Health Finance Committee
Update on Federal Health Initiatives

Nationalhealthcare.in.gov
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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%

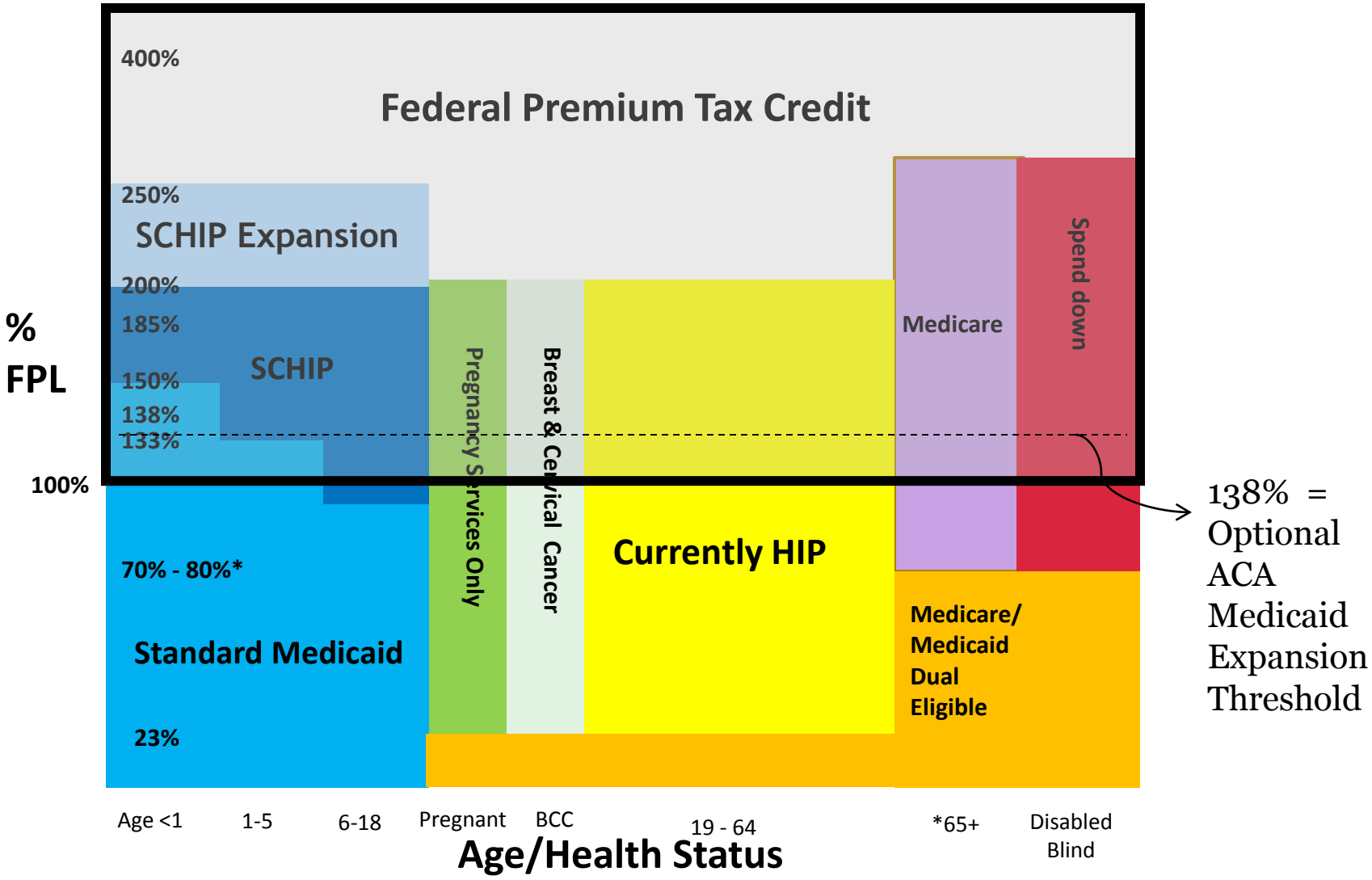
Implications of SCOTUS Decision

- 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

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

FPL	<100% FPL	100% FPL to 138% FPL	139% FPL to 200% FPL	201% FPL to 399% FPL	>400% FPL
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.

Enrollment Projections Under ACA Expansion Standards SFY 2015

Scenarios	SFY 2015 Projected Enrollment	SFY 2015 Full Enrollment
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

Projections SFY 2014 to 2020*	October 2010 Projection: Alternate Participation	October 2010 Projection: Full Participation
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)
Total	**$ 2,586.8**	**$ 3,105.1**

Source: Milliman. October 18, 2010. <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

MEDICAID ACA COST IMPACT COMPONENTS: SFY 2014 - SFY 2020				
ACA Cost Components	**Scenario 1: Woodwork**	**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)
Total ACA Cost Increase	**$611.7**	**$1,710.9**	**$2,037.3**	**$2,550.5**
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:

