

# Healthy Indiana Plan 2.0:

ENHANCED CONSUMER ENGAGEMENT  
AND DECISION-MAKING ARE DRIVING BETTER HEALTH

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# Healthy Indiana Plan 2.0: Enhanced Consumer Engagement and Decision-Making Are Driving Better Health

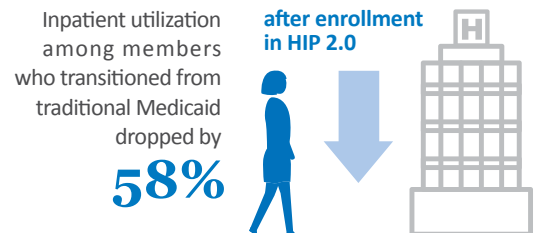
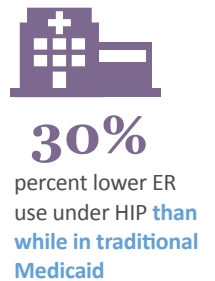
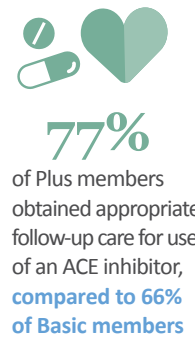
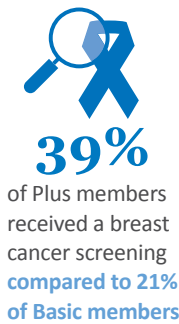
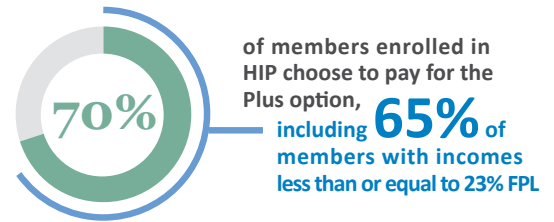
## EXECUTIVE SUMMARY

Following the passage of the Affordable Care Act (ACA), states have taken different approaches to Medicaid reform and expansion. Indiana pursued Medicaid reform under a state-specific model—known as the Healthy Indiana Plan (HIP) 2.0—allowing the state to incorporate unique aspects such as personal responsibility and build on the success of its pre-ACA model.

HIP 2.0 is an innovative approach to Medicaid coverage that is aligned with efforts across all types of health insurance coverage to engage individuals more actively in their health care. HIP 2.0 uses program and benefit design, along with both financial and non-financial incentives, to drive consumer engagement and decision-making.

There are two major benefit plans under HIP 2.0—HIP Plus and HIP Basic. The Plus option has a variety of incentives and enhanced benefits that distinguish it from the Basic option, including no co-payments, vision and dental services, higher service limits, and an enhanced drug benefit. Plus members must make monthly contributions, based on income, to their Personal Wellness and Responsibility (POWER) accounts; like a health savings account, the POWER account is used to pay for deductible expenses.

### Program Outcomes



Overview of HIP 2.0 by Key Program Features	HIP Basic	HIP Plus
<b>Eligible Population</b>	<ul style="list-style-type: none"> <li>Non-disabled adults ages 19-64</li> <li>Income less than or equal to 100% FPL</li> <li>Default plan for individuals in this income range</li> </ul>	<ul style="list-style-type: none"> <li>Non-disabled adults ages 19-64</li> <li>Income less than or equal to 138% FPL</li> <li>Only option for individuals above 100% and up to 138% FPL</li> </ul>
<b>POWER Account Contribution</b>	<ul style="list-style-type: none"> <li>No member contribution</li> <li>State fully funds account</li> </ul>	<ul style="list-style-type: none"> <li>Member contributes \$1-100 monthly</li> <li>State funds the remaining balance</li> </ul>
<b>Co-Payments</b>	<ul style="list-style-type: none"> <li>Co-payments are required for all categories of service</li> </ul>	<ul style="list-style-type: none"> <li>No co-payments for services, except non-emergent ER visits</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>All medical and behavioral health</li> <li>Standard prescription drug benefits</li> <li>No Dental</li> <li>No Vision</li> </ul>	<ul style="list-style-type: none"> <li>All medical and behavioral health</li> <li>Enhanced prescription drug benefits</li> <li>Dental</li> <li>Vision</li> <li>Higher limits for certain benefits</li> </ul>

## INTRODUCTION

### State Flexibility to Expand Medicaid has Spurred New Approaches to Coverage

The Affordable Care Act (ACA), passed in March 2010, included a variety of reforms intended to expand coverage and increase access for individuals previously uninsured.<sup>1</sup> One of the key components of the law was the expansion of Medicaid coverage.

#### Content Highlight

States have taken different approaches to Medicaid expansion and reform since enactment of the ACA. Indiana's HIP 2.0 uses an innovative program and benefit design, along with financial and non-financial incentives, to drive consumer engagement and decision-making.

Passage of the ACA, and the subsequent ruling of the United States Supreme Court,<sup>2</sup> gave states the option to expand Medicaid to low-income adults ages 19 to 64 with incomes up to 138 percent of the federal poverty level (FPL).<sup>3</sup> Many of these individuals were not previously eligible for Medicaid and, absent coverage through an employer, may have gone without health insurance as a result.

States have taken different approaches to Medicaid expansion and reform since the ACA. To date, 26 states (including the District of Columbia) have expanded Medicaid as permitted by the ACA.<sup>4,5</sup> Another six states expanded their Medicaid programs under alternative models via 1115 waivers—tailoring their approach to Medicaid reform to meet state-specific goals and objectives while taking

advantage of the enhanced funding for expansion under the ACA. These states included Indiana, Arkansas, Iowa, Michigan, Montana, and New Hampshire.<sup>6</sup> Pursuing Medicaid reform through an alternative pathway allows states the opportunity to incorporate unique aspects into their Medicaid programs. For instance, personal responsibility is a key feature of Indiana's program.<sup>7</sup>

Another impetus for pursuing an alternative model for Medicaid reform is that some states already had success with different health insurance models before the passage of the ACA and wanted to build on those approaches rather than replace them. In Indiana, this is the Healthy Indiana Plan (HIP)—a waiver program that applied private market, consumer-driven reforms to the Medicaid program.<sup>8</sup> The first iteration of HIP (HIP 1.0) operated from 2008 through 2014, with Anthem's affiliated plan in Indiana (the "health plan" or "plan") serving about 50 percent of the members enrolled in the program by the end of 2014.<sup>9</sup>

