STATE OF INDIANA
State House, Second Floor
Indianapolis, Indiana 46204

August 23, 2010

Governor Mitch Daniels
200 W. Washington Street
Indianapolis, IN 46204

Dear Governor Daniels:

This letter provides an update regarding our progress in evaluating the impact of the Affordable Care Act (ACA). The Family and Social Services Administration (FSSA), Indiana Department of Insurance (IDOI), and other agencies, have analyzed ACA and its impact on Hoosiers. The analysis is on-going, requires significant effort and consumes already limited resources. Therefore, as we proceed in the long term, resources dedicated to other state functions must be diverted to support implementation. Our efforts to thoroughly evaluate ACA's impact are impeded by the lack of federal guidance and issuance of regulations, leaving us with more questions than answers.

The following issues have been identified that need to be addressed at the State level and may require legislative changes. The budget impact is potentially significant, and the State will have to identify a way to pay for the new ACA costs. Because of the budget impact and various deadlines imposed upon States by ACA, many changes must be addressed during the 2011 Legislative Session in order to effectuate on January 1, 2014, as the 2012-2013 fiscal year budget will be formulated. This list is not exclusive, as we anticipate issues to continue to arise.

The below table summarizes the projected impact and potential full exposure to the State's budget resulting from the ACA as of May 21st, 2010. Projections change as more information becomes available and since May, the potential budgetary impact of Spend-down and SSI Eligible category has been increased to $670 million. As we know you are aware, the potential budgetary impacts of the ACA are of significant concern.

Table 1: State Budget Fiscal Impact–SFY 2011 through SFY 2020

Item	Alternate Participation	Full Participation
Medicaid Assistance Expansion to 138%	$972.4 million	$1,330.3 million
Impact of Reduced FMAP on HIP Eligibles	482.5 million	482.5 million
Spend-down and SSI Eligible	670.0 million	670.0 million
Pharmacy Rebate Loss	298.0 million	298.0 million
Physician Fee Schedule Increase to 80% Medicare	600.1 million	831.8 million
Foster Children – Expansion to Age 26	14.8 million	14.8 million
Administrative Expenses	232.5 million	302.5 million
CHIP Program – Enhanced FMAP	(195.2) million	(195.2) million
Breast and Cervical Cancer Program	(14.2) million	(14.2) million
Pregnant Women> 138% FPL	(46.8) million	(46.8) million
Total	$3,041.1 million	$3,673.7 million

Funding: The overarching concerns for agencies are cost and capacity. The Milliman analysis outlined the key cost drivers and the estimate through calendar year 2020 is now projected to be between $3.0 and 3.7B for Hoosier taxpayers. Administrative costs are a part of this estimate and are projected to be between $233 and $303M over ten years. This estimate includes IDOI's implementation cost of $3.44M. As more information concerning the responsibilities and requirements upon IDOI is known, the estimate is expected to increase. From the information technology systems changes that are needed for the Medicaid program to the additional staffing costs to support these initiatives and the new regulatory requirements, the estimates underscore the significant impact to our agencies to conduct the implementation. At this time, the federal government has not offered any details on support for these initiatives. While some grant funding is available, it is not specific to our needs and does not provide long-term funding. We are also reviewing current State spending on health programs to identify potential savings that could be redirected to pay for the $3.0-3.7B cost that is mandated by ACA.

Medicaid Expansion: ACA significantly expands the Medicaid program to all individuals to approximately 138% of the federal poverty level (FPL) in 2014. This will translate into Medicaid coverage for 1 in 4 Hoosiers and will cost the State between $972M-1.3B over ten years. For individuals earning between 138% and 400% of FPL, ACA provides subsidies to purchase commercial insurance through the Exchange(s). The new structure of the expansion has significant and broad implications for Indiana's current health care programs. The patchwork of Indiana's public health programs has evolved over decades in response to federal funding opportunities and the identification of gaps in health care coverage for various populations and disease conditions. ACA's broad Medicaid expansion challenges the current Medicaid categories and requires examination of our current health programs as comprehensive public and private coverage becomes available in 2014 along with the individual mandate. These programs include, but are not limited to, the Medicaid spend down program, HIP, Medicaid pregnancy only coverage, the Children's Health Insurance Program (CHIP), the Indiana Comprehensive Health Insurance Association (the State's high risk pool) and the Breast and Cervical Cancer Program. Restructuring should be considered to ensure Indiana tax payer dollars do not duplicate federal programs and to identify savings that may be used to support the State's new obligations.

