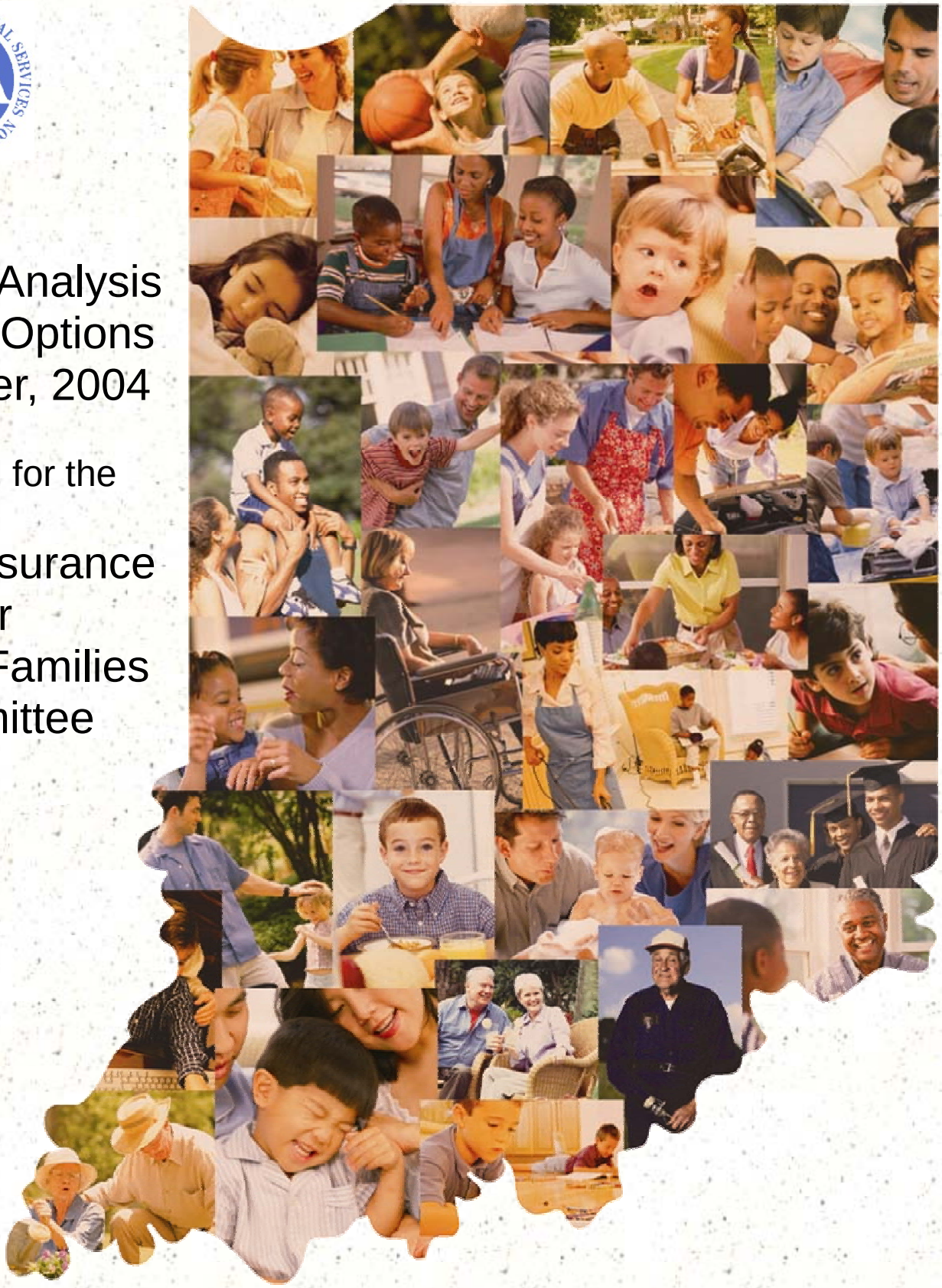
Actuarial Analysis of Policy Options November, 2004

prepared for the

Health Insurance for Indiana Families Committee



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FOREWARD

Hoosiers and people around the United States are paying more for health care than ever before. Increases in health care premiums have left some Hoosiers without insurance, underinsured, or on the verge of losing coverage. Employers face double-digit increases in premiums. Rising health care costs undermine the ability of individuals, businesses, and the state to purchase health care coverage.

There are approximately 45 million uninsured Americans. In Indiana, the percentage of Hoosiers without coverage is lower than the national average. The Family and Social Services Administration (FSSA) telephone survey reached more than 10,000 people and showed an uninsured rate of 9.2%. National studies put Indiana's rate at 12.9%. This means more than 600,000 Indiana citizens do not have health insurance.

The face of the uninsured has changed. It includes mostly working families and larger numbers of the middle class. Being uninsured has a great impact on individuals, families, communities and the economic vitality of the state. People without health insurance often have poorer health status, which affects their ability to work. Lack of health insurance is one of the leading causes of personal bankruptcy. Uninsured patients often delay care ultimately receiving costly emergency room treatment. Safety net hospitals and other institutions created to provide care for the indigent are struggling.

With great concern for these issues, the Indiana Family and Social Services Administration (FSSA) competed for and was awarded a $1.1 million State Planning Grant from the Health Resources and Services Administration (HRSA) in July 2002. The grant provided Indiana the opportunity to study its uninsured population and develop viable policy options for providing access to affordable coverage.

The Indiana State Planning Grant work was guided by the Heath Insurance for Indiana Families committee, a bi-partisan group that included public and private officials, representatives from small and large businesses, insurers, physicians, hospitals, the Indiana University School of Medicine, safety net providers, and advocates that developed options to address the needs of uninsured Hoosiers.

State Planning Grant funds were used to support data collection to aid committee members in their deliberations. The data collected was unparalleled in its scope and depth in providing information on the uninsured and the Indiana health care system.

The following reports were received by the committee. The contents are not endorsed or recommended by the committee.

I. 10,000 Person Household Survey

Over 10,000 Indiana residents were surveyed between February and April 2003 to understand key characteristics of the uninsured. The survey identified who the uninsured

are, where they live, where they receive care, their age, race, employment and health status.

II. Focus Groups of Businesses, Uninsured, Brokers, and Providers

The purpose of the focus groups was to gain insight from those affected by this issue and to understand the local dynamics of how people access care or experience barriers. Forty-seven focus groups were conducted throughout the state with more than 350 individuals. The stakeholder groups included uninsured and underinsured individuals, physicians, hospital administrators, businesses, insurance brokers, and community group. They were asked about cost, the consequences of no coverage, what should be in a basic plan, and their experience with government health programs.

III. Assessment of Indiana Health Funding

This report attempts to catalogue the major funding sources, eligibility requirements, and restrictions on funding. It also examines Indiana's current financing mechanisms and outlines additional opportunities for leveraging federal dollars. The report lays out issues that must be considered in determining whether the options presented are feasible.

IV. Safety Net Assessment

This report is intended to broadly identify and assess the major providers of safety net services in Indiana. It reviews the availability of primary, specialty, mental health, hospital and dental health care services and their financing. The information in the report was derived, in part, from the results of a survey of the Indiana Step Ahead Councils, as well as from interviews with the Indiana Primary Health Care Association (IPHCA), the Rural Health Association, and others. The report also discusses the Indiana Medicaid program and its significance to safety net providers.

V. Assessment of National & State Efforts to Address the Uninsured

This report focuses on the variety of options most commonly used by other states to expand health coverage. The report examines public program expansions, health insurance market reforms and initiatives, tax-based reforms, community-based programs, and strengthening the safety net.

VI. Indiana Market Assessment and Drivers of Health Care Costs

This report examines Indiana's demographic and economic changes that have affected the affordability and structure of private health insurance. The report provides an overview of Indiana's health care sector, the economic impact of cost reduction, Indiana's health insurance market, employer coverage, and cost drivers.

VII. Indiana Market Assessment & Drivers of Health Care Costs

A. Indiana's Health Care Sector and Insurance Market: Summary Report

This report examines Indiana's demographic and economic changes that have affected the affordability and structure of private health insurance. The report provides an overview of Indiana's health care market place including its impact on the overall economy. The report compares Indiana to neighboring states and identifies cost drivers.

B. Indiana's Health Care Sector and Economy Report

Understanding the impacts of rising health care costs on the economy is important, but it can be difficult to measure. In this report, health care services are considered as a source of employment. Finally, this report includes two analyses: a simulation of the impacts of rising health care costs in Indiana, and estimation of the possible impact of greater insurance coverage on hospital uncompensated care.

C. Indiana's Health Insurance Market

This report reviews the literature on state regulation of the small group and individual health insurance markets and describes three types of small-group insurance regulation.

D. Employer Sponsored Coverage in Indiana

This report reviews coverage rates overall (including both private- and public-sector workers and their families), as well as rates of employer offer, eligibility and take up. This report considers aspects of employer-based coverage that have cost implications.

E. Factors That Drive Health Care Costs in Indiana

This report examines trends in health care spending in Indiana for various types of services, changes in service utilization and price data. Several factors that may drive cost increases are considered, including changes in demographics, health insurance, service supply, and population health status.

VIII. Actuarial Analysis of Policy Options

This analysis estimates the number of people eligible and enrolling in the program at various income eligibility levels up to 250 percent of the Federal Poverty Level (FPL). The report also estimates the cost of coverage under three alternative benefits packages. The actuarial analysis of alternative benefits packages addresses the selected expansions in eligibility, program costs under alternative benefits packages, minimizing crowd-out, the impact of premium contribution requirements, and buy-in.

ACKNOWLEDGMENTS

The final report of the Health Insurance for Indiana Families represents the work of many individuals who donated their time, expertise, and energy to oversee the data collection efforts and to develop policy recommendations. The committee and subcommittees met monthly for more than two years and their efforts are sincerely appreciated. Additionally, we would like to thank members of the FSSA Technical Assistance Group which included Kathy Moses, Kari Kritenbrink, Joe Shelton, Judy Tonk and Michelle Geller.

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The HIIF Reports and Recommendations Are Online At :

http://www.in.gov/fssa/programs/chip/insurance/index.html

Actuarial and Economic Analysis of Options to Expand Health Insurance Coverage in Indiana

Final Report

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The Indiana State Planning Grant

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August 30, 2004

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I. OPTIONS TO EXPAND HEALTH INSURANCE COVERAGE IN INDIANA

In this report, we present estimates of the cost and coverage impacts of implementing several alternative programs to expand insurance coverage in Indiana. We begin with actuarial analyses of the cost of alternative benefits packages to be offered in these programs. We then present estimates of enrollment and costs under selected expansions in eligibility under Medicaid and the State Children's Health Insurance Program (SCHIP) of Indiana. In this analysis, we have estimated the number of people eligible and enrolling in the program at various income eligibility levels up to 250 percent of the Federal Poverty Level (FPL).

In addition, we present estimates of the cost of implementing several innovative programs to expand insurance coverage in the state. These include a Medicaid Buy-in and premium assistance for low-income people to purchase private insurance. Our analysis are presented in the following sections:

- Actuarial analysis of alternative benefits packages;
- Eligibility under the Current Medicaid and SCHIP programs;
- Medicaid Buy-in Model;
- Creation of a low-cost private insurance product;
- Premium assistance; and
- Reinsurance and expanding coverage.

A. Actuarial Analysis of Alternative Benefits Packages

We estimated per-member per-month (PMPM) benefit costs for several different plan design options summarized in ***Figure 1***. We then estimated premiums under several variations on an "essential benefits package" designed to provide low-cost coverage to eligible low-income people in Indiana.

1. Initial Benefits Packages

The first option is based on the benefit package for Indiana's Medicaid program (Hoosier Healthwise Package A). The second is based on the benefit package for Indiana's SCHIP program (Hoosier Healthwise Package C). Additional information on coverage for both plans can be found on the web site for the Family & Social Services Administration (FSSA).

For the third plan design option, we started with the SCHIP benefit package and then scaled it back so that it covered only essential services. The definition of "essential" can vary considerably, but we had some guidance from the notes on the plan design discussions that the Health Insurance for Indiana Families (HIIF) Committee had already held. For example, the HIIF notes state that the low-cost option should have very limited hospital coverage and no maternity care (since pregnant women through 200 percent of the FPL are already eligible for Medicaid). They also recommend limited coverage for specialist care and prescription drugs, reflecting that these services are already available to some through the Health Indiana program (i.e., a private organization providing free care).

We decided upon a limit of 5 inpatient days and 5 specialist visits per year, although these can be modified later if the Committee so desires. To reduce the cost further, we took out coverage for mental health and substance abuse services and for chiropractic care. For the remaining covered services, the co-payment requirements are the same as for the SCHIP package.

