

Members

Sen. Patricia Miller, Chairperson  
Sen. Ryan Mishler  
Sen. Vaneta Becker  
Sen. Ed Charbonneau  
Sen. Beverly Gard  
Sen. Ron Grooms  
Sen. Jean Leising  
Sen. Jean Breaux  
Sen. Earline Rogers  
Sen. Vi Simpson  
Rep. Timothy Brown, Vice-Chairperson  
Rep. Steven Davisson  
Rep. Ronald Bacon  
Rep. Suzanne Crouch  
Rep. Richard Dodge  
Rep. David Frizzell  
Rep. Donald Lehe  
Rep. Eric Turner  
Rep. Charlie Brown  
Rep. John Day  
Rep. Craig Fry  
Rep. Scott Reske  
Rep. Peggy Welch



## HEALTH FINANCE COMMISSION

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LSA Staff:

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Kathy Norris, Fiscal Analyst for the Commission

Authority: IC 2-5-23

### MEETING MINUTES<sup>1</sup>

Meeting Date: July 13, 2011  
Meeting Time: 10:00 A.M.  
Meeting Place: State House, 200 W. Washington  
St., the Senate chambers  
Meeting City: Indianapolis, Indiana  
Meeting Number: 1

**Members Present:** Sen. Patricia Miller, Chairperson; Sen. Ryan Mishler; Sen. Ed Charbonneau; Sen. Ron Grooms; Sen. Jean Leising; Sen. Jean Breaux; Rep. Timothy Brown, Vice-Chairperson; Rep. Steven Davisson; Rep. Ronald Bacon; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. David Frizzell; Rep. Donald Lehe; Rep. Charlie Brown; Rep. Craig Fry; Rep. Scott Reske; Rep. Peggy Welch.

**Members Absent:** Sen. Vaneta Becker; Sen. Beverly Gard; Sen. Earline Rogers; Sen. Vi Simpson; Rep. Eric Turner; Rep. John Day.

Chairperson Patricia Miller called the meeting to order at 10:03 a.m. and introduced the members of the Commission. Commission members discussed possible future meeting dates and determined that the Commission's next meeting dates would be held at 10:00 a.m. on September 14, 2011, September 28, 2011, and budget permitting, a meeting in October, 2011. Staff informed the Commission on the process that will be

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<sup>1</sup> These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative>. Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

followed in providing members with Commission meeting notices and agendas.

### **Health Insurance Exchanges Update**

Ms. Seema Verma, consultant to the Family and Social Services Administration (FSSA), presented a Power Point update on Indiana's progress in developing a Health Care Exchange (Exchange) in accordance with the federal Affordable Care Act (ACA). See Exhibit 1. Ms. Verma stated that FSSA has submitted a Medicaid state plan amendment to the federal Centers for Medicare & Medicaid Services (CMS) to use the Healthy Indiana Plan (HIP) as a vehicle for the Exchange. Ms. Verma stated that it is expected that CMS will respond to the state plan amendment by July 14, 2011 and may require Indiana to submit the request as a Medicaid waiver instead of as a Medicaid state plan amendment.

Ms. Verma stated that the Governor executed an executive order on January 14, 2011 to allow the executive branch to plan for and study elements of an Exchange. Ms. Verma summarized federal grants that Indiana has applied for and received concerning federal health care reform. See Exhibit 1, page 4. Ms. Verma also provided the Commission with a summary of the status of three lawsuits concerning the constitutionality of the ACA, including the lawsuit in which Indiana is a plaintiff. See Exhibit 1, page 5.

Ms. Verma commented that Indiana has sought out and received stakeholder input through meetings with, and surveys of, multiple interested groups. Further, Ms. Verma stated that FSSA has contracted with an actuary to provide an actuarial analysis of the possible market impact of an Exchange on the insurance market. See Exhibit 1, pages 12-17. Ms. Verma discussed with the Commission some of the variables that would impact the insurance market place, including that the state's high-risk insurance pool, ICHIA, which has helped keep insurance prices lower, would terminate in 2014. Ms. Verma reviewed the various populations that would utilize an Exchange.

Ms. Verma summarized the various functions of an Exchange and three possible options in which Indiana could operate an Exchange: (1) state or federally-operated; (2) regional or multi-state operated; or (3) non-profit or quasi-governmentally operated. The Commission was reminded by Ms. Verma that the federal government has currently only funded an Exchange through 2015, and that after 2015 the Exchange must be self-sustaining. Ms. Verma reviewed the time lines that the federal government has set for a state's Exchange. The federal government will assess each state's readiness to operate its Exchange in June, 2012. By January, 2013, the federal government will decide who will operate the state's Exchange, and by September or October, 2013, the Exchange should be able to start taking applications for a January 1, 2014 implementation.

Ms. Verma described three design options for the state's Exchange: (1) the "Orbitz" approach, which is a minimal approach that does not influence the market, provides little coordination, utilizes existing brokers, and is the cheapest; (2) the "Amazon" approach, which rates and recommends plans, preserves choices, but could influence the market and result in rating protests; and (3) the active purchaser model, based on the Massachusetts model, which negotiates prices, acts as a bulk purchaser, and assists in achieving the lowest price but would decrease the number of insurers in Indiana and offer limited choice. See Exhibit 1, page 18. Ms. Verma also discussed the advantages and disadvantages to having the Exchange operated by the state instead of the federal government and the survey results on this issue. See Exhibit 1, pages 19-21. Ms. Verma provided the Commission with results of the survey of multiple stakeholders concerning multiple questions concerning the Exchange. See Exhibit 1, pages 22-32.

Ms. Vicki Perry, Advantage Health Solutions, stated that she has some concerns in the planning and implementation of an Exchange. First, Ms. Perry expressed concerns with how the Exchange would consider network adequacy. Ms. Perry expressed an interest in providing equal access to participation in the Exchange to allow for competition and a level playing field for insurers to ensure quality services. Ms. Perry stated that coordination between providers and insurers is essential and would be weakened if the Exchange required a statewide commitment outside of current geographic network boundaries. Second, Ms. Perry expressed a concern with financing the Exchange through an insurer fee. Ms. Perry stated that this would disproportionately affect non-profit insurance companies and adversely affect local community health plans.

Ms. Elena Butkus and Geoff Sandler, Aetna, testified that Aetna covers 18.6 million lives nationally and 163,000 lives in Indiana. Ms. Butkus stated that the establishment of an Exchange at the state level is important, especially concerning the number of carriers allowed to participate and the type of coverage offered. See Exhibit 2.

Mr. Sandler discussed several concerns relating to the design of the Exchange. Mr. Sandler stated that adverse selection will be a challenge to address and that, to reduce adverse selection, the state should limit employer eligibility in the Exchange to small employers to prevent driving up the risk pool. Mr. Sandler commented that adverse selection could result in price increases in the Exchange and impact the overall individual and small group markets in Indiana. Mr. Sandler testified that ways Indiana could reduce adverse selection include: (1) limiting the open enrollment period for the Exchange; (2) providing assistance for enrollment; (3) requiring proof of insurance as conditions to other state programs; and (4) ensuring stable enrollment.

Mr. Sandler also expressed the hope that the Exchange would promote competition in the individual and small group markets. Mr. Sandler stated that the Exchange should allow for employees of a small employer to have a choice of choosing any plan on the Exchange but not impose this as a requirement for insurers. Mr. Sandler also suggested that the Exchange should not recreate existing regulations and adopt standard health information technology and quality rules. Mr. Sandler testified that the Exchange should be financed by broad-based financing mechanisms instead of limiting the financing to insurer assessments. See Exhibit 2.

Mr. Mike Rinebold, Indiana State Medical Association (ISMA), informed the Commission that ISMA has been participating in the process of implementing the ACA. Mr. Rinebold stated that the challenge is to develop a framework that provides a consumer with coverage options and enables consumers to have access to multiple services, including preventative and primary care. Mr. Rinebold testified that physicians and patients should have input in the types of coverage and regulations included in the Exchange. Mr. Rinebold elaborated that consumers should be provided with the necessary information to participate in the Exchange, include cost participation requirements, coverage capitations, and the level of coverage being offered.

Ms. Libby Cierzniak, representing Delta Dental, informed the Commission that the ACA provides for options in offering dental benefits through the Exchange. Ms. Cierzniak testified that the ACA allows for an Exchange to offer limited dental plans as long as the coverage includes pediatric services, and can be either offered as a stand alone plan, bundled, or offered in conjunction with a separately priced plan. Ms. Cierzniak stated that Delta Dental advocates that dental coverage be offered as a separate plan even if it is also offered in conjunction with other plans.

Mr. Paul Chase, AARP, stated that AARP is participating in a Healthcare

Implementation Work Group that includes 54 participants. Mr. Chase informed the Commission that this Work Group has developed a draft of guiding principles for operation of an Exchange. See Exhibit 3. Mr. Chase stated that AARP would like a greater role in discussions in developing an Exchange and stated that the Work Group would be holding a symposium in the fall. Mr. Chase distributed a summary of legislation enacted by other states concerning the development of an Exchange. See Exhibit 4.

The Commission recessed for lunch.

### **Innovations in Nursing Home Services and Housing**

Sister Barbara Ann Zeller, President/CEO of Villas of Guerin Woods, provided the Commission with some informational materials concerning her facility, which is based on a small house model and functions like a home. See Exhibit 5. Sister Zeller stated that the services provided at the facility revolve around the individual, and the architecture of the facility looks like the other residences in the neighborhood. Each villa includes ten private bedrooms with an individual bathroom and are located four or five feet away from the hearth area. Sister Zeller explained that the focus is on maximizing the elder's interests and capabilities and allows for the habitants to participate in making meals and other daily activities.

Mr. Vince McGowen, Magnolia Health Systems, commented that nursing homes are more about real estate than about healthcare. Mr. McGowen stated that the focus should be on how to improve quality of care and how to keep an individual in the home with home health care. Mr. McGowen testified that Indiana has too many nursing homes with a 30% vacancy rate and should look at closing some of the nursing homes to re-balance health care. Mr. McGowen suggested changing the payment system for nursing homes to require a competitive bidding process. Mr. McGowen stated that tax incentives are being offered to owners to build new facilities when existing facilities are sufficient.

Mr. John Cardwell, Generations Project, stated that most individuals do not want to go to a nursing home, and if this is the only option, the individual wants better choices than those that currently exist in Indiana. Mr. Cardwell informed the Commission that 75-90% of Indiana's long term care budget is spent on nursing homes and that this is too high. Mr. Cardwell stated that the money is not being used for cost effective home and community based care.

Mr. Christopher Nanni, Community Foundation of St. Joseph County, informed the Commission of a year-long initiative being conducted in South Bend, Indiana, to increase quality elder care through a regional nursing home learning collaborative. Mr. Nanni testified that Community Foundation will provide eight half-day training sessions in 2011, with four already conducted, for nursing home administrators, directors of nursing, and other management personnel. Mr. Nanni commented that 18 South Bend nursing homes and two Elkhart nursing homes have participated in the training and that Indianapolis is considering replicating these training sessions. Mr. Nanni stated that the training sessions will be followed up with personalized site visits to assist the nursing facilities with issues the nursing facility is facing. See Exhibit 6.

Mr. Paul Chase, AARP, provided the Commission with the definition of "small house health facility" that passed in legislation enacted during the 2011 legislative session. See Exhibit 7. Mr. Chase expressed hope that Indiana will continue to look at new ways to grow alternative long term care options.

Mr. Dennis Lanane, President of United Senior Action of Indiana, testified that

there is a lack of quality nursing home care in Madison County and provided the Commission with examples of poor nursing home care provided in the area. Mr. Lanane stated that his organization would continue to assist Indiana in developing innovations in long term care.

Ms. June Holt stated that her 25 year-old son is a resident of a nursing home and that nursing homes are not structured to care for younger people. Ms. Holt stated that she supports the small home model where individuals have more control of their care. Ms. Holt also questioned how quality of care is measured in nursing homes, stating that the current measurement is by the fewest negative things that have happened instead of good things.

The Commission meeting was adjourned at 2:35 p.m.

# Update on Exchanges



**HEALTH FINANCE COMMITTEE  
SEEMA VERMA  
JULY 13, 2011**

# Recent Progress

- Healthy Indiana Plan (HIP).
  - State Plan Amendment.
    - Response expected from CMS by July 14.
  - Preparation of 1115 waiver.
- Other Initiatives:
  - Rules on new insurance regulations 9/10.
  - Correct Coding Initiative (CCI).
  - Provider credentialing.

# Recent Progress Continued

- Medical Loss Ratio (MLR):
  - Asked for MLR adjustment from HHS.
    - Phased-in approach.
    - Consideration of CDHPs.
  - Responding to questions from the federal government.
- Rate Review:
  - Deemed adequate by federal government.
  - Enhanced reporting requirements to HHS.
- External Review:
  - In compliance through 2014.
  - July 31, 2011 – federal government will make a determination regarding whether the State is compliant beyond 2014.

# Grants

- State applied for:
  - Grants to States for Health Insurance Premium Review.
  - Expansion of MIPPA.
  - ADRC Options for Counseling and Assistance Programs.
  - ADRC Evidence-Based Care Transition Programs.
  - ADRC Nursing Home Transition and Diversion Program.
  - Maternal, Infant and Early Childhood Visiting Program.
  - Strengthening Public Health Infrastructure for Improved Health Outcomes.
  - Exchange Planning Grant.
  - Exchange Level One Grant.
  - Coordinated Care for People with Medicaid and Medicare.\*
- Areas where grants and/or demonstrations will become available: Medicaid/Medicare payments, physician access, public health and education.

# Constitutionality of the Individual Mandate

Case	District Court	Appellate Court	Next Steps
<p><i>State of Florida et al. v. Secretary of Dept. of HHS</i> – Filed on behalf of 25 states and the NFIB (includes Indiana Attorney General).</p>	<p>January 31, 2011: Judge Robert Vinson deemed individual mandate <b>unconstitutional</b> and <b>non-severable</b>.</p>	<p>On appeal in 11<sup>th</sup> Circuit Court of Appeals. Oral arguments held on June 8<sup>th</sup>.</p>	<p>Appellate Court ruling is pending.</p>
<p><i>Commonwealth of Virginia v. Sebelius</i>.</p>	<p>December 13, 2010: Judge Henry Hudson deemed individual mandate <b>unconstitutional but did not strike down entire ACA</b>.</p>	<p>On appeal in 4<sup>th</sup> Circuit Court of Appeals. Oral arguments held on May 10<sup>th</sup>.</p>	<p>Appellate Court ruling is pending.</p>
<p><i>Thomas More Law Center v. Barack Obama</i>.</p>	<p><b>Upheld individual mandate</b> under the commerce clause.</p>	<p>Appealed to 6<sup>th</sup> Circuit Court of Appeals. <b>Upheld validity of individual mandate</b>.</p>	<p>Widely accepted that Thomas More Law Center will petition Supreme Court for review.</p>

# Exchange Functions

***Expedia* for health insurance; tool with which individuals or small employers can find, compare and enroll in health insurance.**

- Eligibility.
  - Seamless eligibility with Medicaid.
  - Tax subsidies.
  - Individual Responsibility Exemption.
  - Appeals.
- Enrollment in health plans.
  - Option: Premium Collection and Aggregation.
- Certify, recertify and decertification of plans offered on Exchange.
- Assign quality ratings to plan, per HHS guidelines.
- Customer Support.
  - Web Portal.
  - Online.
  - By phone.
  - In person.
- Education and outreach.
- Small Business Options Program (SHOP) – small business exchange.
- Cost calculator.
- Risk adjustment for plans.
- Federal Reporting.
  - Provide income data to the IRS, and citizenship or immigration status to SSA & Homeland Security.

# ACA & Healthcare Exchanges

- Only place to purchase insurance with tax subsidies.
- Options:
  - State or federally operated.
  - State or regional/multi-state Exchange.
  - State agency, not-for-profit or quasi-governmental.
- Funded through 2015 by feds; after that must be self-sustaining.

# Tentative Exchange Implementation Timeline

June 2012 (estimated)	Federal assessment of State readiness.
January 2013 (final, per ACA)	Federal decision whether State or Federal Government will operate the Exchange.
September 2013 (estimated)	Potential go-live.
January 1, 2014	ACA implementation date.

## Update on Indiana's Efforts

- **Executive Order was issued by Governor Daniels on January 14, 2011.**
  - Does not commit the State to an Exchange.
  - Allows the State to plan for an Exchange & to study the implications of the Exchange.
  - State can stop if ACA is unconstitutional or for other reasons.
  - Conditionally establishes a not-for-profit entity to operate an Indiana-based Exchange.
  - Leverages current agencies (IDOI and FSSA) without creating new agencies.
- **Exchange Grants.**
  - No obligations if State decides to let the federal government run the Exchange for Indiana.
  - Planning Grant (October 2010).
  - Level 1 Establishment Grant (May 2011).

## Status of Activities

- Stakeholder input – Ongoing.
- Market Impact – actuarial analysis – In progress.
- IT gap analysis – Completed.
- IT plan to support Exchange – In progress.
- Business requirements – In progress.
- Budget Financing plan – In progress.
- Legal issues – Impact on IDOI and FSSA – In progress.