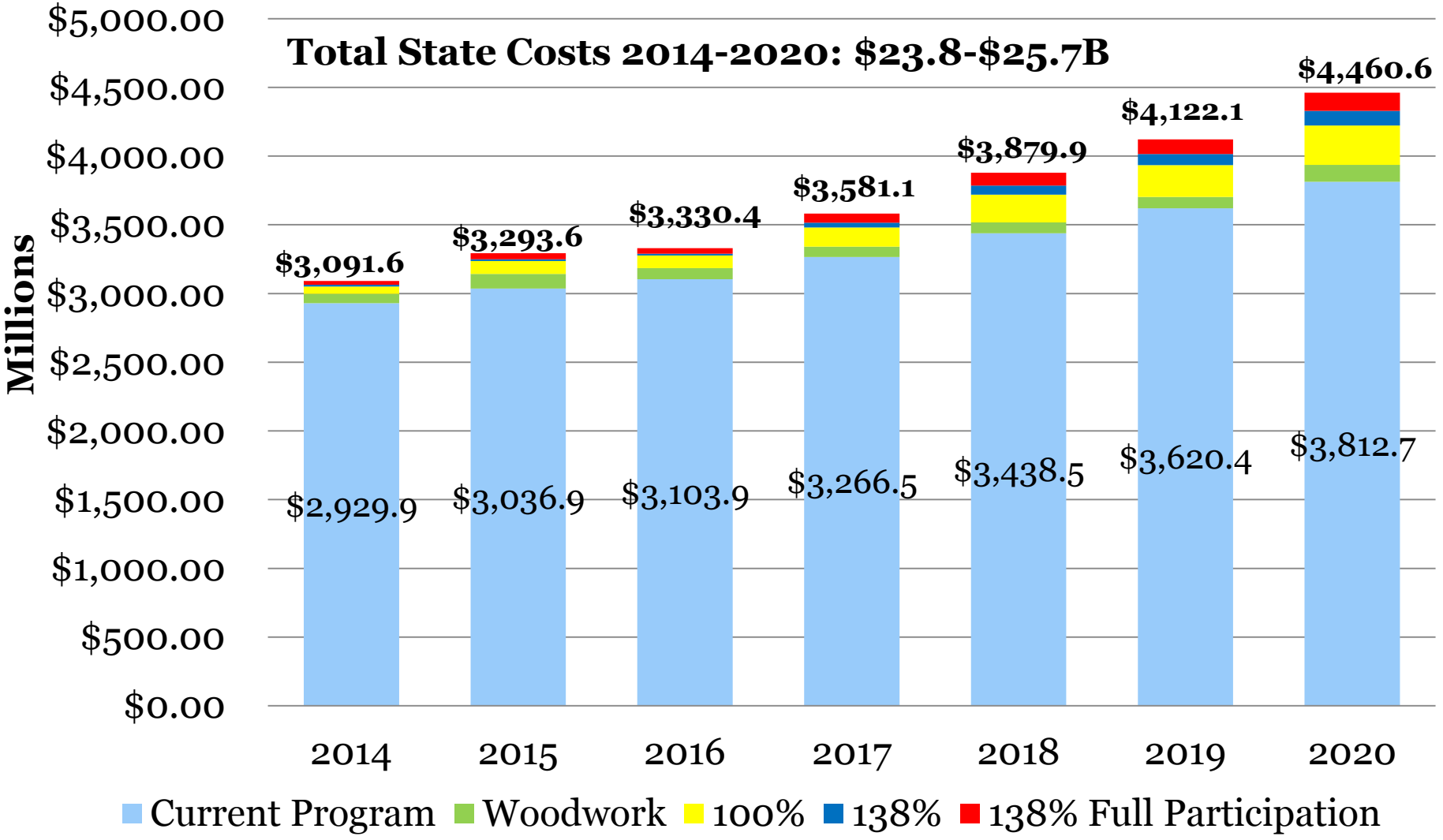
$610 million projected State dollar savings from conversion to 1634 from 209(b)

NOT included in the SFY 2014 - 2020 Baseline Expenditures:

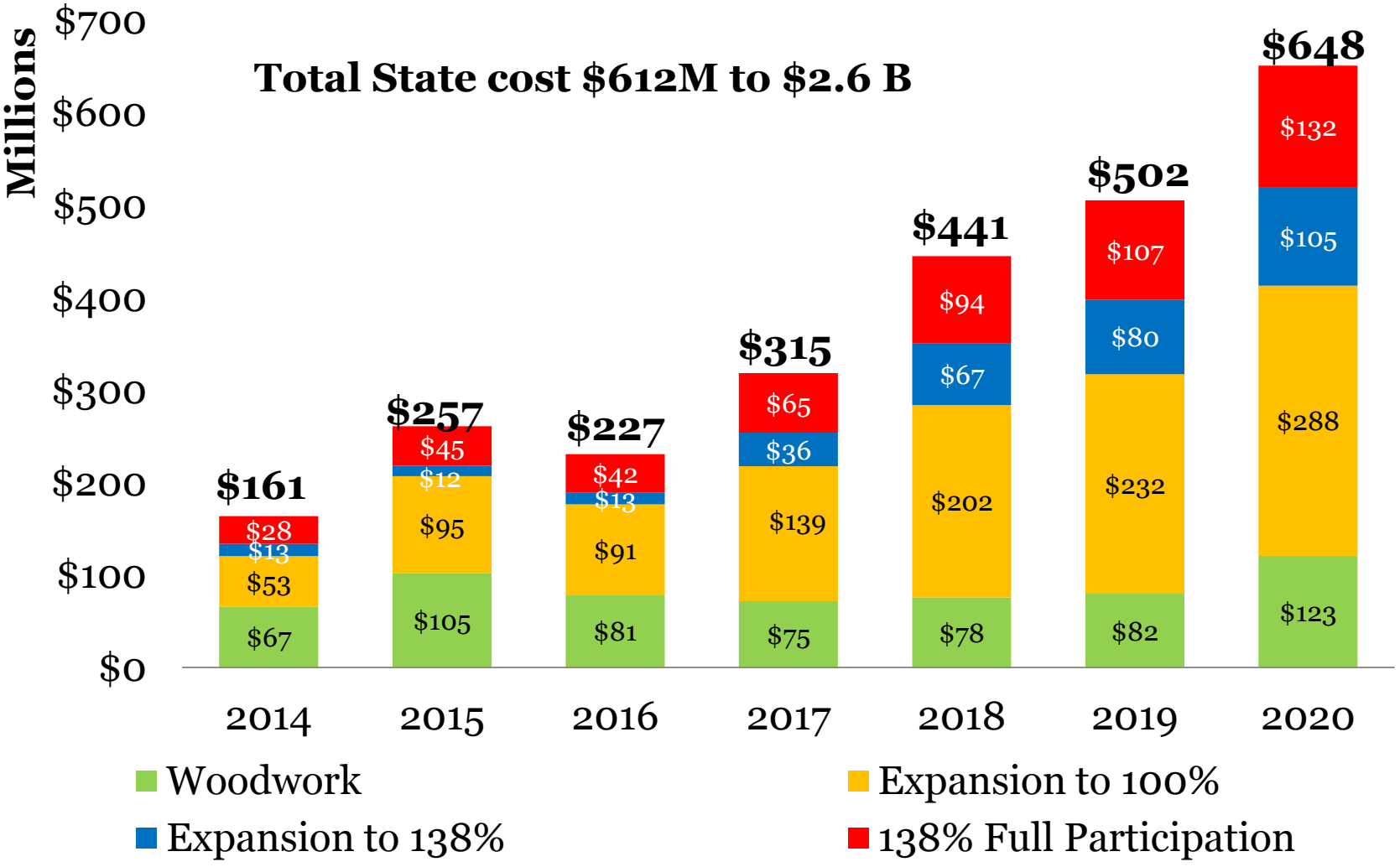
$383 million projected State dollar additional cost if Disabled threshold raised to 100% FPL. Expanding Disabled threshold to 100% FPL would require legislative change

