Indiana Check Up Plan Task Force Report

November 1, 2009

Prepared for:
Governor Mitch Daniels and the Indiana General Assembly

HEALTHY INDIANA PLAN SM
Health Coverage = Peace of Mind

www.HIP.in.gov

1-877-GET-HIP-0 (toll free)

EXECUTIVE SUMMARY

This report, prepared by the Indiana Check Up Plan (ICUP) task force, in partnership with the Family & Social Services Administration (FSSA), examines the Healthy Indiana Plan implementation and current operations as required by HEA 1678. The ICUP task force was established to (1) study, monitor, provide guidance, and make recommendations to the state concerning the program, (2) develop methods to increase availability of affordable coverage for health care services for all Indiana residents, (3) develop an education and orientation program for individuals participating in the plan, and (4) make recommendations to the legislative council.

The ICUP task force began meeting in October 2008, upon receiving appointees from the Indiana State Senate and the Office of Governor Mitch Daniels. Members have monitored the progress of the Healthy Indiana Plan over the past year examining program functions ranging from funding to enrollment to morbidity rates. The Indiana State House of Representatives is required by statute to appoint members, but has not made their appointments.

The ICUP task force is composed of:

Governor's Office Appointees:
Dr. Greg Larkin, Indianapolis
Dr. Mercy Obeime, Indianapolis
Dr. Jerry Fletcher, Indianapolis
Dr. Kevin Burke, Jeffersonville

Senate Appointees:
Clyde Hall, McCordsville
June Lyle, AARP, Indianapolis
Dr. Vidya Kora, Michigan City
Jim Lipinski, Hammond

Appointments not made (House):
Minority health concerns expert
Business representative
Organized labor representative
Consumer representative

Healthy Indiana Plan (HIP)

INTRODUCTION

The Healthy Indiana Plan (HIP) is a Medicaid expansion program operating under a federal waiver to cover individuals who are uninsured and do not qualify for traditional Medicaid under Indiana Medicaid rules. HIP was legislated through House Enrolled Act 1678 in the spring of 2007 and began operations on January 1, 2008. It is a unique program in the public assistance arena for working-age adults. HIP is a consumer-driven, voluntary health insurance plan that seeks to promote personal responsibility and consumerism. As a non-traditional Medicaid program, HIP is not an entitlement program, and therefore can cover a limited number of individuals. It is offered to Hoosiers on a first come, first served basis.

Those eligible for the program are adults between the ages of nineteen and sixty-four. Parents or caretaker relatives of children in the Hoosier Healthwise program are likely candidates. To be eligible for HIP, individuals must fulfill three criteria:

1. Individuals must earn less than 200% of the federal poverty level (FPL)[1],
2. Individuals must not have access to employer sponsored health insurance coverage, and
3. Individuals must be uninsured for previous six months.

HIP offers uninsured Hoosiers access to basic and affordable health coverage, including hospital services, mental health care, physician services, prescriptions, diagnostic exams and disease management. The basic commercial benefits package provides annual coverage of up to $300,000 and a lifetime limit of $1 million. Preventive care services are provided at no charge, up to $500 per year. These services are provided through the enrollee's elected health plan: Anthem or MDwise. A small portion of the HIP population with serious health conditions is assigned the Enhanced Services Plan (ESP).

All participants have a Personal Wellness and Responsibility Account or "POWER Account." HIP requires participants to make a monthly financial contribution towards their health care—on a sliding scale (2 to 5% of $1,100 based on gross family income) based on federal poverty level. Members' POWER accounts hold these required monthly contributions, as well as the State's contribution. The account is used to fund enrollees' health care expenses or deductible up to the $1,100 amount. Members who do not make their required monthly contributions are terminated from the plan and cannot reenroll for twelve months.

Since HIP is modeled in the spirit of a High Deductible Health Plan (HDHP)/Health Savings Account (HSA), it provides incentives for participants to stay healthy, be value and cost-conscious, and to utilize services in a cost-efficient manner. The POWER accounts, much like an HSA, give HIP participants a financial incentive to adopt healthy behaviors that keep them out of the doctor's office and emergency room. Additionally, if all age and gender appropriate preventive care services are completed in the first year, the entire remaining balance in the POWER Account will roll over to the following year to offset the member's contribution.