# Indiana Insurance Market

Market	2010 Covered Lives	Carriers >100 Lives	Market Share Largest Carrier	Market Share Top 5 Carriers
Individual	175,000	49	65%	90%
Insured Small Group (2-50 employees)	250,000	30	63%	85%
Insured Large Group (51+ employees)	425,000	23	66%	93%

Source: Milliman. December 31, 2010 Indiana Supplemental Health Exhibits, collected using Insurance Analyst Pro®, Highline Data LLC.

- Includes only comprehensive policies.
- Values are rounded.

# Indiana Health Insurance Coverage 2010 Profile Ages 0 to 64

Source of Health Insurance	Residents, Age 0 to 64	% of Residents
<b>Uninsured</b>	875,000	16%
<b>Public Programs</b>	950,000	17%
<b>Individual Insurance</b>	200,000	4%
<b>Employer-Sponsored Insurance</b>		
Insured Small Group (2-50 employees)	300,000	5%
Insured Large Group (51+ employees)	475,000	8%
Self-Funded (all employer sizes)	2,825,000	50%
<b>Total Indiana Residents, Age 0 to 64</b>	<b>5,625,000</b>	<b>100%</b>

Source: Herbold, Jill S. and Paul R. Houchens. Milliman, Inc. "2010 Health Insurance Enrollment Projections for Indiana." May 2011.  
 Notes: Insured Markets - December 31, 2010 Indiana Supplemental Health Exhibits, collected using Insurance Analyst Pro®, Highline Data LLC. Public Programs - OMPP eligibility data. Uninsured and Self-Funded - American Community Survey - 2009.  
 Approximately 800,000 Indiana residents age 65+ not included. Most residents age 65+ are covered by Medicare.

# Hoosiers with Employer Sponsored Insurance (ESI)

	Number of Employees	% of Employees that Offer ESI	% of Establishments that Offer ESI	Total Employees
< 50 Employees	96,236	51.3%	57.3%	184,227
50 to 99 Employees	4,768	93.4%	54.1%	96,896
> 99 Employees	32,642	99.5%	61.3%	975,018
All Employer Sizes	133,646	86.5%	60.1%	1,256,141

\*Active private sector employment only. Does not include early retirees, public employees or individuals receiving COBRA.

Source: State Health Access Data Assistance Center. "Memorandum." March 10, 2011. – Agency for Healthcare Research and Quality, MEPS Insurance Component 2008 and 2009

# How Will the Market Change by 2019: Size

	2011	2019 Estimate
<b>Uninsured</b>	875,000	300,000 – 525,000
<b>Public Programs</b>	950,000	1,450,000 – 1,625,000
<b>Individual Insurance</b>	200,000	450,000 - 875,000
<b>Employer-Sponsored Insurance</b>		
Insured Small Group (2-50 employees)	300,000	225,000 – 300,000
Insured Large Group(51+ employees)	475,000	350,000 - 475,000
Self-Funded (All employer sizes)	2,825,000	2,850,000 – 3,125,000
<b>Total Indiana Residents Ages 0 to 64</b>	5,625,000	6,200,000 – 6,500,000

Source: Herbold, Jill S. and Paul R. Houchens. Milliman, Inc. "2019 Health Insurance Enrollment Projections for Indiana." May 2011.

Assumes that Indiana does not offer a federal basic health program.

# How Will the Market Change by 2019: Cost

- **Milliman estimates-**

- Individual market:
  - Total 75% to 95% increase.
    - Merging high risk pool with individual market – 35% to 45%.
    - Essential benefits/benefit expansion – 20% to 30%.
    - Additional factors:
      - Risk pool composition changes.
      - Provider cost shifting.
      - Manufacturer and carrier pass-throughs.
- Small group market:
  - Total 5% to 10% premium increase.
    - Risk pool composition due to items such as:
      - Employers dropping coverage.
      - Inclusion of employers up to 100 in small group market.
      - Election of self-funded plans in community rating environment.

Source: Herbold, Jill S. and Paul R. Houchens. Milliman, Inc. "Individual and Small Group Premium Changes Under the ACA." May 2011.

# How many Hoosiers may use an Exchange?

Individuals	Households	People
Currently Uninsured, 139-399% FPL	259,077	376,212
Currently with Individual Coverage, 139-399% FPL	76,734	123,993
Uninsured, above 400% FPL	38,343	90,089
Individual Coverage above 400% FPL	54,980	110,181
Total	429,134	768,133

Source: State Health Access Data Assistance Center. "Memorandum." March 10, 2011. – American Community Survey, Public Use Microdata Sample, 2009; MEPS Insurance Component, 2008-09 average; data on businesses with fewer than 25 employees and average wages less than \$50,000 per year from Department of Workforce Development.

Small Businesses Currently Offering Employee-Sponsored Insurance (ESI)

	Employees	Dependents	Total enrollees
Offering ESI with fewer than 50 Employees			
Potentially Eligible for a tax credit	96,431	69,353	165,784
Not eligible for tax credit	87,795	69,682	157,477
*ESI with 50-99 Employees	96,896	72,788	169,684
Total	281,122	211,823	492,945

Characteristics of Health Insurance Exchange Offerers

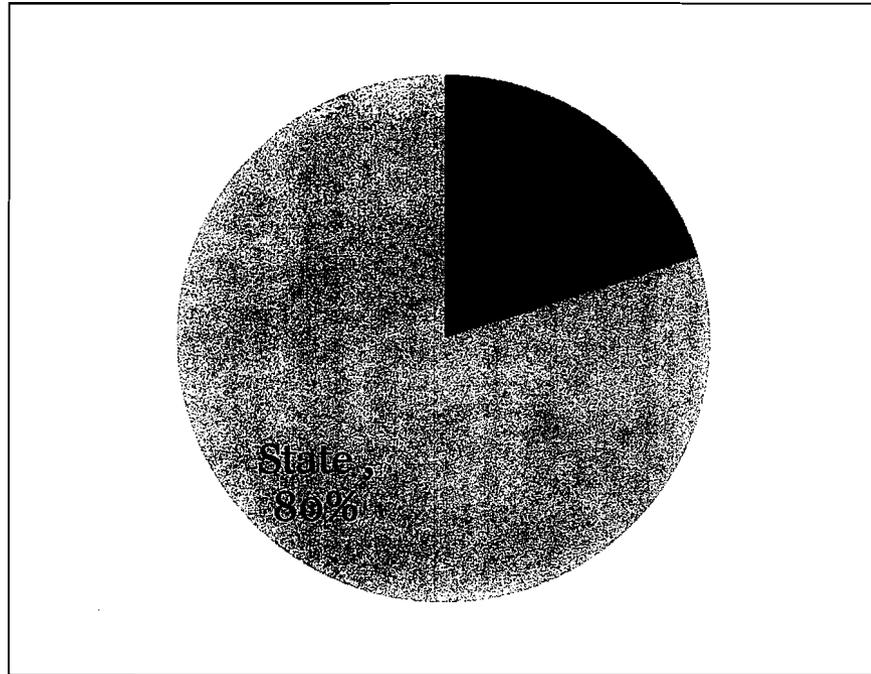
Businesses with fewer than 50 employees, not currently offering health insurance	Number of employees	Number of establishments
Potentially Eligible for a tax credit	244,301	52,771
Not eligible for tax credit	60,917	10,841
50-99 employees, currently not offering insurance	12,656	687
Over 100 employees, currently offering insurance	1,590,568	32,054
Over 100, currently not offering insurance	7,993	588
Total	1,916,435	96,941

Source: State Health Access Data Assistance Center. "Memorandum." March 10, 2011. – American Community Survey, Public Use Microdata Sample, 2009; MEPS Insurance Component, 2008-09 average; data on businesses with fewer than 25 employees and average wages less than \$50,000 per year from Department of Workforce Development.

	<b>Farmer's Market – "Orbitz"</b>	<b>Evaluator Model – "Amazon"</b>	<b>Active Purchaser – "MA Model"</b>	<b>Federal Option</b>
Characteristics	<ul style="list-style-type: none"> <li>•Required functions only</li> <li>•Does not influence the market in any meaningful way</li> </ul>	<ul style="list-style-type: none"> <li>•Rates plan</li> <li>•Identifies "Top Tier" plans by HIX criteria</li> <li>•Market Catalyst</li> </ul>	<ul style="list-style-type: none"> <li>•Negotiates Prices</li> <li>•Bulk Purchaser</li> <li>•May include Medicaid &amp; Public Employees</li> </ul>	Unknown
Consumer Impact	Choices maximized	Choices maximized	Limited choice	Unknown
Small & Individual Market	Maintains separation	Maintains separation Authority to combine	Combines markets	Unknown
External Market	Yes - Exchange rules don't apply externally Benefits of the plan may vary	Yes - Level playing field inside and outside the Exchange	No - None allowed	Unknown
Users	People eligible for tax credits Some additional users	People seeking tax credits Could attract users over time for ease of comparison	High (requires participation)	Unknown
Operational Cost	\$	\$\$ Rating system will create increased administrative tasks	\$\$\$ RFP process	Unknown
Advantages	<ul style="list-style-type: none"> <li>•Preserves competition</li> <li>•Preserves choices</li> <li>•Minimal market disruption</li> </ul>	<ul style="list-style-type: none"> <li>•Competition based on Exchange defined criteria</li> <li>•Preserves choices</li> <li>•Minimizes market disruption but can act quickly to address issues</li> <li>•Influences external market to price variation inside/outside Exchange</li> </ul>	<ul style="list-style-type: none"> <li>•Lowest price products</li> </ul>	Unknown
Disadvantages	<ul style="list-style-type: none"> <li>•Passive to the market</li> <li>•Exchange attracts only high risk or subsidized individuals only</li> <li>•Limited # of plans participate</li> </ul>	<ul style="list-style-type: none"> <li>•Rating protests</li> </ul>	<ul style="list-style-type: none"> <li>•Could decrease number of insurers</li> <li>•Limited choices of plans &amp; networks</li> <li>•Fewer insurers may ultimately lead to higher prices</li> </ul>	Unknown
Small Business	Options: Defined contributions, promote HSA plans, Section 125 plans, wellness programs, HRA/HSA			
Quality	Provide a centralized location to obtain quality data for plans & providers			
Financing	Dependent on model. Options: advertising, fees to insurers, consumers, employers. Licenses/certifications for navigators/brokers.			

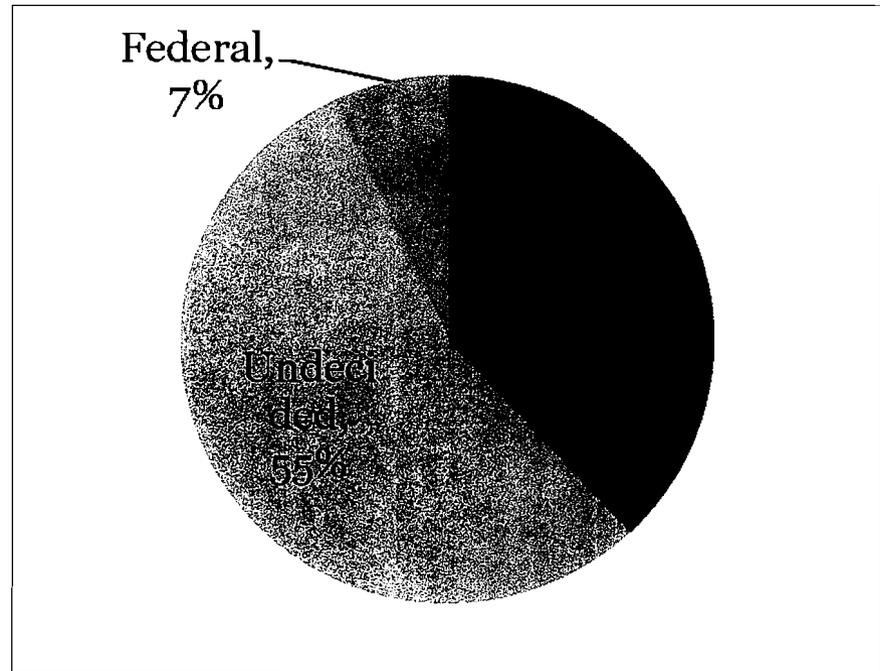
# Exchange: State v. Federal

The September 2010 questionnaire asked respondents to identify who should operate the Exchange.



Above: Insurers

Below: Businesses



Source: Affordable Care Act Questionnaire. State of Indiana. December 1, 2010. <[http://www.in.gov/aca/files/Affordable\\_Care\\_Act\\_Questionnaire\\_Report.pdf](http://www.in.gov/aca/files/Affordable_Care_Act_Questionnaire_Report.pdf)>

## Implications of a Federal Exchange

- No federal model has been offered.
- Cheaper for the State.
- Plan offerings:
  - Could limit plan choices for Hoosiers.
  - Geographic carrier/plan issues.
- Would require carriers to interface with two tiers of government for plan certification: State and federal.
- Federal government would be responsible for risk adjustment and reinsurance (redistribute \$\$ among plans).
- Medicaid eligibility:
  - Federal government making eligibility determinations on behalf of the State.
  - Multiple entry doors.
- Loss of control over customer experience.
- Limited influence over policy.

# Implications for a State-based Exchange

- **Exchange:**

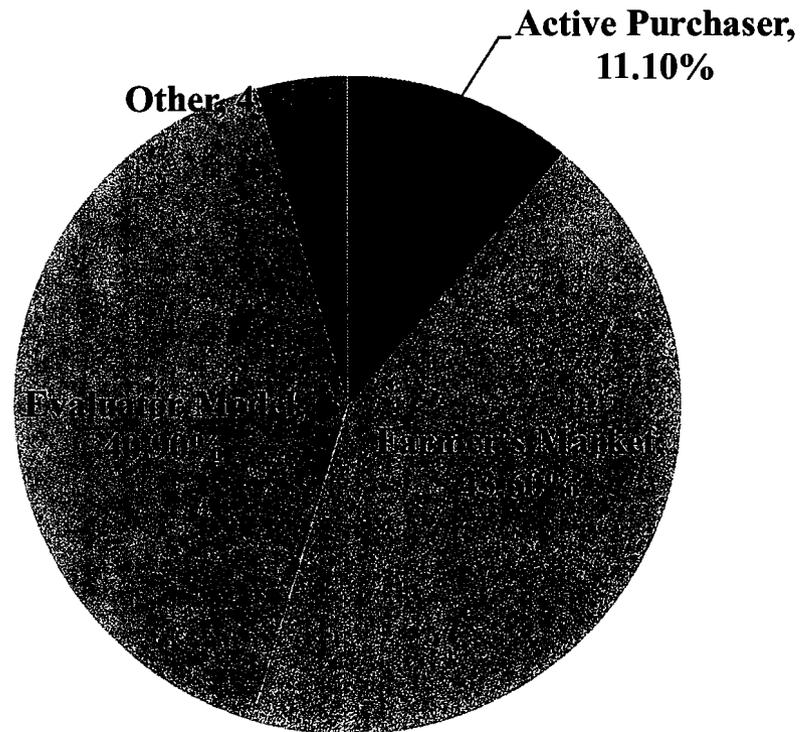
- On-going costs: could these costs increase premiums for the State?
- Complexity.
- Large number of Hoosiers that will use the Exchange.
- State would be responsible for ambitious federal deadline and could create instability in the market.

# Exchange Questionnaire

- 4 tracks.
  - Insurer/Broker.
  - Consumer.
  - Business.
  - Healthcare Provider.
- Exchange Design Topics.
- ~2,600 Respondents.
  - 1461 Consumers, 524 Businesses, 414 Insurers/Brokers, 213 Healthcare Providers.

