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THE HENRY J. KAISER FAMILY FOUNDATION

June 2008

Summary of Healthy Indiana Plan: Key Facts and Issues

Why it is of Interest: On January 1, 2008, Indiana began enrolling adults in its new Healthy Indiana Plan. The plan is the first that allows a state to provide a benefit package modeled after a high-deductible plan and health savings account to a low-income population using Medicaid funds. The state is operating the plan under a federally-approved waiver, which allows it to waive specified federal Medicaid program requirements.

Who it Covers: The plan covers very poor and other low-income uninsured parents (22%-200% FPL or $3,872-$35,200 per year for a family of three in 2008) and other adults (0-200% FPL or $0-$20,800 per year for an individual in 2008) who do not have access to employer-based coverage, Medicare, or regular Medicaid. About 13,000 adults were enrolled as of June 2008. Enrollees tend to be poor (69%), women (65%), age 40 or older (58%), and without dependent children (59%). Enrollment for adults without dependent children currently is capped at 34,000 enrollees; the state estimates it will eventually enroll 86,000 parents.

What it Covers: The benefits include three components provided through managed care plans:

- High-deductible coverage: After meeting a $1,100 deductible, individuals are covered for state-specified benefits up to a $300,000 annual cap and a $1 million lifetime cap.
- POWER Account: This account is used to cover the $1,100 deductible. It is funded by the enrollee (and sometimes an employer), state, and federal government and administered by the enrollee's managed care plan.
- Preventive care: Individuals are covered for preventive care that is not subject to the deductible and does not draw from the POWER Account.

What Enrollees Pay: To obtain and maintain coverage, enrollees must make monthly POWER Account payments, which are scaled by family income and range from 2%-5% of income. The state (along with federal match funds) pays for the gap between enrollees' payments and the $1,100 deductible for the POWER Account. If an enrollee misses a monthly payment, the individual loses coverage, forfeits 25% of his or her POWER Account contributions, and is barred from re-enrolling for 12 months. By obtaining state-specified preventive care, enrollees can carry over state POWER Account contributions to the next year, which helps offset required enrollee payments.

How the Plan is Financed: As a Medicaid waiver program, the plan must be budget neutral to the federal government. The state plans to offset the coverage expansion costs by using a portion of their Disproportionate Share Hospital funds and achieving savings in its existing Medicaid coverage for pregnant women, children, and parents. To assure budget neutrality, the federal government established a per capita cap on federal funds for Healthy Indiana Plan expansion enrollees as well as pregnant women, children, and parents covered through Medicaid. Beyond the savings needed for budget neutrality, the state also has agreed to achieve further savings of $15 million (state and federal) over the five-year waiver period.

Key Issues to Consider: Based on current state estimates, the plan could potentially expand coverage to 120,000 previously uninsured adults; over time, key issues to consider include:

- The affordability and adequacy of the coverage;
- Enrollees' understanding of the coverage;
- The plan's ability to promote personal responsibility, cost transparency, and preventive care;
- The cost-effectiveness of the plan; and
- The impacts on already-eligible Medicaid beneficiaries.

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In December 2007, Indiana received federal approval for a Medicaid waiver to implement the Healthy Indiana Plan. Under the plan, Indiana is using Medicaid funds to provide a benefit package modeled after a high-deductible health plan and health savings account to previously uninsured very poor and low-income adults. Most enrollees are covered through managed care plans; those with certain high-risk medical conditions are covered through a separate fee-for-service plan. The waiver was approved for five years, from January 1, 2008-December 31, 2012. The state began enrolling people on January 1, 2008.

Why the Plan is of Interest

The Healthy Indiana Plan is the first that allows a state to provide a benefit package modeled after a high-deductible plan and health savings account to a low-income population using Medicaid funds. It is also the first plan approved under the President's Affordable Choices initiative, which permits states to divert federal funds being used to support hospital care for the uninsured to instead help uninsured people purchase basic private coverage.

