11-19-2013

Now What? Implementing Health Care Reform in Indiana

Center for Families
Purdue University

Family Impact Seminars

Indiana

Now What? Implementing Health Care Reform in Indiana

Briefing Report
November 2013

Now What?
Implementing Healthcare Reform in Indiana

Indiana Family Impact Seminar
November 19, 2013

Sponsoring Organizations

Center for Families at Purdue University

Department of Family and Consumer Sciences at Ball State University

Indiana Association for the Education of Young Children

Indiana Association for Marriage and Family Therapy

Indiana Council on Family Relations

Indiana Extension Homemakers Association®

Indiana Family Services

Indiana Youth Institute

The Institute for Family and Social Responsibility at Indiana University

National Association of Social Workers – Indiana Chapter

Purdue Extension Health and Human Sciences

Table of Contents

Purpose, Presenters, and Publications

Family Impact Seminars have been well received by federal policymakers in Washington, DC, and Indiana is one of several states to sponsor such seminars for state policymakers. Family Impact Seminars provide state-of-the-art research on current family issues for state legislators and their aides, Governor's Office staff, state agency representatives, educators, and service providers. One of the best ways to help individuals is by strengthening their families. Therefore, the Family Impact Seminars speakers analyze the consequences an issue, policy or program may have for families.

The seminars provide objective, nonpartisan information on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

Now What? Implementing Healthcare Reform in Indiana is the sixteenth in a continuing series designed to bring a family focus to policymaking. The topic was chosen by the very legislators these seminars are intended to inform. This seminar features the following speakers:

Sonya Schwartz, JD
Research Fellow, Georgetown University Health Policy Institute, Center for Children and Families

Schwartz monitors and analyzes policy issues related to health reform implementation, Medicaid, CHIP, health insurance marketplaces, the basic health program, commercial insurance reforms and more. She was most recently a program director at the National Academy for State Health Policy, where she led State Refo(u)rm, an online network for health reform implementation.

Laura Snyder
Policy Analyst, Kaiser Commission on Medicaid and the Uninsured

Snyder focuses her work on state Medicaid budgets, most recently authoring a report explaining the factors underlying the great variability in Medicaid spending across states and the Kaiser Foundation's annual 50-state Medicaid budget survey. She has also been tracking executive branch and legislative developments in states undertaking the ACA Medicaid expansion.

For further information on the seminar contact coordinator Shelley MacDermid Wadsworth, Center for Families, Purdue University, 1202 West State Street, Fowler Hall, West Lafayette, IN 47907-2055 Phone: (765) 494-6026 FAX: (765) 496-1144 e-mail:shelley@purdue.edu

This briefing report and past reports can be found at Purdue's Center for Families website: http://www.cfs.purdue.edu/cff/policymakers/policymakers_publications.html and on the Policy Institute for Family Impact Seminars national website: http://familyimpact seminars.org

We hope that this information is useful to you in your deliberations, and we look forward to continuing to provide educational seminars and briefing reports in the future.

Topic Introduction from the Speakers

An Overview of Medicaid's Role Today and Looking Ahead to 2014 Presentation Summary

Laura Snyder
Policy Analyst at the Kaiser Commission on Medicaid and the Uninsured

I. Medicaid Overview

a. Medicaid has many vital roles in our health care system.
b. Medicaid costs are shared by the states and the federal government. Medicaid is a budget item and a revenue item in state budgets.
c. The elderly and disabled account for the majority of Medicaid spending.
d. At least two-thirds of Medicaid beneficiaries receive care through comprehensive Medicaid managed care plans.
e. Medicaid provides beneficiaries with access to care comparable to private insurance and significantly better than being uninsured.

II. Current Trends in Medicaid Today

a. From the state perspective, many factors are shaping Medicaid today including ACA implementation, delivery and payment system reforms, economic conditions and federal deficit reduction efforts, and continued cost containment and administration.
b. While states remain focused on controlling costs, more states are making program improvements/restoration than restrictions.
c. Program Integrity remains a focus at both the national level and at the state level.
d. Medicaid spending and enrollment growth were moderate in FY 2013, but expected to grow faster in FY 2014 due to the ACA.

III. The Medicaid Expansion

a. Expanding coverage is a key element in health reform.
b. The Medicaid expansion decision has many coverage and fiscal implications for states.
c. Many individuals, particularly those with low income, remain uninsured.
d. The ACA Medicaid expansion is designed to fill current gaps in coverage.
e. Since the Supreme Court decision, states have made different choices about how to implement the ACA coverage expansions.
f. In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.
g. An estimated 4.8 million uninsured nonelderly adults below poverty may fall into the coverage gap in states not adopting the Expansion.

What's Next? Tackling the Remaining Health Coverage Challenges for Children and Families in Indiana
Presentation Summary

Sonya Schwartz
Research Fellow at the Georgetown University Center for Children and Families

Indiana faces three key coverage challenges:

Challenge #1: Coverage gap for low-income adults.

- 181,000 low-income parents and single adults not eligible for Medicaid.
- Options for covering them include:
    1. Straight Up Medicaid Expansion: there is some flexibility around financing, benefits, cost-sharing, delivery system and eligibility and enrollment with this approach.
    2. Medicaid 1115 Waiver: Can offer more flexibility through negotiations with HHS, the state could consider waiver approaches like the Arkansas private option, or proposed models in Iowa, Michigan or Pennsylvania.

Challenge #2: Indiana's rate of uninsured children is higher than the national average.

- Preliminary data shows 142,672 children or 8.4% of all children are uninsured in Indiana in 2012. The national average is 7.2%.
- Covering more children requires a multi-pronged approach including outreach, eligibility expansions both broad and targetedd, and removing red tape barriers to enrollment.
- Expanding coverage for parents creates a welcome matt effect for children.
- Indiana can move toward policies that promote enrollment and retention of kids in Medicaid and CHIP. These include: eliminating waiting periods, reducing paper documentation, **providing multiple points of entry and renewal**, presumptive eligibility for all children, express lane eligibility, 12-month continuous eligibility, and **administrative renewals** (items in bold are required by the Affordable Care Act).

Challenge #3: People need consumer assistance to get covered.

- The Affordable Care Act sets new expectations for consumer assistance in Medicaid, CHIP and in health insurance marketplaces.
- Consumers lack awareness about new coverage options and how they will affect them. Healthcare.gov off to a bumpy start for federal marketplace states like Indiana.
- Indiana's Marketplace currently has 4 issuers offering coverage across the state with at least two in all rating areas of the state but one. But there are still many, many different plan options to choose from.
- There are 5 different types of consumer assistance available in Indiana: certified application counselors; navigators, agents/brokers; state/local agencies and FQHC enrollment counselors.
- However, consumer assistance resources are slim with only about $2 million for navigators, and $2 million for health centers. When you consider the number of uninsured, this is only about $2 per uninsured person of enrollment assistance.

