LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

200 W. Washington, Suite 301
Indianapolis, IN 46204
(317) 233-0696
http://www.in.gov/legislative

FISCAL IMPACT STATEMENT

LS 7404
BILL NUMBER: SB 461

NOTE PREPARED: Apr 13, 2011
BILL AMENDED: Apr 12, 2011

SUBJECT: Health Care Reform Matters.

FIRST AUTHOR: Sen. Miller
FIRST SPONSOR: Rep. T. Brown

BILL STATUS: As Passed House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State & Local

Summary of Legislation: *Provisions concerning the Implementation of Federal Health Care Reform:* This bill provides that a state agency may not implement or prepare to implement provisions of the federal Patient Protection and Affordable Care Act (ACA). It provides specific prohibitions and exceptions for the implementation of the ACA by state agencies. The bill provides that a resident may not be required to purchase a health plan. It also provides that an insurer: (1) is not required to comply with the medical loss ratio requirements of the Act; and (2) must report the medical loss ratio information to the Department of Insurance.

Medicaid Family Planning State Plan Amendment: The bill requires the Office of Medicaid Policy and Planning (OMPP) to prepare a Medicaid state plan amendment to extend Medicaid coverage of certain family planning services for women and men with incomes below 300% of the federal poverty level (FPL). The bill also requires that OMPP adopt a presumptive eligibility process for these services. The bill requires OMPP to report to the Select Joint Commission on Medicaid Oversight (JCMO) during the 2011 interim regarding the proposed state plan amendment. The bill further requires the OMPP to apply by January 1, 2012, to the federal Department of Health & Human services for approval of the state plan amendment.

Medicaid 209(b) Status: This bill allows OMPP to request federal approval to change how the state determines Medicaid eligibility for the aged, blind, and disabled.

Indiana Check-Up Plan [Healthy Indiana Plan (HIP)] Health Care Reform Provisions: The bill requires the Indiana Check up Plan (HIP) to include any federally required bench mark services. It allows, instead of requires, the plan to include dental and vision services. The bill makes the following changes concerning the plan beginning January 1, 2014: (1) changes income eligibility requirements for the plan from 200% to

133%; and (2) removes the requirement that the individual's employer not provide health insurance and that the individual be without health insurance for six months. It also requires a health insurer that provides coverage under the plan until December 31, 2013, to also offer to provide coverage to certain other individuals in a manner consistent with federal law concerning underwriting, rating, and with state approval of the rate. The bill further allows the OMPP to amend the plan in a manner to be used to cover individuals eligible for Medicaid resulting from passage of the federal Patient Protection and Affordable Care Act (ACA).

Indiana Check-Up Plan [Healthy Indiana Plan (HIP)] Provisions: The bill allows a nonprofit organization and health insurers to make deposits into a plan participant's account under specified circumstances. It also requires a plan participant to contribute at least $100 per year.

Health Insurance Provisions: The bill amends current health insurance law to specify application of the law in conformity with the ACA, as amended by the federal Health Care and Education Reconciliation Act of 2010, including provisions concerning coverage of children until age 26, grievances, and rescissions. The bill also makes conforming amendments.

Effective Date: Upon Passage; September 23, 2010 (retroactive); July 1, 2011.

Explanation of State Expenditures: *Summary:* The bill would allow FSSA the authority to discontinue the state Medicaid 209(b) status. The fiscal impact of this provision would depend on administrative actions taken by FSSA in response to federal initiatives in implementing the ACA. OMPP has estimated that depending on how the federal ACA is implemented with respect to 209(b) states, the fiscal impact of this change could vary from a cost of $667 M to a savings of $58 M. The cost would depend on the availability of enhanced federal match for the population that would become newly eligible as a result of discontinuing the state's 209(b) status. This estimate covers the 10-year period from January 1, 2014, to December 31, 2023; it will not impact the upcoming biennium.

Health insurance provisions and revisions to the Indiana Check-Up Plan/HIP will bring Indiana statutes into conformity with federal requirements of the ACA.

Provisions of the bill dealing with the Indiana Check-Up Plan/HIP concerning a minimum contribution of $100 per year would require individual contributions of $890,000 into HIP power accounts resulting in state savings of $302,600.

