TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Economic Impact Statement
LSA Document #14-339

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

Background and Summary of the Proposed Rule

The Indiana Family and Social Services Administration (FSSA) administered a health insurance program known as the Indiana Check-Up Plan for certain individuals not otherwise eligible for Medicaid as set out in 405 IAC 9 (the prior rules). That plan, also referred to as the Healthy Indiana Plan (HIP), existed through a federal waiver and was governed by both state and federal laws. The waiver allowed FSSA to impose certain requirements on participants not otherwise allowed under applicable Medicaid requirements.

On July 1, 2014, FSSA submitted a waiver application for an amended plan (HIP 2.0) to the Centers for Medicare and Medicaid Services (CMS). CMS approved the waiver and issued its Special Terms and Conditions (STCs) for HIP 2.0, which became effective on February 1, 2015. HIP 2.0 expands Medicaid eligibility to include the new adult population eligible under the Patient Protection and Affordable Care Act (PPACA). The new adult population includes individuals between the ages of 19-64 with a household income at or below 138%[1] of the federal poverty level (FPL). In addition, the waiver included the current nondisabled Medicaid population consisting of parents and caretaker relatives and those eligible for transitional medical assistance. FSSA transitioned the current participants in HIP to HIP 2.0 without any break in coverage. Approximately 350,000[2] uninsured Indiana citizens are eligible for HIP 2.0 during the demonstration period.

The benefit plans provided in HIP 2.0 include HIP Basic and HIP Plus plans (Plans). HIP Basic is available to members with a household income at or below 100% FPL who do not make POWER account contributions. HIP Plus is available to all members who make contributions to a POWER account, which is described below. The coverage and services provided by each Plan vary and are set forth in the proposed rules. Additionally, the Plan and cost sharing requirements vary depending on the status of the individual, such as whether the individual is an American Indian/Alaskan Native (AI/AN); medically frail; a parent, caretaker, or low income dependent; pregnant; or receiving transitional medical assistance, all as defined or described in the proposed rules.

Various requirements of the Plans are aimed at promoting increased access to health care services; encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness; and increasing quality of care and efficiency of the health care delivery system. These requirements include the opportunity for a member to receive enhanced benefits when such member makes a contribution to a POWER account, through the HIP Plus plan. A POWER account is a personal health spending account used to pay a member's deductible for covered services. Beginning April 1, 2015, HIP 2.0 also provides certain applicants with a fast track enrollment option that allows such individuals to secure a benefit start date beginning on an earlier date if such individuals are later determined eligible for the program. To do so, the applicant must submit a $10 prepayment or an initial contribution to a POWER account.

Members enrolled in a Plan will receive most of their care through providers who contract with an insurer (Insurer). Under this arrangement, FSSA will pay the Insurer a capitated payment for the members' care. Providers may charge certain copayments described in the proposed rules. The Insurer is primarily responsible for managing costs relative to the capitation payment and for collecting members' contributions to the POWER accounts.

In order to implement HIP 2.0, FSSA put in place emergency rules (LSA Document #15-38 (ER)), which became effective on February 1, 2015. The emergency rules suspend the prior rules and add new sections until the FSSA promulgates the proposed rules. The emergency rules set forth the provisions to implement HIP 2.0 as approved in the STCs. The proposed rules add 405 IAC 10 to the Indiana Administrative Code and are substantially similar to the emergency rules. FSSA anticipates that the proposed rules will take effect on or before the expiration of the emergency rules.

Impact on Small Businesses

The following section provides responses to the requirements outlined in IC 4-22-2.1-5:

1. An estimate of the number of small businesses, classified by industry sector, that will be subject to the proposed rule.

IC 5-28-2-6 defines a small business as a business entity that satisfies the following requirements:

(1) On at least fifty percent (50%) of the working days of the business entity occurring during the preceding calendar year, the business entity employed not more than one hundred fifty (150) employees.

(2) The majority of the employees of the business entity work in Indiana.