HIP 1.0 led to key improvements in the health and well-being of Hoosiers. For example, emergency room (ER) use declined by approximately 15 percent between 2011 and 2013 for plan members enrolled in HIP 1.0.<sup>10</sup> Furthermore, in 2013, ER use among the plan's members in HIP 1.0 was roughly 33 percent lower than ER use among adults enrolled in Hoosier Healthwise (traditional Medicaid).<sup>11</sup> HIP 1.0 also achieved high quality and satisfaction ratings among the plan's members—scoring in the 90th percentile on HEDIS quality metrics in key categories (e.g., preventive care, diabetes control, breast cancer screenings, high blood pressure management, and antidepressant medication management).<sup>12</sup> Overall, over 80 percent of the plan's members were satisfied with their health plan.<sup>13</sup>

Broadly, HIP 1.0 demonstrated that members wanted to be healthier and better engaged in their own care. HIP 2.0, Indiana's alternative Medicaid expansion model launched in February 2015, replaces and builds on the success of the original HIP waiver program.

**The first iteration of HIP (HIP 1.0) operated from 2008 through 2014, with Anthem's affiliated plan in Indiana serving about 50 percent of the members enrolled in the program by the end of 2014.**

### HIP 2.0 Encourages Consumer Engagement in Health Care

HIP 2.0 is aligned with efforts across all types of health insurance coverage to engage individuals more actively in their health care. For example, employer-sponsored insurance plans are increasingly using a variety of incentives and other mechanisms to promote consumer engagement. Typically, these include high deductibles and/or health savings accounts (HSAs), tools to help consumers compare the cost and quality of their care, and employee wellness programs (including incentives for obtaining screenings and meeting certain benchmarks). Medicaid is no different in its desire to better engage individuals in their own health care, with some states incorporating HSAs and wellness incentives into traditional Medicaid programs.<sup>14</sup> HIP aligns with this trend by engaging Indiana Medicaid members in their care—both to encourage them to obtain recommended preventive care as well as to think about cost of care (e.g., avoid unnecessary ER visits that are better treated by primary care providers).

HIP 2.0 uses program and benefit design, along with both financial and non-financial incentives, to drive consumer engagement and decision-making. HIP 2.0 engages members from the time of enrollment – giving each member the opportunity to choose their managed care entity and, for those with incomes at or below 100 percent FPL, their benefit package (i.e., Basic or Plus). Further, through its innovative incentive structure, HIP 2.0 seeks to improve health and contain costs by encouraging wellness and prevention. The program also strives to ensure timely and appropriate use of health services and avoid unnecessary costs that might accompany delays in seeking treatment. These incentives encourage members get the health care they need with the goal of achieving positive health outcomes for all Hoosiers.

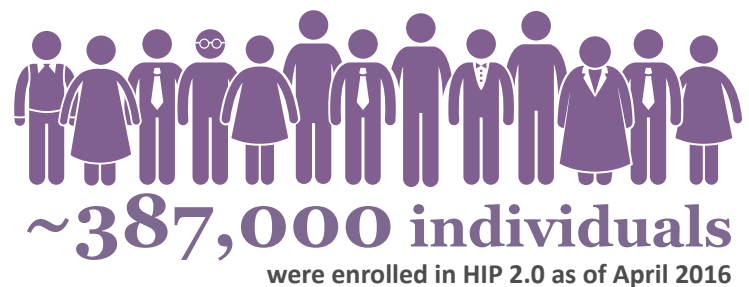
## OVERVIEW OF THE HEALTHY INDIANA PLAN (HIP) 2.0

### Program and Benefit Design

HIP 2.0 extends Indiana’s Medicaid coverage to non-disabled adults, ages 19 to 64, up to 138 percent FPL—an estimated 350,000 adults who were previously uninsured.<sup>15,16</sup> Open enrollment for HIP 2.0 began on January 27, 2015, with coverage first effective on February 1, 2015. As of April 2016, approximately 387,000 individuals were enrolled in HIP 2.0.<sup>17</sup>

### Content Highlight

There are two major benefit plans under HIP 2.0—HIP Plus and HIP Basic. The Plus option requires monthly contributions from enrollees, but also includes a variety of incentives and enhanced benefits that distinguish it from the Basic option.



There are two major benefit plans under HIP 2.0—HIP Plus and HIP Basic.<sup>18</sup> Members in both Basic and Plus have access to all required essential health benefits as well as maternal health services. The Basic option is a default plan available to individuals with incomes at or below 100 percent FPL who opt-out of HIP Plus or who fail to make contributions to Personal Wellness and Responsibility (POWER) accounts. The Basic option requires cost sharing at the time of service for most services (typically \$4-\$8 for doctor visits and prescriptions and up to \$75 for a hospital stay).<sup>19</sup> The Plus option covers individuals with incomes up to and including 138 percent FPL and requires contributions to a POWER account. While Plus is the required option for individuals with incomes above 100 percent FPL, it is also available to individuals at or below 100 percent FPL who choose to pay into POWER accounts. For individuals who enroll in the Plus option, no cost sharing is required at the time of service, except for CMS-allowable co-payments for non-emergent ER use (\$8-\$25).

The absence of cost sharing for services (except non-emergent ER use) for Plus members is one of the features designed to incent members to become more engaged in their care.

**Plus key benefit enhancements over Basic include vision and dental services, higher service limits and a comprehensive drug benefit.**

The Plus option has a variety of incentives and enhanced benefits that distinguish it from the Basic option. Key benefit enhancements over Basic include vision and dental services, higher service limits (e.g., more annual visits for physical, speech, and occupational therapy), and a comprehensive drug benefit. HIP also includes incentives for members to engage in care and obtain preventive services. For instance, members can roll over a portion of unspent POWER account funds into the next plan year by getting recommended preventive care.<sup>20</sup> Members in Plus are eligible to have their roll over amount doubled by the state. Members in Basic who enroll in Plus in a subsequent benefit period are eligible for reduced POWER account contributions of up to 50 percent.<sup>21</sup>

Another set of benefit plans are available—collectively referred to as HIP State Plan—for individuals who are medically frail, low-income caregivers, and pregnant women who choose to leave Basic or Plus once they become pregnant. Unlike Basic and Plus, the State Plan benefit package includes all traditional Medicaid benefits; however, for all but pregnant women, co-payments and POWER account contributions for the State Plan option follows HIP Basic and HIP Plus, depending on if the member is making monthly POWER account contributions. Pregnant Women have no cost sharing, regardless of which plan they are in.

