TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #10-195

DIGEST

Amends 405 IAC 5-3-14 to reduce the time frame for making prior authorization decisions to seven calendar days. Amends 405 IAC 9-2-13 to revise the definition of "emergency services". Amends 405 IAC 9-3-2 to clarify retroactive coverage is not provided for under the plan. Amends 405 IAC 9-4-4 to require insurers and the association to follow standards set forth by the office when assisting individuals with the plan renewal process and to make other technical changes. Amends 405 IAC 9-4-5 to add as a grounds for ineligibility the falsification of information on the plan application and to make other technical changes. Amends 405 IAC 9-4-6 to outline the process for providing notification when enrollment is reopened and to make clarifying technical changes. Amends 405 IAC 9-6-1 to update the enhanced services plan screening process for applicants and members. Amends 405 IAC 9-7-2 to revise coverage of skilled nursing facility services and family planning services, to update the requirements for notifying members close to exceeding the annual and lifetime reimbursement limitations, and to make other technical changes. Amends 405 IAC 9-7-6 to revise the coverage policy for pharmacy services, including legend drugs, nonlegend drugs, and nonlegend insulin. Amends 405 IAC 9-7-8 to identify the insurer's ability to provide a more generous preventive care services benefit and to make other technical changes. Amends 405 IAC 9-7-10 to clarify covered out-of-network nurse practitioner services, to provide out-of-network coverage for services provided by FQHCs and RHCs, and to make other technical changes. Amends 405 IAC 9-7-11 concerning self-referral services to identify additional services that shall not require referral from a member's primary care provider and to make other technical changes. Amends 405 IAC 9-7-12 to require publication of prior authorization policies by the insurers and the association and to reduce the time frame for making prior authorization decisions to seven calendar days. Amends 405 IAC 9-7-13 to revise the noncoverage policy for vitamins, supplements, and over-the-counter drugs. Amends 405 IAC 9-8-2 to make conforming changes. Amends 405 IAC 9-8-3 to identify the process for purchasing buy-in coverage. Amends 405 IAC 9-8-5 to include risk-based managed care as a component of the Medicaid program that can pay pregnancy related claims and to make other technical changes. Amends 405 IAC 9-9-7 to clarify reimbursement for preventive care services and the reimbursement rate for hospitals, FQHCs/RHCs, and pharmacy services. Amends 405 IAC 9-9-8 concerning permissible member payments to delete the option for paying for the difference in cost between a brand name drug and generic substitute. Amends 405 IAC 9-10-7 concerning changing insurers to make conforming technical changes. Amends 405 IAC 9-10-9 to require the return of excess rollover balances to the state and to make conforming technical changes. Amends 405 IAC 9-10-10 to prohibit the billing of individuals for claims originally denied but upheld on appeal when the individual has already been terminated from the program and been paid the pro rata balance, or a portion thereof, of his or her POWER account. Amends 405 IAC 9-10-11 concerning member debt to make conforming changes. Amends 405 IAC 9-10-13 to clarify the payroll deduction payment option. Amends 405 IAC 9-10-14 to require application of lump sum employer contributions equally to member POWER account contributions each month throughout the coverage term. Amends 405 IAC 9-10-17 to update the insurer and association responsibilities for POWER account balance transfers. Amends 405 IAC 9-10-21 concerning failure to renew participation to make conforming changes. Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

405 IAC 5-3-14; 405 IAC 9-2-13; 405 IAC 9-3-2; 405 IAC 9-4-4; 405 IAC 9-4-5; 405 IAC 9-4-6; 405 IAC 9-6-1; 405 IAC 9-7-2; 405 IAC 9-7-6; 405 IAC 9-7-8; 405 IAC 9-7-10; 405 IAC 9-7-11; 405 IAC 9-7-12; 405 IAC 9-7-13; 405 IAC 9-8-2; 405 IAC 9-8-3; 405 IAC 9-8-5; 405 IAC 9-9-7; 405 IAC 9-9-8; 405 IAC 9-10-7; 405 IAC 9-10-9; 405 IAC 9-10-10; 405 IAC 9-10-11; 405 IAC 9-10-13; 405 IAC 9-10-14; 405 IAC 9-10-17; 405 IAC 9-10-21

SECTION 1. 405 IAC 5-3-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-14 Prior authorization decision; time limit

Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15
Affected: IC 12-15-30-1

Sec. 14. Decisions by the office regarding prior review and authorization will be made as expeditiously as possible considering the circumstances of each request. If no decision is made by the office within ~~ten (10)~~

~~working~~ **seven (7) calendar** days of receipt of all documentation specified in sections 5 and 9(1) of this rule, authorization is deemed to be granted within the coverage and limitations specified in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-14; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3306; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 2. 405 IAC 9-2-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-2-13 "Emergency services" defined

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 13. "Emergency services" means covered **inpatient and outpatient** services ~~necessary~~ **that are:**
(1) furnished by a provider qualified to furnish emergency services; and
(2) needed to evaluate or stabilize an emergency medical condition.

(Office of the Secretary of Family and Social Services; 405 IAC 9-2-13; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 3. 405 IAC 9-3-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-3-2 Date of coverage

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 2. **(a)** The effective date of coverage is the first day of the month following the month in which an insurer or association has:
(1) established the POWER account for the conditionally eligible individual; and
(2) notified the division.

(b) There is no retroactive coverage under the plan.