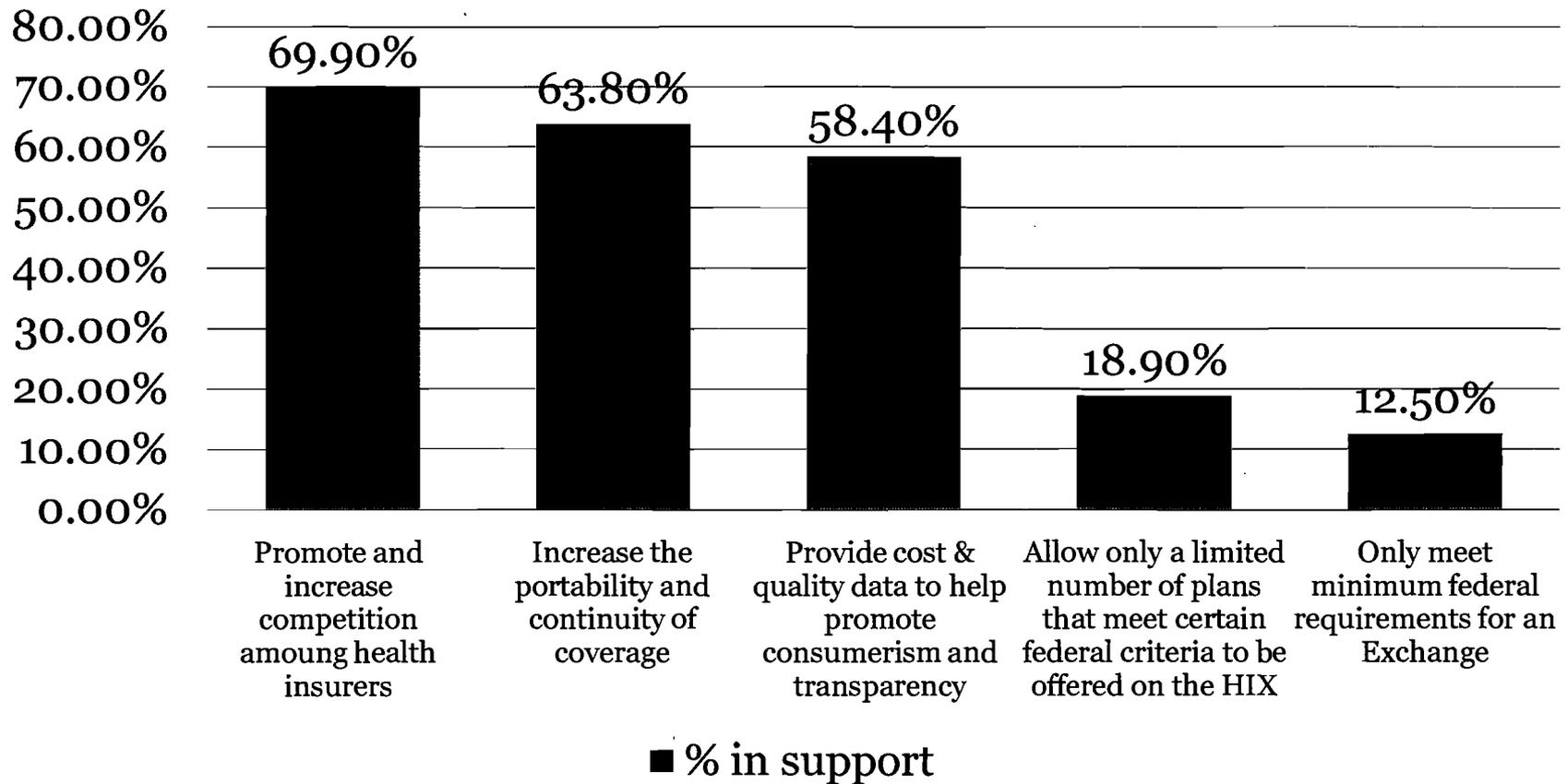
# Exchange Model

**Respondent average: Which model do you think would work best for Indiana?**



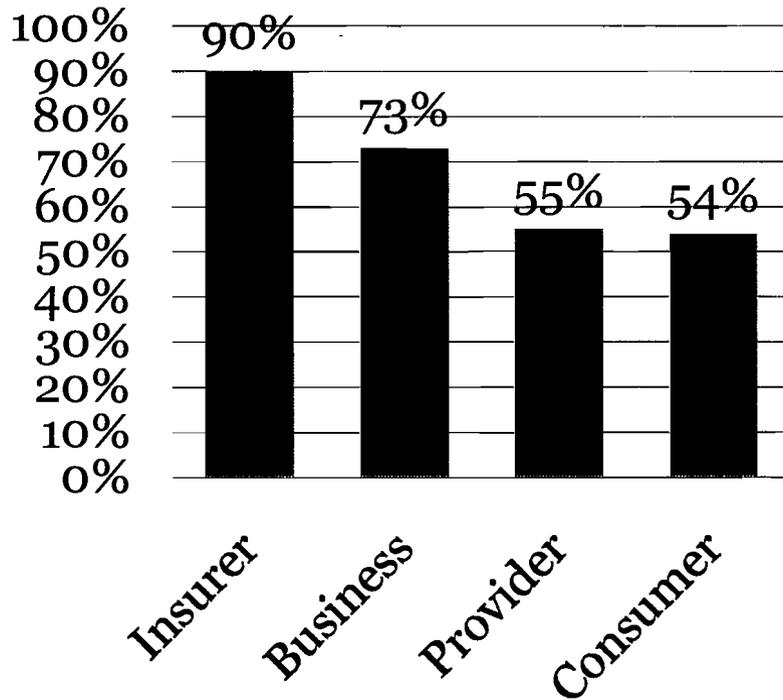
# Exchange Questionnaire: Exchange Goals

Principles respondents thought should guide the formation of an Exchange



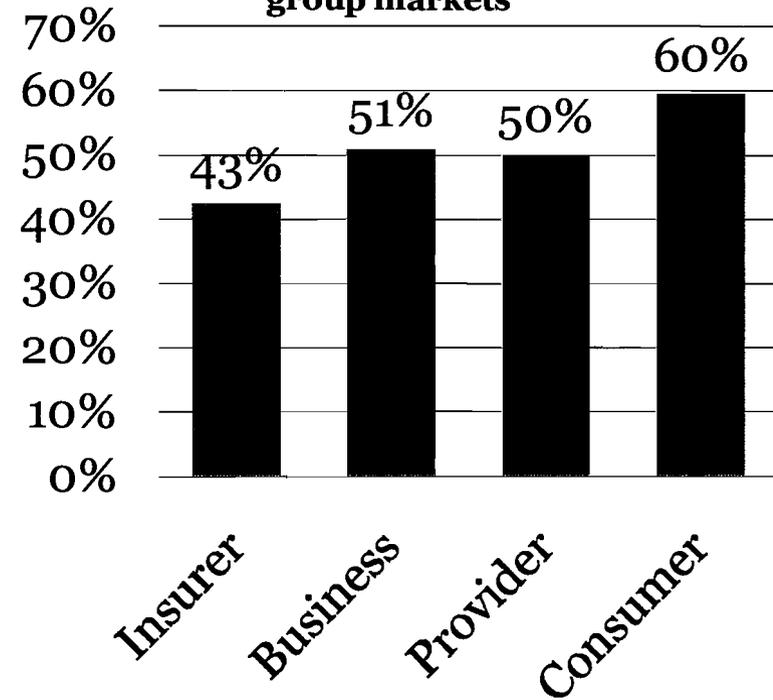
# Exchange Questionnaire: Insurance and Exchange Marketplace

**The HIX should not be the sole avenue  
to purchase insurance**



■ % in agreement

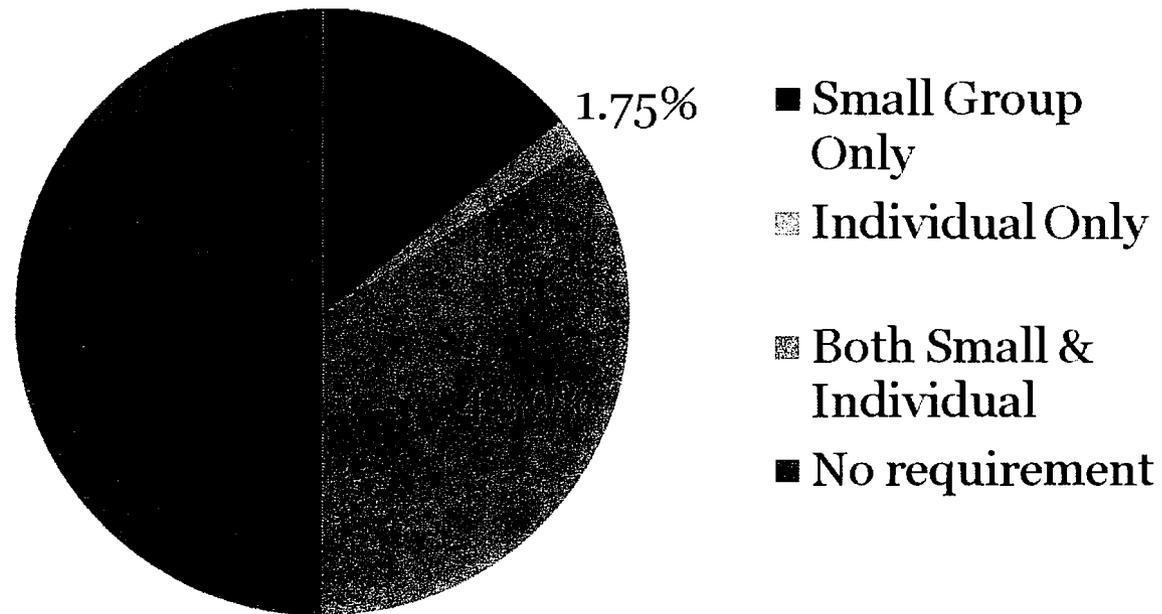
**The rules should be the same in and  
out of the HIX for individual and small  
group markets**



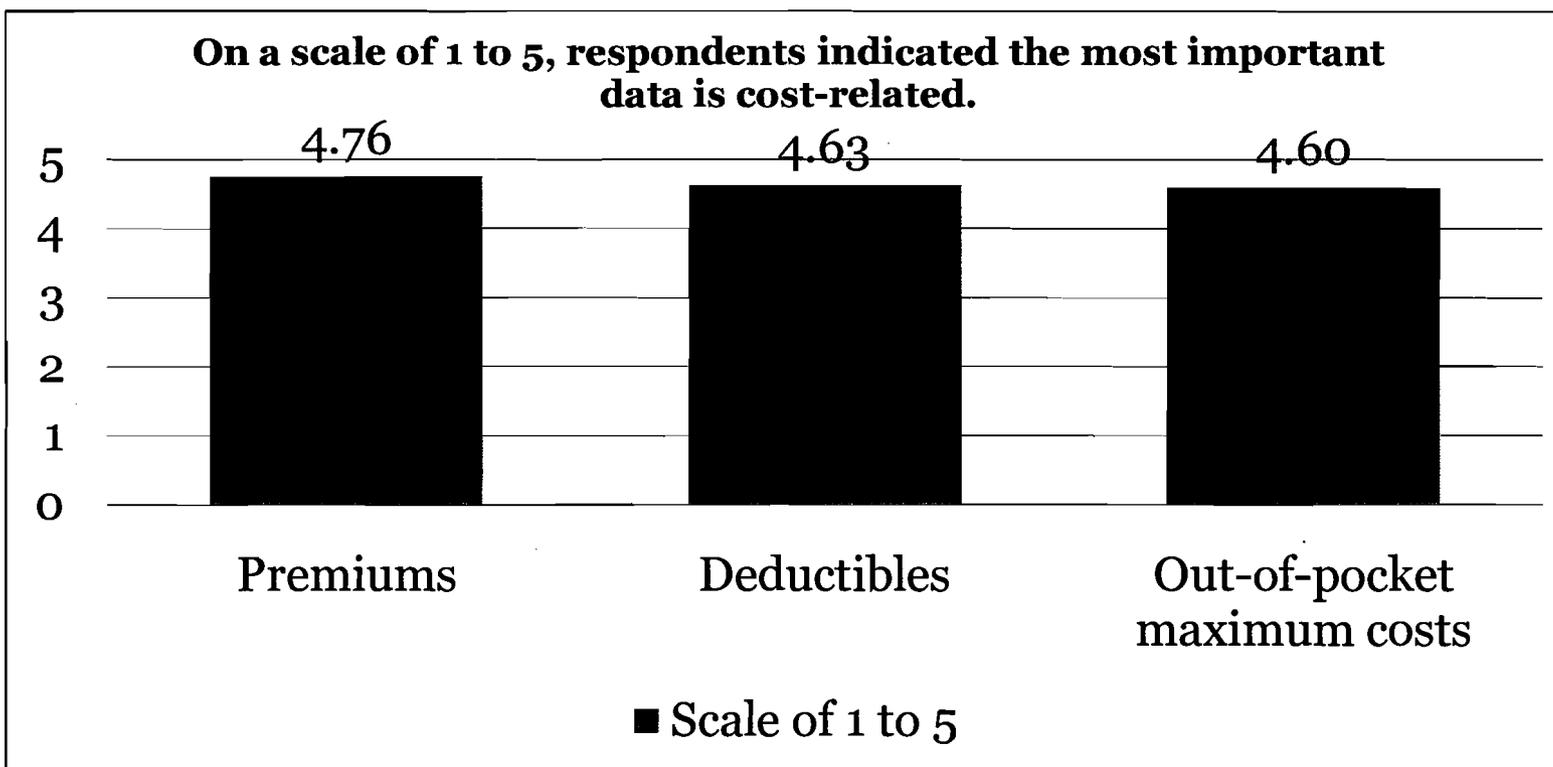
■ % in agreement

# Should all Indiana insurers be required to sell on the Exchange?

**Average % of respondents**

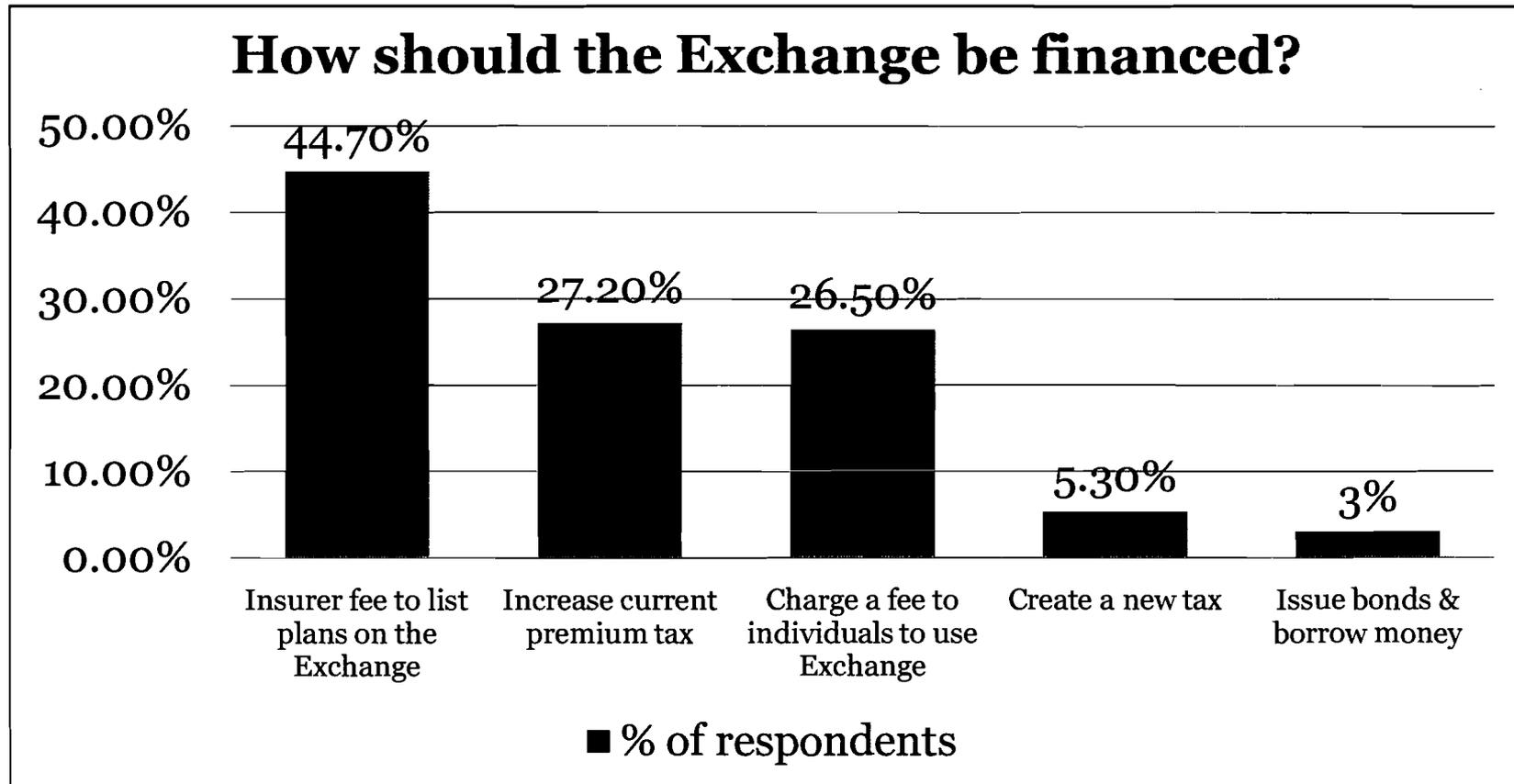


# Exchange Questionnaire: Exchange Data



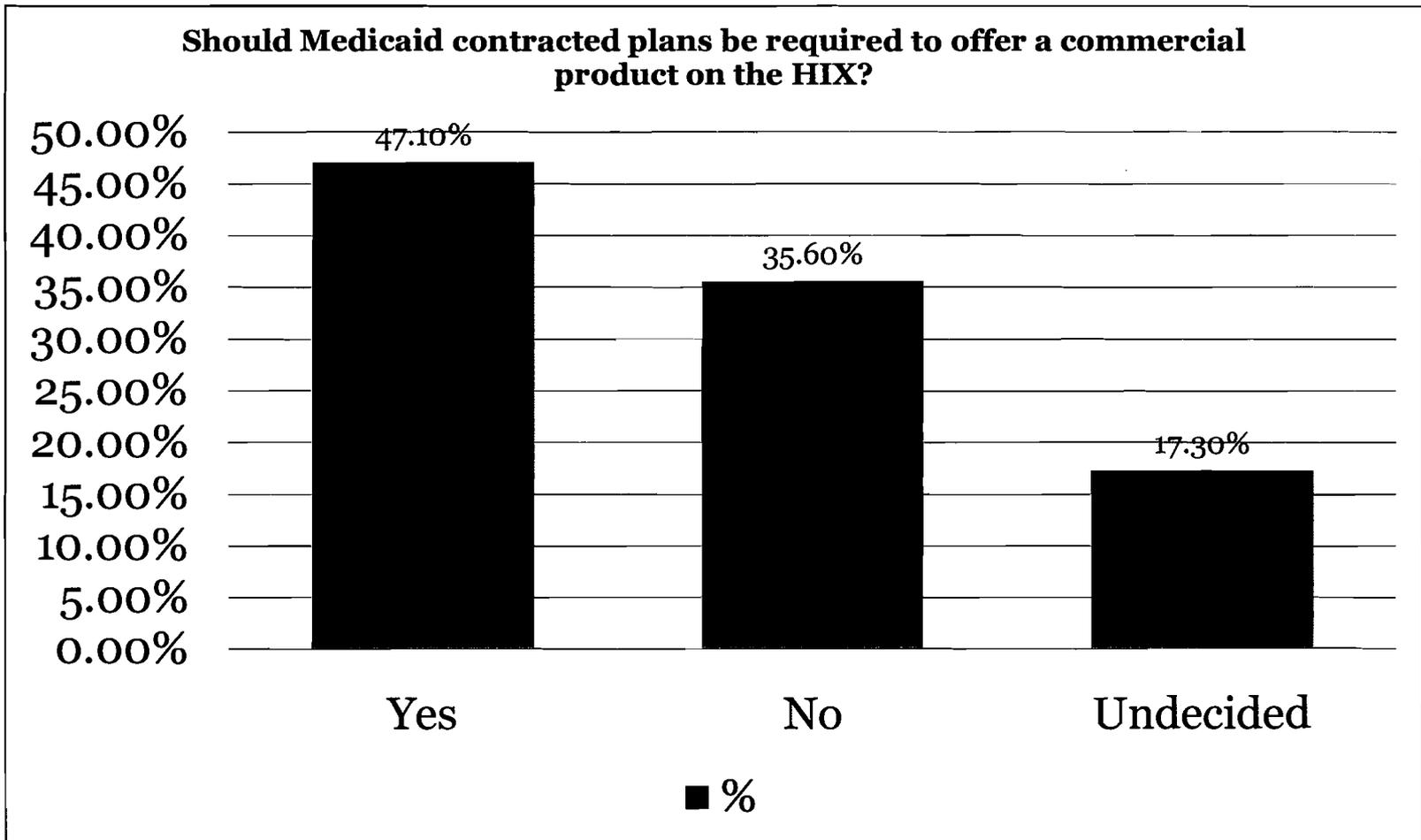
- 41% of respondents are not willing to pay any increase in premium cost for quality data reporting that goes above and beyond the federal requirements.

