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Rep. Steven Davisson  
Rep. Ronald Bacon  
Rep. Suzanne Crouch  
Rep. Richard Dodge  
Rep. David Frizzell  
Rep. Donald Lehe  
Rep. Eric Turner  
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Sen. Ron Grooms  
Sen. Jean Leising  
Sen. Jean Breaux  
Sen. Earline Rogers  
Sen. Vi Simpson



## HEALTH FINANCE COMMISSION

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Casey Kline, Attorney for the Commission

Authority: IC 2-5-23

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

Meeting Date: September 19, 2012  
Meeting Time: 10:00 A.M.  
Meeting Place: State House, 200 W. Washington St.,  
House Chamber  
Meeting City: Indianapolis, Indiana  
Meeting Number: 2

**Members Present:** Rep. Steven Davisson; Rep. Ronald Bacon; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. Eric Turner; Rep. Charlie Brown; Rep. Craig Fry; Rep. Scott Reske; Rep. Peggy Welch; Sen. Patricia Miller, Vice-Chairperson; Sen. Ryan Mishler; Sen. Vaneta Becker; Sen. Ron Grooms; Sen. Jean Leising; Sen. Jean Breaux; Sen. Earline Rogers.

**Members Absent:** Rep. Timothy Brown, Chairperson; Rep. David Frizzell; Rep. Donald Lehe; Rep. John Day; Sen. Ed Charbonneau; Sen. Beverly Gard; Sen. Vi Simpson.

The second meeting of the Health Finance Commission was held jointly with the Interim Study Committee on Insurance. The meeting was called to order by Representative Lehman, Chairman of the Interim Study Committee on Insurance, at 10:05 AM. The Chairman announced that since time would be limited for the meeting due to the scheduling of another committee in the Chamber at 1:00 PM, he would not be taking any testimony on the federal healthcare reform update but would hear limited testimony on the tobacco harm reduction topic.

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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.

## **Update on the Implementation of Federal Healthcare Reform (ACA) (Exhibits 1 and 2)**

ACA Medicaid Expansion Considerations, Seema Verma, Indiana State Health Care Reform Lead (See the slide presentation in Exhibit 1, pages 3-8.)

Ms. Verma reviewed the original ACA mandated expansion of Medicaid and the implications of the subsequent Supreme Court decision ruling the Medicaid expansion to be optional for states. She pointed out areas of uncertainty, areas where the Supreme Court decision will leave potential coverage gaps, and the current status of the Healthy Indiana Plan (HIP) within the overall issue of the Medicaid expansion. Ms. Verma emphasized that although there are a few issues still to be clarified, HIP will be extended until December 31, 2013, under a one-year waiver extension offered by the Centers for Medicare and Medicaid Services (CMS).

Ms. Verma commented that if Indiana chooses to do a full expansion, one in four Hoosiers would be covered by Medicaid. Even if the state does not expand the eligibility, there would still be additional cost due to a woodwork effect - individuals who are currently eligible but are not enrolled for various reasons and may become enrolled or might choose Medicaid coverage due to employers dropping existing coverage. Additionally, she pointed out that if the state chooses not to fully expand Medicaid eligibility to 138% of the federal poverty level (FPL), small employers may face fines for dropping coverage.

Medicaid ACA Cost Impact Projection Update Rob Damler, Principal and Consulting Actuary, Milliman (See the slide presentation in Exhibit 1, pages 9-22. The full Milliman report is in Exhibit 2.)

Mr. Damler reviewed statistics concerning the number of Hoosiers who are uninsured and defined four scenarios for enrollment projections under the ACA. Next, he reviewed the 2010 cost projection of the Medicaid expansion, discussed key changes from that projection that are included in the updated projection, and then described the components of the cost and savings impact for each of the four enrollment scenarios.

Ms. Verma explained the rationale for including potential revenue sources in the presentation and explained that the HIP cigarette tax revenue, the Indiana Comprehensive Health Insurance Association (ICHIA) General Fund appropriation, and Medicaid offsets were some known sources of funds that could be available to finance a Medicaid expansion. She emphasized that there may be additional sources of funds that could be used, but that these specific sources were readily identifiable while others may not be so obvious. Mr. Damler continued by discussing the projected Medicaid expansion costs in comparison to the identified potential funding available for each of the four scenarios.

Commission questions followed regarding the CMS extension of the HIP program, availability of federal tax credits, the health insurance tax, ICHIA, the state's Section 209(b) status, and administrative expenses.

Health Insurance Exchange (HIX) Implementation Update (See the slide presentation in Exhibit 1, pages 23-40. See candidate responses on the HIX issue in Exhibit 2.)

Ms. Verma stated that no decision on the implementation of a Health Insurance Exchange has been made and that the Governor had asked for and received input from the three gubernatorial candidates. ( See Exhibit 2.) She reviewed the functions of an exchange, the implementation timeline, and the numbers and income characteristics of potential users of an exchange. Exchange operation and responsibilities were discussed for three options: a state-

based HIX, a state/federal operated HIX, and a federally operated HIX. She included policy issues that need to be included in the design of an exchange and addressed how consumer assistance might be offered under the three exchange design options. Ms. Verma discussed how health insurance sold off the exchange might be regulated and compared to plans offered on the exchange.

Potential HIX operating costs and financing models were discussed. Ms. Verma emphasized that since details concerning the development of the federal hub and federal regulations have not been made available, estimating initial costs of the HIX and ongoing operating costs is difficult to do with any accuracy. She mentioned several areas that additional federal direction is needed to understand how the exchange will operate with regard to the tax credit, eligibility, or who pays for functions within the three options for the exchange. She concluded by mentioning legislative and regulatory needs that would be required regardless of the operating model selected and those that would be needed depending upon the model that is ultimately selected.

Commission questions followed.

Essential Health Benefits (EHB) Benchmark Plans (See the slide presentation in Exhibit 1, pages 42-52. Candidate responses on the EHB benchmark issue are in Exhibit 2.)

Ms. Verma reviewed the EHB benchmark and how the state is allowed to select its benchmark plan. She added that the state is required to select a preliminary EHB benchmark that will be effective for the next two years by October 1, 2012, although there is an absence of final federal regulations and a lack of federal responses to questions concerning the benchmark plans. She indicated that the selection of the benchmark will be an issue that mainly affects insurance carriers for the next two years and the state may be able to change the initial selection later. Ms. Verma stated that the EHB benchmark selected is important since if the state has mandated insurance benefits not covered under the benchmark plan, the state may be at risk of being required to pay for the mandated services. She then described how the benchmark would be selected for pediatric dental and vision services since no Indiana benchmark option offers these services. (They are usually covered under separate dental and vision policies.) Finally, she described areas of conflicting federal guidance.

Commission questions followed regarding how religious beliefs and choices for care could be handled under the benchmark plan.

Other ACA-Related Items (See the slide presentation in Exhibit 1, pages 53-56.)

Ms. Verma commented on additional areas of concern that have had little federal guidance with regard to implementation. Federally funded Medicaid enhanced primary care payments are required to begin for a two-year period on January 1, 2013. The claims payment system will need to be reconfigured for a temporary period of time; the cost of doing so has not been addressed. New Medicaid provider enrollment requirements being implemented were described as was the balancing incentives payment program which provides for enhanced federal funding for transferring elderly and disabled individuals from nursing facilities to home and community-based care.

The Chairman thanked Ms. Verma for her comprehensive presentation and moved to the next subject.

## **Tobacco Harm Reduction Strategies**

Relative Risk of Smokeless Tobacco Products Brad Rodu, D.D.S., University of Louisville  
(See Exhibit 3, slide presentation and Exhibit 4.)

Dr. Rodu reviewed U.S. smoking and lung cancer mortality statistics since the 1980s and quit-smoking campaign behavioral and nicotine replacement products' effectiveness, citing a 93% failure rate. He compared nicotine to caffeine, as both are legal addictive drugs that can safely be used. Dr. Rodu stated that nicotine is a fairly safe drug, but that smoking, the most widely accepted delivery system, is the deadly part of the equation. He said there are safer nicotine delivery systems such as smokeless cigarettes and smokeless tobacco products that are substantially safer than cigarettes. The alternative products deliver a nicotine level to users that is comparable to smoking, and that modern products are more socially acceptable than chewing tobacco. He described the products and discussed the lower risk of oral cancers from these products as opposed to the risk associated with smoking products or alcohol use. He indicated that there is evidence from Sweden and the U.S. that smokeless tobacco products are safer than cigarettes and that these products can be of assistance in helping smokers to quit smoking.

Dr. Rodu recommended that the state could take steps to reduce the public health harm caused by smoking products by eliminating information on the state tobacco cessation web page indicating that smokeless tobacco is not a safe replacement for cigarettes; by allowing state employees who switch to smokeless tobacco products a discount on health insurance contributions; and allowing smokers an affordable or cheaper option by not equalizing state taxes on smokeless products with those on cigarettes.

Commission questions and discussion followed. Senator Miller asked for independent research that supports these claims be made available to the members of the Commission.

Swedish Experience with Smokeless Tobacco Products Lars E. Rutqvist, M.D., Ph.D.,  
Swedish Match (Exhibits 5, 6, and 7, a slide presentation. See Dr. Rutqvist's written  
testimony in Exhibit 6.)

Steve Buyer, Reynolds American, Federal Government Relations (Exhibits 8, 9, and 10. See Mr. Buyer's written testimony in Exhibit 10.). Mr. Buyer asked that two additional exhibits be distributed to the Commission. (See Exhibit 11 from the National Center for Public Policy Research and Exhibit 12 from the American Council on Science and Health.)

Miranda Spitznagle, Director, Tobacco Prevention and Cessation Commission, Indiana State Department of Health (ISDH). Ms. Spitznagle spoke in opposition to a policy that would advise smokers that smokeless tobacco is a safer product than cigarettes. She commented that federal law provides that tobacco companies cannot advertise a product using relative risk or harm reduction unless the claim has been substantiated by the FDA. If there is substantial evidence, then the FDA is the entity with the most expertise and experience to make that determination. She added that smokeless tobacco is considered to be a gateway product for youth and that smokeless tobacco products are addictive and they do cause disease. She finally stated that the best way to eliminate smoking is to prevent youth smoking and to help smokers quit.

Senator Becker asked Ms. Spitznagle for scientific studies to refute the claims that smokeless tobacco is less harmful.

Daniel McGoldrick, VP, Research, Campaign for Tobacco-Free Kids. Mr. McGoldrick submitted written remarks in opposition to the tobacco harm reduction strategies presented by the tobacco industry. (Exhibits 13 and 14.)

Rachel Pollock and Amanda Rychtanek (See Ms. Pollock's and Ms. Rychttanek's written testimony in Exhibit 15.)

Commission questions followed the presentation.

The Chairman announced that the next meeting of the Health Finance Commission would be October 23, 2012, at 1:00 PM in the Senate Chamber.

The meeting was adjourned at 1:05 PM.

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# Health Finance Committee Update on Federal Health Initiatives

Nationalhealthcare.in.gov  
September 19, 2012

Seema Verma, Indiana State Health Care Reform Lead  
Rob Damler, Milliman & Indiana Medicaid Program Actuary  
Logan Harrison, Indiana Department of Insurance

**Exhibit 1**  
**Health Finance Commission**  
**Meeting #2, Sept. 19, 2012**

# Medicaid

## Before SCOTUS: Medicaid Expansion

- 2014 ACA mandated coverage of all persons under 138% of FPL through Medicaid
- 100-400% FPL: eligible for tax credits via the Exchange
- Enhanced match rate for Medicaid newly eligible
- New eligibility and no asset test

Year	Federal Medicaid Match for “Newly Eligible”	State Share for “Newly Eligible”	Administrative Match
2014-2016	100%	\$0	50%
2017	95%	5%	50%
2018	94%	6%	50%
2019	93%	7%	50%
2020 on	90%	10%	50%

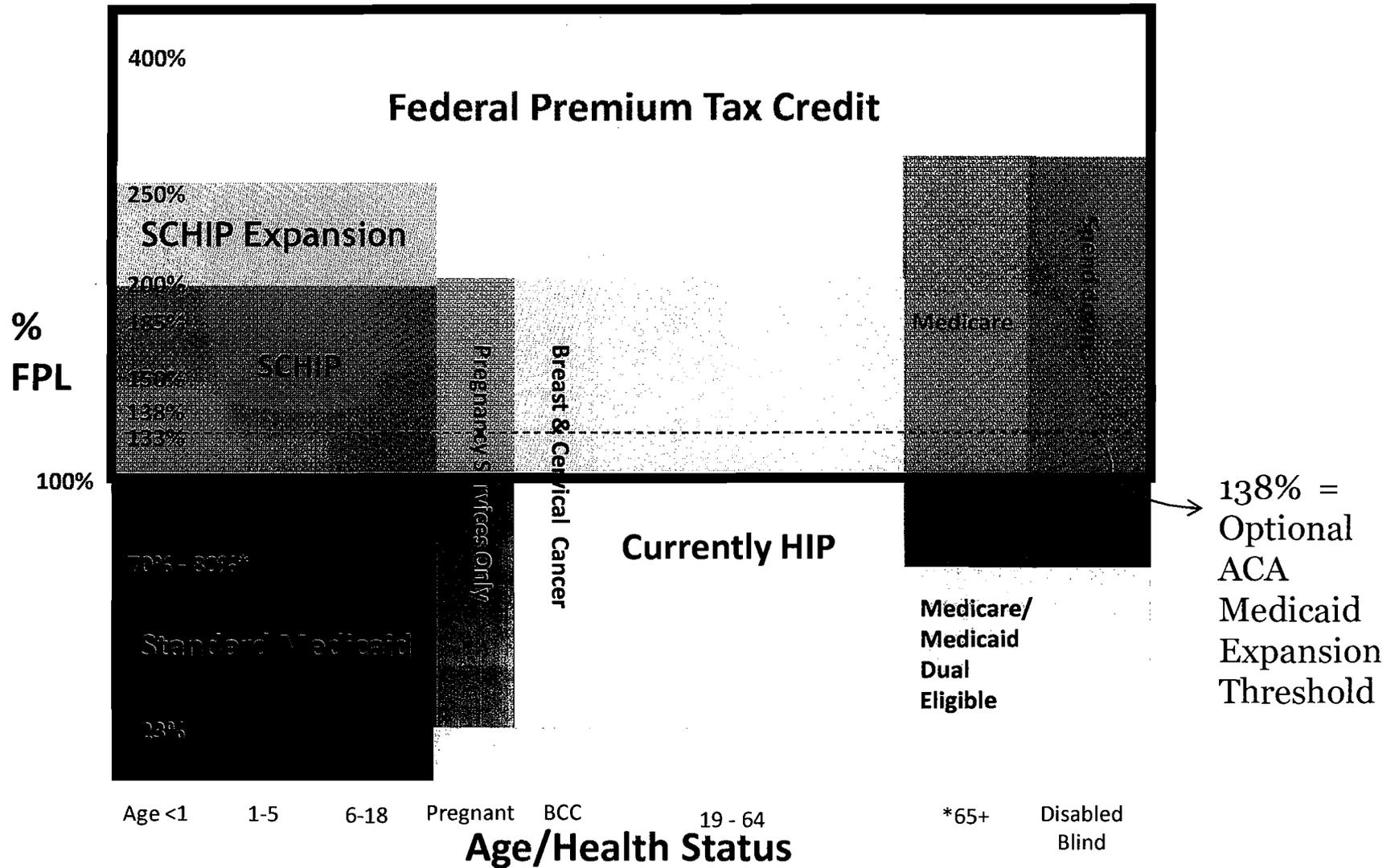
## Implications of SCOTUS Decision

- Medicaid expansion optional for states
- Indiana has made no decision regarding Medicaid expansion
- CMS Response
  - States can expand temporarily
  - Match rate and timing do not change
  - All other Medicaid provisions of the ACA stand (eligibility rules, etc.)
- Open questions:
  - Maine – maintenance of effort?
  - Partial Expansion

# Unintended Consequences of SCOTUS Decision

- Potential coverage gap for low income individuals
  - Individual mandate does not apply to low-income persons
- Increased federal costs - CBO
- Potential increase in employer penalties
- Impact to hospitals
  - Disproportionate Share Hospital Payments (DSH)
  - Cuts in Medicare reimbursement

# 2014: Government Subsidized Healthcare in Indiana



FPL is recalibrated annually and dependent on household size. In 2012, the FPL (100%) for a family of four is \$23,050 of annual income.

\*MOE requirement on CHIP through 2019

# Healthy Indiana Plan (HIP)

- Limited waiver program
  - Covers adults up to 200% FPL
  - Caps on enrollment
- SEA 461 (2011)
  - Coverage vehicle for Medicaid expansion
  - Aligned eligibility to ensure no overlap with tax credits
  - Benefits align
  - Minimum contributions

# CMS HIP Response

- 1- year extension of HIP
- No minimum contribution (\$160 per yr.)
- Not-for-profits POWER account contributions allowed
- Open Issues:
  - No response on using HIP for a potential Medicaid expansion
  - Future of HIP w/out Medicaid expansion
  - No answer on DSH restoration request
  - Plan contributions to POWER account
- Applying for post-2013 waiver extension - deadline is 12/2012
- HIP outcome is important to all states
  - Enrollment based on budget
  - Requires contributions
  - 12 month penalty for failure to make contributions

# Implications of Medicaid Expansion

	<b>Expansion</b>	<b>No Expansion</b>
<b>Medicaid Enrollment</b>	Increase of 350,000-575,000 in Medicaid; 1 in 4 Hoosiers	100,000 new enrollees due to woodwork effect
<b>New costs (2014-2020)</b>	\$1.7 - \$2.6B	~\$612M
<b>Enhanced Federal Funding</b>	\$14.3 - \$26.4B	~\$1.7B
<b>Coverage</b>	Open-ended entitlement if HIP is not used	Coverage gap for those below 100% FPL: 21% of Indiana population or 350,000 uninsured
<b>Economic Impact</b>	Reduced cost-shifting to insured population	Fines for employers with >50 employees
<b>DSH</b>	Reduction of 50% by 2019	Reduction of 50% by 2019

# Uninsured in Indiana

- Approximately 13.4% of Hoosiers are uninsured
  - This equates to ~880,000 individuals under the age of 64 who do not have insurance

<b>FPL</b>	<b>&lt;100% FPL</b>	<b>100% FPL to 138% FPL</b>	<b>139% FPL to 200% FPL</b>	<b>201% FPL to 399% FPL</b>	<b>&gt;400% FPL</b>
2012 Annual Income - family of 4	<\$23,050	\$23,051 to \$31,809	\$31,810 to \$46,100	\$46,101 to \$69,150	>\$69,150
Uninsured	348,900	105,466	160,998	215,214	50,713
% of Uninsured	40%	12%	18%	24%	6%

Source: SHADAC Health Insurance Analysis, American Community Survey data, March 10, 2011, [nationalhealthcare.in.gov](http://nationalhealthcare.in.gov).

# Enrollment Projections Under ACA Expansion Standards SFY 2015

<b>Scenarios</b>	<b>SFY 2015 Projected Enrollment</b>	<b>SFY 2015 Full Enrollment</b>
Pre-ACA Projection	1,113,000	1,113,000
No Medicaid Expansion	1,205,000	1,236,000
Medicaid Expansion to 100% FPL	1,482,000	1,599,000
Medicaid Expansion to 138% FPL	1,632,000	1,795,000

## 2010 Projection: Cost of Medicaid Expansion

<b>Projections SFY 2014 to 2020*</b>	<b>October 2010 Projection: Alternate Participation</b>	<b>October 2010 Projection: Full Participation</b>
Medicaid Expansion to 138% FPL	\$ 951.6	\$ 1,316.7
Impact of Reduced FMAP on HIP Eligibles	482.5	482.5
Spend-down and SSI Eligible (no changes)	568.4	568.4
Physician Fee Schedule Increase to 80% Medicare	592.6	675.8
Foster Children – Expansion to Age 26	14.8	14.8
Administrative Expenses	232.5	302.5
CHIP Program – Enhanced FMAP	(195.2)	(195.2)
Breast and Cervical Cancer Program	(14.2)	(14.2)
Pregnant Woman > 138%	(46.2)	(46.2)
<b>Total</b>	<b>\$ 2,586.8</b>	<b>\$ 3,105.1</b>

Source: Milliman. October 18, 2010. <[http://www.in.gov/aca/files/Affordable\\_Care\\_Act\\_-\\_Financial\\_Analysis\\_Update\\_Oct\\_2010.pdf](http://www.in.gov/aca/files/Affordable_Care_Act_-_Financial_Analysis_Update_Oct_2010.pdf)>

# Key Changes to Medicaid ACA Cost Impact Projection 2014-2020

- Stratifies costs:
  - Woodwork, administrative, expansion to 100% FPL, & 138% FPL
- Updated numbers based on recent regulations & data
- New tax on states - Health Insurer Assessment Fee on Medicaid - MCOs
- Current savings initiatives included in baseline Medicaid expenditures
- Accounts for changes or potential modifications of disability program:
  - Removal of spend down program
  - If no expansion occurs, baseline estimates would need to consider changes
- Excludes \$575M additional State cost if the State does not receive the enhanced FMAP on current HIP enrollees

<b>MEDICAID ACA COST IMPACT COMPONENTS: SFY 2014 - SFY 2020</b>				
<b>ACA Cost Components</b>	<b>Scenario 1: Woodwork</b>	<b>Scenario 2: 100% Expansion</b>	<b>Scenario 3: 133% Expansion</b>	<b>Scenario 4: Full Exposure</b>
Baseline State Expenditures	\$23,208.7	\$23,208.7	\$23,208.7	\$23,208.7
Medicaid Expansion Population	\$0	\$405.0	\$617.6	\$784.2
Woodwork Effect Population	600.1	600.1	600.1	810.4
Physician Fee Schedule Increase	0.0	564.5	581.4	610.6
Foster Children Expansion to Age 26	22.0	22.0	22.0	22.0
Health Insurance Tax	122.8	133.0	138.3	147.7
Administrative Expenses	84.2	246.2	337.9	435.5
CHIP Program – Enhanced FMAP	(176.2)	(176.2)	(176.2)	(176.2)
Breast and Cervical Cancer Program	(1.1)	(43.7)	(43.7)	(43.7)
Pregnant Women > 150% FPL	(40.1)	(40.1)	(40.1)	(40.1)
<b>Total ACA Cost Increase</b>	<b>\$611.7</b>	<b>\$1,710.9</b>	<b>\$2,037.3</b>	<b>\$2,550.5</b>
Total State Spending	\$23,820.5	\$24,919.6	\$25,246.1	\$25,759.3

**Notes:**

Already included in the SFY 2014 - 2020 Baseline Expenditures:

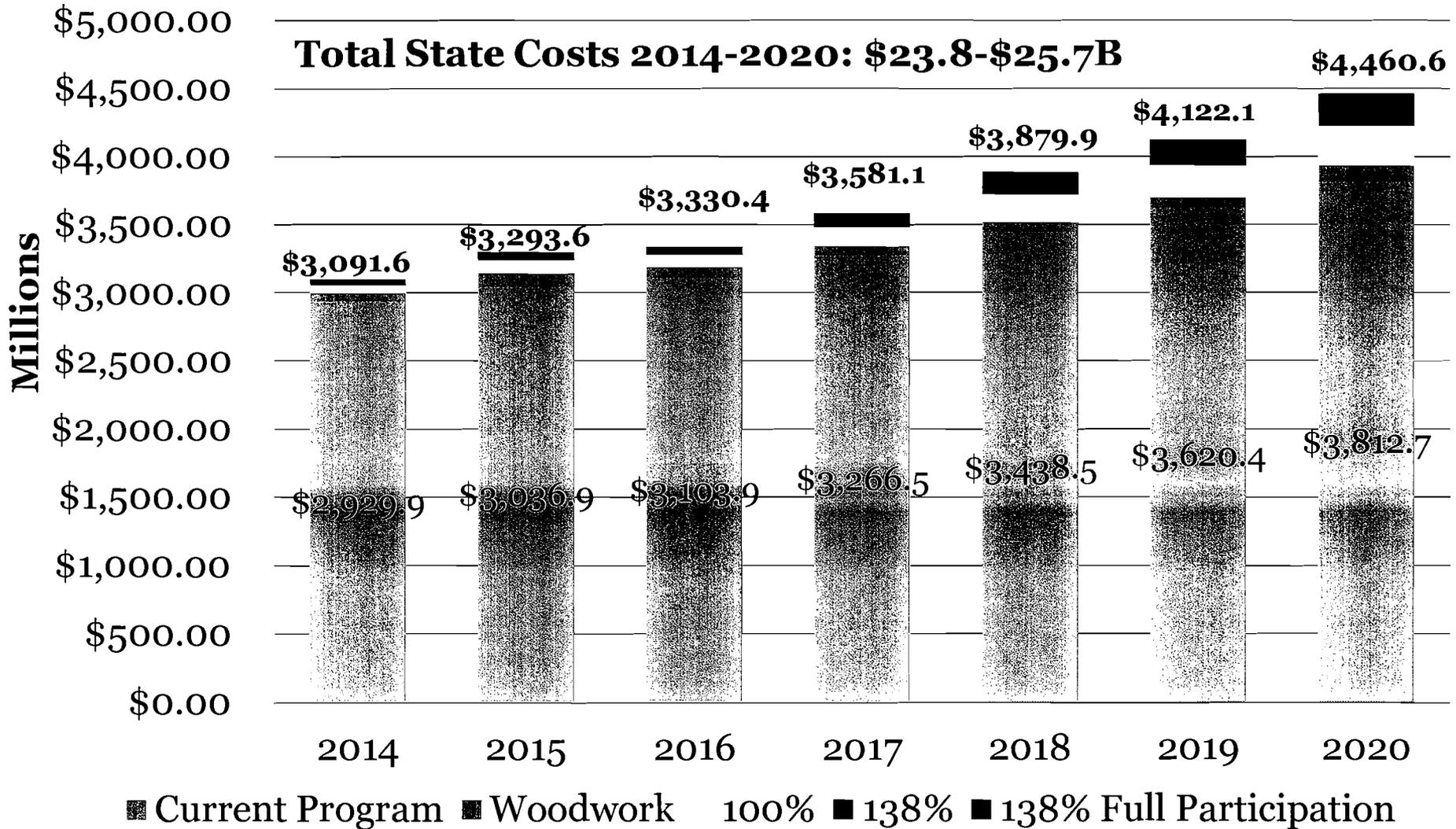
\$610 million projected State dollar savings from conversion to 1634 from 209(b)

NOT included in the SFY 2014 - 2020 Baseline Expenditures:

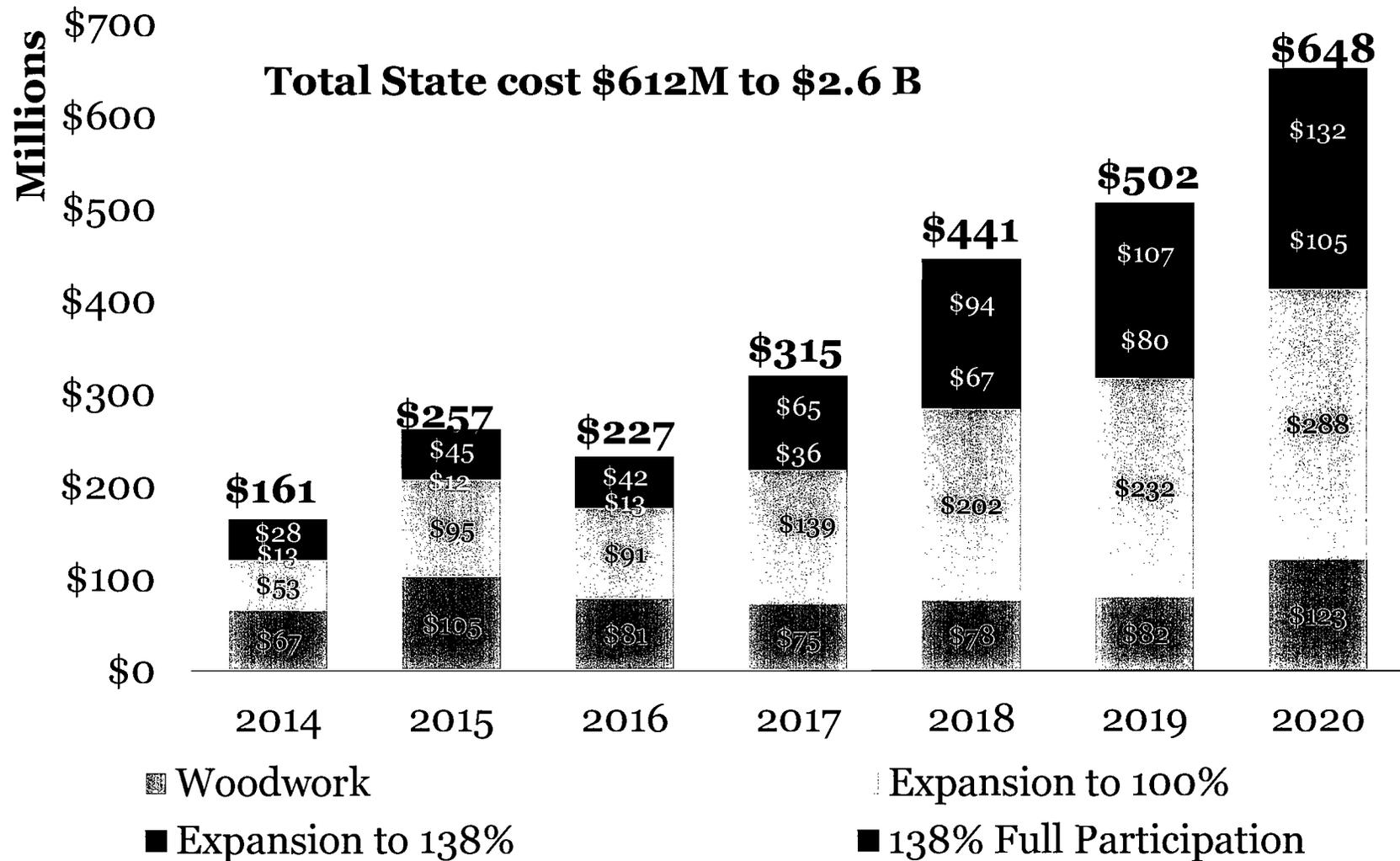
\$383 million projected State dollar additional cost if Disabled threshold raised to 100% FPL. Expanding Disabled threshold to 100% FPL would require legislative change

\$575 million projected State dollar additional cost if the State does not receive the enhanced FMAP on first 36,500 HIP enrollees

