STATE OF INDIANA
HOUSE OF REPRESENTATIVES
THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA 46204

Timothy N. Brown, M.D.
P.O. Box 861
Crawfordsville, IN 47933
Website: www.in.gov/h41
E-mail: H41@iga.in.gov

COMMITTEES
Public Health: Chair
Education
Family, Children and Human Affairs
Interstate and International Cooperation
Rules and Legislative Procedures

November 17, 2011

The Honorable Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

As a member of the Indiana General Assembly and original author of legislation to create the Healthy Indiana Plan (HIP), I write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for HIP for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the Affordable Care Act Medicaid expansion.

HIP currently covers approximately 41,000 individuals but the State of Indiana's actuary anticipates nearly 500,000 Hoosiers will be newly eligible for Medicaid in 2014. Our State legislature passed and Governor Mitch Daniels signed SEA 461, which calls for HIP to be the coverage vehicle. While Governor Daniels' Administration has been working with CMS over the past year to find a path toward approval of this request, I understand they have met resistance. If CMS does not approve the application in a timely manner, State officials have expressed they will need ample time to notify current enrollees that HIP coverage will be cancelled by December 31, 2012. Conversely, if CMS approves the waiver, the State will need sufficient time to expand and build on HIP's success to cover the enormous Medicaid expansion expected in 2014.

When we drafted the original legislation to create the program, the POWER account was designed to be the cornerstone of HIP. Individuals are required to make monthly contributions to the POWER account based on their ability to pay, and the State funds the remainder. Under the State of Indiana's waiver application, enrollees will be required to make a minimum contribution of $160 annually, but individuals will not have to pay more than five percent of income towards health care, per CMS rules.

Congress of the United States

Washington, DC 20510

November 4, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

As Members of the Indiana Congressional Delegation, we write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for the Healthy Indiana Plan (HIP) for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the ACA Medicaid expansion.

HIP currently covers approximately 41,000 individuals but the State of Indiana's actuary anticipates nearly 500,000 Hoosiers will be newly eligible for Medicaid in 2014. The State legislature passed and Governor Mitch Daniels signed SEA 461, which calls for HIP to be the coverage vehicle. While Indiana officials have been working with CMS over the past year to find a path toward approval of this request, we understand they have met resistance. If CMS does not approve the application in a timely manner, State officials have expressed they will need ample time to notify current enrollees that HIP coverage will be cancelled by December 31, 2012. Conversely, if CMS approves the waiver, the State will need sufficient time to expand and build on HIP's success to cover the enormous Medicaid expansion expected in 2014.

The cornerstone of HIP is the POWER account. Individuals are required to make monthly contributions to the POWER account based on their ability to pay, and the State funds the remainder. Under the State of Indiana's waiver application, enrollees will be required to make a minimum contribution of $160 annually, but individuals will not have to pay more than 5% of income towards health care, per CMS rules.

Enrollees have demonstrated a willingness and ability to pay this minimal amount and, as a result, make quality and cost conscious health care decisions. In fact, data provided by the State shows that 97% of HIP members made their required POWER account contributions during the first two years of the program. This fact and additional data cited below make the case that HIP participants are taking greater personal responsibility for their own health, as emphasized by the program:

- During the first 12 months of enrollment non-emergency utilization of the ER by HIP enrollees decreased by 14.8%.
- HIP generic drug utilization is 80% (comparable commercial population: 65%).
- 80% of HIP enrollees complete the preventive services required for POWER account rollover.
- Enrollees are required to complete an annual redetermination. 85% of HIP enrollees submitted their redetermination packets on-time in the first two years of the program. This number rose to 96% in demonstration year three.
- 94% of HIP participants surveyed said they are satisfied with the program, and 99% of respondents indicated that they would re-enroll in the program.

We join the State of Indiana in looking forward to a positive outcome for Hoosiers in need of affordable health care and hope that CMS will approve the State's waiver application as soon as possible.

Sincerely,

/Dick Lugar/

Richard G. Lugar
United States Senator

/Dan Coats/

Dan Coats
United States Senator

/Larry Bucshon/

Larry Bucshon
Member of Congress

/Dan Burton/

Dan Burton
Member of Congress

/Mike Pence/

Mike Pence
Member of Congress

/Todd Rokita/

Todd Rokita
Member of Congress

/Marlin Stutzman/

Marlin Stutzman
Member of Congress

/Todd Young/

Todd Young
Member of Congress

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- 94 percent of HIP participants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program.

