Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Anne Waltermann Murphy, Secretary

" People helping people help themselves"

May 17, 2010

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

Dear Director Mann:

We were pleased to read that Indiana is not required to terminate its Healthy Indiana Plan, which is currently approved through December 31, 2012. We stand ready to work with CMS to implement the Patient Protection and Affordable Care Act (PPACA) and hope we can find a way to use the successful HIP plan as the vehicle for covering the newly eligible population in 2014.

Led by Republican Senator Patricia Miller and Democrat Representative Charlie Brown, and passed in 2007 with overwhelming bipartisan support by the Indiana General Assembly, HIP is the hallmark of State led innovation. HIP provides a CMS-approved benchmark equivalent benefits plan to adults under 200% of the federal poverty level (FPL). Consumer choice drives participants to take into consideration quality and cost when making their health care choices. Based on their ability to pay, participants are required to make monthly contributions into an account (the POWER account) that funds the plan's deductible. Members have the opportunity to lower their contributions if there is a balance in their account, and they complete their requisite preventative health care services. HIP is not an entitlement program but a tightly capped demonstration program funded by an increase in the State cigarette tax. As expected, tax revenues have declined as smoking rates are declining which we can all celebrate.

As HIP has begun its third year enrollment with over 45,000 participants, there is evidence that the POWER account and the foundation of consumer driven tenets are driving personal responsibility. Emergency room usage is lower in HIP than in our other Medicaid programs and is lower than other comparable State Medicaid programs. Over 98% of individuals have made their POWER account contributions on time and those individuals experienced a 27% decrease in emergency room use over their 12-month enrollment period. Over 76% of HIP participants received their required preventative services and over 94% of HIP members report satisfaction with the program. HIP provides an alternative to traditional Medicaid programs and shows strong potential for consumer driven plans to impact patient behavior and encourage personal responsibility.

HIP is a home-grown program that works for Indiana and provides the natural vehicle to provide coverage for Hoosiers that will become Medicaid eligible under PPACA. Indiana has invested over $27 million dollars on the implementation of HIP and continues to make enhancements in the program. Common sense dictates that we take advantage of that investment and find a way to work with CMS to expand HIP.

Moving forward we have several specific questions that need to be addressed:

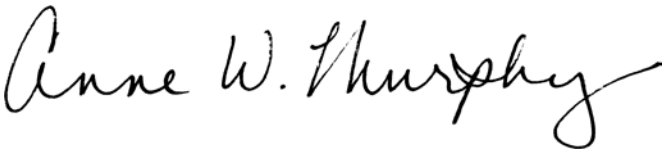
I. In order to provide a smooth transition, after the waiver ends in 2012, how would CMS suggest we handle the time period between 2013 and 2014 for current HIP participants? Indiana is interested in the continuation of the waiver, if HIP can be the coverage vehicle for all the newly eligible individuals under PPACA.

2. Will CMS classify the 45,000 current HIP participants, the majority of which fall under 133% FPL as newly eligible and therefore reimbursed at the higher FMAP? We would point out that the HIP program is not an expansion population but a demonstration project operating under the 1115(b) waiver rule. We caveat this request with the understanding that our funding is limited to the cigarette tax revenue and therefore we might need to curtail enrollment at some point in time.

While it is no secret that Indiana has serious reservations about the negative impact this legislation will have on our federal and state budgets, it is now the law of the land and we will implement the requirements set forth. We have many contractual arrangements hanging in the balance as it relates to HIP as well as the costs and administrative burden of determining eligibility and serving as many as 500,000 new enrollees. For our planning purposes, it is imperative that we receive a concrete and clear understanding soon from CMS on these issues.

Thank you for your attention to this matter.

Sincerely,



Anne W. Murphy