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Authority: IC 2-5-23

HEALTH FINANCE COMMISSION

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Tel: (317) 233-0696 Fax: (317) 232-2554

MEETING MINUTES[1]

Meeting Date:	**August 21, 2013**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., the Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**3**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Ryan Mishler; Sen. Rodric Bray; Sen. Ron Grooms; Sen. Jean Leising; Sen. Pete Miller; Sen. Jean Breaux; Sen. Frank Mrvan; Sen. Greg Taylor; Rep. Ed Clere, Vice-Chairperson; Rep. Steven Davisson; Rep. Ronald Bacon; Rep. Robert Behning; Rep. Suzanne Crouch; Rep. David Frizzell; Rep. Eric Turner; Rep. Dennis Zent; Rep. Charlie Brown; Rep. B. Patrick Bauer; Rep. Gregory Porter; Rep. Robin Shackleford.**

Members Absent: **Sen. Vaneta Becker; Sen. Ed Charbonneau; Sen. Mark Stoops; Rep. Donald Lehe.**

Chairperson Patricia Miller called the meeting to order at 10:05 a.m. and informed

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[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

the Commission that a report from the Indiana Department of Insurance (DOI) discussing the upcoming changes to the Indiana individual health insurance market in 2014 was being distributed for their review and that Logan Harrison from DOI would attend the October Commission meeting to answer any questions members may have. See Exhibit 1.

Traumatic Brain Injury (TBI) Issues

Ms. Faith Laird, Family Social Services Administration (FSSA), stated that Indiana has a Medicaid TBI waiver and updated the Commission on the number of Medicaid recipients that are receiving out-of-state care for a traumatic brain injury. Ms. Laird stated that in 2013, 82 Medicaid recipients were served in out-of-state rehabilitation facilities with a total payment of $6.9 million (federal and state dollars). Ms. Laird stated that 195 slots for the TBI waiver have been awarded with a waiting list of 113 people (although 47 of the 113 are receiving services under the A&D Medicaid waiver). Ms. Laird stated that it is difficult to replicate the out-of-state programs because of the lack of licensing for such a facility in Indiana and that individuals with brain injuries often fail to meet the level of care needed to qualify for an Indiana Medicaid waiver. Ms. Laird stated that FSSA has recently amended the Medicaid TBI waiver to allow an Intermediate Care Facility for Individuals with Disabilities (ICF/ID) care level that is lower than nursing facility level of care in an attempt to provide flexibility and address the issue.

Mr. Terry Whitson, Indiana State Department of Health (DOH), stated that DOH has been working on creating a licensing category for TBI treatment and has been looking at care being provided in a campus environment with multiple levels of care available. Mr. Whitson stated that he expects preliminary rules to be filed in November and the rule-making process generally takes nine months after the initial filing.

Ms. Susie Fitt, a parent of a child who suffers from a brain injury, provided the Commission with her experience of trying to obtain adequate care for her child and her experience in going out-of-state with her son for nine months for care. See Exhibit 2.

Mr. Alan Neuenschwander, a parent of a child who suffers from a brain injury, relayed his experience with obtaining adequate care, specifically mental health care for problems stemming from the brain injury. Mr. Neuenschwander stated that his son was in Michigan for eight months receiving care until they were unable to afford additional care, stating that one month of care in Michigan cost $28,000. Mr. Neuenschwander stated that his son's care now costs $1,800 a month with $600 being the responsibility of the family. Mr. Neuenschwander stated that Indiana needs: (1) brain injury residential treatment in the state; (2) brain injury treatment with tiered strategies; (3) state commitment to learning about brain injuries; (4) less separation of services; and (5) training for health care providers and patients. See Exhibit 2.

Dr. Lisa Lombard, Medical Director, Rehabilitation Hospital of Indiana (RHI), provides care to individuals with TBI in acute care, inpatient rehabilitation and outpatient clinic settings. Dr. Lombard discussed multiple issues that a TBI patient may face, including physical impairments, cognitive dysfunction, and post-traumatic amnesia. Dr. Lombard stated that almost all TBI patients leaving inpatient rehabilitation require 24 hour supervision and options are limited because there are very few post-acute facilities and the existing facilities in Indiana have long waiting lists. Dr. Lombard said that she is often forced to send a TBI patient from inpatient rehabilitation to a nursing facility and that a nursing facility is not the optimum care for a the patient because of a lack of providers trained in TBI, inadequate needed therapies, and the focus is not on community reentry. See Exhibit 2.

Ms. Roberta Schmidt, Neuro Restorative, discussed the new Neuro Restorative residential program that opened in Indiana in June, 2012, and has served 15 residents. Ms. Schmidt described the services available in the program. See Exhibit 3.

Dr. John Hinton, Advantage Health Solutions, stated that Advantage Health Solutions manages the traumatic brain injury program for FSSA which services 75-100 Indiana residents annually with neurocognitive rehabilitation. Advantage Health Solutions coordinates admissions and extensive requests for the program. Dr. Hinton testified that half of the people who are receiving out-of-state services have been unable to return to Indiana because of funding or due to lack of appropriate facilities, stating that some of these individuals have been receiving out-of-state services since the 1990s. See Exhibit 4. Dr. Hinton provided statistics concerning the population and stated that the state has a financial interest in bringing these patients back in-state and providing these patients with a full continuum of care. See Exhibit 4.

Immunizations

Dr. Virginia Caine, Marion County Department of Health, stated that Indiana is ranked 31st in immunizing babies 19-35 months old. See Exhibit 5. Dr. Caine said that adult (19-65 years) immunizations are also significantly lacking and these immunizations are important to eliminate unnecessary carriers of diseases. In 2013, there have been 1,922 vaccine preventable illnesses or diseases in Indiana. See Exhibit 5. Dr. Caine provided possible reasons for low vaccination rates and testified concerning the benefits of vaccinations. See Exhibit 5. Dr. Caine stated that pharmacies are critical healthcare partners and recommended the following: (1) allow all Centers for Disease Control and Prevention (CDC) recommended vaccines to be administered by pharmacists under protocol; (2) eliminate the 65 years and under exclusion in Indiana for a pharmacist to provide the pneumonia vaccine; and (3) maximize the utilization of DOH's Children's and Hoosiers Immunization Registry Program (CHIRP) to increase safety and awareness. The Commission discussed county health departments' recent change in policy required by the federal government in requiring those individuals with insurance coverage to use the insurance in order to receive the immunization.

Mr. David McCormick, DOH, provided the Commission with a list of the immunizations required for children to receive in Indiana and the state adolescent immunization rates. See Exhibit 6. Mr. McCormick stated that DOH has the authority to add immunization requirements to the list for children if the immunization has been recommended by CDC or DOH. Mr. McCormick discussed the CHIRP registry and MYVaxIndiana, a program that allow individual to access the individual's immunization records.

Ambulatory Outpatient Surgical Center (ASC)

Mr. Terry Whitson, DOH, stated that Indiana had 20 ASCs in 1990 and now has around 120. See Exhibit 7. DOH is the state licensing agency and the state surveying entity for federal certification for ASCs. Mr. Whitson discussed the physician requirements for an ASC. Mr. Whitson testified that Indiana law requires an ASC to be operated under the supervision of at least one licensed physician. Also, rules require that a physician be available to the ASC during the period any patient is present in the center. See Exhibit 7. Mr. Whitson discussed healthcare associated infection outbreaks and an outbreak at an ASC in 2008 which resulted in the federal government taking a closer look at infection control in ASCs. The federal government now requires a survey of an ASC every 36 months. Mr. Whitson discussed the Quality Assurance and Performance Improvement (QAPI) program which focuses on evidenced-based quality of care. See Exhibit 7.

Update on the Release of Medicaid Recipient Personal Information

Mr. Lance Rhodes, FSSA, informed the Commission that RCR Corporation, a technology company that has contracted with FSSA to maintain FSSA's document management system and update the system to meet federal requirements and to increase capacity to maintain documents, released an updated management system in April, 2013, that included a programming error. The programming error was made from April 6, 2013, through May 31, 2013, and resulted in the breach of personal information of clients. See Exhibit 8. Mr. Rhodes stated that after a thorough review by RCR to determine the extent of the release of personal information, RCR determined that 64 clients were impacted by the release and RCR is offering credit monitoring services for these clients. Mr. Rhodes stated that Crowe Horvath completed an independent review that confirmed the accuracy of RCR's findings. Mr. Rhodes testified that FSSA has reviewed and adjusted internal processes, reviewed security alternatives, and invoiced RCR for appropriate expenses related to the breach.

The Commission took a brief lunch break before resuming testimony.

The Use of Tanning Beds

Dr. Carrie Davis, Indiana Academy of Dermatology, provided statistics on skin cancer (basal cell, squamous cell, and melanoma), saying that skin cancer is the most common form of any cancer. One of five Americans will develop skin cancer in their lifetime, and ultraviolet light exposure is the leading cause of skin cancer. See Exhibit 9. Dr. Davis stated that there is no such thing as a safe tan, and that even one use of a tanning device can increase one's risk of skin cancer. Dr. Davis testified concerning the risks in using tanning beds and stated that studies have indicated limited effectiveness or noncompliance with parental consent laws in using tanning beds. See Exhibit 9.

Dr. Keeter Sechrist, a dermatologist, testified concerning the huge increase in skin cancer over her 29 years of practice, and attributes the increase to the use of indoor tanning. Dr. Sechrist recommended banning indoor tanning for minors.

Ms. Katie Donnar, melanoma survivor, stated that she began indoor tanning at 13 years old and was diagnosed with malignant melanoma at 17 years old. Ms. Donnar stated that she tanned at a friend's house, at a tanning salon, and finally her family purchased a tanning bed. Ms. Donnar testified that she tanned to look good for cheerleading and dances and did not realize the risks.

Mr. Joe Levy, American Suntanning Association, provided information concerning melanoma, stating that there is no straightforward relationship between melanoma and ultraviolet ray exposure. See Exhibit 10. Mr. Levy stated that a tan is part of nature's design to prevent sunburn damage. Mr. Levy referred to a study that indicated that home tanning units increased risks of skin cancer by 40%, phototherapy medical units increased the risk by 50%, whereas commercial tanning units did not result in a significant increase in risk. Mr. Levy testified that preventing minors from using indoor tanning salons may result in minors resorting to home tanning units. Ms. Lisa Brooking, a smart-tan certified tanning bed provider in southern Indiana, testified concerning the training she has received and the tanning plan she establishes with each customer. See Exhibit 10.

The Disposal of Used Prescription Drugs

Representative Steve Davisson, a member of the Indiana Prescription Drug Abuse Task Force, discussed the problem of prescription drug abuse, stating that 71% of people

abusing painkillers obtained the drug from friends or relatives. See Exhibit 11. Rep. Davisson stated that the Task Force would like to increase the number of "take back sites" in Indiana where residents can return unused prescription drugs for proper disposal. Rep. Davisson discussed the criminal, economic, and environmental impact of drugs that are not disposed of properly, including the polluting of Indiana waterways. Rep. Davisson said that current federal law does not allow pharmacies to maintain collection receptacles, however there are proposed federal regulations that would authorize manufacturers, distributors, and retail pharmacies to voluntarily administer programs and maintain collection receptacles. Indiana state law allows for pharmacies to serve as collection receptacle location sites and Indiana law is consistent with the proposed federal rules. Rep. Davisson discussed a proposed take back program that would allow pharmacies to maintain collection receptacles to offer safe disposal options for communities and discussed challenges of the program. See Exhibit 11.

Mr. Greg Pachmayr, Indiana Board of Pharmacy, discussed Indiana's prescription drug take back rules, the security of the take back receptacles, and privacy protection of individuals. Mr. Pachmayr provided information concerning the proposed federal rules concerning take back programs. Mr. Pachmayr stated that obstacles of a take back program in Indiana include the lack of final federal regulations, the lack of a program model, and the costs of operating a take back site.

Medicaid Managed Care Organizations' Update

Representatives of the three managed care organizations that have contracted with Medicaid to provide coverage for Medicaid recipients answered questions and distributed to the Commission statistics, including the number of enrolled providers, scheduling access, claim payment timeliness, and claim denial reasons:

- Ms. Kristen Metzger, Anthem, See Exhibit 12.
- Ms. Patty Hebenstreit, MDwise, See Exhibit 13.
- Mr. John Barth, mhs, See Exhibit 14.

School Free and Reduced Price Lunch Program

Mr. Chuck Mayfield, Legislative Services Agency, provided information and data concerning the consistency between the percentage of students participating in the Free and Reduced Price Lunch Program (Program) and estimates of the percentage of dependent children meeting the Program's income guidelines (under 130% of the federal poverty guidelines) based on income tax return information. See Exhibit 15. Mr. Mayfield discussed that the discrepancy in Adams County and LaGrange County, which had significantly higher estimated eligibility percentages using the income tax data, may be attributed to the large Amish community where the children generally do not receive free or reduced lunch.

Mr. John Barnes, Indiana Department of Education, provided additional information concerning the Program. See Exhibit 16. Mr. Barnes stated that the Program consists of a proactive application process, providing every student household with an application. Indiana's participation average in the Program is 47%, whereas the United States average participation is 53%. The three percent audit required under the Program is to verify eligibility and only includes those students who do not "directly" qualify through participation in the federal Supplemental Nutritional Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). Mr. Barnes provided participation data. See Exhibit 16. Mr. Barnes stated that some individuals who are selected for audit verification do not respond and are thus removed from the program. Mr. Barnes discussed

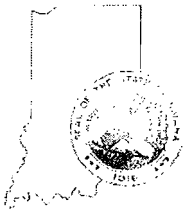
the manner in which the three percent are chosen, including that some are chosen for cause.

Ms. Libby Cierzniak, Indianapolis Public Schools, provided information concerning IPS students' participation in the Program, stating that 46% of the IPS students participating in the program are directly certified and that the audit pool is small. See Exhibit 17.

Ms. Candice Hager, Ft. Wayne Community Schools, stated that the applications are provided to every student and over 50% of her students are directly certified. Ms. Hager stated that their verification audit consists of applications that they think are "error prone" such as citing zero income, "for cause" where people have reported the individual's participation as fraudulent, and random selection. Ms. Hager informed the Commission that .00099% of the applications are removed from the Program.

The meeting adjourned at 4:28 PM.

8/21/13 HFC Exhibit 1



STATE OF INDIANA

MICHAEL R. PENCE, Governor

IDOI

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Stephen W. Robertson, Commissioner

August 6, 2013

Dear Fellow Hoosier,

Attached is a report from the Indiana Department of Insurance ("IDOI") that discusses the upcoming changes to the Indiana individual health insurance market as the Patient Protection and Affordable Care Act ("ACA") is implemented in 2014. Currently, there are approximately 178,000 Hoosiers participating in the Indiana individual health insurance market. Because of ACA, an estimated 300,000 or more Hoosiers could enter the individual health insurance market after 2013.

To be eligible for the federal tax subsidies to offset premium costs paid to health insurance carriers, you *must* purchase your insurance product through the federally facilitated marketplace ("FFM"). If you are not eligible for this subsidy, you may continue to purchase non-FFM insurance policies just like you purchase your individual health insurance policy today but may choose to purchase it through the FFM as well. If you currently receive your healthcare coverage through your employer, this information analysis does not apply to your situation as long as your employer continues to provide coverage as provided for in the ACA.

Even with the implementation of the ACA, the IDOI will continue to regulate all health insurance products sold in the State of Indiana and we will always strive to meet that responsibility in the best interests of all Indiana citizens. Because the federal government will operate and manage the FFM in Indiana, the IDOI will not be able to assist you with the technical parts of the enrollment process on the federal web portal. Please know, however, that we will continue to execute all of those regulatory and consumer protection functions, including complaints against your insurance company, assigned to the IDOI by State law for over two decades.

Sincerely,

Stephen W. Robertson

Stephen W. Robertson
Commissioner of Insurance

The Indiana Department of Insurance ("IDOI") is pleased to release this document for Hoosiers to reference for more details about the individual health insurance options that will be available on the federally-facilitated marketplace ("Marketplace") that is scheduled to begin open enrollment for the 2014 plan year on October 1, 2013. The goal of presenting this information is to provide Hoosiers with additional details on:

- Premium changes in the individual health insurance market from present rates to those offered by health insurers on the federally-facilitated marketplace in 2014;
- The reasons why health insurance rates are changing, in aggregate, and for specific segments of the population; and,
- The effect of the premium tax credit subsidy on out-of-pocket premiums by household income level.

Premium rate changes

Indiana individual health insurance market rating laws currently allow insurers to develop premiums based on age (with an unlimited ratio between young and old), gender, and health status. Further, current rating laws allow insurers to decline coverage to individuals, as well as exclude certain benefits from coverage including maternity and pharmacy services.

The ACA will eliminate rating by health status (i.e., healthy and sick individuals will pay the same rates with healthy individuals subsidizing the rates of sick individuals) and gender (i.e., males and females will pay the same rates with males subsidizing the rates of females), and limit age rating to a 3:1 ratio (i.e., younger population will subsidize the rates of the older population). The ACA also provides that all individuals are guaranteed and may not be declined for health insurance coverage. Finally, the ACA requires essential health benefits, which provides a minimum standard set of benefits.

Detailed information on the number of Hoosiers currently enrolled in specific insurance products and plan designs, as well as associated age, gender, and health status are not publicly available. Therefore, to present sample rates for current individual health insurance market premiums, we have pulled current rates from two sources for the Indianapolis metropolitan area as representative examples:

- **Ehealthinsurance.com**, a website offering individual and family health insurance quotes. We have assumed the rates illustrated on ehealthinsurance.com represent the 'preferred' or best rates that an insurer would offer to a healthy individual or someone in 'excellent' health status. Rates sampled were from Anthem, which has more than 60% market share in the current individual market based on 2012 supplemental health care experience report filings.

- **Indiana Comprehensive Health Insurance Association (ICHIA)**, the high risk pool that is operated by the State of Indiana for Hoosiers who do not currently have access to public coverage, employer sponsored coverage, and are declined coverage by insurers participating in the individual market. We assumed these rates are reflective of an individual in 'poor' health status.

We have illustrated sample premium rates for members and health plans that are similar in design (in terms of deductibles, co-insurance, out-of-pocket maximums) to those that will be offered in the individual health insurance market through the federally-facilitated marketplace in 2014. However, it should be noted that current market plans typically do not cover maternity services and sometimes do not cover mental health and substance abuse services, pharmacy, or other benefits typically covered by employer-sponsored health plans.

In 2014, all individual market plans will be required to offer what is known as the 'essential health benefit package'. Essential health benefits reflect what is covered under most employer sponsored health plans.

Therefore, 2014 individual market plans will cover maternity services, pharmacy, and other benefits that may be excluded from current individual market plans.

It should be noted that the sample plan designs and premiums pulled from ehealthinsurance.com are for illustrative purposes only, and may not be reflective of the price or plan design purchased by a specific Hoosier household. The Ehealthinsurance premiums reflect an August 1, 2013 effective date. The ICHIA premiums reflect an October 1, 2012 effective date.

Figures 1 and 2 illustrate current and 2014 filed premium rates for a 25 and 55 year old single individuals for bronze and silver level plan designs for individuals in excellent and poor health status, respectively. Premium rates for additional ages, family types, plan designs, and a description of the plan designs are available in the Appendix. Please note that the (parenthesis) surrounding a number indicate a negative number or decrease in this case.

Figure 1

Sample Premium Rate Changes – Excellent Health Status

Age / Gender / Family	Health Status	Current Lumenos HSA Plus $5,500	2014 Lowest Cost Bronze	Rate Change	Current Lumenos HSA Plus $3,500	2014 Lowest Cost Silver	Rate Change
25 Year Old Single Male	Excellent	$ 82	$ 212	157.9%	$ 108	$ 266	145.7%
25 Year Old Single Female	Excellent	$ 118	$ 212	79.4%	$ 154	$ 266	72.3%
55 Year Old Single Male	Excellent	$ 253	$ 471	86.5%	$ 332	$ 591	78.0%
55 Year Old Single Female	Excellent	$ 262	$ 471	79.6%	$ 344	$ 591	71.6%

Figure 2

Sample Premium Rate Changes – Poor Health Status

Age / Gender / Family	Health Status	Current ICHIA Plan 5	2014 Lowest Cost Bronze	Rate Change	Current ICHIA Plan 4	2014 Lowest Cost Silver	Rate Change
25 Year Old Single Male	Poor	$ 288	$ 212	(26.3%)	$ 304	$ 266	(12.5%)
25 Year Old Single Female	Poor	$ 551	$ 212	(61.5%)	$ 582	$ 266	(54.3%)
55 Year Old Single Male	Poor	$ 840	$ 471	(43.9%)	$ 888	$ 591	(33.4%)
55 Year Old Single Female	Poor	$ 833	$ 471	(43.5%)	$ 880	$ 591	(32.8%)

Figures 1 and 2 offer the following key observations:

- With the elimination of health status rating, premiums for individuals in excellent health status, regardless of age or gender, may increase by more than 50% relative to comparable plan designs in the current market.

- Conversely, most individuals in ICHIA will receive significant premium decreases, of more than 50% in some cases.
- Young, healthy, adult males may experience premium increases near 150% in 2014. Due to the elimination of gender rating, the premium increase for young, healthy, females is noticeably less.

Based on a national AHIP survey of the individual health insurance market, approximately one-third of the commercial individual health insurance market receives the 'preferred rate', comparable to the rates for 'excellent' health status illustrated in Figure 1. ICHIA enrollment was approximately 7,300 lives in 2012, relative to approximately 183,000 lives in the commercial individual health insurance market based on 2012 insurer filings.

Why are premium rates changing?

The base premium rates are anticipated to change due to several factors beginning in 2014, including:

- Health care trend or inflation – estimated between 8% and 12% based on a sample of insurers' 2014 filings.
- Insured health status – estimated to impact rates 20% or greater.
- Essential health benefits (EHB) requirement – Expansion of covered insured benefits to meet the benefit requirement is estimated to impact rates 5% or greater.
- Minimum actuarial value and maximum out-of-pocket limitations – all non-grandfathered policies sold in the individual health insurance market beginning on January 1, 2014 must have at least a 60% actuarial value and cannot have maximum cost sharing that exceeds $6,350 for single coverage ($12,700 family coverage). The impact of this provision will vary substantially by plan design.
- Additional fees and taxes – estimated to impact rates by 3.5% or greater.
- Transitional reinsurance program – estimated to reduce individual health insurance rates by approximately 10%.

The premium rate changes do not account for the premium tax credit subsidies that some individuals may receive through the federal marketplace. The premium tax credit and cost sharing subsidies are discussed in a later section of this paper.

Healthcare trend or inflation varies by insurer, and is estimated to be between 8% and 12% per year. This accounts for health care trend due to utilization of services, increases in cost of services, and cost changes due to newer technology and innovations.

The health status, or morbidity, of individuals enrolled in the Indiana individual insurance market is anticipated to differ from that of the existing individual insured population. According to one insurer, the morbidity of the individual market is anticipated to be approximately 20% higher than that of the existing small group insurance market. Several factors contributed to this estimate; including:

- The current uninsured population has a higher morbidity or illness burden than the insured population.
    - Morbidity is estimated to increase as previously uninsured individuals enter the market.
- Pent-up demand (individuals gaining access to health insurance for the first time in a significant period of time may utilize more healthcare services due to previously forgoing health services).
- Individual-level purchasing decisions.
- The closing of ICHIA (Indiana's high risk pool). The individuals currently enrolled in ICHIA will be able to purchase insurance in the individual health insurance market.

- A portion of the population choosing to retain grandfathered status.
- Selection due to renewal timing changes. Those with low current rates will delay purchasing an ACA product.

The EHB requirement will result in insurers adding and expanding the coverage of some benefit categories. Examples of the types of benefits being added or expanded include:

- Maternity Coverage
- Prescription Drug Coverage
- Mental Health and Substance Abuse Services
- Pediatric Dental and Vision
- Habilitative Services

In addition to the EHB requirement, limitations on out-of-pocket maximums may also result in premium increases. Finally, for individuals below 250% of the Federal Poverty Level, Cost Sharing Reduction (CSR) plans are available for individuals who elect to enroll in a silver metal level plan on the federally-facilitated marketplace.

Individuals enrolled in these plans are anticipated to have higher utilization levels because out-of-pocket cost sharing is substantially reduced relative to the standard silver plan design. This higher utilization is reflected in insurer rates and contributes to the premium rate change. The impact to premiums of coverage expansion will vary by insurer and specific plan design.

Additional fees and taxes are also contributing to insurer rate increases. Such taxes or fees include the health insurer fee (totaling $8 billion on a national basis in 2014), a marketplace operation fee of 3.5% of plan premium, and an estimated $63 per member assessment for the transitional reinsurance program in 2014.

However, funds (which will be assessed on both individual and employer plans) collected for the transitional reinsurance program will also flow back into the individual market. In 2014 through 2016, federal transitional reinsurance is designed to assist in mitigating a portion of the rate increases in the individual market. The amount of funds available to individual insurers through this program is highest in 2014, which is assisting in reducing insurer rate increases. It is estimated that 2014 individual premiums are being reduced by approximately 10% as a result of the transitional reinsurance program, net of assessments.

What is the impact of the premium tax credit subsidy on out-of-pocket premiums?

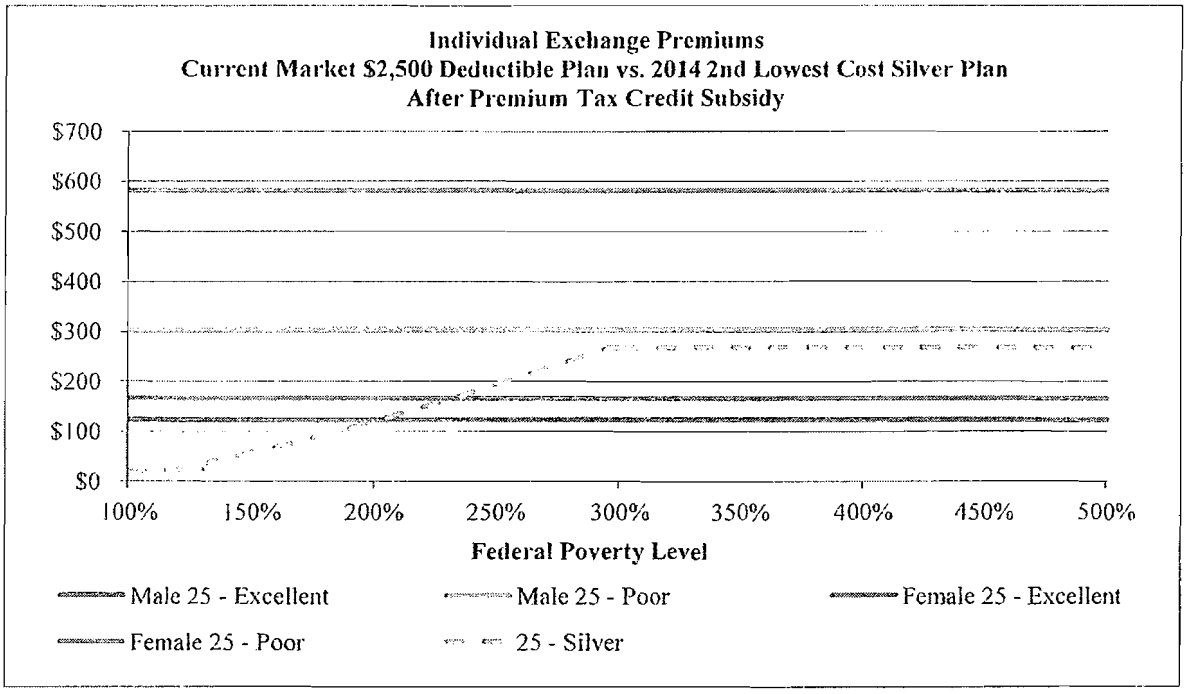
Hoosier households who have household income between 100% and 400% of the Federal Poverty Level (estimated to be approximately $11,500 to $46,000 for single adults and $24,000 to $96,000 for families of four in 2014) who do not have access to affordable employer sponsored health insurance[1], will be eligible for an advanced premium tax credit subsidy through the federal marketplace if the cost of a benchmark plan exceeds a specified percentage of their household income. This subsidy reduces the amount individuals will pay for their health insurance. The value of the premium subsidy is highest for households with income near the poverty line and is reduced as household income increases.

To illustrate the impact of the premium subsidy tax credit on out-of-pocket premiums, we have created charts illustrating current market premiums relative to 2014 out-of-pocket premiums net of the premium

[1] See https://www.healthcare.gov/glossary/affordable-coverage/ for more information on the definition of affordability under the ACA.

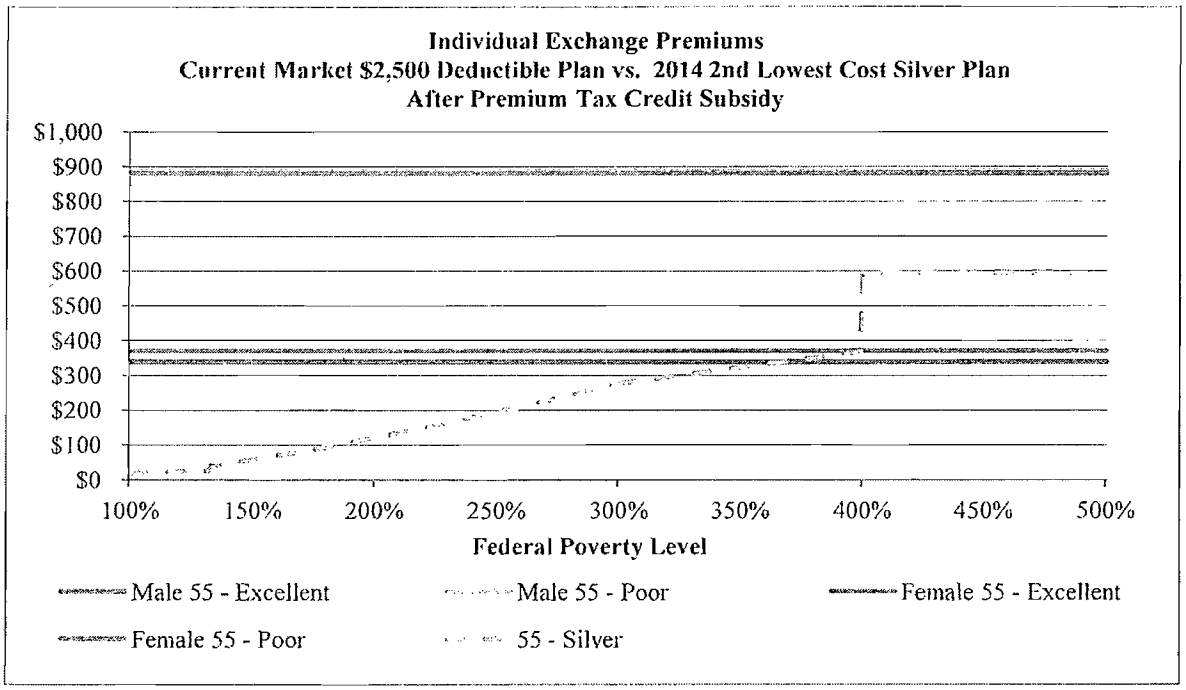
subsidy tax credit. Figures 3 and 4 illustrate the relative premium differences for single 25 and 55 year olds, respectively. Additional ages are available in the appendix. For current premiums, rates are illustrated separately by gender and health status.

Figure 3



Relative to current market premiums, out-of-pocket premium changes resulting from the ACA will range from significant increases to significant decreases, depending upon the individual's age, gender, status, and household income level. Figure 3 indicates that 25 year old males, in excellent health status, may experience increases in out-of-pocket premiums net of the premium subsidy tax credit if their annual income exceeds 200% FPL (approximately $23,000). For 25 year old females also in excellent health status, out-of-pocket premium increases are estimated to incur at 250% FPL (approximately $29,000). However, for individuals that were purchasing coverage in ICHIA, premium decreases will be experienced regardless of household income level. For low-income individuals currently in ICHIA, out-of-pocket monthly premiums may decrease several hundred dollars. It should also be noted that individuals with household income below 250% FPL who purchase a silver plan in the marketplace will also receive a cost sharing subsidy. The cost sharing subsidy increases the average percentage of healthcare costs paid by the plan from 70% to 94% for individuals with income below 150% FPL, 87% for individuals with income between 150% and 200% FPL, and 73% for individuals with income between 200% and 250% FPL.

Figure 4



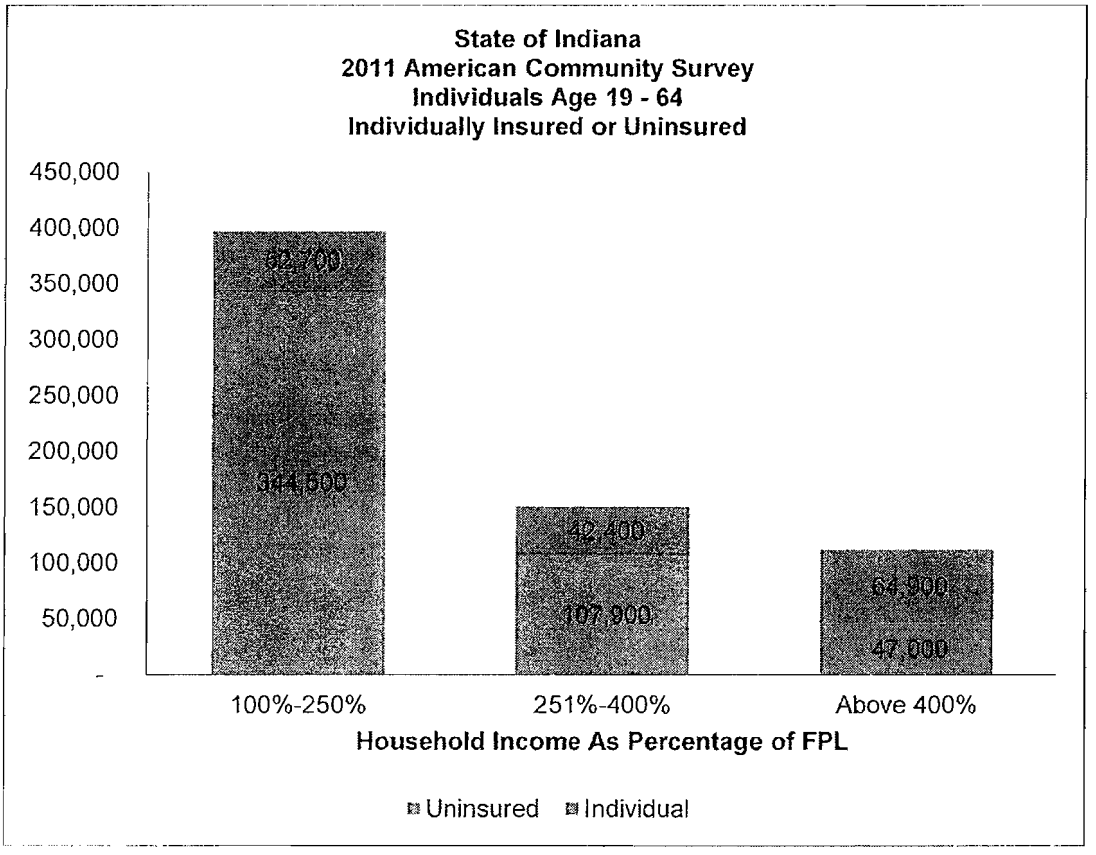
Because premiums under the ACA will be age rated in Indiana based on a 3:1 ratio, the value of the premium subsidies increase with age. As illustrated in Figure 4, the value of the premium subsidy may result in out-of-pocket premium decreases for individuals with household income below 400% FPL (approximately $46,000), regardless of gender or health status. For individuals currently enrolled in ICHIA who have household income below 400% FPL, annual out-of-pocket premium decreases may approach or exceed $10,000 for some individuals.

Figure 4 also illustrates the out-of-pocket premium 'cliff' that is created at 400% FPL due to the elimination of the premium subsidy tax credit at this income level. In the case of a 55 year old with household income just under 400% FPL, out-of-pocket annual premiums may increase by $2,400 if additional income pushed the individual just above 400% FPL.

How many Hoosiers will qualify for premium subsidies in the marketplace?

Figure 5 illustrates the household income distribution of Hoosiers ages 19 to 64 who are currently either uninsured or individually insured for households above the federal poverty line based on estimates from the 2011 American Community Survey.

Figure 5



Among individuals currently purchasing health insurance in the individual market with household income above 100% FPL, approximately 60% are estimated to have incomes less than 400% FPL and thus be ***potentially*** eligible for a premium tax credit subsidy. Approximately 344,500 individuals of the currently uninsured population are estimated to have household income between 100% and 250% FPL. If these households qualify for a premium tax credit subsidy, they will also receive a cost sharing subsidy if a silver plan is purchased in the marketplace. The value of the premium tax credit subsidy will vary by individual based on age and household income.

Households under 400% FPL who are currently uninsured or individually insured may not qualify for a premium subsidy tax credit for several reasons:

- Younger individuals with income below 400% FPL may not qualify for a premium subsidy due to the full premium amount of the second lowest-cost silver plan not exceeding the dollar limit specified under the ACA.
- To the extent an individual was eligible for affordable employer sponsored insurance, whether through their employer or a spouse, the individual would not be eligible for a premium tax credit subsidy in the health insurance marketplace.
- Similarly, if one adult member of the household was currently insured through their employer, but the spouse was purchasing individual market coverage due to family coverage offered by the employer being cost prohibitive, the household would not qualify for a premium subsidy in the marketplace unless the self-only coverage offered by the employer was unaffordable.

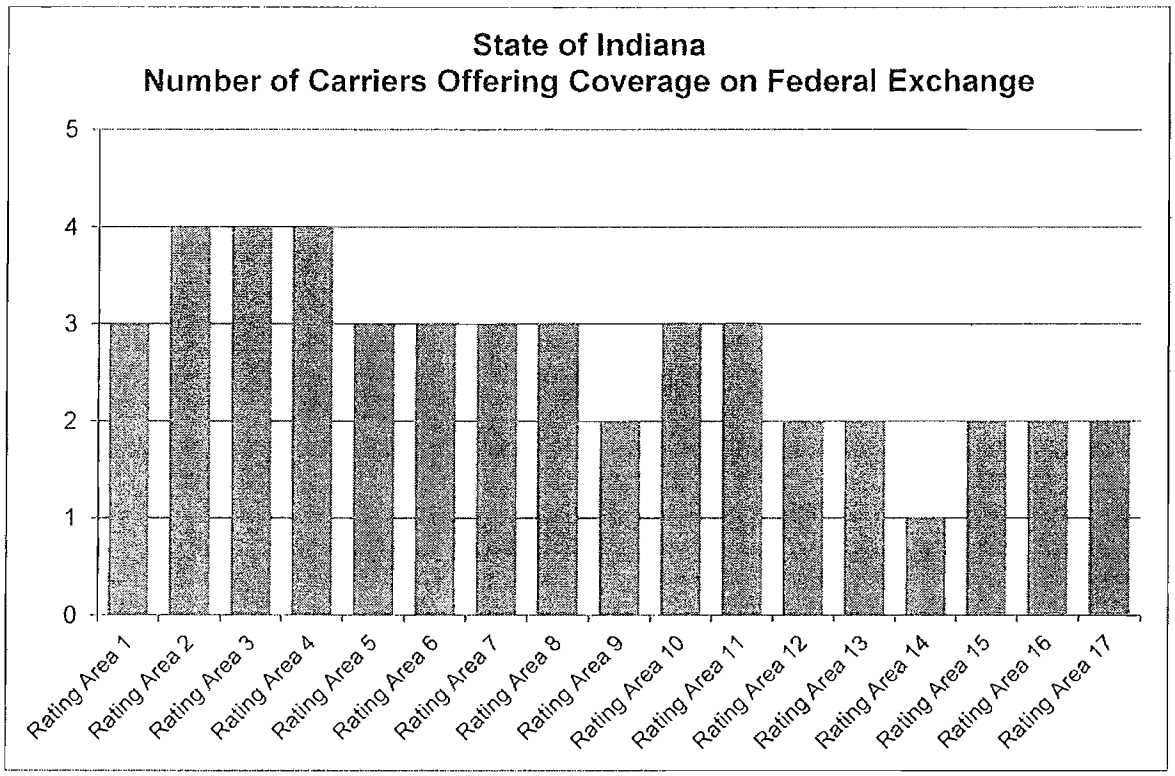
How many carriers are offering coverage in each region of the state?

Based on 2011 insurer filings, the top ten carriers in the state had more than 90% of Indiana's individual health insurance market enrollment. In this same time period, the state's top five carriers had approximately 85% of Indiana's individual health insurance market enrollment. Of the top five carriers in Indiana, only Anthem will be offering plans on the federally-facilitated marketplace in Indiana.

While a total of four carriers will be offering coverage on the federally-facilitated marketplace in Indiana, carriers are not required to offer coverage on a statewide basis. As a result of this, the number of carriers offering plans on the federally-facilitated marketplace varies by rating area. Beginning in 2014, the individual and small group market in Indiana will have a total of 17 different rating areas[2]. It is anticipated that additional carriers will offer coverage to Hoosiers in 2014 outside of the federally-facilitated marketplace.

Figure 6 below illustrates the number of carriers offering coverage for each of Indiana's 17 rating areas.

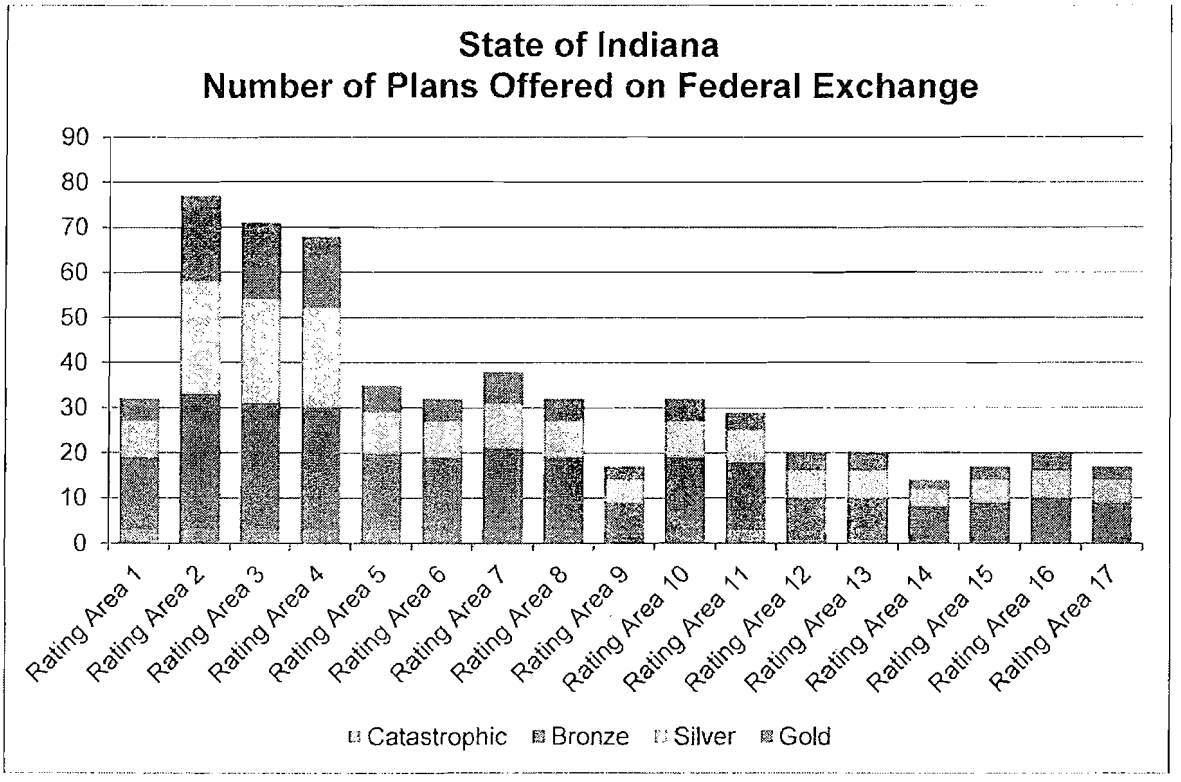
Figure 6



The variability in the number carriers offering coverage by rating area contributes to a high level of variation in the number of benefit plans available in Indiana. Figure 7 below illustrates the number of plans being offered at each metal level for Indiana's 17 rating areas.

