ISSUE BRIEF

MATHEMATICA Policy Research

TIMELY INFORMATION FROM MATHEMATICA

Improving public well-being by conducting high quality, objective research and surveys

JANUARY 2011
NUMBER 1

INDIANA HEALTH REFORM

Healthy Indiana Plan: Lessons for Health Reform

by Timothy K. Lake, Vivian L. H. Byrd, and Seema Verma

Starting in 2008, Indiana provided a new option for affordable health insurance coverage for low-income, working-age adults, known as the Healthy Indiana Plan. This issue brief describes the plan's innovative features, comparing it with similar efforts in other states. It also assesses early experience with enrollment and cost-sharing among participants. Findings provide useful insights to policymakers considering options for expanding coverage for low-income populations under the Affordable Care Act of 2010.

Expanding Health Coverage

The Healthy Indiana Plan (HIP) is an innovative effort to use a consumer-directed health care model to expand health insurance coverage for working-age adults in Indiana who currently lack coverage.[1] The Centers for Medicare & Medicaid Services (CMS) granted Indiana an 1115 Medicaid Research and Demonstration waiver to implement HIP as a Medicaid expansion. Adults are eligible to apply for HIP coverage if they earn less than 200 percent of the federal poverty level (FPL) (approximately $21,660 per year for an individual or $44,000 per year for a family of four), do not qualify for employer-sponsored insurance, and have been uninsured for six months or more. Currently, parents or guardians of children (caretakers) can enroll in HIP. Enrollment for adults without children (non-caretakers) is capped at 36,500 as of the date of this report. In addition to improving statewide access to health care for low-income Hoosiers, HIP is designed to be a fiscally responsible program that promotes value-based decision making, personal responsibility, and illness prevention, and controls the progression of chronic conditions.

HIP's distinct design features and early implementation experience provide useful insights for policymakers seeking to implement health reforms enacted in the Affordable Care Act. HIP has successfully expanded coverage for the uninsured, while giving enrolled members an important financial stake in the cost of their health care and incentives for value-based decision making. Early implementation suggests that members value HIP benefits and that at least some low-income, uninsured adults are willing and able to contribute toward the cost of their care.

Distinct Features of HIP

According to the Kaiser Commission on Medicaid and the Uninsured, 20 states expanded coverage for low-income, uninsured adults before the Affordable Care Act passed in March 2010.[2] Of these states, six—including Indiana—require member cost-sharing (see Table 1). However, HIP is unique in setting a high deductible ($1,100) coupled with a feature similar to a health savings account, called a Personal Wellness and Responsibility account (or POWER account). The POWER account is intended to provide members with incentives to manage their care, including obtaining appropriate preventive care services. Indiana chose to use a deductible and the POWER account rather than small copayments charged at the point of service, partly because of its earlier experience, which indicated that providers frequently do not collect small copayments. In addition, the evidence available to the state suggested that small copayments do not influence utilization patterns.

The POWER Account. Participants fund the $1,100 deductible, either in full or in part, through monthly contributions they make to their POWER accounts. Monthly contribution amounts are assessed on a sliding

