

SENATE BILL No. 434

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2-154.8; IC 12-15-1-18; IC 12-15-2; IC 12-15-2.2; IC 12-15-4; IC 12-15-6-4.

Synopsis: Children's health insurance. Increases for one year the family income eligibility standard for Medicaid for a pregnant woman or a child who is less than 19 years of age to 200% of the federal income poverty level. Requires the office of Medicaid policy and planning to use all funds appropriated for outreach to conduct outreach activities in order to encourage individuals who are eligible for Medicaid but are not enrolled in the Medicaid program to enroll in the Medicaid program. Requires the office of Medicaid policy and planning to provide Medicaid services to a child who is less than 19 years of age and who is eligible for Medicaid for 12 consecutive (Continued next page)

Effective: Upon passage; November 1, 1997 (retroactive); July 1, 1998.

Simpson, Johnson

January 13, 1998, read first time and referred to Committee on Planning and Public Services.



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months from the date when the child's eligibility is determined or until the child becomes 19 years of age, whichever occurs first. Provides that certain entities may determine that a pregnant woman or child is presumptively eligible for Medicaid. Provides that presumptive eligibility ends when a formal determination of Medicaid eligibility is made by an employee of a county office of family and children or the last day of the month following the month during which a presumptive eligibility determination is made, whichever occurs earlier. Provides that applications for Medicaid may be made at a hospital, provider's office, school, day care center, county health department, county office of family and children, or other location in the county where the applicant resides that is approved by the office of Medicaid policy and planning. Allows an interested entity to apply to the office of Medicaid policy and planning to serve as an outstationing center. Requires the office of Medicaid policy and planning to adopt rules to do the following: (1) Establish an eligibility system that relies on objective measures rather than subjective judgments. (2) Consolidate filing an application and interviewing an applicant into one meeting. Provides that a copayment applies to Medicaid services provided to an individual who is a member of a family with an annual income of at least 150% of the federal income poverty level. Establishes the children's health insurance program advisory panel to advise the governor in designing and implementing a children's health insurance program in Indiana. Provides several features that the panel's final program design must include. Establishes a pilot program to allow political subdivisions to form a community care network for pooling and administering funds to be used in providing or arranging to provide health services and items to the employees and residents of the political subdivisions.

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Introduced

Second Regular Session 110th General Assembly (1998)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 1997 General Assembly.

SENATE BILL No. 434

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-7-2-154.8 IS ADDED TO THE INDIANA
2 CODE AS A NEW SECTION TO READ AS FOLLOWS
3 [EFFECTIVE UPON PASSAGE]: **Sec. 154.8. "Qualified entity", for**
4 **purposes of IC 12-15-2.2, has the meaning set forth in**
5 **IC 12-15-2.2-2.**

6 SECTION 2. IC 12-15-1-18 IS ADDED TO THE INDIANA CODE
7 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
8 UPON PASSAGE]: **Sec. 18. The office shall use all funds that are**
9 **appropriated to the office for outreach purposes to conduct**
10 **outreach activities in order to encourage individuals who are:**

11 (1) **eligible for Medicaid; and**
12 (2) **not enrolled in the Medicaid program;**
13 **to apply for and enroll in the Medicaid program.**

14 SECTION 3. IC 12-15-2-15.6 IS ADDED TO THE INDIANA
15 CODE AS A NEW SECTION TO READ AS FOLLOWS



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1 [EFFECTIVE JULY 1, 1998]: **Sec. 15.6. (a) Notwithstanding sections**
 2 **13, 14, 15, and 15.5 of this chapter, an individual:**

3 (1) whose family income does not exceed two hundred percent
 4 (200%) of the federal income poverty level for the same size
 5 family; and

6 (2) who is otherwise eligible for Medicaid under section 13, 14,
 7 15, or 15.5 of this chapter;

8 is eligible for Medicaid.

9 (b) The state's share of any treatment received by an individual
 10 who is eligible for Medicaid under this section is calculated under
 11 Title XXI of the federal Social Security Act.