# Exchange Financing



- Respondents commented that if the Exchange was going to cost additional tax payer funds, then the State should not consider implementing it.

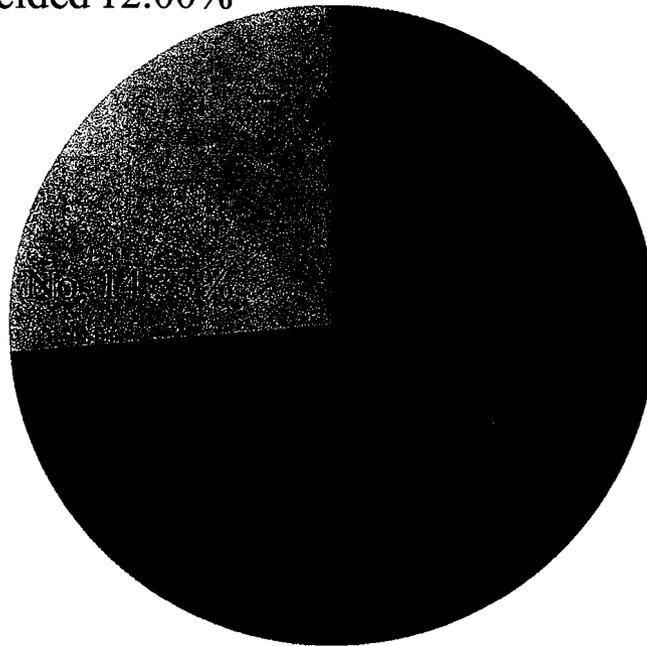
# Exchange Questionnaire: Exchange and Medicaid



# Exchange Questionnaire: SHOP Exchange

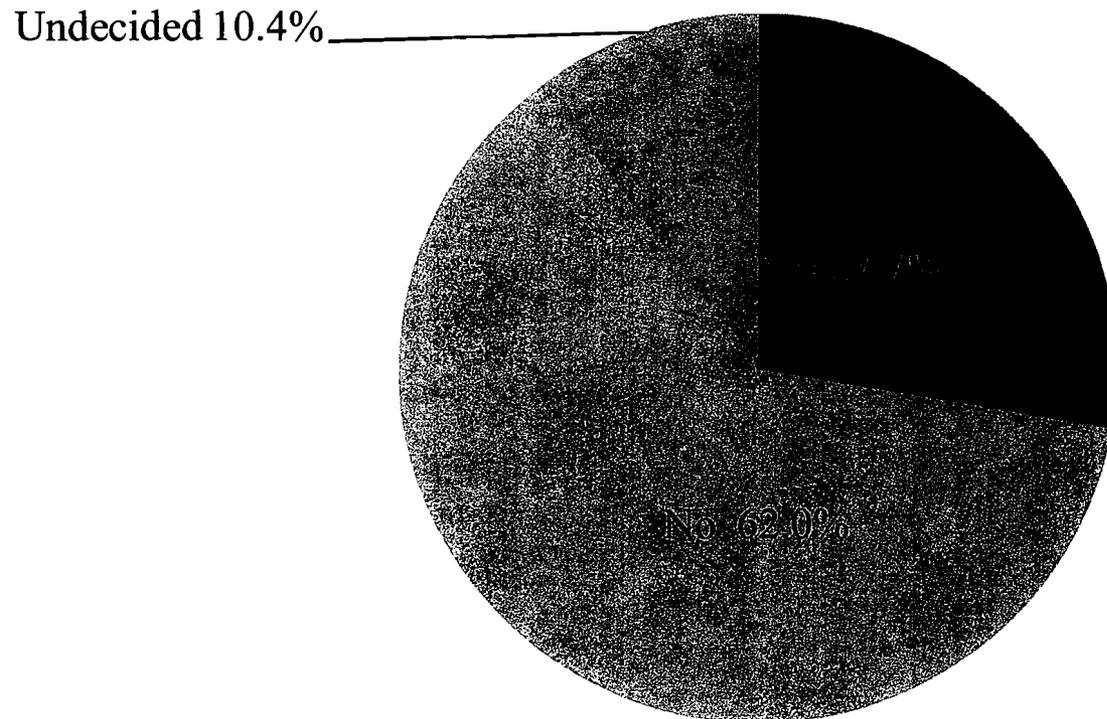
**Should the Exchange consider offering a defined contributions option for employers?**

Undecided 12.00%



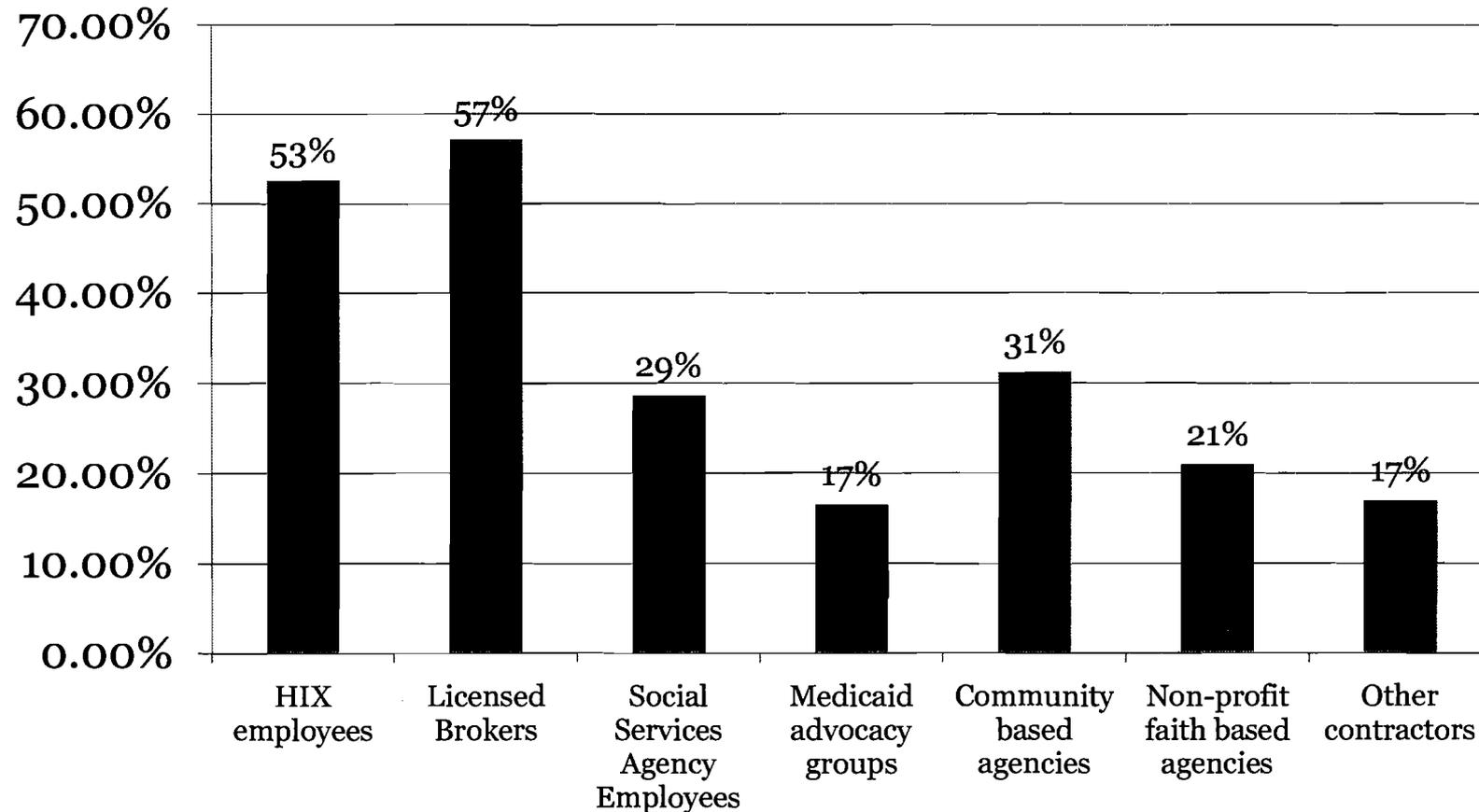
# Exchange Questionnaire: Premiums and Health Plan Enrollment

**Should the Exchange collect premiums for individuals?**



# Exchange Questionnaire: Brokers and Navigators

**What role should the Exchange Navigators play?**



Respondents could select multiple options; this is the average among all four respondent groups.



July 13, 2011

**TESTIMONY OF GEOFFREY SANDLER, FSA, MAAA  
SENIOR ACTUARY, AETNA**

**AND**

**ELENA BUTKUS  
SENIOR DIRECTOR, GOVERNMENT AFFAIRS  
AETNA, MID-AMERICA REGION**

**PROVIDED TO THE**

**INDIANA HEALTH CARE FINANCE COMMISSION**

Aetna is pleased to continue working with the State of Indiana on Exchange issues as the State analyzes the requirements of the Patient Protection Affordable Care Act (PPACA). Aetna is one of the nation's leaders in health care, dental, pharmacy, and other employee benefits. We have 18.6 million medical members nationwide and of most import is that we want to continue to provide our products in the State of Indiana. Thus, how the Exchange is established and under what market rules is of critical importance.

On August 24, 2010, we provided initial comments on Exchanges to the State of Indiana, which are appended to this testimony for your review. We have participated in your insurance market survey as well as met with the Department of Insurance and the Family and Social Services Administration (FSSA) regarding Exchange development.

Embodied in all our comments is that there must be parallel systems whereby the Exchange is available for certain coverages and a parallel system continues to exist outside of the Exchange. In Massachusetts most individuals and small businesses finding access to and enrolling in coverage are doing so outside of the Exchange. According to statistics from the Massachusetts Health Connector, 3.5% of the total insured population in Massachusetts are enrolled through the Exchange. The reason the Exchange is important is that 85% of individuals enrolling through the mechanism are eligible for subsidies. Similarly, the Congressional Budget Office estimates that about 81 percent of individuals purchasing Exchange coverage in 2019 will receive subsidies. As we advance in our analysis of Exchanges, there are several critical issues that we wish to raise with the Health Care Finance Commission today:

- Adverse Selection
- Promoting Competition
- Avoiding Unnecessary Cost Increases

In these categories we have included our comments regarding design issues of the Exchange and mitigating market disruption.

## **ADVERSE SELECTION**

Adverse selection is one of several key challenges that all Exchanges will have to address if states are to offer affordable health insurance products. It is also critical to recognize that the risk pools of insurance sold inside and outside of an Exchange are linked. Therefore, if the Exchange suffers price increases due to adverse selection – this will impact the overall individual and small group markets in Indiana. The future of the two markets are inextricably linked.

Given that adverse selection played a key role in the demise of earlier Exchanges and purchasing cooperatives, it is important that Indiana mitigate this issue as 10 percent of carriers have already exited the Indiana individual marketplace.

To this end, for the Indiana Exchange to be successful we must be prepared to mitigate the impact of insurance reforms that will likely occur and we must limit the eligibility to truly small employers and not combine the individual and small group Exchanges.

### *I. Mitigate impact of insurance reforms*

Adverse selection played a key role in the demise of earlier state experiments with Exchanges and purchasing cooperatives. Although the ACA does impose the new element of an individual mandate, this mandate is far from bullet-proof, and as you know it is under significant judicial and political pressure. Thus, it is critically important that the State mitigate adverse selection in tandem with Exchange implementation in 2014. Among the concrete steps we recommend to combat adverse selection in a new insurance market including Exchanges are the following items that were included in a recent GAO report:

- (1) Modify open enrollment periods
- (2) Expand employer role in auto enrollment and facilitating employee enrollment
- (3) Public outreach and education campaign
- (4) Provide broad access to personalized assessment for enrollment
- (5) Impose taxes to pay for uncompensated care
- (6) Allow greater age premium variation
- (7) Condition government services on proof of insurance
- (8) Use brokers differently
- (9) Require or encourage credit rating agencies to use coverage status as a factor in credit rating.

Other issues are important as well – the Indiana Exchange should focus aggressively on working with the FSSA to identify and verify member eligibility for public subsidies and/or Medicaid,

and, to better assure stable enrollment, provide that Medicaid eligibility once determined by the State/FSSA, continues for one year.

*II. Limit eligibility to small employers and don't combine individual and small group Exchanges:*

Also critical to curbing adverse selection is keeping the Exchange participation limited to very small groups. Under the ACA, states are directed to offer Exchange eligibility to at least group up to size 50 in 2014 and up to group size 100 in 2016. Beginning in 2017, states have the option to allow even larger employers to join the Exchanges. Larger employers currently either self-fund or are rated based on their own experience. Those that would choose to go to the Exchange which would be a community rated environment would do so most often because their own experience is worse than the average which would then lead to higher premiums for the employers most in need of improved affordability – the smallest employers.

Although self-funding is typically perceived to be an option exercised by only the largest employers (e.g., those with several hundreds of employees), the fact is, self-insurance is rapidly becoming a more popular option among smaller employers. According to a report quoted in the Wall Street Journal recently; small-to-midsize employers are driving growth in self-insured health plan enrollment. Indeed, over the previous five years, membership in self-funded insurance plans grew 11 percent, while enrollment in insured plans fell by 13 percent – causing overall self-funded membership to surpass that of fully insured plans. Currently about 58 percent of groups size 200 to 999 self-fund and about 80 percent of employers 1,000 to 4,999 self-fund.

Just as important is that individual and small group Exchanges must not be combined. When we have seen these populations combined, the individual experience tends to be poorer than the small group's experience. This effectively transfers the cost of covering poor risk individuals to small group employers. We do not think that is a fair situation for small employers.

Specifically, small employers are very price sensitive and already have relatively low offer rates. Only 59 percent of employers under size 10 offered coverage to their employees in 2010 and 76 percent of employers 10 to 25 offered coverage. Combining the individual market into the small group market would increase premiums for the small group market. Even more important is that if the individual mandate is repealed and guaranteed issue remains, the cost shift to the small group market could be much greater than we have seen in Massachusetts, for example. As we mentioned previously, the Exchange markets and outside markets are linked. Pooling the individual and small group markets could have damaging effects to small group coverage sold both inside and outside of the Exchange.

## **PROMOTING COMPETITION**

Today, consumers and small employers are frustrated by a lack of competition in many state individual and small group markets. A 2009 NAIC report found that 20 states had only three or fewer carriers with individual health insurance members. A 2009 AMA market share analysis

showed that Blue Cross Blue Shield plans held over 50% market share in over half of the states surveyed.

When constructing Exchange rules, we respectfully ask that you recognize that if the cost of entering the Indiana Exchange is too high – many insurers will not participate. This is especially true of insurers whose membership is distributed across many states. As a result, certain carriers may have a relatively small membership in any particular state and this small membership pool cannot support significant administrative costs associated with participating in that state's Exchange.