I am pleased with the results of the HIP program and join Governor Daniels' Administration in supporting a positive outcome for Hoosiers in need of affordable health care. I ask CMS to approve the State's waiver application as soon as possible.

Sincerely,

/Tim N. Brown, M.D. /

Timothy N. Brown, M.D.
State Representative

TB/pd

November 28, 2011

Indiana Hospital Association

1 American Square • Suite 1900
Indianapolis, Indiana 46282-004
317/633-4870 • 317/633-4875 fax
www.ihaconnect.org

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

On behalf of the Indiana Hospital Association (IHA) and our more than 160 member hospitals throughout Indiana, I urge you to grant the State of Indiana's request to renew the 1115 Medicaid waiver for the Healthy Indiana Plan (HIP). IHA supported the legislation that authorized HIP four years ago, and we remain very supportive of this program today. We appreciate this opportunity to support its extension through calendar year 2015.

Without question, HIP provides health care security to thousands of Hoosiers who would otherwise have no source of coverage. What is uniquely important about HIP, however, is the manner in which coverage is made available. Using a thoughtful approach that takes into consideration the financial circumstances of its enrollees, HIP encourages personal initiative and responsibility with respect to healthcare decision-making. This approach directly contributes to the patients' receipt of quality and cost-effective health care services while generating high levels of satisfaction among enrollees with the program.

We would also note with enthusiasm the provision in the State's waiver renewal application that would discontinue the diversion of federal Medicaid disproportionate share (DSH) dollars effective January 1, 2013. Allowing these DSH funds to become available to Indiana's hospitals while preserving HIP will provide needed financial assistance without reducing coverage.

In conclusion, the IHA believes HIP has been a success. Indiana and its citizens will be well served if HIP is soon extended through calendar year 2015.

Sincerely,

/Doug Leonard/

Douglas J. Leonard, FACHE
President

Community Health Network

7330 Shadeland Station, Suite 200
Indianapolis, Indiana 46256
eCommunity.com

November 30, 2011

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

As a participant in Indiana's healthcare delivery system, I write in support of the State of Indiana's 1115 Medicaid waiver renewal request to extend the demonstration for the Healthy Indiana Plan (HIP) in calendar years 2013-2015. HIP is an innovative Indiana program that has had great success in providing low-income Hoosiers with meaningful, consumer -driven healthcare coverage. It would be a great loss to our state if the waiver renewal was not granted for the requested three year period.

The State legislature passed and Governor Mitch Daniels signed SEA 461 earlier this year, which calls for HIP to be the coverage vehicle for the Patient Protection & Affordable Care Act (PPACA) required Medicaid expansion. HIP currently covers approximately 41,000 individuals, and the State's Medicaid actuary anticipates that 350,000- 500,000 more Hoosiers will be eligible for Medicaid in 2014. This program is successful, and we support its continuation.

We join the State of Indiana in looking forward to a positive outcome for this innovative program and the Hoosiers it serves. On behalf of Community Health Network, I urge you to approve the State's requested three year waiver renewal as soon as possible.

Sincerely,

/Anne W. Murphy/

Anne W. Murphy
V.P. Government Relations

December 9, 2011

Franciscan ALLIANCE

FRANCISCAN
ST.ANTHONY HEALTH
Crown Point

FRANCISCAN
ST.ANTHONY HEALTH
Michigan City

FRANCISCAN
ST. ELIZABETH HEALTH
Crawfordsville

FRANCISCAN
ST. ELIZABETH HEALTH
Lafayette Central

FRANCISCAN
ST. ELIZABETH HEALTH
Lafayette East

FRANCISCAN
ST. FRANCIS HEALTH
Beech Grove

FRANCISCAN
ST. FRANCIS HEALTH
Indianapolis

FRANCISCAN
ST. FRANCIS HEALTH
Mooresville

FRANCISCAN
ST. JAMES HEALTH
Chicago Heights

FRANCISCAN
ST. JAMES HEALTH
Olympia Fields

FRANCISCAN
ST. MARGARET HEALTH
Dyer

FRANCISCAN
ST. MARGARET HEALTH
Hammond

FRANCISCAN
PHYSICIANS HOSPITAL, LLC
Munster

FranciscanAlliance.org

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

On behalf of the Franciscan Alliance, a health system with fourteen hospitals in Indiana and Illinois, we write in support of the State of Indiana's request to extend the Healthy Indiana Plan (HIP) Medicaid demonstration waiver. Our system serves a geographic area with a population of 3.7 million people, and the HIP plan has helped many of our patients in need of health coverage. Extending this program through Calendar Year 2015 would be a benefit to thousands of Hoosiers.

