Healthy Indiana Plan 2.0

HEALTHY INDIANA PLAN SM
Health Coverage = Peace of Mind
Today’s presentation

✓ Why HIP 2.0 and not Medicaid?
✓ How HIP 2.0 works
✓ Provider reimbursement
✓ HIP 2.0 financing
Medicaid Expansion

✓ ACA

✓ Supreme Court Decision - can’t force states to expand Medicaid

✓ Allow states to be “incubators:
  • Chart own path
  • Establish own priorities
  • Devise own solutions

✓ Entice states with 100% federal match 1st 3 years

✓ 26 states + DC took $ - traditional Medicaid expansion
Problems with Traditional Medicaid:

- Income-based entitlement
- Out-dated Model
  - No co-pays/deductibles/co-insurance
  - No repercussions for no-show or non-compliance
  - Minimal choice
- Low incentives to “get healthy”
- Provider reimbursement doesn’t cover cost of care
- Poor access - Dwindling provider network
- Escalating costs with poor outcomes
HIP 2.0 vs. Medicaid Expansion
In 2013, 420,000 Hoosiers were enrolled in HSAs. This represents 9% of insured individuals – higher than the national average.
HIP Success

**HIP improves health care utilization**
- Lowers inappropriate emergency room use by 7% compared to traditional Medicaid
- 60% of HIP members receive preventive care - similar to commercial populations
- 80% of HIP members choose generic drugs, compared to 65% of commercial populations

**HIP results in high member satisfaction**
- 96% of enrollees satisfied with HIP coverage
- 83% of HIP enrollees prefer the HIP design to co-payments in traditional Medicaid
- 98% would enroll again

**HIP promotes personal responsibility**
- 93% of members make required POWER account contributions on time
- 30% of members ask their healthcare provider about the cost of services
HIP 2.0 Structure

- Replaces traditional Medicaid for non-disabled adults

- Three pathways to coverage
  - **HIP Link**: NEW defined contribution plan that helps pay for employer-sponsored health insurance
  - **HIP Plus**: Current program with enhanced benefits including dental and vision
    - Reduced non-payment lock-out period: 6 months instead of 12 months
    - Only option for individuals above 100% FPL
  - **HIP Basic**: Allows individuals below 100% FPL who do not make POWER account contributions to maintain coverage
HIP 2.0 POWER Account Contributions

<table>
<thead>
<tr>
<th>FPL</th>
<th>Monthly Income Single Individual</th>
<th>Monthly Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;22%</td>
<td>$214</td>
<td>$3</td>
</tr>
<tr>
<td>23%-50%</td>
<td>$224 to $487</td>
<td>$8</td>
</tr>
<tr>
<td>51%-100%</td>
<td>$496 to $973</td>
<td>$15</td>
</tr>
<tr>
<td>101%-138%</td>
<td>$983 to $1,342</td>
<td>$25</td>
</tr>
</tbody>
</table>

✓ Employers & Foundations may assist with contributions
# HIP Plan Comparison

<table>
<thead>
<tr>
<th>Covered Groups</th>
<th>HIP Link</th>
<th>HIP Plus</th>
<th>HIP Basic</th>
<th>Medically Fragile</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Optional for individuals with access to cost-effective employer-sponsored insurance</td>
<td>• Income up to 138% FPL</td>
<td>• Income below 100% FPL</td>
<td>• High cost individuals including substance abuse &amp; significant mental health issues</td>
<td></td>
</tr>
<tr>
<td>• Exception: Medically fragile</td>
<td>• Consistent POWER account contributions</td>
<td>• Fail to make POWER account contribution</td>
<td>• Very low income parents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Pregnant women</td>
<td></td>
</tr>
<tr>
<td>Cost-sharing</td>
<td>Enhanced POWER account can be used for premiums, co-payments, or deductibles</td>
<td>POWER account contributions No Other Co-payments, except:</td>
<td>Co-payments for all services: More expensive than HIP Plus</td>
<td>Co-payments or POWER account contribution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Non-emergency ED visit: $25</td>
<td></td>
<td>o Exception: Pregnant women are exempt from cost-sharing</td>
</tr>
<tr>
<td>Benefits</td>
<td>• Employer Plan Benefits</td>
<td>• Comprehensive medical benefits incl. maternity</td>
<td>• Comprehensive medical benefits incl. maternity</td>
<td>• Comprehensive medical benefits incl. maternity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vision &amp; dental benefits</td>
<td>• Lower service limits</td>
<td>• Current Medicaid benefits as required by federal law</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased service limits</td>
<td>• Limited drug benefit</td>
<td>• Enhanced behavioral health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comprehensive drug benefit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HIP 2.0 Basics

Who is eligible for HIP 2.0?