HIP
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

Office of Medicaid Policy & Planning

TABLE 1

STATE EXPANSION PROGRAMS FOR WORKING-AGE ADULTS THAT HAVE COST-SHARING REQUIREMENTS

Program Name	Eligibility Ceiling	Premiums or Monthly Contributions	Copayments	Other Cost-Sharing	Preventive Service Requirement?
Healthy Indiana Plan	200% FPL	Monthly contributions (from $0 to $92 per month) to POWER account based on income, offset by any contributions to CHIP	ER: $3 to $25 for caretakers, depending on income, $25 for non-caretakers[a]	$1,100 deductible, drawn from POWER account	Yes, to roll over POWER account funds to the next year
MinnesotaCare Basic Plus, Basic Plus One, Basic Plus Two	Basic Plus: > 215% to ≤ 275% FPL Basic Plus One: ≤ 250% FPL Basic Plus Two: ≤ 215% FPL[b]	Monthly premium based on income and family size; range: $4 to $499	Medical services: $3 to $25 ER: $6[c]	NA	No
Pennsylvania adultBasic	200% FPL	Monthly premium: $36	Medical services: $10 or $20, depending on the service ER: $50	Co-insurance for most services; $1,000 annual out-of-pocket maximum	No
Vermont Health Access Program	160% FPL	Monthly premium based on income for members above 50% FPL	ER: $25 Rx: $1 or $2, depending on medication	No	No
Washington Basic Health Plan	200% FPL	Monthly premium based on income, family size, and age	Office visits: $15 ER: $100 Rx: $10 Many other services: 20% co-insurance	$250 deductible and 20% co-insurance for many services; $1,500 annual out-of-pocket maximum	No
Wisconsin BadgerCare Plus, Plus Core Plan	200% FPL	None	Most services: $0.50 to $3 for caretakers; $0.50 to $15 for non-caretakers; ER: $3 when income ≤ 100% FPL;[d] $60 when income > 100% FPL	$60 enrollment fee	Yes, physical examination in the first year

Sources: Mathematica review of Minnesota Department of Human Services, "MinnesotaCare Benefit Sets. Effective 1/1/10." Accessed at http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_143938.pdf. Pennsylvania Insurance Department, adultBasic home page accessed at http://www.portal.state.pa.us/protal/server.pt/community/health_insurance/9189/adultbasic/592645. Office of Vermont Health Access, "Health Care Programs Handbook." Accessed at http://www.ovha.vermont.gov/for-consumers/health-care-programs-r-2009.pdf. Washington Health Care Authority, "Washington Basic Health – Benefits and Services." Accessed at http://www.basichealth.hca.wa.gov/benefits/html. Wisconsin Department of Health Services, "Core Plan – Health Care for Adults with No Dependent Children." Accessed at http://www.dhs.wisconsin.gov/badercareplus/core/coveredservices.htm. "BadgerCare+ Covered Services and Co-payments – Standard Plan." Accessed at http://www.dhs.wisconsin.gove/badgercareplus/standard.htm.

Note: Expansion programs for adults in Indiana, Vermont, and Wisconsin, and for caretakers in Minnesota have been authorized by an 1115 Medicaid Research and Demonstration waiver and utilize federal funding. Programs in Pennsylvania and Washington, and Minnesota's program for non-caretaker adults are state programs utilizing state-only dollars. Washington is currently applying for an 1115 Medicaid Research and Demonstration waiver for its Basic Health Plan.

[a]Caretaker adults visiting the ER are charged a copayment ranging between $3 and $25, depending on income. If the visit is deemed an emergency and/or the adult is admitted to the hospital the same day, that fee is either waived or returned to the individual. Non-caretakers are charged $25 for each ER visit, unless admitted to the hospital the same day.
[b]Minnesota Basic Plus and Basic Plus Two programs are for caretaker adults. MinnesotaCare Basic Plus One is for non-caretaker adults.
[c]If the individual is admitted to the hospital, the ER copayment is waived and the fee converts to the daily copayment for inpatient stays.
[d]If the visit is deemed an emergency, the copayment is waived.

scale based on a percentage of household income, with no participant contributing more than $1,100 or 5 percent of his or her income net of any contributions paid to other programs, such as Indiana's Children's Health Insurance Program (CHIP).[3] Members who fully fund their POWER accounts contribute approximately $92 a month to them. If a member pays less than $1,100 into his or her POWER account during the year, the state pays the balance to ensure the account is fully funded. The full $1,100 is available to the member after he or she makes the first monthly contribution. Ongoing monthly contributions allow the member to spread the cost of the deductible over the year, regardless of when the costs of services are incurred—an important feature for many low-income adults.