$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

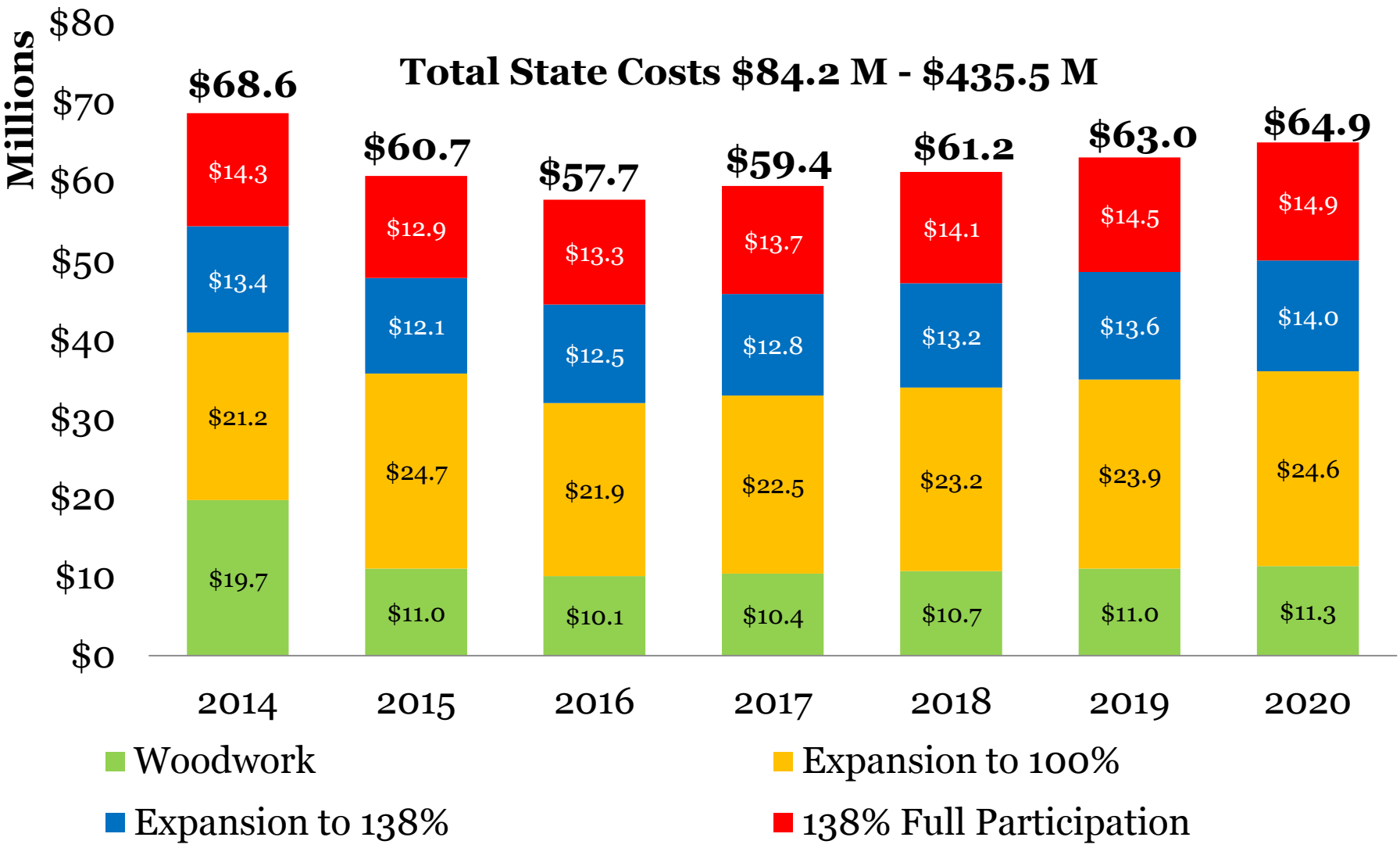


ACA & Expansion State Costs
SFY 2014-2020 *

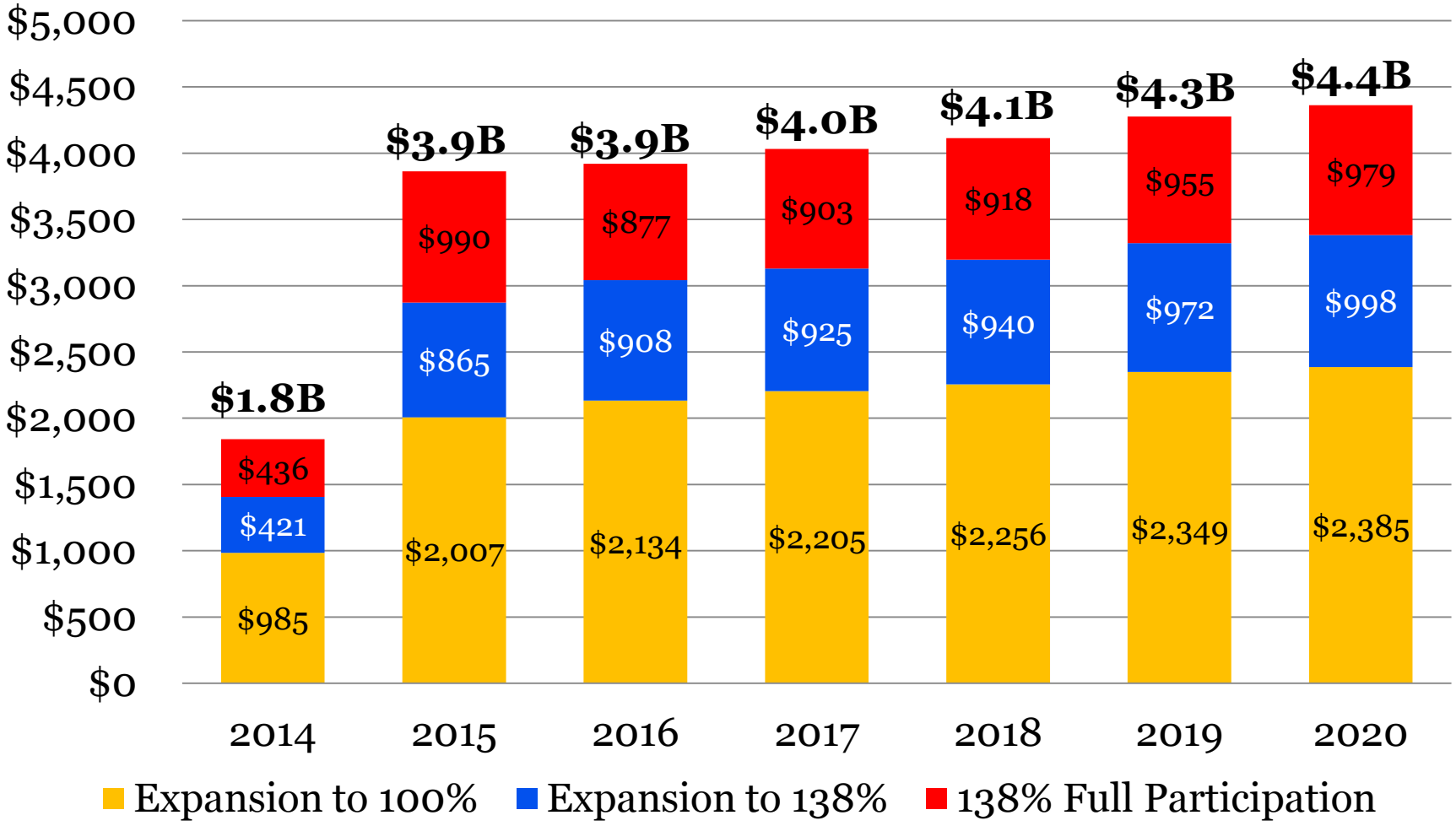


*Includes claims and administrative costs

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



Expansion
Federal Funds: 2014-2020



*Includes claims and administrative funds

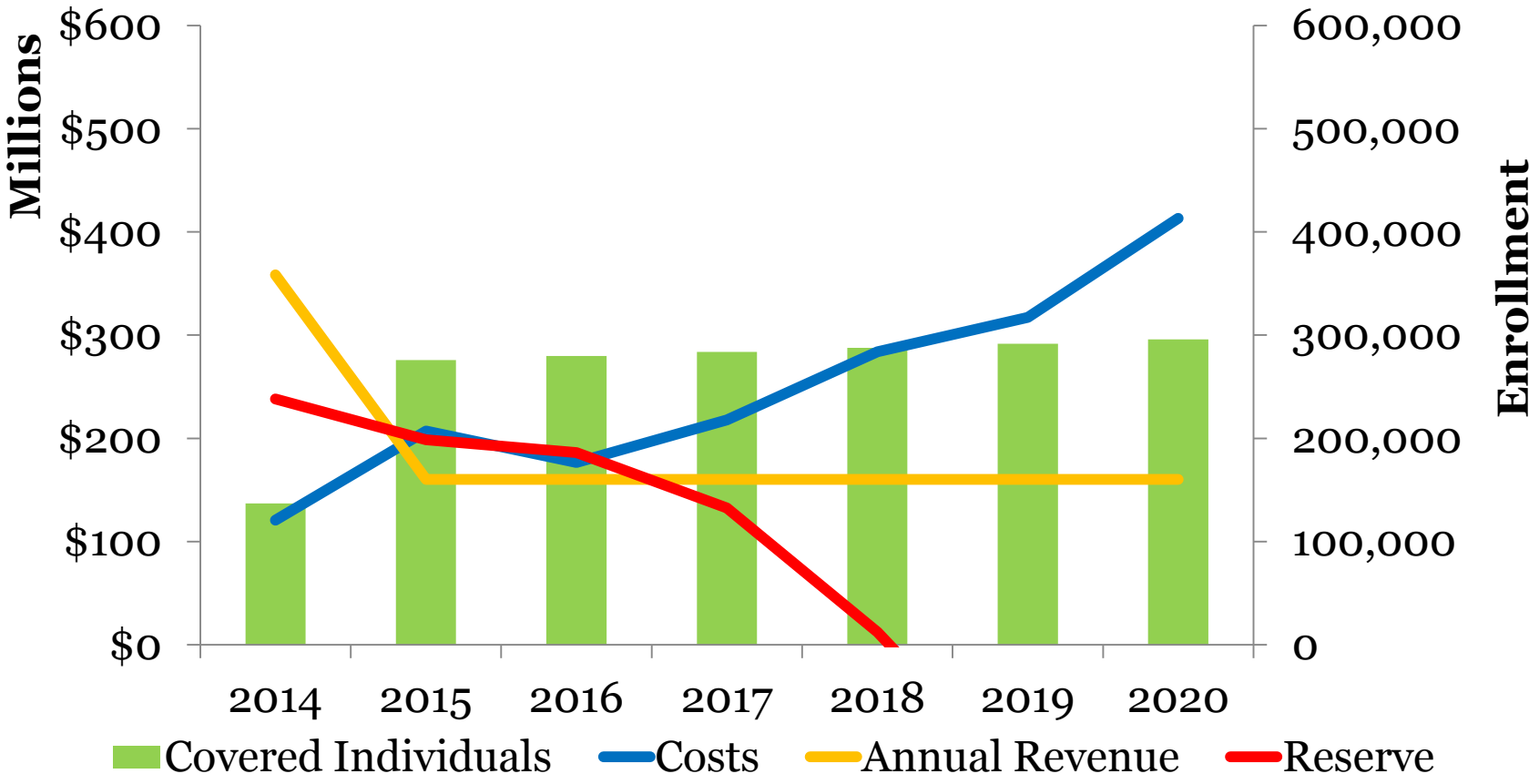
Potential Revenue Sources

- 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*

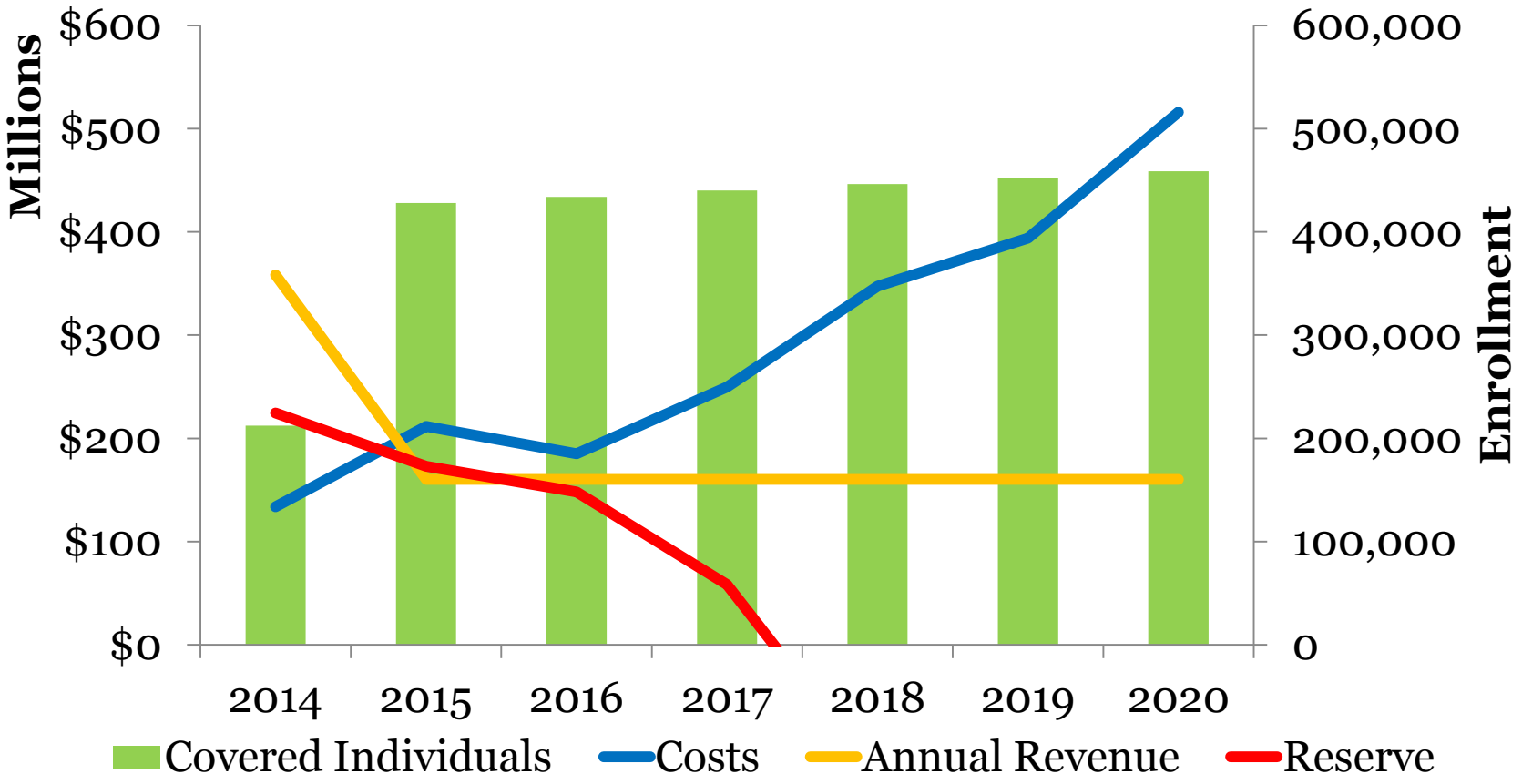
	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	Total
Medicaid Costs and Potential Revenue SFY 2014 to 2020								
Potential Sources of Revenue								
Cigarette Tax	$334.1	$111.6	$111.6	$111.6	$111.6	$111.6	$111.6	**$1,003.7**
ICHIA	$24.3	$48.5	$48.5	$48.5	$48.5	$48.5	$48.5	**$315.3**
Annual Potential Revenue	**$358.4**	**$160.1**	**$160.1**	**$160.1**	**$160.1**	**$160.1**	**$160.1**	**$1,319.0**
ACA Expansion Scenarios - Additional Cost								
Woodwork								
Cost	$67.1	$105.1	$81.2	$74.6	$78.4	$82.2	$123.1	**$611.7**
Potential Revenue Balance	$291.3	$346.3	$425.2	$510.7	$592.4	$670.3	$707.3	**$707.3**
Expansion to 100%								
Additional Cost	$53.2	$94.5	$91.3	$139.0	$201.9	$231.6	$287.5	**$1,099.1**
Cumulative Cost (Woodwork + Expansion to 100%)	$120.4	$199.6	$172.5	$213.6	$280.3	$313.8	$410.6	**$1,710.8**
