities, including as part of its ongoing demonstration monitoring and oversight, it can and has taken action to withdraw those authorities. Taking into account these factors, CMS has determined that, at this time, withdrawal of the authority to require premiums beyond those specifically permitted under the Medicaid statute, as approved in the HIP demonstration, could be disruptive to furnishing coverage and medical assistance to HIP beneficiaries. This position concerns only the HIP demonstration and does not indicate CMS's position regarding any other state demonstration with similar authorities, which must be assessed on a case-by-case basis. Evidence on the effects of premiums in the HIP demonstration is preliminary and was interrupted due to the COVID-19 PHE. During the current demonstration extension period, CMS further strengthened requirements for demonstration monitoring and evaluation, which were incorporated into the Monitoring Protocol and Evaluation Design. Consistent with the special terms and conditions (STC) XII.7 and XV.8, CMS has the authority to require the state to submit a corrective action plan if demonstration monitoring data or evaluation findings indicate substantial, sustained directional change inconsistent with demonstration goals and targets. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC III.10. CMS may suspend implementation of the demonstration or withdraw an authority should the state not implement any corrective actions, or any actions not effectively resolve concerns, in a timely manner.

Background of the Premiums Policies in the Healthy Indiana Plan Demonstration

Under HIP, beneficiaries who consistently make required monthly contributions to their POWER Account, regardless of income, maintain access to an enhanced benefit plan, known as "HIP Plus." Beneficiaries with income at or below 100 percent of the federal poverty level (FPL) who do not make monthly POWER Account contributions, including those at the lowest income levels, would be defaulted to a more limited benefit plan, known as "HIP Basic."[2] Beneficiaries

[2] In addition to HIP Plus and HIP Basic, HIP offers HIP State Plan Plus and HIP State Plan Basic to those who are medically frail, those who participate in transitional medical assistance (TMA), Section 1931 parents and caretakers, and those who are low income (less than 19 percent of the FPL) ages 19 and 20 years; and HIP Maternity for beneficiaries who become pregnant.

with income above 100 percent and up to and including 133 percent of the FPL are required to make monthly POWER Account contributions as a condition of eligibility.[3] Beneficiaries make fixed monthly POWER Account contributions based on five income tiers, approximately equivalent to two percent of income, to enroll and remain in HIP Plus.[4] Beneficiaries with income above 100 percent of the FPL who do not make the required monthly POWER Account contributions would be disenrolled from HIP. The demonstration also included an authority allowing the state to impose a six-month non-eligibility period (lockout) for beneficiaries above 100 percent of the FPL who do not make the monthly POWER Account contributions and are disenrolled from the demonstration. However, on March 21, 2023, the state informed CMS that it had communicated to its stakeholders in its unwinding communication that it did not plan to reinstate the lockout policy. Beneficiaries who are disenrolled will still need to reenroll.

In addition to POWER Account contributions, the state has a tobacco surcharge policy for HIP Plus beneficiaries who report use of tobacco. HIP Plus beneficiaries who have continuous enrollment with a managed care entity (MCE) and continue to report tobacco use in the second year of enrollment but do not participate in tobacco cessation activities would be required to pay a premium surcharge equivalent to 50 percent of the POWER Account contributions. This surcharge is waived during the first year of enrollment to give beneficiaries time to participate in tobacco cessation activities. Removal of the surcharge requires beneficiaries to report a change in tobacco use status to their MCE.

Since the initial approval of a premium requirement in the HIP demonstration in 2015, the affordability of premiums in the Marketplace has changed, most recently through the enactment of the Inflation Reduction Act in 2022, which temporarily extends the American Rescue Plan Act (ARPA) subsidies through the end of 2025.[5] Prior to the ARPA, the required premium contribution for individuals with income at the federal poverty level was about two percent of household income. Through the Inflation Reduction Act, in 2024, the required premium contribution in the Marketplace is zero for individuals with income up to 150 percent of the FPL. However, those subsidies are not available to individuals eligible for a Medicaid program. Given the structure of the HIP model, individuals at or below 133 percent of the FPL are required to pay premiums to either gain or maintain Medicaid coverage or receive a higher benefit package through HIP, while individuals with higher income who receive coverage through the Marketplace may have no premiums. Further, the individuals who fail to enroll into the demonstration or who are disenrolled from the demonstration will not be eligible for Marketplace subsidies if they are otherwise eligible for HIP. If these individuals did apply for Marketplace coverage, the Marketplace is expected to refer them back to Medicaid to enroll in

[3] The beneficiary groups affected include adults aged 19 through 64, including medically frail individuals, parents and caretaker relatives, pregnant women aged 19 and older, and Adult Transitional Medical Assistance beneficiaries. See Section IV, Healthy Indiana Plan Special Terms and Conditions; retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-20230321.pdf.

