UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

STATE OF INDIANA, *et al.*	)	
	)	
Plaintiffs,	)	
v.	)	Case No. 1:13-cv-01612-WTL-TAB
	)	
INTERNAL REVENUE SERVICE, *et al.*,	)	
	)	
Defendants.	)	

DEFENDANTS' REPLY MEMORANDUM IN SUPPORT OF THEIR CROSS-MOTION FOR SUMMARY JUDGMENT

STUART F. DELERY
Assistant Attorney General

JOSEPH H. HOGSETT
United States Attorney

SHELESE WOODS
Assistant United States Attorney

SHEILA LIEBER
Deputy Branch Director

JOEL McELVAIN
Senior Trial Counsel
U.S. Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Avenue, NW
Washington, D.C. 20530
(202) 514-2988
Joel.McElvain@usdoj.gov

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases: **Page**

Statutes:

Rules and Regulations:

Miscellaneous:

Introduction

The plaintiffs assert that "the Federal Government … attempts to explain why the Court should ignore the plain language of the statute." In their telling, the defendants are asking the Court to completely disregard the text of the Affordable Care Act ("ACA") in order to uphold the Treasury regulation that is challenged here. State of Indiana's Mem. in Opp. to Defs.' Cross-Mot. for S.J. and Reply Mem. in Supp. of Its Own Mot. for S.J. ("Indiana Reply") at 6, ECF 65. The plaintiffs devote large portions of their briefs to a rebuttal of this straw argument, rather than engaging with the arguments that the defendants have actually put forth.

In truth, both the plain text of the Affordable Care Act – when the Act is read in full, as it must be – and Congress's obvious purpose in enacting the Act point to the same conclusion: Congress intended that participants in all of the Act's Exchanges may be eligible for premium tax credits, whether the Exchange is state- or federally-run. The Act defines the term "Exchange" to be "a governmental agency or nonprofit entity that is established by a State," 42 U.S.C. § 18031(d)(1), but it does not force the state to operate that entity. Instead, if the state chooses not to establish or operate the "required Exchange," the Act directs the Secretary of Health and Human Services ("HHS") to establish and operate "such Exchange." 42 U.S.C. § 18041(c)(1). When these provisions are read together, as they must be, it is clear that Congress intended for the federally-run Exchange to be the same entity as the Exchange that is, by operation of the statute, the entity "that is established by a State" under Section 18031. Thus, when Section 36B specifies that tax credits are available to pay for premiums for a plan "enrolled in through an Exchange established by the State under [42 U.S.C. § 18031]," 26 U.S.C. § 36B(b)(2)(A), it refers both to state-run Exchanges and to federally-run Exchanges, which are each treated, by operation of law, as the same entities.

The plain text of the statute thus supports Treasury's interpretation of Section 36B. That interpretation is further confirmed by other provisions in Section 36B itself, which reflect Congress's understanding that federal tax credits would be distributed through the federally-run Exchanges; by the remainder of the ACA, which contains numerous provisions that would become nonsensical under the plaintiffs' theory; and by the ACA's purpose and legislative history, which reflect the importance of the premium tax credits to the Act's overall structure and mission. At the very least, Treasury has reasonably interpreted Section 36B in light of these considerations, and its reasonable reading should be accorded *Chevron* deference.

In short, "the plain text of the statute, the statutory structure, and the statutory purpose make clear that Congress intended to make premium tax credits available on both state-run and federally-facilitated Exchanges." *Halbig v. Sebelius*, --- F. Supp. 2d ---, 2014 WL 129023, at *18 (D.D.C. Jan. 15, 2014), *appeal docketed*, No. 14-5018 (D.C. Cir. Jan. 16, 2014); *see also King v. Sebelius*, --- F. Supp. 2d ---, 2014 WL 637365, at *11 (E.D. Va. Feb. 18, 2014), *appeal docketed*, No. 14-1158 (4th Cir. Feb. 21, 2014) ("when statutory context is taken into account, Plaintiffs' position is revealed as implausible"). If this Court were to reach the merits of the plaintiffs' challenge to the Treasury regulation, then, Treasury's reasonable construction of Section 36B should be upheld.

The plaintiffs also persist in their Tenth Amendment challenge to the ACA's large-employer tax and reporting provisions, 26 U.S.C. §§ 4980H, 6056, as well as their claim that Treasury is "estopped" from applying these provisions for the current tax year. Both of these claims are insubstantial. Sections 4980H and 6056 apply equally to state employers as they do to private employers, and they therefore do not violate the Tenth Amendment. And there is no sense in which Treasury should be "estopped" simply because it has exercised its authority to

provide transition relief from the large-employer tax and reporting provisions for the current year.

Argument

I. The Text and Structure of the Affordable Care Act Show that Federal Premium Tax Credits Are Available on Federally-Run Exchanges (Count I)

A. Under Settled Principles of Statutory Construction, a Court Must Construe the Entire Statute, not Isolated Provisions

The plaintiffs continue to insist that the Court read a phrase in 26 U.S.C. § 36B(b)(2)(A) in isolation, divorced of its larger context, and even divorced from a consideration of the provision that is explicitly cross-referenced in that phrase. All established canons of statutory interpretation demand precisely the opposite approach. "In making the threshold determination under *Chevron*, a reviewing court should not confine itself to examining a particular statutory phrase in isolation. Rather, the meaning – or ambiguity – of certain words or phrases may only become evident when placed in context. It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007) (internal quotations and alterations omitted). The Court's "ultimate objective must be to give effect to the congressional intent embodied in the entire statute," and thus the Court must "turn to an examination of the overall text and structure of the statute to ascertain [Congress's] intent." *Mach Mining, LLC v. Secretary of Labor*, 728 F.3d 643, 648 (7th Cir. 2013), *cert. denied*, 134 S. Ct. 1873 (2014). When Section 36B is read in context – as it must be – it is clear that Congress meant for federal premium tax credits to be available for participants in the federally-run Exchanges. Because Treasury offers the best reading of the Act, and at the very

least a reasonable reading of the Act, its interpretation must be sustained under *Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984).

B. Section 36B, When Read in Full and Together with 42 U.S.C. §§ 18031 and 18041, Provides that Federal Premium Tax Credits Are Available on Federally-Run Exchanges

Section 36B(b)(2)(A) cannot be read in isolation, as the plaintiffs demand, because it expressly refers to 42 U.S.C. § 18031, which declares that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State" that meets certain statutory requirements. 42 U.S.C. § 18031(b)(1). *See also* 42 U.S.C. § 18031(d)(1) ("An Exchange shall be a governmental agency or nonprofit entity that is established by a State."). Section 18031 thus presumes that the state establishes the Exchange, but also accounts for the possibility that a state may not do so, by directing that, if a state will "not have any required Exchange operational by January 1, 2014, … the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate *such Exchange* within the State[.]" 42 U.S.C. § 18041(c)(1) (emphasis added). The "required Exchange" in this phrase is the Exchange that Section 18031 directs the state to establish. Thus, the federally-facilitated Exchange is the Exchange that the state is directed to establish under Section 18031: the federal government stands in the shoes of the state in establishing "such Exchange."[1]

It follows from the foregoing that the Section 36B tax credit is available in every Exchange, whether the state itself establishes the Exchange, or whether the federal government

[1] The plaintiffs refer to 42 U.S.C. § 18043, which sets up a mechanism to establish Exchanges in the territories. Reply in Supp. of Pl. Sch. Corps.' Mot. for S.J. and Response to Defs.' Cross Mot. for S.J. ("School Corporations Reply") at 7 n.3, ECF 63. The reason why the Act treats territories separately is clear. Territorial residents do not ordinarily pay federal income tax, 26 U.S.C. §§ 931-33, so Congress needed some mechanism other than the distribution of federal premium tax credits to put the Act into effect for the territories. Residents of all fifty states, of course, do pay federal income tax, whether or not their state has established its own Exchange.

stands in the state's shoes to do so. This reading is necessary to make sense, for example, of Section 18031(d)(1), which defines the "Exchange" as an entity "that is established by a State." That phrase, coupled with Section 18041(c)'s reference to "such Exchange," reflects that the federally-facilitated "Exchange" is the Exchange that the state is directed to establish. That is, the Act takes the state-established Exchange as its foundational assumption, and directs the federal government to act to bring the Exchange into operation if the state chooses not to do so, or fails to do so sufficiently.[2]

The ACA's definitional provisions confirm this reading. The Act treats "Exchange" as a defined term; to confirm this point, it is capitalized each time it appears in the Act. The term is defined to mean "an American Health Benefit Exchange established under [42 U.S.C. § 18031]." 42 U.S.C. §§ 300gg-91(d)(21), 18111. So, when the Act instructs the Secretary to establish "such Exchange," it instructs that "the Secretary shall … establish and operate such [American Health Benefit Exchange established under 42 U.S.C. § 18031]." 42 U.S.C. § 18041(c)(1). The federally-facilitated Exchange, then, *is* the Section 18031 Exchange. The plaintiffs dispute the relevance of these definitional provisions, arguing that the definitional provisions do not speak to which entity has created the Exchange. *See* Indiana Reply 8; *see also* School Corporations Reply 6-7. Their argument misses the point. Section 18031 itself defines the term "Exchange" as an entity that is established by a state. 42 U.S.C. § 18031(d)(1). When the Act directs that the Secretary shall establish the Exchange under 42 U.S.C. § 18031, then, it makes clear that that

[2] The plaintiffs continue to reply on the canon against surplusage. Indiana Reply 10. But, as the defendants have noted, "the canon against surplusage assists only where a competing interpretation gives effect to every clause and word of a statute." *Marx v. General Revenue Corp.*, 133 S. Ct. 1166, 1177 (2013) (internal quotation omitted). The plaintiffs' theory renders superfluous numerous other provisions of the ACA, and therefore "the canon against surplusage is of no use here." *Halbig*, 2014 WL 129023, at *14 n.11.

Exchange is deemed, by the operation of the statute, to be the Exchange that the state is directed to establish under Section 18031.

This reading is further confirmed by 26 U.S.C. § 36B(f)(3). This provision directs every Exchange, expressly referencing the federally-run Exchanges, to provide information to Treasury and to taxpayers regarding the payments of premium tax credits. This provision – which was enacted as part of Section 36B itself – assumes that tax credits are available on the federally-run Exchanges, and would make no sense if there were no tax credits for those Exchanges to process.

The plaintiffs note that the Section 36B(f)(3) reporting requirements apply to all plans purchased on the Exchanges, including plans that are initially purchased without subsidies. They argue that it makes as much sense, under their theory, for Congress to require federally-run Exchanges to report on tax credits that could never be recognized, as it does for Congress to require all of the Exchanges to report on every plan that is sold. School Corporations Reply 12-13. Congress, however, had good reason to require all of the Exchanges, both state- and federally-run, to report on every plan that is purchased through them. It is impossible to know with certainty, at the time that a plan is purchased through an Exchange, whether a tax credit will be claimed for that plan. A taxpayer may choose to purchase a plan without first claiming advance payment of the credit. That taxpayer may choose to claim the tax credit on the income tax return that he or she files the following year, either because the taxpayer's income or family circumstances have changed, or simply because the taxpayer wishes to defer his or her receipt of the valuable tax benefit. When that taxpayer later seeks the tax credit, Treasury will need information about the amount of advance payments that the taxpayer has received (even if that amount is zero) in order to calculate the tax credit. Accordingly, it makes perfect sense for Congress to require all of the Exchanges to report information to Treasury concerning all of the

plans purchased on them; Treasury needs information concerning every plan purchased on the Exchanges, both state- and federally-run, in order to perform its duty under Section 36B(f)(3) to administer the tax credits for all of the Exchanges.

The plaintiffs also argue that the express reference in Section 36B(f)(3) to the federally-facilitated Exchanges shows that Congress intended the two types of Exchanges to be different entities. School Corporations Reply 11-12. They misread the statute. Section 36B(f)(3) applies the reporting requirements to "[e]ach Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act)," that is, 42 U.S.C. §§ 18031(f)(3) or 18041(c). The term outside the parenthetical – "Exchange" – refers to both the state-run Exchanges and the federally-run Exchanges, by virtue of the Act's definitional provisions and Section 18041's specification that the Secretary stands in the shoes of the state to establish the federally-run Exchange. The phrase inside the parenthetical clarifies that the reporting requirements also apply to any private parties with which either the state or the Secretary has contracted to perform certain Exchange functions. 42 U.S.C. §§ 18031(f)(3), 18041(c). The full phrase, then, does confirm that Congress understood the state-run Exchanges and the federally-run Exchanges to be equivalent. The far more natural conclusion to draw from Section 36B(f)(3) is the one drawn by Treasury: Congress expected that premium tax credits would be provided in every Exchange. *See Fund for Animals, Inc. v. Kempthorne*, 472 F.3d 872, 878 (D.C. Cir. 2006) (interpretations that would render particular provisions pointless should be avoided).

Section 36B therefore, when read in its entirety, and in conjunction with the provisions of the ACA describing the Exchange, 42 U.S.C. §§ 18031 and 18041, makes plain that Congress envisioned the federally-facilitated Exchange to be the same entity as the Exchange that the state

is directed to establish, and that Section 36B would operate in every state "to establish a nationwide scheme of taxation uniform in its application." *United States v. Irvine*, 511 U.S. 224, 238 (1994) (federal taxing statute not to be read to be "subject to state control or limitation" absent plain language so requiring). Because, once the Court "appl[ies] the ordinary tools of statutory construction," the intent of Congress is clear – or at the very least, because Treasury has reasonably resolved any statutory ambiguity – its interpretation should be upheld under *Chevron*. *City of Arlington v. FCC*, 133 S. Ct. 1863, 1868 (2013).

C. The Act's Larger Structure Confirms that Its References to State-Established Exchanges Include the Exchange Established by the Secretary on a State's Behalf

It is axiomatic that, "in ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole." *Household Credit Servs., Inc. v. Pfennig*, 541 U.S. 232, 239 (2004); *see also, e.g., Adoptive Couple v. Baby Girl*, 133 S. Ct. 2552, 2563 (2013); *Maracich v. Spears*, 133 S. Ct. 2191, 2203 (2013). "Interpretation of a word or phrase depends upon reading the whole statutory text, considering the purpose and context of the statute." *Senne v. Village of Palatine*, 695 F.3d 597, 601 (7th Cir. 2012) (en banc), *cert. denied*, 133 S. Ct. 2850 (2013). The reading of Section 36B that the plaintiffs offer is not compatible with the rest of the ACA; accordingly, that reading should be rejected.

1. Under the Plaintiffs' Theory, Nobody Would Be Eligible to Buy Insurance on a Federally-Run Exchange, a Result that Congress Could Not Have Intended

Notably, the logic of the plaintiffs' theory would produce the absurd result that nobody would be eligible to buy insurance offered on the federally-facilitated Exchange – with or without a subsidy. This is so because a "qualified individual" who is eligible to buy insurance on

the Exchange is defined as an individual "who resides in the *State that established the Exchange*." 42 U.S.C. § 18032(f)(1)(A)(ii) (emphasis added). There is no separate provision defining "qualified individual" for purposes of the federally-facilitated Exchange. Run to its logical conclusion, then, the plaintiffs' theory would mean that nobody would be a "qualified individual" in a state with a federally-facilitated Exchange. Congress obviously did not intend this result; without any eligible buyers, there would be no reason for the federally-facilitated Exchange to exist. *See Halbig*, 2014 WL 129023, at *15 (under the plaintiff's theory, "[t]he federal Exchanges would have no customers, and no purpose. Such a construction must be avoided, if at all possible.").

The plaintiffs respond that HHS has issued regulations that clarify that Section 18032's residence standards apply to the same extent on both the state-run and federally-run Exchanges. School Corporations Reply 15-16 (citing 45 C.F.R. § 155.305(a)(3)). It is not surprising that HHS has done so; that agency, like Treasury, understands that, when the ACA directs the Secretary of HHS to establish a federally-facilitated Exchange, it directs that the Secretary shall stand in the shoes of the state to do so, and that the state-run Exchange and the federally-run Exchange are to be treated as the same entity. The plaintiffs cannot explain, however, how HHS's regulation could survive under their theory, given that the condition that an applicant "reside[] in the State that established the Exchange," 42 U.S.C. § 18032(f)(1)(A)(ii), could never be met in a state with a federally-run Exchange under their reading of the Act.

The plaintiffs also suggest that the absurdity that their theory creates should be resolved for Section 18032 alone. School Corporation Reply 14-15. They apparently reason that the relevant phrase in 42 U.S.C. § 18032 – "resides in the State that established the Exchange" – may be read to include states with federally-run Exchanges, but that the materially identical

phrase in Section 36B – an "Exchange established by the State under [42 U.S.C. § 18031]" – must be read *not* to do so. But Section 18032 is the very next section of the Affordable Care Act after Section 18031, in the same title, subtitle, and part of the Act as the provision that directs states to establish Exchanges. The plaintiffs' selective reading ignores the principle that adjacent statutory provisions "should be read in harmony." *Adoptive Couple v. Baby Girl*, 133 S. Ct. at 2563; *see also Kloeckner v. Solis*, 133 S. Ct. 596, 606 (2012) (statute should not be read to create an absurdity in "[a]nother section of the statute"); *Robers v. United States*, 134 S. Ct. 1854, 1857 (2014) ("identical words used in different parts of the same statute are presumed to have the same meaning") (internal quotation and alteration omitted).

It makes far more sense to do as Treasury has done, and to read the Act not to create an absurd result in the first place. As explained above, the Act is best read to create a presumption that a state will create an Exchange, and to provide, where a state fails to do so adequately, that the federal government will stand in the shoes of the state to perform the actions needed to ensure that the Exchange that the state is directed to establish under 42 U.S.C. § 18031 is brought into operation. The Act's definition of a "qualified individual" makes perfect sense under this approach. Every person "resides in [a] State that established the Exchange," then, and there is no need to resort to the contortions that the plaintiffs offer to avoid the absurdities created by their theory.

