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FISCAL IMPACT STATEMENT

LS 6526 **NOTE PREPARED:** Feb 17, 2007
BILL NUMBER: HB 1008 **BILL AMENDED:** Feb 15, 2007

SUBJECT: Health Coverage for Children and Adults.

FIRST AUTHOR: Rep. C. Brown **BILL STATUS:** CR Adopted - 1st House
FIRST SPONSOR:

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State & Local
X **DEDICATED**
X **FEDERAL**

Summary of Legislation: (Amended) This bill provides a tax credit for a taxpayer that provides a wellness program to employees.

The bill increases the cigarette tax by 54.5 cents per pack.

The bill provides for 12 continuous months of eligibility for an eligible child under Medicaid and the Children's Health Insurance Program (CHIP). It increases from 200% to 300% of the federal income poverty level the amount of family income a child may have for purposes of CHIP eligibility.

It also specifies a 100% increase in Medicaid reimbursement rates for primary care physicians.

The bill creates the Health Coverage for Children Program, and requires establishment of a health coverage for adults plan, both to be administered by the Office of the CHIP.

The bill requires certain entities to participate in an aggregate prescription drug purchasing program.

The bill provides that a local governmental unit, public library, or school corporation that provides health coverage to its employees may provide the coverage through the state employee health plans. It allows a small employer to provide coverage for employees under the state employee health plans. The bill requires the state employee health plans to be designed in a manner that allows employees to choose specific plans.

The bill requires a policy of accident and sickness insurance and a health maintenance organization (HMO) contract to provide coverage for the child of a policyholder, certificate holder, or subscriber, upon request,

until the child is 24 years of age.

The bill also requires establishment of a demonstration project for a health care management program and a pilot project for small employers to obtain health care coverage for employees.

The bill establishes the Healthy Indiana Task Force. It makes conforming changes.

The bill makes an appropriation.

Effective Date: Upon passage; July 1, 2007.

Summary of Net State Impact: *Tobacco Tax Increase:* The bill provides for a $0.545 increase in cigarette taxes; increasing the tax to $1.10. The bill would change the distribution percentages currently in statute to hold the dollars constant for existing distributions while providing an estimated $253.7 M and $256.8 M for FY 2008 and FY 2009, respectively.

Employer-sponsored Health coverage for children to age 24 is estimated to have a state fiscal impact of $4,630,539.

Expansion of the risk pool for state employee health benefit plans would have an indeterminate fiscal impact.

The Employer Wellness Program tax credit could potentially reduce revenue by $600,000 to $2.5 M annually beginning in FY 2009. The revenue loss could begin in FY 2008 if taxpayers adjust their quarterly estimated payments.

Medicaid and CHIP 12-month continuous eligibility is estimated to cost in excess of $23 M annually.

An actuarial estimate for a 100% increase for all Medicaid rates reimbursed to primary care physicians is not available at this time. However, an estimate for a 100% increase in evaluation & management fees (which is part of the above requirement) may cost approximately $204.4 M, or $77.7 M in state General Funds.

The range of total expense for the expansion of CHIP eligibility to 300% of the FPL is estimated to be between $31.7 M to $43.2 M in FY 2007. The state General Fund share is estimated to be $12.0 M to $16.4 M at the lower Medicaid FMAP (federal medical assistance percentage) rate since enhanced CHIP funding is capped.

The cost of the Health Coverage for Children Program and the Health Coverage for Adults Program is indeterminate at this time.

The Office of the CHIP (Office) is required to conduct an annual study by regions of the state to establish reliable estimates of the number of children eligible and enrolled in various types of health care coverage and the health outcomes or benefits of using the health insurance. The cost of this study is not known at this time.

The Healthy Indiana Task Force is estimated to cost approximately $16,500 per interim session.

