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FISCAL IMPACT STATEMENT

LS 7776

BILL NUMBER: SB 503

NOTE PREPARED: Feb 11, 2007

BILL AMENDED: Feb 8, 2007

SUBJECT: Healthier Indiana Insurance Program.

FIRST AUTHOR: Sen. Miller

FIRST SPONSOR:

BILL STATUS: CR Adopted - 1st House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State and Local

Summary of Legislation: (Amended) *Healthier Indiana Insurance Program*: This bill establishes the Healthier Indiana Insurance Program and the Healthier Indiana Insurance Program Fund.

Expansion of Medicaid Pregnancy-Related Services: The bill requires the Office of Medicaid Policy and Planning (OMPP) to apply to the United States Department of Health and Human Services for: (1) a demonstration waiver to develop and implement the Healthier Indiana Insurance Program to cover certain individuals; and (2) an amendment to the state Medicaid plan to cover pregnancy-related services for pregnant women whose annual household income does not exceed 200% of the federal income poverty level.

Health for High-Risk Hoosiers Program: The bill requires the Indiana Comprehensive Health Insurance Association (ICHIA) to provide, and referred program participants to participate in, medical management services.

Availability of Healthier Indiana Insurance Plan to Individuals and Employers: The bill requires insurers contracting to provide insurance policies for the Healthier Indiana Insurance Program with the Office to make the same health insurance available to individuals and certain employers meeting certain specifications.

Hospital Payment Changes: The bill makes funding changes to the Hospital Care for the Indigent Program (HCI), the Municipal Disproportionate Share Program, and the Medicaid Indigent Care Trust Fund.

Hospital Care for the Indigent Property Tax Levy Revisions: The bill amends the formula in determining a county's Hospital Care for the Indigent property tax levy and the applicable years.

Reporting: The bill requires the Office of Medicaid Policy and Planning to report to the Health Finance Commission regarding the status of the development and implementation of the Healthier Indiana Insurance Program during the 2007 interim session.

Small Employer Health Insurance Purchasing Pool: The bill would require the Department of Insurance and the Office of the Secretary to implement a program to allow certain small employers to join together to purchase health insurance.

Effective Date: Upon passage; July 1, 2007.

Explanation of State Expenditures: (Revised) *Summary:* The bill establishes the Healthier Indiana Insurance Program as a demonstration waiver project under the state Medicaid program. The program is to provide health insurance to custodial parents having an annual household income of not more than 200% of the federal poverty level (FPL) and single individuals having an annual household income of between 100% and 200% of the FPL. Custodial parents may be added to the eligible population of Medicaid and CHIP and would be considered an eligibility expansion group. Childless adults are typically not eligible for Medicaid unless certain disability or age and income standards are met. The Office would need to demonstrate fiscal neutrality within the program in order to add this group in the demonstration waiver. Medicaid waivers, by definition must demonstrate fiscal neutrality and are approved and monitored by the Centers for Medicare and Medicaid Services (CMS) for fiscal neutrality through the term of the demonstration. The bill does not entirely delineate the funding mechanism for this program.

The bill also requires a Medicaid State Plan amendment to expand Medicaid eligibility for pregnant women and infants from 150% of the FPL to 200%. This provision would create an entitlement for services to a total population estimated by OMPP to be approximately 14,733 pregnant women. Total cost of this provision is estimated by OMPP to be \$124.1 M, or approximately \$47.2 M in state General Funds. FSSA staff reports that the additional \$47.2 M is to be financed within the Medicaid budget and not included in the financing plan for the Healthier Indiana Insurance Program.

(Revised) The bill will also cap Hospital Care for the Indigent (HCI) funds used to leverage federal funds for HCI add-on payments to hospitals at \$11.65 M. This provision will guarantee total hospital payments of \$30.66 M - the amounts paid in FY 2006. The bill further provides that for fiscal years after FY 2006, all intergovernmental transfers deposited into the Medicaid Indigent Care Trust Fund shall be used for Medicaid supplemental payments, disproportionate share DSH payments, and the transfer of \$30 M to OMPP for Medicaid expenditures.