The Administration noted that it is allowing the state to implement the plan to "test a model of health coverage that emphasizes private health insurance, personal responsibility, and 'ownership' of health care."[1] The state's goals are to expand coverage (while maintaining access for current enrollees), encourage prevention and personal responsibility, and increase cost transparency and quality by making individuals aware of the cost of health care services.[2]

Eligibility and Enrollment in the Healthy Indiana Plan

Coverage under the plan is available to adults age 19-64 who have been uninsured for at least six months, are not eligible for any employer-sponsored coverage, are not eligible for Medicare or regular Medicaid, and whose family incomes fall within the following ranges:

- Parents with dependent children (including caretaker relatives) 22%-200% FPL ($3,872-$35,200 per year for a family of three in 2008)[3]
- Other adults 0-200% FPL ($0-$20,800 per year for an individual in 2008).

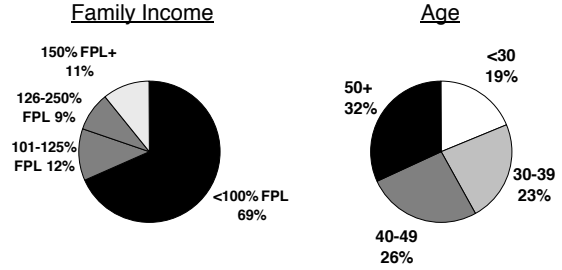
Parent enrollment is not subject to a cap, but the state may lower the income eligibility limit to restrict enrollment levels. The state estimates it will enroll approximately 86,000 parents by the end of the five-year demonstration period. Enrollment of other adults is subject to a cap of 34,000 enrollees.

The state began enrolling adults in the plan in January 2008. Initial response to the plan was much higher than state officials had anticipated. As of June 2008, over 53,000 adults had applied.[4] However, 40% of applications were denied. Analysis of state data on denials as of March 2008 found that about half were related to having or having access to other coverage. A person is ineligible if they have access to any employer-sponsored coverage, regardless of the premium costs for the coverage. About a third (32%) of denials were due to lack of information needed to establish eligibility or income; 13% were due to exceeding income limits; and the remaining 5% were due to other reasons.[5]

As of June 2008, 12,986 adults were fully enrolled in the plan and 7,178 were approved with enrollment pending their first required monthly contribution to the plan.[6] Most (69%) of the 12,986 enrollees were poor (<100% of poverty or $17,600 per year for a family of three in 2008) and about nine in ten (89%) had income below 150% of poverty ($26,400 per year for a family of three in 2008) (Figure 1).[7] Nearly one in three (32%) was age 50 or older with almost one in ten (9%) between ages 60-64.[8] Almost two-thirds of enrollees were women (65%) and roughly six in ten (59%) were adults without dependent children.[9]

Figure 1

Income and Age of Healthy Indiana Plan Enrollees, June 2008



Total = 12,986

The federal poverty level was $17,600 for a family of three in 2008.
SOURCE: Daily HIP Dashboard, June 17, 2008, Family and Social Services Administration, State of Indiana.

Coverage Under the Healthy Indiana Plan

The benefit package is modeled after a high-deductible plan and health savings account. It consists of three components provided through managed care plans (Figure 2):

High-deductible coverage: Unlike regular Medicaid, the coverage is subject to a $1,100 deductible and $300,000 annual and $1 million lifetime benefit caps. After meeting the $1,100 deductible, individuals are covered for state-specified benefits, including inpatient and outpatient care, physician care, prescription drugs, home health care, and mental health care up to the caps. The coverage does not include dental or vision care and coverage for long-term skilled nursing care and physical, speech, and occupational therapy is more limited than under regular Medicaid.[10] The plan also does not cover any pregnancy-related services. Enrollees who become pregnant must enroll in regular Medicaid for coverage of pregnancy-related care.

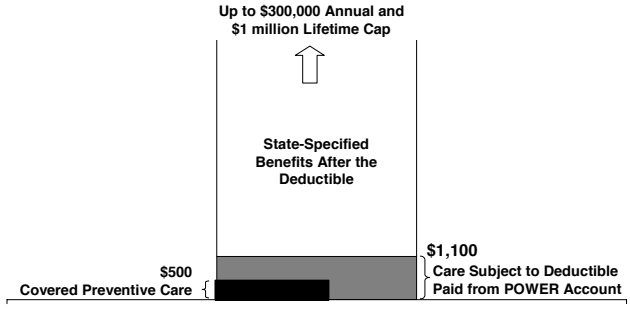
POWER Account: This Personal Wellness and Responsibility (POWER) Account represents the plan's version of a Health Savings Account (HSA) and is used to cover the $1,100 deductible. The account is funded through payments by the enrollee (and sometimes an employer), the state, and the federal government. The accounts are administered by the managed care plans and generally can only be used to pay for authorized services provided by the plan's in-network providers.[11]

Preventive care: The state requires participating managed care plans to cover up to $500 in preventive care per year that is not subject to the deductible and does not draw from the POWER Account. Currently participating managed care plans have chosen not to place any dollar limits on their coverage for preventive care.

