

SENATE BILL No. 165

DIGEST OF INTRODUCED BILL

Citations Affected: IC 11-10-3-7; IC 12-7-2; IC 12-15; IC 16-18-2-187.2; IC 16-21-10; IC 27-8-10.1; IC 27-19-2-15; IC 36-2-13-19.

Synopsis: Healthy Indiana plan. Repeals the prior healthy Indiana plan statutes and makes revisions to the currently operating healthy Indiana plan. Repeals statutes governing the high risk Indiana check-up plan.

Effective: July 1, 2016.

Miller Patricia

January 5, 2016, read first time and referred to Committee on Health & Provider Services.



Second Regular Session 119th General Assembly (2016)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2015 Regular Session of the General Assembly.

SENATE BILL No. 165

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 11-10-3-7, AS AMENDED BY P.L.185-2015,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2016]: Sec. 7. (a) If the department or a county incurs medical
4 care expenses in providing medical care to an inmate who is committed
5 to the department and the medical care expenses are not reimbursed,
6 the department or the county shall attempt to determine the amount, if
7 any, of the medical care expenses that may be paid:
8 (1) by a policy of insurance that is maintained by the inmate and
9 that covers medical care, dental care, eye care, or any other health
10 care related service; or
11 (2) by Medicaid.
12 (b) For an inmate who:
13 (1) is committed to the department and resides in a department
14 facility or jail;
15 (2) incurs or will incur medical care expenses that are not
16 otherwise reimbursable;
17 (3) is unwilling or unable to pay for the inmate's own health care



1 services; and
 2 (4) is potentially eligible for Medicaid (IC 12-15);
 3 the department is the inmate's Medicaid authorized representative and
 4 may apply for Medicaid on behalf of the inmate.

5 (c) The department and the office of the secretary of family and
 6 social services shall enter into a written memorandum of understanding
 7 providing that the department shall reimburse the office of the secretary
 8 for administrative costs and the state share of the Medicaid costs
 9 incurred for an inmate.

10 (d) Reimbursement under this section for reimbursable health care
 11 services provided by a health care provider, including a hospital, to an
 12 inmate as an inpatient in a hospital must be as follows:

13 (1) For inmates eligible and participating in the ~~Indiana check-up~~
 14 ~~plan (IC 12-15-44.2)~~; **healthy Indiana plan (IC 12-15-44.5)**, the
 15 reimbursement rates described in ~~IC 12-15-44.2-14~~.
 16 **IC 12-15-44.5-5.**

17 (2) For inmates other than those described in subdivision (1) who
 18 are eligible under the Medicaid program, the reimbursement rates
 19 provided under the Medicaid program, except that reimbursement
 20 for inpatient hospital services shall be reimbursed at rates equal
 21 to the fee-for-service rates described in IC 16-21-10-8(a)(1).

22 Hospital assessment fee funds collected under IC 16-21-10 or the
 23 **healthy Indiana check-up** plan trust fund (IC 12-15-44.2-17) may not
 24 be used as the state share of Medicaid costs for the reimbursement of
 25 health care services provided to the inmate as an inpatient in the
 26 hospital.

27 SECTION 2. IC 12-7-2-137.8, AS ADDED BY P.L.213-2015,
 28 SECTION 126, IS AMENDED TO READ AS FOLLOWS
 29 [EFFECTIVE JULY 1, 2016]: Sec. 137.8. "Phase out period", for
 30 purposes of ~~IC 12-15-44.2~~ and IC 12-15-44.5, has the meaning set forth
 31 in IC 12-15-44.5-1.

32 SECTION 3. IC 12-7-2-140.5, AS AMENDED BY P.L.213-2015,
 33 SECTION 127, IS AMENDED TO READ AS FOLLOWS
 34 [EFFECTIVE JULY 1, 2016]: Sec. 140.5. "Plan", ~~means the following:~~
 35 **for purposes of IC 12-15-44.2 and IC 12-15-44.5, has**

36 (1) For purposes of ~~IC 12-15-44.2~~, the meaning set forth in
 37 ~~IC 12-15-44.2-1~~.

38 (2) For purposes of ~~IC 12-15-44.5~~, the meaning set forth in
 39 IC 12-15-44.5-2.

40 SECTION 4. IC 12-7-2-144.3, AS AMENDED BY P.L.3-2008,
 41 SECTION 91, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 42 JULY 1, 2016]: Sec. 144.3. "Preventative care services", for purposes



1 of IC 12-15-44.2, IC 12-15-44.5, has the meaning set forth in
 2 IC 12-15-44.2-2. IC 12-15-44.5-2.3.

3 SECTION 5. IC 12-15-44.2-1 IS REPEALED [EFFECTIVE JULY
 4 1, 2016]. Sec. 4: As used in this chapter, "plan" refers to the healthy
 5 Indiana plan established by section 3 of this chapter:

6 SECTION 6. IC 12-15-44.2-2 IS REPEALED [EFFECTIVE JULY
 7 1, 2016]. Sec. 2: As used in this chapter, "preventative care services"
 8 means care that is provided to an individual to prevent disease,
 9 diagnose disease, or promote good health.

10 SECTION 7. IC 12-15-44.2-3 IS REPEALED [EFFECTIVE JULY
 11 1, 2016]. Sec. 3: (a) The healthy Indiana plan is established:

12 (b) The office shall administer the plan:

13 (c) The department of insurance and the office of the secretary shall
 14 provide oversight of the marketing practices of the plan:

15 (d) The office shall promote the plan and provide information to
 16 potential eligible individuals who live in medically underserved rural
 17 areas of Indiana:

18 (e) The office shall, to the extent possible, ensure that enrollment in
 19 the plan is distributed throughout Indiana in proportion to the number
 20 of individuals throughout Indiana who are eligible for participation in
 21 the plan:

22 (f) The office shall establish standards for consumer protection;
 23 including the following:

24 (1) Quality of care standards:

25 (2) A uniform process for participant grievances and appeals:

26 (3) Standardized reporting concerning provider performance,
 27 consumer experience, and cost:

28 (g) A health care provider that provides care to an individual who
 29 receives health insurance coverage under the plan shall participate in
 30 the Medicaid program under IC 12-15:

31 (h) The office of the secretary may refer an individual who:

32 (1) has applied for health insurance coverage under the plan; and

33 (2) is at high risk of chronic disease;

34 to the Indiana comprehensive health insurance association for
 35 administration of the individual's plan benefits under IC 27-8-10.1.

