Senate Bill 461

HEALTH AND PROVIDER SERVICES
JANUARY 19, 2011

Senate Bill 461

- Protects & Positions the State to minimize the funding impact of the ACA.
- Insurance Provisions.
- Medicaid Changes.

Insurance Provisions

SB461 - Dependent Age 26

- Upon request of the policyholder or certificate holder, Ind. Code § 27-8-5-28 provides that a policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child under 24 years.
- In order to comply with ACA, the age limit is raised to 26 years.

SB461- Preexisting Condition Exclusions for Enrollees Under Age 19

- Enrollee under age 19 cannot be denied benefits or enrollment based on preexisting condition.
  - Except individual grandfathered plans, which must enroll a dependent under age 19 upon the request of the insured, but may continue to waive coverage for preexisting conditions for a period of time consistent with Indiana law.
  - Not a requirement that carriers offer child-only coverage.

SB461 - Prohibiting Rescission of Coverage

- Rescission: Treating insurance contract as if it never existed.
  - Provide 30 day notice to each participant who would be affected before coverage may be rescinded.
- Rescission is only permitted if an individual committed fraud or made an intentional misrepresentation of a material fact.

SB461 - External Review

- Provides for an individual to seek an external review if he or she has sought and subsequently has been denied coverage.
- Requires Independent Review Organizations (IROs) conducting external reviews to keep records not less than three (3) years.
- Extends the amount of time a complainant has to file for an external review from 45 days to 120 days.
  - IDOI is concurrently seeking a waiver from HHS because its external review statutes are in substantial compliance with federal requirements.

Medicaid Provisions

SB461 - HIP Changes

- Effective January 1, 2014:
  - Use HIP as the Medicaid ACA expansion vehicle instead of the traditional Medicaid program.
  - Gives Secretary the authority to make benefit modifications to align with ACA requirements. ACA could increase benefit costs 10-15% depending on final CMS rules.
  - Eligibility alignment to reduce of duplication of federal program.

HIP Results

- Currently 21%, or 8,900 HIP members are not required to make POWER account contributions.
- Last year, Milliman studied 6 months of HIP enrollment data and indicated a significant decrease in non-emergent utilization of the ER by those making POWER account contributions.
  - Contributors: 9% decrease in ER use in 3 months.
  - Contributors: 15% decrease in ER use after 6 months.
  - Non-contributors: Initial 5% decline in 3 months and no additional decline thereafter.
- Recently, using the first 2 years of program data, Mathematica has verified Milliman's results.
- Members making contributions had lower inappropriate ER use as compared to those not making contributions.

SB461– HIP Changes

- Effective immediately:
  - Amend code to require individuals to make a minimum contribution of not less than $60 annually.
  - State POWER account savings not substantial, but could drive down premium costs.
  - Allow nonprofit organizations to contribute no more than 50% of the individual's required payment.
  - Health plans may contribute if related to health improvement.

POWER Accounts: Average Monthly Contributions

Average POWER Account Contributions

FPL	Monthly 2008	Monthly 2009	Monthly 2010	Average Annual Contribution (2008 – 2010)
<=100%	$12.49	$13.14	$14.29	$159.65
101% - 125%	$33.43	$34.30	$36.02	$414.98
126% - 150%	$51.11	$52.53	$55.04	$634.72
>150%	$69.49	$71.12	$70.86	$845.89

POWER Accounts: Number Who Were Disenrolled for Failure to Pay the Monthly Contribution

FPL Level	Number Who Failed to Pay Subsequent Payment
Total	1,835 (3%)
<22% FPL	81
23 to 51% FPL	249
51 to 101% FPL	755
101 to 151% FPL	549
> 151% FPL	201