Healthy Indiana Plan (HIP): On May 17, FSSA sent a letter to the Centers for Medicare and Medicaid Services (CMS) requesting additional guidance regarding the future of the Healthy Indiana Plan (HIP). While we have had a conference call with CMS, we were not given any official guidance, and they have promised to respond officially. HIP is a home-grown program that works for Indiana and is the natural vehicle to provide coverage for Hoosiers who become Medicaid eligible under ACA's expansion. We hope that the federal government will allow Indiana to continue its innovative POWER account and other successful aspects of the program. However, minor benefit changes need to be made to bring HIP in line with ACA benchmark benefits requirements. Because CMS has failed to release the ACA benchmark guidelines, we cannot be more specific as to which benefits. Additionally, eligibility for HIP should be reviewed since some HIP eligible Hoosiers may also be eligible for federal subsidies in 2014 to purchase commercial health insurance.

Pharmacy Rebates: As you know, States collect federally required Medicaid rebates from drug manufacturers in exchange for allowing their products to be provided to program beneficiaries. Many states—including Indiana—have worked tenaciously to negotiate additional rebates, known as state supplemental rebates, on top of those that are federally required. Unfortunately for Indiana, the ACA changes the Medicaid rebate rules for prescription drugs by increasing the minimum amount of federal rebates required from pharmaceutical companies effective January 1, 2010 and requires States to return to the federal government 100 percent of the additional increase. This significant change is estimated to cost Indiana $298M through 2019. To date, the federal government has not indicated any kind of financial relief to States after the confiscation of these dollars. While they point to new savings generated by allowing new rebates for managed care populations, this does not apply to Indiana because last year's pharmacy carve out and consolidation already gleaned these savings.

Disproportionate Share (DSH) Payment Reductions: As a result of ACA legislation, DSH payments to hospitals will steadily and dramatically decrease. This could result in a loss of up to $200M annually for the State. In addition, the Indiana Hospital Association estimates that Indiana hospitals will experience steep cuts in Medicare reimbursements rates estimated at $256M annually starting in 2010 and rising each subsequent year. While ACA assumes that everyone will have insurance and therefore DSH and Medicare payments will be less important to hospitals, ACA does not fully address the fact that access-to-insurance does not equal coverage. Many, especially young people, may choose to pay the taxes and not acquire mandatory insurance coverage. Undocumented immigrants will still not be covered. Hospitals will continue to be reliant upon dwindling DSH payments and it is well documented that government payments for Medicare and Medicaid do not fully cover the costs of care. ACA does not address how States should handle the consequences of this reduction of payments as the bill does not bend the cost curve in a meaningful way; it simply cuts payments to providers. Additionally, since ACA has made childless adults a categorical eligible population, the continued diversion of our DSH funding to support the HIP program may be in jeopardy. No guidance has been provided by CMS.

Eligibility system: Currently, Indiana plans to replace the Indiana Client Eligibility System (ICES), and is in the process of procuring a planning vendor to assist us in this process. Our current system is 17 years old. This implementation will be critical to the improvements we are making in the modernized eligibility system. However, the new system is not expected to be operational until 2015, a full year after the implementation. In addition, the system will need to accommodate more than 500,000 new Medicaid recipients and as many as 1.4M individuals if the eligibility system is used to process tax subsidies for the Exchange. Meanwhile, ACA not only requires that States use a new eligibility formula (modified gross adjusted income or MAGI), but that States also run both the old and new eligibility processes to determine the different federal matching funds. This will create significant effort and investment for the State and changes must be made to the current system that will later be replaced. No details on the method for calculating MAGI have been provided by the federal government, leaving us unable to predict the complexity and costs. We are gravely concerned about the increase in volume of the new potential Medicaid beneficiaries and the cost of supporting this increased volume.

Insurance Compliance: Due to mandated changes to health plans, IDOI will require all carriers to include a certification of compliance with ACA provisions with their submissions. This will remove the burden of policy review for those mandated benefits specific to ACA and allow policy analysts to remain focused on policy review for compliance with Indiana laws. Also, all approved filings will contain the following statement: "This Department has approved this filing with the certification of the carrier that all portions specific to ACA are compliant. Any policy form issued with this approval that conflicts with the ACA standards, effective September 23, 2010 and thereafter, must be administered consistently with the minimum requirements of such ACA standards. Failure to comply with said ACA standards after certification could result in immediate cessation of use of this product and additional penalties as determined by IDOI."