[2] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/in-gra.html

Figure 7



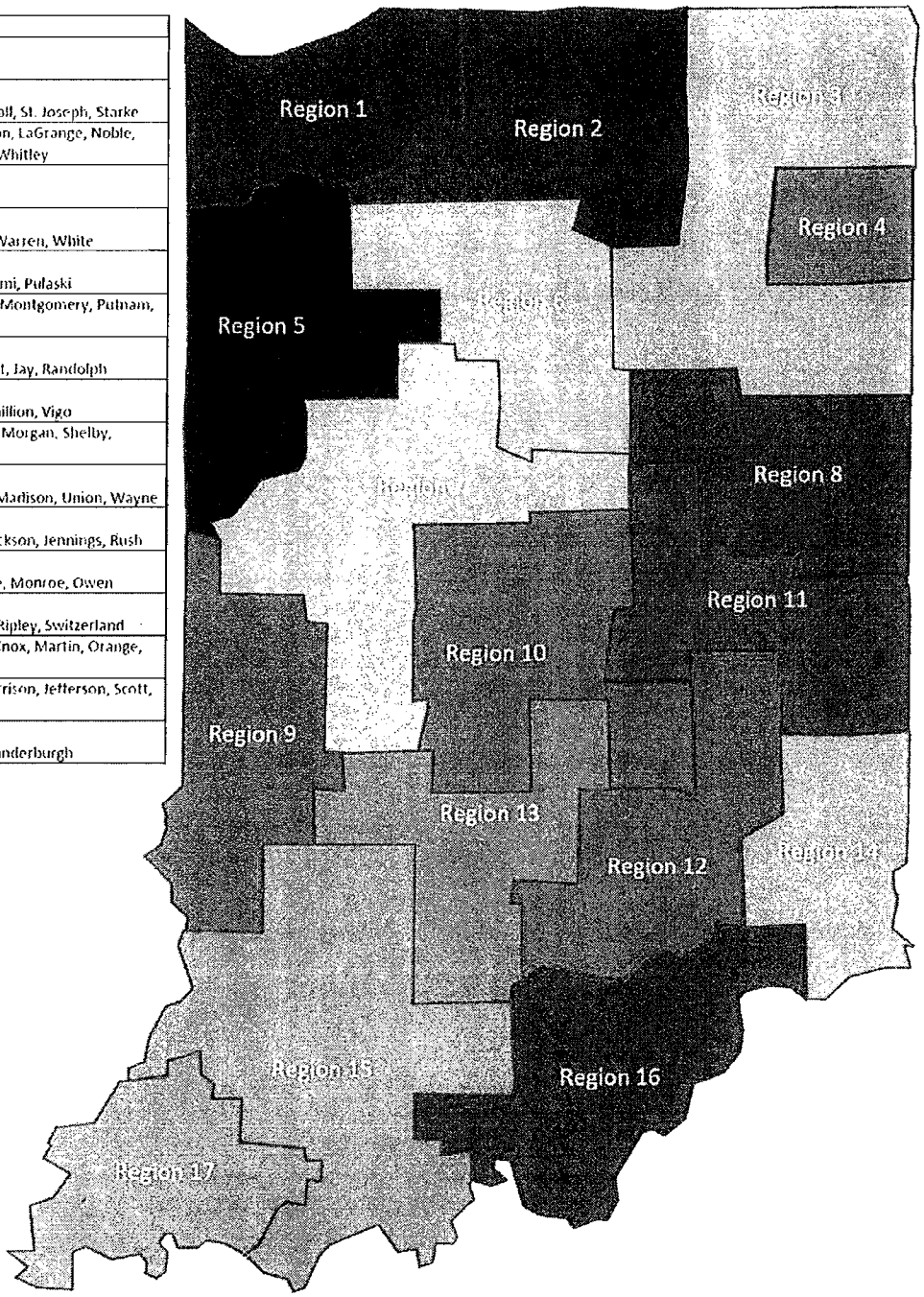
As shown in Figure 7, while some rating areas will have over 70 different plans available on the federal marketplace, other areas will have as few as 14. The number of plans offered also varies greatly by metal level, with approximately 5% of plans being Catastrophic, 45% Bronze, 30% Silver, and 20% at the Gold metal level. In Indiana, there will be no Platinum plans offered on the federal marketplace.

Figure 8

Geographic Rating Areas

Geographic Rating Areas in Indiana

Region	Counties
1	Lake, LaPorte, Porter
2	Elkhart, Kosciusko, Marshall, St. Joseph, Starke
3	Adams, DeKalb, Huntington, LaGrange, Noble, Steuben, Wabash, Wells, Whitley
4	Allen
5	Benton, Jasper, Newton, Warren, White
6	Cass, Fulton, Howard, Miami, Pulaski
7	Carroll, Clinton, Fountain, Montgomery, Putnam, Tippecanoe, Tipton
8	Blackford, Delaware, Grant, Jay, Randolph
9	Clay, Parke, Sullivan, Vermillion, Vigo
10	Boone, Hamilton, Marion, Morgan, Shelby, Hendricks
11	Fayette, Hancock, Henry, Madison, Union, Wayne
12	Bartholomew, Decatur, Jackson, Jennings, Rush
13	Brown, Johnson, Lawrence, Monroe, Owen
14	Dearborn, Franklin, Ohio, Ripley, Switzerland
15	Daviess, Dubois, Greene, Knox, Martin, Orange, Perry, Pike, Spencer
16	Clark, Crawford, Floyd, Harrison, Jefferson, Scott, Washington
17	Gibson, Posey, Warrick, Vanderburgh



Appendix 1

Sample Individual Health Insurance Market Plan Designs

Sample Pre-ACA Plan	Health Status: Excellent Sample 2014 Marketplace Tier Equivalent	Single Deductible	Single Out-of-Pocket Maximum	Coinsurance
SmartSense Plus 30% $10,000	Lowest Cost Bronze	$10,000	$13,500	30%
Lumenos HSA Plus $5,500	Lowest Cost Bronze	$5,500	$5,500	0%
Lumenos HSA Plus $3,500	Lowest Cost Silver	$3,500	$3,500	0%
SmartSense Plus 30% $2,500	Second Lowest Cost Silver	$2,500	$6,000	30%
Premier Plus 20% $1,000	Lowest Cost Gold	$1,000	$4,000	20%

Sample Pre-ACA Plan	Health Status: Poor Sample 2014 Marketplace Tier Equivalent	Single Deductible	Single Out-of-Pocket Maximum	Coinsurance
ICHIA Plan 5	Lowest Cost Bronze	$5,000	$5,900	20%
ICHIA Plan 4	Second Lowest Cost Silver	$2,500	$5,000	20%
ICHIA Plan 2	Lowest Cost Gold	$1,000	$3,000	20%

Sample ACA Plan	2014 Indiana Individual Market Markeplace Plans - Rating Area 10 Single Deductible	Single Out-of-Pocket Maximum	Coinsurance
Lowest Cost Bronze	$6,000	$6,350	0%
Lowest Cost Silver	$3,000	$3,600	10%
Second Lowest Cost Silver	$2,500	$6,350	30%
Lowest Cost Gold	$700	$3,000	10%

Appendix 2

Sample Current Individual Health Insurance Premiums Relative to ACA Filed Marketplace Premiums

Age / Gender / Family	Health Status	Current SmartSense Plus 30% $10,000	2014 Lowest Cost Bronze	Rate Change
25 Year Old Single Male	Excellent	$ 96	$ 212	121.7%
25 Year Old Single Female	Excellent	$ 130	$ 212	63.5%
40 Year Old Single Male	Excellent	$ 153	$ 270	76.6%
40 Year Old Single Female	Excellent	$ 207	$ 270	30.4%
55 Year Old Single Male	Excellent	$ 263	$ 471	79.1%
55 Year Old Single Female	Excellent	$ 293	$ 471	60.9%
40 Year Old Couple	Excellent	$ 339	$ 540	59.2%
55 Year Old Couple	Excellent	$ 526	$ 942	78.9%
40 Year Old Family of 4	Excellent	$ 549	$ 808	47.3%

Age / Gender / Family	Health Status	Current Lumenos HSA Plus $5,500	2014 Lowest Cost Bronze	Rate Change
25 Year Old Single Male	Excellent	$ 82	$ 212	157.9%
25 Year Old Single Female	Excellent	$ 118	$ 212	79.4%
40 Year Old Single Male	Excellent	$ 131	$ 270	106.4%
40 Year Old Single Female	Excellent	$ 178	$ 270	51.7%
55 Year Old Single Male	Excellent	$ 253	$ 471	86.5%
55 Year Old Single Female	Excellent	$ 262	$ 471	79.6%
40 Year Old Couple	Excellent	$ 258	$ 540	109.7%
55 Year Old Couple	Excellent	$ 432	$ 942	117.9%
40 Year Old Family of 4	Excellent	$ 407	$ 808	98.8%

Age / Gender / Family	Health Status	Current Lumenos HSA Plus $3,500	2014 Lowest Cost Silver	Rate Change
25 Year Old Single Male	Excellent	$ 108	$ 266	145.7%
25 Year Old Single Female	Excellent	$ 154	$ 266	72.3%
40 Year Old Single Male	Excellent	$ 173	$ 339	96.3%
40 Year Old Single Female	Excellent	$ 234	$ 339	45.0%
55 Year Old Single Male	Excellent	$ 332	$ 591	78.0%
55 Year Old Single Female	Excellent	$ 344	$ 591	71.6%
40 Year Old Couple	Excellent	$ 339	$ 677	100.0%
55 Year Old Couple	Excellent	$ 568	$ 1,182	108.0%
40 Year Old Family of 4	Excellent	$ 533	$ 1,014	90.2%

Age / Gender / Family	Health Status	Current SmartSense Plus 30% $2,500	2014 Second Lowest Cost Silver	Rate Change
25 Year Old Single Male	Excellent	$ 124	$ 268	116.4%
25 Year Old Single Female	Excellent	$ 166	$ 268	61.1%
40 Year Old Single Male	Excellent	$ 197	$ 341	72.9%
40 Year Old Single Female	Excellent	$ 262	$ 341	30.0%
55 Year Old Single Male	Excellent	$ 339	$ 594	75.1%
55 Year Old Single Female	Excellent	$ 370	$ 594	60.3%
40 Year Old Couple	Excellent	$ 433	$ 681	57.3%
55 Year Old Couple	Excellent	$ 673	$ 1,188	76.6%
40 Year Old Family of 4	Excellent	$ 698	$ 1,019	46.0%

Age / Gender / Family	Health Status	Current Premier Plus 20% / $1,000	2014 Lowest Cost Gold	Rate Change
25 Year Old Single Male	Excellent	$ 229	$ 333	45.9%
25 Year Old Single Female	Excellent	$ 297	$ 333	12.2%
40 Year Old Single Male	Excellent	$ 362	$ 424	17.1%
40 Year Old Single Female	Excellent	$ 466	$ 424	(8.9%)
55 Year Old Single Male	Excellent	$ 644	$ 740	14.9%
55 Year Old Single Female	Excellent	$ 678	$ 740	9.2%
40 Year Old Couple	Excellent	$ 782	$ 849	8.6%
55 Year Old Couple	Excellent	$ 1,255	$ 1,481	18.0%
40 Year Old Family of 4	Excellent	$ 1,227	$ 1,270	3.6%

Age / Gender / Family	Health Status	Current ICHIA Plan 5	2014 Lowest Cost Bronze	Rate Change
25 Year Old Single Male	Poor	$ 288	$ 212	(26.3%)
25 Year Old Single Female	Poor	$ 551	$ 212	(61.5%)
40 Year Old Single Male	Poor	$ 432	$ 270	(37.4%)
40 Year Old Single Female	Poor	$ 575	$ 270	(53.0%)
55 Year Old Single Male	Poor	$ 840	$ 471	(43.9%)
55 Year Old Single Female	Poor	$ 833	$ 471	(43.5%)
40 Year Old Couple	Poor	$ 1,006	$ 540	(46.3%)
55 Year Old Couple	Poor	$ 1,673	$ 942	(43.7%)
40 Year Old Family of 4	Poor	$ 1,383	$ 808	(41.5%)

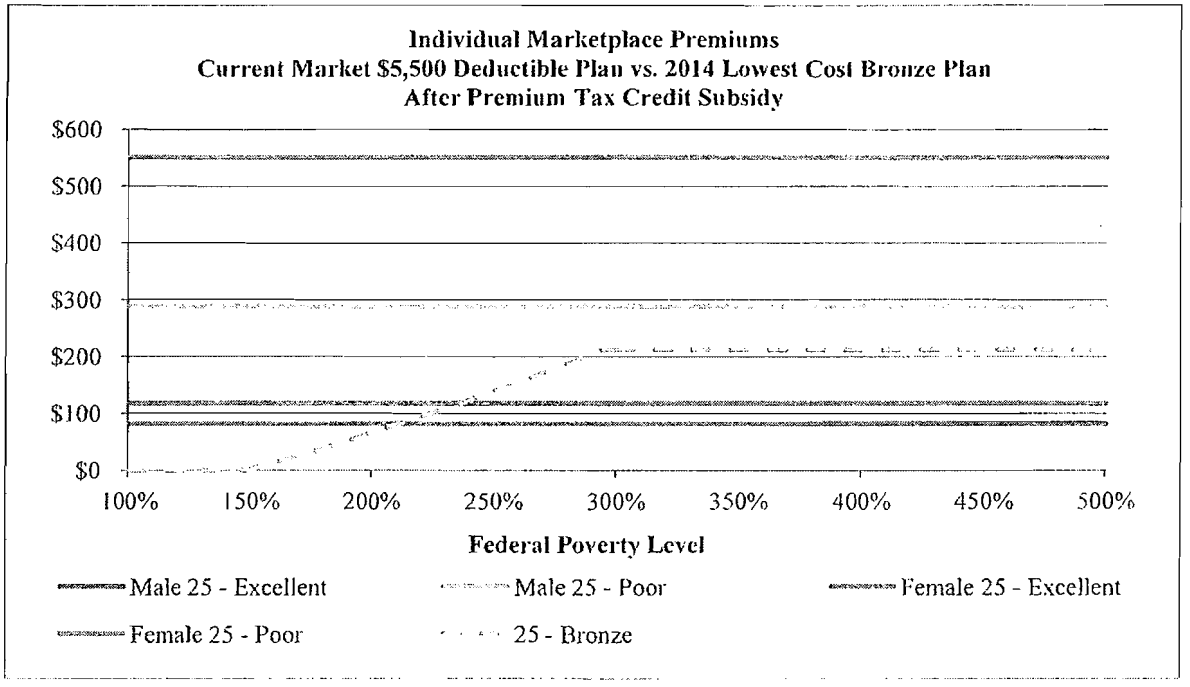
Age / Gender / Family	Health Status	Current ICHIA Plan 4	2014 Lowest Cost Silver	Rate Change
25 Year Old Single Male	Poor	$ 304	$ 266	(12.5%)
25 Year Old Single Female	Poor	$ 582	$ 266	(54.3%)
40 Year Old Single Male	Poor	$ 456	$ 339	(25.7%)
40 Year Old Single Female	Poor	$ 607	$ 339	(44.2%)
55 Year Old Single Male	Poor	$ 888	$ 591	(33.4%)
55 Year Old Single Female	Poor	$ 880	$ 591	(32.8%)
40 Year Old Couple	Poor	$ 1,063	$ 677	(36.3%)
55 Year Old Couple	Poor	$ 1,767	$ 1,182	(33.1%)
40 Year Old Family of 4	Poor	$ 1,461	$ 1,014	(30.6%)

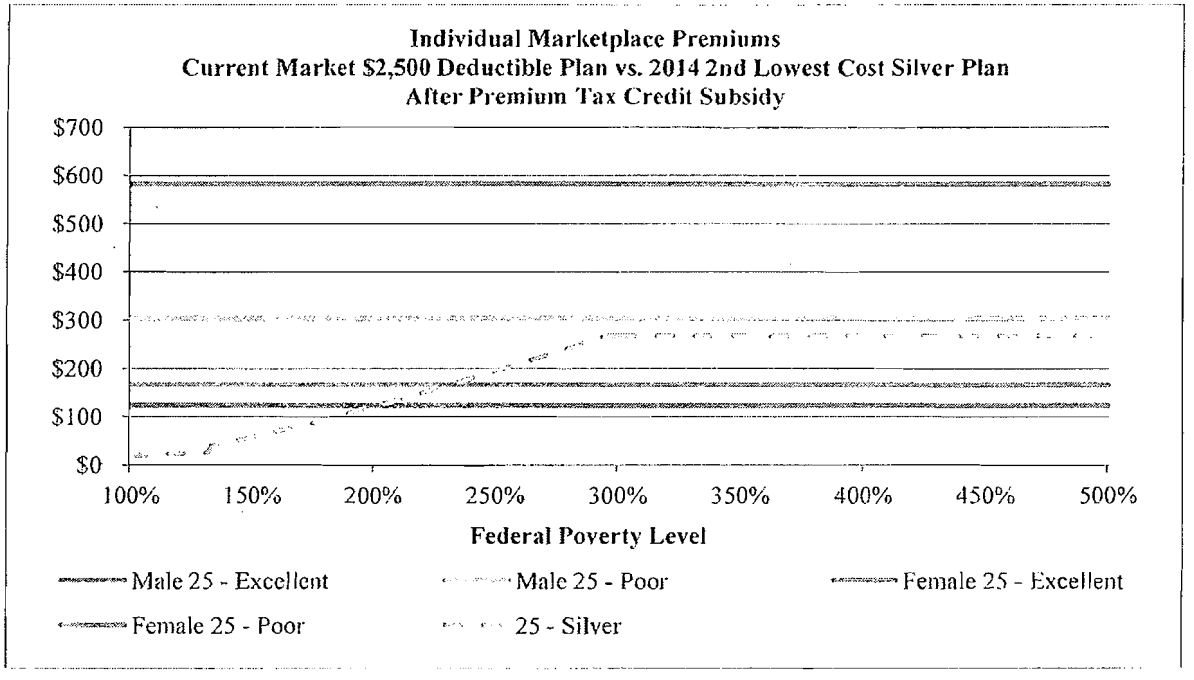
Age / Gender / Family	Health Status	Current ICHIA Plan 4	2014 Second Lowest Cost Silver	Rate Change
25 Year Old Single Male	Poor	$ 304	$ 268	(12.1%)
25 Year Old Single Female	Poor	$ 582	$ 268	(54.0%)
40 Year Old Single Male	Poor	$ 456	$ 341	(25.3%)
40 Year Old Single Female	Poor	$ 607	$ 341	(43.9%)
55 Year Old Single Male	Poor	$ 888	$ 594	(33.1%)
55 Year Old Single Female	Poor	$ 880	$ 594	(32.5%)
40 Year Old Couple	Poor	$ 1,063	$ 681	(35.9%)
55 Year Old Couple	Poor	$ 1,767	$ 1,188	(32.8%)
40 Year Old Family of 4	Poor	$ 1,461	$ 1,019	(30.2%)

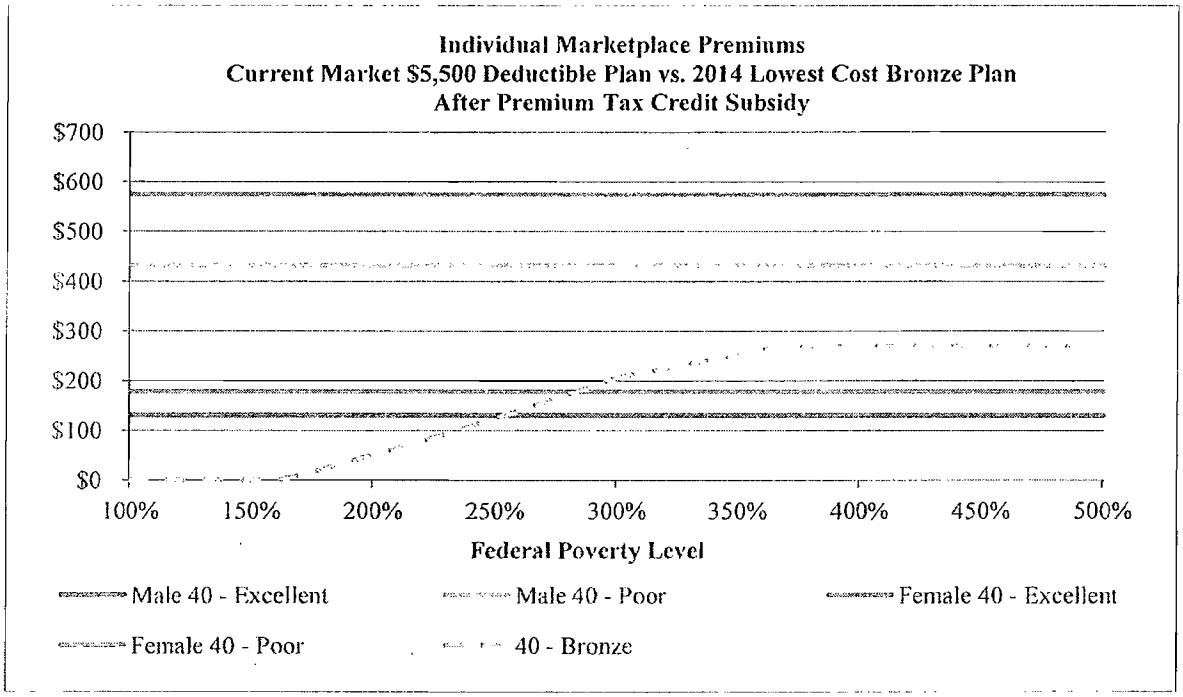
Age / Gender / Family	Health Status	Current ICHIA Plan 2	2014 Lowest Cost Gold	Rate Change
25 Year Old Single Male	Poor	$ 375	$ 333	(11.0%)
25 Year Old Single Female	Poor	$ 722	$ 333	(53.8%)
40 Year Old Single Male	Poor	$ 580	$ 424	(26.9%)
40 Year Old Single Female	Poor	$ 774	$ 424	(45.2%)
55 Year Old Single Male	Poor	$ 1,122	$ 740	(34.0%)
55 Year Old Single Female	Poor	$ 1,125	$ 740	(34.2%)
40 Year Old Couple	Poor	$ 1,354	$ 849	(37.3%)
55 Year Old Couple	Poor	$ 2,248	$ 1,481	(34.1%)
40 Year Old Family of 4	Poor	$ 1,943	$ 1,270	(34.6%)

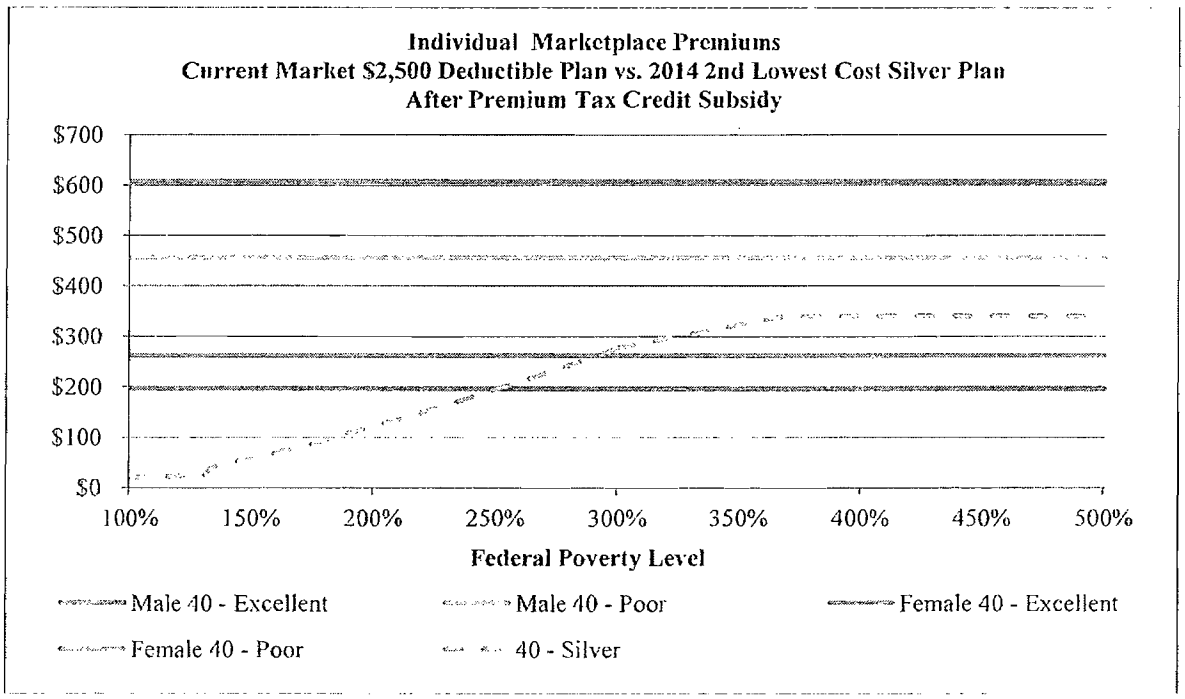
Appendix 3

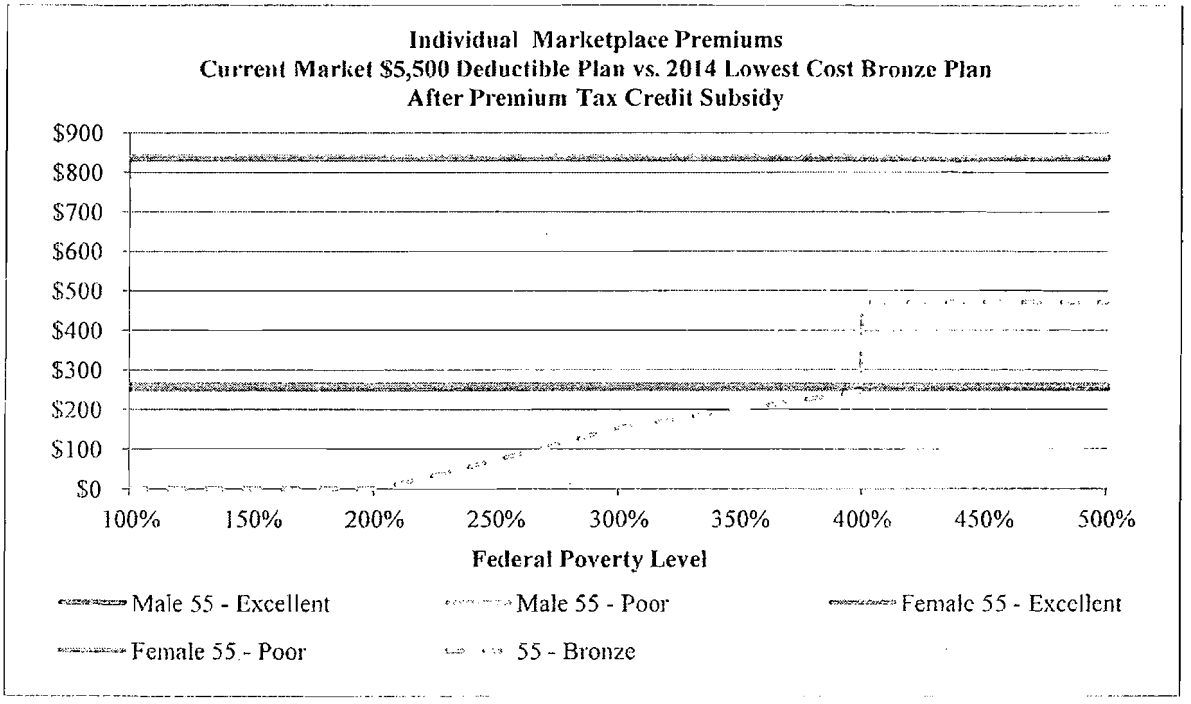
Sample Current Individual Premiums Relative to ACA Marketplace Premiums After Subsidies

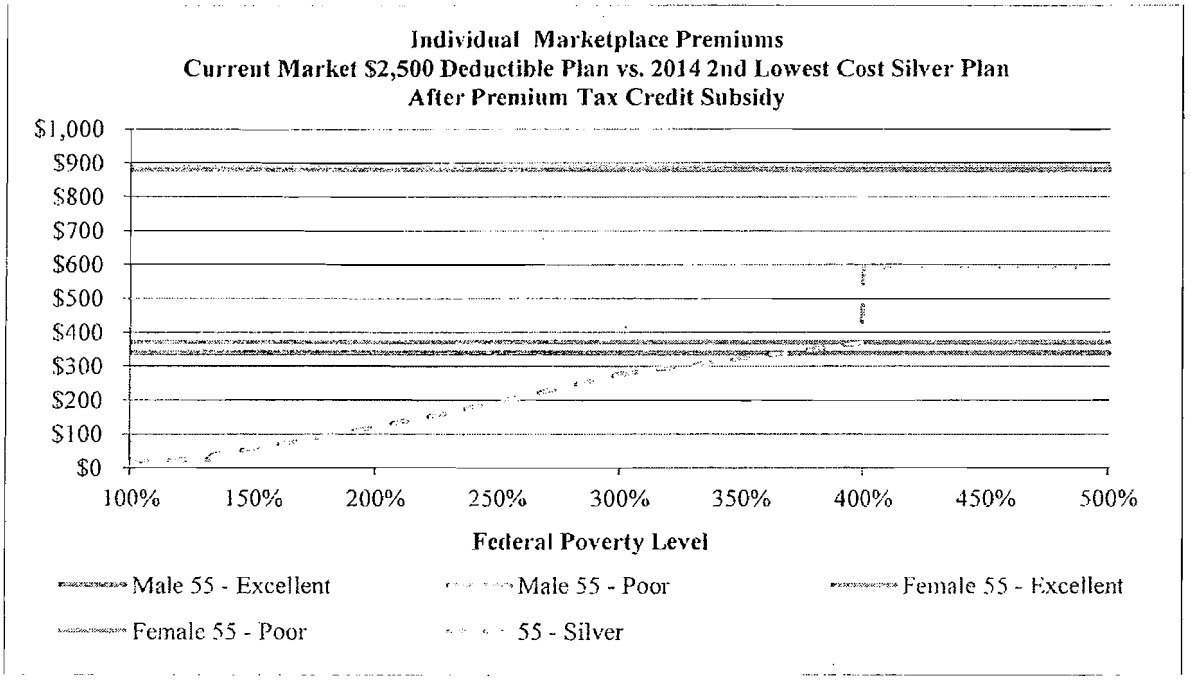


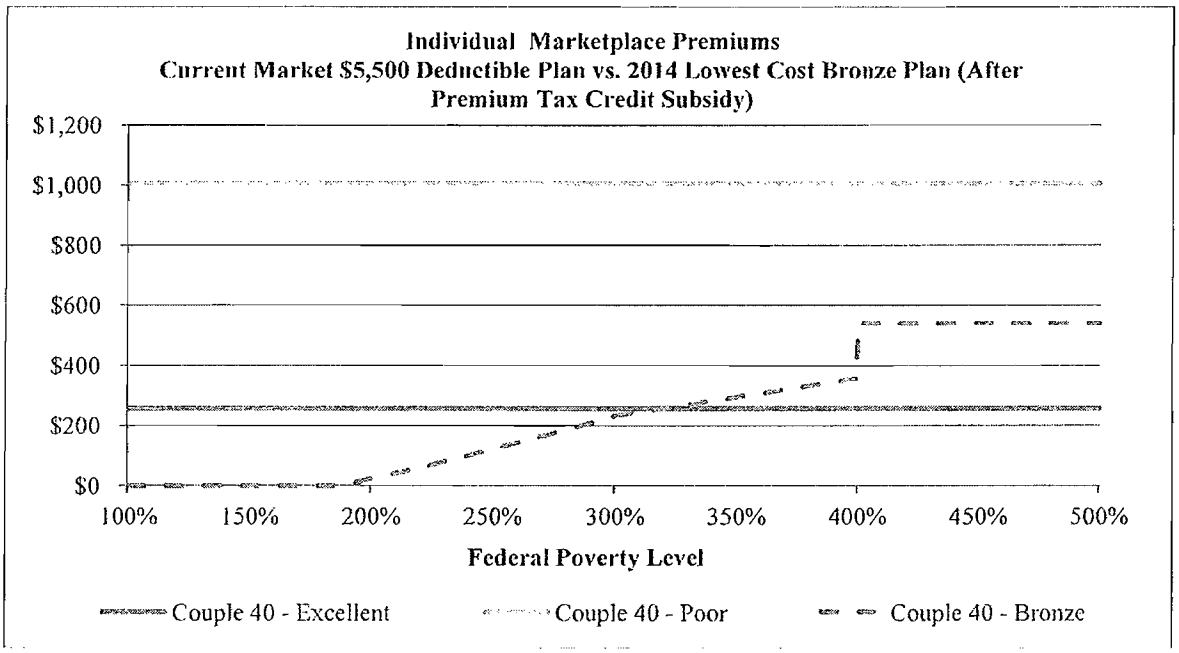


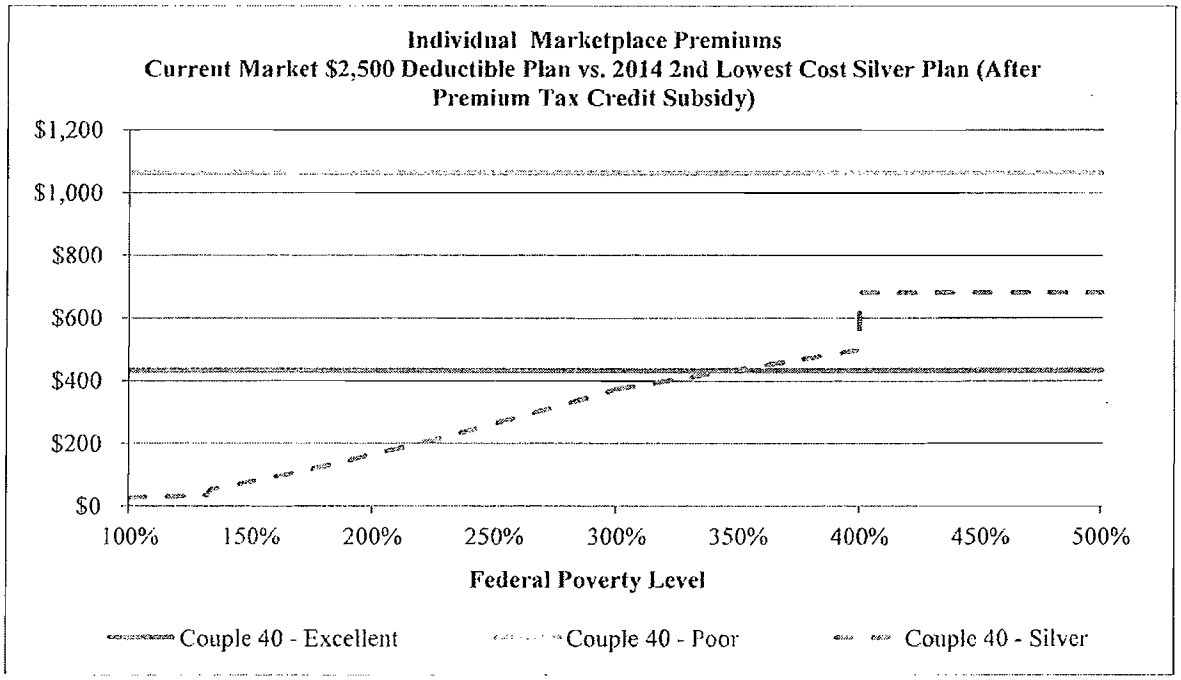

Individual Marketplace Premiums
Current Market $5,500 Deductible Plan vs. 2014 Lowest Cost Bronze Plan
After Premium Tax Credit Subsidy
$700
$600
$500
$400
$300
$200
$100
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Male 40 - Excellent
Male 40 - Poor
Female 40 - Excellent
Female 40 - Poor
40 - Bronze

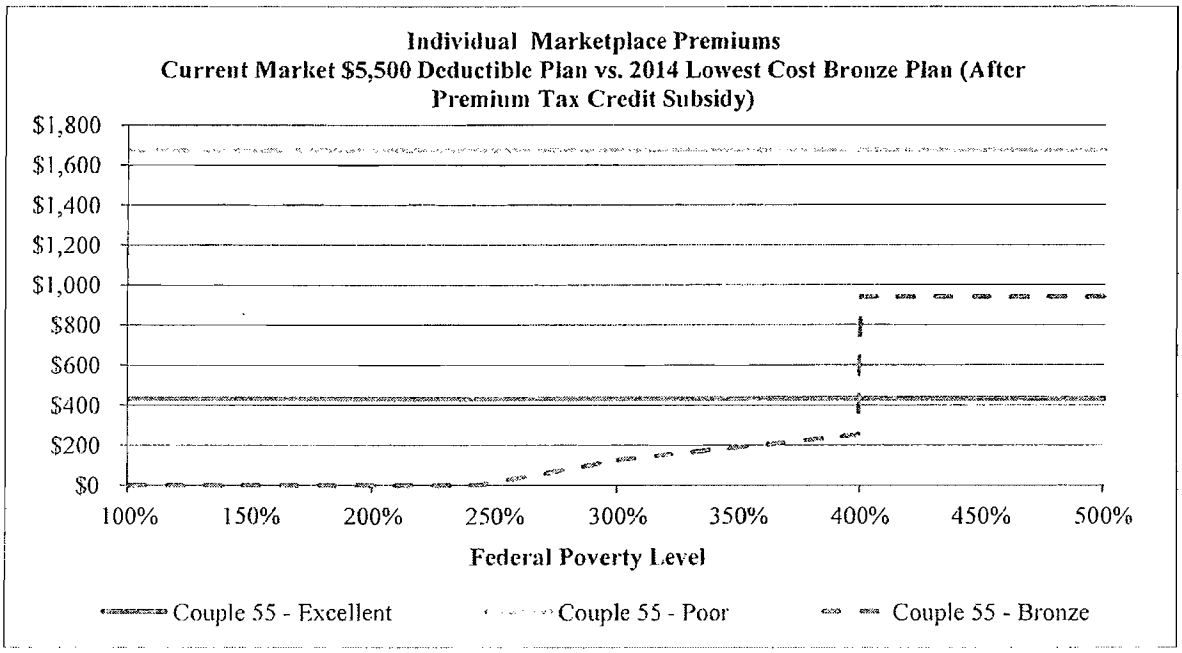

Individual Marketplace Premiums
Current Market $2,500 Deductible Plan vs. 2014 2nd Lowest Cost Silver Plan
After Premium Tax Credit Subsidy
$700
$600
$500
$400
$300
$200
$100
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Male 40 - Excellent
Male 40 - Poor
Female 40 - Excellent
Female 40 - Poor
40 - Silver

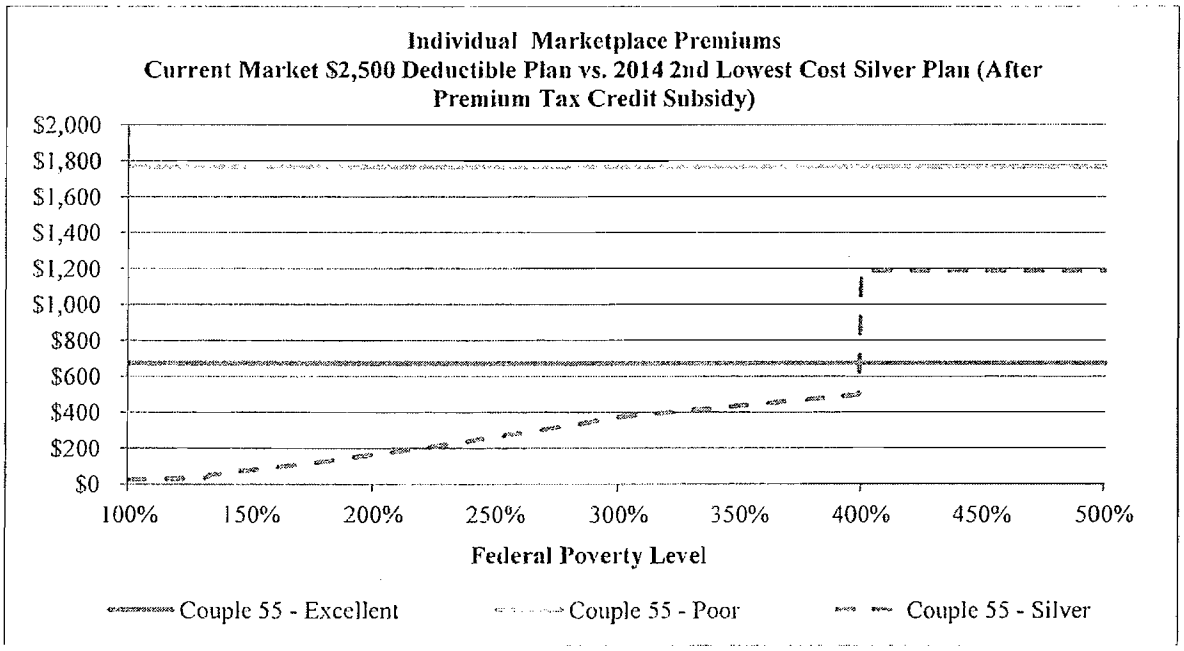

Individual Marketplace Premiums
Current Market $5,500 Deductible Plan vs. 2014 Lowest Cost Bronze Plan
After Premium Tax Credit Subsidy
$900
$800
$700
$600
$500
$400
$300
$200
$100
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Male 55 - Excellent
Male 55 - Poor
Female 55 - Excellent
Female 55 - Poor
55 - Bronze

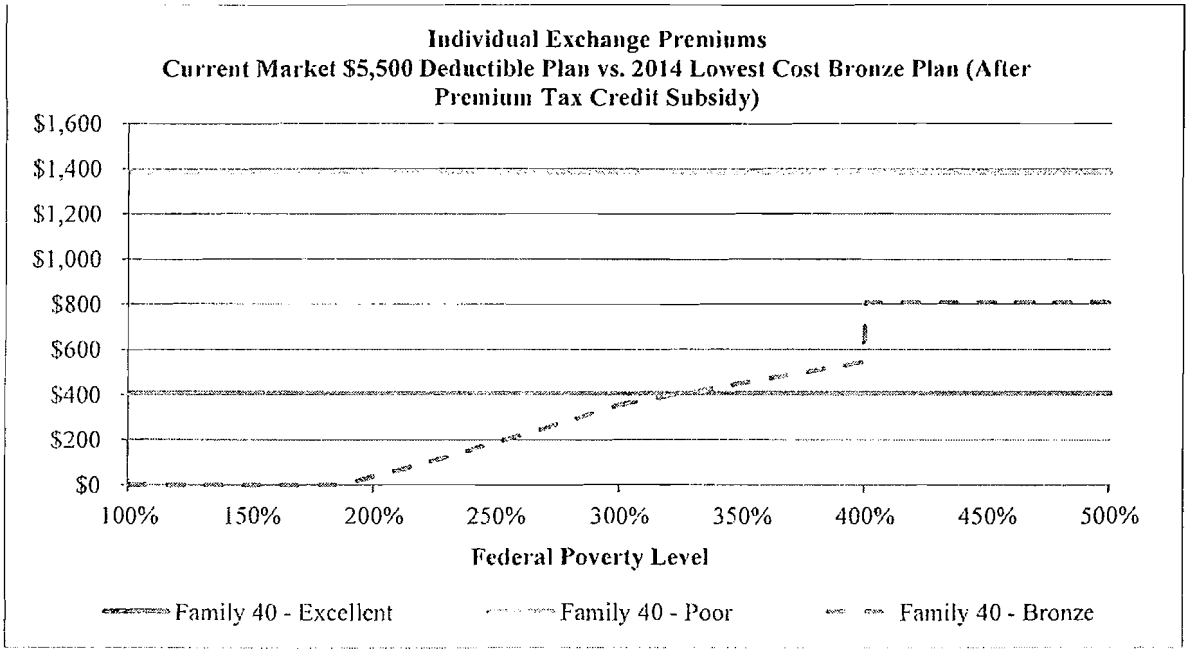

Individual Marketplace Premiums
Current Market $2,500 Deductible Plan vs. 2014 2nd Lowest Cost Silver Plan
After Premium Tax Credit Subsidy
$1,000
$900
$800
$700
$600
$500
$400
$300
$200
$100
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Male 55 - Excellent
Male 55 - Poor
Female 55 - Excellent
Female 55 - Poor
55 - Silver

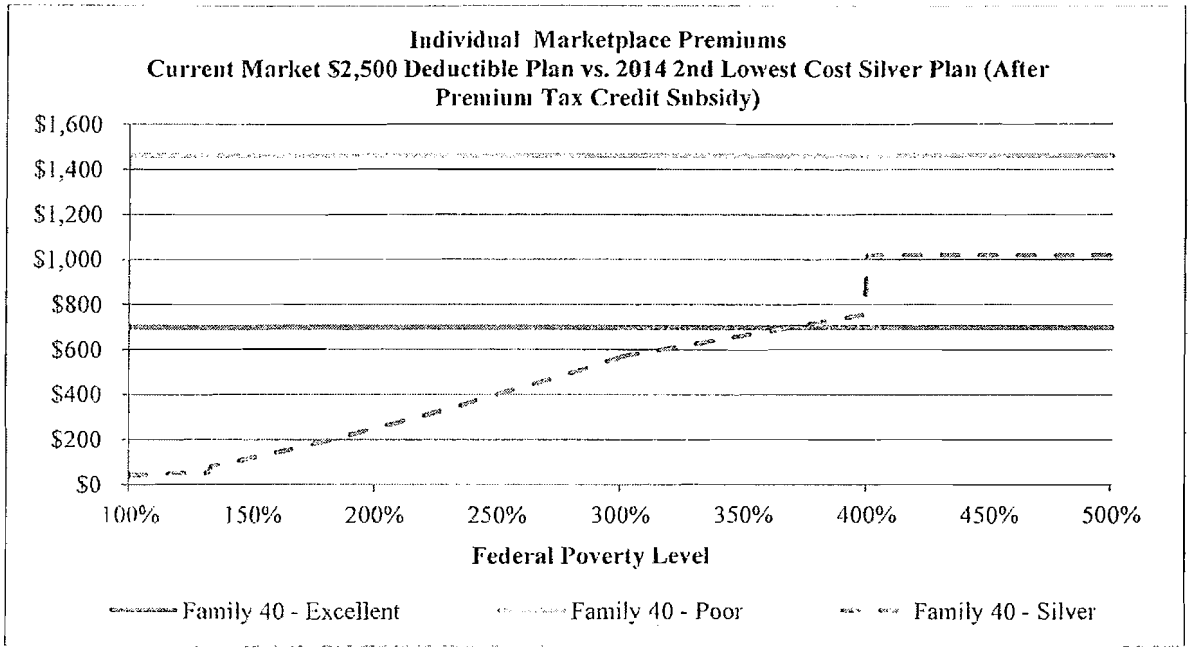

Individual Marketplace Premiums
Current Market $5,500 Deductible Plan vs. 2014 Lowest Cost Bronze Plan (After Premium Tax Credit Subsidy)
$1,200
$1,000
$800
$600
$400
$200
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Couple 40 - Excellent
Couple 40 - Poor
Couple 40 - Bronze


Individual Marketplace Premiums
Current Market $2,500 Deductible Plan vs. 2014 2nd Lowest Cost Silver Plan (After Premium Tax Credit Subsidy)
$1,200
$1,000
$800
$600
$400
$200
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Couple 40 - Excellent
Couple 40 - Poor
Couple 40 - Silver


Individual Marketplace Premiums
Current Market $5,500 Deductible Plan vs. 2014 Lowest Cost Bronze Plan (After Premium Tax Credit Subsidy)
$1,800
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Couple 55 - Excellent
Couple 55 - Poor
Couple 55 - Bronze


Individual Marketplace Premiums
Current Market $2,500 Deductible Plan vs. 2014 2nd Lowest Cost Silver Plan (After Premium Tax Credit Subsidy)
$2,000
$1,800
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Couple 55 - Excellent
Couple 55 - Poor
Couple 55 - Silver


Individual Exchange Premiums
Current Market $5,500 Deductible Plan vs. 2014 Lowest Cost Bronze Plan (After Premium Tax Credit Subsidy)
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Family 40 - Excellent
Family 40 - Poor
Family 40 - Bronze


Individual Marketplace Premiums
Current Market $2,500 Deductible Plan vs. 2014 2nd Lowest Cost Silver Plan (After Premium Tax Credit Subsidy)
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
100%
150%
200%
250%
300%
350%
400%
450%
500%
Federal Poverty Level
Family 40 - Excellent
Family 40 - Poor
Family 40 - Silver

8/21/13 HFC Exhibit 2

BRAIN INJURY ASSOCIATION of INDIANA – August 21, 2013

Testimony Presented to the Indiana Health Finance Committee, Regarding the Need for In-State, In-Patient, Post-Acute Care Facilities

Susie Fitt

Parent and Caregiver

Alan Neuenschwander

Parent and Caregiver

Lisa A. Lombard, MD

Medical Director, Rehabilitation Hospital of Indiana

Testimony before the Indiana Health Finance Committee
Submitted by Susan Fitt / Parent and Caregiver

I was asked by the Brain Injury Association of Indiana to share with you my family's experiences related to brain injury.