2. The Plaintiffs' Theory Would Create Numerous Additional Anomalies that Are Inconsistent with the Basic Statutory Scheme of the ACA

As the defendants have noted, there are numerous additional provisions in the ACA that demonstrate that Congress intended the Act's references to state-operated Exchanges to include the Exchanges that HHS operates on a state's behalf.

The Medicaid maintenance-of-effort requirement. The plaintiffs' theory would create an unanticipated obligation for states in the operation of their Medicaid programs. As the plaintiffs themselves acknowledge, Indiana Reply 17, it follows from their theory that a state with a federally-run Exchange would never be relieved of the Act's temporary maintenance-of-effort requirement for that state's Medicaid program. 42 U.S.C. § 1396a(gg)(1); *see* Defs.' Mem. in Supp. of Their Cross-Mot. for S.J. and in Opp. to Pls.' S.J. Mots. ("Defs.' Mem.") at 25-26, ECF 62. It is not plausible that Congress intended this result. If it had, it would have said so directly, thereby giving notice to the states and the public of the consequences of the state's decision. *See King*, 2014 WL 637365, at *13.

The plaintiffs contend that Congress intended this result, *see* Indiana Reply 17, but their argument cannot be squared with 42 U.S.C. §§ 1396a(gg)(3), which permits a state to obtain a waiver of the maintenance-of-effort requirement upon a certification that the state faces a budget deficit "[d]uring the period that begins on January 1, 2011, and ends on December 31, 2013." Congress obviously chose these dates because, after 2013, the Exchange in each state – whether state- or federally-run – would be in operation. Under the plaintiffs' theory, however, not only would a state with a federally-facilitated Exchange never be relieved of the maintenance-of-effort requirement, that requirement would remain in place even in the face of a state budgetary shortfall. The states simply had no reason to believe that this consequence would follow from the decision to rely on a federally-facilitated Exchange.

Indeed, Indiana has itself relied on the expiration of this provision, reducing benefits for pregnant women in a manner that it could not have done if 42 U.S.C. § 1396a(gg)(1) had not expired. *See* Defs.' Mem. 26. Indiana asserts that its State Medicaid plan "has not changed," and guesses that the defendants are "apparently referring to … [its] request for a one year

renewal of the Healthy Indiana Plan" (a program under which Indiana provides health coverage to persons in addition to those treated as mandatory Medicaid populations under pre-ACA law). Indiana Reply 17. This is incorrect. Indiana sought, and received, an amendment to its State Medicaid plan – that is, the plan that covers its mandatory population, apart from its Healthy Indiana Plan – to reduce benefits for certain persons covered under that plan. *See* Declaration of Anne Marie Costello, ¶¶ 3, 4, ECF 61-10. Indiana could not have sought, or received approval for, that amendment if Section 1396a(gg)(1) had remained in effect. *See* 42 C.F.R. § 430.10 (when it submits State Medicaid plan for approval, the state "giv[es] assurance that [the plan] will be administered in conformity with the specific requirements of title XIX").

In any event, Indiana has *also* sought approval for changes to its Healthy Indiana Plan in a manner that is inconsistent with its theory here. *See* Defs.' Mem. 26 n.6. Indeed, only this month, Indiana has once again contradicted its theory in this lawsuit, seeking approval of an amendment to the Healthy Indiana Plan that assumes that "individuals above 100% FPL who were previously eligible for HIP would have new coverage options and access to premium tax credits and cost-sharing reductions via the federal Marketplace." Ind. Family & Soc. Servs. Admin., *Healthy Indiana Plan HIP 2.0 1115 Waiver Application* at 8 (May 13, 2014) (attached to this brief as Defs.' Exh. 27). Indiana unabashedly defends its right to pursue inconsistent positions, Indiana Reply 18, but this Court should not allow that effort to proceed. *See In re Cassidy*, 892 F.2d 637, 641 (7th Cir. 1990) (estoppel applies where "intentional self-contradiction is being used as a means of obtaining unfair advantage").

Coordination of CHIP benefits with the Exchanges. The plaintiffs' reading is also inconsistent with the ACA's provisions concerning Children's Health Insurance Program ("CHIP") benefits. The Act instructs states to ensure that children (who are not Medicaid-

eligible) have access to plans in an "Exchange established by the State under [Section 18031]," if there is a funding shortfall in the state's CHIP program. 42 U.S.C. § 1397ee(d)(3)(B). The Act also directs HHS, "[w]ith respect to each State," to certify whether plans offered through an "Exchange established by the State under [42 U.S.C. § 18031]" provide benefits for children that are comparable to those offered in the state's CHIP plan. 42 U.S.C. § 1397ee(d)(3)(C). Under the plaintiffs' reading, a state with a federally-facilitated Exchange would necessarily be in violation of these CHIP provisions in the event of a funding shortfall, and HHS could not fulfill its certification obligation for "each State."

The plaintiffs deny this point, suggesting that a state would have no reason to enroll children in an Exchange that it had not established, and that HHS should instead "review the benefits available on the federal Exchanges to ensure that the children are not left behind." School Corporations Reply 16-17. This cavalier suggestion is not responsive to the defendants' argument. The point is that, under the plaintiffs' theory, the state could never fulfill its obligation under the CHIP program to provide an Exchange plan as a backup to ensure coverage for needy children. The plaintiffs' further observation that, under their theory, there would be no plans available to provide coverage for CHIP-eligible children, Indiana Reply 20, only confirms the irrationality of their theory. Congress obviously intended the Act's provisions for the coordination of CHIP benefits with the Exchanges to be meaningful, and to offer vulnerable children a seamless guarantee of coverage.[3]

[3] In the *Florida* litigation, Indiana pursued the same theory with respect to the Act's CHIP provisions (as well as the Act's Medicaid maintenance-of-effort provisions), asserting that these provisions unconstitutionally coerced the state into establishing its own Exchange. The federal government explained there, as it has here, that by virtue of 42 U.S.C. § 18041(c), these provisions would operate in the same manner for federally-run Exchanges as they would for state-run Exchanges, and that the Act gives the states a meaningful choice whether to operate their own Exchanges. The district court accepted the defendants' argument and rejected the

The better reading is the one offered by Treasury, under which the federal government stands in the shoes of the state to operate the Exchange where the state does not do so. Under this reading, Section 1397ee does not impose an obligation on HHS that is impossible to fulfill, and subsidized coverage is available for the children who are protected by the CHIP program. *See Halbig*, 2014 WL 129023, at *14; *King*, 2014 WL 637365, at *13 n.8.

State Innovation Waivers. The plaintiffs' theory would also undermine the ACA's process for state innovation waivers. As the defendants have noted, beginning in 2017, a state that has enacted legislation to provide its own deficit-neutral system of comprehensive, affordable health coverage may seek to opt out of some of the Act's provisions. 42 U.S.C. § 18052. In particular, if a waiver were approved, the state could opt out of the application of premium tax credits under Section 36B; federal funds in the amount of the forgone tax credits would be distributed directly to the state to administer its alternative plan. 42 U.S.C. § 18052(a)(3), (b)(1). Congress thus specified the terms of the deal that it offered to the states – the state could gain approval for Section 36B (and related provisions) not to apply within its borders, but only after the state enacted its own comprehensive health reform legislation meeting specified criteria.

This offer would be pointless under the plaintiffs' reading. The plaintiffs suggest that Congress intended Section 18052 as an incentive to states, reasoning that there would be no

---

plaintiffs' coercion claim. Reply in Supp. of Defs.' Mot. to Dismiss at 6-7, ECF No. 74, *Florida v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91 (N.D. Fla. filed Aug. 27, 2010); *Florida v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1156 n.15 (N.D. Fla. 2010) (adopting the defendants' interpretation), *rev'd in part on other grounds by Nat'l Fed'n of Indep. Business v. Sebelius*, 132 S. Ct. 2566 (2012). Before the Supreme Court, Indiana and the other states switched gears, and argued that "States were given a meaningful choice whether to operate the health benefit exchanges created by the Act," in alleged contrast to the Act's Medicaid provisions that the states challenged. Brief of State Petitioners on Medicaid at 22, No. 11-400, *Florida v U.S. Dep't of Health & Human Servs*. (U.S. filed Jan. 10, 2012). Indiana is now estopped from presenting a different theory as to the operation of these provisions of the Act.

funds available to a state for a waiver if the state had not first established its own Exchange, and they further suggest that Congress meant to allow states to waive out of the Act's system of comprehensive, affordable health coverage simply by doing nothing. Indiana Reply 21; School Corporations Reply 18. To the contrary, Section 18052 underscores Congress's plain intention to ensure that comprehensive, affordable health coverage would be available in every state, either under the system specified by the ACA or under an alternative, equally comprehensive system enacted by the state.

Electronic Calculators and Transmittals of Information to Treasury. Under 42 U.S.C. § 18031(d)(4)(G), every Exchange (whether state-run or federally-run) is required to "make available by electronic means a calculator" that applicants may use to determine the "actual cost of coverage" after Section 36B tax credits and any cost-sharing reductions are applied. Under 42 U.S.C. § 18031(d)(4)(I), every Exchange (again, whether state-run or federally-run) is required to report information to Treasury concerning persons whom those Exchanges have found to be eligible for the Section 36B tax credit. The plaintiffs note that, "if Federal tax credit subsidies are available only to those who purchase coverage on a State-run Exchange, there [would be] no reason" for these rules to apply to the federally-run Exchanges. Indiana Reply 23. We agree. The fact that these requirements *do* apply to the federally-run Exchanges is powerful evidence that Congress intended for the Section 36B tax credit to be available on all of the Exchanges.

Reporting of Social Security Information. The plaintiffs note that the ACA provides that HHS and the "'Exchanges established under section 1311'" are authorized to collect social security numbers as needed to administer the Act's provisions, and they suggest that this provision shows that Congress meant to draw a distinction between state-run and federally-run Exchanges. Indiana Reply 11 (quoting 42 U.S.C. § 405(c)(2)(C)(x)). In fact, it proves the

opposite point. Under the ACA, an applicant for enrollment in a plan on the Exchange is directed to provide his or her social security number to the Exchange (whether state-run or federally-run), so that the applicant's citizenship and immigration status may be verified. 42 U.S.C. § 18081(b)(2). Each Exchange then transmits that information to HHS, which forwards the information to the Social Security Administration, in order to perform the verification. 42 U.S.C. § 18081(c)(1). Under the plaintiffs' reading – where the "Exchanges established under section 1311" exclude the federally-run Exchanges – applicants would be required to provide information to the federally-run Exchanges under 42 U.S.C. § 18081(b) that those Exchanges would lack statutory authorization to accept under 42 U.S.C. § 405(c). Under the defendants' reading of the ACA, in which the state-run Exchanges and the federally-run Exchanges are understood to be the same entities, there is no conflict.

In sum, multiple provisions in the Affordable Care Act "reflect an assumption that a state-established Exchange exists in each state." *Halbig*, 2014 WL 129023, at *16. It defies credulity for the plaintiffs to offer a reading in which "these provisions would be nullified when applied to states without state-run Exchanges, leading to strange or absurd results." *Id.* Instead, it makes far more sense to construe these provisions "consistently with [the government's] interpretation of the Act – *i.e.*, viewing 42 U.S.C. § 18041 as authorizing the federal government to create 'an Exchange established by the State under [42 U.S.C. § 18031]'" on behalf of the state that elects not to establish the required Exchange. *Id.*

D. Treasury's Interpretation Comports with Congress's Clear Purpose in Enacting the Affordable Care Act and with the Act's Legislative History

As the defendants have shown, the plaintiffs' reading of Section 36B would undermine Congress's basic goals in passing that legislation. The plaintiffs profess to be unconcerned about this point, asserting that the language of the ACA should be interpreted without any reference to

the goals that Congress sought to achieve in passing that statute. School Corporations Reply 20. But the principle is well established that a statute must be interpreted in light of its "object and policy." *Maracich v. Spears*, 133 S. Ct. at 2203. This principle applies with special force in cases like this one, where a plaintiff asserts that states have been given a veto over federal policy; in such cases, courts are obliged to "look to the purpose of the statute," so as to guard against "the danger that the federal program would be impaired if state law were to control." *Mississippi Band of Choctaw Indians v. Holyfield*, 490 U.S. 30, 44 (1989). This Court, then, must interpret Section 36B in light of Congress's recognition that the tax credits under that provision "are *key* to ensuring people affordable health coverage." H.R. REP. NO. 111-443, pt. I, at 250 (2010), ECF 61-6 (emphasis added).

The defendants have explained – and the plaintiffs have not disputed – that, without Section 36B tax credits, millions of Americans living in states with federally-facilitated Exchanges would find it impossible to buy affordable insurance; the cost of premiums would rise significantly for millions more Americans; and the ACA's insurance reforms, including the ban on discrimination by insurers on the basis of pre-existing conditions, would be undermined. Defs.' Mem. 9-11. Congress clearly did not intend such a result, and, as explained above, the proper interpretation of the text of the Act precludes that result. Section 36B, then, should be interpreted in keeping with Congress's intent to treat the state-operated Exchange and the federally-facilitated Exchange as the same entity, and to ensure that premium tax credits would be available for participants on all of the Exchanges.

The plaintiffs persist in a post hoc argument divorced from legislative reality, claiming that Congress meant to withhold tax credits from residents of states with federally-run Exchanges, so as to give states an incentive to create their own Exchanges. Indiana Reply 24.

They cite no evidence that Congress had this intent, and no such evidence exists. Their claim simply makes no sense. "A state-run Exchange is not an end in and of itself, but rather a mechanism intended to facilitate the purchase of affordable health insurance. And there is evidence throughout the statute of Congress's desire to ensure broad access to affordable health coverage. It makes little sense to assume that Congress sacrificed nationwide availability of the tax credit … in an attempt to promote state-run Exchanges." *Halbig*, 2014 WL 129023, at *17.

The legislative history further confirms that Congress intended for premium tax credits to be available in every state, regardless of which entity operated the Exchange. The defendants have referred to multiple sources in the Act's legislative history that confirm that Congress so intended. Defs.' Mem. 32-37. For example, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) prepared estimates of the budgetary effects of the ACA, predicated on the belief that tax credits would be available nationwide.[4] The plaintiffs offer that perhaps CBO and JCT "simply misread the statute." School Corporations Reply 21. But, given the central importance that CBO's budget scoring played in Congress's deliberations, if anybody believed that CBO or JCT had erred, the issue would have arisen during the Congressional debates. It did not. To the contrary, members of Congress repeatedly endorsed CBO's estimates, and recited the conclusion that Section 36B tax credits would be available in every state. *See* Defs.' Mem. 33-34 (collecting legislative history). And, as CBO's director describes, "the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional

[4] The JCT also prepared a detailed summary of the Act's tax-related provisions, which recited that the Section 36B premium tax credit "subsidizes the purchase of certain health insurance plans through an exchange," without specifying that the entity that operates the Exchange would be relevant in any way. JCT, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act"* 12 (Mar. 21, 2010), ECF 61-24.

staff when the legislation was being considered." Letter from Douglas Elmendorf, Director, CBO, to Rep. Darrell Issa, Chair, House Committee on Oversight and Gov't Reform at 1 (Dec. 6, 2012), ECF 61-16.[5]

In addition, in passing H.R. 3962, its version of health reform legislation, the House expressly provided for tax credits to be available in every Exchange, whether state- or federally-run. If any House member believed that the Senate's bill had departed from this approach, he or she would have noted this distinction. No such objection was raised. The plaintiffs speculate that the House raised no objections because a "revised healthcare bill from the House would have died a filibustered death in the Senate." School Corporations Reply 23. But the House *did* successfully propose amendments to Section 36B in passing HCERA, the reconciliation bill that accompanied the ACA. Pub. L. No. 111-152, § 1001(a), 124 Stat. 1029, 1030-31 (2010). It is not plausible that the House would have adjusted the amounts of the Section 36B tax credits in enacting the reconciliation bill, HCERA, while ignoring the supposed fact that tax credits would be denied entirely in some states. To the contrary, the House recognized that, under the ACA as enacted, "[f]or states that choose not to operate their own Exchange, there will be a multi-state Exchange run by the Department of Health and Human Services," and all of the Exchanges would "provide[] premium tax credits to limit the amount individuals and families up to 400% poverty spend on health insurance premiums." House Committees on Ways and Means, Energy and Commerce, and Education and Labor, *Health Insurance Reform at a Glance: The Health Insurance Exchanges* 1-2 (Mar. 20, 2010), ECF 61-25.

[5] The plaintiffs note that Senator Nelson opposed a "national Exchange." School Corporations Reply 22. There is no single "national Exchange" under the ACA. Every state has the first option whether to operate the Exchange within its borders. If a state chooses not to do so, the federal government will operate that particular Exchange in that particular state, rather than a single national Exchange. 42 U.S.C. § 18041(c)(1). The plaintiffs' cited news article does not remotely suggest that federal tax credits would not be available on the federally-run Exchanges.

Moreover, the language that became 26 U.S.C. § 36B was developed in the Senate Finance Committee, and that Committee did not at any time express any intent to condition the availability of federal premium tax credits on the existence of a state-operated Exchange. That Committee instead expressed its understanding that the federally-facilitated Exchange would be treated as the same entity as the state-operated Exchange. *See* S. REP. NO. 111-89, at 19 (2009) (directing "the Secretary" to establish "state exchanges" if the state does not do so); *see also Halbig*, 2014 WL 129023, at *17.