**Use of POWER Accounts**

One of the unique features of Indiana’s HIP 2.0 program is the addition of a personal account which is used to pay for deductible expenses over the course of the year. Every member enrolled in HIP has a POWER account, which functions similarly to a health savings account. POWER accounts are used to pay for the first \$2,500 in covered services each year.<sup>22</sup> Members receive a debit card that allows them to pay for services at the point of care. Preventive services are not charged against the POWER Account, and neither are co-payments. After making a payment with the debit card, the member receives a receipt at the provider’s office that shows the cost of the services they just paid for, as well as the amount that now remains in their POWER account. This transparency helps members keep track of their health care spending and better manage the remaining funds in their POWER account.

**Every member enrolled in HIP has a POWER account, which functions similarly to a health savings account.**



Power accounts are used to pay for the first **\$2,500** in covered services each year

Plus members are required to contribute to their POWER accounts. The state funds most of the POWER Account amount, while Plus members make monthly contributions, based on their income, to cover the remaining balance.<sup>23</sup> Monthly contributions to POWER accounts do not exceed two percent of household income; members with incomes below 5 percent FPL make the minimum monthly contribution of \$1.<sup>24</sup> If a member fails to make the POWER account contribution, the member may be dis-enrolled (income above 100 percent FPL) and locked out of the program for a period of 6 months or transitioned to the Basic option (income at or below 100 percent FPL). Members may receive a refund of their POWER account contributions when they leave the program, if their contributions exceed the prorated share of claims incurred. However, if a member is dis-enrolled due to nonpayment, the refund is subject to a 25 percent penalty. Basic members do not make monthly payments as a result of their choice to have cost sharing through co-payments for services instead of making a monthly contribution; the state makes their total POWER account payment for the year.

HIP members can contribute to their POWER accounts on a monthly basis or make the entire annual contribution up-front in a lump sum payment. Members can make payments via credit card or auto-bank draft online via their health plan website or by calling their health plan customer care center, check or money order, or MoneyGram. Alternatively, an employer or non-profit (e.g., community-based organization, church, foundation) can pay a member’s contribution. The POWER account structure is designed to be as flexible as possible, in order to make it easy for members to use the account and engage in their own care.

## HIP 2.0 INNOVATIONS ARE DRIVING MEMBER ENGAGEMENT

Although HIP 2.0 has only been in place since February 2015, observations during the first year of the program reveal a positive impact on consumer behavior and health outcomes. Early results demonstrate that the health plan's members are actively engaged in their health care and suggest that the incentives in HIP 2.0 are starting to achieve their intended outcomes.<sup>25</sup>

### Content Highlight

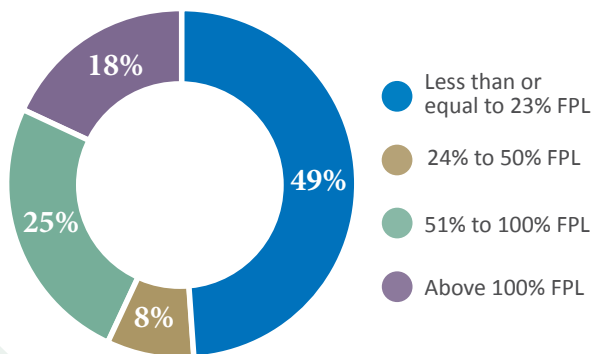
Early observations from the HIP 2.0 program indicate a positive impact on member engagement and health outcomes. Members who pay for Plus are seeking care in more appropriate service settings and actively engaging in the use of their POWER accounts.

### Members Are Paying for Plus

To date, one of the more revealing findings is the extent to which low-income individuals are selecting the Plus option, requiring contributions to the POWER account. Based on data collected by the health plan, nearly 70 percent of the health plan's members enrolled in HIP are choosing to pay for the Plus option,<sup>26</sup> including 65 percent of members with incomes less than or equal to 23 percent FPL<sup>27</sup> (which equates to roughly \$228 in monthly income for an individual).<sup>28</sup> As Figure 1 illustrates, among the plan's members

enrolled in the Plus option, roughly 82 percent have incomes at or below 100 percent FPL.<sup>29</sup> Notably, nearly half of all HIP 2.0 members paying for the Plus option are at the lowest income levels (less than or equal to 23 percent FPL).<sup>30</sup>

Figure 1. HIP 2.0 Members Paying for Plus, by Income Level



Source: Anthem Insurance Companies, Inc.

**Roughly 82 percent have incomes at or below 100 percent FPL. Notably, nearly half of all HIP 2.0 members paying for the Plus option are at the lowest income levels (less than or equal to 23 percent FPL).**

Data indicates that HIP members are actively engaged when it comes to contributing to their POWER accounts. Roughly 45 percent of members paid the full amount of their POWER account contributions in advance. Nearly two-thirds of members (about 63 percent) paid via a non-cash option (e.g., credit card, by phone, or online) even though cash payment options exist; very few members have had their payments covered by an employer (0.01 percent) or by a non-profit organization (0.01 percent).<sup>31</sup>



nearly  
**70%**

of the health plan's members enrolled in HIP are choosing to pay for the Plus option



roughly  
**45%**

of members paid the full amount of their POWER account contributions in advance



nearly  
**63%**

paid via a non-cash option (e.g., credit card, by phone, or online)

## Members Are Reaching Out to Understand Their Benefits

Through the first eight months of HIP 2.0 coverage (starting February 1, 2015), the health plan received more than 756,000 member calls.<sup>32</sup> Topics of member calls include: the plan’s benefits and how to use them, assistance finding a provider, help setting up appointments, and members wanting to pay their POWER account contribution over the phone.<sup>33</sup> Members also contact the health plan to better understand how the POWER account and debit card work. Recent health plan data indicates the most common reasons for calling the health plan include: eligibility verification (25 percent); billing status (18 percent); pay by phone (18 percent); general benefit questions (15 percent); and PCP update/ID card (13 percent).<sup>34</sup> In general, the volume of inquiries reflects that many of these individuals did not have health insurance previously, or did not have the array of benefits they now have under HIP, and need help navigating them.<sup>35</sup>

The frequency with which HIP 2.0 members contact the health plan demonstrates active engagement in their own health care.

