



The Healthy Indiana Plan (HIP) is a consumer-driven health care plan for uninsured Hoosiers between the ages of 19 and 64. Five years of administrative and survey data indicate many successes and lend support to the effectiveness of the HIP program design.

Appropriate Healthcare Utilization

- Unlike traditional Medicaid, HIP decreases inappropriate emergency room (ER) usage. HIP enrollees must make co-payments for non-emergent ER visits. In 2012, only 31% of HIP members visited the ER, as opposed to 38% of adult Hoosier Healthwise members (low-income parents and pregnant women). The required co-payment appears to effectively deter inappropriate ER usage—a 2013 Mathematic Policy Research survey showed that 5% of HIP beneficiaries decided to seek care at an urgent care center or their regular doctor instead of the emergency room because of the co-payment.
- HIP members use preventive care at high rates similar to those with commercial insurance. Between 2010 and 2012, claims data showed that preventive service utilization rates across the entire HIP population ranged from 56% to 60%.
- HIP's design creates an incentive for members required to make POWER account contributions to receive preventive care. If members receive at least one recommended preventive care service, they receive a full rollover of all remaining POWER account funds including those contributed by the State, effectively reducing the amount of their required contributions for the next benefit year. In 2012, 61% of HIP members who were required to make POWER account contributions received at least one recommended preventive service; while only 53% of non-contributors received preventive care.
- HIP members are much more likely to utilize generic drugs when available. HIP member utilization of generic drugs has historically been around 80% compared to 65% generic drug utilization in comparable commercial populations.

Personal Responsibility

- The proportion of individuals determined eligible for HIP making the first required monthly contribution to the POWER account has grown each year of the program. In 2008, 89% of applicants determined eligible made their first required monthly contribution and became full members; and in 2012, 94% completed this process.
- Once enrolled, most members (93% in 2012) continue to make their required POWER account contributions on time.

Program Satisfaction

- A 2013 Mathematica Policy Research survey found that approximately 96% of HIP members were either somewhat or very satisfied with their overall experience with HIP.
- The majority of HIP members (83%) reported that they preferred paying a fixed monthly amount up front with the opportunity to have unspent funds returned (making a POWER account contribution) instead of making a payment each time they visited a health professional, pharmacy, or hospital.
- In this survey, 82% of current enrollees not required to contribute to their POWER account indicated that they would be willing to pay \$5 per month for HIP coverage and 75% indicated they would be willing to pay \$10 per month to remain enrolled.
- Similarly, over 93% of current HIP members required to contribute to their POWER account stated they would be willing to pay an additional \$5 per month to retain HIP coverage and 88% were willing to pay an additional \$10 per month for coverage.
- The survey also indicated that 76% of members felt their contribution was the right amount and 9% of members felt that their contribution was, in fact, too low.