36 (i) The following do not apply to the plan:

37 (1) IC 12-15-6:

38 (2) IC 12-15-12:

39 (3) IC 12-15-13:

40 (4) IC 12-15-14:

41 (5) IC 12-15-15:

42 (6) IC 12-15-21:



- 1 (7) IC 12-15-26.
 2 (8) IC 12-15-31.1.
 3 (9) IC 12-15-34.
 4 (10) IC 12-15-35.
 5 (11) IC 12-15-35.5.
 6 (12) IC 16-42-22-10.
- 7 SECTION 8. IC 12-15-44.2-4 IS REPEALED [EFFECTIVE JULY
 8 1, 2016]. Sec. 4: (a) The plan must include the following in a manner
 9 and to the extent determined by the office:
- 10 (1) Mental health care services.
 11 (2) Inpatient hospital services.
 12 (3) Prescription drug coverage, including coverage of a long
 13 acting, nonaddictive medication assistance treatment drug if the
 14 drug is being prescribed for the treatment of substance abuse.
 15 (4) Emergency room services.
 16 (5) Physician office services.
 17 (6) Diagnostic services.
 18 (7) Outpatient services, including therapy services.
 19 (8) Comprehensive disease management.
 20 (9) Home health services, including case management.
 21 (10) Urgent care center services.
 22 (11) Preventative care services.
 23 (12) Family planning services:
 24 (A) including contraceptives and sexually transmitted disease
 25 testing, as described in federal Medicaid law (42 U.S.C. 1396
 26 et seq.); and
 27 (B) not including abortion or abortifacients.
 28 (13) Hospice services.
 29 (14) Substance abuse services.
 30 (15) A service determined by the secretary to be required by
 31 federal law as a benchmark service under the federal Patient
 32 Protection and Affordable Care Act.
- 33 (b) The plan may do the following:
 34 (1) Offer coverage for dental and vision services to an individual
 35 who participates in the plan.
 36 (2) Pay at least fifty percent (50%) of the premium cost of dental
 37 and vision services coverage described in subdivision (1).
- 38 (c) An individual who receives the dental or vision coverage offered
 39 under subsection (b) shall pay an amount determined by the office for
 40 the coverage. The office shall limit the payment to not more than five
 41 percent (5%) of the individual's annual household income. The
 42 payment required under this subsection is in addition to the payment



1 required under section 11(b)(2) of this chapter for coverage under the
2 plan:

3 (d) Vision services offered by the plan must include services
4 provided by an optometrist.

5 (e) The plan must comply with any coverage requirements that
6 apply to an accident and sickness insurance policy issued in Indiana.

7 (f) The plan may not permit treatment limitations or financial
8 requirements on the coverage of mental health care services or
9 substance abuse services if similar limitations or requirements are not
10 imposed on the coverage of services for other medical or surgical
11 conditions:

12 SECTION 9. IC 12-15-44.2-5 IS REPEALED [EFFECTIVE JULY
13 1, 2016]. Sec. 5: (a) The office shall provide to an individual who
14 participates in the plan a list of health care services that qualify as
15 preventative care services for the age, gender, and preexisting
16 conditions of the individual. The office shall consult with the federal
17 Centers for Disease Control and Prevention for a list of recommended
18 preventative care services:

19 (b) The plan shall, at no cost to the individual, provide payment for
20 not more than five hundred dollars (\$500) of qualifying preventative
21 care services per year for an individual who participates in the plan.
22 Any additional preventative care services covered under the plan and
23 received by the individual during the year are subject to the deductible
24 and payment requirements of the plan:

25 SECTION 10. IC 12-15-44.2-6 IS REPEALED [EFFECTIVE JULY
26 1, 2016]. Sec. 6: To the extent allowed by federal law, the plan has the
27 following per participant coverage limitations:

28 (1) An annual individual maximum coverage limitation of three
29 hundred thousand dollars (\$300,000):

30 (2) A lifetime individual maximum coverage limitation of one
31 million dollars (\$1,000,000):

32 SECTION 11. IC 12-15-44.2-7 IS REPEALED [EFFECTIVE JULY
33 1, 2016]. Sec. 7: The following requirements apply to funds
34 appropriated by the general assembly to the plan:

35 (1) At least eighty-five percent (85%) of the funds must be used
36 to fund payment for health care services:

37 (2) An amount determined by the office of the secretary to fund:

38 (A) administrative costs of; and

39 (B) any profit made by;

40 an insurer or a health maintenance organization under a contract
41 with the office to provide health insurance coverage under the
42 plan. The amount determined under this subdivision may not



1 exceed fifteen percent (15%) of the funds.

2 SECTION 12. IC 12-15-44.2-8 IS REPEALED [EFFECTIVE JULY
3 1, 2016]. Sec. 8: The plan is not an entitlement program. The maximum
4 enrollment of individuals who may participate in the plan is dependent
5 on funding appropriated for the plan.

6 SECTION 13. IC 12-15-44.2-9 IS REPEALED [EFFECTIVE JULY
7 1, 2016]. Sec. 9: (a) An individual is eligible for participation in the
8 plan if the individual meets the following requirements:

9 (1) The individual is at least eighteen (18) years of age and less
10 than sixty-five (65) years of age.

11 (2) The individual is a United States citizen and has been a
12 resident of Indiana for at least twelve (12) months.

13 (3) The individual has an annual household income of not more
14 than the following:

15 (A) Effective through December 31, 2013, two hundred
16 percent (200%) of the federal income poverty level.

17 (B) Beginning January 1, 2014, one hundred thirty-three
18 percent (133%) of the federal income poverty level, based on
19 the adjusted gross income provisions set forth in Section
20 2001(a)(1) of the federal Patient Protection and Affordable
21 Care Act.

22 (4) Effective through December 31, 2013, the individual is not
23 eligible for health insurance coverage through the individual's
24 employer.

25 (5) Effective through December 31, 2013, the individual has:

26 (A) not had health insurance coverage for at least six (6)
27 months; or

28 (B) had coverage under the Indiana comprehensive health
29 insurance association (IC 27-8-10) within the immediately
30 preceding six (6) months and the coverage no longer applies
31 under IC 27-8-10-0.5.

32 (b) The following individuals are not eligible for the plan:

33 (1) An individual who participates in the federal Medicare
34 program (42 U.S.C. 1395 et seq.).

35 (2) An individual who is otherwise eligible for medical assistance.

36 (c) The eligibility requirements specified in subsection (a) are
37 subject to approval for federal financial participation by the United
38 States Department of Health and Human Services.

39 SECTION 14. IC 12-15-44.2-10 IS REPEALED [EFFECTIVE
40 JULY 1, 2016]. Sec. 10: (a) An individual who participates in the plan
41 must have a health care account to which payments may be made for
42 the individual's participation in the plan only by the following:



- 1 (1) The individual.
 2 (2) An employer.
 3 (3) The state.
 4 (4) A nonprofit organization if the nonprofit organization:
 5 (A) is not affiliated with a health care plan; and
 6 (B) does not contribute more than seventy-five percent (75%)
 7 of the individual's required payment to the individual's health
 8 care account.
 9 (5) An insurer or a health maintenance organization under a
 10 contract with the office to provide health insurance coverage
 11 under the plan if the payment:
 12 (A) is to provide a health incentive to the individual;
 13 (B) does not count towards the individual's required minimum
 14 payment set forth in section 11 of this chapter; and
 15 (C) does not exceed one thousand one hundred dollars
 16 (\$1,100).
 17 (b) The minimum funding amount for a health care account is the
 18 amount required under section 11 of this chapter.
 19 (c) An individual's health care account must be used to pay the
 20 individual's deductible for health care services under the plan.
 21 (d) An individual may make payments to the individual's health care
 22 account as follows:
 23 (1) An employer withholding or causing to be withheld from an
 24 employee's wages or salary; after taxes are deducted from the
 25 wages or salary; the individual's contribution under this chapter
 26 and distributed equally throughout the calendar year.
 27 (2) Submission of the individual's contribution under this chapter
 28 to the office to deposit in the individual's health care account in
 29 a manner prescribed by the office.
 30 (3) Another method determined by the office.
 31 (e) An employer may make, from funds not payable by the employer
 32 to the employee, not more than fifty percent (50%) of an individual's
 33 required payment to the individual's health care account.
 34 (f) A nonprofit corporation may make not more than seventy-five
 35 percent (75%) of an individual's required payment to the individual's
 36 health care account.
 37 SECTION 15. IC 12-15-44.2-11 IS REPEALED [EFFECTIVE
 38 JULY 1, 2016]. Sec. 11. (a) An individual's participation in the plan
 39 does not begin until an initial payment is made for the individual's
 40 participation in the plan. A required payment to the plan for the
 41 individual's participation may not exceed one-twelfth (1/12) of the
 42 annual payment required under subsection (b).



