Healthy Indiana Plan (HIP)

"How HIP works"

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HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

www.hip.in.gov
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HIP's Origins: The Problem

When HIP was created:

- Indiana ranked poorly among the other states
  - Smoking- 5th highest
  - Obesity- 10th highest
- Since 1990, the uninsured population in Indiana had increased by 30%
- 67% of Indiana's uninsured were below 200% FPL
- Indiana's Medicaid coverage level for non-disabled adults ranked 47th in the nation (22% FPL)
  - No awareness of cost or incentive to consider costs
  - No incentive for healthy lifestyles

Healthy Indiana Plan: Guiding Principles

- **Personal Responsibility**
- **Fiscal Responsibility for the State**
- **Promote Healthy Behaviors**
- **Promote Appropriate Use of Health Care Services**
- **Promote consumerism and consumer directed principles**

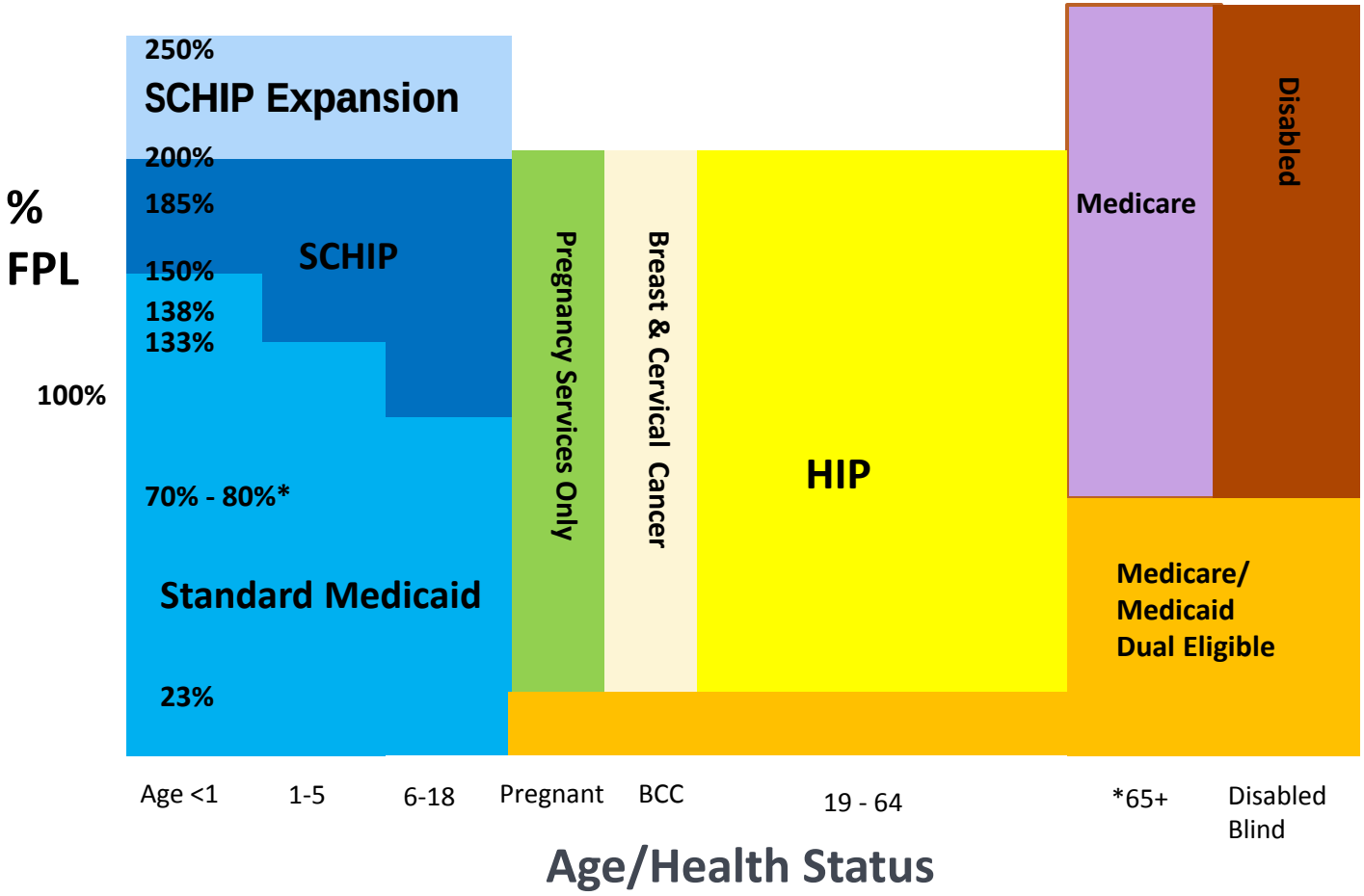
HIP Authority & Financing

- Legislation: 2007 Indiana Legislative Session
  - Passed by bipartisan majority
  - Signed into law by Governor Mitch Daniels
  - Not an entitlement program
- Financing
  - Increased cigarette tax
  - Cigarette Trust fund
    - 8 months to accrue revenue before program began
    - Statutorily protected
- CMS 1115 Waiver
  - 5 year demonstration waiver (2008-2012)
  - Requires budget neutrality
    - Diverted DSH, trend rates on managed care
  - Cap on childless adult enrollment at 36,000

Eligibility Requirements

- Uninsured, non-disabled adults 19-64
- Under 200% federal poverty level (FPL)
- No access to employer-sponsored insurance
- Uninsured for six months

Creation of program: where did HIP fit in?



FPL is recalibrated annually and dependent on household size. In 2012, the FPL (100%) for a family of four is $23,050 of annual income.