## Total State Medicaid Cost with Expansion FY2014-FY2020

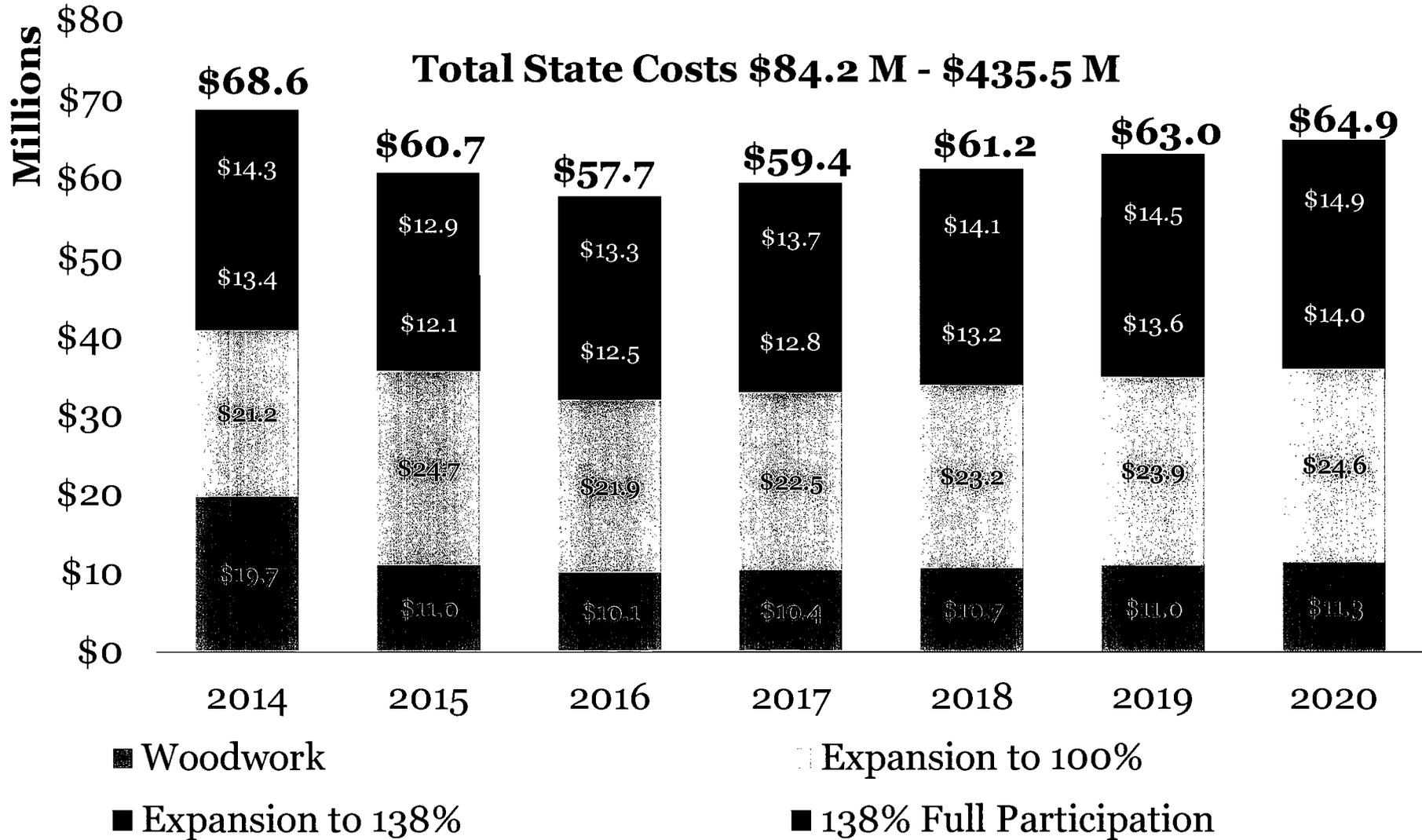


## ACA & Expansion State Costs SFY 2014-2020 \*

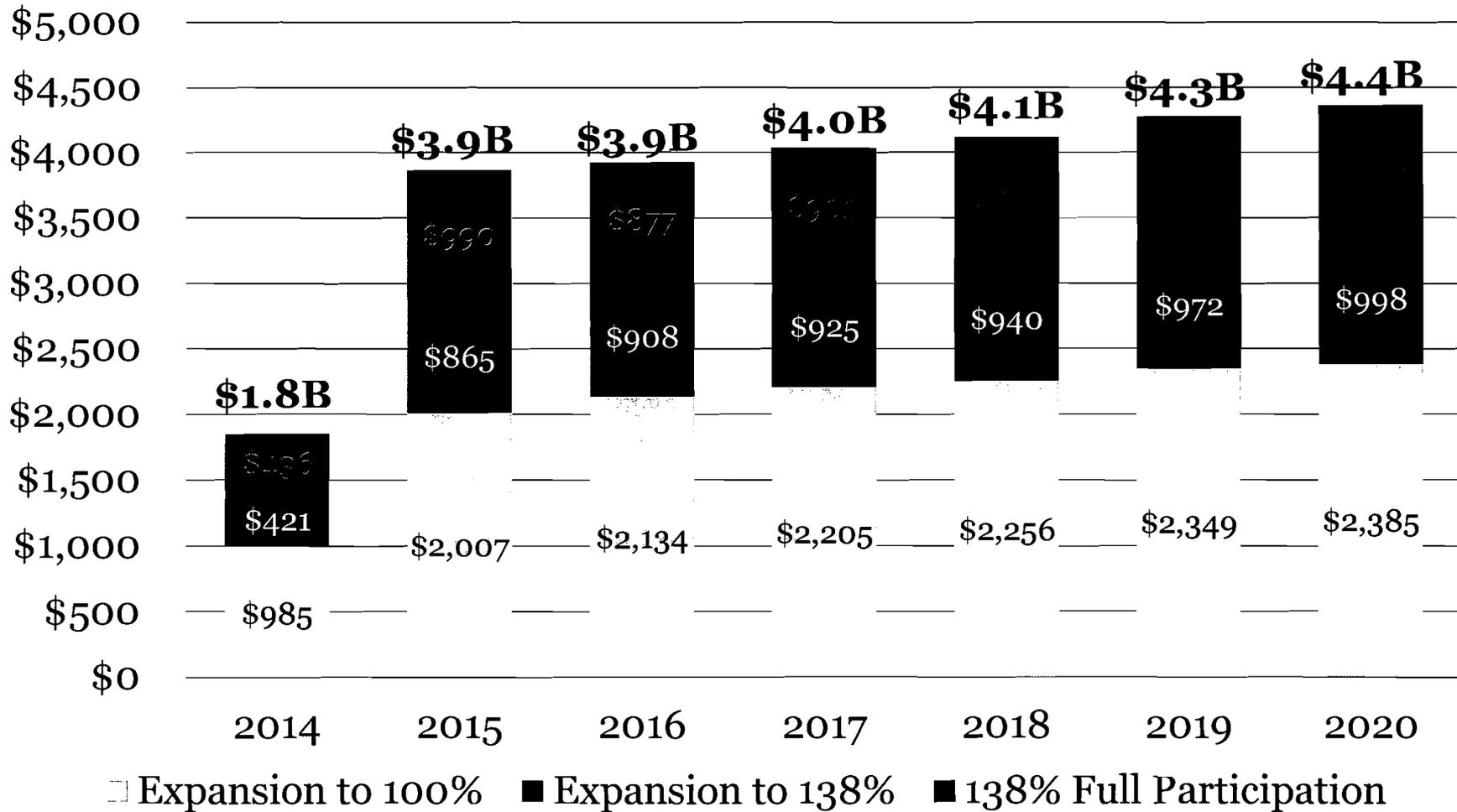


\*Includes claims and administrative costs

## Medicaid State Administrative Costs SFY 2014-2020: ACA & Expansion



## Expansion Federal Funds: 2014-2020



\*Includes claims and administrative funds

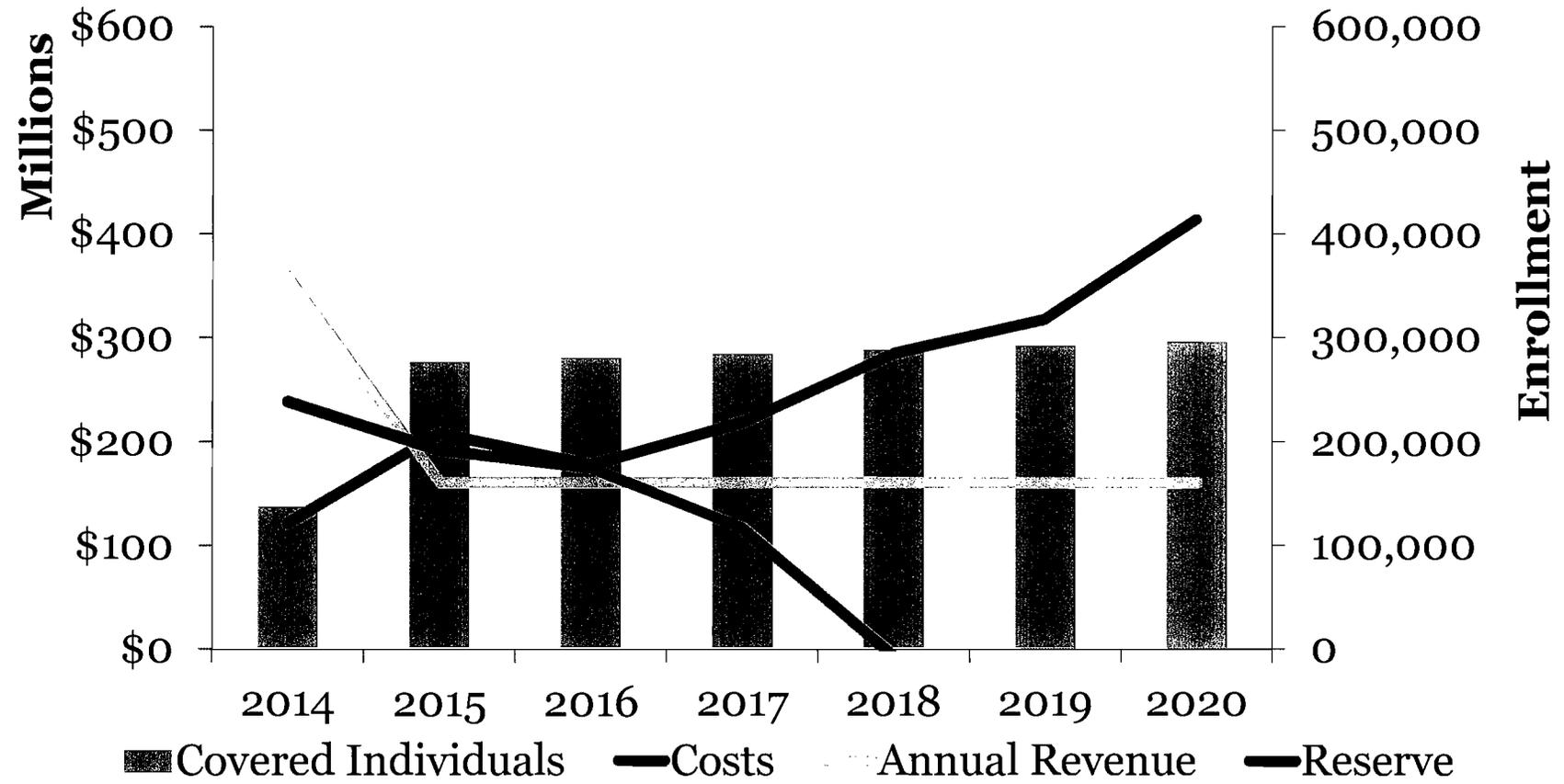
# Potential Revenue Sources

- HIP - Cigarette Assessment
  - \$278.3 M reserve projected 12/31/2013
  - \$334.8 M revenue expected 2014-2017
- Indiana Comprehensive Health Insurance Association (ICHIA)
  - No exclusion on pre-existing conditions
  - Program may sunset
  - Annual \$48.5M
- Medicaid offsets
- Other Sources-?

# Medicaid Expansion Costs and Potential Funds\*

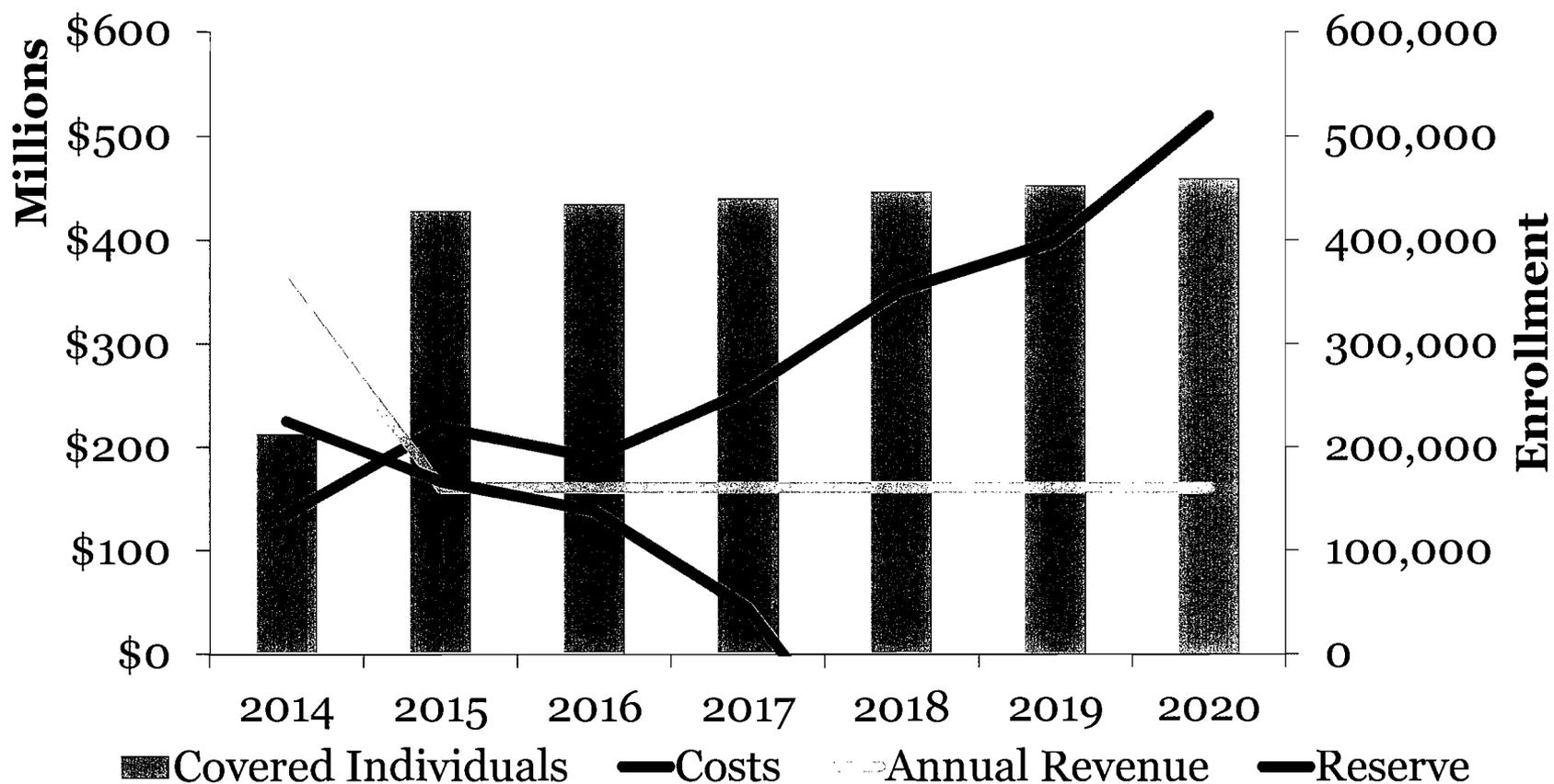
	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	Total
<b>Medicaid Costs and Potential Revenue SFY 2014 to 2020</b>								
<b>Potential Sources of Revenue</b>								
Cigarette Tax	\$334.1	\$111.6	\$111.6	\$111.6	\$111.6	\$111.6	\$111.6	\$1,003.7
ICHIA	\$24.3	\$48.5	\$48.5	\$48.5	\$48.5	\$48.5	\$48.5	\$315.3
<b>Annual Potential Revenue</b>	<b>\$358.4</b>	<b>\$160.1</b>	<b>\$160.1</b>	<b>\$160.1</b>	<b>\$160.1</b>	<b>\$160.1</b>	<b>\$160.1</b>	<b>\$1,319.0</b>
<b>ACA Expansion Scenarios - Additional Cost</b>								
<b>Woodwork</b>								
Cost	\$65.8	\$102.3	\$78.3	\$71.9	\$75.9	\$79.8	\$120.9	\$595.0
Potential Revenue Balance	\$292.6	\$350.4	\$432.1	\$520.3	\$604.5	\$684.8	\$724.0	\$724.0
<b>Expansion to 100%</b>								
Additional Cost	\$54.8	\$104.9	\$98.2	\$145.9	\$208.1	\$237.5	\$292.4	\$1,141.6
Cumulative Cost (Woodwork + Expansion to 100%)	\$120.6	\$207.2	\$176.5	\$217.8	\$284.0	\$317.3	\$413.2	\$1,736.6
Potential Revenue Balance	\$237.8	\$190.7	\$174.3	\$116.6	(\$7.3)	(\$164.5)	(\$417.6)	(\$417.6)
<b>Expansion to 138%</b>								
Additional Cost	\$13.3	\$11.1	\$12.5	\$36.2	\$67.1	\$80.5	\$105.9	\$326.5
Cumulative Cost (Woodwork + Expansion to 138%)	\$133.9	\$218.3	\$189.0	\$254.0	\$351.1	\$397.8	\$519.1	\$2,063.1
Potential Revenue Balance	\$224.5	\$166.3	\$137.4	\$43.5	(\$147.5)	(\$385.1)	(\$744.1)	(\$744.1)
<b>Expansion 138% and Full Participation</b>								
Additional Cost	\$29.8	\$42.7	\$41.9	\$64.7	\$94.1	\$107.7	\$132.2	\$513.1
Cumulative Cost (Woodwork + Expansion to 138% at Full Participation)	\$163.7	\$261.0	\$230.9	\$318.7	\$445.2	\$505.5	\$651.3	\$2,576.3
Potential Revenue Balance	\$194.7	\$93.8	\$23.0	(\$135.6)	(\$420.6)	(\$766.0)	(\$1,257.3)	(\$1,257.3)

# Woodwork and Expansion to 100% FPL: Enrollment, Costs and Potential Revenue\*



\*Potential revenue reflects cigarette tax revenue and ICHIA funds

## Woodwork and Expansion to 138% FPL: Enrollment, Costs and Potential Revenue\*



\*Potential revenue reflects cigarette tax revenue and ICHIA funds

# Exchanges

# What is a Health Insurance Exchange (HIX)?

- Individual HIX & Small Business Health Options or SHOP
- More than a web-based marketplace (“Expedia”) for purchasing insurance
- Functions:
  - Eligibility for assistance programs
  - Place to shop for & purchase health insurance (Qualified Health Plans)
  - Certifies Qualified Health Plans (QHPs) - determines which plans can be offered on Exchange, according to federal criteria
  - Collects & publishes quality data on health plans
  - Premium collection & premium aggregation in SHOP
  - Education & outreach, oversight of individual conducting outreach - Navigators
  - Option -- Risk Adjustment & Reinsurance

## What is the Exchange implementation timeline?

<b>Date</b>	<b>Action Item</b>
November 16, 2012	Governor or governor elect signifies intent
January 2013	Federal decision whether State or Federal Government will operate the Exchange
February -March 2013 (estimated)	Carriers submit plans to Department of Insurance for approval
October 2013	Go-live for Exchange: Required open enrollment period for HIX begins
January 1, 2014	Medicaid expansion takes effect for states who select this option Premium tax credits begin
October 15, 2014	Last date to apply for a federal Exchange grant to fund implementation.

Remaining application deadlines for Exchange grants:

November 15, 2012, February 15, 2013, May 15, 2013, August 15, 2013, November 15, 2013, February 14, 2014, May 15, 2014, August 15, 2014 and October 15, 2014

# Key Exchange Developments

- Implementation funding extended into 2014
  - States change choice with 12 months notice
- Partnership options
  - Consumer Assistance and/or
  - Plan Management
- Federally Facilitated Exchange (FFE)
  - Will do Medicaid eligibility assessment or determination
  - All Plans that meet QHP requirements can offer
- Outstanding regulations & guidance
  - Cost of FFE or Partnership Option
  - Federal hub & federal HIX connectivity
  - EHB
  - Quality
  - How will the FFE will conduct eligibility
  - Appeals - cost implications

## Potential Users of an Indiana Exchange

	<b>Without ACA – 2017 Projection</b>	<b>Estimated Exchange Enrollees 2017</b>
<b>Individual Exchange</b>	<b>Individuals</b>	<b>Exchange Enrollees</b>
Employer Coverage 139% FPL to 400% FPL	1,699,914	101,816
Individual Coverage 139% to 399% FPL	130,734	119,444
Individual Coverage above 400% FPL	100,980	10,098
Currently Uninsured 139-399% FPL	396,856	354,311
Currently Uninsured, above 400% FPL	53,496	8,024
Other coverage 139%+	221,129	44,226
<b>Total - Individual Exchange</b>	<b>2,603,109</b>	<b>637,919</b>
<b>SHOP Exchange</b>	<b>Employees and Dependents</b>	<b>SHOP Exchange Enrollees</b>
Employers with less than 50 Employees	904,441	42,286
Employees with 50 to 99 Employees	202,359	5,603
<b>Total - SHOP Exchange</b>	<b>1,106,800</b>	<b>47,889</b>
<b>Total - Indiana Exchange 2017</b>	<b>3,709,909</b>	<b>685,810</b>

Source: SHADAC w/ projected estimated population growth to 2017. [Nationalhealthcare.in.gov](http://Nationalhealthcare.in.gov)

# HIX Operations & Control

	State-Based HIX	Partnership HIX	Federally-facilitated HIX
State	<ul style="list-style-type: none"> <li>• State control under federal regulation</li> <li>• All Exchange activities responsibility of State:               <ul style="list-style-type: none"> <li>• State Agency or</li> <li>• Not-for-profit</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Plan Management</li> <li>• Consumer Assistance</li> <li>• Both</li> </ul>	States Can retain: <ul style="list-style-type: none"> <li>• Reinsurance</li> <li>• Medicaid &amp; CHIP eligibility or allow Feds to do it</li> </ul>
Federal	State option to defer: <ul style="list-style-type: none"> <li>• Eligibility for premium tax credits &amp; cost sharing reductions</li> <li>• Mandate exemptions</li> <li>• Risk adjustment</li> <li>• Reinsurance</li> </ul>	HHS has ultimate control  Option for State: <ul style="list-style-type: none"> <li>• Medicaid and CHIP eligibility: assessment or determination</li> <li>• Reinsurance</li> </ul>	HHS has ultimate control.  All Exchange activities responsibility of HHS

# Key Market Policy Issues for Exchanges

- Size of employer that can use SHOP Exchange
  - Individual choices:
    - i.e.. How often can a person move tiers? (gold, silver, bronze, platinum)
  - Types of plans that are offered:
    - Defined contribution plans
    - Plan Designs:
      - Health Savings Plans
      - Cost Sharing Requirements
      - Offering of wellness plans
    - Out of network requirements
  - How will dental plans be offered?
    - Bundled with health plan or stand-alone
    - Dental plan certification
- Plan requirements
    - Quality oversight
    - Accreditation timeframe
    - Geographic location
    - Requirement for types of plans that carrier must offer (benefit tier)
    - Essential community providers
    - Payment rates for FQHCs
    - Process for certification

# Consumer Assistance

	State-Based HIX	Partnership HIX	Federally-facilitated HIX
State	<ul style="list-style-type: none"> <li>• Selects entities</li> <li>• Funds Navigator grants</li> <li>• Call Center, Website</li> <li>• Training</li> <li>• Certification</li> <li>• Ongoing monitoring</li> </ul>	<ul style="list-style-type: none"> <li>• Training</li> <li>• Certification requirements</li> <li>• Ongoing monitoring</li> <li>• May make recommendations to HHS for Navigator selection</li> </ul>	<p>No role designated by federal releases.</p> <p>State could potentially pass state-specific Navigator requirements: certification, training, or eligible entities</p>
Federal	No active role.	<ul style="list-style-type: none"> <li>• HHS funds grants</li> <li>• HHS selects Navigators</li> <li>• Call Center, Website</li> </ul>	HHS responsible for all Navigator activities

# Plan Management & IDOI Responsibilities

- Regardless of HIX model, IDOI maintains jurisdiction for all IN plans:
  - Licensing
  - Rate review
  - Financial solvency
  - Coordination with HIX (either State or federal)
- Overall responsibility for market
  - Ensure that off-Exchange market is not at a disadvantage
  - Review of enrollment requirements
  - Open Enrollment Periods

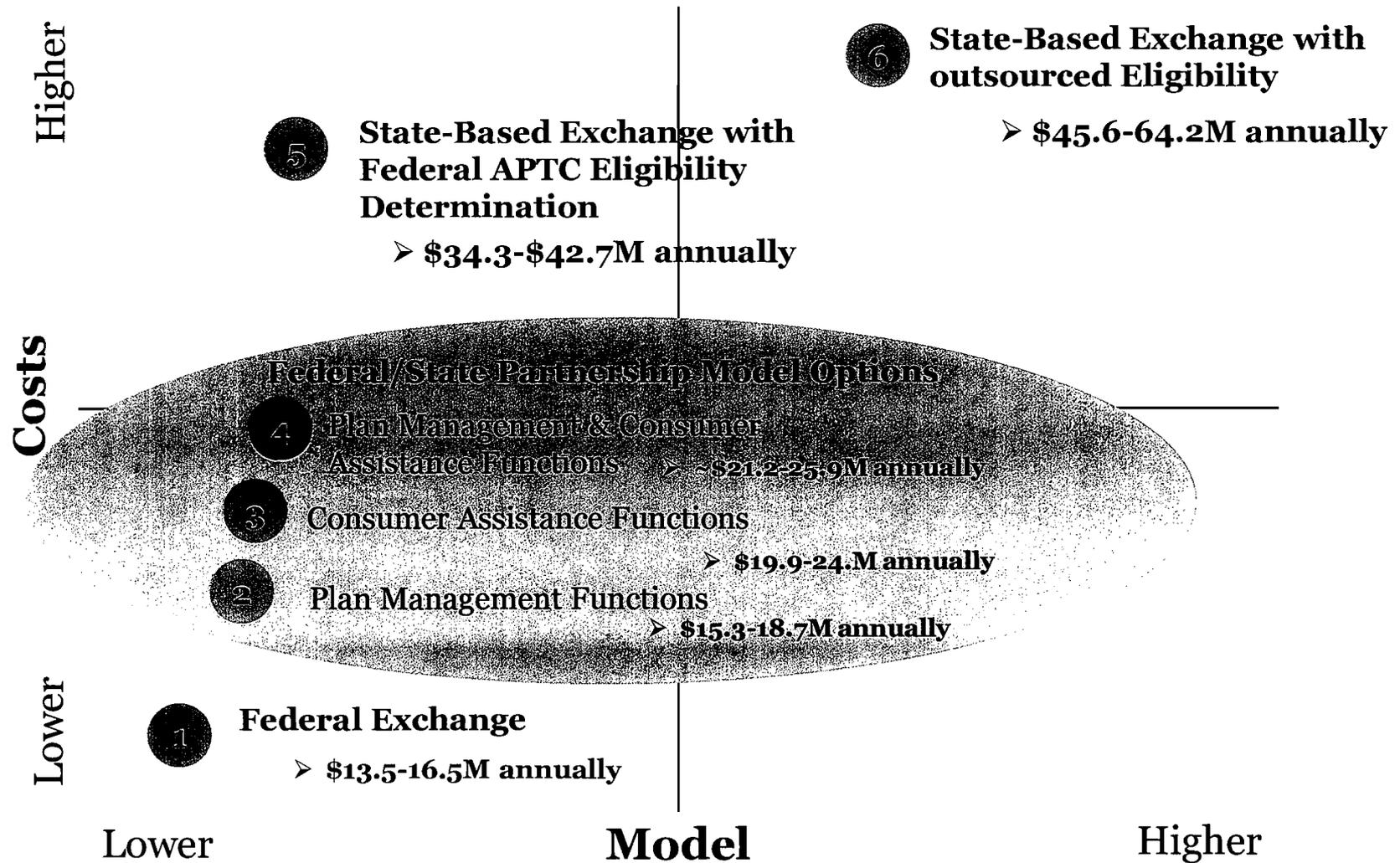
# Federal State Partnership: Plan Management Responsibilities

- Authority: which plans offer on the HIX?
  - Certification of Qualified Health Plans (QHPs)
    - Partnership model: State reviews QHP submissions and makes recommendation to Feds
    - FFE: HHS decides
- Decide policies, such as:
  - Network adequacy
  - Accreditation & quality
  - Certification requirements
- Insurer Impact:
  - Who requires submissions – state and federal?
    - Duplication?
  - Survey: carriers prefer state-based Exchange

# Off-Exchange Plans

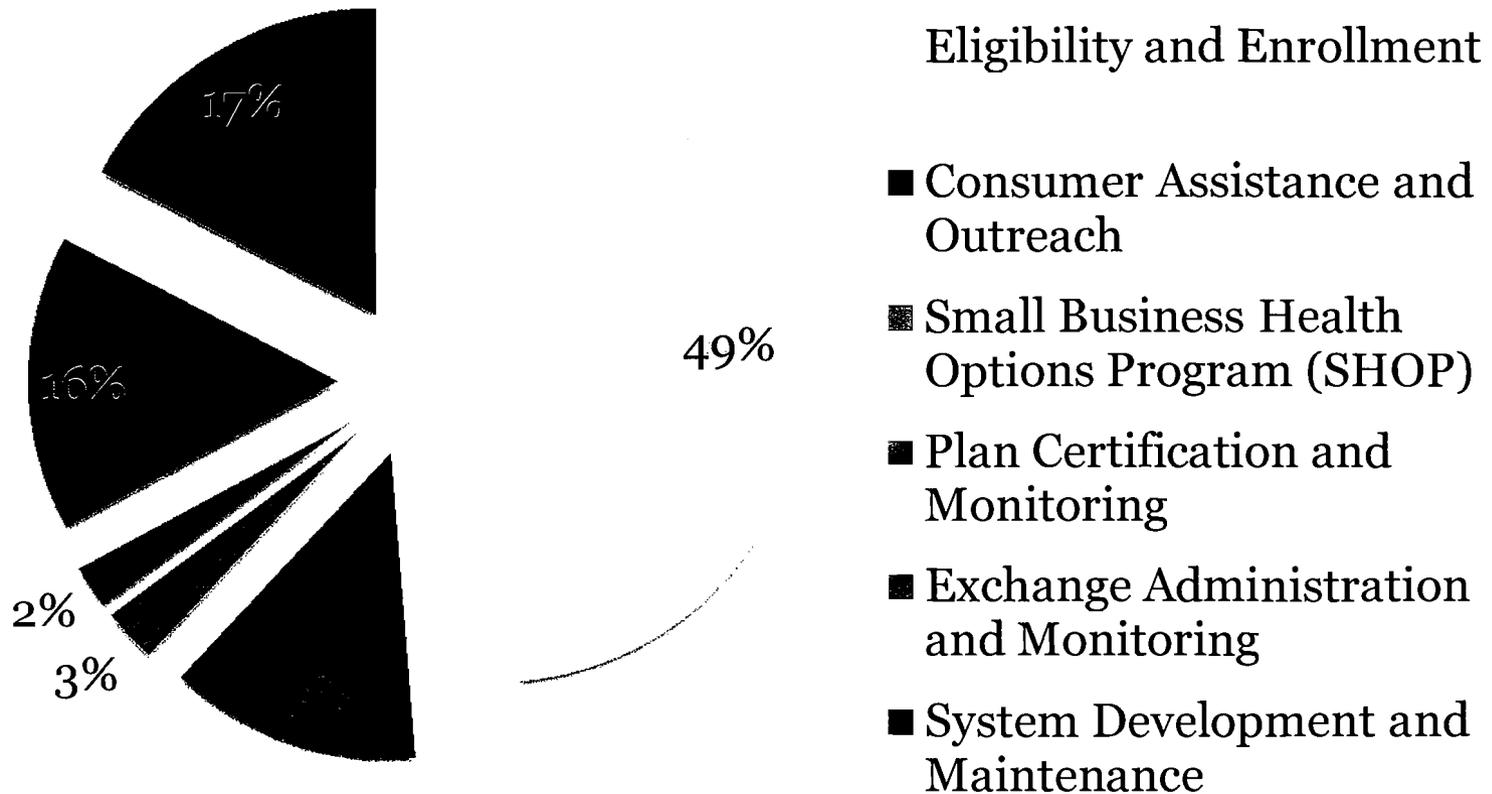
- Annual open enrollment period
  - Majority of carriers in recent survey preferred an open enrollment period off the Exchange to mirror Exchange open enrollment period
- Should some QHP requirements apply?
  - Network adequacy
  - Essential Providers
  - Accreditation
  - Quality Initiatives
  - Identification of actuarial value
- How will consumers compare plans?
  - Actuarial value?
- Consistency in rates off & on Exchange - meaningful differences?

