Indiana Department of Health

2027 Open Enrollment 101

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Medical Services Director

August 28, 2026

AGENCY PRIORITIES

1. Improving Maternal and Infant Health
2. Prevent Chronic Disease
3. Strengthen Data Quality and Transparency

Agenda

- ADAP landscape
- Open Enrollment guidance
- Medicaid work requirements
- Other federal/state updates
- Question and answer
  - Please hold questions until the end or place them in the chat.

ADAP Landscape

Open Enrollment Guidance

Medicaid Work Requirements

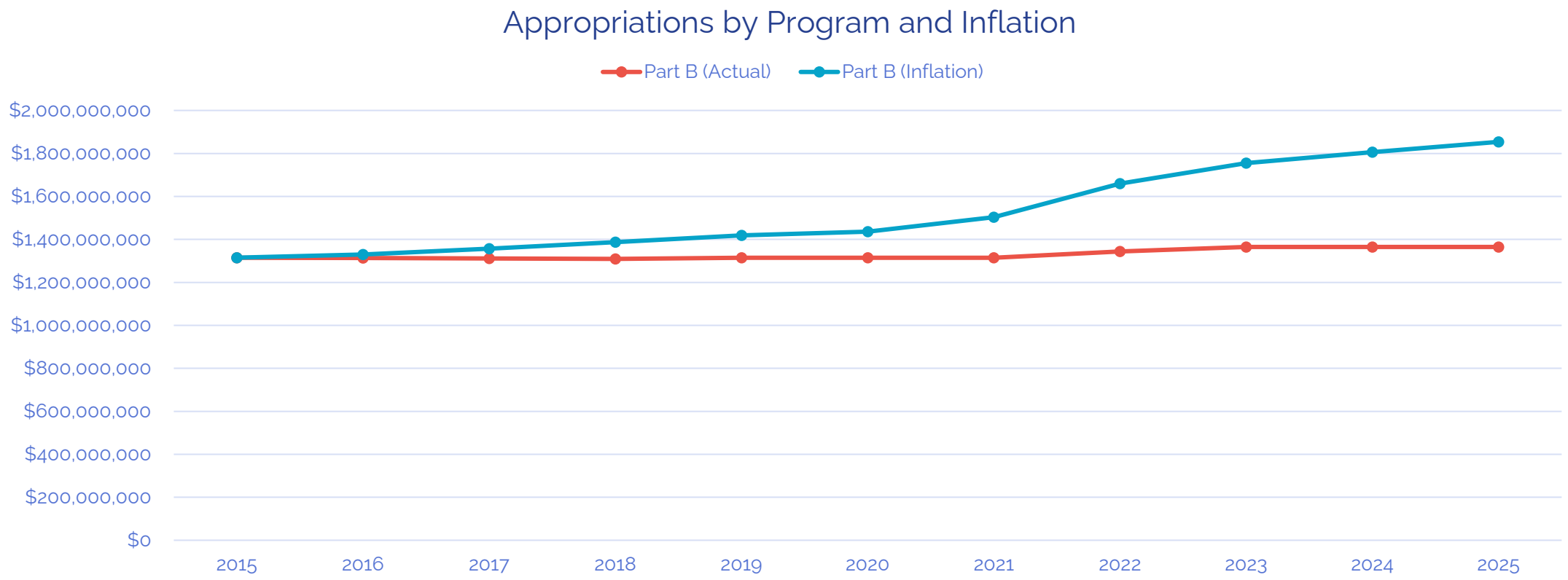
Other Federal/State Updates

Questions and Answer

At the National Level

Factor	Description
Flat federal funding	No increase in federal appropriations since 2014 amid inflation
Rising costs and demand	Increased drug costs, enrollment surge, and higher premiums
Federal policy rollbacks	Medicaid, ACA, and Medicare cuts leaving more uninsured
State budget constraints	Reduced funding leads to eligibility cuts and formulary restrictions

Flat Federal Funding



Sources: HRSA (2025), CPI-U annual averages (2015–2025), U.S. Bureau of Labor Statistics

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Importance of Rebates

- With flat federal funding, ADAPs have become more dependent on 340B rebates to ensure solvency
- ADAPs are eligible to collect 340B rebates on medications purchased by the ADAP, either full-payment or partial-payment
- IDOH collects rebates, generally, on a quarterly basis
- Rebates are invoiced after claims are paid, creating a lag between spending and reimbursement
- Rebate timing impacts cash flow and affects the program's ability to encumber funds
- Rebate revenue fluctuates based on client mix, drug utilization (e.g., Biktarvy vs. Cabenuva), and marketplace pricing
- Increasing shifts to high-cost regimens can raise spending before rebates arrive