12 (c) This section expires June 30, 1999.

13 SECTION 4. IC 12-15-2-15.7 IS ADDED TO THE INDIANA
 14 CODE AS A NEW SECTION TO READ AS FOLLOWS
 15 [EFFECTIVE UPON PASSAGE]: **Sec. 15.7. An individual who is less**
 16 **than nineteen (19) years of age and who is eligible for Medicaid**
 17 **under section 12, 14, 15, or 15.5 of this chapter is eligible to receive**
 18 **Medicaid until the earlier of the following:**

19 (1) The end of a period of twelve (12) consecutive months
 20 following a determination of the individual's eligibility for
 21 Medicaid.

22 (2) The individual becomes nineteen (19) years of age.

23 SECTION 5. IC 12-15-2.2 IS ADDED TO THE INDIANA CODE
 24 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 25 UPON PASSAGE]:

26 **Chapter 2.2. Presumptive Eligibility for Pregnant Women and**
 27 **Children**

28 **Sec. 1. This chapter applies to an individual who may be eligible**
 29 **for Medicaid under the following statutes:**

30 (1) IC 12-15-2-11.

31 (2) IC 12-15-2-12.

32 (3) IC 12-15-2-13.

33 (4) IC 12-15-2-14.

34 (5) IC 12-15-2-15.

35 (6) IC 12-15-2-15.5.

36 (7) IC 12-15-2-15.6.

37 **Sec. 2. As used in this chapter, "qualified entity" means an**
 38 **entity that:**

39 (1) is a provider that is eligible to receive payments under this
 40 article; or

41 (2) is authorized:

42 (A) to determine the eligibility of a child to:

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- 1 (i) participate in a Head Start program under 42 U.S.C.
 2 9831 et seq.;
- 3 (ii) receive child care services for which financial
 4 assistance is provided under the Child Care and
 5 Development Block Grant Act of 1990 under 42 U.S.C.
 6 9858 et seq.; or
- 7 (iii) receive assistance under the women, infants, and
 8 children nutrition program (as defined in
 9 IC 16-35-1.5-5); and
- 10 (B) by the office to be capable of making a determination
 11 described in section 5(1) of this chapter.

12 **Sec. 3.** An entity described in section 2(2)(A) of this chapter may
 13 apply to the office, on a form provided by the office, for
 14 authorization to be a qualified entity under this chapter.

15 **Sec. 4.** The office shall provide each qualified entity with the
 16 following:

- 17 (1) Application forms for Medicaid.
 18 (2) Information on how to assist pregnant women, parents,
 19 guardians, and other individuals in completing and filing the
 20 application forms.

21 **Sec. 5.** The office shall provide Medicaid services to a child or
 22 pregnant woman during a period that:

- 23 (1) begins on the date on which a qualified entity determines,
 24 on the basis of preliminary information, including the
 25 previous year's tax return or a recent pay stub, that the
 26 family income of the child or pregnant woman does not exceed
 27 the applicable family income level of eligibility for the child or
 28 pregnant woman for Medicaid under IC 12-15-2; and
 29 (2) ends on the earlier of the following:

30 (A) The date on which a determination is made by a
 31 representative of the county office with respect to the
 32 eligibility of the child or pregnant woman for Medicaid
 33 under IC 12-15-2.

34 (B) The last day of the month following the month in which
 35 the qualified entity makes the determination described in
 36 subdivision (1).

37 **Sec. 6.** A qualified entity that determines that a child or
 38 pregnant woman is presumptively eligible for Medicaid shall do the
 39 following:

- 40 (1) Notify the office of the determination within five (5)
 41 working days after the date on which the determination is
 42 made.

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(2) Inform:**(A) the parent, guardian, or custodian of the child; or****(B) the pregnant woman;**

that an application for Medicaid is required to be made at a location listed in IC 12-15-4-1 in the county where the child or the pregnant woman resides not later than the last day of the month following the month during which the determination is made.