The plaintiffs suggest that the Senate Finance Committee proposed to give states a veto over a *different* tax credit provided in its bill. School Corporations Reply 22. Even if this were the case, it would not speak to the Committee's intent with respect to the Section 36B tax credit, but in any event the plaintiffs have misread the bill. The Committee proposed a "small employer health insurance credit," which would apply after "the first month the State establishing the exchange has in effect the insurance rating reforms described in subtitle A of title XXII of the Social Security Act." S. 1796, 111th Cong. § 1221 (2009) (proposing to add 26 U.S.C. § 45R(a), (c)(2)). The cross-referenced subtitle would have enacted insurance industry reforms that would be put into effect by the federal government by July 1, 2013, in the absence of action by the state, but that states could have chosen to put into effect more quickly. *Id.* § 1001 (proposing to add Social Security Act, titl. XXII, subtit. A , including in particular § 2225(a)(2), (a)(3)). So, under the Committee's bill, the tax credit would have applied on a nationwide basis, with or without state action; states were not given a veto over the application of that federal tax credit.[6]

[6] The plaintiffs similarly misread a provision in the Senate Health, Education, Labor and Pensions ("HELP") Committee bill (which, in any event, did not form the basis for the language of Section 36B in the Act as enacted). The HELP Committee bill did not provide that "eligibility for tax credits depended on whether states adopted [insurance-industry] reforms." School Corporations Reply 22. Instead, that bill proposed that the residents of every state would be

The plaintiffs also assert that relevant legislative history can be found in an earlier, expired statute that was never referenced in any of the Congressional debates over the ACA. They surmise that, in the Trade Adjustment Assistance Act ("TAAA"), 26 U.S.C. § 35(e), Congress "conditioned health insurance-based tax credits for taxpayers on their states taking certain actions or adopting certain healthcare reforms," and that therefore Congress modeled the ACA after the TAAA. School Corporations Reply 10; *see also* Indiana Reply 14-15. The conclusion does not follow from the premise, but, in any event, the plaintiffs misread the earlier statute. Congress did not "condition[] eligibility" for the tax credit under the TAAA on state action. Instead, Congress provided tax relief for certain workers displaced by foreign competition, which could be used to offset the costs of several different kinds of qualifying health insurance. Some forms of qualifying insurance were available nationwide, although the TAAA permitted states to designate additional kinds of insurance that would meet certain minimum standards. 26 U.S.C. § 35(e). The TAAA, then, provides no support for the plaintiffs' claim that Congress intended, in that statute or in the ACA, to give states a veto over the nationwide availability of the tax relief that it enacted.

The most relevant feature of the TAAA, instead, is its sunset date – January 1, 2014. Pub. L. No. 112-40, § 241(a), 125 Stat. 401, 418 (Oct. 21, 2011). Congress, obviously,

---

eligible for subsidies upon the effective date for the bill's health insurance reforms. S. 1679, 111th Cong. § 142 (2009) (proposing to add Public Health Service Act, § 3104(d)). Those subsidies would have been made available earlier, in both states with their own Exchanges and states with federally-run Exchanges, if the states chose to accelerate the effective date of those reforms. *Id*. (proposing to add Public Health Service Act, § 3104(b), (c)). The bill did expressly propose to condition subsidy eligibility, however, upon the state's agreement to apply the bill's insurance reforms to state and local employers. *Id*. (proposing to add Public Health Service Act, § 3104(d)(1)(D)). The HELP Committee's structure is not reflected in the ACA; the Senate chose to follow the Finance Committee's framework instead. The HELP Committee's bill confirms, however, that Congress knows how to describe conditions on subsidy eligibility *explicitly* when it wishes to do so – in other words, that Congress knows how to give the states clear warning of the consequences of their decision whether to run their own Exchange or not.

understood that the statute would no longer be needed once Section 36B came into effect in 2014. It is doubtful that Congress would have terminated this program for health insurance tax credits, which were available on a nationwide basis for displaced workers, if it had thought that workers in states with federally-facilitated Exchanges would be left with no tax relief at all.

E. The Treasury Department Has Reasonably Interpreted Section 36B to Provide that Federal Premium Tax Credits Are Available on Federally-Run Exchanges

It follows from the foregoing discussion that 26 C.F.R. § 1.36B-1(k) is, at a minimum, "based on a permissible construction of the statute," and should be upheld under *Chevron* step two. *City of Arlington v. FCC*, 133 S. Ct. at 1868. Congress expressly instructed in the ACA that the federally-run Exchange should be treated as the same entity as the Exchange that the Act contemplates that the state would establish. Moreover, Congress directed in Section 36B itself that the federally-run Exchange must assist in administering premium tax credits, an exercise that would be pointless if such credits were not available for participants on that Exchange. The plaintiffs' contrary theory would create a long list of anomalies in the operation of the ACA's provisions, including, most notably, the anomaly that no individuals would be eligible to buy insurance on the federally-run Exchanges. The plaintiffs' theory, further, cannot be reconciled with either Congress's clear purpose to make affordable health coverage available on a nationwide basis, or the Act's legislative history, which shows that Congress understood that premium tax credits would be available for participants in all of the Exchanges. In light of all of these considerations, Treasury reasonably interpreted Section 36B in a manner that is consistent with Congress's intent. That interpretation should be upheld under *Chevron* step two. *See Halbig*, 2014 WL 129023, at *18 n.14; *see also King*, 2014 WL 637365, at *16.

The plaintiffs argue that *Chevron* deference should not apply because, under the doctrine

of constitutional avoidance, the Court should adopt an interpretation of the ACA that does not "usurp State sovereign authority." Indiana Reply 11-12. The Act in no sense "usurps" the authority of the states. Instead, the Act "fundamentally gives States the choice to participate in the exchanges themselves or, if they do not choose to do so, to allow the Federal Government to set up the exchanges." 155 Cong. Rec. S13,832 (Dec. 23, 2009) (Sen. Baucus). It is entirely commonplace for Congress to enact statutes that give states the first option to take regulatory action, and that provide that the federal government will step in in the state's stead, if the state declines to take that option. *See Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 289 (1981); *Florida v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d at 1154-56. *Cf. Michigan v. EPA*, 268 F.3d 1075, 1085 (D.C. Cir. 2001) (under Clean Air Act, EPA acts in "shoes of the state" for a state that declines to adopt an implementation plan). There simply are no "grave doubts" as to the constitutionality of Treasury's interpretation of the Act that could justify the invocation of the avoidance canon. *Almendarez-Torres v. United States*, 523 U.S. 224, 237-39 (1998).

The plaintiffs also argue that *Chevron* deference does not apply in cases involving tax benefits. School Corporations Reply 23-24. As the defendants have shown, *see* Defs.' Mem. 38, there is no "clear statement" principle concerning tax benefits that would defeat *Chevron* deference for the Treasury regulation. Indeed, in *Mayo Foundation for Medical Education and Research v. United States*, 131 S. Ct. 704, 715 (2011), the Court accorded *Chevron* deference to a Treasury regulation that reasonably construed a tax exemption statute. In any event, the question at issue here is not whether tax credits are available under Section 36B or not; all parties agree that they are. The question instead is whether these tax credits are available on a nationwide basis. The relevant canon, therefore, is the principle that "revenue laws are to be

construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application." *United States v. Irvine*, 511 U.S. at 238.

The plaintiffs reason that the uniformity principle applies only to "revenue" laws, not to provisions like Section 36B that provide valuable tax benefits. Indiana Reply 14. To the contrary, the uniformity canon applies with the same force for statutes conferring tax benefits as it does for statutes imposing taxes; in either instance, "the state law may control only when the federal taxing act by express language or necessary implication makes its operation dependent upon state law." *Lyeth v. Hoey*, 305 U.S. 188, 194 (1938).

The plaintiffs also present a new argument concerning *Chevron* deference for the first time in their reply briefs. (This argument is, therefore, waived. *See Griffin v. Bell*, 694 F.3d 817, 822 (7th Cir. 2012).) They contend that the Treasury regulation should not be sustained at *Chevron* step two, because the agency purportedly failed to explain the "factual basis" for its decision. School Corporations Reply 28 (quoting *Bowen v. Am. Hosp. Ass'n*, 476 U.S. 610, 626 (1986)). But the plaintiffs, citing a recent House Committee report that was issued on a purely partisan basis, do not allege that Treasury committed any *factual* error. Instead, they allege that Treasury failed to adopt the *legal* arguments concerning the Act's text and structure that they have presented in this case. Where, as here, a plaintiff raises purely legal grounds to object to an agency's interpretation of a statute, "[t]he analysis of disputed agency action under *Chevron* Step Two and arbitrary and capricious review is often the same[.]" *Halbig*, 2014 WL 129023, at *11 (internal quotation omitted); *id*. at *18 n.14. *See also Mayo Found.*, 131 S. Ct. at 712, 714 (overruling prior case law in which deference to tax regulations depended on "the way in which the regulation evolved," and instead applying *Chevron* step two, which asks "whether the agency's answer is based on a permissible construction of the statute"). And Treasury's

regulation easily survives *Chevron* step two; "the agency's answer is based on a permissible construction of the statute," and "that is the end of the matter." *City of Arlington*, 133 S. Ct. at 1874-75.[7]

II. The Act's Large Employer Provisions Do Not Violate the Tenth Amendment as Applied to State Governments (Counts II, III, and IV)

The plaintiffs also repeat their claim that the Section 4980H large employer tax and the Section 6056 reporting provision, as applied to state governments, violate the Tenth Amendment. Even assuming that the plaintiffs have not waived these claims, and assuming that res judicata does not bar them from relitigating these claims, their theory fails on the merits. The Tenth Amendment is not offended when Congress regulates the states' own activities as employers, at least where, as here, the regulation is one of general applicability. *See Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 554 (1985); *see also Reno v. Condon*, 528 U.S. 141, 150 (2000); *Travis v. Reno*, 163 F.3d 1000, 1002 (7th Cir. 1998); *Florida v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d at 1152-54 & n.14.

The plaintiffs argue that *Garcia* and its progeny do not apply here because, in their view, Section 4980H and 6056 are exercises only of the taxing power, and not also of Congress's commerce power. Indiana Reply 26-28. Section 4980H does fall within Congress's commerce power (as well as its taxing power), as "it is simply another example of Congress's longstanding authority to regulate employee compensation offered and paid for by employers in interstate commerce." *Liberty Univ. v. Lew*, 733 F.3d 72, 93 (4th Cir.), *cert. denied*, 134 S. Ct. 683 (2013).

[7] Needless to say, Treasury vigorously disputes the cited report's misleading characterization of its rulemaking process. In a case (unlike this one) where the agency's resolution of factual or procedural issues in its rulemaking process has been put into question, that dispute would be resolved by a review of the administrative record, not by a review of an outside party's characterization of the rulemaking process. Treasury has not filed an administrative record in this action, because, before the plaintiffs filed their reply briefs, they had not put any factual issue concerning the Treasury regulation into dispute (and they still have not).

(Likewise, there is no doubt that Congress may impose recordkeeping and reporting requirements, as it did in Section 6056, in support of its exercises of its commerce power. *See United States v. Darby*, 312 U.S. 100, 125 (1941).) The premise of the plaintiffs' argument fails, and *Garcia* therefore forecloses the Tenth Amendment claim.

Even if Sections 4980H and 6056 were to be viewed only as exercises of the taxing power, the Tenth Amendment claim would still fail. As the defendants have explained, the intergovernmental tax immunity doctrine is not implicated where Congress subjects state employers to a nondiscriminatory tax. *See South Carolina v. Baker*, 485 U.S. 505, 525 n.15 (1988); *see also Garcia*, 469 U.S. at 543-45; *Massachusetts v. United States*, 435 U.S. 444, 454 (1978); *Travis v. Reno*, 163 F.3d at 1002. Section 4980H applies a tax on nondiscriminatory terms to both public and private employers, and both public and private employers are subject to the same reporting obligations under Section 6056. The provisions therefore do not run afoul of the intergovernmental tax immunity doctrine. Indiana insists that these provisions are invalid because they represent an "unprecedented assertion of federal power" to impose taxes directly on states, Indiana Reply 32, but this simply is not the case. Section 4980H and 6056 operate in the same manner as well-established employment taxes that apply to state employers, such as income tax withholding provisions and the FICA taxes that fund Social Security and Medicare, as well as reporting obligations related to those taxes, such as the requirement to provide a Form W-2 to one's employees and to the IRS. *See* 26 U.S.C. §§ 3125(a), 3126, 3404, 6051.

If the Court were to reach Count IV of the plaintiffs' complaint (and there is no need to do so, as this claim depends on the plaintiffs first prevailing on their challenge to Section 6056), the plaintiffs could not meet their heavy burden to show that Congress would have wanted additional provisions of the ACA to fall if, hypothetically, Section 6056 were to be invalidated

with respect to state employers. *See Nat'l Fed'n of Indep. Business v. Sebelius* ("*NFIB*"), 132 S. Ct. 2566, 2607 (2012) (plurality opinion). The provisions that the plaintiffs challenge – 26 U.S.C. § 125(f) and 29 U.S.C. §§ 218a and 218b – do not depend on Section 6056 for their operation, and each of those provisions "will remain fully operative as a law, and will still function in a way consistent with Congress' basic objectives in enacting the statute." *NFIB*, 132 S. Ct. at 2608 (internal quotations omitted).

III. The Plaintiffs Do Not State a Claim for Estoppel against the Federal Government with Respect to Their 2014 Liability for the Large Employer Tax (Count V)

The plaintiffs continue to seek a declaration of "judicial estoppel," but, for understandable reasons, they no longer seriously pursue this claim in their reply briefs. There is little more that needs to be said regarding this claim. Treasury has exercised its transitional authority under 26 U.S.C. § 7805(a) to provide that Sections 4980H and 6056 will not be applied in 2014. It has memorialized its determination on this score in its regulations. *See* 26 C.F.R. §§ 54.4980H-4(h); 54.4980H-5(g); 301.6056-1(m); 301.6056-2(b). Because the parties are fully in agreement that these provisions will not be applied during the current year, there is no case or controversy with respect to this claim that could warrant judicial relief. *See, e.g., Lawson v. Hill*, 368 F.3d 955, 957 (7th Cir. 2004). In any event, the plaintiffs do not (and cannot) make out any case for estoppel to be applied against the federal government. *See* Defs.' Mem. 42-43.

Conclusion

For the reasons set forth above, the defendants' cross-motion for summary judgment should be granted.

Dated: May 28, 2014

Respectfully submitted,

STUART F. DELERY
Assistant Attorney General

JOSEPH H. HOGSETT
United States Attorney

SHELESE WOODS
Assistant United States Attorney

/s/ Joel McElvain
SHEILA LIEBER
Deputy Branch Director
JOEL McELVAIN
Senior Trial Counsel
U.S. Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Avenue, NW
Washington, D.C. 20530
(202) 514-2988
Joel.McElvain@usdoj.gov

CERTIFICATE OF SERVICE

I hereby certify that on May 28, 2014, a copy of the foregoing document was filed electronically. Notice of this filing will be sent to the following parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

Ashley Tatman Harwel
ashley.harwel@atg.in.gov

Heather Hagan McVeigh
heather.mcveigh@atg.in.gov

Thomas M. Fisher
tom.fisher@atg.in.gov

Kenneth Alan Klukowski
kenklukowski@gmail.com

Andrew M. McNeil
amcneil@boselaw.com

John Zhi Huang
jhuang@boselaw.com

Winthrop James Hamilton
jhamilton@boselaw.com

/s/ Joel McElvain
JOEL McELVAIN
Senior Trial Counsel
U.S. Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Avenue, NW
Washington, D.C. 20530
(202) 514-2988
Joel.McElvain@usdoj.gov

Exhibit 27

Indiana Family and Social Services Administration

HIP 2.0 1115 Waiver Application

Draft
5/13/2014

Contents

Section 1: Executive Summary

The Healthy Indiana Plan (HIP), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state's long and successful history with consumer-driven health plans. Indiana pioneered the concept of medical savings accounts in the commercial market and is also the first and only State to apply the consumer-driven model to a Medicaid population. Provided by private health insurance carriers, HIP offers its members a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account, which operates similarly to a Health Savings Account (HSA).

The private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to make contributions into their accounts. The contributions are designed to preserve dignity among members receiving public assistance and provide them with "skin in the game," which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for improving their health. In addition, the infusion of market principles works to educate members and prepare them to participate in the private market when they are able to transition off the program.

Since 2008, HIP has demonstrated remarkable success in promoting healthy lifestyles and appropriate utilization of health care services by increasing preventive care and decreasing inappropriate use of hospital emergency departments. The program has achieved notable improvements in health care utilization patterns as compared to a traditional Medicaid model that provides little incentive for participants to consider the cost of their publicly funded care or to take personal responsibility for their health.

HIP members have consistently sought primary and preventive care at higher rates than traditional Medicaid members and have utilized hospital emergency departments for non-urgent care less often than their Medicaid counterparts. Member satisfaction surveys consistently report that an overwhelming majority of HIP members - approximately ninety-five percent (95%) in 2012 - are satisfied with the program, and ninety-eight percent (98%) indicated they would re-enroll if they left the program but became eligible again.

After six years of demonstrated success, the State of Indiana seeks to replace traditional Medicaid for all non-disabled adults ages 19-64 and expand HIP to those who fall below 138% of the federal poverty level (FPL). The series of design elements (HIP 2.0) outlined in this Section 1115 Demonstration waiver further HIP's core objectives: make Hoosiers healthier, provide new coverage pathways for uninsured Hoosiers, promote employer sponsored health insurance, create incentives for Hoosiers to transition from public assistance to stable employment, promote personal responsibility and engage participants in making health care decisions based on cost and quality.