The HIP program has experienced strong support among the public, policymakers, and providers for good reason. It is a unique program with a strong focus on promoting wellness that can help provide lessons for the future of healthcare delivery. Surveys indicate that those covered by HIP are extremely pleased with the program.We ask you to allow the renewal of this waiver as requested by the State of Indiana.

Sincerely,

/Kevin D. Leahy/

Kevin D. Leahy
President

CORPORATE OFFICE
PN: 574 256 3935

SHIPPING
1515 Dragoon Trail
Mishawaka, IN 46544

MAILING
P.O. Box 1290
Mishawaka, IN 46546-1290

Indiana University Health

November 17, 2011

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: State of Indiana 1115 Medicaid Waiver Renewal

Dear Administrator Mann:

On behalf of Indiana University Health, Inc., I am writing in support of the State of Indiana's 1115 Medicaid Waiver ("Waiver") renewal request to extend the demonstration for the Healthy Indiana Plan ("HIP") in calendar years 2013-2015.

Indiana University Health ("IU Health") is Indiana's most comprehensive academic medical center and the state's largest safety net provider. Based in Indianapolis, IU Health is affiliated with multiple hospitals and health centers throughout the state of Indiana and maintains a strong partnership with the Indiana University School of Medicine, the nation's second largest medical school and a leader in medical education and research.

IU Health has been a strong proponent of the HIP program since its inception. HIP is an innovative program providing approximately 41,000 Hoosiers access to affordable, consumer-driven healthcare coverage, and its success is well-documented. Data shows that, during the first 12 months of enrollment, non-emergency utilization of ER services by HIP enrollees decreased by 14.8 percent. HIP generic drug utilization is at an impressive 80 percent, comparable to commercial utilization of 65 percent. Moreover, 94 percent of HIP participants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program. It would be a tremendous loss to the people of Indiana if CMS fails to renew the Waiver for the 2013-2015 period.

The success of the HIP program merits its continuation. Consequently, we join the State of Indiana in urging you to approve the State's requested Waiver renewal.

Sincerely,

/Ron Stiver/
Ron Stiver

Cc: Michael Gargano, Secretary, Family Social Services Administration

Ron Stiver
Senior Vice President

Engagement & Public Affairs
340 West 10th Street
Suite 6100
Indianapolis, IN 46202
T 317.963.7988 F 317.962.2247
iuhealth.org

St. Vincent HEALTH

8425 Harcourt Road
Indianapolis, IN
46260

stvincent.org

November 29, 2011

Cindy Mann
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

As a participant in Indiana's healthcare delivery system, I write in support of the State of Indiana's 1115 Medicaid waiver renewal request to extend the demonstration for the Healthy Indiana Plan (HIP) in calendar years 2013-2015. HIP is an innovative Indiana program that has had great success in providing low-income Hoosiers with meaningful, consumer-driven healthcare coverage. It would be a great loss to our state if the waiver renewal was not granted for the requested three year period.

The State legislature passed and Governor Mitch Daniels signed SEA 461 earlier this year, which calls for HIP to be the coverage vehicle for the Patient Protection and Affordable Care Act (PPACA) required Medicaid expansion. HIP currently covers approximately 41,000 individuals, and the State's Medicaid actuary anticipates that 350,000-500,000 more Hoosiers will be eligible for Medicaid in 2014. This program is successful and we support its continuation.

We join the State of Indiana in looking forward to a positive outcome for this innovative program and the Hoosiers it serves. On behalf of St. Vincent Health, I urge you to approve the State's requested three year waiver renewal as soon as possible.

Sincerely,

/Vincent C. Caponi/

Vincent C. Caponi
Chief Executive Officer

VCC:km

IPHCA
Indiana Primary Health Care Association

November 18, 2011

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

As a participant in Indiana's health care delivery system, the Indiana Primary Health Care Association (IPHCA) supports the State of Indiana's 1115 Medicaid waiver renewal request to extend the demonstration for the Healthy Indiana Plan (HIP) in calendar years 2013-2015. HIP is an innovative Indiana program that has had great success in providing low-income Hoosiers with meaningful, consumer-driven healthcare coverage. It would be a great loss to our state if the waiver renewal was not granted for the requested three-year period.