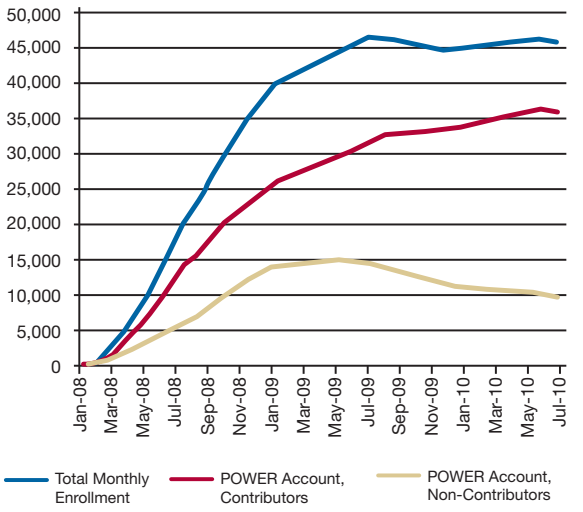
Incentives for Preventive Care. Members roll over to the next year any unspent contributions they made to their POWER accounts, reducing their contributions in the following year. However, to roll over unspent funds contributed by the state, members must have received age- and gender-appropriate preventive services, as specified by HIP.[4] HIP also provides first-dollar coverage for preventive services, so members do not need to draw down their POWER account funds to pay for them. Participating health plans have the option of capping covered preventive service use at $500 annually (and participants would use their POWER account funds for preventive care above that amount). One of the two plans serving HIP members began imposing this limit in July 2010. HIP's emphasis on incentives for using preventive services is unique among expansion states with member cost-sharing.

Incentives for Appropriate Emergency Room (ER) Use. HIP also uses an ER copayment to create incentives for members to seek routine care in appropriate settings, such as clinics or physicians' offices, and to reserve the ER for emergency care only. The state implemented this design feature to address concerns about high rates of ER utilization among Medicaid recipients in Indiana, similar to what is seen nationally.[5] Like the other six states with pre-Affordable Care Act coverage expansions for working-age adults, HIP charges a copayment for ER visits but, unlike the other programs, HIP does not charge copayments for any other type of medical service. All HIP participants must make a copayment when they visit an ER for routine or nonemergency services, and these copayments are the only "out-of-pocket" expense besides monthly POWER account contributions that a HIP participant incurs.[6,7] For caretakers visiting the ER, the copayment amount is $3 to $25, depending on their income. For non-caretakers, the copayment is $25, regardless of income. At $25, HIP copayment for ER services is relatively high compared with what regular Medicaid programs typically charge. However, some state expansion programs that rely only on state funding and are not subject to federal regulations have higher ER copayments. For example, Wisconsin's program charges $60 per visit for adults and Washington's state-funded program charges $100 per visit.

Early Experience

Strong Enrollment Growth and Retention. Steady enrollment growth since the inception of HIP indicates that many low-income, uninsured Indiana residents are willing to contribute toward the cost of their health care (see Figure 1). As of July 31, 2010, 45,657 adults (including 27,373 caretakers and 18,284 non-caretakers) were participating in HIP, with 51,211 on the non-caretaker waiting list.[8] During HIP's first two years (2008 and 2009), more than 61,000 adults were enrolled at some point. Caretakers have made up approximately 60 percent of all enrollees and the other 40 percent have been non-caretakers. Overall, caretakers have been younger: approximately 60 percent were in their 20s and 30s, compared with non-caretakers, of

Figure 1. Monthly HIP Enrollment, Overall and by POWER Account Cost Contribution Status, January 2008–July 2010



Source: State of Indiana, OMPP HIP Dashboard, 2008–2010.

whom nearly 70 percent were 40 or older. In addition, retention rates have been high. Only about 26 percent of all members ever enrolled in HIP in 2008 and 2009 later left the program—a retention rate much higher than the rate for adults in Indiana's regular Medicaid managed care program, known as Hoosier Healthwise.[9] At the time of this issue brief, retention rates in the other five states were not readily available.