Our son, Aaron Yates, acquired a Traumatic Brain Injury in 2001. His injury was very severe, and in fact, we were told we should take him off life support because his quality of life, if he survived, would be no more than a vegetative state. They were wrong.

Our son's recovery was very slow, and once he was discharged from the acute setting, he was not ready for outpatient treatment and required additional treatment at an inpatient, post-acute setting. Indiana did not have such a facility at that time. We had no choice but to place him in a facility out of state. He, and myself, were away from home for over nine months in total. What did this mean to our family?

- A 5 hour drive to the treatment facility
- Due to the severity of his injury, it was necessary for someone to be there (me)
- The cost of housing while there
- Terrible disruption to our family
- Less attention paid to my elderly father (who was living with us at the time)
- Less support from family and friends, also a lack of support for our son from his high school and college friends, who could have given us encouragement and HOPE.
- It strained my marriage
- We had difficulty in maintaining professional ambitions

If Indiana had such a facility, life for our family (at that time) would have been so different. In 2013, we are still working on finding new facilities for post-acute rehabilitation – there hasn't been much improvement in 12 years.

The post-acute setting is a very important window of time necessary for many brain injury survivors. Without this opportunity, continuum of care ceases to exist, and the families and survivors are left to fend for themselves. Many of those individuals fall through the cracks.

Twelve years post-traumatic brain injury, our needs have changed. We are seeking out opportunities for housing for our son. This too has been an incredible task, and as of today, our 31-year-old man is still living with his family. This is something that he never wanted; he wants to be independent – as much as he can with his limitations.

When you leave today, I would ask that you take away what I feel is the most important point of all: Individuals with brain injury are lacking an opportunity to receive a

continuum of care throughout their lives and the duration of their illnesses, due to Indiana's ongoing practice of out-of-state placements.

Brain injury is a chronic condition for many people who suffer Traumatic Brain Injury – the disability persists for the rest of their lives.

Testimony before the Indiana Health Finance Committee
Submitted by Alan Neuenschwander / Parent and Caregiver

On January 10, 2000 my son was a 17 year old high school senior on his way to school on a cold, slippery morning. Hitting a patch of black ice on a city street, my son and the car's driver slid into a guardrail and a telephone pole. My young son suffered a traumatic brain injury resulting in an extended coma, a long stay in ICU, sub-acute hospitalizations, inpatient and outpatient hospitalizations, treatment planning, wide-ranging therapies, tutoring, an awkward transition back to high school, social reintegration, and a long list of other recovery challenges - all this within in the first six months.

Like many families, surviving the early months of recovery is difficult. Going from a near-death experience, to uneven recovery, to an unknown future is often more than the survivor and the survivor's family can manage alone. Every minute, every saved up vacation day, every extra dollar goes to making the most of every available service and treatment. I suppose after a year or so, we thought the worst was behind us. However, brain injury has a way of bringing new problems into a crowded room of broken dreams and broken hearts. Families often divide their lives into two halves. Life before a brain injury. Life after a brain injury.

For many, the early days of recovery are the best. Emergency care is excellent most anywhere in our state. If necessary, being moved to a Level I or Level II trauma center is effectively managed. Finding good inpatient and outpatient therapies is relatively easy to accomplish even when families are required to make some long distance accommodations and sacrifices. Money and services seem to be available in the healthcare world when there is an identifiable beginning and end to treatment. Heart disease, a knee replacement, or even an organ transplant come with treatment expectations, and seemingly that treatment is regularly delivered.

With a broken brain, when problems persist, families come home to the reality that they must figure out solutions on their own because extended treatment options are no longer available for someone with persistent needs.

My son's outcome was not met with physical challenges. He walked perfectly fine. His cognitive skills were all in place. His speech, hearing, and vision were in tact. Intellectually he was quite good. By 2002 he had already completed a semester at IPFW and a semester at IU-Bloomington. My son's biggest challenge showed up in year two. His battle was maintaining stable mental health.

He had no pre-existing mental illness issues, but post injury this problem emerged. His first mental illness hospitalization came in 2002. A second psychiatric hospitalization came in 2005. In 2006, we took my son to Detroit, Michigan to begin an 8-month hospitalization in a brain injury facility devoted to serving brain injury clients only.

You see, after two psychiatric hospitalizations in Indiana, mental health experts expressed to us that they had misgivings that our son could be effectively treated in a mental health facility. They believed a brain injury facility was our best option. Again, an out of state facility was our only option.

This came at great expense. I cashed in retirement dollars with substantial penalties. We received thousands of dollars from generous family members and friends. This care all came without insurance support because my employer would not approve the care. The treatment ended after eight months only because we ran out of money. Had residential services been available in Indiana, those dollars and his treatment would have lasted longer. Unfortunately, Indiana has never offered in-state residential care for brain injury survivors with chronic recovery issues.

The return home to Indiana did not go well. Finding mental health and brain injury services continued to be more of the same. Navigating the mental health system, establishing service eligibility, and finding truly appropriate services all remained difficult. By June, 2007, about 9 months after Detroit, re-hospitalizing became necessary.

This time we used Crisis Intervention Trained (CIT) police officers to get my son to the hospital. Plagued by delusional thinking, my son became a danger to himself and others. From June to September my son stayed in a local psychiatric hospital. We went through Indiana Civil Court to enforce treatment against his wishes. He believed he was fine, he thought he was able to take care of his own affairs. From this local hospital, my son went to the state hospital in Logansport, where he stayed for the next 3 months.

The service at Logansport was excellent. However, this care was not specific to brain injury. Mental illness and brain injury can look quite similar; nevertheless, major differences exist. Mental health professionals continued to have reservations while providing services. They readily admitted they simply are not trained to address many of the treatment complications associated with brain injury. During this respite, when my son was safely being cared for, I quietly focused on finding help that would have lasting success.

With a lot of hard work, I appealed to our local community mental health provider, Indiana Medicaid, and an out-of-state brain injury facility to see if I could get my son approved for brain injury services in a fresh setting. By the end of 2007 my son went from Logansport State Hospital to NeuroRestorative in Carbondale, Illinois, an Indiana Medicaid approved setting. He stayed there the next 30 months.

He slowly restored his life. Recovery was often uneven, but the expertise was obvious. This was a facility where brain injury was understood, where appropriate services were available, and where proven practices of outcome-based solutions are utilized.

My son was once again making progress. A new problem unfolded though. My son was over 6 hours from his Indiana home so visitation was difficult. We also knew that when it was time to bring him back home after treatment he would once again have to re-establish himself in a new setting.

Hoosiers need the following:

1. Brain Injury residential treatment within the state.

2. Brain Injury treatment with tiered strategies, meaning in-patient to out-patient, to community case management where clients can get help in the community at appropriate levels, including post-acute care. These need to be wrap-around services provided by professionals who can readily identify and anticipate triggers and decline. Brain injury is a chronic condition with chronic solutions. Much is required.

3. A statewide commitment to learning. We need to expand our knowledge base. Each year, over 30 THOUSAND Hoosiers suffer brain injury. Of those, 6500 will have some level of permanent disability. We can improve outcomes if we continue to learn from our experiences, taking what we've learned and applying it to the next person and family we encounter. However, we must have appropriate settings to deliver that knowledge.

4. Less separation of services. Whatever new services are established that are exclusive to brain injury, it will always be vital to bridge gaps with existing services. As mentioned before, community mental health centers are an important piece. Also, local hospitals with expertise in rehabilitative services, need to be accessible to more post acute needs. Problems simply do not go away. Every existing agency needs to be utilized because brain injury affects every part of the survivor's life.

5. Training. Training for health care providers. Training for survivors, so that they might have more tools in recovery. Training for caregivers and families. Few people do well after brain injury without strong community and family supports. Good supports require a high level of training.

My son is now nearly 14 years post injury. I still mourn the loss of the son I once knew, but I love the son I have now. He is 31 years old, living independently with Social Security benefits, Medicare, Medicaid, and working over 30 hours per week. He receives services from our local community mental health provider. Is this success? We don't know. He still remains under civil commitment.

This is a precaution because we don't know if treatment may still need to be enforced through the courts in the event of a psychotic break. Since leaving Carbondale back in 2009, my son has been re-hospitalized 3 times. What we have learned through all these

experiences is that recovery works. We can get back to stability much faster because we have many learned skills. These skills guide us in building cooperative supports within in our home community.

I believe if Indiana was more committed to providing brain injury specific services, including residential brain injury facilities, we could all get to a more satisfying and successful destination.

Sincerely,
Alan Neuenschwander

Testimony before the Indiana Health Finance Committee

Submitted by Lisa A. Lombard, MD

Medical Director, Rehabilitation Hospital of Indiana

Assistant Professor, Department of Physical Medicine and Rehabilitation,

Indiana University School of Medicine

Madam Chairperson, Committee members, it is an honor to have the opportunity to address the important issue of availability of post-acute treatment for persons with traumatic brain injury in the state of Indiana. My name is Lisa Lombard. I am a physician, medical director of the Rehabilitation Hospital of Indiana, and Assistant Professor in the department of Physical Medicine and Rehabilitation at Indiana University School of Medicine. For the last 10 years, I have dedicated my professional life to the care of persons with TBI, in acute care, inpatient rehabilitation and the outpatient clinic.

In the field of rehabilitation, we see many patients with life-changing conditions, such as amputations, multiple sclerosis, strokes and spinal cord injuries; however, the condition of TBI presents rather unique challenges. Like these other conditions, persons with TBI may demonstrate physical impairments, such as weakness, coordination and visual disturbances, but this is complicated by cognitive dysfunction that can affect a patient's ability to assist in their care.

Early in recovery from brain injury, patients frequently experience post-traumatic amnesia (also known as PTA), which is a confusional state where the patient is unable to lay down new memories; they do not understand what has happened to them or where they are. They do not understand that their caregivers are there to help. Those in PTA are almost always restless, but can also be aggressive in refusing medications, medical monitoring and therapies. Persons in PTA are best managed in an acute inpatient rehabilitation facility with staff specialized in the care of TBI like the Rehabilitation Hospital of Indiana. Inpatient rehabilitation involves well-integrated teams of physical, occupational and speech therapists, nursing, neuropsychologists, case managers and rehabilitation physicians. Communication and teamwork are necessary to provide consistent coordinated care. Team meetings occur weekly to discuss patients' cases. Everyone is involved in family education and training to help support the family members through this difficult time. It is this high level of specialization and team coordination that makes recovery in this setting possible.

Thankfully, most PTA clears over days or weeks; in a few individuals, it may last months. It is a slow process of recognition of time, place and condition. However, persons who have emerged from PTA continue to demonstrate cognitive impairments. They frequently have poor short-term memory; they often are impulsive, wanting to do activities without regard to safety, such as driving; they can have short-temperedness where minor issues will result in major emotional or physical outbursts; simple organizational plans of day-to-day life are extremely difficult. Added to all of this is the strange circumstance that the brain does not recognize its own problems, and patients frequently deny that they have any cognitive impairment at all.

It is a cruel irony that the physical impairments of TBI frequently improve much faster than the cognitive ones. Patients may become more physically mobile and thus put themselves at higher risk of hurting themselves. The regulatory system of inpatient rehabilitation does not recognize the importance of cognitive rehabilitation as much as the physical, and frequently we are in the position of needing to shepherd the patient and family into the next phase in recovery sooner than we would like. In other circumstances, the hospital-like environment of inpatient rehabilitation is no longer appropriate for patients. Inpatient rehabilitation is designed to be intensive treatment for the short term of approximately 2-3 weeks maximum; it is not designed to be long-term care.

Due to the issues I mentioned earlier, almost all TBI patients leaving inpatient rehabilitation require 24 hour a day, 7 day a week supervision to help guide them in self-care activities and in making good decisions for their safety. This can often put a huge strain on the family, where we are asking individuals to put aside all other activities to provide full-time care for their loved ones. Although we do our best in inpatient rehabilitation to prepare family members for the appropriate way to manage brain injuries, they are often left feeling ill-equipped to deal with difficult situations, such as emotional outbursts, the patient's desire to drive a car, go back to work, or engage in drug or alcohol use. Due to the fact that the person with brain injury may look the same and superficially act the same, extended family members and friends may not be as supportive to the caregiver as they would in the situation of someone with more obvious impairments. Relationships become strained as a spouse, grown child or sibling must become the enforcer of rules. It is a true testament to the fortitude and the dedication of these family members who are forced to go through this.

In situations where the family cannot supply this intensive level of supervision, or if the patient is too aggressive for management in a home environment, the options are limited. The best-case situation would be to have the person with TBI cared for in a post- acute facility. This residential level of care has staff members who are knowledgeable in the management of persons with brain injury. There the focus is on

community reintegration and regaining skills to promote self-reliance for a successful return home. Similar to acute inpatient rehabilitation, the care is well coordinated to ensure consistency of education and purpose. As you have heard this morning, these post-acute facilities are few and far-between for Hoosiers. There is one facility in Indianapolis with a very long waiting list. The other option is to send patients out of state to Illinois or Michigan, where patients are far from their loved ones as well as the physicians who know their care best.

Due to the lack of availability of post-acute care facilities, we are frequently forced to send persons with TBI from inpatient rehabilitation to skilled nursing facilities. While this level of care is appropriate for many other medical conditions and patient populations, it is not the optimum care for those recovering from TBI. Staff members and physicians at nursing facilities, while experienced in taking care of the elderly with conditions such as hip fractures, joint replacements, strokes or dementia, are not specially trained for the unique behavioral and emotional problems of persons with TBI. Patients in nursing homes typically get only 1 hour or less of therapies daily, and therapists will skip a patient who refuses to participate. The average age of persons with TBI is 39 (TBI Model Systems Data, 2010), while 88 % of nursing home residents are above the age of 65 (National Nursing Home Survey, Centers for Disease Control, 2004). The average length of stay in a nursing home is 835 days (National Nursing Home Survey, Centers for Disease Control, 2004), indicating that the focus is not primarily on community reentry. Patients are seen by a physician only once a month. While I have sent young TBI patients to nursing facilities as a last resort, I know that their likelihood of successfully getting back to a home environment is substantially less than it would be in a post-acute facility. The lack of post-acute services in the state of Indiana is causing many Hoosiers with TBI to have sub-optimal outcomes.

Lastly I'd like to highlight the strains the lack of post-acute services in Indiana can cause individuals. I currently have a patient on my inpatient service whom I will call "Thomas." Thomas is a 45 year-old man who is the single parent of a 6 year-old boy. He fell while at work late June sustaining severe injuries to his ribs, pelvis, shoulder, head and brain. A section of his skull had to be removed due to significant brain swelling, and as a result he currently has to wear a helmet to protect his brain should he fall.

During his inpatient rehabilitation stay at RHI, despite some ups and downs, he has made remarkable improvements in his physical and cognitive abilities. He was devastated that he could not accompany his son to his first day of school, but understands the importance of rehabilitation in his recovery process. Thomas' poor

short-term memory and impulsivity make a discharge home as primary caregiver of his son unsafe, and the team's recommendation is that he undergo post-acute care to insure the success of his reentry to home life. A discharge to a nursing facility would not provide him the continued intensive rehabilitation he needs. Due to the lack of post-acute care services in the state of Indiana, we are forced to look to discharge to a facility in Illinois, where for months he will be hundreds of miles away from the son he loves so much, his devoted mother, as well as the neurosurgeons who need to continue to follow him for appropriate timing and management of his cranial reconstruction.

I ask you to please think of the plight of Thomas and the scores of other Hoosiers with brain injuries who so desperately need access to post-acute services. Please expand the availability of this level of care in Indiana

Thank you.

8/21/13 HFC Exhibit 3

Testimony provided by Roberta Schmidt, LCSW, Program Director for NeuroRestorative Indiana, before the Health Finance Commission on August 21, 2013

Chairwoman Miller, Vice-Chairman Clere, and members of the committee, thank you for allowing me to come before you to discuss the current needs of Hoosiers who have experienced a brain injury.

Indiana's continuum of care from acute care in the hospital to acute rehabilitation is excellent for patients with a brain injury. Until last year, we lacked in the area of post-acute rehabilitation. Before NeuroRestorative opened a new residential program in Indiana in June of 2012, a patient had to be moved out of state to a location far from their home if they needed these services, causing stress and financial concerns for their families. This situation also creates a barrier to the family presence and involvement that enhances the recovery process. The only other options available were for the patient to go home with 24-hour supervision provided by a family member, who may have to give up a job, or go to a nursing home.

Our model, which NeuroRestorative has been providing in other states since 1977, offers an alternative that improves quality of life and increases independence. NeuroRestorative is a leading provider of post-acute rehabilitation services for people of all ages with brain and spinal cord injuries and other neurological challenges. Our customized, community-based residences offer a continuum of care and rehabilitation options, including specialized services for children, adolescents, and Military Service Members and Veterans.

This year, NeuroRestorative Indiana has served a total of fifteen participants in our program, with the length of stay varying based on need from seven days to nine months. These individuals have had their lives turned inside out. Moving from an acute hospital directly to the home after a brain injury is a large leap, so our goal is to assist residents as they develop skills with real-world application in a supportive community-based setting, acting as a bridge to home.

On average, our programs do not have more than 6 participants in a home at one time. Small, community-based settings like ours have proven to be the best practice of care for individuals and their families, as over-stimulation can cause agitation and confusion, impeding progress. Because participants need a space to go if they are feeling overwhelmed by the everyday activities of life, private rooms are very important. The needs of the individuals currently residing in each house will determine the number of support staff that are present. Individualized programs are established for each participant based on their physical, emotional, family and spiritual needs.

The skills that participants learn and develop through the program are all focused on real-world applications, ensuring that participants are able to translate the skills gained in the program as they move toward their goals of independence. The following therapeutic services and support staff are all critical components of the level of service we provide.

- **Occupational Therapy** supports individuals in learning how to live independently by building strategies for completing daily tasks, such as bathing, cooking, and laundry; accommodating an individual's short

term memory loss and physical challenges, such as hemiparesis of a limb; reducing pain; and developing organization and problem solving skills.

- **Speech Therapy** provides complete evaluations and an individual plan for each participant in areas such as swallowing, ability to speak, language, executive functioning, and social skills.
- **Physical Therapy** provides interventions to improve individual motor function and rebuild physical endurance.
- **Nursing care** manages all medical needs of our participants, twenty-four hours a day, seven days a week.
- The **Medical Director** is a physiatrist and a board certified brain injury specialist. This person is responsible for all medical needs of each participant and meets with them on admission and every thirty days thereafter. Nursing staff has around-the-clock access to the Medical Director.
- **Case Management** supports participants in finding community resources for their return to home, partnering with agencies like AccessABILITY, Outside the Box, Voc Rehab Services, Cross Roads, and BIAI.
- **Mental Health** services are provided based on the needs of the individual.
- A **dietician** is available for individual evaluations and for support to the entire house.

Our staff has daily discussions regarding the progress and motivation of each participant, which allows for a well-coordinated treatment plan in which all disciplines build off of each other. For example, a speech therapist works with a participant to identify the correct word for a specific item. At the same time, physical therapy is working on balance and walking. Because each therapist is aware of the different goals, they integrate the work. As the participant is practicing walking, staff is asking questions that help the him also work on his speech goal. Simultaneously, knowing that nursing staff would like the individual to progress toward managing his own medication administration, speech and occupational therapy staff put a plan together that integrates that goal into their activities.

The Mayo-Portland Adaptability Inventory (MPAI-4) is the industry standard in measuring functional outcomes for post-acute brain injury programs, focusing on twenty-nine functional measures in three areas: ability, adjustment and participation. Nationally, NeuroRestorative's participants demonstrated an increase in functional independence across all twenty-nine measures and exceeded the national reference sample's average score in every subscale. Over the past thirteen months, NeuroRestorative Indiana saw eight participants move home with the support of their family, one move into an independent living situation, and two return to their previous work settings. The ultimate goal for survivors of a brain injury is to return to their homes and communities, and to continue being productive members of society. The variety of services and staff expertise offered in our program is vital to helping participants regain their dignity and productivity, and to reach their goals.

Testimony of John T. Hinton, DO, MPH
Indiana Senate Health Finance Committee
August 21, 2013

Thank you Senator Miller and members of the Committee for allowing me to provide information on the Indiana Health Care Programs Traumatic Brain Injury Program.

I am John Hinton, Senior Medical Director for Vulnerable Populations at ADVANTAGE Health Solutions and currently the physician manager of the Indiana Health Care Programs Traumatic Brain Injury Program. This program annually serves 75-100 Hoosiers receiving long-term neurocognitive rehabilitation following significant brain injuries as the result of either direct head trauma or due to events where the brain has been starved of oxygen. These Medicaid members may receive out-of-state rehabilitation services for a number of weeks to several months or over a year depending on need and available aftercare placement. ADVANTAGE, as the contracted vendor of the Office of Medicaid Policy and Planning, provides the clinical and administrative expertise in coordinating the Admission and Extension requests for treatment in the program. This program is an example of a public/private partnership that has produced improvements in the delivery of health care services to a very vulnerable population, citizens with brain injuries.

My comments today will focus on insights gained and opportunities identified through the experience of serving this program and are not intended to represent the opinions of FSSA or OMPP.

As you may know, the Indiana Medicaid Traumatic Brain Injury Program provides extended rehabilitation for Hoosiers that require more intense and prolonged services that currently are unable to be provided within Indiana due to existing facility licensure provisions. These individuals have already received acute inpatient treatment, acute short-term rehabilitation, and have often participated in community services.

I would like to review with you some interesting facts:

- Indiana supports services that at this time can only be provided out-of-state
- ADVANTAGE conducts reviews about 25 members enrolled in the program monthly
- Of the members being served out-of-state about one half have been unable to return to Indiana due to lack of appropriate facilities or residential funding to meet their behavioral needs. Some of these members have been in the program since the late 1990s.

On the brighter side:

- The average stay for individuals participating in the program has decreased during the past 4 years by 40% due to more focused management and extensive collaboration for post-treatment placement
- Greater than 50% improvement in functional measures have been achieved by some members discharged in recent years
- Many members are able to return to reside with family or in group supportive settings thanks to the TBI and Community Waiver funds
- A number of program "graduates" have been able to proceed to participate in vocational rehabilitation upon returning to Indiana
- A formal program description and operations plan was implemented in 2012 through the collaboration of ADVANTAGE and OMPP
- The program conducts monthly collaborative rounds with each of the out-of-state facilities to promote improvement and facilitate appropriate services
- The program works diligently to assure that at time of admission every member has an identified site for post-program placement

Unfortunately, a distinct continuum of services and resources that is uniformly accessible for this population does not exist today. Achieving an alignment of resources frequently leaves many of us involved in delivery and managing of care to improvise discharge plans case-by-case. Often it has been only through trial and error that we are able to connect agencies, professionals, members and their families for ongoing services. Although this process has worked for some, it is not always consistently available and reproducible for all participants due to the informal arrangements primarily built upon personal and professional relationships.

Indiana is nationally recognized for its treatment of acute brain injury. The rehabilitation teams at our acute hospitals perform wonderful work. The staff of Hook Rehabilitation and the Rehabilitation Hospital of Indiana are strong advocates and providers of services for these members. However, it is critical that following the acute phase of treatment that the special needs of this population are addressed effectively with the opportunity for long-term in-state residential treatment and then reunification with their family in their community.

It is a fact, that the State can continue to pay for long term care of citizens at out-of state facilities **or** the State can pay for members with brain injuries to achieve the best health possible as well as hire Hoosiers to provide the necessary services within Indiana. This payment can either be in the form of an investment for improvement of the individual's function and a lower level of required services or by paying the higher costs required for long-term custodial services and spending the money out-of-state.

- The cost of State funded custodial services out-of-state can run over $150,000 annually
- The cost of Home and Community Support can be less than $25,000
- Through effective rehabilitation, many individuals with significant traumatic brain injury can return to work and be contributing to the economy and return to productive and satisfying lives

- A recent study by the Center for Business and Economic Research at Ball State University's Miller College of Business cites that:
    - 64% of individuals with TBI can return to work if given appropriate services and care management support
    - The average earning for these individuals 25 years or older is projected to be around $30,000
    - Therefore, what could be an annual liability of $150,000 might not infrequently be converted to an asset and/or be utilized to employ Indiana residents for in-state services.

Indiana makes a significant investment in the emergency, trauma and acute treatment of this population. From both a public health an economic impact it makes sense to not "drop the ball" after providing expensive acute services. The State has a compelling interest to promote a continuum of services that not only improves the quality of life for the affected individual, but also allows them to once again be a contributing asset to their community and State and not be required to travel to Illinois or Michigan for these services, but receive total care in Indiana.

Thank you.

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BALL STATE UNIVERSITY.
CENTER FOR BUSINESS AND ECONOMIC RESEARCH

Potential Economic Impact of Resource Facilitation for Post-Traumatic Brain Injury Workforce Re-Assimilation

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ABOUT THE CENTER

The **Center for Business and Economic Research** is an award-winning economic policy and forecasting research center housed within Ball State University's Miller College of Business. CBER research encompasses health care, public finance, regional economics, transportation and energy sector studies.

Visit the center online at
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ABOUT THE STUDY

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INTRODUCTION

This research note provides an estimate of the potential economic impact of Resource Facilitation (RF) on traumatic brain injury (TBI) patients in Indiana. We simulate the economic impact of this intervention on the estimated population of traumatic brain injury patients in Indiana per year and provide estimates of the earnings losses associated with TBI associated long-term disability. These losses will, potentially, be avoided as a result of RF interventions.

METHOD & ESTIMATION ISSUES

A major benefit of RF is return to work. A recent randomized clinical trial describes those who were treated with RF versus a control group were significantly more likely to return to work .[3] Therefore, in order to quantify the economic impact of RF in Indiana, we begin by modeling the potential annual workforce loss due to TBI-related long-term disability. Then, we can estimate a portion of the economic impact of RF by comparing the lost earnings of TBI patients who were and were not treated with RF. This estimate is a lower bound estimate of the total economic impact. Further discussions will provide estimates of the economic value of additional considerations such as fringe benefits, Medicare/Medicaid costs, and state-level taxes.

ESTIMATION OF THE INCIDENCE OF TBI RESULTING IN LONG-TERM DISABILITY IN INDIANA

Indiana-specific data regarding incidence of TBI-related long-term disability were not readily available. Therefore, national statistics (as described below) were adjusted by a weight of Indiana's population relative to the United States' population to determine the incidence of TBI-related long-term disability in Indiana. The national incidence data was drawn from various sources: specific national statistics for the annual number of TBI-related long-term disabilities; national estimates of the annual number of TBI-related long term disability by age, gender and level of disability; the national statistics of the number of hospitalizations associated with TBI-related long-term disability annually.

ESTIMATION OF WAGES LOST IN INDIANA DUE TO TBI-RELATED LONG-TERM DISABILITY

Methodology 1: The first estimate we provide is a baseline estimate of the potential annual earnings applicable to those in Indiana who suffer a long-term disability due to TBI. This estimation has two parts. First, we use the estimation of TBI incidence in Indiana, as previously described, to estimate the annual workforce loss. Data indicating the number of persons who return to work

with and without RF treatment in conjunction with employment statistics for persons before suffering a TBI are used to adjust the Indiana TBI incidence. Next, we adjust the workforce loss estimation by average annual earnings of an Indiana resident to estimate the annual amount of wages lost due to TBI-related long-term disability.

Methodology 2, Age—Education Adjusted Estimates: To provide estimates of the wages lost in Indiana due to TBI-related long-term disability, we modify the baseline model to incorporate age and educational attainment statistics. First, national statistics for TBI incidence, by age group and education level, were adjusted for Indiana. For this method, we assume workforce eligible persons are individuals no younger than 15 and no older than 79. Another important factor included in this methodology is gender. Males are twice as likely as females to be subject to a TBI and the average male's earnings in Indiana is greater than the average female's earnings for all education attainment groups. Finally, the estimation of workforce loss is adjusted to account for those who return to work with and without RF treatment.

RESULTS

THE INCIDENCE OF TBI RESULTING IN LONG-TERM DISABILITY IN INDIANA

80,000 and 99,000 people in the United States suffer a TBI resulting in a long-term disability due to TBI annually.[5,6,7] The aggregate TBI incidence in the United States annually is between 1,500,000 and 1,700,000.[1,2] This range can be further categorized by injury severity as: mild, moderate, and severe. Approximately, 15%-25% of TBI are moderate to severe requiring hospitalization.[1,3,6,10,11] Using these incidence rates Indiana's share of TBI-related long-term disability is 6,181 persons per year.

ESTIMATION OF WAGES LOST IN INDIANA DUE TO TBI-RELATED LONG-TERM DISABILITY

Methodology 1: With RF treatment, a clinical trial shows 64% are employed post-treatment; while without RF treatment, 36% are employed post-treatment.[3] Therefore, on average 1,003 Indiana residents would return to work with RF treatment. The average earnings for those employed in Indiana and who are 25 years old or older is $30,925.[14] Therefore, the average economic impact of RF treatment is $31,017,775 annually in avoided lost wages.

TABLE 1: TBI-RELATED DISABILITIES PER AGE GROUP IN INDIANA

Age Group	Percentage	Persons	Percent Employed
0-4	15.8 %	979	
5-9	6.8 %	418	
10-14	7.6%	472	
15-19	11.0%	680	36.7%
20-24	9.6%	591	65.5%
25-34	12.5%	770	77.1%
35-44	9.6%	595	77.1%
45-54	8.0%	497	77.8%
55-64	5.0%	311	61.1%
65-74	4.2%	262	23.2%
75 +	9.8%	607	5.8%
Total	**100 %**	**6,181**	

Methodology 2, Age—Education Adjusted Estimates: Next, the lost wages are further adjusted by age, percent employed, and educational attainment. Please see Table 1.[1,2,14]

Adjusting by age, we assume only age groups 15-79 are workforce eligible. This results in approximately 4,313 persons per year who suffer a long-term disability due to TBI. Using the age distribution for Indiana residents affected by TBI-related long-term disability, the percentage of persons employed per age group, and the educational attainment and respective average salaries (Please see Table 2[14]) we estimate the potential annual earnings lost. We adjust this by the return to work rate with and without RF treatment, as previously mentioned.

To map the 15-19 and 20-24 age groups, we assumed persons in those age groups to have less than high school, high school graduate, or some college or associate's degree level of educational attainment. The average earnings for the appropriate educational attainment groups are multiplied by the number of estimated Indiana residents in the respective age groups. The individuals between 25-79 years old were appropriately distributed across each educational attainment level and the respec-

TABLE 2: EDUCATIONAL ATTAINMENT & EARNINGS OF INDIANA RESIDENTS

Education Level	Percentage of Residents	Average Male Wages	Average Female Wages
Less than high school	14.2%	$24,767	$14,259
High school graduate*	36.5%	$34,855	$21,089
Some college or associate's degree	27.3%	$41,415	$25,726
Bachelor's Degree or higher	14.0%	$55,177	$35,480
Graduate degree or higher	7.9%	$68,895	$49,401

**includes equivalency*

tive earnings per educational attainment group were applied. Using this methodology, we estimate the average economic impact of RF treatment to be $22,561,796 annually.

DISCUSSION

It is important to bear in mind the estimates of approximately $31 million and $22.5 million in additional earnings recaptured as a result of RF treatment is a very conservative, annual estimate. Further analysis could be done to illustrate additional loss by incorporating long-term projections of wages lost as opposed to only annualized estimates. This could be done utilizing age groups, similar salary estimates as in method 2, and tracking when each particular age group enters and leaves the workforce; and the present value of the flows. For example, when a 45 year old suffers a disability due to TBI, the economy forgoes roughly 20 years of their earnings. Assuming those wages are $30,000 annually, the present value of the lost earnings is over $1 million over the remainder of the individuals working life. Aggregating this example across our sample provides avoidable lost earnings with a present value in billions of dollars due to annual undertreated TBI in Indiana.

As previously mentioned, there are other potential losses to the state of Indiana due to the annual workforce loss that are not reflected in our estimates. For instance, the estimates do not reflect the annual losses to business tax revenues ($10 million) or personal tax revenues ($4.8 million) that result from workforce loss. Fringe benefits and Medicare/Medicaid costs are other examples of such losses not reflected in this research note.

This study assumes only those who suffer a long-term disability from TBI are lost from the workforce. TBI-related injuries that do not result in a long-term disability could still cause temporary loss to the workforce. However, the current methodology implicitly makes the derived estimates more conservative.

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CENTER FOR BUSINESS AND ECONOMIC RESEARCH RESEARCH NOTE

About the Center:

The Center for Business and Economic Research, formerly the Bureau of Business Research, is an award-winning economic policy and forecasting research center housed within Ball State University's Miller College of Business. CBER research encompasses health care, public finance, regional economics, transportation and energy sector studies. We publish the *American Journal of Business*—a peer-reviewed scholarly journal—and the *Indiana Business Bulletin*—a weekly e-newsletter with weekly commentary and regularly updated data on housing, wages, employment, consumption, exchange rates and dozens of other economic indicators that provide evidence of the direction of change in the local, state and federal economy. In addition to research, we serve as the forecasting element in the Muncie area—holding five state and federal economic forecasting roundtables.

Center for Business and Economic Research
Miller College of Business, Ball State University
Whitinger Business Building, room 149 • Muncie, IN 47306
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www.bsu.edu/cber

8/21/13 HFC Exhibit 5

Where Indiana Stands and What To Do Next

Vaccinations

2013 Legislative Session

- House Enrolled Act 1464- Expanded vaccinations that can be administered under protocol by pharmacists to include: Tetanus, Diptheria, Acellular Pertussis, HPV and Meningitis.
- Also allowed for Pneumococcal (Pneumonia) vaccine to be administered to those 65 and older under protocol by a pharmacists.

United States Vaccination

- 90% of toddlers 19-35 months in age are on schedule with vaccination in the United States according to the United Health Foundation.

- Adult immunization, specifically among 19-65 age population, lags.

- "Once you cross the threshold of the 19th birthday, which is how adults are defined in the immunization world, the proportion of people who are vaccinated is low," William Schaffner, MD (Infectious Disease News)

Adult Immunization

- Immunization is not usually stressed to the 19-65 year old population, so it has not yet become a priority. (Adult Immunizations Significantly Lacking.)

- Vaccines could eliminate unnecessary carriers among this population.

Vaccination in Indiana

- Immunization rankings by the United Health Foundation are based on children ages 19-35 months.
- Using this statistic, Indiana is ranked 31st in comparison to the fifty states and the District of Columbia.
- In 2013 alone, there have been 1,922 vaccine preventable illnesses or diseases in Indiana. (Vaccinate Indiana)

Causes for Low Vaccination Rates

- Limited access for healthcare services.
- Lack of awareness and education among the general public.
- Distrust in the vaccination process.
- Healthcare process that emphasizes treatment before prevention.

Benefits of Vaccination

- Most importantly, vaccination can save lives.
  - Annually in the United States, more than 50,000 adults and 400 children die from vaccine preventable diseases or from their complications.
  - Vaccination prevents 14 million cases illness and diseases and 14,000 deaths each year.
    - According to Institute of Medicine Report , "Calling the Shots on Immunization Finance Policies & Practice"
      - November 26, 2009, Pharmacy Times

Benefits of Vaccination (Cont)

- It is much cheaper to prevent a disease than to treat one.
  - Every $1 spent on immunizations saves $6.30 in direct costs (i.e hospitalizations).
    - Annual aggregate direct cost savings of $10.5 billion.
  - If you include indirect costs (i.e. lost wages), every $1 spent saves $18.40.
    - Annual aggregate savings of $42 billion.

Ref: National Immunization Program, Centers for Disease Control

Benefits of Vaccination (Cont.)

- By preventing a disease or illness, you also elminiate the possibility of a carrier. (eg. Hepatitis B)
- Vaccines do not only protect individuals, but entire communities.
- Vaccines have led to the practical extinction of many infectious diseases which were once terrifying health risks.

Pharmacies as healthcare partners

- According to the National Federation of Infectious Diseases, Doctors are more likely to speak with patients on vaccination when vaccinations are available at pharmacies.
  - From 2011-2012 there was a 10% increase in immunization conversations with patients.

- Pharmacies provide communication and marketing resources many private providers and the public sector do not have.

Pharmacies (Cont.)

- Pharmacies' visibility and resources allow for educating the public at large about vaccinations and are beneficial to immunization awareness.
- Patients who learn of vaccines through pharmacies still have the option of going to a trusted primary care provider.
- Provides another point of access for those that may not frequent or have access to a doctor's office.

Pharmacies (Cont.)

- With over 2,700 pharmacists in Indiana, they can be valuable partners in health crisis.
  - Ex. Last year's whooping cough outbreak.

Where Indiana Laws Stand

- Don't Allow All CDC recommended Vaccines
- Allow all CDC recommended Vaccines to varying ages

Where Indiana Law Stands (Cont.) Pneumococcal Pneumonia

- Only 5 states do not allow Pneumococcal (Pneumonia) Vaccines without a prescription.

- Of those that allow Pneumococcal (Pneumonia) vaccines to be administered under protocol, Indiana is the only that has an age restriction.

Recommendations

- Allow for all CDC recommended vaccines to be administered under protocol.
- Explore eliminating the 65 & under exclusion for the Pneumococcal (Pneumonia) vaccine.
- Maximize the utilization of Children's and Hoosiers' Immunization Registry Program (CHIRP) to increase safety and awareness.

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Immunizations in Indiana
Health Finance Committee Report

Indiana State Department of Health

August 21, 2013

Required Indiana Immunizations

IC 20-34-4-2

Required immunizations

Sec. 2. (a) Every child residing in Indiana shall be immunized against:

(1) diphtheria;
(2) pertussis (whooping cough);
(3) tetanus;
(4) measles;
(5) rubella;
(6) poliomyelitis; and
(7) mumps.

(b) Every child residing in Indiana who enters kindergarten or grade 1 shall be immunized against hepatitis B and chicken pox.

Indiana Administrative Code

410 IAC 1-1-1 Immunization requirements

Authority: IC 16-19-3-5; IC 20-34-4-2Affected: IC 20-34-4

Sec. 1. **Every child less than nineteen (19) years of age residing in Indiana shall be immunized against the following:**

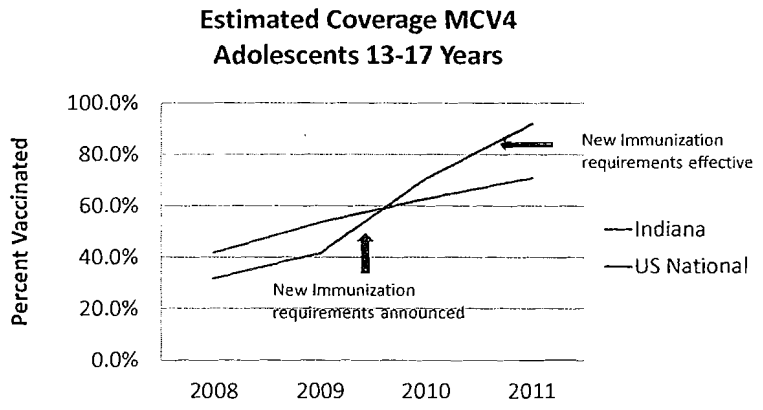
(1) Diseases listed in IC 20-34-4.
(2) Meningitis.
(3) Varicella.
(4) Pertussis (whooping cough).
(5) Additional diseases for which immunizations are recommended by both the Indiana state department of health and the Centers for Disease Control and Prevention (CDC).

Expand Pool of Immunizers

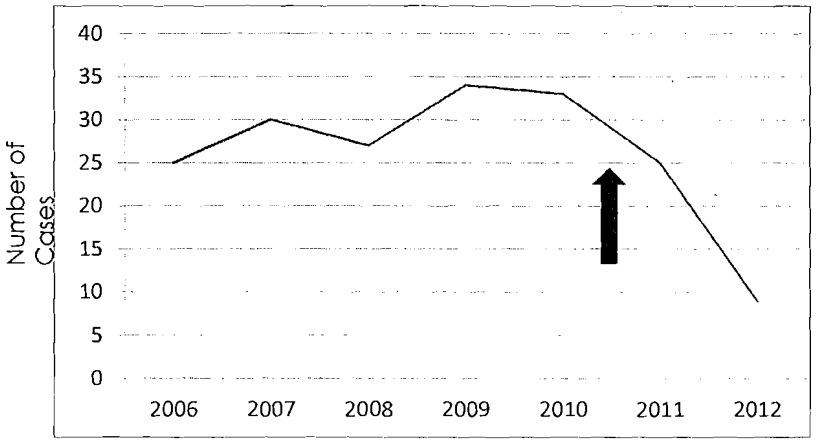
- July 1, 2013, Pharmacists were authorized by Indiana Code to administer MCV4, Tdap, HPV vaccine down to age 11!