Sec. 7. If a child or pregnant woman is determined to be presumptively eligible for Medicaid under this chapter, the:

(1) child's parent, guardian, or custodian; or**(2) pregnant woman;**

shall complete an application for Medicaid as provided in IC 12-15-4 not later than the last day of the month following the month during which the determination is made.

Sec. 8. The office shall adopt rules under IC 4-22-2 to implement this chapter.

SECTION 6. IC 12-15-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) An application or a request for Medicaid for an individual must be **made:**

(1) made to the county office of the county in which the applicant resides; and**(2) in the manner required by the office; and****(2) at one (1) of the following locations in the county where the applicant resides:****(A) A hospital licensed under IC 16-21.****(B) The office of a provider who is eligible to receive payments under this article.****(C) A public or private elementary or secondary school.****(D) A day care center licensed under IC 12-17.2.****(E) The county health department.****(F) The county office.****(G) Any other location approved by the office under subsection (b).**

(b) An entity described in subsection (a)(2) other than the county office may apply to the office, on a form provided by the office, for authorization to serve as an outstationing center where individuals may apply for Medicaid.

(c) One (1) or more employees at each outstationing center shall:

(1) accept applications for Medicaid; and**(2) conduct interviews with applicants;**

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1 during hours and days of the week agreed upon by the office and
2 the outstationing center.

3 (d) The office shall provide each outstationing center with the
4 materials and training needed by the outstationing center to
5 comply with this section.

6 (e) An outstationing center shall forward:

7 (1) each application taken by the outstationing center; and

8 (2) any accompanying materials;

9 to the county office located in the same county as the outstationing
10 center at least one (1) time each week. The county office shall then
11 make the final determination of an applicant's eligibility for
12 Medicaid.

13 SECTION 7. IC 12-15-4-5 IS ADDED TO THE INDIANA CODE
14 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
15 1, 1998]: **Sec. 5. In determining the eligibility of an applicant or
16 recipient for Medicaid, the office shall do the following:**

17 (1) Establish a procedure for eligibility determinations that is
18 primarily based on objective measures rather than subjective
19 judgments.

20 (2) Consolidate the filing of an application for assistance by an
21 applicant and the required interview of the applicant into one

22 (1) meeting.

23 SECTION 8. IC 12-15-6-4 IS AMENDED TO READ AS
24 FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 4. (a) A copayment
25 applies to all services except the following:**

26 (1) Services furnished to individuals less than eighteen (18) years
27 of age.

28 (2) Services furnished to pregnant women if the services relate to
29 the pregnancy or to any other medical condition that might
30 complicate the pregnancy.

31 (3) Services furnished to individuals who are inpatients in
32 hospitals, nursing facilities, including intermediate care facilities
33 for the mentally retarded, and other medical institutions.

34 (4) Emergency services as defined by regulations adopted by the
35 Secretary of the United States Department of Health and Human
36 Services.

37 (5) Services furnished to individuals by health maintenance
38 organizations in which the individuals are enrolled.

39 (6) Family planning services and supplies described in 42 U.S.C.
40 1396d(a)(4)(C).

41 (7) Physical examinations to determine the need for medical
42 services.



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1 (b) Notwithstanding subsection (a), a copayment applies to a
 2 service listed under subsection (a) if the individual to whom the
 3 service is provided is a member of a family with an annual income
 4 of at least one hundred fifty percent (150%) of the federal income
 5 poverty level.

6 SECTION 9. [EFFECTIVE NOVEMBER 1, 1997
 7 (RETROACTIVE)] (a) As used in this SECTION, "panel" refers to
 8 the children's health insurance program advisory panel established
 9 by subsection (c).

10 (b) As used in this SECTION, "program" refers to the
 11 children's health insurance program established to arrange for
 12 health services and related items to uninsured and underinsured
 13 children in Indiana.

14 (c) The children's health insurance program advisory panel is
 15 established.