State Exchanges that fail to increase choices and competition are likely to be viewed as failures by state residents. Therefore, we ask you to consider four issues:

1) Pilot employee choice as an option for insurers, not a requirement

The ACA allows states to adopt Exchanges that continue to follow the traditional small group purchasing method – where an employer chooses a health plan for their employees. ACA also includes “employee choice.” Under this, an Exchange would allow employees within a participating small employer to choose any plan in the Exchange. The Indiana Exchange should make provision of an “employee choice” product optional for insurers. Given the complexities of the employee choice model, Exchanges that rely solely on this approach may be unable to offer viable coverage to small employers at all. The state of Massachusetts struggled for several years to develop an employee option. At its height it attracted only 42 employers and it was eventually abandoned in favor of an employer choice model.

2) Avoid re-creating existing regulations

A subject of recurring uncertainty among state policymakers is the degree to which Exchanges should or should not assume direct regulatory or administrative responsibility in particular areas. For many Exchange standards -- such as provider network standards, marketing rules, and review of rates -- the ACA merely spells out functions that the Exchange shall assure are being performed and/or standards that shall be met. The ACA does NOT require that the Exchange itself must establish and/or itself supervise such functions or standards.

To this end, please consider deferring to DOI or other applicable agency that has current statutory authority to enforcing existing state consumer protection standards both inside and outside of the Exchange. If Indiana empowers its Exchange to establish and enforce their own standards, this will deter many insurers from participating in the Exchange. Specifically, separate Exchange standard enforcement would increase start-up costs for insurers; impose duplicative costs on taxpayers; and create inequities and confusion for consumers. Generally, consumers buying coverage from the same company would face differing protections depending on whether they purchased coverage inside or outside of the Exchange. This is likely to confuse consumers – especially in the nongroup market where turnover is very high and consumers move out of coverage on a regular basis.

3) Provide choice, not standardization

Consumers and small employers will expect state Exchanges to provide enhanced choice of coverage – not a reduction in choice. We do not believe that Indiana should require that benefit offerings be standardized in the Exchange. In our opinion, states that are considering such a move should realize that it would deter insurer participation in the Exchange and slow innovation. With respect to deterring insurer participation in the Exchange, we have designed existing insurance products based on focus groups and market demands. In addition, we have invested significant expenditures in the system architecture to support these benefits as well as the substantial costs of filing forms, rates and other oversight requirements for these products. If Exchanges require that insurers create a new set of products (along with all of the associated filing and approval costs) it would not be financially viable to do so for all state Exchanges. States with unique standardization rules will have fewer insurers than other states.

With respect to slowing innovation, private health plans -- spurred on by the employer community -- have led the way in implementing innovative benefit plan designs, disease management programs and other programs for members with complex chronic conditions. These innovations have been driven by market demands and evidence-based research and are focused on improving quality while controlling costs. By contrast, government-managed programs have consistently lagged behind the private market with respect to benefit design and cost and quality programs.

4) Adopt standard health information technology (IT) and quality rules

Insurers must invest in a variety of IT and related infrastructure in order to participate in Exchanges. It is important that the federal government establishes, and that the states adopt standardized data and quality rules and definitions to form the core of any Exchange. Otherwise the administrative costs associated with participating in multiple state Exchanges could be wasteful and deter insurer participation. The adoption by states of national infrastructure and quality standards could be essential to administrative efficiency and feasibility.

## **AVOIDING UNNECESSARY COST INCREASES**

The primary objective of the Indiana Exchange must be to provide access to affordable health insurance coverage.

The Exchange market as well as the overall individual and small group markets will be facing changes in rating and benefit design required under ACA that will create upward pressure on pricing. The CBO anticipates a 27-30 percent average premium increase in the individual market to occur as a result of the ACA's essential benefit requirements and actuarial value "buy up." For those who have existing health conditions, there will be financial relief. However, many will face premium increases as a result of the changes.

To this end, we believe that the Indiana Exchange should be financed by a broad-based financing mechanism that is not limited to insurer assessments. We ask that Indiana evaluate all available funding sources to support continuing administrative and operational expenses, including grants,

fees, assessments and taxes. Broad-based funding will help maintain the Exchange and protect consumers and small employers from cost over-runs that further increase premiums.

In addition Exchange funding should be strictly limited to the needs of the Exchange and any assessments from the industry should not be used to fund any Exchange services that are performed on behalf of other state or federal programs.

## **CONCLUSION**

Indiana is considered to be one of the most thoughtful yet innovative states when it comes to implementation issues related to PPACA. This is proven in that you are one of the four states chosen to receive a very large grant for Exchange implementation. We are very hopeful that the Indiana Exchange will be implemented in a manner that preserves a level and competitive marketplace and provides consumers and employers a choice among companies and affordable products.

Thank you for the opportunity to provide this input and we look forward to continuing to working with you and the State.

Contact Information:

Elena Butkus (312) 928-3062

[butkuse@aetna.com](mailto:butkuse@aetna.com)



August 24, 2010

Ms. Anne W. Murphy  
Secretary  
Family and Social Services Administration  
402 W. Washington Street, W461  
Indianapolis, Indiana 46204

Mr. Stephen W. Robertson  
Executive Director & Acting Commissioner  
Indiana Department of Insurance, Suite 300  
311 West Washington Street, Room W 478  
Indianapolis, Indiana 46204

Re: Reply to Interagency State Health Reform Task Force

Secretary Murphy and Commissioner Robertson:

Aetna looks forward to working with the Interagency State Health Reform Task Force on implementation of the Patient Protection Affordable Care Act (PPACA) in Indiana. While we work towards implementation of the Act at the federal and State levels and are committed to implementing the provisions of PPACA, at your request we have prepared our thoughts and recommendations with respect to an Indiana Exchange. In addition, we are submitting comment on the issue of utmost concern to our company, the medical loss ratio (MLR) requirement and our recommendation on implementation and advocacy on the MLR.

First, PPACA requires states to establish an Exchange for the individual and small group markets by 2014. Aetna believes that an effective Exchange marketplace is critical to the success of federal reform and our recommendations are that it should:

**(1) Promote consumer choice through a competitive and innovative insurance market.**

**This includes:**

- *Permitting broad insurer participation in the Exchange* if insurers meet state and federal requirements, to allow maximum choice for consumers.
- *Allowing insurers to offer additional buy-up benefits through the Exchange*, creating more customization and product choice to meet consumer needs.

- *Giving insurers the flexibility to offer various combinations of benefit tiers to ensure that insurers can remain in the market even if they are unable to provide all five levels of coverage.*

**(2) Minimize market disruption through thoughtful, incremental implementation of new federal reforms, such as:**

- *Limiting Exchange enrollment to individuals and groups with fewer than 50 employees to expand access to those who need it most and minimize the likelihood that employers with healthier groups will self-fund.*
  - *Individuals and employees of small employers (under 50) are most in need of additional access to insurance.*
  - *Nationwide, 41% of small employers (under 50) offer coverage as compared to 96.2% of employers with 50 or more employees (Kff.org 2009).*
- *Studying the impact of the new federal insurance regulations before requiring more restrictive state mandates (e.g., medical loss ratio, additional benefit mandates) to minimize market disruption for consumers and ensure that premiums remain affordable.*

**(3) Establish an efficient regulatory environment that does not add unnecessary administrative burden and expense by:**

- *Leaving regulation with insurance commissioners and not setting up Exchange regulatory frameworks which could threaten plan solvency and create other problems for consumers.*
  - *Insurers should continue to set actuarially justified premiums rather than requiring plans to either negotiate or meet politically established rates.*
- *Having industry representation on the Exchange Board to ensure that there is insurance and actuarial experience contributing to the ongoing development of state Exchanges.*
- *Continuing to allow insurers to bill and collect premiums for products sold in the Exchange, rather than creating unnecessary expense by turning the function over to the Exchange.*
  - *The ACA prohibits wasteful use of funds by Exchanges [Sec. 1511(d)(5)(B)].*

**(4) Reduce rate shock for consumers by enforcing the individual mandate to ensure that the young and healthy are just as likely to purchase coverage as older or sicker individuals.**

- *The young and healthy may not purchase coverage because the 3:1 age bands will make their coverage more expensive, and the current statute's penalty of \$95 in the initial year of coverage is not meaningful.*

**(5) State enforcement mechanisms could include:**

- *Allowing the Exchange to auto-enroll individuals to facilitate higher participation levels.*
  - *Employers using auto enrollment for 401K plans resulted in 81%-95% participation of workers (largely young workers) as compared to 26%-60% when workers had to opt in (GAO, October 2009).*
- *Creating additional enforcement mechanisms through existing state programs such as the state tax system, vehicle registration or college enrollment.*
- *Establishing an open enrollment period to limit the potential for adverse selection.*

- According to Harvard Pilgrim's former CEO Charlie Baker, between April of 2008 and March of 2009, about 40% of people who bought individual insurance from Harvard Pilgrim stayed covered for less than five months, incurring an average of about \$2,400 per person in monthly medical expenses.
- In 2009, 936 people enrolled with Blue Cross and Blue Shield of Massachusetts for three months or less; the typical monthly premium for these short-term members was \$400, but their average claims exceeded \$2,200 per month (*The Globe*).

Second, as one of the nation's oldest and largest providers of health care benefits, we understand the critical importance of thoughtful development of minimum loss ratio (MLR) definitions and standards under PPACA. These definitions and standards will determine the manner and extent to which health plans invest in activities to improve care quality and safety, reduce fraud, support members with chronic illnesses or complex health conditions, and maintain networks that offer both broad provider choice and affordability. The MLR definitions also will determine the willingness of health plans to enter new markets and/or remain in existing markets, particularly those markets in which the carrier has a relatively small market share. Meaningful consumer choice in the individual and small group markets will depend on the ability of plans to serve members effectively and to compete fairly without undue risk to solvency. To this end, to avoid these types of unintended consequences we recommend that Indiana continue to consider and advocate **large group market MLR aggregation at national level (and ability to aggregate legal entities)** as the current proposal implies that insurers would produce state by state minimum loss ratios for each legal entity in each market segment -- including the large group market. The large group market is comprised of sophisticated purchasers and is working well for employers and employees. A state by state legal entity reporting requirement would hurt consumers through:

*O Reduced Choice of Coverage.* If insurers are required to report large group market MLRs on a state by state and legal entity basis, it would produce distorted MLRs for large employers with HMO, Point of Service and Dual Choice products. Consequently, insurers may not be able to offer these important options. The chart below highlights how large group market MLRs could be distorted under the proposed state by state NAIC framework.

- *HMO Coverage:* Many states require insurers to maintain a separately licensed HMO that is a separate legal entity. As a result, the large employer in the chart below that purchases from one national insurer is technically provided HMO coverage by three different HMO legal entities -- one in each of the three states where its employees are located. The insurer offers the employer a mutualized premium across all three entities of \$303 per month even though the actual employee claim levels vary by state. This employer account has an 88% MLR in aggregate but the state by state MLRs vary from 81% to 93%. As a result, a rebate would be owed in one of the states. A significant portion of large group business is in HMO, as employers cannot easily self fund this product. The end result would be an inability for many insurers to offer HMO coverage to large employers.
- *Point of Service:* This same issue arises with point of service (POS) products. Consumers receive a financial incentive to obtain services "in-network" where coverage is underwritten by an HMO entity but the out- of- network services are often underwritten by a separate,

indemnity, legal entity. As a result, an insurer offering POS coverage in these three states experiences a similar MLR distortion to the HMO situation. Attempting to split the MLR by the portion that is indemnity vs. HMO would produce misleading MLRs and employers may no longer be able to provide this option. This is why it is critical to combine MLR experience for these dual contract products.

- *Dual Option:* The final scenario occurs where a large employer offers employees a choice between PPO and HMO coverage. Insurers price dual option products by blending the HMO and PPO premiums. It is priced as a single product to the employer. Any requirement to separately calculate these would distort the MLRs and preclude the continued viability of these choices.

HMO Legal Entity	Mbrs	Required Premium	Required PMPM	Expected Claims	Priced to MLR	Mutualized Rate	Expected MLR w/Mutualized	Payback
State A	2,500	775,000	\$ 310.00	\$ 272.80	88.0%	\$ 303.33	89.9%	-
State B	2,500	800,000	\$ 320.00	\$ 281.60	88.0%	\$ 303.33	92.8%	-
State C	2,500	700,000	\$ 280.00	\$ 246.40	88.0%	\$ 303.33	81.2%	\$26,385
<b>TOTAL</b>	<b>7,500</b>	<b>2,275,000</b>	<b>\$ 303.33</b>	<b>\$ 266.93</b>	<b>88.0%</b>	<b>\$ 303.33</b>	<b>88.0%</b>	<b>\$26,385</b>
						<b>After Rebate</b>	<b>89.2%</b>	

*O Decreased Competition in the Large Group Market.* Even in the large group market, insurers have relatively small enrollment in certain states. This is often the situation for states with small population levels. If insurers are required to report large employer Medical Loss Ratios on a state by state basis, it could disadvantage these small population states. The smaller the state, the more variability one might expect in the actual results. Credibility may dampen the volatility but doesn't eliminate it. If a carrier anticipates volatility would trigger rebates in small states performing better than expected – with no offsets for poor performing small states -- that carrier may decide to discontinue coverage in smaller states. In addition, this could deprive smaller states of beneficial rating practices. For instance, large employers at the low end of the size range (e.g., 150) may benefit today from rating practices that pool their experience with large employers in other states. State by state MLR reporting would threaten the ability of

insurers to continue this rating practice. The end result would be fewer insurance choices for large employers in small population states.

*O Increased Administrative Costs.* The large group market is a relatively efficient marketplace. However, it is characterized by multi-state and national employer accounts. Any requirement for insurers to disaggregate their expenses on a state by state basis would be administratively complex and expensive. State by state expense reporting is not required today and would require millions of dollars in systems changes. These additional costs would be passed onto large employers.

While Aetna has an interest in many PPACA issues, we believe that Indiana's Exchange and its advocacy and implementation of MLR are of utmost importance. We appreciate the opportunity to input and look forward to working with you.

Sincerely,

Elena E. Butkus

Director Government Affairs, Mid-America Region

**Healthcare Implementation Work Group:  
Guiding Principles for an Indiana Health Insurance Exchange - June, 2011**

**Overarching principle: The Exchange should ensure that all policy and operational choices are considered through the lens of the consumer, and that decisions are made based on the consumer's best interest in terms of quality, affordability and appropriate patient care.**

**1. Structure of Exchange Governing Board**

- Odd number of voting members and staggered terms
- Must include representatives of key stakeholder groups who are eligible to participate in the Exchange (i.e., consumers, providers; small business); selected based on a slate of potential representatives to be submitted by consumer/business/provider organizations having statewide membership
- Ex-officio, non-voting members (i.e., OMPP/FSSA, IDOI, Budget Agency, Key Legislative Committee Chairs)
- Expertise in at least one of the following areas:
  - Health coverage issues of traditionally uninsured/underinsured populations
  - Provision of evidence-based health care to diverse populations
  - Consumer outreach, education, enrollment and assistance
  - Health coverage issues for small business
  - Health benefits plan administration, financing, design
  - Eligibility, enrollment, retention, claims and appeals procedures
  - Health plan IT/data systems
- Proportional representation of stakeholders on standing and ad hoc committees
- Stakeholder Advisory Board that regularly meets, receives reports and provides formal input (i.e., consumers, providers, brokers, agents, employers, insurers)
- Consideration given to racial, ethnic, gender, political and geographic diversity on the Governing Board and advisory boards and committees

**2. Transparency and Consumer Input**

- Meetings of the Board and of any committees must be open to the public and subject to Indiana's Open Door Law (IC 5-14-1.5)
- Exchange records and other documents must be subject to disclosure pursuant to Indiana's Access to Public Records Act (IC 5-4-13)
- The Board must be subject to the Indiana's Ethics and Conflicts of Interest Law (IC 4-2-6)

**3. Privacy and Confidentiality**

- The Board must be subject to all State and federal laws and regulations regarding the privacy and confidentiality of personal information

#### 4. Conflicts of Interest

- Policy prohibiting individuals, entities, and their affiliates who offer a product on the Exchange from serving on the Governing Board
- Policy requiring annual filing of a conflict of interest statement and a statement of ownership interests by Board and staff members
- Policy requiring disclosure of an actual or potential conflict of interest and abstention from relevant Board and committee discussions, votes and duties

#### 5. Key Attributes of the Exchange

##### A. Active Consumer Outreach and Enrollment

- Promote consumer outreach through a variety of communication streams, including use of media, online tools, toll-free numbers and appropriate staffing levels for one-on-one assistance (in-person; phone; online), including tools for diverse populations and those lacking familiarity with health insurance
- Implement and oversee a Navigator Program, develop criteria for selecting qualified entities to serve, and authorize the program to counsel individuals regarding enrollment choices

##### B. Consumer-Friendly Information

- Maintain an Internet website and a regularly updated list of local, fully accessible, public access sites (i.e., libraries, kiosks at county office buildings, etc.) through which enrollees and prospective enrollees may obtain standardized, consumer-friendly comparative information to select the plan that best fits their needs, including an online calculator to assist in determining the actual cost of coverage after application of any premium tax credits and cost-shares
- Develop standardized procedures to notify participants promptly about premium, benefit or network changes and to assist with disputes or problems regarding coverage, access to care, quality and customer service
- Establish procedures for determining eligibility for premium tax credits, reduced cost-sharing and informing individuals about requirements, penalties, and exemptions

