STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Mitchell E. Daniels, Jr.
Governor

February 28, 2007

Secretary Mike Leavitt
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt:

On behalf of the State of Indiana, I am pleased to officially submit a groundbreaking Section 1115 research and demonstration waiver for the Healthy Indiana Plan (HIP), my plan to provide health insurance to low-income Hoosiers.

Consistent with President Bush's recently-announced principles regarding affordable heath insurance, especially the Affordable Choices Initiative, Indiana is at the forefront of state efforts to improve health status, system efficiency, quality, and cost transparency. We are also a national leader in the development of the use of electronic medical records. However, we understand that these initiatives are limited in improving health care and addressing price transparency if a large number of Hoosiers remain uninsured.

To this end, we have designed HIP and this waiver in such a way to promote personal responsibility, encourage preventative care, and lay a foundation for greater transparency in health care costs and financing. Moving away from traditional health plans and subsidies, HIP provides a health savings-type account that is coupled with a high deductible health plan to low-income, uninsured Hoosiers. Indiana's plan, which recently received bipartisan support from the Indiana State Senate, entrusts Hoosiers with the power to be value-conscious consumers of their health care.

I believe HIP has the capacity to serve as the nation's first example of the far-reaching potential of the Affordable Choices Initiative, and I look forward to your favorable review of our proposal. Please contact Mitch Roob, Secretary of the Indiana Family and Social Services Administration, with any questions.

Sincerely,

M E Daniels, Jr.

cc: Rob Portman, Director, Office of Management and Budget
Leslie Norwalk, Acting Administrator, Centers for Medicare & Medicaid Services
Dennis Smith, Director, Medicaid and State Operations,
Centers for Medicare & Medicaid Services
Jackie Garner, Regional Administrator (Chicago),
Centers for Medicare & Medicaid Services
E. Mitchell Roob, Secretary, Indiana Family and Social Services Administration

The Healthy Indiana Plan
Section 1115 Affordable Choices Demonstration Proposal

Submitted by the
Indiana Family and Social Services Administration
February 28, 2007

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EXECUTIVE SUMMARY

Indiana is pleased to submit a groundbreaking Section 1115 demonstration proposal for the Healthy Indiana Plan (HIP) for consideration as part of the Department of Health and Human Services Affordable Choices initiative.

. Indiana is at the forefront of efforts to improve health system efficiency, quality, cost transparency as well as incorporation of electronic medical records However, Gov. Daniels understands that these initiatives can go only so far in improving health care and addressing cost shifting if a large number of Hoosiers still go uninsured. Having a large low-income uninsured population has the effect of encouraging payers and providers to cost shift, and blunts the impact of improvements in the areas of quality and technology.

Therefore, the linchpin of the State's efforts to improve its delivery system is to provide an affordable, basic insurance package available to uninsured Hoosiers. Using the concepts behind the Affordable Choices initiative, Indiana proposes to implement the HIP for uninsured parents of Medicaid and SCHIP children with incomes up to 200% of the federal poverty level (FPL), and uninsured childless adults with incomes from 100% to 200% of the FPL, and pregnant women from 150 to 200% FPL. Childless adults living below the poverty level will continue to receive coverage through the disproportionate share hospital (DSH) program, and individuals with incomes above 200% of the FPL will be able to buy-into the HIP.

Coverage will be provided through capitation or risk based contracts with private insurance carriers. The benefit design includes a basic benefit package offered through a high deductible health plan (HDHP) coupled with personal accounts that are modeled after health savings accounts (HSAs), referred to as a POWER (Personal Wellness and Responsibility) account. The POWER accounts are designed to be compatible with the needs of a low-income population and to encourage preventive care, the appropriate utilization of health care services built in incentives for personal responsibility.

Indiana's commitment to the HSA and HDHP is evidenced by bipartisan legislative support for a tax on tobacco products that will support the offering of these products to low-income individuals. The new tax will provide the nonfederal share of expenditures under the demonstration.

Indiana also recognizes the need to meet federal budget neutrality requirements that pertain to Section 1115 demonstrations. Indiana has historically operated a conservative Medicaid program with coverage for parents only at 23% of the

FPL, one of the lowest in the nation and with extensive managed care for pregnant women and children. Additionally, Indiana's DSH program, at is cap, is focused entirely on health care and supports State hospitals as well as other hospitals. Budget neutrality will be assured by redirecting a portion of the State's DSH allocation, by implementing a new care management strategy for the aged, blind and disabled population enrolled in Medicaid, and by reinvesting the State's historical savings that have been accrued by enrolling Medicaid beneficiaries in risk-based managed care. In addition, the State is requesting enhanced match through the Health Opportunity Account (HOA) mechanism for all contributions to the POWER accounts. At the time of submission of this demonstration proposal, the Indiana Legislature is finalizing the legislation that will make HIP a reality. Indiana's goal is to secure federal approval for HIP by May 1, 2007, and to implement the program by January 1, 2008.

STATEMENT OF PROBLEM

Indiana although a Midwestern state, shares many of the same issues as Southern states. From 2000 to 2005, its population increased less than the national average[1], and 25 counties actually experienced a population decline.[2] Recent U.S. Census figures show that more than one out of every ten Hoosiers lives in poverty, and Indiana's median household income is more than $2,000 less than the national average.[3]

Last year, only about three-quarters of eligible high school students earned a high school diploma.[4] Figures depicting attainment of a Bachelor's degree are similarly discouraging: Indiana ranks 45th in the country, with a mere 21.3% of Hoosiers age 25 or older having a four-year college degree.[5] This places Indiana above only Louisiana, Nevada, Kentucky, Arkansas, Mississippi and West Virginia.[6]

The health coverage situation in Indiana leaves much to be desired. Since 1990, the uninsured population has increased by 30%.[7] Of Indiana's 6.2 million residents, approximately 560,000 are uninsured on any given day.[8] Roughly 14% of the State's population, or 860,000 individuals, have been without health insurance at some time in the past year.[9] Approximately 62% of these uninsured are working-age adults with low incomes, defined as at or below 200% of the Federal Poverty Level (FPL).[10] (The 2006 FPL for a family of four is $20,000.)

Meanwhile, health coverage in the State continues to erode. From 1999 to 2004, only one state in the nation lost more employer-sponsored health insurance than Indiana.[11] Making matters worse, Indiana has the dubious distinction of being one of the lowest Medicaid coverage states in the nation, offering coverage to

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[1] U.S. Census Bureau, State & County QuickFacts: Indiana. From April 1, 2000 to July 1, 2005, Indiana's population only increased by 3.1% while the total U.S. population increased by 5.3%.
[2] Rural Policy Research Institute, University of Missouri-Columbia, *Demographic and Economic Profile: Indiana* (updated May 2006).
[3] U.S. Census Bureau, 2005 American Community Survey Data Profile Highlights. In 2005, Indiana's median household income was $43,993. The national average was $46,242.
[4] Indiana Department of Education, News Release "Statewide High School Graduation Rates Released" (January 2, 2007).
[5] U.S. Census Bureau, 2005 American Community Survey Data Profile Highlights.
[6] *Ibid*.
[7] America's Health Rankings, United Health Foundation 2006
[8] State Health Access Data Assistance Center (SHADAC), University of Minnesota, *2003 Health Insurance for Indiana's Families Summary* (August 2003).
[9] U.S. Census Bureau, Current Population Survey (CPS), 3-year average, 2003-2005.
[10] State Health Access Data Assistance Center (SHADAC), University of Minnesota, *2003 Health Insurance for Indiana's Families Summary* (August 2003).
[11] Economic Policy Institute, *Prognosis Worsens for Workers' Health Care* (November 2005).

non-disabled parents up to only 23% of the FPL. This means many low-income Hoosiers – even those who work – have no health insurance.

A growing number of uninsured individuals affect health care costs for all Hoosiers, especially those who are insured. This is because providers have no choice but to shift the costs of the care for the uninsured to those with insurance. It is estimated that each Indiana family with health insurance paid an additional $953 in premiums in 2005 to cover costs associated with treating the uninsured.[12] As a result, Indiana has experienced double-digit rate increases for health insurance premiums over the last five years.[13] If action is not taken to slow down these trends, by 2010 Hoosier families can expect to experience a $1,494 increase in premiums due to health care for the uninsured.[14]

The poor health status of Hoosiers and the overall high cost of health care in Indiana have also been factors. Indiana ranks 10th in the nation for the number of obese adults and has the 2nd highest percentage of smokers in the nation.[15] Additionally, many Hoosiers fall short when it comes to obtaining critical preventive care services. Women in Indiana receive both mammograms and pap smears at lower rates than the rest of the nation, and 66% of men age 50 or older did not have a colonoscopy in the last five years.[16] Indiana businesses are having difficulty sustaining these costs and other businesses are deterred from locating in Indiana due to the higher costs of health care.

Indiana Governor Mitch Daniels recently announced a comprehensive plan, the Healthy Indiana Plan (HIP) to improve the health status of Hoosiers. This multi-faceted plan may be funded with an increase in the State's cigarette tax. The initial proceeds of the tax will be used for programs to increase childhood immunization rates and decrease the number of Hoosiers who smoke. The remainder of funds will be used to fund the final piece of the comprehensive plan, a Section 1115 Medicaid demonstration to provide insurance for low-income Hoosiers through a HDHP and the POWER accounts.

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[12] Thorpe, Kenneth. Emory University School of Public Health & Families USA, *Paying a Premium* (June 2005).
[13] Kaiser Family Foundation 2004, available at www.kff.org/insurance/chcm090904nr.cfm.
[14] Thorpe, Kenneth. Emory University School of Public Health and Families USA, *Paying a Premium* (June 2005).
[15] Behavioral Risk Factor Surveillance System (BRFSS) Indiana Statewide Survey Data, 2004.
[16] Centers for Disease Control and Prevention, *Chronic Diseases: The Leading Causes of Death in Indiana* (date last reviewed November 14, 2005), available at http://www.cdc.gov/nccdphp/publications/factsheets/ChronicDisease/indiana.htm.

PROPOSAL OVERVIEW

Over the past year, a collaboration of Hoosier private business and public sector leaders have agreed to a broad reorganization and prioritization of local, state and federal resources to address the growing number of uninsured in Indiana. The plan was designed to be compatible with eight core values, which are:

- *Promoting Healthier Hoosiers* – Controlling the increasing cost of health care begins with avoiding unnecessary illness and complications in the first place. By focusing on prevention, promoting healthier lifestyles and better managing chronic disease, Indiana can make a significant impact on health care expenditures. Other key components of the Governor's health care plan are to continue to promote INShape Indiana, a diet and exercise plan for all Hoosiers, increase the rate of immunizations and reduce the number of individuals who smoke by stepping up smoking cessation efforts.
- *Promoting Personal Responsibility* – The Governor recognizes that the State as a purchaser of health care services can control expenditures to a certain degree, e.g., through care management initiatives. However, the ultimate decision about certain behaviors that have a dramatic impact on health status, such as weight reduction and smoking cessation, rest with individuals. Therefore, it is important to devise strategies that incentivize positive health behaviors. Also, in order to truly contain health care expenditures, it is essential to make patients aware of the cost of health care services, so that they may act as partners with providers and payers to make responsible decisions about appropriate and medically necessary care.
- *Using Private Market Solutions* – Any program designed to decrease the number of uninsured in Indiana would rely on a private, market driven approach to delivering care, within quality and accountability guidelines designed and monitored by the State.
- *Promoting System Efficiency and Quality* – Efforts to expand access are unsustainable over the long term without simultaneous endeavors to address cost and quality of the entire health system. Indiana leads the nation with its efforts to promote use of the electronic medical record statewide and has initiated a task force to examine the Indiana care model that will address quality and efficiency for its health care system.
- *Promote Price Transparency by Using Overt, Not Covert Subsidies* – Historically, a great deal of the financing of health care in the State has been through indirect subsidies, e.g., the State using disproportionate

share hospital (DSH) payments to cover inpatient hospital care for the uninsured, and insurance companies raising premiums for the insured in order to pay for those without insurance. Our approach supports the notion that it is more appropriate to subsidize insurance at the "front door" than to continue paying for care for the uninsured through "back door" subsidies. Price transparency cannot occur with large numbers of uninsured that create force providers to cost-shift..