(Revised) The bill also has provisions concerning the implementation of federal health care reform legislation. The bill exempts certain provisions of the federal health care reform legislation. The bill would prohibit an agency from applying for or accepting a grant that complies with or implements provisions of the ACA without the review of the grant by the Legislative Council. The immediate impact of these provisions should essentially be neutral since by prohibiting implementation activities, the bill would maintain the status quo. Any potential fiscal impact would be related to state failures to meet implementation deadlines if the ACA is subsequently implemented. Additionally, if the insurance exchange deadlines are missed, the state may be required to accept a federal insurance exchange.

The bill also requires the OMPP to apply for a Medicaid state plan amendment by January 1, 2012, to create a new state entitlement for family planning services for individuals with incomes at or below 300% of the federal poverty level.

Additional Details:

Provisions concerning the Implementation of Federal Health Care Reform Legislation: The bill would prohibit an agency from applying for or accepting a grant that complies with or implements provisions of the ACA without the review of the grant by the Legislative Council. This provision may require significant review activity of the Legislative Council as the scope of funding included in the ACA is much broader than the health care reform activities. Along with opportunities for federal grant assistance to comply with health care reform provisions, the ACA included extensions and expansions of existing grant programs in public health, medical education, community health clinics, and other programs. If a state agency accepts funding or acts as the single state agency for grants included in the ACA, Legislative Council review would be required to receive what may have been routine funding in the past for an agency activity. This provision would not affect grants that have already been approved, nor would it prevent a private not-for-profit corporation from accepting federal grant funds or moving to implement the ACA.

(Revised) The bill prohibits with exceptions for certain provisions, a state agency from implementing or preparing to implement the Patient Protection and Affordable Care Act. The Department of State Revenue is specified to be the only agency that may cooperate, work, or adopt rules to comply with the ACA if specifically authorized by state statute, although much of the bill authorizes actions that are intended to bring the state into compliance with the ACA. All other agencies are prohibited from adopting rules to implement or comply with the ACA unless the rules are specifically authorized by state statute.

The immediate impact of these provisions should essentially be neutral since by prohibiting implementation activities, the bill would maintain the status quo. Any potential fiscal impact would be related to state failures to meet implementation deadlines if the ACA is subsequently implemented. Additionally, if the insurance exchange deadlines are missed, the state may be required to accept a federal insurance exchange.

Medicaid Family Planning State Plan Amendment: The bill requires the OMPP to apply for a Medicaid state plan amendment by January 1, 2012, to create a new state entitlement for family planning services for individuals with incomes at or below 300% of the federal poverty level. The Family Planning State Plan service is a provision within the ACA - it is unclear as to whether other provisions of the bill would allow OMPP to comply with this provision. Implementation of this provision would have an indeterminate fiscal impact - in the long term this provision should result in savings due to decreased numbers of Medicaid maternity-related expenses. In order to implement this provision, an unknown level of administrative expenses would be necessary as well as the cost of services for the first full year before any potential savings could begin to be realized. Additionally, FSSA would need to consider processing an increased number of Medicaid applications for family planning services , a potential increase in the number of coordination of benefits cases, and interfacing with the required presumptive eligibility system. Family planning services are reimbursed at an enhanced match rate of 90% by the federal government. Other family planning-related services and transportation expenses would be matched at the state's routine FMAP of approximately 66.9%. Family planning services have the potential to reduce Medicaid costs by reducing the number of unintended pregnancies or by increasing the period of time between pregnancies. Additional services that may be covered under this option could also reduce other public health expenditures related to treatment of sexually transmitted infections in the uninsured population.

The bill does not allow for the eligibility to be decreased in the instance the ACA health care reform is implemented as of January 1, 2014. Family planning services offered under the Medicaid State Plan would be available to insured individuals.

Income Eligibility Levels: The bill specifies the income eligibility be set at the Medicaid CHIP state plan level. The CHIP income eligibility level is currently 300% of FPL. The ACA specifies that the income eligibility for family planning services may not exceed the highest income eligibility level established under the state's plan for pregnant women. This is currently established at 200% of the FPL. This discrepancy may be addressed through an option to use the same methodology used to determine the eligibility of a pregnant woman by counting a pregnant woman as a household of two individuals. This would raise the income standard to 269% of FPL for a single individual. It appears that this discrepancy would leave a group of individuals that the statute requires to be covered for whom federal reimbursement would not be available. It is unclear as to whether a 100% state-funded program is intended to cover these individuals or if Medicaid funds at the normal matching rate of 66.9% could be used.

