



Healthy Indiana Plan 2.0: POWER Account Contribution Assessment

Prepared for:

Indiana Family and Social Services Administration (FSSA)

Submitted by:

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Executive Summary

The purpose of this report is to assess the Healthy Indiana Plan (HIP) 2.0's POWER Account Contribution (PAC) policy, specifically the affordability of PAC and the effect of the disenrollment-for-non-payment-of-PAC policy on enrollment. Under HIP 2.0, members receive an HSA-like account — called a “Personal Wellness and Responsibility” or “POWER” Account — to pay for services until they meet the deductible on their health plan. Members are encouraged to make monthly contributions to their POWER Accounts. Members who make these monthly contributions are enrolled in HIP Plus, a plan with enhanced benefits — such as dental and vision coverage — that does not require co-payments for services. Members who do not make these contributions are either: 1) moved from HIP Plus into a more limited benefit plan, HIP Basic, if the member's income is at or below 100 percent of the Federal Poverty Level (FPL) or; 2) not enrolled in or disenrolled from HIP 2.0 coverage if the member's income is above 100 percent of the FPL.¹

Individuals with incomes above 100 percent of the FPL who do not make their *first* PAC are not initially enrolled in HIP coverage, and are referred to as “Never Members” by the Indiana Family and Social Services Administration (FSSA). Individuals with incomes above 100 percent of the FPL who do not make *subsequent* PAC are disenrolled from coverage and are referred to as “Leavers” by Indiana FSSA. Leavers who are enrolled in HIP Plus prior to disenrollment are subject to a six-month disenrollment period; they can submit a new application during this disenrollment period and be considered for other Medicaid programs, but will not be eligible for HIP. Leavers who are enrolled in HIP Basic prior to disenrollment are not subject to a six-month disenrollment period from HIP; they may reapply before six months have passed and be considered eligible for HIP.²

Individuals Not Enrolled or Disenrolled Due to Non-payment of PAC

- **Never Members:** Individuals with incomes above 100 percent of the FPL who are not initially enrolled in HIP coverage because they do not make their *first* PAC
- **Leavers:** Individuals with incomes above 100 percent of the FPL who are fully enrolled in HIP but are later disenrolled from HIP coverage because they do not make *subsequent* PAC

This report reflects available data spanning the beginning of the HIP 2.0 demonstration on February 1, 2015 through December 1, 2016. Key findings and the relevant timeframe for each of the six research questions are reported below. The Final Evaluation Report to be submitted to CMS in 2018 will reexamine these issues using data from two and a half years of program experience.

¹ Individuals with incomes at or below 100 percent of the FPL who never make a PAC are never fully enrolled in HIP Plus; they are enrolled in HIP Basic after their payment deadline passes. The following eligibility categories are exempt from disenrollment even if they have incomes above 100 percent of the FPL and do not make PAC: pregnant women, Native Americans, medically frail individuals and Transitional Medical Assistance (TMA) participants.

² In general, Basic members cannot be disenrolled due to non-payment because their incomes are at or below 100 percent of the FPL. However, if a Basic member's income increases to above 100 percent of the FPL, he or she is no longer eligible for Basic, and must make a PAC to enroll in Plus coverage. If he or she does not make a PAC, he or she is disenrolled from coverage.

Key Findings

Research Question 1: How many individuals lost HIP Plus coverage due to non-payment of the PAC?

Between February 1, 2015 and November 30, 2016, 9,636 unique individuals with incomes above 100 percent of the FPL were disenrolled from HIP *Plus* coverage due to non-payment of PAC and subject to a six-month disenrollment period. This represents five percent of individuals during the timeframe who could be disenrolled or not enrolled due to non-payment of PAC.³ An additional 3,914 individuals with incomes above 100 percent of the FPL were disenrolled from HIP *Basic* coverage due to non-payment of PAC, or two percent of individuals during the timeframe who could be disenrolled or not enrolled due to non-payment of PAC. These individuals were no longer eligible for HIP *Basic* because their incomes increased to above 100 percent of the FPL, and therefore they were required to make a PAC to remain enrolled in HIP. They are not subject to a six-month disenrollment period because they were enrolled in HIP *Basic*, not HIP *Plus*, prior to disenrollment. These two groups sum to a total of 13,550 unique individuals disenrolled from HIP coverage for not making PAC, referred to as “Leavers” throughout this report. Leavers represent seven percent of individuals who could be disenrolled or not enrolled due to non-payment.

An additional 46,176 individuals were not initially enrolled in HIP because they did not make their first PAC, referred to as “Never Members.” Never Members represent 23 percent of individuals who could be disenrolled or not enrolled due to non-payment during the timeframe.⁴

Together, these counts of Leavers and Never Members sum to 57,189 unique members disenrolled or not enrolled due to non-payment, which represents 29 percent of individuals who could be disenrolled or not enrolled due to non-payment during the timeframe.⁵

Research Question 2: How many individuals requested a waiver from the six-month disenrollment period?

Between February 1, 2015 and December 1, 2016, 230 members requested a waiver from the six-month disenrollment period; 201 (87 percent) of whom received a waiver.

Research Question 3: How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER account contributions?

From January 1, 2016 through September 30, 2016, 5,770 members received help paying their PAC. This represents 1.5 percent of members who ever made a PAC. Fifty-seven of these members received help from an employer (less than one percent of members who ever made a PAC) and 5,713 received help from a non-profit organization (1.5 percent of members who ever made a PAC).

³ Individuals can be disenrolled or not enrolled for non-payment if they have incomes above 100 percent of the FPL and are not pregnant, Native American, medically frail or a TMA participant.

⁴ 2,537 individuals were both Never Members and Leavers in this time period, meaning that they applied and did not make their first payment, then reenrolled, but then subsequently stopped making payments and were disenrolled as a result (or vice versa).

⁵ This figure (29 percent) is less than the sum of the percentages reported previously (30 percent) because some individuals were both Leavers and Never Members during the timeframe.

Research Question 4: How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?

Members enrolled in HIP coverage as of November 2016 (in HIP Plus or HIP Basic) and disenrolled individuals as of November 2016 (Leavers and Never Members) were asked a series of survey questions to gauge their perceptions of PAC affordability.⁶

Plus Members and Leavers were asked how often they were worried about having enough money to pay their PAC.

- Among all HIP Plus Member respondents, 59 percent (n=204) reported that they “rarely” or “never” worried about having enough money to pay PAC.
 - Breaking these results out by income level, this is 60 percent (n=107) of HIP Plus Member respondents with incomes at or below 100 percent of the FPL and 53 percent (n=97) of HIP Plus Member respondents with incomes above 100 percent of the FPL.
- On the other hand, 15 percent (n=59) reported that they “always” or “usually” worried about having enough money to pay PAC.
 - By income level, this is 15 percent (n=26) of HIP Plus Member respondents with incomes at or below 100 percent of the FPL and 18 percent (n=33) of HIP Plus Member respondents with incomes above 100 percent of the FPL.
- Leaver respondents were most likely to report worrying about having enough money to pay PAC, with 38 percent (n=53) reporting that they “rarely” or “never” worried and 41 percent (n=57) indicating that they “always” or “usually” worried.

Basic and Plus Members were also asked about their willingness to pay a small amount each month to remain enrolled. The vast majority of Plus and Basic Member respondents reported that they would be willing to pay \$5 to stay enrolled, ranging from 83 percent among Always Basic Member respondents to 92 percent among Previously Plus Basic Member respondents. Among Plus Member respondents, 85 percent of HIP Plus Member respondents with incomes at or below 100 percent of the FPL reported that they would be willing to pay \$5 more, compared to 86 percent of HIP Plus Member respondents with incomes above 100 percent of the FPL.

Basic Members, Leavers, and Never Members were also asked the main reason that they did not make – or stopped making – their PAC.

- The most common reason cited for non-payment among Basic and Leaver respondents was that they “could not afford to pay the contribution,” with 34 percent and 44 percent citing this reason, respectively.
- Among Never Member respondents, the two most common reasons cited for not making payments were “I could not afford to pay the contribution,” (22 percent) and “I was confused about the payment process (I wasn’t sure how much to pay, when to pay, where to pay)” (22 percent).

⁶ In total, 400 Basic Members, 389 Plus Members, 202 Leavers, and 200 Never Members completed the survey. The survey was administered from December 2016 through January 2017.

Research Question 5: How are individuals accessing health care if they are disenrolled due to non-payment of the PAC?

Both enrolled and disenrolled individuals were asked a series of survey questions about access to care. Respondents were first asked whether they made an appointment for routine care or specialized care, or filled a prescription, in the past six months. Leavers who disenrolled from the program fewer than six months previously were asked about use of services since leaving HIP. Leaver and Never Member respondents were less likely than Plus and Basic Member respondents to report making appointments both for routine and specialty care. Leavers and Never Member respondents were also less likely to report filling a prescription in the past six months or since leaving HIP.

Respondents who indicated that they had made appointments or filled a prescription were asked how often they could get an appointment “as soon as needed” or how often it was easy to fill a prescription.

- For routine care, Leaver respondents were less likely than Plus, Basic, and Never Member respondents to report that they could “always” or “usually” get a routine appointment as soon as needed.
 - Fifty-eight percent (n=43) of Leaver respondents could “always” or “usually” get routine appointments as soon as needed, compared to 73 percent (n=53) of Never Member respondents, 74 percent (n=174) of Basic Member respondents and 76 percent (n=232) of Plus Member respondents.
- For prescriptions, Leaver and Never Member respondents were less likely than Plus and Basic Member respondents to report that it was “always” or “usually” easy to fill a prescription.
 - Sixty-nine percent (n=47) of Leaver respondents and 76 percent (n=58) of Never Member respondents reported that it was “always” or “usually” easy to fill a prescription, compared to 85 percent (n=191) of Basic Member respondents and 92 percent (n=254) of Plus Member respondents.

Disenrolled individuals were also asked whether they had insurance coverage at the time of the survey. Forty-seven percent (n=94) of Leaver respondents and 41 percent (n=82) of Never Member respondents reported that they had insurance coverage. Insurance from their own employer was the most common source of coverage reported among insured Leavers and Never Members, with 59 percent (n=55) of insured Leavers and 56 percent (n=46) of insured Never Members reporting coverage from their employer.

Research Question 6: Was the disenrollment period a deterrent for individuals with incomes over 100 percent FPL to miss a PAC?

In order for the disenrollment period to serve as a deterrent for non-payment of PAC, HIP members must understand that they will be disenrolled for non-payment of PAC. The survey asked respondents if they were aware that they would be disenrolled from HIP if they did not make a PAC.

- Eighty-five percent of HIP Plus Member respondents with incomes above 100 percent of the FPL, i.e., members who are maintaining PAC and could be disenrolled due to non-payment, reported being aware that they could be disenrolled for non-payment of PAC.
- Sixty-seven percent of Leaver respondents and 59 percent of Never Member respondents, i.e., members who did not make PAC and were disenrolled or not enrolled as a result, reported being aware that they could be disenrolled or not enrolled for non-payment of PAC.

I. Introduction and Background

Introduction

The goal of this report - *Indiana HIP 2.0: POWER Account Contribution Assessment* - is to assess the Healthy Indiana Plan (HIP) 2.0's POWER Account Contribution (PAC) policy. Per the Special Terms and Conditions (STCs) for Indiana's Section 1115 Demonstration, Indiana must conduct an independent evaluation of the PAC policy that assesses the following (see **Appendix A**):

- The affordability of POWER Account contributions; and
- The effect of the disenrollment-for-non-payment-of-PAC policy on enrollment.

Further, the STCs specify that the evaluation must use the results of a survey of enrolled and disenrolled individuals, including both individuals who are never fully enrolled due to non-payment of PAC and those who are fully enrolled but later disenrolled due to non-payment of PAC, and other available data.

The Indiana Family and Social Services Administration (FSSA) engaged the Lewin Group (Lewin) to conduct this assessment.

Background

HIP 2.0 members are enrolled in a high deductible health plan (HDHP), administered by a Managed Care Entity (MCE). Members receive an HSA-like account — called a “Personal Wellness and Responsibility” or “POWER” Account — to pay for services until they meet the deductible on their health plan.⁷

Members are encouraged to make monthly contributions to their POWER Accounts.⁸ These contributions — called POWER Account Contributions or “PAC” — are indexed to two percent of a member's household income, with a minimum contribution of \$1 per month and a maximum contribution of \$100 per month.⁹ Members who make these monthly contributions are enrolled in HIP Plus, a plan with enhanced benefits — such as dental and vision coverage — that does not require co-payments for services.¹⁰ Members who do not make these contributions within 60 days are, depending on the member's income, either transitioned into a more limited benefit plan if the member's income is at or below 100 percent of the Federal Poverty Level (FPL), or not enrolled in

⁷ The POWER Account's value is equal to their deductible: \$2,500. For members who make a PAC, this amount is a combination of member POWER Account contributions and State contributions. Members contribute two percent of their household income and the State contributes the difference. For members who do not make POWER Account contributions, the POWER Account is fully-funded by the state. After a member has met his/her deductible, services are paid for by the member's MCE. Preventive care services are not paid for using the POWER Account.

⁸ Members can also make an annual contribution to cover the PAC for the entire year. Native Americans and pregnant women are not eligible to pay PAC.

⁹ Per federal regulation 42 CFR 447.78, HIP members are not allowed to pay more than five percent of their household income in a given benefit quarter towards HIP cost sharing requirements. This limit is often referred to as the “5 percent threshold” and includes all payments by the member or his/her family members for the following: Monthly contributions, Co-pays, and Children's Health Insurance Program (CHIP) premiums. HIP Plus members who meet the threshold on a quarterly basis have a PAC amount of \$1 (the minimum) for the remainder of the quarter.

¹⁰ Plus Members are not required to make co-payments for services *except* for non-emergent use of the emergency department.

or disenrolled from coverage if the member's income is above 100 percent of the FPL. More detail on the repercussions of non-payment for each group is provided below.

Transitioned to a more limited benefit plan. Members with incomes *at or below* 100 percent of the FPL who do not make PAC are placed in the more limited benefit plan – HIP Basic – that does not cover some services (e.g. dental and vision) and requires co-payments for most services. These members must wait until their annual redetermination to be eligible for HIP Plus coverage again. For the purposes of this report, we distinguish between two types of Basic Members:

- 1) *Always Basic Members:* Basic Members who did not make their *first* PAC and therefore were never enrolled in Plus coverage
- 2) *Previously Plus Basic Members:* Basic Members who made at least one PAC and therefore were enrolled in Plus for at least one month, but subsequently stopped making PAC and were transitioned to Basic

Not enrolled in coverage. Individuals with incomes *above* 100 percent of the FPL who do not make their *first* PAC are not initially enrolled in coverage. This group is referred to as “Never Members” throughout this report.

Never Members are not subject to a six-month disenrollment period; they may reapply for Medicaid before six months have passed and be considered eligible for HIP and other Medicaid programs.

Disenrolled from coverage. Individuals with incomes *above* 100 percent of the FPL who do not make *subsequent* PAC are disenrolled from coverage. This group is referred to as “Leavers” throughout this report.

Leavers who are enrolled in Plus prior to disenrollment are subject to a six-month disenrollment period; they can submit a new application during this disenrollment period and be considered for other Medicaid programs, but will not be eligible for HIP. After six months, they may reenroll in HIP. Leavers who are enrolled in Basic prior to disenrollment are not subject to a six-month disenrollment period from HIP; they may reapply before six months have passed and be considered eligible for HIP.¹¹

There are three exceptions to the policies described above: medically frail individuals, Transitional Medical Assistance (TMA) participants, and individuals experiencing certain qualifying events.¹² Medically frail and TMA participants are eligible to pay PAC, however, they are exempt from disenrollment for non-payment even if they have incomes above 100 percent of the FPL. Medically frail individuals with incomes above 100 percent of the FPL who do not make PAC are

¹¹ In general, Basic members cannot be disenrolled due to non-payment because their incomes are at or below 100 percent of the FPL and therefore they are not required to pay PAC to remain enrolled. However, if a Basic member's income increases to above 100 percent of the FPL, he or she is no longer eligible for Basic, and must make a PAC to enroll in Plus coverage. If he/she does not make a PAC, he/she is disenrolled from coverage.

¹² Medically frail individuals are members with serious physical, mental, and behavioral health conditions. TMA participants are low-income parents/caretaker relatives between 19 – 185 percent of the FPL who would lose Medicaid coverage due to increased earnings, but who, under TMA, continue to receive Medicaid services for up to one year. Some examples of qualifying events include obtaining and then losing private insurance and living in a state-declared disaster area.

transitioned to a special State Plus Plan with co-payments for services.¹³ TMA participants with incomes above 100 percent of the FPL who do not to make PAC are transitioned to the State Basic Plan. Individuals who experienced certain qualifying events can be reinstated to HIP prior to the end of the six-month disenrollment period if they file a new application and can provide verification of the qualifying event.

