Independent Evaluation of Indiana's Children's Health Insurance Program

Final Report – April 2011

BURNS & ASSOCIATES, INC.
Health Policy Consultants

3030 North Third Street, Suite 200
Phoenix, AZ 85012
(602) 241-8520
www.burnshealthpolicy.com

Executive Summary

As of November 2010, enrollment in Indiana's CHIP was at an all-time high of 83,693, a 4.9 percent increase over the prior year. Over the last five years, enrollment has grown 18.2 percent. Continued enrollment growth in Indiana's CHIP has made Indiana's program more successful than many other states' programs in lowering the uninsured rate among children in low-income families. Indiana's uninsured rate among children in families below 200 percent of the Federal Poverty Level (FPL) is now 9.7 percent compared to the national average of 16.4 percent. This places Indiana 9th lowest among states nationally. The most recent estimate for Indiana is a slight increase from the all-time lowest uninsured rate reported last year of 8.6 percent[1].

Indiana's CHIP eligibility has expanded over time since the original federal legislation was introduced in 1997:

- CHIP Package A (the Medicaid expansion portion) covers uninsured children in families with incomes up to 150 percent of the FPL ($33,075 per year for a family of four in 2010) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.

- CHIP Package C (the non-entitlement portion) rolled out in two eligibility increments. Families in CHIP Package C pay monthly premiums whereas the families in CHIP Package A do not. In addition to the income tests shown below, children cannot have insurance coverage from another source.
    - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 150 percent up to 200 percent of the FPL ($44,100 per year for a family of four in 2010).
    - The second portion was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL ($55,125 per year for a family of four in 2010).

The largest enrollment growth has been among families enrolled in CHIP Package C. In the last five years, this portion of the program has grown 44 percent (compared to a 9.6% increase in CHIP Package A).

Each year, an independent evaluation of Indiana's CHIP is conducted as required by Indiana Code 12-17.6-2-12 which states that

> *Not later than April 1, the office shall provide a report describing the program's activities during the preceding calendar year to the:*
> *(1) Budget committee;*
> *(2) Legislative council;*
> *(3) Children's health policy board established by IC 4-23-27-2; and*
> *(4) Select joint commission on Medicaid oversight established by IC 2-5-26-3.*

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2010. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP, with support from the Division of Family Resources which conducts eligibility determinations.

[1] Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. http://www.census.gov/hhes/www/hlthins/lowinckid.html

Background on Indiana's CHIP

The enrollment of children in Indiana's CHIP is spread proportionally across the regions of the state when compared to the overall census of children in each region. Half of the children enrolled in the CHIP are between the ages of six and 12. This is because children under age six are eligible for Medicaid at higher family income levels. Just over 35 percent of CHIP enrollees are teenagers, while the remaining 13 percent are under age five. This distribution has been the case since the CHIP was introduced.

All CHIP members enroll in the OMPP's Hoosier Healthwise program in the same manner as children and parents in the Medicaid program. CHIP families select from one of the three contracted managed care organizations (MCOs)—Anthem, Managed Health Services or MDwise.

There are only slight differences in the benefit package offered between CHIP Package A and CHIP Package C. Co-pays are charged to CHIP Package C members for prescription drugs and ambulance services, and monthly premiums are also charged to CHIP Package C families on a sliding scale based on family income and the number of children enrolled.

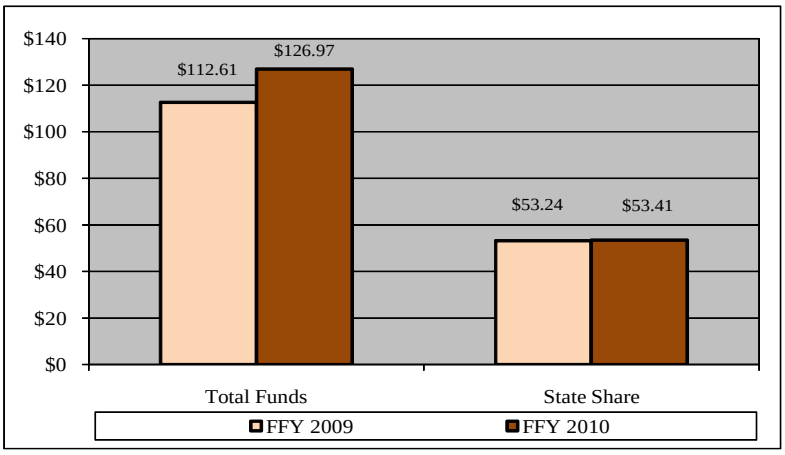
Premiums Charged to Families in Indiana's CHIP Package C

Family FPL	Monthly Premium for 1 Child	Monthly Premium for 2 or More Children
150% up to 175%	$22	$33
175% up to 200%	$33	$50
200% up to 225%	$42	$53
225% up to 250%	$53	$70

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states, subject to an annual cap. In the CHIP, however, the federal match rate is higher than Medicaid. For example, in Federal Fiscal Year (FFY) 2010, for every dollar spent on medical services in Indiana's CHIP, the state paid 23.85 cents and the federal government matched the remaining 76.15 cents. In the Medicaid program, the federal government match rate was 65.93 cents. However, for a time-limited period, the federal government has been matching at an enhanced rate that was allocated under the American Recovery and Reinvestment Act of 2009 (ARRA).