Indiana
A State that Works

Adolescent Immunization Rates

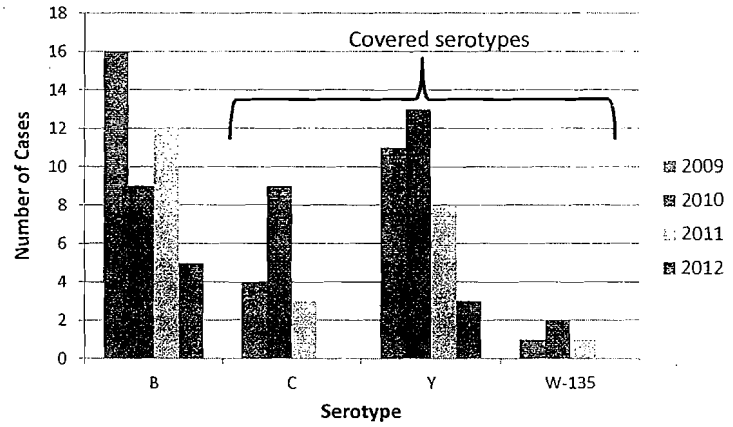


Invasive Meningococcal Cases Indiana 2009-2012



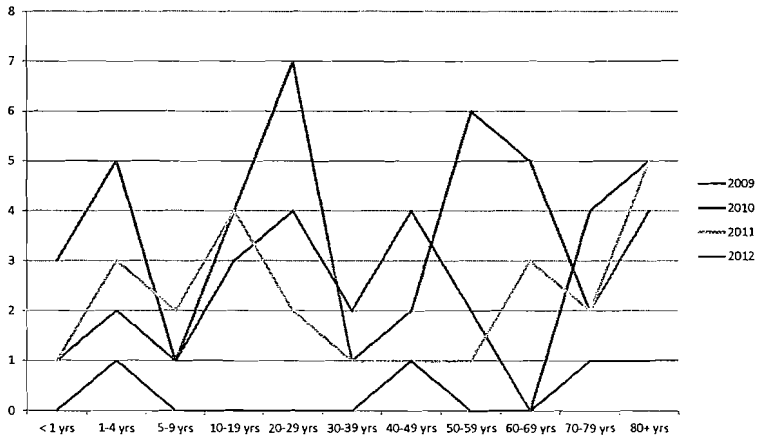
ISDH Epidemiology Resource Center 1/2013

Number of Meningitis Cases by Serotype 2009-2012

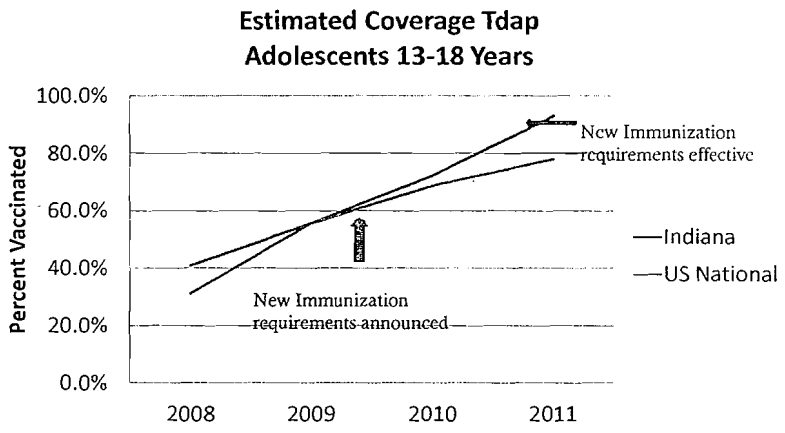


ISDH Epidemiology Resource Center 1/14/2013

Invasive Meningococcal Infections by Age, Indiana, 2009-2012



Adolescent Immunization Rates

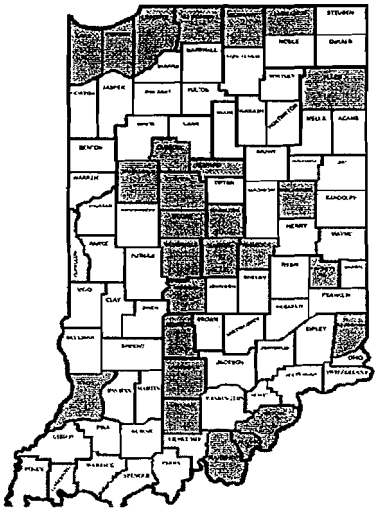


Vaccine Preventable Disease Incidence
Indiana, January - December
2006-2011

Vaccine Preventable Disease		2006	2007	2008	2009	2010	2011	2012
Pertussis (Whooping Cough)		280	68	270	392	744	340	435
Diphtheria		0	0	0	0	0	0	0
Tetanus		2	0	0	2	0	0	2
Measles		1	0	0	0	0	14	15
Mumps		10	3	2	2	4	3	4
Rubella		0	0	0	0	0	0	1
Varicella					463	356	288	469
Invasive Meningococcal Disease		25	30	27	34	33	24	8
Invasive *Haemophilus influenzae* (All Cases)		81	78	93	86	110	117	104
	Cases <5 years	9	6	13	12	15	10	16
	Type b cases <5 years	1	1	2	2	0	1	2
Invasive *S. pneumoniae* (All Cases)		721	702	902	819	783	802	701
	Cases <5 years	64	73	77	82	51	40	37

Pertussis in Indiana, 2012

Orange counties=5 or more cases in 2012



Changes in Pertussis Reporting by State from 2011 to 2012* †

Decrease/No change

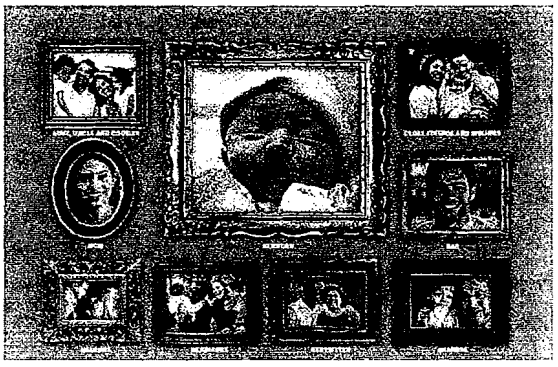
< 2-fold increase

2 to 3-fold increase

≥ 3-fold increase

*Data for 2012 are provisional.

†Cases reported through Week 52 in 2011 were compared with cases reported through Week 52 in 2012; fold-changes were calculated for each state.



DAD – Are You Protecting Your Baby?

VACCINATE AGAINST PERTUSSIS (WHOOPING COUGH)

Protect Your Family

- Vaccinate yourself and family members with a Tdap vaccine to protect against pertussis before the arrival of your child.
- Don't forget that this includes your aunt, grandparent, close family friends and caregivers.
- For Tdap vaccine information talk to your doctor, local health department, or pharmacist. Check with your health plan regarding coverage.

What Is Pertussis?

- Pertussis is a serious disease. Symptoms can include: a runny nose, mild fever and a cough. The cough then turns into severe coughing fits and can last six or more weeks.
- Did you know that pertussis is especially dangerous in newborns because they are too young to receive the pertussis vaccine?
- The disease causes infants to cough so much, that some have trouble breathing, leading to hospitalization and potentially death.

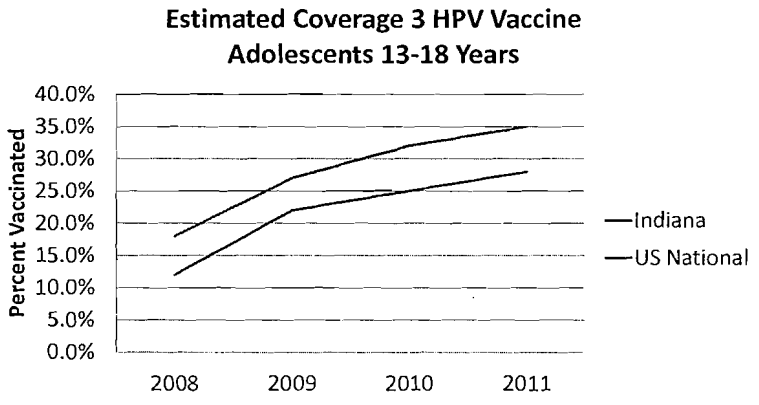
Not Just Kids Are At Risk

- Pertussis easily spreads from person to person, family member to family member. And often, from parent to child.
- Family members can unknowingly spread pertussis to the most vulnerable, your own babies.
- Anyone that has not been vaccinated against pertussis (Tdap vaccine) is at a higher risk of getting pertussis and passing it on to an infant or child.

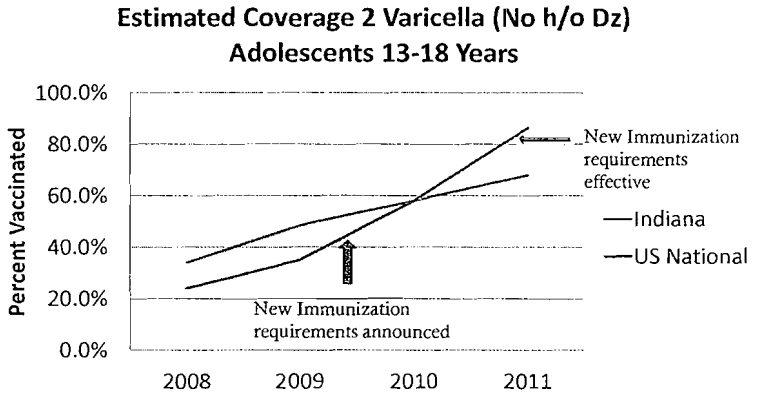
INDIANA IMMUNIZATION COALITION

ASK for a Tdap vaccine today | VISIT vaccinateindiana.org

Adolescent Immunization Rates



Adolescent Immunization Rates



2013-2014 School Year

Below are the number of doses and each vaccine required for school entry. Changes from the 2012-2013 requirements are indicated in blue.

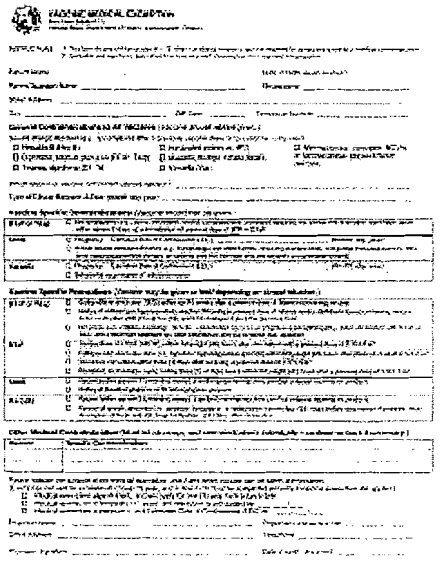
3 to 5 years old	3 Hep B (Hepatitis B) 4 DTaP (Diphtheria, Tetanus & Pertussis) 3 Polio (Inactivated Polio) 1 MMR (Measles, Mumps & Rubella) 1 Varicella	
Kindergarten	3 Hep B 5 DTaP 4 Polio*	2 MMR 2 Varicella 2 Hep A (Hepatitis A)*
Grades 1 to 5	3 Hep B 5 DTaP 4 Polio	2 MMR 2 Varicella
Grades 6 to 10	3 Hep B 5 DTaP 4 Polio	2 MMR 2 Varicella 1 Tdap (Tetanus & Pertussis) 1 MCV4 (Meningococcal)
Grades 11 & 12	3 Hep B 5 DTaP 4 Polio	2 MMR 2 Varicella 1 Tdap (Tetanus & Pertussis) 2 MCV4 (Meningococcal)*

* = recommended not required

2014-2015 School Year (Proposed)

Below are the number of doses and each vaccine required for school entry. Changes from the 2013-2014 requirements are indicated in blue.

3 to 5 years old	3 Hep B (Hepatitis B) 4 DTaP (Diphtheria, Tetanus & Pertussis) 3 Polio (Inactivated Polio) 1 MMR (Measles, Mumps & Rubella) 1 Varicella	
Kindergarten	3 Hep B 5 DTaP 4 Polio*	2 MMR 2 Varicella 2 Hep A (Hepatitis A)
Grades 1 to 5	3 Hep B 5 DTaP 4 Polio	2 MMR 2 Varicella
Grades 6 to 11	3 Hep B 5 DTaP 4 Polio	2 MMR 2 Varicella 1 Tdap (Tetanus & Pertussis) 1 MCV4 (Meningococcal)
Grade 12	3 Hep B 5 DTaP 4 Polio	2 MMR 2 Varicella 1 Tdap (Tetanus & Pertussis) 2 MCV4 (Meningococcal)



Healthcare professionals

Healthcare Personnel Vaccination Recommendations

Vaccine	Recommendations in brief
Hepatitis B	Give 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2). Give IM. Obtain anti-HBs serologic testing 1–2 months after dose #3.
Influenza	Give 1 dose of TIV or LAIV annually. Give TIV intramuscularly or LAIV intranasally.
MMR	For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957, see below. Give SC.
Varicella (chickenpox)	For HCP who have no serologic proof of immunity, prior vaccination, or history of varicella disease, give 2 doses of varicella vaccine, 4 weeks apart. Give SC.
Tetanus, diphtheria, pertussis	Give all HCP a Td booster dose every 10 years, following the completion of the primary 3-dose series. Give a 1-time dose of Tdap to all HCP younger than age 65 years with direct patient contact. Give IM
Meningococcal	Give 1 dose to microbiologists who are routinely exposed to isolates of *N. meningitidis*.

Hepatitis A, typhoid, and polio vaccines are not routinely recommended for HCP who may have on-the-job exposure to fecal material.

Children & Hoosiers Immunization Registry Program (CHIRP)

CHIRP

Children and Hoosiers Immunization Registry Program

Indiana State Department of Health

MyVaxIndiana

MY VAX INDIANA

Keeping Hoosiers Connected & Protected

What Is MyVaxIndiana

FAQs

Indiana

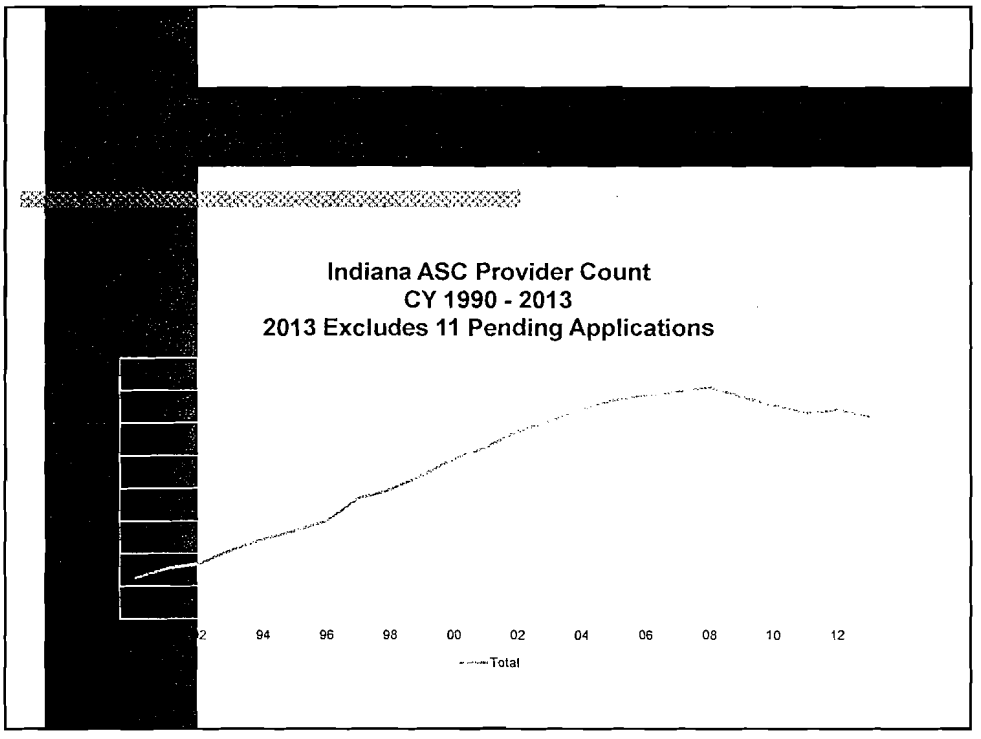
A State that Works

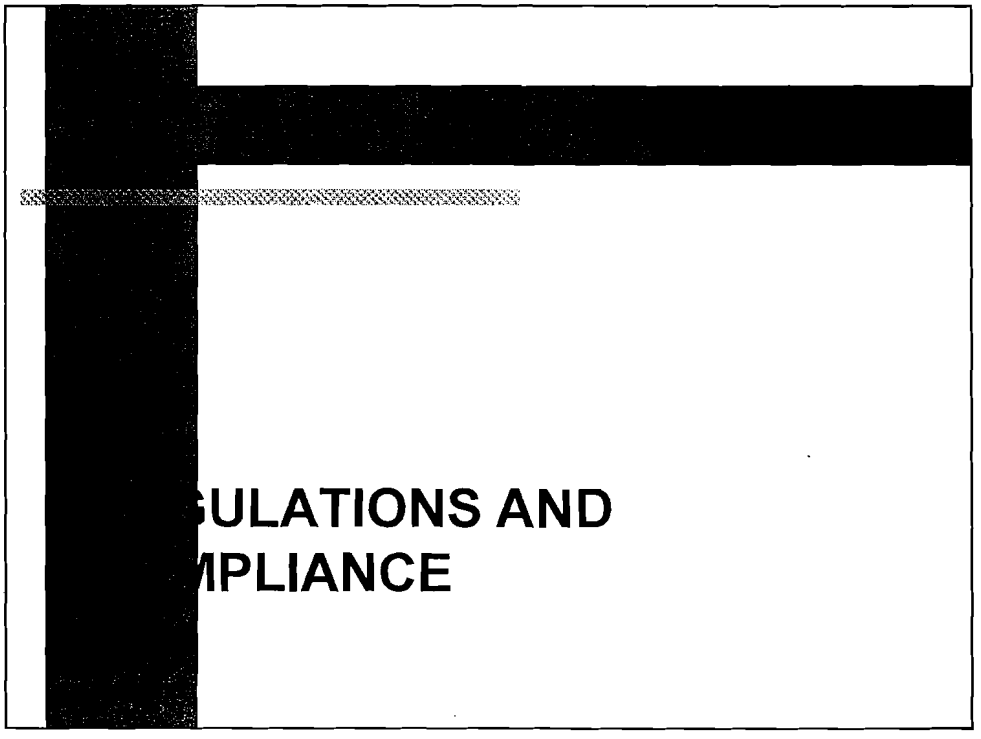
8/21/13 HFC Exhibit 7

Department of Health

nbulatory Surgery Center
censing and Certification

BULATORY SURGICAL
TER DATA


Indiana ASC Provider Count
CY 1990 - 2013
2013 Excludes 11 Pending Applications
94
96
98
00
02
04
06
08
10
12
Total


ULATIONS AND
MPLIANCE

nition of Ambulatory Surgery Center: 6-18-2-14(a)(2)

operated under the supervision of at least e (1) licensed physician or under the pervision of the governing board of the spital if the center is affiliated with a spital

IAC 15-2.5-4(b)(3)(r): Medical Staff

physician shall be available to the center ring the period any patient is present in the nter.

e interpretive guidelines for surveyors clude verification that there is a physician mediately available by phone, during the riod a patient is in the center, to respond to tients requiring emergency care and then ailable on the premises within an acceptable riod of time, if necessary, and in accordance th medical staff policies.

IAC 15-2.1-2(c)(1((a): Medical Staff

equires that a physician with specialized aining or experience in the administration of anesthetic supervise the administration of e anesthetic to a patient and remain present the facility during the surgical procedure, cept when only a local infiltration anesthetic administered.

IAC 15-1.4-1(d)(3): Governing Board

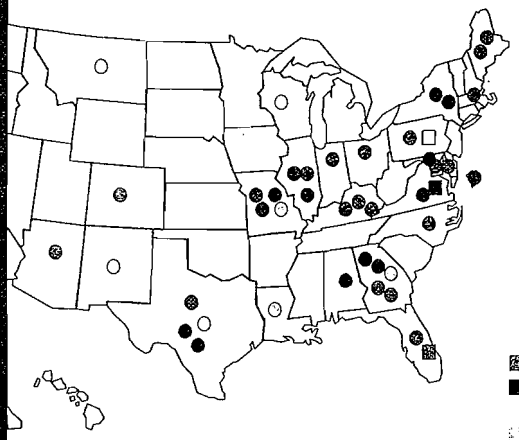
In hospitals with at least 100 acute care staffed ds, provide a licensed physician on the premises at times who has the responsibility to respond to tients requiring emergency care

In hospitals of less than 100 beds, a minimum of a ensed physician who has the responsibility to spond to patients requiring emergency care and who on call at all times and immediately available by one and then available on the premises with 30 nutes

nbulatory Surgery Center

LTHCARE ASSOCIATED
ECTION (HAI) OUTBREAKS

thcare Associated Infections



Hospital (27)
Outpatient Setting (12
LTCF (3)
Community (5)

afe Injection Practices

re of up to 40,000 patients to Hepatitis and HIV

Housing Authority board OKs rent increase for senior citizens

FEELING THE PINCH OF THE FALLING DOLLAR

LAS VEGAS SUN

From Gehry's imagination to Lou Ruvo Brain Institute

FRIDAY

LAS VEGAS REVIEW-JOURNAL

NEVADA'S LARGEST NEWSPAPER

MARCH 14, 2008

Lawyers: 100 fear infection

Health official: Data still being

PUBLIC HEALTH CRISIS

tion Control in

on Control Issues:

-optimal infection control
structure and oversight

roximately 50% of ambulatory surgical
ters (ASC) surveyed by CMS and CDC
serious, noncompliance with the
icare ASC certification standards

th and safety standards
3% had unsafe injection practices

pliance with Infection

d hygiene compliance for healthcare
ker: 40-50%

pliance with timing of surgical
phylaxis was 40%

y facilities have yet to implement
ven prevention measures:
oodstream infections
inary tract infections

from Surgical Care Improvement Project

ASCs were surveyed nationally within 36 nths. Indiana was one of 12 pilot states.

tification surveys are now at 25% of centers year and at least every six years.

lementation of "tracer" methodology

lementation of an "Infection Control" survey ksheet.

	Team Size	Survey Hours
3:	1.3	23.5
0:	2.2	59.7

MS National Data – April 7, 2010

iencies per Certification Survey

8 – 1.0

9 – 7.1

0 – 7.7

1 – 7.1

2 – 5.1

3 – 4.8

ulatory Surgical Center

submitted for the ASCQR program is icly available on the CMS website after s have an opportunity to review the data.

is displayed at the CCN level (by facility)

ıre to participate results in a 2% reduction ıy annual update

proposed rule for 2014: hospital outpatient prospective payment mbulatory surgical center rule

ulatory Surgical Center

ent Burn

ent Fall

ng Site, Wrong Side, Wrong Patient, Wrong
edure, Wrong Implant

pital Transfer/Admission

hylactic Intravenous (IV) Antibiotic Timing

2 reporting for CY 2014 payment determination

ulatory Surgical Center

Surgery Checklist

Facility Volume Data on Selected Surgical
edures

3 reporting for CY 2015 payment determination

ulatory Surgical Center

enza Vaccination Coverage among
thcare Personnel

plications within 30 days of Cataract
ery requiring additional surgical
edures

4 reporting for CY 2016 payment determination

ulatory Surgical Center

oscopy/Poly Surveillance: Appropriate
w-up interval for normal colonoscopy in
age risk patients

oscopy/Poly Surveillance: Colonoscopy
val for patient with a history of
homatous Polyps – Avoidance of
propriate use

4 reporting for CY 2016 payment determination

ulatory Surgical Center

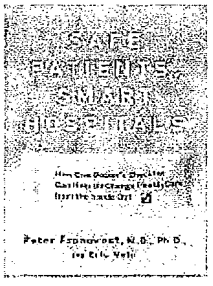
racts: Improvement in patient's visual
tion within 90 days following cataract
ery

4 reporting for CY 2016 payment determination

lity Assurance and
ormance Improvement
PI)

forming health care quality through
uous attention to quality of care and
of life

Science and Changing Culture



mplementation:

pitals (2003)

oice (2005)

state renal disease clinics [dialysis
cs] (2008)

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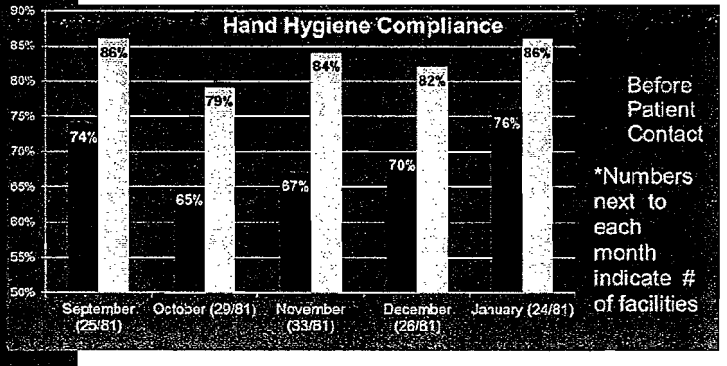

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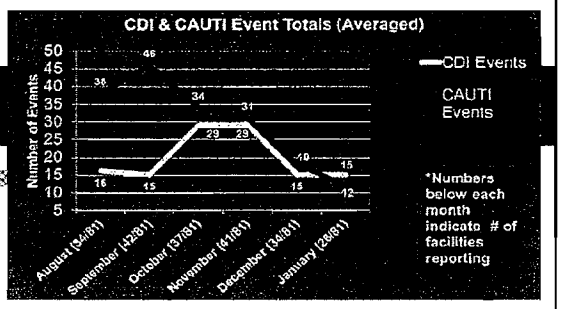

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To promote and provide essential
public health services

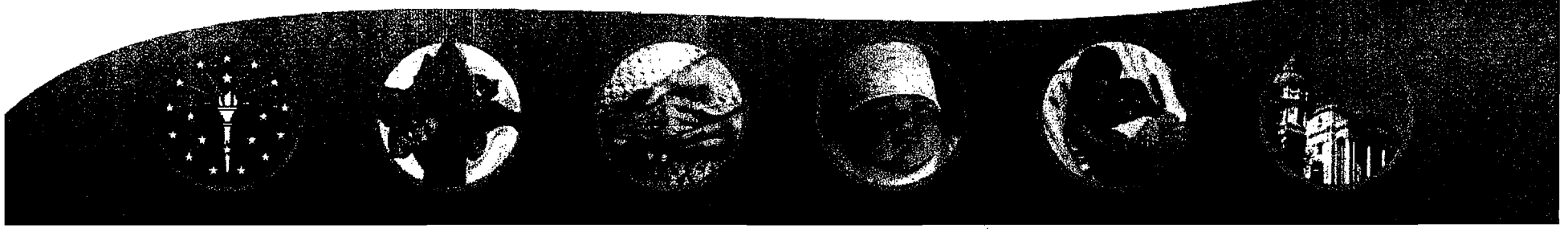
8/21/13 HFC Exhibit 8

The Indiana Family and Social Services Administration

RCR Information Breach and Corrective Action

Lance Rhodes, DFR Director
FSSA Division of Family Resources

August 2013



RCR Corporation: Who are they?

- RCR is a local Indianapolis-based minority business operation in the business application field for 15 years.
- Strengths in the following disciplines:
  - Application systems analyst/Programmer
  - Business analyst and eligibility experience
  - IVR/telephone technology and administration
  - Project management
  - Database Management
- Locations in Indiana, Maryland, Pennsylvania, New Hampshire, Illinois and Florida
- 45 clients
- Current contract is from August 1, 2012 to December 26, 2016

RCR: What do they do for FSSA?

- **RCR is the technology company that maintains DFR's document management system**—a complex computer system generating millions of notices each year, including more than 100 types of routine correspondence that FSSA sends to its clients.

- Solution architects and application database administrators responsible for components and code compromising

RCR: Supporting changes related to federal healthcare reform

- RCR is updating systems and applications to be in compliance with the Patient Protection and Affordable Care Act (PPACA).

- RCR's system updates will ensure FSSA/DFR is prepared to handle new and/or updated applications (state and federal), documents, notices, correspondence, etc.

What Occurred?

- RCR was requested to enhance functionality the document management system in 2012 and released the update in April 2013. The problem was tracked back to this release.

- The error occurred in customized code developed specifically for DFR's document center. This code handled the assembly of correspondence documents.

What types of communications are sent via this system?

Approximately 100 different types of routine correspondence are generated by the system RCR maintains, including:.

- "Pending Verification Checklist" (Lists documentation client needs to provide for eligibility verification)
- Hearings and Appeals documentation (documentation of appointments, decisions and related correspondence)
- Various authorization and consent documents
  - Release of financial information
  - Consent for release of information
  - Determination of disability authorization of release of medical information
- Follow-up appointment information
- Life insurance verification

Error discovery: Why did it take so long to fix the error?

- The programming error was made on April 6, 2013, and affected correspondence sent through May 21, 2013.
  - This error was discovered on May 10, 2013 after a handful of clients had brought it to the state's attention that they had received another client's information.
  - Once the issue was researched and the root cause discovered, the issue was corrected as of May 21, 2013.
- After ensuring the issue was corrected, FSSA instructed RCR to determine the number of individuals affected and stipulated the need for a corrective action plan to prevent future occurrences.
- Though evidence suggested the actual number of clients affected would be extremely low, RCR maintained that given the statutory time frames for reporting, the exact number of clients affected could not be quickly determined. Hence, the reporting set of 180,000+ was identified.

Initial Response

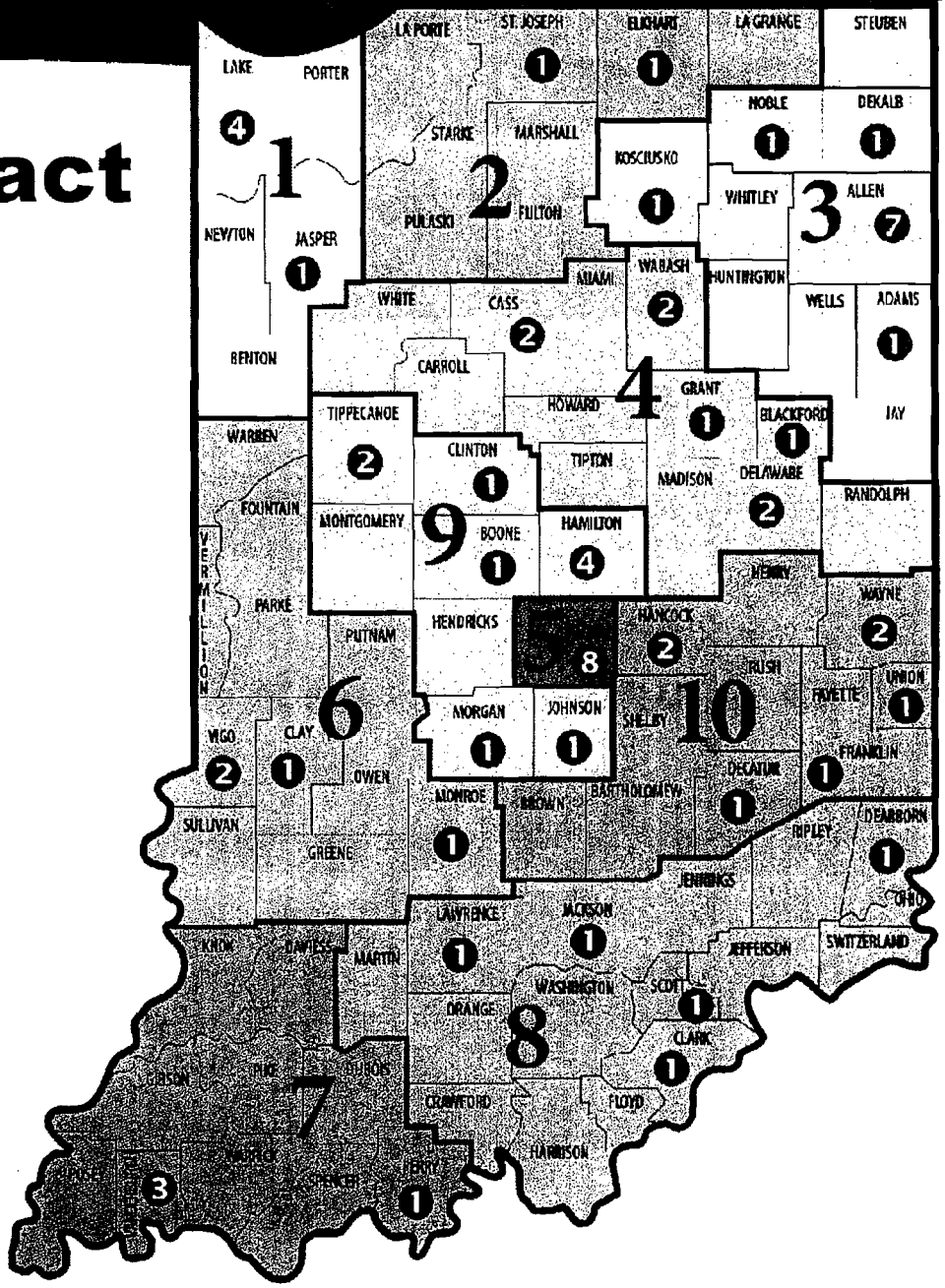
- On May 21, 2013, stopped production in new software system, reverted to old system and immediately followed state and federal guidelines for the actions an agency must take when a situation like this occurs, including:
  - Notifying the state attorney general
  - Notifying the U.S. Department of Health and Human Services
  - Notifying all potentially affected clients
  - Issuing a press release and posting it on the agency's website
- FSSA charged RCR with determining extent of actions. RCR mailed letters of apology to all potentially impacted clients.
- FSSA mailed letters to all potentially affected clients on July 1 to 5, 2013
- Following notification, RCR worked to identify the exact number employing an I-Net system to compare co-mingled with regenerated letters.

Findings and follow-up

- On July 29, 2013, RCR reported 64 clients were impacted (16 full disclosure of SSN and 48 disclosure of other personal information)
  - RCR is offering credit monitoring service to impacted clients
- Crowe Horvath independently reviewing RCR methodology for accuracy
- RCR corrective action plan includes
  - Closer state involvement
  - Higher level of load testing
- FSSA/DFR reviewed and adjusted internal processes and security alternatives
- FSSA will invoice RCR for appropriate expenses incurred related to the breach

Client Impact

DFR Region	# of Clients
1	5
2	2
3	11
4	8
5	8
6	4
7	4
8	5
9	10
10	7
Total	**64**



Follow-up letters sent to clients

FSSA mailed follow-up notices to all 180,000+ clients previously alerted of the possible breach to inform them of the findings report, versions included:

- Clients whose information was breached to inform them RCR will cover credit monitoring for one year
- Clients who were determined to have received other clients' information instructing them the information should be returned to FSSA or destroyed
- Clients determined not to be impacted by the breach to reassure them their information was not disclosed to anyone else (this was the vast majority of the letters)

Questions?

8/21/13 HFC Exhibit 9

THE DANGERS OF INDOOR TANNING

Indiana Academy of Dermatology

August 21, 2013

The Burden of Skin Cancer in the United States

- Skin cancer is the most common form of any cancer in the United States
  - Basal Cell Carcinoma (BCC) ~75% of skin cancers
  - Squamous Cell Carcinoma (SCC) ~20% of skin cancers
  - Melanoma (less common but more deadly)
- More than 3.5 million skin cancers in more than 2 million people are diagnosed annually
- One in five Americans will develop skin cancer in their lifetime
- Skin cancer develops in people of all color and on any skin surface
- Ultraviolet light exposure is the leading cause of skin cancer

Melanoma Facts

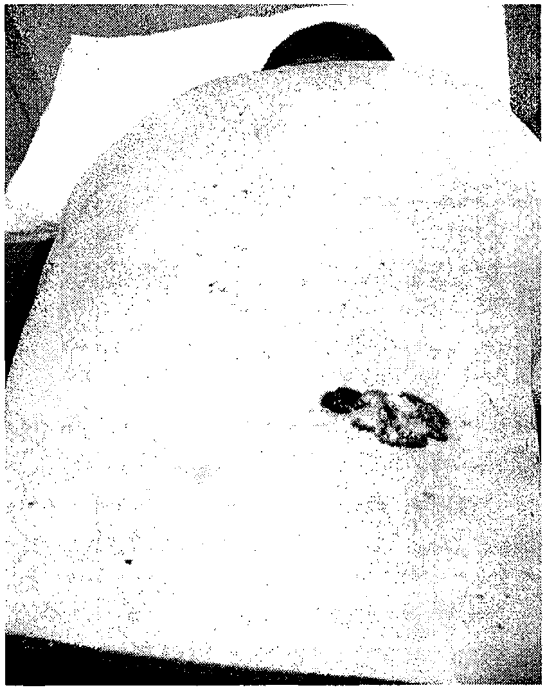
- 1 in 50 Americans will get melanoma
- The incidence rate of melanoma is increasing faster than almost any other cancer (2-3% annually since 1981)
- Melanoma is #1 cause of cancer in people aged 25-29 and the #2 cause in people aged 15-29
- Melanoma incidence is increasing faster in females aged 15-29 than males in the same age group
- Increased incidence of melanoma on the trunk of young women

Melanoma Facts

- One person dies of melanoma almost every hour
- The survival rate for patients whose melanoma is detected early (before it has reached the lymph nodes) is about 95% percent. The survival rate falls to 15 percent for those with advanced disease.
- In 2004, a study found the total direct cost associated with treatment of non-melanoma skin cancer was $1.5 billion
- NCI estimated the total direct cost associated with the treatment of melanoma in 2010 was $2.36 billion
- UV protection can decrease the risk
- Skin cancer is curable if recognized early and treated appropriately

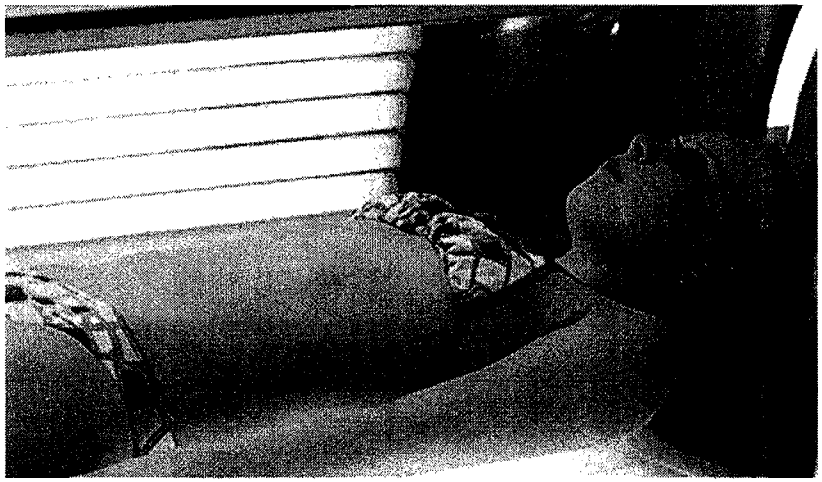
Melanoma Risks

- UV exposure is the leading cause of skin cancer and is preventable
- Exposure to tanning beds before age 35 increases melanoma risk by 75%
- Other risks: sunburns, fair skin, multiple moles, atypical moles, family history, previous melanoma, immunosuppression



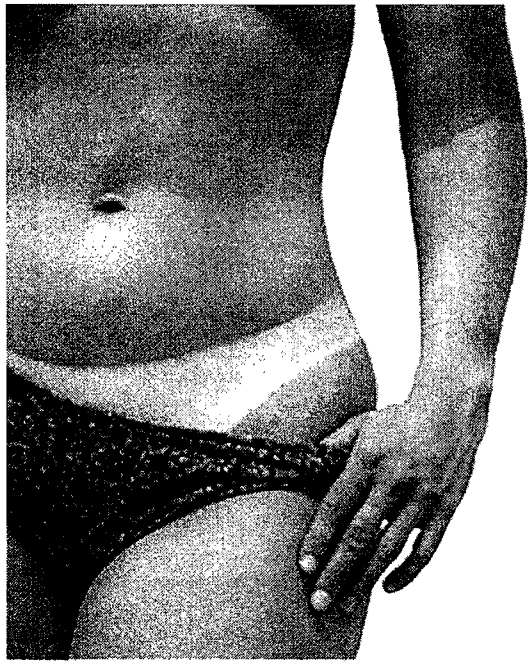
Tanning bed use and skin cancer

- Millions of Americans use tanning beds annually
- Use of tanning beds increases with each year of adolescence
- There is NO such thing as a safe tan
- Tanning devices have UV radiation levels at least as high or higher than natural sunlight
- WHO classifies tanning beds as known carcinogens
- Even one use of a tanning device increases one's risk of skin cancer
- Indoor tanning may also lead to premature aging and eye damage
- Using tanning beds for more than 50 hours increases a person's risks of melanoma by 2.5-3 times
- One study found that of patients diagnosed with melanoma between 18-29 years old, 76% could be attributed to tanning bed use
- Research also shows an increased risk of BCC's and SCC's in tanning bed users



Tanning bed use and skin cancer

- Tanning is addictive--41% of frequent indoor tanners met criteria consistent with a tanning addictive disorder
- Tanning bed users CAN and DO burn from tanning bed use



- Studies show consumers are often uninformed or misinformed about the risks of tanning bed use
  - Younger tanning bed users (minors) are more likely to be unaware of any warning labels on tanning beds compared to older consumers (aged 18-22)
  - 90% of salons stated that indoor tanning did not pose a health risk and 78% claimed that indoor tanning would be beneficial to the health of a fair-skinned teenage girl

Parental consent laws and tanning

- Minors who use tanning beds are 4 times more likely to have a parent who uses a tanning bed
- Studies indicate limited effectiveness of or noncompliance with parental consent laws
- Salons may not follow FDA recommended guidelines on tanning frequency
- Salons target younger consumers

Tanning and skin cancer: past and recent action

- The World Health Organization classifies tanning beds as human carcinogens
- Recent FDA proposal
  - Increase tanning bed classification from Class I to Class II medical device (moderate risk)
  - Requirements that tanning beds have warning labels about health risks
  - Labels should include a strong recommendation that minors under the age of 18 should not use them and encouragement for users to be screened regularly for skin cancer
- 10% excise tax on tanning bed use
- Congressional Skin Cancer Caucus recently formed
- Numerous organizations support restricting minors access to tanning beds
- 35 states have restrictions on youth access to indoor tanning or have parental consent laws
- This year, 47 bills in 31 states related to youth access to indoor tanning devices were introduced

8/21/13 HFC Exhibit 9

American Academy of Dermatology and AAD Association

INDOOR TANNING FACT SHEET

Who Tans Indoors?

- On an average day in the United States, more than 1 million people tan in tanning salons.[1]
- Nearly 70 percent of tanning salon patrons are Caucasian girls and women, primarily aged 16 to 29 years.[2]
- Nearly 28 million people tan indoors in the United States annually. Of these, 2.3 million are teens.[3, 4]
- The indoor tanning industry's revenue was estimated to be $2.6 billion in 2010.[5]

Risks of Indoor Tanning

- The United States Department of Health & Human Services and the World Health Organization's (WHO) International Agency for Research on Cancer panel have declared ultraviolet (UV) radiation from the sun and artificial sources, such as tanning beds and sun lamps, as a known carcinogen (cancer-causing substance).[6]
- Indoor tanning equipment, which includes all artificial light sources including beds, lamps, bulbs, booths, etc., emits UVA and UVB radiation. The amount of radiation produced during indoor tanning is similar to the sun and in some cases may be stronger.[7,8]
- Studies have found a 75 percent increase in the risk of melanoma in those who have been exposed to UV radiation from indoor tanning, and the risk increases with each use. [9,10, 11]
- Evidence from several studies has shown that exposure to UV radiation from indoor tanning devices is associated with an increased risk of melanoma and non-melanoma skin cancer such as squamous cell carcinoma and basal cell carcinoma.[1,2, 10, 12]
- Studies have demonstrated that exposure to UV radiation during indoor tanning damages the DNA in the skin cells. Excessive exposure to UV radiation during indoor tanning can lead to premature skin aging, immune suppression, and eye damage, including cataracts and ocular melanoma. [1,13-16]
- In addition to the above mentioned risks, frequent, intentional exposure to UV light may lead to an addiction to tanning.[17]
- Indoor tanning beds/lamps should be avoided and should not be used to obtain Vitamin D because UV radiation emitted from indoor tanning

equipment is a risk factor for skin cancer. Vitamin D can be obtained through a healthy diet and oral supplements.