Explanation of State Expenditures:

Medicaid & CHIP Provisions

Medicaid and CHIP Continuous Eligibility: The bill would provide that children under the age of 19 years would be continuously eligible for 12 months following a determination of eligibility for Medicaid or CHIP. In the December of 2002, Medicaid Cost Containment Forecast savings estimated for the Medicaid Program due to eliminating continuous eligibility were $23.5 M for FY 2005. The cost of re-instituting this provision is estimated to be somewhat higher due to increased enrollment. It is not clear from the forecast document if CHIP savings are included in the savings estimate. This provision would also apply to the expansion group added with the Health Coverage For Children Program.

Primary Care Physician Reimbursement: The bill would also provide a 100% increase in reimbursement for all primary care physician services within the Medicaid and CHIP programs. An actuarial estimate for a 100% increase for all rates reimbursed to primary care physicians is not available at this time. However, OMPP has estimated the impact of increasing only the evaluation and management fees (a portion of the fees required to be increased) by 25% for all physicians. (Evaluation and management fees are for services such as office visits, hospital visits, emergency room visits, and preventive well care visits.) If it is assumed that all factors remain constant and based on OMPP's estimate, a 100% increase in only evaluation & management fees may cost approximately $204.4 M, or $77.7 M in state General Funds. This provision would also influence the cost of services for the expansion group added with the Health Coverage For Children Program. An estimate of the total cost of this provision will be updated when information becomes available.

CHIP Income Eligibility Increased to 300% of FPL: The bill would increase the income eligibility for CHIP from 200% of the federal income poverty level (FPL) to 300% of FPL. Federal income poverty level guidelines for 2007 are included in the table below.

Persons in the Family or Household	200% FPL	300% FPL
1	$ 20,420	$ 30,630
2	$ 27,380	$ 41,070
3	$ 34,340	$ 51,510
4	$ 41,300	$ 61,950

U.S. Census data estimate that 56.7% of all children under the age of 18 live in households with income below 300% of the FPL. If this percentage is assumed to remain constant when 18-year-olds are included, the population of children under the age of 19 living in households with more than 200% of the FPL but less than 300% of FPL is estimated to be 304,700 children. If this population is assumed to be similar in health care needs to the population of children in Medicaid or to the CHIP C population, a range of total expense may be estimated to range from $31.7 M to $43.2 M in FY 2007. The state General Fund share is estimated to be $12.0 M to $16.4 M at the lower Medicaid FMAP rate. Federal CHIP funds are annually capped and Indiana expends all of the federal CHIP allotment on the current population. The CHIP statute currently authorizes coverage under the program up to 200% of the FPL. However, the state has the flexibility to determine amounts of income that may be disregarded in determining financial eligibility and therefore could effectively implement an eligibility expansion to 300% of poverty for children - other states have expanded to this level. Additionally, the federal CHIP statute and funding expires this year, and the terms of the

reauthorization are unknown at this time.

Medicaid Reimbursement: The Medicaid Program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 38%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 62%. The CHIP program receives enhanced federal reimbursement of approximately 74%. The state share of the CHIP Program is approximately 26% for medical services. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Health Coverage for Children Provisions

Health Coverage for Children: The bill creates the Health Coverage for Children Program to be administered by the CHIP program. The Program is to be coordinated with the existing children's health programs operated by the state. The CHIP Office is required to report details regarding the implementation of the Program to the Select Joint Commission on Medicaid Oversight, and the bill names that Commission as the forum for health care providers, advocates, consumers, and other interested parties to advise the Office with respect to the Program. The bill specifies the Office has rule-making authority to implement the Program.

Benefits: The Office is required to purchase, subsidize, or provide health coverage for eligible children, excluding non-emergency transportation services, that is identical to the coverage provided for children in the CHIP program. The Office may provide partial coverage for children that have health insurance coverage with a high deductible plan or may offer limited benefit packages to cover dental, vision, or provide other particular benefits. Children in the program are to have continuous 12-month eligibility as long as premium payments are made.