An Overview of Medicaid's Role Today and Looking Ahead to 2014

Laura Snyder, Policy Analyst

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

An Overview of Medicaid's Role Today and Looking Ahead to 2014

Laura Snyder, Policy Analyst
Kaiser Commission on Medicaid and the Uninsured
Kaiser Family Foundation

Indiana Family Impact Seminar

November 19, 2013

Figure 1

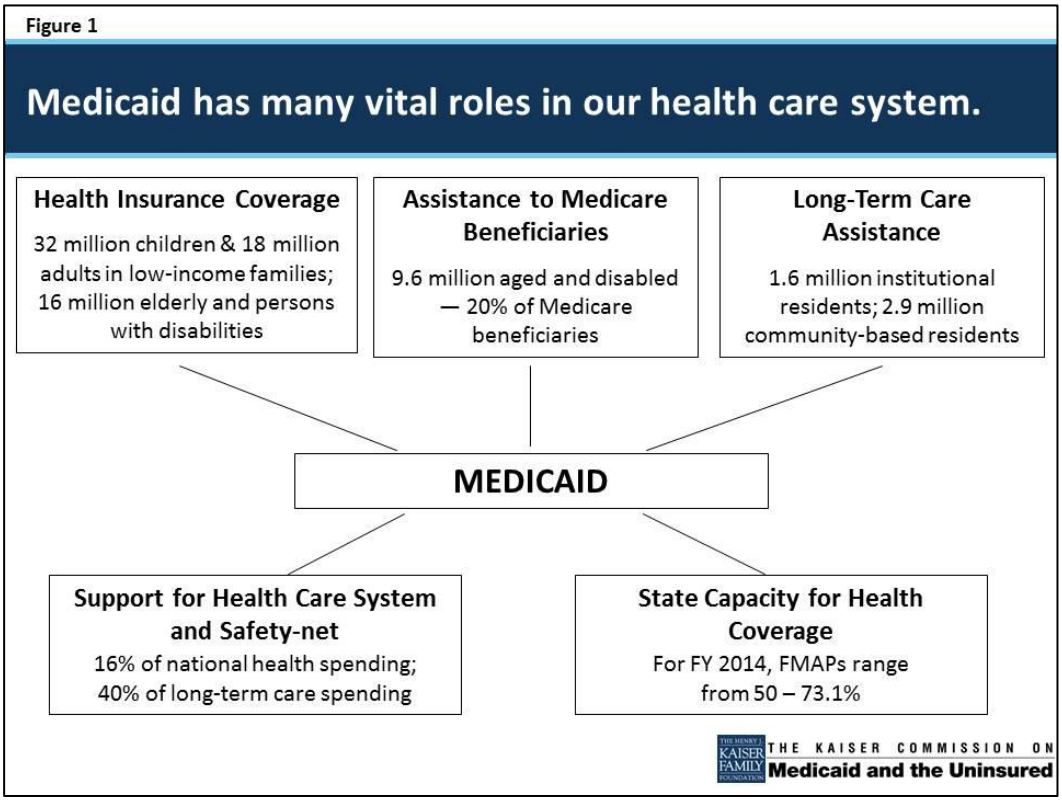
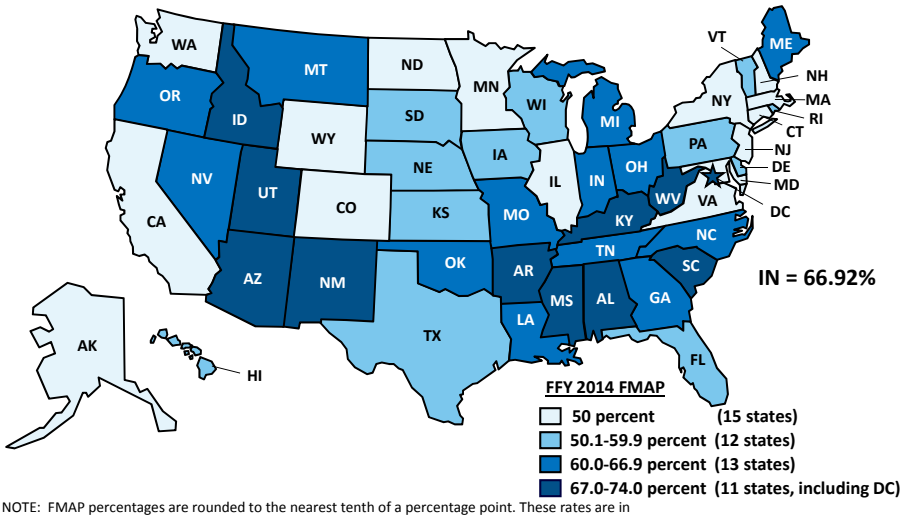


Figure 2

Medicaid costs are shared by the states and the federal government.

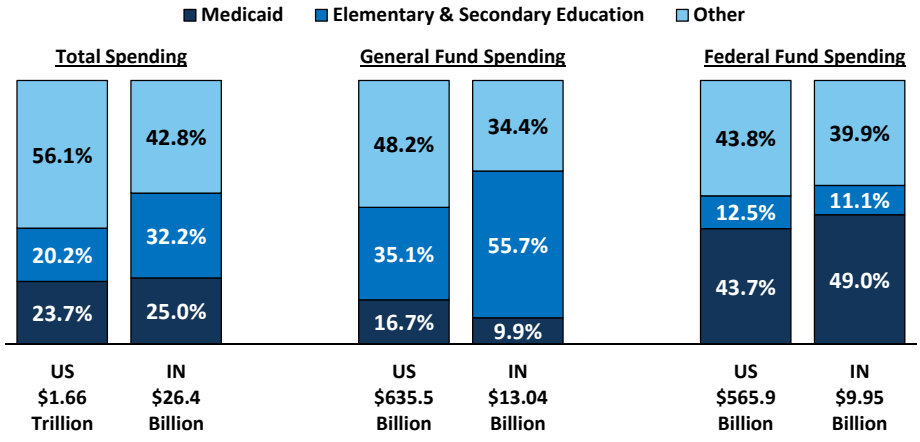


NOTE: FMAP percentages are rounded to the nearest tenth of a percentage point. These rates are in effect Oct. 1, 2013-Sept. 30, 2014.
SOURCE: Federal Register, November 30, 2012 (Vol. 77, No. 231), pp 71420-71423, at http://www.gpo.gov/fdsys/pkg/FR-2012-11-30/html/2012-29035.htm.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 3

Medicaid is a budget item and a revenue item in state budgets.

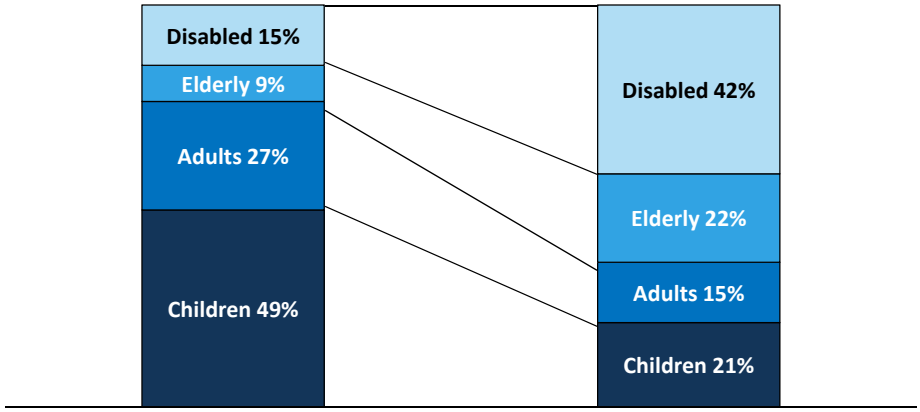


SOURCE: Actual FY 2011 data reported in: State Expenditure Report. NASBO, December 2012.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 4

The elderly and disabled account for the majority of Medicaid spending.

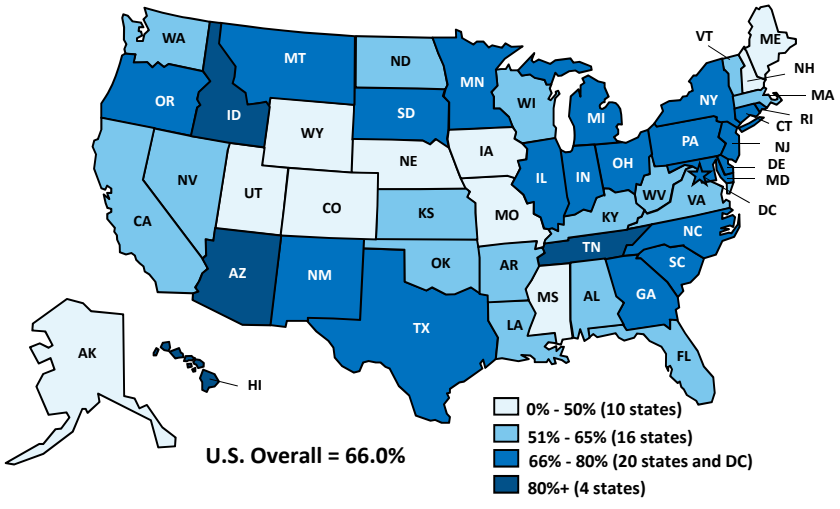


SOURCE: KCMU/Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. MSIS FY 2009 data were used for CO, ID, MO, NC, and WV, but adjusted to 2009 CMS-64.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 5

At least two-thirds of Medicaid beneficiaries receive care through comprehensive Medicaid managed care plans.