[4] For beneficiaries with income at or below 22 percent of the FPL, POWER Account contributions are no more than one dollar per month. This means that these beneficiaries would contribute one dollar per month to remain in HIP Plus.

[5] The temporary extension of these ARPA subsidies through the Inflation Reduction Act happened after the approval of the HIP demonstration extension in 2020 and therefore was not information that was known when CMS approved the extension.

the HIP coverage.[6] Those increased subsidies expire at the end of 2025, after which the HIP premium requirements will be generally consistent with required premium contributions for Marketplace enrollees at similar income levels. Moreover, CMS understands that Indiana will not be applying any lockout period for non-payment of premiums. Therefore, any individuals who are disenrolled from HIP could reenroll immediately upon payment of the first premium. As such, CMS will continue working with your state to ensure that the state continues conducting robust beneficiary outreach to minimize misunderstandings about the demonstration requirements to gain and retain coverage as well as undertaking comprehensive data collection to establish more firmly the effects of premiums on beneficiary coverage.

Evidence on the Effects of Premiums in Medicaid Section 1115 Demonstrations

Evidence on the effects of premiums in Medicaid section 1115 demonstrations suggests that premiums beyond those authorized under the Medicaid statute may reduce access to coverage and care among populations that Medicaid is designed to serve.[7] Beneficiaries who are subject to premiums appear to experience greater disruptions in Medicaid coverage and exhibit lower initial rates of enrollment.[8] Multiple states have observed that many of these beneficiaries miss

---

[6] See Indiana Family and Social Services Administration at https://www.in.gov/fssa/hip/transferring-to-or-from-other-health-coverage/.

[7] **Dague, L. (2014).** The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach. Journal of Health Economics. 37: 1-12. Retrieved from https://www.sciencedirect.com/science/article/pii/S0167629614000642; **Arkansas Department of Human Services. (2021).** Arkansas Works Interim Evaluation Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-appvd-interim-eval-rprt-03062023.pdf; **Bradley, K., Niedzwiecki, M., Maurer, K., Chao, S., Natzke, B., & Samra, M. (2020).** Medicaid Section 1115 Demonstrations Summative Evaluation Report: Premium Assistance, Monthly Payments, and Beneficiary Engagement. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/alt-medicaid-exp-summ-eval-report.pdf; **University of Michigan Institute for Healthcare Policy & Innovation. (2018).** Report on the Impact of Cost Sharing in the Healthy Michigan Plan: Healthy Michigan Plan Evaluation Domains V/VI. Retrieved from https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf?sequence=1&isAllowed=y; **Cliff, B.Q., Miller, S., Kullgren, J.T., Ayanian, J.Z., & Hirth, R. (2022).** Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. American Journal of Health Economics. 8: 127-150. Retrieved from https://doi.org/10.1086/716464; and **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[8] **Dague, L. (2014).** The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach. Journal of Health Economics. 37: 1-12. Retrieved from https://www.sciencedirect.com/science/article/pii/S0167629614000642; **Bradley, K., Niedzwiecki, M., Maurer, K., Chao, S., Natzke, B., & Samra, M. (2020).** Medicaid Section 1115 Demonstrations Summative Evaluation Report: Premium Assistance, Monthly Payments, and Beneficiary Engagement. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/alt-medicaid-exp-summ-eval-report.pdf; **University of Michigan Institute for Healthcare Policy & Innovation. (2018).** Report on the Impact of Cost Sharing in the Healthy Michigan Plan: Healthy Michigan Plan Evaluation Domains V/VI. Retrieved from https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf?sequence=1&isAllowed=y; **Cliff, B.Q., Miller, S., Kullgren, J.T., Ayanian, J.Z., & Hirth, R. (2022).** Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. American Journal of Health Economics. 8: 127-150. Retrieved from https://doi.org/10.1086/716464; and **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from

their premium payments,[9] which often results in a loss of benefits or even disenrollment from coverage.[10] Moreover, there are racial, ethnic and income-related disparities in terms of who experiences the negative effects of the premium requirements,[11] which may further aggravate healthcare inequities.