Cost Sharing: The Office is required to adopt rules to establish cost sharing requirements to include copayments and coinsurance for health care services other than preventive care services and monthly premiums. All cost sharing requirements must be based on a sliding fee scale determined by family income not to exceed 2% of the individual's annual income. The bill provides that in the determination of the cost share required, the Office is not to consider the cost of the coverage.

Eligibility: Eligible children must be under the age of 19 years and a state resident that is not eligible for Medicaid or CHIP. Children must live in households that have income greater than 300% of the FPL and must have been without health insurance coverage for at least 6 months, be a newborn with no affordable health insurance coverage, a child who lost insurance coverage due to a parent's loss of employment, or a child who has lost Medicaid or CHIP coverage.

Required Study: The Office is required to conduct an annual study by regions of the state to establish reliable estimates of the number of children eligible and enrolled in various types of health care coverage and the health outcomes or benefits of using the health insurance. The Office is to: (1) survey families with children who have declined employer-sponsored health care coverage concerning the reason for declining the coverage; and (2) determine the comprehensiveness of employer-sponsored coverage for children, the levels of cost sharing required for that coverage and the amount of cost-sharing required of employees. The study is to compare data from year to year. The study is to be submitted to the Governor and the Legislative Council. Preliminary results are due not later than July 1, 2009, and the final report is due July 1, 2011.

Federal Financial Participation: The bill specifies that the Office shall cooperate with OMPP to request any

necessary State Plan amendments or waivers of federal requirements to allow for the receipt of federal matching funds to implement the program. However, the bill specifies that the Program is to be implemented regardless of federal approval of amendments or waivers. If federal approval for the whole Program or some portion of the Program is not received, federal matching funds would not be available, requiring the program, or portions of it, to use 100% state funding.

Health Coverage for Children and Adults Fund: The bill creates the nonreverting, dedicated Health Coverage for Children and Adults Fund to be administered by the Office. Money in the Fund is annually appropriated for the use of the Office in carrying out the Health Coverage for Children Program. Money in the Fund is to consist of distributions of cigarette tax revenue, appropriations, interest accruing from investments, and donations.

Health Coverage for Adults Provisions

The bill requires the Office to establish a plan through which the Office provides, subsidizes, or purchases health coverage for individuals who are age 19 but less than age 65 who do not have health services coverage. The Office is required to design a plan to cover Indiana residents in households with income 100% of FPL or less. No cost-sharing is to be required for these individuals. Individuals living in households with income of more than 100% but less than 300% of FPL are to be covered with premium and cost-sharing amounts to be determined on a sliding fee scale. Individuals with income greater than 300% of FPL are required to be covered but must assume the cost of the premiums and cost-sharing to be totally assumed by the individual. The benefits covered under the program are to be determined by the Office.

Expansion of Risk Pool in State Employee Health Benefit Plans

Employee Health Coverage--Existing State Employee Health Plans: The state currently contracts with M-Plan and Wellborn (in southern Indiana) for the provision of prepaid health care delivery plans (HMOs). The state also contracts with Anthem to administer the state's self-insurance health plans.

Providing coverage to local governmental units, public libraries, school corporations, and/or certain small employers could affect premium costs, but the specific impact is indeterminable. Whether the impact will be positive or negative will depend on whether the demographics and claims experience of the new populations are found to be at more or less risk. Factors that would have an impact on the costs are outlined below.

Administrative Costs: With respect to the state's self-insurance plans, administrative costs typically make up 15%-20% of the overall benefit costs. Administrative costs are scaled based on the size of the group. There are economies of scale that apply when a large group has the same administration. The larger the group, the lower the charge per member per month (pmpm). Having a large group with the same administration creates cost effectiveness to the administrator. To the extent that the administration can be standardized and efficient in the system, overall health insurance costs can be reduced.

Eligibility Definition: Who is covered by the plans also affects the overall costs. Some units currently cover retirees. This coverage impacts the overall costs since retirees are higher consumers of health care resources. The addition of this population could result in increases for health insurance costs.

