September 30, 2006

Dear Judy,

On behalf of the Indiana State Planning Grant, I am pleased to present our interim report. We appreciate your flexibility in providing a one-year extension, and I believe that will enable us to provide some very solid results. This report contains the results of our data collection, policy development efforts and more recent plans to implement a Medicaid expansion. We have made significant progress over the last couple of years, with huge strides coming in the last year, and our report will hopefully reflect our progress.

We look forward to continuing our efforts and sharing our progress with you and the HRSA staff.

Please call me at (317) 233-5711 or Project Consultant, Seema Verma at (317) 809-8536 with any questions or concerns you may have.

Sincerely,

Lawren Mills
Project Director
Indiana Family and Social Services Administration

Cc: Seema Verma

FINAL INTERIM REPORT

INDIANA STATE PLANNING GRANT

PRESENTED TO:

HEALTH RESOURCES & SERVICES ADMINISTRATION

September 30, 2006

EXECUTIVE SUMMARY

Health Insurance in Indiana

Indiana is below the national average for uninsurance, with Indiana at a 13.1% uninsurance rate versus 16.5%, nationally. However, over the past five years the number has grown, consistent with national trends and the nation's economic downturn. Most of the uninsured in Indiana are low-income adults with incomes below 200% of the federal poverty level (70%), and are employed by small employers, unemployed or a part-time worker.

Health insurance is primarily employer-based, and Indiana employers offer insurance at rates consistent with national averages. Small businesses in Indiana are less likely to offer health insurance; this is of particular concern as over 49% of Indiana businesses are small employers employing less than 50 employees. Take up rates are a concern in Indiana; 40% of uninsured Hoosiers have access to health insurance, but do not take it due to cost. Premiums have risen considerably in the State and employers have responded by shifting costs to employees. Higher health care costs for employees have been the focus of several labor disputes in Indiana. The difficulties of the uninsured are compounded by the fact that Indiana has numerous health professional shortage areas where there are a lack of providers and resources for the uninsured to receive care other than in the emergency room.

Project Activity

Indiana was awarded initial funding in July 2002. Additional funding and extensions were requested and provided in September 2003, 2004 and 2005. 2004 funding reflects pilot project funding. Recent focus of the grant has been on developing a proposal, titled Health INvest, to expand the Indiana Medicaid program to parents of Children's Health Insurance Program (CHIP) children to 200% of the FPL and childless adults between 100-200% of the FPL, and develop a reinsurance component that will focus on encouraging more small businesses to offer health insurance. This is a significant effort as the current program only funds non-disabled adults to 22% of the federal poverty level. Much effort has been expended on developing the financing, enrollment and eligibility plans for the expansion.

The grant dollars have supported the development of the key data reports as well as final recommendations of the Health Insurance for Indiana Families (HIIF), the bipartisan committee of key stakeholders. Key data reports that have been developed over the life of the grant include:

1) Household Survey of 10,000 Hoosiers to identify demographics of the uninsured - State Health Access Data Assistance Center (SHADAC)
2) Interviews of Key Stakeholders - State Planning Grant Staff
3) Assessment of the Indiana Safety Net - Health Management Associates, Health Evolutions and SPG staff
4) Analysis of the Major Health Programs and Their Funding - Health Evolutions

5) Focus Groups of Employers, the Uninsured, Small Businesses, and Insurance Brokers, and Physicians - Health Evolutions
6) Market Assessment and Analysis of the Indiana Health Economy and Drivers of Health Care Costs – Mathematica
7) Supplemental Focus Groups With Business Leaders- Health Evolutions (Year 3)
8) Actuarial Analysis of Policy Options - Lewin Group (Year 3).