1 (b) To participate in the plan, an individual shall do the following:

2 (1) Apply for the plan on a form prescribed by the office. The
3 office may develop and allow a joint application for a household.

4 (2) If the individual is approved by the office to participate in the
5 plan, contribute to the individual's health care account the lesser
6 of the following:

7 (A) One thousand one hundred dollars (\$1,100) per year, less
8 any amounts paid by the individual under the:

9 (i) Medicaid program under IC 12-15;

10 (ii) children's health insurance program under IC 12-17.6;

11 and

12 (iii) Medicare program (42 U.S.C. 1395 et seq.);

13 as determined by the office.

14 (B) At least one hundred sixty dollars (\$160) per year and not
15 more than the following applicable percentage of the
16 individual's annual household income per year, less any
17 amounts paid by the individual under the Medicaid program
18 under IC 12-15, the children's health insurance program under
19 IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et
20 seq.) as determined by the office:

21 (i) Two percent (2%) of the individual's annual household
22 income per year if the individual has an annual household
23 income of not more than one hundred percent (100%) of the
24 federal income poverty level:

25 (ii) Three percent (3%) of the individual's annual household
26 income per year if the individual has an annual household
27 income of more than one hundred percent (100%) and not
28 more than one hundred twenty-five percent (125%) of the
29 federal income poverty level:

30 (iii) Four percent (4%) of the individual's annual household
31 income per year if the individual has an annual household
32 income of more than one hundred twenty-five percent
33 (125%) and not more than one hundred fifty percent (150%)
34 of the federal income poverty level:

35 (iv) Five percent (5%) of the individual's annual household
36 income per year if the individual has an annual household
37 income of more than one hundred fifty percent (150%) and
38 not more than two hundred percent (200%) of the federal
39 income poverty level:

40 (c) The state shall contribute the difference to the individual's
41 account if the individual's payment required under subsection (b)(2) is
42 less than one thousand one hundred dollars (\$1,100):



1 (d) If an individual's required payment to the plan is not made
 2 within sixty (60) days after the required payment date, the individual
 3 may be terminated from participation in the plan. The individual must
 4 receive written notice before the individual is terminated from the plan.

5 (e) After termination from the plan under subsection (d), the
 6 individual may not reapply to participate in the plan for twelve (12)
 7 months.

8 SECTION 16. IC 12-15-44.2-12 IS REPEALED [EFFECTIVE
 9 JULY 1, 2016]. Sec. 12. (a) An individual who is approved to
 10 participate in the plan is eligible for a twelve (12) month plan period.
 11 An individual who participates in the plan may not be refused renewal
 12 of participation in the plan for the sole reason that the plan has reached
 13 the plan's maximum enrollment.

14 (b) If the individual chooses to renew participation in the plan, the
 15 individual shall complete a renewal application and any necessary
 16 documentation, and submit to the office the documentation and
 17 application on a form prescribed by the office.

18 (c) If the individual chooses not to renew participation in the plan,
 19 the individual may not reapply to participate in the plan for at least
 20 twelve (12) months.

21 (d) Any funds remaining in the health care account of an individual
 22 who renews participation in the plan at the end of the individual's
 23 twelve (12) month plan period must be used to reduce the individual's
 24 payments for the subsequent plan period. However, if the individual
 25 did not, during the plan period, receive all qualified preventative
 26 services recommended as provided in section 5 of this chapter, the
 27 state's contribution to the health care account may not be used to reduce
 28 the individual's payments for the subsequent plan period.

29 (e) If an individual is no longer eligible for the plan; does not renew
 30 participation in the plan at the end of the plan period; or is terminated
 31 from the plan for nonpayment of a required payment, the office shall,
 32 not more than sixty (60) days after the last date of participation in the
 33 plan; refund to the individual the amount determined under subsection
 34 (f) of any funds remaining in the individual's health care account as
 35 follows:

36 (1) An individual who is no longer eligible for the plan or does
 37 not renew participation in the plan at the end of the plan period
 38 shall receive the amount determined under STEP FOUR of
 39 subsection (f).

40 (2) An individual who is terminated from the plan due to
 41 nonpayment of a required payment shall receive the amount
 42 determined under STEP FIVE of subsection (f).



1 (f) The office shall determine the amount payable to an individual
2 described in subsection (e) as follows:

3 STEP ONE: Determine the total amount paid into the individual's
4 health care account under section 10(d) of this chapter.

5 STEP TWO: Determine the total amount paid into the individual's
6 health care account from all sources.

7 STEP THREE: Divide STEP ONE by STEP TWO.

8 STEP FOUR: Multiply the ratio determined in STEP THREE by
9 the total amount remaining in the individual's health care account.

10 STEP FIVE: Multiply the amount determined under STEP FOUR
11 by seventy-five hundredths (0.75).

12 SECTION 17. IC 12-15-44.2-13 IS REPEALED [EFFECTIVE
13 JULY 1, 2016]. Sec. 13: Subject to appeal to the office, an individual
14 may be held responsible under the plan for receiving nonemergency
15 services in an emergency room setting, including prohibiting the
16 individual from using funds in the individual's health care account to
17 pay for the nonemergency services. However, an individual may not be
18 prohibited from using funds in the individual's health care account to
19 pay for nonemergency services provided in an emergency room setting
20 for a medical condition that arises suddenly and unexpectedly and
21 manifests itself by acute symptoms of such severity, including severe
22 pain, that the absence of immediate medical attention could reasonably
23 be expected by a prudent layperson who possesses an average
24 knowledge of health and medicine to:

25 (1) place an individual's health in serious jeopardy;

26 (2) result in serious impairment to the individual's bodily
27 functions; or

28 (3) result in serious dysfunction of a bodily organ or part of the
29 individual.

30 SECTION 18. IC 12-15-44.2-14 IS REPEALED [EFFECTIVE
31 JULY 1, 2016]. Sec. 14: (a) An insurer or health maintenance
32 organization that contracts with the office to provide health insurance
33 coverage, dental coverage, or vision coverage to an individual who
34 participates in the plan:

35 (1) is responsible for the claim processing for the coverage;

36 (2) shall reimburse providers at a rate that is not less than the rate
37 established by the secretary. The rate set by the secretary must be
38 based on a reimbursement formula that is:

39 (A) comparable to the federal Medicare reimbursement rate
40 for the service provided by the provider; or

41 (B) one hundred thirty percent (130%) of the Medicaid
42 reimbursement rate for a service that does not have a Medicare



1 reimbursement rate; and
 2 (3) may not deny coverage to an eligible individual who has been
 3 approved by the office to participate in the plan; unless the
 4 individual has met the coverage limitations described in section
 5 6 of this chapter.

6 (b) An insurer or a health maintenance organization that contracts
 7 with the office to provide health insurance coverage under the plan
 8 must incorporate cultural competency standards established by the
 9 office. The standards must include standards for non-English speaking;
 10 minority; and disabled populations.

11 SECTION 19. IC 12-15-44.2-16 IS REPEALED [EFFECTIVE
 12 JULY 1, 2016]. Sec. 16. (a) An insurer or a health maintenance
 13 organization that contracts with the office to provide health insurance
 14 coverage under the plan or an affiliate of an insurer or a health
 15 maintenance organization that contracts with the office to provide
 16 health insurance coverage under the plan shall offer to provide the
 17 same health insurance coverage to an individual who:

18 (1) has not had health insurance coverage during the previous six
 19 (6) months; and

20 (2) does not meet the eligibility requirements specified in section
 21 9 of this chapter for participation in the plan.

