Healthy Indiana Plan 2.0:

Introduction, Plan options, Cost sharing, and Benefits

HEALTHY INDIANA PLAN SM

Health Coverage = Peace of Mind

Objectives

- ✓ After reviewing this presentation, you will understand the following aspects of HIP 2.0:
  - Program features, including the POWER account
  - Plan options
    - HIP Basic
    - HIP Plus
    - HIP Link
    - HIP State Plan
  - Cost sharing requirements
  - Benefits

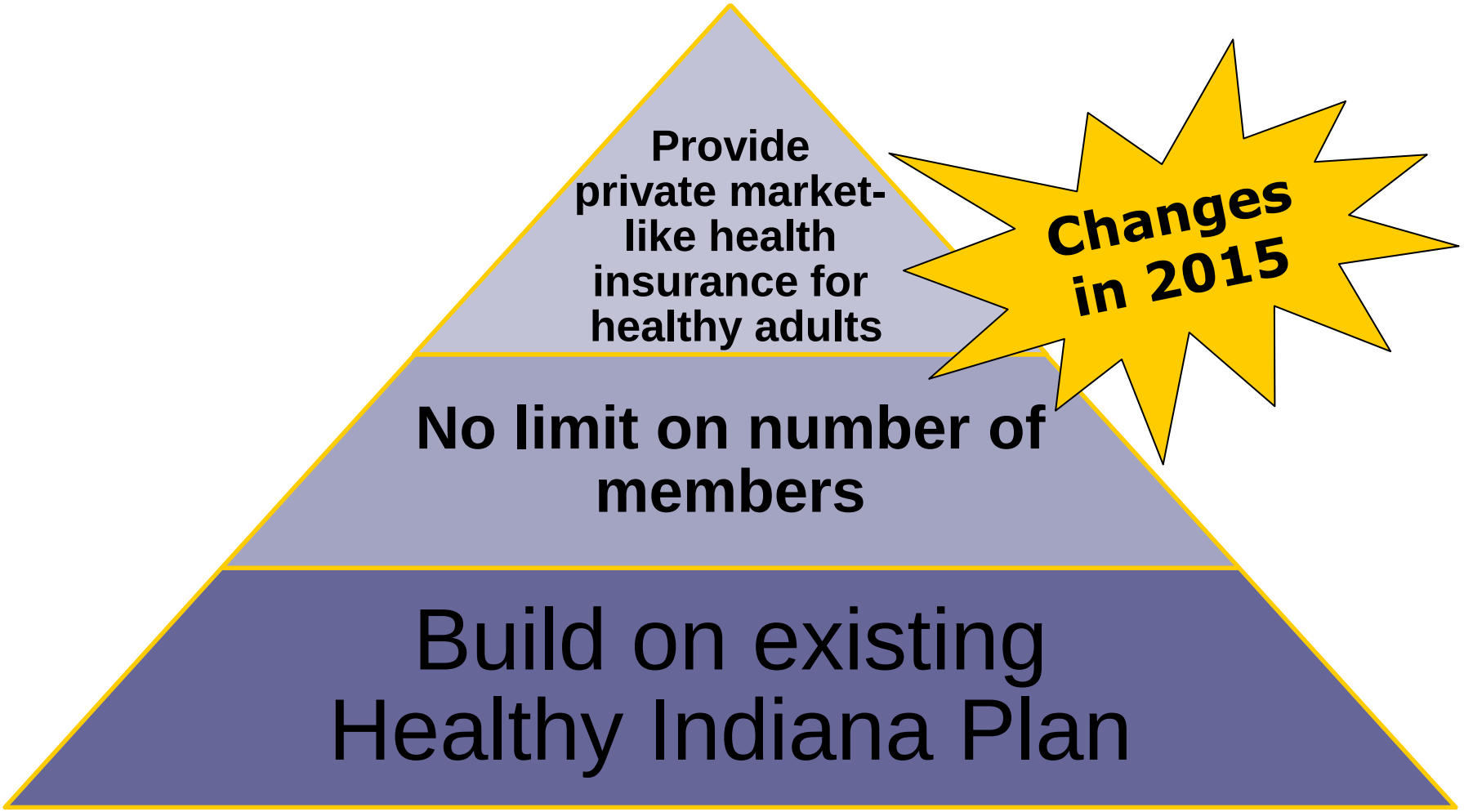
Terminology

Cost Sharing	The costs a member is responsible for paying for health services when covered by health insurance.
Deductible	A form of cost sharing. A deductible is a dollar amount that is paid for initial medical costs before health insurance starts to pay. HIP 2.0 has a $2,500 deductible that is funded by a combination of state and member contributions.
Copayment	A form of cost sharing. Copayments or “copays” refer to a specific dollar amount that an individual will pay for a particular service, regardless of the total cost of the service accessed. The payment may be collected at the time of service or billed later. The HIP Basic plan requires copayments for most services from $4 for a doctors visit or prescription to $75 for a hospital stay.
Federal Poverty Level (FPL)	Determined annually by the federal government. The federal poverty level for 2014 is $973 per month for an individual and $1,988 per month for a family of four. 75% of the federal poverty level is equal to .75 x the federal poverty level for the family size.
Affordable Care Act	Federal law passed in 2010, requires most individuals to have health insurance or face a tax penalty.
Federal Health Insurance Marketplace	Individuals with income over the federal poverty level can purchase insurance plans through the federal government’s Health Insurance Marketplace. Those with incomes between 100% and 400% FPL may receive federal tax subsidies to help pay for coverage.
Preventive Services	Health care services recommended to identify health conditions so they can be treated before they become serious.

Healthy Indiana Plan (HIP) Fundamentals

- ✓ **Covering Hoosiers since 2008**
  - Nation's first consumer-directed health care program for Medicaid recipients
  - Small demonstration program with limited enrollment
- ✓ **Health coverage benefits modeled after an employer-sponsored health insurance plan**
  - Coverage provided by one of three managed care entities (MCE)
  - Members may choose MCE: Anthem, MDwise, or MHS
- ✓ **Pioneering the Personal Wellness and Responsibility (POWER) account**
  - Each member has a health savings-like account called the POWER account that helps pay for initial medical expenses
  - Members and the State contribute to ensure there is enough money to cover initial health expenses
  - There are incentives to manage the account & penalties for members not making contributions

Healthy Indiana Plan (HIP): Introducing HIP 2.0



HIP 2.0: Personal Responsibility

- ✓ HIP member and the State make contributions to POWER account