Figure 1
Health Insurance for Indiana Families: Plan Design Options

Type of Service	Medicaid Benefit Package			CHIP Benefit Package			Limited To Essential Services		
	Covered?	Benefit Limit *	Co-payment	Covered?	Benefit Limit *	Co-payment	Covered?	Benefit Limit *	Co-payment
Hospital Care									
Inpatient	Yes	(see 405 IAC 5)	No	Yes	(see 405 IAC 5)	No	Yes	5 days	No
Outpatient	Yes	(see 405 IAC 5)	$1-$2 for ER visits that do not require hospitalization	Yes	(see 405 IAC 5)	$20 for ER visits that do not require hospitalization	Yes	(see 405 IAC 5)	$20 for ER visits that do not require hospitalization
Physician Office Visits									
Primary Care									
Well-child visits	Yes	No	No	Yes	No	No	Yes	No	No
Adult phys. exams	Yes	No	No	Yes	No	No	Yes	No	No
Other	Yes	30 / year	No	Yes	30 / year	No	Yes	30 / year	No
Specialty Care	Yes	(see 405 IAC 5)	No	Yes	(see 405 IAC 5)	No	Yes	5 visits	No
Clinic Services	Yes	No	No	Yes	No	No	Yes	No	No
Drugs									
Prescription	Yes	(see 405 IAC 5)	$0.50 - $3.00	Yes	(see 405 IAC 5)	$3 generic; $10 brand	No	N/A	N/A
OTC	Yes	(see 405 IAC 5)	$0.50 - $3.00	No (except for insulin)	N/A	N/A	No	N/A	N/A
Lab & X-ray	Yes	No	No	Yes	No	No	Yes	No	No
Mental Health Care	Yes	IP: re-cert. every 60 days; OP: 4/mo. or 20/year	No	Yes	IP: additional limits; OP: 30 per 12 mos.	No	No	N/A	N/A
Substance Abuse	Yes	(see MH)	No	Yes	(see MH)	No	No	N/A	N/A

Figure 1 (Continued)
Health Insurance for Indiana Families: Plan Design Options

Type of Service	Medicaid Benefit Package			CHIP Benefit Package			Limited To Essential Services		
	Covered?	Benefit Limit *	Co-payment	Covered?	Benefit Limit *	Co-payment	Covered?	Benefit Limit *	Co-payment
Medical Supplies and Equipment	Yes	(see 405 IAC 5)	No	Yes	$2,000 (lifetime: $5,000)	No	Yes	$2,000 (lifetime: $5,000)	No
Home Health Care	Yes	(see 405 IAC 5)	No	Yes	(see 405 IAC 5)	No	Yes	(see 405 IAC 5)	No
Therapies	Yes	(see 405 IAC 5)	No	Yes	IP rehab: 50 days; OP: 50 visits per therapy type	No	Yes	IP rehab: 50 days; OP: 50 visits per therapy type	No
Hospice Care	Yes	2 x 90 days (+ 60 day reserve)	No	Yes	2 x 90 days (+ 60 day reserve)	No	Yes	2 x 90 days (+ 60 day reserve)	No
Transportation	Yes	Non-emerg.: 20 one-way trips, up to 50 miles each	$0.50 - $2.00	Yes, for emerg. and between facilities	(non-emerg. only when req.'d by physician)	$10	Yes, for emerg. and between facilities	(non-emerg. only when req.'d by physician)	$10
Family Planning	Yes	(see 405 IAC 5)	No	Yes	(see 405 IAC 5)	No	Yes	(see 405 IAC 5)	No
Nurse Practitioners	Yes	No	No	Yes	No	No	Yes	No	No
Maternity Care (physician, hospital, and/or nurse midwife)	Yes	No	No	Yes	No	No	No	N/A	N/A

Figure 1 (Continued)
Health Insurance for Indiana Families: Plan Design Options

Type of Service	Medicaid Benefit Package			CHIP Benefit Package			Limited To Essential Services		
	Covered?	Benefit Limit *	Co-payment	Covered?	Benefit Limit *	Co-payment	Covered?	Benefit Limit *	Co-payment
Foot Care									
Physician, Lab & X-ray, and Hospital	Yes	No	No	Yes	No	No	Yes	No	No
Podiatrist	Yes	Routine: 6 visits / year	No	No	N/A	N/A	No	N/A	N/A
Chiropractor	Yes	5 visits; 50 treatments	No	Yes	5 visits; 14 treatments	No	No	N/A	N/A

* Per member per year. Additional requirements and limits can be found in the Covered Services and Limitations Rule (405 IAC 5).

NOTE: The following services are included in the Medicaid and CHIP benefit packages but are excluded from our cost estimates: nursing facilities, dental care, and vision care.

2. *Premium Estimates*

To develop the benefit cost estimates, we first looked for information on the actual per-member costs of the Medicaid and children's health insurance programs in Indiana. Much of this information is available in the report entitled *Indiana's Children's Health Insurance Program Annual Evaluation Report*, dated April 1, 2004 and prepared by EP&P Consulting, Inc. The report and other information concerning Indiana's Medicaid and SCHIP programs can be found on the FSSA web site.

We then produced estimates of the per-member costs that would be associated with the Medicaid and SCHIP benefit packages, using our health insurance pricing software (***Figure 2***). The purpose of this was not to determine the absolute dollar amount of the expected benefit costs, but to find the relative value of the CHIP and Medicaid packages. This helped us determine how much of the difference in actual per-member costs for the Medicaid and SCHIP programs was attributable to differences in benefit design vs. differences in the age distribution or other characteristics of the covered populations.

For example, our software predicted that the cost for the CHIP benefit package would be about 98.5 percent of the cost for the Medicaid package, yet the actual ratio was about 74.4 percent. All but six percentage points of this 24-point discrepancy turned out to be attributable to the difference in the age distributions of the persons covered by the two programs. This difference is not explained by differences in provider payment levels since payment levels under SCHIP are the same as under Medicaid.

Figure 2
Health Insurance for Indiana Families PMPM Benefit Costs
(For July 1, 2004 - June 30, 2005)

	Plan Design		
Age of Member	**Medicaid Benefit Package**	**CHIP Benefit Package**	**Limited To Essential Services**
< 1 year	$310.50	$296.63	$133.51
1-2	134.45	128.45	57.81
2-4	72.36	69.13	31.11
5-9	67.18	64.18	28.89
10-14	71.11	67.94	30.58
15-18	99.54	95.10	42.80
19-24	147.18	140.61	63.29
25-34	168.23	160.72	72.34
35-44	206.43	197.22	88.77
45-54	304.62	291.02	130.99
55-64	468.21	447.31	201.33
Weighted Average	$220.20	$210.36	$94.68

Source: Lewin Group Estimates based upon program data.

To allow for additional population differences that wouldn't be captured by the age distribution, we assumed that half of the remaining discrepancy was attributable to these differences, so that the actual value of the SCHIP package was estimated to be 95.5 percent of the value of the Medicaid package. We used the relative cost factors by age found in our pricing software to develop one set of age-related rates for the Medicaid package and another set for the SCHIP package.

The PMPM cost for the third benefit option was developed as follows. First, we compared the distribution of costs by category of service for Indiana's Medicaid and children's health insurance programs to the cost distribution found in our pricing software. We adjusted the latter distribution to match the Indiana data. Then we reduced or eliminated the expected costs for categories that were being strictly limited in, or eliminated from, the essential benefit package.

For example, the cost of mental health, substance abuse, and maternity services were excluded altogether, and the expected cost for inpatient hospital services and for physician services both were reduced by about 60 percent to reflect the strict limitations placed on those categories of service. Once we had an overall PMPM cost estimate, we again applied the relative cost factors from our pricing software to develop a full set of age-related rates for this program.

Figure 3 presents estimates of premiums by sources of funding under nine program alternatives identified in the Indiana SPG process. These include average premium amounts PMPM and the shares paid by alternative sources including employers, employees, the federal government, local government entities, and the state.

Figure 3
Premium for Selected Policy Option

Option	State Match Amount Source	Federal Match	Employer	Employee	Local Entity	Total Funding Available	Premium Cost	State Admini-strative Costs
Option 1	$24-$51 Medicaid MCO Tax Hospital User Fee	$38-$81	$24-$51	$24-$51	0	$109-$234	$95-$220	$14
Option 2: Premium Assistance	$16-$35 Medicaid MCO Tax Hospital User Fee I	$25-$56	$40-$90	$20-$45	0	$101-$226	$95-$220	$6
Option 3: Local Contribution	$20-$42 Medicaid MC Tax Hospital User Fee	$29-$68	$20-$42	$20-$42	$20-$42	$109-$234	$95-$220	$14
Option 4: Local Based Program	Local IGT	$68-$146	0	0	$41-$88	$109-$234	$95-$220	$14
Option 5: All Match Program	$41-$88 employer/ employee MCO or local	$68-$146	$14-$30 toward State Match	$14-$30 toward State Match	$14-$30 toward State Match	$109-$234	$95-$220	$14
Option 6: Tobacco Tax	$41-$88 Tobacco Tax	$68-$146	0	0	0	$109-$235	$95-$220	$14
Option 7: Hasler Wrap Around	$41-$88 Local dollars FQHC Tobacco dollars	$68-$146	0	0		$109-$234	$95-$220	$14
Option 8: Essential Service	N/A Not a State Program	N/A	Determined by Employer	Determine d by Employer	0	$95	$95	N/A
Option 9: Reinsurance								

Source: Lewin Group Estimates.

3. *Variations on the Essential Benefits Package*

We then developed estimates of the premium under five variations on the essential benefits package. These estimates show how the premium varies as we introduce selected changes in benefits covered. These include the following:

- Limits on inpatient days covered;
- Limits on the number of specialty care visits;
- Generic-only coverage of prescription drugs (unless no generic equivalent is available); and
- Mental health and substance abuse coverage.

Average monthly premiums for these plans, as well as brief indications of their major benefit provisions, are presented in **Figure 4a**. Average monthly premiums vary from $68.26 PMPM to $133.21 PMPM. Premiums by age for each plan design are presented in ***Figure 4b***.

Figure 4a
Variations on Essential Benefits Package

	Selected Coverage Alternatives				
	Inpatient Hospital	**Specialty Care**	**Prescription Drugs**	**Mental Health/ Substance Abuse**	**PMPM Cost**
Essential Benefits Package A	5 day limit	5 visit limit	None	None	$94.68
Essential Benefits Package B	None	10 visit limit	None	None	$68.26
Essential Benefits Package C	5 day limit	5 visit limit	Generic only	None	$126.61
Essential Benefits Package D	5 day limit	5 visit limit	Generic only	Covered	$133.21
Essential Benefits Package E	None	10 visit limit	Generic only	None	$97.99

Source: Lewin Group Estimates.

Figure 4b
Variations on Essential Benefits Package:
Age-Specific PMPM Costs for July 1, 2004 –June 30, 2005

	Plan Design				
Age of Member	Essential Benefits Package A	Essential Benefits Package B	Essential Benefits Package C	Essential Benefits Package D	Essential Benefits Package E
< 1 year	$133.51	$96.25	$178.54	$187.85	$138.18
1	$57.81	$41.68	$77.31	$81.34	$59.84
2-4	$31.11	$22.43	$41.60	$43.78	$32.20
5-9	$28.89	$20.82	$38.63	$40.64	$29.90
10-14	$30.58	$22.05	$40.89	$43.02	$31.65
15-18	$42.80	$30.86	$57.24	$60.22	$44.30
19-24	$63.29	$45.63	$84.63	$89.05	$65.50
25-34	$72.34	$52.15	$96.73	$101.78	$74.87
35-44	$88.77	$63.99	$118.70	$124.89	$91.87
45-54	$130.99	$94.43	$175.16	$184.30	$135.57
55-64	$201.33	$145.15	$269.22	$283.27	$208.37
Weighted Average	$94.68	$68.26	$126.61	$133.21	$97.99

Source: Lewin Group Estimates.

After presenting these results to the HIIF Committee, we were asked to develop cost estimates for some additional plan designs that the committee had discussed prior to the start the project. These plan designs, along with average PMPM costs that we developed for each one, are presented below in ***Figure 5***. Note that the costs were developed under several different fee schedules:

a. The current Indiana Medicaid fee schedule, with provider payment rates that are (on average) 78% of the corresponding Medicare payment rates.

b. Provider payment rates that are 110% of the Medicare payment rates, across the board.

c. Medicaid payment rates for hospitals, and payment rates for physicians and other providers and suppliers that are 110% of the corresponding Medicare payment rates.

d. Medicaid payment rates for hospitals, and payment rates for physicians and other providers and suppliers that are 115% of the corresponding Medicare payment rates.

Figure 5
Additional Benefit Packages

	"Enhanced" Essential Benefits	Managed Care with Coinsurance	Managed Care with Copayments
Preventive Care	*cost sharing:* $20	*cost sharing:* $20	*cost sharing:* $20
Other Physician Services	*cost sharing:* 30%	*cost sharing:* 30%	*cost sharing:* $35
DME and Corrective Appliances	*cost sharing:* 50% *annual max:* $1,500	*cost sharing:* 50% *annual max:* $1,500	*cost sharing:* 50% *annual max:* $1,500
Diabetic Supplies	*cost sharing:* 50%	*cost sharing:* 50%	*cost sharing:* 50%
Therapies	*cost sharing:* 20%	*cost sharing:* 20%	*cost sharing:* $30 per visit
SNF	*cost sharing:* 30%	*cost sharing:* 30%	*cost sharing:* $500 per admission
Home Health	*cost sharing:* 30%	*cost sharing:* 30%	*cost sharing:* $10 per visit
Hospice	*cost sharing:* 30%	*cost sharing:* 30%	covered in full
Mandates	not covered		
PDD		*cost sharing:* 50%	*cost sharing:* 50%
Biotech Drugs		*cost sharing:* 50%	*cost sharing:* 50%
Morbid Obesity		*cost sharing:* 50%	optional rider
Inpatient Services	*cost sharing:* 30%	*cost sharing:* 30%	*cost sharing:* $500 per admission
Outpatient Services			
Surgical Procedures	*cost sharing:* 20%	*cost sharing:* 20%	*cost sharing:* $250 per procedure
Lab & X-ray	*cost sharing:* 20%	*cost sharing:* 20%	*cost sharing:* 20%
ER / UC	*cost sharing:* 50% / 20%	*cost sharing:* 50% / 20%	*cost sharing:* $125 / $50
Maternity	*cost sharing:* 30%	*cost sharing:* $500	*cost sharing:* $500
MH / SA	not covered	limited to acute intervention; *cost sharing:* 30%	optional rider
Prescription Drugs	*cost sharing:* $10 for generic 50% for brand	*cost sharing:* $10 for generic $40 for brand 50% for non-formulary OR $10 for generic 50% for brand	*cost sharing:* $10 for generic $40 for brand 50% for non-formulary (not subject to deductible)