22 (b) An insurer, a health maintenance organization, or an affiliate
 23 described in subsection (a) may apply to health insurance coverage
 24 offered under subsection (a) the insurer's, health maintenance
 25 organization's, or affiliate's standard individual or small group
 26 insurance underwriting and rating practices.

27 (c) The state does not provide funding for health insurance coverage
 28 received under this section.

29 SECTION 20. IC 12-15-44.2-18 IS REPEALED [EFFECTIVE
 30 JULY 1, 2016]. Sec. 18. (a) The office may not:

31 (1) enroll applicants;

32 (2) approve any contracts with vendors to provide services or
 33 administer the plan;

34 (3) incur costs other than costs necessary to study and plan for the
 35 implementation of the plan; or

36 (4) create financial obligations for the state;

37 unless both of the conditions of subsection (b) are satisfied:

38 (b) The office may not take any action described in subsection (a)
 39 unless:

40 (1) there is a specific appropriation from the general assembly to
 41 implement the plan; and

42 (2) after review by the budget committee, the budget agency



1 approves an actuarial analysis that reflects a determination that
 2 sufficient funding is reasonably estimated to be available to
 3 operate the plan for at least the following five (5) years:

4 The actuarial analysis approved under subdivision (2) must clearly
 5 indicate the cost and revenue assumptions used in reaching the
 6 determination:

7 (c) The office may not operate the plan in a manner that would
 8 obligate the state to financial participation beyond the level of state
 9 appropriations authorized for the plan:

10 SECTION 21. IC 12-15-44.2-19, AS AMENDED BY P.L.213-2015,
 11 SECTION 135, IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 19:

12 (a) The office may adopt rules under IC 4-22-2 necessary to implement:

13 (1) this chapter; or

14 (2) a Section 1115 Medicaid demonstration waiver concerning the
 15 plan that is approved by the United States Department of Health
 16 and Human Services:

17 (b) The office may adopt emergency rules under IC 4-22-2-37.1 to
 18 implement the plan on an emergency basis:

19 (c) An emergency rule or an amendment to an emergency rule
 20 adopted under this section expires not later than the earlier of:

21 (1) one (1) year after the rule is accepted for filing under
 22 IC 4-22-2-37.1(c); or

23 (2) July 1, 2016.

24 SECTION 22. IC 12-15-44.2-20, AS AMENDED BY P.L.160-2011,
 25 SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 26 JULY 1, 2016]: Sec. 20. (a) The office may establish a health insurance
 27 coverage premium assistance program for individuals who meet the
 28 following:

29 (1) Have an annual household income of the following:

30 (A) Through December 31, 2013, not more than two hundred
 31 percent (200%) of the federal income poverty level.

32 (B) Beginning January 1, 2014, not more than one hundred
 33 thirty-three percent (133%) of the federal income poverty
 34 level, based on the adjusted gross income provisions set forth
 35 in Section 2001(a)(1) of the federal Patient Protection and
 36 Affordable Care Act.

37 (2) Are eligible for health insurance coverage through an
 38 employer but cannot afford the health insurance coverage
 39 premiums.

40 (b) A program established under this section must:

41 (1) contain eligibility requirements that are similar to the
 42 eligibility requirements of the plan;



- 1 (2) include a health care account as a component; and
 2 (3) provide that an individual's payment:
 3 (A) to a health care account; or
 4 (B) for a health insurance coverage premium;
 5 may not exceed five percent (5%) of the individual's annual
 6 income.

7 **(c) The office may adopt rules under IC 4-22-2 necessary to**
 8 **implement and administer this section.**

9 SECTION 23. IC 12-15-44.2-21 IS REPEALED [EFFECTIVE
 10 JULY 1, 2016]. Sec. 21: (a) A denial of federal approval and federal
 11 financial participation that applies to any part of this chapter does not
 12 prohibit the office from implementing any other part of this chapter
 13 that:

- 14 (1) is federally approved for federal financial participation; or
 15 (2) does not require federal approval or federal financial
 16 participation:

17 (b) The secretary may make changes to the plan under this chapter
 18 if the changes are required by one (1) of the following:

- 19 (1) The United States Department of Health and Human Services;
 20 (2) Federal law or regulation.

21 SECTION 24. IC 12-15-44.2-22 IS REPEALED [EFFECTIVE
 22 JULY 1, 2016]. Sec. 22: The office of the secretary may amend the
 23 plan in a manner that would allow Indiana to use the plan to cover
 24 individuals eligible for Medicaid resulting from passage of the Federal
 25 Patient Protection and Affordable Care Act.

26 SECTION 25. IC 12-15-44.5-2, AS ADDED BY P.L.213-2015,
 27 SECTION 136, IS AMENDED TO READ AS FOLLOWS
 28 [EFFECTIVE JULY 1, 2016]: Sec. 2. As used in this chapter, "plan"
 29 refers to the healthy Indiana plan ~~2-0~~ established by section 3 of this
 30 chapter.

31 SECTION 26. IC 12-15-44.5-2.3 IS ADDED TO THE INDIANA
 32 CODE AS A NEW SECTION TO READ AS FOLLOWS
 33 [EFFECTIVE JULY 1, 2016]: **Sec. 2.3. As used in this chapter,**
 34 **"preventative care services" means care that is provided to an**
 35 **individual to prevent disease, diagnose disease, or promote good**
 36 **health.**

37 SECTION 27. IC 12-15-44.5-3, AS ADDED BY P.L.213-2015,
 38 SECTION 136, IS AMENDED TO READ AS FOLLOWS
 39 [EFFECTIVE JULY 1, 2016]: Sec. 3. (a) The healthy Indiana plan ~~2-0~~
 40 is established. This chapter is in addition to the provisions set forth in
 41 IC 12-15-44.2. For the period beginning February 1, 2015, and ending
 42 the date the plan is terminated upon the completion of a phase out



1 period; if a provision in this chapter conflicts with IC 12-15-44.2, this
 2 chapter supersedes the conflicting provision in IC 12-15-44.2.

3 (b) The office shall administer the plan.

4 (c) The following individuals are eligible for the plan:

5 ~~(1) An individual who is eligible and described in~~
 6 ~~IC 12-15-44.2-9.~~

7 ~~(2) (1) The adult group described in 42 CFR 435.119.~~

8 ~~(3) Pregnant women who choose to remain in the plan during the~~
 9 ~~pregnancy.~~

10 ~~(4) (2) Parents and caretaker relatives eligible under 42 CFR~~
 11 ~~435.110.~~

12 ~~(5) (3) Low income individuals who are:~~

13 (A) at least nineteen (19) years of age; and

14 (B) less than twenty-one (21) years of age;

15 and eligible under 42 CFR 435.222.

16 ~~(6) (4) Individuals, for purposes of receiving transitional medical~~
 17 ~~assistance.~~

18 **An individual must meet the Medicaid residency requirements**
 19 **under IC 12-15-4-4 and this article to be eligible for the plan.**

20 (d) The following individuals are not eligible for the plan:

21 (1) An individual who participates in the federal Medicare
 22 program (42 U.S.C. 1395 et seq.).

23 (2) ~~Except for an individual described in subsection (c);~~ An
 24 individual who is otherwise eligible **and enrolled** for medical
 25 assistance.