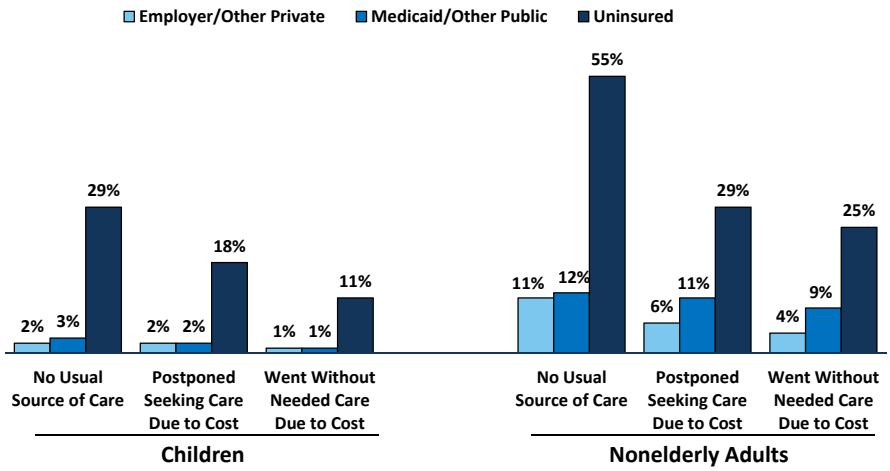


NOTE: Includes enrollment in HIO, Commercial MCO, Medicaid-only MCO, and PCCM.
SOURCE: CMS Medicaid Managed Care Enrollment Report, July 2011.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 6

Medicaid provides beneficiaries with access to care comparable to private insurance and significantly better than being uninsured.

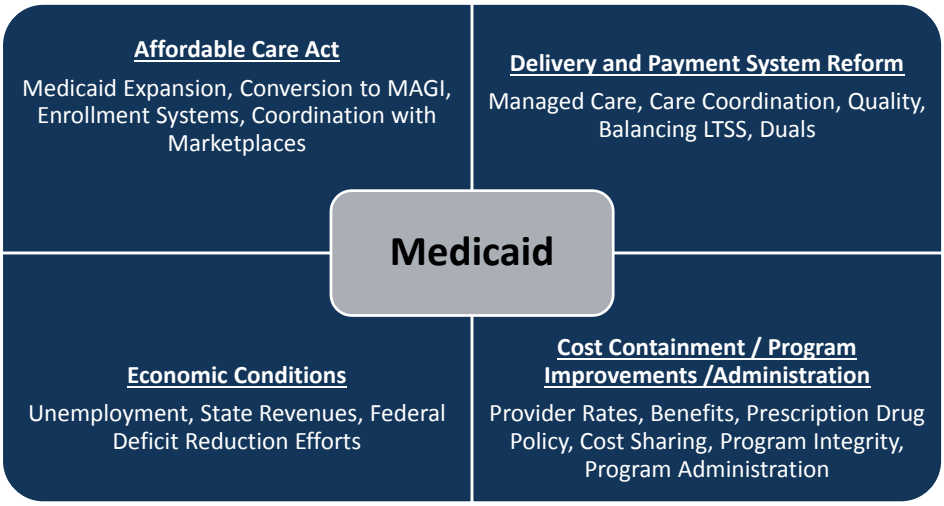


NOTES: In past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05).
SOURCE: KCMU analysis of 2013 NHIS data.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 7

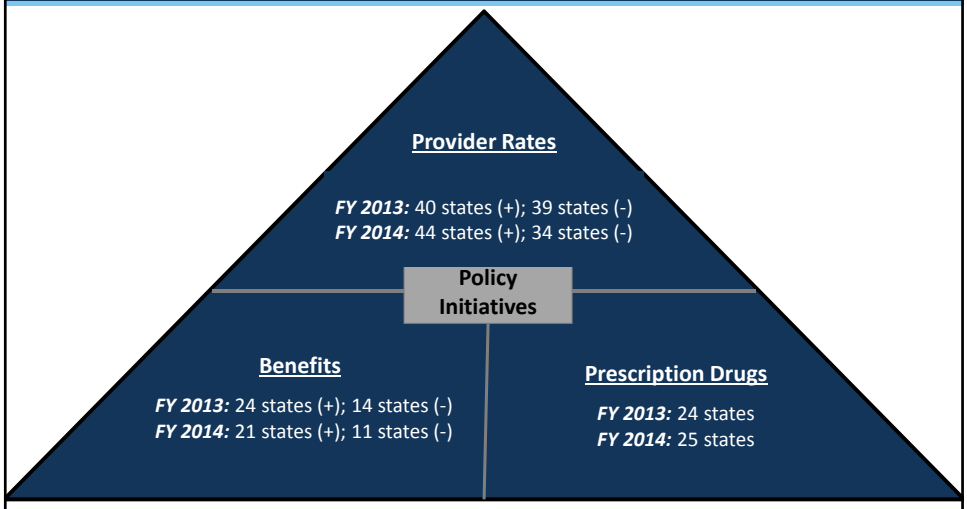
From the state perspective, many factors are shaping Medicaid today.



THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 8

While states remain focused on controlling costs, more states are making program improvements/restoration than restrictions.



Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 9

Program Integrity remains a focus at both the federal and state level.

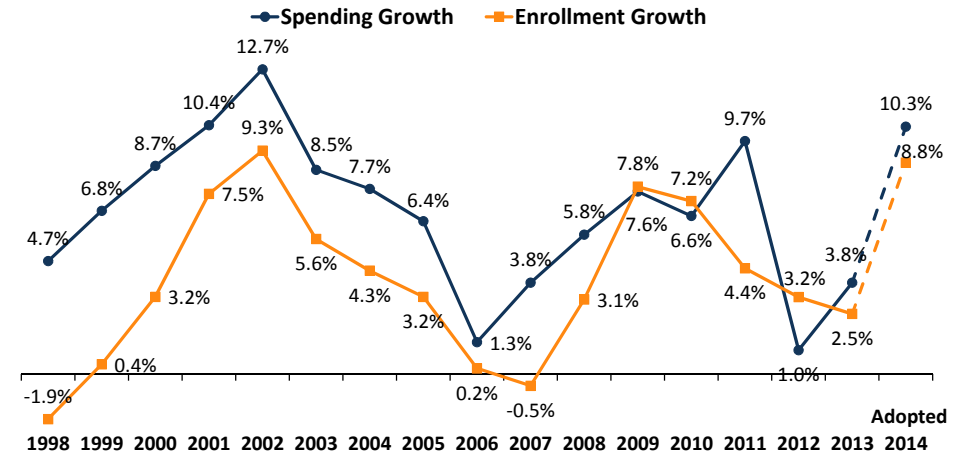
- Key Fraud and Abuse Provisions in the Affordable Care Act:
  - New Funding
  - Enhanced Screening Requirements
  - Required Compliance Plans
  - RAC Audits Expanded
  - New Enforcement Tools
- States reported a number of new and enhanced program integrity initiatives implemented during FY 2013 or planned for FY 2014.
  - Advanced Data Analytics and Predictive Modeling
  - Enhanced Provider Screening (beyond ACA requirements)
  - Public/Private Data Sharing Initiatives

Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 10

Medicaid spending and enrollment growth were moderate in FY 2013, but expected to grow faster in FY 2014 due to the ACA.



