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September 10, 2010

MEMORANDUM

To: Anne Murphy

From: Caroline M. Brown and Rachel Grunberger

Re: Covering New Eligibles under HIP

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

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

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

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

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

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

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

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

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

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

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

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

ACA §§ 1302, 10104.

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

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

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

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

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

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

Id. at 23,076, 23,077.

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

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

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

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

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

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

A key question is whether enrollees could continue to be required to make contributions to the POWER account once they were a Medicaid population, rather than, as currently, a demonstration population under the waiver. We believe there is a persuasive argument that the contributions could continue at current levels, despite Medicaid's limitations on cost-sharing, including the prohibition against premiums for individuals with family income below 150% of the FPL. *See* 42 C.F.R. §§ 447.71, 447.72. As described below, (1) the POWER account contributions comply with Medicaid's 5% cap on aggregate cost-sharing; and (2) POWER account contributions are not premiums.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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