26 **(e) The department of insurance and the office of the secretary**
 27 **shall provide oversight of the marketing practices of the plan.**

28 **(f) The office shall promote the plan and provide information to**
 29 **potential eligible individuals who live in medically underserved**
 30 **rural areas of Indiana.**

31 **(g) The office shall, to the extent possible, ensure that**
 32 **enrollment in the plan is distributed throughout Indiana in**
 33 **proportion to the number of individuals throughout Indiana who**
 34 **are eligible for participation in the plan.**

35 **(h) The office shall establish standards for consumer protection,**
 36 **including the following:**

37 **(1) Quality of care standards.**

38 **(2) A uniform process for participant grievances and appeals.**

39 **(3) Standardized reporting concerning provider performance,**
 40 **consumer experience, and cost.**

41 **(i) A health care provider that provides care to an individual**
 42 **who receives health insurance coverage under the plan shall also**



1 participate in the Medicaid program under this article.

2 (j) The following do not apply to the plan:

3 (1) IC 12-15-6.

4 (2) IC 12-15-12.

5 (3) IC 12-15-13.

6 (4) IC 12-15-14.

7 (5) IC 12-15-15.

8 (6) IC 12-15-21.

9 (7) IC 12-15-26.

10 (8) IC 12-15-31.1.

11 (9) IC 12-15-34.

12 (10) IC 12-15-35.

13 (11) IC 12-15-35.5.

14 (12) IC 16-42-22-10.

15 SECTION 28. IC 12-15-44.5-3.5 IS ADDED TO THE INDIANA
16 CODE AS A NEW SECTION TO READ AS FOLLOWS
17 [EFFECTIVE JULY 1, 2016]: **Sec. 3.5. (a) The plan must include the**
18 **following in a manner and to the extent determined by the office:**

19 (1) Mental health care services.

20 (2) Inpatient hospital services.

21 (3) Prescription drug coverage, including coverage of a long
22 acting, nonaddictive medication assistance treatment drug if
23 the drug is being prescribed for the treatment of substance
24 abuse.

25 (4) Emergency room services.

26 (5) Physician office services.

27 (6) Diagnostic services.

28 (7) Outpatient services, including therapy services.

29 (8) Comprehensive disease management.

30 (9) Home health services, including case management.

31 (10) Urgent care center services.

32 (11) Preventative care services.

33 (12) Family planning services:

34 (A) including contraceptives and sexually transmitted
35 disease testing, as described in federal Medicaid law (42
36 U.S.C. 1396 et seq.); and

37 (B) not including abortion or abortifacients.

38 (13) Hospice services.

39 (14) Substance abuse services.

40 (15) Pregnancy services.

41 (16) A service determined by the secretary to be required by
42 federal law as a benchmark service under the federal Patient



1 **Protection and Affordable Care Act.**

2 **(b) The plan must comply with any coverage requirements that**
 3 **apply to an accident and sickness insurance policy issued in**
 4 **Indiana.**

5 **(c) The plan may not permit treatment limitations or financial**
 6 **requirements on the coverage of mental health care services or**
 7 **substance abuse services if similar limitations or requirements are**
 8 **not imposed on the coverage of services for other medical or**
 9 **surgical conditions.**

10 **(d) The plan may provide vision services and dental services**
 11 **only to individuals who regularly make the required monthly**
 12 **contributions for the plan set forth in section 4.7(c) of this chapter.**

13 **(e) The benefit package offered in the plan:**

14 **(1) must be benchmarked to a commercial health plan**
 15 **described in 45 CFR 155.100(a)(1) or 45 CFR 155.100(a)(4);**
 16 **and**

17 **(2) may not include a benefit that is not present in at least one**
 18 **(1) of these commercial benchmark options.**

19 **(f) The office shall provide to an individual who participates in**
 20 **the plan a list of health care services that qualify as preventative**
 21 **care services for the age, gender, and preexisting conditions of the**
 22 **individual. The office shall consult with the federal Centers for**
 23 **Disease Control and Prevention for a list of recommended**
 24 **preventative care services.**

25 **(g) The plan shall, at no cost to the individual, provide payment**
 26 **of preventative care services described in 42 U.S.C. 300gg-13 for an**
 27 **individual who participates in the plan.**

28 **(h) The plan shall, at no cost to the individual, provide payments**
 29 **of not more than five hundred dollars (\$500) per year for**
 30 **preventative care services not described in subsection (g). Any**
 31 **additional preventative care services covered under the plan and**
 32 **received by the individual during the year are subject to the**
 33 **deductible and payment requirements of the plan.**

34 SECTION 29. IC 12-15-44.5-4, AS ADDED BY P.L.213-2015,
 35 SECTION 136, IS AMENDED TO READ AS FOLLOWS
 36 [EFFECTIVE JULY 1, 2016]: Sec. 4. (a) The plan:

37 (1) is not an entitlement program; and

38 (2) serves as an alternative to health care coverage under Title
 39 XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

40 (b) If either of the following occurs, the office shall terminate the
 41 plan in accordance with section 6(b) of this chapter:

42 (1) The:



- 1 (A) percentages of federal medical assistance available to the
 2 plan for coverage of plan participants described in Section
 3 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act are
 4 less than the percentages provided for in Section
 5 2001(a)(3)(B) of the federal Patient Protection and Affordable
 6 Care Act; and
- 7 (B) hospital assessment committee (IC 16-21-10), after
 8 considering the modification and the reduction in available
 9 funding, does not alter the formula established under
 10 IC 16-21-10-13.3(b)(1) to cover the amount of the reduction
 11 in federal medical assistance.
- 12 For purposes of this subdivision, "coverage of plan participants"
 13 includes payments, contributions, and amounts referred to in
 14 IC 16-21-10-13.3(b)(1)(A), IC 16-21-10-13.3(b)(1)(C), and
 15 IC 16-21-10-13.3(b)(1)(D), including payments, contributions,
 16 and amounts incurred during a phase out period of the plan.
- 17 (2) The:
- 18 (A) methodology of calculating the incremental fee set forth in
 19 IC 16-21-10-13.3 is modified in any way that results in a
 20 reduction in available funding;
- 21 (B) hospital assessment fee committee (IC 16-21-10), after
 22 considering the modification and reduction in available
 23 funding, does not alter the formula established under
 24 IC 16-21-10-13.3(b)(1) to cover the amount of the reduction
 25 in fees; and
- 26 (C) office does not use alternative financial support to cover
 27 the amount of the reduction in fees.
- 28 (c) If the plan is terminated under subsection (b), the secretary may
 29 implement a plan for coverage of the affected population in a manner
 30 consistent with the healthy Indiana plan (IC 12-15-44.2 **(before its**
 31 **repeal)**) in effect on January 1, 2014:
- 32 (1) subject to prior approval of the United States Department of
 33 Health and Human Services; and
- 34 (2) without funding from the incremental fee set forth in
 35 IC 16-21-10-13.3.
- 36 **(d) The office may not operate the plan in a manner that would**
 37 **obligate the state to financial participation beyond the level of state**
 38 **appropriations or funding otherwise authorized for the plan.**
- 39 **(e) The office of the secretary shall annually submit to the**
 40 **budget committee an actuarial analysis of the plan that reflects a**
 41 **determination that sufficient funding is reasonably estimated to be**
 42 **available to operate the plan.**



1 SECTION 30. IC 12-15-44.5-4.5 IS ADDED TO THE INDIANA
 2 CODE AS A NEW SECTION TO READ AS FOLLOWS
 3 [EFFECTIVE JULY 1, 2016]: **Sec. 4.5. (a) An individual who**
 4 **participates in the plan must have a health care account to which**
 5 **payments may be made for the individual's participation in the**
 6 **plan.**