The data collection was the main focus of Year 1 with the final reports produced in Year 2 and some in Year 3. These reports have provided critical information for the State in its efforts to develop a plan to expand its Medicaid program in more recent years. The household survey and focus groups helped to define the major characteristics of the Indiana uninsured, while better understanding community concerns. This data has helped frame the discussion and focus on key areas, such as the low-income uninsured and small businesses. The review of Indiana funding helped highlight the range of health programs, the source, and the amount of funding in Indiana. This data has been used to identify potential sources of revenue that could potentially be used/redirected to fund expansion programs. The Safety Net Assessment helped identify data needs for the State. More importantly, it highlighted the importance of solidifying a default system for the uninsured and the critical need to further develop the safety net, as it is unlikely that any State program could completely eliminate the uninsured. The actuarial analysis has been a major focus this year as the State focused on developing a financing plan for a Medicaid expansion.

Impact of Data

The collective data has been critical to Year 4 efforts that focus on developing the Health INvest plan. The data has been used to project number of enrollees and program costs. It has also been used to provide background information to explain the characteristics of the uninsured and root causes. Additional data from the reports have been used to connect uninsurance to economic development efforts and illustrate the impact of uninsurance on the economy to business leaders.

Mathematica, Inc. developed a study of the market forces in Indiana to identify the drivers of the recent, significant increases in health care premiums businesses and the effect this will have on the number of uninsured in the future. The study produced a macroeconomic view of the health care market place in Indiana, reviewing regulations, providers, insurers and employer experience, costs of care, utilization trends, and health status. These variables were analyzed and compared to other States to determine how they are affecting the cost of health insurance in Indiana. The study also examined the impact of health care costs and insurance premiums on the overall Indiana economy.

The Mathematica report will likely be the most important legacy of the SPG, as for the first time a variety of health care data was brought together in an attempt to draw conclusions on the course of the Indiana health care delivery system. The study revealed that costs of care were being driven primarily by hospital care, provider

practice patterns, and the low health status of Hoosiers. The study also revealed a large number of surgeons, an oversupply of beds, and availability of technology higher in Indiana as compared to national rates. This data has been the subject of much discussion and controversy, providing the impetus to take action. It has helped garner support within the Hospital Association to accept a hospital tax.

The Indiana State Planning Grant has had a significant impact on efforts to reduce the uninsured. Despite the political and economic barriers, the issue of the uninsured continues to gain significant momentum. When the SPG funding was awarded to the State, there was pessimism and skepticism about the success of the effort. Over the past three years, there has been increasing interest in the project's progress. The presence of the grant helped focus the new administration on addressing the uninsured. The SPG grant has been critical to continuing to highlight the issue of the uninsured and keeping the focus on solutions. The series of data reports has promulgated significant discussion and brought together key stakeholders together in a previously unseen collaboration in Indiana.

Policy Options:
The committee completed its final recommendations in October 2004. The recommendations focused on broad principles rather than specific programmatic principles. The diversity of the participants, as well as representation of key interest groups, made more detailed recommendations for sweeping change difficult. The committee recommended initiatives for small business, an expansion of Medicaid, and efforts to strengthen the safety net.

The safety net recommendations were largely intended to help expand existing services and to promote the creation of additional providers, through enhanced technical assistance and support to communities. These recommendations were used by the current administration to help the Health INvest proposal to expand the existing Medicaid population and to explore other options for small businesses.

Section 1: Uninsured Individuals & Families

Overall, 9.2% of Indiana residents are uninsured according to the 2003 Household Survey. Over three-fifths (61.2%) of the people in Indiana are covered by health insurance through an employer. An additional 3.5% purchased private individual insurance. Indiana's public programs cover 26.2% of the population. For context, the U.S. Census Bureau's Current Population Survey (CPS) 2001 estimate of uninsurance for Indiana is 11.8%. The charts below indicate data on the characteristics of the uninsured, including income, age, gender, family composition, health status, and employment status. We did not include any questions on immigration status for fear this would result in lower response rates.