The bill also changes the method by which the HCI levy is determined for 2008 and thereafter.

Details on the Healthier Indiana Insurance Program -

Medicaid Waiver: The bill establishes the Healthier Indiana Insurance Program and requires OMPP to apply for a Medicaid demonstration waiver to develop and implement the Program. The bill specifies that the Program is not an entitlement and participation is dependent upon the level of funding appropriated for the Program. The bill specifies that OMPP may not enroll applicants, approve contracts, or otherwise create a financial obligation for the state other than costs necessary to study and plan for the implementation of the Program without a specific appropriation made by the General Assembly. OMPP is authorized to adopt emergency rules to implement the Program on an emergency basis.

(Revised) *Eligibility:* Individuals eligible for the Program must be over age 18 and under age 65, U.S. citizens, and residents of Indiana for at least 12 months. Eligible individuals may not be eligible for Medicare or Medicaid as a disabled person. Pregnant women are not eligible for services related to the pregnancy. Individuals must not be eligible for health insurance coverage through an employer, and they must have been uninsured for at least 6 months or uninsured due to a job change. Individuals and married couples must apply for the Program, be approved by FSSA, and make defined, timely contributions to an individual Health Care Account, established to help the individual pay the deductible for health care services offered under the Program. The Healthier Indiana Insurance Program will add two groups of eligible individuals; custodial parents and childless adults. Custodial parents may be added to the eligible population of Medicaid and CHIP and would be considered an eligibility expansion group. Childless adults are typically not eligible for Medicaid unless certain disability or age and income standards are met. The Office would need to demonstrate fiscal neutrality within the program in order to add this group in the demonstration waiver.

Financial Eligibility: The custodial parent of a child with whom the child lives, having an annual household income of not more than 200% of the FPL, is eligible for the Program. The legal spouse of a custodial parent is also eligible for the program. Single individuals having an annual household income of at least 100% of poverty and not more than 200% of the FPL are also eligible. The bill does not require the income to be earned income nor does it define an age limit for children living in a home. Federal income poverty level guidelines for 2007 are included in the table below.

Persons in the Family or Household	100%	200%
1	\$10,210	\$20,420
2	\$13,690	\$27,380
3	\$17,170	\$34,340
4	\$20,650	\$41,300

Terms of Participation: Individuals approved for participation, are eligible for 12 months, contingent upon timely payment of the required contribution. At the end of the 12-month period, the individual must apply for a renewal in order to continue Program participation. Certain individuals, defined as high-risk, are also required to participate in the High Risk Hoosiers Program which requires participation by an individual in medical management services. An individual that fails to make a Health Care Account contribution within 30 days of the required payment, may be terminated from the Program. Individuals who are terminated for nonpayment of the required contributions or who do not renew their participation after the end of the 12-month enrollment period may not reapply to participate in the program for at least 18 months.

Health Care Accounts: Participants in the Program must have Health Care Accounts. Contributions to the accounts may be made by employers withholding after tax payroll dollars on the employee's behalf, or directly by an individual in a manner to be prescribed by OMPP. The Health Care Account is to be available to meet the individual's deductible expenses required before the insurance policy purchased on their behalf by the Program assumes the cost of subsequent medical expenses. The state is required to subsidize the Account based on the income level of the participant.

Health Care Account Contributions: Individuals are required to contribute at least \$1,100 per year, but not more than 5% of the individual's annual household income, or at least \$1,100 per year less the individual's