(Office of the Secretary of Family and Social Services; 405 IAC 9-3-2; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 4. 405 IAC 9-4-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-4-4 Eligibility period; renewal

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 4. (a) An applicant who is approved to participate in the plan shall be eligible for a twelve (12) month period unless the member:
(1) fails to make POWER account contributions, **as described in 405 IAC 9-10-16;** or
(2) becomes ineligible under the rules established under section 5 of this rule.

(b) In order to continue participation in the plan, a member must complete the ~~recertification~~ **renewal** process every twelve (12) months. During the ~~recertification~~ **renewal** process, the member shall:
(1) complete a renewal form prescribed by the office; and
(2) submit it, and any necessary documentation, to the division.
The individual's insurer, or association, if applicable, may assist the individual in the renewal process **according to standards set forth by the office;** however, the individual retains the ultimate responsibility for submitting any forms and documentation to the division in a timely manner.

(c) If a member does not submit a complete renewal ~~application~~ **form** on or before the forty-fifth day before the end of the individual's twelve (12) month coverage term, the individual:
(1) shall be disenrolled from the plan; and
(2) may not participate in the plan for a period of twelve (12) months.

(d) An individual enrolled in the plan may not be refused renewal of participation for the sole reason that the plan has reached the plan's maximum enrollment.

(Office of the Secretary of Family and Social Services; 405 IAC 9-4-4; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 5. 405 IAC 9-4-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-4-5 Loss of eligibility

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 5. (a) During the twelve (12) month coverage period, an individual will become ineligible to participate in the plan under the following circumstances:
(1) The individual is no longer an Indiana resident.
(2) The individual obtains access to employer sponsored health insurance through his or her employer.
(3) The individual becomes insured with health insurance other than the plan.
(4) The individual becomes eligible for another Medicaid ~~aid~~ **assistance** category.
(5) The individual is delinquent in making POWER account contributions, as described in 405 IAC 9-10-16.
(6) The individual requests in writing that coverage be terminated.
(7) The individual falsifies information on the application.
~~(7)~~ **(8)** The individual meets one (1) or more of the criteria in section 1(c)(1) through 1(c)(3) of this rule.

(b) Coverage will be terminated for an individual who loses eligibility under this section.

(c) An individual who falsified information on an application in order to obtain plan benefits may be held financially responsible for the amount of payments made on their behalf by the state, including POWER account contributions.

(Office of the Secretary of Family and Social Services; 405 IAC 9-4-5; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 6. 405 IAC 9-4-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-4-6 Enrollment limits

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 6. (a) The maximum enrollment of individuals who may participate in the plan is dependent upon: ~~the~~
(1) state funding appropriated for the plan; ~~and~~
(2) enrollment limits established in the federally approved waiver; **and**
(3) compliance with applicable federal requirements.

(b) The division:
(1) may cease accepting applications; and
(2) shall stop enrolling new applicants;
when notified by the office that the plan has reached, or is ~~close~~ **expected** to ~~reaching,~~ **reach,** maximum enrollment.

~~(b)~~ **(c)** An applicant who meets the eligibility requirements set forth in this rule may not enroll in the plan if the division has ceased enrolling new applicants ~~due to a lack of available funds.~~ **as set forth in subsection (a).**

~~(c)~~ **(d)** Persons who are members at the time enrollment limits have been reached shall not be denied the opportunity to renew their participation in the plan for the sole reason that the plan has reached maximum enrollment.

~~(d)~~ **(e)** A woman:
(1) who is discontinued from the plan solely because of pregnancy; and
(2) for whom health coverage has been transferred to Medicaid;
shall not be denied the opportunity to reapply for participation in the plan for the sole reason that the plan has reached maximum enrollment, if her date of application is not later than sixty (60) days after her pregnancy ends.

(f) The division shall maintain a record of childless adults denied enrollment in the plan when the plan has reached, or is expected to reach, the enrollment limit. This record shall be ordered according to the date and time an applicant was denied enrollment in the plan, with the applicant most recently denied enrollment in the plan appearing last.

(g) The office shall determine:
(1) if, and when, the division shall begin enrolling childless adults in the plan; and
(2) how many enrollment slots are available.

(h) The division shall notify a specified number of individuals, as determined by the office, when a decision is made by the office to open enrollment in the plan to childless adults. Individuals shall be notified in the order of their appearance on the record maintained by the division under subsection (f). The notification shall state that the individual may apply for an open enrollment slot.
(1) An individual invited to apply for an open enrollment slot must submit a completed application within forty-five (45) days of notification. If the individual's application is not submitted within forty-five (45) days of notification, the individual shall be removed from the record maintained by the division under subsection (f).
(2) With the exception of individuals invited to apply for an open enrollment slot, the division shall continue to deny applications until the office determines otherwise.

(Office of the Secretary of Family and Social Services; 405 IAC 9-4-6; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 7. 405 IAC 9-6-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-6-1 Enhanced services plan screening

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2; IC 27-8-10.1

Sec. 1. (a) ~~Each applicant~~ **Applicants and members** shall be asked to complete a series of ESP screening questions during the plan application process ~~An applicant~~ **and the renewal process. Applicants and members** must answer all ESP screening questions before ~~his or her~~ **their** plan application **or renewal form** will be deemed complete.