- *Practicing Fiscal Responsibility* – It is not Indiana's intent to create another entitlement without a firm foundation of sustainable funding. Therefore, the program outlined in this paper caps enrollment depending upon available revenues. Additionally, the current legislation would allow the State Medicaid program to adjust benefits as needed based on available revenue.
- *Helping Hoosier Businesses* – Providing health care coverage for the low-income uninsured not only helps individuals, but also it helps businesses. Employees with health insurance are less likely to miss work due to a health crisis that could have been prevented with regular preventive care.
- *Pro-Work* – Providing subsidized health care coverage that does not depend upon meeting the historically low Medicaid eligibility criteria in use in Indiana removes an important disincentive to better oneself through employment. In addition, the proposal encourages work in that individuals will likely have to be employed in order to afford the required contributions toward the cost of their care.

The Healthy Indiana Plan will depend upon support from the U.S. Department of Health and Human Services for maximum flexibility to structure a sustainable private market model that will empower individuals to make cost-conscious health care decisions that improve their health status, lessen the impact of an inefficient delivery and funding system and reform the provision of health services to low-income, uninsured adults and families. HIP calls for the implementation of the seven values described above through:

- A commitment of new and reprogrammed state financing to bring new federal revenue to Indiana. This will decrease the number of uninsured and the impact of cost shifting to ultimately slow the pace of health care premium cost growth that impacts all Hoosier businesses.
- Dedication of resources to reduce the uninsured population by enfranchising individuals, not entitling institutions.
- Providing a basic high deductible health plan and a Health Savings Account (HSA) look-alike product to low-income uninsured

Hoosiers that promotes personal responsibility for health and lays a foundation for a greater transparency in health care costs and financing.

- Improving care management care of the aged, blind and disabled population through the Care Select initiative
- Creation of an interoperable, statewide healthcare information and communication technology system in which all relevant clinical information about a patient is electronically accessible at the point of care.
- Allowing uninsured individuals that otherwise may not qualify for subsidies and small businesses (less than 50 employees) currently not offering health insurance to purchase the HIP plan with no subsidy.

To accomplish these goals, Indiana is requesting Medicaid Section 1115 authority to provide a high deductible health plan/HSA package to low-income parents of Medicaid and SCHIP children who are not otherwise eligible for Medicaid; to provide the same package to certain uninsured low-income childless adults; and to enroll the aged, blind and disabled Medicaid population in Care Select, an innovative care management program. In addition, the State is seeking authority to redirect DSH payments from inpatient hospital care for the uninsured to instead pay for health coverage. This proposal is being advanced under the principles outlined in the Affordable Choices initiative, recently announced by the President and by the Secretary of Health and Human Services.

CURRENT HEALTH CARE ENVIRONMENT IN INDIANA

Health Care Costs and Trends

National health care spending per capita has risen twice as fast as the gross domestic product. Overall, this growth has been driven by increases in both the utilization and price of health care services. Indiana has averaged lower annual growth (3.8 percent) in health care spending per capita from 1994 to 1998 than the U.S. as a whole (4.0 percent). However, growth at the end of that period exceeded the national average. This is disturbing for Indiana as it suggests that Indiana's spending may surpass national averages. As 1998 is the most recent data available, it is unknown whether higher growth has continued, but it may be responsible for Indiana's rising premiums, lower employer offer rates, and growing numbers of Medicaid enrollees. Ultimately, this may lead to increasing numbers of uninsured and underinsured patients. Key cost drivers in Indiana appear to include population health status and the use and cost of hospital care. Adults aged 45 to 64 are the fastest-growing segment of Indiana's population. The growth in this population segment is especially noteworthy because it is related increases in the prevalence in some of the most costly diseases, including heart disease, diabetes, hypertension, and cerebrovascular disease. These diseases are exacerbated by smoking and obesity, both of which are more common in Indiana than in the nation as a whole. Greater incidence of these diseases has been linked to growing expenditures for hospital care in Indiana. Nationally, they also have been linked to much greater use of prescription drugs.

The high cost of hospital care in Indiana appears to be related to both the high supply of hospital beds and high technological capacity. Both may drive greater utilization of hospital care than the national average. Another potential contributor to the high cost of care in Indiana is the cumulative impacts of Indiana's higher bed supply, higher staffing per bed, higher costs per worker, longer lengths of stay, and the excess capacity implied by lower use-to-capacity measures in the hospital sector. Duplication of high-cost technology among hospitals may also contribute to high and growing hospital expenditures in Indiana.

Indiana also has a very high supply of surgeons, suggesting a relatively aggressive style of care delivery that is consistent with Indiana's higher cost of hospital care. In contrast, per capita spending for physician services is much lower in Indiana than the national average. Although spending for physician

care accelerated in 1998, use of primary and chronic care services nevertheless may be lower than desirable in Indiana.

Finally, the low penetration of HMOs in Indiana has meant that cost control has relied on greater cost sharing instead of either systematic price negotiation or a culture of preventive care and health care management (Chollet et al. 2004). Overall, Indiana has experienced significant growth in its health care costs. These costs are becoming unsustainable for Hoosier businesses and are contributing to the growing number of uninsured. Likewise, uncompensated care costs in Indiana are expected to grow at a rate exceeding health care inflation.

Current Environment for Indiana Employer-Sponsored Insurance

Between 1999 and 2004, Indiana had the 2nd largest decrease in employer-sponsored health insurance in the nation.[17] While the percentage of the population reporting coverage from an employer rose briefly in the late 1990s, economic recession brought a predictable decline in coverage and potentially a return to the historic pattern of steady erosion. In Indiana, the proportion of the population under age 65 with employer-based coverage rose from 71 percent in 1998, peaked at 74 percent in 2000, and had returned to 71 percent by 2002. More recent data from a different survey of the population suggest that employer-based coverage in Indiana was just 61 percent of the population under age 65 in 2003 (SHADAC 2003).[18]

Smaller firms (<50 employees) have an offer rate of 44% versus 98% of large firms (<50 employees). Over 58% of uninsured individuals work for employers with fewer than 50 employees.[19] Small establishments in Indiana, as well as retail and general service establishments and establishments with many part-time and low-wage workers, all have distinctively low rates of coverage. Low employer offer remains an important obstacle to coverage in small establishments in Indiana. But for part-time workers and low-wage workers, eligibility and take-up appear to be greater problems. In establishments where most employees work part-time or are low-wage, employers are less likely to offer coverage; when offered

[17] Prognosis Worsens for Workers' Health Care, Economic Policy Institute, November 2005.
[18] Differences in questioning may account for a somewhat lower rate in the Health Insurance for Indiana Families (HIIF) survey than in the Current Population Survey (CPS). The CPS measures the uninsured as individuals who reported no coverage during the year, while the HIIF asks about current coverage.
[19] *10,000 Person Household Survey*, A Report to the Health Insurance for Indiana Families Committee by SHADAC, September 2003: 25-26
http://www.in.gov/fssa/programs/chip/insurance/survey.html

coverage, workers are both less likely to be eligible and less likely to take it up when eligible.

Health insurance premiums have risen dramatically in Indiana. For the past five years, Indiana's health premiums have been higher than the national average, and higher than neighboring States. Premiums and required employee contributions show very different patterns in Indiana for single and family coverage. Premiums for single coverage increased much faster than premiums for family coverage, and much faster than average wages in the state. This trend has likely contributed to the recent loss of direct coverage among workers in Indiana. Moreover, the strikingly lower growth of premiums in small firms suggests significant changes in the design of the benefits they offer. The most likely explanation for these changes is a transition to greater employee cost sharing in these firms at the point they seek health care services. Employee contributions for family coverage in small firms are much greater than in larger firms, and much greater in low-wage firms than in higher-wage firms for either single or family coverage. It seems likely low-wage establishments epitomize problems that exist more widely in Indiana and will grow with the expansion of low-wage jobs: employers are unable to finance benefits by further raising employee contributions or suppressing wages, and instead turn to paring back benefits to constrain premium increases; and low-wage workers without the means to pay the high contributions required to enroll in coverage unless they urgently need it. This pattern is likely to increase adverse selection in the small-group market (as coverage is concentrated on those with high needs), accelerate premium growth for small low-wage firms, and further erode coverage rates as well as the value of benefit packages offered to low-wage workers who maintain coverage.

Indiana Insurance Regulatory Overview

Generally, Indiana does not have a heavily regulated health insurance industry. Like other states, Indiana enacted a number of health insurance reforms in the last decade to comply with the federal Health Insurance Portability and Accountability Act (HIPAA).[20]

[20]Effective July 1997,
HIPAA required the states to enact specific guaranteed issue, renewal, and portability rules in the small-group market (affecting firms with 2 to 50 employees) in order to retain sole state regulatory authority in this market, and established similar rules for self-insured group plans (where federal law preempts state regulatory authority). In addition, HIPAA required the states to ensure portability from group to individual coverage, offered alternative ways that states could meet this requirement, and established a "federal fall back" rule for states that did not enact any of the HIPAA individual portability options. Indiana statute defines small groups as firms of 2 to 50 employees working at least half-year, with the majority working in

Indiana now requires small-group insurers to guarantee issue and renewal, limits exclusions for pre-existing conditions, and prohibits insurers from considering health status in determining coverage eligibility within groups.

In addition, Indiana constrains variation in the premiums that insurers can charge to small groups, and mandates coverage of certain benefits and types of providers for small group plans.

Indiana prohibits insurers from considering specific claims experience, health status, or duration of coverage in underwriting small groups. Indiana also restricts the variation in premiums that insurers can Indiana also restricts the variation in premiums that insurers can charge to small groups, although the rate band is narrower (2.08:1)[21], than in most other states. Indiana insurers are not required to guarantee issue or to price coverage within rate bands, even for health status. However, Indiana has enacted some protections that may assist consumers. For example, insurers may not permanently exclude coverage for any medical condition (Indiana is one of only 13 states with this provision), impose a waiting period longer than 12 months for coverage of pre-existing conditions, or use a look-back period that exceeds 12 months. In addition, Indiana operates a high-risk pool to guarantee access for HIPAA-eligible[22] leaving group coverage, as well as for other individuals denied coverage in the individual market. In 2002, the Indiana Comprehensive Health Insurance Association (ICHIA) was the sixth largest among the nation's 29 active high-risk pools.[23] Like the experience of many other high-risk pools, enrollment in ICHIA has grown substantially in recent years. ICHIA's benefits are relatively comprehensive. It is one of only four state pools that require a waiting period of just three months for coverage of pre-existing conditions;[24] most state high-risk pools require a waiting period of six to twelve months. In addition, there is no maximum lifetime benefit.[25] ICHIA accepts applicants only if they have been denied coverage in the market, not if

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Indiana. Affiliated companies eligible to file a single state tax return are considered as one employer (IC 27-8-15-14, accessed online at www.in.gov/legislative/ic/code/title27/ar8/ ch15.html on May 2, 2004).