The following demonstrates the results of the ICUP task force's study of HIP. A brief analysis is provided on the various features of HIP, followed by recommendations from the ICUP task force to FSSA Administration and Indiana General Assembly concerning the program.

---

[1] Federal Poverty Level or FPL is the poverty guideline as determined annually by the Department of Health and Human Services and used for determining financial eligibility for certain federal programs.

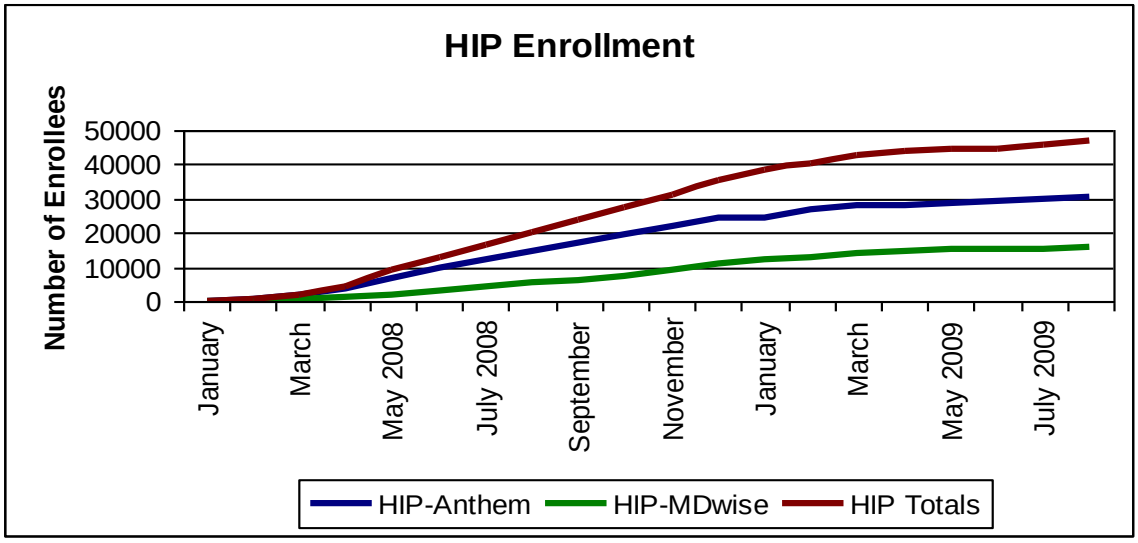
ANALYSIS OF PROGRAM

ENROLLMENT and APPLICATIONS

As of September 30, 2009, and after twenty-one months of enrollment experience, HIP had 46,791 members enrolled in the program, and an additional 3,544 individuals were determined conditionally eligible with enrollment pending receipt of first POWER Account payment.

Additionally, 123,289 applications were denied as of September 30, 2009. The top five reasons for denials included: (1) non-caretaker cap reached; (2)failure to pay initial POWER Account contribution; (3) failure to verify income; (4) insurance coverage within the last six months; and (5) access to insurance through an employer.

The chart below depicts the enrollment from January 2008, when the program began, through August 2009. Anthem and MDwise enrollment is shown; however, the HIP totals line includes both health plans in addition to the Enhanced Services Plan. Because the ESP population only represents one percent of the entire universe, it is not represented separately.



The initial steady increase in enrollment demonstrates the need in Indiana, as well as the success of the state's marketing efforts. Since early to mid-2009, enrollment has not increased as dramatically as in 2008. In March 2009, when the non-caretaker adult cap imposed by the federal government was reached, the State closed the program to non-caretaker adults. Part of the decreased rate of enrollment is due to the number of non-caretaker adults applying for the program, but being unable to enroll because the program is at capacity for this population. Additionally, some individuals are applying for the program but may

be finding themselves ineligible due to access to health insurance through their employer, inability to pay their first POWER account payment or having had insurance within the last six months. Lastly, individuals are required to update their information by completing a redetermination after twelve months of enrollment. The leveling off of the rate of enrollment is also affected by the individuals who complete a redetermination and may no longer be eligible for the program due to a change in income or access to employer sponsored insurance. Enrollees may also become eligible for Medicare or other Medicaid programs due to disability or pregnancy and therefore choose to enroll in a program other than HIP.