Rising Costs and Demand

High cost of long-acting injectable ART

- Long-acting HIV treatment and PrEP products carry substantially higher per-patient annual costs, increasing ADAP spending even with modest uptake

Medication	Monthly Cost (Avg)	Annual Cost (Avg)
Biktarvy – Oral tablet (daily)	~$4,000	**$48,000** per year
Cabenuva – Long-acting injectable (6 doses/year)	~$6,500	**$78,000** per year

Preference to new branded regimens with limited generic alternatives/use

- Modern preferred ART regimens remain brand-only, preventing cost relief from generic competition

Inflationary pressures on all HIV medications

- Year-over-year price increases outpace flat federal ADAP appropriations, creating structural funding gaps

Federal Policy Rollbacks

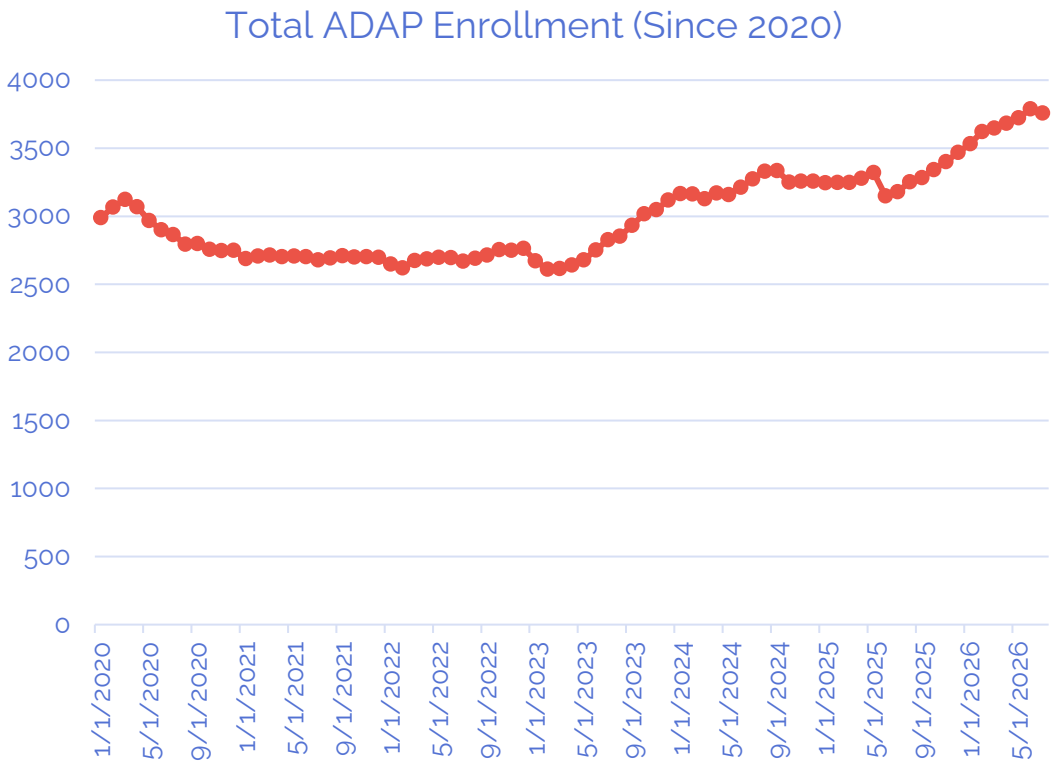
Marketplace

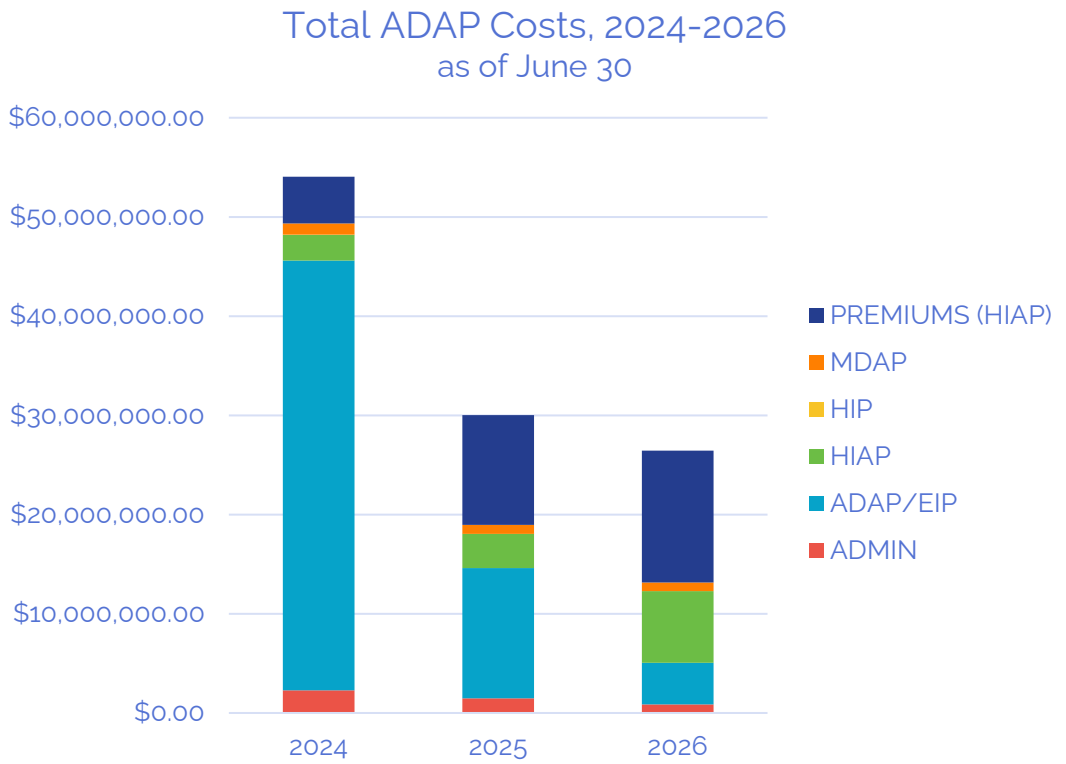
- **Elimination of enhanced PTCs and low-income SEP**
  - Effective Jan. 1, increased premiums and cost-sharing nationwide due to the healthy individuals not enrolling or leaving the ACA marketplace

Medicaid

- **Work/community engagement requirements** (more on this later)
  - Effective 2027, a recent CMS Intern Final Ruling restricts the definition of "complex and serious medical condition" to be based on capability rather than diagnosis. People living with HIV will likely not be exempt.
- **Six-month redeterminations**
  - Effective 2027, requires states to complete six-month redeterminations instead of 12-month.
- **Cost-sharing for expansion adults**
  - Effective 2028/2029, increases cost-sharing for Medicaid expansion

At the State Level





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OE Preliminary Guidance

OE Guidance

- Special Enrollment Period applications are NOT accepted during OE
- New priority measures for OE (see next slide)
- New insurance carriers this OE - TBA!
- Need to ensure equal client distribution between insurance carriers this year
  - Care sites will receive enrollment quotas for each carrier