HIP 2.0 augments the existing waiver by offering HIP to individuals previously excluded from the program due to eligibility restrictions and the enrollment caps designed to maintain budget neutrality. This expansion of HIP targets an estimated 559,000 uninsured non-disabled adults ages 19-64 under 138% FPL. The State proposes a number of modifications to HIP to improve

the program based on early experiences and outcomes. These enhancements preserve and advance HIP's foundational principles of consumerism and personal responsibility in health care.

First, the State will offer new pathways to health care coverage through the Healthy Indiana Plan. The State will maintain and strengthen the POWER account with a higher dollar value to incentivize all HIP members to be prudent utilizers of health care, managing their account appropriately and seeking preventive care. This increased dollar value also serves to more closely align the POWER account with consumer-driven options available in the commercial market. HIP 2.0 will simultaneously lower required contributions for all members to ensure POWER account affordability.

Consistent with the State's original enabling legislation, HIP 2.0 promotes private employer based coverage over public assistance in several ways. First, the State will implement a new optional defined contribution premium assistance program, HIP Employer Benefit Link (HIP Link), designed to support individuals wishing to purchase their employer's sponsored health insurance. In addition, to promote private market family coverage, the State proposes an optional premium assistance program for children currently receiving benefits through the Children's Health Insurance Program (CHIP), whereby the State will provide premium assistance to allow the children to be covered under their parents' employer-sponsored or Marketplace plan.

Under HIP 2.0, members who consistently make required contributions to their POWER account will maintain access to a new "HIP Plus" plan that includes enhanced benefits such as dental and vision coverage. Members under 100% FPL who do not to make monthly POWER account contributions will be placed in the "HIP Basic" plan, a more limited benefit plan. The HIP Basic plan maintains essential benefits, but incorporates reduced benefit coverage and a more limited pharmacy benefit. The HIP Basic plan, unlike HIP Plus, will also require co-payments for all services. In sum, HIP 2.0 provides a significant value proposition that incentivizes members to make POWER account contributions.

Recognizing the strong tie between work and health, HIP 2.0 further promotes private market coverage and employment by introducing the HIP's Gateway to Work program. This program requires HIP participants be referred to the State's workforce training programs and work search resources to create opportunities for HIP members to connect with potential employers. The State aims to assist and encourage HIP members to secure and retain meaningful employment, which will not only improve health outcomes, but will help these individuals become more self-sufficient, and ultimately, complete their transition off public assistance.

The State of Indiana submits this Section 1115 Demonstration waiver to amend and renew HIP for an additional five years. However, this waiver submission is conditioned on the availability of the enhanced federal matching rate and the continuation of the State's provider assessment on hospitals, including CMS approval of the supporting State Plan Amendment. If either funding source is reduced at any point during the five-year waiver period, the HIP 2.0 will automatically terminate for the new expansion population.

HIP 2.0 enhances Indiana's long tradition of leadership in consumer-driven health care. Over the past six years, HIP's innovative design has demonstrated the effectiveness of leveraging private

market innovation to engage individuals in their health care. HIP 2.0 fully preserves the program's approach of combining personal responsibility and consumerism with incentives for positive health behaviors. The proposed enhancements in HIP 2.0 continue to build upon current HIP successes by ensuring access to quality health coverage for low-income Hoosiers while simultaneously creating a pathway for members to achieve independence from public assistance.

Section 2: Background and Current HIP Program Description

Traditional Medicaid programs offer coverage to vulnerable individuals, but numerous studies indicate poor health outcomes in spite of high spending. A University of Virginia study found that Medicaid patients are almost twice as likely to die after an inpatient surgery, stay in the hospital 42% longer, and cost 26% more than individuals with private health insurance.[1] A study conducted by Johns Hopkins similarly found higher mortality rates among Medicaid patients, indicating they are 29% more likely to die within three years following receipt of a lung transplant.[2]

The HIP model was developed as an alternative to traditional Medicaid in order to harness the success of the private health insurance market to lower costs and improve health outcomes for Hoosiers. The program utilizes an account similar to an HSA that empowers enrollees to become active consumers of health care services and to evaluate cost and quality of services. Six years later, HIP has demonstrated significant success in achieving this goal.

HIP's consumer-driven design creates incentives for members to exercise personal responsibility and live healthy lifestyles. This design encourages members to take control of their health care spending and to be active purchasers of health care services. While other efforts aimed at bending the health care cost curve are aimed at providers and insurers, HIP brings the member directly into the equation, aligning incentives across all parties and uniquely empowering the individual to demand cost and quality transparency. Through the introduction of these market forces, HIP is able to yield superior results compared to traditional Medicaid.

2.1 Historical Narrative

Indiana has a long and rich history with consumer-driven health care programs. In 1992, Indiana-based Golden Rule Insurance Company executive, J. Patrick Rooney, pioneered the concept of medical savings accounts with his own employees. Based on its success encouraging his employees to make more cost-conscious health care decisions, Rooney began selling medical savings account plans in 1996 and played an integral role in securing Congressional authorization for tax advantaged HSAs in 2003.

Since then, Indiana employers have increasingly adopted HSAs for employee health plans. In 2006, the State of Indiana introduced consumer-driven health plan options to its nearly 30,000 employees and their dependents. By 2010, eighty-five percent (85%) of state employees elected to enroll in a HDHP plan option attached to an HSA. In 2013, ninety-six percent (96%) of state employees chose a consumer-driven health plan option.

[1] Avik, Roy. (2012). The Medicaid Mess: How Obamacare Makes It Worse. Retrieved from: http://www.manhattan-institute.org/html/ir_8.htm.

[2] *Id*.

The number of consumer-driven plans in the Indiana commercial health insurance market has also continued to increase. As of January 2013, 420,643 Hoosiers were covered by HDHPs/HSAs, representing nine percent (9%) of commercial market enrollment (greater than the U.S. average of 7%). Among all states, Indiana ranked seventh in the percentage of HDHP/HSA enrollees under age 65 with private health insurance.

The impact of the consumer-driven model on health care consumption and spending is significant. Research demonstrates that the HDHP/HSA model in the private market significantly changes member utilization patterns. The State of Indiana saved an average of 10.7% in health care costs annually in its first four years offering HDHPs with HSAs to state employees.[3] The State found that employees enrolled in the HDHP/HSA option used hospital emergency departments at lower rates than those in the traditional plan and had fewer physician office visits, lower prescription costs, and a higher generic medication dispensing rate.[4]

General studies have shown that HSAs are effective in helping consumers make value-based healthcare decisions that ultimately lower costs and increase quality. A five-year Employee Benefit Research Institute study examined health care spending trends after a large Midwest employer replaced its traditional insurance plans with paired HDHPs and HSAs. The study found that total health care spending decreased by twenty-five percent (25%) in all categories in the first year. Additional declines in the pharmacy and laboratory spending categories were observed in subsequent years.[5]

Insurance companies report lower hospital emergency department and specialist use by those with HSA-linked plans.[6] In 2011, an Employer and Account Holder survey found that fifty-four percent (54%) of HSA account holders reported having set aside more money than ever before to pay for health care costs, and twenty-eight percent (28%) reported the account encouraged them to shop for lower-cost prescription drugs.[7]

Given Indiana's rich history and proven track record of success with consumer-driven health care, the State turned to these principles to develop a plan to address its uninsured residents and their health needs. Prior to HIP, the Indiana Medicaid program had one of the lowest eligibility thresholds in the nation. There was little support to expand the State's traditional Medicaid program as an open-ended entitlement that would strain the State's budget in future years. Additionally, a traditional Medicaid plan appeared unlikely to significantly improve participant health status given its lack of incentives for appropriate healthcare utilization.

Following input from numerous stakeholder meetings and bipartisan collaboration, the State of Indiana, under the leadership of Governor Mitch Daniels, designed the Healthy Indiana Plan (HIP) to introduce healthcare consumerism and private market principles to the Medicaid

[3] Gusland, C., Harshey, T., Schram, N., & Swim, T. (2010). Consumer-driven health plan effectiveness, case study: Indiana. Mercer Health & Benefits, LLC.
[4] *Id*.
[5] Fronstin, P. & Roebuck, C.M. (2013). Healthcare spending after adopting a full replacement, high deductible health plan with a Health Savings Account: A five year study. Employee Benefit Research Institute.
[6] Sammer, J. & Miller, S. (2011). Consumer-driven decision: weighing HSAs vs. HRA's.
[7] Miller, S. (2011). HSAs viewed as cost-saving options by employers and account holders.

program. As the program was funded largely by an increase in the cigarette tax, it was designed to maintain limited enrollment in order to ensure a balanced State budget. During the 2007 legislative session, Rep. Charlie Brown authored and Sen. Patricia Miller sponsored a bipartisan bill enabling HIP. After the bill was passed with wide bipartisan support in April 2007, the Indiana Family and Social Services Administration (FSSA) immediately moved to develop an implementation plan and began negotiations with CMS to obtain federal waiver approval. On January 1, 2008, HIP began enrolling working-age, uninsured adults in coverage.

In 2011, following the passage of the Patient Protection and Affordable Care Act (ACA), the Indiana General Assembly reinforced its support for HIP by calling for HIP to be the coverage vehicle for a Medicaid expansion. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), which made several conforming changes related to the ACA, including revising program eligibility thresholds to align with the Marketplace coverage options available to individuals beginning in 2014. In addition, the legislation included a provision authorizing the Secretary of the Family and Social Services Administration to "amend [HIP] in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from the passage of the [ACA]."

The State has repeatedly sought approval to expand and extend HIP coverage. In December 2011, after four successful years of administering HIP and entering the fifth and final year of its original demonstration period, the State submitted a three year waiver extension request. Although CMS did not accept all of the requested legislative modifications to the program, in September 2012, CMS granted a one year extension. In April 2013, the State requested an additional three year extension. This request was again approved in September 2013 for another one year term to run through December 31, 2014.

In the most recent waiver request, CMS granted the State several modifications to HIP eligibility. The waiver contained specific language that allows the State to adjust eligibility levels to control enrollment. Beginning in 2014, HIP eligibility was reduced to cover individuals with household income up to 100% FPL, recognizing that individuals above 100% FPL who were previously eligible for HIP would have new coverage options and access to premium tax credits and cost-sharing reductions via the federal Marketplace. Further, consistent with the changes in the HIP legislation, requirements that an individual be uninsured for at least six months and lack access to employer-sponsored insurance were removed from the HIP eligibility criteria effective January 1, 2014.

The more recent series of one-year, temporary extensions of the HIP program have resulted in a substantial amount of uncertainty for current enrollees lacking alternative coverage options. During this time, the State has consistently sought guidance from CMS regarding the long-term future of HIP and its potential expansion. The State remains committed to the promise of the HIP coverage model improving cost and quality of healthcare services.

As a part of the current waiver renewal application, the State has built on early experiences and outcomes in developing program revisions to improve the program and strengthen the core values of personal responsibility and increased choices for Hoosiers. These program enhancements, detailed below, expand access to coverage for those in need and offer more

control over individual healthcare choice. In order to provide greater certainty for the State in executing these enhancements and greater certainty of coverage for HIP members, the State now seeks a five-year waiver renewal of the program.

2.2 Program Description

2.2.1 Eligibility

HIP targets non-disabled adults between the ages of 19 and 64 with a household income less than 100% FPL who are not otherwise eligible for Medicaid. Currently, Section 1931 parents and caretaker relatives are not eligible for HIP. This population is instead placed in the Hoosier Healthwise program - Indiana's full benefit Medicaid program for children, parents, pregnant women, and certain caretaker relatives. While HIP does not limit enrollment for parents and caretaker relatives with income below 100% FPL, the State does impose a firm enrollment cap of 36,500 on the number of non-caretakers allowed to participate in HIP.

2.2.2 Benefits

The HIP plan provides comprehensive benefits including physician, inpatient, outpatient, mental health services, pharmaceuticals, laboratory services, and other therapies through a Secretary-approved plan. The plan does not cover non-emergency transportation, dental services, or vision services for adults. Pregnancy-related services are also excluded, as all pregnant HIP members are transferred from HIP to the Hoosier Healthwise program for the duration of the pregnancy.

Preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the member up to $500, and are not included in the deductible amount of $1,100. After the plan deductible is met by way of the $1,100 POWER account, the HIP program includes a comprehensive health plan benefits package up to $300,000 annually and a $1 million lifetime benefits limit. Due to the exclusion of maternity and non-emergency transportation benefits, as well as the annual and lifetime limits, the current HIP benefits are not benchmark-equivalent coverage.[8]

2.2.3 Cost-Sharing

HIP provides each member a POWER account, modeled after an HSA, valued at $1,100 per member to match the plan deductible amount. This account is comprised of both individual and State contributions and is used to pay the member's deductible expenses. Instead of traditional cost-sharing with premiums and co-payments, HIP members must make monthly contributions to their POWER account. Unlike traditional premiums or co-payments, HIP members own their contributions and are entitled to their portion of unused contributions if they leave the program.

The member's required contribution amount is 2% of income. The State contributes the remainder of the POWER account funding up to the deductible amount. In order to ensure that the POWER account is fully funded on the first day of service, the State prefunds the account. HIP members may also receive contribution assistance from their employers and not-for-profit organizations. Employers are permitted to pay up to 50% of their employee's required POWER

[8] Milliman. Letter to Pat Casanova, "Benchmark Benefit Analysis of the Healthy Indiana Plan with Enhanced Benefits." January 27, 2011.

account contribution, whereas not-for-profit organizations are permitted to contribute up to 75% of the individual's required POWER account contribution.

After completing an application and meeting the financial and other eligibility criteria, members are "conditionally eligible" for the HIP program. They do not become fully eligible until they make their first POWER account contribution. Once fully enrolled, members must continue to make monthly contributions to maintain their HIP eligibility. If they fail to make this contribution within a 60 day grace period, they are disenrolled from HIP and must wait 12 months to re-apply.

Consistent with CMS rules, the program ensures that no member pays more than 5% of their income. In some cases, this results in situations where members are not required to make any monthly contributions and the State funds the entire account. Non-contributing HIP participation may occur in two ways: (i) the family has exceeded its 5% of income limitation due to payment of CHIP premiums; or (ii) the member has no income.

Other than the monthly contributions to the POWER account, the only other cost-sharing requirement is the co-payment for non-emergency use of hospital emergency departments. For non-caretaker members, the co-payment is $25, while it is only $3 for caretaker members.

HIP members who receive required preventive services are rewarded by allowing any remaining balance (including the State's contribution) in their POWER account to roll over and offset required contributions in the next year. If individuals do not complete the required preventive services, only the pro-rated balance of their individual contribution rolls over. This incentive increases the use of preventive care and encourages prudent use of POWER account dollars. In the long term, the regular use of preventive services under the HIP program reduces costs and improves the health of the individual members and the total HIP population.

Section 3: Current HIP Program Evaluation

Over the course of the demonstration, HIP has continued to achieve its program goals. In accordance with CMS's Special Terms and Conditions (STCs), the State performs an annual evaluation of the HIP program, including claims and administrative data analysis, External Quality Reviews, and survey data collection. In annual reports, the State provides detailed information on program progress and documents the quality and improved access to services under the demonstration.

The HIP program is independently evaluated by Mathematica Policy Research (HIP contracted evaluator), Milliman, Inc. (State actuarial partner), and Burns & Associates (External Quality Review team for both the HIP and Hoosier Healthwise programs). The most recent annual report (2012) was submitted to CMS in December 2013. Outcome data in the annual report highlights HIP's many successes and lends support to the effectiveness of the program's design. The following section summarizes HIP's key accomplishments in the initial demonstration period and outlines new goals for the future of the program.

3.1 Key HIP Accomplishments, 2008-2013

3.1.1 Reducing the number of low income Hoosiers

Since its inception, HIP has offered an important safety net for its members who would have otherwise been uninsured. As of December 31, 2013, HIP has served 116,765 Hoosiers over the course of the six-year program.

3.1.2 Improving access to appropriate, quality-based healthcare services for low income Hoosiers

The HIP program reimburses health care providers at Medicare rates - a key feature which has increased the number of providers accepting HIP, thus broadening the primary and specialty care networks. As a result of these incentives, HIP meets and exceeds access standards statewide. According to the 2013 Burns & Associates External Quality Review focus study on access to care, the access rate among HIP adults was higher in every region than the corresponding age and region cohort in Hoosier Healthwise (Medicaid program covering pregnant women, children, and Section 1931 parents and caretaker relatives).

Two years of Consumer Assessment of Health care Providers and Systems (CAHPS) data demonstrates a high level of member satisfaction with health plan performance. In 2012, all three managed care entities (MCEs) offering HIP coverage received higher ratings for overall healthcare experience, personal doctor, ability to get needed care, ability to get care quickly, doctor communication, and health education than the benchmarks from the year before.

Survey data supports the CAHPS results and verifies a high level of member satisfaction with the program. According to the 2013 Mathematica survey, approximately ninety-five percent (95%) of members reported they were either somewhat or very satisfied with their overall experience with HIP. Further, ninety-eight percent (98%) of members reported they would choose to re-enroll if they left the program but became eligible again.

Mathematica's 2010 HIP member survey suggests improved access to care following enrollment into HIP. When survey respondents enrolled in HIP one month prior were asked to compare their current access to care to when they were uninsured, they reported being:

- More likely to have a primary medical provider (PMP) and more likely to use a doctor's office or clinic as their usual source of care rather than the hospital emergency department;
- More likely to receive preventive care, acute care, specialty care, and prescription medications; and
- Less likely to have an unmet need for healthcare.

Further, the proportion of members reporting not seeking necessary preventive care, treatment for an acute accident, illness or injury, or specialty care in the previous six months due to cost was drastically lower in established members than new members.

