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Indiana: Health Care Reform Amidst Colliding Values

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In May 2007, Indiana enacted comprehensive health reform in the form of the Indiana Check-Up Plan and its centerpiece, the Healthy Indiana Plan (HIP). After intense negotiations, the Centers for Medicare and Medicaid Services granted Indiana the 1115b waiver required for the plan to go into effect in December 2007, and within three months over 30,000 Hoosiers had applied for the program.

HIP is the first Medicaid expansion in the nation to be modeled in the spirit of a high deductible health plan (HDHP)/ health savings account (HSA). This structure melds two themes of American society that typically collide in our healthcare system, rugged individualism and the Judeo Christian ethic. HIP combines these diametrically opposed themes by promoting personal responsibility while providing subsidized health protection to those who can least afford it.

Americans have chosen the marketplace as the venue for delivering healthcare. In a perfect market system of consumers and producers, the individual (patient) evaluates cost and quality when making purchasing decisions. Producers (providers) compete for consumers and provide a set of services at a defined price. But as we know, transactions in the American healthcare system are never this simple due to the presence of a third party—the uninsured who obtain services for free. Their presence forces hospitals to act as wealth redistribution agents that shift the cost of uncompensated care to the paying consumer (the insured).

However, the insured are not left to carry the entire burden, as society eases its conscience through a multitude of government subsidies (Disproportionate Share Hospital, Federally Qualified Health Centers etc.) aimed at subsidizing hospitals and institutions. The result of these institutional entitlements is reduced competition and quality, as subsidized providers have little incentive to attain the highest quality of care or to compete for customers. These subsidies, together with the act of cost shifting itself, create opaque pricing, preventing consumers from adequately evaluating the cost and quality of care.

In 2006, Indiana Governor Mitch Daniels and the Indiana General Assembly asked us to create a health plan for the working poor and chronically uninsured in Indiana. The State had no successful effort to address uninsured adults since the inception of the Medicaid program in the 1960's, and consequently was ranked one of the worst in the nation for coverage. From 1999 to 2004, Indiana had also experienced the second largest decline in employer-sponsored healthcare coverage in the nation and

has seen a 30 percent increase in the number of uninsured since 1990. Compounding the problem, Indiana also has extremely high rates of smoking and obesity and Hoosiers fall short in obtaining requisite preventive care as compared to national rates.

Despite these challenges, in a little over a year, Indiana passed legislation, negotiated a federal waiver and implemented a plan to expand coverage to low-income uninsured. The many conservatives of our state initially balked at the idea of either establishing another entitlement program that could create budget shortfalls for future generations or creating another Medicaid plan that creates a platform for unhealthy lifestyles that leads to abuse of the healthcare system. We managed to overcome these obstacles and our experience provides several lessons for reformers elsewhere:

1) **Inaction is not a market solution.** We pointed out repeatedly that 10 percent of each premium dollar paid by the insured population supported the cost of the uninsured due to cost-shifting by providers. We also explained that 67 percent of Indiana's uninsured are low-income individuals earning less than 200 percent of the poverty level, without any feasibly affordable healthcare option. These statistics made some form of a government subsidy inevitable: Doing nothing would simply result in steeper premium increases and further exacerbate the imbalance of market forces.

2) **Choose reforms that help those who need it, but also increase personal responsibility and utilize market incentives.** As we began to formulate the plan, Governor Daniels introduced the idea of using HDHPs and HSAs as a coverage vehicle for low-income Hoosiers. Hailed by conservatives, HDHPs and HSAs promote the notion of consumerism and promise greater price transparency, competition and quality. By giving participants some "skin in the game," they encourage healthy lifestyles and provide individuals a financial incentive to make cost- and value-conscious healthcare decisions, which in turn increases pressure on providers to demonstrate value and quality. In contrast, Medicaid as it is structured today provides no incentive for participants to consider the cost of their tax-supported care when making healthcare utilization decisions.

HIP targets low-income adults aged 19-64 who have been without health insurance for six months and earn less than 200 percent FPL. (Hoosiers at higher incomes can buy in at market rates.) HIP provides a fully subsidized comprehensive health plan that is offered by private insurers. It requires a \$1,100 deductible and provides up to \$300,000 of annual coverage and \$1 million of lifetime coverage.

Following the HSA model, the Personal Wellness and Responsibility (POWER) Account is used to fund the deductible. Moving away from premiums and copays that are typically too low to incentivize collection by providers, HIP requires individuals to make mandatory monthly contributions – ranging from 2 percent to 5 percent of income, up to \$92/month – to their POWER Account. To prevent participants from obtaining temporary coverage, penalties are stiff for payment lapses: Participants have up to 60 days to make their contribution and are then terminated and cannot reapply for twelve months if a payment is missed.

After their monthly contribution, participants have no other cost sharing requirement except for copays for non-emergency usage of the emergency room. While contributions are higher than traditional Medicaid premiums, participants have total control over how these dollars are spent. Members receive monthly statements detailing the use of the accounts and can apply year-end balances to offset future required contributions only if they have received requisite preventive services. This transforms Medicaid beneficiaries into consumers with an incentive to demand price transparency, make decisions about how to obtain the best value for their purchase, as well as to seek necessary preventive services and maintain a healthy lifestyle.