Figure 5 (Continued)
Additional Benefit Packages

	"Enhanced" Essential Benefits	Managed Care with Coinsurance	Managed Care with Copayments
ANNUAL DEDUCTIBLE (per person / per family)	$1,000 / $2,000	$1,000 / $2,000	$500 / $1,500
COINSURANCE LIMIT (per person / per family)	$3,000 / $6,000	$3,000 / $6,000	(not applicable)
LIFETIME MAXIMUM	$500,000	$500,000	$500,000
PMPM Cost (weighted avg.)			
Provider payment rates:			
Medicaid rates (78%)	$109.43	$118.90	$123.31
110% of Medicare rates	$154.33	$167.68	$173.89
Mdcd. (hosp.) & 110%	$132.11	$144.00	$149.51
Mdcd. (hosp.) & 115%	$135.64	$147.97	$153.47

B. Eligibility Under Current Medicaid and CHIP Programs

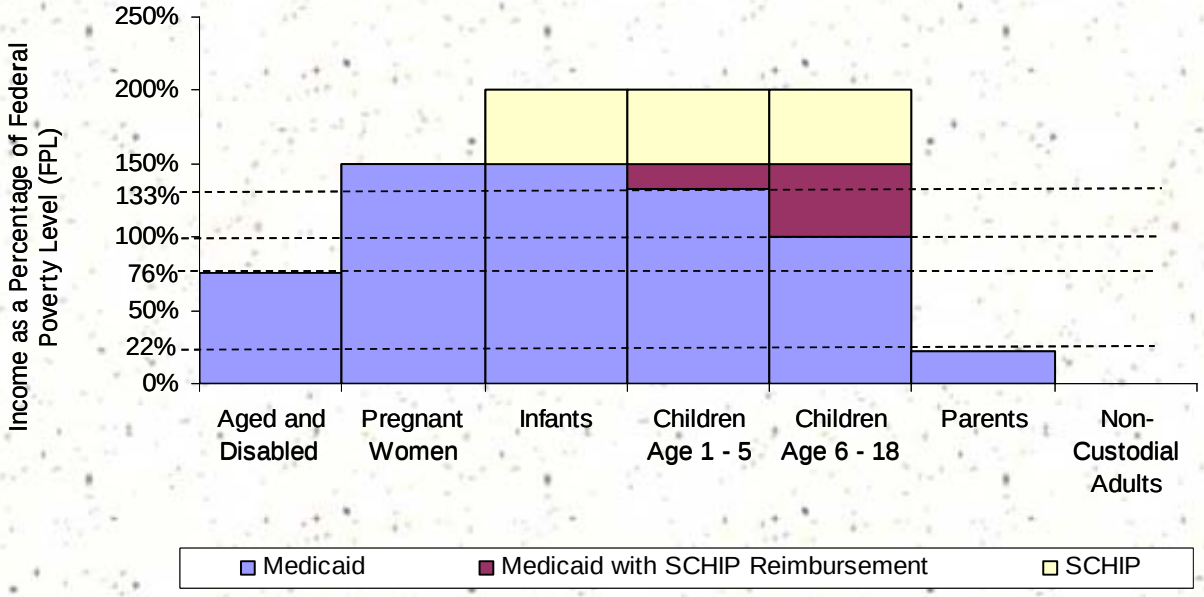
Figure 6 summarizes eligibility in the Indiana Medicaid and CHIP programs. Under the current Indiana Medicaid program, aged and disabled people are eligible for coverage if their income is less than 76 percent of the federal poverty level (FPL) for single people and 92 percent of the FPL for married couples. The program also covers pregnant women and infants to 150 percent of the FPL. Medicaid also covers children under the age of 6 with incomes below 133 percent of the FPL and children age 6 through 18 with incomes below 100 percent of the FPL.

The Indiana CHIP program covers children in families with incomes between the Medicaid income eligibility limit and 200 percent of the FPL. However, SCHIP eligible children with incomes below 150 percent of the FPL are covered through Medicaid under the Medicaid benefits package. However, costs for these children are matched by the federal government at the enhanced match rate for SCHIP. SCHIP eligible children between 150 percent and 200 percent of the FPL are covered under a separate program with its own benefits package

Adults with custodial responsibility for children (usually parents) are also eligible for Medicaid, but only for families with incomes below 22 percent of the FPL. Non-disabled and non-aged adults who do not have custodial responsibilities for children, known as "non-custodial adults,"

are not eligible for the program at any income level except when a waiver is obtained from CMS.[1]

Figure 6
Medicaid and SCHIP Coverage in Indiana Under Current Law
C. Selected Medicaid Expansions Without Premium Requirement



We estimated the impact of expansions in Medicaid/SCHIP coverage for the following eligibility groups:

- Children between 200 percent and 250 percent of the FPL;
- Parents
  - 22 percent to 100 percent of the FPL
  - 100 percent to 150 percent of the FPL
  - 150 percent to 200 percent of the FPL
  - 200 Percent to 250 percent of the FPL
- Non-custodial adults
  - Below 22 percent of the FPL
  - 22 percent to 100 percent of the FPL
  - 100 percent to 150 percent of the FPL
  - 150 percent to 200 percent of the FPL

[1] States may request a waiver to cover non-custodial adults as long as changes are made elsewhere in the program that save enough funds to pay for the expanded coverage so that the waiver is budget neutral to the federal government. There are about six states that have obtained budget neutral Medicaid waivers to cover non-custodial adults, most of whom achieved savings through expanded use of managed care.

- 200 Percent to 250 percent of the FPL

We have made several assumptions in developing these estimates including:

- **Waiting Period Rule:** We assume that people are required to be uninsured for at least six months prior to enrollment as a means of discouraging people from dropping their employer sponsored coverage to obtain subsidized coverage under the Medicaid expansion (i.e., crowd-out). The waiting period rule is waived for people who become unemployed or change jobs;

- **Premium Contribution Requirement:** We also assume that there would be no premium contribution requirement under this scenario;

- **Benefits Package:** We assume that all enrollees would be covered under the Medicaid benefits package described above;

- **Buy-in to Employer Coverage:** We assume in this scenario that the program does not adopt a policy of buying eligible workers into employer health plans when available; and

- **Federal Matching Funds:** We assume that the standard federal matching percentage (FMAP) for Indiana (63.23 Percent) would be used for children and parents only. We assume that there would be no FMAP for non-custodial adults.

Latter in this analysis, we simulate the impact of adopting variations on these assumptions. Our methods and estimates are presented below.

1. *Estimation Methods*

We developed these estimates using the Lewin Group Medicaid Eligibility Simulation Model MEDSim. The model is based upon the Indiana sub-sample of the Current Population Survey (CPS) data for 2002 and 2003, which include a much expanded sample size in these years. We adjusted these data to match the estimates of the number of uninsured reported in the 2003 survey of Health Insurance for Indiana's families conducted under the HRSA SPG.[2] The data for these two years was pooled to form a larger sample of the population.

MEDSim estimates the number of people who are eligible for and enrolled in the current Indiana Medicaid/SCHIP programs based upon the income and family relationship data (e.g., TANF families, children etc.) for families and individuals included in the CPS. We use the actual income eligibility levels for various eligibility groups by family size in Indiana to identify people who are eligible for and enrolled in the current Medicaid/SCHIP programs. MEDSim uses a month-by-month simulation methodology which is designed to account for part-year eligibility.

[2] A key step in reconciling the CPS data with the Indiana survey was to correct for the under-reporting of Medicaid coverage in the CPS.

We then estimate the number of people who would be eligible for the program under the eligibility expansions listed above using the CPS. We also estimate the number of newly eligible people who would enroll based upon multivariate studies of enrollment patterns in the existing Medicaid program. These analyses show how enrollment in the program varies by age, income, employment status, coverage under employer plans (i.e., crowd-out), premium contribution requirements and several other demographic variables.

We made the following assumptions in estimating participation in the program:

- Our multivariate model of Medicaid participation typically predicts an average participation rate of about 70 percent for uninsured people and about 45 percent for people who currently have insurance from some other source. Participation declines at higher income levels.

- We assumed that children currently eligible for Medicaid or SCHIP (SCHIP covers children through 200 percent of the FPL) who are not enrolled would become covered under the program if one of their parents becomes covered under the expansion. We assume no change in coverage for other eligible people who are not enrolled.

As discussed above, the participation estimates assume that there are no premium requirements. Our participation model indicates that premium contribution requirements typically reduce enrollment by about 37 percent when a premium is required.

2. *Eligibility and Enrollment Estimates*

Figure 7 presents our estimates of the number of people who would be eligible for these eligibility expansions and the number of eligible people who would enroll. Estimates are provided separately for children, parents and non-custodial adults (i.e., adults without custodial responsibilities for children). For each of these three groups, we present enrollment and cost estimates at various income eligibility levels.

We estimate that if eligibility were expanded to 250 percent of the FPL for all children and adults, about 852,000 people would become eligible of whom about 531,000 would enroll. The number of uninsured would be reduced by about 407,000 people. Program costs under the Medicaid benefits package would be about $1.4 billion. A federal match is available for the coverage expansions for children and parents. Total costs for this group would be $337 million of which $127 million would be paid by the state.

Federal matching funds would not be available for the non-custodial adults unless a waiver can be obtained. Without a waiver, state costs for this group would be about $1.1 billion. If a federal match can be obtained for this population, the state share of the cost for non-custodial adults would be about $401 million. However, this would require a budget neutral Medicaid Waiver which seems unlikely at this time.

These estimates show an increase in the number of children living below 200 percent of the FPL, even though children are already eligible to 200 percent of the FPL under the current SCHIP program. These are eligible but not enrolled children who would become newly enrolled when one or both of their parents become covered under the expansions for adults.

As shown in ***Figure 7***, the reduction in the number of uninsured is typically less than the number of people enrolling. The difference is the number of people who have shifted from some other form of coverage (i.e., non-group, employer etc.) to the Medicaid/SCHIP program. This will occur despite the waiting requirement primarily due to exceptions permitted for people who lose jobs or change employment during the course of the year.

3. *Program Costs Under Alternative Benefits Packages*

The estimates presented above in ***Figure 7*** assume that enrollees would be covered under the Medicaid benefits package. Costs could be reduced by covering people under less comprehensive benefits packages. For example, as discussed above, we estimate that the total cost of covering all people to 250 percent of the FPL under the Medicaid benefits package would be about $1.4 billion (state and federal shares).

As shown in ***Figure 8***, the total cost of covering this same population under the SCHIP benefits package would be about $1.3 billion. This estimate reflects the fact that the SCHIP benefits package is similar to the Medicaid benefits package except to the extent that small amounts of cost-sharing are required under the SCHIP package.

Costs for this population under the "Essential Services" package would be about $600 million, which is less than half of what costs would be under the Medicaid and SCHIP benefits packages (***Figure 9***).

4. *Minimizing Crowd-Out*

A key specification of the options analyzed above is the requirement that people must have been without insurance for six months to be eligible for the program. The purpose of this provision is to make it impractical for an individual to discontinue their coverage to enroll in the program by requiring them to go without coverage for six months before they can enroll. This is also designed to create a deterrent for employers to discontinue their plans as well. The Indiana SCHIP program currently employs a three-month waiting period.

Figure 7
Estimated Enrollment and Costs Under Selected Medicaid/SCHIP Expansions: With Anti-Crowd-Out Rule and Medicaid Benefits Package [a/]

	Number of Eligible People	Number of People Enrolled	Reduction in Uninsured	Total Costs ($1,000s)	State Costs ($1,000s)	Federal Costs ($1,000s)
Below 22 Percent of FPL						
Children	n/a	n/a	n/a	n/a	n/a	n/a
Parents	n/a	n/a	n/a	n/a	n/a	n/a
Non-Custodial Adults	207,106	135,252	110,019	$335,888	$335,888	--
Total	**207,106**	**135,252**	**110,019**	**$335,888**	**$335,888**	**--**
22-100 Percent of FPL						
Children	12,663	12,663	12,663	$14,070	$5,302	$8,768
Parents	80,485	49,712	37,016	$130,067	$49,009	$81,058
Non-Custodial Adults	132,866	78,302	61,169	$236,430	$236,430	--
Total	**226,014**	**140,677**	**110,848**	**$380,567**	**$290,741**	**$89,826**
100-150 Percent of FPL						
Children	13,085	13,085	13,084	$12,487	$4,705	$7,782
Parents	51,830	24,649	21,598	$56,059	$21,123	$34,936
Non-Custodial Adults	75,861	53,040	42,883	$168,961	$168,961	--
Total	**140,776**	**90,774**	**77,565**	**$237,506**	**$194,788**	**$42,718**
150-200 Percent of FPL						
Children	6,106	6,106	6,106	$6,099	$2,298	$3,801
Parents	50,673	24,806	17,808	$65,461	$24,666	$40,795
Non-Custodial Adults	92,608	59,236	45,942	$179,721	$179,721	--
Total	**149,387**	**90,148**	**69,856**	**$251,281**	**$206,685**	**$44,596**
200-250 Percent of FPL						
Children	36,207	17,418	8,314	$18,364	$6,920	$11,444
Parents	26,005	11,710	5,582	$34,110	$12,853	$21,257
Non-Custodial Adults	66,147	44,829	25,279	$144,817	$144,817	--
Total	**128,359**	**73,957**	**39,175**	**$197,291**	**$164,590**	**$32,701**
All Below 250 Percent of FPL						
Children	68,061	49,272	40,167	$51,019	$19,224	$31,795
Parents	208,993	110,877	82,004	$285,697	$107,650	$178,046
Non-Custodial Adults	574,588	370,659	285,292	$1,065,817	$1,065,817	--
Total	**851,642**	**530,808**	**407,463**	**$1,402,533**	**$1,192,692**	**$209,841**

a/ Assumes no premium contribution requirement. Assumes FMAP of 62.32 percent for children and parents only.
Source: Lewin Group estimates using the Medicaid Eligibility Simulation Model (MEDSim).