  - Together, member and State contributions cover the first $2,500 of health care services received each year
  - Member portion of annual contribution is approximately 2% of household income per year, ranging from $1 to $100 per month
    - Annual contribution may be split between qualifying spouses
  - Members who do not make their monthly contribution face penalties
    - Income over 100% federal poverty level (FPL):
      - Unless exempt, member subject to 6 month lockout period and may not receive HIP benefits*
    - Income less than or equal to 100% FPL:
      - Reduced benefits
      - Must make copayments for each health service
      - Failure to pay the onetime monthly contribution may make receiving health care more expensive for the member
- ✓ For qualifying individuals, portion of unused POWER account funding can be rolled over
  - Receive recommended preventive care each year
    - Increase roll over for HIP Plus members if receive recommended preventive care
  - May use roll over amount to reduce monthly POWER account contribution in HIP Plus the following year

*EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area.

HIP 2.0: Basics

Who is eligible for HIP 2.0?

- Indiana residents*
- Age 19 to 64*
- Income **under 138%** of the federal poverty level **(FPL)***
- Not eligible for Medicare or other Medicaid categories*
- Also includes individuals currently enrolled in:
  - Family planning services (MA E)
  - Healthy Indiana Plan (HIP)
  - Hoosier Healthwise (HHW)
    - Parents and Caretakers (MAGF)
    - 19 and 20 year olds (MA T)

Monthly Income Limits for HIP 2.0 Plans

# in household	HIP Basic Income up to 100% FPL	HIP Plus Income up to ~138% FPL**
1	$973	$1,358.10
2	$1,311	$1,830.58
3	$1,650	$2,303.06
4	$1,988	$2,775.54

*Adults not otherwise Medicaid eligible who have children must make sure their children have minimum essential coverage to be eligible for HIP

**133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.

HIP 2.0: Plan Options

Best Value

HIP Plus

- Initial plan selection for all members
- **Benefits**: Comprehensive, including vision and dental
- **Cost sharing**:
  - Must pay affordable monthly POWER account contribution: Approximately 2% of member income, ranging from $1 to $100 per month
  - No copayment for services*

HIP Basic

- Fall-back option for members with household income less than or equal to100% FPL only
- **Benefits**: Meet minimum coverage standards, **no vision or dental coverage**
- **Cost sharing**:
  - May not pay one affordable monthly POWER account contribution
  - Must pay copayment for doctor visits, hospital stays, and prescriptions

HIP State Plan

- Individuals who qualify for additional benefits
- **Benefits**: Comprehensive, with some additional benefits including vision and dental
- **Cost sharing**:
  - HIP Plus **OR** HIP Basic cost sharing

HIP Link

- ***More information coming soon!***
- To help member pay for employer-sponsored health insurance