There are no copayments for services other than for use of the emergency room. Parents are charged between $3-

Figure 2

Healthy Indiana Plan Coverage



$25 for an emergency room visit, based on income, and childless adults are charged $25 per visit, regardless of income. Parents can have the copayment refunded if it is determined that the visit was an emergency, but plans are not required to refund the copayment amount for other adults.

Although modeled after a High Deductible Health Plan (HDHP) and HSA, there are key differences between the structure of the Healthy Indiana Plan and a HDHP-HSA. First, individuals enrolled in HDHPs in the private market choose whether to participate in an HSA and how much to set aside in the HSA based on their expected medical costs and other factors. In contrast, enrollees in the Healthy Indiana Plan are required to have a POWER Account and their contributions to the account are specified by the state. Further, HSAs are managed by individuals and can be used to pay for a broad set of medical expenses, including services that may not be covered by an individual's HDHP, such as dental and vision care, as well as those services that are applied toward the HDHP deductible. Because individuals manage HSA funds that can be used for a variety of services, HSAs are intended to encourage individuals to "shop around" for medical care based on price and quality, assuming that price and quality information is available. In contrast, POWER Accounts are administered by the managed care plans and generally can only be used pay for authorized services provided by the plan's in-network providers. As such, individuals have much less control over their POWER Account funds than they would over an HSA and more limited choice in how the funds may be used.

Enrollees receive care through managed care plans that contract with the state. All plans are required to provide at least $500 per year in preventive care and the state-specified set of high-deductible coverage benefits. They can choose to cover additional benefits. The plans also are responsible for making payments from enrollees' POWER Accounts for eligible medical expenses. (If an individual incurs medical costs before the POWER Account is fully funded, the managed care plan advances payment to the provider, and the individual remains liable to the plan for these payments.) All covered care, including care paid for with POWER Account funds, is generally limited to approved services provided by the plan's in-network providers. As such, enrollees' coverage and access to care also is related to how tightly the managed care plans control access to services and the breadth of their provider networks.

Currently, there are two managed care plans from which most enrollees choose—Anthem Blue Cross and Blue Shield and MDWise with AmeriChoice. Anthem is an established commercial plan in Indiana that serves some regular Medicaid enrollees. MDWise is an established Medicaid plan in Indiana that has partnered with AmeriChoice to provide Healthy Indiana Plan coverage. Enrollees who have an identified high-risk condition (e.g., cancer, organ transplant recipient, HIV/AIDS) receive benefits through the "Enhanced Services Plan (ESP)," which is a fee-for-service inpatient health plan that also manages the state's high risk pool.

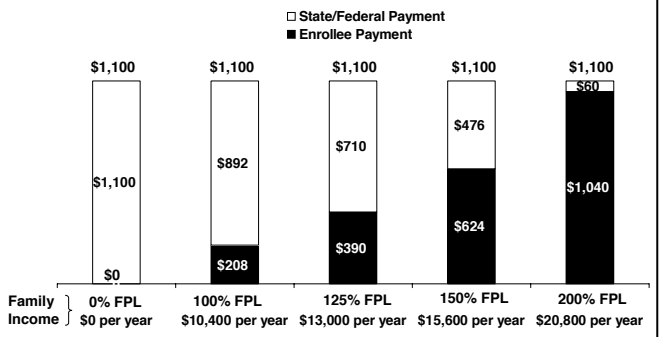
Individuals must select a managed care plan at the time of application. If an individual does not choose a plan, the state will assign a plan upon eligibility approval. Once an individual selects or is assigned to a plan and makes an initial POWER Account payment, the enrollee must remain in that plan for 12 months.[12] As of June 2008, nearly three quarters (74%) of enrollees were enrolled in Anthem, 24% were receiving care through MDWise, and about 1% were in ESP. The state believes that Anthem is experiencing higher enrollment because it has better name recognition in the commercial market. As of June 2008, Anthem also offered a more robust provider network, although MDWise was taking steps to bolster its network.