Evidence from HIP comes from the period from 2015 through 2019, since the premium policies were suspended starting March 2020 due to the COVID-19 PHE. Between 2015 and 2019, approximately 81-87 percent of HIP beneficiaries had income at or below 100 percent of the FPL and approximately 14-19 percent of HIP beneficiaries had income above 100 percent of the FPL.[12] Among the beneficiaries who had income at or below 100 percent of the FPL, approximately 51-55 percent made POWER Account contributions and enrolled in HIP Plus.[13]

---

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[9] **State of Montana. (2020).** Montana Health and Economic Livelihood Partnership (HELP) Program: Section 1115 Waiver Annual Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mt-HELP-program-annl-rpt-jan-dec-2019.pdf; **Arkansas Center for Health Improvement. (2018).** Arkansas Health Care Independence Program Section 1115 Demonstration Waiver Final Report. Retrieved from https://humanservices.arkansas.gov/wp-content/uploads/Final-Report-with-Appendices.pdf; **Maximus. (2022).** Healthy Michigan Plan Executive Summary Report. Retrieved from https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder83/Folder1/Folder183/MIHA_Monthly_Exec_Summary_Report.pdf?rev=cb3e2e9645ee41e6a7ca3f53947fa557; and **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[10] **University of Michigan Institute for Healthcare Policy & Innovation. (2018).** Report on the Impact of Cost Sharing in the Healthy Michigan Plan: Healthy Michigan Plan Evaluation Domains V/VI. Retrieved from https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf?sequence=1&isAllowed=y; **The Kaiser Family Foundation. (2021).** Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers. Retrieved from https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/; and **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[11] **University of Wisconsin-Madison Institute for Research on Poverty. (2019).** Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Retrieved from https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf; **Finkelstein, A., Hendren, N., & Shepard, M. (2019).** Subsidizing Health Insurance for Low Income Adults: Evidence from Massachusetts. American Economic Review. 109(4): 1530-67. Retrieved from https://www.aeaweb.org/articles?id=10.1257/aer.20171455; **The Lewin Group, Inc. (2020).** Healthy Indiana Plan Interim Evaluation Report. Retrieved from https://www.in.gov/fssa/hip/files/IN_HIP_Interim_Evaluation_Report_Final.pdf; **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf; and **The Lewin Group, Inc. (2022).** Healthy Indiana Plan Summative Evaluation Report. *Currently under CMS review.*

[12] **Social and Scientific Systems (2020).** Federal Evaluation of Indiana's Healthy Indiana Plan – HIP 2.0. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-indiana-2020.pdf.

[13] **Social and Scientific Systems (2020).** Federal Evaluation of Indiana's Healthy Indiana Plan – HIP 2.0. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-indiana-2020.pdf.

Of those who had income at or below 100 percent of the FPL and who were enrolled in HIP Plus, approximately 7-10 percent were subsequently transitioned to HIP Basic at some point during their enrollment due to nonpayment of required POWER Account contributions.[14]

Research findings from across different states with section 1115 demonstrations show that charging beneficiaries premiums beyond those authorized under the Medicaid statute results in shorter enrollment spells and more frequent gaps in coverage.[15] For example, in Wisconsin's demonstration, premium increases from $0 to $10 per month resulted in beneficiaries being enrolled for 1.4 fewer months and reduced the probability of remaining enrolled for a full year by 12 percentage points, on average.[16] Premiums are also associated with lower initial enrollment rates, increased disenrollment, and increased obstacles to accessing care.[17] An evaluation of section 1115 demonstrations in several states showed that living in states with monthly premium requirements resulted in a lower probability of enrolling in Medicaid or demonstration-specific coverage.[18]

Evidence across states shows that many beneficiaries subject to premiums miss a premium payment.[19] For example, in Montana, for each month in 2019, an average of 57 percent of

---

[14] **Social and Scientific Systems (2020).** Federal Evaluation of Indiana's Healthy Indiana Plan – HIP 2.0. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-indiana-2020.pdf.

