September 18, 2014

The Honorable Sylvia Burwell
U.S. Secretary of the Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madam Secretary:

On behalf of MDwise, I am writing in support of the recent 1115 waiver application submission by Indiana's Department of Family and Social Services Administration on the state's plan to use the Healthy Indiana Plan (HIP) as the platform to extend Medicaid coverage to those who are currently uninsured. MDwise has worked with the State of Indiana as a Medicaid Health plan for the last 20 years and has been serving Hoosiers in the Healthy Indiana Plan since the inception of the program. The Healthy Indiana Plan has several key program features that benefit its members and stakeholders:

- **HIP Promotes Personal Responsibility**: Our HIP members pay their POWER account contributions on time and are engaged in their healthcare.
- **HIP Promotes Consumer Directed Principles**: HIP members reach out to our customer service department and plan more often than the other State coverage programs. They are engaging in their health care by using technology such as our web portal and online statements.
- **HIP's Focus on Preventive Care has Worked**: Compared to national HEDIS benchmark, MDwise HIP scored at the 90th percentile for adults having access to preventive and ambulatory health services
- **HIP Members Have High Satisfaction with the Healthy Indiana Plan**: 95% of HIP enrollees say they are satisfied with the program and would recommend the program to their family or friends.
- **HIP 2.0 will build upon current HIP success** by ensuring access to quality health coverage for low-income Hoosiers. All members, regardless of income, will receive access to important Essential Health Benefits.

There are several components of the Healthy Indiana Plan that have elicited concern from advocacy groups; however, we believe there is confusion about how the program works. Below are a few areas that we would like to clarify:

POWER Account Member Contributions
The arguments against the POWER Account Contribution (PAC) contain several fundamental misunderstandings of the wavier as it stands today. First, the PAC is in no way a premium; it is a contribution to a personal wellness account. Dollars contributed towards this account belong to the member until the moment they allocate those dollars towards medical services. If the member disenrolls or transfers to another aid category while they have a balance remaining in their account, they receive their portion back from the insurer. Additionally, whatever money a member may have left in their POWER Account at the end of their benefit period will be rolled over for their use during the New Year. Both of these scenarios clearly represent that the PAC in no way constitutes a premium.

The second issue with this interpretation of the waiver is that the State will require members below 100% FPL to make a PAC. All eligible individuals under 100% FPL who choose not to make a PAC will still be enrolled in the Healthy Indiana Plan. Members who go this route will receive a comprehensive benefit package that provides the same essential services as those who do make their PAC in a timely fashion.

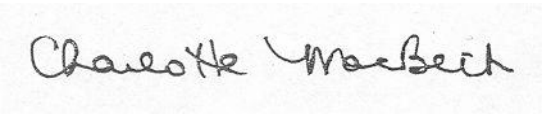
The third issue with the interpretation of the waiver regarding member contributions is related to the lock out period if a member fails to make their contribution. If an enrollee under the poverty line fails to make their PAC, they will not be terminated and locked out; rather they will move to the Basic plan. For enrollees above the poverty line, the lockout period is similar to the Federal Marketplace concept of an Open Enrollment period – where members are expected to pay monthly or they will lose coverage until the next enrollment season

Retroactive Eligibility
The current Healthy Indiana Plan, as well as the modified program, does not allow for retroactive coverage. This concept follows the design of the Federal Marketplace/Affordable Care Act where coverage is prospective only. With a speedy enrollment process, and with the safety net of Hospital Presumptive Eligibility to protect against unforeseen health issues that occur before a member can get approved for ongoing coverage, this program feature should not be a barrier to care. Retroactive Eligibility can lead to complications for issuer's systems and causes confusion to both members and providers. As mentioned in the opening statements, a goal of these programs is to provide as straightforward a coverage option as possible and retroactive eligibility presents a serious barrier to that desire.

We recognize that elements of one state's Medicaid expansion proposal might not work for every state, but it is an important for CMS to permit flexibility for each state to devise creative solutions that will work for their unique populations. The Healthy Indiana Plan is the right plan for Indiana to expand coverage to our most vulnerable citizens. MDwise appreciates the consideration your agency is giving to states by working with them to extend coverage through this innovative waiver proposal.

About MDwise
MDwise is Indiana's only nonprofit health insurance company focused on giving uninsured and underserved Hoosiers the compassionate service and care they want and need. MDwise's services are currently provided to more than 320,000 total members in partnership with nearly 1,600 primary medical providers and a statewide array of specialists, hospitals and other providers. In addition, MDwise is a Qualified Health Plan issuer in the Health Insurance Marketplace. MDwise's services offer a coordinated, comprehensive approach to managing the cost and utilization of Indiana's health care services. With over 20 years of successful service to our members, MDwise is ranked 28th nationally based upon the NCQA's Medicaid Health Insurance Plan Rankings for 2014-2015. For more information, visit MDwise.org.

Sincerely,



Charlotte MacBeth
MDwise President and CEO