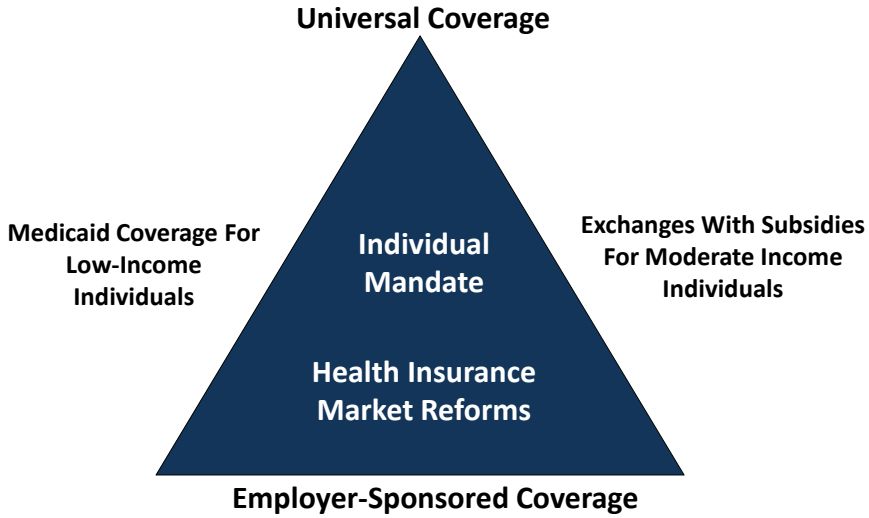
NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: *Medicaid Enrollment June 2012 Data Snapshot*, KCMU, August 2013. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012-2014 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 11

Expanding coverage is a key element in health reform.



THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 12

The Medicaid expansion decision has many coverage and fiscal implications for states.

Federal + State Funds

No Deadline for Adopting the Medicaid Expansion.

Reduction in the Number of Uninsured

Increased Provider Revenue

Increased State Savings

↓ Uncompensated Care Costs

↓ State-funded health programs (eg. Mental health)

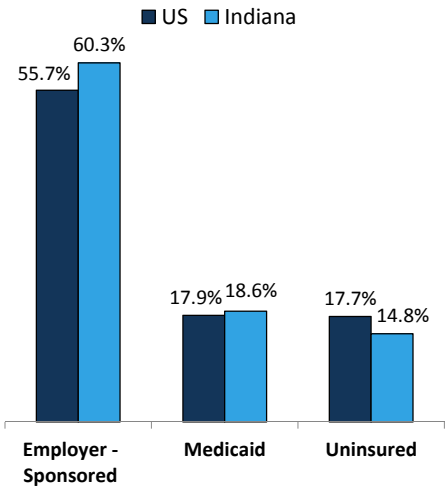
Increased State Economic Activity

↑ Jobs and Revenues

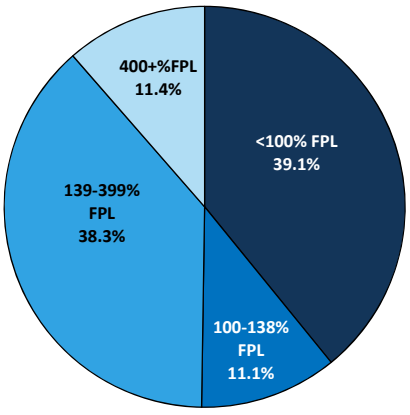
THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 13

Many individuals, particularly those with low income, remain uninsured.



Of the 801,600 uninsured Hoosiers, half have incomes below 138% FPL.



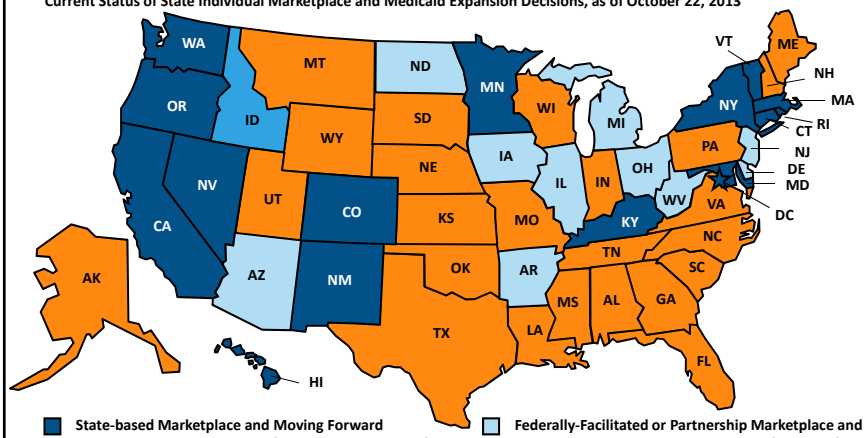
NOTE: Not shown are other public coverage and private insurance purchased by individuals. SOURCE: KCMU/Urban Institute analysis of 2012-2013 ASEC Supplement to the CPS.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 14

Since the Supreme Court decision, states have made different choices about how to implement the ACA coverage expansions.

Current Status of State Individual Marketplace and Medicaid Expansion Decisions, as of October 22, 2013



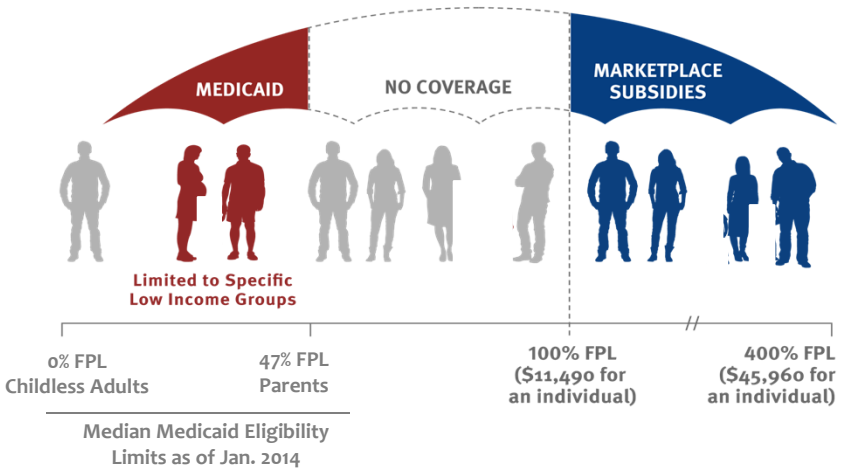
- State-based Marketplace and Moving Forward with the Medicaid expansion (16 States including DC)
- State-based Marketplace and Not Moving Forward with the Medicaid expansion (1 State)
- Federally-Facilitated or Partnership Marketplace and Moving Forward with the Medicaid Expansion (10 States)
- Federally-Facilitated or Partnership Marketplace and Not Moving Forward with the Medicaid Expansion (24 States)

SOURCE: State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, as of October 22, 2013, KFF State Health Facts, http://www.kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/#

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 15

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.

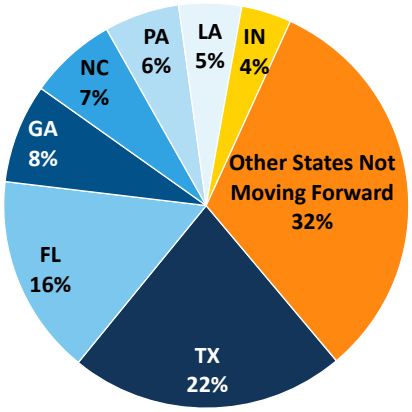


NOTE: Applies to states that do not expand Medicaid. In most states not moving forward with the expansion, adults without children are ineligible for Medicaid .

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 16

An estimated 4.8 million uninsured nonelderly adults below poverty may fall into the coverage gap in states not adopting the Expansion.



4.8 Million in the Coverage Gap

4% of those that fall in this coverage gap (181,930 nonelderly adults) reside in Indiana.

- This includes parents and childless adults.
- Some of these adults will obtain limited coverage through the Healthy Indiana Plan (HIP), though enrollment for childless adults is capped.