[15] **Dague, L. (2014).** The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach. Journal of Health Economics. 37: 1-12. Retrieved from https://www.sciencedirect.com/science/article/pii/S0167629614000642; and **Arkansas Department of Human Services. (2021).** Arkansas Works Interim Evaluation Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-appvd-interim-eval-rprt-03062023.pdf.

[16] **Dague, L. (2014).** The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach. Journal of Health Economics. 37: 1-12. Retrieved from https://www.sciencedirect.com/science/article/pii/S0167629614000642.

[17] **Bradley, K., Niedzwiecki, M., Maurer, K., Chao, S., Natzke, B., & Samra, M. (2020).** Medicaid Section 1115 Demonstrations Summative Evaluation Report: Premium Assistance, Monthly Payments, and Beneficiary Engagement. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/alt-medicaid-exp-summ-eval-report.pdf; **University of Michigan Institute for Healthcare Policy & Innovation. (2018).** Report on the Impact of Cost Sharing in the Healthy Michigan Plan: Healthy Michigan Plan Evaluation Domains V/VI. Retrieved from https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf?sequence=1&isAllowed=y; and **Cliff, B.Q., Miller, S., Kullgren, J.T., Ayanian, J.Z., & Hirth, R. (2022).** Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. American Journal of Health Economics. 8: 127-150. Retrieved from https://doi.org/10.1086/716464.

[18] **Bradley, K., Niedzwiecki, M., Maurer, K., Chao, S., Natzke, B., & Samra, M. (2020).** Medicaid Section 1115 Demonstrations Summative Evaluation Report: Premium Assistance, Monthly Payments, and Beneficiary Engagement. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/alt-medicaid-exp-summ-eval-report.pdf.

[19] **State of Montana. (2020).** Montana Health and Economic Livelihood Partnership (HELP) Program: Section 1115 Waiver Annual Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mt-HELP-program-annl-rpt-jan-dec-2019.pdf; **Arkansas Center for Health Improvement. (2018).** Arkansas Health Care Independence Program Section 1115 Demonstration Waiver Final Report. Retrieved from https://humanservices.arkansas.gov/wp-content/uploads/Final-Report-with-Appendices.pdf; **Maximus. (2022).** Healthy Michigan Plan Executive Summary Report. Retrieved from https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder83/Folder1/Folder183/MIHA_Monthly_Exec_Summary_Report.pdf?

beneficiaries did not pay that month's premium and 74 percent had an overdue premium for a prior month.[20] Available data from Arkansas and Michigan also suggest high rates of nonpayment.[21] In Indiana, between February 2015 through November 2016, 55 percent of all beneficiaries subject to monthly POWER Account contributions had at least one missed premium payment at some point during their enrollment.[22]

Nonpayment of premiums may lead to loss of benefits and coverage, including disenrollment.[23] For example, in Michigan, beneficiaries who were subject to premiums were more likely to be disenrolled from the demonstration than beneficiaries who were not.[24,25] Data from several other states also show that beneficiaries subject to premiums lost coverage or benefits or were subject to debt collection for failure to pay premiums.[26]

In Indiana, between February 2015 and November 2016, among all HIP Plus beneficiaries who missed a payment (324,840 beneficiaries), 88 percent (286,914) were transitioned to HIP Basic (the demonstration's limited benefit plan), four percent (13,550) were disenrolled, and 14 percent

---

rev=cb3e2e9645ee41e6a7ca3f53947fa557; and **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[20] **State of Montana. (2020).** Montana Health and Economic Livelihood Partnership (HELP) Program: Section 1115 Waiver Annual Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mt-HELP-program-annl-rpt-jan-dec-2019.pdf.