HIP POPULATION

Age distribution in HIP has been relatively even, while gender distribution favors women. Nearly two-thirds of individuals enrolled in HIP are female. The plan has also attracted many pre-Medicare eligible Hoosiers, with almost a third of all total HIP members being between the ages of 50 and 64. Costs for these patients are higher due to the increased medical care that traditionally accompanies the aging population. African American enrollment in HIP started slowly, but has increased over the past year. In order to increase minority enrollment, FSSA launched a strategic marketing campaign, which is detailed in the Outreach section of this document. Since this time, African American enrollment has remained around 13%. Finally, just over half of all HIP members are non-caretaker adults (those without dependent children).

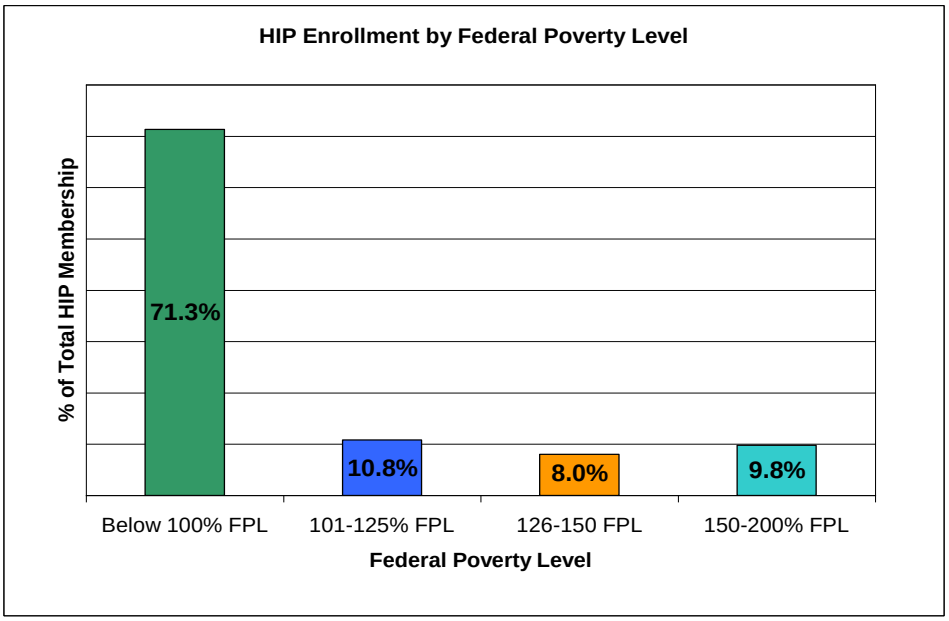
Age		
<20:	3	(0.0%)
20-29:	8,076	(17.5%)
30-39:	11,256	(24.4%)
40-49:	12,727	(27.6%)
50-59:	10,329	(22.4%)
60-64:	3,668	(7.9%)

Race		
Asian	476	(1.0%)
Black	5,774	(12.5%)
Hispanic	1,281	(2.8%)
Indian	31	(0.1%)
Other	714	(1.6%)
White	37,783	(82.0%)