7 **(b) An individual's health care account must be used to pay the**
 8 **individual's deductible for health care services under the plan.**

9 **(c) An individual's deductible must be at least two thousand five**
 10 **hundred dollars (\$2,500) per year.**

11 **(d) An individual may make payments to the individual's health**
 12 **care account as follows:**

13 **(1) An employer withholding or causing to be withheld from**
 14 **an employee's wages or salary, after taxes are deducted from**
 15 **the wages or salary, the individual's contribution under this**
 16 **chapter and distributed equally throughout the calendar year.**

17 **(2) Submission of the individual's contribution under this**
 18 **chapter to the office to deposit in the individual's health care**
 19 **account in a manner prescribed by the office.**

20 **(3) Another method determined by the office.**

21 SECTION 31. IC 12-15-44.5-4.7 IS ADDED TO THE INDIANA
 22 CODE AS A NEW SECTION TO READ AS FOLLOWS
 23 [EFFECTIVE JULY 1, 2016]: **Sec. 4.7. (a) To participate in the plan,**
 24 **an individual must apply for the plan on a form prescribed by the**
 25 **office. The office may develop and allow a joint application for a**
 26 **household.**

27 **(b) A pregnant woman is not subject to the cost-sharing**
 28 **provisions of the plan. Subsections (c) through (g) do not apply to**
 29 **a pregnant woman participating in the plan.**

30 **(c) An applicant who is approved to participate in the plan does**
 31 **not begin benefits under the plan until a payment of at least:**

32 **(1) one-twelfth (1/12) of the two percent (2%) of annual**
 33 **income contribution amount; or**

34 **(2) ten dollars (\$10);**

35 **is made to the individual's health care account established under**
 36 **section 4.5 of this chapter for the individual's participation in the**
 37 **plan. To continue to participate in the plan, an individual must**
 38 **contribute to the individual's health care account at least two**
 39 **percent (2%) of the individual's annual household income per year**
 40 **but not less than one dollar (\$1) per month.**

41 **(d) If an applicant who is approved to participate in the plan**
 42 **fails to make the initial payment into the individual's health care**



1 account, at least the following must occur:

2 (1) If the individual has an annual income that is at or below
3 one hundred percent (100%) of the federal poverty income
4 level, the individual's benefits are reduced as specified in
5 subsection (e)(1).

6 (2) If the individual has an annual income of more than one
7 hundred percent (100%) of the federal poverty income level,
8 the individual is not enrolled in the plan.

9 (e) If an enrolled individual's required monthly payment to the
10 plan is not made within sixty (60) days after the required payment
11 date, the following, at a minimum, occur:

12 (1) For an individual who has an annual income that is at or
13 below one hundred percent (100%) of the federal income
14 poverty level, the individual is:

15 (A) transferred to a plan that has a material reduction in
16 benefits, including the elimination of benefits for vision and
17 dental services; and

18 (B) required to make copayments for the provision of
19 services that may not be paid from the individual's health
20 care account.

21 (2) For an individual who has an annual income of more than
22 one hundred percent (100%) of the federal poverty income
23 level, the individual shall be terminated from the plan and
24 may not reenroll in the plan for at least six (6) months.

25 (f) The state shall contribute to the individual's health care
26 account the difference between the individual's payment required
27 under this section and the plan deductible set forth in section 4.5(c)
28 of this chapter.

29 (g) A member shall remain enrolled with the same health plan
30 during the member's benefit period. A member may change health
31 plans as follows:

32 (1) Without cause:

33 (A) before making a contribution or before finalizing
34 enrollment in accordance with subsection (d)(1); or

35 (B) during the annual plan renewal process.

36 (2) For cause, as determined by the office.

37 SECTION 32. IC 12-15-44.5-4.9 IS ADDED TO THE INDIANA
38 CODE AS A NEW SECTION TO READ AS FOLLOWS
39 [EFFECTIVE JULY 1, 2016]: Sec. 4.9. (a) An individual who is
40 approved to participate in the plan is eligible for a twelve (12)
41 month plan period if the individual continues to meet the plan
42 requirements specified in this chapter.



1 (b) If an individual chooses to renew participation in the plan,
2 the individual is subject to an annual renewal process at the end of
3 the benefit period to determine continued eligibility for
4 participating in the plan. If the individual does not complete the
5 renewal process, the individual may not reenroll in the plan for at
6 least six (6) months.

7 (c) This subsection applies to participants who consistently
8 made the required payments in the individual's health care
9 account. If the individual receives the qualified preventative
10 services recommended to the individual during the year, the
11 individual is eligible to have the individual's unused share of the
12 individual's health care account at the end of the plan period,
13 determined by the office, matched by the state and carried over to
14 the subsequent plan period to reduce the individual's required
15 payments. If the individual did not, during the plan period, receive
16 all qualified preventative services recommended to the individual,
17 only the nonstate contribution to the health care account may be
18 used to reduce the individual's payments for the subsequent plan
19 period.

20 (d) For individuals participating in the plan who, in the past, did
21 not make consistent payments into the individual's health care
22 account while participating in the plan, but:

23 (1) had a balance remaining in the individual's health care
24 account; and

25 (2) received all of the required preventative care services;
26 the office may elect to offer a discount on the individual's required
27 payments to the individual's health care account for the subsequent
28 benefit year. The amount of the discount under this subsection
29 must be related to the percentage of the health care account
30 balance at the end of the plan year but not to exceed a fifty percent
31 (50%) discount of the required contribution.

32 (e) If an individual is no longer eligible for the plan, does not
33 renew participation in the plan at the end of the plan period, or is
34 terminated from the plan for nonpayment of a required payment,
35 the office shall, not more than one hundred twenty (120) days after
36 the last date of participation in the plan, refund to the individual
37 the amount determined under subsection (f) of any funds
38 remaining in the individual's health care account as follows:

39 (1) An individual who is no longer eligible for the plan or does
40 not renew participation in the plan at the end of the plan
41 period shall receive the amount determined under STEP
42 FOUR of subsection (f).



1 **(2) An individual who is terminated from the plan due to**
 2 **nonpayment of a required payment shall receive the amount**
 3 **determined under STEP SIX of subsection (f).**

4 **The office may charge a penalty for any voluntary withdrawals**
 5 **from the health care account by the individual before the end of the**
 6 **plan benefit year. The individual may receive the amount**
 7 **determined under STEP SIX of subsection (f).**

8 **(f) The office shall determine the amount payable to an**
 9 **individual described in subsection (e) as follows:**

10 **STEP ONE: Determine the total amount paid into the**
 11 **individual's health care account under this chapter.**

12 **STEP TWO: Determine the total amount paid into the**
 13 **individual's health care account from all sources.**

14 **STEP THREE: Divide STEP ONE by STEP TWO.**

15 **STEP FOUR: Multiply the ratio determined in STEP THREE**
 16 **by the total amount remaining in the individual's health care**
 17 **account.**

18 **STEP FIVE: Subtract any nonpayments of a required**
 19 **payment.**

20 **STEP SIX: Multiply the amount determined under STEP**
 21 **FIVE by at least seventy-five hundredths (0.75).**

22 **SECTION 33. IC 12-15-44.5-5.5 IS ADDED TO THE INDIANA**
 23 **CODE AS A NEW SECTION TO READ AS FOLLOWS**
 24 **[EFFECTIVE JULY 1, 2016]: Sec. 5.5. The office shall refer any**
 25 **member of the plan who:**