Networks: The type of provider network used can also impact costs. For example, using a preferred provider organization (PPO) can impact costs. (PPOs are a group of doctors who sign a contract agreeing to a certain level of payment for certain services.) The impact would depend on networks currently in use by eligible businesses and local units, and how these networks compare to state plans.

Benefits: The level that employees share in the cost of claims through deductibles, co-payments, and coinsurance affects the overall cost per member paid by the plans. Additionally, how benefits provided by eligible businesses and local units compare with existing state plans is unknown at this time.

Separate Versus Combined Risk Poo: With respect to the state self-insurance plan administered by Anthem, the major health care cost difference between a separate versus combined risk pool would be administrative. All other savings (mandatory participation, common benefits and eligibility, administrative practices, etc.) could be duplicated whether the risk pools were separate or combined. If businesses and local units participated with the state employee group in a single risk pool with like administration, there could be some cost savings through lower administrative costs. Any type of voluntary offering creates adverse selection within the pool. The bill allows employees to choose specific benefits.

With respect to HMOs, based on the assumption that providing coverage to eligible businesses and local units would significantly increase the number of members enrolled in the plan and assuming that benefits, eligibility guidelines, enrollment processes, premium payments, and other operational functions are the same, administrative costs would be the same. If eligible businesses and local units are treated as a separate risk pool, it would have no effect on state employee coverage costs. If the eligible businesses, local units, and the state employee group are treated as one risk pool, it is unclear whether the impact would be positive or negative. The impact would depend on the age, sex, health status, etc. of the eligible businesses' and local units' employees and dependents who enroll for coverage relative to state employees and their dependents currently selecting health care coverage. If the proportion of new high-cost, eligible businesses and local units electing to participate in a particular plan exceeds the proportion of new low-cost, eligible businesses and local units electing to participate, then there would be a greater probability that the state employee health coverage costs would increase.

Employer-Sponsored Health Coverage for Children to Age 24

Health Coverage for Children: As of January 2007, the state enrolled approximately 31,155 state employees in 3 health benefit plans: M-Plan, Anthem, and Wellborn. Total annual premium increases for the 3 plans are estimated to be $4.6 M. The actual impact will likely be less. This increase may not necessarily imply additional budgetary outlays since the state's response to increased health benefit costs may include (1) greater employee cost-sharing in health benefits; (2) reduction or elimination of other health benefits; and (3) passing costs onto workers in the form of lower wage increases than would otherwise occur. It is unknown at this time if the state would absorb added costs or pass the costs on to employees.

Background Information-The following estimates are based on adding coverage up to age 24 for Anthem and Welborn. Estimates for M-Plan are based on coverage until age 26. Estimates for M-Plan for coverage until 24 will be provided when they become available.

Anthem Estimate: Anthem reports that to add coverage up to age 24 would result in a $7.89 increase in per member per month (pmpm). Currently, 20,092 employees are enrolled in an Anthem program. Applying the 2.28 members per employee would result in an Anthem total membership of 45,810. Applying

the $7.89 increase per member would result in an increase of $361,440 per month with an annual increase of $4,337,290.

M-Plan Estimate: M-Plan reports that to add coverage up to age 26 would result in a $0.45 increase per employee per month. Currently, 9,797 employees are enrolled in M-Plan. Applying the $0.45 increase per employee would result in an increase of at most $4,408 per month with an annual increase of at most $52,903.

Welborn Estimate: Welborn reports that to add coverage up to age 24 would result in a $6.94 increase pmpm. Currently, 1,266 employees are enrolled in Welborn. Applying the 2.28 members per employee would result in a total membership of 2,886. Applying the $6.94 increase per member would result in an increase of $20,028 per month with an annual increase of $240,346.

Total annual increases for the 3 plans would equal $4,630,539.