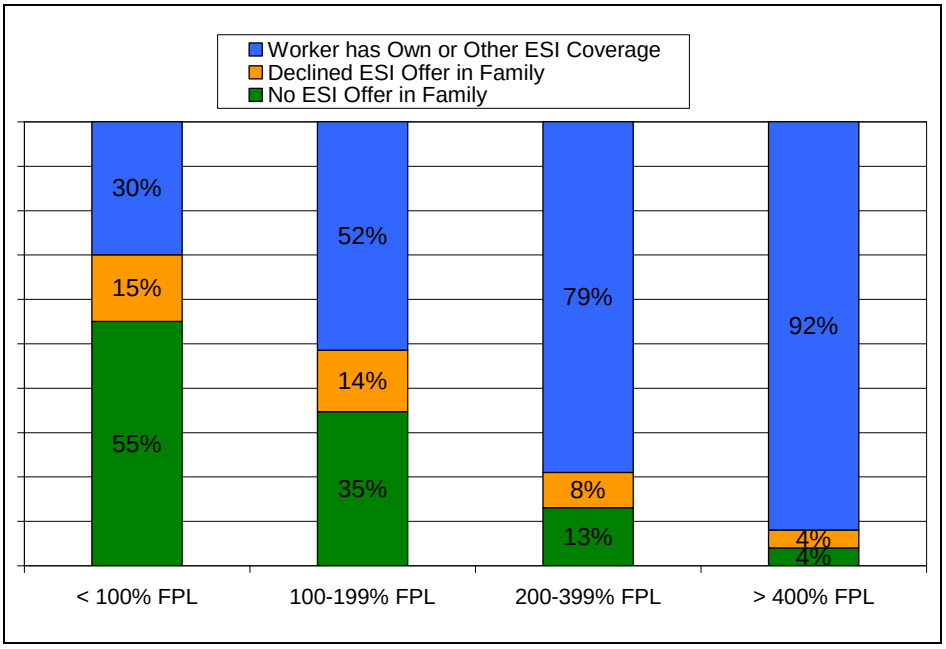
Sex		
M:	17,005	(36.9%)
F:	29,054	(63.1%)

Caretaker Adult		
Yes:	21,517	(46.7%)
No:	24,452	(53.3%)

The graph on the following page demonstrates enrollment volume distributed by FPL. Although HIP is available to uninsured Hoosiers below 200% FPL, over 70% of all HIP members fall below 100% FPL, while only 30% of enrollees are above 100% FPL.



This raises questions about why there are many more enrollees below 100% FPL than above it. A likely answer is that many of these individuals may have access to employer sponsored insurance which makes them ineligible for HIP. In a study conducted by the Kaiser Commission on Medicaid and Uninsured, and represented in the graph below, over 60% of adults between 100% and 200% FPL had access to employer-sponsored insurance. This, along with inability to pay POWER account contributions or qualify for other reasons, could contribute to the disparity between enrollment by FPL.



Note: Percentages may not total 100% due to rounding.
Source: L. Clemans-Cope and B. Garret, *Changes in Employer-Sponsored Health Insurance SponsorsIndiana Check Up Plan, Eligibility, and Participation: 2001 to 2005*, Kaiser Commission on Medicaid and the Uninsured (January2007).

HEALTH PLANS

HIP services are provided through two health plans: Anthem and MDwise. At the time of application, those seeking HIP services elect the health plan of their choice. Currently 65% of enrollees have opted for Anthem and 34% for MDwise. An additional 1% of enrollees were assigned to the ESP which is administered by the Indiana Comprehensive Health Insurance Association (ICHIA). (See below for ESP program analysis.)

Members must remain enrolled in their health plan for a twelve month period before they can re-elect a health plan. Members are permitted to change their health plan before making their first POWER account payment. After receiving conditional eligibility, health plans send a “Welcome Letter” notifying the individual that their first POWER account contribution is due within 60 days. Within this 60 day period, members may change their health plan without cause.

Members may request to change their health plans for cause at any time after exhausting their health plan’s internal grievance and appeals process. “For cause” is defined as receiving poor quality health care coverage and includes the following:

1. Failure of health plan to provide covered services
2. Failure of the health plan to comply with established standards of medical care administration
3. Significant language or cultural barriers
4. Corrective Action levied against the health plan by FSSA
5. Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage

Additionally, when HIP was implemented, the State received complaints about an insufficient number of providers within a reasonable distance of a participant’s home. The problem was greatest in rural areas, and therefore, FSSA targeted provider outreach in these areas. In the meantime, members who did not have a primary care provider within thirty miles of their home were allowed to switch their health plan. Additionally, both health plans allowed their members to see any Medicaid doctor, and Anthem allowed their members to see doctors in the commercial plan network. By the second quarter of operations, provider contracts were fully executed, and both HIP health plans had accessible networks. Since then, the State has received very few requests from members to switch health plans.