[21]That is, insurers may charge the highest-risk small group more than twice as much as they charge the lowest-risk small group for the same coverage, all else being equal.

[22]HIPAA requires that individuals exiting the group market be guaranteed portability of coverage into the non-group market under certain conditions. Indiana guarantees access to the high-risk pool for these individuals to satisfy this requirement. To qualify, applicants must have had at least 18 months of coverage with no lapse of more than 63 days, and need to have exhausted available COBRA benefits.

[23]It is also larger than Kentucky's newly formed high-risk pool. Ohio does not have a high-risk pool.

[24] ICHIA's three-month look-back period for determination of a pre-existing condition also is relatively short.

[25] Only Kentucky, New Mexico, and Tennessee currently do not have a maximum lifetime benefit. However, pools that do impose a limit on lifetime benefits characteristically have raised the limit as enrolled individuals have approached or exceeded it.

they have been "rated up"—charged a higher premium reflecting their specific health status. And the program's premiums are high: Indiana does not band individual rates, and ICHIA caps premiums at 150 percent of market rates.[26]

The State also maintains a voluntary Small Group Reinsurance Pool. However, the pool is not utilized by most insurers and therefore has not had m impact on reducing premiums in the small group market. The State is currently examining strategies to restructure the pool to make it more attractive to small groups.

[26] In comparison, three states cap premiums at 125 percent of average non-group market rates, and most states have recently reduced their caps to no more than 150 percent of market rates.

ELIGIBILITY

Eligibility for Medicaid

The Family and Social Services Administration (FSSA) administers Indiana Health Coverage Programs (IHCP) through the Office of Medicaid Policy and Planning and the Office of Children's Health Insurance Program. Hoosier Healthwise, the managed care program for children and families covered by Medicaid, is the largest IHCP. Other programs include Medicaid Select and Traditional Medicaid.

Hoosier Healthwise provides coverage to qualified low-income families, pregnant women and children. Patients diagnosed with breast or cervical cancers are also eligible for coverage during the course of their treatment. Current income guidelines and other eligibility requirements are outlined below[27]:

- Low-income families. Adults are eligible for coverage if their family income is less than 23% of the FPL and their assets are less than $1,000.[28]
- Pregnant women. Pregnant women up to 150% of the FPL are eligible for coverage. There is no asset test.[29]
- Children. Children are eligible for Medicaid or SCHIP coverage if their family income is less than 200% of the FPL. There is no asset test.[30] Medicaid is available for children whose family income is less than 150% of the FPL. SCHIP is available for children whose family income is between 150% and 200% of the FPL. To be eligible for SCHIP coverage, children must not have creditable health insurance and must satisfy all cost-sharing requirements, including premiums.
- Patients diagnosed with breast or cervical cancer. Members under 65 years of age are eligible for coverage. Members must not have health insurance that covers breast or cervical cancer treatment, need to participate in the Indiana Breast and Cervical Cancer Program and must have a family income that is less than 250% of the FPL.

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[27] Indiana Health Coverage Programs Manual, Chapter 2: Member Eligibility and Services, available at http://www.indianamedicaid.com/ihcp/Manuals/Provider/chapter02.pdf.
[28] Smith, V. and Ellis, E., Kaiser Commission on Medicaid and the Uninsured. *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences* (April 2001).
[29] Kaiser statehealthfacts.org, Indiana Individual State Profile (2005).
[30] *Ibid.*

Traditional Medicaid, or fee-for-service coverage, covers many eligibility categories, including wards and foster children; persons in nursing homes or other institutions; undocumented aliens; persons needing waiver or hospice services; and spend-down populations.[31]

Medicaid Select, the primary care case management program, covers children receiving adoptive services, the aged, the blind, persons with physical or mental disabilities, dual-eligibles, individuals receiving room and board assistance, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Medicaid for Employees with Disabilities (MED) Works participants.[32] The SSI populations are currently eligible for coverage if their family income is under 76% of the FPL.[33]

Eligibility for the Demonstration

Under the demonstration, Indiana intends to extend health insurance coverage through a health savings type account and a high deductible health plan that will be provided to uninsured parents and childless adults. The chart below summarizes the potential number of individuals in each group that could be covered under HIP. The actual number of Hoosiers covered, however, will depend on the amount of available State funds, federal financing flexibility and the savings achieved through the Care Select initiative. The program will be available statewide. In order to remain within the budget for the program, however, there will be enrollment caps for the covered populations.

Subsidized Population Groups	**Eligible Group[34]**
▪ Uninsured parents of Medicaid/SCHIP children with income between 22% and 200% FPL who are not otherwise eligible under any existing Medicaid category.	182,988
▪ Uninsured non-disabled childless adults with incomes between 100% and 200% FPL who are not otherwise eligible under any existing Medicaid category.	168,469

[31] Indiana Health Coverage Programs Manual, Chapter 2: Member Eligibility and Services.
[32] *Ibid*.
[33] Kaiser statehealthfacts.org, Indiana Individual State Profile (2005).
[34] Indiana Analysis conducted by The Lewin Group. June 28, 2006, letter to State officials.

Exclusions

As childless adults are not categorically eligible under the current Medicaid program, Indiana is prepared to make the required budget neutrality argument for this population in order to obtain federal financial participation to partially cover the costs of insuring this population. However, due to the large number of childless adults, the State cannot make this argument for all uninsured childless adults under 200% of the FPL, nor can it afford to cover any group without a federal financial contribution and a contribution from the individual themselves. Although it is Indiana's intent to have as seamless a system as possible, non-disabled childless adults under 100% FPL will not be included as an eligibility group in the demonstration, HIP is designed to be a statewide program for working Hoosiers who will be able to contribute toward the cost of their health care. It is likely that the cost-sharing requirements would be unaffordable to adults earning less than 100% of the FPL, so this decision was made in the interest of balancing the need to make the budget neutrality argument, and have a financially sustainable program that includes both federal and individual contributions with the desire to have broad coverage. Although most of these individuals will remain without health care coverage, the implementation of HIP will infuse dollars into the safety net system, as well as reduce numbers of uninsured. Additionally, remaining funding in the DSH program will also help serve the needs of this population. Together, these measures will strengthen the existing safety net and its capacity to address childless adults below the poverty level and other remaining uninsured populations.

Crowd-Out

Indiana is committed to avoiding the creation of a scenario where employers drop existing coverage, or individuals decide to forego employer-sponsored coverage in order to qualify for HIP Therefore, the plan includes several safeguards designed to prevent workers and employers from dropping their current employer-sponsored insurance (ESI).

- If an individual has access to an employer sponsored plan, they are not eligible for HIP.
- Recertification for coverage under HIP must occur every 12 months.
- Individuals who are currently enrolled in a health insurance program are not eligible for subsidized coverage.
- Individuals must be uninsured for at least 6 months to be eligible for the program.

Additional Qualifying Requirements Include:

- Proof of United States citizenship
- Twelve month Indiana residency

Enrollment and Outreach

In the interest of covering as many people as possible within available resources, there will be multiple avenues for enrollment in HIP. First, individuals who apply for Medicaid through traditional venues but do not meet the current eligibility criteria will be screened for eligibility for the plan. Second, as is the case in the current system, health care providers such as public hospitals will have the ability to screen patients for potential eligibility, although the final eligibility determination will continue to be made as in the current system administered by the Division of Family Resources within FSSA. Parents who are enrolling their children into SCHIP will also be provided with information about HIP. In the interest of enrolling as many uninsured individuals as possible, Indiana will also allow the contracted health plans for HIP to screen for eligibility.

In order to facilitate outreach and enrollment in HIP, the State will permit and encourage the contracted health plans to promote their services to the general community. In accordance with 42 CFR 438.104, however, the plan cannot conduct, directly or indirectly, door-to-door, telephone or other "cold-call" marketing enrollment practices. The plan may market by mail, mass media advertising and community-oriented marketing directed at potential members, subject to OMPP's prior approval. The plan may also market its Healthy Indiana product through authorized agents and brokers. Marketing materials may include Healthy Indiana application forms, as well as instructions for applying for the Healthy Indiana program through the plan. Marketing materials must inform potential members that other plans may be available and that enrollees have the right to choose plans offered by other entities. Applicants will be required to check a box in their application materials acknowledging that they understand other plans may be available.

The plan may offer gifts, incentives, or other financial or non-financial inducements, so long as the Plan acts in compliance with all marketing provisions in the 42 CFR 438.104, and Federal and State regulations regarding inducements. The policy must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy within ten (10) days of its delivery and join another Healthy Indiana plan if, after examination of the policy, the insured person is not satisfied for any reason. The

intention of this provision is to make HIP consistent with other products offered on the open market in Indiana.

The plan must submit to OMPP a marketing and member materials distribution plan quarterly. All member outreach, marketing and education materials, as well as any form letters that are sent to members (e.g., notification or welcome letters, annual notices, etc.) must be submitted to OMPP for approval prior to distribution and in accordance with OMPP policy. In addition, the plan must notify OMPP of any changes to that work plan that occur throughout the year. Any outreach and marketing activities (written and oral) must be presented and conducted in an easily understood manner and format, at a fifth grade reading level, and must not be misleading or designed to confuse or defraud members and/or potential members. Examples of false or misleading statements include, but are not limited to:

- Any assertion or statement that the member or potential member must enroll in the plan to obtain benefits or to avoid losing benefits, or that the plan is the only opportunity to obtain benefits.
- Any assertion or statement that the plan is endorsed by CMS, the Federal or State government, or a similar entity.

The plan cannot entice a potential member to join the plan by offering the sale of any other type of insurance as a bonus for enrollment, and the plan must ensure that a potential member can make his/her own decision as to whether or not to enroll. Marketing shall be designed to reach a distribution of potential members across age and sex categories. Potential members may not be discriminated against on the basis of health status or need for health care services, or on any illegal basis.

Upon approval of the member materials distribution plan, the plan can make these posters available to the local DFR offices and enrollment centers for display in an area where Healthy Indiana application or member enrollment occurs. The local DFR offices and enrollment centers may display these promotional materials at its discretion. The plan may display these same promotional materials at community health fairs or other outreach activities. OMPP must pre-approve all promotional and informational brochures or flyers and all graphics prior to display or distribution.

As is the case with the current SCHIP program, all applicants for HIP will be screened for Medicaid eligibility, and will be enrolled in Medicaid if they qualify.

