# HIP 2.0: The Basics

## Coverage Elements, Financing, Our Agreement and What's Next

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June 9, 2014

Indiana Hospital Association

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# *Highlights of HIP 2.0*

- Full expansion as envisioned under the ACA to all earning up to 138% of the poverty level, covering as many as 350,000 Hoosiers
- No enrollment caps or lifetime/annual limits as in existing HIP program
- Will cover Essential Health Benefits as required under ACA, which include maternity care, *mental health*, etc.
- Modifications to POWER account contributions
- Providers will be reimbursed at Medicare rates, as in current program
- Access further enhanced by increasing physician payment in current Medicaid from about 55%-60% of the Medicare fee schedule to 75%

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# *Highlights of HIP 2.0, cont.*

- Tobacco tax revenue will be used to fund the State's future costs along with contributions from the Hospital Assessment Fee (HAF).
- The net increase in hospital reimbursement is estimated to be approximately $1 billion annually.
- Even when taking into account the Medicare reductions under the ACA, the program is a net positive for hospitals.
- More details about HIP 2.0 can be found at www.HIP.in.gov or http://www.in.gov/fssa/hip/2442.htm.

# HEALTHY INDIANA PLAN VERSION 2.0




# 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

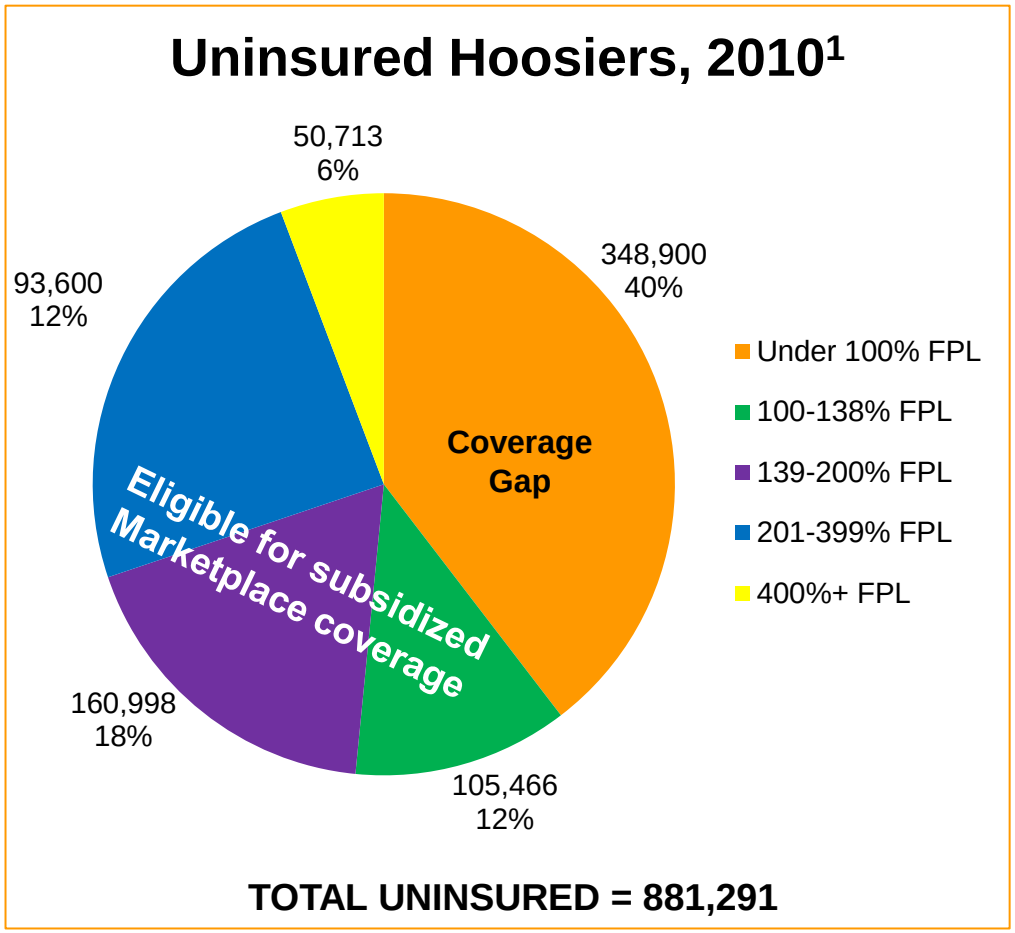
## HIP results in high member satisfaction