Enhanced Services Plan

Participants with high-risk conditions are enrolled in the ESP. This allows these individuals to receive enhanced and specialized case and disease management

suited to their health care needs. Services are provided through the Indiana Comprehensive Health Insurance Association (ICHIA), which has experience in providing health care services to individuals with high-risk, costly medical needs. As of September 30, 2009, 473 individuals have been assigned to the ESP.

Screening for the ESP begins at the time of application; all HIP applicants complete a brief medical questionnaire that asks about certain conditions they may have. Applicants answering yes to any of the questions are placed in the ESP so that they may begin receiving services immediately. The State then contacts the members' providers to verify the condition and will make a final decision as to whether a member should remain in the ESP plan or should be moved to their original plan choice, as indicated on the application. To the participant, the plan operates almost identically to the Anthem/MDwise programs. Members still continue to pay their portion of the POWER account contributions, though it is more likely that their POWER account will be used more quickly. The benefits are identical to those offered by HIP carriers, Anthem and MDwise. The only exception is pharmacy benefits which differ slightly from the other HIP plans. ESP pharmacy benefits are the same as traditional Medicaid pharmacy coverage.

HIP participants with active cancers, HIV/AIDS, Aplastic Anemia, certain blood diseases such as Hemophilia and those who are transplant recipients receive the ESP. As of the publication of this report, 70% of individuals considered for assignment to the ESP reported an active cancer.

Additionally, upon review of the program, FSSA along with the health plans identified additional conditions to include in the ESP. Those conditions include:

Lipid Storage Diseases
Primary Immune Deficiencies
Muscular Dystrophy
Primary Pulmonary Hypertension
Amyotrophic Lateral Sclerosis
Cirrhosis
Chronic Hepatitis C
Cystic Fibrosis
Diabetes with complications
Renal Failure
CMV Retinitis
Tuberculosis
Paraplegia/Quadriplegia.

It is important to note, however, that no participant is excluded from HIP based on their health condition.

NON-CARETAKER ADULTS

Non-caretaker adults, those without a dependant child living in the home, are not entitled to coverage under Title XIX of the federal Medicaid statute. Therefore, in order for states to include this population in various Medicaid waiver programs, the State must meet "budget neutrality," meaning the addition must not cost the federal government additional money.

Indiana diverted a portion of the disproportionate share hospitals funds and held the trend rate for the Hoosier Healthwise Program, meaning there have not been significant increases in Hoosier Healthwise health care costs, to receive a waiver to cover non-caretaker adults. This population is not eligible for standard Medicaid, and therefore Indiana was given a cap on the number of non-caretaker adults it could cover. The cap is 34,000 individuals. Data indicated that as of March 2009, the cap on non-caretaker adults was rapidly being approached, and therefore the program was closed to non-caretaker adults. At this time, FSSA began a wait list for non-caretaker adults who would be eligible were the program not closed to this population. The wait list has continued to grow since March 2009. HIP currently has over 25,000 non-caretaker adults on the wait list. The State continues to process applications for non-caretaker adults, and if the applicant is denied solely because of program closure and all other eligibility requirements are met, they are added to a waitlist on a first come, first served basis.

FSSA has now determined it can realistically enroll additional non-caretaker adults while staying within the federally required cap of 34,000 individuals. FSSA will reopen the program to some of the individuals on the wait list. Approximately 5,000 individuals will receive letters from the State. If they still desire to participate, they will need to indicate that they continue to meet eligibility requirements in writing before the deadline of 45 days. Those who continue to meet eligibility requirements will be enrolled in the program.

Initial enrollment costs have been higher than expected due to high morbidity of the population, particularly with the non-caretaker adult population. According to a report prepared by the actuary employed to evaluate the HIP program, Milliman Inc., the 2008 negotiated capitation rate per member per month was 30 to 50% higher than anticipated, depending on the enrollee.