# Exchange Models- Annual Average Cost 2013 to 2017

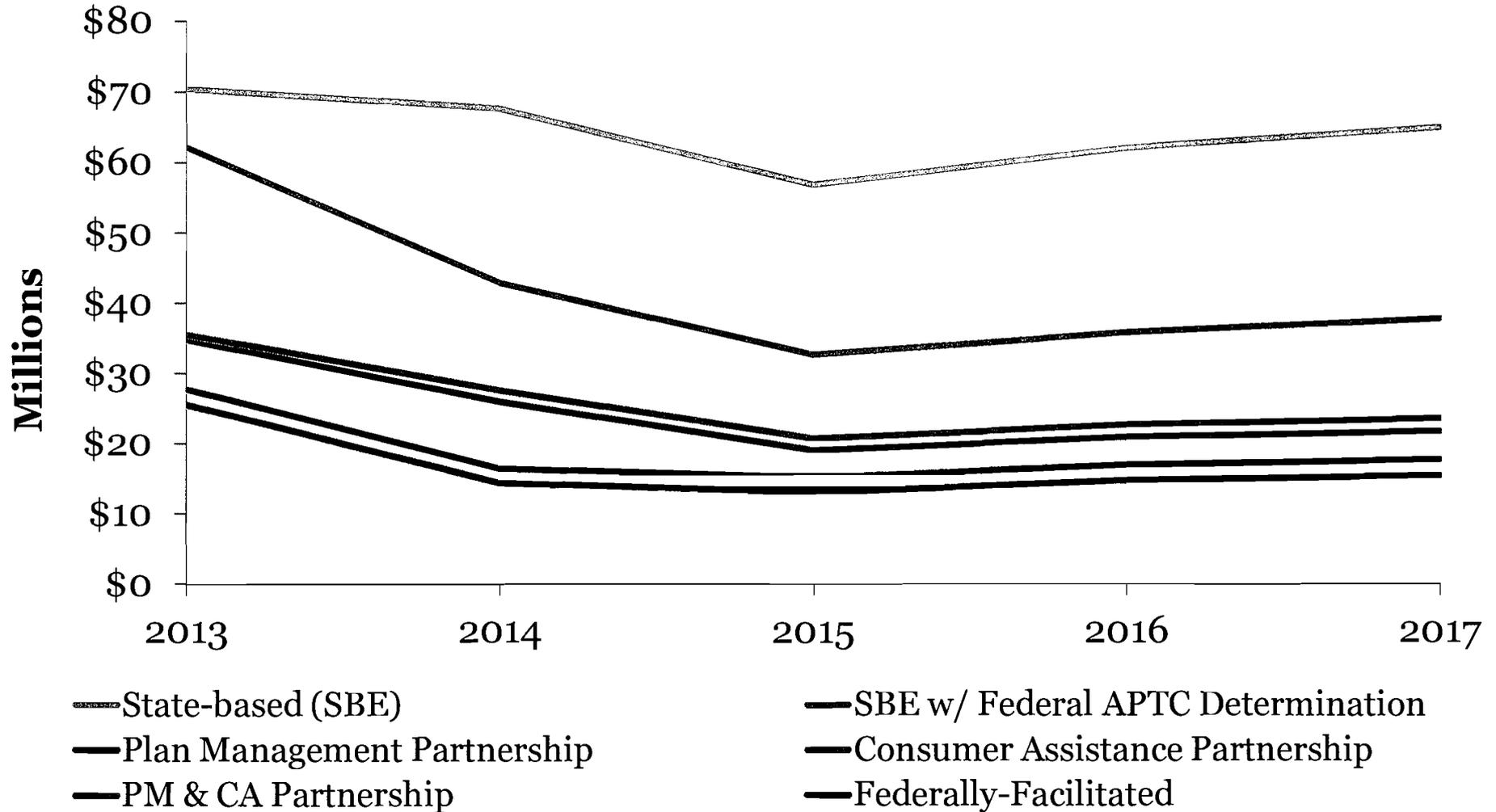


# Annual Average State-based Exchange Costs - High Enrollment Scenario

## Budget % by Area

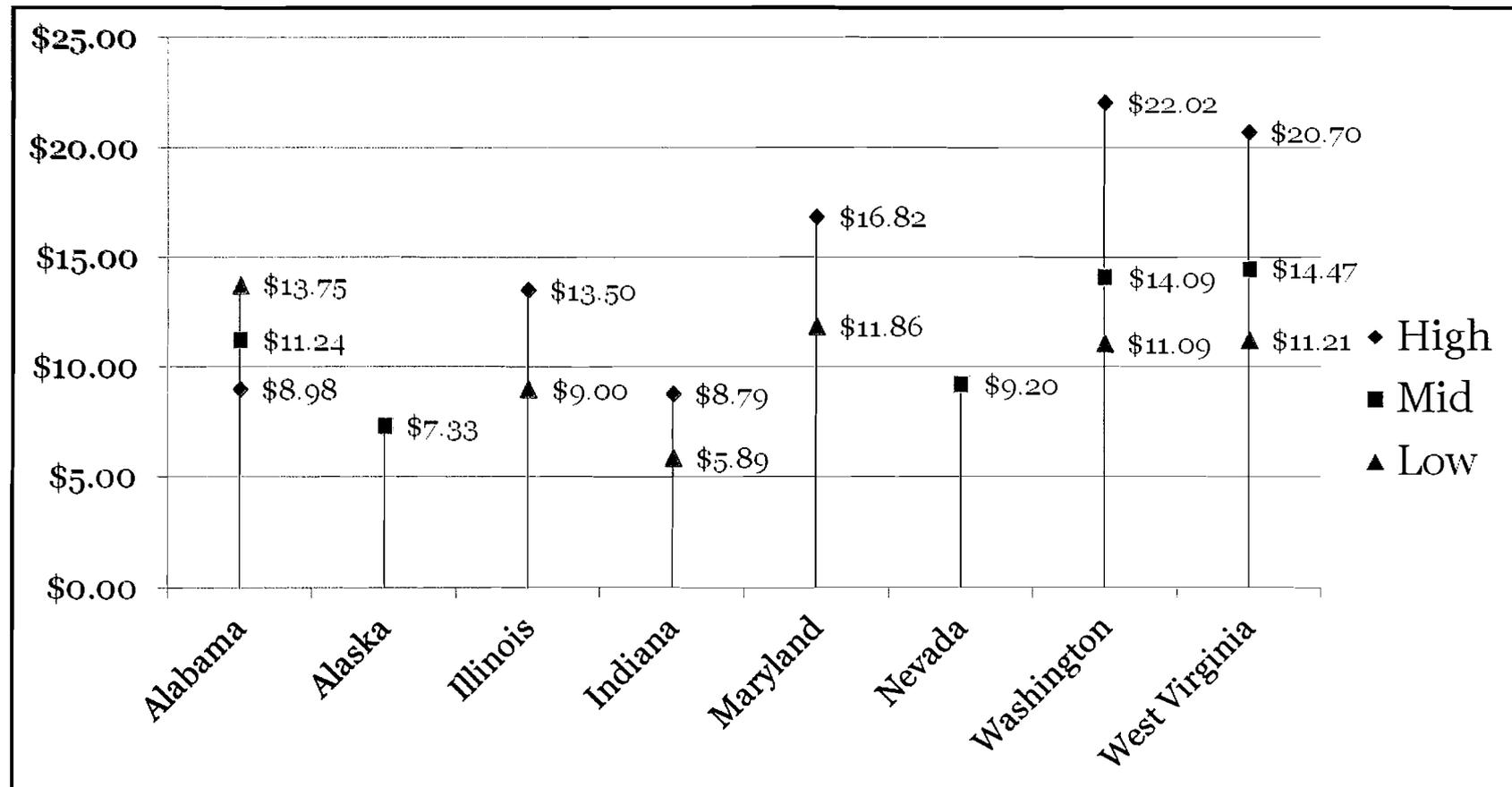


# Five-year Exchange Costs\*



\*High scenario represented

# PMPM Exchange Operating Costs by State in 2015



#### Sources:

Alabama, Financial Sustainability of the Alabama Exchange, page 7  
 Alaska, Health Insurance Exchange Planning Final Report, page 87  
 Illinois Exchange Background Research and Needs Assessment, slide 11

Maryland Health Benefit Exchange, Financing the Exchange Vendor Report, page 16  
 Nevada, Design Review, page 7  
 Washington State Health Benefit Exchange, Self-Sustainability Discussion, page 11  
 West Virginia Health Benefit Exchange, Financial Sustainability Overview, page 18

# HIX Financing

	State-Based HIX	Partnership HIX	Federally-facilitated HIX
Start-up	HIX Grant & Medicaid cost allocation	HIX Grant & Medicaid cost allocation	HIX Grant & Medicaid cost allocation
Ongoing	<p>Options:</p> <ul style="list-style-type: none"> <li>• Assessment upon insurance carriers</li> <li>• User fees</li> <li>• License/certification fee for Navigators and/or producers</li> <li>• Medicaid cost allocation</li> <li>• Advertising</li> </ul>	<p>Cost significantly less than State-based HIX?</p> <p>Will feds pay for State costs?</p> <p>Largely unknown</p>	<p>Federal government has indicated they will likely charge an insurer fee</p> <p>Costs to State unknown</p>

# HIX Legislative & Regulatory Needs

- Regardless of HIX model selected:
  - Protection of traditional state insurance department authorities to protect Hoosiers
    - PPACA: state authority will not prohibit the provisions of the law
    - Retain state authority over insurance market without preventing the application of PPACA
    - Rate review, QHP certification, plan advertising, policy form review, etc.
  - Protections for sharing confidential information among Exchange, State, federal government, insurers, etc.
  - Navigator certification, requirements, oversight & enforcement

## Additional Legislative & Regulatory Needs

State-Based HIX	Partnership HIX	Federally-facilitated HIX
<ul style="list-style-type: none"> <li>• General authority for FSSA and IDOI to work with Exchange</li> <li>• Data sharing between agencies and federal government</li> <li>• HIX governance structure</li> <li>• Financing – assessment on insurers?</li> </ul>	<ul style="list-style-type: none"> <li>• IDOI authority to contract with HIX</li> <li>• Grant authority for state coordination with HIX &amp; HHS on Medicaid and CHIP determinations</li> <li>• Authority for Memorandums of Understanding with HHS</li> </ul>	<ul style="list-style-type: none"> <li>• IDOI authority to contract with HIX</li> <li>• Grant authority for state coordination with HIX and HHS on Medicaid and CHIP determinations</li> <li>• Authority for Memorandums of Understanding</li> </ul>

# Essential Health Benefits

# Essential Health Benefit Benchmark

- EHB - required benefits for:
  - Small group & individual plans
  - For 2014 and 2015
  - Selected every 2 years
- State is allowed to choose its EHB benchmark plan based on options below:
  - Small group market: The *largest plan* by enrollment *within* each of the *three largest products* in Indiana's small group market
  - State Employee Health Plan: three plans with the largest enrollment
  - HMO: largest plan in the largest commercially insured HMO offering in the state
  - Federal employee health plans: three plans with the largest enrollment
- Default plan will be the largest plan in the small group market

# Key Concerns

- EHB Bulletin issued December 2011
- No proposed or final regulations
- Operating from the EHB bulletin, FAQs, and guidance received on calls
- Can these be enforced?
- Questions submitted in writing to HHS on:
  - May 10, August 16, August 22
- No response



# Indiana's EHB Benchmark Options

Benchmark Type	Carrier	EHB Benchmark Option
	Anthem*	PPO Option 6*
Small Group	Anthem	Lumenos HSA Option 5
	United	POS I9L
Commercial HMO	Advantage	HMO 1001
State Employee Plan	Anthem	PPO ASO
	Blue Cross Blue Shield	Standard
Federal Employee Plan	Blue Cross Blue Shield	Basic
	Government Employees Health Association	GEHA

\*Default EHB Benchmark, per federal bulletin

# Essential Benefits Categories

- The benchmark plan selected must include benefits in 10 categories specified by the ACA

1. **Ambulatory patient services**
2. **Emergency services**
3. **Hospitalization**
4. **Maternity and newborn care**
5. **Mental health and substance abuse disorder services, including behavioral health treatment**
6. **Prescription drugs**
7. **Rehabilitative and habilitative services and devices**
8. **Laboratory services**
9. **Preventive and wellness services and chronic disease management**
10. **Pediatric services, with oral and dental**

- ACA excludes annual or lifetime dollar limits on these benefits
  - Includes service limits
- If benefit category is not included in the selected benchmark plan then the State must substitute from another benchmark option

## EHB - State Mandated Benefits

- The federal plan options do not include certain Indiana mandated benefits including:
  - Pervasive Developmental Disorder (autism),
  - Dental anesthesia for the mentally and physically disabled,
  - Physical therapy provided by personal trainers
- HMO option excludes chiropractic services but does not specifically exclude chiropractic providers
  - HMO and Small Group mandates for chiropractic differ
  - Unclear impact on small group plans if HMO option selected as EHB benchmark

# Supplementing Benefits

- No Indiana EHB benchmark option offers comprehensive pediatric vision or dental
  - Required pediatric dental can be supplemented from:
    - Federal Employees Dental and Vision Insurance Program (FEDVIP), or
    - The State's Children's Health Insurance Program (CHIP-Medicaid)
    - Survey of insurers shows preference for supplementing pediatric dental with CHIP
  - Pediatric vision must be supplemented from the FEDVIP plan

# Pediatric Dental Benefits

- FEDVIP and CHIP both offer comprehensive dental coverage
  - FEDVIP has more coverage limitations
  - CHIP has more benefit exclusions

Benefit	FEDVIP	PMPM	CHIP	PMPM
Comprehensive periodontal evaluation	+	\$8.63	-	\$8.45
Crowns	* Covered with more restrictive limits	\$0.75	+	\$0.83
Resin-based fillings	+	\$0.97	-	\$0.00
Periodontal scaling, planning, maintenance	* Covered with more restrictive limits	\$0.14	+	\$0.09
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	+	\$0.77	-	-
Surgical access of an unerupted tooth	+	\$0.03	-	-
Bridges	+	\$0.12	* Requires prior approval, medically necessary only	\$0.06
Dentures	* Covered with more restrictive limits	N/A	* Prior approval required	N/A
Implant-supported dentures	+	\$0.06	-	-
Orthodontia	+	\$7.50-\$15.00	*Craniofacial conditions only, requires prior approval	\$2.00-\$7.00

# Indiana EHB Benchmark Options Analysis

		Federal GEHA	Federal BCBS	State Employee Plan	Lumenos HSA	Anthem PPO	United Health I9K POS	Advantage HMO
Benefit Richness	Rank	1	2	3	4	5	6	7
	Estimated PMPM cost	\$398.61	\$398.38	\$397.67	\$395.12	\$394.75	\$392.31	\$392.24
Required Essential Health Benefit Category	Ambulatory	+	+	+	+	+	+	+
	Emergency	+	+	+	+	+	+	+
	Hospitalization	+	+	+	+	+	+	+
	Maternity	+	+	+	+	+	*	+
	Mental health	+	+	+	+	+	+	+
	Laboratory	+	+	+	+	+	+	+
	Pharmacy	+	+	+	+	+	+	+
	Rehab & Habilitation	*	*	*	*	*	*	*
	Preventive	+	+	*	+	+	+	+
	Pediatric Oral and Vision	-	-	-	-	-	-	-

(+) indicates category is covered; (-) indicates absent and needs to be supplemented; (\*) indicates unclear

# Indiana EHB Benchmark Options Analysis: Benefit Variations Among Plans

Plan	Federal GEHA	Federal BCBS	State Employee Plan	Lumenos HSA	Anthem PPO	United Health I9K POS	Advantage HMO	Estimated Benefit PMPM Cost
Estimated Monthly Cost	\$398.61	\$398.38	\$397.67	\$395.12	\$394.75	\$392.31	\$392.24	
Chiropractic	+	+	+	+	+	+	-	\$1.72
Acupuncture	+	+	-	-	-	-	-	\$1.25
Morbid Obesity (MO) Surgery	+	+	+	-	-	-	-	\$2.25
MO non-surgical treatment	+	+	+	-	-	-	+	N/A
TMJ	+	+	+	+	+	-	-	\$0.68
Hearing Aids	+	+	-	-	-	+	-	\$0.20
Artificial organ transplants	+	-	-	-	-	-	+	N/A
Smoking Cessation	+	+	*	+	-	-	+	\$0.37
Infertility Diagnosis	+	+	-	-	-	+	+	N/A
Infertility Treatment	+	+	-	-	-	+	-	\$0.10
Breastfeeding Education	+	+	+	+	+	-	+	\$0.10
Termination of pregnancy (non-elective)	+	+	+	+	+	+	*	N/A
Elective Abortion	-	-	-	+	+	+	-	N/A

(+) indicates category is covered; (-) indicates absent and needs to be supplemented; (\*) indicates needs additional guidance

# Conflicting Guidance from HHS

- EHB Benchmark Formulary
  - Unclear whether a certain number of drugs for each category and class will be required OR
  - Just a single drug in each category & class
  - Specific drugs not required
- Habilitative Services
  - Unclear how EHB benchmark habilitative services will be defined
    - Plans may have to match the habilitative services covered in the EHB benchmark
    - Plans may choose to develop their own habilitative services definition and benefit package
    - Plans may choose to cover habilitative services at parity with rehabilitative services
- Is purchase of pediatric dental coverage mandatory or optional?
- Age cutoff for pediatric dental?
- Other coverage limitations
  - Prior Authorization Requirements
  - Converting dollar limits to service limits, etc.
- Unclear when/how HHS will convert a specific benchmark selection to a generic benchmark plan

# Other PPACA-related items

## Medicaid Enhanced Primary Care Payments

- Medicare rate for Medicaid primary care payments begins January 1, 2013
- Limited: Two years of enhanced payments
- Enhanced payment is federally-funded
- Concerns:
  - No final federal rule
  - Cost of re-configuring system for temporary period
  - Complicated
  - Post-2015 rate reductions

# Medicaid Provider Enrollment

- December 28, 2011 – First phase of implementation complete. Providers are now subject to increased screening measures prior to enrollment.
- All new enrollments received after January 1, 2012 are required to:
  - Pay an application fee if they are an “institutional” provider and are not enrolled in Medicare or have already paid the fee to another state Medicaid program
  - Use updated forms that include all new screening information
  - Validate submitted information against the EPSL, Social Security Death Master File, MCSIS as well as the OIG Sanction list
  - Conduct a pre-enrollment site visit for all Moderate and High risk providers
- January-July 2012 – 2 additional phases of implementation will bring Indiana into compliance with ACA requirements.
  - Phase 2: Provider Revalidation (each 3 or 5 years) begins
  - Phase 3: All Prescribing and Referring Physicians must be enrolled in Medicaid

## Balancing Incentives Payments Program

- Enhanced matching federal funds for home and community based care (HCBS)
- Funds will be used to support transfer of elderly and disabled individuals from nursing homes to community-based settings
- State projected to receive \$72.8 million
  - Through October 2015
  - Not a grant: receipt of funds depends on individuals moved to HCBS setting
  - Depends on federal funds available
  - Actual amount could be higher or lower

**FOR IMMEDIATE RELEASE**

**FSSA Releases Updated Healthcare Reform Cost Estimates**

INDIANAPOLIS (September 18, 2012) -- The state's costs to implement the federal Affordable Care Act (ACA) would be about \$2.6 billion over seven years if Medicaid is expanded and will increase nearly \$612 million even without expansion. Milliman Inc, the state's actuary, has provided new estimates to the Indiana Family and Social Services Administration (FSSA) about ACA's enrollment and financial impact to the state's Medicaid program based on the recent U.S. Supreme Court decision, which makes a Medicaid expansion optional for states.

Generally, Medicaid expenditures in Indiana are expected to grow at an annual rate of 4.5 percent, from \$2.9 billion in Fiscal Year 2014 to more than \$3.8 billion in 2020. (FSSA's estimate is more conservative than the 6 to 7 percent growth projected by the Centers for Medicare and Medicaid Services.) The Milliman projections for the additional ACA-related Medicaid costs are on top of annual Medicaid expenditure growth.

"In addition to the customary annual increase in our Medicaid budget, this analysis indicates even without expansion, Indiana will experience additional costs of nearly \$612 million over a seven-year period starting in 2014," said Michael A. Gargano, FSSA Secretary.

As passed, the ACA required states to expand coverage to all adults at or below 133% of the Federal Poverty Level (FPL). The Supreme Court ruling has made the Medicaid expansion optional. According to the Milliman report, the state can expect to see these changes beginning in 2014 when the law is implemented:

- A 10% increase in Medicaid enrollment because of referrals, loss of employer-provided coverage and the requirement that everyone have insurance, at a cost of \$600 million.
- A cost up to \$148 million due to a new federal health insurance tax to be imposed on state Medicaid Managed Care programs beginning in 2014. The Medicaid program is required to pay the tax.
- An increase in annual administrative costs of nearly \$60 million to address the growing Medicaid enrollment and other ACA requirements.

"The National Association of State Budget Officers reports Medicaid spending is rapidly approaching one quarter of all state expenditures," said Adam Horst, Director of the Indiana State Budget Agency. "This analysis confirms Medicaid spending under the Affordable Care Act will consume a greater and greater share of the state's budget, with that growth coming at the expense of other priorities such as K-12 and higher education."

Previous Milliman estimates were released on December 3, 2009 (based on draft language of ACA), updated on May 6, 2010 (to reflect final passage legislation), on May 21, 2010 (to reflect a range of fiscal results based on differing participation assumptions) and on October 27, 2010 (as a result of the guidance from CMS on the Federal offset of Medicaid prescription drug rebates).

A copy of today's report can be found at:

**Exhibit 2  
Health Finance Commission  
Meeting #2, Sept. 19, 2012**

[http://www.in.gov/aca/files/ACA Fiscal Impact Update 9.2012.pdf](http://www.in.gov/aca/files/ACA_Fiscal_Impact_Update_9.2012.pdf)

All Milliman reports are available at [www.in.gov/aca](http://www.in.gov/aca) under "Resources."

-30-

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September 18, 2012

Mr. Michael Gargano  
Secretary  
State of Indiana  
Indiana Family and Social Services Administration  
402 W. Washington Street  
Indianapolis, IN 46204

**RE: AFFORDABLE CARE ACT (ACA) – MEDICAID FINANCIAL IMPACT ANALYSIS  
UPDATE**

Dear Secretary Gargano:

Milliman, Inc. (Milliman) has been retained by the Indiana Family and Social Services Administration (FSSA) to provide consulting services related to the financial review of the Affordable Care Act (ACA) as it relates to the provisions impacting the State's Medicaid program and budget. This document replaces prior correspondence dated October 27, 2011. Since the previous report, part of the Affordable Care Act, the Medicaid Expansion, has become optional. Accordingly, this analysis illustrates costs with and without the expansion. It also illustrates the fiscal impact of a partial expansion to 100% of FPL. Finally, this analysis incorporates the impact of the Health Insurance Tax (HIT) and reflects updates that have occurred to the baseline program such as hospital reimbursement changes and the pending decision to transition to 1634 status.

**LIMITATIONS**

The information contained in this letter has been prepared for the Family and Social Services Administration (FSSA). This letter is expected to be publicly available. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for FSSA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In the development of the information presented in this letter, Milliman has relied upon certain data from the State of Indiana and their vendors. To the extent that the data was incomplete or inaccurate, the values presented in the letter will need to be reviewed for consistency and revised as appropriate.



Mr. Michael Gargano  
September 18, 2012  
Page 2

It should be emphasized that actual results will differ from those presented here if experience does not emerge consistent with the assumptions contained in this correspondence.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and FSSA approved May 14, 2010.

### **EXECUTIVE SUMMARY**

Milliman has developed an estimate of the enrollment and fiscal impact associated with the Affordable Care Act (ACA). In its June 28, 2012 decision, the Supreme Court of the United States upheld most of the Act, but gave States the flexibility to decide whether to expand their Medicaid program eligibility to 133% of Federal Poverty Guidelines.

Table 1 illustrates the projected expenditure impact to the State of Indiana Medicaid Assistance program and budget under the following scenarios:

- **Scenario 1: No Medicaid Expansion beyond Current Medicaid Eligibility.** Additional enrollment is projected from those who are already eligible for Medicaid due to pressure from the individual mandate, referrals from the exchange, and potential loss of access to employer sponsored insurance. From SFY 2014 to SFY 2020, even if the State does not expand Medicaid, it will still incur an estimated ***\$611.7 million*** in additional expenditures. (See Table 1 for detail by year and Table 2 for detail by cost type).
- **Scenario 2: Medicaid Expansion to 100% FPL (Partial Expansion).** Residents with incomes from 100% to 400% of FPL are eligible for exchange subsidies. The incremental Non-Federal cost of expanding Medicaid to 100% FPL is estimated at \$1,099.1 million from SFY 2014 to SFY 2020. Added to the \$611.7 cost of ACA without a Medicaid expansion, the total cost under Scenario 2 is estimated at ***\$1,710.9 million*** in additional expenditures. Since the expansion is only a partial expansion, the State may or may not receive the 100% enhanced federal funding for the partial expansion population. However, Scenario 2 assumes the State receives the enhanced Federal funding.
- **Scenario 3: Medicaid Expansion to 133% FPL** (the 133% level specified in ACA is effectively 138%, due to the 5% income disregard). Additional costs for this population are estimated to be \$326.5 million from SFY 2014 to SFY 2020. Added to the \$1,710.9 million cost for adults under 100% of FPL and for ACA costs in the absence of an expansion, the total cost under Scenario 3 is estimated to be ***\$2,037.3 million*** in additional expenditures from SFY 2014 to SFY 2020.
- **Scenario 4: Full Participation.** This scenario illustrates the cost of the 133% expansion (Scenario 3), assuming all eligible individuals below 138% FPL enroll in Medicaid. This includes all individuals who are currently eligible, all adults up to 100% of FPL, and all adults between 100% and 138% FPL, including those who currently have other insurance but would become eligible for Medicaid under an expansion. Scenarios 1 through 3 did not assume 100% participation (Participation rates are illustrated on page 5 and estimated enrollment in Enclosure 5). Scenario 4 represents an estimate of the State's maximum cost exposure. It should not be expected that full participation will occur. Rather, this scenario provides an estimated



upper limit of the exposure. The cost of ACA with the Medicaid expansion to 138% and full participation is estimated to cost \$513.1 million more than with estimated participation in Scenario 3, for a total cost of **\$2,550.5 million** from SFY 2014 to SFY 2020.

Table 1 illustrates costs by year, with total SFY 2014 to SFY 2020 costs illustrated in the last column. The individual scenario costs in Table 1 are illustrated on an incremental basis, each showing the difference in cost from the prior scenario. The scenario costs are illustrated on a cumulative basis in Table 2.

**Table 1**

**State Of Indiana  
 Family and Social Services Administration  
 Affordable Care Act Expenditure Scenarios  
 Non-Federal Dollars, in Millions**

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	2014-2020
Baseline State Expenditures	\$2,929.9	\$3,036.9	\$3,103.9	\$3,266.5	\$3,438.5	\$3,620.4	\$3,812.7	\$23,208.7
Additional ACA Spending								
Scenario 1: No Expansion	\$67.1	\$105.1	\$81.2	\$74.6	\$78.4	\$82.2	\$123.1	\$611.7
Scenario 2: 100% Expansion	53.2	94.5	91.3	139.0	201.9	231.6	287.5	1,099.1
Scenario 3: 133% Expansion	13.4	12.1	12.5	36.2	67.1	80.1	105.2	326.5
Scenario 4: Full Participation at 133% FPL	27.9	45.0	41.6	64.7	94.1	107.8	132.1	513.1
Total ACA Spending Growth	\$161.7	\$256.7	\$226.5	\$314.6	\$441.4	\$501.7	\$647.9	\$2,550.5
Total Medicaid Spending	\$3,091.6	\$3,293.6	\$3,330.4	\$3,581.1	\$3,879.9	\$4,122.1	\$4,460.6	\$25,759.3

Notes: Illustrated costs for each scenario are incremental to previous scenarios.

Values may not sum due to rounding.

The incremental cost of ACA to the State increases through the projection period as federal funding declines. Federal funding for the expansion population declines from 100% during calendar years 2014 through 2016 to 90% beginning in calendar year 2020.

Table 2 illustrates the primary ACA cost components under each scenario. Costs are illustrated on a cumulative basis. For example, costs for the 100% Expansion under Scenario 2 include the costs that would be incurred even if the State decided not to expand Medicaid (Scenario 1). Costs illustrated under Scenario 3: 133% Expansion also include costs for expanding Medicaid enrollment to adults under 100% FPL (Scenario 2) and for costs that would be incurred in the absence of a Medicaid Expansion (Scenario 1).

**Table 2**

**State Of Indiana**  
**Family and Social Services Administration**

**Affordable Care Act – Primary Cost Components**  
**SFY 2014 – SFY 2020**  
**Non-Federal Dollars, in Millions**

ACA Cost Components	Scenario 1 No Expansion	Scenario 2 100% Expansion	Scenario 3 133% Expansion	Scenario 4 Full Exposure
Baseline State Expenditures	\$23,208.7	\$23,208.7	\$23,208.7	\$23,208.7
Medicaid Expansion Population	\$0	\$405.0	\$617.6	\$784.2
Woodwork Effect Population	600.1	600.1	600.1	810.4
Physician Fee Schedule Increase	0.0	564.5	581.4	610.6
Foster Children Expansion to Age 26	22.0	22.0	22.0	22.0
Health Insurance Tax	122.8	133.0	138.3	147.7
Administrative Expenses	84.2	246.2	337.9	435.5
CHIP Program – Enhanced FMAP	(176.2)	(176.2)	(176.2)	(176.2)
Breast and Cervical Cancer Program	(1.1)	(43.7)	(43.7)	(43.7)
Pregnant Women > 150% FPL	(40.1)	(40.1)	(40.1)	(40.1)
<b>Total ACA Cost Increase</b>	<b>\$611.7</b>	<b>\$1,710.9</b>	<b>\$2,037.3</b>	<b>\$2,550.5</b>
<b>Total State Spending</b>	<b>\$23,820.5</b>	<b>\$24,919.6</b>	<b>\$25,246.1</b>	<b>\$25,759.3</b>

Note: Values may not sum due to rounding.

Baseline State Expenditures include all State-funded expenditures: Medicaid Assistance, CHIP Assistance, Intergovernmental Transfers, and other sources.

Illustrated costs assume the State will receive the enhanced FMAP on all newly eligible enrollees, including those who may have recently transitioned from the HIP program. If CMS limits Indiana to the regular FMAP on the first 36,500 HIP enrollees, the State is projected to incur an additional *\$575 million* cost over the period SFY 2014 through SFY 2020.

Baseline State Expenditures include recent program changes and those that are projected to occur regardless of whether the State chooses to implement the Medicaid expansion. These include the pending transition to 1634 status and maintenance of current hospital reimbursement, through the hospital assessment fee program. It is assumed that reimbursement for new expansion enrollees is at the same rates as for current Medicaid enrollees, and where reimbursement is supported through inter-governmental transfer payments, these transfer payments are included as part of the State cost. Baseline expenditures include current CHIP and administrative costs.

For each of the four scenarios, Enclosures 1 through 4 illustrate the ACA cost components by year. In addition to State expenditures, Total (State and Federal) expenditures and Federal expenditures are also illustrated.

The primary cost components are further discussed in the next section.

**DISCUSSION OF COST COMPONENTS*****Medicaid Expansion***

The fiscal impact associated with the ACA includes both currently insured and uninsured individuals, with different assumed participation rates. The impact also includes additional individuals who are currently eligible for Medicaid but not enrolled.

The projected number of individuals who will be eligible for Medicaid under the various scenarios was developed using the 2010 American Community Survey (ACS) data from the U.S. Census Bureau, 2010 Supplemental Health Exhibit data, and the SHADAC Indiana health insurance analysis. The information included detailed information on current income and health insurance coverage for Indiana residents. We have excluded college and graduate students from the analysis. Based on our review of the data, it appears they may not have been appropriately grouped with their parents, causing an inappropriate match between income level and insurance coverage. In addition, many of the uninsured individuals in this population may now be covered under their parents' policies, if the parents have employer sponsored insurance. We have also adjusted the census data to address under-reporting of Medicaid coverage for children.

Enclosure 5 illustrates both the number of individuals expected to be eligible (Full Enrollment) and those projected to actually enroll under each scenario (Projected Enrollment). This is illustrated for SFY 2015, the first full year after the potential Medicaid expansion. The expected participation rate varies by population type and current medical coverage as illustrated below:

- 75% for Currently Insured Parents and Children
- 50% for Currently Insured Adults
- 85% for Uninsured Parents
- 70% for Uninsured Children
- 80% for Uninsured Adults

We have further assumed that 100% of the individuals currently enrolled in HIP will enroll in Medicaid if they are eligible. The composite participation rate across the related populations for each scenario is approximately 75% to 76%, excluding the full participation scenario.

The four scenarios modeled include no expansion, expansion to 100%, and expansion to 138% of federal poverty guidelines. Although Section 2001(a) of the ACA references 133% of FPL for the full expansion, an additional 5% income disregard is provided for during eligibility determination in Section 1004(e)(2) of HCERA. Income for each household was developed based on Modified Adjusted Gross Income (MAGI), as specified in the ACA. The definition of MAGI excludes most public assistance payments. It was modified in November 2011 to include all Social Security benefits.

The analysis reflects the following enhanced Federal Medical Assistance Percentages (FMAP) for the expansion populations:

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018



- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

The woodwork population was assumed to have the same FMAP as the current eligible population.

#### ***Physician Fee Schedule Increase to 80% of Medicare***

The current Indiana Medicaid fee schedule reimburses physicians at approximately 60% of the Medicare fee schedule. It is anticipated that a significant increase in Medicaid enrollees would require the Agency to increase fees paid to physicians in order to ensure access to care. We have estimated that the minimum fee schedule increase needed for physicians would be to 80% of the current Medicare fee schedule. We have estimated that the increase to the fee schedule would be needed for both the expansion to 100% of FPL and the expansion to 138% FPL.

The Affordable Care Act includes 100% Federal funding to increase primary care physician reimbursement to 100% of Medicare for a limited set of evaluation and management and vaccination services. However, the enhanced Federal funding is only available during calendar years 2013 and 2014.

#### ***Foster Children Expansion to Age 26***

Indiana currently provides Medicaid eligibility coverage to Foster Children to age 21. The Affordable Care Act includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. The current annual cost has been estimated at \$7.6 million per year (State and Federal). Assuming these individuals are not considered newly eligible, the State cost through 2020 is estimated as \$22.0 million.

#### ***Health Insurance Tax (HIT)***

The Affordable Care Act mandates an annual fee on the health insurance industry. It starts at \$8 billion in 2014, grows to \$14.3 billion in 2018, and is indexed to premium growth thereafter. The fee is considered an excise tax and is nondeductible for income tax purposes. The fee will be allocated based on market share of premium revenue.

Taxes are generally considered an unavoidable cost of doing business. Since Medicaid managed care capitation rates are required to be actuarially sound, capitation rates would have to be increased to cover the cost of the tax, and also a gross-up to cover the additional federal taxes the increase in capitation revenue would generate.

This analysis estimates capitation rates would have to be increased by 2.5% or \$122.8 million to \$147.7 million for SFY 2014 through SFY 2020 to account for this additional cost to Medicaid managed care plans while remaining actuarially sound.