- 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

# State of the Uninsured in Indiana




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

| FPL[2] | Individual | Family of 4 |
|---|---|---|
| Under 100% | < $11,490 | < $23,550 |
| 100-138% | $11,490-15,970 | $23,550-32,734 |
| 139-200% | $15,971-23,094 | $32,735-47,335 |
| 201-399% | $23,095-45,959 | $47,336-94,199 |
| 400%+ | > $45,960 | > $94,200 |

Indiana Uninsured: 13.6% in 2010

1. SHADAC Health Insurance Analysis. (2011). American Community Survey data. Retrieved from www.nationalhealthcare.in.gov.
2. Office of the Assistant Secretary for Planning and Evaluation. (2013). 2013 Poverty Guidelines. Retrieved from http://aspe.hhs.gov/poverty/13poverty.cfm.

# 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

# New Affordable Contributions

## HIP 2.0 POWER Account Contributions

| FPL | Monthly Income Single Individual | Monthly Contribution |
|---|---|---|
| **<22%** | $214 | $3 |
| **23%-50%** | $224 to $487 | $8 |
| **51%-100%** | $496 to $973 | $15 |
| **101%-138%** | $983 to $1,342 | $25 |

- ✓ Employers & Foundations may assist with contributions

# HIP Plan Comparison

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

# Ensuring Access for all Medicaid Participants to Improve Outcomes

- Maintain Medicare payment rates to support a high-quality provider network in HIP - including higher payments for maternity care to improve birth outcomes
- Increase provider reimbursement in the current Medicaid program to ensure access for the most vulnerable Hoosiers - aged, blind, disabled and children
- Family Coverage option: Parents can enroll their children in employer –sponsored coverage or Marketplace plans

# 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**

# 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

Waiver specifies HIP 2.0 continuity requires:

-Enhanced federal funding

-Hospital assessment program approval

# 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
    - Divert HCI funding
    - $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)

| | SFY 15 | SFY 16 | SFY 17 | SFY 18 | SFY 19 | SFY 20 | TOTAL |
|---|---|---|---|---|---|---|---|
| Federal Portion | $1,596.3 | $2,836.1 | $2,854.2 | $2,949.7 | $3,066.7 | $3,160.4 | **$16,463.4** |
| State Portion | $151.7 | $100.7 | $187.8 | $284.7 | $328.7 | $408.5 | **$1,462.1** |
| ***TOTAL Cost of HIP 2.0*** | ***$1,748.0*** | ***$2,936.8*** | ***$3,042.0*** | ***$3,234.4*** | ***$3,395.4*** | ***$3,568.9*** | ***$17,925.5*** |