The State legislature passed and Governor Mitch Daniels signed SEA 461 earlier this year.SEA 461 calls for HIP to be the coverage vehicle for the Patient Protection & Affordable Care Act (PPACA) required Medicaid expansion. HIP currently covers approximately 41,000 individuals, and the State's Medicaid actuary anticipates that 350,000-500,000 more Hoosiers will be eligible for Medicaid in 2014.This program is successful and we support its continuation.

The Indiana Primary Health Care Association (IPHCA) join the State of Indiana in looking forward to a positive outcome for this innovative program and the Hoosiers it serves.On behalf of IPHCA, I urge you to approve the State's requested three-year waiver renewal as soon as possible.

Sincerely,

/Philip L. Morphew/

Philip L. Morphew
CEO

Indiana Primary Health Care Association, Inc.
429 N. Pennsylvania St., Ste. 333
Indianapolis, IN 46204

P. 317.630.0845
F. 317.630.0849

www.indianapca.org

State of Indiana

Senate

Senator Vi Simpson
Minority Floor Leader
200 West Washington Street
Indianapolis, Indiana 46204
(317) 232-9427
s40@iga.in.gov

Committees:
Rules & Legislative Procedure, RMM
Health & Provider Services
Insurance & Financial Institutions
Joint Rule

November 9, 2011

The Honorable Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

As Members of the Indiana General Assembly and original authors of legislation to create the Healthy Indiana Plan (HIP), we write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for HIP for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the Affordable Care Act Medicaid expansion.

HIP currently covers approximately 41,000 individuals but the State of Indiana's actuary anticipates nearly 500,000 Hoosiers will be newly eligible for Medicaid in 2014. Our State legislature passed and Governor Mitch Daniels signed SEA 461, which calls for HIP to be the coverage vehicle. While Governor Daniels' Administration has been working with CMS over the past year to find a path toward approval of this request, we understand they have met resistance. If CMS does not approve the application in a timely manner, State officials have expressed they will need ample time to notify current enrollees that HIP coverage will be cancelled by December 31, 2012. Conversely, if CMS approves the waiver, the State will need sufficient time to expand and build on HIP's success to cover the enormous Medicaid expansion expected in 2014.

When we drafted the original legislation to create the program, the POWER account was designed to be the cornerstone of HIP. Individuals are required to make monthly contributions to the POWER account based on their ability to pay, and the State funds the remainder. Under the State of Indiana's waiver application, enrollees will be required to make a minimum contribution of $160 annually, but individuals will not have to pay more than five percent of income towards health care, per CMS rules.

Enrollees have demonstrated a willingness and ability to pay this minimal amount and, as a result, make quality and cost conscious health care decisions. In fact, data provided by the State shows 97 percent of HIP members made their required POWER account contributions during the first two years of the program. This fact and additional data cited below make the case that HIP participants are taking greater personal responsibility for their own health, as emphasized by the program:

. During the first 12 months of enrollment non-emergency utilization of the ER by HIP enrollees decreased by 14.8 percent
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. 94 percent of HIP pai1icipants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program.

We are pleased with the results of the HIP program and join Governor Daniels' Administration in supporting a positive outcome for Hoosiers in need of affordable health care. We ask CMS to approve the State's waiver application as soon as possible.

Sincerely,

/Vi Simpson/

Senator Vi Simpson
Minority Floor Leader
State Senate

State of Indiana Senate

Senator Patricia L. Miller
State House
200 West Washington Street
Indianapolis, Indiana 46204-2785
Senate (317) 232-9489
senator.miller@iga.in.gov
www.in.gov/s32

Committees:
Health & Provider Services, Chair
Appropriations
Elections

November 10, 2011

The Honorable Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

As a member of the Indiana General Assembly and one of the original authors of legislation to create the Healthy Indiana Plan (HIP), I write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for HIP for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the Affordable Care Act Medicaid expansion.

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I am pleased with the results of the HIP program and join Governor Daniels' Administration in supporting a positive outcome for Hoosiers in need of affordable health care. I ask CMS to approve the State's waiver application as soon as possible.

Sincerely,

/Pat Miller/

Patricia L. Miller
State Senator

STATE OF INDIANA
HOUSE OF REPRESENTATIVES
THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA 46204

CHARLIE BROWN
9439 LAKE SHORE DRIVE
GARY, IN 46403
219-938-6548 PH
219-938-3881 FAX

COMMITTEES:
PUBLIC HEALTH, RMM
INSURANCE
STATUTORY COMMITTEE ON INTERSTATE AND
INTERNATIONAL COOPERATION

November 9, 2011

The Honorable Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

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participants are taking greater personal responsibility for their own health, as emphasized by the program:

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- 94 percent of HIP participants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program.