(b) If an applicant's **or member's** answers to the ESP screening questions on the plan application **or renewal form** indicate the possible existence of a complex medical condition, **and the applicant or member is determined eligible for enrollment or continued participation in the plan,** the applicant ~~who has been determined eligible for the plan~~ **or member** will be enrolled in ~~an~~ **the** ESP. ~~specifically designated to provide health care services to ESP-eligible individuals.~~

(c) Insurers may also refer members to the ESP if the insurer documents that the member meets

specific criteria, as set forth by the office, for transfer to the ESP. The insurer shall provide the required documentation within one hundred eighty (180) days of the first day of the member's coverage term.

~~(c)~~ **(d)** The office ~~shall~~ **may** review the placement of ~~the applicant~~ **a member** in the ESP ~~within thirty (30) days of the placement and~~ **to** determine whether or not the placement ~~was~~ **is** appropriate, based on one (1) or more of the following:

(1) Review of the ~~applicant's~~ **member's** answers to the ESP screening questions on the plan application **or renewal form.**

(2) Review of the ~~applicant's~~ **member's** medical records.

(3) Communication **with** or other outreach to the ~~applicant~~ **ESP, the member,** or ~~applicant's~~ **the member's** provider or providers.

(4) Review of some or all of the ~~applicant's~~ **member's** past claims history, if available and accessible.

(5) An audit of cases referred to the ESP by the insurers.

~~(5)~~ **(6)** Other review processes, as determined by the office.

~~(d) If the office determines that an applicant was placed appropriately in the ESP, the applicant shall remain enrolled in the ESP.~~ **(e)** If the office determines that enrollment in the ESP ~~was~~ **is** not appropriate, the ~~applicant~~ **member** will be enrolled with the insurer selected on the ~~individual's~~ **member's** plan application **or renewal form.** If no insurer was selected, the ~~applicant~~ **member** will be auto-assigned to an insurer.

(Office of the Secretary of Family and Social Services; 405 IAC 9-6-1; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 8. 405 IAC 9-7-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-7-2 Covered benefits and services; coverage limits

Authority: IC 12-15-44.2
Affected: IC 12-15-44.2

Sec. 2. (a) The following services are covered under the plan according to the coverage criteria, limitations, and procedures specified in this article and in manuals, bulletins, or other documentation published by the insurers, association, and the office:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Skilled nursing facility services, subject to a sixty (60) day maximum **per coverage term.**

(4) ~~Prescription drug coverage.~~ **Pharmacy services.**

(5) Emergency ~~room~~ services. ~~including nonemergent services provided in an emergency setting.~~

(6) Physician office services.

(7) Diagnostic services, including pregnancy testing.

(8) Outpatient services, including covered therapy services as defined in section 4 of this rule.

(9) Comprehensive disease management.

(10) Home health services, including case management.

(11) Urgent care center services.

(12) Preventive care services.

(13) Family planning services ~~as defined in 405 IAC 9-2-17.~~ **with the exception of over-the-counter contraceptives.**

(14) Hospice services.

(15) Substance abuse services.

(16) Services provided at a federally qualified health center (FQHC) or rural health center (RHC).

(17) Durable medical equipment.

(18) Lead screening services and hearing aids for individuals nineteen (19) years of age or twenty (20) years of age.

(19) Any ~~other enhanced~~ **additional** services the insurers or association offers, **as approved by the office and** in accordance with the terms of the insurers' policy or the association's plan.

(b) The following per member reimbursement limitations apply:

(1) An annual individual maximum reimbursement limitation of three hundred thousand dollars ($300,000).

(2) A lifetime individual maximum reimbursement **limitation** of one million dollars ($1,000,000).

(c) Members that may exceed the maximum coverage limitations established in this section shall be:
(1) notified by the office or its designee; and
(2) referred for potential eligibility in other programs;
when the member exceeds **one hundred thousand dollars ($100,000) in paid claims in a year,** two hundred thousand dollars ($200,000) in **paid claims in** a year ~~or~~ **and** nine hundred thousand dollars ($900,000) **in paid claims** in a lifetime.

(Office of the Secretary of Family and Social Services; 405 IAC 9-7-2; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 9. 405 IAC 9-7-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-7-6 Pharmacy services

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 6. **(a)** Covered pharmacy ~~benefits and~~ services include ~~brand name and generic prescription drugs~~ **prescribed legend drugs, nonlegend drugs,** and ~~prescribed over the counter~~ **nonlegend** insulin ~~subject to the following exclusions:~~ **as set forth in this rule.**

(b) A legend drug is covered by the plan if the drug is:
(1) approved by the United States Food and Drug Administration;
(2) subject to the terms of a rebate agreement between the drug's manufacturer and the Centers for Medicare and Medicaid Services (CMS); and
(3) not listed in subsection (c).

(c) The following legend drugs are not covered under the plan:
(1) Those designated by the ~~Centers for Medicare and Medicaid Services~~ **CMS** as less than effective, or identical, related, or similar to a less than effective drug.
(2) Pharmaceutical abortifacients.
(3) Sexual dysfunction medication.
(4) Weight loss medications.
(5) Topical minoxidil preparations.
~~(5)~~ **(6)** Physician samples dispensed in a physician's office.
~~(6)~~ **(7)** Brand name drugs, where generic substitution is possible, in accordance with applicable law ~~Brand name drugs with generic equivalents are covered if the insurer or the association determines~~ **is covered by the plan if** the brand name drug is
~~(A)~~ medically necessary or
~~(B)~~ less costly than the generic. **A brand name drug is medically necessary if the prescriber:**
(A) indicates in the prescriber's own handwriting "brand medically necessary" on the prescription or drug order; and
(B) obtains prior authorization from the office by substantiating the medical necessity of the brand name drug as opposed to the less costly generic equivalent.
In order for brand name drugs to be reimbursable by the office, the prior authorization number assigned to the approved request must be included on the prescription or drug order issued by the prescriber or relayed to the dispensing pharmacist by the prescriber if the prescription is orally transmitted. The office may exempt specific brand name drugs or classes of brand name drugs from the prior authorization requirement.
(8) Drugs specifically excluded from coverage in section 13 of this rule.
~~(7)~~ **(9)** Other drugs as the office may determine.