Potential Revenue Balance	$238.0	$198.5	$186.1	$132.6	$12.4	($141.3)	($391.8)	**($391.8)**
Expansion to 138%								
Additional Cost	$13.4	$12.1	$12.5	$36.2	$67.1	$80.1	$105.2	**$326.5**
Cumulative Cost (Woodwork + Expansion to 138%)	$133.8	$211.7	$185.0	$249.8	$347.4	$393.9	$515.8	**$2,037.4**
Potential Revenue Balance	$224.6	$173.0	$148.2	$58.5	($128.8)	($362.7)	($718.4)	**($718.4)**
Expansion 138% and Full Participation								
Additional Cost	$27.9	$45.0	$41.6	$64.7	$94.1	$107.8	$132.1	**$513.1**
Cumulative Cost (Woodwork + Expansion to 138% at Full Participation)	$161.7	$256.7	$226.6	$314.5	$441.5	$501.7	$647.9	**$2,550.5**
Potential Revenue Balance	$196.7	$100.1	$33.7	($120.7)	($402.1)	($743.7)	($1,231.5)	**($1,231.5)**

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?

Date	Action Item
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

	Without ACA – 2017 Projection	Estimated Exchange Enrollees 2017
Individual Exchange	**Individuals**	**Exchange Enrollees**
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
Total - Individual Exchange	**2,603,109**	**637,919**
SHOP Exchange	**Employees and Dependents**	**SHOP Exchange Enrollees**
Employers with less than 50 Employees	904,441	42,286
Employees with 50 to 99 Employees	202,359	5,603
Total - SHOP Exchange	**1,106,800**	**47,889**
Total - Indiana Exchange 2017	**3,709,909**	**685,810**

Source: SHADAC w/ projected estimated population growth to 2017. Nationalhealthcare.in.gov

HIX Operations & Control

	State-Based HIX	Partnership HIX	Federally-facilitated HIX

State	• State control under federal regulation
	• All Exchange activities responsibility of State:
	  • State Agency or
	  • Not-for-profit
		• Plan Management
		• Consumer Assistance
		• Both
			States Can retain:
			• Reinsurance
			• Medicaid & CHIP eligibility or allow Feds to do it

Federal	State option to defer: • Eligibility for premium tax credits & cost sharing reductions • Mandate exemptions • Risk adjustment • Reinsurance	HHS has ultimate control Option for State: • Medicaid and CHIP eligibility: assessment or determination • Reinsurance	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	• Selects entities • Funds Navigator grants • Call Center, Website • Training • Certification • Ongoing monitoring	• Training • Certification requirements • Ongoing monitoring • May make recommendations to HHS for Navigator selection	No role designated by federal releases. State could potentially pass state-specific Navigator requirements: certification, training, or eligible entities
Federal	No active role.	• HHS funds grants • HHS selects Navigators • Call Center, Website	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