Figure 8
Estimated Enrollment and Costs Under Selected Medicaid/SCHIP Expansions: With Anti-Crowd-Out Rule and SCHIP Benefits Package [a/]

	Number of Eligible People	Number of People Enrolled	Reduction in Uninsured	Total Costs ($1,000s)	State Costs ($1,000s)	Federal Costs ($1,000s)
Below 22 Percent of FPL						
Children	n/a	n/a	n/a	n/a	n/a	n/a
Parents	n/a	n/a	n/a	n/a	n/a	n/a
Non-Custodial Adults	207,106	135,252	110,019	$320,891	$320,891	--
Total	**207,106**	**135,252**	**110,019**	**$320,891**	**$320,891**	**--**
22-100 Percent of FPL						
Children	12,663	12,663	12,663	$13,442	$5,065	$8,377
Parents	80,485	49,712	37,016	$124,259	$46,821	$77,438
Non-Custodial Adults	132,866	78,302	61,169	$225,874	$225,874	--
Total	**226,014**	**140,677**	**110,848**	**$363,575**	**$277,760**	**$85,815**
100-150 Percent of FPL						
Children	13,085	13,085	13,084	$11,929	$4,495	$7,434
Parents	51,830	24,649	21,598	$53,556	$20,180	$33,376
Non-Custodial Adults	75,861	53,040	42,883	$161,417	$161,417	--
Total	**140,776**	**90,774**	**77,565**	**$226,902**	**$186,092**	**$40,810**
150-200 Percent of FPL						
Children	6,106	6,106	6,106	$5,826	$2,195	$3,631
Parents	50,673	24,806	17,808	$62,538	$23,564	$38,974
Non-Custodial Adults	92,608	59,236	45,942	$171,697	$171,697	--
Total	**149,387**	**90,148**	**69,856**	**$240,061**	**$197,456**	**$42,605**
200-250 Percent of FPL						
Children	36,207	17,418	8,314	$17,544	$6,611	$10,933
Parents	26,005	11,710	5,582	$32,587	$12,279	$20,308
Non-Custodial Adults	66,147	44,829	25,279	$138,351	$138,351	--
Total	**128,359**	**73,957**	**39,175**	**$188,482**	**$157,241**	**$31,241**
All Below 250 Percent of FPL						
Children	68,061	49,272	40,167	$48,741	$18,366	$30,376
Parents	208,993	110,877	82,004	$272,940	$102,844	$170,096
Non-Custodial Adults	574,588	370,659	285,292	$1,018,229	$1,018,229	--
Total	**851,642**	**530,808**	**407,463**	**$1,339,911**	**$1,139,439**	**$200,472**

a/ Assumes no premium contribution requirement. Assumes FMAP of 62.32 percent for children and parents only.

Source: Lewin Group estimates using the Medicaid Eligibility Simulation Model (MEDSim).

Figure 9
Estimated Enrollment and Costs Under Selected Medicaid/SCHIP Expansions: With Anti-Crowd-Out Rule and Limited Essential Services [a/]

	Number of Eligible People	Number of People Enrolled	Reduction in Uninsured	Total Costs ($1,000s)	State Costs ($1,000s)	Federal Costs ($1,000s)
Below 22 Percent of FPL						
Children	n/a	n/a	n/a	n/a	n/a	n/a
Parents	n/a	n/a	n/a	n/a	n/a	n/a
Non-Custodial Adults	207,106	135,252	110,019	$144,432	$144,432	--
Total	**207,106**	**135,252**	**110,019**	**$144,432**	**$144,432**	**--**
22-100 Percent of FPL						
Children	12,663	12,663	12,663	$6,050	$2,280	$3,770
Parents	80,485	49,712	37,016	$55,929	$21,074	$34,855
Non-Custodial Adults	132,866	78,302	61,169	$101,665	$101,665	--
Total	**226,014**	**140,677**	**110,848**	**$163,644**	**$125,019**	**$38,625**
100-150 Percent of FPL						
Children	13,085	13,085	13,084	$5,369	$2,023	$3,346
Parents	51,830	24,649	21,598	$24,105	$9,083	$15,022
Non-Custodial Adults	75,861	53,040	42,883	$72,653	$72,653	--
Total	**140,776**	**90,774**	**77,565**	**$102,128**	**$120,496**	**$18,368**
150-200 Percent of FPL						
Children	6,106	6,106	6,106	$2,622	$988	$1,634
Parents	50,673	24,806	17,808	$28,148	$10,606	$17,542
Non-Custodial Adults	92,608	59,236	45,942	$77,280	$77,280	--
Total	**149,387**	**90,148**	**69,856**	**$108,051**	**$88,875**	**$19,176**
200-250 Percent of FPL						
Children	36,207	17,418	8,314	$7,897	$2,975	$4,921
Parents	26,005	11,710	5,582	$14,667	$5,527	$9,141
Non-Custodial Adults	66,147	44,829	25,279	$62,271	$62,271	--
Total	**128,359**	**73,957**	**39,175**	**$84,835**	**$70,773**	**$14,062**
All Below 250 Percent of FPL						
Children	68,061	49,272	40,167	$21,938	$8,266	$13,672
Parents	208,993	110,877	82,004	$122,849	$46,290	$76,560
Non-Custodial Adults	574,588	370,659	285,292	$458,301	$458,301	--
Total	**851,642**	**530,808**	**407,463**	**$603,089**	**$512,857**	**$90,232**

a/ Assumes no premium contribution requirement. Assumes FMAP of 62.32 percent for children and parents only.
Source: Lewin Group estimates using the Medicaid Eligibility Simulation Model (MEDSim).

To illustrate the impact of this anti-crowd-out provision, we estimated enrollment and costs assuming the waiting period is eliminated as shown in ***Figure 10***. In this scenario, we assume the use of the Medicaid benefits package. Total enrollment for all people living below 250 percent of the FPL would increase from about 530,000 people with the waiting period (see ***Figure 7*** above), to about 783,000 people without the waiting period. Program costs would increase from about $1.4 billion to $2.1 billion if the waiting period rule is eliminated (assuming the Medicaid benefits package).

5. The Impact of Premium Contribution Requirements

In all of the scenarios discussed above, we have assumed that enrollees are not required to pay a premium to enroll in the program. In this section, we illustrate the impact that requiring a premium contribution would have on enrollment and costs under the program. In this scenario, we assume the same eligibility requirements as assumed in the scenarios presented above with the waiting period requirement using the Medicaid benefits package. This corresponds to the first scenario, which we presented above in ***Figure 7***.

However, in this scenario, we assume that enrollees with incomes over 150 percent of the FPL are required to make a premium contribution as follows:

- People below 150 percent of the FPL are not charged a premium; and
- A premium equal to the full actuarial costs of benefits under the program is phased-in for people living between 150 percent and 250 percent of the FPL on a sliding scale with income.

Under this scenario, the number of people who enroll would be the same as above for all of the groups that are not charged a premium (i.e., people living below 150 percent of the FPL). However, enrollment would decline among those who are required to pay a premium. We base our enrollment estimates for this group on econometric analyses of enrollment in other programs in the country where premiums are required.[3] These data show that requiring a premium reduces enrollment by between 37 percent and 65 percent depending on the size of the premium required.

[3] Includes data for the Washington Basic Health plan and the Minnesota Care program.

Figure 10
Estimated Enrollment and Costs Under Selected Medicaid/SCHIP Expansions: Without Anti-Crowd-Out Rule and Medicaid Benefits Package a/

	Number of Eligible People	Number of People Enrolled	Reduction in Uninsured	Total Costs ($1,000s)	State Costs ($1,000s)	Federal Costs ($1,000s)
Below 22 Percent of FPL						
Children	-	-	-	$0	$0	$0
Parents	-	-	-	$0	$0	$0
Non-Custodial Adults	210,068	136,001	110,019	$337,211	$337,211	--
Total	**210,068**	**136,001**	**110,019**	**$337,211**	**$337,211**	**--**
22-100 Percent of FPL						
Children	12,663	12,663	12,663	$14,070	$5,302	$8,768
Parents	94,954	55,327	37,016	$146,081	$55,043	$91,038
Non-Custodial Adults	163,536	86,391	61,746	$259,228	$259,228	--
Total	**271,153**	**154,381**	**111,425**	**$419,379**	**$319,573**	**$99,806**
100-150 Percent of FPL						
Children	14,977	14,977	14,976	$14,306	$5,391	$8,916
Parents	106,074	47,754	23,305	$117,446	$44,254	$73,193
Non-Custodial Adults	123,054	76,994	43,434	$280,027	$280,027	--
Total	**244,105**	**139,725**	**81,715**	**$411,780**	**$329,671**	**$82,109**
150-200 Percent of FPL						
Children	8,060	8,060	8,061	$7,673	$2,891	$4,782
Parents	140,617	62,186	18,601	$159,296	$60,023	$99,273
Non-Custodial Adults	186,698	95,985	45,941	$283,227	$283,227	--
Total	**335,375**	**166,231**	**72,603**	**$450,195**	**$346,140**	**$104,055**
200-250 Percent of FPL						
Children	137,747	52,601	8,313	$54,545	$20,553	$33,993
Parents	132,402	47,195	5,582	$124,677	$46,978	$77,699
Non-Custodial Adults	169,107	87,577	25,823	$319,137	$319,137	--
Total	**439,256**	**187,373**	**39,718**	**$498,360**	**$386,668**	**$111,692**
All Below 250 Percent of FPL						
Children	173,447	88,301	44,013	$90,595	$34,136	$56,459
Parents	474,047	212,462	84,504	$547,500	$206,298	$341,202
Non-Custodial Adults	852,463	482,948	286,963	$1,478,830	$1,478,830	--
Total	**1,499,957**	**783,711**	**415,480**	**$2,116,925**	**$1,719,264**	**$397,661**

a/ Assumes no premium contribution requirement. Assumes FMAP of 62.32 percent for children and parents only.
Source: Lewin Group estimates using the Medicaid Eligibility Simulation Model (MEDSim).

We assume that those who continue to enroll with the premium requirement are in poorer than average health and would tend to have higher costs. Using actuarial data on the distribution of enrollees by amount of health spending, we estimated adjustments to the premium to reflect expected selection effects. We do this by assuming that the percentage of people enrolling in the program with zero claims drops from an estimated 13.3 percent of enrollees without a premium. This is done as follows:

- For the 150 percent to 200 percent of FPL group, we estimate that enrollment would decline by about 57 percent due to the member contribution requirement. We assume that the percent of enrollees with zero claims under this scenario drops to about 3.1 percent of enrollees, which increases the premium by about 29.3 percent; and

- For the 200 percent to 250 percent of FPL group, we estimate that enrollment would decline by about 64.2 percent due to the member contribution requirement. We assume that the percent of enrollees with zero claims drops to about 1.6 percent of enrollees, which increases the PMPM cost for this group by about 45.3 percent.

Using these assumptions, we estimate that enrollment would decline from about 530,000 people to about 432,000 people (***Figure 11***). Costs would be reduced from $1.4 billion to $1.2 billion, reflecting the reduction in enrollment and premium payments by those who continue to enroll.

We also simulated the impact of the Medicaid expansion assuming that the premium would be $25 per month for all people with incomes above 150 percent of the poverty level. The impact on enrollment would be smaller than under the sliding scale premium scenario (***Figure 11***) because the premium contribution requirement is smaller. The results of the $25 premium scenario are presented in ***Figure 12***.[4]

6. *Buy-in to Employer Coverage*

Under the current Medicaid and SCHIP programs, the state is permitted to cover eligible people by paying the worker share of premiums in cases where an individual is working for an employer who sponsors health insurance. In general, the state is permitted to do this only in instances where it is cost-effective to do so. This means that the cost of paying the worker share of the premium must be less than the actuarial cost of covering the individual under the current Medicaid/SCHIP program. The state is also required to provide wrap-around benefits covering Medicaid/SCHIP covered services not covered by the employer's plan.

[4] Changes in PMPM costs for those who continue to enroll were estimated using a methodology consistent with that discussed above.

Figure 11
Estimated Enrollment and Costs Under Selected Medicaid/SCHIP Expansions: With Anti-Crowd-Out Rule, Medicaid Benefits and Sliding-Scale Premium a/

	Number of Eligible People	Number of People Enrolled	Reduction in Uninsured	Total Costs ($1,000s)	Premium Revenues ($1,000s)	Costs Less Premium ($1,000s)	State Costs ($1,000s)	Federal Costs ($1,000s)
Below 22 Percent of FPL								
Children	-	-	-	$0	$0	$0	$0	$0
Parents	-	-	-	$0	$0	$0	$0	$0
Non-Custodial Adults	207,106	135,252	110,019	$335,888	$0	$335,888	$335,888	--
Total	**207,106**	**135,252**	**110,019**	**$335,888**	**$0**	**$335,888**	**$335,888**	**--**
22-100 Percent of FPL								
Children	12,663	12,663	12,663	$14,070	$0	$14,070	$5,302	$8,768
Parents	80,485	49,712	37,016	$130,067	$0	$130,067	$49,009	$81,058
Non-Custodial Adults	132,866	78,302	61,169	$236,430	$0	$236,430	$236,430	--
Total	**226,014**	**140,677**	**110,848**	**$380,567**	**$0**	**$380,567**	**$290,741**	**$89,826**
100-150 Percent of FPL								
Children	13,085	13,085	13,084	$12,487	$0	$12,487	$4,705	$7,782
Parents	51,830	24,649	21,598	$56,059	$0	$56,059	$21,123	$34,936
Non-Custodial Adults	75,861	53,040	42,883	$168,961	$0	$168,961	$168,961	--
Total	**140,776**	**90,774**	**77,565**	**$237,506**	**$0**	**$237,506**	**$194,788**	**$42,718**
150-200 Percent of FPL								
Children	3,637	3,637	3,637	$3,335	$1,401	$1,934	$729	$1,205
Parents	50,673	13,731	10,977	$41,177	$13,375	$27,802	$10,476	$17,326
Non-Custodial Adults	92,608	21,709	16,727	$72,749	$23,631	$49,118	$49,118	--
Total	**146,918**	**39,077**	**31,341**	**$117,261**	**$38,407**	**$78,854**	**$60,323**	**$18,531**
200-250 Percent of FPL								
Children	36,207	4,189	1,211	$5,984	$2,772	$3,212	$1,210	$2,002
Parents	26,005	3,932	1,608	$15,495	$7,177	$8,318	$3,134	$5,184
Non-Custodial Adults	66,147	18,323	9,038	$76,391	$35,383	$41,008	$41,008	--
Total	**128,359**	**26,444**	**11,857**	**$97,870**	**$45,331**	**$52,539**	**$45,353**	**$7,186**
All Below 250 Percent of FPL								
Children	65,592	33,574	30,595	$35,875	$4,172	$31,703	$11,946	$19,757
Parents	208,993	92,024	71,199	$242,798	$20,552	$222,246	$83,742	$138,504
Non-Custodial Adults	574,588	306,626	239,836	$890,419	$59,014	$831,405	$831,405	--
Total	**849,173**	**432,224**	**341,630**	**$1,169,092**	**$83,738**	**$1,085,354**	**$927,093**	**$158,261**

a/ Assumes premium contribution requirement is phased-in up to the full amount of the actuarial cost of the coverage between 150 percent and 250 percent of the FPL. Assumes FMAP of 62.32 percent for children and parents only.