Notes: Excludes legal immigrants who have been in the country for five years or less and immigrants who are not lawfully present. The poverty level for a family of three in 2013 is $19,530.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2012-2013 Current Population Survey. See Methods Box for more detail.

THE KAISER COMMISSION ON Medicaid and the Uninsured

Figure 17

Key Takeaways

- **Medicaid plays many vital roles in our health care system.**
  - Provides health insurance coverage for over 66 Million low-income people and represents nearly $1 out of every $6 of health care spending across the country.
  - Provides help to 9.6 Million Medicare beneficiaries; Medicaid represents 40% of all long term care spending.
  - Medicaid represents both an expenditure and revenue item in state budgets.
- **There are many factors that are shaping Medicaid programs today.**
  - ACA implementation, delivery system reform, economic conditions and ongoing federal deficit reduction efforts, continued focus on cost containment and administration.
- **Expanding coverage is a key element of health reform. The ACA Medicaid expansion is designed to fill current gaps in coverage**.
  - The Medicaid expansion decision has many coverage and fiscal implications for states. Coverage for those newly eligible will be 100% federally financed in states that adopt the expansion from January 2014 until December 31, 2016; the federal match will then phase down to 90% in 2020 and beyond. There is no deadline for states to adopt the Medicaid expansion.
  - An estimated 4.8 million uninsured nonelderly adults below poverty may fall into the coverage gap in states not adopting the Expansion at this time.
  - Four percent of those that fall in this coverage gap (181,930 nonelderly adults) reside in Indiana. Some of these adults will obtain limited coverage through the Healthy Indiana Plan (HIP), though enrollment for childless adults is capped.

THE KAISER COMMISSION ON Medicaid and the Uninsured

What's Next? Tackling the Remaining Health Coverage Challenges for Children and Families in Indiana

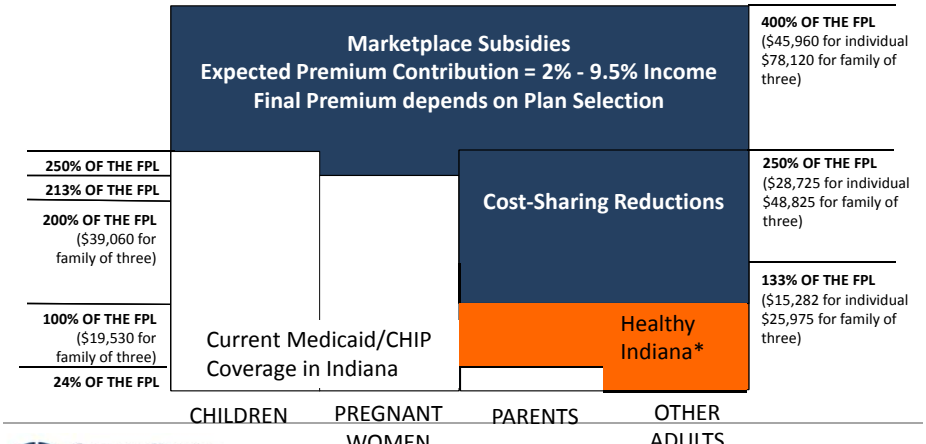
Sonya Schwartz, Research Fellow

Challenge #1 Coverage Gap for Adults

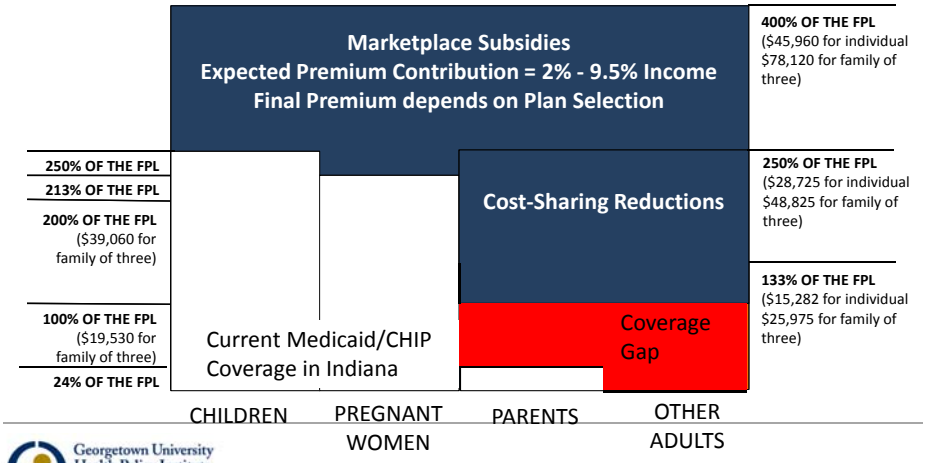
- Healthy Indiana expires December 31, 2014
- Eligibility
  - Adults 19-64 up to the poverty level
  - Children, pregnant women and very low income parents get traditional Medicaid
- Benefits:
  - Account styled like a health savings account and commercial benefit package
  - Enrollees make contributions of 2 to 5 percent of income.
- Financing:
  - Enrollment cap at 36,500 people, regular federal match rate of 67%, not enhanced 100% federal match.

Coverage in Indiana in 2014

* Healthy Indiana is capped at 45,000 enrollees so does not fill this whole group.



Coverage Gap in Indiana After 2014



Georgetown University Health Policy Institute CENTER FOR CHILDREN AND FAMILIES

"Straight Up" Medicaid Expansion

Simple State Plan Option May Be More Flexible Than You Think

Financing	Federal Government pays 100% in 2014 to 2016 for newly eligible under health reform, phases down to 90% in 2020.
Benefits	Commercial-like benefit design options and ability to use different benefit designs for different populations.
Cost-Sharing	Limited co-pays allowed for most adults below poverty. Additional co-pays allowed for adults above poverty. Need a waiver to charge premiums below 150% of the FPL.
Delivery System	Newly eligible adults can go into managed care without a waiver.
Eligibility and Enrollment	Automated based on real-time eligibility determinations, Federal Government pays 90% of system upgrades until 2015.

Georgetown University Health Policy Institute CENTER FOR CHILDREN AND FAMILIES

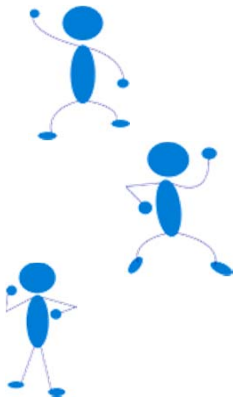
Medicaid 1115 Waiver

- Section 1115 Waivers provide flexibility to design and improve Medicaid in order to:
  - Provide services not covered
  - Improve care, increase efficiency or reduce costs
  - Test new ideas for the program
- Must be "budget neutral"
- Must comport with objectives of the program

Arkansas Medicaid Expansion Approach: "The Private Option"

- Use ACA's enhanced Medicaid funding to buy private insurance on Arkansas' health insurance marketplace
- Medicaid 1115 demonstration waiver approved through 12/31/16
  - Needed a waiver b/c they *required* the expansion population to go into premium assistance in the marketplace

Arkansas Waiver: Eligibility



- Eligibility
  - Childless adults 0-138% of the FPL
  - Parents 17%-138% of the FPL
- Medically frail and American Indians are exempt
- Not phased in or capped

Arkansas Waiver: Benefit Design

- Most benefits same as QHP
- A few additional elements provided fee for service
  - 3 months retroactive coverage
  - EPSDT (for 19 and 20s)
  - non-emergency medical transportation

Arkansas Waiver: Cost-Sharing

- No premiums or cost-sharing below poverty
- Cost-sharing for those 100% to 138% of the FPL at 5% income
- State would make advance cost-sharing reduction payments to QHPs, providers would collect cost-sharing at point of service

Arkansas Waiver: Health Plans

- Enrollment in Marketplace QHPs required
- Choice of at least two silver level QHPs that are viewed to be most-cost effective (auto-assigned if they don't choose)