26 **(1) is employed for less than twenty (20) hours per week; and**
 27 **(2) is not a full-time student;**

28 **to a workforce training and job search program.**

29 **SECTION 34. IC 12-15-44.5-5.7 IS ADDED TO THE INDIANA**
 30 **CODE AS A NEW SECTION TO READ AS FOLLOWS**
 31 **[EFFECTIVE JULY 1, 2016]: Sec. 5.7. Subject to appeal to the**
 32 **office, an individual may be held responsible under the plan for**
 33 **receiving nonemergency services in an emergency room setting,**
 34 **including prohibiting the individual from using funds in the**
 35 **individual's health care account to pay for the nonemergency**
 36 **services and paying a copayment for the services of at least eight**
 37 **dollars (\$8) for the first nonemergency use of a hospital emergency**
 38 **department and at least a twenty-five dollar (\$25) copayment for**
 39 **any subsequent nonemergency use of a hospital emergency**
 40 **department during the benefit period. However, an individual may**
 41 **not be prohibited from using funds in the individual's health care**
 42 **account to pay for nonemergency services provided in an**



1 emergency room setting for a medical condition that arises
 2 suddenly and unexpectedly and manifests itself by acute symptoms
 3 of such severity, including severe pain, that the absence of
 4 immediate medical attention could reasonably be expected by a
 5 prudent layperson who possesses an average knowledge of health
 6 and medicine to:

- 7 (1) place an individual's health in serious jeopardy;
 8 (2) result in serious impairment to the individual's bodily
 9 functions; or
 10 (3) result in serious dysfunction of a bodily organ or part of
 11 the individual.

12 SECTION 35. IC 12-15-44.5-10, AS ADDED BY P.L.213-2015,
 13 SECTION 136, IS AMENDED TO READ AS FOLLOWS
 14 [EFFECTIVE JULY 1, 2016]: Sec. 10. (a) The secretary may make
 15 changes to the plan under this chapter if the changes are required by
 16 one (1) of the following:

- 17 (1) The United States Department of Health and Human Services;
 18 (2) Federal law or regulation.

19 has the authority to provide benefits only to individuals eligible
 20 under the adult group described in 42 CFR 435.119 in accordance
 21 with this chapter.

22 (b) The secretary may negotiate and make changes to the plan,
 23 except that the secretary may not negotiate or change the plan that
 24 would do the following:

- 25 (1) Reduce the following:
 26 (A) Contribution amounts below the minimum levels set
 27 forth in section 4.7 of this chapter.
 28 (B) Deductible amounts below the minimum amount
 29 established in section 4.5(c) of this chapter.
 30 (2) Remove or reduce the penalties for nonpayment set forth
 31 in section 4.7 of this chapter.
 32 (3) Revise the use of the health care account requirement set
 33 forth in section 4.5 of this chapter.
 34 (4) Include noncommercial benefits or add additional plan
 35 benefits in a manner inconsistent with section 3.5 of this
 36 chapter.
 37 (5) Allow services to begin:
 38 (A) without the payment established or required by; or
 39 (B) earlier than the time frames otherwise established by;
 40 section 4.7 of this chapter.
 41 (6) Reduce financial penalties for the inappropriate use of the
 42 emergency room below the minimum levels set forth in section



1 **5.7 of this chapter.**

2 **(7) Permit members to change health plans without cause in**
 3 **a manner inconsistent with section 4.7(g) of this chapter.**

4 **(8) Operate the plan in a manner that would obligate the state**
 5 **to financial participation beyond the level of state**
 6 **appropriations or funding otherwise authorized for the plan.**

7 SECTION 36. IC 16-18-2-187.2, AS ADDED BY P.L.213-2015,
 8 SECTION 138, IS AMENDED TO READ AS FOLLOWS
 9 [EFFECTIVE JULY 1, 2016]: Sec. 187.2. "Incremental fee", for
 10 purposes of IC 16-21-10, means a part of the hospital assessment fee
 11 designated for the use of funding the healthy Indiana plan. ~~2-0~~

12 SECTION 37. IC 16-21-10-5.3, AS ADDED BY P.L.213-2015,
 13 SECTION 140, IS AMENDED TO READ AS FOLLOWS
 14 [EFFECTIVE JULY 1, 2016]: Sec. 5.3. As used in this chapter, "phase
 15 out period" refers to the following periods:

- 16 (1) The time during which a:
 17 (A) phase out plan;
 18 (B) demonstration expiration plan; or
 19 (C) similar plan approved by the United States Department of
 20 Health and Human Services;

21 is in effect for the healthy Indiana plan ~~2-0~~ set forth in
 22 IC 12-15-44.5.

- 23 (2) The time beginning upon the office's receipt of written notice
 24 by the United States Department of Health and Human Services
 25 of its decision to:

- 26 (A) terminate or suspend the waiver demonstration for the
 27 healthy Indiana plan; ~~2-0~~; or
 28 (B) withdraw the waiver or expenditure authority for the plan;
 29 and ~~ends~~ **ending** on the effective date of the termination,
 30 suspension, or withdrawal of the waiver or expenditure authority.

- 31 (3) The time beginning upon:
 32 (A) the office's determination to terminate the healthy Indiana
 33 plan; ~~2-0~~; or
 34 (B) the termination of the plan under IC 12-15-44.5-4(b);

35 if subdivisions (1) through (2) do not apply, and ending on the
 36 effective date of the termination of the healthy Indiana plan. ~~2-0~~

37 SECTION 38. IC 16-21-10-12, AS AMENDED BY P.L.213-2015,
 38 SECTION 146, IS AMENDED TO READ AS FOLLOWS
 39 [EFFECTIVE JULY 1, 2016]: Sec. 12. This section does not apply to
 40 the use of the incremental fee described in section 13.3 of this chapter.
 41 For purposes of this chapter, the entire federal Medicaid
 42 disproportionate share allotment for Indiana does not include the part



1 of allotments that are required to be diverted under the following:

2 (1) ~~The~~ federally approved Indiana "Special Terms and
3 Conditions" Medicaid demonstration project (~~Number~~
4 ~~11-W-00237/5~~). **(Number 11-W-0029615).**

5 (2) Any extension after ~~December 31, 2012~~, of the healthy
6 Indiana plan established under IC ~~12-15-44.2~~.

7 The office shall inform the committee and the budget committee
8 concerning any extension of the healthy Indiana plan after ~~December~~
9 ~~31, 2013~~.

10 SECTION 39. IC 16-21-10-13.3, AS ADDED BY P.L.213-2015,
11 SECTION 148, IS AMENDED TO READ AS FOLLOWS
12 [EFFECTIVE JULY 1, 2016]: Sec. 13.3. (a) This section is effective
13 beginning February 1, 2015. As used in this section, "plan" refers to the
14 healthy Indiana plan ~~2-0~~ established in IC 12-15-44.5.

15 (b) Subject to subsections (c) through (e), the incremental fee under
16 this section may be used to fund the state share of the expenses
17 specified in this subsection if, after January 31, 2015, but before the
18 collection of the fee under this section, the following occur:

19 (1) The committee establishes a fee formula to be used to fund the
20 state share of the following expenses described in this
21 subdivision:

22 (A) The state share of the capitated payments made to a
23 managed care organization that contracts with the office to
24 provide health coverage under the plan to plan enrollees other
25 than plan enrollees who are eligible for the plan under Section
26 1931 of the federal Social Security Act.