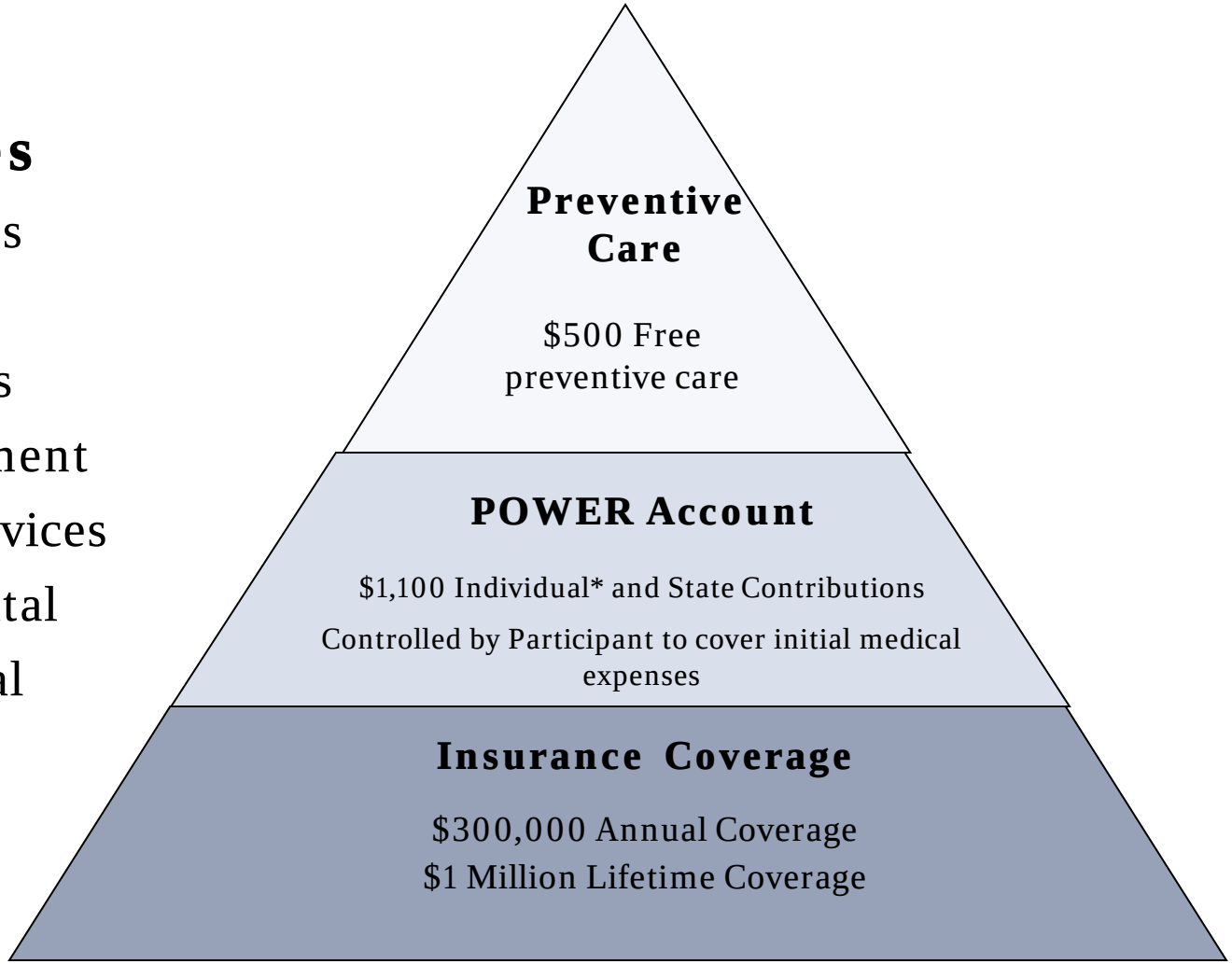
HIP Enrollment

- Current enrollment: 41,633
- 2009: Waiting list created for childless adults
  - Current waiting list: 42,545
  - Two separate initiatives to bring individuals off the waiting list
- Served over 102,000 unique enrollees over the life of the program
- PPACA maintenance of effort: parental adults

How HIP Works

Covered Services

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



POWER Accounts

- State and participant contribute a combined total of $1,100 per adult into account for medical expenses
  - 2-5% of income contributed by the member
  - No member contributes more than 5% of family income
- First $1,100 of medical expenses covered by the POWER account
  - Exception: each year, $500 of preventive care is free
- 2011 plan year: Plans added a POWER account debit card

How are POWER Account contributions calculated?

Group	Members must contribute:
0-100% of FPL	**2%** of total household income
101%-125% of FPL	**3%** of total household income
126%-150% of FPL	**4%** of total household income
151%-200% of FPL caretakers	**4.5%** of total household income
151%-200% of FPL childless adults	**5%** of total household income

POWER Account "Roll Over"

- Unspent funds
  - If received all preventive care service requirements, the entire remaining balance of the POWER account rolls over to the following year reducing the following year's contribution
- Roll-over amount dependent on preventive services received
  - If all age, gender, and pre-existing condition appropriate preventive service goals are met, *all* account funds (state and individual) roll over to offset the following year's contribution
  - If not, only the individual's prorated contribution to the account rolls over
- 1st program year preventive care: physician office visit
- 2nd program year preventive care: age & gender specific
  - Annual physical
  - Mammogram
  - Pap Smear
  - Cholesterol Testing
  - Blood Glucose Screen
  - Tetanus-Diphtheria Screen

Additional Cost Sharing

- Co-pays for *non-emergent* utilization of the ER