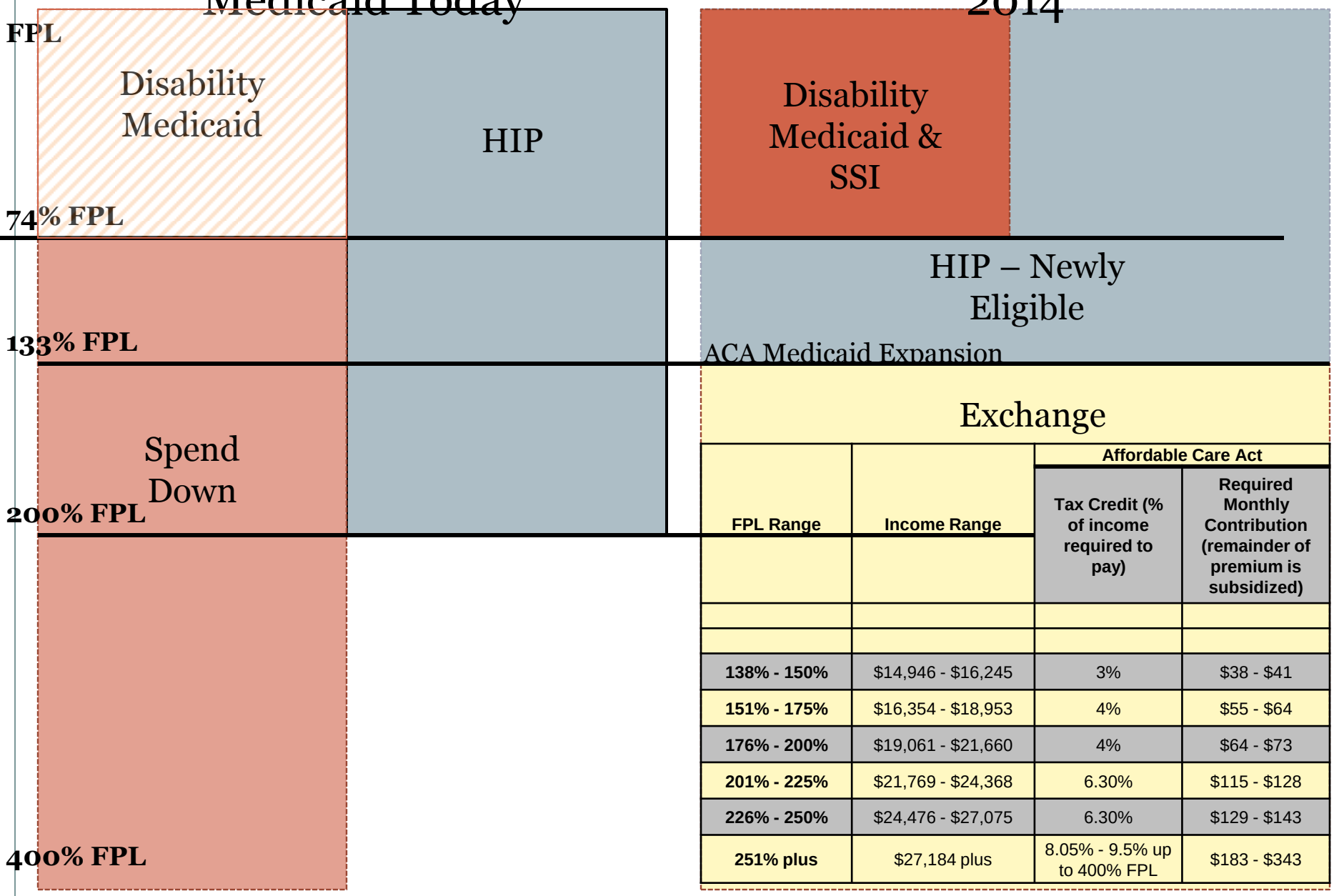
N = 61,797 HIP members as of December 2009

*Information from HIP CMS Annual Report – year 2 (2008 – 2009 combined)

SB461– Medicaid Disability Changes

- 209b vs. 1634
- Spend Down Program (MAC recommendation)

Current Medicaid	2014
< 74% FPL 23,000 SSI individuals not on Medicaid	<74% FPL All individuals below 133% become eligible for Medicaid, including 23,000 SSI recipients not on Medicaid today
74% FPL – 133% disabled individuals are on Spend Down	74-133% receive full Medicaid benefits
> 133% FPL- Spend Down	> 133% FPL tax credits to purchase a product on the Exchange



FPL Range	Income Range	Affordable Care Act	
		Tax Credit (% of income required to pay)	Required Monthly Contribution (remainder of premium is subsidized)
138% - 150%	$14,946 - $16,245	3%	$38 - $41
151% - 175%	$16,354 - $18,953	4%	$55 - $64
176% - 200%	$19,061 - $21,660	4%	$64 - $73
201% - 225%	$21,769 - $24,368	6.30%	$115 - $128
226% - 250%	$24,476 - $27,075	6.30%	$129 - $143
251% plus	$27,184 plus	8.05% - 9.5% up to 400% FPL	$183 - $343