For example, a HIP member, on average, calls Anthem’s affiliated plan 5.5 times per year.<sup>36</sup> Comparatively, a Hoosier Healthwise member calls Anthem’s affiliated plan less than once per year (0.8), on average.<sup>37</sup> Overall, members in HIP 2.0 are contacting the health plan almost 7 times more often than are members in the traditional Medicaid plan.

Anthem’s affiliated health plan HIP 2.0 members are getting engaged in their health care by taking this initial step of making a payment and asking questions to understand their benefits. An overwhelming number of the health plan’s HIP members (nearly 90 percent) are satisfied with their overall health care.<sup>38</sup>



# 756,000

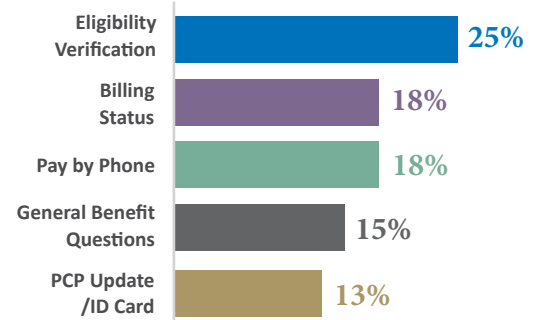
member calls in the first eight months of HIP 2.0 coverage

**Member calls on average:**

**HIP:** 5.5 times a year

**Hoosier Healthwise:** less than once a year

### The most common reasons for calling the health plan



## Personal Responsibility Incentives Appear to Influence Members’ Use of Health Care

To date, experience with HIP 2.0 indicates that health plan members who pay for Plus are accessing their benefits and are more actively engaging in their care.

### Preventive Services

For example, the percentage of health plan members who received screenings for preventive services, such as breast cancer and cervical cancer, is higher for HIP Plus versus HIP Basic members. Roughly 39 percent of Plus members received a breast cancer screening (compared to 21 percent of Basic members) while 27 percent of Plus members obtained a cervical cancer screening (compared to 15 percent of members in Basic). While the proportion of members getting these preventive screenings still has room for improvement, there is a noticeable difference between Plus and Basic. Increased use of preventive care and other services, especially relative to HIP Basic, may be due to the greater incentives to obtain preventive care in the Plus option.

Furthermore, a significant number of HIP Plus members are taking advantage of their health coverage and seeking care in their doctor’s office and other outpatient settings—with roughly 91 percent of members accessing ambulatory care, based on HEDIS data for adult access.<sup>39</sup> Comparatively, a much smaller percentage of members in Basic (70 percent) accessed these same services.<sup>40</sup> Early observations reveal that Plus members are more likely to follow up on care. For example, approximately 77 percent of members in Plus obtained appropriate follow-up care for use of an ACE inhibitor, compared to only 66 percent of members in Basic.<sup>41</sup>

Prescription Drug Benefit

HIP 2.0 has had a measurable impact on access to prescription drugs, with over 2.3 million scripts filled to date.<sup>42</sup> Members enrolled in Plus appear to be more engaged in their prescription drug benefit. Nearly three-quarters (72 percent) of the members enrolled in the Plus option have used their prescription drug benefit—with 56 percent of Plus members doing so within the first 90 days of enrollment.<sup>43</sup> Comparatively, less than half (49 percent) of Basic members have used their prescription drug benefit, with slightly more than one-third (35 percent) doing so in the first 90 days.<sup>44</sup> There are high rates of generic drug dispensing among members in both the Basic (88 percent) and Plus (86 percent) options.<sup>45</sup> Early observations suggest that differential cost sharing for preferred and non-preferred drugs (\$4 and \$8, respectively) may be influencing members enrolled in Basic to select drugs from the preferred list, which helps increase the use of generic prescriptions.



**72%**

of members enrolled in the Plus option have used their prescription drug benefit, **56% within the first 90 days**

*compared to 49% of Basic members, with 35% doing so in the first 90 days*

Enhanced Benefits

Health plan members also are taking advantage of the enhanced benefits—dental and vision coverage—offered through the Plus option. Among HIP Plus enrollees who accessed dental benefits, 57 percent did so within the first 90 days of enrollment in coverage; a larger proportion (70 percent) of Plus members accessed vision benefits within the first 90 days on enrollment.<sup>46</sup> Feedback from focus group interviews conducted with HIP 2.0 members suggests that early use of these benefits—especially dental and vision—is driven by lack of access to these services prior to enrolling in HIP. Individuals are willing to make a contribution to access these benefits.

ER/Inpatient Utilization

Preliminary data also indicates that members are seeking care in more appropriate settings. First and foremost, there has been a notable impact on ER utilization. ER use among HIP members is substantially lower than ER use among enrollees in Hoosier Healthwise (Indiana’s traditional Medicaid program). **Further, data shows:**

**30%** 

**LOWER ER utilization among Plus members**  
*compared to ER use while enrolled in traditional Medicaid<sup>47</sup>*

**21%** 

**LOWER ER use among Plus members**  
*compared to Basic<sup>48</sup>*

**\$2.5 M** 

**in estimated SAVINGS as a result of reduction in ER utilization among members<sup>49</sup>**

**58%** 

**DROP in inpatient utilization among HIP 2.0 members who transitioned from traditional Medicaid**

Although the underlying reasons for the differences between Plus and Basic members have not been analyzed yet, these differences may be due to the lack of copays for physician and outpatient services for Plus members coupled with increasing copays for non-emergent ER use. Feedback from HIP Basic and Plus members indicates that most members primarily go to their doctor or clinic to access health care.<sup>50</sup> A smaller number of members said they primarily go to an urgent care clinic for health care, due to shorter wait times and extended hours. Very few indicated that they go directly to the ER for their care.

Overall, personal responsibility and incentives for preventive care seem to be positively affecting the decisions that members make about their health care.