I am pleased with the results of the HIP program and join Governor Daniels' Administration in supporting a positive outcome for Hoosiers in need of affordable health care. We ask CMS to approve the State's waiver application as soon as possible.

Respectfully yours,

/Charlie Brown/

Charlie Brown
State Representative
House District 3

COVINGTON & BURLING LLP

1201 PENNSYLVANIA AVENUE NW
WASHINGTON, DC 20004-2401
TEL 202.662.6000
FAX 202.662.6291
WWW.COV.COM

BEIJING
BRUSSELS
LONDON
NEW YORK
SAN DIEGO
SAN FRANCISCO
SILICON VALLEY
WASHINGTON

September 10, 2010

MEMORANDUM

To: Anne Murphy

From: Caroline M. Brown and Rachel Grunberger

Re: Covering New Eligibles under HIP

The State of Indiana has asked our opinion as to whether it may use the Healthy Indiana Plan (HIP) as the vehicle for covering the population newly eligible for Medicaid under the Affordable Care Act (ACA). In particular, you have asked whether, in extending HIP to cover ACA's "new eligibles," Indiana can continue to use the Personal Wellness and Responsibility (POWER) Account feature of HIP, which has proven very successful. For the reasons given below, we believe that it can.

In addition, we do not see any barrier to the State moving the HIP program from an 1115 demonstration project to the state plan. However, were the State to continue HIP as a demonstration project, the waiver should be amended to cover newly eligible childless adults as a "hypothetical" Medicaid population for purposes of budget neutrality. This would permit the State to recapture the portion of its disproportionate share hospital (DSH) allotment that is currently diverted to the waiver to satisfy budget neutrality rules.

Background: HIP currently operates under a Section 1115 waiver to provide coverage to certain uninsured adults earning less than 200% of the federal poverty level (FPL).

The adults covered by HIP fall into two categories. The "HIP caretakers" are those who could be covered under Medicaid as caretakers of Medicaid-eligible children. HIP covers adults with incomes or assets above the AFDC income limit set forth in the state plan. (The State plan AFDC income limit is approximately 23% of the FPL and the asset limit is $1,000.) "HIP adults" are uninsured non-custodial parents and childless adults who are not otherwise eligible for Medicaid or Medicare with family income up to and including 200% of the FPL, with no resource limit. For purposes of budget neutrality (a central element of an 1115 waiver), the HIP caretakers are treated as a "hypothetical" population – i.e., one that could be in the state plan but instead is covered under the waiver. The HIP adults are treated as a pure demonstration population. The costs of their coverage cannot exceed the savings that the State has demonstrated elsewhere in the demonstration project. The savings come from a portion of the

DSH allotment that the State does not spend on hospitals, and managed care savings from the Hoosier Healthwise managed care program.

The centerpiece of HIP is the POWER Account, which is modeled on a traditional Health Savings Account (HSA). HIP provides a POWER Account valued at $1,100 per adult to pay for initial medical costs. The POWER Accounts are funded with state, federal, and enrollee contributions. Enrollee contributions are determined on a sliding scale based on the enrollee's income, but do not exceed 5% of an enrollee's gross family income. The State (with federal financial participation) funds the difference between the enrollee's contribution and the $1,100 account value. In calculating the 5% cap, the State takes into account the cost-sharing for all family members (e.g., CHIP premiums for children, POWER account contributions for other HIP participants in the family, Medicare cost-sharing, etc.).

Enrollees use the POWER Accounts to pay for the cost of health care services until the $1,100 threshold is reached. (HIP also provides $500 in "first dollar" preventive benefits at no cost to HIP members; these benefits are exempt from the requirement to use POWER Account funds for the first $1,100 of medical costs.) Once the $1,100 threshold is met, a HIP managed care organization (MCO) or Enhanced Services Plan (for enrollees with identified high-risk conditions) provides coverage for medical services up to an annual maximum amount.

The POWER Account is designed to encourage preventive care, the appropriate utilization of health care services, and personal responsibility. Three years into the program, the State is already seeing evidence that the POWER Account is furthering those goals, with lower emergency room usage in HIP than other programs; over 98% of HIP enrollees making their POWER Account contributions on time; over 76% of HIP enrollees receiving their required preventative services; and over 94% of HIP enrollees reporting satisfaction with the program.