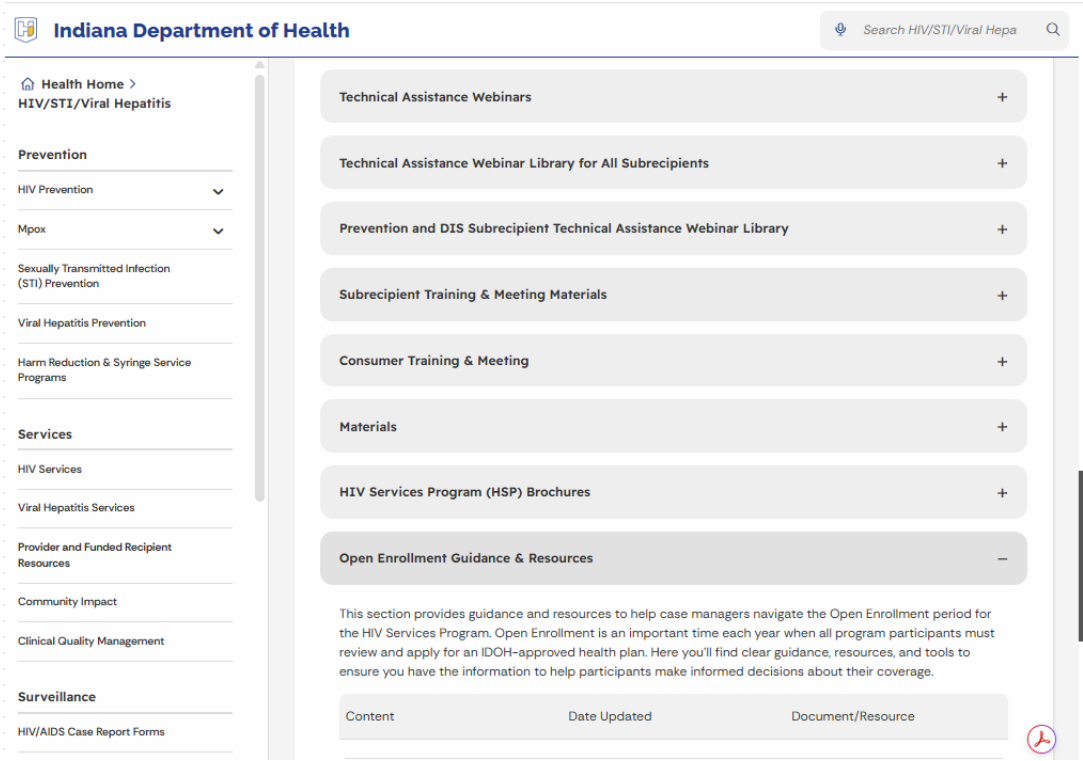
OE Timeline

Nov. 1, 2026	• Open Enrollment begins!
Dec. 15, 2026	• Submission deadline at noon for Jan. 1, 2027 start date
Jan. 15, 2027	• Open Enrollment ends; submission deadline noon for Feb. 1, 2027 start date

OE Webpage *(New)*

- OE Resources will now be housed on the HIV Services Program webpage!
- We will still send resources via email as we release as well as upload them to the website.
- Program managers must make case managers aware of the new section on our webpage.

https://www.in.gov/health/hiv-std-viral-hepatitis/provider-and-funded-recipient-resources#Open_Enrollment_Resources



OE Priority Measures

- **Transition to Marketplace Plans with Advance Premium Tax Credits (APTC):** To help reduce program costs associated with premium rate increases, the HIV Services Program will transition all eligible HIAP enrollees to Marketplace plans with APTC according to the schedule to the right.
  - This includes **all clients regardless of their current plan**. For example, a client enrolled in an MHS off-Marketplace plan may need to switch to a Marketplace plan with APTC. **All CareSource clients must select new plans for 2027,** as CareSource is exiting the Indiana Marketplace.
- **ADAP/EIP Transition to HIAP:** All clients enrolled in ADAP/EIP must enroll in a HIAP plan by Jan. 15, 2027, following the transition schedule to the right.

Priority Population	Guidance
Categorically eligible clients at or below 138% Federal Poverty Level (FPL)	• Attempt to apply for coverage with APTC through HealthCare.Gov • If denied due to HIP eligibility, apply for off-Marketplace coverage, proof of Marketplace denial must be provided.
Categorically eligible clients between 139% and 300% FPL	• Apply for coverage with APTC through HealthCare.Gov
Categorically ineligible clients	• Apply for off-Marketplace coverage

Advance Premium Tax Credits

What are APTCs?

- APTC (Advance Premium Tax Credit) is a federal subsidy that lowers the monthly cost of health insurance purchased through the ACA Marketplace
- APTC can be used by individuals who are 139% to 400% of the Federal Poverty Level in Indiana
- It is calculated based on a household's income relative to the Federal Poverty Level and the cost of the benchmark Second-Lowest-Cost Silver Plan (SLCSP)
- The credit reduces what the enrollee is expected to pay toward premiums. For the Ryan White Program, credits must be applied in advance each month, rather than to be claimed at tax time.

Why APTCs?

- APTCS will help reduce program costs related to insurance premiums
- Estimates show that we will save more than $6M with APTCs

Advance Premium Tax Credits

Understanding reconciliation

- Clients are expected to file taxes to reconcile APTC received during the year by using the form 1095-A to complete forms 1040 and Form 8962
- There are three possible outcomes of the APTC reconciliation:
  - APTC overpayment – client received too much in APTC and owes the government money
  - APTC match – client received the correct amount of APTC, and no further action is needed
  - APTC underpayment – client received too little in APTC, and the government will send a refund

- The above outcomes highlight the importance of making sure HealthCare.Gov contains up-to-date information; it will help clients avoid APTC over- or underpayment.
- If a client receives an APTC underpayment, the client must return the refund amount to the program, as it represents funds advanced on their behalf