All individuals determined eligible for HIP are encouraged to pay PAC. Individuals are *conditionally* enrolled in HIP Plus, and are given 60 days to make a PAC. However, benefits are not provided during conditional Plus enrollment. In this report, we use the terms ‘enrolled in Plus’ or ‘enrolled in Basic’ to refer to members who are *fully* enrolled in Plus or Basic and therefore receiving coverage, not to *conditionally* enrolled individuals.

There are two exceptions to the requirement to pay PAC: pregnant women and Native Americans. Pregnant and Native American members are exempt from all cost-sharing by federal law and therefore are not eligible to pay PAC. Native Americans are enrolled into HIP Plus automatically, without making a PAC.¹⁴ Pregnant women can remain in the plan they were enrolled in before they became pregnant (Basic or Plus), but with no cost-sharing and access to additional benefits – such as non-emergency medical transportation – or they can opt to move to HIP’s maternity plan.¹⁵ For a visual depiction of the HIP 2.0 PAC policies, see **Appendix B**.

II. Data Sources

This assessment relies on the following four data sources: surveys of enrolled, disenrolled and not enrolled individuals, FSSA enrollment data, FSSA administrative data, and MCE data.

Surveys of Enrolled, Disenrolled and Not Enrolled Individuals

Brief surveys were administered to four population groups of interest:

- 1) Current HIP Basic Members
- 2) Current HIP Plus Members
- 3) Leavers
- 4) Never Members

The four surveys were administered via telephone in December 2016 through January 2017. The survey instruments contained a series of close-ended questions pertaining to the affordability of PAC, reasons for non-payment of PAC, awareness of the implications for non-payment of PAC, access to care, and other sources of insurance coverage for disenrolled and not enrolled individuals (see **Appendix C** for the four survey instruments). The questions were modeled after the CMS/Indiana-approved questions used in surveys conducted in December 2015 and January 2016,

¹³ HIP 2.0 maintains a traditional Medicaid benefits package, referred to as the “State Plan,” for some of HIP’s more vulnerable populations, including medically frail individuals, Section 1931 low income parents and caretakers, low income 19 and 20 year olds, and TMA participants. Members who do not qualify for the State Plan (i.e., members not within one of those four groups) are eligible for the Regular Plan.

¹⁴ Native Americans may also opt out of HIP into fee-for-service coverage.

¹⁵ For pregnant women, the exemption from PAC applies during their pregnancy and up to 60 days post-partum.

with minor changes to the survey phrasing and response options based on lessons learned.¹⁶ Consistent with the previous surveys, each survey contained a different set of questions to accommodate differences in circumstances between the four groups, such as whether the member made or was currently making PAC based on their current membership status (Basic, Plus, Leaver, or Never Member).

The samples for the Current HIP Basic and Current HIP Plus surveys were each stratified into two groups to reflect differences in incentives and experience between members. The Basic sample was stratified into: 1) *Always Basic Members* and 2) *Previously Plus Basic Members*. The Plus sample was stratified into: 1) members with incomes above 100 percent of the FPL, i.e. members required to pay PAC to maintain coverage and 2) members with incomes below 100 percent of the FPL, i.e. members eligible for Basic coverage if they do not maintain PAC.¹⁷ Pregnant women and Native Americans were excluded from all samples because they are not eligible to pay PAC. The Plus and Basic Member samples were developed using enrollment data from February 1, 2015 through July 29, 2016, provided by FSSA on December 6, 2016 and enrollment data for November 2016 (as of November 30), provided by FSSA on December 16, 2016. The Leaver and Never Member samples were provided by FSSA on January 10, 2017 and January 6, 2017, respectively, and verified using enrollment data for February 1, 2015 through November 30, 2016, provided by FSSA on January 6, 2017.

Exhibit 1 shows the sample frame and the number of completed surveys for each subgroup. **Appendix D** provides more detail on the sampling strategy.

Exhibit 1: Final Frame Size and Number of Completed Surveys

Group	Final Frame Size	Completed Surveys
Current HIP Basic Members	146,522	400
<i>Always Basic Members</i>	115,065	327
<i>Previously Plus Basic Members</i>	31,457	73
Current HIP Plus Members	233,492	389
Plus Members with incomes at or below 100 percent FPL	196,724	195
Plus Members with incomes above 100 percent FPL	36,768	194
Leavers	5,156	202
Never Members	11,449	200

Source: FSSA Enrollment Data: November 30, 2016 and February 1, 2015 – July 29, 2016; Basic, Plus, Leaver, and Never Member Survey data: December 2016 – January 2017.

The overall response rate for the four survey groups was 4.8 percent, which is calculated as the number of completed surveys divided by the total number of members called. The Plus Member Survey had the highest response rate at 7.8 percent, while the Never Member Survey had the lowest at 3.0 percent. The incidence rate, which is the number of *completed surveys* out of the total number of members reached, was 74 percent.

¹⁶ For a full description of the prior survey methods and results, see: The Lewin Group. 2016. *Indiana HIP 2.0: Interim Evaluation Report*. Retrieved on February 17, 2017 from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf>

¹⁷ Medically frail and TMA participants are excluded from the Plus above 100 percent FPL group because they are eligible for Basic coverage (i.e., exempt from disenrollment) even if they have incomes above 100 percent of the FPL.

FSSA Enrollment Data

HIP 2.0 enrollment data for February 1, 2015 through November 30, 2016, provided by FSSA on January 6, 2017, were used to calculate a number of metrics in the report. The enrollment data contained information on members' demographics (e.g., income, gender), enrollment status (open, closed or denied), eligibility categories (e.g., aid category, and whether the member met any special eligibility requirements, such as TMA), reason codes explaining changes in members' coverage status, and whether members who left HIP subsequently enrolled in another Indiana Medicaid program.

For the purposes of this analysis, we included individuals eligible for the following HIP Medical Assistance aid categories: Regular Plus (MARP), Regular Basic (MARB), State Plus (MASP), State Basic (MASB) and State Plus with Co-pays (MAPC).

FSSA Administrative Data

HIP 2.0 data for February 1, 2015 through December 1, 2016, collected by the Indiana Office of Medicaid Policy and Planning (OMPP) and provided to Lewin on December 12, 2016 and December 21, 2016, were used to identify members who applied for and received a waiver from disenrollment due to non-payment of PAC.

Managed Care Entity Data

Data from the three MCEs participating in HIP 2.0 – Anthem, Managed Health Services (MHS), and MDwise – were used to calculate metrics on third party contributions to PAC and Fast Track payments. MCE third party contributions data, provided on December 5, 2016, represents the time period from January 1, 2016 through September 30, 2016. The MCE Fast Track data, received December 7, 2016 from FSSA, represents the time period from February 1, 2015 through September 30, 2016.

III. Methodology

The evaluation design for this report is based on the POWER Account Contributions and Copayments Monitoring Protocol, developed by FSSA and approved by CMS in 2015 (see **Appendix E**). This report is divided into six sections corresponding to the six research questions outlined in the Protocol:

- 1) How many individuals lost HIP Plus coverage due to non-payment of the PAC?
- 2) How many individuals requested a waiver from the six-month disenrollment period?
- 3) How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER Account contributions?
- 4) How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?
- 5) How are individuals accessing health care if they are disenrolled due to non-payment of the PAC?
- 6) Was the disenrollment period a deterrent for individuals with incomes over 100 percent FPL to miss a PAC?

The results are presented by research question.

IV. Results

Research Question 1: How many individuals lost HIP Plus coverage due to non-payment of the PAC?

This Research Question is divided into two sections, each devoted to a type of HIP payment. The first section – POWER Account Contributions – presents data on the number of members making PAC and the number who failed to make a PAC. The second section – Fast Track Payments – presents data on the number of HIP members making another type of payment, called a ‘Fast Track’ payment, which is applied to a member’s first PAC and expedites the start of their coverage.¹⁸

POWER Account Contributions

This section describes the number of individuals who *made* at least one PAC and the number who *failed to make* at least one PAC during the timeframe. To provide context for the results, the section first introduces data on the number of current HIP members and the number of individuals ever eligible to pay PAC during the timeframe. The section then describes, of those individuals ever eligible to pay PAC, how many paid at least one PAC and how many failed to make at least one PAC. For those who failed to make at least one PAC, we report whether individuals were transitioned to Basic, transitioned to State Plus with Co-pays, disenrolled, or not enrolled as a result of non-payment of PAC. Finally, we report how many disenrolled or not initially enrolled individuals later reenrolled in HIP or another Medicaid program.

1. Current HIP Members (as of November 2016)

In November 2016, 409,935 unique individuals were enrolled in HIP. Of these, 254,229 unique individuals were enrolled in HIP Plus (62 percent) and 155,706 unique individuals were enrolled in HIP Basic (38 percent). Of those enrolled in HIP Plus, 81 percent (n=205,947) had incomes at or below 100 percent of the FPL and 19 percent (n=48,282) had incomes above 100 percent of the FPL.

2. Individuals Ever Eligible to Pay PAC (February 2015 through November 2016)

For the full timeframe from February 2015 through November 2016, there were 590,315 unique individuals determined eligible for HIP who were ever eligible to pay PAC.¹⁹ In the subsequent sections, we report on the percentage of these members who made at least one PAC, and those who did *not* make a PAC and were either transitioned to Basic, transitioned to State Plus with Co-pays, disenrolled, or not initially enrolled as a result of non-payment.

During this timeframe, there were an additional 4,649 unique members who were pregnant or Native American throughout their HIP enrollment, and therefore were never eligible to pay PAC.

¹⁸ Applicants who are likely eligible for another Medicaid program other than HIP – such as members who indicated they were pregnant, disabled, a former foster care child or on Medicare when they applied – are not eligible to make Fast Track payments.

¹⁹ As noted above, all HIP members except pregnant women and Native Americans are required to make PAC to enroll in HIP Plus. As such, only members who were Native American or pregnant in every month in the data are considered not eligible to pay PAC and thus are excluded from the count of members ever eligible to pay PAC.

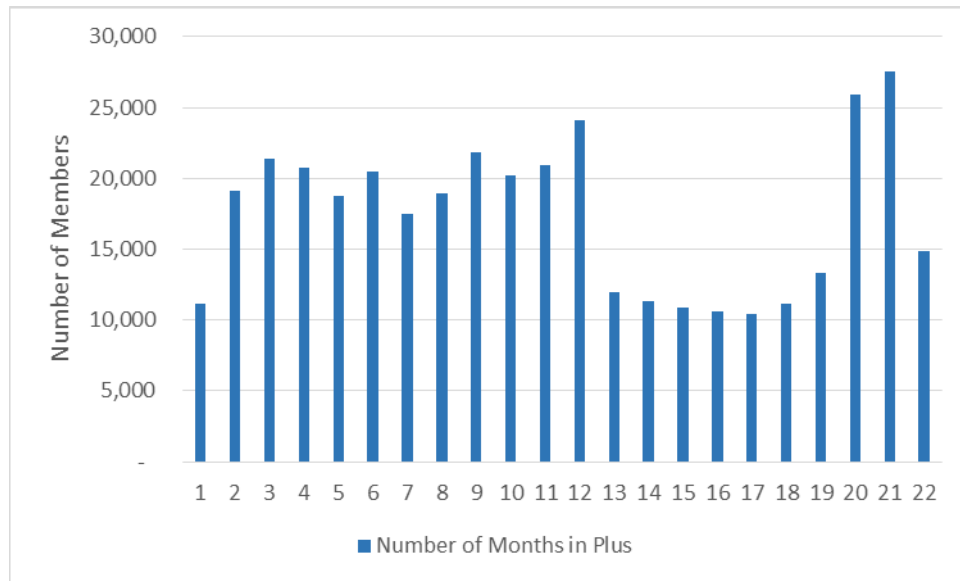
These members are excluded from the counts reported below because they are not eligible to pay PAC.

a. Individuals who Made a PAC

Of the 590,315 unique individuals ever eligible to pay PAC, 383,127 (approximately 65 percent) were fully enrolled in Plus for at least one month (i.e., *Ever Plus*), which indicates that they made at least one PAC.²⁰

Exhibit 2 below shows a distribution of the number of months *Ever Plus* Members were enrolled in Plus from February 2015 through November 2016. This includes members who continued to make their PAC and remained enrolled in Plus, as well as those who stopped making PAC and were transitioned to Basic or State Plus with Co-pays, or disenrolled. Note, this includes members who enrolled at any point during the timeframe from February 2015 through November 2016. As such, some members represented in **Exhibit 2** had the opportunity to pay for up to 22 months if they first enrolled in February 2015, whereas others only had the opportunity to pay for one month if they first enrolled in November 2016.

Exhibit 2: Duration of Plus Enrollment for *Ever Plus* Members as of November 2016 (n=383,127)



Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

Almost 40 percent of *Ever Plus* Members had been enrolled in Plus for over a year as of November 2016.

²⁰ This count includes only those who were fully enrolled in Plus, i.e., receiving benefits; it does not include members who were conditionally enrolled in HIP Plus pending a PAC or the expiration of the 60 day payment period. It also excludes members who were pregnant or Native American during their Plus enrollment because they can be enrolled in Plus without having to make a PAC.

b. Individuals who Did Not Make a PAC

Of the 590,315 unique individuals ever eligible to pay PAC, 324,840 (55 percent) did not make a PAC at some point in time during their enrollment. This includes 286,914 individuals who were enrolled in Basic as a result of non-payment (88 percent of the individuals who did not make a payment), 1,431 individuals who were enrolled in State Plus with Co-pays as a result of non-payment (less than one percent of the individuals who did not make a payment), 13,550 individuals who were disenrolled as a result of non-payment (four percent of individuals who did not make a payment), and 46,176 individuals who were not initially enrolled as a result of non-payment (14 percent of individuals who did not make a payment).²¹ Some of these individuals made a PAC but then stopped making payments, while others never made a payment. Each group is described in more detail below.

The rate of non-payment was higher among individuals with incomes at or below 100 percent of the FPL. Among individuals with incomes at or below 100 percent of the FPL ever eligible to pay PAC, 57 percent did not make at least one payment.²² Among individuals with incomes above 100 percent of the FPL ever eligible to pay PAC, 51 percent did not make at least one payment.²³

i. Individuals Transitioned to Basic Due to Non-payment of PAC

Individuals with incomes *at or below* 100 percent of the FPL and TMA participants at all income levels who do not make PAC are enrolled in HIP Basic.

During the timeframe of February 2015 through November 2016, 286,914 individuals were fully enrolled in Basic for at least one month, meaning that they did not make a PAC. Among those individuals, 40,756 or 14 percent made a payment (i.e., were enrolled in Plus for at least one month) but subsequently stopped making payments and were transitioned into Basic.²⁴ **Exhibit 3** displays a distribution of the number of months of Plus membership for members who transitioned into Basic. Note, some members may have transitioned from Plus to Basic more than once during the timeframe. The data in **Exhibit 3** reflect the first time a member transitioned.

About 60 percent of members who transitioned into Basic made the transition after six months or more of Plus enrollment.

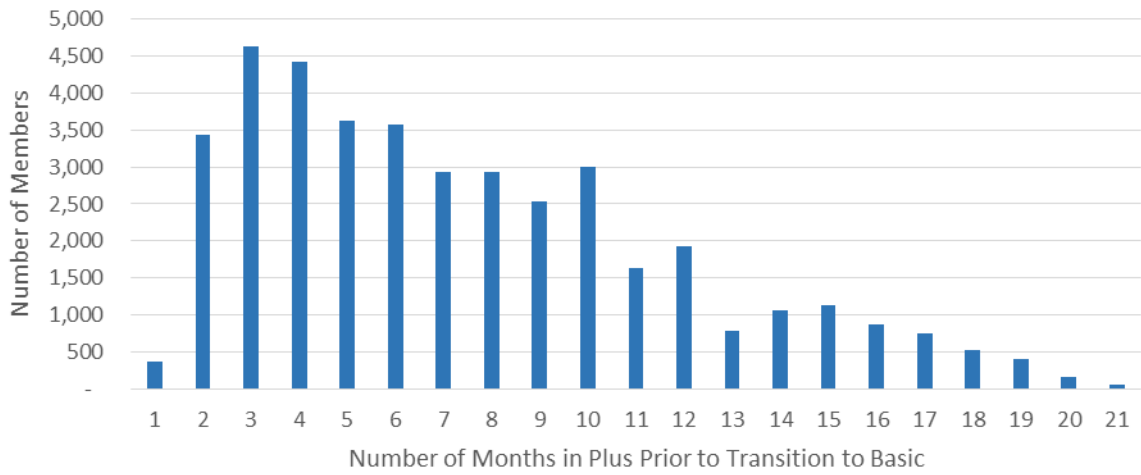
²¹ The percentages reported here are out of all individuals who were eligible to pay PAC but did not make a PAC (324,840), including individuals who are exempt from disenrollment for failure to pay PAC (i.e., individuals with incomes at or below 100 percent FPL, medically frail and TMA participants). The percentages do not sum to 100 because individuals may be in multiple groups during the timeframe if they failed to make multiple payments, however the 324,840 count represents *unique* individuals who did not make at least one payment.