*EXCEPTION: Using Emergency Room for routine medical care

HIP 2.0: Treatment of Unique Populations

Medically Frail	Individuals with a disability determination, certain conditions impacting their physical or mental health or their ability to perform activities of daily living such as dressing or bathing will receive enhanced benefits • HIP Basic or HIP Plus cost sharing will apply but access to vision, dental, and non-emergency transportation benefits is ensured regardless of cost sharing option • Will not be locked out due to non payment of POWER account contribution
Pregnant Women	Pregnant women will have no cost sharing in either HIP Plus or HIP Basic once their pregnancy is reported and will receive additional benefits available only to pregnant women • Pregnant woman may choose to stay in HIP or transfer to HIP Maternity, with comparable benefits
Native Americans	By federal rule, Native Americans are exempt from cost sharing. Can receive HIP benefits without required contributions or emergency room copayments. May opt of HIP in favor of fee-for-service benefits as of April 1, 2015
Transitional Medical Assistance (TMA)	Individuals who no longer qualify as low-income parents or caretakers due to an increase in pay are eligible for HIP State Plan benefits for a minimum of six months even if income is over 138% FPL
Low-income Parents, Caretakers, and 19-20 year olds	Individuals eligible for HIP State Plan Plus or HIP State Plan Basic benefits

HIP 2.0 - PLAN OPTIONS AND BENEFITS

HIP 2.0: Plan Options

HIP Plus

Offers best value for members.

Comprehensive benefits including vision and dental.

To be eligible, members pay a monthly contribution towards their portion of the first $2,500 of health services. Contributions are based on income – approximately 2% of household income per year – ranging from $1 to $100 per month.

No copayment required when visiting doctors or filling prescriptions.

HIP Basic

Fallback option for lower-income individuals.

HIP Basic benefits that cover the essential health benefits but not vision or dental services for adults.

Members pay between $4 and $75 for most health care services.

Receiving health care is more expensive in HIP Basic than in HIP Plus.

HIP Link

Coming Soon!

Members receive help paying for the costs of employer-sponsored health insurance.

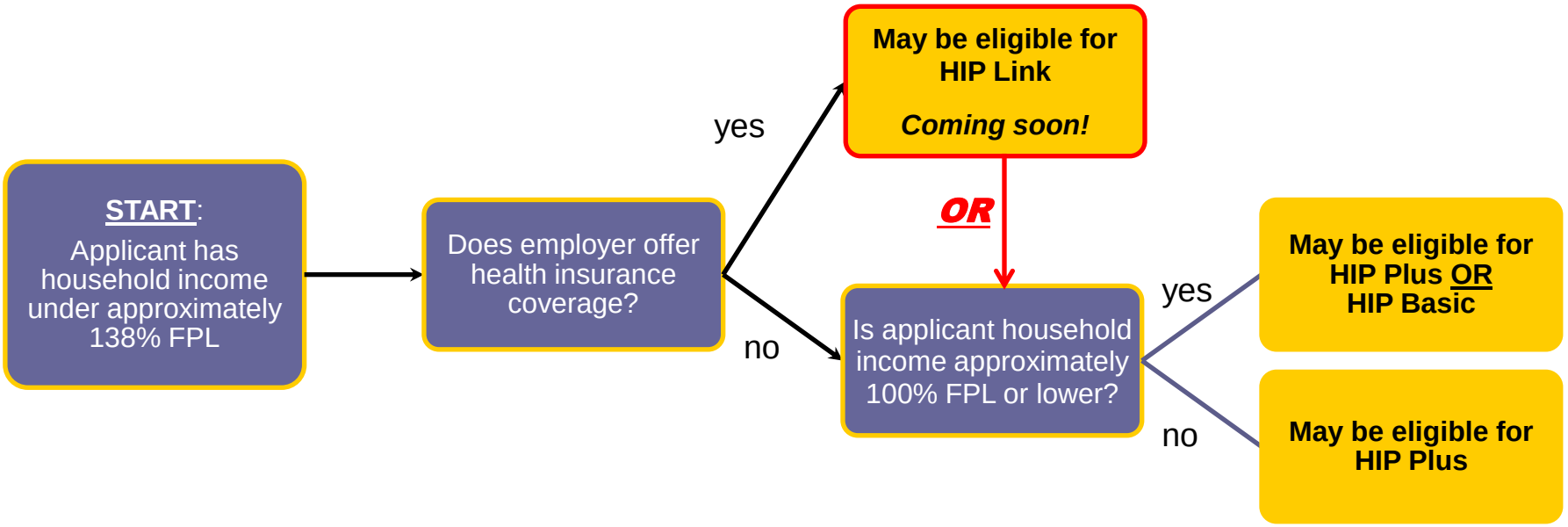
Members with a **qualified and participating** employer are eligible for the employer-sponsored health insurance.

Member may choose HIP Link or other HIP plans.

HIP Link will be an option on the coverage application.

Other benefit and cost sharing options: Individuals who qualify may receive additional benefits through the HIP State Plan Basic & HIP State Plan Plus options, or have cost sharing eliminated per federal requirements.