[21] **Arkansas Center for Health Improvement. (2018).** Arkansas Health Care Independence Program Section 1115 Demonstration Waiver Final Report. Retrieved from https://humanservices.arkansas.gov/wp-content/uploads/Final-Report-with-Appendices.pdf; and **Maximus. (2022).** Healthy Michigan Plan Executive Summary Report. Retrieved from https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder83/Folder1/Folder183/MIHA_Monthly_Exec_Summary_Report.pdf?rev=cb3e2e9645ee41e6a7ca3f53947fa557.

[22] **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[23] **University of Michigan Institute for Healthcare Policy & Innovation. (2018).** Report on the Impact of Cost Sharing in the Healthy Michigan Plan: Healthy Michigan Plan Evaluation Domains V/VI. Retrieved from https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf?sequence=1&isAllowed=y; **The Kaiser Family Foundation. (2021).** Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers. Retrieved from https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/; and **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[24] Disenrollment was defined as a drop from any Michigan Medicaid program without reenrollment within six months.

[25] **University of Michigan Institute for Healthcare Policy & Innovation. (2018).** Report on the Impact of Cost Sharing in the Healthy Michigan Plan: Healthy Michigan Plan Evaluation Domains V/VI. Retrieved from https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf?sequence=1&isAllowed=y.

[26] **The Kaiser Family Foundation. (2021).** Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers. Retrieved from https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

(46,176) were not initially enrolled (applied and did not make first payment).[27] This is of particular concern for individuals who had income above 100 but below 133 percent of the FPL, as they were not eligible for either HIP Basic or for premium subsidies through the Marketplace. Of those 13,550 beneficiaries with income above 100 percent of the FPL who were disenrolled due to nonpayment, 71 percent (9,636) were enrolled in HIP Plus and 29 percent (3,914) were enrolled in HIP Basic prior to disenrollment.[28] Eleven percent (1,496) of those 13,550 beneficiaries who were disenrolled due to nonpayment subsequently reenrolled in HIP or another Medicaid program. A total of 230 beneficiaries requested a waiver from the six-month lockout period and the waiver was granted to 87 percent of those beneficiaries. Disenrollment due to nonpayment increased from 3.3 to 7.0 percent between February 2015 and December 2019 in Indiana.[29] During the COVID-19 PHE, disenrollment and lockout policies were suspended.[30] As a result, in 2020, disenrollment due to nonpayment dropped to 0.4 percent.[31]

Beneficiaries in several states have reported confusion over section 1115 demonstration premium policies in regard to the amounts they owed, the correct methods to pay their premiums, and how to request or claim available exemptions, as well as concerns about their ability to make monthly contributions.[32] In Indiana, HIP Plus beneficiaries also reported challenges in making monthly

---

[27] **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf. The percentages reported here are out of all beneficiaries who were subject to POWER Account contributions but did not make a payment at some point during their enrollment, including beneficiaries who were exempt from disenrollment for nonpayment (i.e., beneficiaries with income at or below 100 percent FPL, medically frail, and TMA participants). The percentages do not sum to 100 because beneficiaries may be in multiple groups during the timeframe if they failed to make multiple payments.

[28] **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf. The 3,914 beneficiaries enrolled in HIP Basic prior to disenrollment likely experienced a change in circumstances that made them ineligible for HIP Basic, such as an increase in income above 100 percent of the FPL. For example, it is likely that these beneficiaries were eligible for HIP Basic and opted not to or could not afford to make POWER Account contributions to enroll into HIP Plus, and therefore, enrolled into HIP Basic. But subsequently they might have, for example, experienced an increase in income above 100 percent of the FPL, thereby making their coverage in HIP subject to a premium payment. When these beneficiaries missed the required payment, they were disenrolled from HIP Basic. Disenrolled beneficiaries are notified of the change via mail and have a 60-day grace period following the due date of their payment before coverage is terminated for nonpayment.

[29] **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[30] These policies were suspended beginning in March 2020.