QualChoice HEALTH INSURANCE

ambetter. of Arkansas

Arkansas BlueCross BlueShield

Iowa Proposed Waiver

Hybrid of wellness and Arkansas model

- Part 1: Adults and parents 50-100% of the FPL enroll in wellness plans would pay premiums
- Part 2: Adults and parents 100-133% of the FPL in Arkansas-style private option/ buy into marketplace

Michigan Expansion Proposal

Medicaid expansion with a sprinkle of Iowa

- People under poverty pay some limited co-pays
- People above poverty pay average monthly co-pay and also premium of 2% of income into health savings account

Pennsylvania Concept Paper

Hybrid of Iowa and Arkansas with a new wrinkle

- All childless adults and newly eligible parents buy coverage in the marketplace.
- Premiums start below poverty
- Work search and job training required for all unemployed, working-age Medicaid beneficiaries

Challenge #2: Indiana Lower than National Average in Kids Coverage

- Preliminary data: 142,672 kids, or 8.4% of all kids, uninsured in Indiana in 2012
- Almost 3,000 school buses full of kids
- Our report will be out on Thursday: http://ccf.georgetown.edu/

Covering more kids needs a multi-pronged approach

Extending the welcome mat through eligibility expansions, both broad and targeted

Getting the word out and assisting families through the process

Removing red tape barriers to enrollment and renewal

Coverage for Parents Creates "Welcome Matt" Effect for Kids

- Arkansas DHS mailed letters to 132,000 households on SNAP
  - Listed members who were likely eligible for Arkansas private option
- 57,982 new enrollees in Arkansas
  - 55,500 adults will get coverage in January
  - 2,539 children enrolled in ARKids First immediately

Policies and Procedures that Promote Enrollment for Kids

	Indiana
1. Eliminate Waiting Periods	
2. Simplified application	⊙
3. Reduced paper documentation	
4. No asset tests and in-person interviews	⊙
5. Electronic verification of eligibility	•
6. Multiple entry points (online, paper, over the phone)	•
7. Presumptive eligibility	
8. Express lane eligibility	
(Note: Items in bold are required to be in place by January 1, 2014 under the ACA)	

Georgetown University Health Policy Institute CENTER FOR CHILDREN AND FAMILIES

Policy and Procedures to Promote Retention for Kids

	Indiana
1. Annual renewals	⊙
2. 12 month continuous eligibility (eliminates need to report increases in income)	•
3. Ex-parte or administrative renewals	
4. Multiple ways to renew	
5. Express lane renewals	
Note: Items in bold are required to be in place by January 1, 2014 under the ACA)	

Georgetown University Health Policy Institute CENTER FOR CHILDREN AND FAMILIES

Challenge #3: Need for Consumer Assistance to Get Covered

ACA sets new expectations for outreach and consumer assistance.

Medicaid & CHIP Agencies

- Conduct outreach
- Use plain language in program information
- Provide enrollment assistance
  - Vulnerable and underserved populations
  - Online, in-person, phone
- May have certified application counselors

Exchanges

- Conduct outreach and public education
- Operate a call center
- Maintain a robust web site
- Create a navigator program
- Must have a certified application counselor program

Lack of Consumer Awareness

According to Kaiser Family Foundation's September polls, about half of the public (51 percent), and two-thirds of the uninsured (67 percent) continue to say they don't have enough information about the law to know how it will impact their families.

Of those consumers who said they do not have enough information, they most wanted answers on the following questions:

1) What are the costs and what will people have to pay?
2) What is the law and how does it work?
3) How will the law improve the health care system?
4) What is the impact of the law on specific groups such as the uninsured or young people?
5) How will people personally be impacted?
6) What are the benefits and other coverage provided?

Georgetown University Health Policy Institute CENTER FOR CHILDREN AND FAMILIES

Source: Kaiser Family Foundation, September 2013. http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-september-2013/

Consumer Choices Increase Need for Assistance

- Research has shown that many choices can be overwhelming
- Consumers of health coverage need assistance in sorting through options
- Consumer assistance is limited, particularly in FFM states
- Future remedies include boosting consumer assistance and active purchasing to demand higher-quality, lower-cost products and limit options
- Important to monitor enrollment and consumer satisfaction

"There's no way people are going to be able to make optimal decisions, except by luck," says Barry Schwartz, a psychology professor at Swarthmore University and author of The Paradox of Choice: Why More Is Less. "If you have 40 or 50 insurance possibilities, there will be less uptake and people will make bad decisions."

Georgetown University Health Policy Institute CENTER FOR CHILDREN AND FAMILIES

Snapshot of Indiana's Marketplace

QHP Overview	
4 issuers offering coverage across the state	Anthem Blue Cross and Blue Shield
	Ambetter from MHS
Between 2 and 4 Issuers in 16 of 17 Rating Areas Only one insurer in Rating Area 14	Physicians Health Plan
Premiums start at $146 without premium tax credit for 27 year old in catastrophic plan.	MDWise

Sources: Healthcare.gov: https://www.healthcare.gov/health-plan-information/

Bumpy Launch for Healthcare.gov

- Opened for business October 1
- Rates on average 16% lower than expected
- Significant eligibility and enrollment IT system technical problems currently being addressed
- Boosting capacity to handle applications by phone and mail in short-term

Early Indiana Enrollment Data

- Preliminary data about Indiana from last week's HHS data report for the month of October 2013:
  - →15,982 applications complete
  - →31,979 individuals applying
  - →35,802 eligible to enroll in federally facilitated marketplace
    - →7,890 eligible for financial assistance in marketplace
    - →701 have selected a marketplace plan
  - →19,477 assessed eligible for Medicaid and CHIP

http://aspe.hhs.gov/health/reports/2013/marketplaceenrollment/rpt_enrollment.pdf

Consumer Assistance in Indiana

	Navigators	Each marketplace must have a navigator program. State must have at least 2 types of entities, including community-based consumer focused nonprofit. States can develop additional training for nonprofits.
	Certified Application Counselors	Each marketplace must have a certified application counselor program. The FFM is designating qualified CAC entities who will screen staff and employees to be trained to assist with application and enrollment. Medicaid administrative match available to fund assisters that help with Medicaid enrollment.
	FQHC Enrollment Counselors	HHS awarded $150 million in grants to 1,159 health centers across the nation to enable them to help uninsured Americans gain affordable health insurance coverage.
	State/local gov agencies	Medicaid eligibility offices will assist consumers with no-wrong door access to coverage.
	Agents/Brokers /Producers	State choice to allow agents and brokers to sell QHP's to individuals and small businesses in FFM. Agents and brokers receive commission directly from issuers.

Snapshot of Indiana's Consumer Assistance

Navigator Funding

HHS awarded four organizations total of more than $2 million:

- Affiliated Service Providers of Iowa, Inc $897,150
- Plus One Enterprises, LTD, LLC $130,875
- Health and Hospital Corporation of Marion County $590,895
- United Way Worldwide $424,586

Health Centers

HHS awarded $2,335,025 to health centers across Indiana to enable them to help uninsured Americans gain affordable health insurance coverage.

- Expect to hire 47 additional workers

CACs

Healthcare.Gov

- Lists 88 organizations when search "find local help" for Indianapolis alone
- Includes CHCs, navigators, and CAC entities
- https://localhelp.healthcare.gov/

Areas to Focus On

- ➔ Coverage gap for low-income adults
  - ❑ Straight up expansion? Medicaid Waiver?
- ➔ Comparatively high rate of uninsured children, many of whom are already eligible for programs
  - ❑ ACA requires state eligibility and enrollment process to for kids coverage programs to improve
  - ❑ Legislature can oversee this transformation
- ❑ Need for consumer assistance to get covered
  - ❑ Refer constituents to existing consumer assistance resources
  - ❑ Use Medicaid admin funds to support enrollment activities

For More Information

Sonya Schwartz

- ss3361@georgetown.edu

Center for Children and Families website

- ccf.georgetown.edu

Say Ahhh! Our child health policy blog

- http://ccf.georgetown.edu/blog/

Assessing the Impact of Policies on Families

Family Impact Checklist: Using Evidence to Strengthen Families

Questions policymakers can ask to bring the family impact lens to policy decisions:

- How are families affected by the issue?
- In what ways, if any, do families contribute to the issue?
- Would involving families result in more effective policies and programs?