Source: Lewin Group estimates using the Medicaid Eligibility Simulation Model (MEDSim)

Figure 12
Estimated Enrollment and Costs Under Selected Medicaid/SCHIP Expansions: With Anti-Crowd-Out Rule, Medicaid Benefits and $25 Premium

	Number of Eligible People	Number of People Enrolled	Reduction in Uninsured	Total Costs ($1,000s)	Premium Revenues ($1,000s)	Costs Less Premium ($1,000s)	State Costs ($1,000s)	Federal Costs ($1,000s)
Below 22 Percent of FPL								
Children	-	-	-	$0	$0	$0	$0	$0
Parents	-	-	-	$0	$0	$0	$0	$0
Non-Custodial Adults	207,106	135,252	110,019	$335,888	$0	$335,888	$335,888	--
Total	**207,106**	**135,252**	**110,019**	**$335,888**	**$0**	**$335,888**	**$126,563**	**--**
22-100 Percent of FPL								
Children	12,663	12,663	12,663	$14,070	$0	$14,070	$5,302	$8,768
Parents	80,485	49,712	37,016	$130,067	$0	$130,067	$49,009	$81,058
Non-Custodial Adults	132,866	78,302	61,169	$236,430	$0	$236,430	$236,430	--
Total	**226,014**	**140,677**	**110,848**	**$380,567**	**$0**	**$380,567**	**$290,741**	**$89,826**
100-150 Percent of FPL								
Children	13,085	13,085	13,084	$12,487	$0	$12,487	$4,705	$7,782
Parents	51,830	24,649	21,598	$56,059	$0	$56,059	$21,123	$34,936
Non-Custodial Adults	75,861	53,040	42,883	$168,961	$0	$168,961	$168,961	--
Total	**140,776**	**90,774**	**77,565**	**$237,506**	**$0**	**$237,506**	**$194,788**	**$42,718**
150-200 Percent of FPL								
Children	4,942	4,942	4,942	$4,893	$1,483	$3,411	$1,285	$2,126
Parents	50,673	21,841	14,304	$64,149	$6,552	$57,597	$21,702	$35,894
Non-Custodial Adults	92,608	32,426	22,925	$112,785	$9,728	$103,057	$103,057	--
Total	**148,223**	**59,209**	**42,171**	**$181,827**	**$17,763**	**$164,064**	**$126,044**	**$38,020**
200-250 Percent of FPL								
Children	36,207	11,320	4,623	$12,550	$3,396	$9,154	$3,449	$5,705
Parents	26,005	9,687	4,487	$32,642	$2,906	$29,736	$11,205	$18,531
Non-Custodial Adults	66,147	32,369	14,655	$120,113	$9,711	$110,402	$110,402	--
Total	**128,359**	**53,376**	**23,765**	**$165,305**	**$16,013**	**$149,292**	**$125,056**	**$24,236**
All Below 250 Percent of FPL								
Children	66,897	42,010	35,312	$44,001	$4,879	$39,122	$11,701	$27,421
Parents	208,993	105,889	77,405	$282,917	$9,458	$273,459	$103,040	$170,419
Non-Custodial Adults	574,588	331,389	251,651	$974,177	$19,439	$954,738	$954,738	--
Total	**850,478**	**479,288**	**364,368**	**$1,301,095**	**$33,776**	**$1,267,319**	**$1,069,479**	**$197,840**

a/ Assumes $25 per member per month premium contribution requirement for all people with incomes over 150 percent of the FPL. Assumes FMAP of 62.32 percent for children and parents only.

Source: Lewin Group estimates using the Medicaid Eligibility Simulation Model (MEDSim).

This approach has not been widely used, largely due to the cost of administering the program. Also, the requirement to provide wrap-around coverage for co-payments and services not covered by the employer plan adds to administrative costs and reduces potential savings from the employer coverage options. However, in the places where the buy-in to employer coverage is used, it is believed to reduce costs for the state.

In this analysis, we estimated the cost impact of adopting the employer buy-in option for people who become covered under the Medicaid/SCHIP options discussed above. We assume that for newly eligible people, the state obtains a waiver permitting them to cover people under employer plans when cost effective *without* requiring the state to provide wrap-around benefits.

We estimated the cost impact of this approach based upon data from the "2003 Health Insurance for Indiana's Families Survey." These data indicate that about 31 percent of uninsured people in Indiana are eligible for coverage under an employer-sponsored health plan but have declined coverage. This includes workers with an employer offering coverage and dependents who could be covered under a spouse or parent's employer health plan.

We controlled the MEDSim model to use this estimate of uninsured people eligible for an employer sponsored plan. The model then provides the distribution of these people by income level. This is important because the percentage of uninsured workers with access to employer coverage tends to decline at lower income levels.

We then assumed that the state buys these people into their employer's health plan by paying the worker share of the premium to cover that individual under the employer plan. We used the average premium and average employee premium share in Indiana employer health plans from the MEPS data (employer survey component) for Indiana employers.

Based on these assumptions, we estimated the cost of the eligibility expansion presented above in ***Figure 7*** (i.e., Medicaid benefits with anti-crowd-out provisions and no premium requirement) assuming the buy-in to employer plans is adopted. We estimate that the cost of the program would drop from $1.4 billion without the buy-in to about $1.2 billion with the buy-in (***Figure 13***). We also present our estimates of the cost of implementing the buy-in together with the sliding-scale premium requirement.

Figure 13
Enrollment and Cost of Medicaid/SCHIP Expansion with Buy-in to Employer Buy-in Coverage [a/ b/]

	Number Enrolled	Number in Employer Buy-in	Program Costs Without Buy-in (thousands)	Buy-in Savings (thousands)	Net Program Cost With Buy-in (thousands)	Federal Share (thousands)	State Share (thousands)
Without Sliding Scale Premium							
All Below 22% FPL	135,252	20,288	$335,888	$25,023	$310,865	--	$310,865
22% to 100% of FPL	140,677	21,101	$380,567	$28,358	$352,209	$83,122	$269,087
100% to 150% of FPL	90,774	21,785	$237,506	$30,171	$207,335	$37,300	$170,035
150% to 200% of FPL	90,148	28,847	$251,281	$39,494	$211,787	$37,592	$174,195
200% to 250% of FPL	73,957	26,624	$197,291	$36,867	$160,424	$26,599	$133,825
Total	530,808	118,645	$1,402,533	$159,913	$1,242,620	$184,613	$1,058,007
With Sliding Scale Premium [c/]							
All Below 22% FPL	135,252	20,288	$335,888	$25,023	$310,865	--	$310,865
22% to 100% of FPL	140,677	21,101	$380,567	$28,358	$352,209	$83,122	$269,087
100% to 150% of FPL	90,774	21,785	$237,506	$30,171	$207,335	$37,300	$170,035
150% to 200% of FPL	39,077	12,504	$117,261	$15,195	$102,066	$23,986	$78,080
200% to 250% of FPL	26,444	9,520	$97,870	$9,954	$87,916	$12,027	$75,889
Total	432,224	85,198	$1,169,092	$108,701	$1,060,393	$156,437	$903,956

a/ Assumes that the program pays the worker contribution for employer sponsored insurance when available if it is "cost effective" to do so. Also assumes that the state does not provide wrap-around coverage for Medicaid covered services that are not covered under the employer plan.
b/ All estimates assume the standard FMAP (62.32 percent) for children and parents only.
c/ Premiums on a sliding scale with income above 150 percent FPL.
Source: Lewin Group estimates using the Medicaid Eligibility Simulation (MEDSim).

The total cost of the program would be $226.4 million. This is the cost of paying the employee share of the premium for people with access to employer coverage who are living below 200 percent of the poverty line, including both uninsured people who are induced to take coverage and currently insured people who qualify. If a waiver can be obtained to implement such a program, the state cost would be about $59.5 million, with the federal government paying the balance of $166.9 million.

D. Medicaid Buy-in

In this scenario, employers would be permitted to contract with the state to provide coverage to low-income workers through the Medicaid program. Under this model, also known as a "Medicaid Buy-in," employers would be permitted to enroll in Medicaid by paying the full actuarial cost of the coverage. The Medicaid buy-in premium would be lower than the cost of purchasing comparable coverage in the private sector due to lower provider payment levels and potentially lower administrative costs. The availability of lower-cost coverage is expected to induce some non-insuring employers to take coverage through the buy-in.

The buy-in premium would be lower than the premium for comparable private coverage due to the following:

- Medicaid payment rates to providers in Indiana are estimated to be about 25 percent lower than private insurer reimbursement levels for hospitals and 38 percent lower for physicians;
- Medicaid receives substantial rebates for prescription drugs (i.e., 18 to 20 percent); and
- Administrative costs under the buy-in are likely to be lower than in private plans because there are no commission payments to brokers and agents, and there is no allowance for insurer profits (estimated to be between eight percent and twelve percent of private insurance premiums for small firms).

Buy-in participants would be required to pay a premium equal to the full cost of their coverage (i.e., average cost per enrollee). Consequently, the program would be fully funded through premium contributions so that no new public funds are required.

Under a variant of this approach, the state could also pay the employee premium share for low-income workers to encourage enrollment in the program. However, this variant would require additional state funds.

1. The Buy-in Model

For illustrative purposes, we assume that the buy-in covers the same services now covered under the SCHIP benefit package. We also assume that the co-payments and benefits limits

would be the same as under the SCHIP coverage, as described above in ***Figure 1***. To be consistent with private sector rating practices, premiums are assumed vary with age.[5]

To avoid shifting large numbers of privately insured people to the buy-in, we assume that employer eligibility would be limited to only small businesses with low-income workers who have not offered insurance in a year or more (a discussion of adverse selections issues is presented below). We assume that employers would be eligible if they satisfy the following criteria:

- Firms with 50 or fewer workers;
- Firms have not offered coverage in 12 months;
- Average annual wages/salaries for workers in the firm must be less than the average earnings for workers in Indiana firms with 50 or fewer workers (assumed to be $23,000);
- The employer must enroll at least 75 percent of their employees; and
- The employer must pay at least half of the premium.

For illustrative purposes, we also assumed that the buy-in would be available to low-income individuals who do not have access to employer coverage. We assume that the program is open to people living below 300 percent of the FPL who do not have access to employer coverage and have been uninsured for at least 12 months. The twelve month waiting period is intended to preserve existing private insurance coverage by making it impractical for an employer or individual to discontinuing their current private insurance policy to become covered under the lower-cost buy-in program.

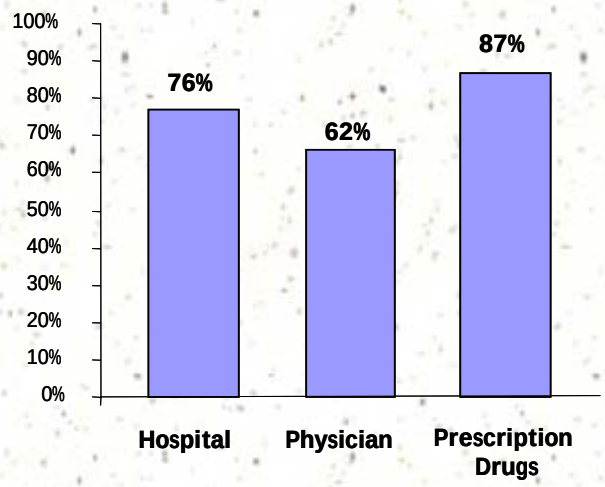
2. Assumptions

The extent to which this approach would expand coverage is dependent on the amount of the difference between the buy-in premium and the premium for comparable coverage in the private sector. The lower the Medicaid buy-in premium is relative to private coverage, the more likely it is to induce uninsured people and non-insuring employers to obtain coverage.

[5] Rating by age is designed to help avert adverse selection by older higher cost populations into the program.

Figure 14
Buy-in to Medicaid Would Offer Coverage for About 20 Percent Less Than Private Insurance

Indiana Medicaid Provider Payments as a Percentage of Private Payments



Estimated Monthly Premium Cost Per Person

◆Existing Employer Plans	$290
◆SCHIP Package Under Buy-in	$235[a/]

a/Includes administrative costs assumed to be 12 percent of benefits costs.
Source: MedPAC analysis of data from the American Hospital Association Survey of Hospitals; and "Comparing Physician and Dentist Fees Among Medicaid Programs," The Lewin Group 2001.