Although the primary purpose of the proposed rules is to outline eligibility and other Plan requirements for individuals (not businesses) who are eligible for coverage under HIP 2.0, some sections of the proposed rules do affect businesses. The proposed rules provide that an employer may choose to make contributions to an employee's POWER account. An applicant will not be required to provide an employer

name when submitting an application for HIP 2.0. Thus, FSSA is not aware which members are employed. Because FSSA does not receive any information about employers at all, it is difficult to predict how many employers may choose to make a contribution. For the same reasons, it is also difficult to predict which of these employers will meet the statutory definition of small business described above. Any small business employer who voluntarily makes contributions to an individual's POWER account will need to become familiar with any administrative processes required by HIP 2.0, but FSSA expects these processes to be minimal. To the extent that a small business employer incurs such minimal administrative costs, such employer does so voluntarily.

All licensed acute hospitals and private psychiatric hospitals making payments under the hospital assessment fee (HAF) will help fund HIP 2.0 starting in 2017. The HAF program is codified in IC 16-21-10 and is designed to increase hospital inpatient and outpatient reimbursement to align with the level of payment that would be paid under the federal Medicare program. Although a small number of hospitals in Indiana may satisfy the statutory definition of small business described above, the HAF program began in 2011 and existed prior to the prior rules and the proposed rules. The proposed rules do not cause hospitals to be subject to the HAF program. It is also important to note that while HAF funds will be utilized to help fund HIP 2.0 starting in 2017, hospitals and other providers will benefit from a reduction in uncompensated care beginning in 2015.

Insurers and providers who choose to participate in HIP 2.0 will also be affected by the proposed rules. FSSA expects that many of the same Insurers and providers that participated in HIP will continue to participate in HIP 2.0 (subject to a rebidding process for Insurers that may occur in two years). The state selected three Insurers through an RFP process to participate in HIP. None of the Insurers meet the definition of small business set forth above. However, it is possible that some of the providers in the Insurer's networks will meet the statutory definition of small business. In 2014, approximately 15,000 provider entities and groups were enrolled in Medicaid. Many of these providers have contracts with an Insurer and participated in HIP. FSSA estimates that more than half of these providers may qualify as small businesses. Because FSSA has determined that certain providers could meet the definition of small business, the responses to the remaining requests contained in this statement will focus solely on these providers.

2. An estimate of the average annual reporting, record keeping, and other administrative costs that small businesses will incur to comply with the proposed rule.

Provider participation in HIP 2.0 is voluntary. However, providers must comply with certain program requirements to remain enrolled as a Medicaid provider and to receive reimbursement. As such, providers will incur specific costs and will need to become familiar with the administrative processes required for participation in HIP 2.0. For example, providers who are not already providing Medicaid services are required to also enroll as a Medicaid provider with FSSA. In order to do so, a provider must pay an approximate $550 application fee at the initial enrollment and a similar fee when the facility changes ownership or adds a new service location. A provider must also undergo a background check. Providers also must comply with certain record retention and reimbursement claim rules and determine ways to collect copayments. Many providers already have these administrative processes in place as a result of participating in traditional Medicaid, Hoosier Healthwise, and HIP. Additionally, these administrative processes are generally consistent with the processes required for providers under many commercial insurance plans in which they participate and are standard operating procedures for medical practices. Thus, the proposed rules do not impose or mandate any administrative costs on any small providers that are not already part of the costs regularly incurred by small business medical providers.

3. An estimate of the total annual economic impact that compliance will have on small businesses subject to the rule.

FSSA estimates that providers may treat more insured patients as a result of the implementation of HIP 2.0. If a provider has the capacity to accept new Medicaid patients and does accept new Medicaid patients, such provider's cost of uncompensated care may decrease. Additionally, the revenues realized by such provider could increase. These providers will also see an increase in administrative costs by accepting new Medicaid patients, but FSSA expects that any increase in provider costs will be more than offset by increases in revenue.