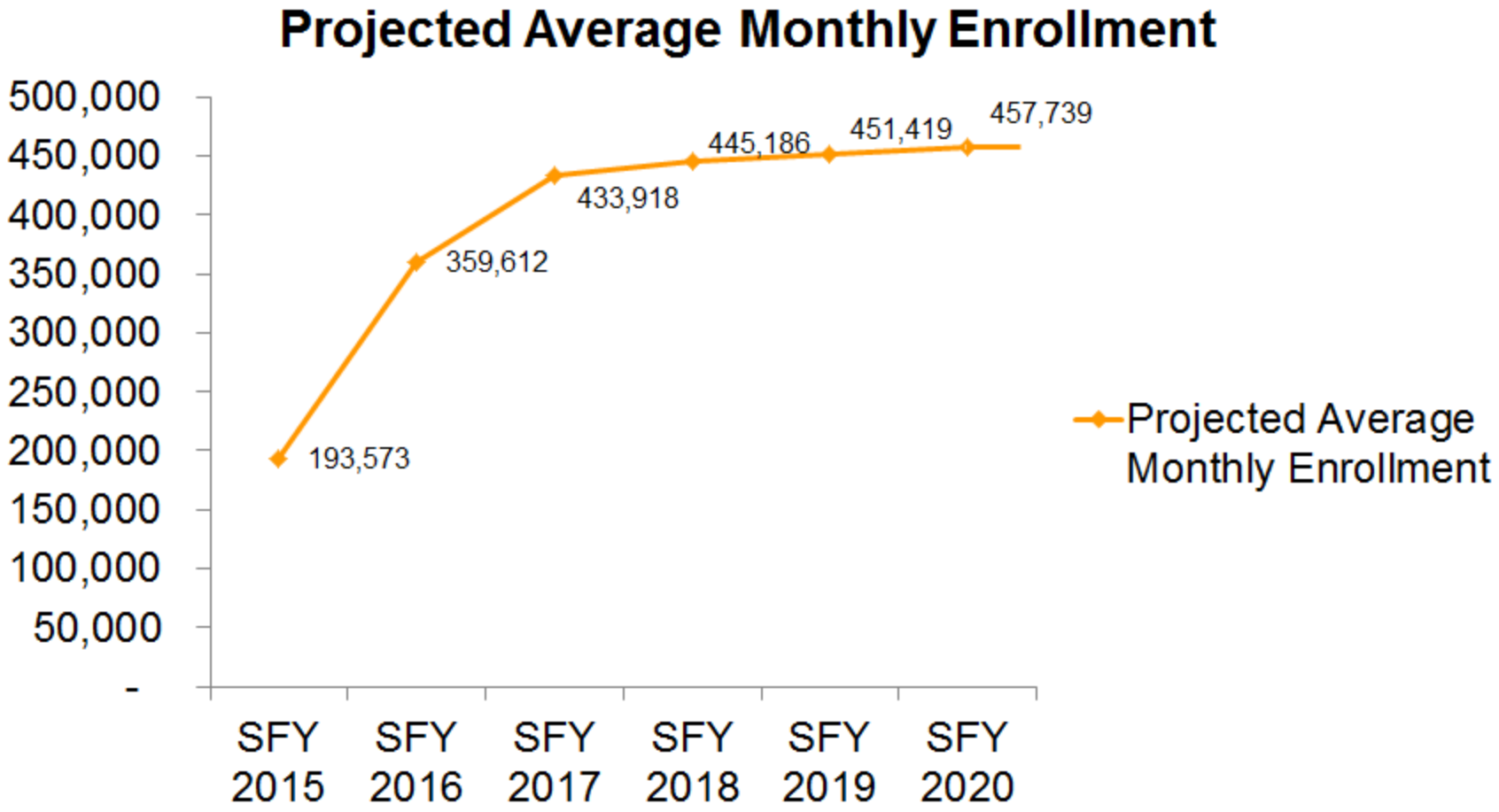
# HIP 6 -Year State Budget
# SFY 2015-2021

| REVENUE | |
|---|---|
| Cigarette Tax Revenue | $ 676M |
| HAF Revenue | $ 959M |
| *Total Revenue* | ***$1,635M*** |
| | |
| COSTS | |
| HIP Expansion Costs<br>(Admin & Provider Rate Increase in Medicaid) | $1,462M |
| Contribution to Medicaid & HIP Trust Fund | $ 173M |
| *Total Costs* | ***$1,635M*** |