contributions to the Children's Health Insurance Program (CHIP) or to the Medicaid or Medicare Program. This provision would allow parents to reduce their required 5% contribution by the amount of CHIP C premiums and CHIP or Medicare copayments. CHIP C premiums range from \$22 to \$50 per month depending on the household income level and the number of children in the household. CHIP C children may also have copayments for prescription drugs and emergency transportation services which could be deducted. (CHIP C financial eligibility is determined by households with incomes greater than 150% of FPL but less than 200% FPL.) The bill prohibits Medicaid recipients from participating in the Program, but a qualifying individual may have a Medicaid recipient as a member of their household. Federal regulations prohibit states from assessing copayments for Medicaid children (less than 150% FPL); certain Medicaid recipients in the aged, blind, or disabled eligibility categories could have prescription drug copayments assessed. While the bill would prohibit Medicare participants from participating in the Program, household members may be Medicare-eligible (e.g., an elderly parent, or a disabled adult or child), and Medicare-associated copayments and deductibles could reduce the individual's required contribution as determined by OMPP. The highest contribution that could be required from any individual would be the minimum dollar amount required for the account of \$1,100 annually, or \$91.67 per month. The bill addresses each covered individual's requirements and appears to indicate that each covered individual must have a Health Care Account. The bill is not specific with regard to the treatment of contributions and Account requirements for legal spouses.

The bill would require the state to contribute any difference between the calculated required individual contribution and the minimum amount required for contribution to the account of \$1,100.

(Revised) *Withdrawals from the Health Care Account:* The Health Care Account is to be used through the year to pay deductible expenses incurred for health care services, excluding the defined preventive care services up to the minimum dollar amount required of \$1,100. At the end of each 12-month enrollment period, individuals who have received the preventive care services defined by OMPP may withdraw remaining funds in excess of \$500 from the Health Care Account to the extent that the funds were contributed by the individual. Any funds withdrawn must be used to pay for dental or vision care services not included as covered services under the plan. Individuals no longer eligible for the program due to increased income, may also withdraw funds to the extent they were contributed to the account as well. Individuals renewing their participation in the Program may also choose to leave funds in excess of \$500 in the Account and reduce the required amount they must contribute to the Account in the next 12-month enrollment period. If an individual is terminated for failure to make timely Account contributions or chooses not to re-enroll in the Program, money remaining in the Account is forfeited and reverts to the state.

(Revised) *Covered Services:* The program is required to provide preventive care services, to be defined by OMPP, for a covered individual up to \$500 per year at no cost to the covered individual. The bill also specifies that individuals may be held responsible for non-emergency use of hospital emergency department services; individuals may be required to pay for these services outside of the Health Care Account. Services related to pregnancy are not included in the program. Dental and vision services will not be covered by the Program. The bill specifies that the Program must include mental health services, inpatient hospital services, prescription drug coverage, emergency services, physician office services, diagnostic services, outpatient services including therapies, disease management, home health services, and urgent care center services. The Office is to determine the manner and extent to which these services are included.

The bill requires the state to annually assume up to \$500 cost for the defined preventive health care services for individuals. Up to \$500 is to be paid at no cost to participating individuals. The bill does not specify if this benefit is to be administered by or covered under the high-deductible health care insurance policy issued by the insurers.

(Revised) *Insurers:* Health benefits insurers or health maintenance organizations (Insurers) that contract with OMPP to provide health care insurance under this program are required to bear the risk of the health insurance program. Insurers may not deny coverage to an eligible individual who has been approved by OMPP unless the maximum coverage levels are met (\$300,000 for the annual individual maximum and \$1M for the individual lifetime maximum). Insurers are responsible for claims processing and are required to reimburse providers at rates equal to Medicare reimbursement rates for the services provided or at 130% of the applicable Medicaid reimbursement rate if there is no corresponding Medicare rate. The bill further provides that Insurers that contract to provide health care insurance under this program must also make the same health insurance available to individuals that may be waiting for an available Program slot or with income that exceeds the financial eligibility limits for the Program. The Insurers must also make the same health insurance available to the employees of an employer that pays at least 50% of the premium and has not offered health insurance as an employment benefit in the previous 12 months. The bill is not specific with regard to the administrative responsibility for the establishment and operations of the Health Care Accounts.

