November 13, 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 3.0 Section 1115 Waiver Application

Dear Secretary Kennedy:

Thank you for the opportunity to submit comments on the Healthy Indiana Plan 3.0 Section 1115 Waiver Application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions, including many individuals who rely on Medicaid coverage. Three in four adults enrolled in Medicaid report one or more chronic conditions.[1] Our organizations therefore have a unique perspective on what individuals and families need to prevent disease, cure illness and manage serious and chronic health conditions. The diversity of our organizations and the populations we serve enables us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge CMS to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Indiana's Medicaid program provides quality and affordable healthcare coverage. Our organizations are deeply concerned by several of the state's proposals in this waiver application, including covering the adult expansion group through a waiver, establishing healthy incentive initiatives and point-of-service copays, and limiting enrollment in the program. Furthermore, we are concerned that this waiver application does not include complete

information needed for our organizations to fully comment on its impact. Our organizations offer the following comments on the Healthy Indiana Plan (HIP) 3.0 Application:

Changes to Adult Expansion Authority

Our organizations are opposed to Indiana's request to remove its adult expansion population from the Medicaid state plan and cover this population solely through the HIP 3.0 demonstration. Moving the adult expansion population to section 1115 waiver authority is unnecessary and does not align with the intended use of section 1115 demonstrations. Section 1115 demonstrations are intended to provide states with the opportunity to implement experimental, pilot, or demonstration projects.[2] Medicaid expansion was first implemented by Indiana in 2015 and is now a fundamental part of the healthcare system, serving over half a million residents in Indiana.[3] Medicaid expansion is a well-established policy, not an experimental one, and is associated with improved health outcomes for patients with chronic disease, greater uptake of preventive care, and lower overall mortality.[4] Moving this population to 1115 waiver authority is unnecessary and goes against recent Centers for Medicare and Medicaid Services (CMS) guidance encouraging reduced reliance on 1115 demonstrations where alternative authorities were available.[5] Our organizations oppose moving the authority to cover the Medicaid expansion group from the state plan to an 1115 waiver.

Healthy Behavior Incentives and Copayments

Our organizations also oppose Indiana's proposed healthy incentive initiative. The state seeks to implement point-of-service copayments as soon as possible, with reduced copays for individuals who complete specified "healthy behaviors" and full copays for those who do not. Our organizations are concerned that, instead of incentivizing these specific services, this policy will restrict access to care. Enrollees who do not complete qualifying activities will effectively be penalized with higher copays. Policies that increase costs or otherwise penalize individuals for not accessing certain types of care have not been found to improve patients' health.[6]

The research is clear: higher copays deter patients from accessing care and result in worse health outcomes.[7] Even small copays are associated with reduced care uptake, including necessary services, and greater use of the emergency room.[8] Among the Medicaid population, research finds that any revenue gains from cost-sharing are offset by increased disenrollment, use of more expensive care and administrative costs.[9] Patients may be forced to choose between paying for care to manage their condition and paying for other necessities. People should not have to forgo basic necessities in order to access lifesaving care and vice versa.

Our organizations are particularly concerned by the proposed $35 copay for non-emergency use of the emergency room, even if the member has participated in the "healthy behaviors" program. This is the highest copay amount that the program can implement under Public Law 119-21. Emergency department copays have been shown to deter patients from seeking care, which can result in negative health outcomes for patients with acute and chronic diseases. For example, a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[10] People should not be financially penalized for seeking lifesaving care to manage critical conditions.

Our organizations are opposed to this proposal and urge CMS to work with the state to impose the lowest allowable copay amounts no earlier than October 2028, as required under P.L. 119-21, to ensure accessible care for this population.

Program Termination or Enrollment Cap
Our organizations are deeply concerned by Indiana's request for confirmation from CMS that the state may either end Healthy Indiana Plan (HIP) expansion coverage or seek amendment of the demonstration to limit enrollment if funding is not sufficient.

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 able to show compliance. For patients in active treatment for a serious or chronic condition, being forced to wait for coverage and lifesaving treatment can have devastating health consequences. Implementation of this policy is also likely to increase administrative burden and overall churn in the program, which is estimated to cost between $400 and $600 per person.[11]

If the state has a specific request to limit enrollment through a section 1115 waiver in the future, it should submit a formal waiver request, subject to public comment periods and formal consideration. Our organizations are opposed to this request as it will jeopardize access to care for thousands of Indianans.

Presumptive Eligibility
Finally, our organizations support the state's proposal to continue its expanded presumptive eligibility program for certain health centers. Presumptive eligibility allows health centers to make temporary, on-the-spot Medicaid eligibility determinations for individuals who appear to qualify for HIP. It is common that individuals are unaware they are eligible for Medicaid until a medical event occurs. Presumptive eligibility allows patients to access critical care without facing financial barriers or being burdened by medical debt. Medicaid-eligible individuals who face substantial costs could end up delaying their treatment because of these costs. For individuals with serious and chronic diseases, a delay in necessary treatment can exacerbate their condition and lead to worsened health outcomes. Our organizations support the state's proposal to continue this program.

Lack of Detail
The state's waiver application lacks several key details, leaving stakeholders unable to assess its impact on Indianans. The state intends to implement copays that exceed the current legal limits, but does not include this request in the state's Requested Waivers list. 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
Our organizations remain strongly opposed to moving authority to cover the Medicaid expansion group from the state plan to a section 1115 demonstration, high copayments and healthy behavior incentives, and program termination or enrollment caps. These policies would restrict patients' access to care, resulting in worse health outcomes. Because the state has not provided a list of requested expenditure authorities or a request to implement higher copays, we urge CMS to require the state to repost this proposal with the missing information, providing stakeholders adequate opportunity to comment on these features.

Thank you for the opportunity to provide comments.

Sincerely,

AiArthritis
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Blood Cancer United
Cancer Nation
Cystic Fibrosis Foundation
Lupus Foundation of America
Lutheran Services in America
National Bleeding Disorders Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Coalition for Hemophilia B
ZERO Prostate Cancer

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[8] Artiga, Samantha et al. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. KFF. June 1, 2017. Available at: https://www.kff.org/medicaid/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

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