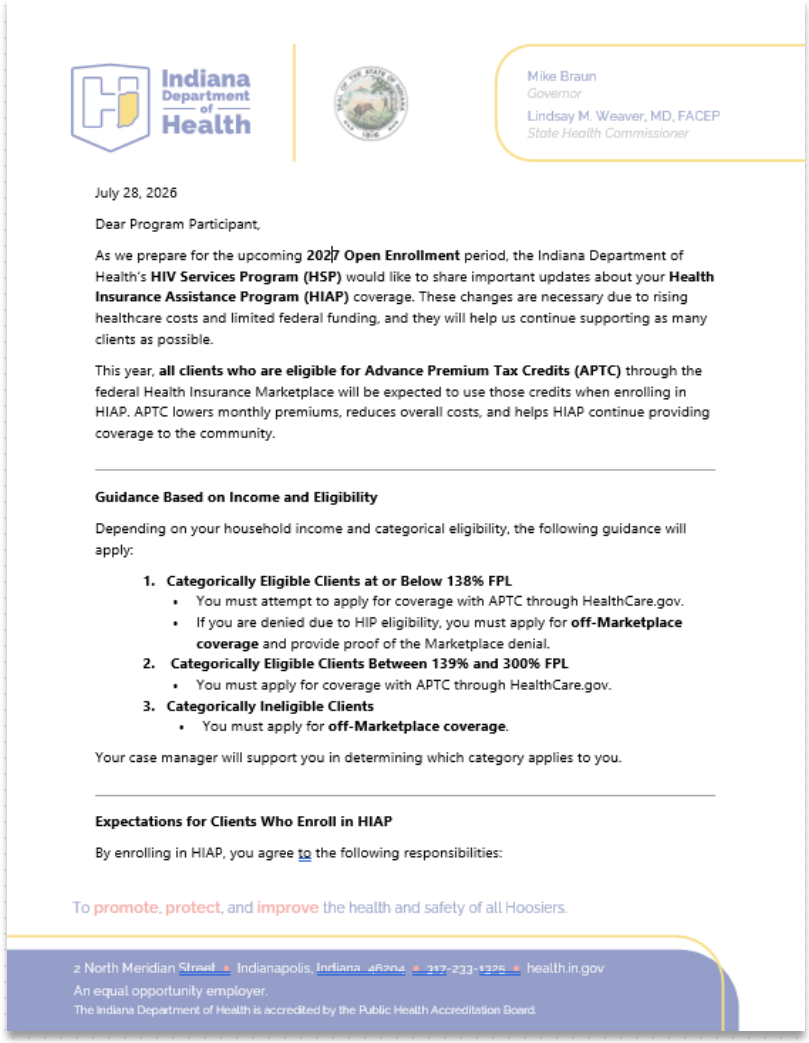
Advance Premium Tax Credits

Expectations for Clients eligible for APTCs

- Take APTC when signing up for HIAP coverage if they are eligible
- Sign an updated Certificate of Understanding (coming in fall 2026)
- Maintain current information in their HealthCare.gov account and report any changes in income, household size, address, or other health insurance coverage within 30 days
  - Failure to do so could result in APTC overpayment, meaning that the client could be responsible to pay back any additional APTCs received
- File taxes to reconcile APTC received during the year (i.e., filing forms 1095-A and 8962)
  - Failure to do so could affect future eligibility for the program and ability to receive APTCs
- Repay the program for any APTC underpayment refund received from the government
  - Failure to do so could affect future eligibility for the program

Preparing Clients

- HIV Services Program (HSP) has developed a client letter to explain the upcoming changes
- Agencies should do the following:
  - Distribute IDOH letter to clients
  - Assist clients in determine household income and categorical eligibility for Marketplace Insurance
  - Review and discuss client readiness for expectations surrounding using APTC



Indiana Department of Health

Mike Braun
Governor
Lindsay M. Weaver, MD, FACEP
State Health Commissioner

July 28, 2026

Dear Program Participant,

As we prepare for the upcoming **2027 Open Enrollment** period, the Indiana Department of Health's **HIV Services Program (HSP)** would like to share important updates about your **Health Insurance Assistance Program (HIAP)** coverage. These changes are necessary due to rising healthcare costs and limited federal funding, and they will help us continue supporting as many clients as possible.

This year, **all clients who are eligible for Advance Premium Tax Credits (APTC)** through the federal Health Insurance Marketplace will be expected to use those credits when enrolling in HIAP. APTC lowers monthly premiums, reduces overall costs, and helps HIAP continue providing coverage to the community.

Guidance Based on Income and Eligibility

Depending on your household income and categorical eligibility, the following guidance will apply:

1. **Categorically Eligible Clients at or Below 138% FPL**
   - You must attempt to apply for coverage with APTC through HealthCare.gov.
   - If you are denied due to HIP eligibility, you must apply for **off-Marketplace coverage** and provide proof of the Marketplace denial.
2. **Categorically Eligible Clients Between 139% and 300% FPL**
   - You must apply for coverage with APTC through HealthCare.gov.
3. **Categorically Ineligible Clients**
   - You must apply for **off-Marketplace coverage**.