Contributions to Costs of Care. Of the roughly 68,000 Hoosiers who applied and were found eligible for HIP through the end of 2009, more than 90 percent were able and chose to make the first monthly contribution necessary to enroll in HIP.[10] Of all members who enrolled at some point during the first two years, only about 3 percent left HIP because they failed to pay their monthly contributions. While overall enrollment in the program grew, so did the percentage of participants who contributed to their POWER accounts. In the second month of the program, February 2008, 52 percent of members were contributors. That figure grew steadily, with 65 percent contributing in January 2009. Of all members enrolled as of July 2010, nearly 79 percent contributed to their POWER accounts; among those with incomes above 100 percent of the FPL nearly all (99 percent) were making contributions (see Table 2). Of those not contributing to their POWER accounts, approximately 13 percent were caretakers who either had no income or were already contributing at least 5 percent of family income to the costs of coverage for their children, through CHIP. The other 87 percent were non-caretakers who had no income.[11]

Lessons for Health Reform

Indiana's HIP is an innovative approach to expanding coverage to low-income adults who would otherwise be uninsured. Although other states also use cost-sharing in coverage expansion programs, only HIP uses a tool similar to health savings accounts to help finance the plan's deductible. Because members finance some or all of their accounts (and therefore, deductibles) throughout their enrollment, they should be more cost-conscious consumers. If members are in fact cost-conscious, which is as yet unknown, this program feature might prove effective as states seek ways to expand care while containing costs, of significant concern to policymakers interested in cost-effective expansions of coverage.

HIP enrollment to date suggests that some uninsured, low-income adults are willing to make relatively substantial financial contributions to their health care. As noted above, after two years of program operations, HIP had served more than 61,000 adults who would have been uninsured otherwise. Estimates based on 2008 American Community Survey data indicate that approximately 16 percent of Indiana residents who were likely eligible for the HIP in 2008 had enrolled in the program by the end of 2009.[12]

TABLE 2

PERCENTAGE OF MEMBERS CONTRIBUTING TO A POWER ACCOUNT BY INCOME LEVEL

Income Level	Enrolled in July 2010	Percentage Contributing to POWER Account
Total	45,658	78.5
≤ 100% FPL	31,489	69.2
101–125% FPL	5,586	98.9
126–150% FPL	3,865	99.5
> 150% FPL	4,711	99.3

Source: State of Indiana. OMPP HIP Dashboard, July 31, 2010.

An array of factors determine program enrollment levels, including awareness of the program among eligible Hoosiers, perceived need for health insurance coverage, and willingness and ability to meet the program's cost-sharing requirements. HIP must also be a fiscally responsible program at both the federal and state levels. At the federal level, the program must be budget neutral.[13] To achieve this requirement, the Special Terms and Conditions of the 1115 demonstration waiver negotiated between the state and the federal government limit the enrollment of non-caretaker adults to 36,500 people.[14] In March 2009, Indiana closed enrollment to non-caretaker adults to ensure HIP did not exceed this condition. Enrollment was opened to the first 5,000 people on the waiting list in November 2009. Presumably, enrollment numbers would be even greater if HIP could enroll all non-caretakers who meet the program eligibility requirements.

At the state level, HIP must operate within the funding available to the program. The state elected to finance program costs with revenues from a cigarette tax.[15] These revenues necessarily constrain the number of Hoosiers who can be served. As a result, HIP was never intended to cover all residents eligible for the program. It is not known at this point whether healthier or sicker residents are more likely to enroll in HIP, but some evidence suggests that the program has so far been most popular among older residents,

who may be more likely to have chronic illnesses. Through the end of 2009, HIP had reached an estimated 9 percent of likely eligible adults ages 19 through 29, 18 percent ages 30 through 49, and 26 percent ages 50 through 64.[16]

The early experience of HIP provides some insight into what states might expect when they begin to implement the required expansion of their Medicaid programs. Older, uninsured adults might be some of the first to enroll when coverage is expanded to 133 percent of FPL. In addition to understanding who enrolls in a program such as HIP, states wishing to implement a similar set of incentives have to understand how the structure of the incentives affects utilization patterns. How do members understand their POWER accounts and the program's incentives? Do members respond to the effect of rolling over POWER account funds from one year to the next by using more preventive services? What effect does a sizable copayment for nonemergency care provided in the ER have on ER use? These and other questions will be explored in future issue briefs.