16 (d) The panel consists of twenty (20) members appointed by the
 17 governor to include the following:

18 (1) The director of the program, who serves as chair of the
 19 panel.

20 (2) Two (2) members of the senate, who may not be from the
 21 same political party.

22 (3) Two (2) members of the house of representatives, who may
 23 not be from the same political party.

24 (4) Fifteen (15) members, each of whom has expertise in at
 25 least one (1) of the following:

26 (A) Delivery of health care services.

27 (B) Health care administration.

28 (C) Health insurance.

29 (D) Education administration.

30 (E) Children's health care needs.

31 (F) Business administration.

32 (e) Each member of the panel serves as a member for the
 33 duration of the panel.

34 (f) The panel shall meet at least one (1) time each month upon
 35 the call of chair.

36 (g) At least eleven (11) members of the panel must be present to
 37 establish a quorum. The affirmative vote of at least eleven (11)
 38 members of the panel is required for the panel to take any action.

39 (h) The panel may appoint subcommittees to assist the panel in
 40 its work.

41 (i) The panel shall do the following:

42 (1) Review federal requirements for the children's health



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- 1 insurance program, including eligibility, outreach, plan
 2 design, coordination with private sector benefits, and fiscal
 3 impact.
- 4 (2) Evaluate the current Medicaid program and recommend
 5 how to coordinate the program with Medicaid.
- 6 (3) Evaluate other state and federal block grant programs,
 7 including programs concerning children with special health
 8 care needs, maternal and child health, and immunizations,
 9 and recommend how to coordinate the program with those
 10 programs.
- 11 (4) Recommend the design and coverage of program plans.
- 12 (5) Collect and evaluate public input on how to implement the
 13 program in Indiana.
- 14 (6) Recommend a blueprint for implementing the program,
 15 including fiscal impact, outreach, administrative structure,
 16 and evaluation.
- 17 (j) The panel shall design a long term children's health
 18 insurance program that includes the following:
- 19 (1) Establishing health benefits managers as persons that have
 20 responsibility for the following:
- 21 (A) Serving as a qualified entity (as defined in
 22 IC 12-15-2.2-2) in order to determine the presumptive
 23 eligibility for pregnant women and children for Medicaid
 24 as provided in IC 12-15-2.2.
- 25 (B) Determining whether an individual is eligible to enroll
 26 in the program.
- 27 (C) Assisting an eligible individual under clauses (A) and
 28 (B) to select a primary care provider.
- 29 (D) Education concerning the following:
- 30 (i) The appropriate use of health services and items.
- 31 (ii) Preventive care.
- 32 (iii) Parental responsibilities for a child's health care.
- 33 (E) Issuing eligibility cards.
- 34 (2) Entering into agreements with at least one (1) person in
 35 each county to provide services as a health benefits manager,
 36 as provided in subdivision (1).
- 37 (3) Requiring that a person that provides health benefits
 38 manager services may not have a financial interest in the
 39 provider of health services and related items.
- 40 (4) Allowing the health benefits manager in each county to
 41 locate at least one (1) office within:
- 42 (A) each county health department;