#### ***Administrative Expenses***

Administrative expense estimates have been provided by the State of Indiana. Projected administrative expenditures include costs for initial modifications to current systems and integration of Medicaid eligibility with the Exchange and the cost of processing applications for potential new Medicaid enrollees.



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On-going costs vary by scenario, as some components of the administrative cost increase with the projected number of new enrollees.

#### ***CHIP Program – Enhanced FMAP***

Under the Act, the CHIP program provides additional Federal Financial Participation (FFP) of up to 23%, with the total Federal share not allowed to exceed 100%. This program begins October 1, 2015 and ends September 30, 2019 (FFY 2016 through FFY 2019). The FFY 2013 FMAP for the CHIP program is 77.01%, so the additional 23% of Federal funding is projected to provide for full federal funding of Indiana's CHIP program during the period October 1, 2015 through September 30, 2019.

#### ***Breast and Cervical Cancer Program***

The State of Indiana currently provides eligibility under the Breast and Cervical Cancer program. This program provides screenings and treatment for uninsured women who qualify for services. It is anticipated that this program may be duplicative of Exchange based coverage as of January 1, 2014. At that time, women in this program will be able to receive the cancer screening and treatment services either on the Exchange or through an expansion of Medicaid. For the scenario with no Medicaid expansion, it has been assumed that the program is continued for participants with incomes under 100% FPL, which includes 97% of program participants.

#### ***Pregnant Women***

The State of Indiana currently provides eligibility to pregnant women up to 200% FPL. The State is required to maintain eligibility for pregnant women at the level established in the State plan as of December 19, 1989, which was 150% of FPL. As women with incomes above 150% of FPL will have access to subsidized coverage through the exchange, Indiana anticipates Medicaid coverage will no longer be needed for these women.

#### ***HIP – Potential Reduced FMAP***

CMS' preliminary indication to the State was that the enhanced (newly eligible) FMAP would not be available for the first 36,500 HIP enrollees. In November 17, 2010 correspondence, the State demonstrated that HIP did not provide a full benchmark benefit package, which would make all HIP enrollees newly eligible. CMS has not yet provided an official response to this correspondence. If CMS does not allow all HIP enrollees to receive the enhanced FMAP, there would be an additional cost to the State, estimated at \$575 million. This cost is not included in any of the tables or enclosures included with this document.

#### **KEY ASSUMPTIONS**

- Implementation of expansion on January 1, 2014.
- Prior HIP participants will be considered newly eligible and subject to the enhanced FMAP.



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- Assumed that pregnant women above 150% FPL and breast and cervical cancer patients above 138% of FPL would be transferred to the Exchange. Due to guaranteed issue and the availability of subsidies, these individuals should be eligible for premium tax credits in the Exchange.
- No changes were assumed for Medicare eligible populations. Under current programs, Medicaid recipients under 138% of FPL are eligible for Medicaid or partial Medicaid (premium and wrap-around coverage), assuming they also meet asset requirements.

### DATA RELIANCE

Milliman relied upon Medicaid enrollment data and claims data paid through June 30, 2012, as provided by the fiscal agent, HP. The data was reviewed for reasonableness and consistency, but accepted without audit.

Additional Medicaid enrollment estimates from the uninsured population and crowd-out from the employer sponsored insurance and individual health insurance markets were developed based on Calendar Year 2010 American Community Survey data for Indiana, 2010 Supplemental Health Exhibit data, and the SHADAC Indiana health insurance analysis. Estimates reflect Indiana residents under age 65, excluding Medicare eligibles and college students.

Projected administrative costs were provided by the State, with assistance provided by Ikaso Consulting.



Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

If you have any questions or comments regarding the enclosed information, please contact me at (317) 524-3512.

Sincerely,

Robert M. Damler, FSA, MAAA  
Principal and Consulting Actuary

RMD/sds  
Enclosures



**ENCLOSURE 1**

STATE OF INDIANA  
 Family and Social Services Administration  
 Health Care Reform Projection - Affordable Care Act  
 No Medicaid Expansion (Woodwork Only)  
 (Values in Millions)

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EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2014 - SFY2020
<b>Medicaid</b>								
Total (State and Federal)	\$8,230.2	\$8,612.1	\$9,063.5	\$9,540.9	\$10,045.8	\$10,580.1	\$11,145.4	\$67,218.0
Federal Funds	\$5,420.1	\$5,699.6	\$6,089.7	\$6,410.5	\$6,749.8	\$7,108.8	\$7,488.6	\$44,967.1
State Funds	\$2,810.2	\$2,912.5	\$2,973.7	\$3,130.4	\$3,296.0	\$3,471.3	\$3,656.8	\$22,250.9
<b>CHIP</b>								
Total (State and Federal)	\$156.5	\$167.3	\$175.7	\$184.5	\$193.7	\$203.4	\$213.6	\$1,294.6
Federal Funds	\$120.5	\$128.9	\$135.3	\$142.1	\$149.2	\$156.6	\$164.5	\$997.1
State Funds	\$36.0	\$38.5	\$40.4	\$42.4	\$44.5	\$46.7	\$49.1	\$297.5
<b>Healthy Indiana Plan</b>								
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Administration</b>								
Total (State and Federal)	\$167.5	\$171.9	\$179.6	\$187.5	\$195.9	\$204.6	\$213.7	\$1,320.6
Federal Funds	\$83.7	\$86.0	\$89.8	\$93.8	\$97.9	\$102.3	\$106.8	\$660.3
State Funds	\$83.7	\$86.0	\$89.8	\$93.8	\$97.9	\$102.3	\$106.8	\$660.3
<b>All Programs</b>								
Total (State and Federal)	\$8,554.2	\$8,951.3	\$9,418.7	\$9,912.9	\$10,435.4	\$10,988.1	\$11,572.6	\$69,833.3
Federal Funds	\$5,624.3	\$5,914.4	\$6,314.8	\$6,646.4	\$6,996.9	\$7,367.7	\$7,759.9	\$46,624.5
State Funds	\$2,929.9	\$3,036.9	\$3,103.9	\$3,266.5	\$3,438.5	\$3,620.4	\$3,812.7	\$23,208.7
<b>Parents / Children: No Medicaid Expansion - Estimated Participation</b>								
<b>Uninsured (State and Federal)</b>								
Children	\$33.7	\$67.0	\$72.2	\$75.8	\$79.6	\$83.6	\$87.7	\$499.6
Parents	\$22.6	\$44.8	\$48.3	\$50.7	\$53.2	\$55.9	\$58.7	\$334.2
<b>Insured (State and Federal)</b>								
Children	\$58.7	\$116.7	\$125.7	\$132.0	\$138.6	\$145.6	\$152.8	\$870.2
Parents	\$8.4	\$16.8	\$18.1	\$19.0	\$19.9	\$20.9	\$22.0	\$125.2
<b>Uninsured (Federal)</b>								
Children	\$22.6	\$45.0	\$48.5	\$50.9	\$53.5	\$56.1	\$58.9	\$335.6
Parents	\$15.2	\$30.1	\$32.4	\$34.1	\$35.8	\$37.6	\$39.4	\$224.5
<b>Insured (Federal)</b>								
Children	\$39.5	\$78.4	\$84.5	\$88.7	\$93.1	\$97.8	\$102.7	\$584.7
Parents	\$5.7	\$11.3	\$12.2	\$12.8	\$13.4	\$14.1	\$14.8	\$84.1
<b>Uninsured (State)</b>								
Children	\$11.1	\$22.0	\$23.7	\$24.9	\$26.1	\$27.4	\$28.8	\$163.9
Parents	\$7.4	\$14.7	\$15.8	\$16.6	\$17.5	\$18.3	\$19.3	\$109.6
<b>Insured (State)</b>								
Children	\$19.3	\$38.3	\$41.3	\$43.3	\$45.5	\$47.8	\$50.1	\$285.5
Parents	\$2.8	\$5.5	\$5.9	\$6.2	\$6.5	\$6.9	\$7.2	\$41.1

STATE OF INDIANA  
 Family and Social Services Administration  
 Health Care Reform Projection - Affordable Care Act  
 No Medicaid Expansion (Woodwork Only)  
 (Values in Millions)

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EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2014 - SFY2020
<b>Foster Children Increase</b>	\$4.4	\$9.2	\$9.7	\$10.2	\$10.7	\$11.2	\$11.8	\$67.1
Federal Funds	\$2.9	\$6.2	\$6.5	\$6.8	\$7.2	\$7.5	\$7.9	\$45.1
State Funds	\$1.4	\$3.0	\$3.2	\$3.3	\$3.5	\$3.7	\$3.9	\$22.0
<b>Breast &amp; Cervical Cancer</b>	(\$0.3)	(\$0.5)	(\$0.6)	(\$0.6)	(\$0.6)	(\$0.6)	(\$0.6)	(\$3.8)
Federal Funds	(\$0.2)	(\$0.4)	(\$0.4)	(\$0.4)	(\$0.4)	(\$0.4)	(\$0.5)	(\$2.7)
State Funds	(\$0.1)	(\$0.2)	(\$0.2)	(\$0.2)	(\$0.2)	(\$0.2)	(\$0.2)	(\$1.1)
<b>Pregnant Women (&gt;150%)</b>	(\$8.0)	(\$16.8)	(\$17.6)	(\$18.5)	(\$19.4)	(\$20.4)	(\$21.4)	(\$122.2)
Federal Funds	(\$5.4)	(\$11.3)	(\$11.8)	(\$12.4)	(\$13.1)	(\$13.7)	(\$14.4)	(\$82.1)
State Funds	(\$2.6)	(\$5.5)	(\$5.8)	(\$6.1)	(\$6.4)	(\$6.7)	(\$7.0)	(\$40.1)
<b>CHIP Program (Enhanced FMAP)</b>	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	\$0.0	\$0.0	\$30.3	\$42.4	\$44.5	\$46.7	\$12.3	\$176.2
State Funds	\$0.0	\$0.0	(\$30.3)	(\$42.4)	(\$44.5)	(\$46.7)	(\$12.3)	(\$176.2)
<b>Health Insurance Tax</b>	\$24.8	\$49.5	\$53.4	\$56.5	\$59.8	\$63.3	\$67.1	\$374.4
Federal Funds	\$16.7	\$33.3	\$35.9	\$38.0	\$40.2	\$42.6	\$45.1	\$251.6
State Funds	\$8.1	\$16.2	\$17.5	\$18.5	\$19.6	\$20.8	\$22.0	\$122.8
<b>Administrative Expenses</b>	\$42.3	\$23.9	\$21.8	\$22.5	\$23.2	\$23.9	\$24.6	\$182.2
Federal Funds	\$22.6	\$12.9	\$11.8	\$12.1	\$12.5	\$12.9	\$13.2	\$98.1
State Funds	\$19.7	\$11.0	\$10.1	\$10.4	\$10.7	\$11.0	\$11.3	\$84.2
<b>All Programs - After Expansion</b>								
Total (State and Federal)	\$8,741.0	\$9,262.0	\$9,749.7	\$10,260.5	\$10,800.4	\$11,371.4	\$11,975.2	\$72,160.1
Federal Funds	\$5,744.0	\$6,120.0	\$6,564.6	\$6,919.3	\$7,283.6	\$7,668.8	\$8,039.4	\$48,339.7
State Funds	\$2,997.0	\$3,142.0	\$3,185.1	\$3,341.2	\$3,516.8	\$3,702.6	\$3,935.8	\$23,820.5
<b>All Programs - Fiscal Impact</b>								
Total (State and Federal)	\$186.8	\$310.7	\$331.0	\$347.6	\$365.0	\$383.3	\$402.6	\$2,326.9
Federal Funds	\$119.7	\$205.6	\$249.8	\$272.9	\$286.7	\$301.1	\$279.5	\$1,715.2
State Funds	\$67.1	\$105.1	\$81.2	\$74.6	\$78.4	\$82.2	\$123.1	\$611.7



**ENCLOSURE 2**

STATE OF INDIANA  
 Family and Social Services Administration  
 Health Care Reform Projection - Affordable Care Act  
 Medicaid Expansion to 100% FPL with Estimated Participation  
 (Values in Millions)

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EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2014 - SFY2020
<b>Medicaid</b>								
Total (State and Federal)	\$8,230.2	\$8,612.1	\$9,063.5	\$9,540.9	\$10,045.8	\$10,580.1	\$11,145.4	\$67,218.0
Federal Funds	\$5,420.1	\$5,699.6	\$6,089.7	\$6,410.5	\$6,749.8	\$7,108.8	\$7,488.6	\$44,967.1
State Funds	\$2,810.2	\$2,912.5	\$2,973.7	\$3,130.4	\$3,296.0	\$3,471.3	\$3,656.8	\$22,250.9
<b>CHIP</b>								
Total (State and Federal)	\$156.5	\$167.3	\$175.7	\$184.5	\$193.7	\$203.4	\$213.6	\$1,294.6
Federal Funds	\$120.5	\$128.9	\$135.3	\$142.1	\$149.2	\$156.6	\$164.5	\$997.1
State Funds	\$36.0	\$38.5	\$40.4	\$42.4	\$44.5	\$46.7	\$49.1	\$297.5
<b>Healthy Indiana Plan</b>								
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Administration</b>								
Total (State and Federal)	\$167.5	\$171.9	\$179.6	\$187.5	\$195.9	\$204.6	\$213.7	\$1,320.6
Federal Funds	\$83.7	\$86.0	\$89.8	\$93.8	\$97.9	\$102.3	\$106.8	\$660.3
State Funds	\$83.7	\$86.0	\$89.8	\$93.8	\$97.9	\$102.3	\$106.8	\$660.3
<b>All Programs</b>								
Total (State and Federal)	\$8,554.2	\$8,951.3	\$9,418.7	\$9,912.9	\$10,435.4	\$10,988.1	\$11,572.6	\$69,833.3
Federal Funds	\$5,624.3	\$5,914.4	\$6,314.8	\$6,646.4	\$6,996.9	\$7,367.7	\$7,759.9	\$46,624.5
State Funds	\$2,929.9	\$3,036.9	\$3,103.9	\$3,266.5	\$3,438.5	\$3,620.4	\$3,812.7	\$23,208.7
<b>Parents / Adults / Children (&lt; 100% FPL) - Estimated Participation</b>								
<b>Uninsured (State and Federal)</b>								
Children	\$33.7	\$67.0	\$72.2	\$75.8	\$79.6	\$83.6	\$87.7	\$499.6
Parents / Adults	\$556.4	\$1,166.0	\$1,225.5	\$1,286.8	\$1,351.1	\$1,418.7	\$1,489.6	\$8,494.0
<b>Insured (State and Federal)</b>								
Children	\$58.7	\$116.7	\$125.7	\$132.0	\$138.6	\$145.6	\$152.8	\$870.2
Parents / Adults	\$166.4	\$348.5	\$366.4	\$384.8	\$404.0	\$424.2	\$445.4	\$2,539.7
<b>Uninsured (Federal)</b>								
Children	\$22.6	\$45.0	\$48.5	\$50.9	\$53.5	\$56.1	\$58.9	\$335.6
Parents / Adults	\$549.0	\$1,151.3	\$1,209.7	\$1,239.2	\$1,262.3	\$1,311.7	\$1,348.7	\$8,071.9
<b>Insured (Federal)</b>								
Children	\$39.5	\$78.4	\$84.5	\$88.7	\$93.1	\$97.8	\$102.7	\$584.7
Parents / Adults	\$163.7	\$343.0	\$360.5	\$369.4	\$376.3	\$391.1	\$402.2	\$2,406.2
<b>Uninsured (State)</b>								
Children	\$11.1	\$22.0	\$23.7	\$24.9	\$26.1	\$27.4	\$28.8	\$163.9
Parents / Adults	\$7.4	\$14.7	\$15.8	\$47.5	\$88.8	\$106.9	\$140.9	\$422.1
<b>Insured (State)</b>								
Children	\$19.3	\$38.3	\$41.3	\$43.3	\$45.5	\$47.8	\$50.1	\$285.5
Parents / Adults	\$2.8	\$5.5	\$5.9	\$15.4	\$27.7	\$33.1	\$43.2	\$133.5

STATE OF INDIANA  
 Family and Social Services Administration  
 Health Care Reform Projection - Affordable Care Act  
 Medicaid Expansion to 100% FPL with Estimated Participation  
 (Values in Millions)

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EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2014 - SFY2020
<b>Foster Children Increase</b>	\$4.4	\$9.2	\$9.7	\$10.2	\$10.7	\$11.2	\$11.8	\$67.1
Federal Funds	\$2.9	\$6.2	\$6.5	\$6.8	\$7.2	\$7.5	\$7.9	\$45.1
State Funds	\$1.4	\$3.0	\$3.2	\$3.3	\$3.5	\$3.7	\$3.9	\$22.0
<b>Breast &amp; Cervical Cancer</b>	(\$0.3)	(\$0.5)	(\$0.6)	(\$0.6)	(\$0.6)	(\$0.7)	(\$0.7)	(\$4.0)
Federal Funds	\$3.2	\$6.6	\$6.9	\$6.5	\$5.7	\$5.7	\$5.2	\$39.7
State Funds	(\$3.4)	(\$7.1)	(\$7.5)	(\$7.1)	(\$6.4)	(\$6.3)	(\$5.9)	(\$43.7)
<b>Pregnant Women (&gt;150%)</b>	(\$8.0)	(\$16.8)	(\$17.6)	(\$18.5)	(\$19.4)	(\$20.4)	(\$21.4)	(\$122.2)
Federal Funds	(\$5.4)	(\$11.3)	(\$11.8)	(\$12.4)	(\$13.1)	(\$13.7)	(\$14.4)	(\$82.1)
State Funds	(\$2.6)	(\$5.5)	(\$5.8)	(\$6.1)	(\$6.4)	(\$6.7)	(\$7.0)	(\$40.1)
<b>CHIP Program (Enhanced FMAP)</b>	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	\$0.0	\$0.0	\$30.3	\$42.4	\$44.5	\$46.7	\$12.3	\$176.2
State Funds	\$0.0	\$0.0	(\$30.3)	(\$42.4)	(\$44.5)	(\$46.7)	(\$12.3)	(\$176.2)
<b>Health Insurance Tax</b>	\$41.7	\$86.4	\$91.3	\$96.4	\$101.7	\$107.3	\$113.2	\$637.9
Federal Funds	\$33.6	\$69.9	\$73.8	\$76.8	\$79.8	\$83.7	\$87.3	\$504.9
State Funds	\$8.1	\$16.5	\$17.5	\$19.5	\$21.9	\$23.6	\$25.9	\$133.0
<b>Phys Fee Schedule Inc (80% Medicare)</b>	\$163.9	\$353.9	\$365.0	\$380.5	\$398.0	\$418.7	\$440.4	\$2,520.5
Federal Funds	\$128.5	\$277.3	\$288.3	\$298.2	\$307.9	\$322.4	\$333.4	\$1,956.0
State Funds	\$35.5	\$76.6	\$76.7	\$82.4	\$90.1	\$96.2	\$107.0	\$564.5
<b>Administrative Expenses</b>	\$88.2	\$76.4	\$68.8	\$70.9	\$73.0	\$75.2	\$77.5	\$530.0
Federal Funds	\$47.3	\$40.7	\$36.9	\$38.0	\$39.1	\$40.3	\$41.5	\$283.7
State Funds	\$40.9	\$35.7	\$32.0	\$32.9	\$33.9	\$34.9	\$36.0	\$246.2
<b>All Programs - After Expansion</b>								
Total (State and Federal)	\$9,659.4	\$11,158.2	\$11,725.2	\$12,331.1	\$12,972.0	\$13,651.3	\$14,368.9	\$85,866.1
Federal Funds	\$6,609.2	\$7,921.7	\$8,448.8	\$8,850.8	\$9,253.2	\$9,717.1	\$10,145.6	\$60,946.5
State Funds	\$3,050.2	\$3,236.5	\$3,276.4	\$3,480.2	\$3,718.8	\$3,934.2	\$4,223.3	\$24,919.6
<b>All Programs - Fiscal Impact</b>								
Total (State and Federal)	\$1,105.2	\$2,206.9	\$2,306.5	\$2,418.2	\$2,536.6	\$2,663.2	\$2,796.3	\$16,032.8
Federal Funds	\$984.9	\$2,007.3	\$2,134.0	\$2,204.5	\$2,256.3	\$2,349.4	\$2,385.7	\$14,322.0
State Funds	\$120.3	\$199.6	\$172.5	\$213.7	\$280.3	\$313.9	\$410.6	\$1,710.9



**ENCLOSURE 3**

STATE OF INDIANA  
 Family and Social Services Administration  
 Health Care Reform Projection - Affordable Care Act  
 Medicaid Expansion to 138% FPL with Estimated Participation  
 (Values in Millions)

Confidential Draft - For Internal Discussion Only

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EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2014 - SFY2020
<b>Medicaid</b>								
Total (State and Federal)	\$8,230.2	\$8,612.1	\$9,063.5	\$9,540.9	\$10,045.8	\$10,580.1	\$11,145.4	\$67,218.0
Federal Funds	\$5,420.1	\$5,699.6	\$6,089.7	\$6,410.5	\$6,749.8	\$7,108.8	\$7,488.6	\$44,967.1
State Funds	\$2,810.2	\$2,912.5	\$2,973.7	\$3,130.4	\$3,296.0	\$3,471.3	\$3,656.8	\$22,250.9
<b>CHIP</b>								
Total (State and Federal)	\$156.5	\$167.3	\$175.7	\$184.5	\$193.7	\$203.4	\$213.6	\$1,294.6
Federal Funds	\$120.5	\$128.9	\$135.3	\$142.1	\$149.2	\$156.6	\$164.5	\$997.1
State Funds	\$36.0	\$38.5	\$40.4	\$42.4	\$44.5	\$46.7	\$49.1	\$297.5
<b>Healthy Indiana Plan</b>								
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Administration</b>								
Total (State and Federal)	\$167.5	\$171.9	\$179.6	\$187.5	\$195.9	\$204.6	\$213.7	\$1,320.6
Federal Funds	\$83.7	\$86.0	\$89.8	\$93.8	\$97.9	\$102.3	\$106.8	\$660.3
State Funds	\$83.7	\$86.0	\$89.8	\$93.8	\$97.9	\$102.3	\$106.8	\$660.3
<b>All Programs</b>								
Total (State and Federal)	\$8,554.2	\$8,951.3	\$9,418.7	\$9,912.9	\$10,435.4	\$10,988.1	\$11,572.6	\$69,833.3
Federal Funds	\$5,624.3	\$5,914.4	\$6,314.8	\$6,646.4	\$6,996.9	\$7,367.7	\$7,759.9	\$46,624.5
State Funds	\$2,929.9	\$3,036.9	\$3,103.9	\$3,266.5	\$3,438.5	\$3,620.4	\$3,812.7	\$23,208.7
<b>Parents / Adults / Children (&lt; 138% FPL) - Estimated Participation</b>								
<b>Uninsured (State and Federal)</b>								
Children	\$33.7	\$67.0	\$72.2	\$75.8	\$79.6	\$83.6	\$87.7	\$499.6
Parents / Adults	\$804.9	\$1,687.7	\$1,773.3	\$1,858.9	\$1,951.0	\$2,044.9	\$2,146.5	\$12,267.2
<b>Insured (State and Federal)</b>								
Children	\$58.7	\$116.7	\$125.7	\$132.0	\$138.6	\$145.6	\$152.8	\$870.2
Parents / Adults	\$285.2	\$597.9	\$628.3	\$658.2	\$690.7	\$723.5	\$759.4	\$4,343.1
<b>Uninsured (Federal)</b>								
Children	\$22.6	\$45.0	\$48.5	\$50.9	\$53.5	\$56.1	\$58.9	\$335.6
Parents / Adults	\$797.5	\$1,673.0	\$1,757.5	\$1,797.1	\$1,829.1	\$1,897.3	\$1,949.8	\$11,701.2
<b>Insured (Federal)</b>								
Children	\$39.5	\$78.4	\$84.5	\$88.7	\$93.1	\$97.8	\$102.7	\$584.7
Parents / Adults	\$282.4	\$592.4	\$622.3	\$636.0	\$647.3	\$671.0	\$689.5	\$4,140.8
<b>Uninsured (State)</b>								
Children	\$11.1	\$22.0	\$23.7	\$24.9	\$26.1	\$27.4	\$28.8	\$163.9
Parents / Adults	\$7.4	\$14.7	\$15.8	\$61.8	\$121.8	\$147.6	\$196.7	\$566.0
<b>Insured (State)</b>								
Children	\$19.3	\$38.3	\$41.3	\$43.3	\$45.5	\$47.8	\$50.1	\$285.5
Parents / Adults	\$2.8	\$5.5	\$5.9	\$22.2	\$43.4	\$52.5	\$69.9	\$202.3

STATE OF INDIANA  
 Family and Social Services Administration  
 Health Care Reform Projection - Affordable Care Act  
 Medicaid Expansion to 138% FPL with Estimated Participation  
 (Values in Millions)

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EXPENDITURES	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2014 - SFY2020
<b>Foster Children Increase</b>	\$4.4	\$9.2	\$9.7	\$10.2	\$10.7	\$11.2	\$11.8	\$67.1
Federal Funds	\$2.9	\$6.2	\$6.5	\$6.8	\$7.2	\$7.5	\$7.9	\$45.1
State Funds	\$1.4	\$3.0	\$3.2	\$3.3	\$3.5	\$3.7	\$3.9	\$22.0
<b>Breast &amp; Cervical Cancer</b>	(\$0.3)	(\$0.5)	(\$0.6)	(\$0.6)	(\$0.6)	(\$0.7)	(\$0.7)	(\$4.0)
Federal Funds	\$3.2	\$6.6	\$6.9	\$6.5	\$5.7	\$5.7	\$5.2	\$39.7
State Funds	(\$3.4)	(\$7.1)	(\$7.5)	(\$7.1)	(\$6.4)	(\$6.3)	(\$5.9)	(\$43.7)
<b>Pregnant Women (&gt;150%)</b>	(\$8.0)	(\$16.8)	(\$17.6)	(\$18.5)	(\$19.4)	(\$20.4)	(\$21.4)	(\$122.2)
Federal Funds	(\$5.4)	(\$11.3)	(\$11.8)	(\$12.4)	(\$13.1)	(\$13.7)	(\$14.4)	(\$82.1)
State Funds	(\$2.6)	(\$5.5)	(\$5.8)	(\$6.1)	(\$6.4)	(\$6.7)	(\$7.0)	(\$40.1)
<b>CHIP Program (Enhanced FMAP)</b>	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	\$0.0	\$0.0	\$30.3	\$42.4	\$44.5	\$46.7	\$12.3	\$176.2
State Funds	\$0.0	\$0.0	(\$30.3)	(\$42.4)	(\$44.5)	(\$46.7)	(\$12.3)	(\$176.2)
<b>Health Insurance Tax</b>	\$50.8	\$105.6	\$111.5	\$117.4	\$123.7	\$130.3	\$137.4	\$776.7
Federal Funds	\$42.7	\$89.1	\$94.0	\$97.4	\$100.6	\$105.2	\$109.4	\$638.4
State Funds	\$8.1	\$16.5	\$17.5	\$20.1	\$23.1	\$25.1	\$28.0	\$138.3
<b>Phys Fee Schedule Inc (80% Medicare)</b>	\$192.8	\$414.5	\$428.6	\$447.3	\$468.2	\$492.3	\$517.8	\$2,961.5
Federal Funds	\$157.3	\$337.9	\$351.9	\$363.3	\$374.2	\$391.3	\$404.2	\$2,380.1
State Funds	\$35.5	\$76.6	\$76.7	\$84.0	\$94.0	\$101.0	\$113.6	\$581.4
<b>Administrative Expenses</b>	\$117.5	\$102.7	\$95.8	\$98.7	\$101.7	\$104.7	\$107.8	\$729.0
Federal Funds	\$63.2	\$54.9	\$51.4	\$52.9	\$54.5	\$56.2	\$57.9	\$391.1
State Funds	\$54.3	\$47.8	\$44.4	\$45.7	\$47.1	\$48.5	\$50.0	\$337.9
<b>All Programs - After Expansion</b>								
Total (State and Federal)	\$10,094.0	\$12,035.4	\$12,645.6	\$13,292.3	\$13,979.5	\$14,703.0	\$15,471.7	\$92,221.5
Federal Funds	\$7,030.3	\$8,786.8	\$9,356.8	\$9,775.9	\$10,193.6	\$10,688.7	\$11,143.2	\$66,975.4
State Funds	\$3,063.7	\$3,248.6	\$3,288.8	\$3,516.4	\$3,785.8	\$4,014.3	\$4,328.5	\$25,246.1
<b>All Programs - Fiscal Impact</b>								
Total (State and Federal)	\$1,539.8	\$3,084.1	\$3,226.9	\$3,379.4	\$3,544.1	\$3,715.0	\$3,899.0	\$22,388.2
Federal Funds	\$1,406.0	\$2,872.3	\$3,042.0	\$3,129.6	\$3,196.7	\$3,321.0	\$3,383.3	\$20,350.9
State Funds	\$133.8	\$211.7	\$184.9	\$249.9	\$347.4	\$393.9	\$515.8	\$2,037.3



**ENCLOSURE 4**

STATE OF INDIANA  
 Family and Social Services Administration  
 Health Care Reform Projection - Affordable Care Act  
 Medicaid Expansion to 138% FPL with Full Participation  
 (Values in Millions)

9/18/2012  
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<b>EXPENDITURES</b>	<b>SFY 2014</b>	<b>SFY 2015</b>	<b>SFY 2016</b>	<b>SFY 2017</b>	<b>SFY 2018</b>	<b>SFY 2019</b>	<b>SFY 2020</b>	<b>SFY 2014 - SFY2020</b>
<b>Medicaid</b>								
Total (State and Federal)	\$8,230.2	\$8,612.1	\$9,063.5	\$9,540.9	\$10,045.8	\$10,580.1	\$11,145.4	\$67,218.0
Federal Funds	\$5,420.1	\$5,699.6	\$6,089.7	\$6,410.5	\$6,749.8	\$7,108.8	\$7,488.6	\$44,967.1
State Funds	\$2,810.2	\$2,912.5	\$2,973.7	\$3,130.4	\$3,296.0	\$3,471.3	\$3,656.8	\$22,250.9
<b>CHIP</b>								
Total (State and Federal)	\$156.5	\$167.3	\$175.7	\$184.5	\$193.7	\$203.4	\$213.6	\$1,294.6
Federal Funds	\$120.5	\$128.9	\$135.3	\$142.1	\$149.2	\$156.6	\$164.5	\$997.1
State Funds	\$36.0	\$38.5	\$40.4	\$42.4	\$44.5	\$46.7	\$49.1	\$297.5
<b>Healthy Indiana Plan</b>								
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Administration</b>								
Total (State and Federal)	\$167.5	\$171.9	\$179.6	\$187.5	\$195.9	\$204.6	\$213.7	\$1,320.6
Federal Funds	\$83.7	\$86.0	\$89.8	\$93.8	\$97.9	\$102.3	\$106.8	\$660.3
State Funds	\$83.7	\$86.0	\$89.8	\$93.8	\$97.9	\$102.3	\$106.8	\$660.3
<b>All Programs</b>								
Total (State and Federal)	\$8,554.2	\$8,951.3	\$9,418.7	\$9,912.9	\$10,435.4	\$10,988.1	\$11,572.6	\$69,833.3
Federal Funds	\$5,624.3	\$5,914.4	\$6,314.8	\$6,646.4	\$6,996.9	\$7,367.7	\$7,759.9	\$46,624.5
State Funds	\$2,929.9	\$3,036.9	\$3,103.9	\$3,266.5	\$3,438.5	\$3,620.4	\$3,812.7	\$23,208.7
<b>Parents / Adults / Children (&lt; 138% FPL) - Full Participation</b>								
<b>Uninsured (State and Federal)</b>								
Children	\$50.0	\$105.0	\$105.4	\$110.8	\$116.2	\$122.0	\$128.0	\$728.5
Parents / Adults	\$965.5	\$2,063.3	\$2,101.2	\$2,204.8	\$2,313.0	\$2,425.0	\$2,544.2	\$14,529.8
<b>Insured (State and Federal)</b>								
Children	\$80.7	\$168.2	\$170.7	\$179.4	\$188.2	\$197.7	\$207.4	\$1,180.4
Parents / Adults	\$480.9	\$1,055.7	\$1,027.9	\$1,079.9	\$1,132.0	\$1,186.8	\$1,244.2	\$7,101.2
<b>Uninsured (Federal)</b>								
Children	\$33.6	\$70.6	\$70.8	\$74.4	\$78.1	\$82.0	\$86.0	\$489.5
Parents / Adults	\$958.1	\$2,048.6	\$2,085.3	\$2,134.4	\$2,171.2	\$2,252.7	\$2,313.7	\$13,877.2
<b>Insured (Federal)</b>								
Children	\$54.2	\$113.0	\$114.7	\$120.6	\$126.5	\$132.8	\$139.3	\$584.7
Parents / Adults	\$478.1	\$1,050.2	\$1,022.0	\$1,047.1	\$1,064.2	\$1,104.2	\$1,133.1	\$6,793.2
<b>Uninsured (State)</b>								
Children	\$16.4	\$34.5	\$34.6	\$36.3	\$38.1	\$40.0	\$42.0	\$241.9
Parents / Adults	\$7.4	\$14.7	\$15.8	\$70.5	\$141.8	\$172.3	\$230.5	\$653.0
<b>Insured (State)</b>								
Children	\$26.5	\$55.2	\$56.0	\$58.9	\$61.8	\$64.9	\$68.0	\$391.2
Parents / Adults	\$2.8	\$5.5	\$5.9	\$32.8	\$67.7	\$82.7	\$111.1	\$308.4