We estimate that the premium for the buy-in would be 20 percent less costly than private coverage (***Figure 14***). The reasons for this difference include:

- Medicaid payment rates for hospital services are about 76 percent of private payment rates in Indiana;[6]
- Medicaid payment rates for physician services are about 62 percent of Medicare payment rates in Indiana, which are typically up to 20 percent less than payments under private plans in the state;[7]
- The Medicaid program receives a rebate of 18 percent to 20 percent for prescription drugs compared with an average rebate of only about 8 percent under private health plans;[8] and
- Medicaid program administrative costs would be lower than in private plans by eliminating the allowance for profit and broker/agent fees in public health plans.

[6] MedPAC, "Report to the Congress: Medicare Payment Policy", March 2001.
[7] "Comparing Physician and Dentist Fees Among Medicaid Programs," The Lewin Group, June 2001.
[8] "Prescription Drug Coverage, Spending, Utilization, and Prices', Report to the President, DHHS, April 2000.

Based upon these data, we estimate that the premium for the SCHIP benefit package using the Medicaid payment levels and network would be about $235 PMPM under the buy-in. This is equal to the estimated average cost of benefits under the SCHIP benefit package under Medicaid payment rates presented above in ***Figure 2*** ($210 PMPM), plus administrative costs of about 12 percent, reflecting the cost of administering coverage for small groups and individuals. This buy-in premium of $235 PMPM is about 20 percent less than the average premium for private employer health insurance per covered worker in Indiana for 2004, which is $290 PMPM (***Figure 15)***.

Figure 15
Estimated Average Monthly Premiums for Private Establishments in Indiana in 2004.

	Monthly Premium	Amount Paid by Worker	Percentage Paid by Worker
Family Coverage	$826.00	$152.00	18.4%
Employee Plus 1	$557.00	$119.00	21.5%
Single Coverage	$302.00	$59.00	19.5%
Cost Per Covered Person	**$290.00**	**$55.00**	**19.0%**

Source: Lewin Group analysis of data from: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2001 Medical Expenditure Panel Survey-Insurance Component. Adjusted from 2001 to 2004 price levels.

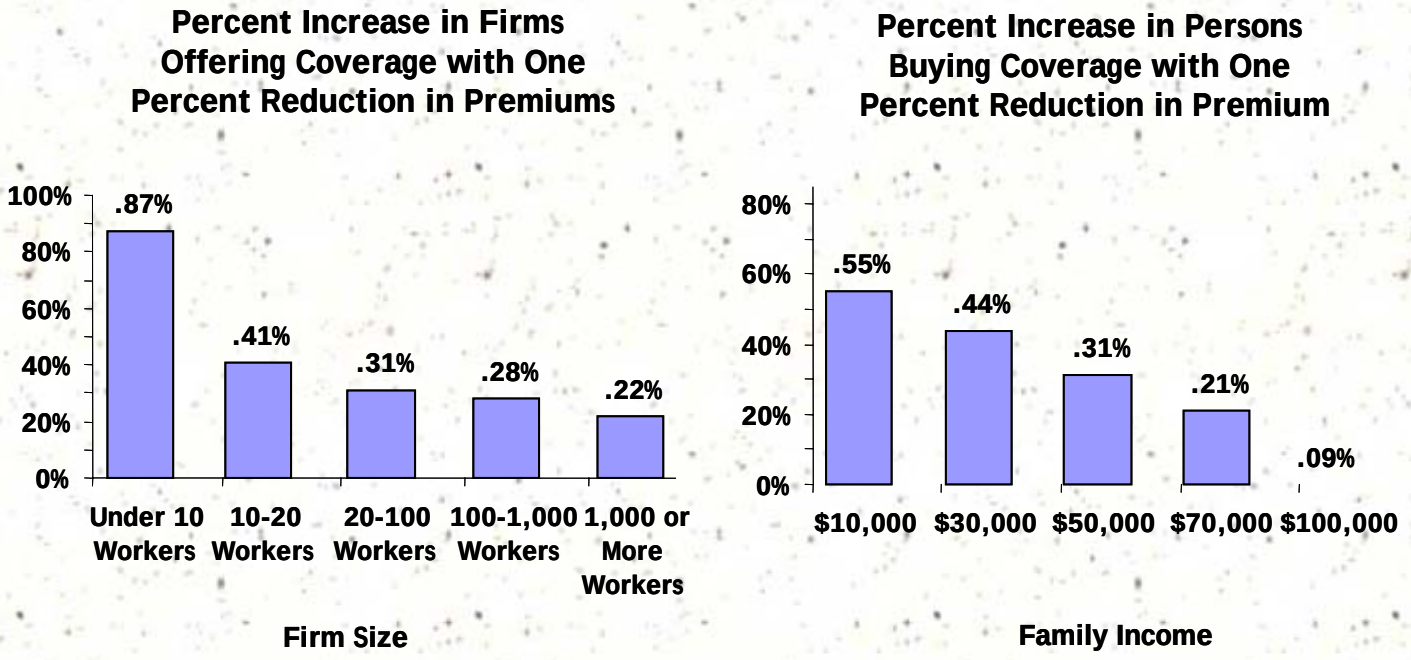
We estimated the number of people who would take coverage based upon econometric analyses of how changes in price affect the employer's decision to offer coverage and the individual's willingness to purchase coverage. These studies indicate the following:[9]

- We estimate that that for every one percent reduction in price, the likelihood that an employer with 10 or fewer workers would offer coverage increases by about 0.87 percent (i.e., a price elasticity of -0.87). The employer price response declines as firm size increases as shown in ***Figure 16***; and

- We estimate that each one percent reduction in the price of insurance increases the likelihood that a lower-income individual would take coverage by about 0.55 percent (i.e., a price elasticity of -0.55). The price response generally declines as income rises as shown in ***Figure 16***.

[9] See: "Documentation to the Health Benefits Simulation Model (HBSM)", The Lewin Group, February, 2003.

Figure 16
Estimating the Number of Employers and Individuals Taking Coverage



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

3. *Estimated Coverage Effects*

Figure 17 presents our estimates of the impact of the Medicaid buy-in on coverage in Indiana. We estimate that there are about 594,000 workers and dependents in Indiana small employers that would be eligible to participate in the buy-in. Of these, we estimate about ten percent would be induced to take the coverage at the lower premium level available under the buy-in. We estimate that this would reduce the number of uninsured by about 70,860 people.

Figure 17
People Eligible and Enrolled under Medicaid Buy-in for Indiana [a/]

	Eligible People	People Enrolled	Reduction in Uninsured	Premium Revenue (in millions)	State Cost: Program Fully Funded with Premiums
Qualifying Firm Eligibility Only					
Workers	381,000	55,293	45,340	$124.0	$0.0
Dependents	213,000	31,122	25,520	$69.6	$0.0
Total	594,000	86,415	70,860	$193.6	$0.0
Individual Eligibility Only					
Adults	320,598	68,446	68,446	$180.7	$0.0
Children	99,412	21,224	21,224	$56.0	$0.0
Total	420,010	89,670	89,670	$236.7	$0.0
Both Firms and Individuals Eligible*					
Total Enrollment	679,106	156,941	143,080	$389.8	$0.0

a/Does not add to total due to overlaps in eligibility.
Source: Lewin Group estimates using the Medicaid Eligibility Simulation (MEDSim).

Total premium revenues would be about $193 million. As discussed above, these premiums would be set at the levels required fully fund coverage under the program. Thus, there would be no need for state funding.

The program also could be made available to individuals only. As discussed above, for illustrative purposes, we assume that program would be available to only uninsured people with incomes below 300 percent of the FPL. Under this scenario, about 89,670 uninsured people would enroll in the program.

The program also could be made available to both small employers and low-income individuals. We estimate that under this scenario, about 679,100 people would be eligible through either the small employer buy-in or the low-income individual buy-in. This figure reflects that there is a substantial overlap in eligibility between these two groups. We estimate that of these, about 143,080 uninsured people would enroll.

4. Broadening Buy-in Eligibility

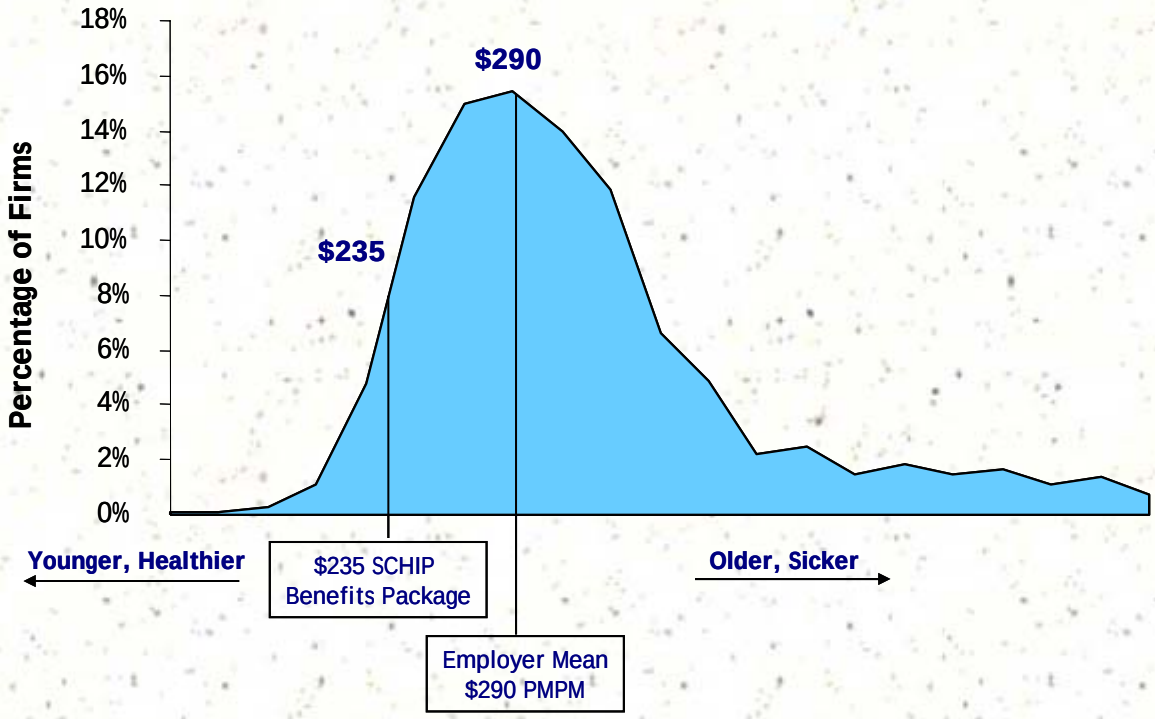
In the analyses presented above, we assumed that eligibility for the Buy-in is limited to small non-insuring employers with predominantly low-wage workers, and uninsured individuals with low-incomes. One option would be to extend eligibility to all employers and individuals in Indiana regardless of income, current insured status and firm size. This would extend access to all Indianans for the lower-cost benefit package based on Medicaid provider payment levels.

One of the issues with this approach is that it could result in a disproportionate accumulation of higher cost people in the Buy-in program. This phenomenon, known as "adverse selection",

would necessitate large increases in the Buy-in premium, thus reducing the effectiveness of the program in expanding coverage.

To illustrate, ***Figure 18*** presents the estimated distribution of employers (weighted by workers) by the average PMPM premium in the current market. The average for Indiana is estimated to be $290 PMPM in 2004. However, the average PMPM amount for each employer differs resulting in considerable variation in PMPM costs for individual employers. This reflects a myriad of differences across employers in covered benefits, deductibles and co-payments and the mix of family and single coverage in each firm.

Figure 18
Employers by PMPM Cost of Benefits Under Current Law



Source: Lewin Group estimates using the Health Benefits Simulation Model adjusted to reflect the 2001 MEPS survey of employers in Indiana, which we updated to 2004 cost levels.

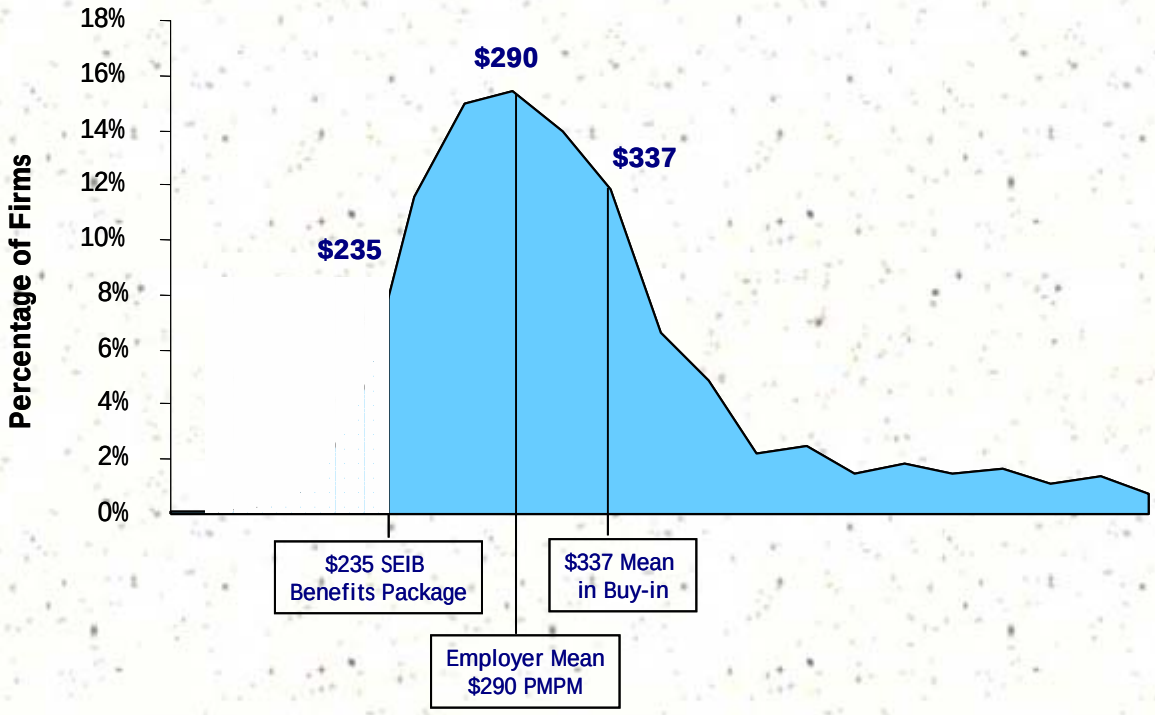
It also reflects differences in insurer rating practices including: experience rating (setting premiums based upon prior health spending); age-rating (premiums vary with the age of enrollees); under-writing (premiums varied by enrollee health status); and self-funding (costs for self-funded plans are the actual amounts paid for services incurred by enrollees). While the sources of premium variation are complex, firms with older and sicker people tend to have the highest premiums, while firms with younger and healthier people tend to have lowest premiums.