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- 1 **(B) federally qualified health centers consistent with**
 2 **federal Medicaid outstationing requirements; or**
 3 **(C) comprehensive primary care delivery sites serving**
 4 **large numbers of Medicaid and uninsured patients as**
 5 **determined appropriate by the office of Medicaid policy**
 6 **and planning with the assistance of the program.**
- 7 **(5) Allowing a county health department to contract to**
 8 **provide health benefits manager services as provided in**
 9 **subdivision (2).**
- 10 **(6) Monitoring the persons that provide health benefits**
 11 **manager services for compliance with this subsection.**
- 12 **(7) Assessing monetary penalties on a person serving as a**
 13 **health benefits manager for failing to comply with the**
 14 **requirements of this subsection.**
- 15 **(8) Adopting a sliding scale formula that specifies the**
 16 **premiums, if any, to be paid by the parent or guardian of a**
 17 **child enrolled in the program based on the parent's or**
 18 **guardian's annual income.**
- 19 **(9) Annually adjusting the participation requirements to**
 20 **reflect the amount of money available to provide health**
 21 **services and related items to children enrolled in the program.**
- 22 **(10) Establishing and administering a program fund to**
 23 **provide premium assistance from the state to children**
 24 **enrolled in the program.**
- 25 **(11) Providing that a child who enrolls in the program must**
 26 **meet the following requirements:**
- 27 **(A) The child and the child's family do not have access to**
 28 **affordable health insurance through an employer.**
- 29 **(B) The child and the child's family have not participated**
 30 **in a health insurance program for at least one (1) year**
 31 **before enrolling in the children's health insurance**
 32 **program.**
- 33 **(C) The child's family agrees to provide copayments for**
 34 **services based on a sliding fee scale developed by the**
 35 **program.**
- 36 **(k) The program shall, subject to approval by the panel, submit**
 37 **a state plan outlining Indiana's initial children's health insurance**
 38 **program to the United States Secretary of Health and Human**
 39 **Services before July 1, 1998.**
- 40 **(l) The program shall, subject to approval by the panel, amend**
 41 **the state plan outlining Indiana's children's health insurance**
 42 **program to describe a program including the elements required**



1 under subsection (j) before April 1, 1999.

2 (m) If the program designed by the panel, including the
3 elements required under subsection (j), includes the provision of
4 health services both to children who are eligible for Medicaid and
5 to children who are not eligible for Medicaid, the program shall
6 apply for any necessary waivers from the United States Secretary
7 of Health and Human Services to provide health services to the
8 children in both groups.

9 (n) The panel shall provide a final report to the governor and
10 the legislative council before November 1, 1998.

11 (o) This SECTION expires January 1, 2000.

12 SECTION 10. [EFFECTIVE JULY 1, 1998] (a) This SECTION
13 does not apply to services provided by a facility licensed under
14 IC 16-28.

15 (b) As used in this SECTION, "community care network"
16 means a system of providing or arranging for health services and
17 related items for the residents of a community within the needs and
18 resources of the community.

19 (c) As used in this SECTION, "political subdivision" has the
20 meaning set forth in IC 34-4-16.5-2.

21 (d) One (1) or more political subdivisions may elect to
22 participate in a pilot program under this SECTION by forming a
23 community care network for the purpose of pooling and
24 administering funds to be used in providing or arranging to
25 provide health services and related items to at least one (1) of the
26 following groups:

27 (1) The employees of the political subdivisions.

28 (2) Enrollees whose health services and items are provided
29 under IC 12-15, if approved by the office of the secretary.

30 (3) The enrollees of the children's health insurance program.

31 (4) The employees of private employers, if appropriate.

32 (5) Other groups of residents approved for inclusion by the
33 board of directors established under subsection (g).

34 (e) A community care network is authorized to pool funds
35 provided to the community care network by the political
36 subdivisions for financing and arranging to provide health services
37 and related items to the employees and residents of the political
38 subdivisions.

39 (f) A community care network is governed by a board of
40 directors.

41 (g) A board of directors must have an odd number of members
42 that is not less than five (5) members but not more than eleven (11)



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members.

(h) Members of a board of directors must include the following:

(1) Representatives of the political subdivisions establishing the community care network.

(2) Representatives of the employees of the political subdivisions establishing the community care network.

(3) Representatives of the residents, if applicable, of the political subdivision establishing the community care network.

(4) Representatives of providers who will provide health services and related items in the community care network.

The political subdivisions establishing the community care network must agree to the number of representatives under subdivisions (1) through (4).

(i) Each member of a board of directors must have demonstrated expertise in health care financing or health care delivery systems, or both.

(j) The executives of the political subdivisions establishing the community care network must:

(1) agree to the number of members each executive may appoint; and

(2) after reaching agreement under subdivision (1), appoint members;

to the board of directors.