Because of the higher federal match rate and the premiums paid by CHIP Package C families, the state share paid towards CHIP Package C members was only $53 when measured on a per member per month (PMPM) basis in FFY 2010. This remained unchanged from FFY 2009. The PMPMs shown here are lower than the amount paid for children in Medicaid portion of Hoosier Healthwise.[2]

Trends in the Medical Cost Per Member Per Month (PMPM) For the Premium Portion of CHIP (CHIP C)



Source: CMS-21 expenditure reports submitted by the State to CMS. Member months derived by B&A from OMPP's data warehouse.

[2] It was discovered after publication of last year's report that the PMPM figures shown for FFY 2008 and FFY 2009 in last year's report were incorrect. Please use the figure shown in this report to compare across years.

Member Satisfaction

The OMPP requires the Hoosier Healthwise MCOs to conduct a survey of parents of children in the program each year. The survey includes a sample of both CHIP and Medicaid children. The mail survey is a standardized tool used by Medicaid health plans nationally and results are reported to a national organization to benchmark plans against each other. In this past year's survey, Indiana's all three Hoosier Healthwise MCOs rated higher than national benchmark on member satisfaction for questions related to Getting Needed Care, Getting Care Quickly and overall Rating of Health Plan. Anthem and MDwise also exceeded the benchmark score last year and Managed Health Services was at the benchmark last year.

Access to Services

B&A examined the accessibility for Hoosier Healthwise (CHIP and Medicaid) children by reviewing the results of reports submitted to the OMPP by each MCO. The OMPP requires that there be a primary medical provider (PMP) within 30 miles of each Hoosier Healthwise member's home. The maps for all three MCOs showed that this threshold is met in every part of the state.

B&A also reviewed access by examining where CHIP members receive primary services and preventive dental services. We matched claims of actual services received at the county level between where the member lives and where the attending provider is located. Of all CHIP members that had a preventive dental visit in CY 2010, 94 percent of children obtained their visit either in their home county of residence or in a contiguous county. Only one county (Whitley) had a high proportion of dental visits received from members from a county not connected to their home county.

For primary care visits, B&A first examined the counties where there may be an access issue because the number of patients that providers are willing to accept (the doctor's panel) for Hoosier Healthwise is greater than 80 percent of the total that the providers in that county contracted for. As of December 2010, there are 15 counties where the pediatric providers' panels are above 80 percent. We then examined the location where CHIP members access primary care using the same method that we did for the dental analysis. When we compared the counties where members traveled further to have a primary care visit against the counties with limited panel capacity, only one county—Tippecanoe—appeared to have limited access for CHIP members based on the data studied.

Service Utilization

B&A measured the percentage of CHIP children that used primary care services, emergency room visits, preventive dental visits, and had a pharmacy script for the periods FFY 2009 and FFY 2010. The overall rate of usage for each category remained unchanged over the two years. Comparisons were also made across various demographic cohorts, such as by MCO, by age and by race/ethnicity.

Percentage of CHIP Children Using Each Service
(for children enrolled at least 9 months in the year)

	in FFY 2009	in FFY 2010
Primary Care Visit (office or clinic setting)	70%	71%
Emergency Room Visit	30%	29%
Preventive Dental Visit	62%	63%
Pharmacy Script	70%	71%

B&A also analyzed the rate at which these services were used by calculating a utilization rate per 1,000 CHIP members overall for 2009 and 2010 and also by each of the demographic cohorts.

Some of the key findings from these analyses are:

- Primary care visits were more prevalent among younger members, as 80 percent of children age five and younger had a visit in FFYs 2009 and 2010. The percentages of children in the older age groups that had a primary care visit were lower (69% for age 6-12 and 67% for age 13 and over in FFY 2010).

- When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other race/ethnicities. African American and Hispanic CHIP children had primary care visits at the same rate in each year (60% and 62%, respectively, in FFY 2010) but it was significantly below the 75 percent rate for Caucasian children.

- In addition to more actual children having a primary care visit, there is also a disparity in the number of visits per 1,000 CHIP children for primary care in an office setting. The rate for Caucasian children is approximately 150 per 1,000 children in any given month, but the rate for African American and Hispanic children is closer to 100 per 1,000 children.

- There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCO, but it more pronounced when reviewed at the per 1,000 member statistic. In CY 2009 and 2010, the average rate among MDwise members was 52 ER visits per 1,000 CHIP members; for Anthem, it was 33 per 1,000; for MHS, it was 38 per 1,000.

- Differences in ER use are found by age group within the CHIP. The highest use is among children under age five (37% of all members in FFY 2010) and lowest among children age six to 12 (26% of all members in FFY 2010).

- One in four CHIP members of all race/ethnicities had used the emergency room in each of the years studied, but African-American children were more likely to have had multiple visits.

- The overall percentage of CHIP members receiving a preventive dental visit was 62 to 63 percent in both FFY 2009 and FFY 2010. This is an increase from 58 percent in FFY 2008.

- The rate of preventive dental visits varies some for CHIP children by region, from a low of 58 percent having a visit in FFY 2010 in the Southeast Region to a high of 68 percent in the East Central Region.

- There is little difference from the statewide average in preventive dental usage among the race/ethnicities studied.

- The overall percentage of members that had a pharmacy script has remained relatively unchanged (71%) in the last two years, but was highest among children under age six (78%).

- The trend in total scripts received, however, is different. The number of scripts per 1,000 CHIP members is highest for children age 13-18 (566 per 1,000 on average in each month of CY 2009 and CY 2010), followed by children age 6-1 2 (426 per 1,000), then by children age 1-5 (334 per 1,000).

- Caucasian children have a utilization rate of 533 scripts per 1,000 members each month, which is 52 percent higher than the rate for African-American children (351 scripts per 1,000) and more than double the rate for Hispanic children (241 scripts per 1,000 children).