Under a Buy-in with the SCHIP benefit package at a premium of $235 PMPM, most employers would find that the Buy-in is less costly than continuing with their current coverage and would tend to enroll in the Buy-in. Conversely, firms now paying less than $235 PMPM would

generally continue with their private coverage because it is less costly to them. Consequently, the Buy-in would include primarily older and sicker populations leaving less costly groups covered in private plans.

The accumulation of higher cost people in the Buy-in would require an increase in the Buy-in premium for the program to be fully funded. In the example presented above, the Buy-in premium would need to be increased from $235 PMPM to $337 PMPM for the program to be fully funded (***Figure 19***). This in-turn would cause only those with private insurance costs in excess of $337 to remain in the program resulting in further Buy-in premium increases. This phenomenon, called a "premium spiral" would result in a kind of high-risk pool that would undermine it's cost savings potential for those who are currently without coverage.

Figure 19
Potential Premium Spiral if Buy-in Eligibility is Extended to All Indiana Employers and Individuals



Source: Lewin Group estimates using the Health Benefits Simulation Model adjusted to reflect the 2001 MEPS survey of employers in Indiana, which we updated to 2004 cost levels.

As discussed above, to avoid these effects, we assumed that eligibility for the program is limited only to small employers and low-income individuals who have been uninsured for 12 months or more. This excludes most currently insuring employers and individuals who already have private coverage, which greatly reduces the potential for adverse selection. We also assume that a three-year limit is placed on enrollment so that participants are required to eventually move to the private market.

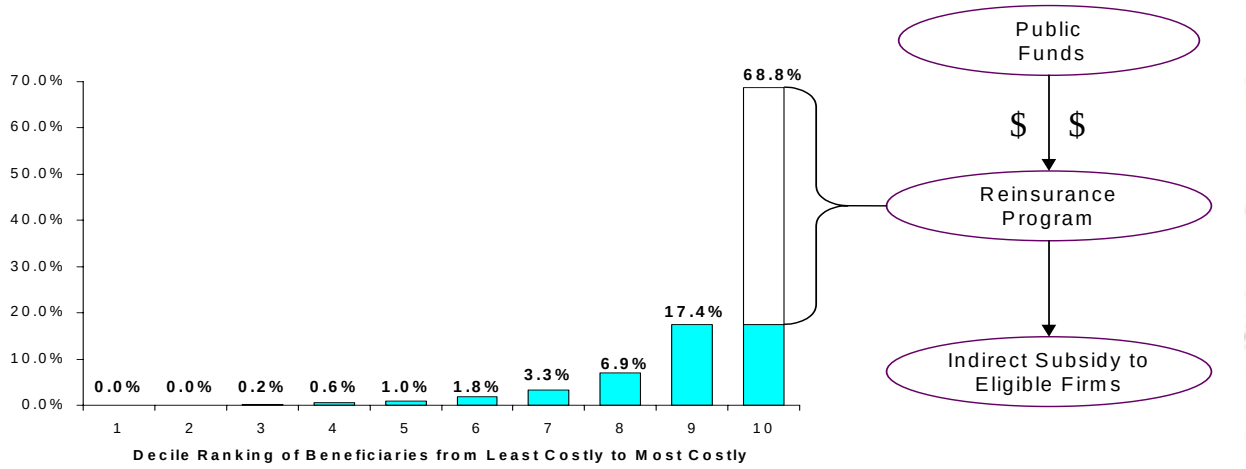
These measures would not completely eliminate adverse selection. It is likely that non-insuring employers and uninsured individuals who are expecting substantial health spending are more likely to enroll. We feel that we have adjusted for this effect by using Medicaid utilization as the basis of our premium estimates. This is because people who enroll in Medicaid are believed to be among the highest cost portion of the population eligible for the program.

E. Create Low-cost Health Insurance Coverage Options

The state could also expand coverage by subsidizing the premium for a low-cost health insurance product for employers and individuals who currently do not provide coverage. In this analysis, we examined the potential impact of creating in Indiana a program modeled on the "Healthy New York" program recently implemented in New York State. This program permits insurers to sell a benefits package that does not include state mandated benefits to only lower-income individuals and employers with lower-wage workers who have been uninsured for 12 or more months. The state also subsidizes premiums for eligible employers and individuals in these plans through a modified reinsurance system.

The state subsidy is provided through a reinsurance mechanism that pays a substantial percentage of health benefits costs for high-cost cases among eligible individuals and employers who purchase the coverage. As shown in ***Figure 20,*** about 70 percent of all costs under a typical health plan are associated with just 10 percent of the covered population.

Figure 20
Percent of Claims for a Typical Health Plan by Decile Ranking of Participants by Spending Level: Illustration of Reinsurance Concept



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

This program subsidizes the cost of coverage for many of these high-cost cases, resulting in lower premiums. Under the Healthy New York program, the state reinsurance program pays 90 percent of costs in excess of $30,000 for each person covered under these plans up to a

maximum covered amount of $100,000 per member. The cost of this reinsurance is paid through trust funds established for this purpose using New York tobacco settlement receipts.

In New York, it is estimated that premiums under the program will be reduced by about 21 percent. About half of this amount is attributed to the elimination of mandated benefits, with the other half attributed to the reinsurance subsidy. This reduction in costs is designed to increase the number of employers and individuals with insurance. The program was implemented in January 2001.

In this analysis, we estimated the impact of adopting a similar program in Indiana. However, this program would have less of an impact on premiums than in New York because Indiana has fewer mandated benefits. These benefits are listed in (***Figure 21***).

Figure 21
Mandated Benefits in the Individual and Small Group Markets in Indiana

- Adopted Children
- AIDS, HIV Related
- Breast Reconstruction
- Diabetes Treatment
- Handicapped Children beyond Age of Maturity
- Infant Screening Tests
- Mental Health Parity if Offered a/
- Minimum Maternity Stay
- Newborns (except pre-ex)
- Off-label Use of Certain Drugs
- Substance Abuse Parity if Offered a/
- Victims of Abuse
- Pervasive Development Disorders
- Colorectal Cancer Screening b/
- Dental Anesthesia/Hospitalization b/
- Inherited Metabolic Disease b/
- Mammography b/
- Prostate Cancer Screening b/

a/ Applies to individual market only.
b/ Small group only

Thus, only the reinsurance subsidy would have a significant impact on premiums in Indiana. For purposes of developing estimates for Indiana, we assumed that the program would reduce premiums for participating firms and individuals by about 16 percent, compared with the estimated 21 percent savings in the Healthy New York program.

For illustrative purposes, we assumed that the program would adopt the eligibility criteria used in the Healthy New York program. Self-employed people and other individuals would be eligible if they have been uninsured for 12 or more months and their income is less than 250 percent of the FPL. Eligibility for employers is limited to firms meeting the following criteria:

- Firms with 50 or fewer workers;
- At least half of employees enroll in the plan;
- Have not offered coverage in 12 or more months;
- Less than 30 percent of employees are earning over $30,000; and
- The employer pays half of the premium.

We estimate that in response to these premium reductions (i.e., about 16 percent), about 18,800 people would take coverage under these health plans. This includes both individuals and people in firms that are induced to purchase subsidized coverage (***Figure 22***). Of these, about 17,600 would be people who otherwise would have been uninsured. The total cost to the state of the reinsurance program would be about $7.0 million in 2004.

Figure 22
Low Cost Benefits Package Model for Individuals and Non-insuring Firms with Less than 50 Workers

	Number Enrolled	Newly Insured	State Cost (in millions)
Three-year Exemption from Mandatory Benefits	6,200	5,800	--
Reinsurance for Participants	12,600	11,800	$7.0
Total Program Enrollment and Costs			
Total Program	**18,800**	**17,600**	**$7.0**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

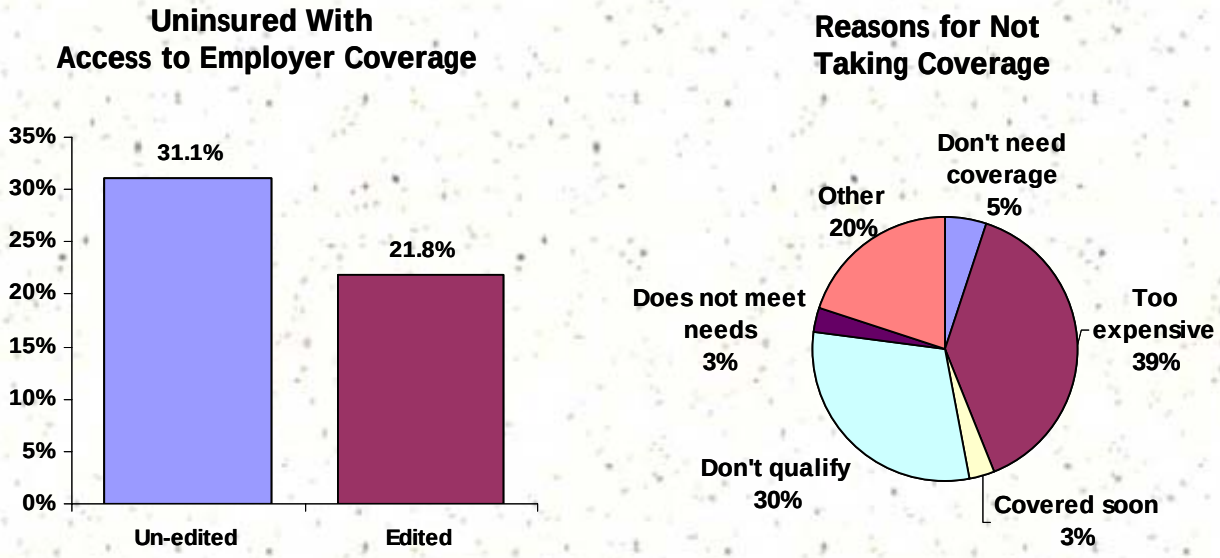
F. Premium Assistance

In this option we assume that a premium assistance program is created to assist low-income people in purchasing employer coverage where available. Eligibility would be limited to only those people who are eligible for employer-sponsored coverage. Under this option, the state pays the employee premium share for people living below 250 percent FPL, who have access to employer insurance.

We estimated the cost impact of this approach based upon data from the Indiana health insurance survey for 2003 conducted under the State Planning Grant. Using these data, we estimate that about 21.8 percent of uninsured people in Indiana are eligible for coverage under an employer-sponsored health plan but have declined coverage. This includes workers with an employer offering coverage and dependents who could be covered under a spouse or parent's employer health plan.

Our estimate of the percentage of uninsured people in Indiana with access to employer health coverage (21.8 percent) is modified from what is reported in the Indiana survey. The survey actually shows that about $31.1 percent of uninsured people in Indiana are eligible for coverage through an employer plan (***Figure 23***). However responses to a follow-up question indicated that about 30 percent of these people do not actually qualify for coverage (i.e., part-time, waiting period, etc.). Based upon these results we reduced the estimated percent with access to employer coverage to 21.8 percent.

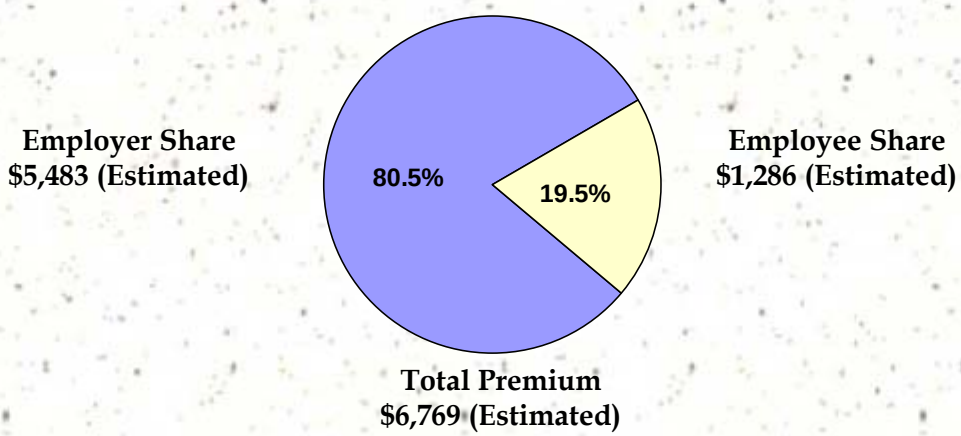
Figure 23
Uninsured in Indiana With Access to Employer Coverage



Source: "2003 Health Insurance for Indiana's Families Survey," Indiana Family and Social Services Administration, State Health Access Data Assistance Center (SHADAC), August, 2003.

Figure 24 presents estimates of average employer health insurance premiums in Indiana and the average portion of the premium paid by the worker. These data are taken from the 2001 MEPS employer survey data for Indiana discussed above, which we have updated to 2004 price levels.

Figure 24
Average Employer Premium And Employee/Employer Shares in Indiana in 2004



Source: Employer component of the Medical Expenditures Panel Survey (MEPS) data.