##### C. Single Point of Entry and Seamless Coverage

- With input from the Stakeholder Advisory Board, develop a single application form regardless of health plan product (including Medicaid and CHIP); seamless transition procedures for individuals and families who experience a change in income that results in a change in the source of coverage; and streamlined enrollment, eligibility determinations and redeterminations (including eligibility for subsidies and for Medicaid and CHIP coverage); require data-sharing agreements with relevant government agencies

##### D. Affordable, Quality Coverage

- Require comparable rules and terms for plans inside and outside the Exchange to promote competitive pricing and to prevent adverse selection

- Give preference to certified health plans that meet the requirements of Medicaid, CHIP and the Exchange in order to provide continuous coverage and care regardless of changes in source of income or subsidy
- Include certified health plan options that allow for choice of provider
- Establish certification requirements that set high but realistic benchmarks for rates and benefits in order to offer a manageable number of qualified plans
- Establish systems for ongoing monitoring, evaluation, and enforcement to ensure sustained high performance and quality and to improve health outcomes
- Require plans to obtain NCQA accreditation and to report HEDIS and CAHPS measures

#### **6. Predictable, Continuous and Equitable Funding**

- Ensure that the Exchange has predictable, continuous, and steady sources of funding to facilitate good management and planning
- Require that any fees generated from health plans apply equally to plans inside and outside the Exchange

#### **7. Hiring and Employment**

- Establish policies regarding worker protection, non-discrimination, and compliance with occupational health and safety laws

DRAFT

## Enacted State Health Insurance Exchange Legislation

June 21, 2011

State	Structure/ Location	Governance	Advisory Committees	Legislative Oversight	Conflicts	Authority	Selection Criteria	Medicaid Integration
<u>California</u> <u>Senate Bill</u> <u>Assembly Bill</u>	State agency	Board of Directors appointed based on expertise plus state agency heads	Consultation required, but no specific advisory committees	File reports	Board and employees may not be affiliated with insurers, producers, health care providers	May require standardized products and competitive selection process. Number of insurers may be limited. Must limit to insurers selling same products inside and outside Exchange	Based on "optimal combination of choice, value, quality and service." Premium increase history may be considered.	Screen and enroll
<u>Colorado</u>	Nonprofit public entity	Appointees, majority must be business representative or individuals not connected with insurers	None specified	Legislative Exchange Implementation Review Committee will guide implementation and recommend additional legislation	Recusal in cases of economic benefit or financial interest	"Shall not solicit bids or engage in active purchasing of insurance. All carriers ... may be eligible to participate in the exchange."	To be determined	
<u>Connecticut</u>	Quasi-public agency	Appointed based on expertise	Consultation required, but no specific advisory committees		Board and employees may not be affiliated with insurers, producers, health care providers. One year revolving door prohibition.	May limit number of plans provided if there is adequate number and choice. Must limit participation to insurers selling same products inside and outside Exchange	May take premium increase history into consideration	Screen and enroll. Ensure seamless transitions Evaluate feasibility of a Basic Health Plan

State	Structure/ Location	Governance	Advisory Committees	Legislative Oversight	Conflicts	Authority	Selection Criteria	Medicaid Integration
<u>Hawaii</u>	Private nonprofit	Interim appointed 15 member Board with 3 insurers, 4 health care providers, 4 agencies, and representatives from consumers, unions, employers and FQHCs			Board to establish conflict and recusal standards. Members can't act if they have a financial interest	Interim board makes recommendations for 2012 legislation	All qualified plans must be offered in the Exchange	Medicaid agency to determine eligibility for Medicaid and tax subsidies
<u>Maryland</u>	Public corporation and independent unit of state government	Appointed board with agency heads, 3 representatives of consumers and employers, 3 experts. Selected to reflect gender, race, ethnic and geographic diversity	Required for insurers, HMOs, health care providers including LTC, experts, employers, unions, consumers, advocacy organizations and academics		Board and staff may not be affiliated with insurers, MCOs, or producers. Required disclosure of actual or potential conflicts	Board in consultation with advisory committees makes recommendations to legislature on selective contracting, through competitive bidding or a negotiation and certification of just plans that meet certain requirements such as promoting patient-centered medical homes, adopting electronic health records, meeting minimum outcome standards, implementing payment reforms to reduce medical errors and preventable hospitalizations, reducing disparities, ensuring adequate reimbursements, enrolling low-risk members and underserved populations, managing chronic conditions, inclusion of benefits beyond federal "essential benefit" requirements etc	To be determined	Determine eligibility and facilitate enrollment
<u>Nevada</u>	Independent agency	Board with appointed members, each with expertise or experience as a consumer, plus agency heads	Discretionary		Board members cannot be connected with or represent insurers. No exclusion of independent producers or health care providers	By end of year Board shall adopt a plan for implementation and operation to be submitted to Governor and legislature	To be determined	Create a single point of entry and promote continuity of coverage and care

State	Structure/ Location	Governance	Advisory Committees	Legislative Oversight	Conflicts	Authority	Selection Criteria	Medicaid Integration
<u>Oregon</u>	Public corporation	Seven appointees no more than two from insurer providers or producers; at least 2 consumer – one consumer, one small business employer.	Requires an Individual and Employer Consumer Advisory Committee. May have others and solicit input from producers.		Board members can participate in discussions but can't vote in cases of conflict. Employees can't work or be associated with insurers providers or producers.		Board sets selection standards, but may only include plans with "acceptable consumer and provider satisfaction ratings."	Requires one streamlined application and enrollment process for exchange and Medicaid.
<u>Vermont</u>	Within the Department of Vermont Health Access	Administered by the department in consultation with the advisory committee	A consumer, patient, business, and health care provider advisory group. Funding available for participants. Also requires consultation with state health care ombudsman required			May offer coverage to anyone, including Medicaid and Medicare and workers compensation if allowed. May contract with a single entity for administration and management of all plans. Required to seek a waiver to allow the state to suspend operation of the exchange and to receive the federal funding in lieu of the federal premium tax credits, cost-sharing subsidies, and small business tax credits provided in the ACA.	Must consider affordability; rate increase history, prevention, quality, and wellness requirements: marketing practices, network adequacy, essential providers in underserved areas, services to underserved individuals and populations, accreditation, quality improvement, and information on quality measures for health benefit plan performance; standards for participation in the Blueprint for Health; etc.	Screen and enroll. Ensure seamless transitions
<u>Washington</u>	Public private partnership	Nine member appointed – specialists and representatives of "health consumer advocates" and small business.	Advisory committee for health care providers and other stakeholders		Appointment barred if member would have a financial interest and members must resign or be removed in a conflict develops.	Ongoing. Board to work in collaboration with the joint select committee on health reform implementation. Board may apply for funding and take other steps towards implementation. Board and joint committee will develop recommendations for other legislative options on operation, merger of individual and SHOP, coordination with state programs, basic health plans, selection criteria, role of agents, brokers, risk management and adjustment, cost containment, etc.		

State	Structure/ Location	Governance	Advisory Committees	Legislative Oversight	Conflicts	Authority	Selection Criteria	Medicaid Integration
West Virginia	Government entity within Office of Insurance Commissioner	Four members appointed to represent: individual consumers; small employers; organized labor; and insurance producers; four agency heads, one representative of insurers, and one representative of health care providers	Must consult with stakeholders, including consumers, carriers, producers, providers and advocates.. May establish advisory committees of consumers and others.			No specific standards or limitations	No specific standards or limitations	

# The Villas of Guerin Woods

*Enhancing the Quality of Life  
for Elders*

The Villas of Guerin Woods enhance the quality of life for elders age 62 and older by enabling:

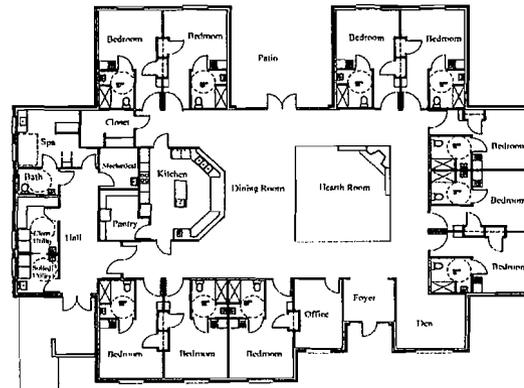
- Privacy
- Individuality
- Freedom of choice
- Safety & Security
- Care and assistance of the highest quality
- Increased mobility and safe accessibility
- Relationships with people of all ages
- A sense of well being

The Villas of Guerin Woods offer necessary social and medical support 24 hours a day and seven days a week within a residential social model where the focus is on living life rather than simply receiving care. Elders are at the center of the organizational structure; all services revolve around the elders.



## The Villas

Each 7,100-square-foot villa contains 10 private bedrooms with full, private bathrooms, a large living room with fireplace, an open kitchen and dining room, a therapeutic spa, a den, a patio/garden and a small office that replaces the nursing station and is used by visiting clinical staff.



The Villas are self-contained residences. Fees are competitive. The Villas are licensed by the state of Indiana and certified for Medicare, Medicaid and Medicaid Waiver Vouchers.

## A Place to Call Home

With the exception of the private bedrooms, all areas of The Villas are accessible to elders. Elders have the opportunity to decorate and furnish their own rooms. Within reason, elders decide their own routines. Meals are cooked in each villa; if they so desire, elders may help with meal preparation and other chores in which they have interest. Meals are served at a large dining table with elders, staff and guests sharing food and conversation.

Elders are cared for by certified nursing assistants, licensed practical nurses and registered nurses called *Compatissants* (French for "tender hearted"). *Compatissants* receive special training and function as "universal workers" preparing meals, providing light housekeeping, personal laundry services and personal care services.

*Compatissants* report to the director of nursing. Social services, activities, occupational, speech and physical therapy professionals provide appropriate clinical services for the elders. Other professional staff includes an administrator and a medical director and a nurse practitioner who provide needed medical services.

## Guerin Inc.

Guerin Inc. was established to construct facilities for the Providence for Children campus. Since 1999, the campus has grown to include two group homes for foster children, six three-bedroom apartments for families reuniting with children in foster care, a training center/office building and an administrative residence.

In 2005, Guerin Inc. opened Guerin Woods, a 15-acre development for senior citizens that adjoins the Providence House campus. Guerin Woods includes Guerin Woods Apartments, 22 two-bedroom apartments for individuals and couples age 62 and older with limited incomes, and Guerin Woods Senior Center, open to all senior citizens in Floyd and surrounding counties.

The Meadows of Guerin, Inc., a HUD 202 funded development, features 24 one-bedroom apartments for persons age 62 and older with limited incomes. The Meadows adjoins Guerin Woods.

### *The Villas of Guerin Woods*

The Villas of Guerin Woods provides a new concept in assisted living and comprehensive nursing care. With the opening of The Villas, Guerin Inc. provides a full continuum of elder care at Guerin Woods.

## Mission Statement

It is the mission of Guerin Inc. to provide assistance, by way of residential facilities and life skills services, to persons of all ages who are in need. The mission includes a goal of providing decent, affordable housing to low- and moderate-income people.

## Partnership

Guerin, Inc. shares a management agreement with Providence Self Sufficiency Ministries Inc. (PSSM). Through the agreement, Guerin Inc. provides facilities and PSSM provides administration, staffing and programming for Providence House, Guerin Woods and The Meadows.

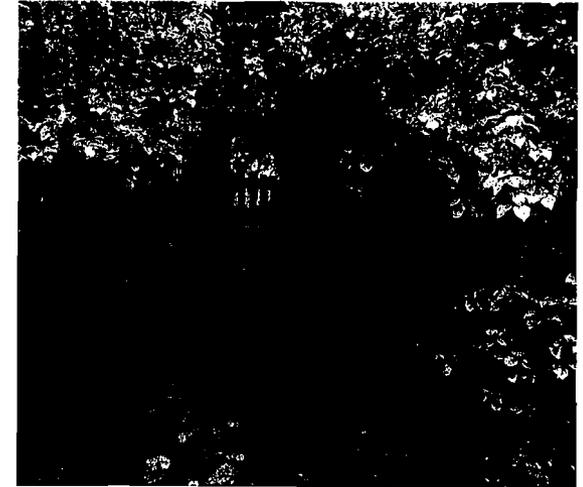
### For more information, contact:

Sister Barbara Ann Zeller, SP,  
at 812-951-1878

Visit the web at  
[www.guerininc.org](http://www.guerininc.org)  
[www.pssm.org](http://www.pssm.org)



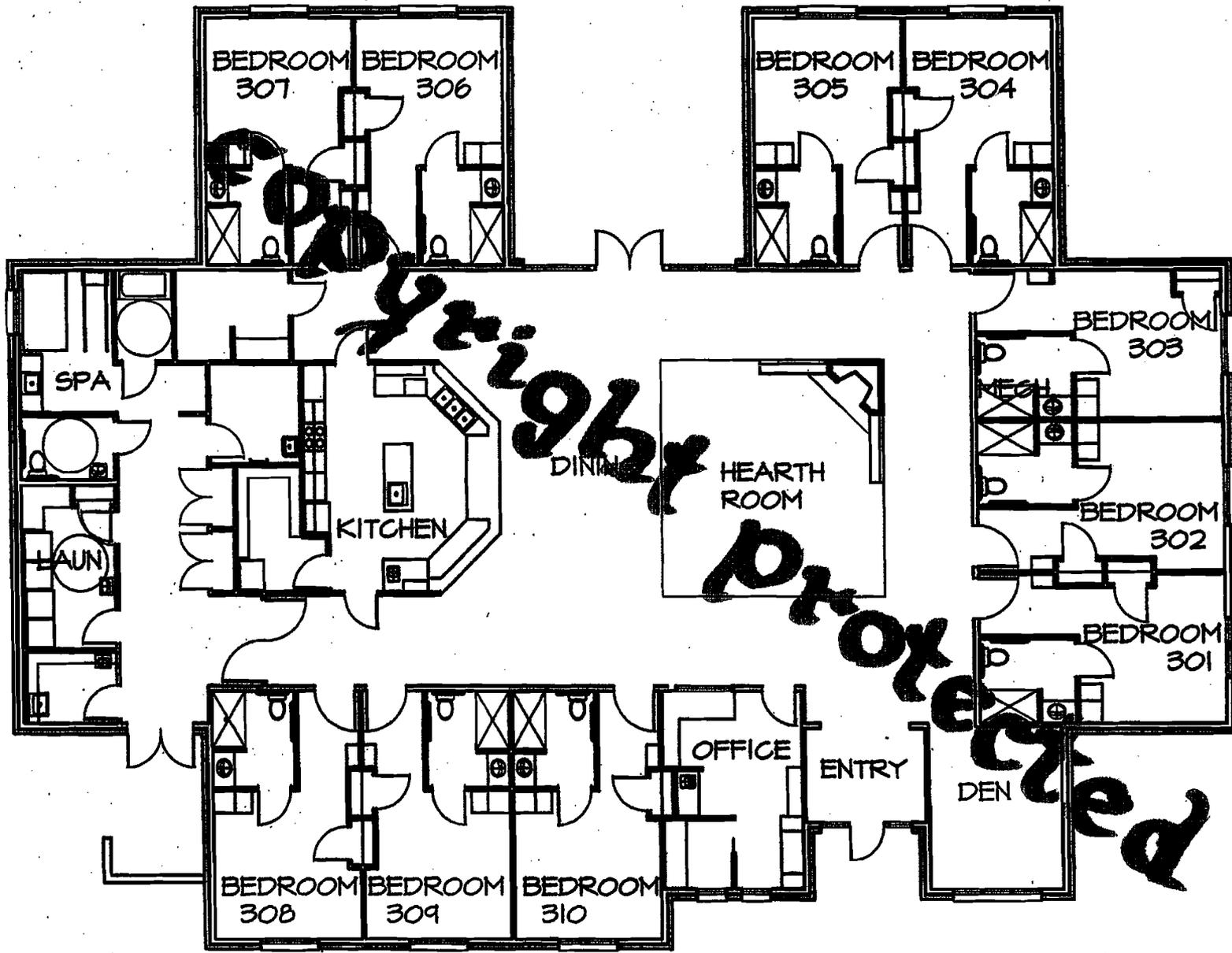
The Villas of Guerin Woods accept persons for treatment and services regardless of race, color, national origin, disability and age.