STATE OF INDIANA  
 Family and Social Services Administration  
 Health Care Reform Projection - Affordable Care Act  
 Medicaid Expansion to 138% FPL with Full Participation  
 (Values in Millions)

9/18/2012  
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<b>EXPENDITURES</b>	<b>SFY 2014</b>	<b>SFY 2015</b>	<b>SFY 2016</b>	<b>SFY 2017</b>	<b>SFY 2018</b>	<b>SFY 2019</b>	<b>SFY 2020</b>	<b>SFY 2014 - SFY2020</b>
<b>Foster Children Increase</b>	\$4.4	\$9.2	\$9.7	\$10.2	\$10.7	\$11.2	\$11.8	\$67.1
Federal Funds	\$2.9	\$6.2	\$6.5	\$6.8	\$7.2	\$7.5	\$7.9	\$45.1
State Funds	\$1.4	\$3.0	\$3.2	\$3.3	\$3.5	\$3.7	\$3.9	\$22.0
<b>Breast &amp; Cervical Cancer</b>	(\$0.3)	(\$0.5)	(\$0.6)	(\$0.6)	(\$0.6)	(\$0.7)	(\$0.7)	(\$4.0)
Federal Funds	\$3.2	\$6.6	\$6.9	\$6.5	\$5.7	\$5.7	\$5.2	\$39.7
State Funds	(\$3.4)	(\$7.1)	(\$7.5)	(\$7.1)	(\$6.4)	(\$6.3)	(\$5.9)	(\$43.7)
<b>Pregnant Women (&gt;150%)</b>	(\$8.0)	(\$16.8)	(\$17.6)	(\$18.5)	(\$19.4)	(\$20.4)	(\$21.4)	(\$122.2)
Federal Funds	(\$5.4)	(\$11.3)	(\$11.8)	(\$12.4)	(\$13.1)	(\$13.7)	(\$14.4)	(\$82.1)
State Funds	(\$2.6)	(\$5.5)	(\$5.8)	(\$6.1)	(\$6.4)	(\$6.7)	(\$7.0)	(\$40.1)
<b>CHIP Program (Enhanced FMAP)</b>	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	\$0.0	\$0.0	\$30.3	\$42.4	\$44.5	\$46.7	\$12.3	\$176.2
State Funds	\$0.0	\$0.0	(\$30.3)	(\$42.4)	(\$44.5)	(\$46.7)	(\$12.3)	(\$176.2)
<b>Health Insurance Tax</b>	\$60.4	\$128.9	\$131.9	\$138.9	\$146.3	\$154.0	\$162.1	\$922.5
Federal Funds	\$52.2	\$111.7	\$113.7	\$117.7	\$121.3	\$126.7	\$131.5	\$774.8
State Funds	\$8.2	\$17.2	\$18.1	\$21.2	\$25.0	\$27.3	\$30.7	\$147.7
<b>Phys Fee Schedule Inc (80% Medica)</b>	\$221.5	\$475.2	\$492.0	\$513.9	\$538.0	\$565.7	\$594.8	\$3,401.0
Federal Funds	\$185.2	\$396.5	\$413.3	\$426.2	\$438.4	\$458.0	\$472.8	\$2,790.4
State Funds	\$36.4	\$78.6	\$78.7	\$87.6	\$99.7	\$107.7	\$121.9	\$610.6
<b>Administrative Expenses</b>	\$148.7	\$130.7	\$124.5	\$128.3	\$132.1	\$136.1	\$140.2	\$940.6
Federal Funds	\$80.1	\$70.0	\$66.8	\$68.9	\$70.9	\$73.0	\$75.2	\$505.0
State Funds	\$68.6	\$60.7	\$57.7	\$59.4	\$61.2	\$63.0	\$64.9	\$435.5
<b>All Programs - After Expansion</b>								
Total (State and Federal)	\$10,558.1	\$13,070.2	\$13,563.7	\$14,260.0	\$14,991.8	\$15,765.4	\$16,583.1	\$98,792.4
Federal Funds	\$7,466.6	\$9,776.6	\$10,233.3	\$10,678.9	\$11,111.9	\$11,643.3	\$12,122.5	\$73,033.1
State Funds	\$3,091.6	\$3,293.6	\$3,330.4	\$3,581.1	\$3,879.9	\$4,122.1	\$4,460.6	\$25,759.3
<b>All Programs - Fiscal Impact</b>								
Total (State and Federal)	\$2,003.9	\$4,118.9	\$4,145.0	\$4,347.1	\$4,556.4	\$4,777.3	\$5,010.5	\$28,959.1
Federal Funds	\$1,842.2	\$3,862.1	\$3,918.5	\$4,032.6	\$4,115.0	\$4,275.6	\$4,362.6	\$26,408.6
State Funds	\$161.7	\$256.7	\$226.5	\$314.6	\$441.4	\$501.7	\$647.9	\$2,550.5



**ENCLOSURE 5**

**State of Indiana  
Family and Social Services Administration**

**SFY 2015 Enrollment Projections Under ACA Expansion Scenarios**

	<b>SFY 2015 Projected <u>Enrollment</u></b>	<b>SFY 2015 Full <u>Enrollment</u></b>
<b><i>Pre-ACA Projection</i></b>		
Current Programs		
Medicaid	1,025,000	1,025,000
CHIP	<u>88,000</u>	<u>88,000</u>
<b>Total Projected Medicaid Enrollment</b>	<b>1,113,000</b>	<b>1,113,000</b>
 <b><i>No Medicaid Expansion</i></b>		
Additional Enrollment from those already Eligible (Woodwork)		
Children	77,000	106,000
Parents	14,000	16,000
Other Enrollment Changes		
Foster Child Expansion	5,000	5,000
Pregnant Women Over 150% FPL	<u>(4,000)</u>	<u>(4,000)</u>
Total Additional Enrollment with No Expansion	92,000	123,000
<b>Total Projected Medicaid Population with No Expansion</b>	<b>1,205,000</b>	<b>1,236,000</b>
 <b><i>Medicaid Expansion to 100% FPL</i></b>		
Currently Uninsured		
Parents	66,000	75,000
Childless Adults	151,000	185,000
Currently Insured Population (Crowd-out)		
Parents	24,000	32,000
Childless Adults	36,000	71,000
Total Additional Enrollment from Expansion to 100% FPL	277,000	363,000
<b>Total Projected Medicaid Population After Expansion to 100% FPL</b>	<b>1,482,000</b>	<b>1,599,000</b>
 <b><i>Medicaid Expansion to 138% FPL</i></b>		
Currently Uninsured		
Parents	43,000	49,000
Childless Adults	60,000	74,000
Currently Insured Population (Crowd-out)		
Parents	32,000	43,000
Childless Adults	15,000	30,000
Total Additional Enrollment from Expansion to 138% FPL	150,000	196,000
<b>Total Projected Medicaid Population After Expansion to 138% FPL</b>	<b>1,632,000</b>	<b>1,795,000</b>

# Response to Gov. Daniels on Indiana and Implementing the Affordable Care Act

The Honorable Mitchell E. Daniels, Jr.  
Governor of the State of Indiana  
Office of the Governor  
State House, Second Floor  
Indianapolis, IN 46204

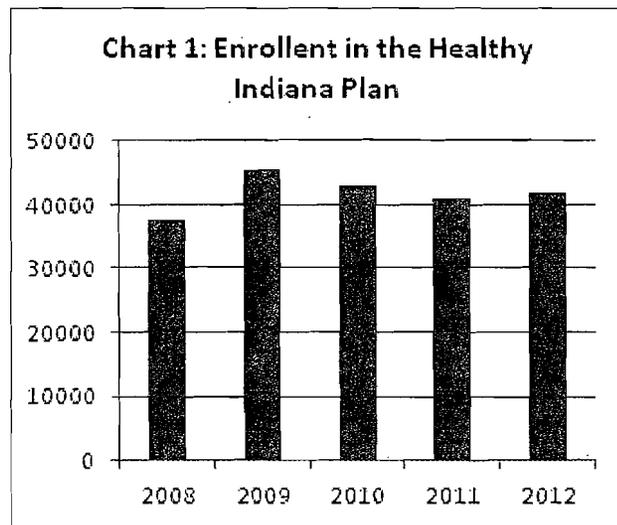
Dear Governor Daniels:

Thank you for your July 30 letter requesting guidance from all three candidates for governor of Indiana regarding decisions Indiana must make about the implementation of several provisions of the Affordable Care Act. Given the impact of these decisions on every Hoosier and the fact that the weight of such decisions will be borne by the next administration, I commend you for your solicitous approach.

Americans have the highest quality health care in the world. For most Hoosiers, the biggest challenge is the cost of that care. Too many are priced out of the health insurance market. The two most obvious solutions to this challenge are increasing the number of good-paying jobs and improving the affordability of health care itself.

For years, Hoosiers have struggled to find solutions to rising health care costs and access to health care, especially for our most vulnerable citizens. In 2007, a bipartisan, innovative solution to both cost and access was developed right here in Indiana.

Under your leadership, the Healthy Indiana Plan was adopted, giving Hoosier adults between 19 and 64 access to health care in a consumer-driven model that empowers health care consumers to direct their own care. More than 40,000 Hoosiers have access to health care under the Healthy Indiana Plan (see Chart 1), along with a POWER account that gives them a financial incentive to find the most affordable health care services and to improve their health.



According to a recent survey, 94 percent of participants were satisfied with the program and 99 percent indicated that they would re-enroll. The Healthy Indiana Plan therefore empowers Hoosiers in a way that will increase access to health care and drive down the cost, and I believe it is the model that should serve as the starting point for all future discussions of health care reform in Indiana.

Unfortunately, the Obama Administration and its allies in Congress charted a far different course in 2010. The Affordable Care Act raised taxes on every Hoosier taxpayer and business (see Table 1), doubled down on an already broken and unaffordable Medicaid system, and, left unchecked, it will destroy all the progress we have made on health care access, not to mention our economic competitiveness and fiscal solvency for our state and country.

**Table 1: Examples of Major Tax Increases in the Affordable Care Act**

<b>Tax Increase</b>	<b>Description</b>
Medical Device Tax	New 2.3% excise tax on medical device manufacturers
Individual Mandate	New 2.5% tax on individual adjusted gross income
Employer Mandate	New minimum tax of \$2,000 per employee if the employer has at least 1 employee covered by a federal health care subsidy
Medicare Premium Tax Increase	Increase in Medicare payroll tax rate for individual taxpayers with income of \$200,000 or married taxpayers with income of \$250,000
Tax on Investment Income	New 3.8% tax on investment income for individual taxpayers with income of \$200,000 or married taxpayers with income of \$250,000

Source: Kaiser Family Foundation

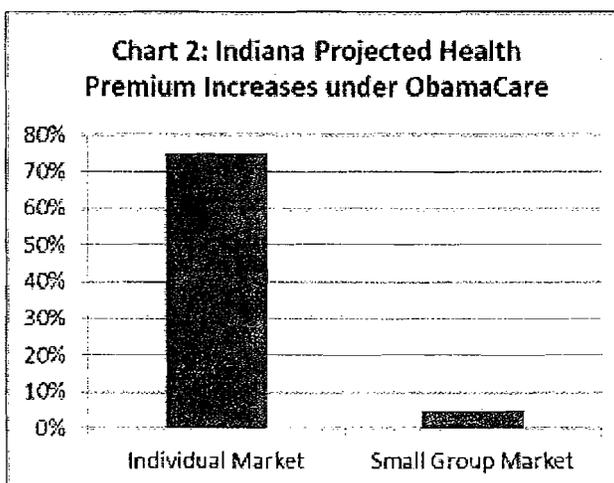
As you are aware, I opposed the Affordable Care Act and believe it must be repealed. It erodes the freedom of every American, opening the door for the federal government to legislate, regulate and mandate nearly every aspect of our daily lives under the guise of its taxing power. It is not merely a government takeover of health care, but, as the Supreme Court recently concluded, it is a massive tax increase on Hoosiers and small business owners.

Every day in Indiana people tell me that ObamaCare is stifling our recovery. If it is not repealed in full, Hoosiers will face higher health care costs and increased taxes.

The tax increases in ObamaCare have directly led to lost job opportunities here in Indiana, as seen by Cook Medical's recent announcement that it will not expand operations in Indiana due to the medical device tax. The Medicaid program continues to be one of Indiana's largest budget items. Its costs grow every year and we have struggled to pay for our existing program. The Medicaid expansion would increase dependency by putting one quarter of all Hoosiers on Medicaid and could cost Indiana billions between now and 2020.

The health care law also will drastically increase the cost of health care premiums in Indiana – at least a 75 percent increase in the individual market and a 5 percent increase in the small group market (see Chart 2). This will lead to even more dependency on government subsidies for health care.

The Affordable Care Act also violates the inherent sovereignty of the State of Indiana. The Supreme Court invoked this principle in striking down as unconstitutional part of the health care law for coercing the states through its massive expansion of Medicaid. As the Supreme Court explained just last year, diminishing the sovereignty of the states



Source: Milliman analysis, May 2011

against the federal government imperils the liberties of the citizens and families within those states.

Indiana needs the freedom and flexibility to develop health care solutions that best meet the needs of our citizens, without interference from Washington. We must face our challenges in health care with the belief in more freedom, not more government.

Indiana has proven that we can find innovative solutions to the problems of affordability and access to health care. We don't need a federal, one-size fits all solution that hampers our ability to promote Hoosier solutions to Hoosier problems.

Because ObamaCare erodes the freedom of every Hoosier, will increase the cost of health insurance, and will cripple job creation in our state, I believe the State of Indiana should take no part in this deeply flawed healthcare bureaucracy.

Despite my opposition to the Affordable Care Act in principle, I do understand that some who opposed the health care law nonetheless believe Indiana would be better off if we set up our own exchange.

Beyond my previous objections to ObamaCare, I have carefully considered this option, and believe there is too much uncertainty surrounding the Affordable Care Act to make it prudent for Indiana to even consider moving forward in implementing our own exchange.

First, the national debate over the Affordable Care Act is far from over. While the Obama Administration, its allies in Congress and the Supreme Court have had their say on this health care law, the American people will have their say in November. With such political uncertainty surrounding the Affordable Care Act, it would not be prudent for the state to require Hoosiers to spend their time and hard-earned money on the implementation of a federal health care law that may be overturned in the next Congress.

Second, there is too much regulatory uncertainty surrounding the operation of exchanges. The federal government is still delinquent on complete guidance for exchanges and there are many unanswered questions. Just last week, it was revealed that the federal government still refuses to answer whether the Healthy Indiana Plan can serve as the coverage vehicle for the Medicaid expansion under the Affordable Care Act. Furthermore, a state operated exchange will still be subject to federal oversight, regulation and delay in the future. Operating our own exchange might seem like a way around the health care law's onerous regulations right now, but the way the regulations are written, the federal government will be hyper-regulating state-based exchanges. This would reduce the State of Indiana to a branch office of the Department of Health and Human Services, and leave Indiana lawmakers to blame for the price increases that will occur and for market related decisions that are largely outside their control. All told, this is entirely too much regulatory uncertainty to justify moving forward at this time.

Third, there is fiscal uncertainty. The cost to Hoosier taxpayers for setting up our own exchange could be at least \$50 million per year and perhaps higher. There is no evidence that this investment will improve the lives of Hoosiers, or will lower the cost of health insurance. This is money that would be better invested in helping our kids achieve educational results, providing tax relief for all Hoosiers, or addressing the cost drivers of health care and improving quality and health outcomes.

Finally, there is legal uncertainty surrounding state-operated exchanges. Some experts argue that the Affordable Care Act's mandate on employers, which would raise taxes on Hoosier businesses by imposing a tax penalty if those employers fail to provide federally-approved health coverage policies for their employees, can only be triggered by the granting of premium subsidies to finance purchasing individual policies on a state-based exchange. The Internal Revenue Service recently issued an interpretive rule attempting to clarify that subsidies which clearly apply to purchases made on state-based exchanges also apply to purchases made on federal exchanges, which makes it all the more likely that the issue will be litigated at some point in the future.

With our unemployment rate at 8.2 percent and too many Hoosiers out of work, I will not support the implementation of an Indiana exchange when there is a chance that doing so would lead to a tax increase on Hoosier employers.

For all the foregoing reasons, it is my recommendation that the State of Indiana should not establish or operate a state-based health insurance exchange under the Affordable Care Act. In a word, Indiana should say 'no' to implementing ObamaCare.

Your letter also noted that the Affordable Care Act requires that insurance plans offered in the small and individual group market provide certain "essential health benefits." I am aware that the State of Indiana has a choice to make in determining what is or is not "essential" for the purposes of the law and the decision has to be made by September 2012 or the federal government will make the decision for Hoosiers.

Given this expansive regulation of the insurance market in Indiana, my advice on essential benefits is that the choice be made with Hoosier values in mind. That means I believe Indiana should not endorse any "essential health benefits" package that goes beyond the requirements of Indiana law, especially as regards Hoosier values. Of course, the State of Indiana should endorse no plan that mandates abortion coverage or require Hoosiers to subsidize abortion through their health insurance premiums in the small and individual group markets.

Thank you for requesting my counsel on these important matters. I believe Hoosiers deserve to know where each candidate for governor stands on the Affordable Care Act.

Accordingly, if I have the privilege of being elected to serve as the next governor of Indiana, you may convey to the appropriate authorities within the federal government that my firm position will be that the State of Indiana should not establish or operate a state-based Health Insurance Exchange under the Affordable Care Act.

I am grateful for your leadership, and I remain steadfast in my belief that we Hoosiers have demonstrated our capacity to solve the issues of health care access and affordability, and once ObamaCare is repealed Indiana can play a leading role in promoting healthcare reform that lowers the cost of healthcare without eroding our freedom or prosperity.

Sincerely,

A handwritten signature in black ink that reads "Mike Pence". The signature is written in a cursive, flowing style with a long horizontal line extending from the end of the name.

Mike Pence  
Republican Candidate for Governor



**Rupert**  
For Governor

The Honorable Mitchell E. Daniels, Jr.  
Governor of the State of Indiana  
Office of the Governor  
State House, Second Floor  
Indianapolis, IN 46204

Dear Governor Daniels:

August 24<sup>th</sup>, 2012

Thank you for your exemplification of true statesmanship in requesting the opinions of all three candidates for governor of Indiana regarding the timely decisions that Indiana must make on the implementation of the Affordable Care Act. I would also like to thank you for making your staff available to each campaign for research and analysis of the limited data available to the state. Your tripartisan effort proves once again that you have been a leader that has the best intentions of Hoosiers at heart.

For the past few months, in preparation for this issue, my team and I have been studying the exchanges currently setup in Massachusetts and Utah, the Interstate Health Insurance Compact legislation currently enacted in Indiana and six additional states, and recently the information presented by your office during our August 13<sup>th</sup> meeting. From this research we have learned that there are many questions posed by the states to Health and Human Services (HHS) that will be left unanswered long after the mandated deadline for a decision has passed. This fact has been a guiding factor in the development of my responses to your request for input.

In your July 30<sup>th</sup> letter, you requested our opinions on three timely topics;

1. Of the four Essential Health Benefits benchmarks, as mandated by Health and Human Services, which should Indiana select to qualify potential insurance plans being placed within an exchange?
2. From the selected benchmark, which insurance plan should be used as the baseline for all future insurance plans being added to an exchange?
3. What type of Health Insurance Exchange should Indiana adopt? State exchange, federal exchange or a hybrid exchange?



**Rupert**  
For Governor

**Essential Health Benefits Benchmarks**

Health and Human Services has mandated that one of the following benchmarks be selected as the qualifier for the selection of a standard baseline insurance plan for an exchange.

1. One of the three largest small group plans in the state by enrollment
2. One of the three largest state employee health plans by enrollment
3. One of the three largest federal employee health plan options by enrollment
4. The largest HMO plan offered in the state's commercial market by enrollment

After reviewing, with your office, the varying plans that would be available as a standard under each benchmark I believe there to be more choice and room for growth in selecting Option 1: *One of the three largest small group plans in the state by enrollment.*

**Benchmark Insurance Plan**

At first glance, the three largest small group plans in the state by enrollment have very little difference. Each covers the 10 Essential Health Benefits Services (Ambulatory, Emergency, Hospitalization, Maternity, Mental Health, Laboratory, Pharmacy, Rehab & Habilitation, Preventive and Pediatric Oral and Vision) as mandated by HHS. The estimated cost of each plan is between \$392.31 and \$395.12 per member per month. That is a difference of \$2.81.

When you look at the differences between the individual plans and the additional non-mandated services covered by each a clearer long-term picture comes into focus.

Plan	Cost PMPM	Chiropractic	TMJ	Hearing Aids	Smoking Cessation	Infertility Diagnoses	Infertility Treatment	Breast Feeding Education	Non-elective Abortion	Elective Abortion
Lumenos HSA	\$395.12	X	X	--	X	--	--	X	X	X
Anthem PPO	\$394.75	X	X	--	--	--	--	X	X	X
United Health 19K POS	\$392.31	X	--	X	--	X	X	--	X	X



# Rupert

For Governor

If we want to foster a competitive free-market environment within an exchange, we need to allow insurance providers room to grow their plans. Providers will need a base line that covers any and all mandates as well as common secondary services, but other secondary or specialty services should be optional and at the discretion of the purchaser.

Since it gives the most room for option growth and is the medium price level, I believe Indiana should select **Anthem PPO** as our Benchmark Insurance Plan.

## Health Insurance Exchange (HIX)

When initially discussing the options for who could run a health insurance exchange in Indiana my gut reaction was, "Indiana, not D.C., knows what's best for Hoosiers." I thought surely it would be better, in the long run, for Indiana to run its own exchange. There are many politicians and candidates around Indiana that still feel that way. My honest opinion on this, after months of research, has changed.

Health Insurance Exchange Operator		
Indiana	Indiana-Federal	Federal
<b>State: All activities</b>	<b>State: Some activities</b>	<b>State: No responsibilities</b>
Call/Data Center	Call/Data Center	Can retain:
Customer Service	Customer Service	Medicaid eligibility
Medicaid eligibility	Plan management	CHIP eligibility
CHIP eligibility		Reinsurance
Plan management	<b>Option to Defer to HHS:</b>	
Reinsurance	Medicaid eligibility	<b>HHS: All activities</b>
<b>Option to Defer to HHS:</b>	CHIP eligibility	
Premium tax credit eligibility	Reinsurance	
Cost sharing reduction		
Mandate exemptions	<b>HHS: All other activities</b>	
<b>HHS: No responsibilities</b>		

If we take on the full responsibility of running the exchange we also take on the full financial burden with it. The current estimates for this liability to Hoosier taxpayers are between \$50 - 65 million a year. That estimate is nothing more than an educated guess. We have no idea how many new enrollees there will be each year. We have no real way to gauge the time it will take to process each application, perform mandatory assistance eligibility, walk each "customer" through their options, and recertify each person yearly. We also know very little about how the Health and Human Services 'Eligibility Data Hub' will operate or how efficient it will ultimately be. Remember how inaccurate and inefficient E-Verify was when it started? There have been estimates that Indiana could face a financial



# Rupert

For Governor

burden between \$130 - 200 million per year if the procedures and exchange of data are overly cumbersome and inefficient.

There are some who are suggesting that we sit on our hands and do nothing or to just let the federal government run the exchange. I do not see that as ever being a legitimate option. I do not believe that Hoosiers would be supportive of handing over our state's authority and responsibility to the whims of federal agencies and bureaucracies. By doing nothing, in hopes that Congress repeals the Affordable Care Act, we would be essentially handing it over.

If we allow a 100% federally run exchange in Indiana, Hoosiers will have no voice in the plan management, number of plans, cost intervals, required services, or requirements for brokers and consumer councilors.

In a Hybrid exchange, Indiana would retain control over plan management and customer assistance. We would also be able to set requirements and regulations, as needed, for consumer councilors and insurance brokers. The major financial burden in a state run exchange comes from the processing and reinsurance of Medicaid and CHIP. Under a hybrid exchange, some of those functions and costs can be deferred back to Health and Human Services.

In the interest of ensuring multiple options and accountability and to limit financial liabilities for Hoosiers, I believe Indiana should develop a State-Federal Hybrid Health Insurance Exchange.

## **Interstate Health Insurance Compacts**

There is another option on the table, albeit a long shot, that should be considered and investigated further, Interstate Health Insurance Compacts. There are over 200 Interstate Compacts currently operating for various purposes.

The Indiana General Assembly has already authorized your office to develop and or join an Interstate Health Insurance Compact. There are six other states that have done the same in their respective legislatures. Additionally, there are ten states that have this type of legislation pending.

An Interstate Health Insurance Compact is simply an agreement between two or more states, that is approved to by Congress, to join together to take on the responsibility for health care management and regulation within the member states (except for military and veteran health care, which will remain a responsibility of the federal government). These types of compacts are directly mentioned and expressly permitted within the Affordable Care Act.



# Rupert

For Governor

There are many questions about how a Compact would receive federal healthcare funding, to what level and for how long. There are also questions about the likelihood of Congress approving such a compact. I still think this is an idea that should be explored and debated more in the public, even if it's not fully an option at this stage.

## The Future of Indiana

Since we are required, by Health and Human Services, to make a partially blind decision... I would suggest that any plan for implementation of the Affordable Care Act must give Hoosiers the greatest amount of control and authority over regulation and plan management. At the same time, the plan should also keep Hoosiers from being overly burdened with the unknown costs of managing the exchange.

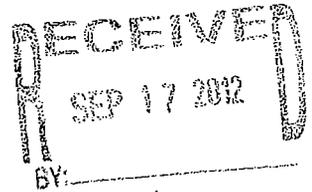
If Hoosiers call me to serve as the next Governor of Indiana, I request that all appropriate federal agencies be informed of our intention to develop and operate a State-Federal Hybrid Health Insurance Exchange within Indiana. I would also ask that the proper documentation be sent to those agencies for the purpose of receiving any federal grants for the development and operation of said exchange.

Additionally, I would request that your administration continue its efforts to save the Healthy Indiana Plan (HIP). Health and Human Services has been holding Indiana's application for a waiver to allow any Medicaid Expansion funding to pass through HIP for over two years now. The program your administration started to help Hoosiers meet their medical needs and practice preventative care is unrivaled.

Again, I want to thank you for your tripartisan leadership in seeking the opinions of all three candidates for Governor of Indiana. Hoosiers need to know not only where each of us stands on the implementation of the Affordable Care Act, but also how each of us will handle the unforeseen challenges that Indiana will face.

In Liberty,

Rupert Boneham  
Libertarian Candidate for Governor



August 30<sup>th</sup>, 2012

The Honorable Mitchell E. Daniels, Jr.  
Governor of the State of Indiana  
Office of the Governor  
State House, Second Floor  
Indianapolis, IN 46204

Dear Governor Daniels:

Thank you for providing an opportunity to meet and discuss outstanding issues related to the implementation of the Affordable Care Act. This is a subject that will affect every Hoosier, and as someone who has beaten cancer, I deeply understand the importance of health insurance. Safeguarding the healthcare of Hoosiers is not a game. If given the opportunity to govern, my lieutenant governor Vi Simpson and I will protect the best interests of the people of the state and enforce the law in a way that will benefit all Hoosiers.

First, as you know, the federal government is very prescriptive with respect to Essential Health Benefit plans. In order to assist states in the selection of minimum benefits for plans in the Exchange, the federal government has named four options, all of which must cover services in ten different areas. I fully support the Healthy Indiana Plan benefit levels. However, the federal government requires maternity and emergency transportation benefits and HIP does not pay for those services at this time. Indiana's EHB must include the ten required covered services and should include as many non-mandated, but necessary services as possible. Accordingly, I support using Indiana's Healthy Indiana Plan as the basis for our EHB plan, with additional coverage as required by the federal government.

Second, the federal government has offered Indiana several options in moving forward with an Exchange. States may choose a state-designed and controlled Exchange; they can choose a hybrid system that allows for a partnership with the federal government but still allows for state control; or they can choose a regional partnership with other states. The only other option is for a federally controlled exchange where the state does not have the ability to provide input, but in which its citizens must participate. The latter would force Hoosiers to participate in a national system without any input or control.

At the present time, I believe that the hybrid system is the best option because it not only allows for a federal-state partnership, but it also allows for shared costs, significantly reducing the state's financial investment in the program. My belief is that the most responsible position for the Governor to take is the one that you have been pursuing all along - to meet deadlines and apply for grant monies available to keep all options open to us. Because of the your actions, Indiana has already received \$8 million to begin this process.

To be clear, political gamesmanship on an issue that involves matters of life and death for Hoosiers is not wise. Studies show that nearly one million Hoosiers may participate in a new health exchange. Regardless of one's party affiliation, we need to acknowledge that the

Affordable Care Act is the law of the land. My job as governor will be to protect the best interests of the people of this state and make healthcare more affordable and more accessible for all Hoosiers. The plan I have outlined above will result in a healthier Hoosier workforce, a growing economy and more successful employers.

Not participating in the ACA at all is simply not an option. If the state takes no action on these issues, Hoosiers will be left at the mercy of the federal government, without any protections from the state. If we choose not to make a choice, Hoosier citizens will pay the price, and the state will still incur additional costs to be covered in the federal exchange. Doing nothing is simply a bad idea for our citizens.

As Governor, I will make tough decisions when they need to be made. Regardless of the decision or the issue, Hoosier voters deserve to know that when I make those decisions, they will not be made because of rigid partisan ideology, but Hoosier practicality. Throughout Indiana's history, commonsense has served us well, and I pledge to continue that tradition.

Sincerely,

A handwritten signature in black ink that reads "John". The signature is stylized and includes a period at the end.

John F. Gegg

# **Tobacco Harm Reduction**

**Brad Rodu**

**Professor, Department of Medicine**

**James Graham Brown Cancer Center**

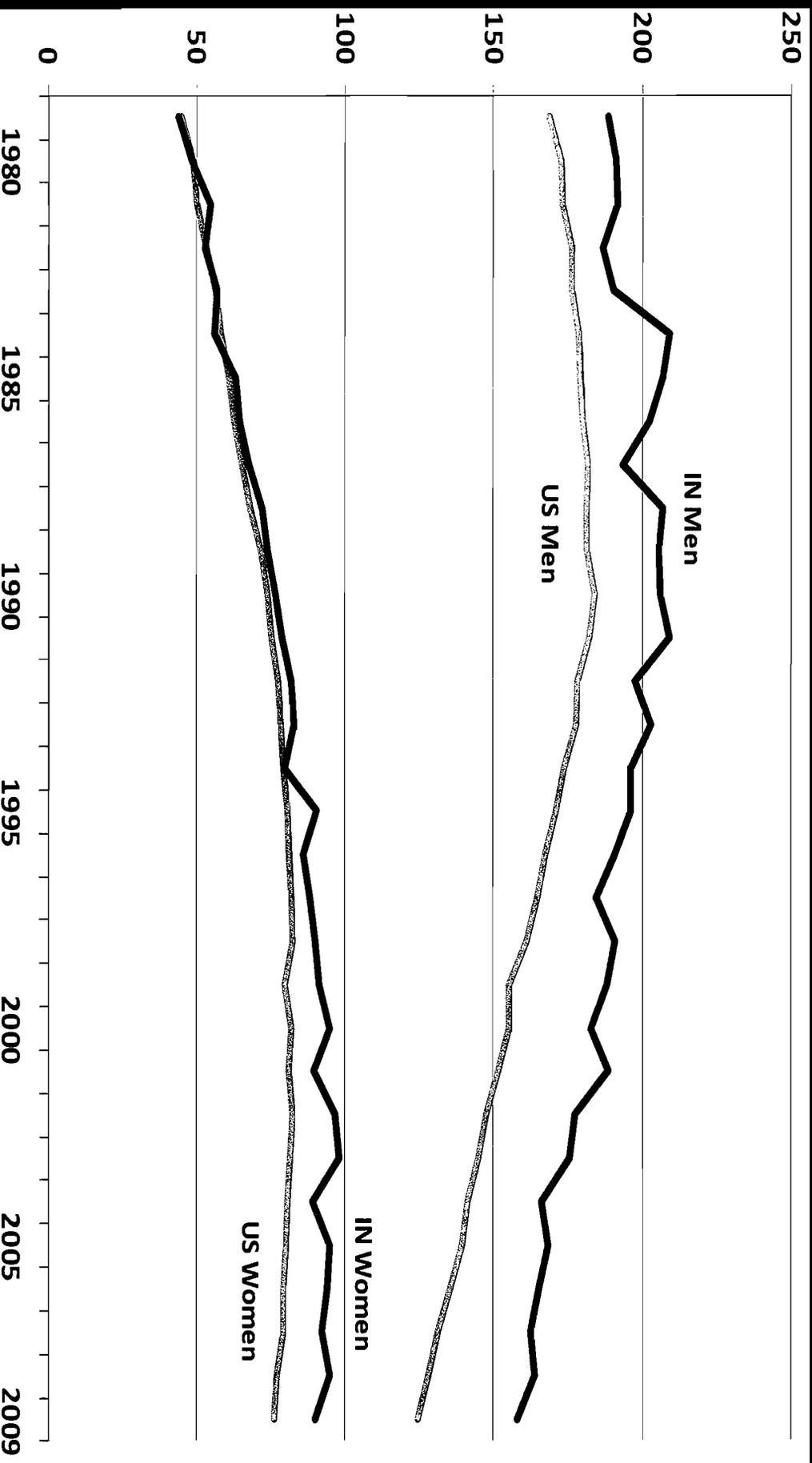
**University of Louisville**

**Exhibit 3  
Health Finance Commission  
Meeting #2, Sept. 19, 2012**

# **The Smoking Status Quo: Unacceptable**

- **The American Anti-Smoking Campaign is  
45 Years Old**
- **According to the CDC:  
45 million smokers in the U.S.  
443,000 deaths every year in the U.S.  
9,700 in Indiana**

# Lung Cancer (ICD 161-162) Mortality in Men and Women Age 35+, Indiana and the US, 1979-2009



## **If the Status Quo Continues**

**In the next 20 years:**

- **8 million Americans will die from smoking**

**All are adults over 35 years of age**

**None of them are now children**

# The Failed Anti-Smoking Campaign

- **The Campaign's Only Message:  
Quit Nicotine and Tobacco, or Die**
- **The Campaign's Only Quitting Tactics:  
Ineffective Behavioral Therapy  
Ineffective Use of Nicotine**

Rodu and Cole. *Technology* 6: 17-21, 1999.