- In a recent survey of adolescent tanning bed users, it was found that approximately 58% had burns due to frequent exposure to indoor tanning beds/lamps.[18]
- The FDA estimates that there are approximately 3,000 hospital emergency room cases a year due to indoor tanning bed and lamp exposure.[19]

Legislation/Regulation

- On May 6, the FDA issued a proposed order that recommends against the use of tanning beds by minors under 18, calls for the reclassification of indoor tanning devices from a Class I to a Class II medical device, and would require labeling on indoor tanning devices that clearly communicates the risks of skin cancer to all users. The Academy supported the proposed order.

- In 2013, Illinois, Nevada, Oregon and Texas passed laws that prohibit minors under the age of 18 from indoor tanning. Additionally, Connecticut and New Jersey passed laws that prohibit minors under the age of 17 from using tanning devices.

- On Oct. 9, 2011, California became the first state in the nation to prohibit the use of indoor tanning devices for all children and adolescents under the age of 18. On May 2, 2012, Vermont became the second state to ban indoor tanning for those 18 years and younger.

Academy Position Statement on Indoor Tanning

- The American Academy of Dermatology Association (AADA) opposes indoor tanning and supports a ban on the production and sale of indoor tanning equipment for non-medical purposes.
- The American Academy of Dermatology supports the WHO recommendation that minors should not use indoor tanning equipment because indoor tanning devices emit UVA and UVB radiation and overexposure to UV radiation can lead to the development of skin cancer.
- Unless and until the FDA bans the sale and use of indoor tanning equipment for non-medical purposes, the Academy supports restrictions for indoor tanning facilities, including:
    - No person or facility should advertise the use of any UVA or UVB tanning device using wording such as "safe," "safe tanning," "no harmful rays," "no adverse effect" or similar wording or concepts.

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American Academy of Dermatology and AAD Association

SKIN CANCER FACT SHEET

Incidence Rates

- More than 3.5 million non-melanoma skin cancers in more than 2 million people are diagnosed in the United States annually.[1]
    - It is estimated that there will be about 137,990 new cases of melanoma, the most serious form of skin cancer, in 2013 – 61,300 noninvasive (in situ) and 76,690 invasive (45,060 men and 31,630 women).[2]
- Current estimates are that 1 in 5 Americans will develop skin cancer in their lifetime.[3,4]
- By 2015, it is estimated that 1 in 50 Americans will develop melanoma in their lifetime.[5]
- Melanoma incidence rates have been increasing for at least 30 years.
    - The incidence rate of melanoma has increased by approximately 2.8% per year since 1981 (1981-2008). [6]
- Caucasians and men over 50 are at a higher risk of developing melanoma than the general population.[7]
    - The incidence in men ages 80 and older is three times higher than women of the same age.[2]
    - Melanoma incidence rates in Caucasians are 5 times higher than in Hispanics and 23 times higher than in African Americans. [2]
- Although before age 40, melanoma incidence rates are twice as high in women than in men, after 40, rates are higher in men than women. [2]
    - Melanoma is the most common form of cancer for young adults 25-29 years old and the second most common form of cancer for adolescents and young adults 15-29 years old.[8]
    - Melanoma is increasing faster in females 15-29 years old than males in the same age group.[9,10]
    - Melanoma in Caucasian women under the age of 44 has increased 6.1% annually, which may reflect recent trends in indoor tanning.[6]
- A 2005 study found that basal cell carcinoma and squamous cell carcinoma are increasing in men and women under 40. In the study, basal cell carcinoma increased faster in young women than in young men.[11]

Survival Rates

- Basal cell and squamous cell carcinomas are the two most common forms of skin cancer, but are easily treated if detected early.[2]
- Both basal cell carcinoma and squamous cell carcinoma have cure rates approaching 95% if detected early and treated promptly.[12]
- The five-year survival rate for people whose melanoma is detected and treated before it spreads to the lymph nodes is 98 percent.[2]
- Five-year survival rates for regional and distant stage melanomas are 62% and 15%, respectively.[2]

Mortality Rates

- Approximately 75 percent of skin cancer deaths are from melanoma.[2]
- On average, one American dies from melanoma every hour. In 2013, it is estimated that 9,480 deaths would be attributed to melanoma – 6,280 men and 3,200 women.[2]
    - From 2005-2009, the death rate in Caucasians under the age of 50 decreased by 2.8% in men and 2% in women each year.
    - During the same time period, death rates for Caucasians aged 50 and older have increased 1.1% in men and stayed the same in women.
- An estimated 3,170 deaths from other skin cancers will occur in the United States in 2013.[2]
- The World Health Organization estimates that more than 65,000 people a year worldwide die from melanoma.[13]

Risk Factors

- The major risk factor for melanoma of the skin is exposure to ultraviolet light.[2]
    - Avoiding this risk factor alone could prevent more than 2 million cases of skin cancer every year.[2]
    - In 2010, new research found that daily sunscreen use cut the incidence of melanoma, the deadliest form of skin cancer, in half.[14]
- Increasing intermittent sun exposure in childhood and during one's lifetime is associated with an increased risk of squamous cell carcinoma, basal cell carcinoma, and melanoma.[15]
- Exposure to tanning beds increases the risk of melanoma, especially in women aged 45 years or younger.[16]
    - In females 15-29 years old, the torso/trunk is the most common location for developing melanoma, which may be due to high-risk tanning behaviors.[9,10]
- People with more than 50 moles, atypical moles, light skin, freckles, a history of sunburn, or a family history of melanoma are at an increased risk of developing melanoma.[2,17]

- Melanoma survivors have an approximately 9-fold increased risk of developing another melanoma compared to the general population.[18]

Prevention & Detection

- Since exposure to ultraviolet light is the most preventable risk factor for all skin cancers[2], the American Academy of Dermatology encourages everyone to protect their skin by applying sunscreen, seeking shade and wearing protective clothing.
- Warning signs of melanoma include changes in size, shape, or color of a mole or other skin lesion, or the appearance of a new growth on the skin.[2]
- Individuals with a history of melanoma should have a full-body exam by a board-certified dermatologist at least annually and perform regular self-exams for new and changing moles.[19]

Cost

- In 2004, the total direct cost associated with the treatment for non-melanoma skin cancer was $1.5 billion in the United States.[20]
- According to the National Cancer Institute, the estimated total direct cost associated with the treatment of melanoma in 2010 was $2.36 billion in the United States.[21]

Learn more about skin cancer:

- Dermatology A to Z: Basal cell carcinoma
- Dermatology A to Z: Melanoma
- Dermatology A to Z: Squamous cell carcinoma
- Skin cancer detection
- Skin cancer prevention

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American Academy of Dermatology Association
Excellence in Dermatology™

PROTECT TEENS FROM THE DANGERS OF INDOOR TANNING BY SUPPORTING LEGISLATION TO PROHIBIT THE USE OF TANNING DEVICES BY MINORS

Help Educate Your State's Residents and Protect the Health of its Youth

- Throughout US history, state and federal legislatures have consistently used legislation to educate the public and protect our youth from various health hazards.
- The American Academy of Dermatology Association, the American Academy of Pediatrics, and the World Health Organization, support policies to prohibit the use of tanning devices by minors under the age of 18.
- Use of indoor tanning beds increases with each year of adolescence. Indoor tanning rates among 14-, 15-, 16-, and 17-year-old girls in the past year are 8.5%, 13.6%, 20.9%, and 26.8%, respectively.[i]

Indoor Tanning Devices Present a Significant Health Hazard

- Use of tanning devices early in life is linked to increased risk of melanoma, the deadliest form of skin cancer, later in life.[ii]
- UV radiation from tanning devices is classified as "carcinogenic to humans."[iii]
- Tanning devices have UV radiation levels that *far exceed* what is found in natural sunlight and have a different ratio of UVA to UVB.[iv]

Indoor Tanning Causes Melanoma and Non-Melanoma Skin Cancers

- A person who has used tanning devices for more than 50 hours, 100 sessions, or 10 or more years is 2.5 to 3 times more likely to develop melanoma than a person who has never tanned indoors.[v]
- Among those who had ever used a tanning bed and were diagnosed between 18 and 29 years of age, 76% of melanomas were attributable to indoor tanning.[vi]
- Ever-indoor tanning was associated with a 69% increased risk of early-onset basal cell carcinoma (BCC). Risk was higher in those who begin indoor tanning at earlier ages (less than 16 years old).[vii]
- Indoor tanners are 2.5 times more likely to develop squamous cell carcinoma than non-indoor tanners.[viii]

The Increase of Skin Cancer Comes at a Very High Cost

- According to the National Cancer Institute, the estimated total direct cost associated with the treatment of melanoma in 2010 was $2.36 billion.[ix]

There is No Such Thing As a "Safe" Tan

- A tan is evidence of skin damage; hence, there is no "safe tan."[x]
- Proponents of indoor tanning argue it is a good source of vitamin D. This is a false and misleading claim. Vitamin D is produced in the body through exposure to UVB rays. To minimize burning, modern indoor tanning devices emit predominantly UVA rays, and do not emit enough UVB to provide an efficient source of vitamin D.[xi]
- Tanning is addictive. Research has shown that 41% of frequent indoor tanners met criteria consistent with a tanning addictive disorder and an additional 33% met criteria for problematic tanning behavior.[xii]

DESPITE ALL OF THESE SCIENTIFIC FACTS,
THE PUBLIC REMAINS MOSTLY UNAWARE OF THE DANGERS OF TANNING

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[ix] "The Cost of Cancer." National Cancer Institute at the National Institutes of Health. 2011. http://www.cancer.gov/aboutnci/servingpeople/cancer-statistics/costofcancer (accessed 26 Aug. 2011).

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Restricting Minors Access to Tanning Beds in Indiana
List of Supportive Organizations

AIM at Melanoma

American Academy of Dermatology Association

American Association for Health Education

American Cancer Society

American Society for Dermatologic Surgery Association

Dermatology Nurses Association

Indiana Academy of Dermatology

Indiana Academy of Ophthalmology

Indiana State Medical Association

Indiana State Nurses Association

Joanna M. Nicolay Melanoma Foundation

Melanoma International Foundation

National Coalition for Skin Cancer Prevention

Outrun the Sun

Prevent Cancer Foundation

Society for Pediatric Dermatology

Society of Dermatology Physician Assistants

Organizations with position statements supporting a ban on indoor tanning by minors or who support policies that prohibit such bans:

American Academy of Dermatology

American Academy of Pediatrics

American Society for Dermatologic Surgery Association

World Health Organization

U. S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY AND COMMERCE – MINORITY STAFF

False and Misleading Health Information Provided to Teens by the Indoor Tanning Industry

Investigative Report

Prepared for Rep. Henry A. Waxman, Rep. Diana DeGette, Rep. Frank Pallone, Jr., Rep. Rosa L. DeLauro, and Rep. Carolyn Maloney

2/1/2012

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I. EXECUTIVE SUMMARY

The World Health Organization and the National Toxicology Program classify indoor tanning beds as a "known" human carcinogen. The American Academy of Pediatrics calls indoor tanning beds "generally unsafe for children" and, along with the American Academy of Dermatology Association, recommends a ban on their use by anyone under 18. Yet despite the mounting evidence of the dangers of indoor tanning, millions of young people use tanning salons each year – and this use is on the rise. The most frequent indoor tanners are young white females.

Rep. Henry A. Waxman, Ranking Member of the House Committee on Energy and Commerce, Rep. Diana DeGette, Ranking Member of the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations, and Rep. Frank Pallone, Jr., Ranking Member of the House Committee on Energy and Commerce Subcommittee on Health, along with Reps. Rosa L. DeLauro and Carolyn Maloney, requested this investigation to determine if tanning salons are providing accurate information about cancer and other risks to teenage girls who purchase indoor tanning sessions. Committee investigators representing themselves as fair-skinned teenage girls contacted 300 tanning salons nationwide, including at least three in each state and the District of Columbia. The investigators asked each salon a series of questions about its policies and the risks and benefits of tanning. Committee investigators also reviewed the print and online advertising of tanning salons.

The vast majority of tanning salons contacted by Committee investigators provided false information about the serious risks of indoor tanning and made specious claims about the health benefits that indoor tanning provides. Specifically, Committee investigators found:

- **Nearly all salons denied the known risks of indoor tanning.** When asked whether tanning posed any health risks for fair-skinned teenage girls, 90% of the salons stated that indoor tanning did not pose a health risk. When asked about the specific risk of skin cancer, over half (51%) of the salons denied that indoor tanning would increase a fair-skinned teenager's risk of developing skin cancer. Salons described the suggestion of a link between indoor tanning and skin cancer as "a big myth," "rumor," and "hype."

- **Four out of five salons falsely claimed that indoor tanning is beneficial to a young person's health.** Four out of five (78%) of the tanning salons claimed that indoor tanning would be beneficial to the health of a fair-skinned teenage girl. Several salons even said that tanning would prevent cancer. Other health benefits claimed by tanning salons included Vitamin D production, treatment of depression and low self-esteem, prevention of and treatment for arthritis, weight loss, prevention of osteoporosis, reduction of cellulite, "boost[ing] the immune system," sleeping better, treating lupus, and improving symptoms of fibromyalgia.

- **Salons used many approaches to downplay the health risks of indoor tanning.** During their calls, Committee investigators representing themselves as fair-skinned teenage girls were told that young people are not at risk for developing skin cancer; that rising rates of skin cancer are linked to increased use of sunscreen; that government regulators had certified the safety of indoor tanning; and that "it's got to be safe, or else they wouldn't let us do it." Salons also frequently referred the investigators to industry websites that downplay indoor tanning's health risks and tout the practice's alleged health benefits.

- **Tanning salons fail to follow FDA recommendations on tanning frequency.** The Food and Drug Administration recommends that indoor tanning be limited to no more than three visits in the first week. Despite this recommendation, three quarters of tanning salons reported that they would permit first-time customers to tan daily; several salon employees volunteered that their salons did not even require 24-hour intervals between tanning sessions.

- **Tanning salons target teenage girls in their advertisements.** The print and online advertising for tanning salons frequently target teenage and college-aged girls with student discounts and "prom," "homecoming," and "back-to-school" specials. These youth-oriented specials often feature "unlimited" tanning packages, allowing frequent — even daily — tanning, despite research showing that frequent indoor tanning significantly increases the likelihood that a woman will develop melanoma, the deadliest form of skin cancer, before she reaches 30 years of age.

II. BACKGROUND

A. The Growing Popularity of Indoor Tanning

Tanning salons first appeared in the U.S. in the 1970s. Their popularity grew slowly at first. By 1988, only 1% of American adults reported using indoor tanning facilities. But by 2007, that number had reached 27%.[1]

Millions of young people use tanning salons each year — often without full knowledge of the risks of indoor tanning — and this use is on the rise. The most frequent indoor tanners are young white females. Researchers consistently find high rates of indoor tanning among white 16- to 18-year-old girls, with some studies reporting that as many as 40% of youth in this

[1] Denis K. Woo and Melody J. Eide, *Tanning Beds, Skin Cancer, and Vitamin D: An Examination of the Scientific Evidence and Public Health Implications*, Dermatologic Therapy (2010) (hereinafter, "*Tanning Beds, Skin Cancer, and Vitamin D*").

demographic have used indoor tanning facilities.[2] Having a parent or guardian who has used indoor tanning in the last year is associated with a 70% increase in the likelihood that a young person will visit a tanning salon.[3]

Tanning salons tend to be concentrated in areas with more teenagers and young women aged 15 to 24.[4] This proximity is itself associated with a 40% increase in likelihood of indoor tanning among teens.[5]

B. Cancer and Other Health Risks

Ultraviolet (UV) light is electromagnetic radiation with a wavelength longer than visible light but shorter than X-rays. Sunlight contains UV radiation and emits three bands of the UV spectrum: UVA, UVB, and UVC. Exposure to either UVA or UVB light can cause DNA damage that leads to carcinogenesis.[6] The primary culprit in sunburn is UVB, and scientists once believed it to be the only carcinogenic part of the solar spectrum. Recent research, however, has confirmed that UVA exposure also contributes to development of skin cancer.[7]

Indoor tanning is a potent source of ultraviolet radiation, especially UVA. While many assume that the lamps in tanning beds contain less or similar amounts of light to that emitted by the sun, the UVA radiation emitted by these devices can be as much as 10 to 15 times more powerful than midday sunlight. Tanning lights also emit UVB radiation, although depending on the type of tanning device, the UVB emitted may be similar to or less powerful than the UVB emitted by the sun.

This radiation makes tanning beds dangerous. Medical research has identified indoor tanning as a cause of skin cancer, including melanoma, the deadliest form of the disease. The World Health Organization's International Agency for Research on Cancer (IARC) classifies tanning beds as a "Group 1" carcinogen, a category that also includes asbestos, arsenic, and

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[2] *Id.*; Joni A. Mayer et al., *Adolescents' Use of Indoor Tanning: A Large-Scale Evaluation of Psychosocial, Environmental, and Policy-Level Correlates*, American Journal of Public Health (May 2011) (hereinafter, "*Adolescents' Use of Indoor Tanning*").

[3] *See Adolescents' Use of Indoor Tanning.*

[4] Vilma Cokkinides et al., *Indoor Tanning Use among Adolescents in the US, 1998 to 2004*, Cancer (Jan. 2009) (hereinafter, "*Indoor Tanning Use among Adolescents*").

[5] *Indoor Tanning Use among Adolescents*; *Tanning Beds, Skin Cancer, and Vitamin D*; *Adolescents' Use of Indoor Tanning.*

[6] Exposure to UVC is also carcinogenic, but UVC rays from the sun do not reach the earth's surface, so they do not present the same human health risks as UVA and UVB.

[7] *See Tanning Beds, Skin Cancer, and Vitamin D.*

tobacco smoke.[8] Similarly, the National Toxicology Program classifies tanning beds as "known to be human carcinogens."[9]

The risk of melanoma is especially high for youth and young adults who engage in indoor tanning. According to the IARC, the melanoma risk is "increased by 75% when use of tanning devices starts before 30 years of age."[10] For those who report having undergone ten or more indoor tanning sessions in the first three decades of life, the risk of being diagnosed with melanoma before the age of 30 is six times higher than the risk for those who have never tanned indoors.[11] Scientists have found this risk to persist after controlling for sunburns and outdoor sunbathing habits of melanoma victims.[12] One recent study determined that for young people diagnosed with melanoma between the ages of 18 and 29 years old, "76% of melanomas were attributable to sunbed use."[13]

Indoor tanning can cause "sunburn," just like too much sun exposure. Nearly 60% of indoor tanners report experiencing burns after indoor tanning sessions, a major risk factor for melanoma.[14] The risk of melanoma is highest for women reporting sunburns during adolescence.

Scientists have also documented a link between indoor tanning and other forms of skin cancer. Researchers have found that a single use of a tanning bed can increase one's chance of acquiring basal cell carcinoma, even after controlling for a history of sunburns, sun exposure, and sunbathing.[15] Recently published peer-reviewed research by scientists at the Yale Cancer

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[8] *See* International Agency for Research on Cancer, *Agents Classified by the* IARC Monographs, *Volumes 1-102* (available online at *http://monographs.iarc.fr/ENG/Classification/ClassificationsGroupOrder.pdf*) (visited Jan. 26, 2012).

[9] U.S. Department of Health and Human Services, Public Health Service, National Toxicology Program, *Report on Carcinogens, 12th ed.: Exposure to Sunlamps or Sunbeds* (2011).

[10] *Special Report: Policy, A Review of Human Carcinogens — Part D: Radiation*, The Lancet (Aug. 2009); *see also Tanning Beds, Skin Cancer, and Vitamin D*.

[11] Anne E. Cust et al., *Sunbed Use During Adolescence and Early Adulthood Is Associated with Increased Risk of Early-Onset Melanoma*, International Journal of Cancer (May 2011) (hereinafter, "*Sunbed Use During Adolescence and Early Adulthood*").

[12] *See* Marit Bragelien Veirød et al., *A Prospective Study of Pigmentation, Sun Exposure, and Risk of Cutaneous Malignant Melanoma in Women*, Journal of the National Cancer Institute (Oct. 2003); J Westerdahl, *Risk of Cutaneous Malignant Melanoma in Relation to Use of Sunbeds: Further Evidence for UV-A Carcinogenicity*, British Journal of Cancer (2000).

[13] *See Sunbed Use During Adolescence and Early Adulthood.*

[14] *See Indoor Tanning Use among Adolescents.*

[15] *See Tanning Beds, Skin Cancer, and Vitamin D.*

Center showed that young people who have ever tanned indoors see a 69% increase in risk for developing basal cell carcinoma before the age of 40. Approximately one in four of these cancers, and 43% of the basal cell carcinomas in young women, could be prevented if people never used indoor tanning beds.[16] The IARC found a similar link between indoor tanning and squamous cell carcinomas.[17] The risk associated with indoor tanning is especially high for people with fair skin.[18]

The increased popularity of indoor tanning has coincided with a sharp rise in skin cancer.[19] Melanoma is now the most common form of cancer for white women between the ages of 15 and 29 years old. Since 1980, the rate of melanoma in this group has increased by 50%.[20] Non-melanoma skin cancers have also seen a dramatic rise; by 2007, about 13 million Americans had had at least one such cancer. According to peer-reviewed research published in the Archives of Dermatology, the rate of non-melanoma skin cancer in the U.S. is "reaching epidemic proportions."[21]

In addition to increasing cancer risks, tanning can cause ocular damage, premature aging of the skin, and exacerbate other medical conditions.[22]

There are no health benefits to indoor tanning that outweigh the risks associated with the practice. There is no "safe or moderate tan." Even short exposure to tanning can cause DNA damage. While many indoor tanners report using tanning beds to develop a "base tan" to protect against sunburns, researchers have concluded that indoor tanning offers no effective sunburn protection.

The tanning industry frequently promotes the benefits of Vitamin D and its association with UV light as an advantage of indoor tanning. Peer-reviewed medical research, however, shows that indoor tanning is an ineffective source of Vitamin D promotion. Although exposure to UVB light can produce Vitamin D, those most at risk of Vitamin D deficiency — people with darker skin — photosynthesize less Vitamin D. Moreover, the amount of UVB emitted from

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[16] *See* Leah M. Ferrucci et al., *Indoor Tanning and Risk of Early-Onset Basal Cell Carcinoma*, Journal of the American Academy of Dermatology (Dec. 2011).

[17] *See Tanning Beds, Skin Cancer, and Vitamin D.*

[18] Rutao Cui et al., *Central Role of p53 in the Suntan Response and Pathologic Hyperpigmentation*, Cell (Mar. 2007) (hereinafter, "*Central Role of p53*"); *Tanning Beds, Skin Cancer, and Vitamin D.*

[19] *Tanning Beds, Skin Cancer, and Vitamin D.*

[20] National Cancer Institute, *NCI Cancer Bulletin* (July 2008).

[21] *Study Finds "Epidemic" of Skin Cancer*, ABC News (Mar. 2010).

[22] *See* James M. Spencer and Rex A. Amonette, *Indoor Tanning: Risks, Benefits, and Future Trends*, Journal of the American Academy of Dermatology (1995).

tanning devices varies, with some popular devices emitting relatively low levels. For most individuals, five to thirty minutes of midday sun twice each week accompanied by a healthy diet provides sufficient Vitamin D. For those with Vitamin D deficiency, physicians recommend oral supplements rather than increased exposure to UV radiation.[23]

C. Federal and State Regulation

Under the Federal Food, Drug, and Cosmetic Act (FDCA), the Food and Drug Administration currently regulates tanning beds as Class I medical devices, the most lightly regulated device category. Other medical products regulated as Class I devices include band-aids, rubber gloves, and tongue depressors. Class I devices are subject to limited federal oversight; they are supposed to be those devices that "present minimal potential harm" to the user.

Tanning beds are subject to FDA's general controls for medical devices (including rules about good manufacturing practices, recordkeeping, reporting, adulteration, and misbranding) and performance standards specific to tanning beds.[24] These standards: (1) establish limits on a tanning bed's irradiance emissions; (2) require a mechanism by which a user of the device may terminate the tanning session at any time; (3) mandate that tanning bed manufacturers include protective eyewear with their products when distributed; (4) mandate the presence of a timer on each tanning bed (though the regulations state explicitly that "[t]he timer requirements do not preclude a product from allowing a user to reset the timer"); and (5) require that all tanning beds include the following warning label:

> DANGER--Ultraviolet radiation. Follow instructions. Avoid overexposure. As with natural sunlight, overexposure can cause eye and skin injury and allergic reactions. Repeated exposure may cause premature aging of the skin and skin cancer. WEAR PROTECTIVE EYEWEAR; FAILURE TO MAY RESULT IN SEVERE BURNS OR LONG-TERM INJURY TO THE EYES. Medications or cosmetics may increase your sensitivity to the ultraviolet radiation. Consult physician before using sunlamp if you are using medications or have a history of skin problems or believe yourself especially sensitive to sunlight. If you do not tan in the sun, you are unlikely to tan from the use of this product.[25]

While FDA does not prescribe any particular limits on the frequency or duration of indoor tanning sessions, it has issued guidance to manufacturers on recommended exposure frequency during the first week of indoor tanning. FDA requires that manufacturers of tanning devices provide directions for a tanning device's use to purchasers. These directions must include a recommended exposure schedule, and FDA guidance suggests that this schedule

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[23] *See Tanning Beds, Skin Cancer, and Vitamin D.*

[24] 21 U.S.C. § 360c(a)(1)(B).

[25] 21 C.F.R. § 1040.20(c)-(d).

recommend no more than three tanning sessions in the first week of indoor tanning exposure.[26]

FDA is presently considering a reclassification of tanning beds, potentially triggering more stringent protections. On March 25, 2010, the General and Plastic Surgery Devices Panel of FDA's Center for Devices and Radiological Health Advisory Committee met to review recent scientific literature on risks posed by indoor tanning and to recommend whether changes to the devices' classification or regulatory controls are needed. The panel considered a presentation by FDA staff and testimony from the medical community and tanning salon industry. Testifying on behalf of the American Academy of Pediatrics, Johns Hopkins University Professor of Pediatrics and Dermatology Bernard Cohen stated that "the Academy believes that tanning lamps are generally unsafe for children and calls on the Food and Drug Administration to regulate them as such." He said the American Academy of Pediatrics supports a ban on tanning by children and teenagers, testifying: "In order to safeguard children and adolescents from the dangers of unsafe ultraviolet radiation exposure, the American Academy of Pediatrics recommends a ban on the use of tanning devices by individuals under the age of 18, unless under the guidance of their physician."[27]

The FDA advisory panel concluded unanimously that tanning beds should not be Class I medical devices, with panelists split as to whether they should be Class II devices or Class III devices, which are subject to the strictest FDA controls. A majority of the panel favored age restrictions for tanning bed use. The panel also recommended enhanced education, training, and testing of tanning bed operators and improved labeling of tanning beds. In the words of one physician on the panel, dermatologist Dr. Erin Walker, such revisions to current regulations must make clear the medical consensus that "there is no such thing as a safe tan."[28] The FDA is currently considering these recommendations.

Some states have responded to the growth in the tanning industry and the mounting medical evidence of a link between tanning and skin cancer with regulations limiting access to tanning beds by children and adolescents. Over 30 states have enacted legislation regulating indoor tanning by teens — most commonly, by requiring parental consent for use of a tanning bed.[29] Even in states with these restrictions, the effectiveness of the regulations remains a

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[26] FDA, Consumer Health Information, *Indoor Tanning: The Risks of Ultraviolet Rays* (Nov. 2009).

[27] FDA, Transcript of General and Plastic Surgery Devices Panel Meeting (Mar. 25, 2010) (available online at http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/MedicalDevices/MedicalDevicesAdvisoryCommittee/GeneralandPlasticSurgeryDevicesPanel/UCM210232.pdf) (visited Jan. 26, 2012).

[28] *Id.*

[29] *See Indoor Tanning Use among Adolescents*; *Tanning Beds, Skin Cancer, and Vitamin D*. Over twenty states have enacted laws requiring parental permission for children who wish

concern. Studies of compliance with parental consent laws in Texas, North Carolina, and Minnesota and Massachusetts have found tanning salon compliance rates of 11%, 13%, and 19%, respectively.[30] Despite an increase over the last decade in states requiring some form of parental permission for indoor tanning, researchers have found no measurable decrease in indoor tanning among older adolescent girls.

California recently enacted legislation banning indoor tanning by children altogether.[31] The law took effect on January 1, 2012. California is the first and only state to protect children via a ban on indoor tanning. The indoor tanning industry opposed California's ban, while the American Academy of Dermatology praised it, commending the state for "protecting youth from the dangers of indoor tanning."[32]

III. PURPOSE AND METHODOLOGY

Ranking Members Waxman, DeGette, and Pallone, along with Reps. DeLauro and Maloney, requested that the Democratic Committee staff investigate how tanning salons communicate risks to teens who seek information about indoor tanning sessions. In response to this request, Committee staff investigators, including college students interning with the Committee, telephoned indoor tanning salons across the country representing themselves as fair-skinned 16-year-old girls considering purchasing indoor tanning sessions for the first time.

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to purchase indoor tanning sessions, with the age at which this requirement expires varying from 15 to 18. *See, e.g.*, Ariz. Admin. Code R 12-1-1414 A2; Ark. Stat. Ann. § 20-27-2202; Conn. Gen. Stat. § 19a-232; Fla. Stat. Ann. tit. § 381.89; Ga. Code Ann. § 31-38-8; Ind. Code Ann. § 25-8.4-15, 16; Ky. Rev. Stat. § 217.922; La. Rev. Stat. Ann. § 40:2701-18; Md. Health Code Ann. § 20-106; Mass. Gen. Laws Ann. ch. 111 Pub. Health § 211; Mich. Comp. Laws Ann. § 333.13405; Minn. Stat. Ann. § 325H.08; Miss. Dept. of Health Regs. tit. 15 part III subpart 78 ch. 2; Ohio Admin. Code 4713-19-09(B); OAR 333-119-0090(2); R.I. Dept. of Health Rules and Regs. for the Registration of Tanning Facilities, Part III § 9.5; S.C. Code Ann. ch. 61 § 106-4.5; Tenn. Code Ann. § 68-117-104; Utah Code Ann. § 26-15-13; Va. Code § 59.1-310.3; Wyo. Enrolled Act 26. Several other states require parental permission for older adolescents and prohibit indoor tanning for very young children, typically under the age of 14. *See, e.g.*, Del. Code Ann. tit. 16 § 30D; Ill. Admin. Code tit. 77 § 795.190(c); 10-144 Maine Dept. of Human Servs. Ch. 223 12A(3)(f); N.H. Rev. Stat. Ann. § tit. XXX 313-A:31; N.J. Rev. Stat. § C.26:2D-82.1; N.Y. Pub. Health Law § 3555; N.C. Gen. Stat. § 104E-9.1; N.D. Cent. Code § 23-39; Tex. Health and Safety Code Ann. § 145.008. Wisconsin has banned indoor tanning for those under 16, but has no parental consent requirements for older children. Wis. Code Ann. § 255.08(9)(a).

[30] *See Indoor Tanning Use among Adolescents in the US; Tanning Beds, Skin Cancer, and Vitamin D.*

[31] Cal. Bus. and Prof. Code §§ 22706, 2241.3.

[32] *See California Bans Indoor Tanning for Minors*, N.Y. Times (Oct. 10, 2011).

Committee investigators spoke with employees at 300 indoor tanning salons nationwide, including at least three salons in all 50 states and the District of Columbia.

On calls with salons, investigators asked: (1) whether the salon offered discounts to students or teens; (2) how frequently a new customer would be permitted to use the salon's tanning beds; (3) whether indoor tanning posed any risks for people with fair skin; (4) whether indoor tanning increased one's risk of acquiring skin cancer; and (5) whether indoor tanning provided any health benefits. When salons referred callers to information provided on a website, investigative staff reviewed these materials.

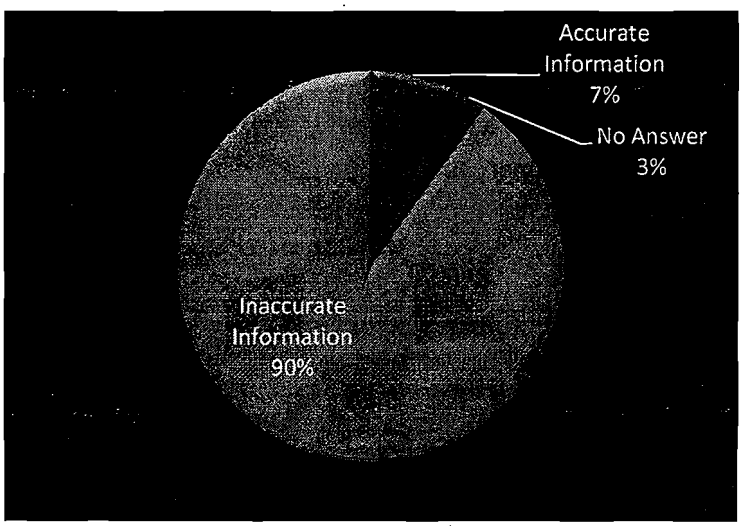
Committee staff also collected and reviewed advertising and promotional material created by indoor tanning salons. In particular, staff reviewed tanning salon websites, Facebook pages and posts for and by tanning salons, and print advertising.

IV. FINDINGS

A. Tanning Salons Provided False Information about the Health Risks of Indoor Tanning

The vast majority of the 300 tanning salons contacted by Committee staff provided inaccurate and misleading information about the health risks of indoor tanning. When Committee staff representing themselves as fair-skinned 16-year-old girls asked tanning salons whether indoor tanning would present any health risks, 90% of the salons reported that it presented no risk and only 7% reported that risks were present. The remaining 3% of salons did not provide clear answers about health risks.

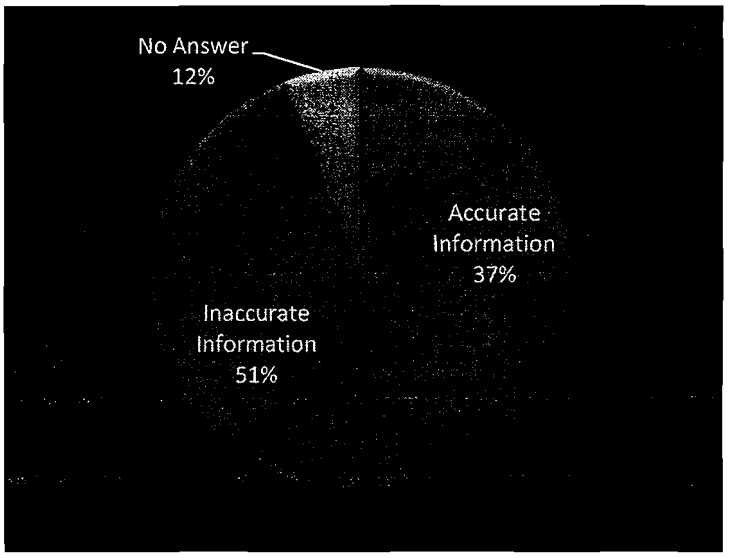
Figure 1:
90% of Salons Provided Inaccurate Information about Tanning Risks



When Committee investigators pressed salons about the specific threat of skin cancer, the majority of tanning salons provided information that was inaccurate and misleading. More than half (51%) of the 300 salons claimed that indoor tanning would not increase a young, fair-skinned person's risk of developing skin cancer. "No, no, no — that's not true whatsoever," insisted one salon employee. "Tanning

beds do not cause melanoma," another assured Committee staff. Others described cancer risks as "a big myth," "rumor," and "hype" that had not been "proven." "People who are meant to get skin cancer are just going to get skin cancer," one employee explained. "We wouldn't offer it if we thought it caused cancer," stated another.

Figure 2:
51% of Salons Denied a Link between Indoor Tanning and Skin Cancer



Even salons that accurately reported skin cancer risks misleadingly described those risks. One equated the skin cancer risk associated with indoor tanning as similar to that posed by the sunlight absorbed while "walking to your car." Another compared the risk of cancer from indoor tanning to that presented by "standing in front of the microwave" oven.

Several salons provided misleading advice about who is at risk for skin cancer. Employees at two salons told investigators representing themselves as 16-year-olds that skin cancer from indoor tanning is only a concern for "for an old person" or "older people." Another suggested that use of sunscreen could actually increase one's risk for skin cancer, explaining that "skin cancer rates increased when sunscreen started being promoted."

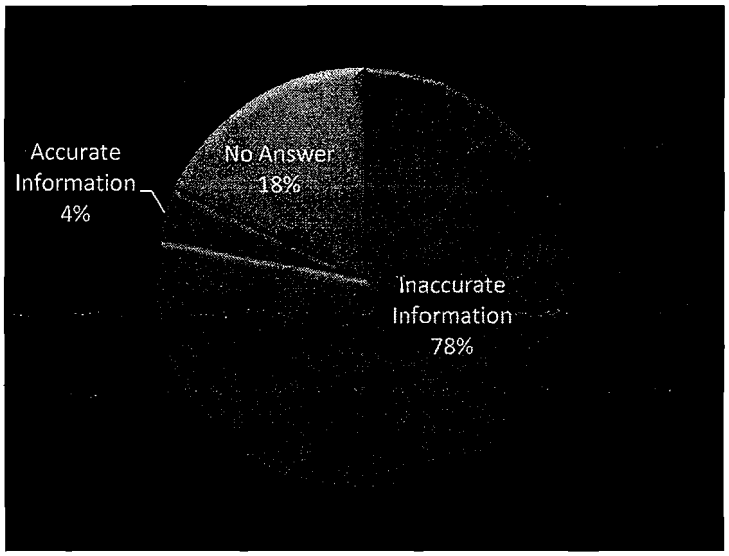
In discussing cancer risks, some salons pointed to the regulatory environment for indoor tanning as evidence of a lack of risk. These salons suggested that the current state of regulation amounted to confirmation of the practice's safety, telling Committee investigators: "If it was incredibly bad for you, you wouldn't be allowed to do it"; "It's got to be safe, or else they wouldn't let us do it"; "you can get skin cancer from being outside . . . but our [tanning] beds are certified and regulated"; and "the FDA wouldn't approve tanning salons if it weren't safe."

Salons also provided false information about skin damage and the risk of burns that might occur in a fair-skinned, first-time indoor tanner. Several suggested that indoor tanning is significantly less risky than casual exposure to natural sunlight. Others were unconcerned about skin damage from any source. One suggested that "aggressive tanning" is necessary when trying to build a tan in a fair person. Another told the caller that fair-skinned clients "just have to get that burning out of the way."

B. Tanning Salons Provided Inaccurate or Misleading Information about Health Benefits of Indoor Tanning

Tanning salons frequently claimed that indoor tanning would be beneficial to the health of teenagers, despite medical consensus to the contrary. Overall, 78% of the salons reached by Committee staff claimed that indoor tanning would provide health benefits. "Tanning is very good for you," one salon employee volunteered.

Figure 3:
78% of Salons Claimed Indoor Tanning Is Beneficial to Health



The most common benefit claimed by salons was promotion of Vitamin D production, with 60% of salons asserting that indoor tanning would be a good source of Vitamin D. Physicians do not recommend indoor tanning as a source of Vitamin D, however. Those most at risk of Vitamin D deficiency are least likely to increase Vitamin D levels through tanning because they typically have darker skin. Moreover, the level of UVB radiation from tanning devices, which is what can produce Vitamin D, can vary considerably, with several popular devices emitting relatively low levels that would not contribute significantly to Vitamin D production.

Employees at eleven salons claimed that indoor tanning would prevent cancer. One named skin cancer, breast cancer, colon cancer, and prostate cancer as diseases that could be prevented though use of tanning beds.

Other health benefits mentioned by salons contacted by Committee staff include treatment of depression and low self-esteem, treatment for acne, prevention of and treatment for arthritis, weight loss, prevention of osteoporosis, "skin tightening," reduction of cellulite, "boost[ing] the immune system," improved sleeping, treating lupus, and improving symptoms of fibromyalgia.

C. Tanning Salons Regularly Disregarded FDA Safety Recommendations

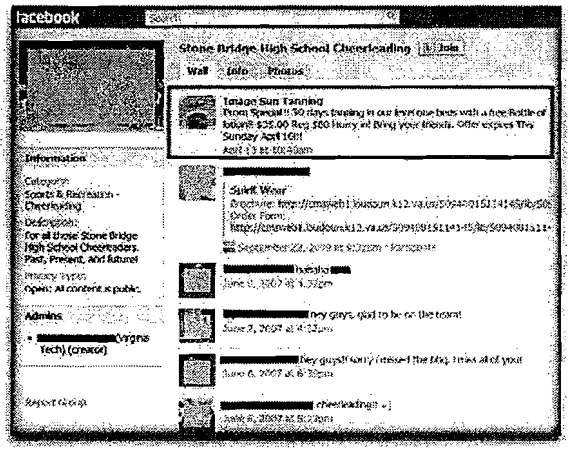
Three quarters of tanning salons did not follow FDA recommendations on tanning frequency. The FDA recommends that indoor tanning be limited to no more than three visits in

the first week. Despite this recommendation, 74% of the salons that Committee staff contacted stated that they would permit first-time, fair-skinned teenage girls to tan daily, and four salon employees volunteered that their salons did not require 24-hour intervals between tanning sessions.

D. Tanning Salons Targeted the Teen Market in Advertisements

The tanning salons contacted by Committee investigators frequently targeted youth in their marketing promotions. Among the tanning salons contacted by Committee investigators, over half (52%) offered discounts to students or teens.

Committee investigators reviewed over one hundred tanning salon websites and newspaper advertisements and found that "prom," "homecoming," and "back-to-school" specials are common. "It's time to start on that Homecoming tan!!!" states a typical advertisement. Committee investigators also found that tanning salons are active users of social media, with many maintaining Facebook pages and Twitter accounts. Salons post notices about discounts on their own social media sites and also on Facebook pages for student groups, such as cheerleading squads.



The most common discounts offered to young people in the advertising materials reviewed by Committee staff were reduced rates on "unlimited" tanning packages, which allow customers to visit a salon as often as they wish in a particular period of time (typically, one month). This type of discounting raises concern because, while any use of indoor tanning increases skin cancer risks, frequent tanning sessions significantly increase the chance of acquiring melanoma.

E. Tanning Industry Websites Provide Misleading Information

When presented with requests for health information about indoor tanning, tanning salons frequently directed investigators to tanning industry websites that create a misleading picture of the risks and benefits of indoor tanning. Most commonly, they suggested that teens curious about the health impact of indoor tanning visit www.tanningtruth.com or www.smarttan.com. Both sites are associated with the "International Smart Tan Network," a tanning industry trade association. The sites downplay the cancer risk associated with indoor tanning and tout the practice's alleged health benefits.

Visitors to www.tanningtruth.com see a series of large-print pro-tanning statements running across the top of the screen while navigating the website. The statements begin with an assertion that "[s]aying sunlight is harmful and therefore we should avoid it is as misleading as saying that water causes drowning, and therefore we should avoid it." Statements that follow suggest that medical advice about the use of sunscreen and avoidance of indoor tanning is driven by the profit motives of pharmaceutical companies and dermatologists.

The website's discussion of the health impacts of tanning present a different picture than that provided by peer-reviewed medical research. Under a tab labeled "What are the real risks of indoor tanning?" the industry website questions the link between indoor tanning and melanoma, saying that "the relationship between melanoma and ultraviolet light remains unclear." Under a tab labeled "Are there any benefits to indoor tanning?" the trade association claims that tanning is "nature's sunscreen," treats cosmetic skin conditions, and promotes Vitamin D production. The site then suggests that indoor tanners produce a "sufficient" level of Vitamin D, "non-tanners" produce a "deficient" level, and dermatologists experience a "severe deficiency" of Vitamin D.

The other industry website, www.smarttan.com, also provides misleading information about Vitamin D and tanning. On this website, salon operators may purchase "D-Angel" training, which "teaches [salon] employees why Smart Tanning is vindicated and why they should spread the truth about UV and Vitamin D to their friends and family." It provides a link to a website for the "Vitamin D Council," which suggests that Vitamin D promotion yields a host of health benefits, including prevention of cancer, heart disease, diabetes, autism, multiple sclerosis, chronic digestive diseases, food allergies, and tuberculosis, as well as treatment for lupus.