New Eligibles and Benchmark Coverage. Beginning in 2014, the ACA will require States to cover individuals with incomes up to 133% FPL (plus 5% disregard) who are not otherwise eligible under current Medicaid categories. The new eligibles must be provided with a "benchmark" benefit package.

Section 2001 of the ACA mandates that medical assistance provided to the new eligibles must consist of benchmark coverage described in Section 1937(b)(1) of the Social Security Act or benchmark-equivalent coverage described in Section 1937(b)(2) of the Act, unless the individual is exempt from mandatory enrollment in a benchmark benefit plan. Moreover, the benefits package provided to new eligibles must include the "essential health benefits" available under the State Health Insurance Exchanges. *See* ACA §§ 2001, 1302, 10104. The ACA requires the Secretary of the Department of Health and Human Services (Secretary) to define the essential health benefits, which must include at least the following general services:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health benefits and substance use disorder services

- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management; and
- pediatric services including oral and vision care.

ACA §§ 1302, 10104.

Section 1937(b)(2)(A) of the Social Security Act requires benchmark-equivalent plans to cover "items and services" within each of the following categories: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunization. In addition, "[o]ther appropriate preventive services, as designated by the Secretary," must be covered. Social Security Act § 1937(b)(2)(A).

As of July 1, 2010, 42 C.F.R. § 440.335 requires that benchmark-equivalent plans also cover:

- emergency services; and
- family planning services, supplies, and other appropriate preventive services, as designated by the Secretary.

75 Fed. Reg. 23,068, 23,103 (Apr. 30, 2010).

Moreover, although not required by Section 1937 of the Social Security Act, CMS has interpreted certain changes to the statute made by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. 111-3, to require that the following be included:

- Early Periodic Screening, Diagnosis, and Treatment Services
- non-emergency medical transportation.

Id. at 23,076, 23,077.

HIP and Benchmark Coverage. As set forth in the Section 1115 waiver, HIP currently offers the following benefits:

- Inpatient Facility
  - medical/surgical
  - mental health/substance abuse (covered same as any other service)
  - skilled nursing facility (60-day maximum)
- Outpatient Facility
  - surgery
  - emergency room (co-payment for non-emergency services)
  - urgent care
  - physical/occupational/speech therapy (25-visit annual maximum for each type)
  - radiology/pathology

  - pharmacy and blood
  - cardiovascular
- Professional Services
  - inpatient/outpatient surgery
  - inpatient/outpatient/ER visits
  - office visits/consults
  - preventive services (at least $500 annual first dollar coverage)
  - physical/occupational/speech therapy (25-visit annual maximum for each type)
  - cardiovascular
  - radiology/pathology
  - outpatient mental health/substance abuse (covered the same as any other illness)
- Ancillary Services
  - prescription drug (brand name drugs not covered where generic substitute is available)
  - home health, including hospice/home IV therapy (excludes custodial care; includes hospice)
  - ambulance (emergency ambulance transportation only)
  - durable medical equipment/supplies/prosthetics
  - family planning services (excluding abortion or abortifacients; includes contraceptives and sexually transmitted disease testing)
  - lead screening services (ages 19 & 20 only)
  - hearing aides (ages 19 & 20 only)
  - Federally Qualified Health Center and Rural Health Center services (subject to HIP benefit coverage limits)
  - disease management services

The State's Section 1115 demonstration project does not expressly state that HIP is "benchmark" coverage. However, in order for the Secretary to have approved HIP caretakers as a "hypothetical" population that could have received benefits under the state plan, CMS necessarily concluded that the HIP benefits could have been provided under the state plan as a benchmark or benchmark equivalent package. (One of the benchmarks is "Secretary-approved coverage.")

Since the waiver was first approved, however, both Congress and CMS have stipulated that certain benefits, not included in HIP, must be included in a benchmark or benchmark equivalent package. Therefore, if HIP is to be the benchmark package for the new eligibles, we believe that certain benefits will have to be added to the HIP package. Based on the requirements described above, Indiana likely will have to add non-emergency transportation and maternity care services to the HIP benefits package, as well as dental and vision for any HIP participants under age 21. The State also will have to ensure that the package includes any "essential health benefits" defined by the Secretary in future regulations. But given the relative consistency between the existing HIP benefits package and the benefits currently required for benchmark-equivalent plans, we believe Indiana can use the HIP benefits package (with minor modifications) to cover the new eligibles.