## WHAT'S DRIVING THESE RESULTS?

Although the body of literature on the impact and effectiveness of consumer incentives and personal responsibility in health care is still evolving, there are some early findings that support the approach HIP takes to better engage members in their care. Research shows that there has been a sizeable increase in private employers' and public programs' use of financial incentives to encourage

### Content Highlight

HIP 2.0 uses a variety of incentives to drive members' health care decisions. Early observations of HIP 2.0, including feedback from members, suggest that increased ownership over one's health care has a positive impact on how members engage in their care.

preventive services, as well as healthier behaviors and participation in wellness activities.<sup>51</sup> Historically, the private sector has taken the lead in this area—implementing incentive programs to improve health and reduce costs for employers and employees.<sup>52</sup> Health plans and wellness programs serving non-Medicaid members have demonstrated that financial incentives for consumers can influence health behaviors, enhance long-term health outcomes, and reduce costs.<sup>53</sup> Even small financial incentives have been shown to influence individual behavior.<sup>54,55</sup> In general, insight from the private sector supports the extension of incentive-based strategies to individuals enrolled in Medicaid.<sup>56</sup>

Early efforts to apply such incentives to Medicaid programs have met some success,<sup>57</sup> in line with early findings from HIP 2.0. Similar to

efforts in commercial insurance plans, HIP engages Indiana Medicaid members in their care, encouraging members to receive recommended preventive care, to access care in the most appropriate settings, and to think about the cost of care. To achieve these goals, HIP uses a variety of financial incentives to drive consumer engagement and decision-making.

### HIP 2.0 Benefit Design and Incentives Drive Consumer Engagement

HIP 2.0 offers multiple motivators for individuals to select and pay the contributions for Plus. A significant motivator is the dental and vision benefits in the Plus option. Focus group interviews with HIP 2.0 members revealed that many members are gaining these benefits for the first time and are excited to have access to these services.<sup>58</sup> For example, one member transitioning from HIP 1.0 to HIP 2.0 called prior to coverage taking effect for assistance finding a dentist and setting up an appointment for the first day she was eligible for services.<sup>59</sup>

HIP Plus members also have no co-payments for services, other than non-emergent use of the ER. Members, including those with lowest incomes, see the immediate value of access and the cost savings associated with no co-payments.<sup>60</sup> Focus group feedback indicates that members want to be on the HIP Plus plan for dental and vision coverage as well as no co-payments. Indeed, the focus groups revealed that many members did not fully understand their coverage options in the first year, and more may have selected the Plus option for these benefits, had they had a better understanding of the benefits of Plus.<sup>61</sup>



**Focus group feedback indicates that members want to be on the HIP Plus plan for dental and vision coverage as well as no co-payments.**

The results in Indiana are similar to the limited experience of other state Medicaid programs that have introduced enhanced benefit packages as a way of driving consumer engagement. For example, in West Virginia's Mountain Health Choices Program, Medicaid beneficiaries had access to an enhanced benefits package if they signed an agreement with the state to engage in healthy behaviors. Although take-up of the Choices program was low, members who participated in the program were more likely than non-participants to visit their doctors and take their medications.<sup>62</sup>

HIP’s incentives for preventive care also resonate with some members. In addition to the POWER account incentives for obtaining preventive care, the health plan offers a \$20 gift card to members who receive their preventive care. The health plan also offers incentives to members who complete a health needs survey online (\$20 gift card) or by telephone (\$10 gift card).<sup>63</sup> Focus groups suggest that most members understand the importance of preventive care; more than half of participants said they receive their recommended preventive care.<sup>64</sup> Yet the extent to which a gift card or similar incentive motivates a member to seek preventive care varies. Focus groups revealed that a \$10 or \$20 gift card would be enough incentive for some members, but not enough for others.<sup>65</sup> The health plan continues to evaluate the type and amount of incentives that are in place to determine what changes may be needed to further drive member engagement.

## Preventive Care Incentives



**\$20  
gift card**

to members who receive their preventive care



**\$20  
gift card**

to members who complete a health needs survey online

*Focus groups revealed that a \$10 or \$20 gift card would be enough incentive for some members, but not enough for others.*

**Findings from other Medicaid programs support the potential of incentives designed to encourage members to seek preventive care. For example:**

**116%  
increase**



- ▶ In Idaho’s Wellness Preventive Health Assistance Program, Medicaid beneficiaries earned \$10 per month for maintaining up-to-date well-child visits and immunizations; the \$10 went toward paying premiums. A study of the program found a 116 percent increase in the number of children with up-to-date well-child visits and immunizations compared to a 13 percent increase among children who were not eligible to receive the incentives.<sup>66,67</sup>



- ▶ A study of Minnesota’s incentive program for Medicaid well-child visits found that the incentives significantly increased the likelihood that a well-child visit would be obtained by the member.<sup>68</sup>



- ▶ In Florida’s Enhanced Benefits Reward\$ Program, Medicaid beneficiaries redeemed roughly half of the credits available for complying with healthy behaviors; 25 percent of the credits were awarded for adult or child primary care office visits and 45 percent were for childhood preventive care.<sup>69,70</sup>



- ▶ Anecdotally, the availability of gift cards for obtaining a mammogram led to an increase in the number of screenings among women enrolled in a Medicaid managed care plan.<sup>71</sup>

There are a variety of other non-monetary ways in which the health plan is able to engage HIP members. For example, the health plan has a dedicated customer service group to address member questions and concerns. Care managers work with members to help them navigate their benefits and get connected to the right services and supports. The health plan also communicates through mailing key information on benefits, such as how to use the debit card associated with the POWER account.

One of the unique aspects of HIP 2.0 is that the program offers incentives and disincentives to members. Early observations of HIP 2.0 suggest that increased ownership over one’s health care has a positive impact on how members engage in their care. Focus groups confirmed that a co-payment would deter many from going to the ER when it is not a true emergency.<sup>72</sup>

**Some members said if they knew there was a co-payment required at the ER, they would first go to an urgent care center or the doctor for non-emergent conditions.**

Some members said if they knew there was a co-payment required at the ER, they would first go to an urgent care center or the doctor for non-emergent conditions.<sup>73</sup> Anecdotal evidence suggests that enhanced responsibility in the form of co-payments has members thinking differently about how to use services. Likewise, the personal ownership in and functionality of the POWER account and debit card seems to increase engagement for some members. The debit card gives members a sense of responsibility for paying directly from their accounts. Furthermore, the cost transparency features—the monthly POWER account statements and the ability to track account debits and balances in real-time online as well as after a payment was made with the debit card—empower members to better manage the funds in their

POWER accounts. The rollover and refund policies associated with the POWER account may also be incentives for members to shop and spend wisely on their services, knowing that they will retain unspent funds. Feedback suggests that, although many members need additional education on how to use the POWER accounts, members who do use them feel empowered, feel in control of their own health care, and are eager to engage in their benefits.<sup>74</sup>

Finally, members appreciate the opportunity to take ownership in their health care. Members talk about making contributions for Plus in ways that reflect their desire to be engaged, saying they are “allowed to pay” or “want to pay” for Plus, and that they “get to choose” the plan that is best for them.<sup>75</sup>