Rodu and Cole. *International J Cancer* 97: 804-806, 2002.

# The Anti-Smoking Campaign- Behavioral Therapy

- NCI Manual for Physicians- Counsel Patients to:
  - “Keep your hands busy- doodle, knit, type a letter”
  - “Cut a drinking straw into cigarette-sized pieces and inhale air”
  - “Keep a daydream ready to go”

Source: How to help your patients stop smoking. NIH Pub. No. 93-3064, 1993

# The Anti-Smoking Campaign- Faulted Use of Nicotine

- **Temporary – 6 to 12 weeks**
- **Expensive – per unit and per box**
- **Very Low Dose – unsatisfying for smokers**
- **7% Success\* – “Efficacious”, “Modest”**

\*Hughes et al. Meta-analysis in Tobacco Control, 2003.

# Comparing Nicotine to Caffeine

## Addictive Drugs Can Be Used Safely

### Properties of Nicotine and Caffeine

#### Pleasurable Effects:

Enhance concentration and performance  
Provide a sense of well being  
Elevate mood

#### Powerfully Addictive:

Irreversible for many consumers

#### Can be Used Safely:

Do not cause Cancer, Emphysema,  
Heart Diseases

#### Delivery Systems:

Caffeine- Coffee, tea, cola drinks  
Nicotine- Smoke versus smokeless

# **Tobacco Harm Reduction Permanent Nicotine Maintenance**

## **Smokeless Tobacco**

- **Nicotine levels comparable to smoking**
- **Vastly safer than smoking (>98%)**
- **Evidence from Sweden – and the U.S. – that smokeless works**
- **Modern products are socially acceptable**

# American Smokeless Tobacco



Moist Snuff



Chewing Tobacco

Powdered  
Dry Snuff



# **Smokeless Tobacco Use is 98% Safer Than Smoking**

- **No risk for emphysema, lung cancer, and heart disease**
- **Mouth cancer risk - Very low in absolute terms\***

**\* 22 studies over 50 years: Rodu and Cole, Oral Surgery 2002.**

# Smokeless Tobacco and Health: Oral Cancer

## Relative Risks

Smoking ~10  
Alcohol Abuse ~4

## American Smokeless Tobacco\*

Chewing tobacco	1.2
Moist snuff	1.0
Powdered Dry Snuff	4.0

**Incidence Rate in Long-term ST users (At RR=4):  
26 per 100,000 person-years (py)\*\***

\* Over 20 epidemiologic studies, reviewed in: B Rodu, P Cole. Oral Surgery 93: 511-515, 2002.

\*\* New England Journal of Medicine 304: 745-749, 1981.

# Comparing Risks of Smokeless Tobacco, Automobiles and Cigarettes

Annual Death Rate from:

Powdered dry snuff<sup>1</sup>      12 per 100,000 users

Automobiles<sup>2</sup>      11 per 100,000 users

Cigarettes<sup>3</sup>      > 600 per 100,000 users

1. New England Journal of Medicine, 1981.

2. National Highway Traffic Safety Administration, 2009.

3. American Cancer Society data, 1999.

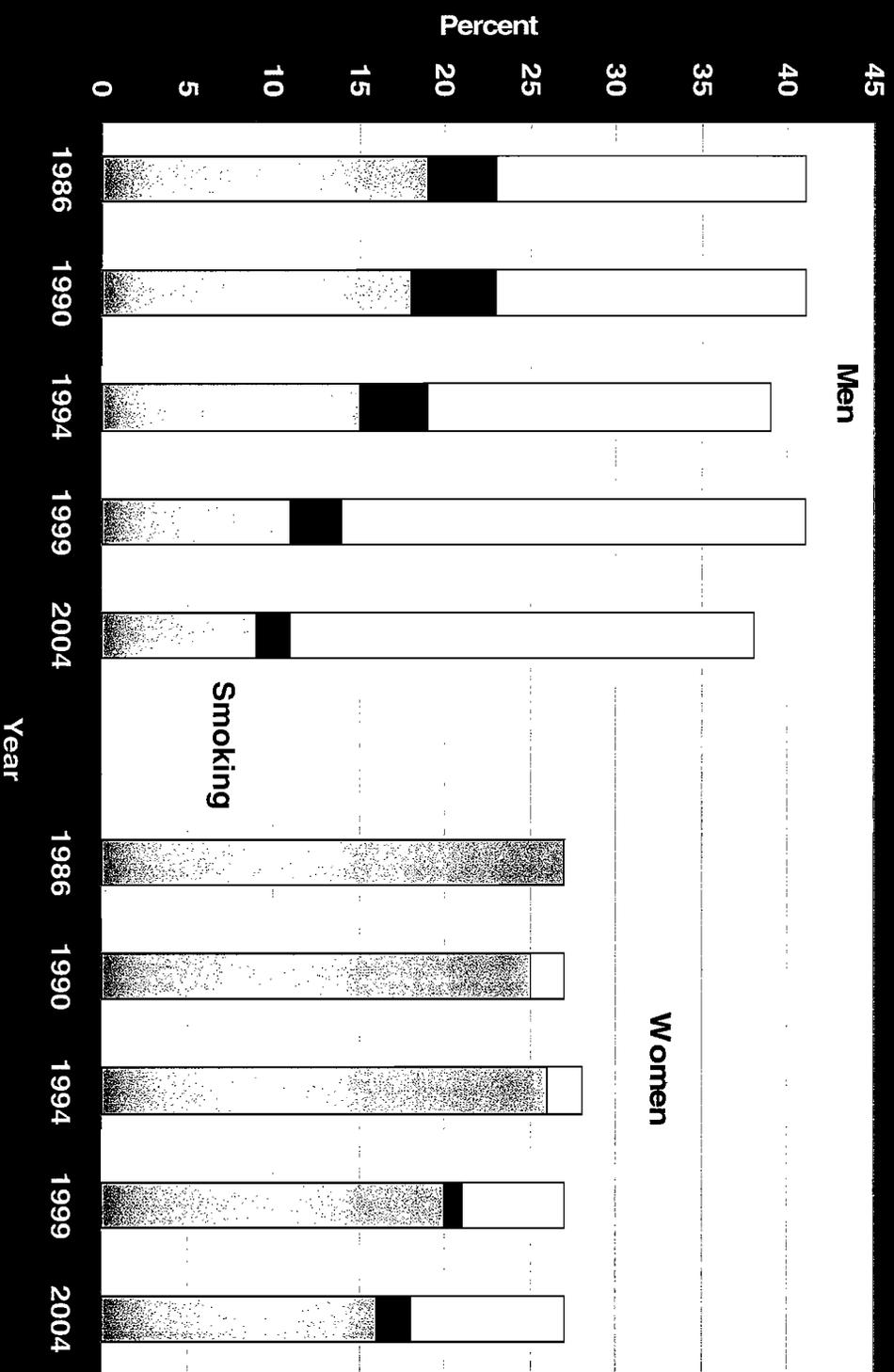
# **Smokeless Tobacco Has Worked For Swedish Men For 50 Years**

- **High rate of smokeless tobacco use.**
- **Lowest smoking rate in Europe.**
- **Lowest rate of lung cancer and other smoking-related diseases in Europe**
- **If EU men smoked at the rate of Swedish men, almost 274,000 lives per year would be saved\***

**\*B Rodu and P Cole. *Scandinavian Journal of Public Health*, 2009.**

# Tobacco Use in Northern Sweden

From J Int Med 2002; Scand J Pub Health 2005



# Growing Discussion about Tobacco Harm Reduction

## 2002 Royal College of Physicians Report

”...[smokeless] tobacco...10 to 1,000 times less hazardous than smoking...some manufacturers want to market ST as a harm reduction option...may find support for that in the public health community”

## 2007 Royal College of Physicians Report

Smokers smoke predominantly for nicotine,...nicotine itself is not especially hazardous.

### Harm reduction

- a fundamental component of many aspects of medicine and...everyday life...has not been applied to smoking.
- has the potential to save millions of lives, and deserves consideration.

# **Growing Discussion about Tobacco Harm Reduction**

**2006 *Addictive Behaviors*, NCI Funded**

**“...4 million [American] smokers would switch to the low-carcinogen smokeless tobacco.”**

**American Council on Science and Health**

***Harm Reduction Journal*, 2006 and 2011**

**”...there is a strong scientific and medical foundation for tobacco harm reduction, which shows great potential as a public health strategy to help millions of smokers.”**

# Tobacco Harm Reduction The Owensboro, KY Campaign

# Dump the smoke. But keep on lovin' the nicotine.

With cigarettes, **it's the smoke that kills.** Smoke-free products are proven to be the smarter and safer way to enjoy nicotine – and one of the most effective ways to quit cigarettes.\*

[SwitchAndQuitOwensboro.org](http://SwitchAndQuitOwensboro.org)

\* Rodu and Phillips, Harm Reduction Journal 5, 18, 2008

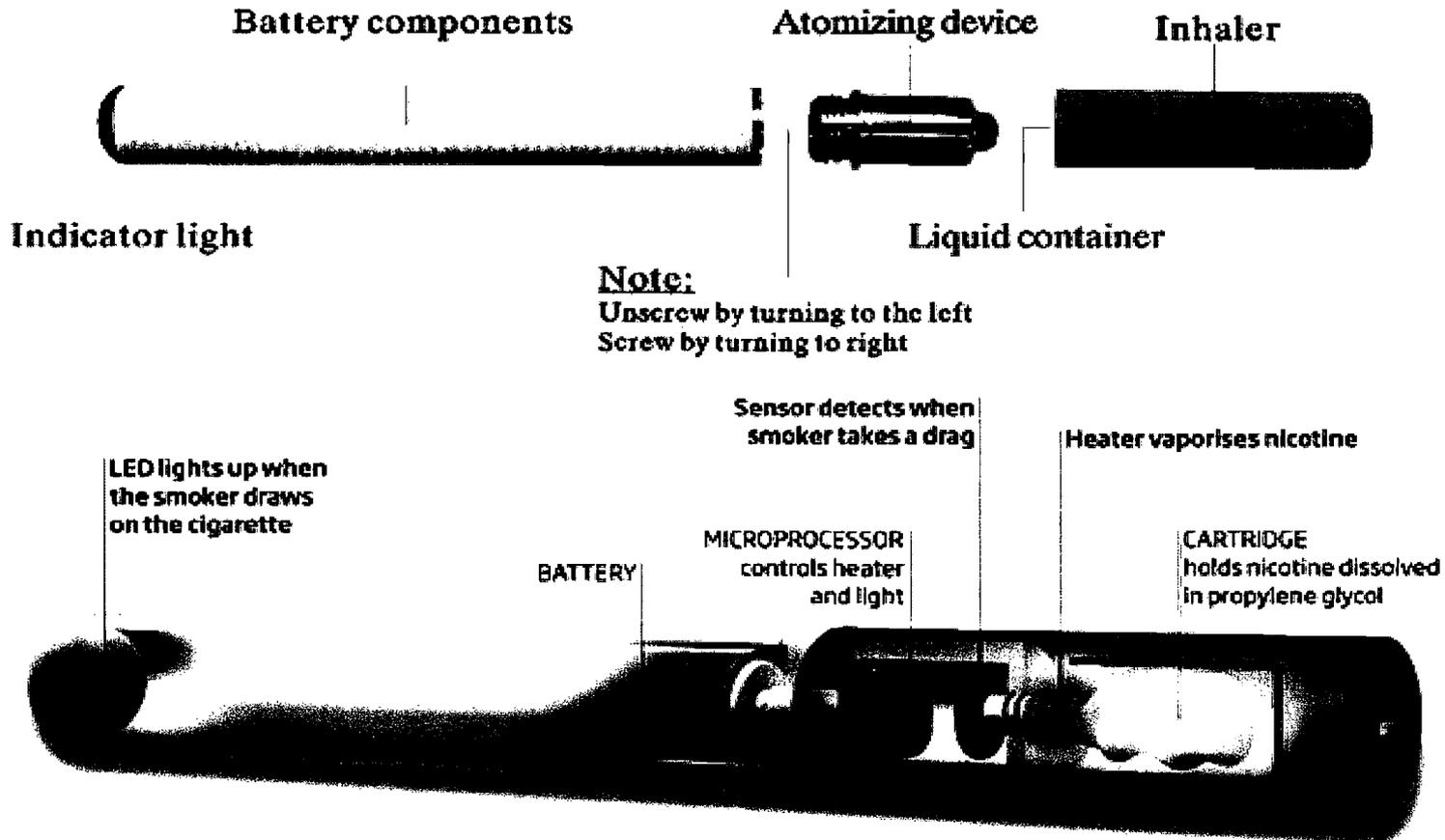


James Graham Brown Cancer Center

UNIVERSITY OF  
LOUISVILLE



# E-cigarettes



## Smoke without fire

Suck on an e-cigarette and it produces a cloud of nicotine-carrying vapour with none of the toxic by-products of burning tobacco

# Tobacco Harm Reduction: Take-Homes

- Eliminate misinformation on state government tobacco web pages such as:  
“smokeless tobacco doesn’t mean harmless tobacco... One can of chew equals about four packs of cigarettes...an almost instant addiction... Smokeless tobacco is not a safe replacement for smoking cigarettes”
- Don’t “equalize” taxes on smokeless tobacco with those on cigarettes: it denies smokers affordable options
- State employee smokers who switch save essentially as many health care dollars as smokers who quit
- Set insurance rates that don’t penalize smokers who switch

# **For More Information**

**[www.smokersonly.org](http://www.smokersonly.org)**

**[Rodutobaccotruth.blogspot.com](http://Rodutobaccotruth.blogspot.com)**

**[www.SwitchandQuitOwensboro.org](http://www.SwitchandQuitOwensboro.org)**

Brad Rodu is a Professor of Medicine at the University of Louisville, holds an endowed chair in tobacco harm reduction research, and is a member of the James Graham Brown Cancer Center at U of L. For almost twenty years Dr. Rodu has conducted research on tobacco harm reduction, involving permanent nicotine maintenance with safer tobacco products by smokers who are unable or unwilling to quit smoking with conventional cessation methods. Dr. Rodu earned his dental degree from the Ohio State University. After an oral pathology residency program at Emory University, Dr. Rodu completed fellowships at the University of Alabama at Birmingham (UAB) sponsored by the American Cancer Society and the National Cancer Institute. He was on the UAB faculty from 1981 to 2005, with appointments in several departments in the Schools of Medicine, Public Health and Dentistry. Dr. Rodu's research is supported by unrestricted grants from tobacco manufacturers to the University of Louisville and by the Kentucky Research Challenge Trust Fund.

**Lars E. Rutqvist, M.D., Ph. D.**

**Dr Rutqvist holds the position as Senior Vice President for Scientific Affairs at Swedish Match AB. He joined the company in 2006 after a career of more than 25 years in clinical oncology and academic medicine at the Karolinska Hospital & Institute in Stockholm, Sweden. He served as Head of the Department of Oncology, Karolinska University Hospital at Huddinge during 2000-2005, and was appointed Professor of Oncology at the Karolinska Institute in 2001. He also served for many years as the Chairman of the Karolinska Institute's Research Ethics Committee. His academic work has mainly been in the fields of clinical cancer epidemiology, cancer clinical trials, and cancer prevention. He has published more than 200 papers in international scientific journals.**

## **Prevention of Smoking Related Disease: the Swedish Experience**

Lars E. Rutqvist, M.D., Ph. D.

I have come here today to share with you the experiences from Sweden with tobacco harm reduction. I have worked for many years as a clinical oncologist at the Karolinska Institute in Stockholm. I became interested in the concept of tobacco harm reduction some 20 years ago through my research work in cancer epidemiology and cancer prevention. It was also this interest which brought me to Swedish Match to head the Scientific Affairs Team a few years ago.

I can think of no one who today would deny that what has happened in Sweden with tobacco is a very positive public health story. The so called "Swedish Experience" is widely referenced by researchers, prestigious institutions, and other proponents of a more pragmatic and results-oriented approach to tobacco control.

The basic facts are the following: total tobacco consumption in Sweden is comparable to that in other western countries, but Sweden has during the past three to four decades developed the lowest smoke-related mortality. This paradox is explained by the fact that cigarettes are no longer the dominant tobacco product, like they continue to be in most countries, including the US. They have to a large extent, particularly among males, been replaced by snus, which is a traditional form of spit-less, moist snuff.

In the mid 1960s several authoritative reports on the health effects of smoking were published, like the Surgeon General's Report in 1964. These reports were widely publicized in Sweden, which prompted smokers to look for alternatives, and they turned to snus, the traditional smokeless product which had been used in Sweden for centuries. Back then there was not much scientific evidence on the risk differential between cigarettes and smokeless products, but using

snus was deeply rooted in Swedish culture, and the product was widely viewed as being more “natural” or “organic” than cigarettes.

The switch from cigarettes to snus was largely a grass-roots phenomenon. It was not the result of any government actions or decisions to promote snus as a less risky alternative; it was not the result of marketing which has been quite restricted in Sweden ever since the mid 1960s, for instance, snus has never been marketed for harm reduction purposes or as a smoking cessation agent.

The fact that snus can replace cigarettes was something Swedish smokers found out by themselves, and was primarily spread by word-of-mouth among family and friends. Using snus instead of smoking simply became a popular trend.

That said, short of actually promoting snus, government authorities in Sweden, NGOs, and academia have always distinguished between smoking and using snus in their communication about tobacco and health. More recently, when compelling science became available, they have generally acknowledged the vast risk differential between smoking cigarettes and using snus.

The basis of the Swedish Experience scientific claims are rooted in numerous research articles published during the past 30 years. This research has failed to produce convincing evidence of associations between long-term snus use and any of the diseases that contribute to the excess mortality among smokers, such as, cancer (including oral cancer), cardiovascular disease, and chronic pulmonary conditions.

No wonder then that the Swedish public health statistics have started to look very favorable since the 1980s: Swedish males smoke the least, and use snus the most, and show, for instance, the lowest rate of lung cancer in the entire European Union. Rates of oral cancer and other typically smoke-related conditions are also among the lowest in the European Union countries. In fact, estimates show that if the rest of the European Union would have the same smoke-related mortality as Swedish males, hundreds of thousands of lives would be saved every year.

When talking about Swedish or Scandinavian research on health effects of snus it is important to underscore that all of this research has been done by

independent, university-based research groups. None of it has been done or has been funded by the tobacco industry.

There are those who want to downplay the importance of the Swedish Experience, particularly the relevance of snus for the record low rates of smoke-related disease. They might say, for instance, that smoking prevalence has gone down in recent years also among Swedish females (who have not taken up snus to the same extent as males), and that prevalence is low also in places like Massachusetts or Canada, without extensive use of smokeless tobacco, and their conclusion is “we don’t need snus or smokeless tobacco, we don’t need tobacco harm reduction as a new element in our tobacco control programs, there could be unintended consequences, in short, we are doing fine as it is”.

It is of course true that smoking prevalence has trended downwards in most parts of the western world in recent years, but I don’t think anyone has suggested that switching to a smokeless alternative is the only effective method to combat the smoking epidemic. There are obviously other effective tobacco control measures, but there is no other country where the decrease in smoking started so early and has been as profound as in Sweden, particularly among males. And there are certainly no examples of a similar distinctly positive public health outcome.

Is the Swedish Experience just a historical serendipity that happened long ago in a far away country with no relevance to what’s happening today? From a tobacco control perspective it is futile to debate whether the experiences from Sweden can or cannot be transferred to the US. It is probably more fruitful to consider how this experience is relevant, and how it can inform the ongoing regulatory science process in this country.

It is important to realize that the main determinants in society are actually the same in the US today as they were in Sweden in the late 60s: you have large numbers of addicted smokers who are interested in quitting, but who find it difficult to give up tobacco altogether, and who are looking for alternatives, and there is widespread availability of smokeless products that many smokers might find to be an acceptable substitute, and for which there is compelling science showing vastly decreased health risks compared to cigarettes

Also, some potentially important determinants of a switch from cigarettes are present in the US today, but were not in Sweden during the 60s: there are extensive smoking bans, and smoking is no longer the social norm. Both of these factors provide extra incentives for smokers who want to quit by switching to a smokeless alternative.

But sadly, there are some important determinants that are not present today in the US: there is far less public acceptance of smokeless alternatives, in fact, there is even scientific data illustrating that knowledge and beliefs among the US public are very far from what compelling science has shown for many years about the relative health risks of different tobacco products. This might be related to a lack of truthful communication over many years about what the science actually shows. I have learned that many Americans still believe that, from a health point of view, switching from cigarettes to smokeless tobacco simply means trading your risk of lung cancer with that of oral cancer. This is clearly contrary to what modern science tells us.

So, in closing, let me say that truthful communication represents the greatest challenge for any American decision-maker, any politician, or any organization interested in promoting public health through a pragmatic, science-based tobacco control program.

Therefore, I call upon you to do three things: combat the wide-spread public misconceptions, promote a science-based regulatory process, and, finally, acknowledge that tobacco harm reduction policies, as part of a comprehensive tobacco control program, have the potential to save lives, and significantly benefit public health in this country.



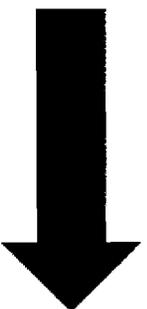
# Tobacco Harm Reduction: the Swedish Experience

Lars E. Rutqvist, M.D., Ph. D.  
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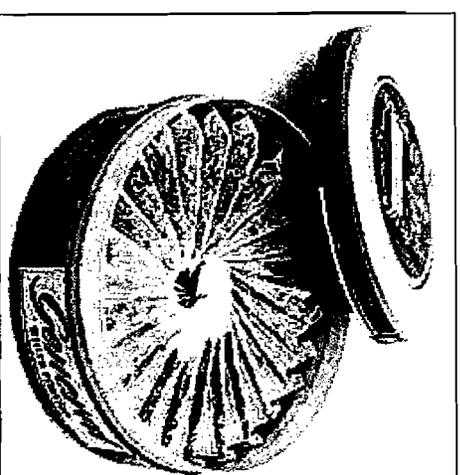
**Exhibit 7**  
**Health Finance Commission**  
**Meeting #2, Sept. 19, 2012**

# Swedish Experience

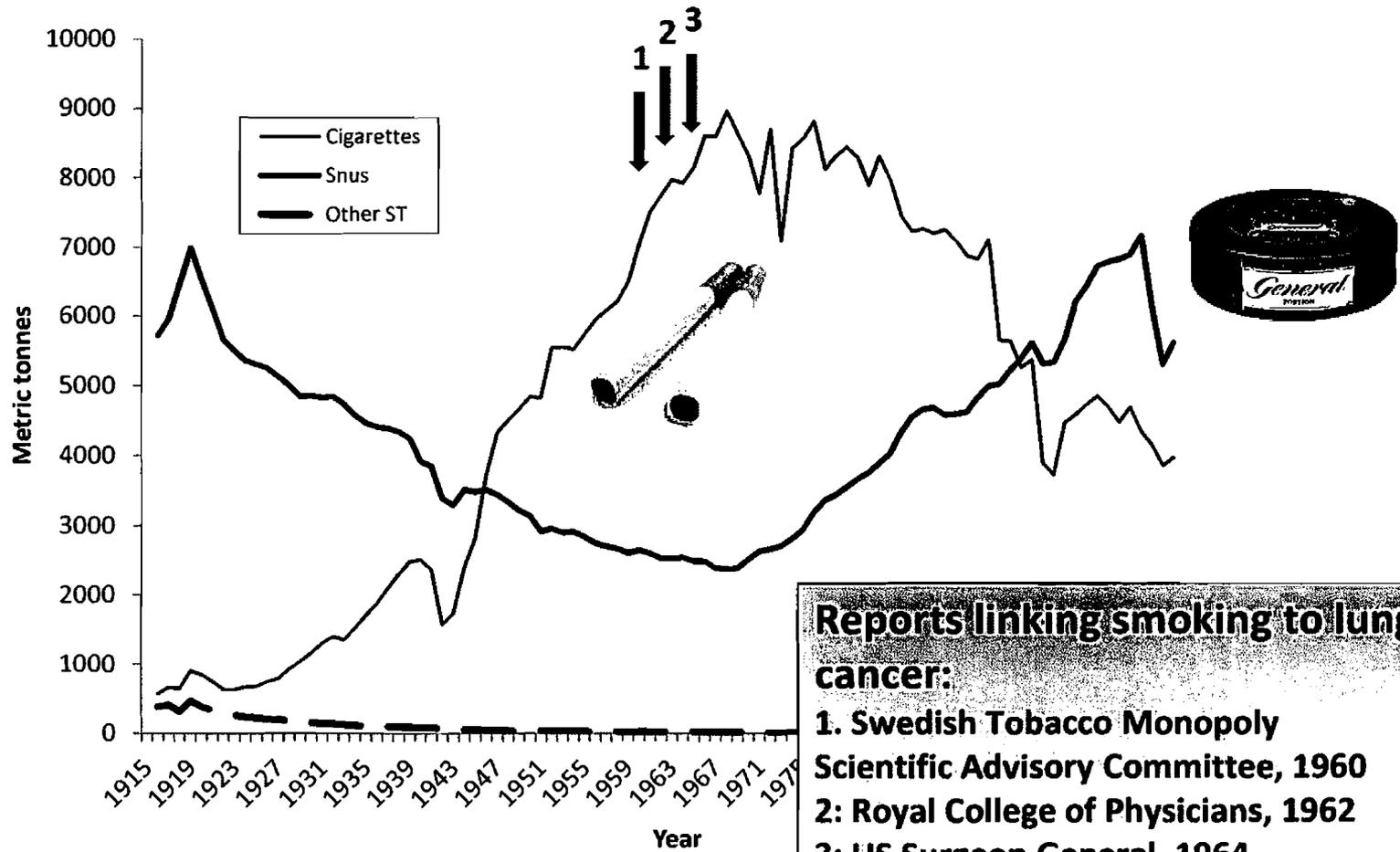
1960s



Today



# Swedish tobacco market 1916-2008



**Reports linking smoking to lung cancer:**

1. Swedish Tobacco Monopoly Scientific Advisory Committee, 1960
2. Royal College of Physicians, 1962
3. US Surgeon General, 1964

# **A switch from cigarettes to snus started in the late 1960s**

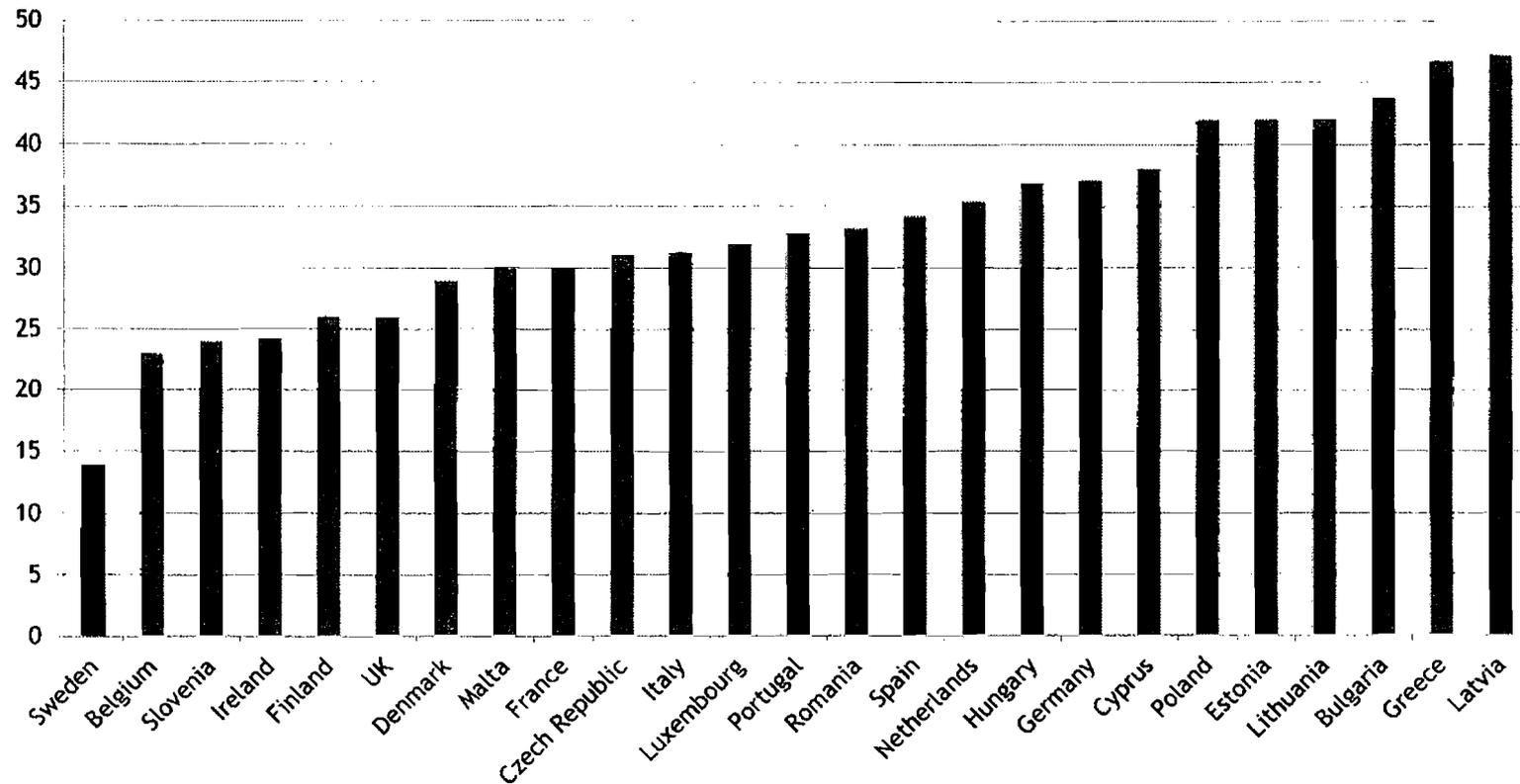
- Grass-roots phenomenon
- Snus viewed as a more “natural” or “organic” product than cigarettes.
- Snus had been part of Swedish culture since more than 200 years
- Snus never marketed as a smoking cessation aid or harm reduction product
- Government, NGOs, academia have always distinguished between snus and cigarettes

# Scientific studies on health effects of Swedish snus 1980-2012

- More than 150 published scientific studies
- 500,000+ individuals
- Long-term use
- Research areas:
  - Cancer
  - Cardiovascular ds
  - Other

