Health Plan Summary

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Agenda

- Health Plan Mission
- Plan Priority Areas
- Eligibility Requirements
- Enrollment
- Plan Overview
- Covered Benefits
- POWER Account Overview
- Marketing Requirements
- Project Timeline
- RFS Parameters and Pricing
- Key Departures from Hoosier Healthwise

Health Plan Mission

Mission

- To utilize proceeds from an increased cigarette tax to improve the health of Hoosiers

Approach

- Direct cigarette tax revenues to public health programs and to provide health insurance to uninsured Hoosiers least able to afford coverage
- Promote personal responsibility for health
- Increase transparency in health care costs and financing
- Encourage value and price-conscious consumerism

Goals

- Reduce number of uninsured in Indiana
- Slow trajectory of health care premiums created by cost shifting from uninsured to insured Hoosiers
- Transition away from traditional subsidies to hospitals to providing insurance for individuals
- Give more Hoosiers power to be value-conscious consumers of health care

Plan Priority Areas

Prevention

- $500 “first-dollar” preventative services coverage
- Encouraged participation in programs like smoking cessation counseling
- Age and gender-specific preventative care guidelines and reminders

Personal Responsibility

- POWER Accounts that give participants financial incentive to adopt healthy behaviors and seek the best value when they receive health care
- Increased roll-over of POWER Account funds for members who access preventative care

Value

- Innovative deductible health plan structure
- Competitive procurement to leverage statewide volume

Cost-Conscious Consumption

- Members empowered to make informed decisions through POWER accounts
- Encouraged responsible utilization by charging for improper use of ER services

Eligibility Requirements

- Ages 18 to 64
- United States citizen
- Annual household income of not more than 200% of Federal Poverty Level
- Ineligible for health insurance through employer
- Uninsured for at least 6 months
- Not eligible for an existing Medicaid program