## *The Villas of Guerin Woods*

A life-enhancing community  
providing dignity,  
respect and choice  
for elders needing assisted living  
and comprehensive nursing care

**Guerin Inc.**  
8037 Unruh Drive  
Georgetown, Indiana 47122  
812-951-1878



**FLOOR PLAN - BUILDING 1003 SNF**

7/13/11 HFC Exh. 5

## TRADITIONAL NURSING HOME COMPARED TO THE SMALL HOUSE MODEL

*The small house model challenges the philosophy, the architecture and the organizational structure of the traditional nursing home.*

### Traditional Nursing Home

### Small House Model

#### PHILOSOPHY

Large numbers of people providing care for large numbers of patients

Creates an environment of “knowing” – typically staff to Elder ratio is 1-5. Due to the ratio, staff know Elders better and have a greater sense of their ability to positively affect Elders’ lives. Because staffing is consistent, staff recognize even subtle changes in Elders and are able to immediately meet their changing needs

Most commonly have double bedrooms and shared bathrooms

Private rooms with private bathrooms for all Elders regardless of payer status

Multiple and large dining rooms with many Elders

One long dining room table accommodating all Elders including those unable to eat by mouth

Food prepared in central kitchen and transported to multiple dining rooms

All food prepared in the small house with cooking happening throughout the day to stimulate Elder appetites. Food is served family style on china not on trays

Kitchen is off limits to Elders and visitors

Elders and visitors have access to kitchen and help prepare meals and special family recipes

Medical/clinical model emphasizes provision of services to frail patients

Social and medical support is provided within a residential social model where the focus is on living life rather than simply receiving care

Services provided accommodate efficiency of staff time and well defined schedules

No rigid predetermined schedules. Elders decide within reason when to get up, when they have breakfast, personal care preferences as in bathing and when they go to bed

Elder rooms are usually furnished with few personal furnishings allowed

Elders decorate and furnish their own rooms bringing cherished furniture and personal items

Staff wear uniforms and scrubs

Staff wear jeans, khakis and clothing they ordinarily wear at home to enable the “at home” atmosphere

## ARCHITECTURE

Usually 120+ beds divided into units of 20-40

Typically 7000 square feet accommodating 10 Elders

Lounges and dining rooms usually are at the end of long corridors

No Elder has to go more than 45 feet to get from their private room to the heart of the small house enabling increased mobility

Space belongs to the institution; Elders have access to their room and public areas, but many spaces are off-limits

All areas of the house are accessible to Elders

Nurses station is usually in the center of most units

None. Medication and nursing supplies are kept locked in cabinetry in Elder rooms and dispensed from each Elder's room

## ORGANIZATION

Nurse controls unit activity

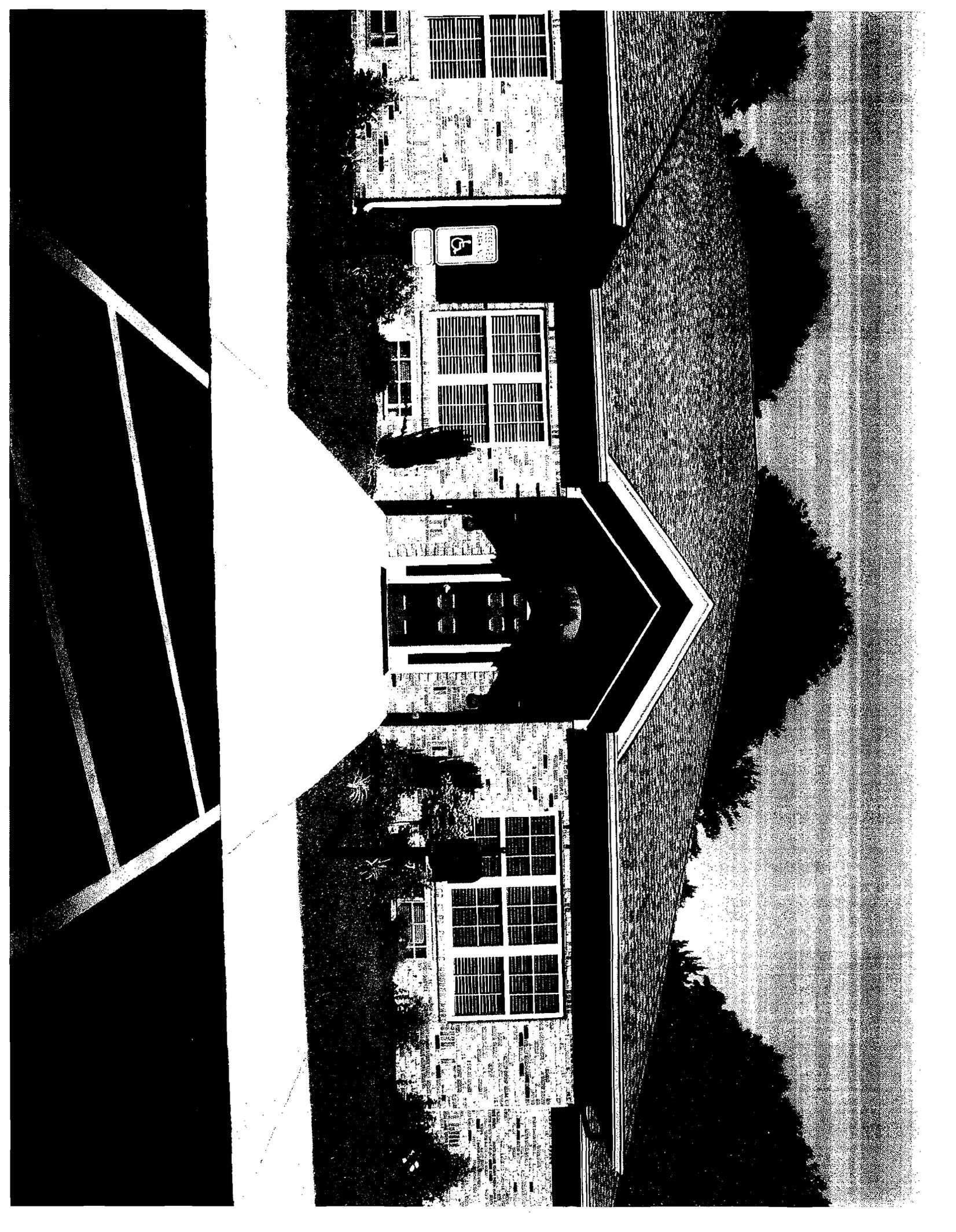
Nurses visit the house to provide skilled services while certified nurse aides literally "run" the house functioning as universal workers providing direct care, laundry, housekeeping and cooking

Staffing is departmental with segmented tasks

No middle management. CNA's manage and "run" the house

Decisions made by the organization

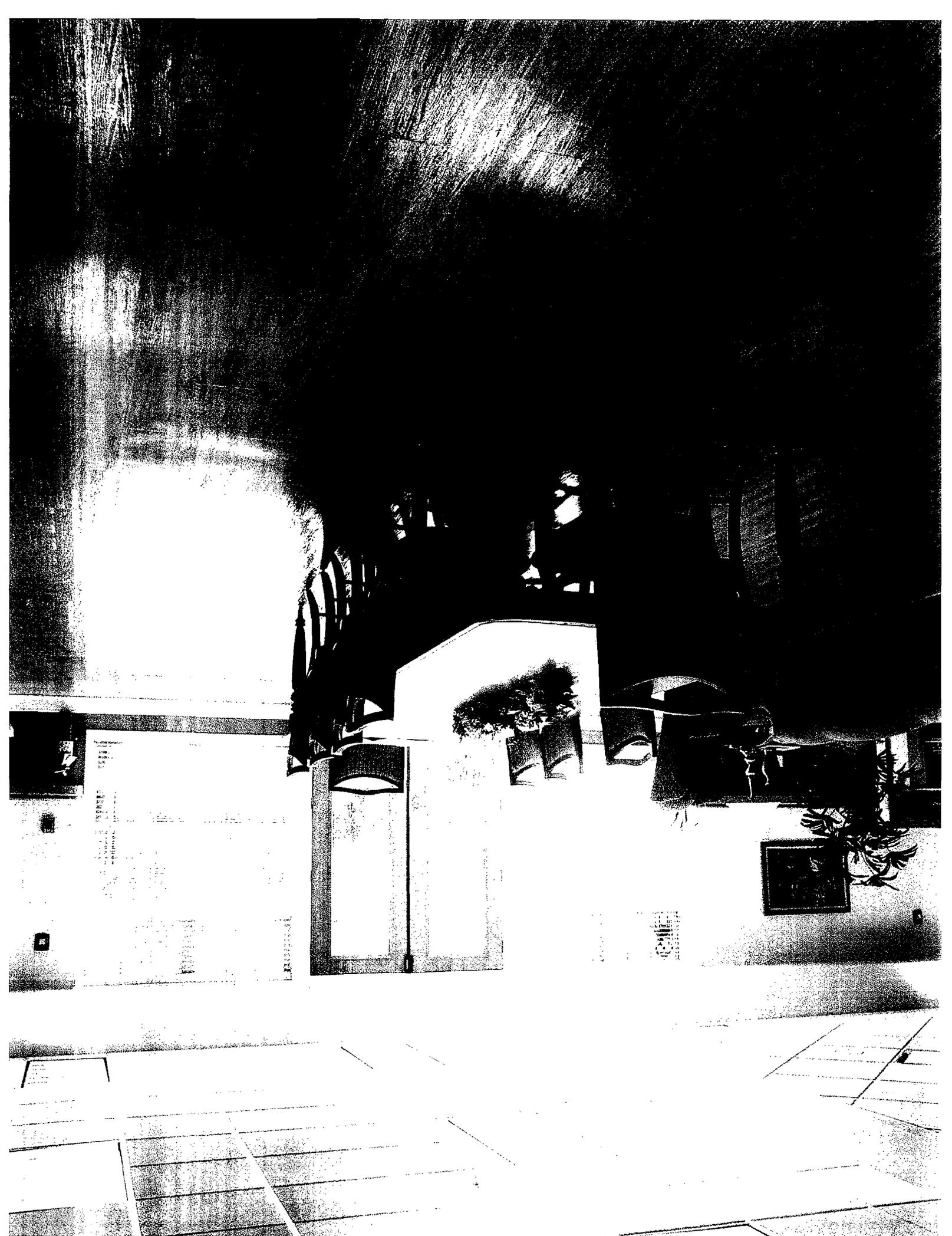
Decisions made by Elders when feasible. Elders plan menus, activities, house routines





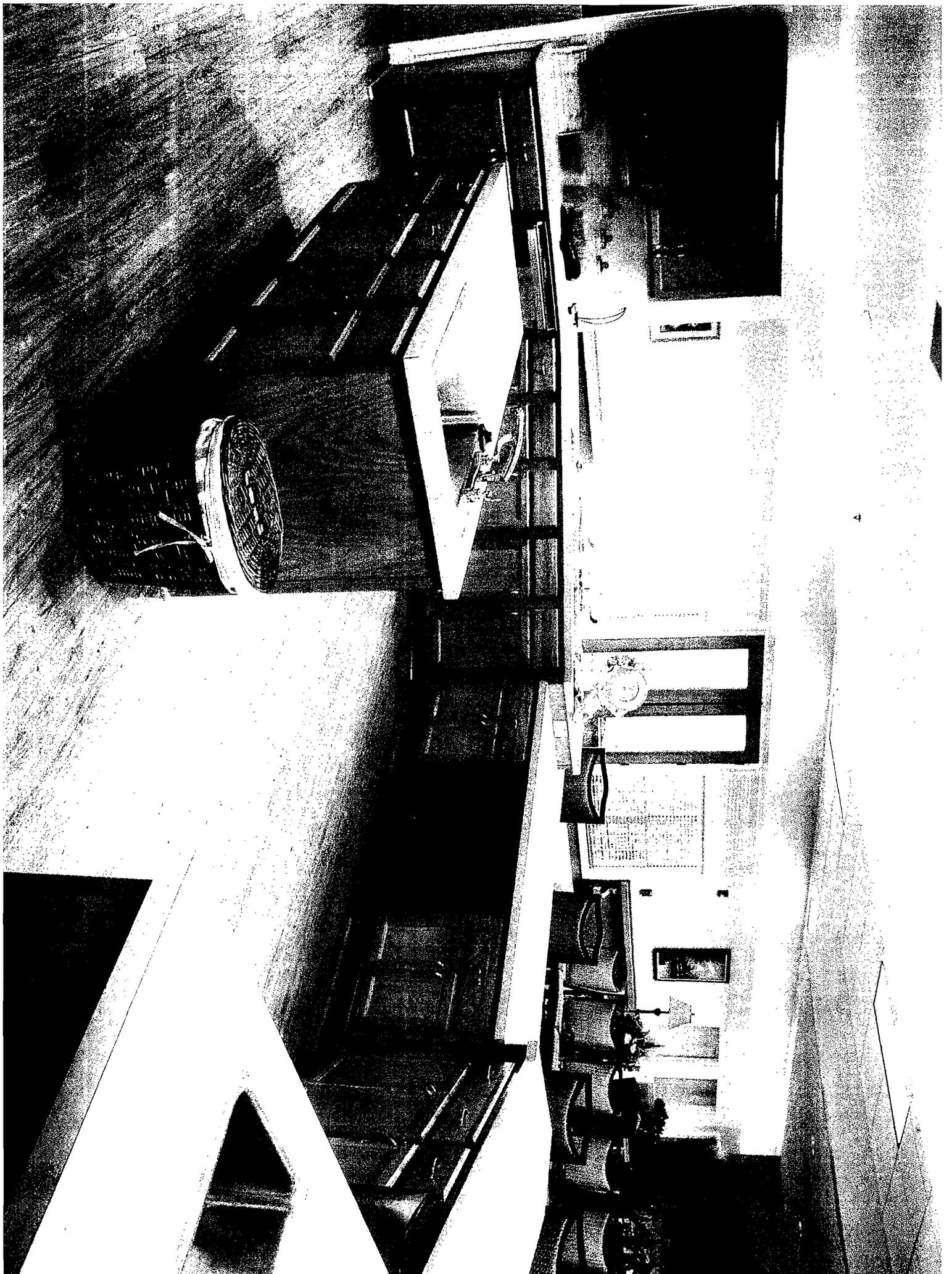


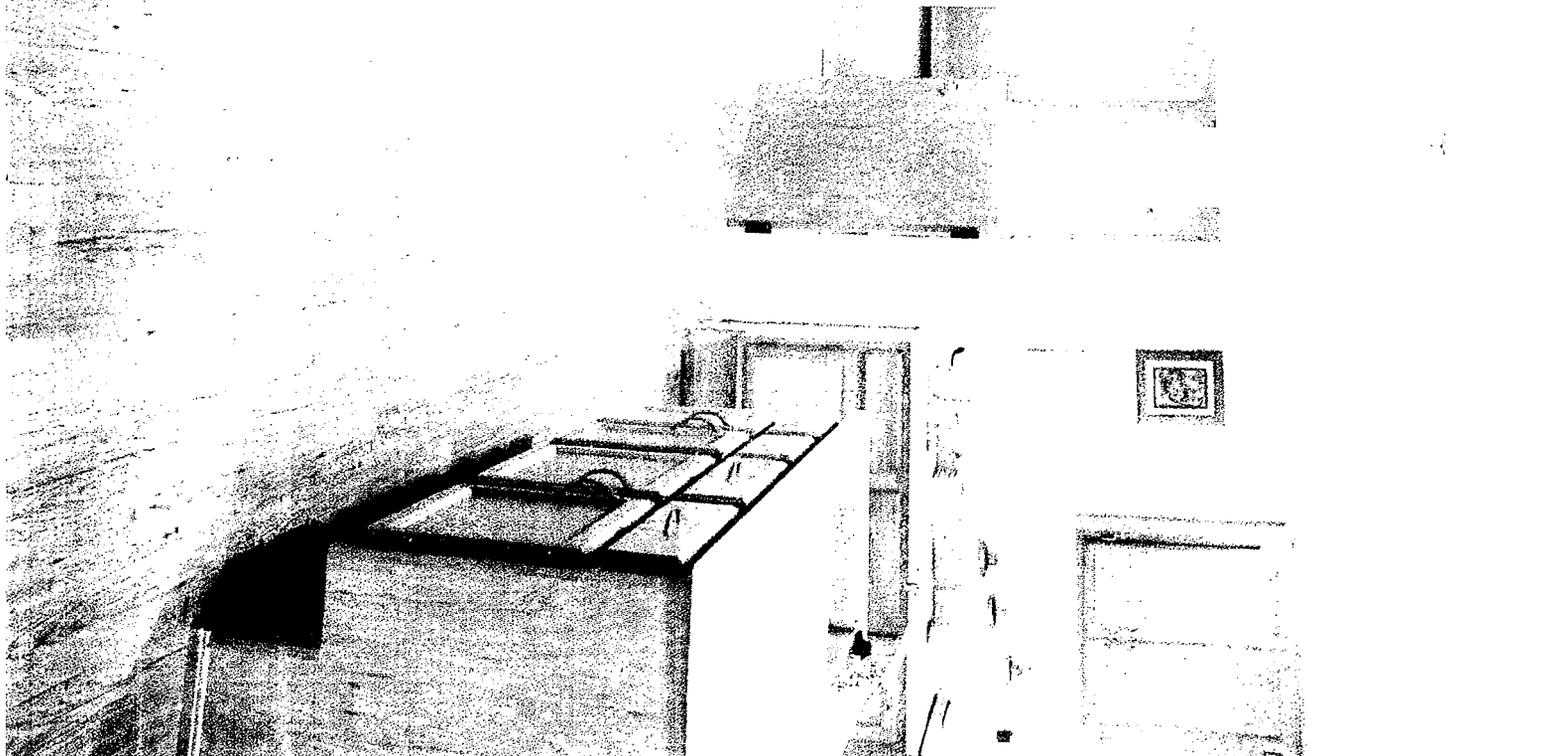
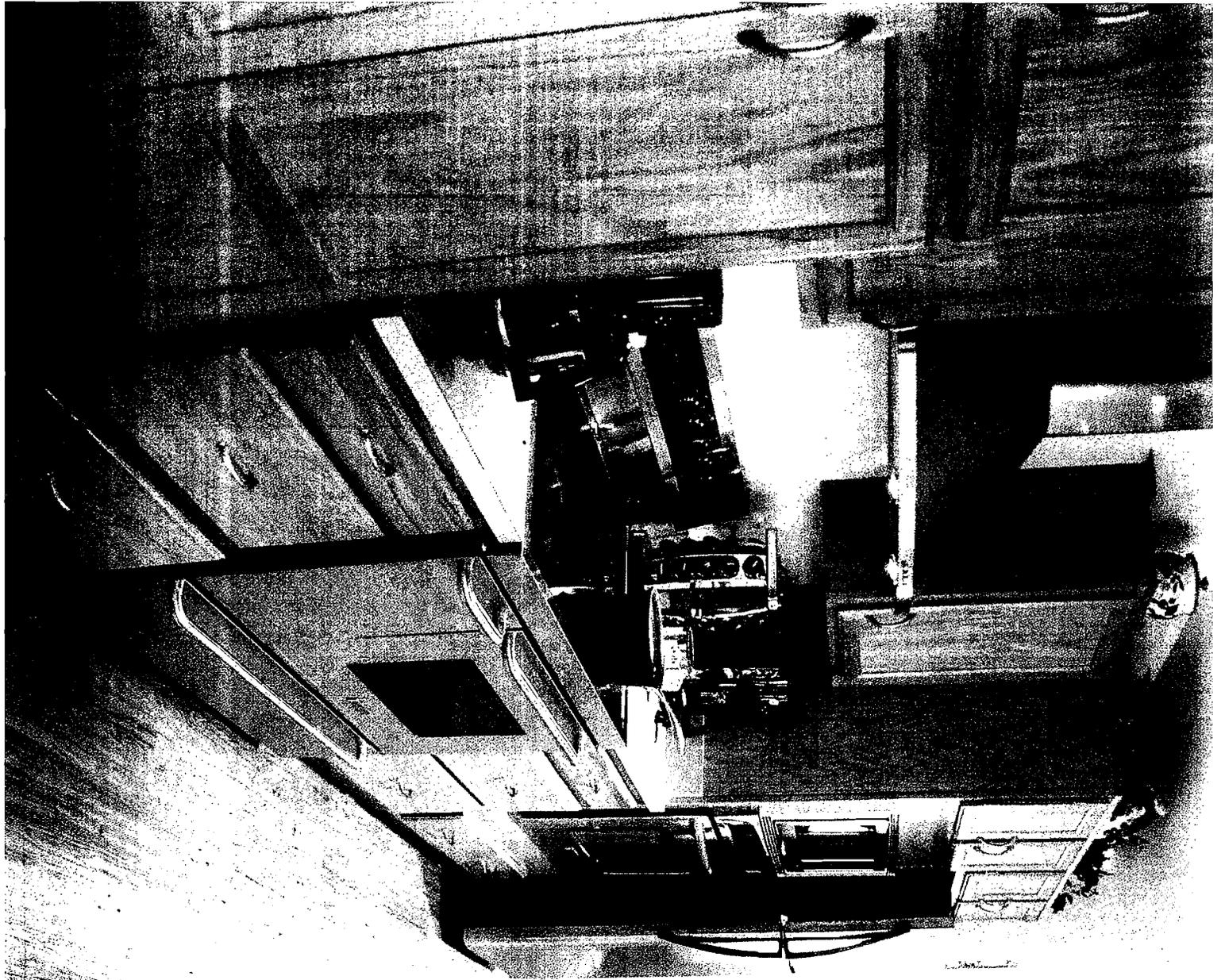