(d) A nonlegend drug, with the exception of nonlegend insulin, is covered by the plan to the extent such drug is:
(1) included on the Medicaid nonlegend drug formulary;
(2) included on the Medicaid preferred drug list; and

(3) not specifically excluded from coverage in section 13 of this rule.

(e) Nonlegend insulin is covered to the extent it is subject to the terms of a rebate agreement between the drug's manufacturer and the CMS.

(Office of the Secretary of Family and Social Services; 405 IAC 9-7-6; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 10. 405 IAC 9-7-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-7-8 Preventive care services

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 8. (a) The first five hundred dollars ($500) of covered preventive **care** services is not subject to the deductible. Covered preventive **care** services in excess of five hundred dollars ($500) are subject to the deductible. **The insurers and the association may offer a more generous preventive care services benefit if approved by the office.**

(b) The office shall develop a list of required age, gender, and preexisting condition preventive **care** services based on U.S. Centers for Disease Control and Prevention guidelines. Completion of these services are required in order for the state's contribution to the member POWER account to be used toward the members' required POWER account contribution in the subsequent year, **as described in 405 IAC 9-10-9.** The list shall be published by October 1 each year.

(c) The office **or its designee** shall provide the list developed under subsection (b) to a member. Members must receive preventive **care** services applicable to them in order to qualify for the full carry forward of POWER account funds described in 405 IAC 9-10-9.

(d) Members ~~are~~ **may be** responsible for obtaining and submitting proof to the insurer or association that ~~preventative~~ **preventive care** services were obtained. Instructions for submitting proof will be provided to members by the insurers and the association.

(Office of the Secretary of Family and Social Services; 405 IAC 9-7-8; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 11. 405 IAC 9-7-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-7-10 Out-of-network services

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 10. The following services are covered, even if provided out-of-network:
(1) Family planning services.
(2) Emergency ~~medical~~ services.
(3) Medically necessary covered services, if the member's insurer or the association is unable to provide the services in-network within:
  (A) thirty (30) miles of the member's residence for primary care; and
  (B) sixty (60) miles of the member's residence for specialty care.
(4) Nurse practitioner services, **provided within the scope of the applicable license and certification.**
(5) Covered services provided at a federally qualified health center (FQHC) or rural health clinic (RHC).

(Office of the Secretary of Family and Social Services; 405 IAC 9-7-10; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 12. 405 IAC 9-7-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-7-11 Self-referral services

Authority: IC 12-15-44.2-19
Affected: IC 12-15-11; IC 12-15-44.2; IC 27-8-14.5-6

Sec. 11. **(a)** Members may receive the following covered services without a referral from their primary medical provider or prior authorization or precertification from their insurer or the association:
(1) Family planning services.
(2) Emergency ~~medical~~ services.

(b) Members may receive the following covered services without a referral from their primary medical provider, subject to any requirements regarding the use of in-network providers:
(1) Psychiatric services provided by a provider licensed under IC 12-15-11.
(2) Behavioral health services.
(3) Immunization services.
(4) Diabetes self-management training services, as set forth in IC 27-8-14.5-6.

(Office of the Secretary of Family and Social Services; 405 IAC 9-7-11; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 13. 405 IAC 9-7-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-7-12 Prior authorization

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 12. (a) An insurer and the association may implement utilization control procedures, including prior authorization or precertification of services. Services furnished by the insurer and the association must be sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished.

(b) **Insurers and** the ~~office~~ **association** shall publish ~~the~~ **their** prior authorization procedures. ~~used by each insurer and the association. The procedures:~~
~~(1) shall be published as a provider bulletin; and~~
~~(2) may be updated from time to time.~~
The initial publication **of prior authorization procedures** and any updates **to prior authorization procedures** shall be made effective not earlier than forty-five (45) days after the date ~~the bulletin is mailed~~ **of publication. For purposes of this section, "publication" means, at minimum, making the prior authorization procedures available by posting the prior authorization procedures on the insurers' or the association's public website.**

(c) The ~~bulletin~~ **insurers' and the association's prior authorization procedures** shall include all information necessary for a provider to submit a prior authorization request. ~~to the insurers and the association.~~

~~(c)~~ **(d)** A provider that:
(1) has an agreement with the office; and
(2) renders services to a member;
must follow the procedures published under subsection (b) whether **or not** that provider has a contract with the insurer or ~~not.~~ **the association.**

~~(d)~~ **(e)** Decisions by insurers and the association regarding prior authorization and precertification shall be made as expeditiously as possible considering the circumstances of each request. If no decision is made within ~~fourteen (14)~~ **seven (7)** calendar days of receipt of all documentation required, authorization is deemed to be granted.