Table 1 Indiana's Uninsurance Rates by Selected Population Groups

	Uninsurance Rate
Total Population	9.2%
Age	
0 - 5 years	4.9%
6 - 18 years	5.5%
19 -24 years	26.8%
25 –34 years	15.1%
35-54 years	9.8%
55-64 years	7.0%
65 years and over	1.1%
Race/Ethnicity	
Black/African American	14.1%
American Indian	7.9%
Asian	3.2%
Hispanic*	11.5%
White	8.7%
Other	8.4%
Marital Status	
Widowed	4.6%
Married	5.7%
Divorced	13.3%
Separated	12.6%
Living with Partner	25.7%
Single	19.4%
Family Income (% of FPL)	
<50%	16.8%
50-99%	22.6%
100-132%	21.4%
133-184%	17.6%
185-199%	14.3%
200-249	7.6%
250-299%	6.8%
≥300%	4.0%
Level of Education	
Less than High School	16.5%
High School Graduate	11.5%
Some College	8.1%
College Graduate	5.6%
Postgraduate	1.7%
Health Status	
Excellent	7.6%
Very Good	7.5%
Good	10.6%
Fair	16.5%
Poor	10.5%
Chronic Condition	
Functional impairment	10.1%
Asthma	12.0%
Diabetes	3.9%
Heart disease	4.1%
High cholesterol or blood pressure	6.6%
Stroke	1.5%

*For those reporting Hispanic ethnicity and some other race, Hispanic was selected as racial classification

Table 2. Uninsurance Rates in Indiana for Single Parents Under 65 Years	
	Uninsurance Rate
	Uninsurance Rate
Total Population	9.2%
Employment Status	
self-employed	13.3%
Employed by Someone Else	7.4%
Not Employed/Unemployed Worker	21.2%
Retired	3.4%
Student	8.5%
For Those Who are Employed	
Number of Jobs	
One Job	8.0%
More than one job	8.3%
Hours Worked per Week	
0-10	6.4%
11-20	11.1%
21-30	14.1%
31-34	7.8%
41 hours or more	6.1%
Type of Job	
Permanent	7.1%
Temporary	23.3%
Seasonal	18.6%
Full - Time	6.4%
Part - Time	12.6%
Size of Employer	
<11 employees	16.0%
11-50 employees	11.2%
>50 employees	7.7%

Kids in Household	53.8%	46.2%
No kids in Household	50.1%	49.9%

The household survey found that just over 40% of people in Indiana have potential access to either private or public health insurance coverage. An estimated 3 in 10 uninsured Hoosiers (31.1%) are potentially eligible for employer-sponsored insurance because their employer or spouse's employer offers coverage. An additional 12.7% are potentially eligible for coverage by a public program. However, 59.7% of people are not deemed eligible for either program. Uninsured adults are deemed eligible if their household income is 23% FPL or lower. Uninsured children are deemed eligible if household income is 200% FPL or less. A person, currently without insurance, was regarded as ineligible if he or she did not meet either requirement for public or employer-sponsored coverage.

The household survey asked respondents whether they had ever asked for or been given information about one of Indiana's public health care programs, such as Medicaid. Seventy percent of the survey respondents report not having received such information from any of the public health insurance programs. About three-quarters (73%) of uninsured people surveyed are willing to enroll in a public program if they learned they were eligible. When asked if they would enroll if the programs were free, this figure increases to 91%. These results indicate that the "eligible but not enrolled" group would enroll if they learned more about public health care programs.

People living in non-MSA areas of Indiana have slightly higher uninsurance rates than those who live in MSA areas. Using point-in-time estimates, the areas with the highest levels of uninsurance are in the eastern portion of the State (11.2%) and Northwest region (10.7%). By contrast, the Southeast region (8.3%) and Northeast (8.4%) have the lowest rates of uninsurance among the geographic regions examined in this analysis. A map of the State is contained in the Appendix. Among the MSAs, the highest rates of uninsurance were observed in the Gary (11.1%) and Muncie (10.5%) MSAs; the lowest rate was seen in Lafayette (4.5%).

The uninsured in Indiana rely largely on available safety net services, and many receive care in emergency rooms or through private providers. As a result, they report lower health status than the insured in Indiana.

Almost all those who participated in the key informant interviews and the household survey agreed that cost is the major barrier to health insurance. Affordable coverage is based on a percentage of income and varies according to income. Some populations may not value health insurance or think they need it. This is especially true in lower socioeconomic levels where health care is not valued in the context of other priorities, such as food and clothing. Not valuing health insurance may be especially true with younger populations, regardless of socioeconomic status.

