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Centers for Medicare & Medicaid Services
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200 Independence Avenue, SW
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STATEMENT & FAST FACTS

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Contact: CMS Media Relations
(202) 690-6145 | press@cms.hhs.gov

CMS and Indiana Agree on Medicaid Expansion

CMS Administrator Marilyn Tavenner and HHS Secretary Sylvia Burwell issued the following statement today after Indiana became the 28th state – plus the District of Columbia – to expand Medicaid under the Affordable Care Act.

"With today's agreement, Indiana will become the 28th state, plus the District of Columbia, to expand Medicaid under the Affordable Care Act. This agreement will bring much needed access to health care coverage to an estimated 350,000 uninsured low-income Hoosiers over the next three years," said **CMS Administrator Marilyn Tavenner.** "HHS and CMS are committed to working with states to design programs uniquely their own, while maintaining essential health benefits guaranteed under the Affordable Care Act and other key consumer protections consistent with the law."

"I continue to be encouraged by interest from governors from all across the country who want to bring health care coverage to low-income people in their states by expanding Medicaid. They understand both the economic benefits of Medicaid expansion and the health and financial security it brings to their residents," said **HHS Secretary Sylvia Burwell**. "The Administration will continue to work with governors interested in expanding Medicaid to devise approaches that work for their states while keeping faith with the law's goals and consumer protections."

The expansion is paid for with 100 percent federal funds through 2016. Federal funding rates gradually decline beginning in 2017, but never fall below 90 percent of costs.

Fast Facts on Healthy Indiana Plan:

Beneficiaries will begin to have access to quality, affordable coverage with the essential benefits guaranteed by law beginning on February 1, 2015 for eligible individuals.

Indiana's plan establishes POWER Accounts, which beneficiaries will use to pay for some of beneficiaries' health care expenses. These accounts will be funded, in part, through beneficiary contributions.

Beneficiaries will have access to all of the essential health benefits that are required under the law. The agreement allows two benefit packages (HIP Plus and HIP Basic), each covering all essential health benefits required by law and available to people based on their premium (POWER Account) contributions.

Individuals who are charged premiums (in the form of POWER account contributions) will enroll in HIP Plus and have no other cost sharing, expect for certain emergency room services. These individuals will also have the opportunity to reduce their premiums through incentives like receiving preventive care or through a rollover of their POWER account. For people with incomes at or under 100% of the federal poverty line (FPL) who elect to pay cost-sharing rather than premiums, cost sharing will comply with regular program limits and total cost sharing will not exceed 5 percent of the family income.

CMS did not approve a work requirement as part of this agreement. Indiana will seek to encourage employment through a state-funded incentive program that will be administered separate from the Medicaid program. Participation in this program will not impact coverage or costs for individuals. While states may promote employment through state programs operated outside of the demonstration, this is not permitted under the Medicaid program.

Co-payments for certain emergency room services to some individuals will be allowed in connection with a study testing whether copays encourage care in the most appropriate settings while not harming beneficiary health. Federal law allows waivers on cost sharing payments only based on meeting several criteria including the presence of a control group so that the impact can be carefully studied. Individuals who seek treatment at the emergency room will be charged copays ($8 for the first visit, $25 for the second visit). Those assigned to a "control" group will not be charged.

Individuals with incomes at or below 100% FPL are not subject to a lockout of essential benefits. A person who is not medically frail and has income above the poverty line who stops paying premiums can be locked out of coverage for six months – reduced from 12 months in the current Indiana plan – and subject to certain exceptions. The new demonstration shortens the lock out period from 12 months under HIP 1.0 to six months, limits the lock out to only people with incomes above 100% FPL who are not medically frail, and adds additional exceptions for some individuals. For instance, individuals with incomes at or below 100% FPL will also be given a 60-day grace period after non-payment of premiums before being automatically enrolled in HIP Basic.

Several features of HIP 1.0 were not continued as part of this new demonstration. These policies would not be authorized as part of a Medicaid expansion demonstration that, under the Affordable Care Act, triggers the enhanced federal matching funds. This agreement does not permit:

- Capped enrollment;
- Premium payments as a condition of eligibility for people with incomes below the federal poverty level; and
- Premium payments in excess of 2 percent of income.