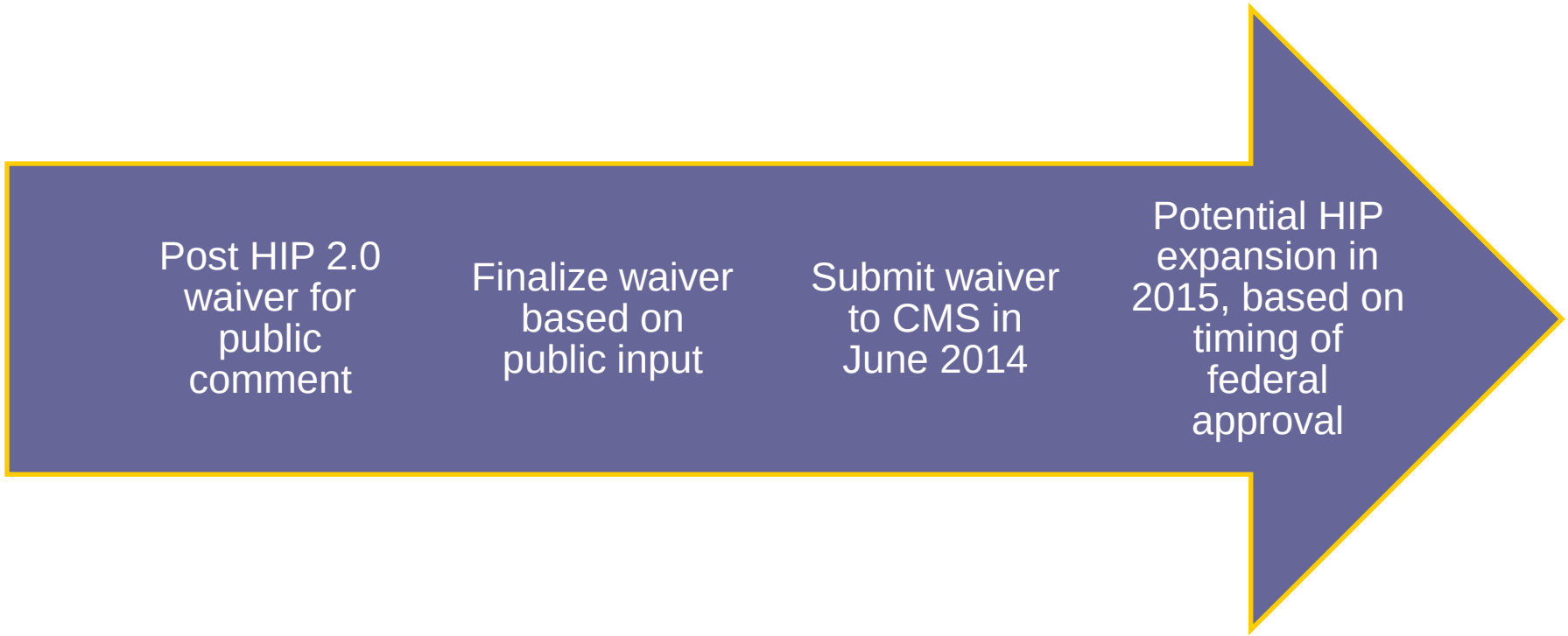
# Current & Projected HAF

| | SFY 15 | SFY 16 | SFY 17 | SFY 18 | SFY 19 | SFY 20 | *TOTAL* |
|---|---|---|---|---|---|---|---|
| Projected HAF on current program | $889.4 | $941.4 | $979.2 | $993.0 | $1,046.5 | $1,134.6 | ***$5,984.1*** |
| New HAF | - | - | $125.2 | $222.1 | $266.1 | $345.9 | ***$959.3*** |

# Projected Average Monthly Enrollment



# Next Steps


Post HIP 2.0 waiver for public comment
Finalize waiver based on public input
Submit waiver to CMS in June 2014
Potential HIP expansion in 2015, based on timing of federal approval

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# *Start Date and Term Sheet*

- IHA developed an agreement ("term sheet") with the State as an expression of mutual good faith intentions with regard to expansion and the financing of the program.

- Non-binding agreement is contingent upon CMS approval of the waiver.

- ***Start Date:*** Given the nature of the federal waiver approval process, the State cannot firmly commit to a Jan. 1, 2015 effective date for expanded coverage. *However, the State will make every reasonable effort to implement HIP 2.0 as soon as practicable on or after Jan. 1.*

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# HAF Funding

- No HAF funding will be used in SFYs 2015 and 2016 (effectively no state match when ACA enhanced FMAP is 100%).
- Use of HAF is strictly limited to expansion expenses (payment to MCEs for medical expenses, POWER account funding, and limited administrative costs) and increases for physician payments in the current Medicaid program.
- Hospitals' obligation to fund these expenses ceases immediately if the waiver is terminated for any reason.
- The State has committed to work with IHA to address the design of the underlying fee program needed to maintain or improve the equity and to mitigate any adverse impacts of using HAF to fund HIP 2.0.

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# Non-HAF Funding Sources

- The portion of the tobacco tax that established for funding existing HIP will represent the "first dollar" commitment to the program, reducing the amount needed from the HAF (currently about $112 M per year).
- In addition, the balance of the HIP Trust Fund will remain dedicated to the program, either for regular expenses or in case of a phase-out (current balance is around $338 M).
- IHA will work to explore other funding sources (other provider fees, excise taxes, etc.) in the future that could supplement HAF contributions.

