Indiana Comprehensive Health Insurance Association

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Indiana Comprehensive Health Insurance Association
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Director Horst:

Program Overview:
The Indiana Comprehensive Health Insurance Association (ICHIA) was created by the Indiana General Assembly in 1981 as a not for profit association to provide health insurance for Indiana citizens who were unable to obtain medical coverage in the open commercial market. The ICHIA program operates as a safety net for our State's uninsurable by providing health insurance to all designated as eligible under the law.

There are currently approximately 7,300 participants in the program. Enrollment occurs throughout the year and the rates are reviewed and actuarially determined on an annual basis. The statute designates that the rates may not be more than one hundred fifty percent (150%) of the average premium rate charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year.

This program was enacted to address the increasing number of uninsured and was designed in accordance with the model recommended by the National Association of Insurance Commissioners. These programs are now referred to as High Risk Programs by the federal regulatory entities involved in their oversight. They are an alternative to Guaranteed Issue, Assigned Risk, or other mandated health insurance coverage.

ICHIA also manages the care of patients in two (2) other State programs:

- The State Alternative Mechanism for those citizens with portability rights under the Health Insurance Portability and Accountability Act (HIPAA) and manages those eligible under the Act's provisions. There are currently approximately 3,000 covered under this program.
- Enrollees in the Healthy Indiana Program that are high risk and high cost patients. The Enhanced Services Plan is the name of this program. There are currently approximately 1,000 covered under this program.

Summary of Recent History:
ICHIA was a small and stable program well into the mid 1990's. The membership grew slowly and steadily as did the net losses. However, the program grew drastically in membership and net losses during the period from 1997 through 2002. Several severe medical cost disease conditions, such as AIDS/ HIV patients, Hemophilia patients, Kidney patients and other conditions that were subsidized by sponsoring

organizations were legislatively allowed into the ICHIA program causing its losses to skyrocket. The net losses in the ICHIA program rose from $17 MM in 1997 to $66.7 MM in 2002.

Aggressive medical management initiatives were undertaken, and those combined with the legislative actions taken in 2003 and 2004 brought the net loss down from $66.7 M in 2002 to $29 M in 2004.

Those legislative changes included revision to the funding mechanism, revising the eligibility requirements, adding mandatory participation in the disease management programs, and increasing the residency requirement for participation from 90 days to 1 year. Further, the provider reimbursement rates were reduced to Medicare +10% for a 1 year period.

Funding:
Currently the ICHIA net loss (premiums minus expenses) is divided between the State (75% of the net loss) and the State licensed insurance carriers (25% of the net loss). Tax credits previously granted to carriers have been eliminated for assessments paid after January 1, 2005.

Current Situation:

Beginning in the 2nd quarter of 2009, the State Department of Health began increasing the number of HIV positive patients it placed in the ICHIA program from approximately 1,100 to over 1,500. This increase in exceptionally high cost patients, and in particular the drug expense, caused the overall medical cost of the program to increase dramatically.

What are the causes of the large cost increase?

1. The HIV/AIDS patients (1,511 designated as ISDH) now represent over $30,000,000 per year in drug expense alone.
2. Hemophilia patients (52) represent approximately $20,000,000 per year in blood factor cost.
3. Overall, the pharmacy costs have increased to almost $50,000,000 per year, an increase of 16% during 2010. Specialty Drug Treatments have increased sharply as well. In particular, there are now 2 patients that have an Enzyme Deficiency with the cost for treatment for each at approximately $1,200,000 per year.
4. Medical costs continue to climb generally and the actuaries are anticipating that trend will continue. The anticipated medical cost increases over the next year for Indiana is in the range of approximately 8 to 12% per year.
5. The continued introduction of new and costly technology has a disproportionate impact on this population of high intensity and specialized services utilizers.
6. Increased hospital and outpatient surgery services have had a significant impact on the cost to this population in the last 3 years.
7. The growing lack of primary care providers has increased the emergency room instances, especially in the rural areas, and those costs are quite high for patients with numerous medical conditions.

What has or will be done to address the cost increase?

1. The premiums of the participants were increased twice in the last 12 months. The combined increase was 14%.

2. The pharmacy benefit was changed to increase the deductible of each plan type by $200 per year.
3. The pharmacy copays for each tier were increased by $4 for a 30 day supply and $10 for a 90 day supply.
4. Implementing an added Drug Compensation for the ISDH members ($5M/year savings).
5. Implementing a Specialty Drug Treatments home infusion protocol to target ways to reduce this expense.
6. Negotiate an additional 7 – 10% discount from highest medical provider organizations ($5M/year savings).
7. Expand the Enhanced Care Model across the State for the highest cost cases ($1.5M/year savings).
8. Continue to increase premiums beyond the budgeted amount to maintain a spread of 1 to 2% over the medical cost trend (each 1% increase represents approximately $600K in 2010; $1.2 M/year savings).
9. Modify the RX copays to add tier for specialty drugs/ therapies ($1M/year savings).
10. Maintain the current cost for all administration services through June 2013 (eliminating the increase assumed represents approximately $120K/year savings).
11. Modify the Medical Management Contract with APS to redirect their services to targeted conditions ($200K/year savings).
12. Impose a greater coinsurance (50% rather than 40%) if care is provided outside the State when the services are available in State ($300K/year savings).

What legislative actions are possible

1. Revise the eligibility provision to require applicants to first apply for the Pre-existing Condition Insurance Plan (the new Federal High Risk Plan) and the Healthy Indiana Program. ICHIA applicants are already required to apply to Medicaid first.
2. Authorize the ICHIA Board to implement a reduced reimbursement rate at not less than Medicare +10%, and revise the no balance billing language to clarify the applicability to the new reimbursement mechanism.
3. Cap the membership and stop taking new enrollees.
4. Impose a penalty for employers, brokers, and agents to exclude ("Dumping") an employee from their group coverage due to a medical condition(s).

Summary

In summary, the ICHIA program has made great progress in reaching solutions for the many recent challenges it has faced and will continue to do so. The problems created by the increase in high cost participants create an immediate impact that takes some time to mitigate. Simply stated, there are things that can and are being done to improve the cost spike, but these take time to fully implement and reverse the trend. The Board of Directors remain committed to managing the Association to serve the direction of the legislature. Comprised of the Insurance Commissioner, the State Budget Agency, and senior executives of the health insurance industry, the Board has been very quick and effective in addressing the challenges in this program. However, the changes that are scheduled to take place as a result of the new

federal Affordable Care Act and the likely continued increases expected in medical costs, will produce significant cost demands in this program.

The need for an insurance option for those unable to obtain coverage elsewhere is greater now than ever. There have been more small employers dropping their group insurance, and more terminated employees forced to seek individual coverage with pre-existing conditions that exclude them from the commercial market. Without the ICHIA program, these citizens would not only be uninsured, but generally uninsurable and their cost would virtually all be uncompensated care. In addition, the growing number of uninsured due to "Baby Boomers" increasing medical conditions, high commercial medical cost and trend, and greater uncertainty in the commercial carriers offerings, all underscore the importance of this high-risk program.

With the expected advent of the health insurance Exchange to begin on January 1, 2014, the mission of the ICHIA program will have been met and will no longer be necessary. The elimination of pre-existing exclusions and the inability to exclude applicants for coverage means the ICHIA program can be legislatively terminated. Simply stated, the approach now becomes developing a strategy that will address the short term needs to maintain the program until December 31, 2013 when the Exchange is scheduled to be in place.

Respectfully submitted

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