HIP and the POWER Account. We believe that Indiana can continue to use the POWER Accounts as the central feature of the HIP program. We have not identified any provision in Title XIX that would prohibit the State from giving enrollees greater control of their health care decisions or encouraging positive health behaviors by requiring use of the POWER account.

A key question is whether enrollees could continue to be required to make contributions to the POWER account once they were a Medicaid population, rather than, as currently, a demonstration population under the waiver. We believe there is a persuasive argument that the contributions could continue at current levels, despite Medicaid's limitations on cost-sharing, including the prohibition against premiums for individuals with family income below 150% of the FPL. *See* 42 C.F.R. §§ 447,71, 447.72. As described below, (1) the POWER account contributions comply with Medicaid's 5% cap on aggregate cost-sharing; and (2) POWER account contributions are not premiums.

POWER Accounts and 5% Aggregate limit. While Medicaid cost-sharing rules vary by income level, service, and eligibility group, in general some cost-sharing is permissible, provided that, in the aggregate, it does not exceed 5% of family income. HIP complies with this requirement. For the "newly eligible" population up to 138% FPL for whom HIP would be a benchmark package, POWER account contributions are capped at 4% of family income.

Under HIP, as it is currently structured, the sliding scale for enrollee contributions to the POWER Account is as follows:

Annual Household Income	**Maximum Power Account Contribution**
All enrollees at or below 100% FPL	No more than 2% of income
All enrollees above 100% through 125% FPL	No more than 3% of income
All enrollees above 125% through 150% FPL	No more than 4% of income
HIP Caretakers above 150% through 200% FPL	No more than 4.5% of income
HIP Adults above 150% through 200% FPL	No more than 5% of income

The regulations require that the cost sharing for *all* individuals in the family be under the 5% cap. It is our understanding that the POWER account contributions are already calculated in this manner and that, for example, the amount that a family pays in CHIP premiums is deducted from the amount that is to be contributed to the POWER account. Therefore, it does not appear that any changes to POWER account contribution levels would have to be made in order to be compliant with Medicaid cost-sharing rules.

However, the regulations also require that the income be measured on a monthly or quarterly period (as specified by the State). To the extent that HIP looks at annual income, it

may need to adjust to a monthly or quarterly calculation, although we believe that is a requirement that the Secretary can waive under Section 1115.

POWER Account Contributions are Not Premiums. In addition to the 5% overall cap, Medicaid regulations include limits on certain types of cost-sharing, including premiums. Premiums may not be charged to individuals with income below 150% of the FPL, which would include all new eligibles. We do not believe an enrollee contribution to the account is a "premium," as that term is understood in both the Medicaid and traditional HSA context, and therefore this limitation should not prevent Indiana from requiring POWER account contributions.

Section 1916A of the Social Security Act defines "premium" to include "any enrollment fee or similar charge." But the enrollee contribution to the POWER Account is not an "enrollment fee;" rather, it is a contribution towards the $1,100 amount in the account. In that way, it is closer to either a deductible or co-insurance (although, unlike those two, it does not relate to a particular service at the time it is paid). There is no prohibition against deductibles or co-insurance (or any cost-sharing other than premiums) for individuals with incomes below 150% of the FPL (except for children, pregnant women, and institutionalized individuals, who would fall into Medicaid eligibility categories other than the new eligibles).

Section 1938 of the Social Security Act, which authorizes state demonstration programs involving "Health Opportunity Accounts" (HOAs), refers to the amounts paid into HOAs as "contributions," not premiums. HOAs are modeled on traditional HSAs, with contributions coming from States, charitable organizations, or other persons or entities that may transfer funds to the State without violating the donation rules of Section 1903(w). There is no indication in Section 1938 or CMS guidance on HOAs that the contributions are in the nature of premiums or enrollment fees. *See* Social Security Act § 1938; *see also* CMS Letter to State Medicaid Directors No. 07-001 (Jan. 10, 2007).

Moreover, in the traditional HSA context, there is a clear distinction between use of funds contributed to an HSA and payment of health insurance premiums. *See* Internal Revenue Service, *Publication 969, Health Savings Accounts and Other Tax Favored Health Plans* (2009), *available at* http://www.irs.gov/publications/p969/ar02.html (describing restrictions on the use of HSA funds to pay insurance premiums); *see also* U.S. Dep't of Treasury, *HSA Frequently Asked Questions*, available at http://www.ustreas.gov/offices/public-affairs/hsa/faq_using.shtml (stating that an individual can only use an HSA to pay health insurance premiums if the person is collecting federal or state unemployment benefits, or if the individual has COBRA continuation coverage through a former employer). The POWER Account is modeled on the traditional HSA and, accordingly, the contributions to a the POWER Account should be viewed as distinct from premiums or enrollment fees.