Public Employer Wellness Programs and Wellness Program Tax Credits

The bill requires a public employer to provide a wellness program that rewards: (1) overweight employees for losing weight and all employees for maintaining a healthy weight; or (2) employees for not using tobacco. The current state health insurance plan provides a $500 decrease in the employee's health insurance deductible if they commit not to use any form of tobacco in 2007. The state also provided a $10 single and $15 family biweekly reduction in health insurance premium if the employee participated in the One Care Street program. The employee has to complete a survey and set a health action goal. The current state programs satisfy the bill's requirement resulting in no additional state fiscal impact.

Employer Wellness Program Tax Credit: The Department of State Revenue (DOR) will incur some administrative expenses relating to the revision of tax forms, instructions, and computer programs to incorporate the new wellness program tax credit. The Department's current level of resources should be sufficient to implement these changes.

Health Care Management Demonstration Project

The demonstration project would involve designing a program that would assign a percentage of Marion County Medicaid recipients to receive Medicaid services from Wishard Hospital and the clinics operated by the Health and Hospital Corporation (HHC). The waiver group would receive health care services based on a specified Veterans' Administration model.

In FY 2004, Medicaid reported 151,419 total Medicaid enrollments for Marion County. Of the total, 66% were participating in Hoosier Healthwise Managed Care or Primary Care Case Management. The remaining 34% consisted of fee-for-service patients and Medicaid Select enrollment. The demographic composition of the Medicaid eligibles that would be assigned to the demonstration project is not specified by the bill, although the group must be large enough to obtain meaningful data. Administrative actions would determine if the demonstration population would consist of specified populations inclusive of pregnant women, TANF adults, children, the aged, or the disabled. The demonstration project would, similar to a managed care organization (MCO), require the waiver of the Medicaid recipient's freedom of choice of provider selection and could potentially require patient reassignment from existing MCOs or Medicaid Select providers.

Required Study: The bill requires the CHIP Office to conduct a study in consultation with the Regenstrief Institute for Health Care to determine the impact of the program on quality of care and cost. The cost of the study will be determined partially by administrative actions that establish the size and the demographic composition of the recipient group assigned to the demonstration.

The program design is required to include incentive payments for providers and administrators to reward them for achievement of defined objectives. The bill does not specify the means of payment for services provided to Medicaid recipients (e.g., fee-for-service or capitation). This would be determined by administrative action in the development and design of the demonstration project. How an incentive payment would interact with the method of payment for services would influence the ultimate cost of this provision.

Small Employers Pilot Project

Small Employers Health Care Benefits Pilot: The bill requires OMPP and the HHC to develop a pilot program through which small employers unable to provide health care benefits for their employees may obtain access to affordable health insurance. The bill specifies that if the pilot project results in a premium rate that is 20% lower than a comparable health benefit plan available to small employer groups, an insurer may not enter into or enforce a "most favored nation" clause in an agreement with the HHC (i.e., an insurer would not be able to require the HHC to offer the same discounted prices to the insurer).

Healthy Indiana Task Force

The bill would establish the Healthy Indiana Task Force consisting of 16 lay members. The Task Force is to study and provide guidance to the state concerning the expansion of coverage for health care services for all children in Indiana, to develop methods to increase the availability of affordable coverage for all Indiana residents, and to make recommendations to the Legislative Council before November 1, 2008. The committee is to operate under the policies governing study committees adopted by the Legislative Council. Legislative Council resolutions in the past have established budgets for interim study committees in the amount of $16,500 per interim for committees with 16 members or more.

Explanation of State Revenues: *Tobacco Tax Increase:* The bill provides for a $0.545 increase in cigarette taxes; increasing the tax to $1.10. The bill would change the distribution percentages currently in statute to hold the dollars constant for existing distributions while providing an estimated $253.7 M and $256.8 M for FY 2008 and FY 2009, respectively.

Employer Wellness Program Tax Credit: This bill establishes a nonrefundable tax credit for employers that provide certain wellness programs to their employees. The tax credit could potentially reduce state revenue from the Adjusted Gross Income (AGI) Tax, the Financial Institutions Tax, and the Insurance Premiums Tax. Based on survey research estimating the prevalence of wellness programs and the average cost of these programs, the tax credit could potentially reduce revenue by $600,000 to $2.5 M annually beginning in FY 2009. The revenue loss could begin in FY 2008 if taxpayers adjust their quarterly estimated payments. To the extent that additional firms add wellness programs as a result of the tax credit, the revenue loss would be higher that the estimated range. In addition, cost inflation and employment trends suggest that the revenue loss could potentially grow by 1% to 2% per year.