3) **Be fiscally responsible.** Of concern for both conservatives and liberals alike was the potential impact of a new program on the State's budget. No one wanted to create a program that could not be sustained over time. In order to address this, we designed an "anti-entitlement provision." With Indiana having one of the lower cigarette taxes in the nation, Governor Daniels suggested funding the plan through an increase in the State's cigarette tax. The increase would then serve a dual purpose of discouraging smoking, while also funding the Healthy Indiana Plan. The Governor did not prescribe a specific value for the increase, but noted to the Legislature that the level of the increase would dictate how many uninsured Hoosiers could be covered. Although the discussion identified increases as high as a \$1.00, ultimately legislators settled on a modest 44-cent increase, bringing Indiana's total cigarette tax to 99.5 cents. After funding the other components of the plan, this increase will provide coverage for 120,000 Hoosiers.

The legislation restricts the State from providing services "beyond the level of state appropriations authorized for the plan." This essentially contains the plan's budget to the amount of revenues collected through the cigarette tax, and would require the State to adjust the program through either the number of enrollees or the benefits to assure they could stay within the budget. This assures that the program will not be a burden to future generations and that growth can be controlled and maintained. In reality, if there is growth in the program, legislators will still be pressured to find additional funding to support growing enrollees and costs. Nevertheless, the implications of a non-entitlement program were enormous, as it gave many legislators the peace of mind to allow them to support the bill.

4) **Reach out across party lines and to multiple constituencies.** The bill obtained bi-partisan support and passed by large measures in our split legislature largely due to the efforts of both our Republican Senate Sponsor, Patricia Miller, and our Democratic House Sponsor, Charlie Brown. They worked effectively together and the leadership of both houses reached across the aisle to colleagues who had long kept healthcare issues outside of partisanship. These relationships were further cemented by a passionate coalition of antismoking and health advocates who provided support and actively engaged in the dialogue. Indiana hospitals, also supported the plan, despite the fact that it diverted a portion of their institutional entitlement in the form of their Disproportionate Share Hospital (DSH) funding to the new program.

5) **Compromise and cut deals.** In developing HIP, we never let the perfect be the

impediment of the good. We were able to pass Medicaid reform in Indiana because, while we certainly had our own philosophy and priorities, we made a point of listening to the concerns of all stakeholders and responding to those concerns whenever possible, even when it involved making changes to our plan. For example, providers were initially reluctant to support the plan, as current Medicaid rates had not been increased since 1993. In response, the governor and the legislature not only raised Medicaid rates, but also provided for Medicare rates, instead of Medicaid rates, under the HIP plan to assure an adequate delivery system for the new covered population. The mental health community in particular improved the plan by rallying for full mental health parity, which was included in the final version of the bill.

In another example, in response to criticisms about the HSA model expressed by advocates for low-income Hoosiers, the HIP plan provides upfront subsidies to the POWER Account to assure the account is fully funded to cover the deductible. HIP also provides \$500 of first dollar coverage for preventive care to assure that participants did not skimp on important preventive services. We also broadly defined preventive services to include smoking cessation and smoking patches in an effort to aggressively address the State's smoking problem. (The end result on prevention was even better than the legislation due to successful competition between Anthem Blue Cross Blue Shield and MDWise with Americhoice, the two plans that won the State's bid to offer the product. Our market concept went to work immediately generating expanded services, with both plans choosing to offer unlimited coverage for all preventive care services.)

6) With the exception of compromise, don't take any of the above lessons too seriously. The face of the uninsured in each state is different. Therefore, a one size fits all federal solution will not work, especially for the 85 percent of the population that is insured. States must be empowered to develop local solutions. HIP is Indiana's solution, but we fully recognize that leaders in other states, in dialogue with their constituents, may reach different solutions.

Federal policy, and in particular CMS' waiver process, should provide maximum leeway for this sort of state experimentation. For example, Indiana's legislation did not limit HIP to specific categories such as parents of SCHIP-eligible children. Ultimately, we felt that if someone is low-income, uninsured, and willing to make the monthly contributions and play by the HIP rules, he or she should be allowed to participate—regardless of parental status. Medicaid laws, however, see this issue differently, and CMS insisted on capping coverage for childless adults at 34,000 lives, leaving the remaining slots for parents of SCHIP-eligible children. One can argue the merits of CMS' and Indiana's respective positions, but in the end Indiana should have been allowed to make the decision it viewed as best for its citizens.

Looking To The Future

Already, we see areas we would like to improve. The \$1,100 deductible may be too low for those persons with chronic illnesses. We wonder if there should be additional copays for those individuals not paying up to the five percent CMS limit to further encourage appropriate utilization. Currently, POWER Account contributions can only be made by the State, individuals and employers. Perhaps plans should be able to

operate incentive programs and make contributions into the accounts as well. Interest in the plan is high and it is likely that the amount of the cigarette tax may need to be revisited.

Nevertheless, our hard work has resulted in a single plan that is the melting pot of philosophical approaches and compromises; a plan that has attracted liberals and conservatives; and a plan that has withstood the test of CMS scrutiny and Medicaid rules. Through each round of review and approval the plan was tweaked, but with each turn, the health savings account model remained intact. The unique structure of the plan holds the promise of redesigning the Medicaid program as we know it today. For the first time, HIP brings recipients and the State together in a market based partnership to use resources judiciously, and to promote provider competition resulting in improved transparency, quality and value for all Hoosiers.

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