The key informant interviews indicated that most people do not participate in public programs due to stigma attached with enrolling in these programs or not being aware of the programs that are available. Some immigrant populations are also distrustful of public programs.

As premiums have increased significantly in Indiana, many employers have shifted costs to their employees through higher deductibles and copays. So while people may have insurance, out-of-pocket costs are significant enough to deter them from seeking health care. We were not able to define this, but recognize that the underinsured is a growing issue in Indiana. Hoosiers are generally very concerned about health care coverage. However, the key informant interviews unanimously showed that most people are comfortable with employer-sponsored insurance, rather than a government-sponsored program. There is some interest in subsidies; however, tax credits were not considered to be an incentive to seek coverage, as incentives are difficult to implement.

Section 2: Employer Based Coverage

The State commissioned Mathematica Inc. to conduct a series of reports on the health care market in Indiana. As part of this analysis, a variety of data from the Indiana household survey, MEPS, and CPS data were used to construct a picture of the employer-based market. This data was used to reinforce to the State and policy makers that both low-income workers and small businesses must be addressed in order to increase coverage in the State.

Returning to a long term trend, employer coverage among Hoosiers under age 65 has fallen since 2000 due to fewer workers obtaining coverage from their own employers. For policy makers, this pattern may be both reassuring and disturbing. Stable coverage among dependents suggests that crowd out related to expanded public coverage for children are not growing. Small establishments in Indiana, as well as retail and general service establishments, with many part-time and low-wage workers all have distinctly low rates of coverage. Low employer offer rates remain an important obstacle to coverage in small establishments in Indiana. Yet, for part-time workers and low wage workers, eligibility and take up rates appear to be greater problems. The magnitude of these problems is apparent when we observe establishments where these workers predominate. In establishments where most employees work part-time or are low-wage, employers are less likely to offer coverage. When offered coverage, workers are both less likely to be eligible and less likely to take it up when eligible. This is true throughout the State, and geography does not appear to be an issue, although specific analysis has not been conducted.

Premiums and required employee contributions show very different patterns in Indiana for single and family coverage. Premiums for single coverage increased much faster than premiums for family coverage, and much faster than average wages in the state. This trend probably has contributed to the recent loss of direct coverage among workers in Indiana. Moreover, the striking lower growth of premiums in small firms and estimated in average premiums in low-wage firms- suggests significant changes in the design of the benefits they offer. The most likely explanation for these changes is a transition to greater employee cost sharing in these firms at the point they seek health care services.

Employee contributions for family coverage in small or low wage firms are much greater than such contributions in larger or higher wage firms for either single or family coverage. It seems likely that low-wage establishments epitomize problems that exist more widely in Indiana and will grow with the expansion of low wage jobs. These problems are: (1) employers who are unable to finance benefits by further raising employee contributions or suppressing wages, (2) employers who then scale back benefits to constrain premiums increases, and (3) low-wage workers without the means to pay the high contributions only enroll in coverage if they urgently need it. This pattern is likely to increase adverse selection in the small-group market, accelerate premiums for small low wage firms, and further erode coverage, as well as the adequacy of coverage, among low wage workers who maintain coverage.

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Section 3: Health Care Marketplace

The data on the health care marketplace is a collection of information from the Mathematica study, stakeholder interviews, literature review, and an assessment of other State efforts to expand coverage.

Currently, Indiana has a range of insurance products with a variety of benefits available. There is not much variation in benefits between the individual, small and group markets, as long as cost is not an issue. The products are offered by a variety of insurers. Indiana-based insurance company Anthem and some local hospital-owned insurance companies dominate the market. Indiana does have a number of self-insured plans, which makes the effects of regulation difficult.