(k) The board of directors of each community care network shall establish a community care network fund to pay for health services and related items for participants in the network.

(l) The board of directors shall establish guidelines for the community care network that include the following:

(1) Quality assurance.

(2) Benefit levels.

(3) Improved access to health care.

(4) Cost containment through early intervention.

(5) Medical staff expertise.

(6) Coordination of community resources.

(7) Community, parental, and school involvement.

(m) A community care network must be certified by the state department, the department of insurance, and the office of the secretary of family and social services under this SECTION. The department of insurance must certify that a community care network possesses necessary financial reserves.

(n) A community care network may contract with:

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1 (1) an accident and sickness insurance company, including
2 reimbursement agreements under IC 27-8-11; or

3 (2) a health maintenance organization (as defined in
4 IC 27-13-1-19);

5 to provide or arrange for the provision of health services and items
6 for the employees and residents of the political subdivisions
7 establishing the community care network.

8 (o) Any plan of self-insurance must include an aggregate
9 stop-loss provision.

10 (p) A contract under subsection (o) may be awarded only after
11 the community care network uses a public bidding process for the
12 contract.

13 (q) The political subdivisions establishing the community care
14 network:

15 (1) shall appropriate to the community care network any
16 funds necessary to provide health services and related items
17 for employees of the political subdivisions; and

18 (2) may appropriate funds for health services and items
19 provided to other residents of the political subdivisions.

20 (r) If Medicaid funds are used by a community care network to
21 pay for health services and related items, the office:

22 (1) shall assure that patients served by federally qualified
23 health centers, rural health clinics, and other primary care
24 providers that target uninsured or Medicaid patients have
25 equal or better access to comprehensive quality primary care
26 services; and

27 (2) may, with the assistance of the state department, apply to
28 the Secretary of the United States Department of Health and
29 Human Services for any waivers necessary to implement this
30 SECTION.

31 (s) If the state department of health and the office of Medicaid
32 policy and planning seek a waiver under IC 12-15 to establish a
33 managed care program or other demonstration project, the state
34 department and the office shall not seek a waiver of:

35 (1) federally qualified health centers and rural health clinic
36 services as mandatory Medicaid services under:

37 (A) 42 U.S.C. 1396a(10)(A);

38 (B) 42 U.S.C. 1396d(a)(2)(B); and

39 (C) 42 U.S.C. 1396d(a)(2)(C); or

40 (2) reasonable cost reimbursement for federally qualified
41 health centers and rural health clinics under 42 U.S.C.
42 1396a(a)(13)(E).

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- 1 **(t) A community care network established under this SECTION**
- 2 **shall file an annual report with the state department of health not**
- 3 **later than March 1 that provides information requested by the**
- 4 **state department of health.**
- 5 **(u) Not later than January 1, 2002, the state department of**
- 6 **health, with the assistance of the department of insurance and the**
- 7 **office of the secretary of family and social services, shall begin to**
- 8 **evaluate the community care networks established under this**
- 9 **SECTION.**
- 10 **(v) Not later than November 1, 2002, the state department of**
- 11 **health shall report to the legislative council and the governor**
- 12 **regarding whether community care networks should be established**
- 13 **legislatively on an ongoing basis.**
- 14 **(w) A community care network may not begin operation before**
- 15 **January 1, 1999.**
- 16 **(x) This SECTION expires January 1, 2003.**
- 17 **SECTION 11. [EFFECTIVE UPON PASSAGE] (a) Not later than**
- 18 **January 1, 1999, the office of the secretary of family and social**
- 19 **services, with the assistance of the office of Medicaid policy and**
- 20 **planning, shall adopt rules under IC 4-22-2 to carry out**
- 21 **IC 12-15-4-1, as amended by this act, and IC 12-15-4-5, as added**
- 22 **by this act.**
- 23 **(b) This SECTION expires January 1, 2000.**
- 24 **SECTION 12. An emergency is declared for this act.**

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