Your case manager will support you in determining which category applies to you.

Expectations for Clients Who Enroll in HIAP

By enrolling in HIAP, you agree to the following responsibilities:

To promote, protect, and improve the health and safety of all Hoosiers.

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The Indiana Department of Health is accredited by the Public Health Accreditation Board.

HIAP SEP Qualifying Events

Marketplace and Off-Exchange

- Loss of other coverage
- Gaining or becoming a dependent
- Error, misrepresentation, inaction, or misconduct
- Health plan violations
- Newly ineligible for APTCs
- Permanent move
- Domestic violence/spousal abandonment
- Medicaid/CHIP denial
- Gaining access to Health Reimbursement Arrangement (HRA)/Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
- Employer stops contributing to COBRA

Marketplace Only

- Gaining newly eligible immigration status
- Release from incarceration
- Newly eligible for APTCs
- Change in cost sharing reduction (CSR) eligibility
- Moving out of Medicaid gap
- American Indian or Alaska native (AI/AN)
- Material plan or benefit display error
- Clearing a data-matching issue

Source: ADAP Considerations for the 2025 Plan Year

ADAP Landscape
Open Enrollment Guidance
Medicaid Work Requirements
Other Federal/State Updates
Questions and Answer

Disclaimer

- This is an evolving situation. Any information in this section is subject to change.

- **For up-to-date information, check the FSSA webpage:**

https://www.in.gov/fssa/hip/hip-work-requirements/

Indiana Department of Health

Medicaid Work Requirements

- Beginning **Jan. 1, 2027**, federal rules will require adults enrolled in Medicaid Expansion programs (i.e., HIP) to meet work and community engagement requirements to keep their coverage
- This applies to **non-pregnant adults (19-64 years old)** who are **enrolled in HIP** and are **not enrolled in Medicare**.

- Enrollees must complete **80 hours per month*** of qualifying activities which may include the following:
  - Employment (earning at least $580/month)
  - School attendance (half-time or more)
  - Apprenticeships
  - Workforce training programs
  - Volunteering/community service

- *Enrollees can combine hours from different activities to reach 80 hours per month.

Exemptions

- Are under 26 and were formerly in foster care
- Are a member of a federally recognized tribe
- Are a parent or caregiver of a child age 13 or younger
- Are a caregiver of a person with a disability
- Are a veteran with a total (100%) disability rating
- Are pregnant, or it has been 12 months or less since your pregnancy ended
- Are incarcerated or were released in the last 90 days.
- Are following the work rules for SNAP or TANF
- Are in a drug or alcohol treatment program
- Are medically frail or have special medical needs. This includes:
  - Being blind or having a disability
  - Having a substance use disorder
  - Having a serious mental health condition
  - Having a serious physical, intellectual, or developmental disability
  - Having another serious or complex medical condition

Exemptions – “Medically Frail”

- A new federal ruling changed the definition of “medically frail.”
  - Serious medical conditions must be shown to **significantly impair** ability to work
  - Blanket exemptions (e.g., for people with HIV or cancer) are **no longer allowed**