**Provider Collaboration and Education Efforts Drive Positive Outcomes**

Engaging the provider community was a priority at the outset of HIP 2.0. In order to attract providers beyond those that normally participate in Medicaid, HIP provides enhanced reimbursement for services delivered to members enrolled in the program. Providers are paid the Medicare rate or 130 percent of the Medicaid rate if a Medicare code does not exist for the particular service.<sup>76</sup> The network of hospitals, physicians, and specialists participating in HIP continues to grow. For instance, from February to September 2015, the health plan’s network of providers participating in HIP 2.0 grew by approximately 540 primary care physicians and 850 dentists.<sup>77</sup>

Identifying unique and innovative ways to work with HIP providers and other community partners to promote the overarching goals of HIP 2.0 has driven positive results. One notable partnership, in particular, is the “clinic days” program being implemented by the plan as a way to remove barriers to accessing care. During each clinic day, the plan works with providers to block out appointment times for members with identified care gaps, reaches out to members to schedule those appointments, and coordinates transportation for members who need it.

The health plan has two collaborative approaches to improve compliance with receipt of recommended preventive care. In one program, the plan co-locates temporary staff, referred to as embedded service navigators, at provider sites to perform targeted outreach to members who have not yet received preventive care or other key services.<sup>78</sup> Navigators scheduled over 700 preventive care visits at the provider sites during the early stages of the program.<sup>79</sup> Under the other program, nearly two dozen high volume providers reach out to and schedule visits with members who haven’t received preventive care (using a list supplied by the health plan). Providers are eligible to receive up to an additional \$30 per member, per visit if the health plan meets certain benchmarks for select HEDIS measures (e.g., last year, the measures were well-child measures; this year the measure is Adult Access to Primary Care).<sup>80</sup>

The health plan is also hosting webinars for providers to educate them on the HIP program, helping providers to better engage their patients who are HIP members. To encourage providers to join, the webinars offer continuing education credits (CECs) to those who participate.<sup>81</sup>

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from February to September 2015, the health plan’s network of providers participating in HIP 2.0 grew by



## CONTINUING THE EARLY SUCCESS OF HIP 2.0 IN PARTNERSHIP WITH THE STATE

Early results from HIP 2.0 suggest that members are responding to the incentives and enhanced benefits provided by the program. Yet these early observations also highlight areas where HIP 2.0 can be strengthened to enhance outcomes for members and the state.

### Content Highlight

Building on the early successes of HIP 2.0, there are opportunities to strengthen outcomes for members and the state. Member education and outreach, along with enhanced provider collaboration, will help expand the positive impact of the program.

### Lessons Learned and Opportunities for Improvement

One clear finding is that member education is critical to expanding the impact of HIP 2.0. Members care about their benefits and are engaged in using them, once they understand what's available to them.<sup>82</sup> Despite the efforts of the state, health plans, providers, and community organizations, there are still many members who don't fully understand the benefits available through HIP and how to access them.

For instance, some members were not aware of the Plus option or its benefits.<sup>83</sup> Education and outreach efforts should include helping members understand the benefits of and differences between the Plus and Basic options. Likewise, very few participants in the focus

groups were aware that monthly POWER account contributions for the following year may be reduced if certain preventive care services are completed. Those who do not regularly receive preventive services said this will motivate them to do so.<sup>84</sup> In addition to education, shortening the time lag between plan renewal and rollover of the POWER account may help members better connect obtaining preventive services with the POWER account incentive.

One area of focus for health plans and the state is to continue educating both members and providers on the purpose and use of the POWER account. During focus groups, some members said that using a POWER account makes them feel good because they know where the money is going or that they have control. These early results are notable. However, members did not fully understand the accounts and want to learn more.<sup>85</sup> Further education on the POWER accounts may help increase members' feeling of ownership over their health care.

Provider outreach and education can help improve member engagement.<sup>86</sup> Health plans and the state should continue to help providers understand HIP so that they can engage members in their benefits as well. Focus group participants indicate that they have encountered physicians who do not ask for the debit card after their appointment.<sup>87</sup>

The frequency and manner in which consumers are engaged also matters. Regular touch points with members increase engagement. Most members included in focus groups indicated that they want to receive reminders about checkups from their health plan.<sup>88</sup> Identifying the most effective medium of communication is critical. For instance, utilizing email and text outreach may be particularly helpful in engaging younger members.

Finally, experience so far highlights that removing barriers to accessing primary and preventive care is crucial. As members better understand their benefits, they want to access services like preventive care. But, according to HIP members in focus groups, difficulties accessing care can be a deterrent to getting all of the recommended preventive services.<sup>89</sup> For example, long wait times for appointments or at the doctor's office and inconvenient provider hours can all deter members from obtaining needed care. Health plans, providers, and other community partners can mitigate some of these challenges by increasing awareness of and access to health plan tools that are designed to ease these barriers.

### Future Efforts to Enhance Consumer Engagement

The health plan is continuing to invest in innovations that will improve consumer engagement in the program. For instance, the health plan is developing additional incentive programs designed to reward greater use of preventive care, less reliance on the ER, and more broadly help members become more discerning consumers of health care services.<sup>90</sup> The plan is also conducting outreach designed to reduce ER utilization through enhanced education on available alternatives, targeting counties and members with high rates of ER use.

The health plan will roll-out an innovative approach to reach members in their communities—setting up health risk assessment kiosks in Walmart locations across the state. Members will be able to complete their assessments in a convenient and familiar setting and receive a gift card that can be used to pay their POWER account at the MoneyGram location within Walmart or buy certain approved goods that they may need. Finally, the health plan’s “community advocates” program will create a peer-to-peer resource for outreach, enrollment, and education of HIP-eligible or -enrolled individuals.

## CONCLUSION

HIP 2.0 has demonstrated early success with respect to members’ engagement in their health care. This experience adds to the narrative of positive outcomes attributable to approaches that utilize consumer incentives and enhanced responsibility. It also suggests that, when designed appropriately, even small contribution requirements or financial incentives can positively influence how members think about and access health care. Although this model is still relatively new in Medicaid, Indiana is demonstrating the ways in which alternative approaches to Medicaid expansion can produce positive outcomes for both the member and the state.

Activities over the course of the first year of implementation have also revealed some lessons learned and areas where HIP 2.0 can continue to grow and better reach Hoosiers across Indiana. Continued consumer education and outreach by health plans, the state, community partners, and even providers, will help HIP 2.0 realize its full potential for consumer engagement and improvement in the health of members.