²² This includes members with income *never* above 100 percent of the FPL *at any point during their enrollment*, in other words, their income was always at or below 100 percent of the FPL. Specifically, the numerator for this calculation includes individuals with incomes always at or below 100 percent of the FPL who did not make a payment (Basic members with income always at or below 100 percent of the FPL) and the denominator includes those in the numerator plus members who were always enrolled in Plus (always paid) and always had incomes at or below 100 percent of the FPL.

²³ This includes members with income above 100 percent of the FPL at any point during their enrollment. Specifically, the numerator for this calculation includes individuals with incomes ever above 100 percent of the FPL who did not make a payment (Leavers, Never Members, members in Basic with income above 100 percent of the FPL, and MAPC members) and the denominator includes those in the numerator plus members who were always enrolled in Plus (i.e., always paid) with income ever above 100 percent of the FPL.

²⁴ This count includes only those individuals who transitioned immediately from HIP Plus coverage to HIP Basic coverage following non-payment. Individuals with gaps between their Plus and Basic coverage, or who moved to Plus *after* being enrolled in Basic, e.g., at their redetermination, are not included in this count.

Exhibit 3: Duration of Plus Enrollment Prior to Transition for Members who Transitioned to Basic (n=40,756)



Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

Exhibit 4 displays the first month of Basic enrollment for members who transitioned into Basic. The months with the highest number of transitions were July 2015 and January 2016.

Exhibit 4: First Month of Basic Enrollment for Members who Transitioned to Basic (n=40,756)

First Month in Basic After Transition	Count	Percent
April 2015	9	<1%
May 2015	27	<1%
June 2015	28	<1%
July 2015	7,400	18%
August 2015	212	1%
September 2015	2,507	6%
October 2015	1,905	5%
November 2015	1,116	3%
December 2015	841	2%
January 2016	4,761	12%
February 2016	1,307	3%
March 2016	2,794	7%
April 2016	1,663	4%
May 2016	789	2%
June 2016	1,814	4%
July 2016	2,105	5%
August 2016	2,925	7%
September 2016	2,981	7%
October 2016	3,312	8%
November 2016	2,260	6%

Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

ii. Individuals Transitioned to State Plus with Co-pays Due to Non-payment of PAC

Medically frail members with incomes above 100 percent of the FPL who do not make PAC are enrolled in State Plus with Co-pays (MAPC). From February 1, 2015 through November 30, 2016, 1,431 individuals were fully enrolled in MAPC for at least one month, meaning that they did not make a PAC.

iii. Individuals Disenrolled Due to Non-payment of PAC

Individuals with incomes *above* 100 percent of the FPL are disenrolled from coverage for not making PAC. During the studied timeframe, February 1, 2015 through November 30, 2016, 13,550 unique individuals were enrolled in HIP at least one month but did not make a payment and were disenrolled as a result, referred to as “Leavers.” This includes 3,914 unique individuals who were enrolled in HIP Basic prior to disenrollment and 9,636 individuals enrolled in Plus prior to disenrollment.

The 3,914 individuals enrolled in Basic prior to disenrollment are not subject to a six-month disenrollment period. These members likely experienced a change that made them ineligible for Basic, for example an increase in income above 100 percent of the FPL.²⁵ In other words, these members failed to make their first PAC, and were transitioned to Basic as a result, but then became ineligible for Basic due to an income increase and therefore were required to pay PAC to remain enrolled. When these members did not make PAC, they were disenrolled from HIP Basic. This group represents two percent of individuals during the timeframe who could be disenrolled or not enrolled due to non-payment of PAC.²⁶

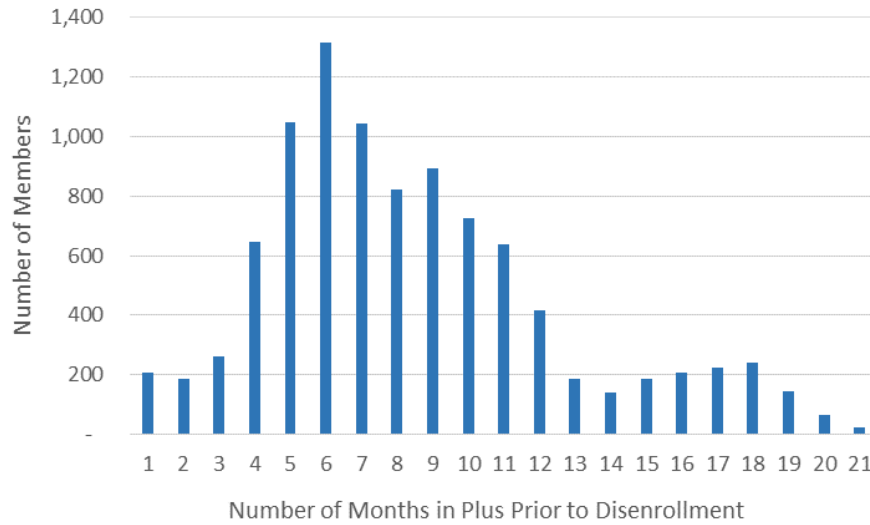
The 9,636 individuals enrolled in Plus prior to disenrollment were subject to the six-month disenrollment period.²⁷ This group represents five percent of individuals during the timeframe who could be disenrolled or not enrolled due to non-payment of PAC. **Exhibit 5** displays a distribution of the number of months of Plus membership prior to non-payment for Leavers enrolled in Plus at least one month, i.e., who made at least one PAC. Among Leavers who made at least one PAC, about 62 percent were enrolled in Plus for more than six months before being disenrolled from the program due to non-payment.

²⁵ Members with incomes above 100 percent of the FPL could also have experienced a loss of TMA status, which would also make them ineligible for Basic.

²⁶ Individuals can be disenrolled or not enrolled for non-payment if they have incomes above 100 percent of the FPL and are not pregnant, Native American, medically frail or a TMA participant.

²⁷ Some of these members may have subsequently received a waiver from the six-month disenrollment period. As reported in Research Question Two below, 201 members received a waiver from the six-month disenrollment period during the timeframe.

Exhibit 5: Duration of Plus Enrollment for Leavers Ever Enrolled in Plus (n=9,636)



Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

Exhibit 6 displays the last month of enrollment for members who were disenrolled due to non-payment. The months with the highest number of disenrollments were August through October 2016.

Exhibit 6: Last Month of Enrollment for Leavers (n=13,550)

Last Month Before Disenrollment	Count	Percent
March 2015	27	<1%
April 2015	21	<1%
May 2015	3	<1%
June 2015	296	2%
July 2015	1	<1%
August 2015	440	3%
September 2015	625	5%
October 2015	273	2%
November 2015	374	3%
December 2015	8	<1%
January 2016	1,136	8%
February 2016	1,095	8%
March 2016	859	6%
April 2016	695	5%
May 2016	647	5%
June 2016	530	4%
July 2016	337	2%
August 2016	1,513	11%
September 2016	1,602	12%
October 2016	1,827	13%
November 2016	1,241	9%

Source: FSSA Enrollment data: February 1, 2015 – November 30, 2016

iv. Individuals Not Enrolled Due to Non-payment of PAC

An additional 46,176 individuals were not initially enrolled in HIP because they did not make their first PAC, referred to as “Never Members.”²⁸ This represents 23 percent of individuals who could be disenrolled or not enrolled as a result of non-payment.

c. Disenrolled or Not Enrolled Individuals who Re-Enrolled in HIP or other Medicaid Programs

As mentioned previously, Leavers who are enrolled in Plus prior to disenrollment are subject to a six-month disenrollment period. However, they can submit a new application during this disenrollment period and be considered for other Medicaid categories aside from HIP. After six months have passed, they may also reapply for HIP.

Never Members and Leavers who were in Basic prior to disenrollment are not subject to this six-month HIP disenrollment period; they may reapply and be reconsidered eligible for HIP before six months have passed.

Eleven percent (1,496) of the Leavers and 53 percent (24,424) of the Never Members reenrolled in HIP or another Medicaid program as of November 2016.

Fast Track Payments

Under HIP 2.0, HIP Plus coverage begins the first day of the month in which an individual makes their POWER Account contribution. In April 2015, HIP 2.0 established a means for eligible HIP members to expedite the start of their coverage called “Fast Track.” Fast Track allows individuals to make a \$10 payment at the time of application, after applying, or while the application is being processed, as a mechanism to expedite the start of HIP Plus coverage. The \$10 payment is applied towards the member’s first POWER Account contribution.²⁹ If a member makes a Fast Track payment and is determined eligible for HIP, his or her HIP Plus coverage begins the first of the month in which he or she made the Fast Track payment.³⁰

Exhibit 7 describes the number of members – by income category – who made Fast Track payments, based on data provided by the MCEs. Across all three MCEs, 116,000 unique members made a Fast Track payment. This represents 20 percent of the ever-enrolled HIP 2.0 members.³¹

²⁸ 2,537 individuals were both Never Members and Leavers during the timeframe, meaning that they applied and did not make their first payment, then reenrolled, but then subsequently stopped making payments (or vice versa).

²⁹ If the individual is not found eligible for HIP, the state will refund the payment. If the member’s POWER Account contribution amount is less than \$10 per month, the \$10 payment is applied to their first coverage month, with the remaining amount applied to future months.

³⁰ Applicants who are likely eligible for another Medicaid program other than HIP – such as members who indicated they were pregnant, disabled, a former foster care child or on Medicare when they applied – are not eligible to make Fast Track payments.

³¹ The denominator for this calculation is the total number of members ever enrolled in MARB, MASB, MARP, or MASP from February 1, 2015 through November 30, 2016.

Exhibit 7: Number of Members Making a Fast Track Payment, by Member Income Level

Income Level	Number of Members Making Fast Track Payments
All Income Levels	116,000
Less than or equal to 100 percent FPL	95,554
Greater than 100 percent FPL	20,446

Source: MCE data: February 1, 2015 – September 30, 2016

Notes: 14 records were dropped because they had payment dates prior to the implementation of the Fast Track program (i.e., before 4/1/2015). Income from the first month of enrollment was used.

Individuals can make Fast Track payments online via credit card any time during the application process: at the time of application, after applying, or while the application is being processed. Individuals who do not apply online (or choose not to make a Fast Track payment when applying) are sent a Fast Track invoice from their MCE. As shown in **Exhibit 8**, the majority of members making a Fast Track payment made the payment after receiving a Fast Track invoice from their MCE.

Exhibit 8: Timing of Fast Track Payment Submission

Timing of Payment Submission	Percentage of All Members Making Fast Track Payments
Made Fast Track payment at the time of application	11%
Made Fast Track payment after submitting an application but before receiving an invoice from their MCE	3%
Made Fast Track payment after receiving an invoice from their MCE	87%

Source: MCE data: February 1, 2015 – September 30, 2016

Research Question 2: How many individuals requested a waiver from the six-month disenrollment?

As noted above, members with incomes above 100 percent of the FPL who do not make subsequent PAC are disenrolled from HIP and are not allowed to return for six months.³² However, members may apply for a waiver from the six-month disenrollment period. Specifically, individuals may be reinstated to HIP prior to the end of the six-month disenrollment period if they file a new application and can provide verification that they experienced one of the following qualifying events:³³

- Obtained and subsequently lost private insurance coverage;
- Had a loss of income after disqualification due to increased income;
- Took up residence in another state and later returned;
- Were a victim of domestic violence; or

³² Medically frail and TMA participants are exempt from disenrollment.

³³ Indiana HIP 2.0 Special Terms and Conditions, Section VII, Paragraph 12, Section D.

- Were residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty (60) calendar days prior to date of member termination for non-payment.

Exhibit 9 describes the number of members who applied for and were granted a waiver from the six-month disenrollment period. In total, 201 members received a waiver from the disenrollment period in the first 21 months of HIP 2.0. Some of these members may be included in the count of Leavers subject to the six-month disenrollment period reported above (9,636) if they experienced a gap of at least one month in coverage, however this cannot be confirmed at this time.

Exhibit 9: Number of Disenrollment Waivers and Exemptions

HIP Members Applied for Waiver/Exemption	Granted Waiver/Exemption	Denied
230	201	29

Source: Administrative data from the Indiana Family and Social Services Administration's Office of Medicaid Policy and Planning: February 1, 2015 – December 1, 2016

Research Question 3: How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER account contributions?

HIP 2.0 enrollees can have all or a portion of their PAC paid for by employers or non-profit organizations.

Exhibit 10 presents information on the number of employers and non-profit organizations making contributions on behalf of HIP members from January 1, 2016 through September 30, 2016.

Exhibit 10: Employer and Non-Profit Organization Contributions

Entity	Metric	2016 YTD Total
Employer Contributions	Number of Employers Participating	40
	Number of Members on Whose Behalf an Employer Makes a Contribution	57
	Total Amount of Employer Contributions	\$2,528.51
	Average Amount of Employer Contributions Per Member	\$44.36
Non-profit Contributions	Number of Non-Profit Organizations Participating	138
	Number of Members on Whose Behalf a Non-Profit Makes a Contribution	5,713
	Total Amount of Non-Profit Contributions	\$66,142.52
	Average Amount of Non-Profit Contributions Per Member	\$11.58

Source: MCE data: January 1, 2016 – September 30, 2016

From January 1, 2016 through September 30, 2016, 5,770 members received help paying their PAC. This represents 1.5 percent of members who ever made a PAC. Participation from non-profit organizations was higher than employer participation, with 138 non-profit organizations making contributions on behalf of 5,713 members (1.5 percent of members who ever made a PAC),

compared to 40 employers making contributions on behalf of 57 members (less than one percent of members who ever made a PAC).³⁴

Plus Member survey results provide additional information on the extent of third party assistance with PAC. Plus Members were first asked whether they made a monthly or annual contribution to be in HIP. Of the 389 Plus Members who completed the survey, 361 responded that they made a contribution. These members were then asked whether they received help with the cost of making contributions from someone else such as a family member, friend, employer, health care provider or charity. About 24 percent of HIP Plus Member respondents (n=76) indicated that they received help from a third party.³⁵

Those who reported receiving help were asked about the source(s) of their help. Individuals could indicate more than one source of assistance. **Exhibit 11** shows the most common responses.

Exhibit 11: Help with POWER Account Contribution

Source of Assistance	Number of Members	Percentage
Help from a Family Member	66	87%
Help from a Friend	17	24%

Source: Plus Member Survey data: December 2016 – January 2017, weighted percentages reported. Other options for which there were five or fewer responses include a charity or religious organization, a health care provider such as a doctor’s office or hospital, an employer, and some other source.

Plus Members were most likely to report receiving help from a family member (87 percent) or a friend (24 percent). Very few members reported receiving help from an employer (n=3) or a charity or religious organization (n=5), which is consistent with the low participation reported by MCEs, shown in **Exhibit 10** above.

Research Question 4: How do HIP 2.0 enrollees perceive the affordability of PAC and non-payment penalties?

Survey data from individuals enrolled in HIP coverage as of November 2016 (in HIP Plus or HIP Basic) and disenrolled or not enrolled individuals as of November 2016 (Leavers and Never Members) were used to assess member perceptions of the affordability of PAC and their self-reported reasons for not making PAC.

Perceptions of PAC affordability

1. Members’ Frequency of Worrying about Ability to Pay PAC

Current HIP Plus Members and Leavers were asked a series of questions to gauge their perceptions of PAC affordability. Respondents were first asked, “Did you make a monthly or annual contribution when you were in HIP?” Respondents who reported that they made a monthly or

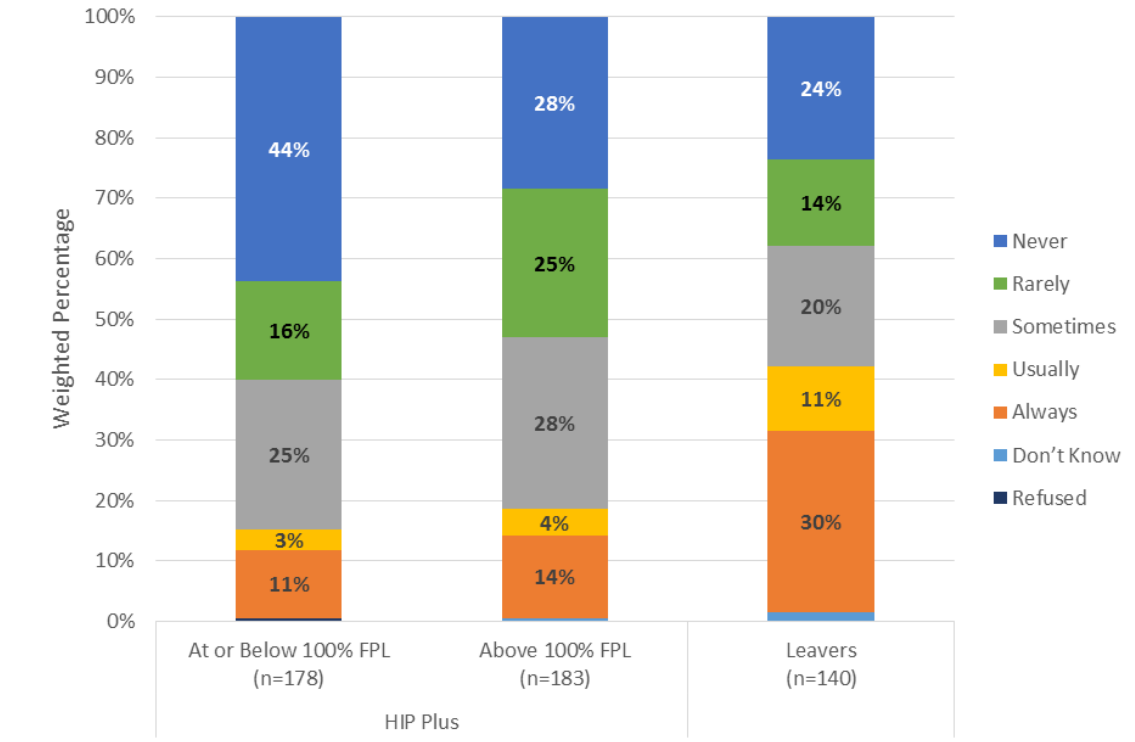
³⁴ HIP Employer Link – HIP’s contribution premium assistance program designed to support individuals wishing to purchase their employer’s sponsored health insurance – began in June 2015.