POWER Account Contributions

Healthy Indiana Plan enrollees make monthly payments to their POWER accounts to obtain and maintain coverage. Coverage under the plan does not become effective until the first of the month after the state receives and processes an individual's first POWER Account payment. An individual's payment is based on family income, ranging from 2% of income for families below 100% of poverty to 5% of income for families at 200% of poverty (Figure 3). Employers may also contribute up 50% of their employee's contributions. In families with two enrolled adults, each adult has an $1,100 POWER Account, but the total of both enrollees' payments cannot exceed the limit for the family. For families with adults enrolled in the Healthy Indiana Plan and a child or children enrolled in regular Medicaid and/or SCHIP, the aggregate amount of regular Medicaid and/or SCHIP premiums and cost sharing and Power Account payments is limited to 5% of income.

Figure 3

Annual POWER Account Payments for An Individual by Income, 2008



Family income based on the federal poverty level for an individual as of 2008.

Individuals with no income as well as some families whose contribution amounts are reduced by Medicaid or SCHIP premium and/or cost sharing amounts are not required to pay anything toward the POWER Accounts. As of June 2008, these "zero contribution" enrollees accounted for almost one in three (32%) of the plan's enrollees.[13]

The state (along with federal Medicaid match funds) pays for the gap between the enrollees' payments and the $1,100 deductible amount required for the POWER Account. The state makes its entire annual contribution in a single payment after receiving notice that the enrollee made his or her first month's contribution.

Individuals lose coverage and forfeit a portion of their POWER account contributions if they do not make their monthly payments. If an enrollee does not make a POWER account payment within 60 days of its due date, the state terminates his or her coverage. The enrollee also loses 25% of his or her share of funds remaining in the POWER Account; the remaining 75% is refunded. Individuals terminated from coverage are barred from re-enrolling in the plan for a full year and must pay any owed POWER Account payments before they can re-enroll.

The state redetermines eligibility for the plan and required POWER account payments on an annual basis. The coverage period for the Healthy Indiana Plan is 12 months. At the end of 12 months, the state re-determines an individual's eligibility for the program and recalculates the POWER account payments. Individuals can also have their payments adjusted one time within the year for a change in income and as needed throughout the year to reflect changes in family size.[14] If an individual becomes ineligible at the time of re-determination or another time, the enrollee's entire share of the POWER Account balance is refunded. If a person fails to complete the re-determination process or chooses not to reenroll, he or she is terminated from coverage and barred from re-enrolling for at least 12 months. Further, the individual loses 25% of his or her share of any remaining POWER Account funds; the remaining 75% is refunded.

State funds in POWER Accounts can be carried over to the next year if individuals obtain state-specified preventive care. At the end of the 12-month coverage period, an enrollee may have funds remaining in his or her POWER Account. If an individual obtained all specified preventive services during the year, all remaining funds in the POWER Account, including state contributions, are carried forward to the next year, and the enrollee's payments for the next year are reduced by the amount carried forward. If the enrollee did not obtain all specified preventive care, only the enrollee-funded portion of the remaining funds is carried forward; any remaining state funds are returned back to the state. The enrollee's payments for the next year are reduced by the amount carried forward. For 2008, the only preventive service required to carry over state POWER Account funds is a wellness office visit. The state is developing a list of disease-specific preventive care that will be required for 2009.

Healthy Indiana Plan Financing and Impact on Previously Eligible Medicaid Groups

Because the Healthy Indiana Plan is being operated under Section 1115 Medicaid waiver authority, it must be budget neutral to the federal government. This means that, over the waiver period, the state's program cannot cost the federal government more than would have been spent without the waiver. To assure budget neutrality, the federal government established a per capita cap on federal funds available to the state over the waiver period, which limits the amount of federal funds the state can receive for people covered under the waiver based on pre-set per person costs and an annual growth rate.