[31] **The Lewin Group, Inc. (2022).** Healthy Indiana Plan Summative Evaluation Report. *Currently under CMS review.*

[32] **University of Michigan Institute for Healthcare Policy & Innovation. (2018).** Report on the Healthy Michigan Voices 2016-17 Survey of Individuals No Longer Enrolled in the Healthy Michigan Plan. Retrieved from https://www.michigan.gov/documents/mdhhs/Domain_IV_-_2018_Eligible_But_Unenrolled_Report_652005_7.pdf; **The University of Iowa Public Policy Center (2020)**. Iowa Wellness Plan Summative Evaluation Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ia-wellness-plan-summative-eval-rpt-05132020.pdf; and **Social & Scientific Systems, Inc. and the Urban Institute. (2020).** Federal Evaluation of Montana Health and Economic Livelihood.

premium payments due to confusion over how much they owed, when they had to pay, or difficulty affording the payments.[33] Ninety-three percent of beneficiaries reporting these challenges had income at or below 100 percent of the FPL.[34] In focus groups with individuals who had income at or above 100 percent of the FPL and were never enrolled in HIP or got disenrolled from HIP due to premium nonpayment, many reported confusion about POWER Account contributions and expressed difficulty in trying to reenroll in HIP coverage.[35] According to beneficiary surveys, the main reason that HIP Plus respondents did not make a payment was due to affordability of payments (ranging from 22 percent to 45 percent between 2017 and 2019).[36] Eight percent in this group of respondents also cited not knowing why or how to make a payment as a reason for nonpayment, a decrease from 21 percent in the 2017 beneficiary survey.[37] The HIP evaluation report attributes those improvements to the state's communication campaign to educate beneficiaries, which included materials and videos on POWER Accounts.[38]

Research on section 1115 demonstrations with premium requirements also indicates that premiums may exacerbate disparities in health coverage, as historically under-resourced populations may be disproportionately affected by these policies.[39] For example, findings from

---

Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summativeeval-rpt-montana-2020.pdf; and **Askelson, N.M., Brady, P., Wright, B., Bentler, S., Momany & E.T., Damiano, P. (2019).** Purged from the Rolls: A Study of Medicaid Disenrollment in Iowa. Health Equity. 3(1): 637-643. Retrieved from https://www.liebertpub.com/doi/full/10.1089/heq.2019.0093; **Social & Scientific Systems, Inc. and the Urban Institute. (2020).** Federal Evaluation of Montana Health and Economic Livelihood. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-montana-2020.pdf; see also University of Michigan Institute for Healthcare Policy & Innovation (2018).

[33] **Social and Scientific Systems (2020).** Federal Evaluation of Indiana's Healthy Indiana Plan – HIP 2.0. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-indiana-2020.pdf.

[34] **Social and Scientific Systems (2020).** Federal Evaluation of Indiana's Healthy Indiana Plan – HIP 2.0. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-indiana-2020.pdf.

[35] **Social and Scientific Systems (2020).** Federal Evaluation of Indiana's Healthy Indiana Plan – HIP 2.0. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-indiana-2020.pdf.

[36] **The Lewin Group, Inc. (2022).** Healthy Indiana Plan Summative Evaluation Report. *Currently under CMS review.*

[37] **The Lewin Group, Inc. (2022).** Healthy Indiana Plan Summative Evaluation Report. *Currently under CMS review.*

[38] **The Lewin Group, Inc. (2022).** Healthy Indiana Plan Summative Evaluation Report. *Currently under CMS review.*

[39] **University of Wisconsin-Madison Institute for Research on Poverty. (2019).** Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Retrieved from https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf; **Finkelstein, A., Hendren, N., & Shepard, M. (2019).** Subsidizing Health Insurance for Low Income Adults: Evidence from Massachusetts. American Economic Review. 109(4): 1530-67. Retrieved from https://www.aeaweb.org/articles?id=10.1257/aer.20171455; **The Lewin Group, Inc. (2020).** Healthy Indiana Plan Interim Evaluation Report. Retrieved from https://www.in.gov/fssa/hip/files/IN_HIP_Interim_Evaluation_Report_Final.pdf; **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf; and **The Lewin Group, Inc. (2022).** Healthy Indiana Plan Summative Evaluation Report. *Currently under CMS review.*

several states show that premium policies led to decreased enrollment and shorter enrollment spells for Black beneficiaries compared to their White counterparts, and for beneficiaries with lower income compared to those with higher income.[40] In Indiana, compared to non-Hispanic White beneficiaries, Black beneficiaries had a higher likelihood of disenrollment and being switched from HIP Plus to HIP Basic due to nonpayment.[41] Additionally, beneficiaries ages 40 and older were disenrolled less frequently due to nonpayment or other reasons compared to beneficiaries younger than age 30.[42] Beneficiaries under age 30 with income at or below 100 percent of the FPL were more likely to transition from HIP Plus to HIP Basic compared to beneficiaries ages 30 and over.[43] Finally, of those beneficiaries enrolled in HIP Plus, those with income at or below 100 percent of the FPL were more likely to miss at least one payment during their enrollment than those with income over 100 percent of the FPL (57 percent compared with 51 percent).[44]