³⁵ One member responded “Don’t Know,” one “Refused.”

annual contribution (n=361 for Plus Members, n=140 for Leavers) were then asked a series of questions on their perceptions of PAC affordability and their reasons for non-payment.³⁶

Respondents were first asked how often they worried about having enough money to pay their contribution. As shown in **Exhibit 12**, less than 20 percent of HIP Plus Member respondents reported that they “always” or “usually” worried about having enough money to pay PAC.

Exhibit 12: Members’ Frequency of Worrying about Ability to Pay PAC, by Member Type



Source: Plus Member and Leaver Survey data: December 2016 – January 2017, weighted percentages reported

HIP Plus Member respondents with incomes at or below 100 percent of the FPL were least likely to report worrying about having enough money to pay PAC, with 15 percent (n=26) reporting that they “always” or “usually” worried. Among Plus Members with incomes above 100 percent of the FPL, 18 percent (n=33) reported that they “always” or “usually” worried.³⁷ Leavers were most likely to worry about their ability to pay PAC, with 41 percent (n=57) reporting that they “always” or “usually” worried.

2. Members’ Willingness to Pay More

To further explore members’ perceptions of the affordability of PAC, HIP Plus and HIP Basic Members were asked about their willingness to pay to remain enrolled in HIP. Basic Members were asked if they would be willing to pay \$5, and then \$10 each month to remain enrolled. HIP

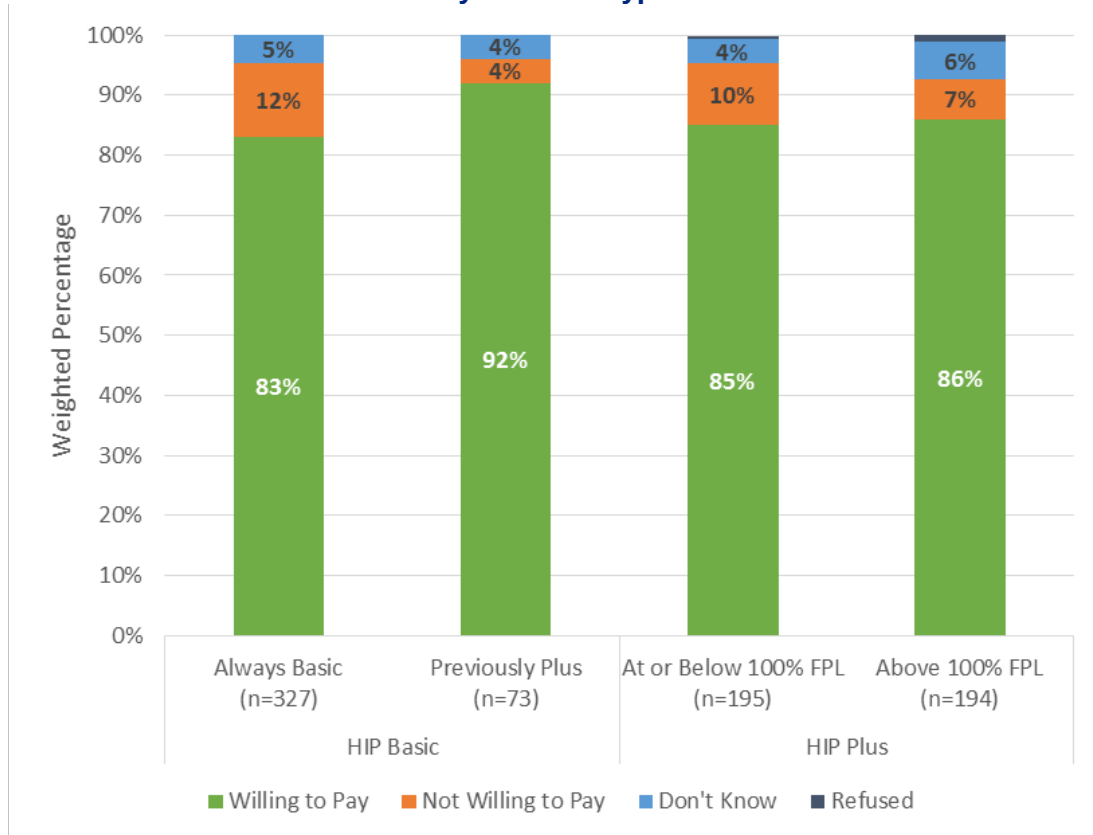
³⁶ Twenty-eight Plus members and 62 Leavers responded that they “did not make a monthly or annual contribution to be in HIP,” or selected “Don’t know” or “Refused.”

³⁷ One Plus member and two Leavers responded “Don’t Know” to this survey question. One Plus member “Refused.”

Plus Members were asked if they would be willing to pay \$5 *more*, and then \$10 *more* each month to remain enrolled.

As shown in **Exhibit 13**, the majority of HIP 2.0 Basic and Plus Members were willing to pay \$5 or \$5 more each month to remain enrolled in HIP 2.0.

Exhibit 13: Members’ Willingness to Pay \$5 (Basic) or \$5 More (Plus) to Remain Enrolled, by Member Type

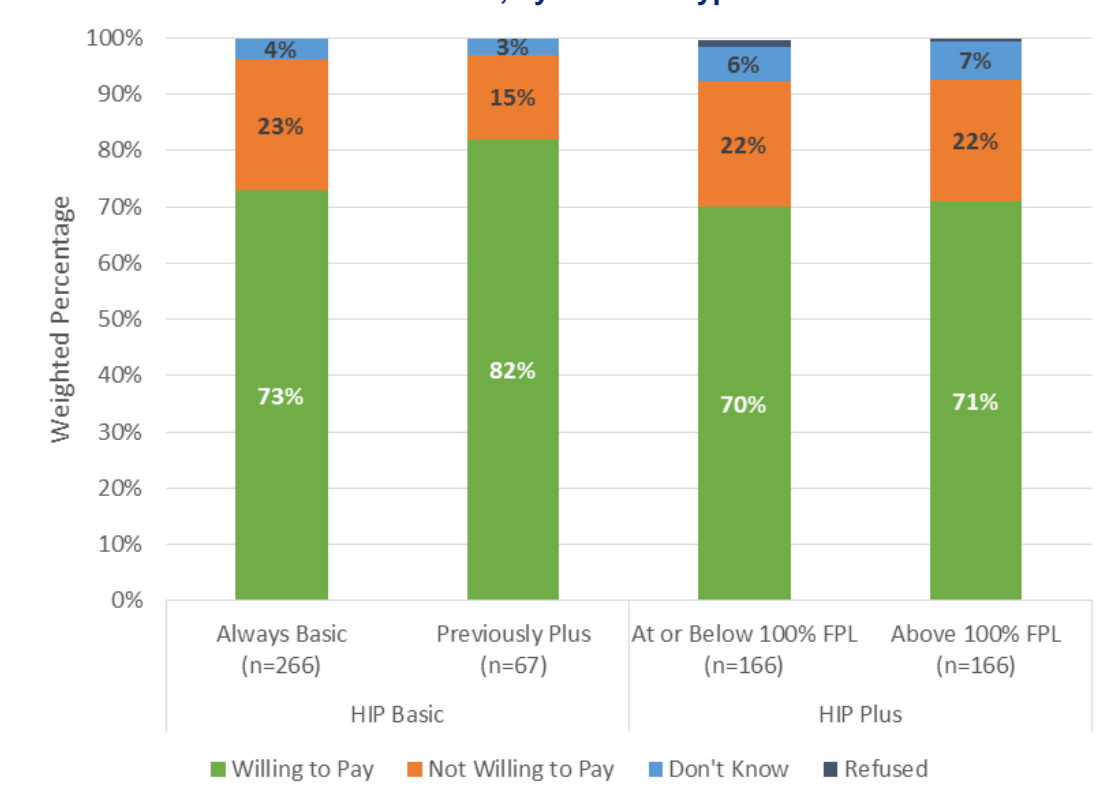


Source: Basic and Plus Member Survey data: December 2016 – January 2017, weighted percentages reported

Among members who were not making monthly contributions (Basic Members), 83 percent (n=266) of *Always Basic* Member respondents and 92 percent (n=67) of *Previously Plus* Basic Member respondents reported that they would be willing to pay \$5 each month to remain enrolled. Among those who were already making monthly contributions (Plus Members), approximately 85 percent (n=166) of Plus Member respondents with incomes at or below 100 percent of the FPL and 86 percent (n=166) of Plus Member respondents with incomes above 100 percent of the FPL reported that they were willing to pay \$5 more each month to remain enrolled.

If members responded that they were willing to contribute \$5 (or \$5 *more*, in the case of Plus Members), they were then asked if they were willing to contribute \$10 (or \$10 *more* for Plus Members). **Exhibit 14** shows that the majority of members who reported that they were willing to pay \$5 (or \$5 more) also reported that they were willing to pay \$10 (or \$10 more) to remain enrolled.

Exhibit 14: Members' Willingness to Pay \$10 (Basic) or \$10 More (Plus) to Remain Enrolled, by Member Type



Source: Basic and Plus Member Survey data: December 2016 – January 2017, weighted percentages reported

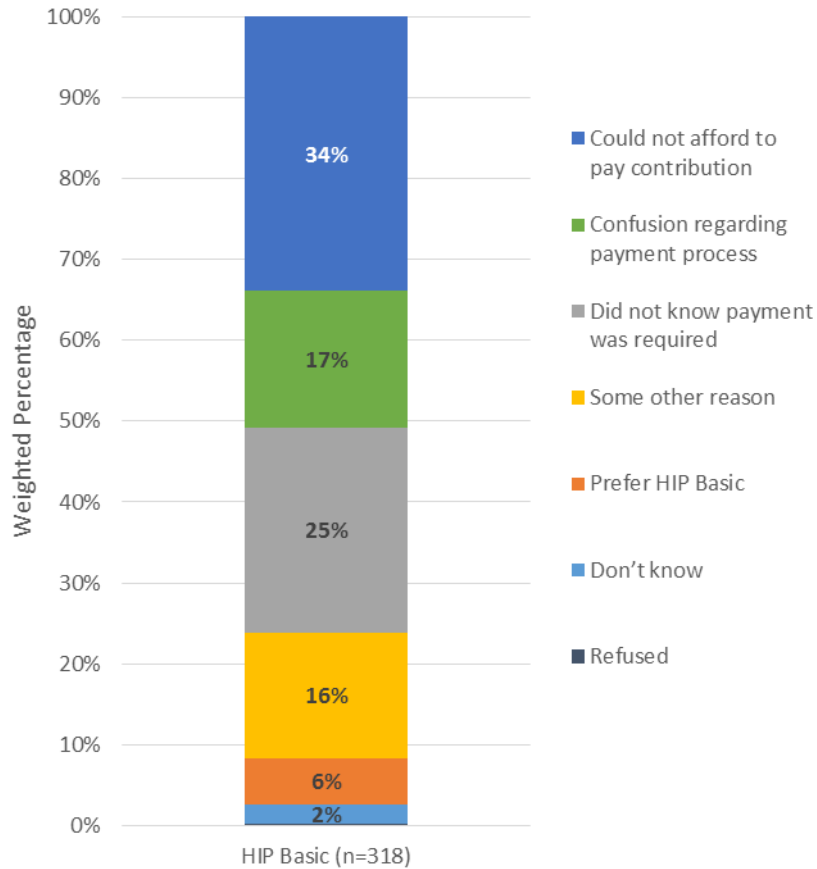
Reasons for non-payment of PAC

To understand why Basic Members, Leavers, and Never Members did not pay their PAC, respondents were first asked to confirm that they did not make or had stopped making a contribution to be in HIP. Three-hundred and eighteen Basic Members (78 percent) confirmed that they were not currently making a contribution to be in HIP, 124 Leavers (61 percent) confirmed that they had stopped making contributions, and 168 Never Members (84 percent) confirmed that they did not make their first contribution to be in HIP.

Individuals who confirmed their payment status were then asked why they did not make – or stopped making – payments. The surveys allowed for response choices that were relevant for each specific group. For example, for the Leaver and Never Member surveys, response options included events that would render an individual ineligible for HIP coverage, such as moving out of Indiana or an increase in income. For Basic Members, these response options were not included because they do not apply to Basic Members, given that they are still enrolled in and eligible for HIP.

Exhibit 15 displays Basic Member respondents' reported reasons for non-payment.

Exhibit 15: Reasons for Non-Payment of PAC, Basic Member Respondents

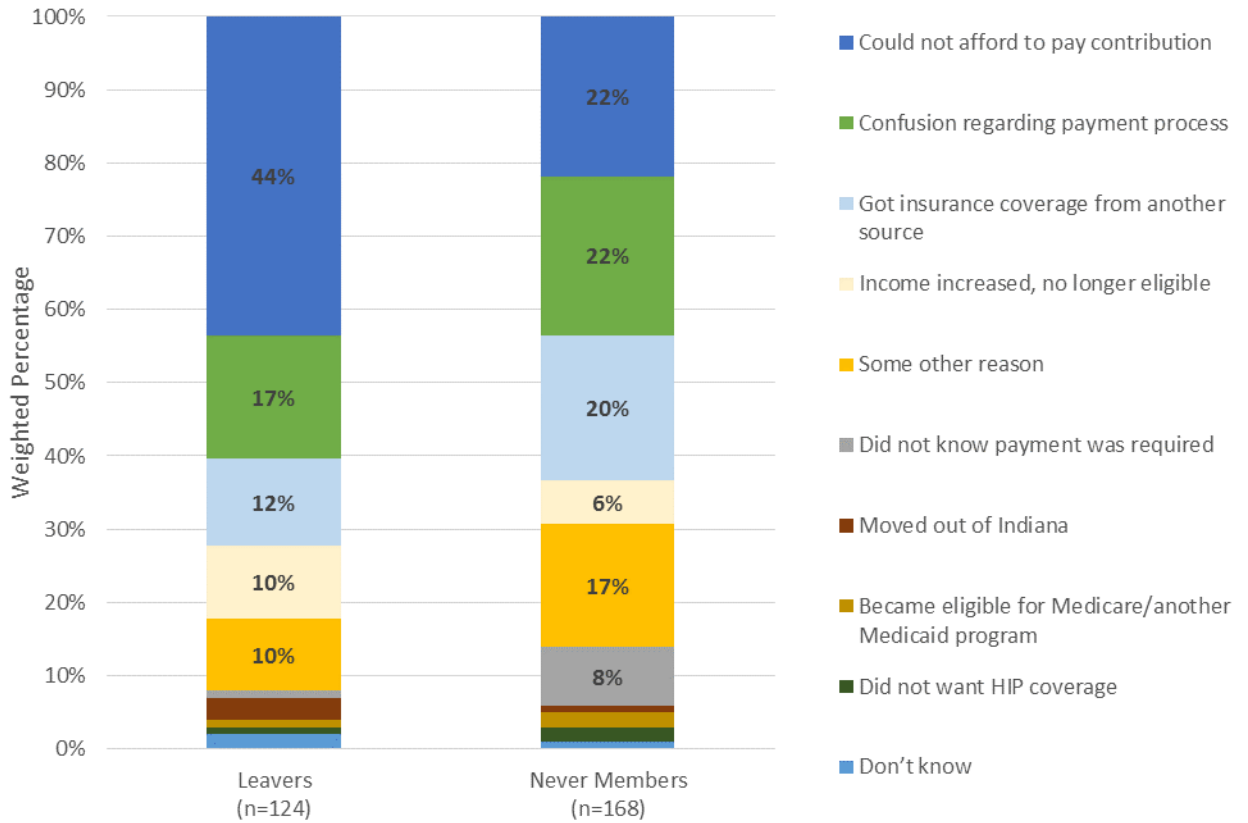


Source: Basic Member Survey data: December 2016 – January 2017, weighted percentages reported

The most common reason cited for Basic Member respondents not making payments was “I could not afford to pay the contribution,” with 34 percent (n=109) of Basic Member respondents citing this as the main reason for not making PAC. Previously Plus Basic Member respondents were slightly more likely to choose “I could not afford to pay the contribution,” as their main reason for non-payment, with 42 percent (n=20) of Previously Plus Basic Member respondents choosing this reason, compared to 32 percent (n=89) of Always Basic Member respondents.