PAYMENTS & POWER ACCOUNTS

POWER accounts are funded with member and State contributions and set to an annual maximum level equal to the deductible of $1,100. Employers may also make up to 50% of the member's required contribution to the POWER account. Thus far, employers with participants enrolled in HIP through Anthem have contributed $60,942. Employers with participants enrolled through MDwise have contributed $1,600.The State has indicated that MDwise has been encouraged to conduct more outreach with their enrollees' employers to raise the amount of the employer contributions.

No participant makes more than a 5% contribution to their POWER account. Contributions on a sliding scale are made as follows:

- 0-100% FPL: 2%
- 100-125% FPL: 3%
- 125-150% FPL: 4%
- 150-200% FPL: 4.5-5%

Caretaker adults in the 150-200% income bracket contribute 4.5%, while non-caretaker adults contribute 5%. The State contribution, then, is the difference between the member contribution and $1,100.

At the end of the first year, the initial data does not indicate that the POWER account contributions have a disparate impact on lower income Hoosiers. In fact, in the first year, only 638 HIP enrollees were removed from the program due to failure to pay the POWER account contribution. However, there were 4,050 applicants who were determined eligible for HIP but never were enrolled due to failure to make their initial POWER account payment. This may suggest that these individuals were unable to make the contribution required of them to participate in HIP.

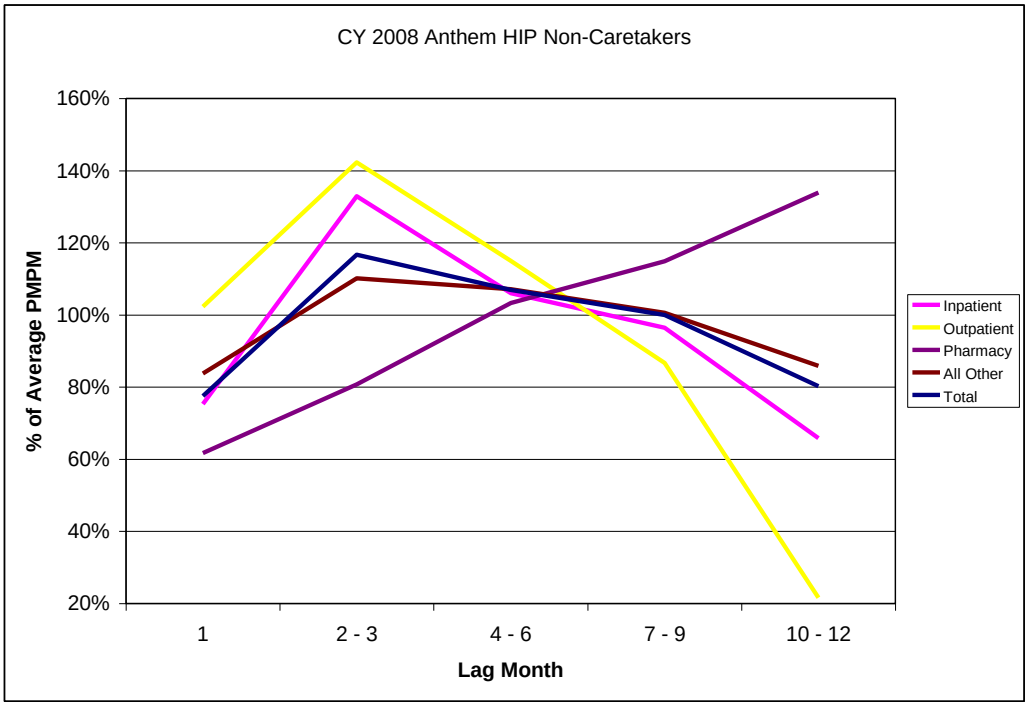
Surprisingly, nearly one-third of all HIP members had no contribution requirement at all. A participant's required contribution is adjusted to account for contributions to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). In some circumstances, these contributions were significant enough that the State paid the entire POWER account contribution. As of September 30, 2009, 29% of fully eligible enrollees, or 13,345 participants, were not making contributions to their POWER account.

At the time of the publication of this report, there is no data to report on POWER account rollovers for HIP enrollees who have engaged in all appropriate preventive services as required by their health plan.