## END NOTES

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<sup>1</sup>The Patient Protection and Affordable Care Act (signed into law on March 23, 2011) and the Health Care and Education Reconciliation Act of 2010 (signed into law on March 30, 2010) are collectively referred to as the Affordable Care Act.

<sup>2</sup>Supreme Court of the United States. (2012, June 28). National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al., No. 11-393. Retrieved from <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf> (accessed January 13, 2016).

<sup>3</sup>The income eligibility level for Medicaid was raised to 133% FPL plus an additional 5 percentage points for income disregards, for a total level of 138% FPL.

<sup>4</sup>The Henry J. Kaiser Family Foundation. (2016, March 14). Status of State Action on the Medicaid Expansion Decision. Retrieved from <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (accessed May 5, 2015).

<sup>5</sup>National Academy of State Health Policy. (2016, April 22). State Reform Map: Where States Stand on Medicaid Expansion Decisions. Retrieved from <https://www.statereform.org/Medicaid-Expansion-Decisions-Map> (accessed May 5, 2016).

<sup>6</sup>Ibid. 'Alternative models' means models that comply with federal Medicaid regulations but include placing population in exchanges or contain aggressive personal responsibility components. Although several states are exploring Medicaid expansion through an alternative model, only Arkansas, Indiana, Iowa, Michigan, New Hampshire, Pennsylvania and Montana have received approval from the Centers for Medicare & Medicaid Services (CMS) for their plans. However, Pennsylvania abandoned implementation of the "Healthy Pennsylvania Plan" and implemented a traditional Affordable Care Act Medicaid expansion. Given the dynamic nature of this environment, it is possible that the number and mix of states pursuing alternative approaches may change after the publication of this paper, as states may reconsider and/or rescind their current expansion strategies.

<sup>7</sup>Internal Anthem, Inc. analysis of state Medicaid expansion decisions and executive pronouncements, as of November 6, 2015.

<sup>8</sup>Indiana Family and Social Services Administration. (2014, May 14). History of Consumer-Driven Health Care in Indiana. Retrieved from [http://www.in.gov/fssa/hip/files/Infographic\\_consumer\\_driven\\_health\\_history.pdf](http://www.in.gov/fssa/hip/files/Infographic_consumer_driven_health_history.pdf) (accessed November 6, 2015).

<sup>9</sup>Data are from Anthem Insurance Companies, Inc. (February 12, 2016).

<sup>10</sup>Ibid.

<sup>11</sup>Ibid.

<sup>12</sup>Ibid.

<sup>13</sup>Data are from Anthem Insurance Companies, Inc. (February 12, 2016). Consumer satisfaction rate of 80 percent is based on scores from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey reported in 2014.

<sup>14</sup>Center for Health Care Strategies. (2014, May). Examples of Consumer Incentives and Personal Responsibility Requirements in Medicaid: Technical Assistance Tool. Retrieved from [http://www.chcs.org/media/Consumer-Incentive-Matrix\\_060414.pdf](http://www.chcs.org/media/Consumer-Incentive-Matrix_060414.pdf) (accessed December 10, 2015).

<sup>15</sup>Health Management Associates. (2015, October 7). HMA Weekly Roundup: Trends in State Health Policy, 1-3. Retrieved from <https://www.health-management.com/assets/Weekly-Roundup/100715-HMA-Roundup.pdf#nameddest=infocus> (accessed October 8, 2015).

<sup>16</sup>Indiana Family and Social Services Administration. (2014, July 2). HIP 2.0 1115 Waiver Application, 50. Retrieved from [http://www.in.gov/fssa/hip/files/HIP\\_2\\_0\\_Waiver\\_\(Final\).pdf](http://www.in.gov/fssa/hip/files/HIP_2_0_Waiver_(Final).pdf) (accessed November 6, 2015).

<sup>17</sup>State of Indiana, Family and Social Services Administration. (2016, May 17). Medicaid Monthly Enrollment Reports, Enrollment Count by Age Group and Health Program: April 2016. Retrieved from <http://www.in.gov/fssa/ompp/4881.htm> (accessed June 17, 2016). Enrollment includes all HIP members (Plus, Basic, State Plan Plus, State Plan Basic) as of April 2016.

<sup>18</sup>State of Indiana. (no date). About the HIP Program. Retrieved from <http://www.in.gov/fssa/hip/2494.htm> (accessed October 12, 2015).

<sup>19</sup>Ibid.

<sup>20</sup>Manatt, Phelps & Phillips, LLP. (2015, January 29). Manatt on Medicaid: CMS Approves Indiana Waiver to Expand Medicaid. Retrieved from <https://www.manatt.com/medicaid-update/cms-approves-indiana-waiver.aspx> (accessed October 14, 2015).

<sup>21</sup>Indiana Family and Social Services Administration. (2014, July 2). HIP 2.0 1115 Waiver Application, 31-32. Retrieved from [http://www.in.gov/fssa/hip/files/HIP\\_2\\_0\\_Waiver\\_\(Final\).pdf](http://www.in.gov/fssa/hip/files/HIP_2_0_Waiver_(Final).pdf) (accessed November 6, 2015).

<sup>22</sup>State of Indiana. (no date). Healthy Indiana Plan FAQs. Retrieved from <http://www.in.gov/fssa/hip/2452.htm#power> (accessed October 12, 2015).

<sup>23</sup>Ibid.

<sup>24</sup>Centers for Medicare and Medicaid Services. (2015, January 27). Healthy Indiana Plan 2.0 Section 1115 Demonstration Fact Sheet, 2. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-fs.pdf> (accessed October 12, 2015).

<sup>25</sup>For the purposes of this paper, unless otherwise specified, data include all HIP members, often segmented by Plus and Basic.

<sup>26</sup>Data are from Anthem Insurance Companies, Inc. (February 12, 2016) and represent the period of February 1, 2015 through September 30, 2015.

<sup>27</sup>Data are from Anthem Insurance Companies, Inc. (June 14, 2016) and represent a current snapshot of for members at or below 23 percent FPL.

<sup>28</sup>Monthly income calculation is based on the federal poverty guidelines effective as of January 2016. The income estimate for 23 percent FPL was calculated using an on-line tool from ABC for Health, Inc., <http://www.safetyweb.org/fpl.php> (accessed February 12, 2016).