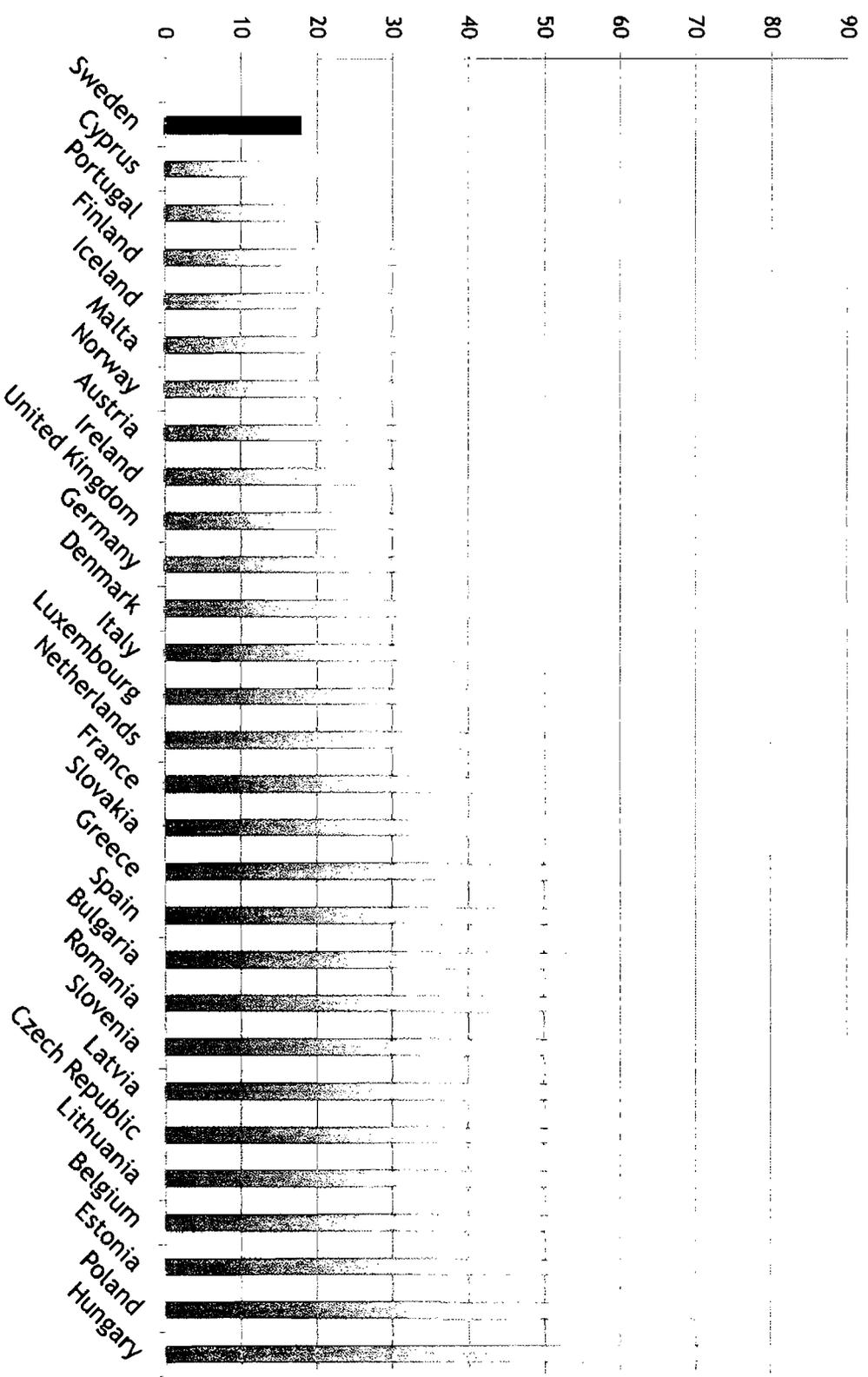


# Percentage of daily smokers (males) aged 15+ in the European Union



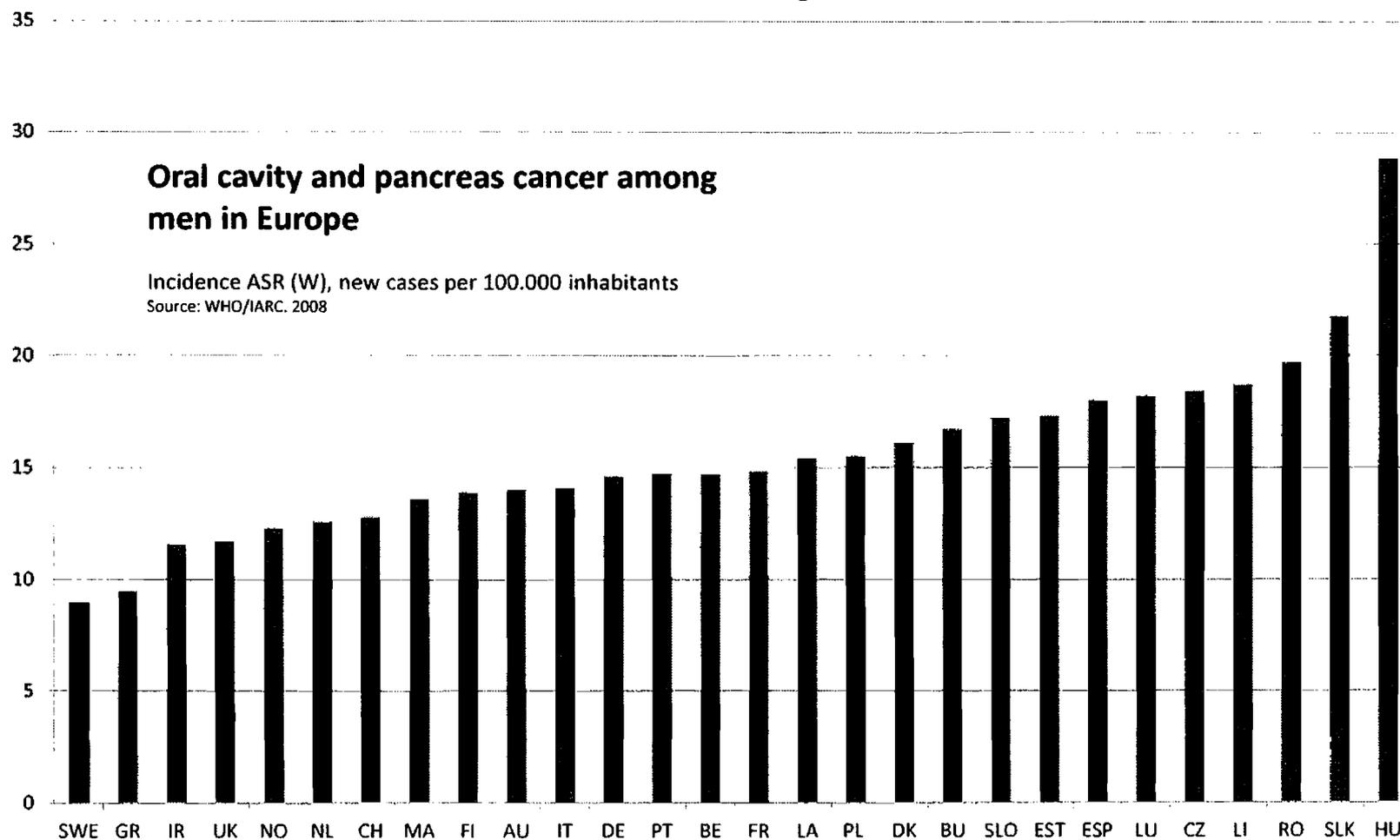
Source: WHO-HFA, 2007

# Incidence of male lung cancer in the European Union



Source: WHO-HFA, 2007

# Incidence of oral & pancreatic cancer among men in the European Union



Source: WHO/IARC, 2008

# A comparison of male tobacco related death rates between Sweden and the European Union

	<b>Death rates attributable to tobacco</b>		
	<b>Men age 60-69 in Sweden</b>	<b>Men age 60-69 in EU countries</b>	
Lung cancer	87	91 - 399	median 220
Other cancer	36	41 - 217	median 105
All cardiovascular disease	72	107 - 618	median 170
All causes	222	378 - 1388	median 550

**Male death rates attributable to tobacco are lower in Sweden than in any other European Union country**

# Relevance to the US?

- The most important determinants are the same in the US today as in Sweden during the 60s
  - Large number of addicted smokers interested in quitting
  - Widespread availability of a product that many smokers might find to be an acceptable substitute
- Some potentially important determinants are present today in the US (but were not in Sweden in the 60s)
  - Extensive public smoking bans
  - Smoking "de-normalized"
- Some determinants are not present in the US
  - Public acceptance of snus/ST as substitute for cigarettes
  - Truthful communication about "continuum of risk"

# Challenges

- **Truthful communication** about health risks associated with different tobacco products
- **Combat** widespread public misconceptions
- **Promote** a science based regulatory process
- **Acknowledge** that tobacco harm reduction has the potential to save lives and benefit public health

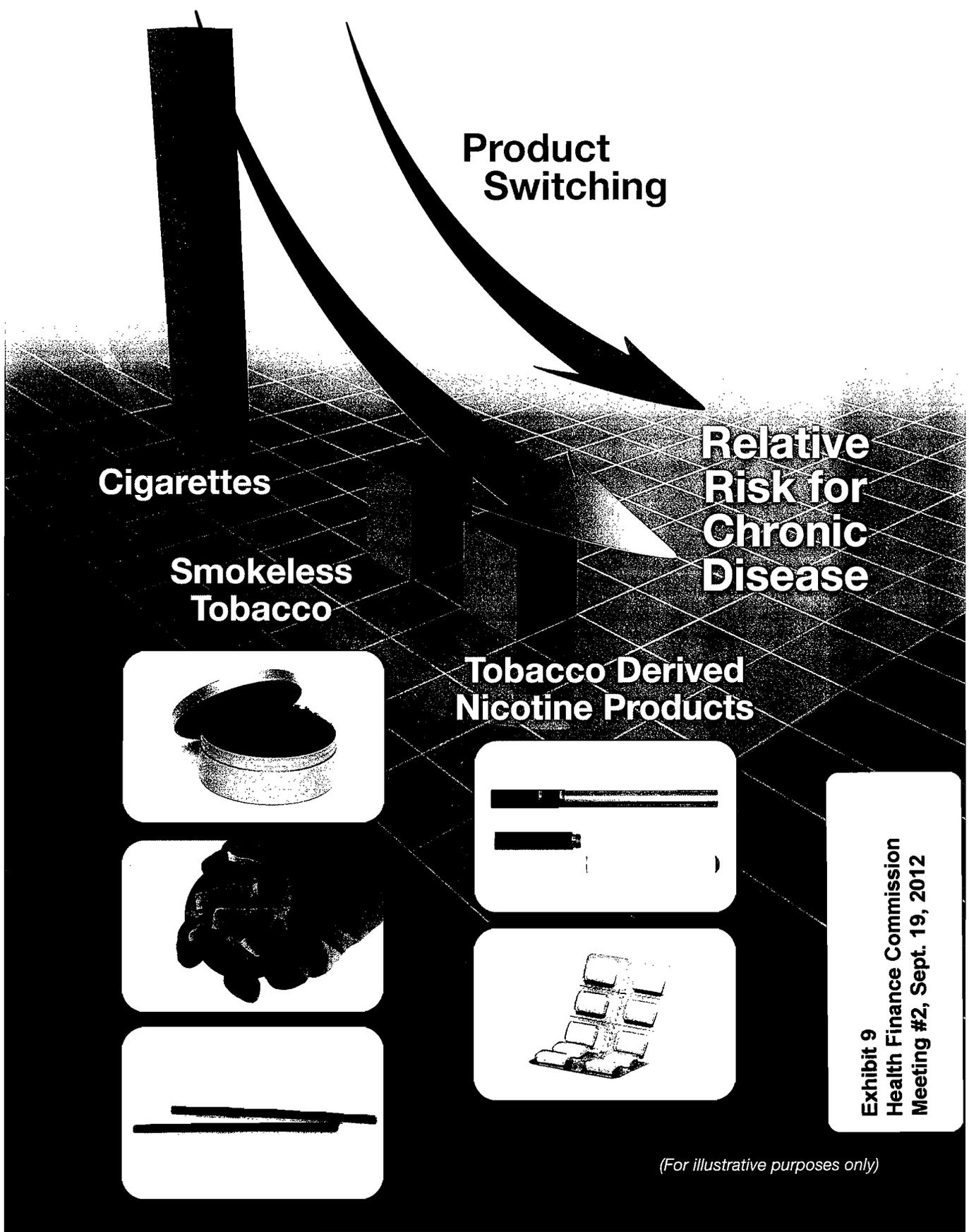
**- Thank You -**

Stephen E. Buyer, JD

Steve Buyer is the managing partner of the Steve Buyer Group, LLC. He is the former U. S. Representative of the 4th and 5<sup>th</sup> Congressional Districts of Indiana from 1993-2011. He served on the House Armed Services, Judiciary, Energy & Commerce, and Veterans Affairs committees while in Congress. He has extensive experience in public health policy, i.e. Military Health Delivery System, VA Healthcare, Medicaid, Medicare, and private health systems. He is also a retired Colonel, U. S. Army Reserve, JAG Corps.

**Exhibit 8**  
**Health Finance Commission**  
**Meeting #2, Sept. 19, 2012**

# Risk Continuum for Tobacco Products



# **Health Finance Commission**

## **Indiana General Assembly**

Wednesday, Sept. 19, 2012

Hearing on HR 59

Tobacco harm reduction strategies to reduce smoking-attributable death and disease

**Prepared Testimony By:**

**Stephen E. Buyer**

**Former U.S. Rep. for Indiana's 4th and 5th Congressional Districts**

**Exhibit 10  
Health Finance Commission  
Meeting #2, Sept. 19, 2012**

Mr. Chairman and members of the committee, I am very happy to be here in my home state and grateful for the opportunity to speak to this diverse group about something that is important to me and, I believe, should be important to the people of Indiana and its policymakers.

Some of you may know my background, but for those who do not, I will give you an idea of how I became involved broadly in tobacco issues and more specifically in the issue of Tobacco Harm Reduction (THR).

I recently retired from the United States Congress after 18 years. I can now look back and recognize the immense commitment it takes to step forward to act as an advocate for the people who sent you to the state capitol. I compliment each of you for your willingness to enter into public office. Your service is of significant importance and much appreciated.

I'm sure that when you first decided to enter into public service, many around you wanted to know why you had made the decision. Most of you, including myself, could answer pretty quickly that we were doing so because we wanted to make a difference. I know that was true for me.

As a long-standing advocate of Harm Reduction Strategies, I introduced H.R. 1261 in 2008. This legislation was supported by more than 400 scientists who advise the American Council on Science and Health because my bill was a tougher, science-based alternative to Congressman Henry Waxman's H.R. 1256 which became law. The American Council on Science and Health, which endorsed my legislation, said of the Waxman bill, *"H.R. 1256 will not only fail to reduce the ravages of cigarette-induced disease and death—it will likely worsen it. The new regulation of tobacco 'additives' will not lower the toxic and carcinogenic mixture induced by the combustion and inhalation of cigarette smoke. The enhanced restrictions on lower-risk tobacco products, such as smokeless and 'clean' nicotine—which has been shown to assist addicted smokers in quitting—will condemn the over 40 million addicted smokers to the same old 'quit or die' pair of options."* My bill was debated and voted down in the Energy and

Commerce Committee and on the House floor. The advocates of an "abstinence only" anti-tobacco policy were too great for me to overcome. I still believe the time has come for harm reduction strategies to be applied to tobacco health related policies.

Once I left Congress I learned quickly that I did not need a title or a position of power to influence and improve public health policy. To be an agent of change you can do it from the outside and attack tobacco manufacturers like many anti-tobacco organizations do or you can do it from the inside. I have chosen to be an agent of change from the inside. I am now a paid consultant to Reynolds American, Inc, (RAI) the parent company of RJ Reynolds Tobacco Company as an advocate of Harm Reduction Strategies to promote healthier choices and improved health outcomes for smokers. I compliment RAI's operating companies for making investments in and offering for sale to adult tobacco consumers smokeless tobacco and nicotine products. Smokers may find these products as the path to tobacco altogether while others may transition to these less harmful products rather than continuing to obtain tobacco enjoyment from the tobacco product carrying the highest risk to one's health...the legal tobacco product called "cigarettes."

Now, when I think about my background where I came from and where I chose to serve the nation's interest, it has been primarily in the area of health policy.

I am not a doctor. I come from a family of dentists. My grandfather was a dentist, my father is a dentist, my brother is a dentist, my sister is a dentist, and my uncle was a dentist. I chose to be a lawyer.

My exposure to a family of dentists has taught me a lot about preventive medicine.

In America, we are fiercely independent, and many have a mindset that we will smoke whatever we want. We will drink whatever we want. And we will eat whatever we want, regardless of the consequences to our bodies...and yet, because of preventive medicine, we have great looking teeth.

With preventive medicine engrained in me, I embarked on my journey of working on public health policy in Congress. My first assignment was to the Personnel Subcommittee of the House Armed Services Committee.

This meant I was responsible for the military health delivery system. Then, I served on the House Veterans Affairs Committee and worked with the Veterans' Administration health systems, and I was also placed on a task force that was trying to figure out how to address some of the future financial issues of Medicare.

I learned that one-third of our Medicare expenditures are diabetes related. This experience reinforced my early training at home about the importance of preventive medicine.

We decided to get on the front end of this and to educate people and give them the tools to make informed decisions. First, we had to make them aware so people of high risk of diabetes or who had the disease could make healthier choices.

We moved billions of dollars to the front end focused on prevention and education so we could save billions on the back end. That is public health policy. And, that is the same opportunity you have here today... to make sound public health policy to improve the quality of life, increase productivity of Hoosiers, while saving healthcare costs to this great state by embracing a harm reduction strategy for smoking, tobacco products, and nicotine products.

You are discussing ways to educate and inform people about the comparative risks associated with tobacco in its various forms, and I commend you for that.

I learned a lot on the task force through that process, as I am sure you are learning a lot here today about this topic.

My next effort in the VA was to try to deal with Post-Traumatic Stress Disorder (PTSD) for our service men and women coming back from the first Gulf War. I learned about individuals who are suffering from stress and who are also smoking cigarettes and consuming alcohol. In order to treat these individuals, you have got to get them off of the alcohol and cigarettes before you can then begin to work on the stress-related issues they have.

So during all of this, I began to learn more about tobacco and alcohol and how all of these are related.

At the same time, I also worked to create what is called "TRICARE for Life" for military retirees.

Why is all of this significant? Because it taught me about taking on really big issues and being able to do exactly what you are doing here today. And, I assure you reducing the death and disease caused by cigarette smoking is a really big issue, and unfortunately, Tobacco Harm Reduction has some very powerful opponents.

My message is that one person, and in this case 23 legislators, can actually stand up and exercise leadership and make a difference. You all learned that in your communities, otherwise you would have never run for office.

While I was in public office, I took on one of the most controversial issues for this country – tobacco. I don't use tobacco products, but I do believe the people you represent deserve to know the truth.

I am here today because I believe that the public has been, and continues to be, misinformed by the public health community about risks presented by tobacco in its various forms.

I do not understand completely why so many embrace "abstinence only" as a public health policy; but I do know, if you truly care about our state and you want to embrace a health policy that

saves lives, reduces risks, and could potentially save money, you will take a look at Tobacco Harm Reduction policies and implement them in this state.

There is a significant misinformation campaign taking place right now in the public health community, and I want to give you a couple of examples of how this is taking place at the national level and at the state level.

The U.S. Centers for Disease Control and Prevention states, "Smokeless tobacco is not a safe alternative to smoking cigarettes." You see this printed on web sites and even on containers of smokeless tobacco. This is a misleading statement.

The U.S. Food and Drug Administration states, "To date, no tobacco product has been scientifically proven to reduce the risk of tobacco-related disease, improve safety or cause less harm than other tobacco products." This is the FDA stating this. This is a false statement.

Here at the state level, you have the Indiana State Department of Health echoing this misleading information. On a health department fact sheet titled, "Spit Tobacco Use in Indiana," it states "Spit tobacco is not a safe alternate to cigarettes." This fact sheet is available on the department's web site.

In addition, the web site for Indiana's Tobacco Prevention and Cessation Commission web site uses the terms "tobacco" and "smoking" interchangeably. I would submit to you that the language matters on this issue if you want residents to have complete and accurate information and to make informed decisions about cigarette smoking. Unfortunately, tobacco consumers are now confused and many believe that smokeless tobacco products are just as harmful as cigarettes. This is a false premise.

All of this raises the question: "Why are the federal government and the state department of health putting out false and misleading information about tobacco products." Tobacco control advocates believe that all tobacco related products are equally harmful despite science that proves otherwise.

Well, allow me to speak from my own experience in this area.

In 2009, when Congressman Henry Waxman wanted the FDA to take control of regulating tobacco products, I stood up and submitted an alternative plan that would educate the public on the health risks associated with various tobacco and nicotine products.

For this effort, I was marginalized and mocked.

I faced opposition from well-known societies and foundations like the American Lung Association, the American Cancer Society, and the American Heart Association.

I am not disparaging these organizations because I believe they have each done many wonderful things for this country, but on the issue of tobacco, these groups have staked a position that abstinence is the only way when it comes to tobacco. It's a strategy called "Quit or Die." You either stop using all tobacco or you face your chances with deadly diseases like lung cancer, heart disease, and emphysema. They have embraced this public health policy for the nation and they use a powerful lobbying effort for federal and state public health departments to promulgate this policy.

Now, I would like to challenge you to think about other things that go on in this nation, like sexual behaviors. We promote abstinence when it comes to sexual behaviors, but you know that this in itself is not enough. "Abstinence only" public health policy to address the pandemic of sexually transmitted disease will not work. It needs to be coupled with sex education so people can make healthier choices regarding their sexual behaviors.

Over the years, I have advocated the full spectrum. I have voted to invest the public treasury for abstinence programs, but I'm also pragmatic, and I think we ought to educate and promote safe sex. This is the application of abstinence policies coupled with a harm reduction strategy to reduce the risks and promote better public health in our society.

Similarly, programs meant to reduce the risks associated with drug use have been widely used.

Congressman Waxman himself has been a vocal proponent of needle exchanges for individuals addicted to heroin. These exchanges provide clean needles to addicts to keep them from contracting deadly diseases associated with dirty needles. This is a harm reduction strategy.

There are ways to also reduce the risks associated with tobacco use. When Abstinence programs fail, Harm Reduction programs should be sought.

I believe we need to migrate the population of cigarette smokers to less harmful, smokeless tobacco and nicotine product options.

I commend the organizations that have had a hand in moving us from a time in 1965 when 42 percent of the population smoked cigarettes to now when you see that number at 19-22 percent of the population. Some of the population has migrated and the nation has become healthier. The problem now is that fewer people are quitting.

In fact, since 2003, the smoking rate has fluctuated between 19 and 22 percent. We have not seen any significant change in the percentage since the early days of the anti-tobacco movement.

It appears that the roughly 43 million Americans who smoke have made a choice to smoke regardless of the known health risk. Remember, that many have been wrongly misled to believe that smoking a cigarette is just as harmful as smokeless tobacco thereby robbing them of making an informed decision of migrating to a less harmful smokeless tobacco product. It is also conceivable that a strong percentage of that total number have tried to quit.

If you are an American who wants to quit, you now have two choices. You can try to quit cold-turkey or you can use pharmaceutical Nicotine Replacement Therapies (NRTs). These are products like

the patch, gum and lozenges. Scientific studies have shown that these products have an effectiveness rate of about 7 percent.

In Indiana, the state department of health will actually provide to eligible individuals a two-week supply of NRTs free of charge. Now, think about that, the state is giving away a nicotine product with a 7 percent effectiveness rate to residents. That doesn't sound like success to me. Seven percent sounds like a failure. For the 7 percent who quit that is great; however, for the other 93 percent who failed to quit and for the over 40 million smokers, the present public health policy for tobacco is locking these smokers into a system of failure instead of embracing a compassionate approach to public policy that will educate tobacco consumers to make informed choices of safer alternatives to obtain their nicotine. We need to move smokers to less harmful tobacco products to nicotine products to eventually quitting.

Now, I mentioned moving or migrating the population of smokers. How do you do that?

The only way you can migrate a population of smokers to eventually quit is move them down the continuum of risk from the most harmful to the least harmful tobacco and nicotine products. No tobacco product is safe. Tobacco and nicotine are legal products. I have an illustration here today of a continuum of risk for tobacco products. Nicotine is what people are seeking through a wide range of delivery systems. You will see that at the top of the continuum of risk is the most deadly form of tobacco – cigarettes. Smoking cigars, cigarettes, and pipes are by far the most harmful ways to deliver nicotine in conjunction with hundreds of carcinogens that are mainly responsible for the major adverse health effects such as lung cancer, heart disease, and chronic obstructive pulmonary disease. Then there are the smokeless oral tobacco products that have low nitrosamines. Health experts are now claiming that the risk of adverse effects associated with Swedish snus for example is lower than that associated with smoking, by an overall 90 percent. Then there are products that don't contain tobacco but rather provide nicotine extracted from tobacco. And then there are the medicinal nicotine products used in therapies to assist people in quitting.

According to the large body of science out there on this topic, it is the smoke from cigarettes that causes most of the health-related issues – emphysema, lung cancer, heart disease. Simply put, it's the smoke stupid.

So, if people want to gain access to nicotine you have to change the delivery system. You do that by educating them so that they can migrate. Migrate to a different less harmful and safer tobacco and nicotine product.

This will take a serious education effort because people have already been inundated with so much false information about smokeless tobacco products. In fact, several studies show that roughly 85 percent of smokers believe that smokeless tobacco is just as or more harmful than cigarette smoking.

This issue of educating tobacco consumers is made even more complicated because when the Congress passed the tobacco bill, tobacco companies are prohibited from communicating to consumers about the relative risks of specific tobacco products.

The anti-tobacco lobby is pugnacious and zealous to its abstinence policy, and I am very hopeful that someday they will recognize and accept Tobacco Harm Reduction because if they truly want less risk and healthier outcomes it can only be accomplished through coupling abstinence goals with tobacco harm reduction strategies.

I would submit that some of you already practice harm reduction in your own personal life today. Many of us trim the fat away before eating a piece of meat. Some of us choose a salad for lunch instead of a bacon cheeseburger. Others might simply drink water rather than sugar-sweetened soft drinks. We practice harm reduction in our lives every day, but cigarette smokers don't know that there are less risky products.

In addition to educating the public and putting out complete and accurate information to smokers, we as policymakers should move to a tax policy that does not create artificial barriers to switching from cigarettes to smokeless products.

I am pleased to say that in Indiana, there has been progress on this. In 2011, the legislature recognized the relative risk of tobacco products when it adjusted the smokeless tobacco tax rate. This was a step in the right direction, and the legislature should seriously consider reducing the rate on smokeless tobacco.

Most scientific studies show that smokeless tobacco is at least 90 percent less risky than cigarette smoking, so an appropriate ratio between cigarettes and smokeless would be 10 to 1 or greater.

Another area where we should be using policies to help incentivize smokers to make better decisions is in the areas of health and life insurance.

In Indiana, the state provides a \$25-per-pay-period “non-tobacco use incentive” to employees who do not use any tobacco products. A better approach would be to provide a tiered incentive plan that recognizes that smokeless tobacco is not the same as cigarette smoking. Smokeless tobacco consumers could receive the full \$25 incentive or receive a smaller incentive.

Some insurance forms ask individuals if they are smokers or if they are tobacco users. They do this to calculate risk and to determine how much to charge.

A better system would recognize a difference in risk for cigarette smoking and smokeless tobacco products and charge a lower premium for products that do not cause any of the deadly diseases associated with cigarette smoking. This would provide yet another education opportunity and offer an incentive for people to migrate from the most risky form of tobacco to the least risky form. Anti-tobacco

advocates argue against smokeless tobacco fearing these products will be a gateway for people to smoke. The Swedish experience proves otherwise.

Another example would be the Indiana department of health issuing an updated fact sheet providing accurate information about the health risks posed by smokeless tobacco products.

I have spoken about making a difference and about the powerful forces that will attempt to prevent you from embracing tobacco harm reduction. Let me give you some examples from my own personal life.

I am a Republican, and as I went through the process of introducing an alternative approach to tobacco regulation, I was trying to get individuals to sign on to my bill and to advocate exactly what I have been talking about.

I encountered leaders who would tell me that they could not support my legislation because their wives or good friends raise money for organizations like the American Cancer Society or the American Lung Association or the American Heart Association.

I understand this because when I was practicing law in Monticello, IN, before I went to Congress; I raised money for the American Cancer Society. There are socialites within the community who assist and participate in these Association fundraisers. I get that, but I just want you to know that on the inside there will be people you can explain harm reduction to them and they will understand it, but because of these social relationships, they may be unwilling to take a position.

That's why they call it politics, right? All of those different issues, you face that. I don't care what the issue is. There is something that drives them away from pragmatism and common sense, and I assure you that you will find the social interaction obstacle in this issue.

Frankly, before embarking on my journey, I had the same conversation that I am having with you with all of my relatives who are dentists. They are on the frontline of preventative medicine and treat many smokers. I'll admit that many were skeptical when I first broached this topic. If nothing else, most people believe that smokeless tobacco causes oral cancer and must do so at a higher rate than cigarette use. But when I presented them with the facts, they understood that smokeless tobacco products presented less risk than cigarettes.

You have that same opportunity today to educate yourself and others, despite the social obstacles and legislative challenges in creating a science based balanced approach to public health policy. I believe we should seek to minimize harmful effects of smoking cigarettes rather than condemning all tobacco products. It is time to couple the public health goal of abstinence with a harm reduction strategy that will migrate tobacco smokers down the continuum of risk from use - to safer use - to managed use - to abstinence.

# THE NATIONAL CENTER



## FOR PUBLIC POLICY RESEARCH

Amy M. Ridenour

Chairman

David A. Ridenour

President

I'm writing to commend the Health Finance Commission for considering how Tobacco Harm Reduction can help reduce smoking related disease and death in Indiana. I'd also like to share some thoughts on science-based harm reduction and how small public policy changes which recognize tobacco harm reduction could yield significant public health goals.

There's no question that smokers need to be given a variety of tools to help them quit smoking cigarettes. Unfortunately, there is no one way to help smokers that guarantees cessation. Although the ideal would be to get everyone to quit all forms of tobacco use, real world experience and science point to a much more pragmatic approach, rooted in tobacco harm reduction. This method utilizes a range of non-combustible products to help people move down a risk continuum, from the most dangerous product – cigarettes – to less harmful alternatives, such as snus, dissolvable tobacco products, e-cigarettes, and other smokeless merchandise.

In fact, the United States Food and Drug Administration (FDA) is currently taking a serious look at smokeless tobacco products in developing a regulatory approach towards modified, i.e., reduced-risk tobacco products. Tobacco harm reduction strategies are based on the simple fact that cigarettes are more dangerous than other tobacco products, like snus, dissolvable tobacco, and e-cigarettes. With cigarettes, tobacco is burned and inhaled, and that is what makes them far more harmful than tobacco and nicotine products that do not produce carcinogenic smoke.

Particularly instructive is the report issued by the FDA's Tobacco Product Scientific Advisory Committee (TPSAC) in its March 2012 report on Dissolvable Tobacco Products (DTPs). The official findings of the government report took into account the fact that dissolvable smokeless tobacco products could have a beneficial impact on public health because of the products' "differing risk profile for tobacco-caused diseases and premature mortality from...partial to complete replacement of cigarette use by DTPs."

Specifically, the report acknowledged that, "[b]ased on understanding of the delivery of toxins to cigarette smokers, exclusive use of DTPs should be less hazardous than regular smoking of cigarettes now marketed in the United States."

With certain caveats, the report further found, "that exclusive use of DTPs by an individual would greatly reduce risk for smoking caused disease compared with regular use of cigarettes. The TPSAC framework indicates several ways that DTPs could reduce the population disease burden caused by tobacco use: 1) decreasing the number of smokers, if availability of DTPs increases successful cessation or decreases the likelihood of initiation and use of smoked products, and 2) decreasing the risk of tobacco caused disease, if availability of DTPs sufficiently reduces cigarette smoking."

**Exhibit 11**  
**Health Finance Commission**  
**Meeting #2, Sept. 19, 2012**

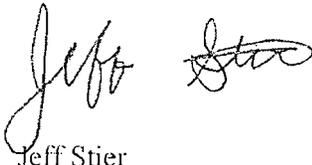
In other words, the FDA concluded that smokers switching from cigarettes to non-combustible products would be good for public health.

I encourage the state of Indiana to endorse a range of policies that would create an environment which would benefit the public health in this way. Although the Food and Drug Administration regulates tobacco products, states do have opportunities to take advantage of the public health promise of tobacco harm reduction. For instance, whereas so called "sin taxes" are used to discourage certain behaviors, those taxes ought to be consistent with the risk of the products the government seeks to discourage. While I oppose sin taxes, I believe that so long as they are in place, they should be applied in a way that is consistent with sound public health policy. Some states tax cigarettes (most harmful) at the same rate as far less harmful smokeless tobacco products. Such an approach undermines the very stated purpose of the sin tax, by removing a financial incentive to move to a lower-risk product.

Along the same lines, other financial incentives can be adjusted as well. For instance, the state of Indiana's \$25 per-pay period discount on health insurance rates to non-tobacco users recognizes that non-tobacco users have fewer health risks and thus lower medical expenses. A similar incentive should be created to encourage smokers to reduce their tobacco-related risks by offering some lesser discount for non-smokers who use smokeless tobacco products to quit smoking.