  - Plans responsible for reviewing claims to determine emergent v. non-emergent utilization of ER
- No other co-pays for HIP members

Who	Amount of ER co-pay
Parents, <100% FPL	$3
Parents, 100-150% FPL	$6
Parents, 150-200% FPL	$25 or 20% of total bill, whichever is less
All Childless Adults	$25 or 20% of total bill, whichever is less

Indiana's Implementation Timeline

- ☑November 2006- Governor Daniels announces plan
- ☑April 2007- General Assembly passes HEA 1678
- ☑May 2007- Submit RFP for Health Plans
  - Five health plans submit proposals
- ☑June 2007- Begin Regular Waiver Negotiations with CMS and OMB
- ☑August 2007- Health Plans Selected
  - Anthem Blue Cross Blue Shield
  - MDwise and United Healthcare were asked to come together to offer HIP (Subcontracting relationship)
  - Enhanced Services Plan- ICHIA

Implementation Timeline

- ☑ September 2007- Conceptual Agreement with CMS
- ☑ November 2007- Contract signed with health plans
- ☑ December 14, 2007- Official Waiver Approval
  - Funding for 130,000
  - Limits on Childless Adults
  - Eligibility Begins at Age 19 not 18
  - No Dental or Vision Coverage
  - No Plan Involvement in Enrollment
  - Must Allow Legal Aliens to Participate
  - Moved Contribution for 150-200% from 5% to 4.5% for parents

Although, the waiver process made some small changes, the basic structure for HIP including benefit package and POWER Account remained unchanged

1115 Waiver Requests

- Vary administration of services within HIP managed care plans
- Allow State the freedom of choice of providers
- 12 month prohibition on re-enrollment
- Limits on non-emergent transportation
- Restriction on enrollment until first POWER account contribution made
- Ability to vary benefits from those offered to categorically needy group
- Exclude POWER account funds from income and resource tests
- Offer only one choice of plan for individuals with certain high-risk conditions
- Retroactivity
- Prepayment review waiver
- POWER Account contributions
- Dental and vision
- Limit enrollment to funds available in cigarette tax fund