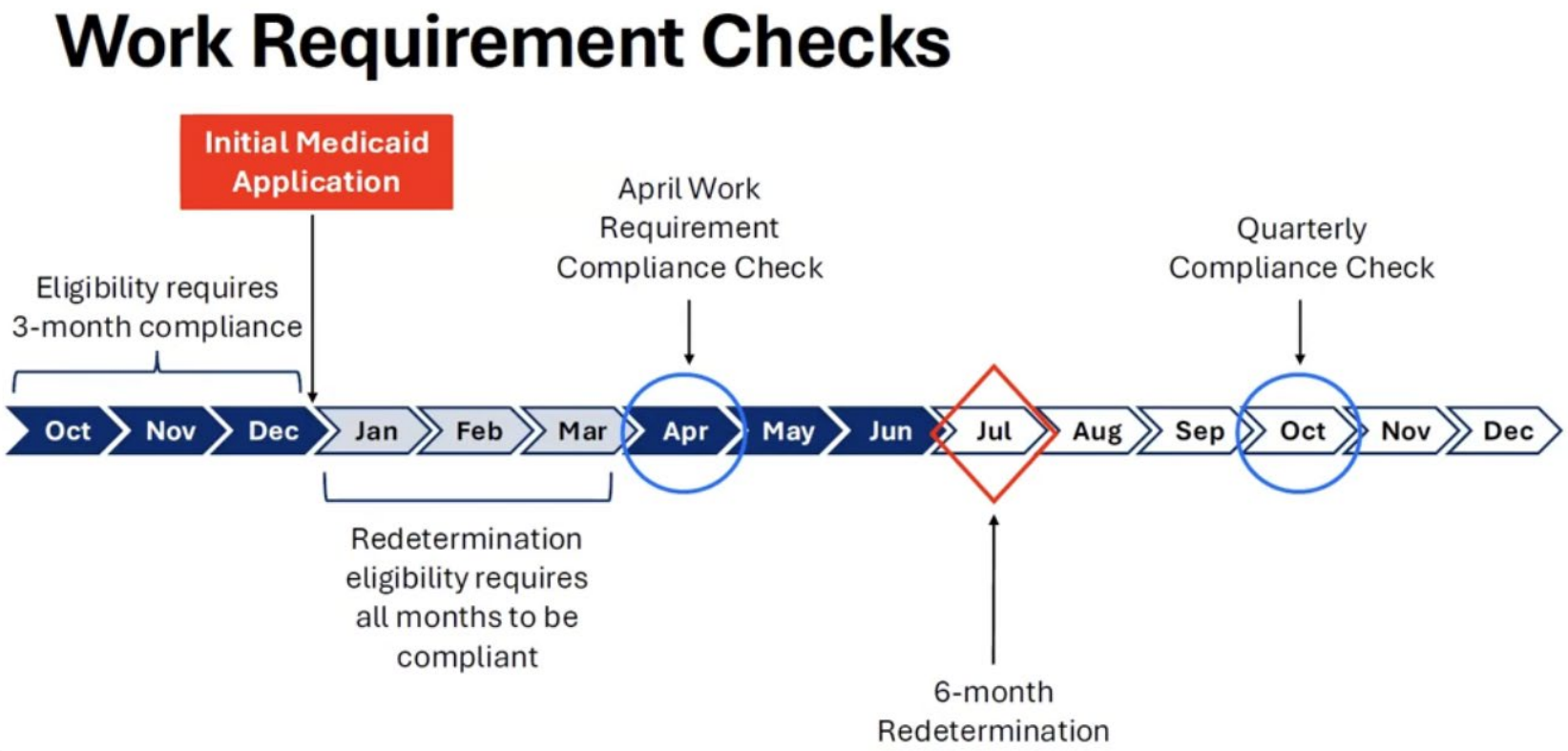
- The information above reflects **national-level guidance**, which may not fully match what Indiana FSSA is currently communicating — and **that’s okay**
- Indiana FSSA is still in the process of **interpreting and implementing** the new federal requirements
- As implementation continues, **Indiana’s guidance may differ**
- **Case managers and clients should always follow Indiana FSSA’s official instructions**, as those represent the policies and processes that apply within the state

Maintaining Compliance

- **How often will Indiana Medicaid verify compliance with requirements?**
  - **On or after Jan. 1, 2026** – Non-exempt clients need to ensure they meet work requirements compliance three months before the new year (i.e., starting in October 2026)
  - **At application:** Non-exempt clients must demonstrate compliance for the three (3) consecutive months preceding the month of application
  - **Three-month checks:** Non-exempt clients must demonstrate compliance every three months

- Indiana Medicaid must first attempt to use *ex parte* verification to confirm work requirements compliance.
- If *ex parte* verification does not work, Indiana Medicaid will reach out to the client
  - It is not clear what information clients need to provide. We've reached out to Indiana Medicaid for clarification

Maintaining Compliance



Source: https://indianacapitalchronicle.com/2026/08/12/up-to-300000-hoosiers-could-face-medicaid-work-mandate/

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Preparing Clients

- Indiana FSSA is sending out *Notice of Healthy Indiana Plan Work Requirements*, starting 7/1/2026
- Indiana FSSA has developed a "Partner Toolkit" to help raise awareness
- HSP has developed a client letter to explain the upcoming changes
- Agencies should do the following:
  - Use flyers and posters from the FSSA toolkit
  - Distribute IDOH letter to clients
  - Assess and prepare clients for the change