BENEFITS

HIP features a basic benefit package delivered through an innovative insurance product that encourages individuals to take a more proactive role in managing their health and payment for health care services. Qualified individuals will be eligible for a fully subsidized high-deductible health plan. The benefit package will include physician services, inpatient and outpatient care, prescription drugs, durable medical equipment, home health, diagnostic services and therapies, up to an annual maximum of $300,000 and a $1 million lifetime maximum. See Attachment 2 for a draft list of proposed services to be included in the basic benefit package. Individuals who are at risk of exceeding the maximum amount of coverage because of a chronic illness will be covered through a new program of the Indiana Comprehensive Health Insurance Association (ICHIA) program. Indiana will claim federal financial participation for the cost of HIP eligible individuals who are covered through ICHIA. Prescription drug coverage is limited to generic drugs if available. The plan requires a deductible of $1,100 per adult and provides for full coverage with no cost sharing (except for non-emergency services provided in an emergency department) after the deductible is met. Mental health benefits will be limited to inpatient care and prescription drugs. Benefits will exclude vision and dental. Maternity and outpatient mental health services will be available through current FSSA programs and will not be a part of this benefits plan.

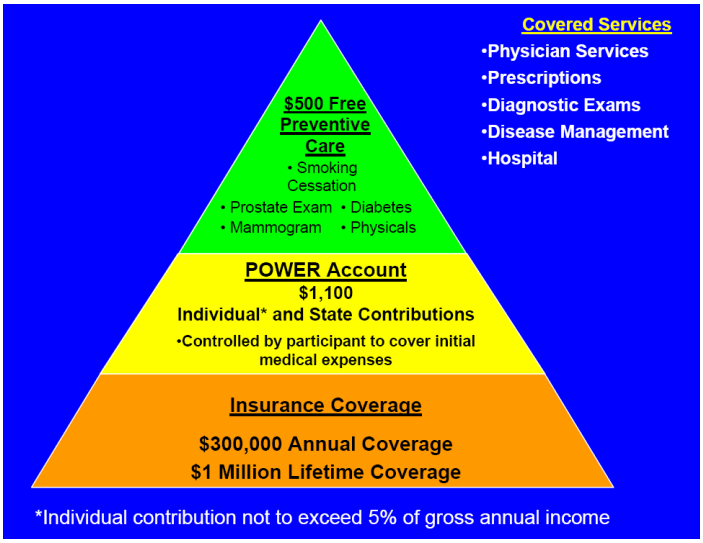
Preventive Services

One innovative feature of the demonstration is the removal of barriers to receiving preventive care, in spite of the high-deductible health plan design. The plan includes an annual budget of $500 of "first dollar" coverage for preventive services, meaning cost sharing for preventive care is not required and is separate from the deductible. The budget may be used to cover routine preventive services such as mammograms, colorectal screenings, smoking cessation classes and smoking patches. These services will be identified annually by the Office of Medicaid Policy and Planning based on the Centers for Disease Control and Prevention Preventative Services Guidelines, and will be those services that can be substantiated through provider claims data.

Personal Wellness & Responsibility (POWER) Accounts

The high deductible plan will be offered in conjunction with a "POWER" Account." The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA). Both accounts contain contributions from the individuals to meet deductible costs. Individuals are encouraged to make value

and cost conscious decisions as they can have access to these funds and use them to defray medical costs in the future. However, there are key differences between traditional HSAs and the POWER accounts. As the POWER Account is not a traditional HSA account, contributions to the account are not tax-free. This is not a concern because of the low tax liability of the target population. In both cases, an account would exist side-by-side with a high deductible health plan (HDHP). This type of arrangement has been considered problematic for lower income individuals, particularly those who have been uninsured, because of the financial burden of setting aside funds in the HSA, in addition to the cost of the HDHP and co-pays. Furthermore, when an individual's funds need to be used for preventive care, this may present a disincentive to seeking needed care. In HIP, the POWER accounts are designed to be compatible with the needs of a low-income population. Preventive services are covered up to $500 per year and are included in the HDHP. Therefore, the first $500 of preventive services is not subject to the deductible. Because of preventive services being funded with first dollar coverage, it is not likely that individuals would forego preventive care in order to preserve a balance in the POWER account.



The POWER Accounts are funded with required individual contributions and in some cases, a state contribution. The individual is allowed to access the account through a "debit card" and can use it to pay for services up to the deductible amount. The card can only be used for approved plan benefits delivered by approved providers, which assures the individual has access to Medicaid negotiated provider rates. Additionally it provides assurance to the State and taxpayers that the account will not be used for unproven medical treatments. At the conclusion of the 12-month coverage term, individuals can access the prorated funds they have contributed over a required minimum balance of $500, if they have completed preventive services deemed appropriate for their specific age and gender. The funds accessed in this fashion can be used to pay for non-covered medical services such as vision and dental care. This is another incentive to receive

needed preventive care. In addition, the ability to access leftover funds is considered an important incentive to control health care expenditures.

The next year's state and participant contributions are pro-rated to reflect the balance in the account. In other words, the required contribution would be the lower of 5% of income or the difference between $1,100 and the remaining balance in the account. If a person is no longer eligible for coverage, they can access his or her share of the remaining balance. For example, if there is $300 left in the account, and the participant contributed a third of the account overall, then he/she would receive $100. This "cash-back option" provides a financial incentive for individuals to adopt healthy lifestyles in order to obtain better overall health, as well as to utilize health care services in a cost effective manner. If a person drops out of the program after 12 months, they will not have access to any funds in the account. Additionally, once a person drops out of the program, they must wait 18 months before they reapply.

Service Delivery System

FSSA will contract with between two and four commercial carriers for the operation of the plan. Insurance companies will provide a standard commercial benefit plan to participants. The plan has been priced at Medicare rates in order to encourage participation by health providers. FSSA will pay plans on a per member per month basis, with insurers bearing full risk. Rates will be age and sex rated. Plans will also develop varying disease management programs for those individuals with chronic health care conditions and can include financial incentives for appropriate health behaviors. Plans will compete on the basis of the provider networks they offer, as well as customer service options they make available to participants. This free market competition is intended to help assure the high quality of plan services.

Additionally, as part of the application, individuals will be asked to complete a general health questionnaire. The health questionnaire will identify those individuals with "high risk conditions," as identified by the Office of Medicaid Policy and Planning (OMPP). OMPP will contract with the Indiana Comprehensive Health Insurance Pool (ICHIA), the State's high-risk pool to provide insurance to these individuals. ICHIA has significant expertise in managing high cost individuals. Individuals will have the same cost-sharing requirements but the State will pay a higher premium and the amount of the POWER account may be higher. Limits on services, annual, and lifetime benefits may also be altered to address the intense service needs of this population.

The following diseases and conditions are an example of potential "high risk conditions" that will trigger an ICHIA referral:

ICHIA Disease States and Conditions			
Addison's Disease	Chrohn's Disease	Leukemia	Scoliosis
Artificial Heart Valve	Cystic Fibrosis	Lupus Erythematosus	Sickle Cell Anemia
Bronchopulmonary Dysplagia	Dermatomyositis	Kidney Transplant within the last two (2) years	Splenic Anemia
Cancer (malignant tumor) within the last four (4) years	Insulin Dependent Diabetes Mellitus	Multiple or Disseminated Sclerosis	Still's Disease
Cardiomyopathy	Epilepsy	Muscular Dystrophy	Syphyllis of Cardiovascular System
Cerebral Palsy	Hemophilia	Myasthenia Gravis	Tabes Doralis
Cirrhosis of the Liver	HIV or AIDS	Paraplegia or Quadriplegia	Thalassemia
Chronic Obstructive Pulmonary Disease	Hydrocephalus	Perenicious Anemia	Topectomy and Lobotomy
Myocardial Infarction within the last two (2) years	Lead Poisoning with Cerebral Involvement	Polyarteritis	Ventilator Dependency

Healthy Indiana enrollees will also be asked to fill out general health questionnaires upon re-enrollment. If the general health questionnaire indicates that the member has developed a "high risk condition," the member will be disenrolled from the Plan and referred to ICHIA.

ICHIA referrals will only occur at the time of an initial Healthy Indiana eligibility determination or at the beginning of a new coverage term. If a member develops a "high risk condition" at any time during a coverage term, the member will not be referred to ICHIA until the beginning of the next coverage term. Additionally, ICHIA referrals will be reviewed annually, to determine if they can be served by the commercial insurers.

COST-SHARING REQUIREMENTS

Individual Contributions

An important aspect of HIP is personal responsibility through cost sharing. The plan is designed in such a way that cost sharing should not represent a barrier to the receipt of preventive health care services, as described in the section on preventive care, but places an incentive for participants to make value and cost conscious decisions about how and where they receive their care.

The required individual contributions will be equivalent to 5% of gross annual family income, per current CMS guidelines, up to a maximum of $1,100 annually, which is equivalent to the required deductible and the initial balance in the POWER account. Moreover, the required contribution will be adjusted to account for any contributions made to the Medicare or other Medicaid program such as SCHIP. Contributions can be collected through payroll deductions and/or direct payments. All contributions will be deposited in the beneficiary's POWER Account. After the POWER account is depleted, or the deductible is met, beneficiaries will receive full coverage with no cost sharing, except for a $50 co-payment for emergency room services that do not result in an inpatient admission. Because the $50 co-payment will be in addition to the 5% of income required to be contributed toward the POWER account, Indiana will be asking for authority under Section 1115 to impose this co-payment.

The cost-sharing design of HIP is innovative in that all individual contributions go toward meeting the deductible, and are potentially available to the individual if unspent. This design avoids important drawbacks that are present in other cost-sharing models. For example, cost sharing in the form of co-payments can tend to discourage individuals from seeking important preventive services. However, HIP provides $500 in first dollar coverage for preventive care. Requiring participants to pay premiums may discourage enrollment because it is difficult for a healthy low-income individual to see the value in paying a premium when there are many competing demands on their scarce financial resources. However, if they are aware that prudent management of their health care expenditures and adopting lifestyles that keep them healthy can leave them with available funds at the end of the year, and lower next year's contribution, they are provided with a unique incentive to devote funds toward health insurance. It is important to note, however, that the funds are not available unless individuals are compliant with needed preventive and screening services.

State Contribution

There will be two parts to the State's contribution to the cost of coverage. In addition to covering the full cost of the high deductible health plan and the preventive benefit, the State will fill the gap between the individual's contribution (up to 5% of income) and the $1,100 deductible to assure the POWER Account is fully funded.

Voluntary Employer Contributions

In keeping with the goal of helping Hoosier businesses offer a benefit to their employees if they have been heretofore unable to do so, employers may elect to make a contribution towards their employees' POWER Accounts.

CARE SELECT INITIATIVE

Appreciating the benefits of coordinated care in Medicaid—as well as the growing need to control costs—FSSA has developed a care coordination model called Care Select. Beginning in late 2007, Care Select will serve the aged, blind and disabled (ABD) populations currently enrolled in Indiana Medicaid.

There are three (3) fundamental goals of the Care Select program:

- To more effectively tailor benefits to the ABD population's needs by using evidence-based medicine to manage services by duration, scope and severity;
- To improve the quality of care and health outcomes for the ABD population; and
- To control the growth of health care costs for the ABD population.

The Care Select program will help control the growth of health care costs in part by facilitating a better use of community resources; reducing duplication of resources; fostering appropriate and accessible health care; reducing ER visits; reducing avoidable hospitalizations; and providing more effective health promotion and prevention activities. ABD populations can benefit from an increased use of evidence-based guidelines; less fragmented care and improved patient education, among other things. FSSA has designed the Care Select program with these concepts in mind.

The Care Select program will be comprised of various care management, case management and utilization management activities. FSSA will contract with a Care Management Organization (CMO) to provide these services through interdisciplinary care teams. The CMO will proactively assist all members, but special attention will be paid to those members determined to be at risk for an acute or catastrophic episode of care in the future.