These questions sound simple, but they can be difficult to answer. The Family Impact Checklist is one evidence-based strategy to help ensure that policies and programs are designed and evaluated in ways that strengthen and support families in all their diversity across the lifespan. This checklist can also be used for conducting a family impact analysis that examines the intended and unintended consequences of policies, programs, agencies, and organizations on family responsibility, family stability, and family relationships.

Family impact analysis is most incisive and comprehensive when it includes expertise on (a) families, (b) family impact analysis, and (c) the specifics of the policy, program, agency, or organization. Five basic principles form the core of a family impact checklist. Each principle is accompanied by a series of evidence-based questions that delve deeply into the ways in which families contribute to issues, how they are affected by them, and whether involving families would result in better solutions. Not all principles and questions will apply to every topic, so it is important to select those most relevant to the issue at hand.

The principles are not rank-ordered and sometimes they conflict with each other. Depending on the issue, one principle may be more highly valued than another, requiring trade-offs. Cost effectiveness and political feasibility also must be taken into account. Despite these complexities, family impact analysis has proven useful across the political spectrum and has the potential to build broad, bipartisan consensus.

More detailed guidelines and procedures for conducting a family impact analysis are available in a handbook published by the Policy Institute for Family Impact Seminars at http://www.familyimpactseminars.org.

Principle 1. Family responsibilities.

Policies and programs should aim to support and empower the functions that families perform for society—family formation, partner relationships, economic support, childrearing, and caregiving. Substituting for the functioning of families should come only as a last resort.

How well does the policy, program, or practice:

Strong	Adequate	Limited	N/A	
☐	☐	☐	☐	help families build the capacity to fulfill their functions and avoid taking over family responsibilities unless absolutely necessary?
☐	☐	☐	☐	set realistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members depending on their family structure, resources, and life challenges?
☐	☐	☐	☐	address root causes of assuming financial responsibility such as high child support debt, low literacy, low wages, and unemployment?
☐	☐	☐	☐	affect the ability of families to balance time commitments to work, family, and community?

Principle 2. Family stability.

Whenever possible, policies and programs should encourage and reinforce couple, marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself. How well does the policy, program, or practice:

Strong	Adequate	Limited	N/A	
☐	☐	☐	☐	strengthen commitment to couple, marital, parental, and family obligations, and allocate resources to help keep the marriage or family together when this is the appropriate goal?
☐	☐	☐	☐	help families avoid problems before they become serious crises or chronic situations that erode family structure and function?
☐	☐	☐	☐	balance the safety and well-being of individuals with the rights and responsibilities of other family members and the integrity of the family as a whole?
☐	☐	☐	☐	provide clear and reasonable guidelines for when nonfamily members are permitted to intervene and make decisions on behalf of the family (e.g., removal of a child or adult from the family)?
☐	☐	☐	☐	help families maintain regular routines when undergoing stressful conditions or at times of transition?
☐	☐	☐	☐	recognize that major changes in family relationships such as aging, divorce, or adoption are processes that extend over time and require continuing support and attention?
☐	☐	☐	☐	provide support to all types of families involved in the issue (e.g., for adoption, consider adoptive, birth, and foster parents; for remarried families, consider birth parents, stepparents, residential and nonresidential parents, etc.)?

Principle 3. Family relationships.

Policies and programs must recognize the strength and persistence of family ties, whether positive or negative, and seek to create and sustain strong couple, marital, and parental relationships.

How well does the policy, program, or practice:

Strong	Adequate	Limited	N/A	
□	□	□	□	recognize that individuals' development and well-being are profoundly affected by the quality of their relationships with close family members and family members' relationships with each other?
□	□	□	□	involve couples, immediate family members, and extended family when appropriate in working to resolve problems, with a focus on improving family relationships?
□	□	□	□	assess and balance the competing needs, rights, and interests of various family members?
□	□	□	□	take steps to prevent family abuse, violence, or neglect?
□	□	□	□	acknowledge how interventions and life events can affect family dynamics and, when appropriate, support the need for balancing change and stability in family roles, rules, and leadership depending upon individual expectations, cultural norms, family stress, and stage of family life?
□	□	□	□	provide the knowledge, communication skills, conflict resolution strategies, and problem-solving abilities needed for healthy couple, marital, parental, and family relationships or link families to information and education sources?

Principle 4. Family diversity.

Policies and programs can have varied effects on different types of families. Policies and programs must acknowledge and respect the diversity of family life and not discriminate against or penalize families solely based on their cultural, racial, or ethnic background; economic situation; family structure; geographic location; presence of special needs; religious affiliation; or stage of life.

How well does the policy, program, or practice:

Strong	Adequate	Limited	N/A	
□	□	□	□	identify and respect the different attitudes, behaviors, and values of families from various cultural, economic, geographic, racial/ethnic, and religious backgrounds, structures, and stages of life?
□	□	□	□	respect cultural and religious routines and rituals observed by families within the confines of the law?
□	□	□	□	recognize the complexity and responsibilities involved in caring for and coordinating services for family members with special needs (e.g., cognitive, emotional, physical, etc.)?
□	□	□	□	ensure the accessibility and quality of programs and services for culturally, economically, geographically, racially/ethnically, and religiously diverse families?
□	□	□	□	work to ensure that operational philosophies and procedures are culturally responsive and that program staff are culturally competent?
□	□	□	□	acknowledge and try to address root causes rather than symptoms of the issue or problem (e.g., economic, institutional, political, social/psychological causes)?

Principle 5. Family engagement.

Policies and programs must encourage partnerships between professionals and families. Organizational culture, policy, and practice should include relational and participatory practices that preserve family dignity and respect family autonomy.

How well does the policy, program, or practice:

Strong	Adequate	Limited	N/A	
□	□	□	□	provide full information and a range of choices to families, recognizing that the length and intensity of services may vary according to family needs?
□	□	□	□	train and encourage professionals to work in collaboration with families, to allow families to make their own decisions (within the confines of the law), and to respect their choices?
□	□	□	□	involve family members, particularly from marginalized families, in policy and program development, implementation, and evaluation?
□	□	□	□	affirm and build upon the existing and potential strengths of families, even when families are challenged by adversity?
□	□	□	□	make flexible program options available and easily accessible through co-location, coordinated application and reimbursement procedures, and collaboration across agencies, institutions, and disciplines?
□	□	□	□	establish a coordinated policy and service system that allows localities and service providers to combine resources from various, diverse funding streams?
□	□	□	□	acknowledge that the engagement of families, especially those with limited resources, may require emotional, informational, and instrumental supports (e.g., child care, financial stipends, transportation)?
□	□	□	□	connect families to community resources and help them be responsible consumers, coordinators, and managers of these resources?

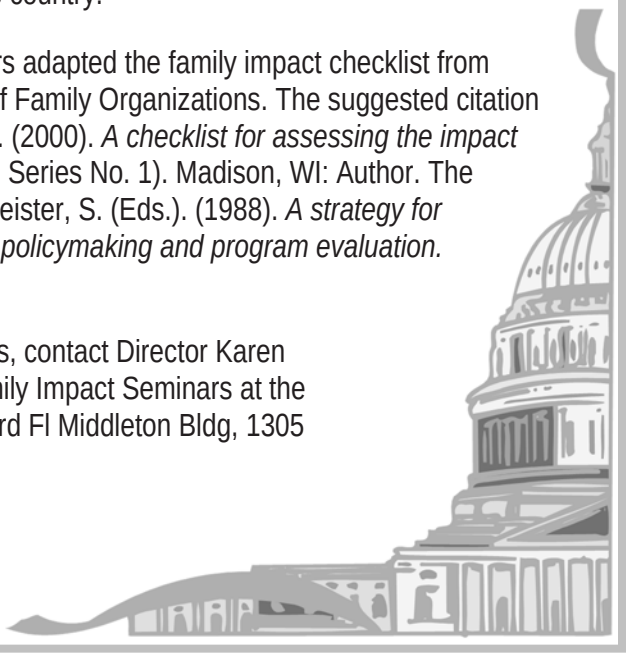
□	□	□	□	build on social supports that are essential to families' lives (e.g., friends; family-to-family support; community, neighborhood, volunteer, and faith-based organizations)?
□	□	□	□	consider the whole family (even if it is outside the scope of services) and recognize how family decisions and participation may depend upon competing needs of different family members?