HEALTH OUTCOMES

Initial data indicates that the HIP population has significant health issues at the time of enrollment. A low-income population that has been without health insurance for at least six months often has untreated illnesses that are advanced and complicated to treat. The chart on the following page demonstrates non-caretaker utilization during the initial enrollment period. The figure shows measurements of inpatient, outpatient, pharmacy and physician services relative to average per member, per month (PMPM) costs. The 100% line measures the average PMPM for a commercial population during the first year of coverage for the population represented. Though not shown below, the pattern for caretaker utilization is similar to that of the non-caretaker.

As indicated below, HIP enrollees did not receive much care during the first month of enrollment. For all services except for outpatient hospital services, the PMPM cost levels are below the first-year average. The high use of outpatient hospital services is most likely due to emergency room utilization. During months two and three, HIP enrollees tended to access a high number of inpatient (IP) and outpatient (OP) services. However, once in HIP for a period of time, utilization of inpatient and outpatient medical services dropped as members began to manage their conditions with prescription medications. Additionally, many HIP enrollees initially may have multiple health issues accumulated during a period of time during which they were uninsured. This would also explain the initial surge of accessing inpatient and outpatient services once enrolled in HIP.



Data provided by Milliman, Inc.

While utilization has been higher than expected, no member reached the annual limit of $300,000 and only one member reached $200,000.

Traditional Medicaid members typically have high emergency room utilization, where they can obtain services at any time for no cost to them. In order to create an incentive for participants to receive care in a less costly doctor's office, HIP assesses members a $25 co-payment for non-emergency use of hospital emergency room services. HIP emergency room utilization after the first year was 772 visits per 1,000, notably lower than the Hoosier Healthwise Medicaid program which was 844 visits per 1,000. However, emergency room use is still high.

REDETERMINATIONS

As of September 30, 2009, 26,357 HIP enrollees had reached the 12 month benchmark at which they are required to complete a redetermination to prove continued eligibility. Eighty percent of these individuals have submitted their redetermination in a timely manner. Of these individuals, 74.7% were eligible for continued HIP benefits and 25.3% were deemed ineligible.

OUTREACH

Upon the implementation of HIP, the FSSA contracted with Tomatofish to develop a marketing strategy. Governor Mitch Daniels participated in a television ad announcing HIP during the weeks prior to the opening of the program and co-sponsors of the legislation, Representative Charlie Brown and Senator Patricia Miller, participated in a radio ad. FSSA has also collaborated with a number of local organizations to conduct outreach throughout the State.

At the end of the first year of HIP, the administration was aware of the low minority enrollment in the program. FSSA and SR Advise (formerly a partner at Tomatofish) subcontracted with a minority marketing expert, Vernon Williams, to conduct a grassroots outreach effort aimed at increasing minority enrollment from 7% to 12%. Through radio and billboard advertisements, as well as partnership with community agencies and organizations, the administration not only achieved, but exceeded, the 12% goal. Minority enrollment continues to hover around 13%.

Additionally, Anthem and MDwise have active marketing programs and conduct comprehensive member outreach. Each plan has developed unique member programs. Anthem implemented incentive programs that were available at the onset of the program, as well as a web portal, “My Anthem,” for members in July 2008. Anthem’s incentives included a $50 gift card for completing tobacco cessation counseling or a weight management program, and a $100 gift card for enrolling in a health coach program, and a $100 gift card for completing the health coach program.

MDwise launched two incentive programs in August 2008. The first was a program to reward MDwise members for taking the time to do a Health Needs Assessment. If they completed the assessment in their first 20 days fully enrolled, they received a $50 gift certificate. The second MDwise incentive gave members a gift certificate if they have a primary care physician visit within the first ninety days of being a member.

CONCLUSIONS AND RECOMMENDATIONS

1. REDUCE EMERGENCY ROOM UTILIZATION

Emergency room utilization still remains high. It is the recommendation of the ICUP task force that the administration undertake several strategies to reduce emergency room utilization. These strategies might include: researching emergency room utilization rates on a geographical and demographic basis in order to target outreach for that population; re-examining Welcome Packets from both Anthem and MDwise in order to better educate new members on healthcare options; and encouraging stronger care management from the health plans.