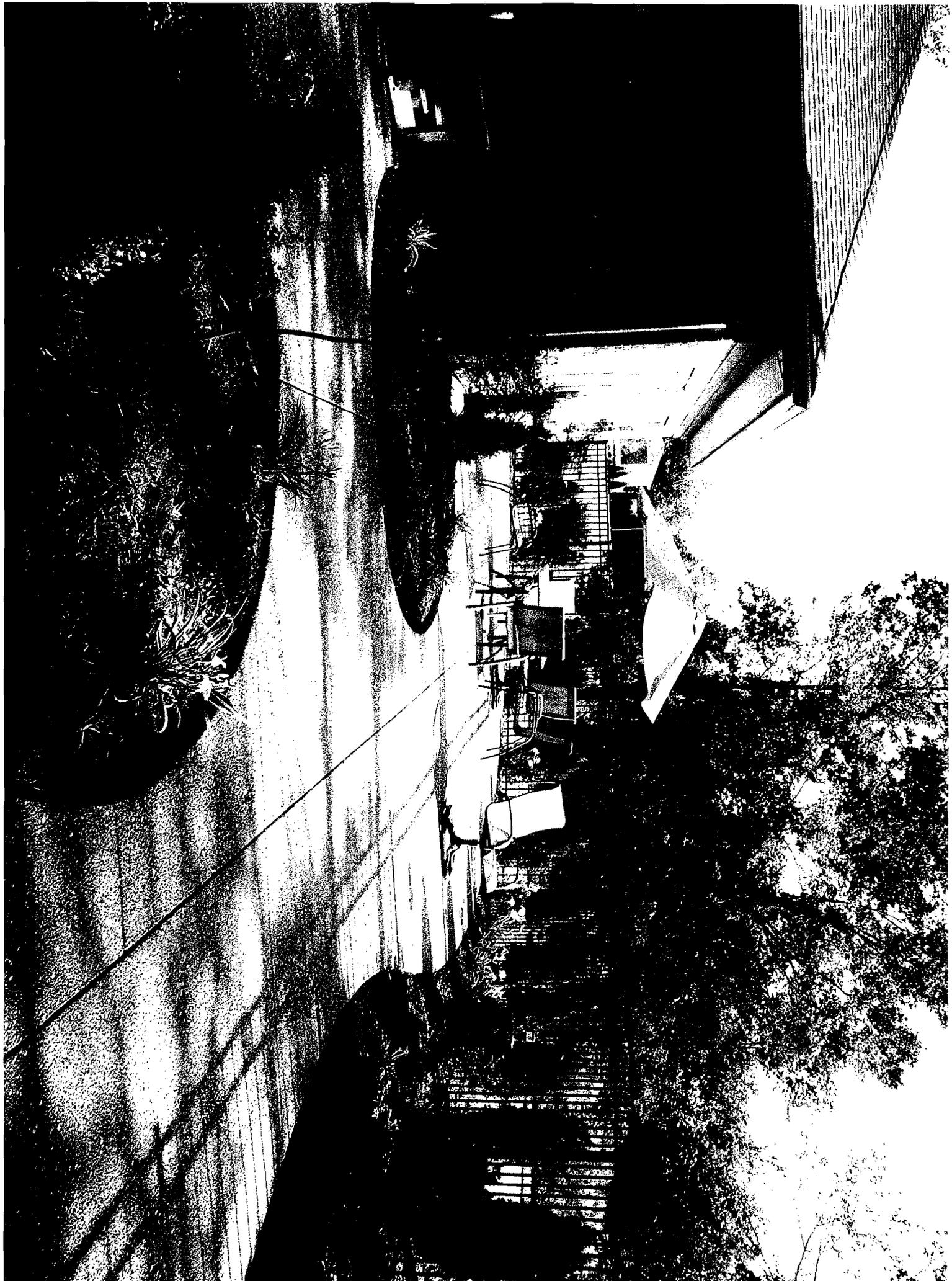




08/13/2008







## WHAT PEOPLE ARE SAYING ABOUT THE VILLAS OF GUERIN WOODS

In coming to do the initial life safety inspection, the inspector from the Division of Fire and Building Safety Indiana Department of Homeland Security commented, “when my Dad needs a place, this is where he will come.”

When a son was called saying that we were ready to open a new Villa and that his mother who had been on our waiting list for 10 months could choose which room she wanted, he exclaimed, “I’ve never driven a Cadillac but I’m about to find out how it feels to own one!” And, after his mother was here a couple of days, he commented again, “this place is awesome!”

An Elder commented, “Years ago I knew I would be living in the Villas. Now that I am here, I want the world to know of this wonderful place....it should be known and copied throughout the world!”

While searching for a Director of Nursing, a staff RN asked her friend having been a Director for 20 years and in retirement for a year and one-half to come see the place where she works. On arrival, the former Director said “This is the way it should be and immediately applied for the Director of Nursing position.”

An Elder who had been in a nursing home for a couple of years transferred to our Villas and during her first two weeks with us she persistently refused to get out of bed, refused to come to the dining room for her meals and insisted on returning to the nursing home where she had come from because she didn’t have to do any of these things there. She phoned her daughter no fewer than 12 times a day insisting that she take her back to the nursing home where she had been. With great intention, her refusals were re-directed. At her care plan meeting thirty days following her admission when asked if there were anything we could do to make her stay with us better, she responded, “ If this place were any nicer you would have to close it down!”

An Elder’s daughter wrote a note saying, “the kind words, hugs and kisses Mom receives from her caregivers there is so appreciated by our family; she has told me numerous times about caregivers giving her a hug and/or kiss on her forehead goodnight, and I can tell how much it means to her. One evening when I picked her up to take her on an outing, the caregiver who was going to end her shift while we were gone bent down and hugged her and said good bye, that meant so much to me.”

As a wife and daughter were touring the Villas to decide if their husband/father should be placed with us, the daughter turned to her mother and said, “This place smells like bacon and the other one smelled like urine.”

At the death of her Father, an Elder of the Villas, a daughter wrote, "Everyone went the extra mile for my Dad. There are not enough words to express how thankful we are for the loving care, understanding and friendship extended to Daddy. The entire staff is very dedicated to the Elders' needs. As a family member, Guerin Woods truly fulfills its mission statement, 'Life centers on privacy, dignity, respect, freedom of choice, and care and assistance of the highest quality to create a true and nurturing sense of being safe at home.'"

A daughter commented, "I'm impressed daily with the care and the facility with its home environment, the meals, the patio.... It is a combination of the care and the facility that makes this place so incredible compared to a regular facility. The care is personable, Mom knows everybody and everyone is treated like family."

A daughter noted, "My Father was in a typical nursing home for one year. I almost dreaded going to the facility because I knew he wasn't happy and was depressed. He actually stopped talking. I began to see improvement the first week he was at the Villas and tell my friends and family that they definitely need to get on the waiting list as the care is magnificent."

## **GOALS**

### **VILLAS OF GUERIN WOODS**

**A community for elders needing assisted living and comprehensive nursing care.**

The Villas enhance the quality of life for elders by developing self-contained dwellings that enable

- Dignity
- Aging in place
- Personal privacy
- Individuality
- Freedom of choice
- Respect
- Maximize individual competencies
- Safety and security
- Physical comfort
- Enjoyment
- Quality activities
- Care and assistance of the highest quality
- Increased mobility and safe accessibility
- Relationships with people of all ages
- A sense of well being



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## St. Joseph County Regional Nursing Home Learning Collaborative

*“Practical and inspirational...This is the best training I have ever attended...I would love to see this program statewide.”*

(From Participant Evaluations)

### OBJECTIVE

To engage nursing home administration throughout St. Joseph County in high quality professional development opportunities that improve overall quality of care.

### REASON

The Community Foundation of St. Joseph County has a significant endowed fund, The Robert P. & Clara I. Milton Fund for Senior Housing. The primary focus of the fund is to allow vulnerable and underserved seniors to age in place. A 2010 study, however, ranked Indiana in the bottom ten states nationally with regard to quality of care in nursing homes. While the Milton Fund continues to focus on aging in place, the Community Foundation also recognizes that seniors with the most acute caregiving needs are often unable to remain in their homes, and as a result there is an ongoing need for quality nursing home care. In order to better understand the barriers to quality nursing home care in Indiana, the Community Foundation held listening sessions with the majority of the nursing homes in St. Joseph County in the fall of 2010. The result is the regional nursing home learning collaborative.

### STRUCTURE

- From January 2011 – January 2012, eight half day trainings will be held for Administrators, Directors of Nursing (DONs) and other key staff/management.
- Topics include: Leadership Development; Staff Stability; Team Building; Supervision; Critical Thinking; Quality Improvement; Individualized Care.
- In addition to training, personalized site visits are offered by highly trained professional consultants to address whatever issue the nursing home desires. The site visit is voluntary, lasts half a day, and a nursing home may request multiple visits depending on their need.
- Mentors, referred to as Community Partners, are offered to nursing homes to assist them in working toward their goals. These Community Partners consist of trained professionals in the field of aging and are organized by REAL Services, our Area Agency on Aging.
- After each half-day training, a group of stakeholders meets in the afternoon in order to process the session, plan for the next session, and continually review the initiative to best meet the needs of nursing home management.
- The long term goal is to institutionalize the training locally, potentially through our local community college, so that a targeted leadership training can be offered on an ongoing basis in a cost effective manner. Discussion to date has identified the following areas:
  - 1) Administrators: need for ongoing professional development that is monthly, networks with other Administrators, and offers CEUs.
  - 2) Nurses: need for managerial skills, especially as it relates to managing other nurses and CNAs. This could possibly be a specially structured course with stipends and shift coverage offered.

- 3) Certified Nursing Assistants (CNAs): need for financial literacy and other personal topics as well as professional development in areas such as clinicals, aging literacy, medical terminology, etc. These trainings may be offered onsite.
  - 4) Staff Development Coordinators: need for more effective and creative ways to educate and train staff. This may be achieved through networking and sharing best practices.
- Cost for the initial year is about \$100,000, funded entirely by the Community Foundation. There is no cost to nursing homes to participate.

## **PARTNERS**

- B&F Consulting: Barbara Frank & Cathie Brady
- Health Care Excel: Kathy Hybarger & Connie Steigmeyer
- Area 2 Agency on Aging: REAL Services
- Area 2 Ombudsmen
- Trade Associations
- Ivy Tech Community College
- WorkOne Northeast

## **MEASUREMENT**

Originally, the intent was to use information from the Quality Indicator/Quality Measure reports pre and post initiative. The timing of our initiative, however, does not correspond well with the change to the Minimum Data Set (MDS 3.0). Because of the transition from 2.0 to 3.0 there is not enough data for the current calendar year to generate QI/QM reports.

For this initiative, we will be using the following assessment tools:

- 1) Pre and post Quick Outcome Assessment distributed prior to the first training and again after the final training.
- 2) Ongoing goal assessments: each nursing home will identify goals and report progress towards these goals at each training.
- 3) An online survey/evaluation will be created by the Community Foundation and administered to homes several months after the collaborative ends. This will help measure impact after the training has ended.
- 4) Nursing home report cards will be monitored pre and post initiative.
- 5) At the conclusion of the yearlong training, B&F Consulting will do a final “analytical reflection” based on their experience of our sector. They will provide suggestions and give us a sense of how we compare to others nationally.

## **HIGHLIGHTS**

- All nursing homes in St. Joseph County are participating (18) as well as two from Elkhart for a total of 20.
- Trust has been established between the Community Foundation and nursing homes as well as among the various homes. The result is that participants share freely both their successes and failures.
- After only four trainings, nursing homes have begun to make changes and implement best practices at their facilities.
- Average attendance at trainings is 70.
- Ten site visits conducted to date, another eight scheduled for the end of July.
- Indianapolis is in the process of replicating this initiative.
- A listserv was created by the Community Foundation for nursing home Administrators and DONs.

**Definition and Process for Constructing a "Small House Health Facility"**  
(Excerpted from HEA 1001, 2011 Session)

SECTION 161. IC 16-18-2-331.9 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 331.9. "Small house health facility" means a freestanding, self-contained comprehensive care health facility that has the following characteristics:

- (1) Has at least ten (10) and not more than twelve (12) private resident rooms in one (1) structure that has the appearance of a residential dwelling that is not more than eight thousand (8,000) square feet and includes the following:
  - (A) A fully accessible private bathroom for each resident room that includes a toilet, sink, and roll in shower with a seat.
  - (B) A common area living room seating area.
  - (C) An open full-sized kitchen where one hundred percent (100%) of the resident's meals are prepared.
  - (D) A dining room that has one (1) table large enough to seat each resident of the dwelling and at least two (2) staff members.
  - (E) Access to natural light in each habitable space.
- (2) Does not include the following characteristics of an institutional setting:
  - (A) A nurse's station.
  - (B) Room numbering or other signs that would not be found in a residential setting.
- (3) Provides self-directed care.

SECTION 163. IC 16-28-16 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Chapter 16. Moratorium on Medicaid Certification of Comprehensive Care Beds

Sec. 6. (a) A person planning to construct a small house health facility shall apply to the state department for a license under this article.

(b) An applicant under this section, including an entity related to the applicant through common ownership or control, may apply to the state department for Medicaid certification of not more than fifty (50) comprehensive care beds for small house health facilities per year.

(c) The state department may not approve certification of more than one hundred (100) new comprehensive care beds designated for small house health facilities per year.

(d) The state department shall approve an application for Medicaid certification for a small house health facility:

- (1) in the order of the completed application date; and
- (2) if the applicant meets the definition of a small house health facility and the requirements of this section.

(e) A person that fails to complete construction and begin operation of a small house comprehensive care health facility within twelve (12) months after the state department's approval of the application forfeits the person's right to the Medicaid certified comprehensive care beds approved by the state department if:

(1) another person has applied to the state department for approval of certified comprehensive care beds for participation in the state Medicaid program at least one (1) small house health facility; and

(2) the person's application was denied for the sole reason that the maximum number of Medicaid certified comprehensive care beds specified in subsection (c) had been approved for small house health facilities.

Sec. 7. This chapter expires June 30, 2014.