V. CONCLUSION

Indoor tanning significantly increases skin cancer risks and presents a number of other significant health concerns. These risks are particularly acute for teenagers and young adults. Indoor tanning salons, however, regularly deny these risks. When Committee investigators contacted 300 tanning salons to ask about the risks indoor tanning posed to fair-skinned teenage girls, the vast majority of salons denied that indoor tanning increases health risks.

The dangers to teenage girls are exacerbated by tanning industry practices. Committee investigators found that the marketing practices of tanning salons target teenagers and young adults, often offering back-to-school, homecoming, and prom promotions.

8/21/13 HFC Exhibit 10

Indiana Health Finance Commission Testimony
Joseph Levy, American Suntanning Association
August 21, 2013

Thank you, Chairwoman Miller and Members of the Committee. I am Joseph Levy, scientific advisor to the American Suntanning Association and executive director of the International Smart Tan Network, the training and educational institute for the North American sunbed community. For 21 years I have developed UV training materials for thousands of professional sunbed centers and state regulators and serve as our chief scientific liaison as a long-time member of the American Society for Photobiology.

Melanoma researcher and professor of dermatology Dr. Jonathon Rees from Newcastle University once wrote that melanoma is an example of politics and science becoming tragically intertwined and that an amicable separation is required.

That's because melanoma is more common in INDOOR workers than it is in OUTDOOR workers, according to the World Health Organization. It is much more common in men than in women. It is increasing much faster in OLDER men than it is in younger women. And it's most common on parts of the body that DON'T get regular UV exposure.

The proponents of restricting access to sunbeds have not effectively respected that crucial aspect of the science. It is part of the nuance of sun care that is missing in their overall campaign. And while we ALL agree on sunburn prevention, this important caveat about practical sun care is our biggest source of disagreement.

And that's the problem. That's what Rees was talking about.

And THAT's why research dermatologist Dr. Bernard Ackerman -- the man largely credited with founding the field of dermatopathology and who trained more dermatopathologists than anyone else on the planet -- supports what I'm telling you. Ackerman spent his career calling for balance in sun care - and in his last monograph he explicitly said that Smart Tan's position on melanoma is right. And encouraged the American Cancer Society and the American Academy of Dermatology to reconsider their positions. Ackerman is considered by many to be the highest-decorated dermatologist in American history. And he promoted sunburn prevention - not sun avoidance - and that suntans are natural. And he's not alone.

That's why Dr. Sam Shuster, a British Professor of Dermatology, has written if you think a tan is "damage" to the skin you should tell that to Charles Darwin: That a tan is part of nature's intended design to prevent sunburn. Calling it "damage" is like calling exercise "damage" to muscle tissue.

That's why IARC scientist Dr. Sara Gandini has done a meta-anlysis of 60 studies showing clearly that the greatest risk factors for melanoma are having more than 40 moles, having red hair and a having family history of melanoma - and that these factors are far greater than any UV associations.

That's why research dermatologist Dr. Richard Weller is now getting worldwide press with research suggesting that the benefits of regular non-burning sun exposure may be 80-to-1 what the alleged risks are. He used a sunbed to prove that UVA exposure produces nitric oxide in the skin and lowers blood pressure.

That's why Boston University endocrinologist and worldwide vitamin D pioneer Dr. Michael Holick has published hundreds of papers and books preaching balance because UV exposure is the body's true natural source of vitamin D.

In other words: This ISN'T straightforward. Saying that UV exposure from any source is harmful and should be avoided is like saying that water causes drowning, and therefore we should avoid water. It misrepresents the complex and intended relationship that all living things have with UV light.

Professional sunbed salons are perfectly willing to teach that balanced message. And we do. With warning signs and consent forms that are already part of our standard protocol and which are accepted nationwide. We teach balance and responsibility in a CREDIBLE fashion - one that respects the intelligence of the consumer.

Think of a tanning salon like a public pool. Trained salon operators are the lifeguards at that pool. Our job is to use the best system in the world -- our FDA exposure schedules -- to help prevent sunburn.

What we'd ask you to consider is this: There are many other "pools" available to those who believe that non-burning sun exposure is a responsible choice. Home tanning units. Outdoor pools and backyards. And none of them have lifeguards.

But let's talk about our "pool" again. Proponents of this bill have failed to disclose a very important caveat about research into the risk of sunbeds -- most of it does NOT actually study tanning salons. For example, fully HALF of the subjects in the WHO report -- the one they claim showed a 75 percent increase in melanoma risk for under-35 users -- HALF were home unit users or used sunbeds in dermatology offices to treat psoriasis. If you remove the home units and the dermatology units, 75 percent becomes just 6 percent. It's their own data. And I've supplied that to you.

They didn't tell you that removing Skin Type I subjects from the data -- fair skin people who DO NOT TAN IN SALONS in the United States, but who are in the studies from solaria in Europe used for therapeutic reasons -- removes the increase in risk.

In the United States trained operators screen them out using screening we developed with Dr. Thomas Fitzpatrick (the Harvard University dermatologist who DEVELOPED the

Fitzpatrick Skin Type System). Removing them from the studies ELIMINATES reported risk for people with skin that can tan.

Proponents of this bill also have misled you about the nature of the word "carcinogen" as it relates to UV exposure and sunbeds and what it actually means to be a "level one carcinogen" according to the federal government.

They have said UV is in the same category as tobacco, arsenic and even plutonium to scare you. What they DIDN'T tell you is that, also in that same Level one category, are BIRTH CONTROL PILLS, salted fish, red wine, even sawdust and many other things we DO experience in our daily lives. What they didn't tell you is that, on that list of carcinogens, only ONE stands out as something every human on this planet NEEDS in order to live. UV light.

Comparing UV exposure to cigarettes? Proponents of age-based restrictions for tanning have crossed the country this year stating that "Tanning device usage is as carcinogenic as cigarette smoking." As State Rep. Ed Henry said in a public health committee in Alabama to a dermatologist who said tanning was as dangerous as tobacco, "You don't walk outside and get TOBACCO naturally."

Professional sunbed centers in the U.S. today are trained to use FDA-created exposure schedules to gradually induce a suntan while minimizing the risk of sunburn. This is not a random procedure. Our market has strived to improve that protocol through constructive cooperation with state and federal regulators and through even more aggressive self-regulation. Combined, that differentiates us from most of the rest of the world where sunbeds are frequently used in unmonitored settings without trained operators to prevent sunburn.

Bottom line: If teenage access to sunbed salons is unnecessarily restricted, three out of every four teenagers who today use sunbeds in professional tanning centers with their parents' permission will purchase or use unregulated HOME tanning equipment and will simply tan more aggressively outdoors, leading to an INCREASE in injury. International Communications Research, a firm that does public health surveys for the Harvard School of Public Health, did that survey. It will happen. Check EBAY or CRAIGSLIST yourself -- the units are out there. That would simply create an underground, unregulated, uncontrolled "garage tanning industry" and you will be CREATING a problem - not solving one.

In conclusion, we are here to be part of the solution and to discuss this issue constructively. And if legislators and groups in Indiana would like to work with us to discuss the science and real-world solutions to the issue of sun care education, we're here. We'll do that. Wouldn't we ALL be better served by that? Certainly we can do that so that the Indiana legislature can move on to other pressing matters. We can work TOGETHER to send a balanced message to this state and your constituents that sun care is serious business WITHOUT over-reaching and going beyond the data. We're willing to be a constructive player in that equation. I'm happy to take your questions.

The Affect of Sunbed Location on Melanoma Risk: A Pooled Analysis[1]

Papas MA, Chappelle AH, Grant WB

Summary

A 2006 International Agency for Research on Cancer meta-analysis reported a "limited" and "weak" positive association between sunbed use and cutaneous malignant melanoma (meta-odds ratio = 1.15, 95% confidence interval: 1.0, 1.3). That same review also reported a positive association between ever-use of a sunbed and cutaneous malignant melanoma (meta-odds ratio = 1.75; 95% CI, 1.35-2.26) for first exposure to sunbeds before 35 years of age. This figure has been widely referenced, yet the distinction of the exact characterization of sunbed usage, as detailed in the data collection, limits the interpretability of these findings and raises further questions. Usage of unsupervised home sunbeds and sunbeds used by doctors as medical devices make up half of the cases reported in the data in addition to commercial sunbed usage. This contamination of the data appears to significantly affect the results. When commercial sunbed usage is considered independent of home and medical usage of sunbeds, the IARC review data no longer suggest a significant association.

HOME TANNING UNITS

STUDY	Case Yes	Case No	Control Yes	Control No	Calculated Odds Ratio
Swerdlow 1988	No data or assumptions provided				
Walter 1990	71	431	40	498	2.05
Westerdahl 1994					
Chen 1998	96	483	51	417	1.63
Chen 1998 (people <25)	57	483	26	417	1.89
Westerdahl 2000	34	319	38	538	1.51
Veierod 2003					
Bataille 2005	126	113	142	107	0.84
TOTAL	327	1346	271	1560	**1.40** (95% CI: 1.17-1.66)

INDOOR TANNING SALONS

STUDY	Case Yes	Case No	Control Yes	Control No	Calculated Odds Ratio
Swerdlow 1988	No data or assumptions provided				
Walter 1990	59	431	55	498	1.24
Westerdahl 1994					
Chen 1998	44	483	44	417	0.86
Chen 1998 (people <25)	14	483	16	417	0.76
Westerdahl 2000	52	319	64	538	1.37
Veierod 2003					
Bataille 2005	189	169	212	161	0.85
TOTAL	344	1402	375	1614	**1.06** (95% CI: 0.89-1.24)

MEDICAL 'PHOTOTHERAPY' SESSIONS

STUDY	Case Yes	Case No	Control Yes	Control No	Calculated Odds Ratio
Walter 1990	17	431	10	498	**1.96** (95% CI: 0.89-4.33)

[1] Papas MA, Chappelle AH. Differential Risk of Malignant Melanoma By Sunbed Exposure Type. Proceedings of 3rd North American Congress of Epidemiology. Am J of Epid. 2011; 1003

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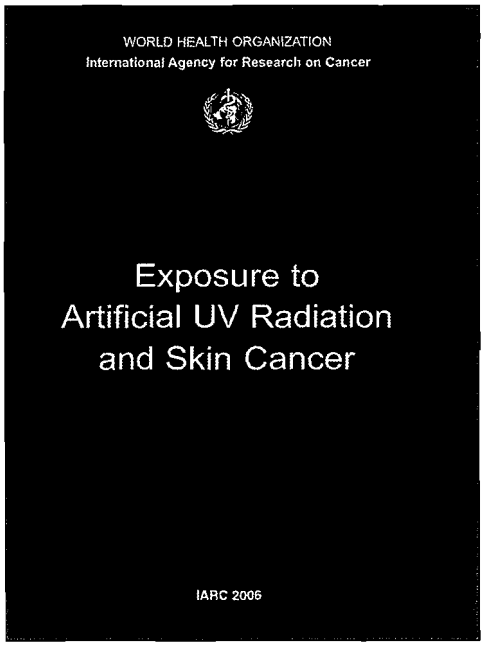
The WHO Report on Sunbeds:
The Data Implicate Dermatology Phototherapy - Not Tanning Salons

1) IN 2006 WHO convened a panel of scientists who published a report saying clearly: "Epidemiologic studies to date give no consistent evidence that use of indoor tanning facilities in general is associated with the development of melanoma skin cancer."

That report also suggested "sunbed" use increased melanoma risk 75% in users under age 30. But "sunbed" actually meant dermatology phototherapy units, not professional salon sunbeds. WHO's own data showed that dermatology phototherapy units increase risk 96 percent while commercial salon units have no statistically significant increase in risk. (Papas 2011). The data has been pooled together by lobbying groups who continue to suggest incorrectly that the 75 percent number applies to tanning salons.



2) In 2009 WHO convened a second group of scientists to review the agency's list of known carcinogens. The panel concluded that since sunlight had long been included on the list of potential carcinogens that sunbeds should also be included on the list. (Being listed a carcinogen does not mean a substance is harmful in any dose. Sunlight is also necessary for all living things). No new science was conducted.

3) In July 2009 WHO staff published and promoted a short essay in The Lancet suggesting that the WHO listed sunbeds as a carcinogen - failing to report that "sunbeds" meant dermatology use of sunbeds, instead leaving the press to believe that the report studied indoor tanning salons. It did not. And WHO has not corrected the error.

4) In 2011 Dr. Mia Papas, an epidemiologist at the University of Delaware, presented data at the North American Congress of Epidemiology showing that only half of the subjects in the 7 studies used to create the "75%" statistic were tanning salon users, and that tanning salons studies alone in the data did not increase melanoma risk significantly. Dermatology usage of sunbeds in phototherapy procedures, in contrast, accounted for a 96% increase in risk in the WHO data.

5) To date, WHO still has not corrected this error, despite the fact that several expert scientists have questioned the WHO's conclusions.

Association of Health Care Journalists
Better coverage. Better health.

Tanning beds: What do the numbers really mean?

May. 7, 2010

Dr. Ivan Oransky, M.D., editor of Reuters Health, AHCJ treasurer

May has been declared "Melanoma Awareness Month" or "Skin Cancer Awareness Month" – depending on which group is pitching you – and reporters are doubtlessly receiving press releases and announcements from a number of groups, including the Melanoma Research Foundation, the Skin Cancer Foundation, hospitals, doctors and other organizations.

Those press releases often point to the World Health Organization, which reports that "use of sunbeds before the age of 35 is associated with a 75% increase in the risk of melanoma" – a statistic often repeated in news stories about tanning beds. But what does that really mean? Is it 75 percent greater than an already-high risk, or a tiny one? If you read the FDA's "Indoor Tanning: The Risks of Ultraviolet Rays," or a number of other documents from the WHO and skin cancer foundations, you won't find your actual risk.

That led AHCJ member Hiran Ratnayake to look into the issue in March for *The* (Wilmington, Del.) *News Journal*, after Delaware passed laws limiting teens' access to tanning salons. The 75 percent figure is based on a review of a number of studies, Ratnayake learned. The strongest such study was one that followed more than 100,000 women over eight years. But as Ratnayake noted, that study "found that less than three-tenths of 1 percent who tanned frequently developed melanoma while less than two-tenths of 1 percent who didn't tan developed melanoma." That's actually about a 55 percent increase, but when the study was pooled with others, the average was a 75 percent increase. In other words, even if the risk of melanoma was 75 percent greater than two-tenths of one percent, rather than 55 percent greater, it would still be far below one percent.

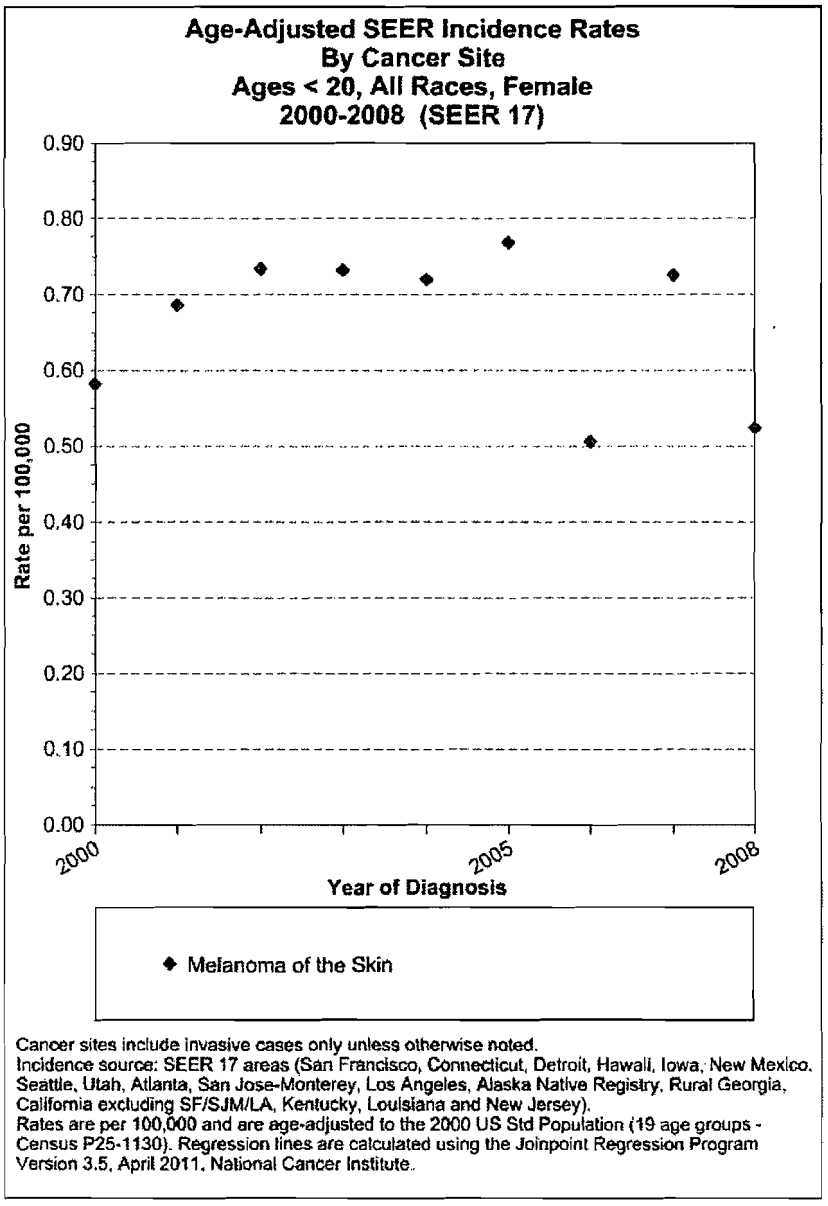
For some perspective on those numbers, Ratnayake interviewed Lisa Schwartz, M.D.,M.S., whose work on statistical problems in studies and media reports is probably familiar to many AHCJ members. "Melanoma is pretty rare and almost all the time, the way to make it look scarier is to present the relative change, the 75 percent increase, rather than to point out that it is still really rare," Schwartz, a general internist at Veterans Affairs Medical Center in White River Junction, Vt., told him.

In a nutshell, the difference between skin doctors' point of view and Schwartz's is the difference between relative risk and absolute risk. Absolute risk just tells you the chance of something happening, while relative risk tells you how that risk compares to another risk, as a ratio. If a risk doubles, for example, that's a relative risk of 2, or 200 percent. If it halves, it's .5, or 50 percent. Generally, when you're dealing with small absolute risks, as we are with melanoma, the relative risk differences will seem much greater than the absolute risk differences. You can see how if someone is lobbying to ban something – or, in the case of a new drug, trying to show a dramatic effect – they would probably want to use the relative risk.

This is not an argument for or against tanning beds. It's an argument for clear explanations of the data behind policy decisions. For some people, the cosmetic benefits of tanning beds – and the benefit of vitamin D, for which there are, of course, other sources – might be worth a tiny increase in the risk of melanoma. For others, any increased risk of skin cancer is unacceptable. (And of course, for the tanning industry, the benefits can be measured in other ways – dollars.) But if reporters leave things at "a 75 percent increase," you're not giving your readers the most important information they need to judge for themselves.

So when you read a study that says something doubles the risk of some terrible disease, ask: Doubles from what to what?

National Cancer Institute Data:
Melanoma Incidence Decreasing in Women Under Age 20



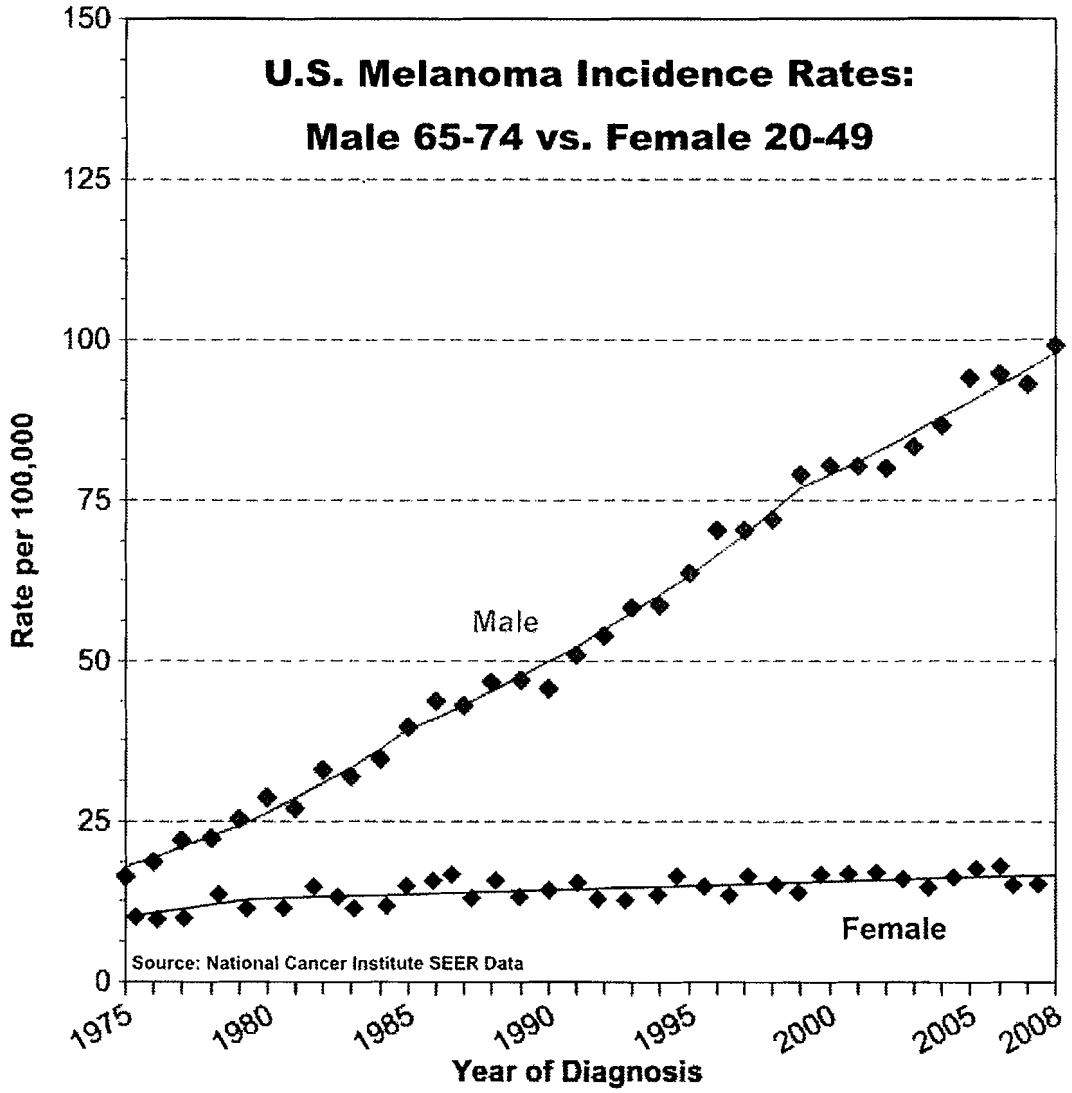
WHAT THIS CHART SHOWS:

- Melanoma incidence in women under 20 is extremely rare -- about 1 case per 200,000 -- and has decreased in the past 10 years, according to the National Cancer Institute's data.

NATIONAL CANCER INSTITUTE

MELANOMA INCIDENCE: INCREASING IN MEN

The National Cancer Institute shows that melanoma incidence is increasing much faster in men than in women since the early 1970s. For women under age 50, incidence rates have actually leveled off and are declining. But dermatology industry lobbying groups continue to promote the opposite -- leading the press to believe that melanoma is increasing fastest in young women. The best data suggest otherwise.



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The Professional Sunbed Community's Scientifically Supported Position

Sun exposure is natural and intended and humans get less today than at any point in human history. That's why indoor tanning sunbeds were first developed in sunlight-deprived northern European countries for therapeutic purposes. In North America, tanning is primarily a cosmetic business, but millions of customers visit sunbed salons because indoor lifestyles deny them regular sunlight.

Putting The Risks of UV Exposure in Proper Perspective:

- A 2009 opinion paper published by the World Health Organization cited a 75% increased risk for melanoma with the use of sunbeds before the age of 35. The report failed to cite that the medical phototherapy units used in the studies made up the majority of the increased risk – 96% while commercial sunbed use showed an increased risk of only 6%.

- Melanoma is more common in ***indoor*** workers (World Health Organization) who get 3-9 times *less* UV exposure than outdoor workers. It is more common on parts of the body that *don't* get regular sun exposure. While sunburn and overexposure are to be avoided, there is still no clear direct experimental evidence showing a causative mechanism between UV and melanoma, according to dermatology's own lobbying groups. And no study to date has examined non-burning exposure in sunbeds. And it's true: some independent dermatology researchers question whether UV and melanoma are related at all.

- Many researchers have discredited the WHO indoor tanning report because it does not actually study sunbeds used in salons and does not acknowledge that UV exposure is also a necessary component of life.

- The professional sunbed industry educates clients about the risk of overexposure and sunburn.

Competition - Not Science - Is Driving the Anti-Tanning Message

- Dermatology's objection to tanning salons isn't scientific: It's competitive. Dermatologists use sunbeds in their offices (which they call "safe") to treat cosmetic skin conditions at 20 times the price billed to insurance companies.

- Because 3 million salon tanners are self-treating skin conditions as a side-effect of their cosmetic tanning regimen, dermatology is competing with tanning salons for this business. Dermatology admits it has lost more than 95 percent of its $5 billion phototherapy business to tanning salons because it is more expensive than salon sunbed sessions.

- If dermatology's objection to sunbeds were scientific, they would not be using sunbeds to treat purely cosmetic skin conditions in their offices.

U.S. Indoor Tanning: Leading the World In Professionalism

- More than 90 percent of professional indoor tanning units emit about 95 percent UVA and 5 percent UVB in regulated dosages similar to summer sun. Recommended exposure schedules developed by the U.S. FDA in cooperation with the tanning industry allow trained indoor tanning operators to set incremental exposure times, based on the "skin type" of a patron, that deliver consistent non-burning dosages of UV light to allow a tanner to gradually build a tan.

- While tanning units may be 2-3 times as intense as summer sun, the duration of exposure is short and controlled - typically 5-20 minutes - and thus the total UV output is controlled, to minimize the risk of sunburn.

- The North American tanning community teaches clients a balanced message of moderation and sunburn prevention – properly educating clients about the potential risks of overexposure to sunlight.

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THE 10% TAN TAX: LOST JOBS AND CLOSED STORES

The Affordable Care Act imposed a 10% tax on all UV tanning services in tanning salons, taking effect July 2010 -- the first tax to take effect under this legislation. The tax has had a profound negative effect on suntanning centers.

- It has closed 4,000 women-owned businesses since 2009.
- It has cost the economy an estimated 50,000 jobs.
- It has raised only 1/3 of revenue projections for the Affordable Care Act.

TAN TAX RECEIPTS FAR BELOW PROJECTIONS

- When the tax was implemented in 2010, the government estimated that an average of $67.5 million would be collected by the IRS each quarter for 10 years.
- **The receipts reported by the IRS averaged $21.7 million in the first seven quarters -- which is less than 1/3 of the projected revenue.** The number of businesses filing returns dropped significantly due to the large number of closings.

BUSINESS CLOSINGS AND LOST JOBS

- There are an estimated 14,000 professional U.S. tanning businesses today -- down from 20,000 in 2009. The 10% tan tax was the main factor for 4,000 of these closings in a time when small businesses were already struggling.
- 75% of these professional businesses are owned by women compared to a national average of 26.1% in all other industries.
- The tax slowed growth in the surviving salon businesses and slowed hiring.
- Though these are small businesses, the industry employs nearly 100,000 Americans.

SCIENCE NEVER SUPPORTED THE TAX

- The tax was conceived as a well-documented political deal. It was introduced in December 2009 as a substitute for a would-be 5% tax on elective cosmetic surgery.

"Goodbye Botax. Hello tanning tax," Janet Adamy, a reporter for The Wall Street Journal, wrote in her blog on December 20, 2009. "Amid pressure from doctors, Senate Majority Leader Harry Reid decided to remove a proposed 5% tax on elective cosmetic surgery in the health bill that was expected to raise $5 billion over a decade. In place of what was known as the Botax, he added a 10% tax on indoor tanning services. ...The change is a victory for the American Medical Association, which urged lawmakers to remove the cosmetic-surgery tax after Sen. Reid included it in a draft of the bill he unveiled in November. The medical industry argued that the tax effectively discriminated against women, since they're more likely to undergo such procedures."

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5 Reasons 'Tan Ban' Legislation Would Be A Mistake

While the professional tanning community supports constructive and cooperative measures to increase UV awareness and sunburn prevention, a matter our market takes very seriously, passage of legislation denying teenagers with their parents consent access to indoor tanning facilities would actually hurt more people than it helps and will lead to an *increase* in sunburn and skin injury. Proponents of such a measure, however well-intentioned, ignore conflicting research and confounding information and are doing the wrong thing for the right reasons. Specifically:

1. The science does not support it. Professional tanning salons are not the problem. Ban proponents have misrepresented the World Health Organization's data on this topic, which actually points to medical use of sunbeds for the treatment of cosmetic skin diseases and unmonitored home tanning units, but not professional tanning salons[i]:

WHO REPORT BY CATEGORY	RISK FACTOR
Dermatology psoriasis sunbeds:	96% increase
Professional tanning salon sunbed usage	6% increase

2. Parents do not support it. Two-thirds (67.1 percent) of American parents with teenagers support the tanning industry's current parental consent standard, according to a study of more than 1,000 adults with teenagers conducted by International Communications Research. Only 27.3 percent were in favor of new restrictions on teenage access to tanning facilities.

3. A ban will cost businesses and taxpayers money to implement. Enforcement of this provision will cost taxpayers money to implement, will hurt small businesses and ultimately will not affect consumer behavior. Bill proponents are overstating the risks of regular non-burning UV exposure and consumers know it -- they will seek other options.

4. A ban will accomplish the opposite of what sponsors intend. Independent surveys have established that teens will simply tan more aggressively outdoors or will turn to unregulated home tanning units in friends' basements if they are not permitted to tan in salons with their parents consent. That simply drives the issue underground into sunbeds that do not have the exposure controls that are present in professional tanning facilities. Sunburn will increase, not decrease.

5. Dermatology uses sunbeds to treat cosmetic conditions. Dermatology uses identical sunbeds in their offices to treat cosmetic skin diseases. "Phototherapy" (at up to $100 a session, billed to insurance companies) is more intense and can involve sunburn and even second-degree burning as a side effect. If this were a health-care issue, dermatology would suspend their own use of sunbeds for cosmetic purposes. But they haven't. In fact, they've lobbied to preserve it, introducing legislation calling their sunbeds "safe" and mandating that insurance companies no longer charge $50 co-pays for dermatology sunbed sessions.

CONCLUSION: The present system works. Requiring signed consent from a parent/guardian is working. It's what most parents want. The tanning market supports constructive efforts to bolster this standard.

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[i] [i] Papas MA, Chappelle AH. Differential Risk of Malignant Melanoma By Sunbed Exposure Type. Proceedings of 3rd North American Congress of Epidemiology. Am J of Epid. 2011; 1003

8/21/13 HFC
Exh. 10

SMART TAN®
EDUCATIONAL INSTITUTE

SMART TAN SKIN TYPE SYSTEM™ SKIN TYPE IDENTIFICATION QUESTIONNAIRE

1. What is the natural color of your untanned skin?
0 - Reddish - White
2 - White - Beige
4 - Beige
8 - Light Brown
12 - Brown
16 - Black
Score: ☐

2. What is your natural hair color?
0 - Red, Light Blonde
2 - Blonde, Light Brown
4 - Brown
8 - Dark Brown
12 - Brownish-Black
16 - Black
Score: ☐

3. What is your eye color?
0 - Lt. Blue, Lt. Green, Lt. Grey
2 - Blue, Green, Grey
4 - Grey, Lt. Brown
8 - Brown
12 - Dark Brown
16 - Black
Score: ☐

4. How many freckles do you naturally have on your untanned body?
0 - Many
2 - Some
8 - Few
12 - None
Score: ☐

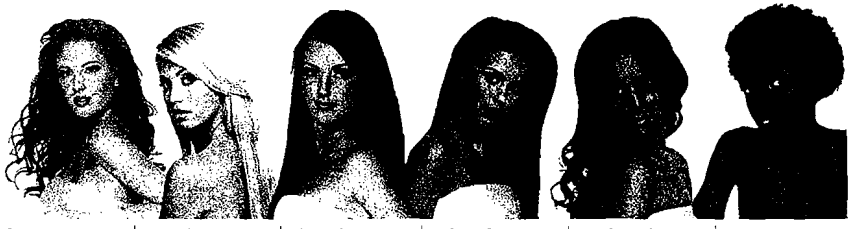
5. Which best describes your genetic heritage?
0 - Celtic, Caucasian
2 - Caucasian, Lt. Skinned European
4 - Caucasian, Dark Skinned European
8 - Caucasian, Mediterraneon
12 - Middle Eastern, Indian, Asian, Hispanic
16 - Aborigine, African, African American
Score: ☐

6. Which best describes your SUNBURN potential?
0 - Always Burns w/o Tanning
2 - Usually Burns, But Can Tan
4 - Occasionally Burns, But Tans Moderately
8 - Seldom Sunburns and Tans Moderately
12 - Rarely Sunburns and Tans Profusely
16 - Rarely Sunburns
Score: ☐

7. Which best describes your TANNING potential?
0 - Never Tan
2 - Can Tan Lightly
8 - Can Tan Moderately
12 - Can Get a Dark Tan
Score: ☐

Add all your points to get your total score and match the TOTAL with the correct skin type listed below:

Total Score ☐



0 - 7	8 - 21	22 - 42	43 - 68	69 - 84	85 +
Skin Type I	**Skin Type II**	**Skin Type III**	**Skin Type IV**	**Skin Type V**	**Skin Type VI**
Cannot tan. Very sensitive to sunlight.	Sensitive to sunlight.	Normal sensitivity to sunlight.	Skin is tolerant of sunlight.	Skin is brown. Very tolerant.	Skin is black. Extreme tolerance.

CLIENT RELEASE AND INFORMED CONSENT

Name_____ Date _____

Address_____

City_____ State/Province_____ Zip/Postal_____

Phone _____ Cell_____

Date of Birth _____ E-mail_____

PLEASE ANSWER THESE QUESTIONS:

- Have you ever tanned outdoors?..... Yes____ No____
- Do you tan easily? ..... Yes____ No____
- Do you sunburn easily? ..... Yes____ No____
- Have you tanned in the last 30 days? ..... Yes____ No____
- Are you currently pregnant? .....Yes____ No____
- Are you currently taking medication that is photosensitizing?..... Yes____ No____
- Have you ever developed a rash, blister, an allergic reaction or sun poisoning from tanning?..... Yes____ No____
- Are you being treated for a condition where UV light or excessive heat may pose a problem?.....Yes____ No____

PLEASE READ THE GOVERNMENT WARNING STATEMENT AND READ AND INITIAL THE FOLLOWING:

DANGER: Ultraviolet radiation. (1) Follow instructions. (2) Avoid overexposure. (3) As with natural sunlight, overexposure can cause eye and skin injury and allergic reactions. (4) Repeated exposure may cause premature aging of the skin and skin cancer. (5) Wear protective eyewear. Failure to may result in severe burns or long-term injury to the eyes. (6) Medications or cosmetics may increase your sensitivity to the ultraviolet radiation. Consult physician before using a sunlamp if you are using medications or have a history of skin problems or believe yourself especially sensitive to sunlight. (7) If you do not tan in the sun, you are unlikely to tan from use of this product.

_____ I have read and understand the warning statement above about the potential risks of sunbed usage.
_____ I have been shown how to use the tanning equipment properly and will follow directions.
_____ I have been shown how to use government-approved protective eyewear and will wear it every session.
_____ I have been advised that certain foods, medications or cosmetics may increase my sensitivity to UV light.
_____ I will advise a salon operator of any change in medications or any new use of medications.
_____ I understand that I should not tan outdoors or in another sunbed on days I am tanning in this salon.
_____ I have been advised to consult a physician if I have a history of skin problems or am sensitive to sunlight.
_____ I understand that tanning is a process and multiple visits may be necessary before results begin to show.
_____ I will advise an operator of any burn, rash or injury I believe to result from use of the tanning equipment.
_____ I have completed the Skin Type Form on the back of this document with a staff member.

I have read the contents of this consent form carefully and state that I am not aware of any medical condition or any other reason that would prohibit me from tanning. I understand that I will not be allowed to exceed the maximum allowable time posted on the tanning device. I have been given adequate instructions for the proper use of the tanning equipment, understand the risks involved, and use it at my own risk. I hereby agree to release this salon, its owners, operators and manufacturers from any damages that I might incur due to the use of this facility.

Signature _____ Date _____

Signature of Parent (Required if under 18) _____

Witness (Salon Rep) _____ Date _____

_____ For illiterate or visually impaired persons, I have read the warning in the presence of a witness (who signed the signature line) and to the best of knowledge the consumer understands the risk associated with this warning.

_____

☐ I would like to receive e-mail offers and information from this salon.
☐ I would like to receive text message offers and information from this salon.

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8/21/13, HFC, Exhibit 11

INDIANA PRESCRIPTION DRUG ABUSE PREVENTION TASK FORCE

Disposal of Prescription Drugs

Health Finance Commission

August 21, 2013

Presentation Overview

- **The Problem of Prescription Drug Abuse**
- **Criminal Impact**
- **Prescriptions Dispensed**
- **Federal vs. State Regulations**
- **Take Back Program**
- **Program Challenges**

The Problem of Prescription Drugs

Hoosier Health

- 71% of people abusing painkillers obtained them from friends or relatives (NSDUH, 2010).
- In 2011, 796 Hoosiers died from unintentional poisoning deaths (ISDH).

Environmental Impact

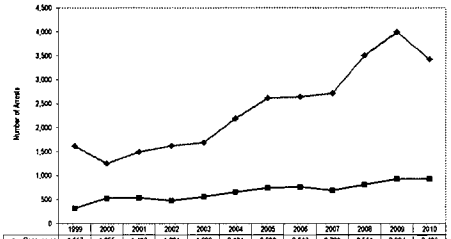
- Medicinal substances have been found in Indiana waterways, causing harm to aquatic wildlife and ecosystems.

Economic Impact

- Prescription drug abuse costs money– money for treatment, money stolen from insurance companies by "doctor shoppers" and money spent to prosecute for possession and unlawful sales.

Criminal Impact

Number of Arrests for Possession and Sale/ Manufacture of "Other Drugs" (Barbiturates & Benzedrine) in Indiana, 1999–2010, Uniform Crime Reports (UCR)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Possession	1,617	1,255	1,493	1,621	1,688	2,191	2,620	2,643	2,720	3,511	3,994	3,426
Sale	316	528	537	476	556	659	746	767	890	815	930	931

Source: National Archive of Criminal Justice Data, Inter-university Consortium for Political and Social Research, University of Michigan, 1999-2010 UCR; Wright, E (2013)

INDIANA PRESCRIPTION DRUG ABUSE

www.bitterpill.in.gov

Controlled Substances, Schedules II-V, Dispensed in Indiana, 2008-2011, INSPECT

	2008	2009	2010	2011
Opioids	5,849,460 (50.3%)	6,376,664 (50.2%)	5,591,679 (49.3%)	5,830,367 (45.8%)
CNS Depressants	3,558,007 (30.6%)	3,902,414 (30.7%)	3,514,361 (31.0%)	3,889,652 (30.5%)
Stimulants	1,149,939 (9.9%)	1,353,939 (10.6%)	1,309,265 (11.5%)	1,419,003 (11.1%)
Others	1,077,686 (9.3%)	1,080,914 (8.5%)	926,234 (8.2%)	1,604,214 (12.6%)
Total	**11,635,092 (100.0%)**	**12,713,931 (100.0%)**	**11,341,539 (100.0%)**	**12,743,236 (100.0%)**

Source: Indiana Professional Licensing Agency, Board of Pharmacy. INSPECT 2008-2011

INDIANA PRESCRIPTION DRUG ABUSE

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Federal vs. State Regulations: The Collection of Controlled Substances

Drug Enforcement Agency

- Secure and Responsible Drug Disposal Act of 2010 (proposed rules)
- These regulations propose to allow authorized manufacturers, distributors, reverse distributors, and retail pharmacies to voluntarily administer mail-back programs and maintain collection receptacles.

Indiana State Law

- Indiana State Law allows for pharmacies to serve as collection receptacle location sites.
- Law enforcement officers are not required to be on site for the collection of these prescription drugs.
- The DEA's proposed rules are consistent with our current state law.

It is unknown when the DEA rules will be finalized and put into effect. Until then, federal and state regulations concerning controlled substances are discordant.

INDIANA PRESCRIPTION DRUG ABUSE

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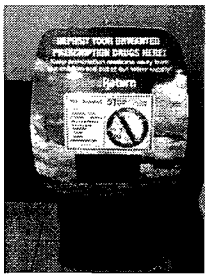
Take Back Program Overview



The proposed take back program would provide pharmacies the opportunity to maintain collection receptacles at their retail stores to offer safe disposal options for their communities.

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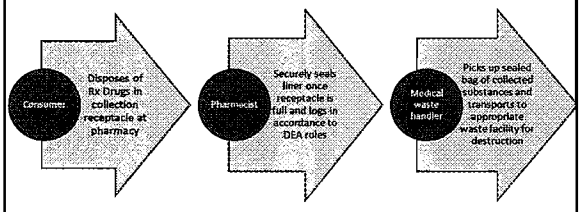
Pharmacy Take Back: How it Works



INDIANA PRESCRIPTION DRUG ABUSE
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Role of Participating Pharmacy

Pharmacy responsibilities:

- Register with the DEA to serve as an authorized take back site (per proposed DEA rules)
- House a secured collection receptacle on site at their retail pharmacy
- Coordinate the transportation or shipment of medical waste once the receptacles are full
- Log the pick-up and transportation of full content (per proposed DEA rules)

Cost to pharmacy: Collection receptacle = ~ $800
Transportation/Shipping of medical waste to an authorized facility to be incinerated = ~ $30 – 60/pick-up or shipment

INDIANA PRESCRIPTION DRUG ABUSE
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Challenges We Face

While this pilot program is in compliance with state law, it will not be in compliance with federal regulations until the proposed rules are finalized.

Apply for an exemption from the DEA

There is a cost and liability to participating pharmacies and reverse distributors.

Provide an incentive for participation

There isn't an existing model for a take back program utilizing pharmacies or reverse distributors.

We know that Take Back works, but we need to increase accessibility.

INDIANA PRESCRIPTION DRUG ABUSE
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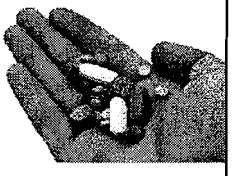
Conclusion

- Prescription drug abuse
- Drug diversion
- Accidental poisonings
- Environmental protection
- Crime prevention



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Questions?

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8/21/13 HFC, Exhibit 12

Anthem®

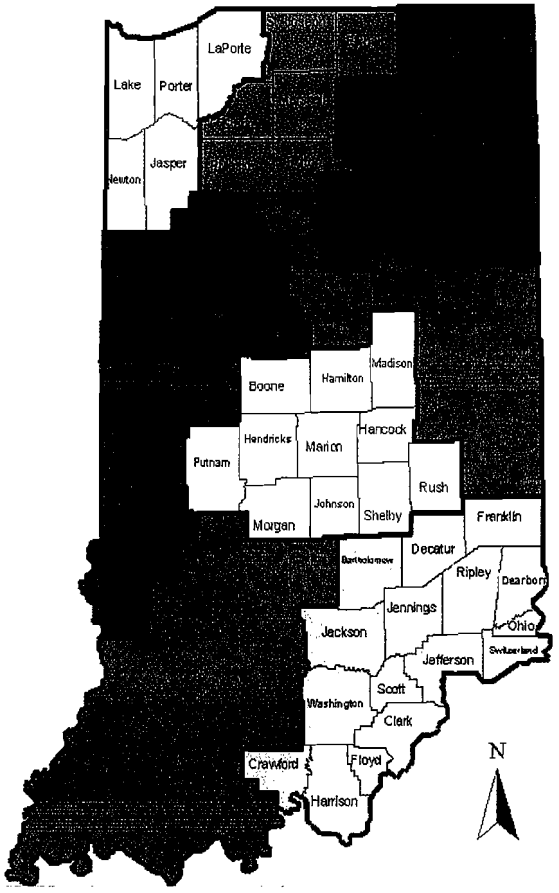
Anthem Enrolled Providers by Region

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Central	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
East Central	86 1/133	79 1/145	47 1/243	26 1/440	130 1/88	10 1/1,144
North Central	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Northeast	141 1/148	184 1/113	33 1/632	38 1/549	38 1/549	48 1/434
Northwest	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Southeast	175 1/104	114 1/160	59 1/309	51 1/357	29 1/629	90 1/203
Southwest	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
West Central	121 1/88	58 1/183	28 1/379	10 1/1,060	47 1/226	17 1/623

*HHW access requires that a PMP is available within 30 miles of every member's residence.
*Counts include Pediatric sub-specialties.