One aspect of budget neutrality is that the state must offset the costs for expanding coverage to groups who could not be covered through Medicaid in the absence of a waiver. As such, the state must find program savings and/or redirect existing funding to offset the cost of the Healthy Indiana Plan expansion to childless adults.[15] The state plans to offset these costs by achieving savings in its existing Medicaid coverage for pregnant women, children, and parents and by using a portion of its Disproportionate Share Hospital (DSH) allotment. Because the state plans on achieving savings related to coverage of existing Medicaid groups, these groups were brought under the waiver authority and became subject to a per capita cap on federal funds. However, the state has not specified how it plans to achieve savings for these groups. In terms of DSH funds, the state is approved to redirect up to 25% of its $200 million annual federal DSH allotment, or $50 million, to the expansion. It passed a tobacco tax increase that will generate the state funds needed to draw down the $50 million in diverted federal DSH funds.

Beyond the offsets required to meet the waiver's budget neutrality requirements, the state has also agreed to achieve an additional $15 million in savings (state and federal) over the course of the five-year waiver period. Depending on how the state achieves these savings, actual spending for the regular Medicaid groups under the waiver may need to be lower than the budget neutrality caps for the savings to be realized. If the state does not achieve these savings, it must return the federal share of the difference between $15 million and the verified level of savings achieved to the federal government. The state has not specified how it will achieve these savings.

Key Issues to Consider

Based on the state's current coverage estimates, the Healthy Indiana Plan could potentially expand coverage to some 120,000 previously uninsured adults, accounting for about 15% of the state's non-elderly uninsured as of 2005-2006.[16] As the plan is monitored over time, following are some key issues to consider:

Is the plan affordable for eligible individuals? Most eligible individuals are required to make monthly POWER Account payments to obtain and maintain coverage. The state has scaled the payments by income and limited them to a percent of family income. However, a substantial amount of research shows that the low-income population, particularly those with the lowest incomes, is sensitive to even relatively low costs.[17] As such, these payments may serve as a barrier to enrollment for some eligible individuals. Additionally, low-income individuals often have fluctuating incomes and limited ability to cover unexpected costs, which may make it difficult to consistently make the payments over time. The state generally allows for one payment adjustment per year based on income, but some individuals still may have difficulty making a payment if they have unexpected expenses, such as a car repair, during a given month. Individuals who miss a payment are terminated from coverage, barred from reenrolling for 12 months, and lose 25% of their POWER Account contributions. Monitoring enrollment denials and coverage terminations related to non-payment of POWER Account contributions will be key for assessing the affordability of the program for eligible individuals.

Does the coverage meet enrollees' health care needs? The benefits covered under the plan will enable previously uninsured enrollees to access many important services. However, the benefits covered under the plan are more limited than regular Medicaid and subject to $300,000 annual and $1,000,000 lifetime caps. It will be important to monitor access to care for enrollees, particularly the high-risk individuals enrolled in the ESP Plan. Additionally, those with the most health care needs are at risk for hitting the benefit caps. The state has noted that individuals who reach the caps will likely become eligible for regular Medicaid, but it will be important to track what happens to individuals who reach these caps. Monitoring the timeliness and ease of transitions to regular Medicaid for pregnant women will also be key since the plan does not cover pregnancy-related services.

How well do beneficiaries understand the limitations of their coverage? In order for beneficiaries to use the high-deductible coverage effectively and for them to remain protected from medical costs, they must clearly understand the limitations of their coverage. Not only must they understand which services are covered or not and be aware of limitations on services, they must also understand that care is only covered if it is authorized by their managed care plan and obtained from an in-network provider. If a beneficiary fails to understand any of these limitations and obtains uncovered care, he or she will be liable for the costs of that care, which could create a significant financial burden. Further, it is important for beneficiaries to understand that not completing the re-determination process at the end of the 12-month coverage period has significant impacts on their access to coverage and as well as financial consequences. Individuals who do not complete re-determination or choose not to re-enroll are barred from re-enrolling in the program for 12 months and lose 25% of their share of any funds remaining in their POWER Account.