In the interest of remaining on track with Indiana's Care Select goals, the initiative is being implemented as part of the Hoosier Healthwise waiver under Section 1915(b) authority. This ensures that Indiana has the necessary authority to issue the Request for Services (RFS) for the CMO. Indiana envisions that the Section 1915(b) waiver will operate concurrently with the HIP demonstration, and that savings from care management will be re-invested as a source of funding for coverage of childless adults in HIP.

Some of the CMO's specific duties will include identification of member needs and risks; identification of services members are currently receiving; identification of members' unmet needs; stratification of members into care

levels; linking members to services (i.e., care coordination); making sure that members are receiving appropriate care in the appropriate setting by the appropriate providers; and ensuring that members receive holistic health care. Maximizing independence and member self-determination will be a fundamental tenant of the Care Select program. The kinds of services that will be coordinated are set forth in the figure below:

The Care Select program is in the early stages of implementation. A Request for Services (RFS) for a CMO contractor was issued in December 2006. Care Select will be rolled out in the Central Region of Indiana by October 2007. This region consists of 11 counties. Other regions will be phased in at a later date. Care Select will be a statewide program no later than July 2009.

ACCOUNTABILITY AND MONITORING

Evaluation

By pairing high deductible health plans with POWER accounts, HIP represents an innovative approach to Medicaid benefit design. As such, Indiana is keenly interested in evaluating the program's impact and anticipates that the information obtained from the evaluation will help inform policy makers across the country as states continue to look for inventive ways to expand coverage and contain costs. If adjustments to the program are needed over time, the evaluation will also provide FSSA with the necessary data to make informed program modifications and help enhance HIP's future effectiveness.

The State has identified overall evaluation objectives, key research questions and hypotheses, data sources and methodologies that can serve as a framework for the evaluation. In order to obtain an objective assessment of HIP's impact, FSSA intends to contract with an outside entity to perform the evaluation. In addition, the State understands that CMS sometimes contracts with evaluators to measure outcomes under Section 1115 demonstrations. In the event there is a CMS-sponsored evaluation of HIP, Indiana will fully cooperate with the effort.

Evaluation Objectives

HIP provides the State and CMS with a significant opportunity to evaluate the nation's first large scale experiment with a high deductible health plan paired with an HSA look-alike product in Medicaid. The evaluation will thus focus on this and other novel aspects of the demonstration, keeping the State's seven core values in mind. Specifically, the following evaluation objectives have been identified by the State:

- To evaluate take-up and participation in HIP as demonstrated by: a) level and duration of enrollment; and b) changes in the State's uninsurance rate.
- To evaluate the effectiveness of pairing high deductible health plans with HSA look-alike products for a low income population as demonstrated by: a) changes in utilization behavior; b) engagement in healthy behaviors; c) cost-consciousness; and d) consumer satisfaction.
- To evaluate the impact of HIP on access to preventative care as demonstrated by: a) utilization of preventive services; and b) improved outcomes measures.
- To evaluate the effectiveness of the Care Select initiative in relation to cost and consumer needs and outcomes as demonstrated by: a)

changes in overall consumer health status; b) improved management of chronic illness; c) cost-savings; and d) consumer satisfaction.
- To evaluate the effectiveness of free market competition in Medicaid as demonstrated by: a) the number of insurers and benefit designs from which a consumer may choose; and b) consumer satisfaction.
- To evaluate the impact of HIP on the health care safety net as demonstrated by the increased ability of safety net providers to care for childless adults below the poverty level.

Research Questions/Hypotheses

The research questions and the State's hypotheses are organized by topic area below. The ultimate goal of the evaluation will be to describe and measure the impact of the more innovative aspects of HIP's design.

Participation

Research Questions

- What is the level of the target population's awareness of HIP?
- What is the rate of enrollment in HIP? How does it compare to the rate of enrollment in SCHIP?
- What is the effect of allowing insurers to directly market to individuals?
- What is the average duration of enrollment in HIP?
- How many are disenrolled due to failure to pay their monthly contribution?
- What factors result in losing coverage under HIP (e.g., income increases, income decreases, failure to pay individual contributions, etc.)?
- What are the characteristics of eligible individuals that choose not to enroll in HIP?

Hypotheses

It is expected that:

- Program visibility and rate of enrollment will be high due to the ability to fund POWER accounts with payroll deductions, the existence of multiple enrollment avenues and the ability of commercial insurers to market their plans to the public.

- The percentage of uninsured Hoosiers, particularly working adults with low incomes, will decrease as enrollment in HIP increases.

POWER Accounts

Research Questions

- How do HIP consumers choose to spend their account funds?
- What is the average amount of account funds that remain unspent at the end of a year?
- How many consumers have unspent account funds? What is the average amount of unspent funds? How many consumers use fund balances to lower their contribution in the following year?
- How many use unspent funds to pay for dental or vision services. Which services are used more readily, dental or vision?
- When provided the opportunity, do employers voluntarily contribute to the account? If so, what is the average contribution?
- To what degree is cost consciousness fostered by the requirement that consumers contribute to the account? Are lower-cost services substituted for higher-cost services when compared to other Medicaid populations? Do consumers exhibit a more informed understanding of the cost of health care services when compared to other Medicaid populations?
- To what degree does the POWER account promote healthy behaviors and self-determination in making health care decisions? Will increased enrollee involvement in health care decision-making result in a decrease in emergency department use and unnecessary inpatient utilization?
- Will insurers provide accounts in excess of the $1,100 deductible for high-risk enrollees? If they do, what is their experience?
- To what extent are consumers satisfied with HIP's design, the POWER account, and their debit card?

Hypotheses

It is expected that:

- Consumers will begin to make value and cost-conscious decisions, as well as engage in healthy behaviors, due to their financial stake in the program.
- Utilization patterns will change, including reduced emergency department use, substitution of lower cost prescription drugs, a reduction in unnecessary inpatient utilization, etc.

- Transparency in the health care system will increase and providers will become more accountable for their outcomes.
- High rates of consumer satisfaction will indicate HIP's compatibility with the needs of a low-income population.

Preventive Services

Research Questions

- Will the overall health status of the target population improve?
- How many have conditions they warrant a referral to ICHIA?
- How much of the $500 of first dollar coverage for preventive services are used by consumers to obtain necessary services?
- What is the utilization rate for preventive services such as smoking cessation and immunizations? How does it compare to the overall Medicaid population, commercial and national rates?
- What is the utilization rate for screening services such as mammograms, pap smears, diabetes screenings and colonoscopies? How do these compare to national benchmarks?

Hypotheses

It is expected that:

- The $500 in first dollar coverage for preventive services will be an important design feature that will eliminate substantial barriers to receiving preventive care.
- The opportunity to receive a rebate will motivate consumers to obtain recommended preventive care services.
- Health status for the target population will improve and will be comparable to national rates if not better.
- Preventive care utilization will increase and Indiana's current low rates of mammogram testing, pap smears and colonoscopies will improve.
- Other indicators of preventive care, including emergency department utilization, will also improve.

Care Select

Research Questions

- Will management of chronic illness and use of evidence-based guidelines in the target population improve?
- What amount of cost-savings is generated?

- Will consumer satisfaction with the quality of care improve?
- Will health status of the target population improve?
- Will utilization measures like emergency department use and preventable hospitalizations decline?

Hypotheses

It is expected that:

- Coordination of care will improve—consumers will receive appropriate care in the appropriate setting and duplicative services will be reduced.
- According to HEDIS measures and other evidence-based guidelines, individuals in the Care Select program will receive the care recommended for their chronic condition, if any.
- Emergency department use and preventable inpatient hospitalizations will decline.
- Consumer satisfaction with quality will increase.

Consumer Choice and Quality of Care

Research Questions

- What is the number and type of insurers participating in HIP? Do consumers have many choices in available plan designs?
- To what extent do insurers provide additional services?
- To what extent do insurers create innovative disease management programs for people with chronic illnesses?
- What kind of incentives do insurers provide for preventive health services and healthy behaviors? What is the level of patient participation in preventive health services and healthy behaviors?
- What is the level of consumer satisfaction with the quality of care?

Hypotheses

It is expected that:

- Two to four insurers will participate in HIP, competing based on provider network, plan design and customer service.
- Insurers will develop innovative plan designs, including disease management programs and incentives for preventive services and healthy behaviors.

- In comparison to other Medicaid populations, a high percentage of consumers will participate in healthy behaviors and obtain preventive health services.
- Consumer satisfaction with quality as measured by the Consumer Assessment of Health Plan Survey (CAHPS) will be high.

Status of the Safety Net

Research Questions

- How is the safety net, including public hospitals, affected by the demonstration in terms of their ability to provide needed care for childless adults below the poverty level?
- What types of networks are created? Do they include traditional safety net providers?
- Do participants seek care at traditional safety net venues or is care provided by more commercially oriented providers?
- Are new funds infused into the safety net system as a result of the demonstration?

Hypotheses

It is expected that:

- The safety net will be better able to accommodate the needs of childless adults due to an increase in the number of insured persons obtaining care at their institution.

Data Sources

Final decisions regarding data sources will depend upon the exact evaluation design. However, at this time FSSA anticipates that the data sources will include claims and encounter data as well as targeted surveys to the extent permitted by funding availability.

TITLE XIX WAIVERS

In order to implement HIP, Indiana is seeking both waiver authority under Section 1115(a)(1) and expenditure authority for costs not otherwise matchable (CNOM) under Section 1115(a)(2). These are:

Waiver Requests

- 1902(a)(10)(B) (amount, duration and scope), to the extent necessary to offer a different benefit package to demonstration eligibles through HIP.

- 1902(a)(23) (freedom of choice), to the extent necessary to enroll aged, blind and disabled beneficiaries in the Care Select initiative. (Given that Care Select will exist concurrently in the Hoosier Healthwise Section 1915(b) program, CMS may determine that this authority is not necessary.)

Expenditure Authority

- To the extent necessary to cover non-disabled childless adults not otherwise eligible under any Medicaid eligibility category.
- To the extent necessary to receive FFP for a health coverage model that has the potential to require more than 5% of income in the form of cost-sharing (ER co-payment only).
- To the extent necessary to permit enhanced matching for individual and state contributions to POWER accounts.

FINANCING AND BUDGET NEUTRALITY

Indiana proposes to fund HIP through several proposed new State revenue sources. The amount of revenue raised will determine how many Hoosiers can be covered. As discussed earlier, HIP calls for individual contributions to help cover the cost of the plan. In line with improving the health of Hoosiers and reducing smoking rates in Indiana, the Governor proposes raising the cost of cigarettes by at least 25 cents. The Governor proposes that the first $35M of any new revenue be directed toward smoking cessation ($24M) and reduction programs and immunizations programs ($11M). The remaining funds will be directed exclusively to covering uninsured Hoosiers. The Governor is supportive of further increases in the cost of cigarettes but has left the exact amount and resulting breadth of coverage to the State Legislature to determine. The attached budget worksheet provides more detail.

Indiana will seek federal matching funds for the cost of the plan and has utilized a multi-faceted approach to meeting the federal budget neutrality test for Section 1115 demonstrations. The elements of the approach are outlined below.