Anthem

Hoosier Healthwise Regions



1	2			5		7	8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region

Anthem

Anthem General Appointment Scheduling Access

Urgent Care: 95% of members treated no later than the end of the following workday after initial contact

Non Urgent, Sick: 74% of members treated within 72 hours of request

Routine, Non Urgent Adult: 98% of members treated within 6 weeks of member's request

Prenatal: 62% treated within 14 days of member's request

Preventive, Adult: 90% treated within 14 days
Preventive, Child: 84% treated within 14 days

Specialist Routine Visit within 21days: 76%

In Office Wait Time: 94% within 15 minutes
Call Back Triage: 88% within 30 minutes

Anthem

Anthem Claims Payment Timeliness – HHW
Physical and Behavioral Health Combined

	Facility Claims* (UB-04)	Professional Claims** (CMS 1500)
% Paper Claims Paid Within 30 Days	**98%**	**99%**
% Electronic Claims Paid Within 21 Days	**99%**	**99%**
% Denied	**6%**	**5%**

*A facility claim is one billed on a UB-04 / CMS-1450 claim form by institutional providers including hospitals, skilled nursing facilities and home health care providers.

**A professional claim is one billed on a CMS-1500 claim form by physicians and professional services providers including physical, occupational and speech therapists. Specific ancillary providers are also to use this claim form.

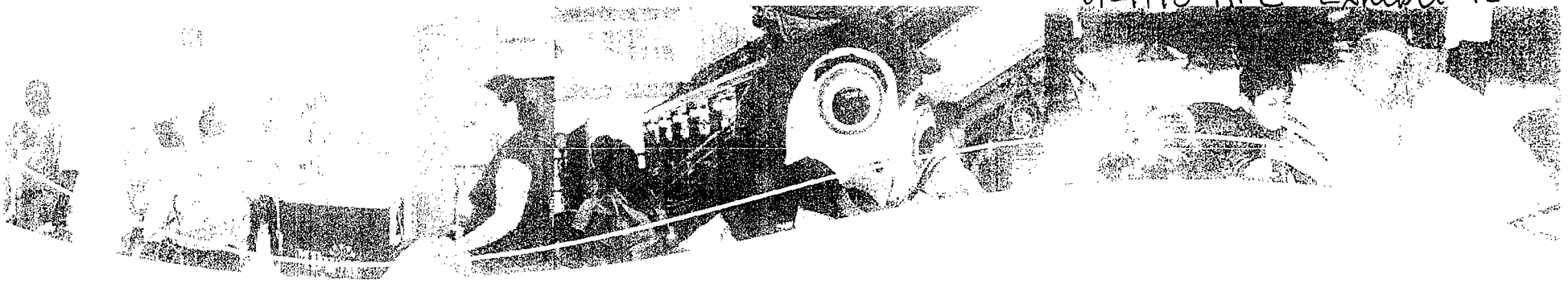
Anthem.

Anthem Top Claim Denial Reasons – HHW
Physical and Behavioral Health Combined

Facility (UB-04)	Professional (CMS 1500)
1. Authorization not obtained	1. Services rendered by non participating provider
2. Services rendered by non participating provider	2. Authorization not obtained
3. Not a covered benefit under the plan	3. Referral not obtained

Anthem

8/21/13 HFC Exhibit 13



Health Finance Commission

August 21, 2013

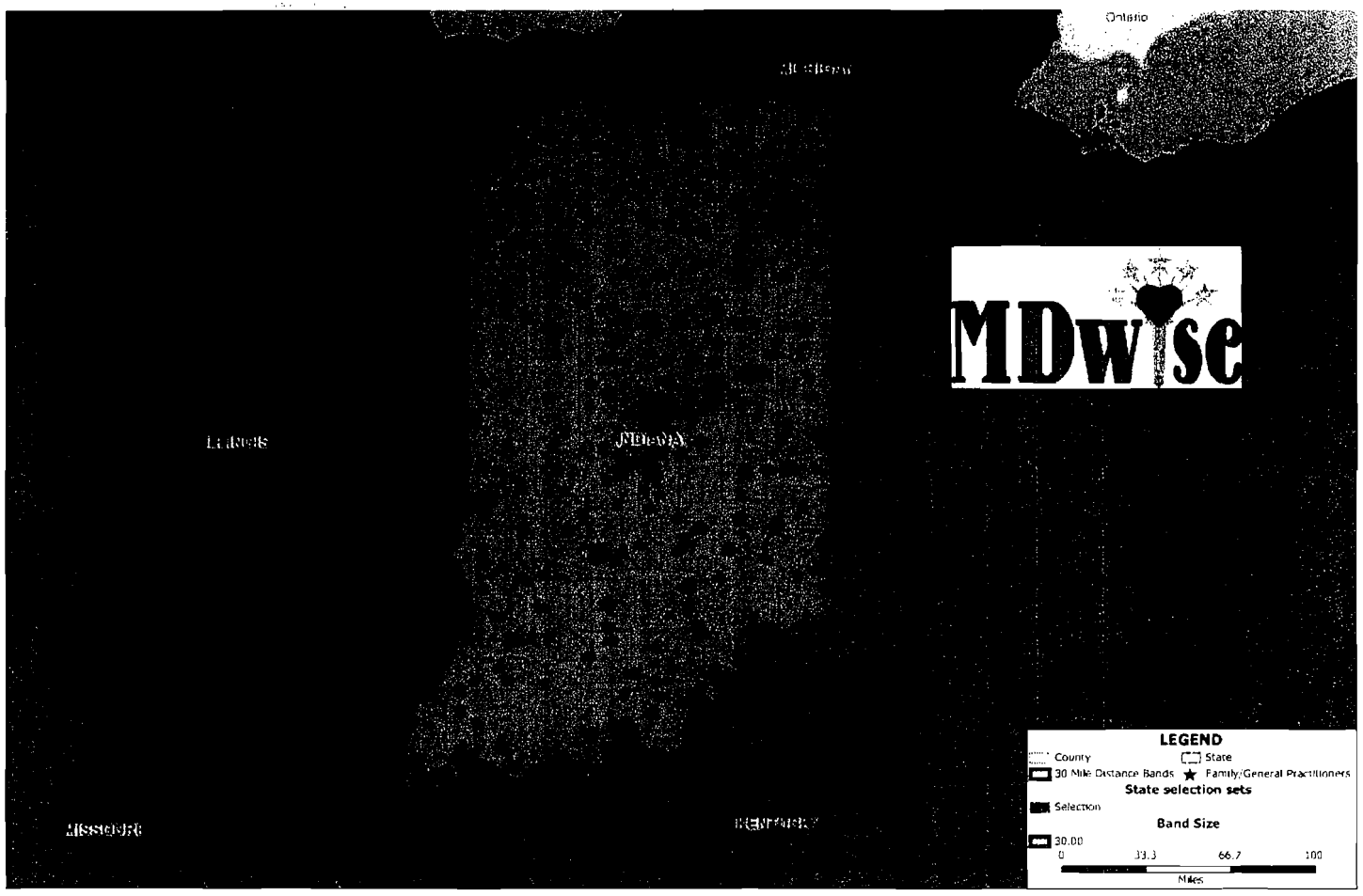
Exclusively serving Indiana families since 1994.

MDwise

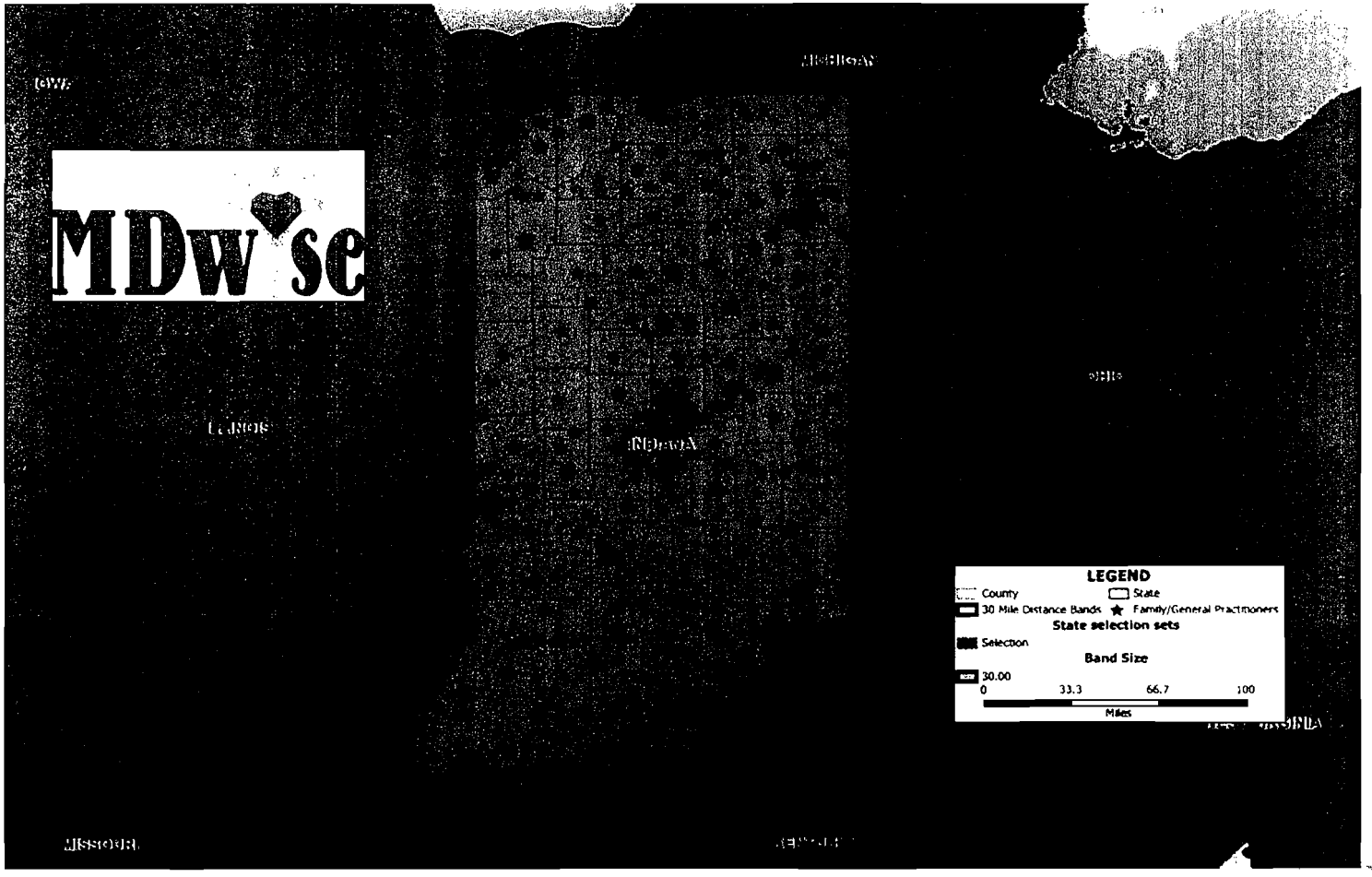
Primary Medical Provider (PMP) Access Standards

- PMPs should adhere to the following access standards in providing care to MDwise members.
- Appointment Category Appointment Standards includes:
  - Urgent/Emergent Care Triage 24 hours/day
  - Non-Urgent Symptomatic 72 hours
  - Routine Physical Exam 3 months
  - Initial Appointment (Non-pregnant Adult) 3 months
  - Routine Gynecological Examination 3 months
  - New Obstetrical Patient Within 1 month of date of attempting to schedule an appointment
  - Initial Appointment Well Child Within 1 month of date of calling to schedule an appointment
  - Children with Special Health Care Needs 1 month

HHW PMPs: General/Family Practitioners



HIP PMPs: General/Family Practitioners

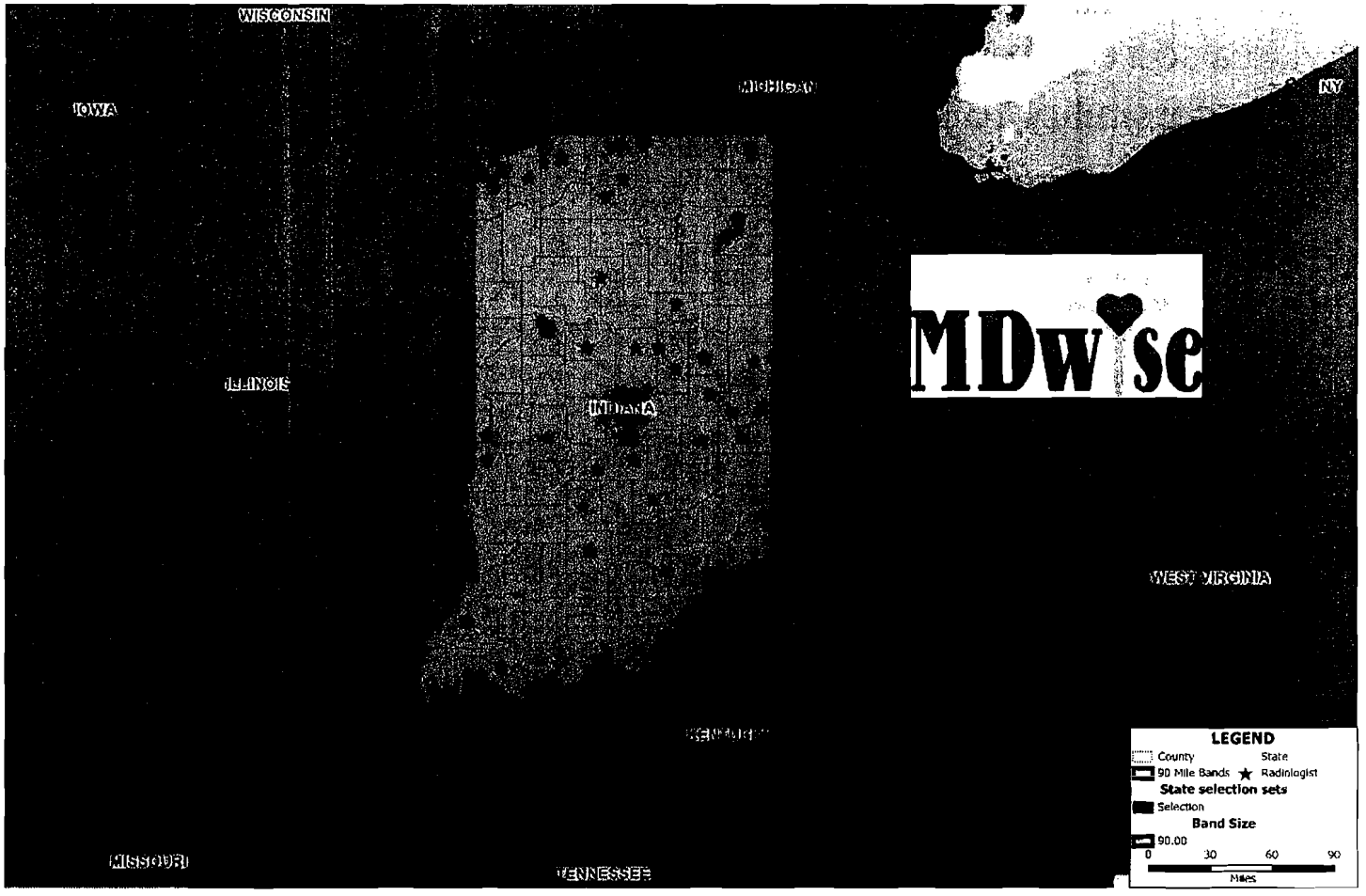


Specialist Access Standards

- MDwise also requires the following standards to be maintained regarding patient accessibility to specialist referrals.
- Appointment Category Appointment Standards includes:
  - Emergency 24 hours
  - Urgent 48 hours
  - Non-Urgent Symptomatic 4 weeks

MDwise

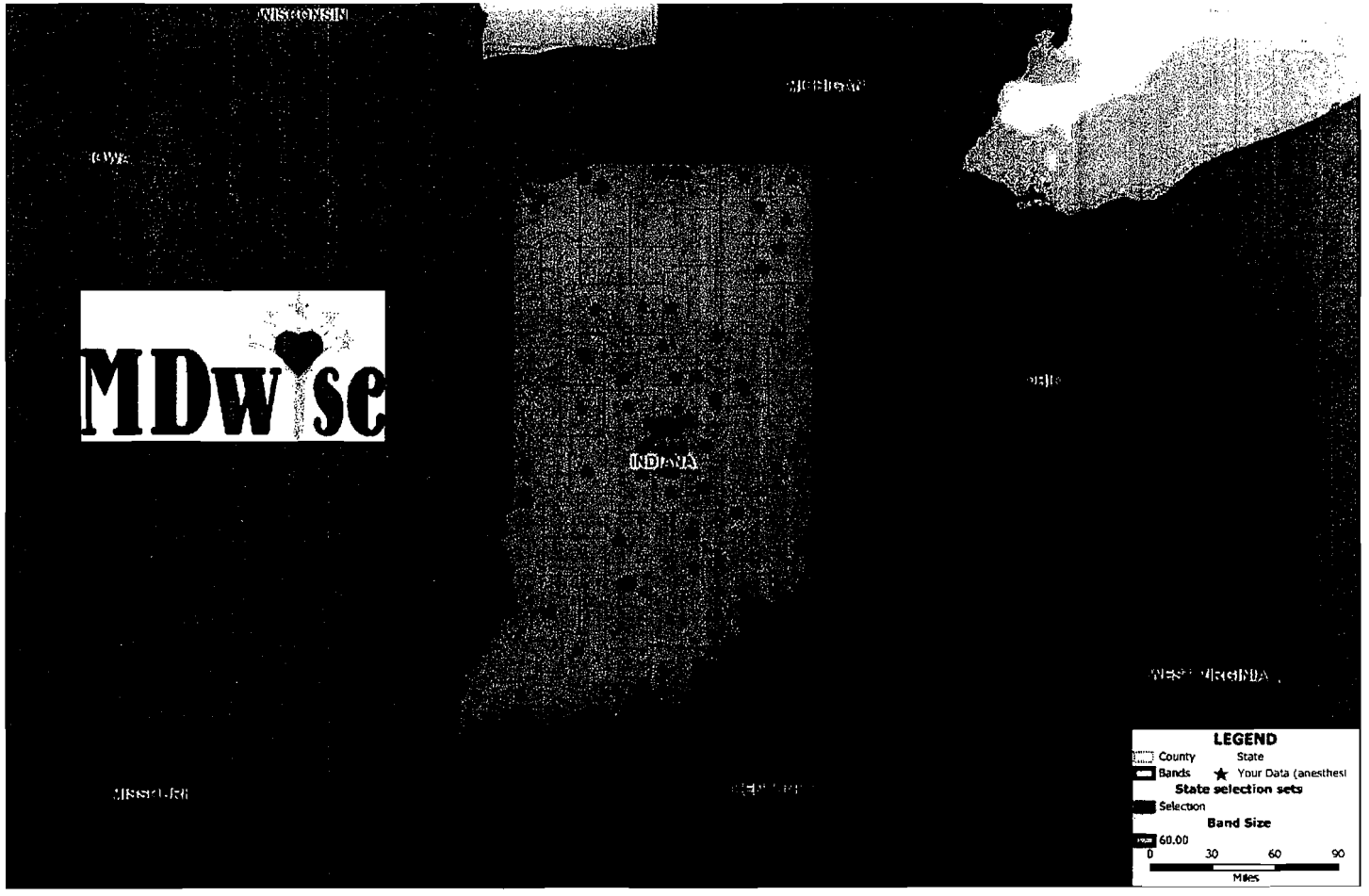
MDwise Specialists: Radiologists



MDwise

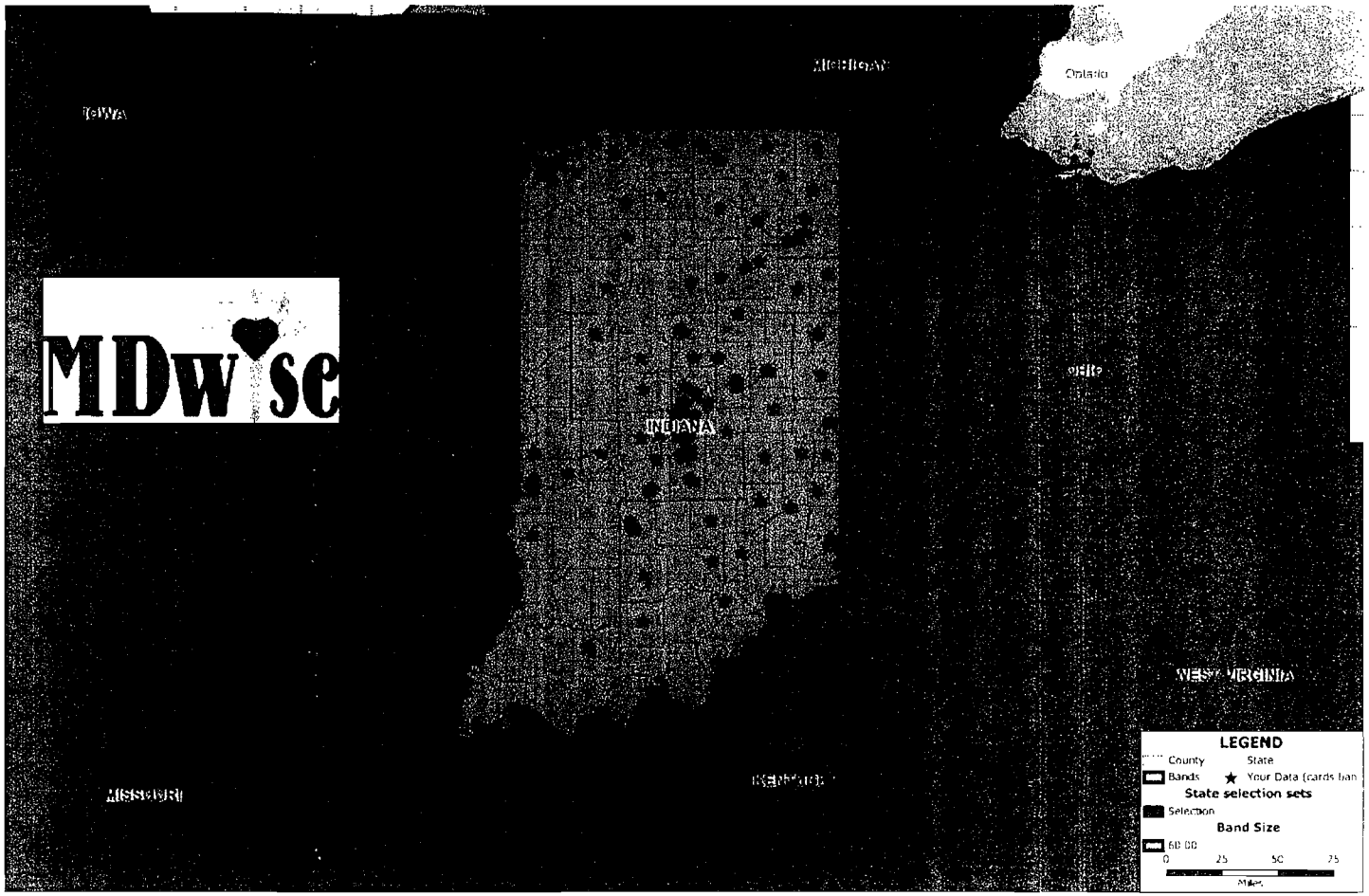
MDwise Specialists: Neurosurgeons

MDwise Specialists: Anesthesiologists

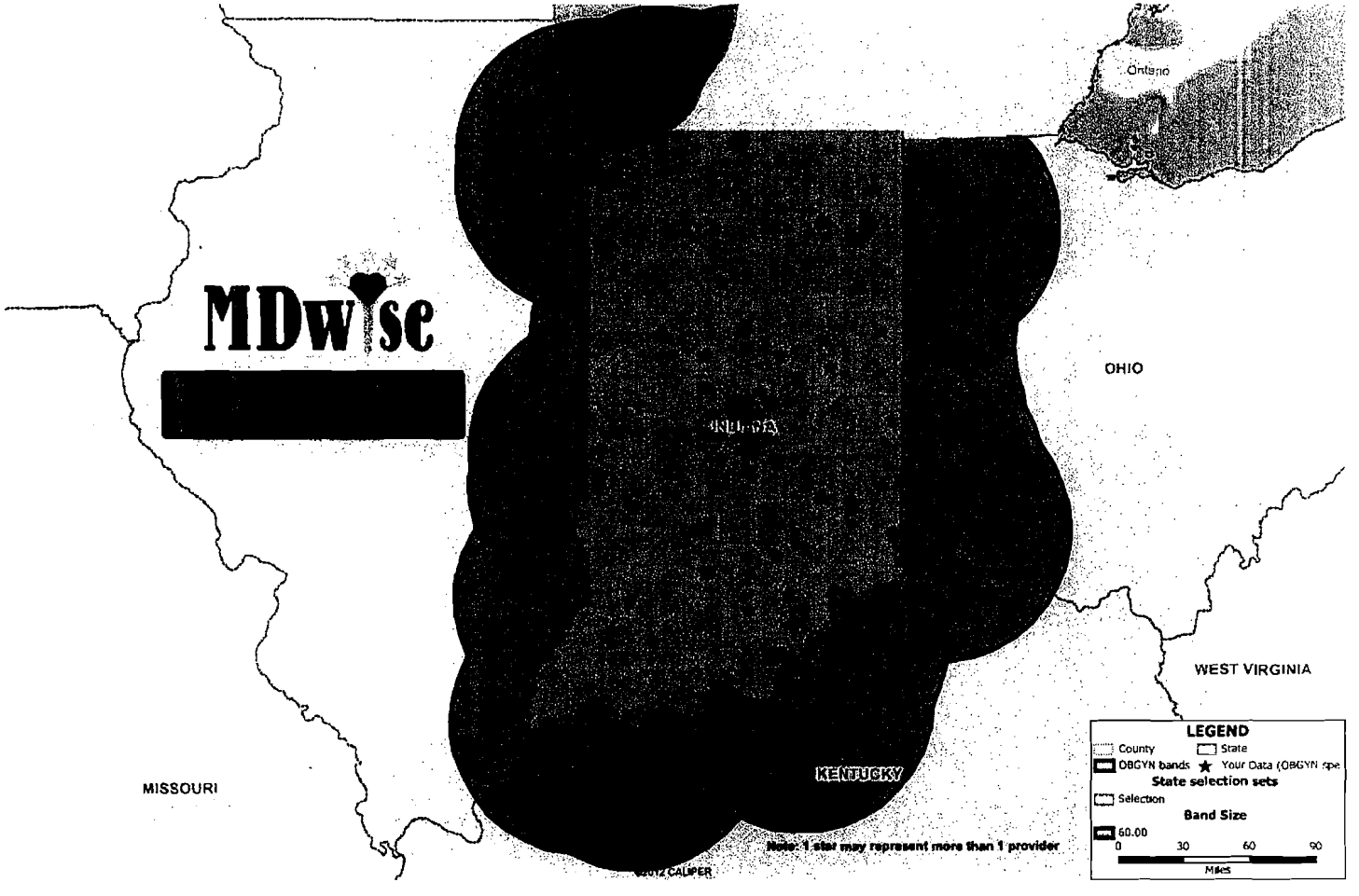


MDwise

MDwise Specialists: Cardiologists



MDwise Specialists: OB/GYNs



MDwise

HHW MCO Enrolled Providers By Region and Members per Provider

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Northwest	247	76	20	16	47	16
	1/162	1/526	1/2,001	1/2,502	1/851	1/2,502
North Central	82	30	11	7	31	9
	1/195	1/533	1/1,454	1/2,285	1/516	1/1,777
Northeast	245	68	21	14	37	7
	1/162	1/583	1/1,889	1/2,834	1/1,072	1/5,669
West Central	174	27	20	6	25	7
	1/170	1/1,100	1/1,486	1/4,953	1/1,188	1/4,245
Central	343	219	93	46	142	71
	1/245	1/384	1/904	1/1,829	1/592	1/1,185
East Central	165	21	21	12	30	7
	1/194	1/1,531	1/1,531	1/2,680	1/1,072	1/4,594
Southwest	120	44	44	17	44	15
	1/87	1/239	1/239	1/619	1/239	1/701
Southeast	128	31	37	16	21	19
	1/146	1/603	1/505	1/1,168	1/890	1/984

MDwise

HIP MCO Enrolled Providers and Members per Provider

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Statewide	1003	403	247	145	265	158
	1/9	1/23	1/37	1/63	1/35	1/58

MDwise

Claims Payment Timeliness
HHW Physical Health: Jan – Dec 2012

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	99% (45,014/45,499)	99% (349,021/351,186)
% Electronic Claims Paid Within 21 Days	100% (391,663/392,475)	100% (1,470,613/1,472,548)
% Denied	2% (7,931/437,974)	2% (32,325/1,823,734)
Total Claims Received (includes clean & unclean, paper & electronic)	660,758	2,452,894

MDwise

Claims Payment Timeliness
HHW Behavioral Health: Jan – Dec 2012

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	99% (7,948/8,056)	100% (66,209/66,339)
% Electronic Claims Paid Within 21 Days	100% (60,520/60,789)	100% (157,408/157,729)
% Denied	2% (1,537/68,845)	3% (7,346/224,068)
Total Claims Received (includes clean & unclean, paper & electronic)	77,915	258,257

MDwise

Claims Payment Timeliness
HIP Physical Health: Jan – Dec 2012

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	99% (4,336/4,396)	100% (33,097/33,171)
% Electronic Claims Paid Within 21 Days	100% (32,945/33,077)	100% (76,978/77,036)
% Denied	0% (85/37,473)	0% (94/110,207)
Total Claims Received (includes clean & unclean, paper & electronic)	52,611	164,660

MDwise

Claims Payment Timeliness
HIP Behavioral Health: Jan – Dec 2012

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	99% (172/174)	100% (4,777/4,789)
% Electronic Claims Paid Within 21 Days	100% (504/504)	100% (3,778/3,779)
% Denied	0% (2/678)	0% (3/8,568)
Total Claims Received (includes clean & unclean, paper & electronic)	948	11,042

MDwise

Top 10 Clean Claims Denial Reasons
HHW Physical Health Jan – Dec 2012

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Not a covered benefit under member's plan	1. Not a covered benefit under member's plan
2. The disposition of this claim service is pending further review	2. Health – Units Adjust – See Exp code
3. Svcs essential to px not coded	3. Claim submit time exceeded
4. Primary/Sec diagnosis POA error	4. The disposition of this claim service is pending further review
5. Health – Units Adjust – See Exp code	5. Exceeds the maximum number of units
6. Payment included in other billed service	6. Same procedure paid to different provider
7. Deny all claim lines	7. Age exceeds extreme range for procedure
8. Claim submit time exceeded	8. Inapp coding for contract/agree
9. Payment made per the Indiana Medicaid DRG or per diem fee schedule	9. Procedure code incidental to primary procedure
10. Patient is not enrolled in this portion of our benefit package	10. Patient is not enrolled in this portion of our benefit package

Top 10 Clean Claims Denial Reasons
HHW Behavioral Health: Jan – Dec 2012

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Claim is duplicate of previous submission for member	1. Exceeds allowed amount
2. Exceeds allowed amount	2. Claim is duplicate of previous submission for member
3. Non-covered charges	3. Payment reflects COB, if 0$, max liability met
4. Payment reflects COB, if 0$, max liability met	4. Claim submit time exceeded
5. Claim submit time exceeded	5. Non-covered charges
6. Services denied at the time authorization/precertification was requested	6. Services are not reimbursable when billed by an LCSW, LMHC, CCSW, ACSW, MSW, MA, or PHD
7. Payment is included in the allowance for another service/procedure	7. Mutually exclusive procedures cannot be done in the same day/setting
8. Payment covered under Inpatient per diem	8. Services denied at the time authorization/precertification was requested
9. Service will be processed on a separate claim	9. Service will be processed on a separate claim
10. Patient is not enrolled in this portion of our benefit package	10. Patient is not enrolled in this portion of our benefit package

MDwise

Top 10 Clean Claims Denial Reasons
HIP Physical Health Jan – Dec 2012

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.	1. Member has a restricted card and must use assigned providers for benefit coverage
2. Requires prior authorization	2. Diagnosis not valid for benefit
3. Claim has been manually denied	3. Claim has been manually denied
4. Duplicate claim submission	4. No authorization on file, not an auto-pay diagnosis; claim paid at the agreed contract Triage flat fee
5. Invalid CPT/HCPCS code	5. Service not a plan benefit
6. According to OPPS, service cannot be reimbursed as billed. Please resubmit claim with corrected information.	6. Paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment
7. The claim was subjected to NCCI editing methodologies	7. This is not Family Planning
8. Past filing limit	8. Invalid CPT/HCPCS code
9. Member has a restricted card and must use assigned providers for benefit coverage	9. Capitated service
10. Adjustment of a claim previously denied	

MDwise

Top 10 Clean Claims Denial Reasons
HIP Behavioral Health: Jan – Dec 2012

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Member has a restricted card and must use assigned providers for benefit coverage	1. Member has a restricted card and must use assigned providers for benefit coverage

MDwise

8/21/13 HFC Exhibit 14

Health Finance Commission

*August 21, 2013**

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MHS Enrolled HHW Providers By Region, Summer 2013

Region	PMPs (Per Members)	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngo-logist	Psychiatrist	Urologist
Northwest	129	23	5	9	35	12
	1/182	1/1025	1/4716	1/2620	1/673	1/1965
North Central	185	39	43	16	46	16
	1/203	1/965	1/875	1/2352	1/818	1/2352
Northeast	214	62	10	17	30	7
	1/83	1/286	1/1778	1/1046	1/592	1/2540
West Central	61	26	20	9	30	6
	1/171	1/402	1/523	1/1164	1/349	1/1746
Central	306	211	90	53	120	59
	1/155	1/225	1/527	1/896	1/395	1/805
East Central	130	43	29	15	38	10
	1/139	1/421	1/624	1/1207	1/476	1/1811
Southwest	157	52	34	15	33	22
	1/103	1/313	1/479	1/1086	1/465	1/741
Southeast	129	77	45	31	32	22
	1/144	1/241	1/412	1/599	1/580	1/844

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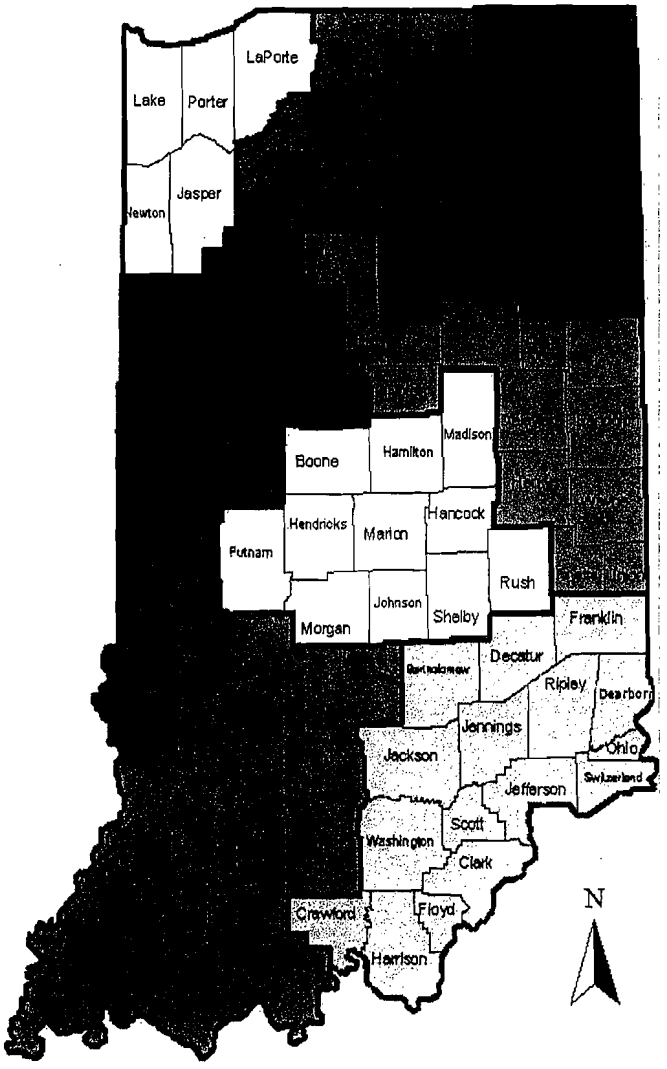
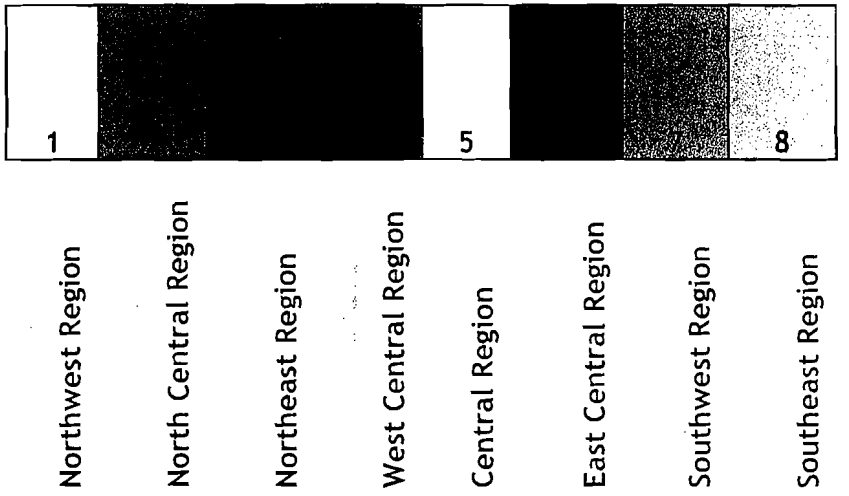
MHS Enrolled HIP Providers, Summer 2013

	PMPs (Per Members)	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Statewide	912	455	297	146	360	152
	1/4	1/8	1/12	1/25	1/10	1/24

Hoosier Healthwise Regions





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Primary Care Providers – New Member Appointments

PMP VISIT – NEWLY ASSIGNED MHS MEMBERS	MHS STANDARD: MAXIMUM TIME TO APPT.
Exams / physicals for adults	Within 3 months
Family planning exam	
New pregnancy visit	
Children with special needs	Within 1 month
Well-child check-ups	
Wait times in-office	One Hour or less for appointment scheduled one or more days in advance*

*may be affected by unforeseen emergency

MHS Audits of 100% our PMPs Annually:

- MHS audits appointment availability in accordance with standards above.
- MHS audits for PMP emergency availability and instructions.
- MHS notifies any provider not meeting standard & re-audits to ensure compliance.
- MHS currently has 98% compliance.

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Claims Payment Timeliness – Physical Health

Q1 & Q2 2013	Facility Claims (UB-04)	Professional Claims (CMS 1500)	Overall
% Paper Claims Paid Within 30 Days	97.38%	98.42%	98.28%
% Electronic Claims Paid Within 21 Days	99.31%	99.81%	99.71%
% Denied	5.77%	7.85%	7.45%

Top 10 Claims Denial Reasons – Physical Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. THE TIME LIMIT FOR FILING HAS EXPIRED	1. THE TIME LIMIT FOR FILING HAS EXPIRED
2. BILL PRIMARY INSURANCE FIRST, THEN RESUBMIT WITH EOB	2. BILL PRIMARY INSURANCE FIRST, THEN RESUBMIT WITH EOB
3. AUTHORIZATION NOT ON FILE	3. AUTHORIZATION NOT ON FILE
4. CLAIM AND AUTHORIZATION SERVICE PROVIDER NOT MATCHING	4. CODE EDIT – NOT COMPLIANT WITH BILLING REGULATIONS
5. DENIED - SERVICE NOT MEDICALLY INDICATED	5. PLEASE RESUBMIT TO CENPATICO FOR CONSIDERATION
6. PLEASE RESUBMIT TO CENPATICO FOR CONSIDERATION	6. CLAIM AND AUTHORIZATION SERVICING PROVIDER NOT MATCHING
7. NOT AN MCO COVERED BENEFIT	7. THIS SERVICE IS NOT COVERED
8. MEMBER NAME, NUMBER OR DATE OF BIRTH NOT MATCHING, CORRECT AND RESUBMIT	8. PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
9. INCORRECT BILLING OF HIP CLAIM – DOES NOT MATCH MEDICARE	9. MEMBER NAME, NUMBER OR DATE OF BIRTH NOT MATCHING, CORRECT AND RESUBMIT
10. PROBLEM WITH PRIMARY INSURANCE EOB, PLEASE RESUBMIT WITH ORIGINAL DOCUMENT	10. CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS

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Your Choice for Better Healthcare

Claims Payment Timeliness – Behavioral Health

Q1 & Q2 2013	Facility Claims (UB-04)	Professional Claims (CMS 1500)	Overall
% Paper Claims Paid Within 30 Days	93.74%	99.39%	98.85%
% Electronic Claims Paid Within 21 Days	99.40%	99.70%	99.52%
% Denied	32.58%	11.31%	15.66%

Top 10 Claim Denial Reasons – Behavioral Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. INVALID REVENUE CODE & HCPCS/CPT-4 PROCEDURE CODE COMBINATION BILLED	1. BENEFIT LIMIT FOR SERVICES WITHOUT AN AUTHORIZATION HAS BEEN MET
2. REVENUE CODE IS NON-COVERED WHEN BILLED WITH HCPCS/CPT-4 CODES	2. THE TIME LIMIT FOR FILING HAS EXPIRED
3. BILL PRIMARY INSURANCE FIRST, THEN RESUBMIT WITH EOB	3. BILL PRIMARY INSURANCE FIRST, THEN RESUBMIT WITH EOB
4. THE TIME LIMIT FOR FILING HAS EXPIRED	4. SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
5. PLEASE RESUBMIT CLAIM TO THE MEDICAL PLAN FOR CONSIDERATION	5. DUPLICATE SUBMISSION – ORIGINAL CLIAM STILL IN PEND STATUS
6. AUTHORIZATION NOT ON FILE	6. CPT HCPC REV CODE & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT
7. PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY	7. AUTHORIZATION NOT ON FILE
8. CLAIM AND AUTHORIZATION TREATMENT TYPE NOT MATCHING	8. PLEASE RESUBMIT TO THE MEDICAL PLAN FOR CONSIDERATION
9. INVALID OR MISSING DISCHARGE STATUS, PLEASE RESUBMIT	9. PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY
10. DUPLICATE SUBMISSION – ORIGINAL CLAIM STILL IN PEND STATUS	10. PLEASE RESUBMIT CLAIM TO THE STATE FOR CONSIDERATION

8/21/13 HFC, Exhibit 15

LEGISLATIVE SERVICES AGENCY

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MEMORANDUM

To: Senator Patricia Miller, Chairperson Health Finance Commission

From: Chuck Mayfield

Re: Free and Reduced Price Lunch Program

Date: August 13, 2013

This memorandum reports on the consistency between the percentage of students receiving free or reduced lunches and estimates of the percentage of dependent children meeting the income guidelines for the free and reduced lunch program based on income tax return information. The free and reduced lunch participation percentages are from the 2011 school year as reported by the Department of Education (DOE). The income tax return information used for the dependent children eligibility estimates is from CY 2011.

The free and reduced lunch application is used to determine if a student is eligible for Textbook Reimbursement (a $39 M state program), the 21st Century Scholars Programs (a $109.6 M state program), and the distribution of about $1.1 B in Tuition Support Complexity Grants. Attachment A shows the comparison of the two calculations by county. The calculations were done on a county basis because reporting of taxpayers by county of residence is substantially more accurate than reporting by school corporation of residence. Overall, the participation percentages from the DOE data are very close to the estimated eligibility percentages from the income tax data. The DOE data shows 46.6% of the public school students statewide participated in the free and reduced lunch program while the estimate using the income tax data shows a percentage eligible of 44.3%, a difference of about 2.31%.