Among Leaver and Never Member respondents, “I could not afford to pay the contribution” was also a common reason cited for non-payment of PAC, as illustrated in **Exhibit 16**. Approximately 44 percent (n=54) of Leaver respondents reported that they could not afford to pay the contribution. Among Never Member respondents, the two most common reasons cited for not making payments were “I could not afford to pay the contribution,” (n=37; 22 percent) and “I was confused about the payment process (I wasn’t sure how much to pay, when to pay, where to pay)” (n=37; 22 percent).

Exhibit 16: Reasons for Non-Payment of PAC, Leaver and Never Member Respondents



Source: Leaver and Never Member Survey data: December 2016 – January 2017, weighted percentages reported

Research Question 5: How are individuals accessing health care if they are disenrolled due to non-payment of PAC?

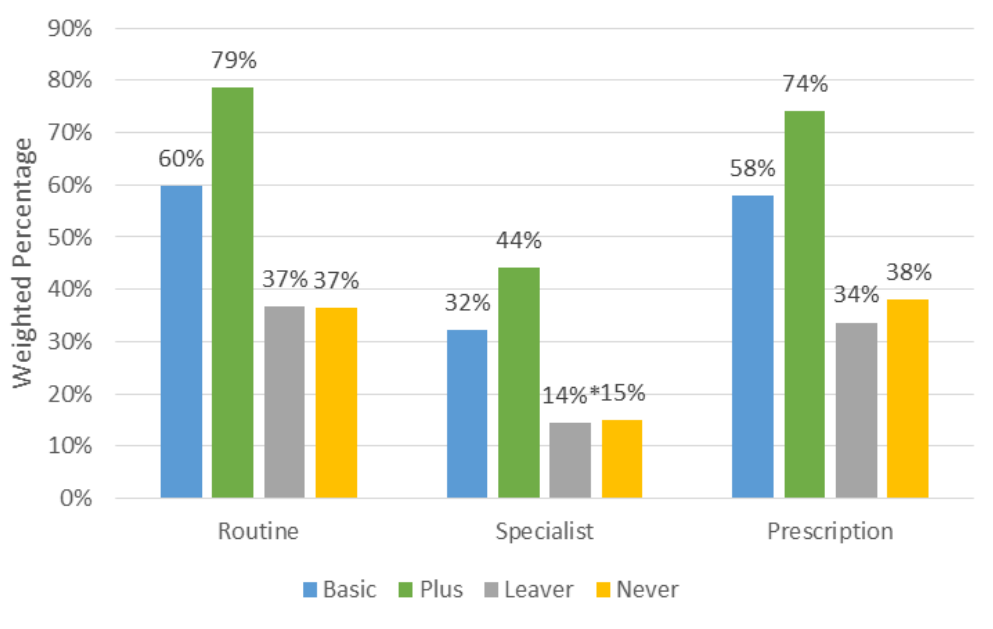
Access to Care

The Basic, Plus, Leaver, and Never Member surveys included a series of questions about whether respondents made appointments for health care services in the past six months, or since leaving HIP for Leavers who disenrolled from HIP fewer than six months previously. Specifically, the surveys asked whether members had:

- 1) Made any appointments for a routine check-up at a doctor’s office or clinic;
- 2) Made any appointments to see a specialist; or
- 3) Filled a prescription.

Exhibit 17 shows the percentages of Basic, Plus, Leaver, and Never Member respondents who reported making appointments for routine or specialized care or filling a prescription.

Exhibit 17: Percentages of Survey Respondents who Made an Appointment for Routine or Specialty Care and Filled Prescriptions in the Past Six Months



Source: Basic, Plus, Leaver, and Never Member Survey data: December 2016 – January 2017, weighted percentages reported.

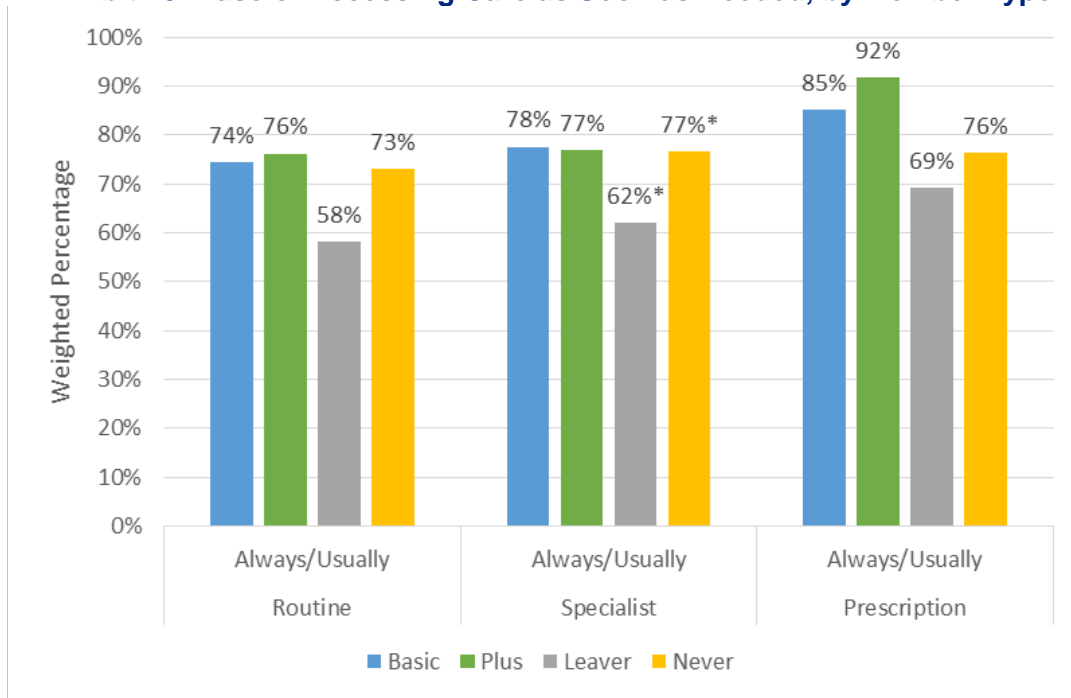
Note: Asterisks next to the percentage represent instances where the sample size is fewer than 30 respondents, which indicates reduced confidence in the findings.

Leaver and Never Member respondents were less likely than Plus and Basic Member respondents to report making appointments both for routine and specialty care. Leavers and Never Member respondents were also less likely to report filling a prescription in the past six months or since leaving HIP.

Respondents who reported that they had made an appointment or filled a prescription were then asked about their access to these services, specifically whether, for routine or specialty care, they could get an appointment “as soon as you needed,” and for prescriptions, “how often was it easy to get your prescription medicine from your health plan.” Respondents could select “never,” “sometimes,” “usually,” or “always.”³⁸ Exhibit 18 shows the percentage of respondents indicating that they could “always” or “usually” access care as soon as needed.

³⁸ Respondents could also select “Don’t know” or “Refused.”

Exhibit 18: Ease of Accessing Care as Soon as Needed, by Member Type



Source: Basic, Plus, Leaver, and Never Member Survey data: December 2016 – January 2017, weighted percentages reported.

Note: Asterisks next to the percentage represent instances where the sample size is fewer than 30 respondents, which indicates reduced confidence in the findings.

A majority of respondents in every member group reported that they “always” or “usually” could access care as soon as needed, as opposed to “never” or “sometimes.” For routine appointments, Leaver respondents were less likely than Plus, Basic and Never Member respondents to report that they could “always” or “usually” get an appointment as soon as needed, with 58 percent (n=43) of Leaver respondents selecting “always” or “usually,” compared to 73 percent (n=53) of Never Member respondents, 74 percent (n=174) of Basic Member respondents and 76 percent (n=232) of Plus Member respondents. With respect to prescriptions, Leavers and Never Member respondents were less likely than Plus and Basic Member respondents to report that it was “always” or “usually” easy to fill a prescription, with 69 percent (n=47) of Leaver respondents and 76 percent (n=58) of Never Member respondents selecting these options, compared to 85 percent (n=191) of Basic Member respondents and 92 percent (n=254) of Plus Member respondents.

Access to Other Insurance Coverage after Leaving HIP

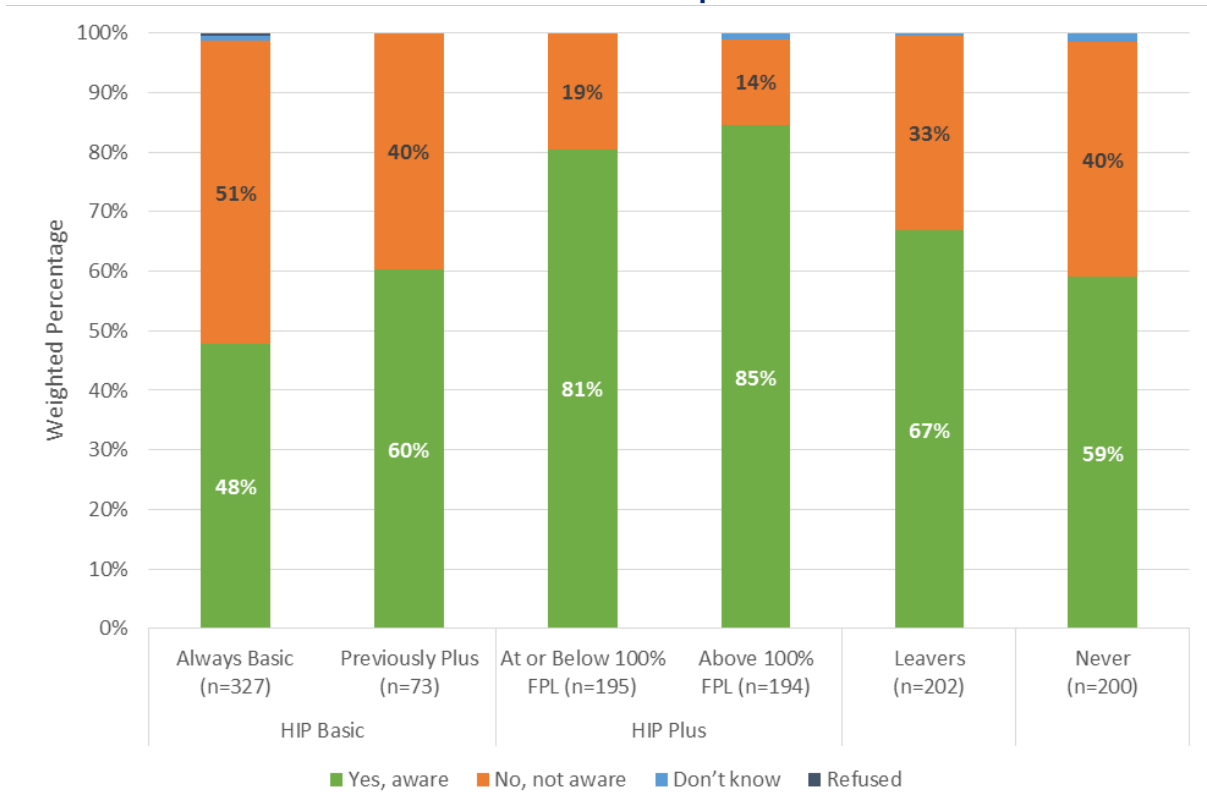
The Leaver and Never Member surveys also asked respondents whether they had health insurance coverage after leaving HIP. Forty-seven percent (n=94) of Leaver respondents and 41 percent (n=82) of Never Member respondents reported that they had insurance coverage at the time of the survey. Insurance from their own employer was the most common source of coverage reported among both Leaver and Never Member respondents, with 59 percent (n=55) of Leaver respondents with insurance and 56 percent (n=46) of Never Member respondents with insurance reporting

coverage from this source.³⁹ An additional nine percent (n=8) of Leavers with insurance and 12 percent (n=10) of Never Members with insurance reported coverage from their spouse’s employer.

Research Question 6: Was the disenrollment period a deterrent for individuals with incomes over 100 percent of the FPL to miss a PAC?

The four surveys also included a series of questions to gauge enrolled, disenrolled and not enrolled members’ understanding of the repercussions of non-payment: disenrollment or no enrollment for individuals with incomes over 100 percent of the FPL and transition to Basic for members with incomes under 100 percent of the FPL.⁴⁰ These questions were not analyzed to assess causality, but rather members’ understanding of the effects of non-payment. **Exhibit 19** shows the survey responses for each member group.

Exhibit 19: HIP Member Understanding of the Repercussions of Non-payment, by Member Group



Source: Basic, Plus, Leaver, and Never Member Survey data: December 2016 – January 2017, weighted percentages reported.

³⁹ Respondents who reported that they did not have insurance coverage were not asked the source of their insurance coverage. As such, the percentages reported here are out of the Leaver and Never Members respondents *who reported that they had insurance*.
⁴⁰ As noted above, TMA participants and medically-frail were excluded from the sample of Plus Members with incomes above 100 percent of the FPL because they are exempt from disenrollment.

Among all of the groups, HIP Plus Member respondents, particularly HIP Plus Member respondents with incomes above 100 percent of the FPL, reported the greatest understanding of the repercussions of non-payment. Eighty-five percent (n=164) of HIP Plus Member respondents with incomes above 100 percent of the FPL, i.e., members who are maintaining PAC and could be disenrolled due to non-payment, reported being aware that they could be disenrolled for non-payment of PAC.

Sixty-seven percent of Leaver respondents (n=135) and 59 percent of Never Member respondents (n=118), i.e., members who did not make PAC and were disenrolled or not enrolled as a result, reported being aware that they could be disenrolled or not enrolled for non-payment of PAC. Always Basic Member respondents, i.e., members who had never made a PAC, were least aware of the repercussions of non-payment, with 48 percent (n=154) reporting that they were aware that members are transitioned to Basic for non-payment of PAC.

V. Limitations

Surveys have some inherent limitations which may affect this analysis. First, individuals who were not able to be contacted or who did not complete the survey could have different responses than individuals who did complete the survey. Additionally, respondents may introduce errors if they do not accurately recall events, for example making an appointment in the past six months. To minimize recall bias, the survey look-back timeframe for questions related to access was limited to the past six months, or in the months since they left HIP, for Leavers who left HIP fewer than six months previously. In addition, the survey questions assessing access to care asked about whether respondents *made* appointments. It may be possible that a member needed health care but did not make an appointment because he or she did not think it would be possible to get the appointment. Thus, asking about scheduled appointments may underreport potential access issues.

In addition, some eligibility variables received from FSSA, namely the reason codes, may lead to a biased estimate of the number of individuals disenrolled or not enrolled for missing a PAC. Reason codes were used to identify individuals disenrolled or not enrolled due to non-payment of PAC, specifically the reason code 276. Individuals with 1) an enrollment status of closed or denied in a given month, 2) a 276 reason code and no other reason code in that month, and 3) without full coverage in the month prior to the closure/denial (for Never Members) or without coverage in the month following the closure/denial (for Leavers) were counted as individuals disenrolled or not enrolled due to non-payment.⁴¹ The 276 code is system-generated, meaning that if a member fails to make a PAC, the code is automatically applied to the member's record. Individuals could have other reasons for not making a PAC, for example gaining access to employer-sponsored coverage, which may not be documented in the reason code enrollment data. Such issues with the reason code data could result in overreporting or underreporting of the number of individuals disenrolled or not enrolled due to non-payment.

⁴¹ Individuals with a 276 in the month *before* they were disenrolled were also considered disenrolled due to non-payment to account for lags in processing. Also, members with a 276 reason code in November 2016 were considered Leavers even though due to the data timeframe, it could not be verified that these members did not have coverage in December 2016. For Leavers, we also verified that members had a fully enrolled month *prior* to being disenrolled.

VI. Appendices

Appendix A: Relevant Special Terms and Conditions

Relevant text from the Special Terms and Conditions (STCs) is included below. The requirements from Section XIII, STC 5 pertain to this evaluation; Section VIII, STC 5 pertains to the Monitoring Protocol in **Appendix E**.

a. Section XIII, STC 5

5. HIP Plus POWER Account Contribution Evaluation. Indiana must use the results of the contribution monitoring data—including the survey of enrolled and unenrolled individuals—described in Section VIII STC 4—as well as other available data to conduct an independent evaluation that examines POWER Account contributions policy for HIP Plus beneficiaries.