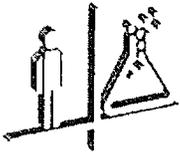
I encourage the commission to recognize the fact that smokeless tobacco products are far less harmful than cigarettes and can be used to help smokers reduce their tobacco-related risks. As such, it makes sense to tax and regulate these products in a way that is aligned with the science.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeff Stier". The signature is written in a cursive style with a large initial "J" and a long, sweeping underline.

Jeff Stier

Senior Fellow, National Center for Public Policy Research  
Director, Risk Analysis Division



## AMERICAN COUNCIL ON SCIENCE AND HEALTH

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www.acsh.org • acsh@acsh.org

September 14, 2012

The Indiana Legislative Council  
General Assembly Health Finance Commission

RE: Support for HR 59, "Tobacco harm reduction strategies to reduce smoking-attributable death and disease"

The American Council on Science and Health (ACSH), a consumer education and advocacy nonprofit devoted throughout our 35 year history to the promotion of sound science in public health policy, urges the Indiana General Assembly's Health Finance Commission to promote the benefits of Tobacco Harm Reduction (THR) in helping smokers quit based on study findings.

Our own research of this subject, published in a peer-reviewed academic journal, as well as many others, support our assertion that the methodologies comprising THR — the substitution of low-risk tobacco and nicotine-delivery products for lethal cigarettes — have significant potential benefits in terms of reducing the tragic toll of cigarette smoking by supplying addicted smokers with the substance they crave--nicotine--but at a much reduced cost in terms of adverse health effects.

While we are in full agreement with HR 59 that no form of tobacco use is entirely "safe"— i.e. without an increased risk of adverse health effects — and that therefore all recreational tobacco use should be discouraged, it is still necessary to acknowledge the fact that there are 46 million addicted adult smokers in our nation, about 20% of the total population (21% among Indiana's adult population). Further, while almost three-quarters wish to quit, and almost one-half do indeed attempt to quit each year, well under one-tenth succeed. One reason for this abysmal "success" rate is that the methods approved by the FDA — including the nicotine patch (NRT), gum, inhalers, and pharmaceuticals such as Zyban and Chantix — and promoted by the official public health authorities and the large nonprofits, all too often fail to help smokers quit. Indiana's current policy, of supplying NRT patches to smokers who contact the state's quitline, already acknowledges the concept of THR, but now the Health Finance Commission must encourage the state's health departments to widely publicize the benefits of THR and make these products more readily available to those who desperately seek to quit smoking

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**Exhibit 12**  
**Health Finance Commission**  
**Meeting #2, Sept. 19, 2012**

The established authorities' positions on using reduced risk products to deliver adequate nicotine levels to requite smokers' cravings and help them get off deadly cigarettes is based on long-held mistrust of and contempt for the tobacco companies — well-deserved feelings based on those companies' irresponsible and abusive behavior during the 20th century. But in order to truly help addicted smokers quit, those biases must be put aside and the current facts must be dealt with.

Given the 21st century's stringent regulatory oversight and the clear (albeit too slow) downward-trend in cigarette sales along with the irrefutable evidence of "the Swedish Experience," which illustrates how Swedish men have shifted their tobacco use pattern from lethal cigarettes towards much safer "snus" (smokeless tobacco in small teabags), it is in tobacco companies' interests as well as public health's for them to market reduced risk products. They couldn't get away with the nefarious behaviors of the 20th century, even if they had such an inclination.

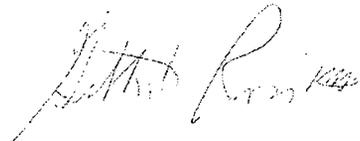
Those who support THR, including ACSH, merely ask the Health Finance Commission to rely on the readily available scientific evidence to recommend policies promoting THR. This should include not only snus-type smokeless tobacco aimed at helping addicted smokers quit cigarettes, but also the newer products such as dissolvable tobacco and electronic-cigarettes (e-cigarettes): any product likely to be effective at helping addicted smokers quit cigarettes. We firmly believe that the more comprehensive the investigation, the more reasonable people will come to understand that the official policies of adhering to "there is no safe tobacco product, so abstinence is the only answer" amounts to a "quit or die" position, the status quo, with the ongoing toll of over 400,000 smoking-related deaths each year. This is no longer an acceptable position from a public health perspective, and we hope you will agree that such policies are desperately needed, indeed long overdue.

Thank you for your consideration.

Sincerely,



Elizabeth M. Whelan, Sc.D., M.P.H.  
President



Gilbert Ross, M.D.  
Executive and Medical Director

P.S. We are pleased to attach a copy of ACSH's peer-reviewed study "Helping Smoker's Quit: The Science Behind Tobacco Harm Reduction" for your consideration.

**Evidence-Based Tobacco Prevention & Cessation**

**Testimony of:**

**Daniel McGoldrick**

**Vice President, Research**

**Campaign for Tobacco-Free Kids**

**Before the:**

**Indiana Health Finance Commission**

**Indianapolis, IN**

**September 19, 2012**

**Exhibit 13  
Health Finance Commission  
Meeting #2, Sept. 19, 2012**

Chairperson Brown, Vice Chairperson Miller, and Members of the Commission:

Thank you for the opportunity to present written testimony on evidenced-based approaches to tobacco prevention and cessation in Indiana. Indiana has a history of implementing some evidence-based practices to reduce tobacco use but can do much more by following an approach based on solid science rather than one that lacks evidence.

In recent months, tobacco companies and others have approached state health departments and state legislatures like yours to try to convince them to pursue harm reduction strategies using smokeless tobacco and other products. These proposals have included asking states to promote smokeless tobacco as less harmful than smoking, taxing smokeless tobacco at a lower rate, and even diverting tobacco prevention funding to this approach.

As you hear these proposals for states to do the bidding of tobacco companies, you should keep in mind some important points:

- **The largest cigarette companies now own the largest smokeless tobacco companies.** Phillip Morris' parent company, Altria, now owns United States Smokeless Tobacco, which sells Copenhagen, Skoal and other brands. Reynolds American now owns American Snuff Company (formerly Conwood), which sells Grizzly, Kodiak and other brands.

- **These harm reduction proposals come on the heels of some of the largest declines in cigarette consumption in history.** It is rather unlikely that cigarette companies actually want their smoking customers to quit using this highly profitable and addictive product. These proposals are more likely an effort to keep customers addicted and get new ones addicted, as well.

As I will describe, there are evidence-based strategies that Indiana can put into place to reduce tobacco use, but promoting smokeless tobacco use as a harm reduction strategy is not one of them.

### **Smokeless Tobacco Harms and Use in Indiana**

- Smokeless tobacco is not a safe alternative to smoking.<sup>1</sup> Smokeless tobacco is harmful to health.<sup>2</sup> The National Cancer Institute, the American Cancer Society, the U.S. Surgeon General and the U.S. Public Health Service have all concluded that smokeless tobacco products as sold in the United States are addictive and cause serious disease, including cancer.<sup>3</sup> We should not be sending any message to our children that smokeless tobacco use is acceptable.
- The tobacco companies have a long history of marketing smokeless tobacco to kids and have successfully transformed smokeless tobacco from a product used primarily by older men to one used by boys and young men. Their graduation strategy was specifically designed to entice the young with flavors like cherry (a former smokeless salesperson said: “Cherry Skoal is for somebody who likes the taste of candy, if you know what I’m saying”),

products that were easier for kids to use (like long cut and pouches), and lower nicotine products and then graduating them to stronger products.<sup>4</sup>

- Much smokeless tobacco marketing appeals to youth, and lower taxes on these products make them more affordable. In addition, smokeless tobacco companies have test-marketed their new products, including R.J. Reynolds' first iteration of candy-like Dissolvables, on Hoosiers countless times. It's no wonder then that 13.9% of Indiana high school boys use smokeless tobacco—slightly higher than the national smokeless rate (12.8%).<sup>5</sup>
- Tobacco companies spend billions of dollars each year marketing cigarettes and smokeless tobacco products.<sup>6</sup> In 2008, the most recent year for which data are available, tobacco companies spent more than \$10 billion marketing their products, including an estimated \$307 million in Indiana alone.<sup>7</sup> They clearly don't need Indiana or any other state's help marketing their products.
- There is a direct correlation between perceived harm of tobacco use and prevalence of tobacco use. As perceived harm goes down, prevalence of tobacco use often goes up. Does Indiana really want to deliver a message to kids that smokeless tobacco is not harmful when the tobacco companies are already spending billions of dollars to get them to use their tobacco products?

### **Reducing Tobacco Use in Indiana**

- Everyone except the tobacco companies and their supporters wants to see tobacco use and its harms reduced. Of course, the best way to reduce harm is to stop youth initiation and encourage and help all tobacco users to quit.
  
- We know from the science what strategies work to prevent kids from starting to smoke or use smokeless and encourage and help adult users to quit. They include:
  - Higher tobacco taxes
  - Smoke-free laws
  - Funding for tobacco prevention and cessation programs, and
  - Public and private health plan coverage for tobacco cessation.
  
- Indiana has put some of these strategies in place and is thus making progress in reducing tobacco use, but it can do much more to accelerate progress based on strategies that have an evidence base:
  - Indiana's tobacco tax, at just under a dollar (\$0.995), is roughly 50 cents below the national average (\$1.49) and ranks 32<sup>nd</sup> in the country. An increase in the tobacco tax is one of the most effective ways to reduce tobacco use in Indiana. We estimate that a \$1 increase in Indiana's cigarette tax would prevent more than 50,000 Indiana kids from becoming smokers and encourage more than 35,000 adult smokers to quit, saving more than 25,000

tobacco caused deaths and more than \$1.5 billion dollars in health care costs.

- Indiana ranks 24<sup>th</sup> in the nation when it comes to funding tobacco prevention, spending just 12.8% of what the CDC recommends for tobacco prevention and cessation programs.<sup>8</sup> Instead of cutting its tobacco prevention program, as Indiana has done in recent years, the state should invest more of its \$600 million in tobacco tax and settlement revenue in its program, which is working, and not divert resources and attention to approaches that lack evidence.
- New this year, Indiana passed a smoke-free law that covers most public places and workplaces. However, smoking continues to be permitted in some spaces, such as bars. Comprehensive smoke-free laws that cover all workplaces, restaurants and bars not only protect everyone from the harms of secondhand smoke but encourage smokers to quit and help them succeed in doing so.<sup>9</sup>

Before engaging in any harm reduction strategies that have little, if any, evidence behind them, Indiana can put in place those strategies outlined above that have a strong evidence base. These harm reduction strategies are a distraction from what works, and that is exactly why the tobacco industry is pushing them. Their own documents outline a strategy for diminishing funding for tobacco prevention funding.<sup>10</sup>

## Harm Reduction

The tobacco companies and their allies are suggesting that, because not all smokers have quit, we should promote smokeless tobacco as a less harmful alternative. They are taking their case to state governments, as here in Indiana, to enlist their help in the harm reduction agenda.

Again, the best harm reduction is to not use tobacco products AT ALL. While harm reduction strategies should not be dismissed outright, they must be conducted only after being subjected to rigorous scientific scrutiny. There are many reasons the state of Indiana (and other states) should not engage in this strategy as the tobacco companies and their allies are suggesting.

- There is little, if any, evidence that smokeless tobacco is effective at helping smokers quit. The 2008 Update of the U.S. Public Health Service Clinical Practice Guidelines regarding tobacco cessation concluded, **“the use of smokeless tobacco products is not a safe alternative to smoking, nor is there evidence to suggest that it is effective in helping smokers quit.”**<sup>11</sup> In fact, many new smokeless tobacco products are being marketed as a way to get a nicotine fix when smokers cannot smoke. Such marketing discourages smokers from taking the one step that is sure to protect their health, which is to quit smoking entirely. Far from reducing the harm from smoking, this kind of marketing perpetuates harm. In addition, a 2009 study found that it was more likely for American smokeless tobacco users to switch to cigarettes than for smokers to switch to smokeless.<sup>12</sup>

- **If tobacco companies want to claim that a product is less harmful, the federal Family Smoking Prevention and Tobacco Control Act (the Tobacco Control Act), passed by huge bipartisan majorities in both houses of Congress in 2009, provides a formal path for them to do so through the Food and Drug Administration (FDA).** Tobacco product manufacturers may make modified risk claims about their products, but appropriately, only after they have demonstrated conclusively to the FDA that these products, as marketed, will benefit public health.<sup>13</sup> This critical standard takes into account not only whether the product is less harmful as used by the individual, but also that any reduction in harm to the individual is not offset by the impact on more wide-spread initiation and cessation that comes from marketing the claim.
- This is admittedly a high standard for modified risk claims, but it is more than justified. Given the tobacco industry's history of marketing so-called reduced harm cigarettes like light cigarettes (which they knew were no less harmful but could be used to keep smokers smoking<sup>14</sup>), it is critical that any modified risk claim or other harm reduction strategy meet the public health standard.
- Moreover, we know that smokeless tobacco products have been marketed to promote youth initiation and to discourage cessation by offering smokers a "nicotine bridge" for those places where they cannot smoke. This makes the public health standard even more important. Even if smokeless tobacco is less harmful, if marketing it that way only serves to

initiate more into tobacco use and discourage quitting, there will be no benefit to public health.

- If the tobacco companies want to promote smokeless tobacco or anything else as a smoking cessation product, they can apply through the FDA just like other cessation products by demonstrating with science that their products are a safe and effective way to quit smoking. If the evidence is anywhere near what they claim, this should not present a problem for them. And while they complain about the costs of doing so, know that they spend over \$10 billion marketing their products and countless other dollars on lobbying and other efforts to stop those strategies that do work to reduce smoking. Even if they don't have the money, a small price increase would easily bring in additional revenue. Every other smoking cessation product goes through this process; the makers of the products that kill people should bear at least this much responsibility.
- By asking Indiana and other states to pursue a harm reduction strategy for them, tobacco companies are attempting to circumvent the FDA Tobacco Control Act and its provisions on modified risk claims. If they want to pursue such a strategy, the tobacco companies should use their own resources to meet the standards in the Tobacco Control Act.
- Tobacco harm reduction is a complicated and risky strategy that currently lacks an evidence base, and it will require resources to develop and evaluate that evidence base. It is incumbent on the tobacco companies to

produce the evidence base if they wish to pursue such a strategy, and the FDA's new Center for Tobacco Products has the resources and authority to review and evaluate applications for modified risk claims.

- Indiana's resources and taxpayer dollars SHOULD NOT be used to the tobacco companies' bidding in this area, especially when the tobacco companies and the FDA already have the resources and the authority to pursue this strategy to the degree that it is merited. It is doubtful that any state agency has the resources to evaluate harm reduction strategies with the rigor that is demanded to protect public health.
- You will hear a lot about how smokeless tobacco has been successful as a harm reduction strategy in Sweden. Aside from the fact that these data are not conclusive and that Indiana isn't exactly Sweden, you should also know that, unlike in the U.S., Sweden has very strict controls on how the product is manufactured and that marketing of the product is NOT ALLOWED.<sup>15</sup> If a harm reduction strategy were ever pursued in the U.S., there would need to be strict product standards (which U.S. states are preempted by federal law from enacting), rigorous review of the science to ensure a public health benefit, and strict limits on marketing. Proponents of harm reduction are promoting none of these things, nor do states have the resources, capacity, or authority to pursue them.
- With more than 9,500 Hoosiers dying from tobacco use every year and over \$2 billion spent treating tobacco-caused disease each year in the state,<sup>16</sup>

Indiana should use its resources and taxpayer dollars on those tobacco prevention and cessation strategies that are based in science rather than on those lacking evidence. This is the best way to reduce the dramatic toll that tobacco takes on the health and economy of Indiana. The last thing we need to do is use Indiana taxpayer dollars to help tobacco companies market their deadly products to our kids.

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<sup>1</sup> U.S. Department of Health and Human Services (HHS), *The Health Consequences of Using Smokeless Tobacco: A Report of the Advisory Committee to the Surgeon General*, Bethesda, MD 20892, NIH Publication No. 86-2874, April 1986, <http://profiles.nlm.nih.gov/NN/B/B/F/C/>.

<sup>2</sup> See also Campaign for Tobacco-Free Kids Factsheet, *Health Harms from Smokeless Tobacco Use*, and the references therein, at <http://www.tobaccofreekids.org/research/factsheets/pdf/0319.pdf>.

<sup>3</sup> HHS, *The Health Consequences of Using Smokeless Tobacco: A Report of the Advisory Committee to the Surgeon General*, Bethesda, MD 20892, NIH Publication No. 86-2874, April 1986, <http://profiles.nlm.nih.gov/NN/B/B/F/C/>. National Institutes of Health (NIH), National Cancer Institute (NCI), *Smoking and Tobacco Control Monograph 2: Smokeless Tobacco or Health: An International Perspective*, September 1992, [http://cancercontrol.cancer.gov/tcrb/monographs/2/m2\\_complete.pdf](http://cancercontrol.cancer.gov/tcrb/monographs/2/m2_complete.pdf). HHS, Public Health Service, National Toxicology Program, *Report on Carcinogens, Eleventh Edition*, January 31, 2005, <http://ntp.niehs.nih.gov/index.cfm?objectid=32BA9724-F1F6-975E-7FCE50709CB4C932>. World Health Organization (WHO) Scientific Advisory Committee on Tobacco Product Regulation, Scientific Advisory Committee on Tobacco Product Regulation Recommendation on Smokeless Tobacco Products, 2003. Fiore, MC, et al., *Treating Tobacco Use and Dependence: 2008 Update*, U.S. Public Health Service Clinical Practice Guideline, May 2008, [http://www.surgeongeneral.gov/tobacco/treating\\_tobacco\\_use08.pdf](http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf).

<sup>4</sup> "The Marketing of Nicotine Addiction by One Oral Snuff Manufacturer," *Tobacco Control* 4(1), Spring 1995. Freedman, AM, "How a Tobacco Giant Doctors Snuff Brands to Boost Their Kick," *The Wall Street Journal*, October 26, 1994.

<sup>5</sup> CDC, *Youth Risk Behavior Surveillance System—United States 2011*. <http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf>

<sup>6</sup> U.S. Federal Trade Commission (FTC), *Cigarette Report for 2007 and 2008*, 2011, <http://www.ftc.gov/os/2011/07/110729cigarettereport.pdf>. FTC, *Smokeless Tobacco Report for 2007 and 2008*, 2011, <http://www.ftc.gov/os/2011/07/110729smokelesstobaccoreport.pdf>. Data for top 6 manufacturers only.

<sup>7</sup> See Campaign for Tobacco-Free Kids factsheet, *State-Specific Tobacco Company Marketing Expenditures 1998 to 2008*.

<sup>8</sup> CDC, *Best Practices for Comprehensive Tobacco Control Programs*, Atlanta, GA: U.S. Department of Health and Human Services (HHS), October 2007, [http://www.cdc.gov/tobacco/tobacco\\_control\\_programs/stateandcommunity/best\\_practices](http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices).

<sup>9</sup> See Campaign for Tobacco-Free Kids factsheets on smoke-free laws and secondhand smoke at [http://www.tobaccofreekids.org/facts\\_issues/factsheets/policies/secondhand\\_smoke/](http://www.tobaccofreekids.org/facts_issues/factsheets/policies/secondhand_smoke/).

<sup>10</sup> <http://legacy.library.ucsf.edu/tid/ayg53a00/pdf>

<sup>11</sup> Fiore, MC, et al., *Treating Tobacco Use and Dependence: 2008 Update*, U.S. Public Health Service Clinical Practice Guideline, May 2008, [http://www.surgeongeneral.gov/tobacco/treating\\_tobacco\\_use08.pdf](http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf).

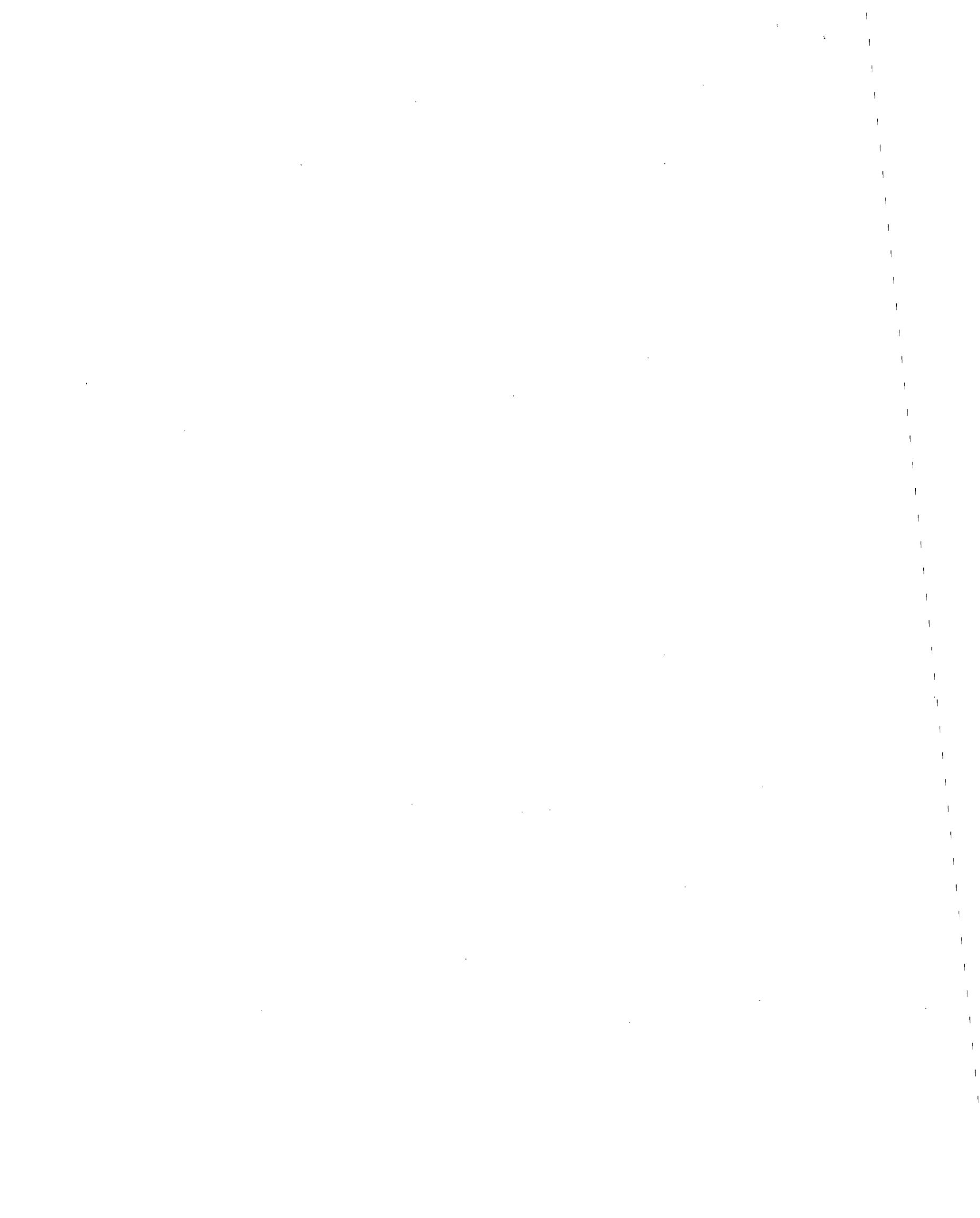
<sup>12</sup> Zhu, S-H, et al., "Quitting Cigarettes Completely or Switching to Smokeless Tobacco: Do U.S. Data Replicate the Swedish Results?" *Tobacco Control* 18(2):82-7, April 2009.

<sup>13</sup> U.S. Food and Drug Administration, Modified Risk Tobacco Products, <http://www.fda.gov/TobaccoProducts/Labeling/TobaccoProductReviewEvaluation/ucm304465.htm>

<sup>14</sup> NCI, *Risks Associated with Smoking Cigarettes with Low Machine-Yields of Tar and Nicotine; Report of the NCI Expert Committee*. National Institutes of Health. National Cancer Institute. Smoking and Tobacco Control Monograph 13.

<sup>15</sup> Data from Swedish website established by the Swedish Cancer Society, the National Institute of Public Health, the Heart-Lung Foundation and Doctors against Tobacco. Sweden National Tobacco Act (1993:581), Section 14, <http://www.sweden.gov.se/content/1/c6/08/62/43/ea7210ac.pdf>.

<sup>16</sup> See Campaign for Tobacco-Free Kids factsheet, *The Toll of Tobacco in Indiana*.



## Richard Feldman: Big tobacco lures new generation of addicts

indystar.com

### Exhibit 14

Health Finance Commission  
Meeting #2, Sept. 19, 2012

"Hook 'em early, hook 'em for life."

This is a quote from an internal tobacco industry document regarding their marketing strategy: Find new young tobacco users to replace smokers who continually die prematurely of tobacco-related diseases.

What a great business to be in: the profitable business of addiction.

Smoke-free laws have swept the nation with 29 states and hundreds of municipalities enacting smoking bans. It's rapidly becoming socially unacceptable to smoke in enclosed public places including worksites, restaurants and bars. What is a smoker to do in these hostile times?

The tobacco industry has the answer for maintaining the next generation of tobacco-addicted people to preserve big profits for the corporations and their stockholders. What is this industry to do in these changing times?

Its response is new innovative tobacco products. No longer can the tobacco industry rely on cigarette sales with youth smoking rates dropping, the national adult smoking rate sinking to an all-time low of less than 20 percent, and overall cigarette consumption plummeting.

The initial objective of the industry in a sinking smoking-tobacco market: Encourage new fun ways for young people to smoke. Sweetened cigars and cigarillos in multiple flavors including mint, apple, wine, chocolate, vanilla honey and cherry have hit the market in a big way. Sales of cigarillos and little cigars have increased 150 and 240 percent respectively since 1997. Product names include Swisher Sweets, Captain Black, and Black and Mild. These products are subject to lower tobacco taxes and have fewer marketing restrictions than do cigarettes. They offer, especially to youth to whom they are marketed, a novel and cheaper alternative to cigarettes. And since these diminutive cigars are easier to inhale, they are a great starter product to initiate the novice smoker. A safer alternative? Cigars are highly associated with heart disease, various other illnesses and a variety of cancers, including oral cancer. If little cigars are inhaled, the smoker is at risk for the full range of maladies associated with cigarettes including lung cancer.

The federal legislation establishing the FDA regulation of tobacco banned similar products of candy and fruit-flavored cigarettes in September 2009. Unfortunately, the legislation did not specifically include small cigars, cigarillos and other sweetened smokeless tobacco products.

The industry response also includes new generations of smokeless tobacco. Products are also sweetened and flavored to appeal to youth. Snus is a spitless tobacco packaged in small teabag-like pouches and placed between the lip and gum. Marlboro and Camel are two popular snus brands.

Other innovations in smokeless tobacco are finely milled sweetened and flavored tobaccos that dissolve in the mouth called Camel Orbs, Sticks, and Strips. Produced by RJ Reynolds, all look and taste like candy, making them appealing to children. Since each piece contains up to three times the nicotine of a cigarette, eating these products like candy could result in nicotine poisoning. This is especially true with toddlers who may find these sweet products and ingest them. They too are not safe alternatives to

smoking; we know that smokeless tobacco carries significant increased risks for various cancers and other ailments.

Of course, tobacco-friendly Hoosierland was chosen to be a test market for snus and dissolvable tobacco products. Devised by the dark tobacco industry empire, these new ways to ingest carcinogens, toxins and nicotine underscore the necessity for the FDA regulatory powers over tobacco products.

Legislation has been introduced in Congress that would diminish the FDA's authority over some of these alternative tobacco products. If enacted, this legislation would only serve to facilitate the tobacco industry's efforts to maintain adult nicotine dependence and lure our children into a lifetime of addiction.

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It is evident that tobacco products are harmful to those who use them as well as to people who come in contact with users. The state of Indiana has realized that this is a serious problem and has taken measures to reduce the harm caused by tobacco. While the efforts put forth by Indiana have been very positive and enterprising, there needs to be more focus on developing effective educational programs that teach children about the harms of tobacco in order to de-normalize common misconceptions and prevent youth from ever using.

Many states across the United States have focused on passing laws that limit citizen's exposure to tobacco. Among these are Illinois with the Smoke Free Illinois Act, Michigan with the Dr. Ron Davis Smoke-Free Air Law, and Ohio with the Smoke Free Workplace Program (Illinois 2008, MCDH 2012, ODH 2008). The state of Indiana has kept up with this trend of protecting its residents from being harmed by tobacco through limiting where smoking can take place. Indiana's new statewide smoking ban, officially entitled House Enrolled Act No. 1149, or the Smoke Free Air Law, went into effect on July 1, 2012. This expansive piece of legislation prohibits smoking in most public spaces and places of employment, as well as in state-owned vehicles and school buses. It also prohibits smoking within eight feet of an entrance of a public place or place of employment (ISDH 2012). While these acts are incredibly positive first steps in reducing the harm caused by tobacco and reducing citizen's unwanted exposure to tobacco products, it is important that more be pursued. In order to substantially diminish the negative effects of tobacco use, the focus must now be placed on reducing the number of people who use tobacco. Even though tobacco exposure will now be limited, people are still going to be exposed to its harmful effects. If the state of Indiana can get to a place where no one is using these products, then no one can be harmed by them.

In addition, Indiana is taking another positive step to administer tobacco harm-reduction strategies to reduce smoking-attributable death and disease. One significant avenue being taken to achieve this goal is through the 2015 Indiana Tobacco Control Strategic Plan which has developed several tobacco harm reduction strategies. These include encouraging the use of e-cigarettes and nicotine patches, promoting education for youth in schools, implementing smoke-free initiatives, among other strategies (ITPC 2009).

One substantial harm-reduction strategy that has already been implemented is encouraging the use of e-cigarettes as a substitute for regular cigarettes. E-cigarettes address the addiction to both the habit of smoking and that of nicotine while having less harmful effects than regular cigarettes (Noll-Marsh 2009). Although this product is useful in reducing the harm of tobacco, it is not accessible to all people. E-cigarettes have expensive start-up costs and market towards older consumers (Nitzkin 2009). This product addresses priority number three, decreasing adult rates of smoking, of the 2015 Indiana Tobacco Control Strategic Plan, but there is still much to be done for those who are younger and for those who cannot afford to purchase products such as the e-cigarette.

As seen here, many accomplishments have been made in the state of Indiana to reduce the negative effects that tobacco has on its citizens. However, now these first steps must be taken further. It is not enough to brush the surface of harm-reduction strategies. The reason individuals are getting sick and dying from exposure to tobacco products is because people continue to use these products every day. Here, Indiana has the opportunity to become a leader among the United States in protecting its citizens from the harms of tobacco. In order to do this, Indiana should now focus its attention on reducing the number of people who use tobacco products by developing effective tobacco education programs for children and implementing the harm-reduction strategy of promoting education for youth in schools.

Indiana's need to focus on educational programs is justified by the appalling statistics regarding youth and tobacco. Centers for Disease Control and Prevention (CDC) found that each day, roughly 3,800 children try smoking for the first time. For one thousand of these children, the day they first try a cigarette will be the start of them smoking on a daily basis and more than half will ultimately die as a result of this habit (CDC 2012). Youth are key in de-normalizing tobacco use, as reducing the number of them influenced into trying tobacco products drastically cuts down on the number of adult users in future years. It is essential that Indiana give great attention to educating youth through effective prevention programs, seeing as those who have the highest tobacco-use rates are among those least likely to be reached through school-based programs (Glynn 1991).

States that implemented tobacco prevention programs in schools have seen a drastic decrease in the percentage of youth who use tobacco.

For example, after introducing prevention programs in schools across the state, New York saw a decline in cigarette use of 68.6% among middle school students and 53.5% of high school students, resulting in 168,000 fewer youth smokers. From 1997 to 2011, the number of Maine high school students who used tobacco dropped 61% after a tobacco prevention program was executed through the state's schools. When Indiana made the responsible choice to put prevention programs into practice, the state witnessed a drop in tobacco use for high school students from 31.6% to 17%. The percentage of middle school tobacco users decreased to 4% from 9.8% (Campaign 2012).

While drastically reducing the number of high school and middle school students that use tobacco products is a huge accomplishment for Indiana, the state needs to take into consideration ways to increase the effectiveness of educational programs already in place and set valuable guidelines for the future. One program aspect shown to work is teaching students how to be media literate. Informed youth are able to see how the tobacco industry relies on recruiting them to replace the numerous tobacco users who die each year. Also, extremely successful programs are those that make the negative consequences of tobacco use relatable to the lives of youth. When connections are made, youth can visualize how using tobacco could hinder any future goals they have. One final part of program success is tailoring programs to accommodate the diverse needs of the students attending programs (CDC 2010). Youth from a rural town in Indiana have different needs to be addressed than youth from an inner-city school in the northwest.

The efforts by Indiana to reduce the harm tobacco has on citizens is noticeable and encouraging. To continue to significantly reduce the negative effects of tobacco, the state must substantially reduce the number of people who use tobacco. In order to accomplish this, focus must turn to developing effective educational programs that teach youth about the harms of tobacco and de-normalize ideas children might hold about tobacco use. By putting attention on the youngest generation and reducing the number of children who ever use tobacco products, the harms and negative effects caused by this substance will be greatly reduced and the health of Indiana will flourish.

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