Like other states, Indiana enacted a number of health insurance reforms in the last decade to comply with the federal HIPPA regulations. Indiana now requires small group insurers to guarantee issue and renewal, limits exclusions for pre-existing conditions, and prohibits insurers from considering health status in determining coverage eligibility within groups. In addition, Indiana constrains variation in the premiums that insurers can charge to small groups and mandates coverage of certain benefits and types of providers for small group plans. Indiana also prohibits insurers from considering specific claims experience, health status, or duration of coverage in underwriting small groups. Indiana also restricts the variation in premiums that insurers can charge to small groups, although the rate band is narrower, than in most other states.

Indiana regulates individual insurance less aggressively than some other states. Indiana insurers are not required to guarantee issue or to price coverage within rate bands, even for health status. However, Indiana has enacted some protections that may assist consumers. For example, insurers may not permanently exclude coverage for any medical condition, impose a waiting period longer than 12 months for coverage of pre-existing conditions, or use a look-back period that exceeds 12 months.

Indiana operates a high-risk pool to guarantee access for individuals' denied coverage in the individual market. With nearly 9,800 covered lives in 2002, Indiana Comprehensive Health Insurance Association (ICHIA), the State's high-risk pool, is now the sixth largest among the nation's 29 active risk pools. Like the experience of many other high-risk pools, enrollment has grown substantially. In 2002, net enrollment in ICHIA increased by 3,300 individuals for a net gain of 50 percent. ICHIA's recent enrollment growth has been faster than that in other states. ICHIA's benefits are comprehensive, and the waiting period is just three months for coverage of pre-existing conditions. In 2002, ICHIA enrollment represented just over 3 percent of Indiana's individually insured population, but less than 1 percent of the state's combined individually insured and uninsured populations. Unlike most other state pools, ICHIA accepts applicants only if they have been denied coverage in the market, not if they have been rated up—charged higher premiums due to health status. However, premiums are high, individual rates are not banded, and ICHIA caps premiums at 150% of market rates. Because ICHIA does not capture much risk, it is unlikely to either increase individual coverage or reduce market

premiums substantially. Overall, the affordability of coverage appears to remain a significant problem in Indiana, especially for older Hoosiers.

While other State experiences have been considered, Indiana legislators have only introduced legislation to allow mandate-light plans to be offered in the private market. Indiana's Chamber of Commerce and other business related organizations support efforts to allow some of the more costly mandates to be removed, so that coverage is more affordable. A statewide mandatory reinsurance pool has been considered, but discarded as a plausible option because of Indiana's high number of self-insured plans. Additionally, ERISA laws may make implementation unlikely and ineffective.

The Health INvest proposal will not achieve universal coverage. Currently there is possible funding to expand coverage to parents of Medicaid and CHIP kids to 200% FPL and childless adults from 100-200% FPL. Over 30% of the uninsured in Indiana earn over 200% of the FPL. The State has given careful consideration to the impact of the Medicaid expansion on the private market. It is hoped that the premium assistance option along with other provisions will help eliminate or reduce crowd-out. Additionally, the State's proposal will also address small businesses. Ultimately, the expansion in coverage will strengthen the safety net, as they will hopefully experience a reduction in their uncompensated care costs and will allow them to focus their resources on a smaller uninsured population.

Section 4: Options for Expanding Coverage

The HIIF committee completed its recommendations in October 2004. The new administration began in January 2005 and made the development of a proposal to address the uninsured a top priority and the focus of the pilot funding. Most of 2005 and 2006 was been spent exploring a range of financing options to support the expansion. The administration explored a financing strategy that would realign current spending on the safety net, specifically disproportionate share (DSH) funding and Medicaid upper payment limits (UPL). Currently, this funding is directed to providers; the goal is to empower individuals by providing them with health insurance. Health INvest calls for a hospital tax. The hospital tax would be a broad-based tax on all hospitals' and outpatient surgical centers' gross revenue. The tax would have an incremental increase over time to continue to finance the growing program. The last two pieces of the funding mechanism are a cigarette tax, which would generate $100 million dollars for the expansion, and possible federal funding through Costs Not Otherwise Matchable (CNOM). Program beneficiaries would also be required to make contributions.