<sup>29</sup>Data are from Anthem Insurance Companies, Inc. (February 12, 2016) and represent the period of February 1, 2015 through September 30, 2015.

<sup>30</sup>Ibid.

<sup>31</sup>Ibid.

<sup>32</sup>Ibid.

<sup>33</sup>Anthem Public Policy Institute telephone interview with Anthem Insurance Companies, Inc. subject matter expert, November 19, 2015.

<sup>34</sup>Data are from Anthem Insurance Companies, Inc. (May 11, 2016) and represent the period of February 1, 2015 through January 31, 2016.

<sup>35</sup>Anthem Public Policy Institute telephone interview with Anthem Insurance Companies, Inc. subject matter expert, November 19, 2015.

<sup>36</sup>Data are from Anthem Insurance Companies, Inc. (May 11, 2016) and represent the period of February 1, 2015 through April 30, 2016.

<sup>37</sup>Ibid.

<sup>38</sup>Data are from Anthem Insurance Companies, Inc. (February 12, 2016) and represent the period of February 1, 2015 through September 30, 2015. Consumer satisfaction rate of nearly 90 percent is based on recent scores from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

<sup>39</sup>Data are from Anthem Insurance Companies, Inc. (February 12, 2016) and represent the period of February 1, 2015 through September 30, 2015. Data are for members age 45-64 and exclude members enrolled in State Plan Plus and State Plan Basic.

<sup>40</sup>Ibid.

<sup>41</sup>Data are from Anthem Insurance Companies, Inc. (February 12, 2016) and represent the period of February 1, 2015 through September 30, 2015.

<sup>42</sup>Data are from Anthem Insurance Companies, Inc. (February 16, 2016) and represent the period of February 1, 2015 through January 23, 2016.

<sup>43</sup>Ibid.

<sup>44</sup>Ibid.

<sup>45</sup>Ibid.

<sup>46</sup>Data are from Anthem Insurance Companies, Inc. (February 16, 2016) and represent the period of February 1, 2015 through September 30, 2015.

<sup>47</sup>Ibid.

<sup>48</sup>Ibid.

<sup>49</sup>Ibid.

<sup>50</sup>Feedback from Anthem Insurance Companies, Inc. HIP 2.0 member focus groups facilitated by Cabello Associates on behalf of Anthem Insurance Companies, Inc. Nine focus groups were held across the state between November 4 and November 9, 2015.

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- <sup>54</sup>Sutherland, K., Christianson, J., Leatherman, S. (2008, December).
- <sup>55</sup>Kane, R., Johnson, P., Town, R., Butler, M. (2004, November). A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior. *American Journal of Preventive Medicine* 27, no. 4. Retrieved from [http://www.ajpmonline.org/article/S0749-3797\(04\)00178-3/pdf](http://www.ajpmonline.org/article/S0749-3797(04)00178-3/pdf) (accessed December 10, 2015).
- <sup>56</sup>Blumenthal, K., Saulsgiver, K., Norton, L., Troxel, A., Anarella, J., Gesten, F., Chernew, M., Volpp, K. (2013). 503.
- <sup>57</sup>Crawford, M. and Onstott, M. (2014, November). 1.
- <sup>58</sup>Anthem Public Policy Institute telephone interview with Anthem Insurance Companies, Inc. subject matter expert, November 19, 2015.
- <sup>59</sup>Ibid.
- <sup>60</sup>Ibid.
- <sup>61</sup>Feedback from Anthem Insurance Companies, Inc. HIP 2.0 member focus groups facilitated by Cabello Associates on behalf of Anthem Insurance Companies, Inc. Nine focus groups were held across the state between November 4 and November 9, 2015.
- <sup>62</sup>Crawford, M. and Onstott, M. (2014, November). 3.
- <sup>63</sup>Indiana Health Coverage Programs. (2015, December 8). IHCP bulletin, BT201581. Retrieved from <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201581.pdf>, accessed December 9, 2015).
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- <sup>66</sup>Greene, J. (2011, October). Using Consumer Incentives to Increase Well-Child Visits Among Low-Income Children. *Med Care Res Rev* 68, no. 5, 579-593. Retrieved from <http://mcr.sagepub.com/content/68/5/579.abstract> (accessed December 10, 2015).
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- <sup>73</sup>Ibid.
- <sup>74</sup>Ibid.



<sup>75</sup>State of Indiana. (2016, January 27). HIP 2.0 Anniversary Video. Retrieved from <https://www.youtube.com/watch?v=AyFW4fhRKaM&feature=youtu.be> (accessed February 16, 2016).

<sup>76</sup>Program information from Anthem Insurance Companies, Inc. (February 12, 2016).

<sup>77</sup>Data are from Anthem Insurance Companies, Inc. (September 23, 2015) and represent the period of February 1, 2015 through September 1, 2015.

<sup>78</sup>Anthem Public Policy Institute telephone interview with Anthem Insurance Companies, Inc. subject matter expert, December 9, 2015.

<sup>79</sup>Ibid.

<sup>80</sup>Ibid.

<sup>81</sup>Anthem Public Policy Institute telephone interview with Anthem Insurance Companies, Inc. subject matter expert, November 20, 2015.

<sup>82</sup>Ibid.

<sup>83</sup>Feedback from Anthem Insurance Companies, Inc. HIP 2.0 member focus groups facilitated by Cabello Associates on behalf of Anthem Insurance Companies, Inc. Nine focus groups were held across the state between November 4 and November 9, 2015.

<sup>84</sup>Ibid.

<sup>85</sup>Ibid.

<sup>86</sup>Anthem Public Policy Institute telephone interview with Anthem Insurance Companies, Inc. subject matter expert, November 19, 2015.

<sup>87</sup>Feedback from Anthem Insurance Companies, Inc. HIP 2.0 member focus groups facilitated by Cabello Associates on behalf of Anthem Insurance Companies, Inc. Nine focus groups were held across the state between November 4 and November 9, 2015.

<sup>88</sup>Ibid.

<sup>89</sup>Ibid.

<sup>90</sup>Anthem Public Policy Institute telephone interview with Anthem Insurance Companies, Inc. subject matter expert, November 19, 2015.

**About the Anthem Public Policy Institute**

The Anthem Public Policy Institute was established to share data and insights to inform public policy and shape the health care programs of the future. The Public Policy Institute strives to be an objective and credible contributor to health care innovation and transformation through publication of policy-relevant data analysis, timely research, and insights from Anthem's innovative programs.

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