Enrollment

Eligibility Determination

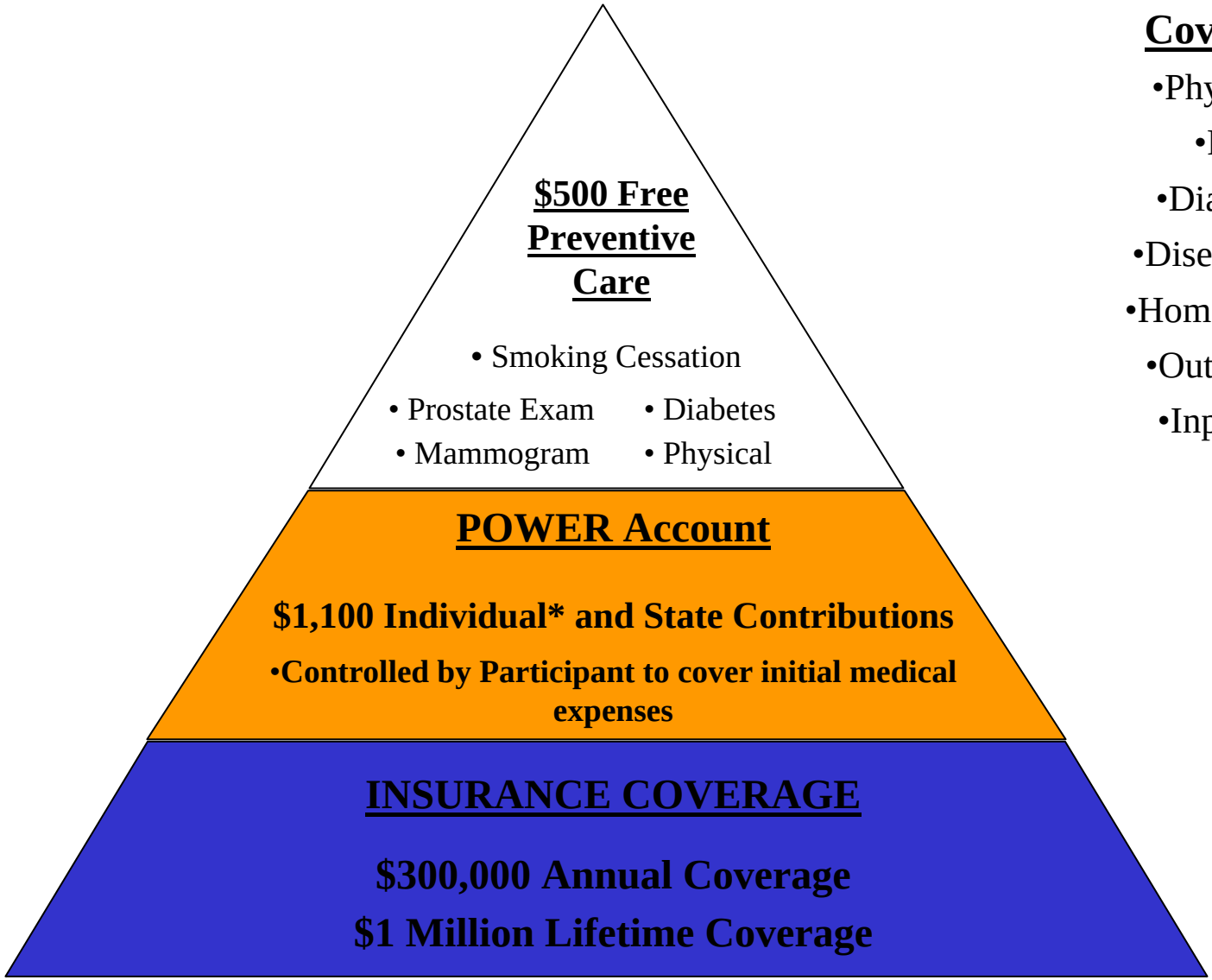
Applicant…

- Completes health status form
- Provides personal information on application
- Submits eligibility verification documents
- Briefed on choice of insurers

Enrollment

- Applicant submits first POWER Account contribution with application
- DFR reviews application and confirms eligibility and contribution amount
- Applicant's first POWER Account contribution processed
- State makes its contribution to POWER Account
- Member notified of coverage start date and sent member handbook, POWER Account information, and preventative services guidelines

Plan Overview



*Individual contribution not to exceed 5% of gross annual income

Covered Services

- Physician Services
- Prescriptions
- Diagnostic Exams
- Disease Management
- Home Health Services
- Outpatient Hospital
- Inpatient Hospital

Covered Benefits

- **Physician Care**
  - PMPs within 30 miles and specialty providers within 60 miles of each member

- **Pharmacy**
  - Minimum of generics covered in each drug class
  - Brand name coverage for drugs without a generic version

- **Preventative Care Services,** such as:
  - Mammograms, PAP smears
  - Flu shots
  - Annual physicals
  - Smoking cessation therapies

- **Mental Health & Substance Abuse**

- **Specialized Services**
  - In and outpatient hospital
  - Emergency services
  - Disease management
  - Diagnostic services
  - Home health

- **Vision and Dental Riders** (available for purchase: individuals pay 50% of premium, in addition to POWER Account contribution)

POWER Account Overview

Member

- Makes monthly contributions from payroll or other mechanism
- Contributions between 2-5% of gross family income depending on income level
- Monitors account balance
- May seek contribution from employer

State

- Determines POWER account contribution
- Promptly makes entire contribution after member's first contribution received
- Uses plan data to monitor utilization of preventative services

POWER Account

- $1,100 per year available to pay for initial medical costs
- Unused funds are rolled over to reduce the member's contribution in the next coverage term IF preventative services are utilized
- Medical costs above $1,100 covered by state-sponsored basic commercial benefits package

Member's Debit Card

- Used to pay for authorized services by plan providers
- Helpline access to check account balance
- Email notification after each transaction

Marketing Requirements

- CMS minimum requirements
- General marketing; may use agents
- No cold calls or door-to-door
- Must include materials to employers on making contributions
- Incentives may be given but must be aligned with CMS regulations
- Uninsured for at least 6 months
- Must inform potential applicants that other plans are available

Project Timeline

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan

Evaluation

Step 1: Adherence to Requirements

Step 2: Technical Proposal – 30 pts.
Business Information – 15 pts.
Cost Proposal – 10 pts.
Team will review clarifications, presentations and/or target pricing and revise scores accordingly

Step 3: Revised Step 2 scores – 55 pts.
Minority and Women Business Participation – 20 pts.
Indiana Economic Impact – 15 pts.
Buy Indiana – 10 pts.

- Pass Legislation
- Develop RFS

- Conduct statewide community meetings
- Conduct bidder conferences
- Modify RFS based on feedback

- Evaluate proposals
- Conduct oral presentations
- Conduct initial negotiations

- Negotiate with Awarded Respondent(s)

- Complete Readiness Review
- Complete full implementation
- Prepare for January 2008 Start Date

5/4 Release RFS

6/15 Receive Proposals

8/10 Issue Award Recommendation

10/15 Execute Contract

10/26 Finalize Plan Implementation

Jan 2008 Go Live

RFS Parameters and Pricing

- Pricing based on age and gender and removal of high risk individuals
- Medicare rates to providers
- Established maximum price based on actuarial estimates
- Mechanisms to measure and reward plan performance
- Includes evaluation criteria such as Indiana Economic Impact, Buy Indiana, and use of Minority and Woman-Owned Businesses

Key Departures from Hoosier Healthwise

- Participation is not limited to HMOs
- Deductible health plan design with POWER account
- Reimbursement at Medicare rates
- Buy-in option with no subsidy for those that do not qualify for the plan
- Application through the Plans
- No enrollment broker
- "General Health Questionnaire" and potential for referral to State's high-risk plan with intensive disease management component
- Focus on prevention, plans will create innovative approaches to encourage healthy lifestyles
- Email accounts for beneficiaries