1115 Waiver Status

- Applied for a waiver renewal in December 2011
- CMS Response:
  - 1- year extension of HIP
  - No minimum contribution ($160 per yr.)
  - Not-for-profits POWER account contributions allowed
  - Open Issues:
    - No response on using HIP for a potential Medicaid expansion
    - Future of HIP w/out Medicaid expansion
    - No answer on DSH restoration request
    - Plan contributions to POWER account
- HIP outcome is important to all states
  - Enrollment based on budget
  - Requires contributions
  - 12 month penalty for failure to make contributions

HIP Health Plans

- 3 plan carriers:
  - Anthem
  - MDwise
  - Managed Health Services (added in 2011)
- 2011 plan year: HIP managed care contracts combined with managed care contracts for pregnant women, children and low-income families
  - Better care coordination for Indiana enrollees

Enhanced Services Plan (ESP)

- HIP application screen for complex medical conditions
  - Has *NO* bearing on eligibility
- Individuals will be assigned to the ESP vendor- Indiana Comprehensive Health Association (ICHIA)
  - May be transferred from ESP to a health plan at redetermination, if claims history does not verify need for ESP
- ESP will provide:
  - Comprehensive disease management services
  - Access to special networks and providers to meet individual needs

ESP (cont'd)

- Cost of care required State to identify ways to reduce risk of health plans
- 2009 – altered enrollment process for ESP and increased the list of qualifying conditions
  - Additional qualifying conditions include:
    - Tay Sach's Disease, Nieman Pick Disease, and Fabry's Disease; Primary Immune Deficiencies, including DiGeorge Syndrome, Combined Immune Deficiency, Wiskott Aldrich Syndrome, and T cell deficiency; Muscular Dystrophy; Primary Pulmonary Hypertension; Amyotrophic Lateral Sclerosis; Cirrhosis; Chronic Hepatitis B; Hepatitis C; Cystic Fibrosis; Diabetes with Ketoacidotic coma, Hyperosmolar coma, Renal Complications, Retinopathy, peripheral vascular complications, or Coronary Artery Disease; ESRD/Renal Failure; CMV Retinitis; Tuberculosis; and Paraplegia/Quadriplegia.
- Plans have 6 months after application to refer a member to ESP, using an underwriting software developed by the State's actuary
- Current ESP enrollment: approx 1,500

HIP Demographics

Enrollment by Age (2008-2011)	< 20	68
	20-29	16,683
	30-39	26,151
	40-49	24,423
	50-59	16,728
	60+	6,440

Enrollment by Sex (2008-2011)	Female	58,652
	Male	31,841

Enrollment by Race (2008-2011)	Asian	1,360
	Black	11,138
	Hispanic	3,089
	Indian	64
	Other	1,458
	White	73,384

Preliminary HIP Experience: DY 3 CMS Report

- Increased use of preventive care:
  - If member completes preventative services, entire remaining POWER account balance rolls over to offset future contributions
  - 80% of HIP enrollees complete the preventive services required for the POWER account rollover
    - Less than half of these members had a balance left in their account to be rolled over (high rate of chronic conditions)
- POWER Account utilization
  - 79% were required to contribute to their POWER account
  - Over 90% of enrollees make their POWER Account contributions

Preliminary HIP Experience: 2010 Milliman Study

- Decreased inappropriate ER usage:
  - Data shows ER use declines with longer enrollment in HIP
  - Differences in patterns between contributors and zero contributors
    - Contributors: 9% decrease in ER utilization in first three months of enrollment and 15% in first 6 months
    - Zero contributors: 5% decrease in ER utilization after first 3 months and no additional declines

	Utilization Rate per 1,000 (2010)	
Population	ER Visits	% Avoidable
HHW – Adults	1,343.5	54%
HIP – Caretakers	719.8	48%
HIP – Non-Caretakers	994.3	43%
Commercial (Adult only) (1)	205.7	40% - 50%
Commercial (Adult only) (2)	194.1	40% - 50%
Ohio Medicaid - Adults	1,230.2	45% - 50%

Source: Milliman, Inc. 2010

2010 HIP Mathematica Survey

- Before enrolling in HIP, 90% of members surveyed reported the cost of care and lack of insurance caused them to forego care
- 95% surveyed knew their POWER account contribution amount, and 60% of members knew the balance in their account
  - 45% reported checking their account at least monthly
  - 70% reported the POWER account contribute was just right, and only 8% said it was too high
- 90% of established members reported having a PMP within the last six months
- 94% of member said they were satisfied and 99% indicated they would re-enroll
- 80% of HIP enrollees indicated they needed dental care