- Indiana residents ages 19 to 64
  - income under 138% of the federal poverty level (FPL)
  - who are not eligible for Medicare or otherwise eligible for Medicaid

- Includes Individuals currently enrolled in:
  - Healthy Indiana Plan (HIP)
  - Hoosier Healthwise (HHW)
  - Parents and Caretakers (MAGF)
  - 19 and 20 year olds (MAT)
HIP 2.0 Basics

When does service coverage begin?

- 2015
- HIP & applicable HHW members converted to HIP 2.0 without having to reapply
- New applicants may submit Indiana health coverage application and be considered for HIP coverage
  - No retroactive coverage

What types of services are covered?

- HIP Basic members
  - Minimum Essential Coverage providing the Essential Health Benefits
- HIP Plus members
  - HIP Basic benefits with additional services including bariatric surgery, TMJ treatment, and more allowed physical, speech and occupation therapy visits
  - Vision
  - Dental
Transition to HIP 2.0

Who provides services to HIP 2.0 members?

- Eligible Providers must enroll as Indiana Health Care Provider with Indiana Medicaid &
  - Must enroll with Managed Care Entity (MCE) to provide in-network services to HIP members
  - All HIP members will have a Primary Medical Provider (PMPs)

Who pays for services?

- Risk-based MCEs
  - Anthem
  - MDWise
  - Managed Health Services (MHS)

*Does not include emergency service providers
Transition to HIP 2.0

How will members be placed in a MCE?

- Current members will stay with current MCE
- New members select MCE
  - On application OR
  - Call enrollment broker after application OR
- Auto-assigned by HP

How should one answer member questions?

- Refer members to their MCE
  - Anthem: (866) 408-6131
  - MDWise: (800) 356-1204
  - MHS: (877) 647-4848

*Does not include emergency service providers
Cost-sharing

1. Member does not pay co-payment after 5% of household income spent on out-of-pocket health care costs
2. Pregnant women and Native Americans exempt from cost-sharing
3. Provider cannot deny service based on member inability to pay
# Co-payment Amounts - HIP Basic

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP Basic Co-Pay Amounts &lt;=100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$4</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$75</td>
</tr>
<tr>
<td>Preferred Drugs</td>
<td>$4</td>
</tr>
<tr>
<td>Non-preferred drugs</td>
<td>$8</td>
</tr>
<tr>
<td>Non-emergency ED visit</td>
<td>Up to $25</td>
</tr>
</tbody>
</table>

*$8 for first non-emergent emergency department (ED) visit; $25 for any additional
HIP Reimbursement Rates

- Medicare rates for current and new HIP members
- Increase in legacy Medicaid reimbursement to around 75% Medicare
# New/Proposed E/M reimbursement structure

<table>
<thead>
<tr>
<th>Procedure/code</th>
<th>Current Medicaid (Non Facility)</th>
<th>HIP/HIP 2.0</th>
<th>New “legacy” Medicaid (Non Facility)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGD biopsy single/multiple/ 43239</td>
<td>$181.60</td>
<td>$377.05</td>
<td>$282.78</td>
</tr>
<tr>
<td>Office visit (new)/99203</td>
<td>$47.44</td>
<td>$102.28</td>
<td>$76.71</td>
</tr>
<tr>
<td>Office visit (established)/99213</td>
<td>$31.96</td>
<td>$69.32</td>
<td>$51.99</td>
</tr>
<tr>
<td>Initial hospital care/evaluation/99222</td>
<td>$80.67</td>
<td>$132.80</td>
<td>$99.60</td>
</tr>
<tr>
<td>ER visit/99283</td>
<td>$43.82</td>
<td>$59.78</td>
<td>$44.84</td>
</tr>
<tr>
<td>Cataract removal/66984</td>
<td>$550.51</td>
<td>$630.34</td>
<td>$472.75</td>
</tr>
<tr>
<td>Chest x-ray 2 view/71020</td>
<td>$25.03</td>
<td>$29.13</td>
<td>$21.85</td>
</tr>
<tr>
<td>EKG/93000</td>
<td>$20.63</td>
<td>$15.78</td>
<td>$11.84</td>
</tr>
</tbody>
</table>