Healthier Indiana Insurance Fund: The bill establishes the dedicated, non-reverting Healthier Indiana Insurance Fund to: (1) administer the Program; (2) provide Program co-payments (Accounts subsidies), preventive care services, and insurance premiums; (3) fund tobacco use prevention and cessation programs; (4) fund programs to promote the general health and well-being of Hoosiers; and (5) promote research in health and life sciences fields to include grants to universities for operating and capital expenses. The Fund is to be administered by FSSA. The expenses of administering the Fund are to be paid from money in the Fund. The Treasurer is authorized to invest money in the Fund in the same manner as other public funds may be invested.

The Fund is to consist of Cigarette Tax revenues designated by the General Assembly to be allocated to the fund; other dedicated funds designated to be appropriated to the fund; available federal funds; and gifts or donations. The bill specifies that funding from each source shall be segregated into a separate account within the fund to provide for the return of any unencumbered balances available at year-end to programs that diverted funding into the Healthier Indiana Insurance Program Fund. If participation in the Healthier Indiana Insurance Program is less or costs are lower than anticipated in any year, and diverted from previously funded programs, those funds could, at year-end be returned to the original program.

Health for High-Risk Hoosiers Program: The bill establishes the High-Risk Hoosiers Under the Healthier Indiana Insurance Program (High-Risk Program) to be administered by the Indiana Comprehensive Health Insurance Program (ICHIA). ICHIA will administer the medical management services that are required to be covered for individuals who are determined by FSSA, using criteria to be developed, to be too high-risk to participate in the insurance pool for the Healthier IN Program. The bill provides that individuals covered by the Healthier Indiana Insurance Program are eligible for the High-Risk Program but, they must be referred by FSSA and are required to participate in medical management services.

Details on the Expansion of Medicaid Pregnancy Related Services -

Waiver: The bill requires OMPP to apply for three Medicaid State Plan amendments. The first is to expand Medicaid coverage for pregnant women to cover women with incomes from 150% of FPL to 200%. The bill specifies that the amendment may not be implemented until the second required State Plan amendment, which changes the Hospital Upper Payment Limit Program, and the third required State Plan amendment,

which changes the state's DSH Program, are in effect.

A State Plan amendment would create an entitlement status for the new population group. These individuals would not be required to participate in any other program in order to be eligible for services under the Medicaid program. The bill also does not make application for the amendments contingent upon implementation of the Healthier Indiana Insurance Program.

A Medicaid State Plan amendment could only be applied to the population of pregnant women up to 185% of 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 a Medicaid eligibility expansion to 200% of poverty for all pregnant women. The Plan amendment would also be required to cover the additional group of infants born with Medicaid coverage from birth until one year of age. This is a federal requirement. Under CHIP, an unknown percentage of the expansion group of infants, already receive services subsidized by the state.

Medicaid Fiscal Impact: This provision would create an entitlement for services to a total population estimated by OMPP to be approximately 14,733 pregnant women. The average cost of pregnancy care in the Medicaid program is reported to be \$8,421. Total cost of this provision is estimated by OMPP to be \$124.1 M, or approximately \$47.2 M in state General Funds. (This is the total cost to add the population of pregnant women to Medicaid and CHIP). FSSA staff reports that the additional \$47.2 M is to be financed within the Medicaid budget and not included in the financing plan for the Healthier Indiana Insurance Program. This eligibility expansion does not appear to be addressed in the December 13, 2006, Medicaid Forecast presented to the Budget Committee.

CHIP Impacts, Infants: Under the CHIP C program, all children in families with income between 150% and 200% of FPL can be covered at low cost to families. The premium amounts are between \$22 and \$50 per month, based on the family income and the number of family members covered. There are also small co-payments for some services. The bill provides that the CHIP premiums and co-payments can be used to decrease the required individual contributions to the Health Care Account, effectively increasing the state subsidy for a custodial parent's coverage under the Healthier Indiana Insurance Program. The expansion of eligibility for pregnant women under the Medicaid program up to 200% of FPL would also include the shift of all current CHIP infants, and any subsequently born, to the Medicaid program. CHIP premium revenue would be reduced by the amount being contributed to cover children under the age of one year who are in families with income below 200% of FPL.