Background Information: The bill provides a nonrefundable tax credit against a taxpayer's AGI Tax,

Financial Institutions Tax, or Insurance Premiums Tax liability for the cost of providing a wellness program to the taxpayer's employees that rewards:

(1) overweight employees for losing weight and all employees for maintaining a healthy weight; or
(2) employees for no using tobacco.

The tax credit is equal to 50% of the cost incurred by the taxpayer in providing the wellness programs during the taxable year. The tax credit is nonrefundable, but excess credits may be carried forward to succeeding taxable years. The bill prohibits a taxpayer from carrying back excess credits. If the taxpayer is a pass through entity and does not have a tax liability, the credit could be taken by shareholders, partners, or members of the pass through entity in proportion to their distributive income from the pass through entity. Since the credit is effective beginning in tax year 2008, the fiscal impact would likely commence in FY 2009. However, the fiscal impact could begin in FY 2008 if taxpayers with wellness programs reduce their quarterly estimated payments the first half of 2008.

Revenue from the corporate AGI Tax, the Financial Institutions Tax, and the Insurance Premiums Tax is deposited in the state General Fund. Eighty-six percent of the revenue from the individual AGI Tax is deposited in the state General Fund, and 14% is deposited in the Property Tax Replacement Fund.

Survey research by the Kaiser Family Foundation suggests that about 5% of private sector employees in Indiana could potentially have access to wellness programs offering weight loss programs and/or smoking cessation programs. Survey research by the Wellness Councils of America (WELCOA) suggest that only about 6% of employer-provided wellness programs offer no incentives to encourage program participation by employees. Based on the median employment scale and wellness program budget of firms responding to the WELCOA survey, the average cost of employer-provided wellness programs could range from about $10 to $40 per employee. Current estimates by the Bureau of Labor Statistics indicate private sector employment totals about 2.5 million, with long-run growth of about 1.1% annually.

Medicaid: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

Explanation of Local Expenditures:

Expansion of Risk Pool in State Employee Health Benefit Plans

The bill will affect expenditures for health insurance for local units. Whether the bill will increase or decrease expenditures is unknown. Additionally, the impact will vary depending upon each local unit.

Employer-Sponsored Health Coverage for Children to Age 24

Health Coverage for Children: This bill requires a policy of accident and sickness insurance and an HMO contract to provide coverage for the child up to age 24 at the request of the policyholder, certificate holder, or subscriber. This provision will affect expenditures for health insurance for local units. Whether the bill will increase or decrease expenditures is unknown. Additionally, the impact will vary depending upon each local unit.

Public Employer Wellness Programs

Local units of government could experience an increase in expense depending on the type of wellness program established. The wellness program has to reward overweight employees for losing weight and all employees for maintaining a healthy weight or employees for not using tobacco. There are approximately 2,750 local units of government that employee about 190,000 employees. If each employer gave a $100 reward for weight control or not using tobacco, the impact could be $19,000,000. The impact would be offset to some extent by possible future reduced health costs by the employer.

Explanation of Local Revenues:

State Agencies Affected: Department of State Personnel; DOR; Office of CHIP, OMPP, Family and Social Services Administration.

Local Agencies Affected: All.

Information Sources: Christy Tittle, Department of State Personnel, 317-232-3241; 2006 Annual Membership eSurvey, Wellness Councils of America, http://www.welcoa.org/. Employer Health Benefits Annual Survey, 2005 & 2006, Kaiser Family Foundation, http://www.kff.org/. State and Area Employment, Hours, and Earnings, U.S. Bureau of Labor Statistics, http://www.bls.gov.

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