However, there are some counties that show a significant difference. Both Adams county and LaGrange county have significantly higher estimated eligibility percentages using the income tax data than the DOE participation percentages. Both counties have a large Amish community where the children generally do not receive free or reduced lunch. This could explain these differences. Table 1 below reports the difference in the calculation using the DOE participation percentages and the estimated eligibility percentages based on the income tax data.

Table 1	
% Difference between DOE Participation Percentage and Estimated Eligibility Percentage	# Counties
Less than -10%	2
-10% to -5%	2
-5% to -4%	2
-4% to -3%	0
-3% to -2%	3
-2% to -1%	4
-1% to 0%	12
0% to 1%	13
1% to 2%	13
2% to 3%	7
3% to 4%	10
4% to 5%	7
5% to 10%	4
Greater than 10%	9
Total	92

Additional Information on Free and Reduced Lunch Eligibility: Eligibility for the federal free and reduced lunch program is based on a student's family income. A student whose family income is less than 130% of the federal poverty guidelines is eligible for a free school lunch. A student is also eligible for the free school lunch program if the student's family qualifies for Temporary Assistance for Needy Families (TANF) or food stamps. A student whose family income is at least 130% but less than 185% of the federal poverty guidelines is eligible for a reduced price lunch. Attachment B is the form letter that schools send to parents informing them about the free and reduced lunch program and the application a family must complete.

For the 2012-13 school year 1,125,413 public and private school students participated in the school lunch program. There were 441,900 students (39.3%) who qualified for the free lunch program and 80,849 students (8.0%) who qualified for the reduced lunch program. Attachment C lists the percentage of students in each public school corporation who received free and reduced lunches during the 2012-13 school year. This percentage ranged from a low of 5.4% for the Zionsville Community Schools to 98.4% for the Timothy L. Johnson Academy in Fort Wayne.

The percentage of students receiving free and reduced lunches is used in the FY 2014 school formula to calculate the Tuition Support Complexity Grant, which totals about $1.1 B. For FY 2015, the Tuition Support Complexity Grant's calculation changes and uses the percentage of students that are eligible for textbook assistance. The change was made because the free and reduced lunch program is a federal program and the state does not have the same ability to verify eligibility data for

the free and reduce lunch programs as it does with a state program and application like the textbook assistanced program. The income guidelines currently are the same for both programs. As a result, the free and reduced lunch program application currently has a checkbox at the bottom of the application to allow the student to also apply for textbook assistance. If a separate application is required for the textbook assistance program, there could be increased administrative costs for local schools and the state Department of Education to administer the program.

School Lunch Percentage for 2011

Department of Education Data Compared to Department of Revenue State Income Tax Information

County	Name		% of Students Receiving Free or Reduced Lunch	% of Dependent Children with Family Income Below 185% of Poverty	Diff
01	Adams	5,372	38.01%	59.99%	21.98%
02	Allen	65,748	47.49%	45.56%	-1.93%
03	Bartholomew	13,078	42.15%	39.28%	-2.87%
04	Benton	1,371	43.69%	43.59%	-0.10%
05	Blackford	2,465	51.64%	50.97%	-0.68%
06	Boone	10,982	22.05%	21.86%	-0.18%
07	Brown	2,314	47.06%	46.77%	-0.29%
08	Carroll	2,726	46.96%	39.02%	-7.94%
09	Cass	6,836	52.72%	54.44%	1.72%
10	Clark	23,713	42.17%	46.90%	4.73%
11	Clay	4,711	49.42%	46.68%	-2.74%
12	Clinton	6,202	52.13%	51.67%	-0.46%
13	Crawford	1,665	60.66%	53.71%	-6.95%
14	Daviess	4,785	46.37%	55.07%	8.69%
15	Dearborn	9,356	32.47%	33.24%	0.77%
16	Decatur	4,643	46.16%	43.64%	-2.52%
17	DeKalb	8,419	47.12%	41.44%	-5.68%
18	Delaware	17,567	52.64%	48.35%	-4.29%
19	Dubois	8,539	30.02%	31.08%	1.06%
20	Elkhart	37,856	56.46%	54.79%	-1.67%
21	Fayette	4,191	62.23%	55.65%	-6.58%
22	Floyd	12,970	42.78%	35.58%	-7.19%
23	Fountain	3,185	43.77%	43.08%	-0.69%
24	Franklin	4,298	38.30%	37.83%	-0.47%
25	Fulton	2,707	47.69%	51.70%	4.01%
26	Gibson	5,684	34.27%	34.16%	-0.11%
27	Grant	11,649	59.33%	53.85%	-5.48%
28	Greene	5,540	46.48%	43.12%	-3.36%
29	Hamilton	56,009	14.89%	17.40%	2.51%
30	Hancock	13,145	26.44%	26.61%	0.17%
31	Harrison	6,193	40.22%	38.95%	-1.28%
32	Hendricks	27,915	25.94%	22.80%	-3.14%
33	Henry	7,870	51.78%	46.66%	-5.12%
34	Howard	14,098	49.46%	46.20%	-3.26%
35	Huntington	6,133	43.26%	41.80%	-1.46%
36	Jackson	7,616	45.37%	46.06%	0.70%
37	Jasper	5,880	38.32%	36.94%	-1.38%
38	Jay	3,650	53.32%	58.59%	5.27%
39	Jefferson	5,035	50.13%	46.49%	-3.64%
40	Jennings	5,289	56.31%	51.24%	-5.07%
41	Johnson	26,327	35.71%	31.91%	-3.80%
42	Knox	5,881	45.37%	44.14%	-1.23%
43	Kosciusko	12,993	49.06%	45.33%	-3.73%
44	LaGrange	6,458	49.52%	60.54%	11.02%
45	Lake	102,264	53.83%	45.91%	-7.92%
46	LaPorte	19,401	52.62%	48.01%	-4.61%
47	Lawrence	7,259	48.62%	46.62%	-2.00%

School Lunch Percentage for 2011

Department of Education Data Compared to Department of Revenue State Income Tax Information

County	Name		% of Students Receiving Free or Reduced Lunch	% of Dependent Children with Family Income Below 185% of Poverty	Diff
48	Madison	20,674	55.36%	50.83%	-4.53%
49	Marion	161,799	60.07%	59.15%	-0.92%
50	Marshall	8,998	51.93%	47.38%	-4.56%
51	Martin	1,564	43.54%	43.36%	-0.18%
52	Miami	5,484	52.63%	48.95%	-3.67%
53	Monroe	15,126	34.81%	36.71%	1.90%
54	Montgomery	6,850	45.14%	43.61%	-1.53%
55	Morgan	11,624	41.16%	38.83%	-2.34%
56	Newton	2,396	48.50%	42.19%	-6.31%
57	Noble	33,022	47.64%	48.56%	0.92%
58	Ohio	889	37.35%	40.03%	2.69%
59	Orange	3,449	59.38%	52.41%	-6.97%
60	Owen	2,718	51.25%	51.99%	0.74%
61	Parke	2,445	53.17%	53.66%	0.49%
62	Perry	3,147	45.92%	39.40%	-6.52%
63	Pike	1,910	41.05%	39.78%	-1.26%
64	Porter	29,445	32.95%	28.59%	-4.36%
65	Posey	4,227	29.71%	26.21%	-3.51%
66	Pulaski	2,179	45.94%	44.90%	-1.04%
67	Putnam	6,425	47.47%	41.29%	-6.18%
68	Randolph	4,577	52.98%	52.19%	-0.79%
69	Ripley	4,620	38.87%	40.04%	1.17%
70	Rush	2,830	47.88%	45.33%	-2.55%
71	Saint Joseph	47,881	50.78%	47.01%	-3.77%
72	Scott	4,298	58.03%	53.77%	-4.26%
73	Shelby	7,774	42.87%	43.83%	0.96%
74	Spencer	3,516	35.89%	33.27%	-2.62%
75	Starke	4,061	57.25%	50.62%	-6.63%
76	Steuben	4,198	46.76%	46.68%	-0.08%
77	Sullivan	3,328	50.69%	42.80%	-7.89%
78	Switzerland	1,388	52.59%	52.64%	0.04%
79	Tippecanoe	22,613	41.64%	41.64%	-0.01%
80	Tipton	2,656	35.28%	34.15%	-1.13%
81	Union	1,573	46.41%	46.89%	0.48%
82	Vanderburgh	28,626	49.88%	43.54%	-6.35%
83	Vermillion	2,660	52.03%	45.79%	-6.24%
84	Vigo	16,229	53.56%	49.60%	-3.96%
85	Wabash	5,398	49.13%	44.74%	-4.39%
86	Warren	1,195	37.74%	38.00%	0.26%
87	Warrick	10,173	29.13%	27.83%	-1.30%
88	Washington	4,481	51.44%	51.70%	0.26%
89	Wayne	11,437	56.33%	55.06%	-1.26%
90	Wells	4,770	35.81%	38.07%	2.27%
91	White	4,742	49.09%	46.86%	-2.23%
92	Whitley	6,349	33.71%	34.07%	0.36%
STATE		1,163,732	46.60%	44.29%	-2.31%

Dear Parent/Guardian:

Children need healthy meals to learn. [Insert school name] offers healthy meals every school day. The breakfast regular price is $[insert regular paid breakfast price]; lunch is $[insert regular paid lunch price]. Your children may qualify for free meals or for reduced price meals. Reduced price is $[insert reduced price] for breakfast and $[insert reduced price] for lunch.

1. **Who can get free or reduced price meals?** All children in households receiving Food Stamps or TANF can get free meals regardless of your income. Also, if your household income is within the limits on the Federal Income Chart, your children can get free or reduced price meals.
2. **Do I need to fill out an application for each child?** No. Complete the application to apply for free or reduced price meals. Use one application for all students in your household. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: [insert name, address, phone number]
3. **Can foster children get free meals?** Yes, foster children that are under the legal responsibility of a foster care agency or court, are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income.
4. **My child's application was approved last year. Do I need to fill out another one?** Yes. Your child's application is only good for that school year and for the first few days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.
5. **Should I fill out an application if I received a letter this school year saying my children are approved for free meals?** Please read the letter you got carefully and follow the instructions. Call the school at [insert school phone number] if you have questions.
6. **I get WIC. Can my children get free meals?** Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out an application.
7. **Can migrant, homeless, or runaway children get free meals?** Yes, children who meet the definition of homeless, runaway, or migrant qualify for free meals. If you haven't been told your children will get free meals, please call or e-mail [insert school, homeless liaison or migrant coordinator information] to see if they qualify.
8. **May I apply if someone in my household is not a U. S. citizen?** Yes. You or your children do not have to be a U.S. citizen to qualify for free or reduced price meals.
9. **Who should I include as members of my household?** You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children who live with you. If you live with other people who are economically independent (for example, people who do not support, who do not share income with you or your children, and who pay a pro-rate share of expenses), do not include.
10. **Will the information I give be checked?** Yes, we may ask you to provide written proof.
11. **What if my income is not always the same?** List the amount that you normally receive. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.
12. **We are in the military; do we include our housing allowance as income?** If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.
13. **My spouse is deployed to a combat zone. Is her/his combat pay counted as income?** No, if the combat pay is received in addition to her basic pay because of her deployment and it wasn't received before she was deployed, combat pay is not counted as income. Contact your school for more information.
14. **My household was directly certified for free meals by the school based on our Foster, Food Stamp, or TANF status. Do I also need to fill out a free and reduced application?** If your household was directly certified by the school, you do not need to fill out a free and reduced application to receive benefits.
15. **My household was approved last school year for benefits. How long do I have once the new school year begins to turn my application in to continue receiving benefits?** If a household applied last school year, there is a 30 operating day roll-over starting with the first day of school. If a household does not apply for benefits during this 30 operating day roll-over, the household will lose their benefits after the 30 days, and the household will go back to a paid status.
16. **If I don't qualify now, may I apply again later?** Yes. You may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free and reduced price meals if the household income drops below the income limit.
17. **My family needs more help. Are there other programs available?** To find out how to apply for food stamps or other assistance benefits, contact your local assistance office.

18. **What if I disagree with the school's decision about my application?** You should talk to the school officials. You also may ask for a hearing by calling or writing to [insert name, address, phone number, e-mail].

We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: [insert name, address, school]. If you have other questions or need help, call [insert phone number]. Si necesita ayuda, por favor llame at teléfono: [insert phone number]. Si vous voudriez d'aide, contactez nous au numero: [insert phone number].

Sincerely,

[Insert Signature]

INSTRUCTIONS for APPLYING

Households getting TANF or Food Stamps:

1. In Part 1, list each enrolled child, include the TANF or Food Stamp case number for any child, and the name of the school. **EBT and Hoosier Healthwise numbers DO NOT qualify you for benefits.**
2. In Part 2, enter the name and case number of any other household member who has a valid TANF or Food Stamp case number.
3. In Part 3, check the appropriate box, if any.
4. In Part 5, an adult must sign the application. The last four digits of the Social Security number are not required.
5. Part 6 and Part 7 are optional for meal benefits.

Migrant, Homeless, or Runaway:

1. In Part 1, list each enrolled child which are homeless, migrant, or runaway and the name of the school.
2. In Part 3, check the appropriate box and contact the school's homeless liaison or migrant coordinator.
3. In Part 5, an adult must sign the application. The last four digits of the Social Security number are not required.
4. Part 6 and Part 7 are optional for meal benefits.

Foster Child:

If all children in the household are foster children:

1. In Part 1, list each enrolled foster child and the school name for each child. Check the box indication the child is a foster child.
2. In Part 5, an adult must sign the application. The last four digits of the Social Security number are not required.
3. Part 6 and Part 7 are optional for meal benefits.

If some of the children in the household are foster children:

1. In Part 1, list each enrolled child, include the TANF or Food Stamp case number for any child with a case number, and the name of the school. Check the box if the child is a foster child.
2. In Part 2, enter the name and case number of any other household member who has a valid TANF or Food Stamp case number.
3. In Part 3, check the appropriate box and contact the school's homeless liaison or migrant coordinator for any listed child which are homeless, migrant, or runaway.
4. If no one in the household has a valid TANF or Food Stamp case number, in Part 4 list everyone related or unrelated living in your household. Include yourself, spouse, all children, grandparents, other relatives, and unrelated people. Use another sheet of paper if you need to.
    a. For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income , list the amount each person got for the month from welfare, child support alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits. Under All Other Income, list Worker's Compensation, unemployment or strike benefits, regular contributions, from people who do not live in your household, and any other income. Do not include income from SNAP, FDIR, WIC, Federal

education benefits, and foster payments received by the family from the placing agency. For ONLY the self-employed, under Earnings From Work, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income. If you have no income, put a checkmark (√) in the box.

5. In Part 5, an adult household member must sign the form, and if income information was provided, the adult household member must provide the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).
6. Part 6 and Part 7 are optional for meal benefits.

All Other Household Types: Including WIC households

1. In Part 1, list each enrolled child.
2. Skip Part 2 and Part 3.
3. In Part 4, list everyone related or unrelated living in your household. Include yourself, spouse, all children, grandparents, other relatives, and unrelated people. Use another sheet of paper if you need to.
   a. For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. Do not include income from SNAP, FDIR, WIC, Federal education benefits, and foster payments received by the family from the placing agency. For ONLY the self-employed, under Earnings From Work, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income. If you have no income, put a checkmark (√) in the box.

INCOME TO REPORT:

Earnings from Work Before Deductions
- Wages/salaries/tips
- Strike benefits
- Unemployment compensation
- Workman's compensation
- Net income from self-owned business or farm

Welfare/Child Support/Alimony
- Public assistance payments
- Welfare payments
- Alimony payments
- Child support payments

Pensions/Retirement/Social Security
- Pensions
- Retirement income

Social Security
- Veteran payments
- Supplemental Social Security Income

All Other Income
- Earnings from second job
- Disability benefits
- Interest/Dividends
- Cash withdrawn from savings
- Income from Estates/Trusts/Investments
- Regular contributions from persons not living in the household
- Royalties/Annuities/Rental Income

Any other monies that may be available to pay for the child's meals

4. Part 5. An adult must sign the application and list the last four digits his/her Social Security number, or put a checkmark (√) in the box if you have no social security number.
5. Part 6 and Part 7 are optional for meals benefits

Your children may qualify for free or reduced price meals if your		FEDERAL INCOME CHART FOR SCHOOL YEAR 2013-2014				
	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1.....	21,257	1,772	886	818	409
	2.....	28,694	2,392	1,196	1,104	552

household income falls within the limits on this chart.	3.....	36,131	3,011	1,506	1,390	695
	4.....	43,568	3,631	1,816	1,676	838
	5.....	51,005	4,251	2,126	1,962	981
	6.....	58,442	4,871	2,436	2,248	1,124
	7.....	65,879	5,490	2,745	2,534	1,267
	8.....	73,316	6,110	3,055	2,820	1,410
	For each additional person:	+7,437	+620	+310	+287	+144

OTHER BENEFITS: Put a checkmark where you want the information released. By signing this section you will allow the school to release information that shows you have applied for free or reduced price benefits under the NSLP. The information will only be used for the programs you have marked on the application.

Textbook Assistance

–**You must answer this question and sign, in order to receive textbook assistance.** You are not required to answer this question to receive meal benefits.

PLEASE NOTE: For **Textbook Assistance**, these are specific things that you must complete in addition to the required items for meal benefits.

1) Living with parent/caretaker relative,

(The definition of a caretaker relative is a relative, either by blood or by law, who lives with the child and exercises parental responsibility [care and control] in the absence of the child's parent. Examples include, but are not limited to: Grandparents, Aunts, Uncles, Cousins, Step-Parents, and Adult Siblings.)

2) grade, and

3) check if you are applying for textbook assistance and sign under Other Benefits.

Your application must contain 2 signatures for meals and textbooks.

Hoosier Healthwise

– Your child(ren) may qualify for free or low-cost health insurance under Medicaid or Hoosier Healthwise. If you **DO WANT** this information released for the purpose of Hoosier Healthwise, please sign. For more information about Hoosier Healthwise health insurance, call 1-800-889-9949.

Attachment B

Prescribed by State Board of Accounts | School Form No. 521 / 2012

[insert school corporation name] | [insert corp. #]

SCHOOL CORPORATION | CORP. NUMBER

APPLICATION FOR FREE OR REDUCED PRICE MEALS AND OTHER BENEFITS

Effective July 1, 2005 - One Application per **Household**

Part 1. NAME OF CHILD (First Name, MI, Last Name)	LIVING WITH PARENT or CARETAKER RELATIVE	BIRTH DATE	SCHOOL	GRADE	CHECK IF A FOSTER CHILD	TANF or Food Stamps Case # (If you receive both benefits, list the TANF Case #)
	YES - NO				☐	/ / / / / / / / /
	YES - NO				☐	/ / / / / / / / /
	YES - NO				☐	/ / / / / / / / /
	YES - NO				☐	/ / / / / / / / /
	YES - NO				☐	/ / / / / / / / /
	YES - NO				☐	/ / / / / / / / /

If ALL children listed above are foster children, skip to Part 5 and sign. If ANY of the children have a food stamp/TANF case number, skip to Part 5 and sign.

Part 2. If any member of your household (adult or non-student) has a valid Food Stamp or TANF case number, please provide the name and case number for the person who receives the benefit and then skip to Part 5.

Name:_____ Case Number: ____/____/____/____/____/____/____/____/____/____/____

Part 3. If any child you are applying for is migrant, homeless, or a runaway, check the appropriate box and call [insert your school's homeless liaison/migrant coordinator] at [insert phone number]. **Migrant** ☐ **Homeless** ☐ **Runaway** ☐

Part 4. LIST ALL HOUSEHOLD MEMBERS	ALL OTHER HOUSEHOLD TYPES GROSS (before deductions) HOUSEHOLD INCOME FROM ALL SOURCES *Examples: $100 / monthly or $100 / every 2 weeks or $100 / twice a month or $100 / weekly*																											
NAME	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	Twice A Month	Monthly	Yearly	Welfare Payment Child Support Alimony	Weekly	Every 2 Weeks	Twice A Month	Monthly	Yearly	Pension Retirement Social Security	Weekly	Every 2 Weeks	Twice A Month	Monthly	Yearly	All Other Income	Weekly	Every 2 Weeks	Twice A Month	Monthly	Yearly	Check if NO income
Example: Jane Smith	*$ 200*	☐	☒	☐	☐	☐	*$ 150*	☒	☐	☐	☐	☐	*$ 100*	☐	☐	☐	☒	☐	*$ 50*	☐	☐	☐	☒	☐	☐
1.	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	☐
7.	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	☐

Part 5. SIGNATURE: An adult household member must sign the application. If Part 4 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "No Social Security Number" box. While disclosure of the last 4 digits of a social security number is voluntary, the National School Lunch Act requires the last 4 digits of a social security number or an indication of "no social security number" for approval of the application. (See Use of Information Statement on the back of this page) *I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.*

X_____ *** - ** - __ __ __ __ ☐ No Social _____

Signature Of Adult Household Member | Social Security Number | Security Number | Home Telephone # / Work Telephone #

_____ _____ _____

Printed Name of Adult Household Member | Date Signed | Home Address/Apt # | Zip Code

Part 6. OTHER BENEFITS – This section does not need to be completed to receive free or reduced price meal benefits.

Do you want to receive textbook assistance?

O YES If, YES, SIGN TO THE RIGHT→
O NO

I certify that I am the parent/guardian of the child(ren) for whom application is being made. My signature below authorizes the release of information on this application for textbook assistance. I give up my right of confidentiality for this purpose only. This application information will be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. PARTS 260 AND 265.

X_____ _____

SIGNATURE OF PARENT/GUARDIAN | DATE

SCHOOL USE ONLY
O Approved
O Denied
O Not Applicable

SEE PAGE 2 IF YOU WANT THIS INFORMATION RELEASED FOR THE PURPOSE OF HOOSIER HEALTHWISE.

This application information may be shared with the Family and Social Services Administration for the purpose of identifying children who may qualify for free or low-cost health insurance under Medicaid or Hoosier Healthwise. If you want the application information shared for this purpose, please sign below. I certify I am the parent/guardian of the child(ren) for whom application is being made. I authorize the release of information for this purpose.

X_____ _____ For information about Hoosier Healthwise health insurance, call 1-800-889-9949.
Signature of Parent/Guardian Date

Part 7. RACE AND ETHNICITY:	Mark one or more racial identities:	Mark one ethnic identity:
Optional - You are not required to answer this question. No child will be discriminated against because of race, color, sex, national origin, age, or disability.	O Asian O Black or African American O American Indian or Alaska Native O Native Hawaiian or Other Pacific Islander O White	O Hispanic or Latino O Not Hispanic or Latino

Use of Information Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to *USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410* or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

INCOME CONVERSION to YEARLY:	WEEKLY INCOME X 52	
EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY INCOME X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size:_____ Total Income:$_____ per: O Weekly O Every 2 Weeks O Monthly O Twice a Month O Yearly

OR Categorical Eligibility: O Food Stamps O TANF O Migrant O Homeless O Runaway O Foster

Eligibility Determination: O Approved Free O Approved Reduced price O Denied

Reason for Denial: O Income Too High O Incomplete Application O Other(Reason)_____

Signature of Determining Official:_____ Date:_____

Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____

Date Verification Notice Sent:_____ Date Response Due from Households:_____ Date Second Notice Sent (or N/A): _____	Approval Based On: O Food Stamps / TANF Case Number O Household Size and Income O Other _____	Verification Results: O No Change O Free to Reduced O Free to Paid O Reduced to Free O Reduced to Paid	Reason for Change: O Income:_____ O Household Size: _____ O Change in Food Stamps /TANF O Did not respond O Other: _____	Date Notice of Change Sent:_____ Date Change Made:_____

Date Hearing Requested:_____	Verifying Official's Signature:_____
Hearing Decision: _____	Date:_____

Attachment C

% of Students Receiving Free or Reduced Priced Lunch

Sorted by Percentage

		2012-13
9730	Neighbors New Vista HS - Porter Co	0.00%
9890	Indiana Virtual School	0.00%
0630	Zionsville Community Schools	5.39%
9655	Hope Academy	8.11%
9315	Signature School Inc	9.17%
3060	Carmel Clay Schools	10.08%
9665	Montessori Academy @ Geist	11.72%
7875	West Lafayette Com School Corp	14.16%
3005	Hamilton Southeastern Schools	14.53%
0125	M S D Southwest Allen County	15.04%
0225	Northwest Allen County Schools	17.12%
3030	Westfield-Washington Schools	17.27%
3115	Southern Hancock Co Com Sch Corp	17.99%
4740	School Town of Munster	18.35%
3160	Lanesville Community School Corp	18.88%
1315	Barr-Reeve Com Schools Inc	18.89%
4205	Center Grove Com Sch Corp	18.98%
6510	East Porter County School Corp	19.45%
4615	Lake Central School Corp	19.95%
6530	Union Township School Corp	20.58%
9870	Discovery Charter School	20.66%
9625	IN Acad for Sci Math Humanities	21.19%
9875	Rock Creek Community Academy	21.36%
3295	North West Hendricks Schools	21.58%
9805	Hoosier Academy - Indianapolis	22.22%
4660	Crown Point Community Sch Corp	22.43%
6520	Porter Township School Corp	22.58%
3305	Brownsburg Community Sch Corp	23.14%
2100	Southeast Dubois Co Sch Corp	23.25%
3315	Avon Community School Corp	24.16%
1560	Sunman-Dearborn Com Sch Corp	24.41%
3070	Noblesville Schools	24.49%
4645	Tri-Creek School Corp	24.86%
4325	South Knox School Corp	24.96%
2155	Fairfield Community Schools	25.06%
1180	Rossville Con School District	25.37%
3135	Mt Vernon Community Sch Corp	25.41%
6895	Batesville Community Sch Corp	25.96%
2040	Northeast Dubois Co Sch Corp	26.16%
2765	South Gibson School Corp	26.20%
9620	Burris Laboratory School	26.31%
4940	South Central Com School Corp	26.93%
0015	Adams Central Community Schools	27.18%
3470	Northwestern School Corp	27.37%
9865	Hoosier Academy - Virtual Pilot	27.43%
6470	Duneland School Corporation	27.66%

% of Students Receiving Free or Reduced Priced Lunch

Sorted by Percentage

		2012-13
4580	Hanover Community School Corp	27.78%
6560	Valparaiso Community Schools	27.91%
7385	North Spencer County Sch Corp	28.25%
7175	Penn-Harris-Madison Sch Corp	28.28%
8625	Smith-Green Community Schools	28.33%
8525	Frontier School Corporation	28.36%
3325	Danville Community School Corp	28.42%
2120	Greater Jasper Con Schs	28.77%
3145	Eastern Hancock Co Com Sch Corp	28.87%
6600	M S D North Posey Co Schools	28.88%
3330	Plainfield Community Sch Corp	29.36%
9705	Hammond Academy of Science & Tech	29.42%
5255	South Madison Com Sch Corp	29.68%
1910	Mt Pleasant Twp Com Sch Corp	29.74%
3490	Western School Corp	30.35%
3025	Hamilton Heights School Corp	30.48%
9690	Renaissance Academy Charter	30.73%
6460	M S D Boone Township	30.82%
8435	Northern Wells Com Schools	31.04%
3335	Mill Creek Community Sch Corp	31.16%
3480	Eastern Howard School Corp	31.18%
9320	Community Montessori Inc	31.29%
8130	Warrick County School Corp	31.33%
4255	Nineveh-Hensley-Jackson United	31.35%
8425	Southern Wells Com Schools	31.48%
1900	Cowan Community School Corp	32.14%
9765	Cyber Charter School	32.50%
4915	Tri-Township Cons School Corp	32.62%
2275	Middlebury Community Schools	32.77%
8665	Whitley Co Cons Schools	32.82%
1940	Daleville Community Schools	33.82%
5245	Frankton-Lapel Community Schs	34.44%
7285	Shelby Eastern Schools	35.07%
4720	School Town of Highland	35.25%
5900	Monroe-Gregg School District	35.25%
3125	Greenfield-Central Com Schools	35.26%
0815	Southeastern School Corp	35.27%
7350	Northwestern Con School Corp	35.38%
7945	Tipton Community School Corp	35.52%
0940	West Clark Community Schools	35.56%
9650	Herron Charter	36.09%
5705	Richland-Bean Blossom C S C	36.11%
0615	Western Boone Co Com Sch Dist	36.40%
0750	Carroll Consolidated Sch Corp	36.53%
3785	Kankakee Valley School Corp	36.70%
4805	New Prairie United School Corp	36.71%

% of Students Receiving Free or Reduced Priced Lunch

Sorted by Percentage

		2012-13
9860	International School of Columbus	36.72%
6590	M S D Mount Vernon	36.74%
5620	North Miami Community Schools	36.79%
7865	Tippecanoe School Corp	36.79%
5625	Oak Hill United School Corp	37.01%
5740	Monroe County Com Sch Corp	37.05%
9835	The Bloomington Project School	37.17%
6080	Rising Sun-Ohio Co Com	37.29%
5835	North Montgomery Com Sch Corp	37.31%
8375	Northeastern Wayne Schools	37.38%
5525	Loogootee Community Sch Corp	37.49%
9325	Options Charter School - Carmel	37.50%
6325	Perry Central Com Schools Corp	37.62%
2815	Eastbrook Community Sch Corp	37.67%
5310	Franklin Township Com Sch Corp	37.72%
4860	M S D of New Durham Township	38.25%
3405	Blue River Valley Schools	38.49%
2285	Wa-Nee Community Schools	38.55%
5930	Mooresville Con School Corp	38.67%
2440	Covington Community Sch Corp	38.78%
7360	Southwestern Con Sch Shelby Co	39.06%
8050	M S D Wabash County Schools	39.07%
7935	Tri-Central Community Schools	39.23%
3435	Shenandoah School Corporation	39.31%
5845	South Montgomery Com Sch Corp	39.40%
2725	East Gibson School Corporation	39.43%
7610	Hamilton Community Schools	39.53%
0775	Pioneer Regional School Corp	39.63%
3055	Sheridan Community Schools	39.74%
1835	DeKalb Co Ctl United Sch Dist	39.98%
6620	Eastern Pulaski Com Sch Corp	40.11%
8115	M S D Warren County	40.28%
8305	Nettle Creek School Corp	40.47%
8535	Tri-County School Corp	40.55%
1375	North Daviess Com Schools	40.61%
8360	Centerville-Abington Com Schs	40.69%
1150	Clinton Central School Corp	40.92%
1875	Delaware Community School Corp	40.95%
1160	Clinton Prairie School Corp	41.18%
2260	Baugo Community Schools	41.19%
6445	Pike County School Corp	41.35%
2920	Bloomfield School District	41.46%
0365	Bartholomew Con School Corp	41.86%
2650	Caston School Corporation	41.92%
5480	Bremen Public Schools	41.96%
6900	Jac-Cen-Del Community Sch Corp	42.11%

Attachment C

% of Students Receiving Free or Reduced Priced Lunch

Sorted by Percentage

		2012-13
7150	John Glenn School Corporation	42.64%
3695	Brownstown Cnt Com Sch Corp	42.78%
1885	Wes-Del Community Schools	42.79%
5910	Eminence Community School Corp	42.79%
5495	Triton School Corporation	42.87%
6910	Milan Community Schools	43.08%
6715	North Putnam Community Schools	43.57%
0665	Lebanon Community School Corp	43.58%
1620	Lawrenceburg Com School Corp	43.65%
4525	Westview School Corporation	43.66%
4730	School City of Hobart	43.76%
4455	Whitko Community School Corp	44.08%
9725	Canaan Community Acad-Jefferson Co.	44.09%
2400	New Albany-Floyd Co Con Sch	44.14%
6705	South Putnam Community Schools	44.33%
4225	Franklin Community School Corp	44.41%
3180	North Harrison Com School Corp	44.49%
1805	DeKalb Co Eastern Com Sch Dist	44.62%
1600	South Dearborn Com School Corp	44.75%
2110	Southwest Dubois Co Sch Corp	44.83%
6055	Central Noble Com School Corp	45.01%
7605	Fremont Community Schools	45.23%
7445	South Spencer County Sch Corp	45.29%
4515	Prairie Heights Com Sch Corp	45.33%
9830	Beacon Academy	45.45%
4145	Clark-Pleasant Com School Corp	45.47%
7950	Union Co/Clg Corner Joint Sch Dist	45.48%
3815	Rensselaer Central School Corp	45.52%
3625	Huntington Co Com Sch Corp	45.59%
0035	South Adams Schools	45.78%
0370	Flat Rock-Hawcreek School Corp	45.90%
9640	Options Charter Sch - Noblesville	45.91%
6755	Greencastle Community Sch Corp	45.97%
5470	Argos Community Schools	46.30%
1655	Decatur County Com Schools	46.34%
9340	New Community School	46.48%
0395	Benton Community School Corp	46.54%
2825	Madison-Grant United Sch Corp	46.66%
3455	C A Beard Memorial School Corp	46.66%
6350	Tell City-Troy Twp School Corp	46.72%
4245	Greenwood Community Sch Corp	46.74%
2455	Southeast Fountain School Corp	46.75%
1895	Liberty-Perry Com School Corp	46.78%
8445	M S D Bluffton-Harrison	46.78%
7215	Union-North United School Corp	46.83%
3415	South Henry School Corp	47.02%

Attachment C

% of Students Receiving Free or Reduced Priced Lunch

Sorted by Percentage

		2012-13
8010	North Vermillion Com Sch Corp	47.04%
5945	North Newton School Corp	47.16%
3710	Crothersville Community Schools	47.19%
2475	Franklin County Com Sch Corp	47.29%
4345	Wawasee Community School Corp	47.62%
6995	Rush County Schools	47.79%
3190	South Harrison Com Schools	47.98%
7715	Southwest School Corp	48.16%
2435	Attica Consolidated Sch Corp	48.43%
2940	Eastern Greene Schools	48.43%
6060	East Noble School Corp	48.47%
8045	Manchester Community Schools	48.51%
0255	East Allen County Schools	48.64%
7615	M S D Steuben County	48.66%
9810	Hoosier Academy - Muncie	48.84%
8215	East Washington School Corp	49.01%
2735	North Gibson School Corp	49.12%
8565	Twin Lakes School Corp	49.25%
0025	North Adams Community Schools	49.45%
5075	North Lawrence Com Schools	49.51%
6805	Randolph Southern School Corp	49.53%
9905	IN Connections Acad Virtual Pilot	49.58%
1730	Greensburg Community Schools	49.76%
4415	Warsaw Community Schools	49.80%
2980	White River Valley Sch Dist	49.94%
8020	South Vermillion Com Sch Corp	50.11%
1820	Garrett-Keyser-Butler Com	50.31%
5925	M S D Martinsville Schools	50.32%
5085	Mitchell Community Schools	50.39%
2950	Linton-Stockton School Corp	50.40%
6145	Orleans Community Schools	50.42%
7255	Scott County School District 2	50.52%
4945	LaPorte Community School Corp	50.66%
4700	Griffith Public Schools	51.08%
4315	North Knox School Corp	51.41%
8205	Salem Community Schools	51.41%
6865	South Ripley Com Sch Corp	51.59%
2645	Rochester Community Sch Corp	51.62%
0755	Delphi Community School Corp	51.65%
6160	Springs Valley Com School Corp	51.71%
7515	North Judson-San Pierre Sch Corp	51.73%
3995	Madison Consolidated Schools	51.79%
5265	Alexandria Com School Corp	51.89%
1125	Clay Community Schools	51.93%
0670	Brown County School Corporation	51.94%
6195	Spencer-Owen Community Schools	52.05%

Attachment C

% of Students Receiving Free or Reduced Priced Lunch

Sorted by Percentage

		2012-13
7645	Northeast School Corp	52.07%
9385	Christel House DORS	52.50%
3460	Taylor Community School Corp	52.51%
6820	Monroe Central School Corp	52.71%
8355	Western Wayne Schools	53.08%
4000	Southwestern-Jefferson Co Con	53.37%
7495	Oregon-Davis School Corp	53.99%
3945	Jay School Corp	54.01%
6375	North Central Parke Con Sch Corp	54.48%
8220	West Washington School Corp	54.60%
3675	Seymour Community Schools	54.77%
5615	Maconaquah School Corp	54.77%
6795	Union School Corporation	54.85%
8030	Vigo County School Corp	54.86%
6825	Randolph Central School Corp	54.87%
4535	Lakeland School Corporation	55.05%
7365	Shelbyville Central Schools	55.16%
2960	M S D Shakamak Schools	55.46%
6155	Paoli Community School Corp	55.51%
6630	West Central School Corp	55.59%
0515	Blackford County Schools	55.65%
5485	Plymouth Community School Corp	55.73%
6550	Portage Township Schools	55.83%
9330	Irvington Community School	55.88%
4445	Tippecanoe Valley School Corp	56.54%
5400	School Town of Speedway	56.77%
5370	M S D Washington Township	57.00%
7775	Switzerland County School Corp	57.05%
2270	Concord Community Schools	57.48%
7995	Evansville-Vanderburgh Sch Corp	57.50%
5995	South Newton School Corp	57.62%
6750	Cloverdale Community Schools	57.75%
1010	Greater Clark County Schools	58.11%
4015	Jennings County Schools	58.65%
5455	Culver Community Schools Corp	58.72%
9895	Indiana Math Science Academy North	58.77%
5330	M S D Lawrence Township	58.93%
5520	Shoals Community School Corp	58.93%
4600	Merrillville Community School	59.04%
3445	New Castle Community Sch Corp	59.49%
1300	Crawford Co Com School Corp	59.81%
9885	Gary Middle College, Gary	60.19%
0875	Logansport Community Sch Corp	60.56%
5855	Crawfordsville Com Schools	60.67%
5635	Peru Community Schools	60.74%
1405	Washington Com Schools Inc	60.78%

Attachment C

% of Students Receiving Free or Reduced Priced Lunch

Sorted by Percentage

		2012-13
6260	Southwest Parke Com Sch Corp	60.81%
4335	Vincennes Community Sch Corp	60.82%
5340	M S D Perry Township	60.95%
2855	Mississinewa Community School Corp	61.21%
8060	Wabash City Schools	62.81%
9465	Rural Community Schools Inc	62.96%
9755	Carpe Diem (Indianapolis)	63.22%
6835	Randolph Eastern School Corp	63.57%
2395	Fayette County School Corp	63.60%
5300	M S D Decatur Township	63.63%
4215	Edinburgh Community Sch Corp	63.68%
9445	Charles A Tindley Accelerated Schl	63.71%
9745	Tindley Preparatory	63.79%
7525	Knox Community School Corp	63.84%
7200	School City of Mishawaka	64.51%
9880	Career Academy at South Bend	64.71%
4760	Whiting School City	65.09%
5280	Elwood Community School Corp	65.09%
5380	Beech Grove City Schools	65.09%
5350	M S D Pike Township	65.38%
9790	Anderson Preparatory Academy	65.84%
2305	Elkhart Community Schools	67.18%
1000	Clarksville Com School Corp	67.19%
9845	Xavier School of Excellence	67.66%
2315	Goshen Community Schools	68.01%
5360	M S D Warren Township	68.53%
3500	Kokomo-Center Twp Con Sch Corp	68.85%
7230	Scott County School District 1	69.10%
3640	Medora Community School Corp	69.14%
6065	West Noble School Corporation	69.33%
7855	Lafayette School Corporation	69.39%
8515	North White School Corp	69.57%
9310	Charter School of the Dunes	69.61%
9360	Veritas Academy	70.31%
0235	Fort Wayne Community Schools	70.49%
6340	Cannelton City Schools	71.49%
7205	South Bend Community Sch Corp	72.72%
1970	Muncie Community Schools	73.07%
4925	Michigan City Area Schools	73.07%
5375	M S D Wayne Township	73.90%
8385	Richmond Community School	73.98%
9795	Robert H Faulkner Academy	74.23%
1170	Community Schools of Frankfort	74.31%
9460	Thea Bowman Leadership Academy	74.33%
9910	Excel Center for Adult Learners	74.47%
2865	Marion Community Schools	74.81%

Attachment C

% of Students Receiving Free or Reduced Priced Lunch

Sorted by Percentage

		2012-13
4590	River Forest Community Sch Corp	76.03%
5275	Anderson Community School Corp	77.10%
9695	Imagine Master Academy	78.35%
9670	Indplis Metropolitan High School	78.37%
4680	Lake Station Community Schools	79.16%
9750	Anderson Excel Center	80.06%
9390	Flanner House Elementary School	80.26%
4690	Gary Community School Corp	81.13%
9760	Smith Collegiate Preparatory	81.16%
9645	Challenge Foundation Academy	81.54%
4710	School City of Hammond	81.59%
5385	Indianapolis Public Schools	81.74%
9715	Andrew Academy	82.95%
9535	Gary Lighthouse Charter School	83.94%
9785	Indiana Math and Science Academy	84.29%
4650	Lake Ridge Schools	85.25%
9495	Joshua Academy	87.19%
9545	21st Century Charter Sch of Gary	87.29%
9680	Paramount School of Excellence Inc	88.99%
9380	Christel House Academy	89.23%
9615	Andrew J Brown Academy	89.36%
9370	Fall Creek Academy	89.83%
9555	East Chicago Urban Enterprise Acad	90.13%
9590	Monument Lighthouse Charter School	90.44%
9575	Indpls Lighthouse Charter School	90.65%
9595	East Chicago Lighthouse Charter	90.78%
9585	West Gary Lighthouse Charter	91.52%
9685	Aspire Charter Academy	91.78%
9920	Damar Charter Academy	92.50%
9400	KIPP Indpls College Preparatory	92.55%
9480	Fountain Square Academy	92.65%
9820	Imagine MASTer on Broadway	92.90%
9635	KIPP Lead College Prep Charter	92.95%
9850	Imagine Life Sciences Acad - West	93.33%
9485	SE Neighborhood Sch of Excellence	93.62%
9565	Galileo Charter School	94.09%
4670	School City of East Chicago	94.62%
9815	Imagine Life Sciences Acad - East	97.50%
9740	Thurgood Marshall Leadership Academy (Ft	97.58%
9720	Padua Academy	98.39%
9350	Timothy L Johnson Academy	98.41%

8/21/13 HFC Exhibit 16

Indiana Department of Education

Glenda Ritz, NBCT
Indiana Superintendent of Public Instruction

Indiana Administration of USDA Child Nutrition Program (National School Lunch Program) (Free and Reduced Lunch)

"Free and Reduced Lunch" Program Facts

- USDA Program
- All Public Schools and some Private Receive Subsidy
  - Reimbursement
    - Federal pays $0.28 of Paid Meals (Non-Free/Reduced)
    - Reduced Price Meal (Student pays $0.40)
    - Free Meal (Student pays $0.00)
    - Indiana Ave full paid meal is $2.05
- Characteristics of the Program
  - Proactive Application Process
    - All student households receive application
  - Do No Harm
  - Verify Eligibility Only (3% cap on verification)
- Students on F&R as a Percent of Total School Population
  - Indiana Average 47% - US Average 53% - Michigan 48%
- IDOE consistently does well on USDA Audits

Process

USDA Audits IDOE

IDOE Reviews Schools

Schools Verify Household Application

SY 2012-2013 Facts

1,125,000 Students

531,749 Students on Free/Reduced
(47% of 1,125,000)

378,153 by Direct or Category
153,596 by Individual Application

4,690 Selected for Verification
(3% of 153,596)

4,690 Selected for Household Verification

3,611 Reviewed

1,079 Unavailable for Review

544 Category Changed (15% of 3,611)

512 Dropped from Program (14.7% of 3,611)

Reasons for being Dropped

- No longer on SNAP (Food Stamp) or TANF
- Error on first application
- Unable to verify income
- Income ineligible
- Misreporting Income
- Choose not to verify income

8/21/13 HFC Exhibit 17

Indianapolis Public Schools

Free/reduced lunch eligibility (1997-2012)

ALL STUDENTS	1997	2002	2007	2009	2011	2012
Percentage eligible for free or reduced lunch	75%	79%	78%	85%	86%	86%

STUDENTS ELIGIBLE FOR FREE/REDUCED LUNCH (by category)	1997	2002	2007	2009	2011	2012	# of Students 2012
Receiving SNAP or TANF (directly certified by FSSA)	43.4%	45.0%	42.6%	60.4%	68.7%	70.0%	**18,096**
Receiving SNAP or TANF (not directly certified by FSSA)	12.1%	11.2%	11.0%	5.5%	6.7%	4.6%	**1,186**
Homeless, foster, migrant, institutionalized	n/a	n/a	2.5%	1.6%	1.5%	1.9%	**489**
Income/household size	44.4%	43.8%	43.8%	32.5%	23.1%	23.5%	**6,065**
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**25,836**