- a) As part of this evaluation, the state shall survey statistically significant groups of individuals who:
 - i) are income eligible but do not enroll in HIP;
 - ii) have been disenrolled for non-payment of POWER account contribution; and
 - iii) are in HIP Basic.
- b) The survey shall include questions about the affordability of HIP POWER account contributions.
- c) The interim evaluation report must be submitted within 60 days after DY 2, include hypotheses, and address the effect of the lockout policy on enrollment and reenrollment for HIP Plus beneficiaries broken down by income level and questions including:
 - i) How many individuals were disenrolled by income level?
 - ii) What are the reasons beneficiaries did not make contributions?
 - iii) What health care needs did individuals have while they were in the lockout period and how did they address those needs?
- d) Information provided in this interim evaluation report must also be addressed in the evaluation design, interim evaluation report as described in paragraph 8 of this section, and final evaluation report as described in paragraph 9 of this section. A delay in submitting this report could subject the state to penalties described in paragraph 16 of section III.

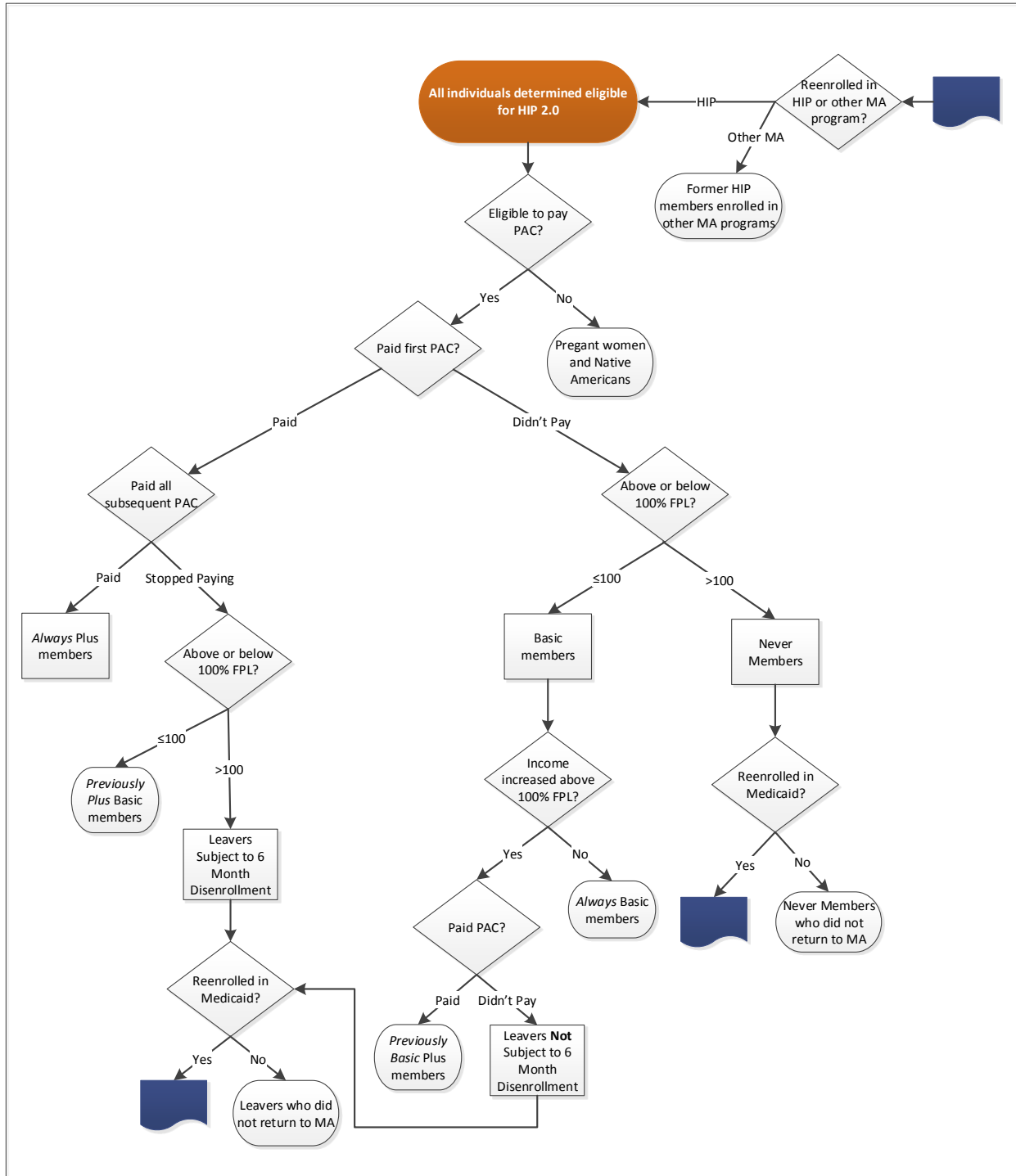
b. Section VIII STC 5

5. Power Account Contributions and Copayments Monitoring Protocol. Within 180 days after approval of this demonstration, the state must submit criteria by which the state shall monitor required beneficiary contributions (both POWER account contributions and copayments). As part of monitoring, the state shall engage an independent entity to, each year, survey individuals enrolled in HIP 2.0, individuals who are eligible but not enrolled, and individuals who have disenrolled for nonpayment of contributions. The state must include a list of the data it will report to CMS in quarterly reports and actual data where it is available. Such data must include but is not limited to the number of:

- a) Individuals subject to POWER account contributions and copayment requirements;
- b) Individuals whose required POWER account contributions have been reduced or have benefited from the roll-over incentive due to preventive care;
- c) The number of individuals who received POWER account contributions from employers and not-for-profit entities and the average total amounts by income level;

- d) Individuals with overdue POWER account contributions including those with POWER account contributions past due less than and greater than 60 days;
- e) The number of beneficiaries subjected to a 6-month lockout, number exempted and meeting qualifying event criteria, and the reasons for non-payment as reported in the survey;
- f) Information about the MCO's collection activities including the number of beneficiaries subject to collection, amounts due, and amounts paid;
- g) The number of individuals who are obligated to make POWER account contributions, POWER account debts;
- h) The number of individuals who have reached the 5 percent threshold on a monthly or quarterly basis;
- i) The number of individuals in the differing co-payment structures for nonemergency use of the ER;
- j) The number of individuals who have called the nurse hotline and the number who subsequently visited the ER;
- k) The number of individuals charged the \$8 non-emergency use of the ER copayment; and
- l) The number of individuals charged the \$25 non-emergency use of the ER copayment.

Appendix B: Diagram of HIP 2.0 POWER Account Contribution Policies



Note: MA refers to Medical Assistance (i.e., Medicaid). The blue shapes signify a break in the flow: members who reenroll in Medicaid and therefore may reenter the process from the beginning.

Appendix C: Survey Instruments

Basic Member Survey

Survey of Current Healthy Indiana Plan (HIP) Members – BASIC

DESCRIPTION: This survey applies to individuals currently enrolled in HIP BASIC, per eligibility data.

INTERVIEWER INITIALS:				LEWIN ID:									
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INTRODUCTION: Hello my name is _____ calling from Opinion Access Corporation on behalf of the new Healthy Indiana Plan, also known as HIP or HIP 2.0. May I please speak with (INSERT NAME FROM SAMPLE)?

(OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY)

Today we're talking with HIP members to get their opinions about the services they receive. We're interested in your opinions about the plan.

IF NEEDED: You may know this by the name of your Medicaid health plan such as Anthem, MDwise or MHS. You may know HIP as your Medicaid health insurance.

IF NEEDED: Please remember that the answer that you provide today will NOT affect your benefits and all responses will remain anonymous.

IF NEEDED: Your name was picked from a list of all people who receive health care through HIP. By sharing your opinions you can help HIP improve services for everyone.

Q1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (or HIP) for Hoosiers age 19 to 64. Are you enrolled in the “Healthy Indiana Plan” or “HIP” at this time?

- YES → CONTINUE WITH THE SURVEY, GO TO Q3
- NO _____
- DON'T KNOW _____ → GO TO Q2
- REFUSED _____

Q2. Sorry, but just to confirm, based on the information we have from HIP, it looks like you are currently enrolled in the “Healthy Indiana Plan” or “HIP.” Is this correct?

- YES → CONTINUE WITH THE SURVEY, GO TO Q3
- NO _____
- DON'T KNOW _____ → GO TO CLOSE
- REFUSED _____

Q3. How long have you been enrolled in the “Healthy Indiana Plan” or “HIP?”

- LESS THAN 3 MONTHS
- 3 MONTHS TO LESS THAN 6 MONTHS
- 6 – 12 MONTHS
- MORE THAN 12 MONTHS
- DON'T KNOW
- REFUSED

Next, please think about how you have received health care such as doctors’

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appointments in the past 6 months.

Q4. In the last 6 months, while enrolled in HIP, did you make any appointments for a check-up or routine care at a doctor’s office or clinic?

- YES → GO TO Q5
 - NO
 - DON'T KNOW
 - REFUSED
- } → GO TO Q6

Q5. In the last 6 months, while enrolled in HIP, how often did you get an appointment for a check-up or routine care at a doctor’s office or clinic as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q6. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, while enrolled in HIP, did you make any appointments to see a specialist?

- YES → GO TO Q7
 - NO
 - DON'T KNOW
 - REFUSED
- } → GO TO Q8

Q7. In the last 6 months, while enrolled in HIP, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q8. In the last 6 months, while enrolled in HIP, did you get any new prescription medicines or refill a prescription?

- YES → GO TO Q9
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q10

Q9. In the last 6 months, while enrolled in HIP, how often was it easy to get your prescription medicine from your health plan?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

AWARENESS

Q10. Were you aware that if you did not make a monthly or annual contribution, you would be moved from HIP Plus to HIP Basic?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service. HIP Basic is the fallback option for members who don't make their POWER account contributions. Unlike HIP Plus, HIP Basic does not cover vision or dental services and members are required to make copayments for most services.)

- YES
- NO
- DON'T KNOW
- REFUSED

AFFORDABILITY

Q11. If HIP required you to pay \$5 each month, would you continue to stay enrolled?

- YES
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q13

Q12. What about \$10? Would you continue to stay enrolled if HIP required you to pay \$10 each month?

- YES
- NO

- DON'T KNOW
- REFUSED

REASONS FOR NON-PAYMENT

Q13. According to information from HIP, you are not currently making a contribution to be in HIP. Is this correct?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service.)

- YES, I AM CURRENTLY **NOT** MAKING A CONTRIBUTION → **GO TO Q14**
 - NO, I AM CURRENTLY MAKING A CONTRIBUTION
 - DON'T KNOW
 - REFUSED
- **GO TO CLOSE**

Q14. What is the main reason you are not making the contribution?

I'm going to read a few statements. Please tell me which one of these statements best describes your reason. (NOTE TO INTERVIEWERS: If respondent thinks more than one applies, redirect them to choose the main reason.)

- I WAS CONFUSED ABOUT THE PAYMENT PROCESS (I WASN'T SURE HOW MUCH TO PAY, WHEN TO PAY, WHERE TO PAY)
- I DIDN'T KNOW A PAYMENT WAS REQUIRED TO BE IN HIP PLUS
- I COULD NOT AFFORD TO PAY THE CONTRIBUTION
- I PREFER HIP BASIC COVERAGE (I PREFER TO PAY FOR EVERY SERVICE I USE, I DON'T USE A LOT OF SERVICES)
- SOME OTHER REASON
- DON'T KNOW
- REFUSED

CLOSE: Those are all of our questions. On behalf of the Healthy Indiana Plan, we thank you for participating in this survey. Your answers will help improve the program.

Plus Member Survey

Survey of Current Enrollees in the Healthy Indiana Plan (HIP) PLUS

DESCRIPTION: This survey applies to individuals currently enrolled in HIP PLUS, identified with eligibility data.

INTERVIEWER INITIALS:				LEWIN ID:										
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INTRODUCTION: Hello my name is _____ calling from Opinion Access Corporation on behalf of the new Healthy Indiana Plan, also known as HIP or HIP 2.0. May I please speak with (INSERT NAME FROM SAMPLE)?

(OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY)

Today we're talking with HIP members to get their opinions about the services they receive. We're interested in your opinions about the plan.

IF NEEDED: You may know this by the name of your Medicaid health plan such as Anthem, MDwise or MHS. You may know HIP as your Medicaid health insurance.

IF NEEDED: Please remember that the answer that you provide today will NOT affect your benefits and all responses will remain anonymous.

IF NEEDED: Your name was picked from a list of all people who receive health care through HIP. By sharing your opinions you can help HIP improve services for everyone.

Q1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (or HIP) for Hoosiers age 19 to 64. Are you enrolled in the “Healthy Indiana Plan” or “HIP” at this time?

- YES → CONTINUE WITH THE SURVEY, GO TO Q3
 - NO
 - DON'T KNOW
 - REFUSED
- } → GO TO Q2

Q2. Sorry, but just to confirm, based on the information we have from HIP, it looks like you are currently enrolled in the “Healthy Indiana Plan” or “HIP.” Is this correct?

- YES → CONTINUE WITH THE SURVEY, GO TO Q3
 - NO
 - DON'T KNOW
 - REFUSED
- } → GO TO CLOSE

Q3. How long have you been enrolled in the “Healthy Indiana Plan” or “HIP?”

- LESS THAN 3 MONTHS
- 3 MONTHS TO LESS THAN 6 MONTHS
- 6 – 12 MONTHS
- MORE THAN 12 MONTHS
- DON'T KNOW
- REFUSED

ACCESS

Next, please think about how you have received health care such as doctors' appointments in the past 6 months.

Q4. In the last 6 months, while enrolled in HIP, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- YES → GO TO Q5
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q6

Q5. In the last 6 months, while enrolled in HIP, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q6. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, while enrolled in HIP, did you make any appointments to see a specialist?

- YES → GO TO Q7
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q8

Q7. In the last 6 months, while enrolled in HIP, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q8. In the last 6 months, while enrolled in HIP, did you get any new prescription medicines or refill a prescription?

- YES → GO TO Q9
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q10 OR Q11, AS APPROPRIATE

Q9. In the last 6 months, while enrolled in HIP, how often was it easy to get your prescription medicine from your health plan?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

AWARENESS

Q10. (ONLY ASK OF THOSE WHO ARE AT OR BELOW 100% FPL) Are you aware that if you do not make a monthly or annual contribution, you will be moved from HIP Plus to HIP Basic?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service. HIP Basic is the fallback option for members who don't make their POWER account contributions. Unlike HIP Plus, HIP Basic does not cover vision or dental services and members are required to make copayments for most services.)

- YES
- NO
- DON'T KNOW
- REFUSED

Q11. (ONLY ASK OF THOSE WHO ARE ABOVE 100% FPL) Are you aware that if you do not make a contribution you can be disenrolled from HIP and not allowed to return for 6 months?

(IF NEEDED: Disenrolled means you would no longer have coverage.)

- YES
- NO
- DON'T KNOW
- REFUSED

AFFORDABILITY

Q12. Did you make a monthly or annual contribution when you were in HIP?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.')

- NO, I DID NOT MAKE A MONTHLY OR ANNUAL CONTRIBUTION IN HIP → **GO TO Q18**
- YES, MONTHLY CONTRIBUTION → **GO TO Q13**
- YES, ANNUAL CONTRIBUTION → **GO TO Q14**
- DON'T KNOW → **GO TO Q18**
- REFUSED → **GO TO Q18**

Q13. When you were enrolled in HIP, how much money did you pay each month?

(NOTE TO INTERVIEWERS: Enter a value between 1 and 9,999)

\$ |__|, __|__|__|

- DON'T KNOW
- REFUSED

Q14. When you were enrolled in HIP, how much money did you pay each year or annually? (NOTE TO INTERVIEWERS: Enter a value between 1 and 9,999)

\$ |__|, __|__|__|

- DON'T KNOW
- REFUSED

Q15. In the past 6 months, how often were you worried about having enough money to pay your contribution?

- NEVER
- RARELY
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q16. When you paid your contribution, did you get any help with the cost from someone else such as a family member, friend, employer, healthcare provider or charity?

- YES → **GO TO Q17**
- NO
- DON'T KNOW → **GO TO Q18**
- REFUSED

Q17. Please tell me yes or no if you received help in making contributions from each of these sources:

- FAMILY MEMBER
- FRIEND
- CHARITY OR RELIGIOUS ORGANIZATION
- A HEALTHCARE PROVIDER SUCH AS A DOCTOR'S OFFICE OR HOSPITAL
- EMPLOYER
- SOME OTHER SOURCE

Q18. If HIP required you to pay \$5 more each month, would you continue to stay enrolled?

- YES → GO TO Q19
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO CLOSE

Q19. What about \$10 more? Would you continue to stay enrolled if HIP required you to pay \$10 each month?

- YES
- NO
- DON'T KNOW
- REFUSED

CLOSE: Thank you for answering these questions. On behalf of the Healthy Indiana Plan, we thank you for participating in this survey. Your answers will help improve the program.

Leaver Survey

**Survey of Healthy Indiana Plan (HIP) Previous HIP Plus Members
(Income Above 100 Percent of the Federal Poverty Level)**

DESCRIPTION: This survey applies to previous HIP Plus members with income over 100% FPL who were disenrolled from the program due to non-payment of the POWER Account Contribution (PAC).

INTERVIEWER INITIALS:				LEWIN ID:										
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INTRODUCTION: Hello my name is _____ calling from Opinion Access Corporation on behalf of the new Healthy Indiana Plan, also known as HIP or HIP 2.0. May I please speak with (INSERT NAME FROM SAMPLE)?

(OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY)

Today we're talking with Hoosiers who previously had HIP insurance but no longer have it. We're interested in your opinions about the plan.

Q1. In February 2015, the State of Indiana introduced a new Medicaid program called HIP, sometimes called the "Healthy Indiana Plan." Information from HIP shows that you had coverage through HIP, but are no longer enrolled in the program. Is this correct?

(IF NEEDED: 'No longer enrolled' means you currently do not have coverage through HIP.)

- YES → GO TO Q3
- NO, I NEVER HAD COVERAGE THROUGH HIP → GO TO Q2
- NO, I AM CURRENTLY ENROLLED IN HIP → GO TO Q2
- DON'T KNOW → GO TO Q2
- REFUSED → GO TO Q2

Q2. Sorry, but just to confirm, based on the information we have from HIP, it looks like you had coverage through HIP but are not currently enrolled at this time. Is that correct?

- YES → GO TO Q3
- NO, I NEVER HAD COVERAGE THROUGH HIP → GO TO CLOSE
- NO, I AM CURRENTLY ENROLLED IN HIP → GO TO CLOSE
- DON'T KNOW → GO TO CLOSE
- REFUSED → GO TO CLOSE

Q3. How long were you enrolled in HIP?

- LESS THAN 3 MONTHS
- 3 MONTHS TO LESS THAN 6 MONTHS
- 6 – 12 MONTHS
- MORE THAN 12 MONTHS
- DON'T KNOW
- REFUSED

ACCESS

Next, please think about how you have received health care such as doctors' appointments in the past 6 months since you left HIP or if you have been off of HIP for less time, think about that time.

Q4. In the last 6 months, since you left HIP, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- YES → GO TO Q5
 - NO → _____
 - DON'T KNOW _____
 - REFUSED _____
- GO TO Q6

Q5. In the last 6 months, since you left HIP, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q6. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, since you left HIP, did you make any appointments to see a specialist?

- YES → GO TO Q7
 - NO _____
 - DON'T KNOW _____
 - REFUSED _____
- GO TO Q8

Q7. In the last 6 months, since you left HIP, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q8. In the last 6 months, since you left HIP, did you get any new prescription medicines or refill a prescription?

- YES → GO TO Q9
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q10

Q9. In the last 6 months, since you left HIP, how often was it easy to get your prescription medicine?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

AWARENESS

Q10. Were you aware that, in HIP, if you did not make a monthly or annual contribution, you would be disenrolled from the program and not allowed to return for 6 months?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' 'Disenrolled' means you no longer have coverage.)

- YES
- NO
- DON'T KNOW
- REFUSED

AFFORDABILITY

Q11. Did you make a monthly or annual contribution when you were in HIP?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.')

- NO, I DID NOT MAKE A MONTHLY OR ANNUAL CONTRIBUTION IN HIP → GO TO Q17
- YES, MONTHLY CONTRIBUTION → GO TO Q12

- YES, ANNUAL CONTRIBUTION → GO TO Q13
- DON'T KNOW → GO TO Q17
- REFUSED → GO TO Q17

Q12. When you were enrolled in HIP, how much money did you pay each month?
(NOTE TO INTERVIEWERS: Enter a value between 1 and 9,999)

\$ |__|, __|__|__|

- DON'T KNOW
- REFUSED

Q13. When you were enrolled in HIP, how much money did you pay each year or annually? (NOTE TO INTERVIEWERS: Enter a value between 1 and 9,999)

\$ |__|, __|__|__|

- DON'T KNOW
- REFUSED

Q14. When you were enrolled in HIP, how often were you worried about having enough money to pay your contribution?

- NEVER
- RARELY
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

REASONS FOR NON-PAYMENT

Q15. According to information from HIP, you stopped making your contributions. Is this correct?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service.)

- YES, I STOPPED MAKING CONTRIBUTIONS → GO TO Q16
 - NO, I DID NOT STOP MAKING CONTRIBUTIONS
 - DON'T KNOW
 - REFUSED
- GO TO Q17

Q16. What is the main reason you stopped making the contribution?

I'm going to read a few statements. Please tell me which one of these statements best describes your reason. (NOTE TO INTERVIEWERS: If respondent thinks more than one applies, redirect them to choose the main reason.)

- I WAS CONFUSED ABOUT THE PAYMENT PROCESS (I WASN'T SURE HOW MUCH TO PAY, WHEN TO PAY, WHERE TO PAY)
- I DIDN'T KNOW A PAYMENT WAS REQUIRED
- I COULD NOT AFFORD TO PAY THE CONTRIBUTION
- I DIDN'T WANT HIP COVERAGE
- MY INCOME INCREASED; SO I WAS NO LONGER ELIGIBLE
- I MOVED OUT OF INDIANA
- I GOT INSURANCE COVERAGE FROM ANOTHER SOURCE, SUCH AS MY EMPLOYER OR MY SPOUSE'S EMPLOYER
- I BECAME ELIGIBLE FOR COVERAGE THROUGH MEDICARE OR ANOTHER MEDICAID PROGRAM
- SOME OTHE REASON
- DON'T KNOW
- REFUSED

OTHER COVERAGE

Q17. Do you have any health insurance coverage right now?

- YES → GO TO Q18
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO CLOSE

Q18. What is your primary source of insurance coverage?

I'm going to read some sources of insurance coverage. Please tell me which ONE of these is your primary source of insurance coverage.

(IF NEEDED: If you have more than one source, then tell me which one is the main source of coverage)

- THROUGH YOUR OWN EMPLOYER
- THROUGH YOUR SPOUSE'S OR PARTNER'S EMPLOYER
- MEDICARE
- MEDICAID OR HOOSIER HEALTHWISE, OR HOOSIER CARE CONNECT
- TRICARE
- VETERAN'S ADMINISTRATION (VA)
- AN INDIVIDUAL POLICY
- MARKETPLACE
- SOME OTHER SOURCE
- DON'T KNOW
- REFUSED

CLOSE: Those are all of our questions. On behalf of the Healthy Indiana Plan, we thank you for participating in this survey. Your answers will help improve the program.

Never Member Survey

Survey of Individuals Never Enrolled in the Healthy Indiana Plan (HIP) 2.0 – Did Not Make the Initial PAC

DESCRIPTION: This survey applies to individuals **NOT** currently enrolled in HIP who applied for HIP coverage but did not make their first Power Account Contribution (PAC). At the time of the application these individuals were over 100% of the FPL. Individuals in this population were identified using eligibility data.

INTERVIEWER INITIALS:				LEWIN ID:									
------------------------------	--	--	--	------------------	--	--	--	--	--	--	--	--	--

INTRODUCTION: Hello my name is _____ calling from Opinion Access Corporation on behalf of the new Healthy Indiana Plan, also known as HIP or HIP 2.0. May I please speak with (INSERT NAME FROM SAMPLE)?

(OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY)

Today we're talking with Hoosiers who applied for HIP insurance but did not enroll in the program. We're interested in your opinions about the plan.

Q1. In February 2015, the State of Indiana introduced a new Medicaid program called HIP, sometimes called the “Healthy Indiana Plan.” Information from HIP shows that you applied for coverage through HIP but that you never enrolled in the program. Is this correct?

(IF NEEDED: ‘Never enrolled’ means you never had coverage through HIP.)

- YES → GO TO Q3
- NO, I NEVER APPLIED FOR HIP COVERAGE → GO TO Q2
- NO, I HAD OR CURRENTLY HAVE COVERAGE THROUGH HIP → GO TO Q2
- DON'T KNOW → GO TO Q2
- REFUSED → GO TO Q2

Q2. Sorry, but just to confirm, based on the information we have from HIP, it looks like you applied for coverage through HIP but that you never enrolled in the program. Is that correct?

- YES → GO TO Q3
- NO, I NEVER APPLIED FOR HIP COVERAGE → GO TO CLOSE
- NO, I HAD OR CURRENTLY HAVE COVERAGE THROUGH HIP → GO TO CLOSE
- DON'T KNOW → GO TO CLOSE
- REFUSED → GO TO CLOSE

ACCESS

Next, please think about how you have received health care such as doctors' appointments in the past 6 months.

Q3. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- YES → GO TO Q4
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q5

Q4. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q5. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

- YES → GO TO Q6
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q7

Q6. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

Q7. In the last 6 months, did you get any new prescription medicines or refill a prescription?

- YES → GO TO Q8
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q9

Q8. In the last 6 months, how often was it easy to get your prescription medicine?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS
- DON'T KNOW
- REFUSED

AWARENESS

Q9. This question is about contributions to HIP, the Healthy Indiana Program for which you applied but did not enroll. Were you aware that if you did not make your first contribution, that you would not be enrolled in HIP?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' 'Not enrolled in HIP' means you didn't have coverage through HIP.)

- YES
- NO
- DON'T KNOW
- REFUSED

REASONS FOR NON-PAYMENT

Q10. According to information from HIP, you did not make your first contribution to enroll in HIP coverage. Is this correct?

(IF NEEDED: A contribution is a certain amount of money you pay each month or once a year to be in HIP. Some call this a 'POWER Account Contribution,' or a 'PAC'; others call it a 'payment' or 'bill.' This does **not** refer to a co-payment; a co-payment is a fee you pay to a doctor every time you receive a health care service.)

- YES, I DID NOT MAKE A CONTRIBUTION → **GO TO Q11**
- NO, I MADE A CONTRIBUTION _____ → **GO TO Q12**
- DON'T KNOW
- REFUSED _____

Q11. What is the main reason you did not make the contribution?

I'm going to read a few statements. Please tell me which one of these statements best describes your reason. (NOTE TO INTERVIEWERS: If respondent thinks more than one applies, redirect them to choose the main reason.)

- I WAS CONFUSED ABOUT THE PAYMENT PROCESS (I WASN'T SURE HOW MUCH TO PAY, WHEN TO PAY, WHERE TO PAY)
- I DID NOT REALIZE A PAYMENT WAS REQUIRED

- I COULD NOT AFFORD TO PAY THE CONTRIBUTION
- I DIDN'T WANT HIP COVERAGE
- MY INCOME INCREASED; SO I WAS NO LONGER ELIGIBLE
- I MOVED OUT OF INDIANA
- I GOT INSURANCE COVERAGE FROM ANOTHER SOURCE, SUCH AS MY EMPLOYER OR MY SPOUSE'S EMPLOYER
- I BECAME ELIGIBLE FOR COVERAGE THROUGH MEDICARE OR ANOTHER MEDICAID PROGRAM
- SOME OTHER REASON
- DON'T KNOW
- REFUSED

OTHER COVERAGE

Q12. Do you have any health insurance coverage right now?

- YES → GO TO Q13
- NO
- DON'T KNOW → GO TO CLOSE
- REFUSED

Q13. What is your primary source of insurance coverage?

I'm going to read some sources of insurance coverage. Please tell me which ONE of these is your primary source of insurance coverage.

(IF NEEDED: If you have more than one source, then tell me which one is the main source of coverage)

- THROUGH YOUR OWN EMPLOYER
- THROUGH YOUR SPOUSE'S OR PARTNER'S EMPLOYER
- MEDICARE
- MEDICAID OR HOOSIER HEALTHWISE, OR HOOSIER CARE CONNECT
- TRICARE
- VETERAN'S ADMINISTRATION (VA)
- AN INDIVIDUAL POLICY
- MARKETPLACE
- SOME OTHER SOURCE
- DON'T KNOW
- REFUSED

CLOSE: Those are all of our questions. On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve the program.

Appendix D: Survey Sampling Strategy

A. Survey Sampling Strategy

A simple sampling method was used to draw the samples for this study. Frames were obtained for each of six population groups:

- 1) *Always* Basic Members
- 2) *Previously Plus* Basic Members
- 3) Plus members *at or below* 100 percent of the FPL
- 4) Plus members *above* 100 percent of the FPL
- 5) Leavers
- 6) Never Members

The Plus and Basic Member samples were developed using enrollment data for November 30, 2016, provided by FSSA on December 16, 2016, and enrollment data from February 1, 2015 through July 29, 2016, provided by FSSA on December 6, 2016. The Leaver and Never Member samples were provided by FSSA on January 10, 2017 and January 6, 2017, respectively. Lewin verified the Leaver and Never Member samples using enrollment data for February 1, 2015 through November 30, 2016, provided by FSSA on January 6, 2017. Members were removed from the samples if they 1) were not present in the enrollment data in any month, 2) were currently enrolled in HIP or another Medicaid program according to the data, or 3) were exempt from disenrollment (i.e., if they met any of the following criteria in their last month of enrollment: income at or below 100 percent of the FPL, Native American, pregnant, medically frail or TMA).¹ For the Leaver sample, members who were not enrolled at least one month in HIP were also excluded. For the Never Member sample, members who had been enrolled in HIP for one month or more were excluded.²

A simple random sample size of 5,000 for each Basic and Plus subgroup was drawn from each of the Basic and Plus frames after removing members who were pregnant or Native American, or had obviously non-working phone numbers, including missing phone numbers and phone numbers equal to zero or 999-999-9999. The list of sampled members was then turned over to a sampling subcontractor who called individuals in the sample until a goal sample size was reached.³ For Leavers and Never Members, the survey subcontractor was provided the full universes of Leavers and Never Members (after removing members with obviously non-working numbers) because non-

¹ Individuals who were currently enrolled in HIP as of November 2016 were excluded from the samples to ensure that Leaver and Never Member results reflected the experience of members who were not currently enrolled in HIP.

² Never Members ever enrolled in HIP as of November 2016 were excluded from the Never Member sample to ensure that Never Member results reflected the experience of members who had never been enrolled in HIP.

³ AIRvan Consulting served as the survey contractor on this project. They provide services in market research, communication programs, and qualitative and quantitative research. The company abides by professional standards of the Council of American Research Organizations (CASRO), the Marketing Research Association, the Public Relations Society of America, the American Marketing Association, and the International Association of Business Communicators. The call center, Opinion Access Corp. (OAC), is comprised of recognized industry experts who have worked in the field of marketing research quantitative data collection for over two decades. OAC uses state-of-the-art CATI interviewing with quality controls and monitoring and supervisor-to-interviewer ratios that meet or exceed standards set by the Marketing Research Association. They are a CAHPS certified research facility.

response was expected to be very high. The goal sample size was nominally 150 in each of the groups.

The final frame and sample sizes obtained are shown in *Exhibit D-1*.

Exhibit D-1: Final Frame and Sample Sizes Obtained

Group	Final Frame Size*	Final Sample Size
Current HIP Basic Members	146,522	400
Always Basic Members	115,065	327
Previously Plus Basic Members	31,457	73
Current HIP Plus Members	233,492	389
Plus members at or are below 100 percent of the FPL	196,724	195
Plus members above 100 percent of the FPL	36,768	194
Leavers	5,156	202
Never Members	11,449	200

*Data Source: FSSA Enrollment Data: November 30, 2016 and February 1, 2015 – July 29, 2016. These represent counts after removing 1) members with obviously non-working phone numbers, 2) Native Americans and 3) pregnant women from all frames. TMA participants and medically-frail individuals were also removed from the frames for Plus members above 100 percent of the FPL, Leavers and Never Members. Individuals with incomes at or below 100 percent FPL in their last month of enrollment were also removed from the Leaver and Never Member frames.⁴

As can be seen from the table, target sample sizes were more or less obtained. The quotas for each subgroup actually increased from 150 to 200 during surveying because the deadline for survey completion was extended. In some instances, the survey firm completed a few additional interviews above the 200 target. This occurs because if multiple interviewers are on the line with multiple respondents when the quota is reached, the interviewers continue the interviews in progress even though the quota has already been reached.

In some instances, the survey firm obtained less than 200 interviews for each subgroup. This arose as it was discovered after sampling was completed that some members were mistakenly considered *fully* enrolled in Basic or Plus, but had actually only been *conditionally* enrolled in Basic or Plus. This issue most affected the Basic samples, leading to a much greater sample size of Always Basic Members than Previously Plus Basic Members. Within the Basic frame, 65,438 members were incorrectly categorized as *Previously Plus* rather than *Always Basic* because they had been *conditionally* enrolled in the Plus plan. This led to 127 sampled members making the shift from Previously Plus to Always Basic. Similarly, the issue led 13 Plus members to be dropped from the results because these members were not fully enrolled in Plus according to the enrollment data, only conditionally enrolled in Plus.

Because the sampling was done according to a simple random sampling scheme, the weighting is correspondingly simple. Subgroup analyses were not planned and thus no oversampling was done of any population groups. Thus, each individual group in the survey was simply weighted up to the appropriate frame. The only exception was the Always Basic group, where the original sample was weighted up to the original frame (from which it was actually sampled), while the additional 127 members were weighted up to 65,438, the portion of the original Previously Plus frame that shifted

⁴ The final frame sizes for Leavers and Never Members differ from the total counts of Leavers and Never Members during the timeframe (13,550 and 46,176 respectively) because the samples provided by Indiana FSSA only included Leavers and Never Members as of July 2016 who had not returned to HIP or other Medicaid programs as of November 2016. Also, the final frames did not include members with obviously non-working phone numbers or who were exempt from disenrollment.

to Always Basic. Any analyses of the data should be performed using these weights to be representative of the population at hand.