The Institute aims to strengthen family policy by connecting state policymakers with research knowledge and researchers with policy knowledge. The Institute provides nonpartisan, solution-oriented research and a family impact perspective on issues being debated in state legislatures. We provide technical assistance to and facilitate dialogue among professionals conducting Family Impact Seminars in 28 sites across the country.

The Policy Institute for Family Impact Seminars adapted the family impact checklist from one originally developed by the Consortium of Family Organizations. The suggested citation is Policy Institute for Family Impact Seminars. (2000). *A checklist for assessing the impact of policies on families* (Family Impact Analysis Series No. 1). Madison, WI: Author. The checklist was first published in Ooms, T., & Preister, S. (Eds.). (1988). *A strategy for strengthening families: Using family criteria in policymaking and program evaluation.* Washington DC: Family Impact Seminar.

For more information on family impact analysis, contact Director Karen Bogenschneider of the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension, 3rd Fl Middleton Bldg, 1305 Linden Drive, Madison, WI 53706.

Phone (608) 263-2353
FAX (608) 265-6048
http://www.familyimpactseminars.org



Resources and Additional Information

Additional Resources

- Sonya Schwartz: ss3361@georgetown.edu
- Center for Children and Families website: ccf.georgetown.edu
- Say Ahhh! Our child health policy blog: http://ccf.georgetown.edu/blog/

KFF Resources on the Uninsured

- The Uninsured Primer: http://www.kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/
- The Uninsured: An Interactive Tool: http://www.kff.org/interactive/the-uninsured-an-interactive-tool/
- The Uninsured: A Primer – Key Facts about Health Insurance on the Eve of Coverage Expansions: http://www.kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/

KFF Resources on Medicaid

- Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014: http://www.kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014/
- Why Does Medicaid Spending Vary Across States: A Chartbook of Factors Driving State Spending: http://www.kff.org/medicaid/report/why-does-medicaid-spending-vary-across-states/
- Medicaid Eligibility for Adults as of January 1, 2014: http://www.kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/
- What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidencehttp://www.kff.org/medicaid/issue-brief/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/
- Medicaid Expansion Through Premium Assistance: Arkansas and Iowa's Section 1115 Demonstration Waiver Applications Compared: http://www.kff.org/health-reform/fact-sheet/medicaid-expansion-through-premium-assistance-arkansas-and-iowas-section-1115-demonstration-waiver-applications-compared/
- Medicaid Expansion Through Marketplace Premium Assistance: http://www.kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/
- The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid: http://www.kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/
- Healthy Indiana Plan: Key Facts and Issues: www.kff.org

KFF RESOURCES ON THE MARKETPLACE

- State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act: http://www.kff.org/health-reform/issue-brief/state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits-under-the-affordable-care-act/ Resources
- Subsidy Calculator: Premium Assistance for Coverage in Exchanges: http://www.kff.org/interactive/subsidy-calculator/
- State Health Insurance Marketplace Profiles: http://www.kff.org/state-health-marketplace-profiles/
- For Consumers: Understanding Health Reform: http://www.kff.org/aca-consumer-resources/

Sponsoring Organizations and Descriptions

The Center for Families at Purdue University focuses on improving the quality of life for families and strengthening the capacity of families to provide nurturing environments for their members. To accomplish this, the center works with four important groups whose efforts directly impact quality of life for families: educators, human service providers, employers, and policymakers. With informed sensitivity to family issues, these groups have the power to improve the quality of life for families in Indiana and beyond.

Purdue Extension Health and Human Sciences provides informal educational programs that increase knowledge, influence attitudes, teach skills, and inspire aspirations. Through the adoption and application of these practices, the quality of individual, family, and community life is improved. Health and Human Sciences Extension is a part of the mission of the College of Health and Human Sciences at Purdue University and the Purdue Extension Service

The Department of Family and Consumer Sciences at Ball State University includes a variety of majors from interior design and residential property management to nutrition and marriage and family relations. We offer courses in family relations, infant/toddler, child development, marriage, life-work management, family stress and family policy. Students are also required to take interdisciplinary coursework. In addition, students are required to complete a 400 hour internship at a family or child related facility which also includes government internships. Our curriculum has been designed to fulfill the academic requirements to become a Certified Family Life Educator (CFLE). CFLEs have received academic training in ten substantive areas related to the family, one of which is family policy, and are certified by the National Council of Family Relations, a professional organization.

The Institute for Family and Social Responsibility is a joint venture of the Schools of Social Work and Public and Environmental Affairs designed to bring the resources of Indiana University researchers to the assistance of public policy makers on issues impacting Hoosier families. The Institute's mission is to bring together the resources of citizens, governments, communities and Indiana University to better the lives of children and families. Ongoing research projects have examined the impacts of welfare reforms, the efficiency of the township system of government, the adequacy of child support guidelines, community responses to the Temporary Assistance to Needy Families legislation, performance contracting for intensive family preservation services, and AIDS education for incarcerated youth. The Institute serves as the National Child Support Enforcement Research Clearinghouse.

The mission of the Indiana Association for the Education of Young Children (Indiana AEYC) is to promote and support quality care and education for all young children birth through age eight in Indiana. Indiana AEYC is the state's largest and most influential organization of early childhood care and education professionals and parents promoting and supporting quality care and education for all young children. Over 2,200 members represented through sixteen local chapters, and a budget of over $6 million dollars. Indiana AEYC supports early care and education professional development through the T.E.A.C.H. (Teacher Education and Compensation Helps) scholarship project, the Indiana Non Formal Child Development Associate (CDA) project and by conducting the largest statewide conference. Indiana AEYC also supports highest level of early care and education facilities by partnering with the Indiana FSSA/DFR/Bureau of Child Care to implement Paths to QUALITY™ and the Indiana Accreditation Project for over 820 early childhood facilities statewide.

Indiana Family Services represents families and respond to their needs by strengthening member agencies and creating alliances to promote excellence in advocacy and service for families throughout Indiana. Member agencies offer a wide variety of programs, including counseling, sexual abuse assessment, homemaker services, children's programs, services for victims of domestic violence, as well as many other diverse programs for over 90,000 individuals, approximately 80 percent of whom are low income. These services are offered regardless of race, creed, or color on a sliding fee scale supported by local United Ways and governmental grants.

The Indiana Association of Marriage and Family Therapy is part of the American Association of Marriage and Family Therapy. Since the founding of AAMFT in 1942, they have been involved with the problems, needs and changing patterns of couples and family relationships. The association leads the way to increasing understanding, research and education in the field of marriage and family therapy, and ensuring that the public's needs are met by trained practitioners. The AAMFT provides individuals with the tools and resources they need to succeed as marriage and family therapists.

It is the mission of the Indiana Extension Homemakers Association® to strengthen families through continuing education, leadership development, and volunteer community support. We share information on new knowledge and research with our members and communities, promote programs on developing skills and family issues, and we support projects which help children and families in today’s world.

The Indiana Youth Institute promotes the healthy development of Indiana children and youth by serving the people, institutions and communities that impact their well-being. It is a leading source of useful information and practical tools for nonprofit youth workers, educators, policymakers, think tanks, government officials, and others who impact the lives of Hoosier children. In addition, it is an advocate for healthy youth development on the local, state, and national level.

The mission of the National Association of Social Workers – Indiana Chapter is to promote the quality and integrity of the Social Work profession while supporting social workers in their mission to serve diverse populations and to ensure justice and equality for all citizens of the state.