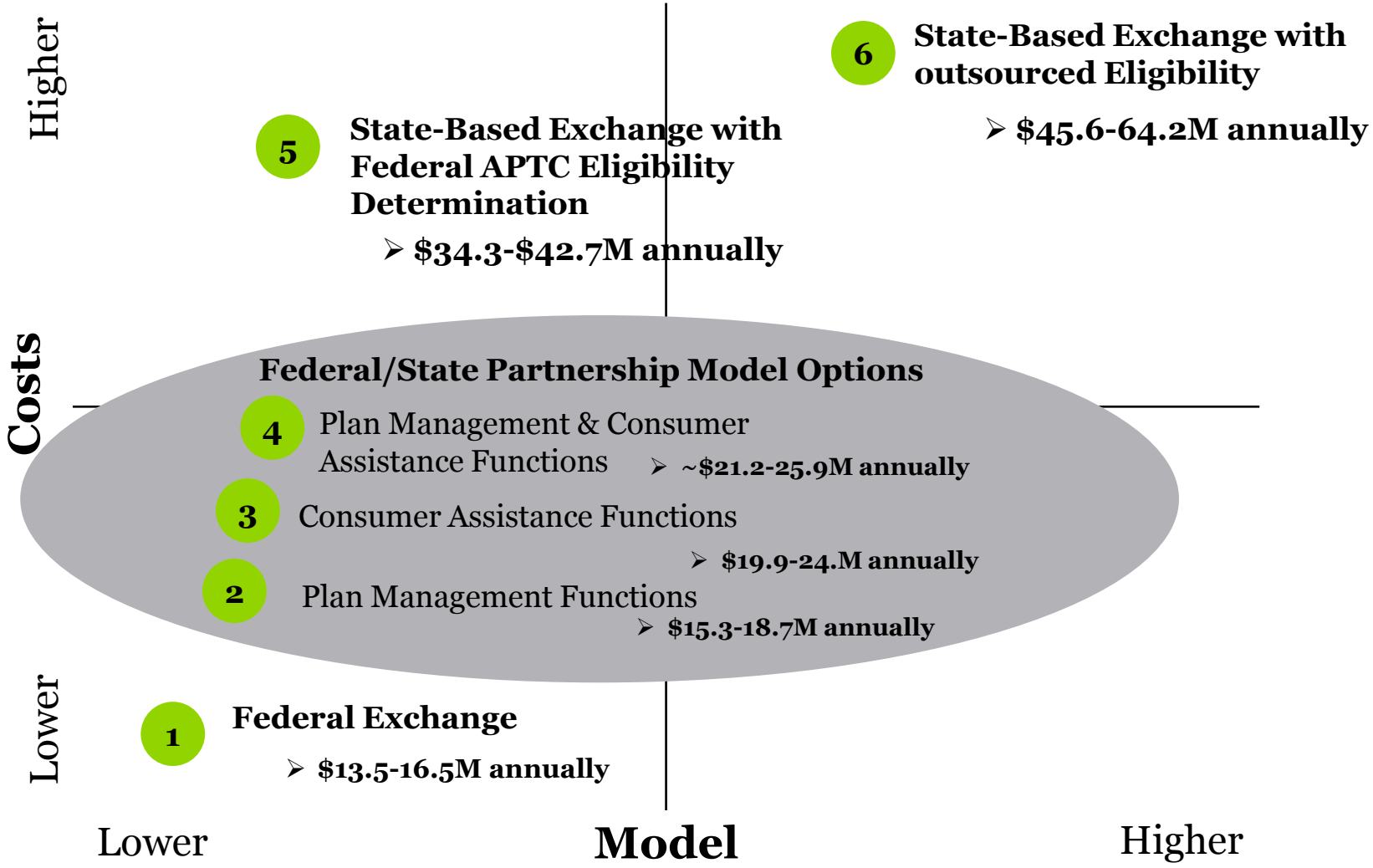
Federal State Partnership: Plan Management Responsibilities

- 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

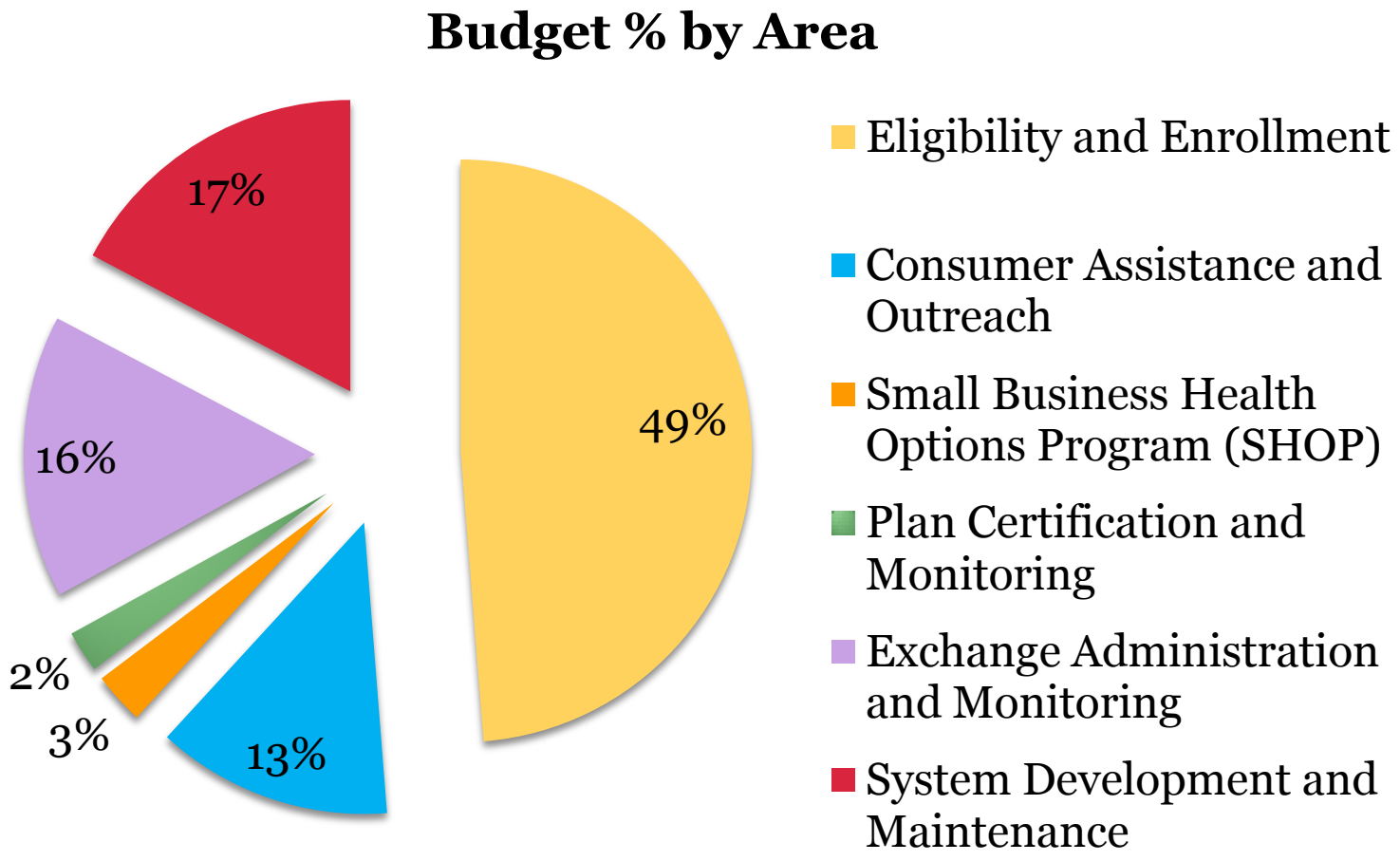
Off-Exchange Plans

- 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?