* These proposed rates are subject to change after final determination of rate methodology.
- Goal is to increase Medicaid aggregate payment at least 15%
- Some codes go down, most go up
- Net total new Medicaid reimbursement to be around 75% Medicare
State of the Uninsured in Indiana

Uninsured Hoosiers, 2010¹

- Eligible for subsidized Marketplace coverage: 160,998 (18%)
- Coverage Gap: 105,466 (12%)
- Under 100% FPL: 50,713 (6%)
- 100-138% FPL: 348,900 (40%)

TOTAL UNINSURED = 881,291

How do the Federal Poverty Levels translate to annual income? - 2013

<table>
<thead>
<tr>
<th>FPL²</th>
<th>Individual</th>
<th>Family of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 100%</td>
<td>&lt; $11,490</td>
<td>&lt; $23,550</td>
</tr>
<tr>
<td>100-138%</td>
<td>$11,490-$15,970</td>
<td>$23,550-$32,734</td>
</tr>
<tr>
<td>139-200%</td>
<td>$15,971-$23,094</td>
<td>$32,735-$47,335</td>
</tr>
<tr>
<td>201-399%</td>
<td>$23,095-$45,959</td>
<td>$47,336-$94,199</td>
</tr>
<tr>
<td>400%+</td>
<td>&gt; $45,960</td>
<td>&gt; $94,200</td>
</tr>
</tbody>
</table>

Indiana Uninsured: 13.6% in 2010

Maintaining Financial Sustainability

**HIP 2.0 will be sustainable & will not increase taxes for Hoosiers**

- HIP 2.0 will continue to utilize HIP Trust Fund dollars

- Indiana hospitals will help support costs to expand HIP 2.0 starting in 2017

- Waiver specifies HIP 2.0 continuity requires:
  - Enhanced federal funding
  - Hospital assessment program approval
HIP 2.0 Gateway to Work

✓ All individuals who complete the application for HIP coverage will be connected to job training and job search programs offered by the State of Indiana
Hospital Assessment Fee (HAF) Background

✓ HAF authorized in 2013

✓ Assessed against all licensed acute hospitals and private psych hospitals

✓ Designed to increase hospital inpatient and outpatient reimbursement to align with Medicare payments rates

✓ State maintains 28.5% of HAF to cover Medicaid costs

✓ HAF Board oversees assessment formula
  • 2 Hospital Association Members
  • 2 State Appointees
State & IHA Term Sheet

✓ Annual Cigarette Tax Revenues are used first for HIP expansion

✓ Starting in 2017, recalculate HAF fund such that State HAF portion is sufficient to cover:
  • Cost of HIP expansion, including all administrative costs with cap
  • Cost of increasing provider reimbursement in current Medicaid program to 75% of Medicare rates.
  • Annual Contribution of $50M to Medicaid program
    o Divert Hospital Care for the Indigent (HCI) funding
    o $12M to HIP Trust Fund & together with current Trust Fund balance assures 1-year of operational costs
### Total Cost of HIP Expansion (State and Federal)

<table>
<thead>
<tr>
<th></th>
<th>SFY 15</th>
<th>SFY 16</th>
<th>SFY 17</th>
<th>SFY 18</th>
<th>SFY 19</th>
<th>SFY 20</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal Portion</strong></td>
<td>$1,596.3</td>
<td>$2,836.1</td>
<td>$2,854.2</td>
<td>$2,949.7</td>
<td>$3,066.7</td>
<td>$3,160.4</td>
<td>$16,463.4</td>
</tr>
<tr>
<td><strong>State Portion</strong></td>
<td>$151.7</td>
<td>$100.7</td>
<td>$187.8</td>
<td>$284.7</td>
<td>$328.7</td>
<td>$408.5</td>
<td>$1,462.1</td>
</tr>
<tr>
<td><strong>TOTAL Cost of HIP 2.0</strong></td>
<td>$1,748.0</td>
<td>$2,936.8</td>
<td>$3,042.0</td>
<td>$3,234.4</td>
<td>$3,395.4</td>
<td>$3,568.9</td>
<td>$17,925.5</td>
</tr>
</tbody>
</table>
## HIP 6 - Year State Budget
### SFY 2015-2021