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Marketplace Updates

Updates that Affect HSP

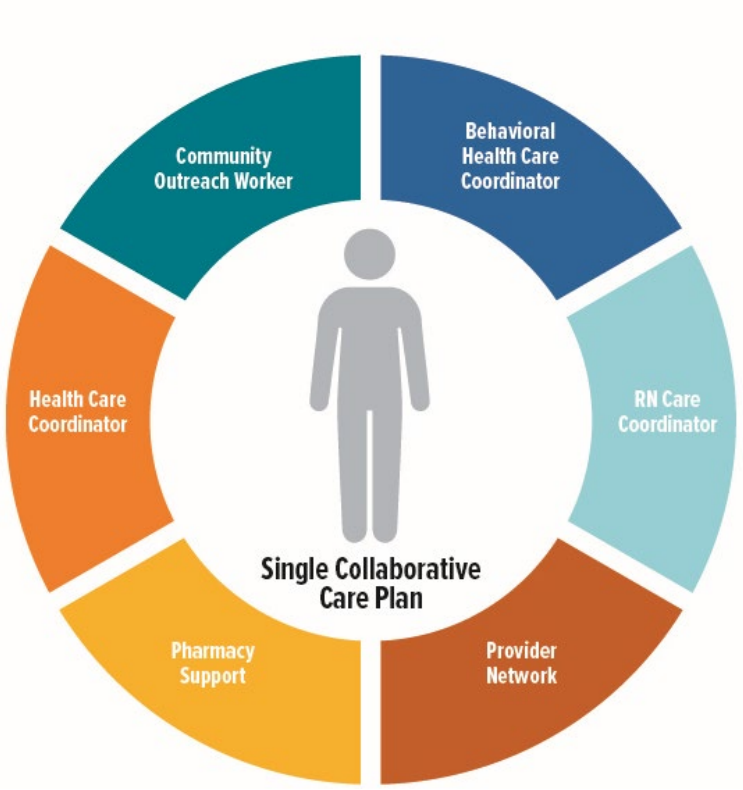
- *Past Due Premiums Required Before Coverage Effectuation (Eff. 8/25/2026 – vacated)*
- Excludes Gender-Affirming Care from Essential Health Benefits (eff. 2027)
- Elimination of Enhanced PTCs and Low-Income SEP
- *Shortened Open Enrollment Period (vacated)*

Updates that Don't Affect HSP as much

- DACA Recipients Ineligible for Marketplace Coverage
- Elimination of PTC Eligibility for Certain Immigrants
- *Additional Verification For Commonly-Used SEPs – vacated*
- *$5 Monthly Fee for Certain Enrollees Who Do Not Actively Re-Enroll – vacated*

Medicaid Updates

- Work/Community Engagement Requirements
  - Effective 1/1/2027
- 6-Month Eligibility Redeterminations
  - Effective 1/1/2027
- Cost-Sharing for Expansion Adults Up to $35
  - Effective 10/1/2028
- Long-Stay Nursing Home Transition (PathWays)
  - Effective 7/1/2026
- Home Health and Home- and Community Based Services Changes
  - Effective 11/30/2026
- Public Charge Rule - Expanded Basis for Evaluation
  - Effective 9/16/2026



Medicare Updates

- Medicare is continuing the Medicare Prescription Payment Plan (MPPP) option in 2027
- This allows clients to smooth their prescription cost-sharing over the course of the plan year
- When someone opts into MPPP, a client's Part D insurance company will cover full cost of medications at the pharmacy, then the client will make reimbursement payments to their Part D insurance company (separate from their premium) up to the Medicare OOP max.
  - **IDOH HSP is NOT encouraging new and future MDAP clients to enroll in the MPPP**
  - **MDAP cannot assist with costs associated with MPPP to Part D insurance companies**
- Medicare will likely continue outreach to notify Medicare beneficiaries of this option
- Case managers should notify all MDAP clients of this new option and that they should NOT opt into it. MDAP already covers all medication cost-sharing, which means clients have no need for this new program. This new program could incur costs for the client that IDOH cannot assist with.

Medicare Updates

- The Part D annual out-of-pocket (OOP) maximum increases to $2,400 in 2027
- Case managers should remind Medicare clients to check whether their Medicare plan is continuing for the next year or if they need to enroll in a new plan
  - For clients with separate Parts A/B/D, the OE period is Oct. 15-Dec. 7
  - For clients with Part C (Medicare Advantage), the OE period is Jan. 1–March 31
- Case managers should work with ADAP/EIP clients who lack a Part D plan to enroll in one during the fall OE period (Oct. 15-Dec. 7)

- For clients newly enrolling into Medicare, you can refer clients to the Indiana State Health Insurance Assistance Program (SHIP)

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Q&A

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THANK YOU FOR ALL YOU DO!