3.1.3 Promoting value-based decisions making and personal health responsibility

HIP has successfully demonstrated that financial incentives encourage members to be thoughtful healthcare purchasers and take personal responsibility for their health care decisions. These incentives begin with enrollment, when most HIP members are required to contribute to their POWER account to fund a portion of their deductible expenses as a condition of ongoing coverage.

Each year of the demonstration, the proportion of members making their initial contributions to complete the enrollment process has increased. In 2008 - the first year of the program - about eighty-nine percent (89%) of conditionally eligible members required to make contributions did, thus becoming fully enrolled. In 2012, ninety-four percent (94%) of conditionally eligible members completed this requirement. The annual rate of members failing to make subsequent required monthly contributions has never exceeded seven percent (7%).

Generally, HIP members indicate a willingness to accept even more responsibility for the cost of their health care and report that the required contributions are affordable. According to the 2013 Mathematica survey, seventy-six percent (76%) of members feel the amount of their monthly POWER account contribution was the right amount and nine percent (9%) felt that is was, in fact, too low. Additionally, about eighty-two percent (82%) of HIP members are willing to pay $5 more per month to remain enrolled in HIP, and seventy-five percent (75%) are willing to pay $10 more. Members also prefer the POWER account contribution method over making co-payments. The survey found that eighty-three percent (83%) of members preferred to pay a fixed monthly amount up front with the opportunity to receive unspent funds back over making co-payments each time they visited a health professional, pharmacy, or hospital. The POWER account rollover incentive appears to motivate members to consider the value of the services they seek and spend their funds carefully.

HIP members demonstrate active engagement in managing their health care dollars and understanding the cost of services. According to Mathematica's 2013 survey of HIP participants, thirty percent (30%) of participants indicated they ask their provider about the cost of their care when they seek treatment; more than three quarters (77%) of members had a basic understanding of the POWER account; and nearly sixty percent (60%) reported checking the account balance at least monthly. A 2009 Product Acceptance Research survey of HIP members showed that sixty percent (60%) of respondents think differently about how or where they get health care since enrolling in HIP.

HIP member eligibility is reassessed annually, and enrollees are required to complete a redetermination application and return it in a timely manner to maintain eligibility. Over the first two years of the demonstration, eighty-five percent (85%) of members returned their application packet in a timely manner, and by the end of 2012, the return rate increased to ninety-two percent (92%). Providing redetermination paperwork in a timely manner fosters a higher continuity of care and improved health outcomes.

Claims data shows the effort to prevent non-emergent visits to the emergency department (ED) through co-payments effectively deters inappropriate use. Co-payments ($25 for non-caretakers

and $3 for caretakers) cannot be made from the POWER account. According to a Milliman analysis, in 2012 only thirty-two percent (32%) of HIP members visited the ED, compared to thirty-eight percent (38%) of comparable traditional Medicaid participants (pregnant women, Section 1931 parents and caretaker relatives).

Notably, non-caretaker member use of the ED has declined steadily over the course of the demonstration. Between 2009 and 2013, there was a seventeen percent (17%) decrease in the percentage of non-caretaker HIP members visiting the ED; and the number of non-caretaker ED visits per 1,000 members dropped by thirty-four percent (34%) over the same timeframe. The disease burden is high among non-caretaker members, and the declining ED utilization rates may reflect the required co-payment's effectiveness in deterring inappropriate use and promoting use of services in non-emergent, primary care settings.

Required contributions to the POWER account and having "skin in the game," may also improve ED utilization rates. According to a Milliman analysis, members making POWER account contributions visited the ED at a rate of 556 visits per 1,000 members; while members not required to make POWER account contributions visited the ED at a rate of 869 visits per 1,000 members. Even though co-payments for non-emergent use of the ED cannot be made from the POWER account, those who contribute to the account appear to exhibit more cost-conscious and responsible ED use behaviors.

3.1.4 Promoting primary prevention

HIP rewards preventive care use by allowing the entire POWER account balance (State and individual contributions) to roll over and offset the amount of the required contribution in the next benefit year if the member receives at least one age- and gender-appropriate service. This policy incentivizes members making POWER account contributions to receive preventive care in order to reduce their annual contributions. Additionally, HIP's policy to cover the first $500 of preventive services without drawing from the POWER account drastically reduces barriers to preventive care access.

HIP members receive preventive care at rates similar to a commercially insured population. Between 2010 and 2012, the percentage of all HIP members receiving preventive services increased from fifty-six percent (56%) to sixty percent (60%). Preventive service utilization rates by age and gender remained constant or rose slightly in all groups except for females ages 19-34. Overall, utilization rates for at least one preventive service increased with age; and women were far more likely than men to receive preventive care (69% versus 39% in 2012).

In 2012, sixty-one percent (61%) of HIP members required to make POWER account contributions received at least one recommended service, while only fifty-three percent (53%) of non-contributors received preventive care. This indicates that member investment and benefits linked to preventive service utilization may both play a part in reinforcing preventive care use over emergency department use.

3.1.5 Ensuring State fiscal responsibility and efficient management of the program

HIP continues to stay well within its federally-mandated waiver budget neutrality margin, and the enabling state legislation requires costs not exceed the revenue generated by the cigarette tax

designated for the program. According to Milliman estimates, the State maintained a waiver margin well above the total CMS-approved limit between 2008 and 2011.

These margins are based on per member, per month (PMPM) costs for Hoosier Healthwise (HHW) caretakers, children, and pregnant women that grew at a slower rate than the projected Medicaid spending established in the Special Terms and Conditions of the HIP waiver. In 2012, however, increased hospital reimbursement rates under a hospital assessment fee program (established by the State legislature in 2007) effectively raised the PMPM costs for HHW participants and reduced the waiver margin to a negative figure. Cumulatively, however, the State has maintained a waiver margin well below the five-year budget neutrality requirement.

Over the first three years of the demonstration, CMS also required the State to implement cost-saving initiatives for the program. These initiatives were in the areas of third-party liability cost recoveries, estate recovery, and collections through identified fraud and abuse. Together, these initiatives generated savings of nearly $20 million. This level of savings exceeded the requirements set forth in the STCs for the first five years of the demonstration ($15 million).

In 2012, CMS also approved two cost-saving projects related to strategic purchasing agreements for incontinence supplies and hemophilia blood factor products. That same year, the State began to carve out pharmacy benefits, consolidating all state-administered pharmacy services into one contract to achieve additional savings. Because of the pharmacy carve out, the waiver margin increased by $72 million from 2010 to 2011. Through 2012, the State diverted approximately $50 million of Disproportionate Hospital Share (DSH) funds to the HIP program annually. In 2013, the cost-saving initiatives generated sufficient savings to make the DSH fund re-allocation unnecessary.

By design, revenue generated from the cigarette tax serves as the major financing mechanism for HIP. In State Fiscal Year 2013, the cigarette tax generated $430 million, of which $123 million was allocated to HIP with the remainder allocated to other public health programs. The amount of cigarette tax revenue allocated to HIP has fluctuated annually over the course of the demonstration, ranging from $120 to $130 million each year.

3.2 Future Goals of the Demonstration

The State proposes several modifications intended to advance HIP's underlying principles and goals:

1. Reduce the number of uninsured, low income Hoosiers and increase access to healthcare services;
2. Promote value-based decision-making and personal health responsibility;
3. Promote disease prevention and health promotion to achieve better health outcomes;
4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families;
5. Facilitate HIP member access to job training and stable employment to reduce dependence on public assistance; and
6. Assure State fiscal responsibility and efficient management of the program.

Section 4: HIP 2.0

The State seeks waiver authority to implement program modifications and improvements based on lessons learned in the first six years of the demonstration.

1. Eliminate traditional Medicaid and expand HIP to all non-disabled adults ages 19-64 under 138% FPL without enrollment caps;
2. Create an optional defined contribution premium assistance program to promote family coverage and private market options over public assistance programs;
3. Augment the POWER account for all HIP members with a new rollover methodology which maintains incentives for preventive care and judicious management of the account;
4. Lower monthly POWER account contribution amounts based on the member's household income level to assure affordability, while maintaining the contribution requirement;
5. Offer a new enhanced benefit plan to include vision and dental services for individuals making consistent POWER account contributions;
6. Offer a basic benefit plan with required co-payments for all services for members under 100% FPL choosing not to make POWER account contributions;
7. Adjust non-payment penalties for all members; and
8. Support HIP member self-sufficiency by requiring individuals to be referred to job search and training programs.

4.1 Eligibility

Under the current demonstration, HIP is available to non-caretaker adults with incomes at or under 100% FPL and to parents and caretaker relatives between the Hoosier Healthwise income threshold (the Modified Adjusted Gross Income (MAGI) equivalent of the Aid to Families with Dependent Children (AFDC) payment standard specified in the State Plan) and 100% FPL. HIP currently operates with an enrollment cap of 36,500 for non-caretaker adults and has no cap for eligible parents and caretaker relatives.

Beginning in 2015, the State proposes the elimination of traditional Medicaid and enrollment caps for all non-disabled (caretakers and non-caretakers) between the ages of 19 and 64 with income at or under 138% FPL. With this change, the State intends to include Section 1931 parents and caretaker relatives who are currently eligible for Hoosier Healthwise in the HIP portion of the demonstration. In so doing, the State would provide all non-disabled adults, ages 19-64 with incomes under 138% FPL the opportunity to participate in HIP. Including Section 1931 parents and caretaker relatives in HIP would not only promote better health outcomes for these individuals, but would also reduce churn between the programs, create administrative efficiencies and provide a seamless experience for the members.

Additionally, beginning in 2016, the State proposes an optional defined contribution premium assistance program to assist otherwise eligible individuals with access to cost-effective employer-sponsored health insurance (ESI) to obtain private market coverage as an alternative to HIP.

4.1.1 Populations Ineligible for HIP

Individuals eligible for State Plan services under traditional Medicaid or the State's separate Children's Health Insurance Program (CHIP) are excluded from HIP and are described below in Table 4.1.1(A).

Table 4.1.1(A): Current Medicaid Populations Ineligible for HIP

1. Mandatory categorically needy children eligible under section 1925 for Transitional Medical Assistance.
2. Pregnant women (42 CFR 435.116).
3. Infants and children under age 19 (42 CFR 435.118).*
4. Children eligible through the State Children's Health Insurance Program.*
5. Reasonable classifications of individuals under age 21 (42 CFR 435.222).
6. Individuals qualifying for Medicaid on the basis of blindness.
7. Individuals qualifying for Medicaid on the basis of disability.
8. Individuals qualifying for Medicaid on the basis of age.
9. Institutionalized individuals assessed a patient contribution towards the cost of care 1902(f).
10. Individuals dually eligible for Medicare and Medicaid (42 CFR 440.315).
11. Children receiving foster care or adoption assistance under title IV-E of the Act.
12. Women who need treatment for breast or cervical cancer and are eligible under 1902(a)(10)(A)(ii).
13. Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v).
14. Former foster care children up to age 26 (42 CFR 435.150).
15. Independent foster care adolescents (42 CFR 435.226).

**These children are currently enrolled in the Hoosier Healthwise program. Although they will not be eligible for HIP, beginning in 2016, they will be eligible to participate in the optional defined contribution premium assistance program, as detailed in Section 4.1.3.*

The current HIP program also excludes the following individuals from HIP coverage:

Table 4.1.1(B): Individuals Currently Ineligible for HIP (2014)

1. Those eligible for Medicaid or CHIP under the state plan with the exception of the family planning option, as described in Table 4.1.1(A) above.
2. Those eligible for Medicare.
3. Pregnant women for the purpose of pregnancy related services.
4. Those otherwise eligible for medical assistance.
5. Those with income in excess of 100% FPL.
6. Those who fail to pay a POWER account contribution within 60 days, not inclusive of the first POWER account contribution, are excluded from HIP eligibility for 12 months if they fail to pay.

This waiver application includes changes to the eligibility criteria, non-payment penalties and maternity coverage for the HIP program. If these requests are granted individuals with income up to and including 138% FPL will be eligible for HIP beginning in 2015. Additionally, parents and caretaker relatives eligible under 42 CFR 435.110 and Transitional Medical Assistance will become eligible for HIP. In 2016, individuals with access to cost-effective ESI will be eligible to participate in an optional defined contribution premium assistance program as an alternative to HIP, as set forth in Section 4.1.3. Finally, maternity services will be added as HIP covered benefits, allowing women who become pregnant to maintain their HIP coverage without an eligibility category change unless such a change is requested.

The following individuals will be excluded from HIP coverage beginning in 2015:

Table 4.1.1(C): Individuals Ineligible for HIP 2.0

1. Those eligible for another Medicaid category under the State Plan, with the exception of the adult group under 42 CFR 435.119, family planning under 42 CFR 435.214 and parents & caretaker relatives eligible under 42 CFR 435.110 or Transitional Medical Assistance (see Table 4.1.1(A)).
2. Those eligible for Medicare.
3. Those otherwise eligible for medical assistance.
4. Those with MAGI in excess of 138% FPL (133% with 5% disregard).
5. After making the first POWER account contribution, those above 100% FPL who fail to pay subsequent contributions within 60 days.*

** Member would be locked out of HIP for 6 months, but would be able to reapply for coverage after that time.*

4.1.2 Populations Eligible for HIP

HIP will include all non-disabled adults between the ages of 19 and 64 with income at or under 133% FPL, as determined using MAGI methodologies. As this methodology includes a 5% income disregard, the HIP eligibility threshold would be effectively set at 138% FPL, as outlined in Table 4.1.2. HIP 2.0 will include parents and caretaker relatives eligible under 42 CFR 435.110 and Transitional Medical Assistance under Section 1925 of the Social Security Act.

Starting in 2016, the State will implement an optional defined contribution premium assistance program to provide financial assistance for low income individuals wishing to participate in their ESI plan as described in Section 4.1.3. Individuals (described in Table 4.1.2) with access to cost-effective ESI will have the option to participate in the State's defined contribution premium assistance program.

Table 4.1.2: HIP 2.0 Program Eligibility

Description	FPL and/or other qualifying criteria	Demonstration Eligibility Group(s)	Consistent with below group(s) prior to January 1, 2015
Adults ages 19 to 64 who are not otherwise eligible for comprehensive Medicaid benefits or Medicare	Income under 138% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% income disregard; pay POWER account contribution; no resource limit	Adults (As described at 42 CFR 435.119 "the adult group")	HIP Caretakers & HIP Adults
Parents & caretaker relatives eligible under 42 CFR 435.110 or Transitional Medical Assistance	Income under the State's AFDC payment standard in effect as of May 1, 1988, converted to a MAGI-equivalent amount by household size; no resource limit	HIP Caretaker	Hoosier Healthwise (HHW) Caretakers

4.1.3 Optional Defined Premium Assistance Program

In 2007, the legislation creating HIP also authorized the optional creation of a premium assistance program to promote private market coverage for individuals with access to employer-

sponsored insurance (ESI). Specifically, IC §12-15-44.2-20 provides that the premium assistance program must: (i) contain eligibility requirements similar to HIP; (ii) include a health savings account (HSA) component; and (iii) ensure the individual's payment to either the HSA or the premium not exceed 5% of his or her annual household income.

In 2016, the State will exercise this option in HIP 2.0, seeking the appropriate waivers and authorities to implement the HIP Employer Benefit Link (HIP Link), an optional defined contribution premium assistance program for all HIP-eligible individuals with access to ESI and meeting the HIP Link eligibility criteria set forth below. The State will implement the HIP Link premium assistance program in Year 2 of the demonstration waiver to allow time to coordinate operations. HIP Link allows individuals the choice to participate in their ESI plan or to select the traditional HIP program for their health insurance. This structure empowers Hoosiers with a greater choice and increased access to providers while also addressing potential crowd-out of private plans.

All HIP eligible adults with access to ESI will receive options counseling through an enrollment broker contracted with the State on whether enrollment in HIP or enrollment in their ESI plan would be best suited to their individual needs and situation. The enrollment broker will evaluate the ESI plans to estimate the likelihood that the individual would incur any additional out of pocket costs in the HIP Link program beyond the state's defined contribution premium assistance.

Eligibility for HIP Link will be determined as follows:

1) Individual must be eligible for HIP but not considered medically frail, as defined by responses on the HIP application;
2) Individual must be 21 years of age or older;
3) Individual must have access to and be eligible to participate in their employer-sponsored plan; and
4) The employer must be contributing at least 50% of the premium cost.

As required by the enabling statute, the State would maintain a POWER account for individuals participating in the HIP Link program. This account will function like the POWER accounts described in Section 4.4 and the member would retain incentives to manage the account and to complete preventive care. The member and the State will each make required contributions to the account, but in this case be used for premiums as well as out-of-pocket expenses, including copayments, deductibles.

Individual required contributions will follow the same schedule as outlined in Section 4.4.1. The State will reduce the POWER account for individuals under 100% FPL who do not make contributions to their POWER account or who miss payments. Further, the State will determine its contribution to the account in an amount based on average commercial employee premiums and out of pocket expenses, which will be less than the total cost of the HIP Plus plan. Through this structure, the State will ensure that the ESI coverage is cost-effective relative to the

aggregate amount of expenditures that the State would have made to cover the HIP Link members under the HIP Plus plan.

The State will not provide wrap-around benefits, as election to participate in the ESI plan through HIP Link is optional. To ensure the quality of ESI plans, all small group plans must provide essential benefits and all large group and self-insured plans are subject to the minimum value requirements and are recognized as minimum essential coverage. The choice to enroll in the HIP Link option or to choose HIP benefits will be left to the individual.

Like HIP members, women that become pregnant when enrolled in HIP Link will have the option to remain enrolled in HIP Link coverage or to transfer to the HHW program. Otherwise, members may only change enrollment between the HIP and HIP Link programs during the initial eligibility determination or re-determination periods. However, HIP members with access to ESI will be eligible for a special re-determination period during their employer's open enrollment, in order to align the HIP and HIP Link enrollment periods.