<table>
<thead>
<tr>
<th>REVENUE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarette Tax Revenue</td>
<td>$676M</td>
</tr>
<tr>
<td>HAF Revenue</td>
<td>$959M</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$1,635M</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COSTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP Expansion Costs</td>
<td>$1,462M</td>
</tr>
<tr>
<td>(Admin &amp; Provider Rate Increase in Medicaid)</td>
<td></td>
</tr>
<tr>
<td>Contribution to Medicaid &amp; HIP Trust Fund</td>
<td>$173M</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td><strong>$1,635M</strong></td>
</tr>
</tbody>
</table>
## Current & Projected HAF

<table>
<thead>
<tr>
<th></th>
<th>SFY 15</th>
<th>SFY 16</th>
<th>SFY 17</th>
<th>SFY 18</th>
<th>SFY 19</th>
<th>SFY 20</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Projected HAF on current program</strong></td>
<td>$889.4</td>
<td>$941.4</td>
<td>$979.2</td>
<td>$993.0</td>
<td>$1,046.5</td>
<td>$1,134.6</td>
<td>$5,984.1</td>
</tr>
<tr>
<td><strong>New HAF</strong></td>
<td>-</td>
<td>-</td>
<td>$125.2</td>
<td>$222.1</td>
<td>$266.1</td>
<td>$345.9</td>
<td>$959.3</td>
</tr>
</tbody>
</table>
Projected Average Monthly Enrollment
Next Steps

- **MAY**
  - Posted HIP 2.0 waiver for public comment

- **JUNE**
  - Finalized waiver based on public input

- **JULY**
  - Waiver submitted to CMS in July 2014

- **SEPT**
  - Federal public comment period ended

Potential HIP expansion in 2015, based on timing of federal approval
Public Education Phases:

I - Introduction
  - Governor Pence announcement
  - Web resources
  - Public hearings
  - “Road show”

II - Waiver submission/negotiation

III - Rollout/Public education

IV - Production
In summary: HIP 2.0...

✓ Is Indiana-specific solution
  • Establishes our own priorities
  • Builds off of successful program

✓ Expands coverage AND improves access

✓ Consumer-directed (ownership)
  • Price transparency
  • Patient/provider partnership
  • Focus is on outcomes
Questions?
Supplemental material
## New/Proposed E/M reimbursement structure: Total expenditures ("legacy Medicaid")

<table>
<thead>
<tr>
<th>Service Category/Description</th>
<th>At Current Rates (in millions)</th>
<th>At Proposed Rates (in millions)</th>
<th>Percent change</th>
<th>Proposed Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>501: Surgery</td>
<td>$70.7</td>
<td>$83.1</td>
<td>17.6%</td>
<td></td>
</tr>
<tr>
<td>502: Maternity Delivery</td>
<td>$24.4</td>
<td>$21.7</td>
<td>(10.8%)</td>
<td>0-10%</td>
</tr>
<tr>
<td>503: Maternity Non-Delivery</td>
<td>$3.0</td>
<td>$6.1</td>
<td>102.2%</td>
<td></td>
</tr>
<tr>
<td>504: Office Visits/Consults</td>
<td>$101.9</td>
<td>$159.6</td>
<td>56.6%</td>
<td></td>
</tr>
<tr>
<td>505: Well Baby Exams</td>
<td>$1.4</td>
<td>$2.2</td>
<td>63.3%</td>
<td></td>
</tr>
<tr>
<td>506: Hospital inpatient visits</td>
<td>$57.2</td>
<td>$66.3</td>
<td>16.0%</td>
<td></td>
</tr>
<tr>
<td>507 ER Visits</td>
<td>$47.0</td>
<td>$51.5</td>
<td>9.5%</td>
<td></td>
</tr>
<tr>
<td>508: Radiology/Pathology</td>
<td>$42.8</td>
<td>$39.4</td>
<td>(7.9%)</td>
<td></td>
</tr>
<tr>
<td>509: Outpatient Behavioral Health</td>
<td>$61.7</td>
<td>$59.4</td>
<td>(3.9%)</td>
<td>0-5%</td>
</tr>
</tbody>
</table>