In addition, Congress has recognized, in the context of HOAs, that programs designed around HSA-like accounts have the capacity to yield tremendous benefits, such as creating patient awareness of the high cost of medical care, providing incentives to patients to seek preventive care services, reducing inappropriate use of health care services, and enabling patients to take responsibility for health outcomes. *See* Social Security Act § 1938. And, in the HOA context, States have significant flexibility with respect to cost sharing. *See id.* (providing that the

requirements of Sections 1916 and 1916A do not apply to HOA demonstration programs). Taking the position that contributions to the POWER Account are premiums -- and therefore are prohibited for individuals below 150% FPL -- would be inconsistent with these policy objectives.

Finally, we note that the HIP demonstration project documents include a statement that among the Title XIX requirements "not applicable" to HIP is Section 1916(a)(1), "to the extent necessary to enable Indiana to charge premiums for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP adults)." Because the enrollment fee is never referred to as a "premium" in the terms and conditions, we believe this can be interpreted as a determination, by CMS, that the POWER account contributions are not premiums and therefore the prohibition on premiums is "not applicable" to the HIP program.

HIP and Retroactive Eligibility. Like many 1115 waivers, HIP has a waiver of the provision requiring Medicaid coverage for the three-months prior to application, if the individual met eligibility requirements. Nothing in ACA would prevent continued waiver of that provision. However, HIP would have to continue as an 1115 waiver and not under the state plan.

HIP and Budget Neutrality. Even if the State continues HIP under the 1115 demonstration project authority (rather than under the state plan), once the HIP adults are Medicaid eligible, they can (like the HIP caretakers) be treated as a hypothetical population that "pays for itself" under budget neutrality principles (*i.e.*, counted as expenditures both under the waiver and in the without waiver baseline). This means that there is no longer a need to "pay" for this population with diverted DSH funds or Hoosier Healthwise savings.

One option that the State might want to consider is seeking an amendment to the waiver under which HIP adults are treated as Medicaid eligibles because the State could, hypothetically, become an "early expansion" State. ACA permits States to expand coverage to the new eligibles before 2014. As a practical matter, the State would not be in a position to enroll all the newly eligible HIP adults at the same time, but would have to control enrollment in order to permit provider capacity to grow and to provide sufficient time for orderly growth. This appears to have been envisioned by ACA, which permits States to phase in enrollment by income level. The build up of enrollment of HIP adults, as a hypothetical population, would let the State "hit the ground running" once the new eligibility criteria become mandatory on January 1, 2014.

Please let us know if you have questions about any of the foregoing.

1. Number of people affected by enhanced coverage, benefits or retained enrollment.
   OMPP Response: It is assumed that the current 42,000 individuals enrolled under the Healthy Indiana Plan 1115 waiver would continue coverage under a waiver extension. Milliman, Inc. conducted an analysis on behalf of the Medicaid program, and 302,000-413,000 additional adults may be eligible for Medicaid in 2014.

2. Number of potential new eligible people.
   OMPP Response: Per an assessment conducted by Milliman, Inc. 302,000-413,000 adults could be eligible for Medicaid under the Affordable Care Act (§1902(a)(10)(A)(i)(VIII)).

3. Does this plan provide eligibility simplification?
   OMPP response: Not at this time, however, review of the rules for Modified Gross Adjusted Income may provide more clarity.

4. Will provider payments increase?
   OMPP Response: No. Provider payments will maintain their current Medicare reimbursement rate and structure in the State's current 1115 waiver. For CMS defined E&M codes, we will increase as directed.

5. Does this plan provide delivery system innovation?
   OMPP Response: HIP, as per the current 1115 waiver, provides delivery system innovation in that it encourages personal responsibility and cost conscious consumption of healthcare services. HIP places a unique emphasis on the receiving of preventive care services and healthy behaviors.

6. Has your office received any expression of interest in this amendment from the Governor's office, Congressional offices, or other outside parties?
   OMPP Response: The Office has received expressions of interest from outside parties, including the Office of the Governor, members of the Indiana General Assembly and Indiana's Congressional delegation members Representative Mike Pence, Representative Dan Burton, Representative Larry Bucshon, Representative Todd Rokita, Representative Marlin Stutzman and Representative Todd Young. The State met with a variety of external stakeholders, and the amendment was by and large supported by these groups.