In addition to the premium assistance program for other HIP-eligible adults described above, the State will promote family coverage options by allowing families the option of obtaining premium assistance for ESI and Marketplace health plans for children enrolled in Indiana's Hoosier Healthwise program. This optional program will be implemented pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and therefore, the State requests no waivers related to the implementation of the program at this time.

Once the program is implemented in 2016, parents at all income levels will have the option of enrolling their Medicaid-eligible children into the current HHW program or selecting the HIP Link defined contribution premium assistance option to allow their children to be covered under their employer-sponsored plan. Parents with incomes above 138% FPL who have Medicaid-eligible children will also have the option of enrolling those children in their Marketplace plan.

Family coverage through one carrier is intended to promote better health outcomes by reducing the network and benefit fragmentation created by separate Marketplace, employer, and HHW plans. Currently, the State conducts a joint procurement for managed care entities to provide services to HIP and HHW (parents/caretakers, pregnant women, and children) members. By consolidating coverage in this way, family members are able to seek care within the same provider network, thereby promoting communication and continuity of care. The State will continue to promote integrated family healthcare by allowing families to elect coverage through a premium assistance program, with HHW children enrolling in their parent's employer-sponsored insurance or Marketplace health plans.

For families with income above 138% FPL, the State will only provide premium assistance for the portion of the ESI or Marketplace premium related to covering the children. For families under 138% FPL, the State will subsidize the ESI premium for caretakers as well. In all cases, the State will ensure the premium assistance is cost-effective in accordance with federal regulations.

In the premium assistance model for children, the State will provide wrap-around coverage for Early Periodic Screening Diagnosis and Treatment (EPSDT) services. Current SCHIP premiums will still be collected but the State will provide cost-sharing support to ensure families do not exceed the 5% maximum out-of-pocket expense limit for all coverage.

4.1.4 Enrollment Limit

The original HIP legislation prevents the State from enrolling new members in HIP if revenues are insufficient to support them. By leveraging the enhanced federal matching funds available to cover adults, the State anticipates sufficient funding to eliminate the need for an enrollment cap for the waiver demonstration period. The State's decision to seek an expansion of HIP is conditioned on the anticipated enhanced federal match and the continuation of the State's provider assessment on inpatient and outpatient hospitals.

The Indiana General Assembly passed an extension of the hospital assessment fee in 2013; and HIP 2.0 relies on ongoing federal approval of the provider assessment on inpatient and outpatient hospitals in Indiana's State Plan Amendment (SPA). Should the enhanced Federal match rate be modified in the future, or should the provider assessment be reduced or eliminated by statute, regulation, or denial of the SPA, the State proposes an automatic termination of HIP 2.0 for the new expansion population.

4.2 Employment Initiative

Research has demonstrated that employed individuals are both physically and mentally healthier, as well as more financially stable.[9,10] To this end, the State will introduce the new Gateway to Work program to promote employment by integrating the State's various work training and job search programs with HIP. Through this employment initiative, all eligible HIP members will be provided with general information on the State's job search and training programs. HIP participants who are unemployed or working less than 20 hours a week will be referred to available employment, work search and job training programs that will assist them in securing gainful employment.

All non-disabled adults on the program who are unemployed or working less than 20 hours a week will be referred, as a condition of HIP 2.0 eligibility, to the State's existing workforce training programs and work search resources. Full-time and part-time students will be exempted from the referral for each year they are enrolled in a postsecondary education institution or technical school. The HIP application will screen for education and employment status and contain an acknowledgement of the referral.

All identified eligible individuals will receive information on available employment resources, including IndianaCareerConnect.com available through the Indiana Department Workforce Development (DWD). IndianaCareerConnect.com is the most comprehensive source of Indiana

[9] F. M. McKee-Ryan, Z. Song, C. R. Wanberg, and A. J. Kinicki. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. *Journal of Applied Psychology*, 90 (1), 53–76.

[10] K. I. Paul, E. Geithner, and K. Moser. (2009). Latent deprivation among people who are employed, unemployed, or out of the labor force. *Journal of Psychology*, 143 (5), 477–491.

job openings in the state. It provides individuals access to current job openings, the ability to create and upload a resume, explore a career, and research the job market.

4.3 Benefits

Current HIP benefits are authorized as Secretary-approved coverage. HIP is not presently benchmark-equivalent coverage as it does not cover maternity services and includes a $300,000 annual and a $1 million dollar lifetime coverage limit. Please see the attachment prepared by Milliman, Inc. demonstrating that current HIP benefits are not benchmark-equivalent coverage.

Pursuant to this waiver request, the State will update benefits to ensure that they meet Alternative Benefit Plan (ABP) requirements; and the State intends to maintain its waiver for non-emergency transportation. HIP will eliminate the lifetime and annual coverage limits and maternity services will be an option in all HIP benefit plans. In addition, enrollees under 100% FPL will have a choice of the HIP Basic plan or the new "HIP Plus" plan containing an enhanced benefit package. Enrollees above 100% FPL will have access to the HIP Plus plan; while enrollees who are pregnant, Medicaid-eligible parents and caretaker relatives, or qualify as medically frail will be enrolled in HIP but receive benefits equivalent to coverage on the State Plan.

Table 4.3: Benefit Plan Options

Enrollee Status	HIP Basic	HIP Plus	State Plan Benefits
<100% FPL	X	X	
>100% FPL		X	
Pregnant Women			X
Medically Frail			X
Section 1931 parents and caretaker relatives			X

All HIP members will receive a comprehensive package, consistent with private market plans and based on benefits available in one of the State's ABP options. However, members under 100% FPL will have a choice of 1) the HIP Basic benefit package that applies co-payments to services or 2) the enhanced HIP Plus benefit package that only has co-payments on non-emergency use of the hospital emergency department and requires members to make contributions to their POWER account. The HIP Plus plan will be utilized by all members above 100% FPL, and will be optional for members under 100% FPL.

4.3.1 Benefit Chart

Table 4.3.1: Benefit Package

Eligibility Group	Benefit Package
The Adult Group • Non-medically frail <100% FPL electing HIP Basic benefits	Secretary-approved coverage that is benchmarked to a basic commercial EHB package.
The Adult Group • Non-medically frail 0%-	Secretary-approved coverage that is benchmarked to a comprehensive commercial EHB package that includes some State

138% FPL, Ages 19-64 electing HIP Plus	Plan services such as adult vision and dental.
The Adult Group • Medically frail, pregnant women, & Section 1931 parents and caretaker relatives 0%-138% FPL, Ages 19-64	Secretary-approved coverage that is the State Plan benefits.

4.3.2 Social Security Act Section 1937 Alternative Benefit Plans

Beginning in 2015, HIP will utilize three Secretary-approved Alternative Benefit Plan (ABP) coverage options under Section 1937 of the Social Security Act to provide benefits for eligible individuals. The Secretary-approved ABP option for the HIP Basic plan will be indexed to the lowest actuarial value EHB option – Indiana's largest HMO. HIP Basic will provide a benefit package that covers all of the EHBs. The Secretary-approved ABP option for the HIP Plus plan will be indexed to a comprehensive commercial market benefit plan and will add State Plan services including coverage for adult vision and dental. The ABP for pregnant women, Section 1931 parents and caretaker relatives, and the medically frail will be the Secretary-approved coverage currently detailed in the State Plan.

Additional details regarding the ABP benefits are included in Indiana's ABP Medicaid State Plan Amendments.

4.3.3 Covered Benefits

Benefits are indexed to those offered in commercial market EHB options or the State Plan, depending on the benefit package. The State is, however, requesting the requirement to offer non-emergency transportation services be waived for both the HIP Basic and HIP Plus plans; with these transportation services provided to pregnant women, Section 1931 parents and caretaker relatives, and the medically frail.

Table 4.3.3(A): Covered Benefits Chart

Benefit	Description of Amount, Duration and Scope			Reference
	HIP Basic Plan	**HIP Plus Plan**	**Pregnant Women, Section 1931 Parents and Caretaker Relatives & Medically Frail**	
EHB Category: Ambulatory Patient Services				
Primary Care Physician Services[11]	Covered Service.			1905(a)(5)

[11] Includes advanced practice registered nurse practitioners (APRNs).

Specialty Physician Visits	Covered Service.			1905(a)(5)
Home Health Services	Covered Service. 100 visits per year.	Covered Service. 100 visits per year.	Covered Service. No limits.	1905(a)(7)
Chiropractic Care	Not Covered.	Not Covered.	Covered. 50 visits per year.	1905(a)(6)
Outpatient Surgery	Covered service.			1905(a)(2)
TMJ	Not covered.	Covered service.	Covered service.	
Allergy Testing	Covered service.			1905(a)(13)
Chemotherapy	Covered service.			
IV Infusion Services	Covered service.			
Radiation Therapy	Covered service.			
Dialysis	Covered service.			
Dental Services	Not covered.	Covered service. Limited to basic commercial package.	Covered service.	2105(c)(5)
Vision Services	Not covered.	Covered service.	Covered service.	1905(a)(6)
EHB Category: Emergency Services				
Emergency Department Services	Covered service. Non-emergency visits to the emergency department subject to $25 co-payment.			1905(a)(29)
Emergency Transportation: Ambulance and Air Ambulance	Covered service.			
Urgent Care/Emergency Clinics (non-hospital facilities)	Covered service.			
EHB Category: Hospitalization				
General Inpatient Hospital Care	Covered service.			1905(a)(1)

Inpatient Physician Services	Covered service.			1905(a)(1)
Inpatient Surgical Services	Covered service.			1905(a)(1)
Non-Cosmetic Reconstructive Surgery	Covered service.			1905(a)(1)
Transplants	Covered service.			1905(a)(1)
Congenital Abnormalities	Covered service.			1905(a)(1)
Anesthesia	Covered service.			1905(a)(1)
Hospice Care	Covered service.			1905(a)(18)
Skilled Nursing Facility	Covered Service. Limited to 100 days.	Covered Service. Limited to 100 days.	Covered Service. No service limits.	1905(a)(4)
EHB Category: Mental Health and Substance Abuse				
Mental/Behavioral Health Inpatient	Covered service.			1905(a)(1)
Mental/Behavioral Health Outpatient	Covered service.			1905(a)(2)
Substance Abuse Inpatient Treatment	Covered service.			1905(a)(1)
Substance Abuse Outpatient Treatment	Covered service.			1905(a)(2)
EHB Category: Prescription Drugs				
Prescription Drugs	Covered service.			1905(a)(12)
Tobacco cessation drugs	Covered service.			
EHB Category: Rehabilitative and Habilitative Services and Devices				
Physical Therapy, Occupational Therapy, Speech Therapy	Covered Service. Limited to 60 combined visits.	Covered Service. Limited to 75 combined visits.	Covered service. 12 visits every 30 days without Prior Authorization.	1905(a)(11), 1905(a)(13)
Durable Medical Equipment	Covered service.			1905(a)(29)
Prosthetics	Covered service.			1905(a)(12)

EHB Category: Laboratory				
Lab Tests	Covered service.			1905(a)(3)
X-Rays	Covered service.			1905(a)(3)
Imaging- MRI, CT, and PET	Covered service.			1905(a)(3)
Pathology	Covered service.			1905(a)(13)
EHB Category: Preventive Care				
Preventive Care Services	Covered service. Limited to ACA required preventive services.[12]		Covered service.	1905(a)(13)
Other Benefits				
Non-emergency Transportation	Not covered. Waiver requested.	Not covered. Waiver requested.	Covered service.	1905(a)(10)
EPSDT for Ages 19 & 20 Only	Covered service.			
Bariatric Surgery	Not covered.	Covered service.	Covered service.	1905(a)(1)
Long Term Care	Not covered.	Not covered.	Covered service.	1905(a)(4)
MRO	Not covered.	Not covered.	Covered service.	

Table 4.3.3(B): Benefits Not Provided

Benefit	Description of Amount, Duration and Scope	Reference
Acupuncture	Not covered.	1905(a)(29)
Infertility Diagnoses and Treatment	Not covered.	1905(a)(29)
Hearing Aids	Not covered.	1905(a)(29)
Residential Services	Not covered.	1905(a)(29)
Other	Any other services not covered by the medical assistance program.	1905(a)(29)

Members identified as medically frail, Section 1931 parents and caretaker relatives, and members who become pregnant and decide against transfer to the HHW pregnant women category will be given a full benefit wrap to the State Plan benefits, including chiropractic services and non-emergency transportation services. The State requests a waiver of the requirement to offer non-emergency transportation for all other populations.

[12] Includes services with an "A" or "B" rating from the United States Preventive Task Force, immunizations recommended by the Centers for Disease Control and Prevention, and additional preventive care screenings for women as provided in the Health Resources and Services Administration guidelines.

4.3.4 Long Term Services and Supports (LTSS) Benefits

Outside of limited skilled nursing facility services, LTSS are not provided on HIP. Medically frail individuals who need LTSS are eligible for a full benefit wrap through the State Plan services.

4.3.5 Populations Exempt from Alternative Benefits Plans

4.3.5.1 Medically Frail

Due to complex medical management and health needs, individuals with incomes up to and including 138% FPL who meet the definition of medically frail will be enrolled in HIP but will receive all State Plan services. Consistent with 42 CFR §440.315(f), an individual will be considered medically frail if he or she has one or more of the following: 1) disabling mental disorder; 2) a chronic substance abuse disorder; 3) serious and complex medical condition; 4) physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activity of daily living; or 5) a disability determination, based on Social Security Administration criteria. The State anticipates that most of its severely mentally ill population will be identified and served under the Behavioral and Primary Health Care Coordination (BPHC) program, Indiana's pending 1915(i) State Plan option for adults with serious mental illness.

Over the course of the current demonstration project, Indiana has worked to identify high risk members. Previously, the process was handled through the Enhanced Services Plan (ESP), which was operated by the Indiana high risk insurance pool. While the high risk pool has phased out, the infrastructure for ESP still exists. Indiana will continue to work with the MCEs to build upon the ESP processes to continue to identify and appropriately serve medically frail HIP members.

Indiana will implement robust retrospective and prospective screening processes to identify medically frail individuals.

- The HIP application will screen for certain high risk conditions and indicators of medical frailty. The MCEs must also conduct a detailed health risk assessment with all members presenting high risk indicators on the initial application within ninety (90) days, confirming the medical frail status as appropriate. Based on data, in subsequent years of the demonstration the State may require MCEs to conduct health risk assessments on all individuals to screen for medically frail enrollees.

- Consistent with the ESP process, MCEs may identify individuals as medically frail based on their claims history. The MCEs must apply Milliman underwriting guidelines to score each member. Members with qualifying conditions or a risk score at or above a defined threshold would be considered medically frail and granted the State Plan benefit wrap.

- Indiana will periodically look at claims for identified "medically frail" individuals to verify all members were categorized appropriately. Individuals who no longer qualify as medically frail will have the option of the HIP Basic or HIP Plus plans.

Throughout the demonstration waiver, Indiana will continually monitor and evaluate the process to identify the medically frail, ensuring appropriate identification and coverage.

4.3.5.2 Pregnant Women and Section 1931 Parents and Caretaker Relatives

Women who become pregnant while enrolled in HIP may elect to stay in HIP or transfer to Medicaid coverage offered for pregnant women. Women who elect to stay in HIP will receive a benefit wrap including all State Plan benefits and limitations for the duration of their pregnancy. As detailed in Table 4.3.3(A) this benefit wrap will include enhanced benefit limits for therapy services, access to chiropractic services, and non-emergency transportation. In addition, women who elect to stay in HIP will have all of their required cost-sharing suspended for the duration of their pregnancy, as set forth in Section 4.4.8.

Women that are enrolled in their ESI plans through HIP Link and become pregnant may choose to stay with the ESI plan or transfer to Hoosier Healthwise. Women that choose to stay with their ESI plan will not receive the benefit wrap but will have all of their required contributions suspended for the duration of their pregnancy.

HIP 2.0 includes Section 1931 parents and caretaker relatives as a new population. Section 1931 parents and caretaker relatives participating in HIP will receive the same benefits as on the State Plan, including non-emergency transportation and chiropractic services not currently available to HIP members.

Cost-sharing requirements for populations exempt from Alternative Benefit Plans are detailed in Section 4.4.8.

4.4 Cost-Sharing

HIP utilizes two forms of cost-sharing: POWER account contributions and co-payments to promote consumerism and personal responsibility. The State ensures these costs do not exceed 5% of family income. The State will consider all contributions made by the household - including CHIP and Medicare premiums - in the 5% contribution limit.

HIP provides each member with an HSA-like account - the POWER account - to cover the plan's deductible. Instead of traditional cost-sharing of premiums and co-payments, most HIP members make upfront monthly contributions to the POWER account based on household income. The State pre-funds the difference between the member's required annual POWER account contribution and the plan's deductible to ensure adequate funding for deductible expenses early in the benefit period. Once the POWER account contribution is made, the individual has no additional cost-sharing except for a co-payment for inappropriate emergency department usage, as described in Section 4.4.7.

The State will continue to ensure the POWER account is fully funded by making upfront contributions to the account. Employers and non-for-profit organizations may also contribute a portion of the individual's share. A debit card, programmed only to be used for covered services through network providers, allows members to access POWER account funds and control how their account dollars are spent. Members receive monthly statements similar to Explanation of Benefits (EOB) statements to understand the costs of services received and the account balance.

The State intends to maintain the existing cost-sharing structure with some modifications to promote consumerism. The changes include:

1. Lowering required contributions and adjusting the calculation methodology;
2. Modifying non-payment penalties;
3. Adjusting the POWER account based on member's payment compliance;
4. Modifying the POWER account rollover process;
5. Increasing the POWER account maximum;
6. Introducing a graduated co-payment amount for inappropriate emergency department (ED) utilization; and
7. Proposing an alternative cost-sharing structure for ABP-exempt populations.