As shown in ***Figure 25***, we estimate that this program would induce about 118,650 uninsured people to take the coverage available to them through an employer, assuming the program is available to people living below 250 percent of the FPL. The total cost of premium subsidies for these people would be about $153.7 million. Coverage also could be extended to people living below 250 percent of the FPL who are already covered under employer plans. This would provide benefits to about 123,350 currently insured people at a cost of $81.3 million.

Figure 25
Premium Assistance: State Pays Employee Share for Workers Below 250 Percent of FPL

	Currently Uninsured who Declined Employer Coverage		Currently with Employer Coverage		Total Eligible Population	
Age of Member	Number of People	Cost of Subsidy (millions)	Number of People	Cost of Subsidy (millions)	Number of People	Cost of Subsidy (millions)
All Below 22% FPL	20,288	$26.3	25,233	$16.6	45,521	$42.9
22% to 100% FPL	21,101	$27.3	29,829	$19.7	50,930	$47.0
100% to 150% FPL	21,785	$28.2	13,209	$8.7	34,994	$36.9
150% to 200% FPL	28,847	$37.4	20,292	$13.4	49,139	$50.8
200% to 250% FPL	26,624	$34.5	34,782	$22.9	61,406	$57.4
Total	118,645	$153.7	123,345	$81.3	241,990	$235.0

Source: Lewin Group estimates using the Medicaid Eligibility Simulation (MEDSim)

The total cost of the program would be $235.0 million. This is the cost of paying the employee share of the premium for people with access to employer coverage who are living below 250 percent of the poverty line, including both uninsured people who are induced to take coverage and currently insured people who qualify. If a waiver can be obtained to implement such a program, the state cost would be about $88.8 million, with the federal government paying the balance of $146.2 million.

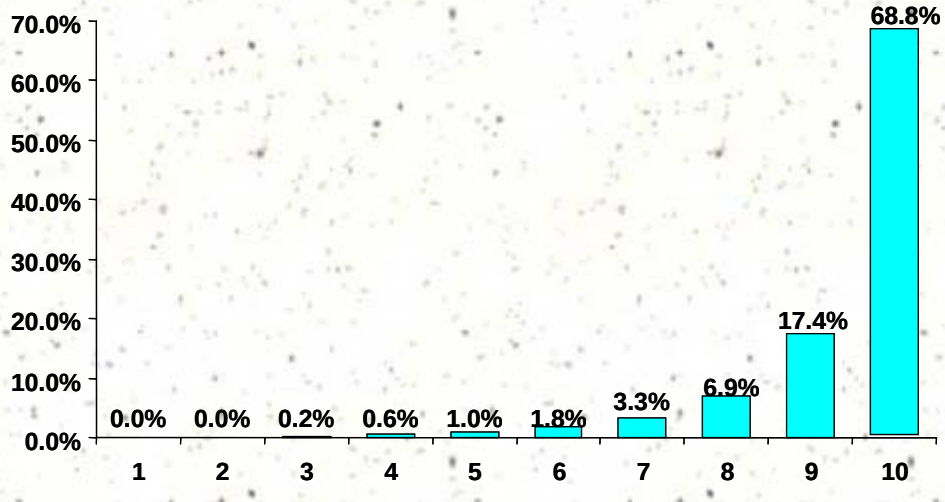
G. Reinsurance Model

One of the options that we analyzed would create a reinsurance pool for small groups that is designed to spread risk and stabilize premiums. Under this model, all employers who purchase health insurance for their workers would be required to participate in the reinsurance pool. The reinsurance pool would then cover costs over a specified amount for each person in these groups. All participating groups would then be required to pay a uniform premium per enrollee to the reinsurance program to finance the pool. This spreads the risk for high cost cases across all groups purchasing insurance in the small group market.

The program would actually be administered through insurance rather than requiring the employer to pay a reinsurance premium to the pool in addition to the premium they now pay to their insurer. The insurer would pay a uniform dollar amount to the reinsurance pool out of the premiums paid by the insurer (The reinsurance premium would be set at the amount required to fully fund the program). The insurer would also document cases with expenses in excess of the reinsurance threshold to the reinsurance pool, that would then make the payment to the insurer. This would make the reinsurance program transparent to the employers who purchase the coverage, except to the extent that the premium amounts paid by the employer.

As shown in ***Figure 26***, about 70 percent of all health spending is incurred by only about 10 percent of the population. These are typically people with acute conditions requiring inpatient hospitalization and/or other high cost services. Firms that accumulate a disproportionate share of high cost cases can have exceptionally high health care costs, resulting in significant variation in costs across groups. This can result in very high premiums for groups that insurers perceive to be likely to have a disproportionate share of such cases. Reinsurance can serve to spread the risk across groups and insurer more evenly resulting in reduced premium variation across groups.

Figure 26
Percent of Claims for a Typical Health Plan by Decile Ranking of Participants by Spending: Illustration of Reinsurance Concept



To illustrate, a program could be created that requires all employer groups with 50 or fewer workers who purchase health insurance in Indiana to participate in the pool. The pool would cover 90 percent of costs for each participating individual in excess of $35,000, which is on average equal to roughly 10 percent of total covered expenses for the privately insured population. Affected employer groups would then be required to pay a uniform reinsurance premium per enrollee that is designed to be sufficient to cover the full cost of reinsurance program costs.

As discussed above, the MEPS employer survey data for Indiana indicates that premiums average about $290 PMPM for people covered under Indiana employer health plans. Under this example, each employer purchasing small group insurance would pay a premium amount that is set at a level sufficient to cover the cost of all reinsurance payments under the program. Because in this example, the program is designed to cover about 10 percent of health spending, the reinsurance premium would be about $29 PMPM (i.e., 10 percent of $290).

The effect of this program is to level costs across firms with varying levels of risk. As discussed above, insurers in Indiana are permitted to vary small group premiums with risk characteristics such as age and health status.[10] Consequently, premiums tend to vary across groups in proportion to their expected costs. Reinsurance would have the effect of reducing this premium variation.

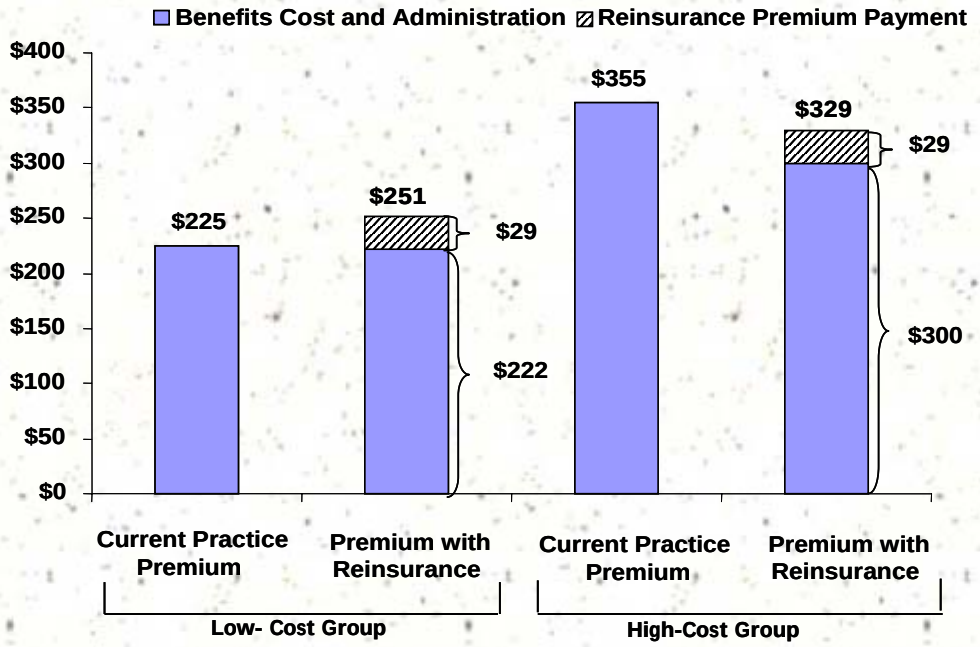
For example, consider a group with above average risk characteristics that is currently paying a premium of $355 PMPM, compared with the state-wide average of $290 PMPM (***Figure 27***). Lets also assume that benefits costs covered by the plan are reduced to about $300 PMPM due to reinsurance, for a savings of $55 PMPM (i.e., $355 PMPM - $300 PMPM). However, this group would pay a reinsurance premium of $29 PMPM bringing total costs for the group to $329. This is a net reduction in total spending for the group of $26 PMPM (i.e., $355 PMPM - $329 PMPM).

Costs would on average increase for groups with below average risk characteristics. For example, a lower cost group paying $225 might see savings of only about $3 PMPM due to the group's favorable health risk characteristics. However, these savings are more than offset by the $29 PMPM reinsurance premium. Thus, total costs for this group increase from about $225 PMPM without the reinsurance program to about $251 PMPM with reinsurance. Thus, while the reinsurance model reduces differences in premiums across groups, some employers would pay less while others would pay more.

This example illustrates that total health spending for small employers is not reduced by reinsurance. Total spending for small employers as a group is not reduced. For example, total costs for these two groups average about $290 both with (i.e., $251 + $329/ 2) and without the reinsurance program (i.e., $225 + $355/ 2). This reflects that changes in insurance vehicles, such as reinsurance - do nothing to change the actual cost of health services provided to participants. Thus it has little or no effect on average premiums.

[10] In Indiana, premium rates for similar employers may not vary from the midpoint rate by more than 35 percent above or below the midpoint rate.

Figure 27
Impact of Reinsurance on Monthly Premiums for Low and High-Cost Groups



For example, the average premium is currently $290 PMPM in Indiana. If we implement a reinsurance program, average benefits costs for all participating employer groups would decline by about $29 PMPM (i.e., 10 percent) to $261 PMPM (*Figure 28*). However, when the reinsurance premium of $29 is added back in, total costs are still $290 PMPM.

Figure 28
Reinsurance Has Little Impact on Average Costs if Funded With Insurer Premiums

Source: Illustrative Assumptions

However, reinsurance could have an effect on insurer administration and other retention costs including profits. For example, the use of a reinsurance mechanism reduces risk to the insurer that they will have unexpectedly high costs, which could result in a reduced allowance for risk in setting premiums (i.e., reduced risk premium). However, this is not likely to be a significant factor among insurers with risk pools that are large enough that overall costs are relatively predictable without the help of reinsurance. Also, reinsurance adds another layer of administration that will actually add to the overall cost of insurance.

Reinsurance does pool risk among insured groups resulting in reduced premium variation across groups. It can also serve to stabilize premium growth at renewal by adjusting premiums based primarily on the loss experience for all small groups. This would reduce the number of employers seeing avoids the groups who see very high premium increases (e.g., 20 percent to 40 percent) at renewal. It can also dampens the incentive for insurers to engage in risk selection by reducing the relative cost advantages of marketing coverage to healthier groups (i.e., "cherry picking").

However, reinsurance does not reduce system-wide health spending, and can actually add a small amount to overall health care costs. While premiums increase for some and decrease for others, the overall average premium is largely unaffected. Because overall costs are not affected, reinsurance will do little to reduce the number of uninsured. In fact some studies of risk pooling - and therefore premium leveling - have found that there can be loss of coverage among those lower-cost groups who would see premiums increase due to the reinsurance premium. In addition, reinsurance systems are vulnerable to the fact that lower-cost firms can escape the pool by adopting a self-funded plan – which is exempt from state regulation of insurance – and purchasing commercial reinsurance to guard against the risk of catastrophic losses.

H. Summary Comparison of Options

Figure 29 presents a summary of the cost and coverage impacts of selected policy options. These include expansions in Medicaid eligibility for parents and non-custodial adults with and without the buy-in to employer coverage for people with access to employer-sponsored insurance. We also present estimates under the Medicaid Buy-in option, which provides access to the Medicaid provider network and provider payment levels for lower income-people at a premium sufficient to fund the program. We also present estimates of the impact of creating a low-cost coverage option using reinsurance and the impact of a premium Assistance program for low-income people with access to employer health insurance.

For each of these proposals, we present estimates of the number of people enrolling and the reduction in the number of uninsured. We also show the net cost of these programs to the Indiana state government and the amounts that would be covered with federal funds. Results for variations on the Medicaid income eligibility levels and premium requirements can be taken from the detailed tables presented above.

Figure 29

Summary Comparison of Selected Coverage Expansion Alternatives

	Number Enrolled	Reduction in Uninsured	Total Program Cost (millions)	Federal Costs (millions)	State Cost (millions)
Medicaid Expansion for Parents (Section 1931)					
Parents Below FPL	62,375	49,679	$144.1	$89.8	$54.3
Parents and children Below 250 Percent FPL	160,149	122,170	$336.7	$209.8	$126.9
Medicaid Expansion for Non-Custodial Adults					
Non-Custodial Adults Below FPL	213,554	171,188	$572.3	--	$572.3
Non-Custodial Adults Below 250 Percent FPL	370,659	285,292	$1,065.8	--	$1,065.8
Medicaid Expansion for all Adults With and Without Buy-in to Employer Coverage					
All Below 250 Percent of FPL Without Buy-in to Emp. Coverage	530,808	407,462	$1,402.5	$209.8	$1,192.7
All Below 250 Percent of FPL With Buy-in to Emp. Coverage	530,808	407,462	$1,242.6	$184.6	$1,058.1
Medicaid Buy-In Option (i.e., People Permitted to Purchase Medicaid at Full Cost)					
Buy-In Participants	156,940	143,080	--	--	--
Low-Cost Insurance Product (i.e., Reinsurance and No Mandatory Benefits)					
Reinsurance Pool Participants	18,800	17,600	$7.0	--	$7.0
Premium Assistance for Low-income Uninsured With Access to Employer Coverage					
Uninsured with Access to Employer Coverage	118,640	118,640	$153.7	--	$153.7

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).