(Revised) Hospital Care for the Indigent (HCI) Program Changes: The bill would freeze hospital payments under the HCI program at FY 2006 levels. This provision would allow hospitals to once again, discontinue submitting claims for the HCI program to OMPP for processing. Hospitals were required to resume submitting claims for purposes of calculating the county property tax levy requirements in FY 2004. OMPP would also realize a decrease in claims processing volume as a result. By way of reference to the volume of work involved, OMPP had approximately 30,922 applications for reimbursement under the HCI program in FY 2006; 11,320 hospital claims were processed for a total amount of \$31.3 M priced at Medicaid reimbursement rates. Hospitals are not currently reimbursed for claims, rather they receive HCI add-on payments leveraged for federal reimbursement available within the Medicaid program.

This bill designates \$11.65 M of HCI funds to be leveraged with federal funds by methods to be determined by OMPP that will provide hospitals with approximately \$30.66 M in total payments. The bill specifies that the payments distributed must equal the amount of the 2006 claim payments. The \$11.65 M is reported to

be the amount necessary to distribute the same level of funding to the hospitals as was provided in FY 2006.

The bill provides that HCI physician and emergency transportation claims would continue to be submitted, processed, and reimbursed for services up to a maximum amount of \$3 M per year. This group submitted 30,968 claims that were priced at Medicaid reimbursement rates for \$4.4 M in FY 2006. Since the pool of dollars available for reimbursement for this group is capped at \$3 M, in FY 2006 each provider's claims were proportionally reduced and paid at approximately 67.86% of the Medicaid rate for the services provided. HCI program administration costs are also payable from the Fund.

The bill specifies that the remainder of the HCI funds after the \$3 M for physicians and transportation services and the program administration costs are to be transferred to the Medicaid Indigent Care Trust Fund to be used to make supplemental hospital payments under the DSH and municipal DSH programs. In addition the Office is authorized to transfer \$30 M annually to the Medicaid program. (Currently the Office transfers \$21 M.) In 2007, the gross HCI levy will raise \$61.1 M.

The bill specifies that for each fiscal year after FY 2006, the total municipal DSH hospitals shall be capped at \$35 M. Municipal DSH hospitals are defined as county and municipal hospitals that have a Medicaid utilization rate greater than 1%. This group previously received about \$25 M in total under this program. The bill also provides payment caps on Medicaid supplemental payments made to privately owned DSH hospitals.

The bill further provides that for fiscal years after FY 2006, all intergovernmental transfers deposited into the Medicaid Indigent Care Trust Fund shall be used for Medicaid supplemental payments, disproportionate share DSH payments, and the transfer of \$30 M to OMPP for Medicaid expenditures.

OMPP is required to apply to the U.S. Department of Health and Human Services for approval of an amendment to the state's upper payment limit program and to make changes to the state's DSH program. These two amendments may not be implemented until the Medicaid eligibility expansion for pregnant women Medicaid State Plan amendment is in place.

Explanation of State Revenues:

Explanation of Local Expenditures:

Explanation of Local Revenues: (Revised) *HCI Property Tax Levy Changes:* The bill amends the HCI property tax levy for 2008 to be based on taxes first due and payable in 2007 multiplied by the assessed value growth quotient calculated as specified. The levy would be determined in the same manner in subsequent years. The bill removes a provision that requires the HCI levy to be based on a three-year rolling average of payable claims attributed to the county subject to a maximum levy based on assessed value growth. This provision would have taken effect for taxes due and payable in 2009. The estimated maximum levy under current law is estimated at \$63.7 M for 2008; the statewide levy under this proposal is estimated to be \$63.7 M. HCI collections are transferred by the counties to the state HCI Fund for reimbursement of eligible physician and transportation provider claims up to an amount of \$3 M. The balance of the fund is transferred to the Medicaid Indigent Care Trust Fund to provide state matching funds to leverage federal funds for HCI hospital add-on payments and other Medicaid expenditures.

State Agencies Affected: OMPP and CHIP Program, Family and Social Services Administration.

Local Agencies Affected: County and municipal hospitals.

Information Sources: FSSA.

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