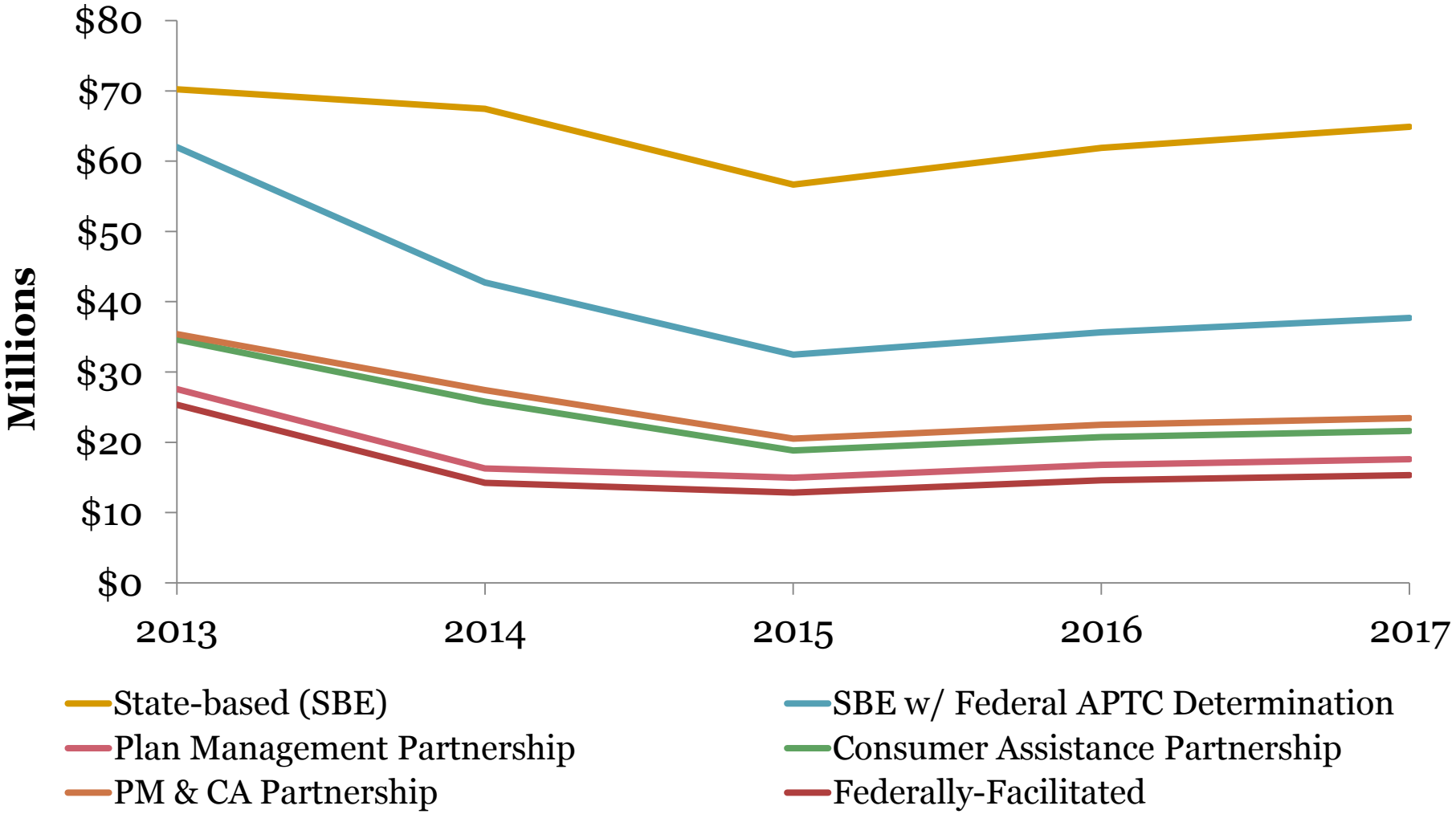
Exchange Models- Annual Average Cost 2013 to 2017