Other features of the expansion will include a modified Health Savings Account and a basic benefits package that will provide preventative care services with first dollar coverage, up to $500. It will not cover brand name medications. or vision, or dental services. The benefits package excludes pregnancy coverage and mental health coverage as those are provided through our current Medicaid program for individuals up to 200%FPL. The benefits plan will include a deductible. We are also exploring the development of mechanisms and incentives to providers to encourage increased focus on

prevention and conduct health assessments on their clients. Health INvest also allows beneficiaries to apply their subsidies toward their employer sponsored plan. Finally, Health INvest will include a proposal to restructure the small group reinsurance pool.

Section 5: Consensus & Building Strategy

The Indiana Family and Social Services Administration (FSSA) serves as the State Planning Grant recipient and also provides key leadership to the project. Secretary Mitch Roob personally oversees the development of Health INvest and has also assigned his key staff to the project. The Governor and his staff are also involved with the development of Health INvest. Lawren Mills and consultant Seema Verma are providing assistance to overall development. FSSA has contracted with Health Management Associates (HMA), the Lewin Group, Sellers and Feinberg, Milliman, to help support the development of the plan. We benefit from the additional staff involvement of FSSA's Chief of Staff, Medicaid and Health Policy Director, Legislative Affairs Director and Communications Director.

Secretary Roob is currently at the helm of efforts to develop consensus around the financing plan and build legislative support. He has had many meetings with insurance carriers, the Indiana Hospital Association, safety net hospitals, and Medicaid managed care organizations. These meetings are designed to allow for input into the proposed expansion plan. Secretary Roob has conducted meetings around the state to gain input from constituencies in every geographic area. Legislation will be needed to move forward with the expansion. Secretary Roob has begun to, and will continue to meet with key Legislators involved in health policy. Grant funding has been used to develop a communications plan and materials including a website that contains all materials that will help focus the message and explain the expansion program to audiences.

The political environment in Indiana currently is favorable to pass the expansion program in full. The Governor is reviewing Health INvest is expected to endorse it. Important key legislators on a bipartisan basis are engaged in discussion with Secretary Roob on the expansion program. Secretary Roob will be presenting the program on October 17, 2006 to a summer legislative committee for the first stage of approval.

Section 6: Lessons Learned & Recommendations to States

The State specific data was critical to the development of the Health INvest proposal. The data helped move discussions from the anecdotal to more substantive issues. The qualitative information was useful to get a sense of the pulse of the community. The staff was not originally aware of the importance of addressing issues with the health care delivery system. The stakeholder interviews were of utmost importance to this effort. This helped shaped the direction of data collection efforts and shaped the Year 2 supplemental funding that focused on addressing the Indiana health care cost drivers.

The market analysis and study of the Indiana cost drivers will likely be the legacy of the SPG. The study conducted by Mathematica attempted to examine a cross section of health care data, including utilization, cost, and health status to determine the growth in cost in Indiana. Such data had never been compiled and examined in total, and addressed some of the key facets contributing to uninsurance in our State. This data received the most attention both within and outside of the committee. Although the results were controversial, it helped forge a discussion of the Indiana health care delivery system. While recommendations for addressing the uninsured are important, we believed it was also important to addressing the core causes of uninsurance, especially those that relate to the health care delivery system. Having this data earlier in the process may have resulted in more substantive recommendations around the health care delivery system. Much of the other data, the household survey, focus groups, etc, ended up reflecting the national picture. While still important to our discussion, the data supported much of the anecdotal evidence, whereas the cost driver study provided brand new information.

Indiana completed all of the data collection it originally set forth to complete. The safety net assessment was probably the most difficult as there was a clear lack of information available in the State. The consultants that developed this report cited this as a major barrier to completing the report, and more data is needed to conduct a more focused geographic picture of the uninsured. The focus groups relied on using existing meetings of target audiences to conduct their focus groups, which was the best method of convening the appropriate participants.