- Reinvestment of Managed Care Savings: Indiana is cognizant of the fact that the main tool for funding coverage of noncategorical populations through a Section 1115 demonstration has historically been the redirection of funds that would otherwise be paid to hospitals as disproportionate share (DSH) payments. In addition, under some of the early Health Insurance Flexibility and Affordability (HIFA) demonstrations, states were permitted to use excess SCHIP allotment to finance coverage of childless adults. Pursuant to the Deficit Reduction Act, the SCHIP option no longer exists. Since Indiana is not a state with a high DSH allotment, creative options are necessary in order to finance childless adults in the budget neutrality agreement. Therefore, Indiana proposes to reinvest the savings from its implementation of risk-based managed care to cover this population.
- Flexibility of the SPA Process: Indiana could expand coverage to parents under the current state plan. However, the State will expand coverage through a waiver instead, so that the benefit of program design innovations (such as the POWER accounts) can be demonstrated. Because parents are a categorical group under the Medicaid statute, however, they will be considered a "pass-through" population for the purpose of constructing the budget neutrality agreement.

- Medicaid Savings: By far, the most expensive group in the current Indiana Medicaid program is the ABD population. Indiana will be incorporating into the demonstration an innovative care management approach for this group, and the savings accrued will be applied to the budget neutrality test. Indiana has been conservative in estimating the projected savings for this initiative; savings could be greater than the projections included in the budget neutrality spreadsheets.
- DSH Funding*:* The current DSH program funds both state hospitals as well as other public and private institutions**.** As health insurance coverage rates increase, there should be an associated decrease in the need for funding for uncompensated care at hospitals. In recognition of this, Indiana will be applying a significant part of its DSH allocation toward the demonstration in order to help meet budget neutrality. This reduction in the DSH program will be directed at non-State facilities.
- Cost Limits: An important part of the budget neutrality picture is the idea of controlling the cost of the expansion group so that it does not exceed the funding available from DSH and Medicaid savings. Indiana will keep the costs of the childless adults to be covered under the demonstration low by requiring premium payments, by using a defined contribution approach and by limiting availability of coverage to those with incomes between 100% and 200% of the FPL.
- Health Opportunity Accounts (HOA): Consistent with the guidance that has been issued with respect to the HOA option under the Deficit Reduction Act, Indiana's budget neutrality calculations provide for enhanced matching funds (at the SCHIP rate) for individual and state contributions to the POWER accounts.

The attached budget neutrality spreadsheets present the calculations that result from the assumptions outlined above.

ATTACHMENT 1: BUDGET NEUTRALITY CALCULATIONS

ATTACHMENT 2: PROPOSED BASIC BENEFIT PACKAGE

HEALTHY INDIANA PLAN

Without Waiver Summary (TC)	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
XIX - Mandatory Populations	1,643,349,979	1,808,241,864	1,990,007,161	2,190,408,460	2,411,396,350	10,043,403,813
XIX - Optional Populations	90,826,081	224,240,924	305,136,567	394,817,931	494,086,871	1,509,108,373
Total	1,734,176,060	2,032,482,788	2,295,143,727	2,585,226,390	2,905,483,220	11,552,512,186

With Waiver Summary	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
XIX - Mandatory Populations	1,643,349,979	1,808,241,864	1,990,007,161	2,190,408,460	2,411,396,350	10,043,403,813
XIX - Optional Populations	90,826,081	224,240,924	305,136,567	394,817,931	494,086,871	1,509,108,373
Waiver Populations	112,452,497	158,798,442	210,281,340	311,916,573	425,015,139	1,218,463,992
Managed Care Savings	(378,435,000)	(129,485,000)	(135,964,250)	(142,732,463)	(149,894,086)	(936,510,798)
DSH	(80,000,000)	(80,000,000)	(80,000,000)	(80,000,000)	(80,000,000)	(400,000,000)
Total	1,388,193,557	1,981,796,230	2,289,460,818	2,674,410,501	3,100,604,274	11,434,465,380
Waiver Margin	**345,982,503**	**50,686,558**	**5,682,910**	**(89,184,111)**	**(195,121,053)**	**118,046,806**

Coverage Estimates		DY 01	DY 02	DY 03	DY 04	DY 05
Number of Eligibles						
	Parents	167,426	167,426	167,426	167,426	167,426
	Childless Adults	184,030	184,030	184,030	184,030	184,030
	Total	**351,456**	**351,456**	**351,456**	**351,456**	**351,456**
Anticipated Enrollment						
	Parents	25,114	58,599	75,342	92,084	108,827
	Childless Adults	27,605	36,806	46,008	64,411	82,814
	Total	**52,718**	**95,405**	**121,349**	**156,495**	**191,640**
Anticipated Coverage Rate						
	Parents	15.0%	35.0%	45.0%	55.0%	65.0%
	Childless Adults	15.0%	20.0%	25.0%	35.0%	45.0%
	Total	15.0%	27.1%	34.5%	44.5%	54.5%

	A	B	C	D	E	F	G	H
1	**HEALTHY INDIANA PLAN**							
2								
3	**HISTORIC DATA: BASE YEAR (BY) AND 4 PRIOR YEARS FOR MANDATORY POPULATIONS**							
4								
5	**TIME PERIOD AND ELIGIBILITY GROUP SERVED:**							
6		**2002**	**2003**	**2004**	**2005**	**2006**	**5-YEARS**	
7	**TOTAL EXPENDITURES**							
8	TANF Adults	$ 226,380,855	$ 260,872,263	$ 296,224,312	$ 314,718,750	$331,900,128	$1,430,096,308	
9	**ELIGIBLE MEMBER MONTHS**	878,092	982,705	1,098,423	1,143,240	1,162,087		
10	**COST PER ELIGIBLE**	$ 257.81	$ 265.46	$ 269.68	$ 275.29	$ 285.61		
11	**TREND RATES**						**5-YEAR**	
12			**ANNUAL CHANGE**				**AVERAGE**	
13	TOTAL EXPENDITURE		0.152360092	0.135514786	0.062433896	0.054592801	10.04%	
14	ELIGIBLE MEMBER MONTHS		11.91%	11.78%	4.08%	1.65%	7.26%	
15	COST PER ELIGIBLE		2.97%	1.59%	2.08%	3.75%	2.59%	
16								
17	**TOTAL EXPENDITURES**							
18	ABD Non-Duals	$ 465,009,589	$ 503,947,328	$ 572,010,235	$ 616,338,551	$652,898,707	$2,810,204,410	
19	**ELIGIBLE MEMBER MONTHS**	505,427	537,717	570,784	596,617	595,145		
20	**COST PER ELIGIBLE**	920.0331383	937.1980577	1002.148335	1033.05563	1097.041405		
21	**TREND RATES**						**5-YEAR**	
22			**ANNUAL CHANGE**				**AVERAGE**	
23	TOTAL EXPENDITURE		8.37%	13.51%	7.75%	5.93%	8.85%	
24	ELIGIBLE MEMBER MONTHS		6.39%	6.15%	4.53%	-0.25%	4.17%	
25	COST PER ELIGIBLE		1.87%	6.93%	3.08%	6.19%	4.50%	
26								
27	**TOTAL EXPENDITURES**							
28	ABD Duals	$ 378,074,929	$ 334,871,846	$ 376,554,477	$ 416,009,240	$310,061,220	$1,815,571,712	
29	**ELIGIBLE MEMBER MONTHS**	671,240	704,110	734,532	755,042	740,883		
30	**COST PER ELIGIBLE**	$ 563.25	$ 475.60	$ 512.65	$ 550.97	$ 418.50		
31	**TREND RATES**						**5-YEAR**	**ADJUSTED**
32			**ANNUAL CHANGE**				**AVERAGE**	**AVERAGE***
33	TOTAL EXPENDITURE		-11.43%	12.45%	10.48%	-25.47%	-4.84%	11.00%
34	ELIGIBLE MEMBER MONTHS		4.90%	4.32%	2.79%	-1.88%	2.50%	4.00%
35	COST PER ELIGIBLE		-15.56%	7.79%	7.48%	-24.04%	-7.16%	8.00%
36								
37	*Adjusted average reflects growth from SFY2003 to SFY2005 to more accurately reflect actual growth rates and exclude two artificial factors							
38	that affected trend rates between 2002 and 2006. Between 2002 and 2003, the Office of Medicaid Policy and Planning (OMPP)							
39	changed the coordination of benefit rule for Medicare eligible recipients, significantly reducing payment for claims paid primarily by Medicare.							
40	This created a negative trend between 2002 and 2003. In addition, the introduction of Medicare Part D in 2006 reduced pharmacy expenditures,							
41	creating another negative trend between 2005 and 2006.							

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**HEALTHY INDIANA PLAN**						**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION**											
2																		
3	**MANDATORY POPULATIONS**										**NEW OPTIONAL POPULATIONS**							
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**DEMONSTRATION YEARS (DY)**					**TOTAL**		**ELIGIBILITY**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
5	**GROUP**	**RATE**	**OF AGING**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**		**GROUP**	**RATE**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**
6	**TANF Adults**										**Parents 22-100% FPL - One Parent**							
7	Eligible Member Months	7.26%	30	1,384,628	1,485,152	1,592,974	1,708,624	1,832,670			Eligible Members		6,458	15,070	19,375	23,681	27,986	
8	Total Cost Per Eligible	2.59%	30	$ 304	$ 312	$ 320	$ 329	$ 337			Total Cost Per Eligible		$ 3,881	4,098	4,329	4,574	4,835	
9	Total Expenditure			$ 421,564,931	$ 463,881,762	$510,446,371	$ 561,685,152	$ 618,067,298	$ 2,575,645,515		Total Expenditure		$ 25,063,498	61,760,100	83,874,825	108,324,007	135,311,718	$ 414,334,148
10																		
11	**ABD Non-Duals**										**Parents 22-100% FPL - Two Parents**							
12	Eligible Member Months	4.17%	30	659,143	686,629	715,261	745,088	776,158			Eligible Members		5,614	13,099	16,842	20,585	24,328	
13	Total Cost Per Eligible	4.50%	30	$ 1,225	$ 1,280	$ 1,337	$ 1,398	$ 1,460			Total Cost Per Eligible		$ 3,529	$ 3,720	$ 3,922	$ 4,137	$ 4,365	
14	Total Expenditure			$ 807,222,382	$ 878,723,315	$956,557,551	$ 1,041,286,071	$ 1,133,519,546	$ 4,817,308,865		Total Expenditure		$ 19,811,806	$ 48,722,844	$ 66,053,920	$ 85,158,740	$ 106,198,045	$ 325,945,355
15																		
16																		
17	**ABD Duals**										**Parents 100-150% FPL - One Parent**							
18	Eligible Member Months	4.00%	30	817,209	849,897	883,893	919,249	956,019			Eligible Members		2,996	6,990	8,987	10,984	12,981	
19	Total Cost Per Eligible	8.00%	30	$ 507	$ 548	$ 592	$ 639	$ 690			Total Cost Per Eligible		$ 3,623	$ 3,851	$ 4,093	$ 4,352	$ 4,626	
20	Total Expenditure			$ 414,562,666	$ 465,636,786	$523,003,238	$ 587,437,237	$ 659,809,505	$ 2,650,449,433		Total Expenditure		$ 10,854,508	$ 26,917,407	$ 36,787,253	$ 47,797,689	$ 60,055,647	$ 182,412,503
21																		
22																		
23											**Parents 100-150% FPL - Two Parents**							
24	**EXISTING OPTIONAL POPULATIONS - none**										Eligible Members		2,583	6,028	7,750	9,473	11,195	
25											Total Cost Per Eligible		$ 3,444	$ 3,643	$ 3,855	$ 4,080	$ 4,319	
26											Total Expenditure		$ 8,895,852	$ 21,960,366	$ 29,873,823	$ 38,646,922	$ 48,350,523	$ 147,727,487
27																		
28																		
29											**Parents 150-200% FPL - One Parent**							
30											Eligible Members		3,582	8,359	10,747	13,135	15,523	
31											Total Cost Per Eligible		$ 3,051	$ 3,245	$ 3,451	$ 3,671	$ 3,905	
32											Total Expenditure		$ 10,928,682	$ 27,122,991	$ 37,088,504	$ 48,214,482	$ 60,609,934	$ 183,964,592
33																		
34											**Parents 150-200% FPL - Two Parents**							
35											Eligible Members		3,881	9,054	11,641	14,227	16,814	
36											Total Cost Per Eligible		$ 3,935	$ 4,170	$ 4,420	$ 4,687	$ 4,970	
37											Total Expenditure		$ 15,271,735	$ 37,757,217	$ 51,458,242	$ 66,676,092	$ 83,561,004	$ 254,724,289
38																		
39													25,114					