4. A statement justifying any requirement or cost that is imposed by the proposed rule and not expressly required by law. The statement must reference any data, studies, or analyses relied upon by the agency in determining imposition of the requirement or cost is necessary.

The proposed rules implement the HIP 2.0 requirements as set forth in the STCs. The few provisions impacting small business providers involve claims reimbursement and program integrity measures, both requirements under state and federal law and applicable to all Medicaid providers. Additionally, in order to participate as a provider under HIP 2.0, the provider must typically contract with an Insurer and comply with the requirements of such Insurer, some of which the Insurer is required to pass on to the provider under applicable federal or state law or in accordance with the Insurer's contract with the state. Insurers may also

impose certain requirements in their contracts with providers. If the provider participates in traditional Medicaid, Hoosier Healthwise, or other similar programs, the provider will already be familiar with such requirements. In addition, many of these requirements are similar to requirements that appear in commercial insurance plans. As a result, most providers are very familiar with the administrative costs associated with participating in health insurance plans like HIP 2.0.

5. Any regulatory flexibility analysis that considers any less intrusive or less costly alternative methods of achieving the same purpose.

Health care providers generally incur costs to participate in health insurance plans, including Medicaid. A provider that participates in traditional Medicaid or similar programs already incurs costs similar to those required by HIP 2.0. Thus, it is not expected that HIP 2.0 will require more burdensome or intrusive requirements than typical insurance plans or programs in which providers participate.

Other factors considered:

A. Establishment of less stringent compliance or reporting requirements for small businesses.

Any compliance or reporting requirements for small business providers that result from the proposed rules are either required by federal law, the STCs, and/or the provider's contract with an Insurer, and are typical requirements for all medical providers regardless of size. Thus, FSSA is not able to consider lesser requirements for small businesses. Additionally, all participation for small businesses is voluntary.

B. Establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses.

Any compliance or reporting requirements for small business providers that result from the proposed rules are either required by federal law, the STCs, and/or the provider's contract with an Insurer, and are typical requirements for all medical providers regardless of size. Thus, FSSA is not able to consider less stringent deadlines for small businesses. Additionally, all participation for small businesses is voluntary.

C. Consolidation or simplification of compliance or reporting requirements for small businesses.

Any compliance or reporting requirements for small business providers that result from the proposed rules are either required by federal law, the STCs, and/or the provider's contract with an Insurer, and are typical requirements for all medical providers regardless of size. Thus, FSSA is not able to simplify the requirements for small businesses. Additionally, all participation for small businesses is voluntary.

D. Establishment of performance standards for small businesses instead of design or operational standards imposed on other regulated entities by the rule.

The operational standards for small business providers that result from the proposed rules are either required by federal law, the STCs, and/or the provider's contract with an Insurer, and are typical standards for all medical providers regardless of size. Thus, FSSA is not able to provide different standards for small businesses. Additionally, all participation for small businesses is voluntary.

E. Exemption of small businesses from part or all of the requirements or costs imposed by the rule.

HIP 2.0 implements the STCs. Under the STCs, providers are subject to the same requirements regardless of size. Thus, FSSA is not able to exempt small business providers from these requirements. Additionally, all participation for small businesses is voluntary.

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[1] The federal poverty limits in the proposed rules are based on modified adjusted gross income (MAGI). Applicable federal requirements include an income disregard equal to 5% of FPL for purposes of determining income eligibility for individuals whose Medicaid eligibility is based on MAGI. As a result, for persons with a household income at or below 138% of FPL, the proposed rules incorporate a 133% of FPL threshold to reflect the 5% disregard.

[2] The numbers in this analysis are taken from the 1115 Waiver – Healthy Indiana Plan Expansion Proposal dated February 13, 2015, prepared by Milliman, Inc. (Study), reduced by the amounts projected for HIP Link, which is not part of the proposed rules. Because these numbers were produced based on certain assumptions described in the Study (such as the number of new enrollees who may take advantage of HIP 2.0), it is possible that actual numbers may be different from these projections.

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