CMS is not aware of specific evidence from any state that demonstrates that charging premiums beyond those authorized under the statute to beneficiaries who would otherwise be eligible for coverage, on its own, facilitates coverage directly or indirectly. On the contrary, evidence from research across several states on premium policies in section 1115 demonstrations seems to suggest that premiums may reduce access to coverage and care among populations that Medicaid is meant to serve.[45] Given this, CMS continues to have concerns with premium requirements in

---

[40] **University of Wisconsin-Madison Institute for Research on Poverty. (2019).** Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Retrieved from https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf; **Finkelstein, A., Hendren, N., & Shepard, M. (2019).** Subsidizing Health Insurance for Low Income Adults: Evidence from Massachusetts. American Economic Review. 109(4): 1530-67. Retrieved from https://www.aeaweb.org/articles?id=10.1257/aer.20171455; and **The Lewin Group, Inc. (2020).** Healthy Indiana Plan Interim Evaluation Report. Retrieved from https://www.in.gov/fssa/hip/files/IN_HIP_Interim_Evaluation_Report_Final.pdf

[41] **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[42] **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[43] **The Lewin Group, Inc. (2022).** Healthy Indiana Plan Summative Evaluation Report. *Currently under CMS review.*

[44] **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[45] **Dague, L. (2014).** The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach. Journal of Health Economics. 37: 1-12. Retrieved from https://www.sciencedirect.com/science/article/pii/S0167629614000642; **Arkansas Department of Human Services. (2021).** Arkansas Works Interim Evaluation Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-appvd-interim-eval-rprt-03062023.pdf; **Bradley, K., Niedzwiecki, M., Maurer, K., Chao, S., Natzke, B., & Samra, M. (2020).** Medicaid Section 1115 Demonstrations Summative Evaluation Report: Premium Assistance, Monthly Payments, and Beneficiary Engagement. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/alt-medicaid-exp-summ-eval-report.pdf; **University of Michigan Institute for**

section 1115 demonstrations generally and therefore, throughout the remainder of the current HIP approval period, CMS expects Indiana to rigorously monitor the demonstration, including the premium authority, and report metrics data in accordance with the state's approved Monitoring Protocol. Demonstration evaluation requirements were also substantially fortified in the HIP demonstration with its most recent extension, and in alignment with the STC requirements, Indiana is expected to continue conducting comprehensive demonstration evaluation per the demonstration's approved Evaluation Designs, including submission of three interim and one summative evaluation reports during the demonstration approval period.

As such, at this time, CMS is not taking any action on the HIP demonstration, as CMS intends to minimize disruptions to the state's unwinding efforts and any commensurate unintended impacts on beneficiary eligibility determinations and enrollment with the resumption of Medicaid renewals following the COVID-19 PHE. It is our expectation that CMS and the state of Indiana will continue working in close collaboration to ensure that the state conducts systematic monitoring and comprehensive evaluation of the effects of the demonstration on the state's Medicaid beneficiaries, which may in turn support undertaking future actions to continue ensuring Indiana's program is in the best interest of the populations Medicaid is designed to serve.

If you have any questions, please contact Jacey Cooper, Director, CMS State Demonstrations Group, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Healthcare Policy & Innovation. (2018). Report on the Impact of Cost Sharing in the Healthy Michigan Plan: Healthy Michigan Plan Evaluation Domains V/VI. Retrieved from https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf?sequence=1&isAllowed=y; **Cliff, B.Q., Miller, S., Kullgren, J.T., Ayanian, J.Z., & Hirth, R. (2022).** Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules. American Journal of Health Economics. 8: 127-150. Retrieved from https://doi.org/10.1086/716464; and **The Lewin Group, Inc. (2017).** Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.