~~(e)~~ **(f)** The following services are exempt from any procedures established under this section:
(1) Emergency services.
(2) Family planning services.

(Office of the Secretary of Family and Social Services; 405 IAC 9-7-12; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 14. 405 IAC 9-7-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-7-13 Noncovered services

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 13. The following services are not covered under the plan:
(1) Services that are not medically necessary.
(2) Maternity and related services.
(3) Dental services.
(4) Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly.
(5) Vision services.
(6) Elective abortions and abortifacients.
(7) Nonemergency transportation services. For purposes of this section, nonemergency transportation services are defined as transportation services that are unrelated to an emergency medical condition as defined in 405 IAC 9-2-12.
(8) Chiropractic services, except for those services covered under the plan that are within the scope of practice of a chiropractor (e.g., physical therapy).
(9) Drugs excluded from the plan under section 6 of this rule.
(10) Long-term or custodial care.
(11) Experimental and investigative services, as determined by the office.
(12) Daycare and foster care.
(13) Personal comfort or convenience items.
(14) Cosmetic services, procedures, equipment, or supplies, and complications directly relating to cosmetic services, treatment, or surgery, with the exception of reconstructive services performed to correct a physical functional impairment of any area caused by:
(A) disease;
(B) trauma;
(C) congenital anomalies; or
(D) a previous medically necessary procedure.
(15) Hearing aids and associated services, except for individuals nineteen (19) years of age or twenty (20) years of age.
(16) Safety glasses, athletic glasses, and sunglasses.
(17) LASIK and any surgical eye procedures to correct refractive errors.
(18) Vitamins, ~~supplements, and over-the-counter medications,~~ with the exception of ~~insulin.~~ **vitamins included in the Medicaid:**
(A) nonlegend formulary; and
(B) preferred drug list.
(19) Supplements, with the exception of food supplements and nutritional supplements that meet the coverage requirements set forth in 405 IAC 5-24-9(a).
(20) Nonlegend drugs, except as provided in section 6 of this rule.
~~(19)~~ **(21)** Wellness benefits other than tobacco use cessation.
~~(20)~~ **(22)** Diagnostic testing or treatment in relation to infertility.
~~(21)~~ **(23)** In vitro fertilization.
~~(22)~~ **(24)** Gamete or zygote intrafallopian transfers.
~~(23)~~ **(25)** Artificial insemination.
~~(24)~~ **(26)** Reversal of voluntary sterilization.
~~(25)~~ **(27)** Transsexual surgery.
~~(26)~~ **(28)** Treatment of sexual dysfunction.
~~(27)~~ **(29)** Body piercing.

~~(28)~~ **(30)** Over-the-counter contraceptives.
~~(29)~~ **(31)** Alternative or complementary medicine including, but not limited to, the following:
(A) Acupuncture.
(B) Holistic medicine.
(C) Homeopathy.
(D) Hypnosis.
(E) Aroma therapy.
(F) Reiki therapy.
(G) Massage therapy.
(H) Herbal, vitamin, or dietary products or therapies.
~~(30)~~ **(32)** Treatment of hyperhidrosis.
~~(31)~~ **(33)** Court ordered testing or care, unless medically necessary.
~~(32)~~ Travel-related expenses including mileage, lodging, and meal costs, except for mileage paid to emergency transportation providers.
~~(33)~~ **(34)** Missed or canceled appointments for which there is a charge.
~~(34)~~ **(35)** Services and supplies provided by, prescribed by, or ordered by immediate family members, such as:
(A) spouses;
(B) caretaker relatives;
(C) siblings;
(D) in-laws; or
(E) self.
~~(35)~~ **(36)** Services and supplies for which a member would have no legal obligation to pay in the absence of coverage under the plan.
~~(36)~~ **(37)** The evaluation or treatment of learning disabilities.
~~(37)~~ **(38)** Routine foot care, with the exception of diabetes foot care.
~~(38)~~ **(39)** Surgical treatment of the feet to correct:
(A) flat feet;
(B) hyperkeratosis;
(C) metatarsalgia;
(D) subluxation of the foot; and
(E) tarsalgia.
~~(39)~~ **(40)** Any:
(A) injury;
(B) condition;
(C) disease; or
(D) ailment;
arising out of the course of employment if benefits are available under any worker's compensation act or other similar law.
~~(40)~~ **(41)** Examinations for the purpose of research screening.

(Office of the Secretary of Family and Social Services; 405 IAC 9-7-13; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 15. 405 IAC 9-8-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-8-2 Changing insurers

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 2. (a) Members shall remain enrolled with the same insurer during the member's twelve (12) month coverage term. Members may request to change insurers only in the following circumstances:
(1) Before making their first POWER account contribution, or within sixty (60) days of being assigned to an insurer, whichever comes first. The insurer shall print prominently in its first communication to conditionally eligible individuals a notice stating in substance that the individual may change insurers:
(A) before making the first POWER account contribution; or
(B) within sixty (60) days of being assigned to an insurer;
whichever comes first.
(2) For cause, at any time after exhausting the insurer's internal grievance and appeals process. Members who are not satisfied with the results of the insurer's grievance and appeals process may submit a request to

change insurers to the enrollment broker. If the request is not granted, the member may file an appeal in accordance with 405 IAC 9-5-1. However, if the request is not acted upon by the first day of the second month following the month in which the member files the request, the:

(A) request will be deemed approved; and

(B) member will be transferred to the new insurer.