Medical Loss Ratio (MLR) & Insurance Premiums: Questions remain regarding the definition of MLR. This is one of the most critical elements to health reform as it impacts not only how premiums are calculated and when rebates will be required, but also how insurers will perform (or if they will perform) many functions currently provided as standard services. Insurers in the small group and individual market will be expected to provide rebates to their customers if their MLRs are lower than the established thresholds starting in 2012. If the definition is not correctly determined, there will be a dramatic decline of insurer options to the public which may very likely result in higher insurance premiums, a lower standard of care and increased fraudulent activity. The outcome of this debate has significant implications for small insurance carriers in Indiana. The MLR requirements for individual plans may be so stringent that companies will exit the individual marketplace. Indiana has already received two confirmations of companies that will no longer participate in the individual market. The potential loss of insurers from the Indiana market reduces choices and competition and could drive provider reimbursement lower. We are also concerned about the impact of all the reforms on insurance premiums in Indiana. The requirement to provide health insurance to dependents to age 26, the new preventive services requirement, elimination of annual and lifetime maximums and new rating restrictions is sure to collectively raise premiums for Hoosiers. A recently completed internal review by Humana indicated that within the next year the changes in ACA will be directly responsible for a 2% to 4% increase in their policy premiums.

Health System Infrastructure: It is anticipated that pent-up demand will create access issues for consumers following the expansion of coverage. Recent reports on the Massachusetts individual mandate confirm this presumption. The ACA does very little to address workforce needs despite its dramatic coverage expansion. Providing a health insurance card will not translate into health care coverage for the uninsured without an adequate health workforce and infrastructure capacity. Indiana residents could face difficulties getting appointments with doctors and as a result, emergency rooms may be clogged diverting providers away from true emergencies. The ACA contains some grant programs to address capacity and infrastructure needs, and we will be reviewing these opportunities with the Indiana State Department of Health.

Medicaid clients in particular could face significant access issues under reform because provider rates were not addressed by ACA. Medicaid provider rates have historically been underfunded. We fear that with the influx of newly insured entering the marketplace, providers will be more selective about the patients they see, and Medicaid beneficiaries will face difficulty finding providers that will accept their coverage. While the ACA did provide some rate increases for

primary care providers, these last for only two years and leave States with the choice of finding funding to continue the increase or to slash rates.

Health Care Exchanges: The centerpiece of the ACA is the creation of Health Care Exchanges, which may be run federally, by the State or by a non-profit contracted by the State. Information from HHS regarding Exchanges has been scant; however, we continue to research options. HHS has the availability of an Exchange Planning grant up to $1 million per state and we are prepared to submit a proposal for these funds. While the timeline and deadlines to establish Exchanges are not far away given the complexity of the implementation approaching, the federal government has not released any guidelines on Exchange requirements making our analysis very difficult. In addition, there is little experience with State Exchanges, and there are only two established health Exchanges in the nation. At this time, we continue to research this issue, its impact on cost and quality of and access to health insurance products, and the costs to the State to set up and maintain an Exchange.

ACA Grants: There are grant opportunities available to States under ACA; however, definitive information regarding the use of grant dollars remains vague in many cases. Close scrutiny must be applied to each grant request to determine if it is in the best interest of Indiana. We have applied for some grants and continue to be vigilant about leveraging federal dollars for Indiana. However, many grants have "strings attached," may require State match or provide initial funding but do not address long-term sustainability, meaning Indiana taxpayers would pay the bill to keep these programs going once the grant funding ends.

ACA may be a federal act, but much of the responsibility and cost of implementation falls to the States. Many of the requirements amount to unfunded mandates to States at a time when they can be least afforded. We still await the necessary federal guidance to move forward with our implementation. However, with interagency cooperation and State guidance, we are prepared to fulfill our responsibilities to the citizens of Indiana.

Sincerely,

Anne W. Murphy
Secretary, Family & Social Services Administration

Stephen W. Robertson
Executive Director and Acting Commissioner, Department of Insurance