Annual Average State-based Exchange Costs – High Enrollment Scenario

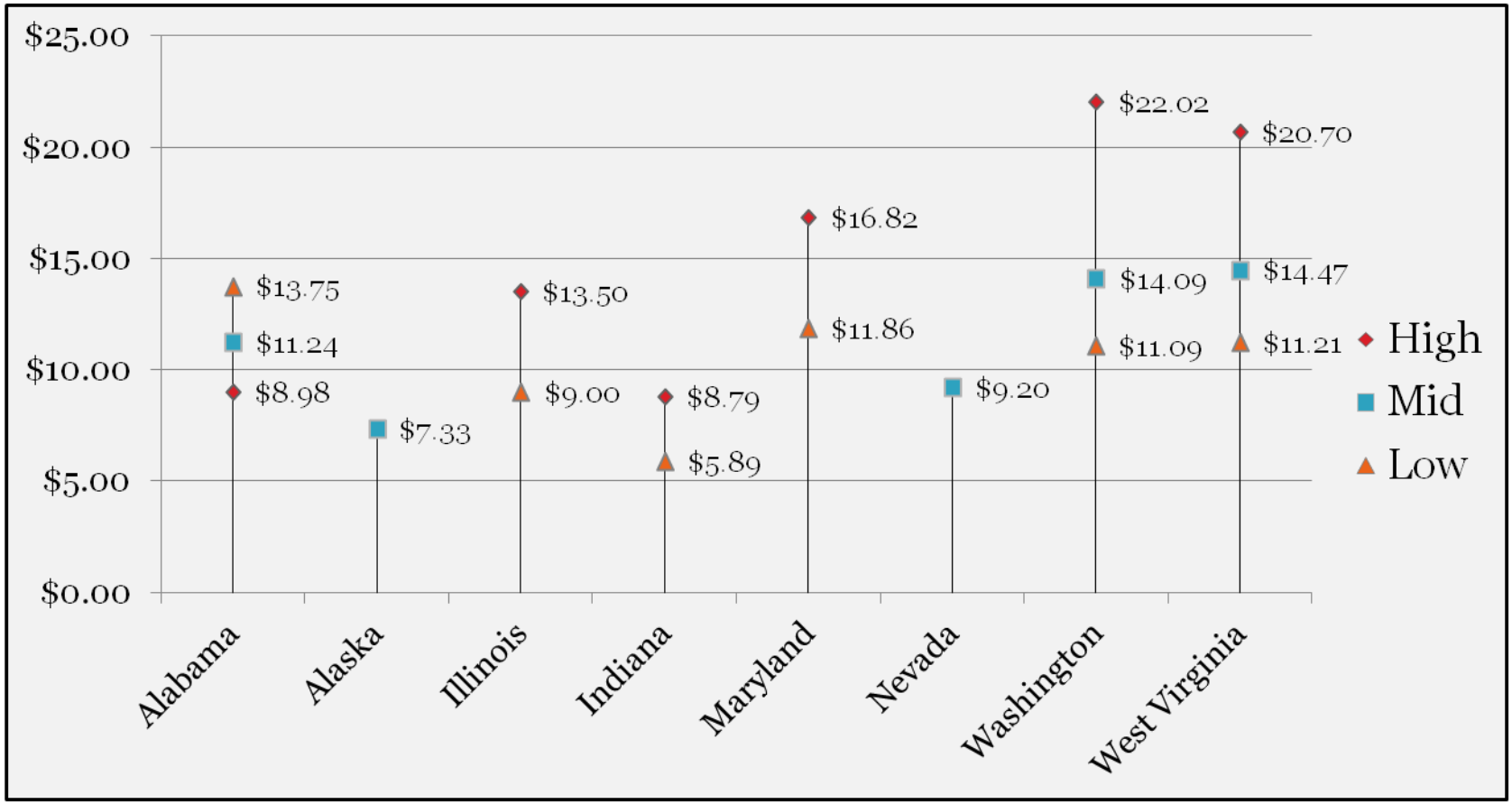


Five-year Exchange Costs*



*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	Options: • Assessment upon insurance carriers •User fees • License/certification fee for Navigators and/or producers • Medicaid cost allocation • Advertising	Cost significantly less than State-based HIX? Will feds pay for State costs? Largely unknown	Federal government has indicated they will likely charge an insurer fee Costs to State unknown

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
• General authority for FSSA and IDOI to work with Exchange • Data sharing between agencies and federal government • HIX governance structure • Financing – assessment on insurers?	• IDOI authority to contract with HIX • Grant authority for state coordination with HIX & HHS on Medicaid and CHIP determinations • Authority for Memorandums of Understanding with HHS	• IDOI authority to contract with HIX • Grant authority for state coordination with HIX and HHS on Medicaid and CHIP determinations • Authority for Memorandums of Understanding

Essential Health Benefits

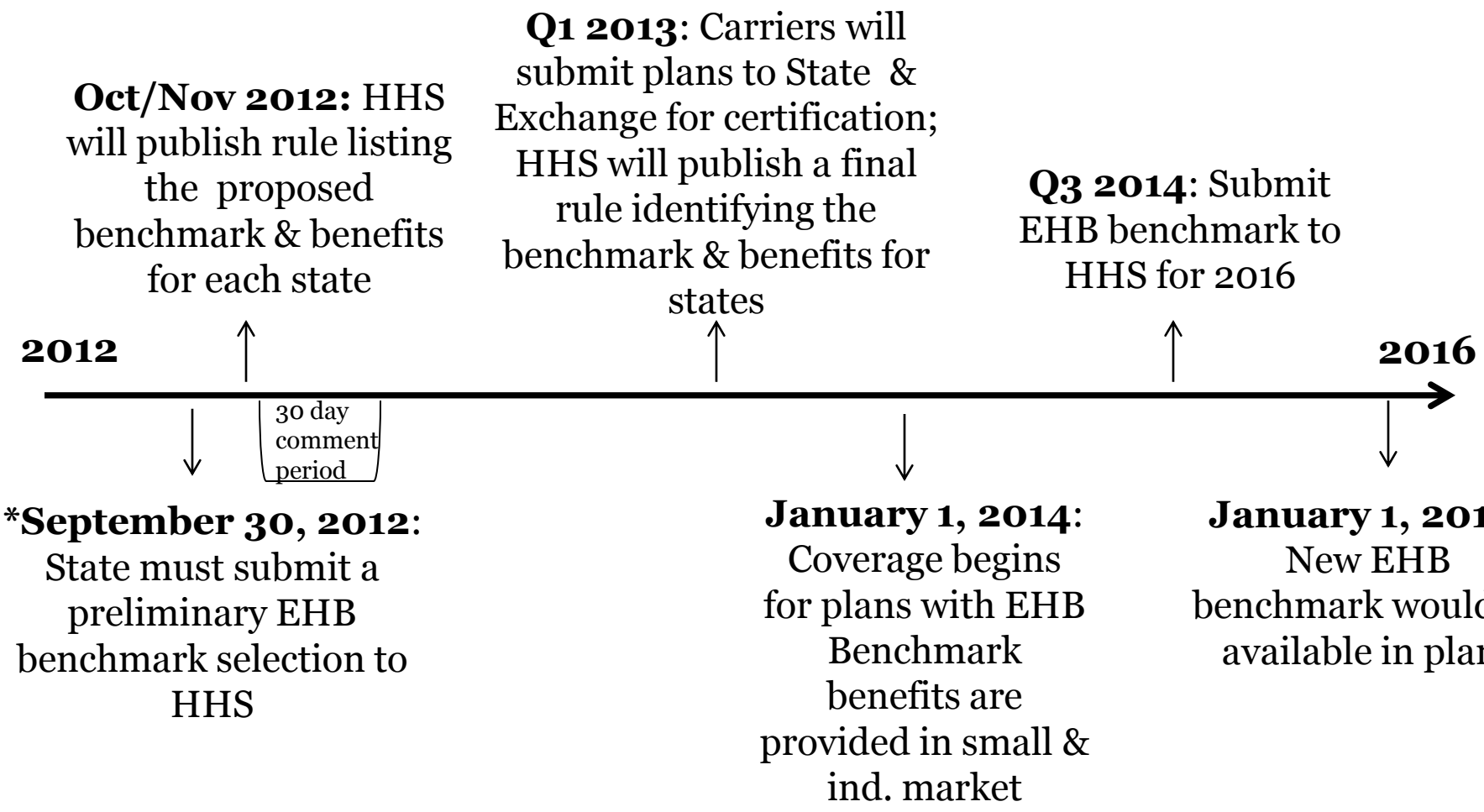
Essential Health Benefit Benchmark

- 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

EHB Timeline



*** This has not been issued in writing by HHS; subject to change.**

Indiana's EHB Benchmark Options

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