(3) At ~~redetermination,~~ **renewal,** if the member submits the request to the enrollment broker forty-five (45) days prior to the end of the member's coverage term.

(b) For purposes of subsection (a)(2), "for cause" means poor quality of health care coverage and includes, but is not limited to, the following:

(1) Failure of the insurer to provide covered services.

(2) Failure of the insurer to comply with established standards of medical care administration. These standards are:

(A) based on those developed by the American Accreditation HealthCare Commission, Inc.; and

(B) available upon request.

(3) Significant language or cultural barriers.

(4) Corrective action levied against the insurer by the office.

(5) Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

(c) The state will notify members that they may change insurers without cause forty-five (45) days prior to the end of their coverage term if the member applies for a second or subsequent coverage term.

(d) This section shall not apply to individuals assigned to the ESP.

(Office of the Secretary of Family and Social Services; 405 IAC 9-8-2; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 16. 405 IAC 9-8-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-8-3 Buy-in program; eligibility

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2; IC 27-8-10

Sec. 3. (a) Qualified individuals not enrolled in the plan shall be able to purchase, without a state subsidy, the plan benefit package from participating insurers. Insurers, or their affiliates, shall offer the same health insurance coverage provided under the plan for purchase to the following qualified individuals:

(1) Individuals eligible for the plan under 405 IAC 9-4 but unable to participate due to enrollment limitations.

(2) Individuals not eligible for the plan, so long as the individual has ~~been uninsured~~ **not had health insurance coverage** during the previous six (6) months.

(b) To qualify for the purchase of the health insurance coverage set forth in subsection (a), an individual shall:

(1) apply for participation in the plan as set forth in 405 IAC 9-3-1(a); and

(2) provide a copy of the division's eligibility determination notice to the insurer before purchasing coverage.

The division's eligibility notice shall include the information necessary for an insurer to determine the rate the insurer shall charge, as set forth in section 4 of this rule.

~~(b)~~ **(c)** Coverage provided under the buy-in program shall be the same as coverage under the plan; however, insurers may offer additional riders to buy-in program participants.

(d) The office may refer an individual with an ESP-eligible condition to the association for the purchase of health insurance coverage under IC 27-8-10.

~~(c)~~ **(e)** No state funding will be provided for the buy-in health insurance coverage provided under this section,

nor will individuals have any appeal rights with the state for any actions taken by insurers concerning the buy-in program.

(Office of the Secretary of Family and Social Services; 405 IAC 9-8-3; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 17. 405 IAC 9-8-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-8-5 Pregnant members; identification; referral

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 5. (a) Insurers and the association must notify members who are, or are likely to become, pregnant that pregnancy services are not covered under the plan. Insurers and the association must:

(1) refer pregnant members to the division; and

(2) assist the members in transferring to a different ~~aid category of the~~ Medicaid ~~program, if requested by the member.~~ **assistance category.**

(b) Pregnancy related claims submitted to plan insurers and the association will not be paid under the plan. The claims will be paid under the fee-for-service **or risk-based managed care components of the** Medicaid program, provided that proof of pregnancy that meets Medicaid standards has been submitted.

(Office of the Secretary of Family and Social Services; 405 IAC 9-8-5; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 18. 405 IAC 9-9-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-9-7 Reimbursement process; provider reimbursement rates; POWER account

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 7. (a) A provider shall be reimbursed for covered services as follows:

(1) Until the member's deductible is met, with POWER account funds accessed through the member's POWER account and paid by the insurer or the association. If the member lacks sufficient POWER account funds at the time of service, the insurer or the association must pay for any portion of the plan reimbursement rate that cannot be paid with POWER account funds but shall reconcile these prepaid amounts as additional POWER account funds are received from the member.

(2) For **at least** the first five hundred dollars ($500) of covered preventive **care** services, by the insurer or the association. **The first five hundred dollars ($500) of covered preventive care services, at minimum, are not subject to the member's deductible.**

(3) For covered services under the member's health plan after the deductible has been met, by the insurer or the association. The provider shall be reimbursed at the plan reimbursement rate.

(b) A plan provider shall not be reimbursed for any portion of the reimbursement rate for covered services that is in excess of the maximum coverage limitations established in 405 IAC 9-7-2.

(c) Reimbursement is not available for services provided to individuals who are not enrolled in the plan on the date the service is provided except as required under section 4(b) of this rule.

(d) The plan reimbursement rate defined in 405 IAC 9-2-23(1) does not include:

(1) critical access hospital payments;

(2) graduate medical education payments; or

(3) disproportionate share hospital payments.

(e) Insurers shall reimburse federally qualified health centers (FQHCs) and rural health clinics (RHCs) for covered FQHC and RHC services at the Medicare all-inclusive rate for each visit, as established by the Medicare fiscal intermediary and according to Medicare policy. In the event the amount paid by insurers is less than the amount set forth in 42 U.S.C. 1396a(bb), the office shall make a supplemental payment in accordance with 42 U.S.C. 1396a(bb)(5).

(f) Pharmacy services, medical supplies, and medical equipment reimbursed by the office shall be reimbursed at the Medicaid reimbursement rate.

(Office of the Secretary of Family and Social Services; 405 IAC 9-9-7; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 19. 405 IAC 9-9-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-9-8 Member payment liability

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 8. Providers must accept plan reimbursement as payment in full. A ~~plan~~ provider cannot collect from a member any portion of the provider's charge for a covered service that is not reimbursed by the insurer or the association, with the exception of the following:

(1) Emergency room copayments authorized under this article.