2. CHIROPRACTIC BENEFIT

During the 2009 legislative session, several attempts were made to include chiropractic services in HIP. While the taskforce recognizes the benefits of chiropractic services, we recommend that the Indiana General Assembly choose not to mandate chiropractic services be included in HIP. As we stated in a June 15, 2009 letter to the Indiana General Assembly, HIP was designed to provide health insurance coverage for chronically uninsured Hoosiers. HIP is not an entitlement program and the limited funding directly determines the number of Hoosiers that may be covered under the plan. The original intent of the legislation was to provide only basic services in order to maximize funds available for providing essential health care services to the greatest number of uninsured Hoosiers. The current HIP benefits package does provide coverage for physical therapy services and does not limit the type of provider that can provide these services. Additionally, the current HIP plans may contract with chiropractors to provide covered benefits. We emphasize that the addition of chiropractic services would cost the program approximately $2.5 million annually, resulting in 2,400 fewer insured Hoosiers.

Additionally, the legislation originally intended for dental and vision services to be covered. However, the Centers for Medicare and Medicaid Services (CMS) did not permit this in the administration's waiver request. It is the opinion of the ICUP task force that the legislature consider adding dental and vision coverage before considering the expansion of services offered by chiropractors.

3. SURVEY

It is the recommendation of the ICUP task force that FSSA survey HIP participants seeking information on their experience with the plan. From this information, the administration can enhance program features based upon participant feedback.

4. FUTURE FUNDING FOR HIP

Several attempts were made during the 2009 legislative session to use cigarette tax funds allocated to HIP to finance other programs. Though there is currently a large balance in the fund, these monies will be necessary to fund the program throughout the coming years. The ICUP task force strongly recommends that the Indiana General Assembly protect the funds allocated and collected from the cigarette tax to fund HIP to ensure eligible Hoosiers will be able to continue to enroll and receive services in this program.

5. MINIMUM CONTRIBUTIONS

The original intent of the legislation was that HIP encourage value based decisions. Therefore, the ICUP task force believes that requiring a monthly contribution, of at least five dollars, to a health care savings account is a key step to assuming personal responsibility. During the 2009 legislative session, Senate Bill 472 contained language to reform the POWER account payments such that no members would have a zero contribution. It is the recommendation of the ICUP task force that the Indiana General Assembly consider making this change to the original HIP legislation.

Additionally, SB472 contained language to allow non-for-profit groups to contribute up to 50% of the POWER account payment in the same manner as an employer. The ICUP task force recommends that the General Assembly consider amending the language of the original HIP legislation in order to allow not-for-profit groups to participate in the program through POWER account contributions.

6. POWER ACCOUNT ROLLOVERS

Since no data was available at the time of this report's publication regarding POWER account rollovers, the ICUP task force recommends that FSSA evaluate POWER account rollovers once sufficient data is available.

7. PROVIDER ACCESS

The ICUP task force believes there is still a lack of awareness of HIP amongst providers and perhaps an unwillingness for some providers to supply services to HIP patients. This issue is greatest amongst specialists. The ICUP task force recommends that FSSA study the demographics of hospital and provider participation and encourage Anthem and MDwise to conduct additional outreach and education for providers, especially specialists.

8. COVERAGE FOR NON-CARETAKER ADULTS

Due to the budget neutrality requirement by CMS, the State is unable to cover more than 34,000 non-caretaker adults. Because there are already 25,000

individuals on the wait list, the ICUP task force recommends that FSSA continue to study and make recommendations to expand coverage to more non-caretaker adults. Additionally, the ICUP task force recommends that FSSA request that CMS raise the 34,000 cap on non-caretaker adults.

9. PREMIUM ASSISTANCE

The ICUP task force recommends that FSSA evaluate the option of establishing a health insurance coverage premium assistance program authorized by IC 12-15-44-20 for individuals under 200% FPL who are eligible for health insurance coverage through an employer but cannot afford the premiums.

10. ICUP TASK FORCE RENEWAL

According to House Enrolled Act 1678, the ICUP task force will expire on December 31, 2009. The ICUP task force recommends that the Indiana General Assembly consider amending the language in the bill to extend the task force until December 31, 2011.