	A	B	C	D	E	F	G	H	I	J
1	**HEALTHY INDIANA PLAN**									
2							**DEMONSTRATION WITH WAIVER (W/W) BUDGET PROJECTION**			
3										
4	**MANDATORY POPULATIONS**									
5				**DEMONSTRATION YEARS (DY)**					**TOTAL WW**	
6	**ELIGIBILITY GROUP**	**TREND RATE**		**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**		
7	**TANF Adults**									
8	Eligible Member Months	7.26%	30	1,384,628	1,485,152	1,592,974	1,708,624	1,832,670		
9	Total Cost per Eligible	2.59%	30	304	312	320	329	337		
10	Total Expenditure			421,564,931	463,881,762	510,446,371	561,685,152	618,067,298	2,575,645,515	
11	**ABD Non-Duals**									
12	Eligible Member Months	4.17%	30	659,143	686,629	715,261	745,088	776,158		
13	Total Cost per Eligible	4.50%	30	1,225	1,280	1,337	1,398	1,460		
14	Total Expenditure			807,222,382	878,723,315	956,557,551	1,041,286,071	1,133,519,546	4,817,308,865	
15	**ABD Duals**									
16	Eligible Member Months	4.00%	30	817,209	849,897	883,893	919,249	956,019		
17	Total Cost per Eligible	8.00%	30	507	548	592	639	690		
18	Total Expenditure			414,562,666	465,636,786	523,003,238	587,437,237	659,809,505	2,650,449,433	
19										
20	**Total Spending - Mandatory Pop.**			1,643,349,979	1,808,241,864	1,990,007,161	2,190,408,460	2,411,396,350	10,043,403,813	
21										

	M	N	O	P	Q	R	S	T	U	V
4	**NEW OPTIONAL POPULATIONS**									
5					**DEMONSTRATION YEARS (DY)**					**TOTAL**
6	**ELIGIBILITY GROUP**	**Premium**	**Power Acct**		**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WW**
7	Parents 22-100% FPL (One Parent)					**133.4%**	**28.6%**	**22.2%**	**18.2%**	
8	Estimated Enrollment				6,458	15,070	19,375	23,681	27,986	
9	Total Cost Per Eligible	$ 3,180	$ 701		3,881	4,098	4,329	4,574	4,835	
10	Total Expenditure	$ -			25,063,498	61,760,100	83,874,825	108,324,007	135,311,718	414,334,148
11	Parents 22-100% FPL (Two Parents)					**133.3%**	**28.6%**	**22.2%**	**18.2%**	
12	Estimated Enrollment				5,614	13,099	16,842	20,585	24,328	
13	Total Cost Per Eligible	$ 2,753	$ 776		3,529	3,720	3,922	4,137	4,365	
14	Total Expenditure				19,811,806	48,722,844	66,053,920	85,158,740	106,198,045	325,945,355
15	Parents 100-150% FPL (One Parent)					**133.3%**	**28.6%**	**22.2%**	**18.2%**	
16	Estimated Enrollment				2,996	6,990	8,987	10,984	12,981	
17	Total Cost Per Eligible	$ 3,470	$ 153		3,623	3,851	4,093	4,352	4,626	
18	Total Expenditure	$ -			10,854,508	26,917,407	36,787,253	47,797,689	60,055,647	182,412,503
19	Parents 100-150% FPL (Two Parents)					**133.4%**	**28.6%**	**22.2%**	**18.2%**	
20	Estimated Enrollment				2,583	6,028	7,750	9,473	11,195	
21	Total Cost Per Eligible	$ 2,948	$ 496		3,444	3,643	3,855	4,080	4,319	
22	Total Expenditure	$ -			8,895,852	21,960,366	29,873,823	38,646,922	48,350,523	147,727,487
23	Parents 150-200% FPL (One Parent)					**133.4%**	**28.6%**	**22.2%**	**18.2%**	
24	Estimated Enrollment				3,582	8,359	10,747	13,135	15,523	
25	Total Cost Per Eligible	$ 2,960	$ 91		3,051	3,245	3,451	3,671	3,905	
26	Total Expenditure				10,928,682	27,122,991	37,088,504	48,214,482	60,609,934	183,964,592
27	Parents 150-200% FPL (Two Parents)					**133.3%**	**28.6%**	**22.2%**	**18.2%**	
28	Estimated Enrollment				3,881	9,054	11,641	14,227	16,814	
29	Total Cost Per Eligible	$ 3,524	$ 411		3,935	4,170	4,420	4,687	4,970	
30	Total Expenditure				15,271,735	37,757,217	51,458,242	66,676,092	83,561,004	254,724,289
31										
32	**Total Optional Population Spending**				90,826,081	224,240,924	305,136,567	394,817,931	494,086,871	1,509,108,373
33										

	X	Y	Z	AA	AB	AC	AD	AE	AF	AG
4	**EXPANSION POPULATIONS**									
5					**DEMONSTRATION YEARS (DY)**					**TOTAL**
6	**ELIGIBILITY GROUP**	**Premium**	**Power Acct**		**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WW**
7	Childless Adults 100-150% FPL (Single Adult)					**33.3%**	**25.0%**	**40.0%**	**28.6%**	
8	Estimated Enrollment				11,574	15,432	19,290	27,005	34,721	
9	Total Cost per Eligible	$ 2,924	$ 552		3,476	3,674	3,885	4,109	4,348	
10	Total Expenditure				40,231,224	56,702,415	74,944,700	110,970,544	150,949,558	433,798,440
11	Childless Adults 100-150% FPL (Two Adults)					**33.3%**	**25.0%**	**40.0%**	**28.6%**	
12	Estimated Enrollment				2,001	2,668	3,336	4,670	6,004	
13	Total Cost per Eligible	$ 3,348	$ 754		4,102	4,331	4,574	4,833	5,107	
14	Total Expenditure				8,208,102	11,554,921	15,259,448	22,568,507	30,664,574	88,255,552
15	Childless Adults 150-200% FPL (Single Adults)					**33.3%**	**25.0%**	**40.0%**	**28.6%**	
16	Estimated Enrollment				10,852	14,469	18,087	25,321	32,556	
17	Total Cost per Eligible	$ 4,166	$ 336		4,502	4,778	5,071	5,384	5,716	
18	Total Expenditure				48,855,704	69,130,422	91,725,271	136,319,809	186,091,300	532,122,506
19	Childless Adults 100-150% FPL (Two Adults)					**33.4%**	**25.0%**	**40.0%**	**28.6%**	
20	Estimated Enrollment				3,177	4,237	5,296	7,414	9,532	
21	Total Cost per Eligible	$ 4,214	$ 557		4,771	5,053	5,353	5,673	6,012	
22	Total Expenditure				15,157,467	21,410,684	28,351,921	42,057,713	57,309,708	164,287,493
23										
24					112,452,497	158,798,442	210,281,340	311,916,573	425,015,139	1,218,463,992
25										

February 23, 2007

Ms. Seema Verma
Family & Social Services Administration
402 West Washington Street
W-461-MS 25
Indianapolis, In 46204

Dear Seema;

The purpose of this letter is to present our estimates of the cost and coverage impacts of the "Healthy Rewards" program.

Health Rewards Program

The healthy rewards program would provide to eligible people a high deductible health plan (i.e., $1,100) combined with a variation on the Health Savings Account (HSA) insurance products now being marketed in the private sector.

The program would be open to parents between the current Medicaid income eligibility level of 22 percent of the federal poverty level (FPL) and 300 percent of the FPL. Childless adults living between 100 percent and 300 percent of the FPL are also eligible. SCHIP is also expanded to cover children through 300 percent of the FPL. To limit the number of people shifting from private to public coverage (i.e., "Crowd-out"), the program requires that individuals be uninsured for at least six months prior to enrollment.

Under this program, eligible individuals are provided with a health plan with an annual deductible of $1,100 per person. Spending over that amount would be covered in full. In addition, individuals would make a contribution to a Healthy Rewards Account sufficient to cover $1,100 deductible.

However, the state would pay a portion of the individual's contribution such that the families combined out-of-pocket expense does not exceed five percent of income. Here, out-of-pocket expenses are defined to be the amount of the individual's contribution account plus any SCHIP premium payments they are making for any children in the family. Thus a substantial portion of the individual's contribution would actually be made by the state program.

Individuals would use the funds in the account to pay for services up to the deductible amount. Any amount of the individual's contribution that remains in the account at the end of the year would be refunded to the individual. Similarly,

the state share of the unused contribution would be recovered by the state at the end of the year. Thus, the unused portion of contributions to the account is split between the individual and the state in proportion to the amount of their initial contributions to the individual's account.

This design is intended to create an incentive for individuals to conserve on their use of health services. Individuals would face the cost of care up to the deductible amount. The potential recovery of these contributions at the end of the year would create an incentive to use the health care system as efficiently as possible, thus reducing health spending overall.

We also assume that the income eligibility level for pregnant women would be increased to 300 percent of the FPL.

Methods Used

We developed estimates of the cost and coverage impacts of this proposal using the Lewin Group Health Benefits Simulation Model (HBSM). HBSM is a micro-simulation model of the US health care system that is designed to provide state-level estimates of changes in health policy. The primary population database used in the model is the March Current Population Survey (CPS) data for 2004 developed by the Bureau of the Census. We adjusted these data to correct for under-reporting of Medicaid enrollment in the survey.

The model estimates the number of people eligible for coverage expansions through Medicaid or other proposed programs based upon the income and family characteristics of people included in the Indiana sub-sample of the CPS. These data were then used to estimate the premium cost for enrollees and the amount of the contribution to be paid by the individual and the state. The use of a micro-simulation approach enabled us to model the complex interactions of factors affecting costs, such as the distribution of people by income, age, sex and health spending amounts.

We then estimated the proportion of eligible people who enroll based upon historical data on program enrollment, which reflects the effect of a contribution requirement on the likelihood of enrolling. We adjusted the enrollment simulation to reflect that while the program will require participants to make a contribution to these accounts, much of their contribution is likely to be refunded to them at the end of the year, depending upon their utilization of health services. We estimate that about 43 percent of each individual's contribution is expected to be recovered by participants at the end of the year.