The SPG studies revealed that costs of care were being driven primarily by hospital care, provider practice patterns, and the health status of Hoosiers. The study revealed the large number of surgeons, an oversupply of beds, and increased availability of technology in Indiana as compared to the nation. This data has been the subject of much discussion and controversy. While health status and hospital building were already being discussed, practice patterns and the utilization of technology were not recognized as issues. The data helped confirm some of concerns about hospital building in Indiana. This is expected to impact the insurance industry and providers, but at this time it is too early to determine the effect this data or the potential policy options will have on the insurance market.

Section 7: Recommendations to the Federal Government

Moving, forward Indiana recommends the federal government provide funding to support on-going research around the uninsured. Many of the data collections are valuable but only for a defined time period, these reports need to be updated and support from the federal government would be helpful. While the national data sets are useful, it is always more helpful to have more specific State, county and city data. The presence of Academy Health and the State Coverage Initiatives (SCI) has also been extremely helpful. The ability to contact a single source that has its pulse on state efforts as well as key experts has been critical and will be moving forward. SCI has provided Indiana with a great deal of technical assistance and has also put us in touch with consultants that have helped shaped our policies.

The SPG grant process has helped give rise to many efforts to address the uninsured. It will be helpful to evaluate those efforts so that other States may learn from those experiences. Evaluation should cover not only the number of people covered but the overall impact on the health care market place and the safety net.

Section 8: Overall Assessment of SPG Program Activity

Indiana is highly likely to submit a plan to CMS for a Medicaid waiver and will also see legislation in 2007. We have already had conversations with CMS and they have been very positive. The effect of the SPG grant has been more positive in the last 2 years largely due to our leadership changes. The grant was helpful in developing research and gathering data but could not incite outcomes without the leadership of the administration.

As stated earlier, Indiana will explore a Medicaid expansion and reinsurance model for small businesses. At this point it has been a monumental task to gain the support of the Executive branch. Never before has there been so much interest on health care for the uninsured. We have also had support from the legislature. It is hard to predict the overall outcome at this point, and we will have a better idea early next year when our Legislature convenes.

The likelihood that the Health INvest program that was developed under the SPG program will be implemented is high. Indiana is moving forward with policy development and is gaining momentum on obtaining Legislative approval. Pending Legislative approval, Indiana will move forward with implementation of the program. The sustainability of the program is planned to be long term. While working out the financing Indiana was diligent in working out financial sustainability of the program.

The SPG program activity created momentum to expand the Medicaid program and with that expansion make changes only to that population that would be covered under the expansion. No changes to the existing Medicaid program were made due to the SPG program.

There is reluctance to expand social programs and the impact an expansion could have on the State's budget.

The data collection effort was critical. Without it, we would have no basis for developing our proposal. We had the data we needed at our finger tips when our leadership was ready to move on a proposal.

There are no specific data collection activities that Indiana would have conducted differently based on our experience.

Our stakeholder groups have changed over time as we have learned that steering committees have limited value. In some ways they slowed the process down as it was difficult to gain consensus around a single plan. The committee ended up embracing

concepts and generalities. The administration used those to develop its proposal. The committee with inherent opposing viewpoints was not likely to develop a single plan.

We plan to end the data collection activities as a result of the SPG grant coming to a close. We will continue the policy development and analysis component.

Academy Health was critical to our efforts. Time and time again we have sought their expertise and have always met a very helpful staff. They gave us constructive feedback and also put us in touch with other key experts. Their meetings is particular were always on the pulse of the latest policy debate and were very timely.

The HRSA SPG meetings were helpful in that they helped provided a network of technical assistance, and allowed us to meet with people facing the same challenges.

The project and SPG program was particularly helpful in the early years when we were developing our survey. The calls they held after CPS released their annual data were also helpful.

We did not use the Arkansas Mulit-State Integrated Database System.

We did not use the Agency for Healthcare Research and Quality's technical assistance and survey work.

As discussed earlier, the SPG grant will leave a legacy of initiating the discussion around the uninsured, providing solid evidence and data to keep policy issues. If our State passes legislation expanding Medicaid and for a new reinsurance pool, the grant will be ultimately responsible for supporting this effort.