4.4.1 Required Contributions

Beginning in 2015, the current member contributions will be replaced with new flat rate member contributions based on FPL. The set contribution levels are intended to simplify program administration, facilitate clear communication with members, and increase affordability. The proposed flat contribution amounts set forth in Table 4.4.1 maximize contribution rates at each income bracket.

Program data demonstrates that there are certain income thresholds at which members fail to make timely POWER account contributions at higher rates. In 2012, approximately ninety-two percent (92%) of members under 22% FPL failing to pay the initial contribution had a required contribution of less than $5 per month. Therefore, to reduce the financial barrier for members at or under 22% FPL, the required contribution will be reduced to $3 per month. Among members between 23% and 50% FPL failing to pay their initial contribution, seventy percent (70%) had a contribution between $5 and $15 per month. The proposed flat contribution for this group is $8 per month. For members between 51% and 100% FPL who failed to pay their initial contribution, approximately half had a monthly contribution amount between $15 and $30 per month. The new proposed flat contribution for this income group is $15 per month. For the population above 100% FPL, contribution levels will align with the rates applicants are required to pay toward premiums for plans offered through the Marketplace.

Table 4.4.1 POWER Account Flat Rate Monthly Contributions by FPL

FPL	Proposed Monthly Contribution	2012 Average Monthly Contribution
<22%	$3	$7.94
23%-50%	$8	$10.32
51%-100%	$15	$17.77

101%-138%	$25	$39.69*

** The amount shown represents the average 2012 monthly contribution for members 100-150% FPL.*

4.4.2 Non-Payment Penalties

HIP encourages members to maintain insurance coverage throughout the year instead of waiting to seek coverage when they are ill. To this end, HIP's policies encourage year-round participation which will help members avoid ACA-mandated penalties for not having insurance. Due to proposed changes in the program structure, the State requests modified penalties to account for the different experience for members at or above 100% FPL and those under 100% FPL.

4.4.2.1 Above 100% FPL: Lock-Out

For members at or above 100% FPL, the State plans to maintain the current lock-out structure for non-payment, but with a slight adjustment. As in the current procedure, monthly payments are required to maintain eligibility. To incentivize regular payment, members making contributions for 12 consecutive months will receive a free pass to Indiana's State Parks. To dis-incentivize non-payment, members failing to meet their contribution requirements will be terminated from the program and must wait for a specified period before they may re-enroll.

The State proposes a reduction in the current 12-month lock-out period to align with federal Marketplace policies. Starting in 2015, individuals above 100% FPL would have a 60 day grace period in which to make their monthly payment. During this time all claims would be paid. After 60 days, the member would be disenrolled and would not be permitted to re-enroll for a period of six months. When the individual re-enrolls, he or she would not be required to pay any debt that accrued due to non-payment. This proposed lock-out policy is more lenient than that of the Marketplace, which suspends claims payment after 30 days, disenrolls members after 90 days, and allows re-entry only during the next open enrollment period (which could translate to 7 months without insurance coverage).

4.4.2.2 Under 100% FPL: Basic Plan Cost-Sharing

Participation in the HIP Plus plan with upfront payments is optional for individuals with family income under 100% FPL. Members under 100% FPL enrolled in the HIP Plus plan who miss required payments (either initial or subsequent) would be placed into the HIP Basic plan as an alternative to disenrollment. As described above, HIP Basic plan will require co-payments for all services in lieu of monthly contributions to the POWER account while also providing a reduced benefit package (compliant with all of the essential health benefits requirements). Other than at annual redetermination, members in the HIP Basic plan will be ineligible to transfer into the HIP Plus plan. The HIP Basic plan with its reduced benefits package incentivizes members to maintain personal responsibility while creating a safety net for those who do not elect to make monthly contributions.

As an alternative to monthly contributions, members in HIP Basic will be required to pay co-payments for all health care services, except for preventive care and family planning services, in accordance with the table below. All co-payments will be monitored to ensure the individual does not exceed the 5% of annual income cap on cost-sharing.

Table 4.4.2 HIP Basic Plan Co-payment Schedule

Service	HIP Basic Plan Co-Pay Amounts ≤100% FPL
Preventive Care Services*	$0
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ED visit	Up to $25**

**Including family planning services*

***Graduated payment from $8-$25, as described in Section 4.4.7.*

4.4.3 Program Bifurcation Impact on POWER Account

As a result of the program bifurcation for HIP members at or above 100% FPL and those under 100% FPL, the treatment of the POWER accounts will also be slightly different for each of the populations participating in the HIP Plus and HIP Basic plans.

4.4.3.1 POWER accounts for members above 100% FPL

For individuals at or above 100% FPL, the POWER account will mirror the current process. Members must make monthly contributions to their POWER account as a condition of continued eligibility. Individuals over 100% FPL will not receive HIP coverage until the first day of the coverage month after the initial contribution is received. Thereafter, the member must continue to make monthly contributions or face a lock-out period as discussed above.

4.4.3.2 POWER account for members under 100% FPL in the HIP Basic plan

While the HIP Basic plan does not require monthly contributions, it is important that the plan structure continue to promote personal responsibility, principles of consumerism, and positive health behaviors; therefore, the POWER account will continue for HIP Basic members. To preserve consumerism principles and goals, members will receive monthly POWER account statements detailing the cost of utilized services and account activity. The member will manage a fully funded HSA-like account without direct financial "skin in the game". Instead, HIP Basic members will be responsible for all required co-payments charged at the time of service, as detailed above. The funds in the POWER account may not be utilized for member co-payments; but will instead cover the remaining plan deductible.

Despite the lack of direct financial contributions to the POWER account, there are incentives for HIP Basic members to obtain preventive health care services and manage the account judiciously. At the end of the benefit year, HIP Basic members will be eligible to enroll in the HIP Plus plan, provided they begin making required monthly contributions. If the member completes preventive services and has a balance in the POWER account, he or she will be eligible for discounts to reduce the HIP Plus contributions, should he or she elect to enroll in the

subsequent year. This model maintains the consumerism component, as it includes incentives for HIP Basic members to manage the POWER account judiciously and make cost-conscious decisions. If the HIP Basic member is successful in doing so, he or she is allowed to transfer to HIP Plus plan at a lower personal cost and enjoy the plan's enhanced benefits.

4.4.4 POWER Account Rollover

The consumer-driven model's inherent incentive structure helps bend the health care cost curve downward over time. Because HIP members have a direct financial stake in their health care decisions, they have reason to manage their POWER accounts judiciously and to take advantage of the free preventative care services offered by the plan. Therefore, it is important that the State maintain this financial incentive for every HIP member, regardless of their benefit plan or required POWER account contribution amount.

The State will adjust the current POWER account roll-over process to reflect the overall increase in the POWER account value, reduced member contributions to the account, and increased State contributions to the account. These modifications preserve HIP's underlying incentive structure and further the purpose of the POWER account. In addition, the State will modify the timing of the roll-over calculation to occur closer to the time of redetermination.

4.4.4.1 HIP Plus Roll-Over

HIP Plus members who consistently contribute to their POWER account during the plan year will be eligible to roll-over the member's unused share of the POWER account balance.

If a HIP Plus member receives all recommended preventive care services during the plan year, the member will be eligible to have their unused share, or "roll-over amount", doubled by the State as an added incentive. Depending on the balance in the account, this roll-over amount may significantly reduce or even eliminate required contributions in future plan years.

The roll-over amounts for HIP Plus members are calculated as follows:

1. First, the member's portion of the remaining POWER account balance (the Member Share) is determined by the following formula:

   Amount of the member's required annual contribution for the expiring term

   Plus Any balance rolled over from previous coverage terms

   Divided by 2,500 (the fully funded POWER account total)

2. Second, the Base Roll-Over Amount is determined as follows:

   Member Share *multiplied by* the remaining balance in the POWER account

3. Finally, the Final Roll-Over Amount is determined based on whether the member obtained recommended preventive services. The preventive services bonus is applied to the Base Roll-Over Amount as follows to determine the Final Roll-Over Amount:

   If preventive services are completed during the plan year:

   Base Roll-Over Amount x 2 = Final Roll-Over Amount

   If preventive services are not completed during the plan year:

Base Roll-Over Amount x 1 = Final Roll-Over Amount

4.4.4.2 HIP Basic Roll-Over

HIP Basic members not contributing to their POWER accounts will still maintain the incentive to manage the account judiciously and receive recommended preventative care services. Members of the HIP Basic plan will have the opportunity to reduce their HIP Plus required contribution in future years, with a slightly different roll-over process. The discount available to HIP Basic members is directly related to the percentage of the POWER account balance remaining at the end of the plan year. For example, if a member has 40% of their POWER account balance remaining at the end of the plan year, they may reduce their required HIP Plus contribution by 40% in the following year, provided they have received their recommended preventive services. However, this discount is limited to 50% in order to avoid inappropriately rewarding individuals for failing to satisfy their original POWER account contribution requirement.

The roll-over amounts for members participating in the HIP Basic plan are calculated as follows:

1. First, the Roll-Over Percentage is calculated by the following formula:
   Remaining balance in the POWER account

   Divided by 2,500 (the fully funded POWER account total)

   Multiplied by 100 to yield a percentage < = 50%

2. The determination of the Final Discounted Contribution amount for participation in the HIP Plus plan for the subsequent year would be determined as follows:

   Required flat rate contribution for the subsequent year based on FPL

   Minus [Roll-over Percentage *multiplied by* the required contribution]

4.4.4.3 Roll-Over Scenarios

In summary, below are several roll-over scenarios.

Table 4.4.4.3(A): Member at 45% FPL and a $400 (16%) POWER Account Balance

	Year 1 Contribution Amount for HIP Plus	Preventive Services	Final Roll-Over Amount	Year 2 Reduced Annual Contribution	Year 2 Monthly Cost to Participate in HIP Plus	Total Year 2 Percentage Reduction
HIP Plus Plan*						

Scenario 1	$96.00 annual *($8.00/ month)*	NO	$15.36	$80.64	$6.72 per month	16%
Scenario 2	$96.00 annual *($8.00/ month)*	YES	$30.72	$65.28	$5.44 per month	32%
HIP Basic Plan**						
Scenario 3	0	NO	0	0	$8.00 per month	0%
Scenario 4	0	YES	0	$80.64	$6.72 per month	16%

** The specific calculation for the HIP Plus Plan is as follows:*

Member Share: 96/2500= .0384;

Base Roll-Over Amount: .0384 x 400 remaining balance in POWER account= $15.36;

Base Roll-Over Amount is multiplied times a factor of 1 for no preventive services for a total of $15.36.

Base Roll-Over Amount is multiplied times a factor of 2 for preventive services for a total of $30.72.

*** The specific calculation for the HIP Basic plan is as follows:*

Roll-Over Percentage: 400/2500 x 100= 16%

Flat rate contribution for Year 2 would be $96.00 annually/ $8.00 per month based on 45% FPL

The Final Discounted Contribution amount would be $96- (16%x96) = $80.64

Table 4.4.4.3(B): Member at 75% FPL with a $2,000 (80%) POWER Account Balance

	Year 1 Contribution Amount for HIP Plus	Preventive Services	Final Roll-Over Amount	Year 2 Reduced Annual Contribution	Year 2 Monthly Cost to Participate in HIP Plus	Total Year 2 Percentage Reduction
HIP Plus Plan						
Scenario 1	$180.00 annual *($15.00/ month)*	NO	$144.00	$36.00	$3.00 per month	80%
Scenario 2	$180.00 annual *($15.00/ month)*	YES	$288.00	$0	$0 per month	100%
HIP Basic Plan						
Scenario 3	0	NO	0	0	$15.00 per month	0%
Scenario 4	0	YES	0	$90.00	$7.50 per month	50%*

** The discount for HIP Basic plan members receiving preventive care services is capped at 50%.*

4.4.5 Health Incentive Program

To further promote positive health outcomes, the State proposes to allow the MCEs to implement a rewards program which would allow members to "earn" additional dollars to be contributed to their POWER account. The MCEs may deposit health incentives directly into the member's POWER account for specified healthy behaviors, such as completion of a risk assessment, smoking cessation, weight loss, etc. The member may use the funds to offset their required monthly contributions by up to fifty percent (50%). The State will work with health plans to develop the list of approved incentives.

4.4.6 Increase POWER Account Maximum

This waiver seeks to increase the amount of the POWER account to $2,500 (rather than the current $1,100) to better align with the current HSA standard and increase the amount of dollars members are managing. The current $1,100 deductible was established in 2007 and has not changed since that time to account for medical inflation. However, despite the increase in the deductible, the required member contribution will not increase. Rather, the State would merely contribute more to the account, thereby providing more dollars for the member to directly manage while utilizing healthcare services. The increased contribution to the account would be offset by a lower premium paid to the insurance carriers, and, therefore, the change is expected to be cost-neutral.

In addition, all preventive services (including annual examinations, smoking cessation programs, and mammograms) as well as all MRO services provided to medically frail HIP members, are covered without charge to the member and are not included in the deductible amount. All HIP members will have the opportunity to manage more funds in the POWER account due to the increased deductible. Currently, given the high level of chronic disease among the HIP population, relatively few members (just over one-third) eligible for a rollover had any funds remaining in their POWER account at the end of the eligibility period to carry forward. By increasing the POWER account amount, the State hopes to increase the number of members with account balances remaining at the end of the year in order to provide a greater incentive for these members to obtain preventive care, as well as to maximize the consumerism experience for members by giving them the opportunity to manage more of their health care spending.

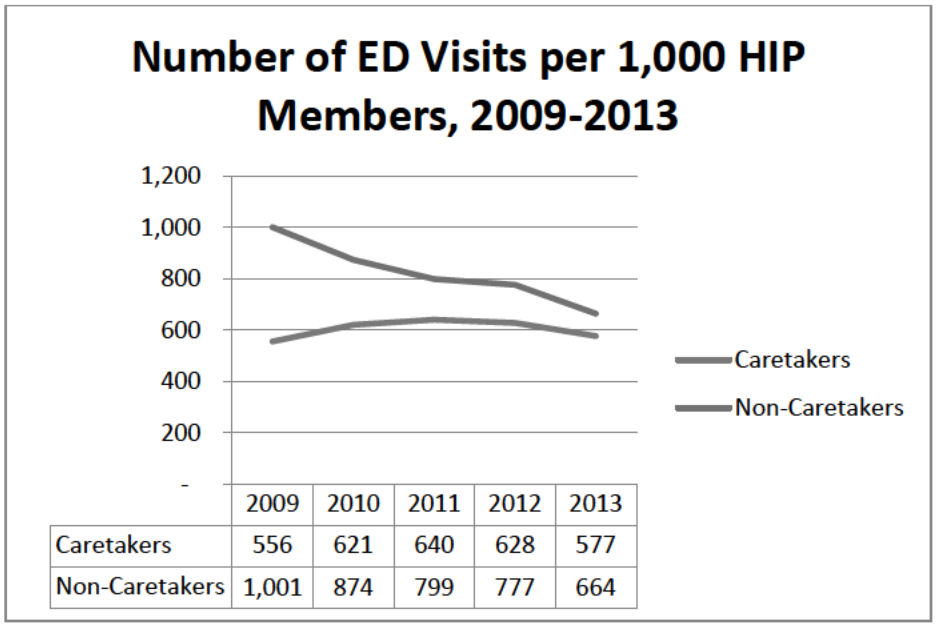
4.4.7 Co-payments Non-Emergency Use of Emergency Department

The State seeks a waiver of cost sharing limits under Section 1916(f) of the Social Security Act. With the exception of pregnant women, all HIP enrollees, including those in the HIP Plus and HIP Basic plans, will be charged a maximum $25 co-payment for non-emergency use of hospital emergency department (ED) under the new waiver. This demonstration waiver will analyze whether this untested use of co-payments for all HIP members encourages beneficiaries to seek non-emergency services from appropriate providers, thereby improving quality of care.

During the first six years of the program, HIP charged only non-caretakers a $25 co-payment to discourage inappropriate use of emergency services. Consistently over this period, HIP member ED claims data has shown that the required co-payment serves as an effective deterrent to inappropriate utilization. Non-caretakers must currently pay $25 co-payments for inappropriate ED use, while caretakers must pay $3.

Although the non-caretaker population experiences a higher degree of morbidity and chronic disease burden than the caretaker population, their rate of ED use has decreased significantly over the course of the demonstration. In 2009, thirty-eight percent (38%) of HIP non-caretakers visited the ED at least once, but in 2013, only thirty-one percent (31%) did so. Additionally, in 2009, HIP non-caretakers had 1,001 ED visits per 1,000 members; but by 2013, this was reduced to 664 visits per 1,000 members--a decrease of thirty-four percent (34%) (See Figure 4.4.7 below). In contrast, both the percentage of HIP caretakers visiting the ED at least once and the number of visits per 1,000 caretaker members rose slightly between 2009 and 2013. The larger co-payment for non-caretakers appears to deter members from inappropriate utilization of the ED.

Figure 4.4.7 Emergency Department Visit Trend, 2009-2013



	2009	2010	2011	2012	2013
Caretakers	556	621	640	628	577
Non-Caretakers	1,001	874	799	777	664

With strong evidence indicating the higher co-payment for non-caretakers has decreased inappropriate emergency department use more effectively than the lower co-payment for caretakers, the State seeks approval to test a graduated co-payment applicable to all HIP members except pregnant women, regardless of HIP benefit package or FPL. The first inappropriate emergency department visit would require an $8 co-payment; and subsequent inappropriate emergency department utilization would require a $25 co-payment.