Will the plan effectively encourage personal responsibility, cost transparency, and preventive care? The plan seeks to encourage personal responsibility, cost transparency, and preventive care largely through the use of the POWER Accounts and the incentive of carrying state POWER Account funds over to the next year to reduce required contribution levels. However, the managed care plans, rather than the individuals, administer and make payments from the POWER Accounts and funds from the accounts generally can only be used for approved services provided by the plan's in-network providers. As such, individuals have limited control over these funds. In order for beneficiaries to be aware of the cost of health care services paid for from the accounts, the plans need to communicate POWER Account activity in a timely and easily accessible manner that beneficiaries understand. Further, in order for the accounts to encourage preventive care, beneficiaries need to be clearly educated about how

their use of preventive care affects their ability to carry over the state portion of POWER Account funds and the preventive services they are required to obtain to carry over the funds. Additionally, the incentive of carrying over funds must be meaningful enough to beneficiaries to influence their behavior.

Is the plan cost-efficient? Under this plan, the state is using Medicaid funds to provide coverage that has more limited benefits and higher payment requirements for enrollees than typically allowed in Medicaid. However, analysis finds that per capita coverage costs (when individual contributions are included) are actually higher under the plan than in regular Medicaid.[18] This reflects the fact that, overall, Medicaid coverage costs less than private coverage for comparable individuals, which is related to higher administrative costs and provider payments in private coverage. In the Healthy Indiana Plan, the state will be paying providers at the Medicare rate, which is higher than what it pays providers under its regular Medicaid program.

Will the plan lead to reductions for previously eligible Medicaid beneficiaries? To assure budget neutrality under the waiver, the state plans to achieve savings in its Medicaid coverage for pregnant women, children, and parents. Further, these groups became subject to a cap on federal funds. Beyond the savings required for budget neutrality, the state also has agreed to achieve an additional $15 million in Medicaid savings over the waiver period. Overall, the need to achieve savings and the cap on federal funding create incentives for the state to limit or reduce costs in its existing Medicaid program, which could potentially affect the scope of benefits and access to care for previously eligible Medicaid beneficiaries.

This brief was prepared by Samantha Artiga of the Kaiser Commission on Medicaid and the Uninsured. The author thanks the Indiana state officials who provided valuable data and information on the Healthy Indiana Plan and the colleagues who reviewed and provided helpful comments on this brief.

ENDNOTES

[1] Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, Waiver Approval Letter, December 14, 2007, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Healthy%20Indiana%20Plan%20Current%20Approval%20Documents.pdf, last accessed on May 21, 2008.
[2] Centers for Medicare and Medicaid Services, Special Terms and Conditions for the Healthy Indiana Plan, pg. 3, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Healthy%20Indiana%20Plan%20Current%20Approval%20Documents.pdf, last accessed on May 21, 2008.
[3] Parents below 22% FPL were eligible for regular Medicaid before implementation of the Healthy Indiana Plan, and continue to receive regular Medicaid coverage. Parents below 22% FPL who are not eligible for Medicaid because they exceed resource limits ($1,000) are eligible for the Healthy Indiana Plan.
[4] Phone communications with state official.
[5] E-mail communications with state official.
[6] Daily HIP Dashboard, as of Tuesday, June 17, 2008.
[7] Ibid
[8] Ibid
[9] Ibid
[10] Solomon, J., "Paying More for Less: Healthy Indiana Plan Would Cost More than Medicaid While Providing Inferior Coverage," Center on Budget and Policy Priorities, January 24, 2008.
[11] Coverage for services from out-of-network providers is available in limited circumstances, such as for family planning services and emergency services.
[12] Enrollees may change plans for cause such as: failure of insurer to provide covered services; failure of insurer to comply with established standards of medical administration; significant language or cultural barriers; corrective action levied against the insurer by the state agency, or other circumstances determined by the state agency to constitute poor quality of health coverage.
[13] Daily HIP Dashboard, as of Tuesday, June 17, 2008.
[14] Additional changes due to income are considered on a case-by-case basis.
[15] It does not need to find offsetting savings for custodial parents because they could be covered under regular Medicaid without a waiver and, thus, are considered a "pass-through" population.
[16] Uninsured data as of 2005-2006 from Kaiser Family Foundation State Health Facts Online, based on Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).
[17] Hudman, J. and M. O'Malley, "Health Insurance Premiums and Cost-sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured, March 2003; Ku, L., "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 2003; and Artiga, S. and M. O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured, May 2005.
[18] Solomon, J., op cit.

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