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# HIP Trust Fund

- Beginning in SFY 2017, HAF will fund $11.5 M annually in deposits to the HIP Trust Fund to keep balance at one-year's worth of state program costs.
- These funds will be separately accounted for, and utilized only for a phase-down. Interest accruing on any HAF funds deposited will remain in the HIP Trust Fund.
- In the event of a phase-out, any remaining HAF contributions will be refunded to hospitals on a pro-rata basis.
- In 2020, the HAF Committee will "reset" this contribution based on the balance of the Trust Fund. If the amount is sufficient to cover annual state expenses, this funding could be reduced or suspended.

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# *Protections and Triggers for Termination*

- The HAF Committee must approve the funding formula for this program before it can be implemented. Also, extension of the initial waiver of this program or other changes must also be approved by the Committee.

- The State and IHA both sought "triggers" that would end the waiver in the event that Congress changes the 100%-90% enhanced FMAP, limit provider fee programs like HAF, or otherwise impact the arrangement. If any of these events occur, the program would end after a yet-to-be determined phase-out period.

- In the event of a waiver termination and phase-out, IHA and the State must agree on a plan. It should be noted that the agreement provides that during a phase-out, hospital services must continue to be reimbursed at Medicare rates.

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# *Other HAF Provisions*

- Prior to implementing the program, the State and IHA must agree upon a process for accounting for actual costs incurred.
- It is important to note that HAF funding for the State's costs will be based on enrollment or actual costs incurred, the most accurate, timely, consistent, and verifiable data possible will be used.
- IHA and the State will agree on a mechanism for ensuring that HAF funding for the program is clearly accounted for separately from funding for the existing Medicaid program.

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# Managed Care Elements

- As in the current HIP program, HIP 2.0 will use Managed Care Entities (MCEs). We fully believe the State's intent is to continue to contract with three (or perhaps more) MCEs for HIP, but per federal law they will contract with no fewer than two.
- MCEs must pay providers at full Medicare rates for services rendered to HIP 2.0 enrollees (130% of Medicaid if no rate).
- A minimum medical loss ratio of 87% must be maintained such that at least 87% of the premiums MCEs receive are paid to health care providers.

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# *Managed Care Elements, cont.*

- An important element in our negotiation dealt with members' concerns over narrow networks, and we are satisfied that this will not occur. Under our agreement the MCEs cannot implement any restricted networks.

- IHA agreed to work with the State to maximize the success of the program, particularly encouraging monthly contributions so that enrollees will remain in the "HIP Plus" plan.

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# *Behavioral Health Issues*

- The agreement affirms that the medically fragile population under the program will be entitled to State Plan services including Medicaid rehabilitation option (MRO) services.

- As part of the 1115 waiver process for this program, the State and IHA will work to seek to permit reimbursement for inpatient services for adults that would otherwise be prevented by the "IMD exclusion."

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# *Other Provisions Cont'd*

- Since HIP does not provide retroactive coverage, use of Hospital Presumptive Eligibility (HPE) will be key.
- The State has committed to fully implementing HPE as provided under the ACA and to limit restrictions on use of this process.
- IHA and the State will immediately begin exploring state budget-neutral opportunities for leveraging additional federal funds.
- The State has also committed to a study regarding MCEs' practices of denying prior authorizations for hospital services.
- An important element dealt with concerns over narrow networks, and we are satisfied that this will not occur; under our agreement the MCEs cannot implement any restricted networks.

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# Questions?

- June 9, 2014 at 11:00 a.m. at Hendricks Regional Health YMCA, 301 Satori Pkwy, Avon
- June 9, 2014 at 1:00 p.m. at Ivy Tech Community College Northeast, Student Life Center, Room 121, 3701 Dean Drive, Fort Wayne
- June 13, 2014 at 11:00 a.m. at St. Elizabeth Hospital, 1701 S. Creasy Lane in Lafayette
- June 16, 2014 at noon at Memorial Lodge, 2590 S. Newton Street in Jasper
- June 16, 2014 at 9:30 a.m. in Indianapolis at Community East Hospital, in the hospital cafeteria, 1500 North Ritter Avenue