B. Survey protocol

The survey firm used computer-assisted telephone interviewing (CATI) to collect data. This telephone methodology provides for interviewer assistance with complicated skip patterns, unaided responses, and consistency in evaluation and limitations of sample bias. Additionally, it provides for expedient collection of the data, allows for better sample control, and can provide more complete data than other types of data collection methodologies.

The CATI first removed any duplicate phone numbers from the sample such that one record for each phone number was randomly selected to be preserved within the sample.⁵ After removing duplicates, the survey team set quotas for each sample group. To comply with Telephone Consumer Protection Act (TCPA) guidelines, phone numbers were then separated into two buckets for each group: 1) Cell phones and 2) Landlines by running the lists against national databases. Quotas were then set for each of the six subgroups with the goal of reaching a cell phone versus landline proportion that was within about 10 percent of the proportion in the sample.

The CATI algorithm then randomly identified participants in each of the buckets to be loaded for dialing. When the quota (i.e., total number of interviews) was reached in a category, no additional attempts to reach individuals were made in that category. The CATI system pulled a random selection from the sample for each quota group. Any phone numbers found inactive (i.e., instances where it would not be possible to call again) were flagged and were not included in additional contact attempts during the survey period. Inactive phone numbers include: disconnected numbers, wrong numbers, fax numbers, a response of “no such person lives here,” those who refused to start the survey, and those who started but were “qualified refusals.” Qualified refusals were those who stayed on the phone long enough to answer the qualifying questions, but refused or dropped off at some point and did not complete the survey. All “live” numbers such as those at which a busy signal or answering device was reached would be eligible to be called again until the quota for each membership category was filled.

Calling took place between 5 pm and 9 pm on weekdays, and 11:30 am to 9 pm on weekends. Any individual who was interested in taking the survey, but who could not participate at the time he or she was initially reached, was given the option of a callback at a specific time. The CATI system would then initiate a call at the scheduled time. If the person was available, the interview would be conducted. If there was no answer, the number would be placed in the “live” category with the potential to be called back.

Due to a data error, the Basic and Plus samples initially provided by Indiana FSSA included members not enrolled in HIP. The issue was not discovered until the incorrect samples had been loaded into the CATI and the survey firm had begun calling. When the correct samples for the Basic and Plus groups were obtained, the correct samples were run against the previous incorrect samples, and any numbers that were in the first incorrect sample were marked as duplicates, and thus removed from the new sample universes available for dialing. As a result, 110 members present in both samples were inadvertently removed from the samples. We do not expect this to bias the results significantly.

⁵ Theoretically we expect some phone numbers to *correctly* appear multiple times in the sample if members selected into the sample are in the same household or live in a group home. However, this deduplication was part of the standard CATI procedures, and therefore was a required step in the process. In sum, 418 members were marked as duplicates and removed from the sample, though their phone numbers still had the opportunity to be called (because one of each duplicate phone number was preserved in the sample).

Appendix E: POWER Account Contributions and Copayments Monitoring Protocol

POWER Account Contributions and Copayments Monitoring Protocol

7/30/2015

POWER Account and Copayments Infrastructure Monitoring Protocol describes the process to be used to monitor POWER account contributions and copayments from beneficiaries in order to report required metrics to the Centers for Medicare and Medicaid (CMS).

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Background

POWER Account and Copayment

- a) *A description of POWER accounts and copayments, focusing on the differences between the two*

Indiana's HIP 2.0 POWER account is similar to a health savings account arrangement under a consumer-directed health plan. The POWER account holds state and beneficiary contributions (including beneficiary contributions donated by employers or other entities). POWER account funds are used to pay for the first \$2,500 in claims; claims beyond the initial \$2,500 are fully covered through capitation payments or other payments made by the state. POWER accounts may not be used to pay for beneficiary copayments. However, for those who elect HIP Link enrollment, POWER account funds are used to pay premium and cost sharing amounts.

Beneficiaries with income at or below 100 percent of the FPL, medically frail beneficiaries, and section 1931 parents and caregivers, and low-income 19 and 20 year old dependent beneficiaries who do not pay their monthly POWER account contributions (PAC) within the sixty (60) day grace period are enrolled in HIP Basic and subject to co-payments. Those above 100 percent of the FPL who are not in an exempted category may be disenrolled for a period of six months for not paying PAC. Exempted members are those who are pregnant, American Indians/Alaska Natives, medically frail, or those with out-of-pocket expenses that exceed 5 percent of income.

Data Collection

- b) *A description of how the state will collect data from the plans regarding the amount of POWER account contributions and copayments due.*

The member's income, as requested and verified through the Indiana Application for Health Coverage, determines an individual's POWER account contribution or their eligibility for HIP Basic, if they do not make their POWER account contribution. The state sends MCEs the initial POWER account contributions; subsequent contributions are collected by the MCEs directly from each enrollee. The state sends the MCEs data regarding the amount of POWER account contributions; it is never calculated or changed by the MCE.

POWER account contributions are indexed to 2 percent of household income. For example, a HIP plus member whose annual countable income is \$9,800 will have a required annual contribution of \$196. This is divided by 12 to determine a predictable monthly PAC of \$16.33. The maximum monthly POWER account contribution is \$100 and the minimum contribution for all HIP Plus members is \$1.

Individuals who i) elect to not make their POWER account contribution; ii) have income over 100 percent FPL; and iii) are not in one of the exempted groups described above (medically frail, pregnant, American Indian, or have out-of-pocket expenses that exceed 5% of income), are disenrolled from HIP and may not re-enroll for six months. Those with income under 100 percent FPL and who are not in an exempted group will default to HIP Basic which does not offer optional benefits, including dental, eye coverage, enhanced pharmacy, bariatric surgery, lower service limits, and no copayments for all medical and pharmacy services, other than emergency

department visits. Individuals in HIP Basic have a copayment, which is collected at the point of service. Copayment amounts are as follows:

- No copayment is required for preventive care, maternity services or family planning services
- Four dollar (\$4.00) copayment for outpatient services
- Seventy-five dollar (\$75.00) copayment for inpatient services
- Four dollar (\$4.00) copayment for preferred drugs
- Eight dollar (\$8.00) copayment for non-preferred drugs
- Up to a twenty-five dollar (\$25.00) copayment for a non-emergency ER visit

Members may not pay copayments out of POWER accounts. The state sends any updated POWER account contribution requirements or copayment requirements to the MCEs, which are required to regularly report information regarding member POWER accounts. The details and frequency of the regular reports provided by MCEs are described in the POWER account excerpt of the HIP Reporting Manual included in Enclosure 1.

Tracking

- c) *The state's operational plan ensures that POWER account contributions and copayment liability (on a per visit basis) will be accurately tracked, as well as monthly statements will be provided to the beneficiary.*

The member invoices sent from the health plan contain information that includes the current monthly POWER account contribution owed, POWER account contributions that are past due and POWER account contributions paid to date. Similar to an explanation of benefits (EOB), the member is kept aware of the amounts they have paid into their POWER account and the amount and cost of services they have received while enrolled in the program.

Per the State's contract with MCEs, each must mail POWER account statements to members on a monthly basis. The statements are required to contain information on the account balance, the member's annual and monthly contribution amounts, and the State's annual contribution amount. In addition, the contract specifically allows the MCE to combine the POWER account statements with the Explanation of Benefit (EOB) information also required under the contract. One MCE combines the information, while the other two send POWER account balances separately from EOBs. The comprehensive statements include (i) POWER account balances showing all withdraws and deposits; (ii) comprehensive contribution activity; (iii) all claims activity for the period; and (iv) status towards the member's preventive service target.

MCEs are contractually obligated to track member cost-sharing and provide regular and ad hoc reports to the state.

Monitoring

- d) As part of HIP 2.0, Indiana and the Centers for Medicare and Medicaid (CMS) have agreed upon a series of measures that will be used to test the state's hypothesis that POWER accounts will provide incentives to actively manage account funds in order to maintain benefits that are not offered in HIP Basic, thereby encouraging more cost-conscious healthcare consumption behavior*

By monitoring these populations' use of POWER accounts and copayments, and taking member surveys into account, the state will determine their impact on three of Indiana's HIP 2.0 goals:

1. Reduce the number of uninsured low income Indiana residents and increase access to health care services
2. Promote value-based decision making and personal health responsibility
3. Promote disease prevention and health promotion to achieve better health outcomes

Specifically, by using member survey data, in conjunction with eligibility, enrollment and health plan data, Indiana will report metrics to test the state's hypotheses.

Design

- e) To address the key questions identified above, CMS requires Indiana to monitor and report on 12 unique measures. In the section below, we describe each measure and its corresponding hypothesis in detail.*

Methodology

- f) For each of the agreed upon metrics, the following methodology will be used for collecting, analyzing and reporting the findings, as described below. The methodology is consistent with the draft evaluation plan submitted to CMS.*

Tracking and Reporting Key Metrics

In this section, we describe each of the required metrics and their relationship to each of the five research questions. We also provide detail for each metric, including:

- Data sources
- Reports where the measure appears
- How the measure is calculated
- An example of how the results will be displayed

1. *How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER account contributions?*

HIP 2.0 permits employers and third party organizations to help enrollees pay their POWER account contributions.

Measures that support this research question include:

- # of individuals receiving POWER account contributions (PAC) from employers and/or not-for-profit entities (by entity type)
- Average amount paid by employer and/or not-for-profit (by member income level)

The evaluation plan uses MCE reports with measures that are reported to CMS on a quarterly and annual basis. The MCE reports are created monthly and also provide year to date totals. The State will use the year-to-date totals in each report to avoid double counting unique individuals and employers by summarizing monthly data.

Figure 1. Number of Members receiving POWER account contributions (PAC) from Third Parties by FPL (Example)

# of Members	# of individuals receiving POWER account contributions (PAC) from employers	# of individuals receiving POWER account contributions (PAC) from non-profit organizations
Average amount paid by FPL		
0 – 4%		
5 – 10%		
11 – 22%		
23 – 50%		
51 - 75%		
76 – 100%		
101 – 137%		
138%		

1. How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?

The State will conduct a survey about the perceived affordability and reasons for non-payment to explain why members do or do not make monthly contributions. Survey questions will build on the HIP 1.0 survey that Mathematica developed for a consistent comparison of perceptions in HIP 1.0 and 2.0.

Measures that support this research question include (*Note: relevant survey questions are under development*):

- Reasons for non-payment of PAC
- Perception of ability to make POWER account contribution
- Member aware of non-payment penalties?
- Perceived affordability of the PAC, by income level

- Reasons individual did not make contribution, by income level

These measures will be populated using member and leaver data from a sample drawn from the POWER account contribution data. The survey sample will be drawn in such a way to allow more detailed understanding of specific program features. It will include persons at a range of poverty levels, both persons who made and did not make contributions and will differentiate between people who did not make their first payment versus those who did then later decided not to make subsequent payments. Comparison between those who made payments and those who did not allows us to show differences in perceptions of affordability. Differentiating between those who made their initial payment and then stopped versus those who did not may yield further information about reasons for non-payment.

To answer questions about affordability, the survey will ask members about their perceptions of the amount of the PAC as too high or too low, and if the amount impacts their decision to remain

Example 1.

If HIP required you to pay \$10 more each month, would you continue to stay enrolled?

1. YES
2. NO
- DON'T KNOW
- REFUSED

What about \$5 more? Would you continue to stay enrolled if HIP required you to pay \$5 each month?

1. YES
2. NO
- DON'T KNOW
- REFUSED

Example 2.

Would you say the amount you contribute each month is:

1. Way too much
2. A little too much
3. The right amount
4. Below the right amount, or
5. Way below the right amount
6. DON'T KNOW
7. REFUSED

Example 3.

How do you prefer to pay for your health care? Do you prefer to pay...

1. Up front with a fixed amount every month, and the money that is not spent for care would be returned to you when you leave the program
2. Or would you prefer to pay for every time you go to a health professional, the pharmacy, the ER, or hospital?
- DON'T KNOW
- REFUSED

in the program. Where appropriate, the survey will include questions employed in the HIP 1.0 survey instrument. Following are examples of such questions:

The data to answer this hypothesis would come from survey data and POWER account data, as well as an extract report from the MCEs identifying members and their monthly POWER account status. This file will be structured as one row per member per month and would include the member identifier, month/year, and an indicator showing the POWER contribution status (paid yes or no). It would also include an identifier on each row to exclude persons not required to make a PAC payment, such as those who are pregnant or Alaska Native/American Indian. The survey sample would then be drawn from this data. Data displays would be structured as follows:

Figure 2. Perceptions of Affordability (Example)

Reasons for non-payment by FPL	Members who make ongoing payments	Members who did not make first payment	Members who made first payment but not subsequent payments
Number of Members			
0 – 4%			
5 – 10%			
11 – 22%			
23 – 50%			
51 - 75%			
76 – 100%			
101 – 137%			
138%			

Figure 3. Reasons for Non-Payment Summary (Example)

Reasons for non-payment by FPL	Members who did not make first payment	Members who made first but not subsequent payments
Number of Members		
0 – 4%		
5 – 10%		
11 – 22%		
23 – 50%		
51 - 75%		
76 – 100%		
101 – 137%		
138%		

Figure 4. Member Awareness of Non-Payment Penalty

	Member aware of non-payment penalty
Yes	
No	

2. How many individuals lost HIP Plus coverage due to non-payment of the PAC?

individuals eligible for PAC (by income level)

individuals exempted from PAC

individuals meeting qualifying event⁶ criteria

individuals in HIP Basic

of months PAC paid, average per member

individuals approved for HIP and over 100% FPL who do not pay first PAC

individuals with overdue PAC (less than and greater than 60 days)

Rate of non-payment of PAC, by FPL

Rate of disenrollment for failure to pay PAC

of individuals making fast-track payments, by FPL

Timing of fast-track payment submission

Timing of eligibility change due to non-payment (transition to Basic or lockout), by # of months paid and by month in the year

Figure 5. Counts of Individuals with Regard to PAC

⁶ Qualifying events are:

- Obtained and lost private coverage
- Lost income after disqualification due to increased income
- Took up residence in another state then returned
- Is a victim of domestic violence
- Was in a county subject to a disaster declaration
- Is medically frail

Income Level	# of individuals subject to PAC	# of individuals exempted from PAC	# of individuals meeting qualifying event	# of individuals in HIP Basic
0 – 4%				
5 – 10%				
11 – 22%				
23 – 50%				
51 - 75%				
76 – 100%				
101 – 137%				
138%				

Figure 6. Statistics Relating to PAC Participation

Income Level	Average # of months PAC paid per member	# of individuals approved for HIP who do not pay first PAC	# of individuals with overdue PAC	Rate of non-payment of PAC	Disenrollment Rate for failure to pay PAC
0 – 4%					
5 – 10%					
11 – 22%					
23 – 50%					
51 - 75%					
76 – 100%					
101 – 137%					
138%					

3. How many individuals requested a waiver from the six month lockout?

HIP 2.0 includes provisions that allow members to request a waiver of the six month lockout. Members who are disenrolled may reenroll prior to the end of the 6 month period by obtaining an exception from the state if the member:

- i. Obtained and subsequently lost private insurance coverage;
- ii. Had a loss of income after disqualification due to increased income;
- iii. Took up residence in another state and later returned;
- iv. Is a victim of domestic violence;
- v. Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty (60) calendar days prior to date of member termination for non-payment; or

vi. Is medically frail.

Measures that support this research question include:

- # individuals subjected to 6 month lockout, by FPL
- # individuals requesting waiver of lockout
- # individuals granted waiver of lockout

Figure 7. Counts of Individuals Affected by Lockout

Income Level	# of individuals subject to 6 month lockout	# of individuals requesting waiver of lockout	# of individuals granted waiver of lockout
0 – 4%			
5 – 10%			
11 – 22%			
23 – 50%			
51 - 75%			
76 – 100%			
101 – 137%			
138%			

4. How are individuals accessing healthcare if they are locked out due to non-payment of the PAC?

Measures that support this research question include:

- Individual health care needs during lockout period, by income level
- How health care needs are addressed during lockout period, by income level

Data for these measures would be sourced from the member survey. Depending on needed sample sizes, the member survey may need to oversample members who are locked out. Member demographic information can be extracted from the EDW.

Figure 8. Distribution of Health Services Received During Lockout

	Individuals with incomes greater than 100% of FPL
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Doctor visits	
Emergency room visits	
Prescriptions	

5. Was the lockout period a deterrent for individuals over 100% FPL to miss a PAC?

To answer this research question, the survey will ask members above 100% FPL how much of a factor the lockout period was in their decision to maintain PAC. This can be done with the following metrics:

- # of members reporting that the lockout period was a major factor, minor factor, or not a factor at all in maintaining PAC

A similar question about the role of the lockout period can also be asked of members who made their initial PAC but subsequently missed a PAC and were locked out.