(2) Payments made with POWER account funds before the deductible of the member's health plan is met.

~~(3) The difference between a brand name drug and its generic substitute when only the cost of the generic substitute is covered by the insurer or the association.~~

(Office of the Secretary of Family and Social Services; 405 IAC 9-9-8; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 20. 405 IAC 9-10-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-10-7 Changing insurers before first POWER account contribution

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 7. Members may change insurers:

(1) before making their first POWER account contribution; or

(2) within sixty (60) days of being assigned to an insurer;

whichever comes first. After the first POWER account contribution is made, they may not change insurers without cause, **as determined by the office or its designee,** for the duration of the twelve (12) month ~~eligibility period.~~ **coverage term.**

(Office of the Secretary of Family and Social Services; 405 IAC 9-10-7; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 21. 405 IAC 9-10-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-10-9 Annual recalculation of POWER account contribution

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 9. (a) For members who remain eligible for the plan at the end of the coverage term, POWER account contributions shall be recalculated by the state as part of the ~~redetermination~~ **renewal** process. This may occur after the new coverage term has begun.

(b) If some or all of a member's POWER account balance is rolled over at the end of the coverage term, the amount of the member's POWER account contribution for the new coverage term shall be reduced by the amount of the member's rolled-over account balance from the previous coverage term. Insurers or the association must notify the member of:

(1) this rollover amount; and

(2) the new amount to be billed to the member in equal monthly installments in the new coverage term.

(c) For a member's second term of coverage and subsequent coverage terms, POWER account contributions are determined in the following manner:

(1) Steps described in section 8 of this rule that are used to calculate first term contribution are repeated for the next coverage term.

(2) Remaining balance of POWER account from previous coverage term is determined.

~~(3)~~ **(A)** If recommended preventive care services goals established under 405 IAC 9-7-8 were met, remaining balance is subtracted from the annual contribution amount for the next coverage term to determine adjusted required contribution.

~~(4) Adjusted required contribution is divided by twelve (12) to determine monthly contribution.~~

~~(5)~~ **(B)** If recommended preventive care services goals were not met, total member and employer contributions from the previous year are calculated and divided by one thousand one hundred dollars ($1,100). This ratio is multiplied by the total amount remaining in the member's POWER account, and the result is subtracted from the annual contribution amount for the next coverage term to determine the adjusted required contribution.

~~(6)~~ **(3)** Adjusted required contribution is divided by twelve (12) to determine monthly contribution.

~~(7)~~ **(d)** Reconciliation of the POWER account **for rollover** will not occur before one hundred eighty-five (185) days after the end of the coverage term.

(e) In the event the amount of the member's POWER account balance that is rolled over at the end of the coverage term exceeds the amount of the member's POWER account contribution for the new coverage term, the member shall not receive a refund of the excess amount. The excess funds shall be returned to the office.

(Office of the Secretary of Family and Social Services; 405 IAC 9-10-9; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 22. 405 IAC 9-10-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-10-10 POWER account balance; termination and disenrollment

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2; IC 32-34

Sec. 10. (a) If a member loses plan eligibility due to nonpayment of POWER account contributions, as specified in section 16 of this rule, the member shall be paid a portion of the balance remaining in his or her POWER account. This amount is calculated as follows:

(1) Total member and employer contributions made during the latest coverage period are calculated and divided by the total amount paid into the POWER account from all sources.

(2) This ratio is multiplied by the total amount remaining in the individual's POWER account.

(3) The result is multiplied by seventy-five hundredths (.75) to determine the amount to be returned to the individual.

(b) If a member loses plan eligibility for other reasons, as specified in 405 IAC 9-4-5(a)(1) through 405 IAC 9-4-5(a)(4) and 405 IAC 9-4-5(a)(7), the member shall be paid a portion of the balance remaining in his or her POWER account, calculated as follows:

(1) Total member and employer contributions made during the latest coverage period are calculated and divided by the total amount paid into the POWER account from all sources.

(2) This ratio is multiplied by the total amount remaining in the member's POWER account.

(3) The result is returned to the individual.

(c) The insurer or the association must return the prorated share of any POWER account balance within sixty (60) days of the member's last date of participation with the insurer or the association, less any amount paid on the member's behalf. If the insurer or the association receives claims for covered services with dates of service during the prior coverage period after the POWER account balance has been paid to a former member and these claims require a POWER account payment, the insurer or the association may bill the former member for the POWER account portion of the services. **The insurer or the association may not bill the former member for claims originally denied but upheld on appeal if the appealed claim is paid more than sixty (60) days following the member's last date of participation with the insurer or the association.**

(d) Employer contributions to POWER accounts are considered part of the member's contribution for purposes of calculating POWER account balance amounts to be returned to individuals.

(e) Any remaining POWER account balances must be remitted to the state.

(f) In the event that a member:
(1) cannot be located; or
(2) otherwise does not claim the prorated share of the POWER account balance made available under this section;
the insurer or the association shall handle the unclaimed balance pursuant to the Unclaimed Property Act (IC 32-34).