Individuals Eligible for Services: The bill specifies that the state plan amendment will include women and men as eligible for services. The Centers for Medicare and Medicaid Services (CMS) guidance on eligibility specifies that all individuals in a state who are not pregnant and who meet the income eligibility guidelines must be included for services. CMS has indicated that states may not exclude individuals based on gender or age - states may not exclude adolescents or men. Just as in the Medicaid program, individuals with private insurance coverage would not be barred from eligibility for Medicaid family planning coverage - insurance would be billed first with Medicaid serving as the payer of last resort.

Presumptive Eligibility: The bill requires OMPP to include presumptive eligibility in the state plan amendment. Under this provision, the state would permit certain qualified family planning providers to grant temporary eligibility to individuals. Providers would be paid for services delivered during the presumptive eligibility period, and the state would receive federal reimbursement at the appropriate level - either the 90% available for family planning services or approximately 66.9% for family planning-related services. Documentation of citizenship is not required for an individual to be determined presumptively eligible. It is required for an individual to continue to be enrolled for family planning services.

Covered Services and Products: The bill specifies that family planning services may not include the use of a drug or a device intended to terminate a pregnancy after fertilization occurs. The CMS guidance issued July 2, 2010, states that states are required to cover the entire package of family planning services and supplies that are covered under their full-benefit Medicaid State Plan. States may be reimbursed at the enhanced 90% matching rate for these services and supplies. The state may request the restriction specified for family planning products available in the state plan amendment or amend the current State Plan to restrict products available to all Medicaid recipients. It is not known if CMS would approve this provision of the bill. In addition, states are required to cover *at least some* family planning-related services in the state plan amendments. These services may be defined by the state and consist of diagnostic and treatment services provided in a family planning setting as a part of or as follow-up to a family planning visit. These services would be reimbursed at the routine state FMAP (About 66.9%).

Other Federal Requirements for Family Planning State Plan Amendments: All general Medicaid rules apply to family planning state plan amendments. States may not impose premiums, cap enrollment, or impose cost-sharing requirements for family planning services. States are also required to cover transportation services needed by family planning service eligibles. States may be allowed to provide compensation to providers for enrollment assistance activities such as presumptive eligibility applications or continuing Medicaid eligibility applications.

Eligibility Revision for Medicaid Aged, Blind, and Disabled- Medicaid 209(b) Status: The bill would allow FSSA to revise the state's status as a Medicaid 209(b) state to a 1634(a) status, which recognizes an SSI

disability determination as eligibility for Medicaid and discontinues the spend-down requirement. This provision would become effective with the implementation of ACA Medicaid provisions. Any increase in the aged, blind, and disabled population on Medicaid that might result will have an unknown impact on the 100% state-funded burial assistance program for aged, blind, and disabled Medicaid recipients. By electing the 1634(a) status, SSI eligibles would be fully eligible for Medicaid benefits with no need for a separate Medicaid application process or a spend-down calculation, eliminating the duplicative OMPP eligibility process and the need to administer the spend-down program.

If FSSA determines to eliminate the 209(b) status, the number of aged, blind, and disabled individuals on Medicaid may increase. OMPP has estimated that initially an additional 23,000 aged, blind, or disabled individuals would become eligible for Medicaid. However, with the implementation of the ACA, the cost to the state to convert would depend on the number of the newly eligible population that would be assumed at the 100% federal match rate for the initial years of ACA implementation. OMPP has estimated that depending on how the federal ACA is implemented with respect to 209(b) states, the ten-year fiscal impact of this change could vary from a cost of $667 M to a savings of $58 M.

Any increase in the aged, blind, and disabled population on Medicaid will have an impact on the 100% state-funded burial assistance program for aged, blind, and disabled Medicaid recipients. This program currently makes payments to funeral directors and cemeteries as defined in state statute. Expenditures were approximately $1.38 M in FY 2010. The fiscal impact on this program would depend on the ultimate configuration of the ACA implementation.

Elimination of the 209(b) status would eliminate the spend-down program. States that elected 209(b) status were required to implement a program for the medically needy to allow individuals who are otherwise eligible, to spend-down excess income to become eligible for Medicaid. If the state elects the 1634(a) status, SSI eligibles would be fully eligible for Medicaid benefits with no need for spend-down, eliminating the need to administer that program. OMPP has supplied an estimate of $141 M of savings over a ten-year period, associated with the elimination of the spend-down for persons with incomes above 133% of the FPL. (There was an average of 37,854 total members per month that had spend- down obligations during FY 2008.)