27 (B) The state share of capitated payments described in clause
28 (A) for plan enrollees who are eligible for the plan under
29 Section 1931 of the federal Social Security Act that are limited
30 to the difference between:

31 (i) the capitation rates effective September 1, 2014,
32 developed using Medicaid reimbursement rates; and

33 (ii) the capitation rates applicable for the plan developed
34 using the plan's Medicare reimbursement rates described in
35 ~~IC 12-15-44.2-14(a)(2)~~ **IC 12-15-44.5-5(a)(2).**

36 (C) The state share of the state's contributions to plan enrollee
37 accounts.

38 (D) The state share of amounts used to pay premiums for a
39 premium assistance plan implemented under
40 IC 12-15-44.2-20.

41 (E) The state share of the costs of increasing reimbursement
42 rates for health care services provided to individuals enrolled



- 1 in Medicaid programs other than the plan.
 2 (F) The state share of the state's administrative costs that, for
 3 purposes of this clause, may not exceed one hundred seventy
 4 dollars (\$170) per person per plan enrollee per year, and
 5 adjusted annually by the Consumer Price Index.
 6 (G) The money described in IC 12-15-44.5-6(a) for the phase
 7 out period of the plan.
 8 (2) The committee approves a process to be used for reconciling:
 9 (A) the state share of the costs of the plan;
 10 (B) the amounts used to fund the state share of the costs of the
 11 plan; and
 12 (C) the amount of fees assessed for funding the state share of
 13 the costs of the plan.

14 For purposes of this subdivision, "costs of the plan" includes the
 15 costs of the expenses listed in subdivision (1)(A) through (1)(G).
 16 The fees collected under subdivision (1)(A) through (1)(F) shall be
 17 deposited into the incremental hospital fee fund established by section
 18 13.5 of this chapter. Fees described in subdivision (1)(G) shall be
 19 deposited into the phase out trust fund described in IC 12-15-44.5-7.
 20 The fees used for purposes of funding the state share of expenses listed
 21 in subdivision (1)(A) through (1)(F) may not be used to fund expenses
 22 incurred on or after the commencement of a phase out period of the
 23 plan.

24 (c) For each state fiscal year for which the fee authorized by this
 25 section is used to fund the state share of the expenses described in
 26 subsection (b)(1), the amount of fees shall be reduced by:

- 27 (1) the amount of funds annually designated by the general
 28 assembly to be deposited in the healthy Indiana plan trust fund
 29 established by IC 12-15-44.2-17; less
 30 (2) the annual cigarette tax funds annually appropriated by the
 31 general assembly for childhood immunization programs under
 32 IC 12-15-44.2-17(a)(3).

33 (d) The incremental fee described in this section may not:
 34 (1) be assessed before July 1, 2016; and
 35 (2) be assessed or collected on or after the beginning of a phase
 36 out period of the plan.

37 (e) This section is not intended to and may not be construed to
 38 change or affect any component of the programs established under
 39 section 8 of this chapter.

40 SECTION 40. IC 16-21-10-13.5, AS ADDED BY P.L.213-2015,
 41 SECTION 149, IS AMENDED TO READ AS FOLLOWS
 42 [EFFECTIVE JULY 1, 2016]: Sec. 13.5. (a) The incremental hospital



1 fee fund is established for the purpose of holding fees collected under
2 section 13.3 of this chapter.

3 (b) The office shall administer the fund.

4 (c) Money in the fund consists of the following:

5 (1) Fees collected under section 13.3 of this chapter.

6 (2) Donations, gifts, and money received from any other source.

7 (3) Interest accrued under this section.

8 (d) Money in the fund may be used only for the following:

9 (1) To fund exclusively the state share of the expenses listed in
10 section 13.3(b)(1)(A) through 13.3(b)(1)(F) of this chapter.

11 (2) To refund hospitals in the same manner as described in
12 subsection (g) as soon as reasonably possible after the beginning
13 of a phase out period of the healthy Indiana plan. ~~2-0-~~

14 (e) Money remaining in the fund at the end of a state fiscal year
15 does not revert to the state general fund.

16 (f) The treasurer of state shall invest the money in the fund not
17 currently needed to meet the obligations of the fund in the same
18 manner as other public funds may be invested. Interest that accrues
19 from these investments shall be deposited in the fund.

20 (g) Upon the beginning of a phase out period of the healthy Indiana
21 plan, ~~2-0-~~ money collected under section 13.3 of this chapter and any
22 accrued interest remaining in the fund shall be distributed to the
23 hospitals on a pro rata basis based upon the fees authorized by this
24 chapter that were paid by each hospital for the state fiscal year that
25 ended immediately before the beginning of the phase out period.

26 SECTION 41. IC 27-8-10.1 IS REPEALED [EFFECTIVE JULY 1,
27 2016]. (High Risk Indiana Check-Up Plan Participants).

28 SECTION 42. IC 27-19-2-15, AS AMENDED BY P.L.213-2015,
29 SECTION 254, IS AMENDED TO READ AS FOLLOWS
30 [EFFECTIVE JULY 1, 2016]: Sec. 15. (a) "Public health insurance
31 program" refers to health coverage provided under a state or federal
32 government program.

33 (b) The term includes the following:

34 (1) Medicaid (42 U.S.C. 1396 et seq.).

35 (2) The healthy Indiana plan established by ~~IC 12-15-44.2-3-~~

36 **IC 12-15-44.5-3.**

37 (3) The children's health insurance program established under
38 IC 12-17.6.

39 SECTION 43. IC 36-2-13-19, AS ADDED BY P.L.185-2015,
40 SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
41 JULY 1, 2016]: Sec. 19. (a) This section applies to a person who:

42 (1) is subject to lawful detention;



- 1 (2) incurs or will incur medical care expenses that are not
 2 otherwise reimbursable during the lawful detention;
 3 (3) is unwilling or unable to pay for the person's own health care
 4 services; and
 5 (4) is potentially eligible for Medicaid (IC 12-15).
- 6 (b) For a person described in subsection (a), the sheriff is the
 7 person's Medicaid authorized representative and may apply for
 8 Medicaid on behalf of the person.
- 9 (c) A county executive and the office of the secretary of family and
 10 social services shall enter into a written memorandum of understanding
 11 providing that the sheriff shall reimburse the office of the secretary for
 12 administrative costs and the state share of the Medicaid costs incurred
 13 for a person described in this section.
- 14 (d) Reimbursement under this section for reimbursable health care
 15 services provided by a health care provider, including a hospital, to a
 16 person as an inpatient in a hospital must be as follows:
- 17 (1) For individuals eligible under the ~~Indiana check-up plan (IC~~
 18 ~~12-15-44.2)~~, **healthy Indiana plan (IC 12-15-44.5)**, the
 19 reimbursement rates described in ~~IC 12-15-44.2-14.~~
 20 **IC 12-15-44.5-5.**
- 21 (2) For individuals other than those described in subdivision (1)
 22 who are eligible under the Medicaid program, the reimbursement
 23 rates provided under the Medicaid program, except that
 24 reimbursement for inpatient hospital services shall be reimbursed
 25 at rates equal to the fee-for-service rates described in
 26 IC 16-21-10-8(a)(1).
 27 Hospital assessment fee funds collected under IC 16-21-10 or the
 28 Indiana check-up plan trust fund (IC 12-15-44.2-17) may not be used
 29 as the state share of Medicaid costs for the reimbursement of health
 30 care services provided to the person as an inpatient in the hospital.
- 31 (e) The state share of all claims reimbursed by Medicaid for a
 32 person described in subsection (a) shall be paid by the county.