(Office of the Secretary of Family and Social Services; 405 IAC 9-10-10; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 23. 405 IAC 9-10-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-10-11 Member debt

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 11. (a) In some cases, the one thousand one hundred dollar ($1,100) deductible will be met before a member has made all of his or her required contributions. The fact that a POWER account may not yet have been fully funded does not relieve the insurer or the association of the responsibility to pay providers for covered services rendered. Insurers or the association may deduct amounts owed by the member from future POWER account contributions.

(b) If a member ends participation in the plan before the conclusion of his or her twelve (12) month coverage term and the insurer or the association has made an advance payment of the deductible that has not been repaid through member POWER account contributions, or if the member owes past due POWER account contributions, the insurer or the association may collect from the individual. All collection activities must be approved by the office. The state will require the individual to settle any debts owed to insurers or the association before the individual can return to the plan.

(c) The amount owed by a member under this section shall be calculated as follows:
(1) Divide member's POWER account contribution amount (as determined under section 8 of this rule) by one thousand one hundred dollars ($1,100).
(2) Multiply the amount of claims paid up to one thousand one hundred dollars ($1,100) during the coverage term by the amount determined in subdivision (1).
(3) Subtract the total monthly individual contributions paid by the member during the coverage term by the amount determined under this subdivision.
The remaining amount is the member's debt.

(d) The member's debt shall be subtracted from any amounts owed by the insurer or association under section 10(a) or 10(b) of this rule before a distribution of the member's portion of the POWER account balance can be paid.

(e) No amount will be owed when the end of participation in the plan is due to:
(1) the death of the member;
(2) transfer to any other Medicaid ~~aid~~ **assistance** category; or
(3) transfer between insurers or an insurer and the association.

(f) Members are also liable for any nonsufficient funds check charges that may be incurred by the plans or association resulting from payment processing.

(Office of the Secretary of Family and Social Services; 405 IAC 9-10-11; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 24. 405 IAC 9-10-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-10-13 POWER account contributions; billing; payment options

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2-10

Sec. 13. (a) Insurers or the association shall bill and collect the member's required POWER account contribution as follows:
(1) Members may pay their required contribution in equal monthly installments.
(2) Families may make combined payments on behalf of all family members enrolled in the plan, with payments distributed evenly among the POWER accounts of each family member.

(b) Insurers and the association must provide members with the following contribution payment options:
(1) **Employer withholding (after taxes), under IC 12-15-44.2-10, including** acceptance of automatic payroll deduction.
(2) U.S. mail.
(3) Cash, money order, cashier's check, and personal check.
~~(4) Employer withholding (after taxes), under IC 12-15-44.2-10.~~

(c) Insurers and the association may offer additional options for making the required contribution.

(d) After plan coverage begins, subsequent POWER account contributions paid by check or money order must be available for member use within five (5) calendar days after the check has cleared.

(Office of the Secretary of Family and Social Services; 405 IAC 9-10-13; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 25. 405 IAC 9-10-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-10-14 Employer contributions; insurer and association oversight

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 14. Insurers and the association are required to monitor employer contributions to ensure that they do not exceed fifty percent (50%) of the individual's contributions. Insurers and the association are not required to accept POWER account contributions from more than one (1) employer. ~~Plans~~ **Insurers and the association** may accept one-time, lump sum contributions from employers **so long as the total sum is divided by the number of months remaining in the member's coverage term and this amount is applied to reduce the member's POWER account contribution each month remaining in the member's coverage term.**

(Office of the Secretary of Family and Social Services; 405 IAC 9-10-14; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 26. 405 IAC 9-10-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-10-17 POWER account balance transfers

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 17. (a) If a member:
(1) disenrolls from one (1) insurer or the association; and
(2) transfers to a new insurer or the association;
the insurer or the association shall transfer the member's POWER account balance to the state within thirty (30) days.

(b) If the transfer occurs at the end of a coverage term, the **original** insurer or the association is responsible for determining the amount of the transferring member's permitted rollover balance, as well as any amounts that must be credited back to the state. ~~The insurer or the association shall:~~
~~(1) forward the rollover amount to the state; and~~
~~(2) credit the state its share of the account balance, if applicable.~~
(1) The original insurer or the association shall:
(A) transfer the entire POWER account balance, if any, to the state within one hundred eighty-five (185) days of the end of the coverage term;
(B) indicate the member's permitted rollover balance;
(C) indicate the portion of the POWER account balance that must be remitted to the state; and
(D) indicate whether recommended preventive care services goals were met, if this information is available.
(2) The new insurer or the association will receive the applicable rollover amount from the state within five (5) days of the state's receipt of the funds and shall adjust monthly POWER account contribution amounts accordingly.

(Office of the Secretary of Family and Social Services; 405 IAC 9-10-17; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

SECTION 27. 405 IAC 9-10-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-10-21 Failure to renew participation in the plan

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 21. (a) If a member fails to complete all necessary steps to maintain or renew eligibility in the plan during ~~redetermination,~~ **renewal,** the member will not be permitted to reapply for the plan for a period of at least twelve (12) months.

(b) The insurer or the association is required to refund the member's pro rata share of his or her POWER account balance, if any, within sixty (60) days of the member's last date of participation in the plan. The amount payable to the member shall be determined in accordance with the process set forth in section 10(b) of this rule. If the insurer or the association receives claims for covered services that would have been paid from the POWER account after the POWER account balance has been paid to a former member, the plan may bill the former member for the POWER account portion of such services, according to section 10(c) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 9-10-21; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA)

Notice of Public Hearing

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