Elimination of the 209(b) status would allow Medicaid to discontinue duplicative administrative expenses. Indiana requires an application for Medicaid and does an eligibility determination separate from the SSI process. (The Indiana Medical Review Team currently conducts the medical eligibility determination for the Social Security Administration.) If the 209(b) status were to be eliminated, Medicaid eligibility would be determined simultaneously with the Social Security Administration's determination for SSI benefits. Medicaid applications might only be required for applications for long-term care or waiver services, or for individuals denied SSI due to excess income but otherwise eligible. Administrative cost savings associated with the elimination of the separate eligibility determination process have been estimated by OMPP to be $3 M over the ten-year period from 2014 to 2023.

Health Insurance Provisions: The health insurance provisions included in the bill will bring state statutes into compliance with the provisions of the ACA. Since the Department of Insurance must already comply and implement the ACA provisions, there is no additional fiscal impact associated with the change to the state statutes.

Indiana Check-Up Plan [Healthy Indiana Plan (HIP)] Health Care Reform Provisions: The provisions of the bill regarding HIP would allow the operation of the program under the current state statute until the effective date of the ACA implementation on January 1, 2014, at which time HIP would be brought into

compliance with ACA requirements. The bill would allow FSSA the authority to decrease the income eligibility for HIP to 133% of the federal income poverty level (FPL), revise the benefit plan, and make any other changes that would allow Indiana to use the HIP design to cover individuals eligible for Medicaid resulting from the passage of the ACA. The fiscal impact of these provisions would depend on federal requirements and actions taken by FSSA.

Indiana Check-Up Plan [Healthy Indiana Plan (HIP)] Provisions: HIP Minimum Contribution: The bill would require a minimum contribution of $8.33 per month, or a total of $100 per year, from all participants in the HIP program. Currently, approximately 8,900 individuals are exempted for various reasons from making sliding scale-based payments into their health savings account. This provision would result in annual health savings account deposits of $890,000 being made by participating individuals rather than the state and federal governments. The state share of the savings would be about $302,600. HIP is funded with cigarette tax dollars deposited in the Indiana Check-Up Plan Trust Fund.

HIP Assistance or Incentives: The bill would allow a not-for-profit organization that is not affiliated with a health care plan to contribute up to 75% of an individual's required premium payment. This provision would allow not-for-profits to provide some assistance to HIP enrollees either on a temporary or long-term basis. The bill would also allow an insurer or managed care organization contracted with the OMPP to provide rewards as incentives. The bill specifies that the incentives cannot be given to induce an individual to receive services from a particular health care provider or facility. Rewards must be deposited in the individual's health care account, or if the account is fully funded, it may be provided directly to the individual. These provisions would have no direct fiscal impact on the state.

Medicaid is jointly funded by the state and federal governments. The effective state share of program expenditures is approximately 34% for most services. Medicaid medical services are matched by the effective federal match rate (FMAP) in Indiana at approximately 66%. Certain family planning services and supplies are matched with 90% federal funding. Administrative expenditures with certain exceptions are matched at the federal rate of 50%. Federal ARRA enhanced Medicaid stimulus funding will be available to the state until June 30, 2011.

209(b) Background Information: Indiana is one of approximately 11 states with more restrictive financial criteria than SSI and one of only 2 states with a more restrictive definition of disability. [Current Indiana statute provides that an SSI recipient, in order to be eligible for Medicaid services, must have a physical or mental impairment or disease that appears reasonably certain to continue for at least four years (SEA 79-2000). The SSI medical standard requires a duration of 12 months, rather than 4 years. However, although Indiana has not relinquished its 209(b) status, as a result of court cases the medical definition of disability has, in practice, been made consistent with the national standard.]

Explanation of State Revenues:

Explanation of Local Expenditures: *Potential 209(b) Status Elimination:* The potential change in the number of SSI beneficiaries eligible for Medicaid along with the elimination of spend-down requirements and the provision of subsidized coverage under the ACA may have an impact on township poor relief by decreasing the number of requests for assistance due to lack of Medicaid or other coverage, requests for assistance due to current Medicaid spend-down requirements, and requests for burial assistance. The extent to which the bill might decrease requests for township assistance is indeterminate.

Explanation of Local Revenues:

State Agencies Affected: FSSA, OMPP, DFR; Department of Insurance.

Local Agencies Affected: Local government-owned hospitals; Township trustees.

Information Sources: FSSA; Social Security Administration; Guttmacher Institute, Memo and attachments: "CMS Guidance on Family Planning State Plan Amendments" at http://www.guttmacher.org/pubs/Family-planning-SPA.pdf

Fiscal Analyst: Kathy Norris, 317-234-1360.