The State wishes to encourage all HIP members to seek care in the appropriate setting. By expanding the co-payment to all HIP members, the State expects that more members will do so. The previous HIP population would serve as a control group for comparison purposes. In addition, to further educate and engage HIP members regarding appropriate care settings, the ED co-payment will be waived for any member who contacts their MCE's 24 hour nurses hotline prior to utilizing a hospital ED.

Any risk to HIP members from the increased cost-sharing would be mitigated by the federal regulatory protections that apply to non-emergency utilization of the ED, which help prevent any

damage to the health of the member resulting from the cost-sharing. Specifically, the State would ensure that, in accordance with 42 C.F.R. § 447.54(d), the hospitals (i) conduct an appropriate medical screening under §489.24 subpart G to determine that the individual does not need emergency services; (ii) determine that there is an alternative provider that can deliver the non-emergency care in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing, and (iii) provide a referral to coordinate scheduling for treatment by the alternative provider.

Further, to expand access to alternative providers, the State also intends to allow the HIP MCEs to expand their networks to include the addition of non-traditional urgent health care settings such as retail clinics. Expanded networks will provide more convenient access points and further reduce inappropriate emergency department usage. Ultimately, through this initiative, the State hopes to drive appropriate care utilization, higher quality of care, and better health outcomes for HIP members.

4.4.8 Cost-Sharing for Populations Exempt from Alternative Benefit Plan (ABP) enrollment

HIP 2.0 will cover three populations currently exempt from ABP enrollment: pregnant women, the medically frail, and Section 1931 parents and caretaker relatives. These populations will be assessed cost-sharing as detailed by the table below.

Table 4.4.8: Cost-Sharing for ABP-Exempt Populations

	Pregnant Women	Medically Frail	Section 1931 Parents and Caretaker Relatives
Cost-Sharing Requirements	All cost-sharing requirements waived.	Medically frail may choose to pay co-payments or POWER account contributions.	Section 1931 parents and caretaker relatives will choose between co-payments or POWER account contributions.
POWER Account	Pregnant women will continue to manage and receive the benefit of the POWER account.	Medically Frail will continue to manage and receive benefit of the POWER account regardless of choice of co-payment or contribution plan.	Section 1931 parents and caretaker relatives will continue to manage and receive benefit of the POWER account regardless of choice of co-payment or contribution plan.

4.4.9 Cost-Sharing for HIP Link

Members choosing to enroll in their ESI plans through the HIP Link option will be required to pay monthly contributions consistent with the HIP Plus plan, as outlined in Section 4.4.1. Similar to HIP, the HIP Link program seeks to encourage members to take personal responsibility for their healthcare by regularly making their required monthly contributions. To dis-incentivize non-payment, HIP Link members that fail to meet their monthly contribution requirements will have $50.00 deducted from their defined contribution POWER account balances for each missed

contribution. Individuals will not be eligible to have this $50.00 recovered, including under an exception process if they have health care expenses that exceed the funding in the defined contribution POWER account.

In addition to the dis-incentive, HIP Link members will also have the same positive incentives as other HIP members through the opportunity to roll-over funds to reduce future POWER account contributions. Similar to the HIP Plus roll-over process, the HIP Link member is only eligible to roll-over the prorated remainder of the individual's contribution. A HIP Link member's ability to roll-over contributions will depend on if they have made all of their required POWER account contributions and if they have received their required preventive care. HIP Link members that have not made all of their required POWER account contributions may be eligible to receive roll-over indexed to the HIP Basic plan roll-over schedule, as outlined in Section 4.4.4.2. These members will only be eligible for roll-over if they have received their required preventive services, and their total roll-over will be limited to 50% of their required contribution. HIP Link members that have made all their required contribution may be eligible to receive roll-over indexed to the HIP Plus roll-over schedule, as outlined in Section 4.4.4.1. These members will be eligible for roll-over if they have a balance left in their POWER account and will receive a matching roll-over from the State if they have completed their preventive services.

Section 5: Hypotheses and Evaluation Plan

Mathematica developed an evaluation plan for HIP during the program's initial demonstration period. As described in Section 3, HIP has used these evaluation mechanisms to track program successes, challenges, and progress toward achieving its established goals. Throughout the demonstration period, the evaluation tools have revealed the positive impact of incentives and consumer-driven design in changing health care utilization behaviors. During the new demonstration period, Indiana will modify the original evaluation design to focus on new areas of study. Evaluation reports will address HIP's progress to meeting program goals in addition to the evaluation questions listed in the Special Terms and Conditions (STCs).

Evaluation reports will include outcome data on the following HIP goals:

1. Reduce the number of uninsured low income Hoosiers and increase access to health care services;
2. Promote value-based decision making and personal health responsibility;
3. Promote disease prevention and health promotion to achieve better health outcomes;
4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families;
5. Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance; and
6. Assure State fiscal responsibility and efficient management of the program.

The requested HIP program revisions set forth in Section 4 will support the program goals and increase access to private health care coverage. To track the progress toward program goals, the State has identified the following areas for new research and evaluation efforts. The tables below present a preliminary plan for how the State may evaluate its efforts, with possible future adjustments.

#	Hypothesis	Methodology	Data Sources and Metrics
Goal 1: Reduce the number of uninsured low income Hoosiers and increase access to health care services.			
1.1	**HIP will reduce the number of uninsured Hoosiers with income under 138% FPL over the course of the demonstration.**	Track rates of uninsured Hoosiers with income: • Under 138% FPL; • 100%-138% FPL; and • Under 100% FPL.	Current Population Survey & American Community Survey: • Health insurance coverage estimates, all ages, all poverty levels; and • Health insurance coverage estimates, by poverty level.
		Track the number of Hoosiers served by the HIP program over the course of the demonstration.	HIP enrollment figures: • Annual and monthly enrollment counts; and • Unique number of Hoosiers enrolled in HIP (rolling).
1.2	**HIP will increase access to quality health care services among the target population.**	Track member feedback for perceived access to different types of health care services before and after enrollment in the HIP program.	Member survey: • Percentage of members who report having a usual source of care; • Measure of ability to obtain primary care visit; • Measure of ability to obtain specialty care visit; and • Measure of ability to obtain a prescription.
		Measure geo-access standards for primary and specialty care for all health plans.	HIP health plan network and geo-access data: • Proximity of primary care providers for all members; and • Proximity of specialist types for all members.
		Measure member health plan satisfaction indicators.	CAHPS survey: • Rating of plan overall; • Ability to get needed

#	Hypothesis	Methodology	Data Sources and Metrics
			care quickly; • Provider communication; • Coordination of care; and • Other relevant CAHPS indicators.
Goal 2: Promote value-based decision making and personal health responsibility.			
2.1	**HIP policies will encourage member compliance with required contributions and provide incentives to actively manage POWER account funds.**	Track initial HIP Plus vs. HIP Basic enrollment by FPL.	Enrollment records for HIP Plus: • Overall enrollment; • Number above 100% FPL; and • Number under 100% FPL. Enrollment records for the HIP Basic plan: • Overall enrollment; • Number enrolled in HIP Plus later; and • Number enrolled in the HIP Basic plan after failing to make contribution to POWER account.
		Track HIP members making initial and subsequent flat-rate POWER account contributions: • Overall; • Above 100% FPL; and • Under 100% FPL.	Health plan contribution and enrollment data: • Number and percentage making initial POWER account contribution; • Number and percentage making subsequent POWER account contributions within allowed time; • Number and percentage locked out due to non-contribution; and • Number and percentage transitioned from HIP Plus to HIP Basic due to non-contribution.

#	Hypothesis	Methodology	Data Sources and Metrics
			Member Survey: • Perception of ability to make POWER account contributions.
		Track and compare average remaining POWER account balances at the end of a benefit period between: a) HIP Plus members; b) HIP Basic members who enroll in HIP Plus at the end of their benefit period; and c) HIP Basic members who *do not* enroll in HIP Plus at the end of their benefit period.	Administrative data: • Percentage of POWER accounts that have a balance at the end of a benefit period; and • Average POWER account balance amount at the end of the benefit period.
		Track HIP Plus member pro-rata share of balance POWER account rollover rates and the average amount by which contributions are reduced in the next benefit period for: • Base rollovers (100% of member pro-rata share of balance); and • Preventive care rollovers (200% of member pro-rata share of balance).	Administrative data: • Percentage of HIP Plus members that have a POWER account balance at the end of the benefit period; • POWER account rollover rates for HIP Plus members (100% and 200%); and • Average amount by which HIP Plus member contributions are reduced in the next benefit period.
		Track the average amount by which required contributions are discounted for HIP Basic members transitioning to HIP Plus at redetermination.	Administrative data: • Average discount for required contributions in the next benefit period for HIP Basic members transitioning to HIP Plus.
		Track the co-payment collection rate for HIP Basic	Provider survey: • Percentage of HIP

#	Hypothesis	Methodology	Data Sources and Metrics
		members.	patients for which providers report regularly collecting co-pays.
2.2	**HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than: a) HIP Basic members; and b) traditional Hoosier Healthwise members.**	Track health service utilization rates for following groups, controlling for health status, age and other relevant variables: a) HIP Plus members; b) HIP Basic members who enroll in HIP Plus at the end of their benefit period; and c) HIP Basic members who *do not* enroll in HIP Plus at the end of their benefit period.	Claims data: • ED use • Primary care encounters; • Preventive care codes; and • Pharmacy (overall costs, brand vs. generic dispensing rate).
2.3	**HIP's (i) graduated copayments required for non-emergency use of the ED, (ii) ED prior authorization process, and (iii) efforts to expand access to other urgent care settings will together effectively deter inappropriate ED utilization.**	Compare annual rates of inappropriate ED utilization between HIP populations for the years *before* (2008-2014) and *after* (2015 and beyond) for non-caretakers and caretakers.	Claims data: • Annual overall ED utilization rates (percent of members and visits/100,000 members) • Annual non-emergency ED utilization rates (percent of members and visits/100,000 members)
		Compare annual rates of alternative urgent care setting utilization (e.g. retail clinics) between HIP populations for the years *before* (2008-2014) and *after* (2015 and beyond) the HIP 2.0.	Claims data: • Annual rates of alternative urgent care setting utilization (percent of members and visits/100,000 members).
		Survey HIP members on whether the co-payment for non-emergency use of the ED caused them to seek services with their primary care physician or in an alternative urgent care setting.	Member survey • Percentage of members who report the required co-payment for non-emergency use of the ED caused them to seek services with their primary care physician or in an alternative

#	Hypothesis	Methodology	Data Sources and Metrics
			urgent care setting in lieu of the ED.
		Compare annual rates of members seeking prior authorization through the nurses' hotline prior to seeking ED services.	MCE reported data: • Number of members that utilized ED services • Number of members utilizing nurse's hotline for ED prior authorization • Number of members receiving affirmative prior authorization for ED services
		Compare annual rates of members paying increased copayments based on repeated inappropriate ED utilization	MCE reported data: • Number of members that utilized inappropriate ED services: o Only once o Two times o Three times o More than three times
Goal 3: Promote disease prevention and health promotion to achieve better health outcomes.			
3.1	**HIP will effectively promote member use of preventive, primary, and chronic disease management care to achieve improved health outcomes.**	Track and compare heath service utilization rates between HIP and traditional Medicaid members.	Claims data: • Primary care encounters; • Specialist care encounters; • ED visits; • Preventive care codes; and • Chronic disease management codes.
		Track and compare POWER account rollover and contribution discount rates for: • HIP Plus members; and • HIP Basic members who enroll in HIP	Administrative data: • POWER account preventive care rollover rates (200% of member pro-rata contribution amount) for HIP Plus members; and • Average discount in required contributions

#	Hypothesis	Methodology	Data Sources and Metrics
		Plus at the end of a benefit period.	for HIP Basic members who enroll in HIP Plus at the end of the benefit period.
		Track preventive care utilization rates and trends among different age and gender groups.	Claims data: • Number, type, and frequency of preventive care services used; and • Gender- and age-specific rates of pre-determined preventive service utilization.
		Track participation in health plans' chronic disease management programs.	Health plan data: • Chronic disease management program participation numbers and rates; and • Selected chronic disease management aggregate program outcomes.
Goal 4: Promote private market coverage and family coverage options to reduce provider and network fragmentation within families.			
4.1	**HIP's defined contribution premium assistance program will increase the proportion of Hoosiers under 138% FPL covered by employer-sponsored insurance (ESI).**	Track Hoosiers with income under 138% FPL covered by ESI over the demonstration.	Current Population Survey & American Community Survey: • ESI coverage rate estimates, all ages.
		Track Hoosiers with income under 138% FPL receiving defined contribution premium assistance to purchase ESI each year of the demonstration.	HIP Program enrollment and premium assistance records • Number of HIP enrollees who receive premium assistance to purchase ESI—monthly and annually; and • Percentage of HIP enrollees who receive premium assistance to purchase ESI—monthly and annually.
4.2	**HIP's ESI premium assistance option for family coverage will increase the number of low income families in which the parents and children have access to**	Track the number of parents eligible for and utilizing premium assistance for their children to enroll in the family coverage ESI plan in	HIP program ESI premium assistance records: • Number and percentage of parents who are eligible for premium assistance for their children; and

#	Hypothesis	Methodology	Data Sources and Metrics
	the same provider network.	lieu of CHIP.	• Number and percentage of parents who accept premium assistance to enroll in ESI family coverage.
Goal 5: Facilitate HIP member access to job training and stable employment to reduce dependence on public assistance.			
5.1	**Referrals to Department of Workforce Development (DWD) employment resources at the time of application will increase member employment rates over the course of the demonstration.**	Track the number of HIP applicants referred for work search and job training assistance.	HIP enrollment figures: • Number of HIP applicants annually and monthly.
		Track the number of HIP members who accept/participate in work search/job training programs.	Member survey: • Percentage of members who report engagement in work search/job training activities after the time of HIP application—one month, six months, and one year.
		Compare rates of full and part-time employment among the enrolled population at application and after six months, one year, and two years into the program.	Member survey: • Percentage of enrollees with full or part-time employment at program entry, six months, one year, and two years into the program.
		Track the number of HIP individuals transitioning off the program due to increased income.	Eligibility and enrollment figures: • Number of members who lose HIP eligibility due to income increase—monthly and annual.
Goal 6: Assure State fiscal responsibility and efficient management of the program.			
6.1	**HIP will remain budget-neutral for both the federal and state governments.**	Conduct a budget neutrality analysis and document adherence to waiver margin.	Milliman budget neutrality estimates and reports: • Calculation of the waiver margin (annual and cumulative); • Documentation of all state and federal costs; and

#	Hypothesis	Methodology	Data Sources and Metrics
			• Demonstration of budget neutrality.

Section 6: Public Comment

The public comment period initiates May 21, 2014. Upon conclusion of the comment period this section will contain a summary of the comments received.

Section 7: Types of waivers being requested

FSSA requests the following waivers:

7.1 Title XIX Waivers

1. **Amount, Duration, Scope, and Comparability** **Section 1902(a)(10)(B)**
   To the extent necessary to enable Indiana to vary services offered to individuals within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or in the absence of managed care arrangements.
   To the extent necessary to enable Indiana to offer an alternative limited benefits package to HIP members under 100% FPL who do not make their POWER account contributions.

2. **Freedom of Choice** **Section 1902(a)(23)**
   To the extent necessary to enable Indiana to restrict the freedom of choice of providers for demonstration eligibility groups.

3. **Reasonable Promptness** **Section 1902(a)(3)/Section 1902(a)(8)**
   To the extent necessary to enable Indiana to prohibit re-enrollment for 6 months for HIP members above 100% FPL who are disenrolled for failure to make POWER account contributions.

   To the extent necessary to enable Indiana to delay provision of medical coverage until the first day of the month following an individual's first contribution to the POWER account.

4. **Methods of Administration: Transportation** **Section 1902(a)(4)**
   insofar as it incorporates 42 CFR 431.53
   To the extent necessary to enable Indiana not to assure transportation to and from medical providers for HIP members, except for those who are exempt from Alternative Benefit Plans and receiving State Plan benefits, including pregnant, individuals determined to be medically frail, and Section 1931 parents and caretaker relatives.

5. **Eligibility Section** **Section 1902(a)(10)(A)**
   To the extent necessary to enable Indiana not to provide medical coverage for HIP members enrolled in the HIP Plus plan above 100% FPL until the first day of the month

following an individual's first contribution to the POWER account, or for members under 100% FPL who fail to make an initial POWER account payment within 60 days following the date of eligibility.

6. **Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**
To the extent necessary to enable Indiana to offer to HIP members, known as "the adult group" in the proposed rule at 42 CFR 435.119, benefits that differ from the benefits offered to the categorically needy group.

7. **Retroactive Eligibility** **Section 1902(a)(34)**
To the extent necessary to enable Indiana not to provide medical coverage to HIP members in the HIP Plus plan for any time prior to the first of the month following an individual's first contribution to the POWER account, and to allow Indiana not to provide medical coverage to HIP members initially enrolled in the HIP Basic plan until after the date of the eligibility determination.

8. **Prepayment Review** **Section 1902(a)(37)(B)**
To the extent necessary to enable Indiana not to ensure that prepayment review be available for disbursements by members of HIP to their providers.

9. **Cost-Sharing** **Section 1916A**
To the extent necessary to enable Indiana to require POWER account contributions for members in the HIP Plus plan, co-payments up to 5% of household income for HIP members in the HIP Basic plan, and graduated co-payments up to $25 for all HIP members, except pregnant women, using a hospital emergency department for non-urgent care.

10. **Vision and Dental Coverage** **Section 1902(a)(34)**
To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of HIP who are enrolled in the HIP Basic plan for failure to make POWER account contributions.

Section 8: Financing Reports

Please see attached financing report prepared by Milliman Inc.