Premiums

The premiums used to estimate the cost of the insurance portion of the program were developed by the actuaries of Milliman Inc. These premiums vary by age and gender. These premiums are:

	Parents		Childless Adults	
Age	**Males**	**Females**	**Males**	**Females**
Under age 19	$107.00	$107.00	$107.00	$107.00
19 – 24	$115.46	$219.95	$103.91	$197.96
25 – 34	$146.60	$259.60	$131.94	$233.64
35 – 44	$222.25	$322.58	$200.02	$290.33
45 - 54	$371.12	$438.02	$334.01	$394.22
55 – 64	$649.20	$615.12	$584.28	$553.61

We assumed an average cost of $5,173 for pregnant women.

Estimates

Our estimates are presented in the three tables attached. They are:

Figure 1: Program enrollment and reduction in the number of uninsured;

Figure 2: Program Costs for newly enrolled. Includes premium costs, the state contribution to individual accounts less the amount of recoveries at year end, and the cost of covering currently eligible but not enrolled children who would become covered as their parent(s) become covered under the program; and

Figure 3: Average program costs and individual contributions for the Health Rewards Program.

Please contact me at 703 269-5610 if you have any questions.

Sincerely;

John Sheils, Vice President

Figure 1: Number of Affected People

	Eligible Adults	Newly Enrolled Adults	Reduction in Uninsured Adults	Newly Enrolled Children	Total Reduction in Uninsured
22% - 100% FPL					
One Parent Family	43,056	16,297	13,527	1,881	15,408
Two Adults Only	0	0	0	0	0
Two Parent Family	37,427	13,059	10,839	1,029	11,867
Single Adult	0	0	0	0	0
Pregnant Women	0	0	0	0	0
TOTAL	80,483	29,356	24,365	2,910	27,275
100% - 150% FPL					
One Parent Family	19,970	5,911	4,906	4,302	9,208
Two Adults Only	13,342	3,820	3,171	0	3,171
Two Parent Family	17,223	4,927	4,089	1,885	5,975
Single Adult	77,158	22,082	18,328	0	18,328
Pregnant Women	0	0	0	0	0
TOTAL	127,693	36,740	30,495	6,188	36,682
150% - 200% FPL					
One Parent Family	23,882	5,230	4,341	1,193	5,534
Two Adults Only	21,183	3,709	3,079	0	3,079
Two Parent Family	25,868	5,669	4,705	788	5,493
Single Adult	72,347	12,672	10,518	0	10,518
Pregnant Women	17,350	14,773	4,906	0	4,906
TOTAL	160,630	42,053	34,904	1,981	36,885
200% - 250% FPL					
One Parent Family	15,361	6,005	4,984	6,562	11,545
Two Adults Only	13,625	7,249	6,017	0	6,017
Two Parent Family	16,637	7,248	6,016	6,504	12,520

Single Adult	46,532	16,257	13,493	0	13,493
Pregnant Women	9,038	7,682	2,551	0	2,551
TOTAL	101,193	44,441	36,886	13,066	49,951
250% - 3200% FPL					
One Parent Family	11,857	1,026	852	993	1,845
Two Adults Only	10,517	4,172	3,463	0	3,463
Two Parent Family	12,842	3,674	3,050	2,761	5,811
Single Adult	35,918	8,203	6,809	0	6,809
Pregnant Women	7,460	6,039	2,006	0	2,006
TOTAL	78,594	23,115	19,186	3,754	22,939
22% - 300% FPL					
One Parent Family	114,126	37,615	28,609	14,931	42,688
Two Adults Only	58,666	18,453	15,729	0	12,266
Two Parent Family	109,997	39,105	28,698	12,967	38,616
Single Adult	231,955	74,127	49,148	0	42,340
Pregnant Women	33,848	28,494	9,463	0	7,457
TOTAL	548,592	175,705	145,835	27,898	154,548

Source: Health Benefits Simulation Model (HBSM)

Figure 2: Total Program Costs in 2006 (millions)

	Premium	State Contribution	Kids Costs Less Premiums	Contribution Recoveries	Total New Spending	Cost / Newly Enrolled	Cost / Newly Insured
22% - 100% FPL							
One Parent Family	$51.8	$11.4	$2.0	$4.9	$60.3	$3,319	$3,916
Two Adults Only	$0.0	$0.0	$0.0	$0.0	$0.0	$0	$0
Two Parent Family	$36.0	$10.1	$1.1	$4.4	$42.8	$1,718	$3,608
Single Adult	$0.0	$0.0	$0.0	$0.0	$0.0	$0	$0
Pregnant Women	$0.0	$0.0	$0.0	$0.0	$0.0	$0	$0
TOTAL	$87.8	$21.6	$3.1	$9.3	$103.2	$1,822	$3,782
100% - 150% FPL							
One Parent Family	$20.5	$0.9	$4.6	$0.4	$25.6	$2,506	$2,779
Two Adults Only	$12.8	$2.9	$0.0	$1.2	$14.4	$2,064	$4,552
Two Parent Family	$14.5	$2.4	$2.0	$1.1	$17.9	$1,644	$2,999
Single Adult	$64.6	$12.2	$0.0	$5.2	$71.5	$1,770	$3,902
Pregnant Women	$0.0	$0.0	$0.0	$0.0	$0.0	$0	$0
TOTAL	$112.4	$18.4	$6.6	$7.9	$129.5	$1,763	$3,529
150% - 200% FPL							
One Parent Family	$15.5	$0.5	$1.1	$0.2	$16.9	$2,625	$3,046
Two Adults Only	$15.6	$2.1	$0.0	$0.9	$16.8	$4,531	$5,459
Two Parent Family	$20.0	$2.3	$0.7	$1.0	$22.0	$3,413	$4,011
Single Adult	$52.8	$4.3	$0.0	$1.8	$55.2	$4,358	$5,251
Pregnant Women	$75.9	$0.0	$0.0	$0.0	$75.9	$5,137	$15,468
TOTAL	$179.8	$9.1	$1.8	$3.9	$186.8	$4,243	$5,065
200% - 250% FPL							
One Parent Family	$20.4	$0.0	$3.5	$0.0	$23.9	$1,898	$2,066
Two Adults Only	$39.0	$2.9	$0.0	$1.2	$40.7	$5,611	$6,760
Two Parent Family	$27.7	$0.8	$3.5	$0.3	$31.6	$2,301	$2,528

Single Adult	$60.9	$2.2	$0.0	$0.9	$62.1	$3,822	$4,605
Pregnant Women	$39.5	$0.0	$0.0	$0.0	$39.5	$5,137	$15,468
TOTAL	$187.5	$5.8	$6.9	$2.5	$197.8	$3,439	$3,959
250% - 300% FPL							
One Parent Family	$6.1	$0.0	$0.3	$0.0	$6.4	$3,163	$3,462
Two Adults Only	$23.4	$1.2	$0.0	$0.5	$24.1	$5,770	$6,952
Two Parent Family	$13.4	$0.1	$0.9	$0.0	$14.3	$2,224	$2,463
Single Adult	$34.0	$0.0	$0.0	$0.0	$34.0	$4,144	$4,992
Pregnant Women	$31.0	$0.0	$0.0	$0.0	$31.0	$5,137	$15,468
TOTAL	$107.8	$1.3	$1.2	$0.5	$109.8	$4,086	$4,786
22% - 300% FPL							
One Parent Family	$114.2	$12.8	$11.5	$5.5	$133.0	$2,532	$3,055
Two Adults Only	$90.9	$9.0	$0.0	$3.9	$96.0	$5,202	$6,103
Two Parent Family	$111.6	$15.8	$8.2	$6.8	$128.7	$2,472	$3,090
Single Adult	$212.3	$18.6	$0.0	$8.0	$222.9	$3,007	$4,535
Pregnant Women	$146.4	$0.0	$0.0	$0.0	$146.4	$5,137	$15,468
TOTAL	$675.3	$56.2	$19.7	$24.2	$727.0	$3,571	$4,185

Source: Health Benefits Simulation Model (HBSM)

Figure 3: Average Spending Per Person and Per Family

	Average Per Adult				Average Per Family			
	Average Premium	Average State Contribution	Average Individual Contribution	Average Kid Premium	Average Premium	Average State Contribution	Average Individual Contribution	Average Kid Premium
22% - 100% FPL								
One Parent Family	$3,180	$701	$399	$0	$3,180	$701	$399	$0
Two Adults Only	$0	$0	$0	$0	$0	$0	$0	$0
Two Parent Family	$2,753	$776	$324	$0	$5,507	$1,552	$648	$0
Single Adult	$0	$0	$0	$0	$0	$0	$0	$0
Pregnant Women	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	$2,990	$734	$366	$0	$3,846	$944	$470	$0
100% - 150% FPL								
One Parent Family	$3,470	$153	$947	$0	$3,470	$153	$947	$0
Two Adults Only	$3,348	$754	$346	$0	$6,696	$1,508	$692	$0
Two Parent Family	$2,948	$496	$604	$0	$5,896	$992	$1,208	$0
Single Adult	$2,924	$552	$548	$0	$2,924	$552	$548	$0
Pregnant Women	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	$3,059	$501	$599	$0	$3,473	$569	$680	$0
150% - 200% FPL								
One Parent Family	$2,960	$91	$1,009	$212	$2,960	$91	$1,009	$212
Two Adults Only	$4,214	$557	$543	$0	$8,428	$1,113	$1,087	$0
Two Parent Family	$3,524	$411	$689	$138	$7,048	$822	$1,378	$276
Single Adult	$4,166	$336	$764	$0	$4,166	$336	$764	$0
Pregnant Women	$5,137	$0	$0	$0	$5,137	$0	$0	$0
TOTAL	$4,275	$217	$496	$45	$4,811	$244	$559	$51
200% - 250% FPL								
One Parent Family	3,393	0	1,100	529	3,393	$0	$1,100	$529
Two Adults Only	5,385	396	704	0	10,771	$793	$1,407	$0
Two Parent Family	3,828	107	993	435	7,657	$214	$1,986	$869

Single Adult	3,747	132	968	0	3,747	$132	$968	$0
Pregnant Women	5,137	0	0	0	5,137	$0	$0	$0
TOTAL	4,220	131	779	142	5,042	$156	$931	$170
250% - 300% FPL								
One Parent Family	5,903	0	1,761	1,202	5,903	$0	$1,761	$1,202
Two Adults Only	5,608	285	889	0	11,216	$569	$1,778	$0
Two Parent Family	3,634	21	1,201	546	7,267	$42	$2,402	$1,093
Single Adult	4,144	0	1,308	0	4,144	$0	$1,308	$0
Pregnant Women	5,137	0	0	0	5,137	$0	$0	$0
TOTAL	4,665	55	894	140	5,618	$66	$1,076	$169
22% - 300% FPL								
One Parent Family	$3,315	$372	$748	$160	$3,315	$372	$748	$160
Two Adults Only	$4,794	$475	$641	$0	$9,589	$950	$1,282	$0
Two Parent Family	$3,226	$456	$657	$172	$6,453	$912	$1,314	$344
Single Adult	$3,585	$314	$815	$0	$3,585	$314	$815	$0
Pregnant Women	$5,137	$0	$0	$0	$5,137	$0	$0	$0
TOTAL	$3,843	$320	$620	$65	$4,534	$377	$731	$77

Source: Health Benefits Simulation Model (HBSM)