Notes

[1]Typically, consumer-directed health plans combine a high deductible with a health savings account or health reimbursement arrangement. Definition taken from "Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage." Government Accountability Office, April 2006.

[2]Kaiser Commission on Medicaid and the Uninsured. "Expanding Medicaid to Low-Income Childless Adults Under Health Reform: Key Lessons from State Experiences." July 2010.

[3]Participants pay the following percentages of their income, depending on their income level: at 0–100% FPL they pay 2%; at 101–125% FPL they pay 3%; at 126–150% FPL they pay 4%; at 151–200% FPL caretakers pay 4.5%, non-caretakers pay 5%. Information available at http://www.in.gov/fssa/files/HIP_FAQs.pdf.

[4]Examples of required preventive services include annual physicals, mammograms, and colorectal screenings.

[5]According to a recent article in the *Journal of the American Medical Association*, between 1997 and 2007 emergency department visits increased from 352.8 to 390.5 per 1,000 persons; adults with Medicaid accounted for most of the increase in emergency department visits. Tang, Ning, John Stein, Renee Y. Hsia, Judith H. Maselli, and Ralph Gonzales. "Trends and Characteristics of US Emergency Department Visits, 1997–2007." *Journal of the American Medical Association*, vol. 304, no. 6, 2010, pp. 664–670.

[6]For all adults, these fees are waived or returned if the adult is admitted to the hospital on the same day as the visit. Caretaker copayments are also waived if the member is found to have an emergency condition.

[7]State of Indiana. Request for Service #10-40, Attachment D, Contractor Scope of Work. Accessed at http://www.in.gov/idoa/proc/bids/rfs-10-40/40attd.pdf.

[8]Interest in enrollment by non-caretakers exceeded the original cap set by CMS of 34,000, leading to formation of a waiting list. Given the extensive demand, Indiana and CMS agreed to increase the non-caretaker cap to 36,500.

[9]Mathematica analysis of HIP eligibility records extracted from the MedInsight system on January 12, 2010.

[10]OMPP data request number 7257, June 2, 2010.

[11]Mathematica analysis of enrollment records from January 2008 through June 2009, conducted August 27, 2010.

[12]The analysis presented here used the 2008 American Community Survey to estimate, by state region, the size of the population likely eligible for the HIP program (uninsured, ages 19 to 64, and with income less than 200% of FPL if non-caretakers, or income of 22 to 200% of FPL if caretakers). This information was paired with HIP enrollment records for 2008–2009, which include county of residence, to assess the degree to which HIP has enrolled its target population in the first two years of program operations.

[13]All Medicaid 1115 demonstration and research waivers are required to be budget neutral for the federal government. That is, programs like HIP cannot cost the federal government more than it would have paid without the program.

[14]The limit set on the number of non-caretakers who could be enrolled in HIP at any given point in time was based on the projected impact of enrolling this subgroup of adults on the budget neutrality requirement.

[15]The cigarette tax was implemented on July 1, 2007. As of May 2010, the tax had generated approximately $343 million for HIP. Revenues from this tax are also used to fund tobacco prevention programs and the state's child vaccination program.

[16]Ibid. January 12, 2010.

For more information, contact Carol Irvin at (617) 301-8972, cirvin@mathematica-mpr.com.

ABOUT THE AUTHORS

Timothy K. Lake, a senior researcher at Mathematica, conducts research on costs, quality, and access to health care services in public and private sector programs. He holds a Ph.D. in health services research from the Johns Hopkins School of Public Health.

Vivian L. H. Byrd, a research analyst at Mathematica, conducts research related to Medicaid and state health coverage expansions. She has an M.P.P. from the Ford School of Public Policy at the University of Michigan.

Seema Verma, is the president of SVC, Inc., a health policy consulting company that focuses on government health programs. She has an M.P.H. from the Johns Hopkins School of Public Health.