Income Eligibility for HIP 2.0 Plans



Monthly Income Eligibility Thresholds

# in household	Income up to 100% FPL	Income up to ~138% FPL*
1	Up to $973	Up to $1,358.10
2	Up to $1,311	Up to $1,830.58
3	Up to $1,650	Up to $2,303.06
4	Up to $1,988	Up to $2,775.54

*133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.

HIP Plus vs. HIP Basic for Members with Income Less than or equal to 100% FPL

HIP Plus

- More affordable
- Predictable monthly contributions
- More benefits
- Option to earn reductions to future monthly contributions
  - May reduce future contributions by **up to 100%**

HIP Basic

- May be more expensive
- Unpredictable costs
- Fewer benefits
- Potential to reduce future monthly contributions for HIP Plus enrollment, but these reductions are **capped at 50%**

HIP 2.0: State Plan

- ✓ Available for certain qualifying individuals
  - Low-income (<19% FPL) Parents and Caretakers
  - Low-income (<19% FPL) 19 & 20 year olds
  - Medically Frail
  - Transitional Medical Assistance (TMA)
- ✓ Benefits equivalent to current Medicaid benefits
  - All HIP Plus benefits covered with additional benefits, including transportation to doctor appointments
  - State Plan benefits replace HIP Basic or HIP Plus benefits
    - State Plan benefits are the same, regardless of HIP Basic or HIP Plus enrollment
- ✓ Keep HIP Basic or HIP Plus cost sharing requirements
  - HIP State Plan Plus: Monthly POWER account contribution
  - HIP State Plan Basic: Copayments on most services

HIP 2.0: Plan Variations

Population	Benefits	Cost Sharing	Other
Adults 19-64 income ≤100% FPL	HIP Basic or HIP Plus	HIP Basic or HIP Plus	All 19 & 20 year olds receive EPSDT*
Adults 19-64 income between 100% and ~138% FPL	HIP Plus	HIP Plus	
Low-income Parents or Caretaker Adults	State Plan Benefits	HIP Basic or HIP Plus	
Low-Income 19 & 20 Year Olds	State Plan Benefits	HIP Basic or HIP Plus	
Medically Frail	State Plan Benefits	HIP Basic or HIP Plus	
Pregnant Women	HIP Basic or HIP Plus	None	Receive additional benefits only available to pregnant women. May choose to move to State Plan Benefits (MAGP).
Native Americans	HIP Plus	None	By federal law exempt from cost sharing**
Transitional Medical Assistance	HIP State Plan Basic or HIP State Plan Plus	HIP Basic or HIP Plus	May receive HIP Basic if income over 100% FPL

* Early Periodic Screening Diagnoses and Testing (EPSDT) as a benefit available to those 20 years old and younger that provides vision, dental, hearing aids, therapy, and preventive services

** Effective April 1, 2015, Native Americans may choose to opt out of HIP and into fee-for-service

HIP 2.0: Essential Health Benefits

Essential Health Benefits	HIP Plus	HIP Basic	HIP State Plan
Ambulatory (Doctor Visits)	Covered – Includes coverage for Temporomandibular Joint Disorders (TMJ) 100 visit limit for home health	Covered – No TMJ coverage 100 visit limit for home health	Covered - Includes TMJ coverage & chiropractic services. Home health limit does not apply
Emergency*	Covered	Covered	Covered
Hospitalization	Covered - Includes Bariatric Surgery	Covered - No Bariatric Surgery	Covered - Includes Bariatric Surgery
Maternity	Covered	Covered	Covered
Mental Health	Covered	Covered	Covered
Laboratory	Covered	Covered	Covered
Pharmacy	Covered	Covered - Generic Preferred	Covered
Rehab & Habilitation	Covered – 75 visits annually of physical, speech and occupational therapies 100 day limit for skilled nursing facility	Covered – 60 visits annually of physical, speech and occupational therapies 100 day limit for skilled nursing facility	Covered - Requires prior authorization but not limited to 60/75 visits annually Skilled nursing facility limit does not apply
Preventive	Covered	Covered	Covered
Pediatric	Early Periodic Screening Diagnosis and Testing (EPSDT) services covered for 19 & 20 year olds		

*Includes emergency-related transportation

HIP 2.0: Other Benefits

Other Benefits	HIP Plus	HIP Basic	HIP State Plan
Adult Vision	Covered	Not Covered	Covered
Adult Dental	Covered – Limited to 2 cleanings per year and 4 restorative procedures	Not Covered	Covered
Transportation	Not Covered	Not Covered	Covered
Medicaid Rehabilitation Option (MRO)	Not Covered	Not Covered	Covered
Pregnancy-Only	Additional benefits for pregnant women including transportation and chiropractic services.	Additional benefits for pregnant women including transportation, vision, dental and chiropractic services.	Pregnant women receive access to all pregnancy-only benefits on HIP Plus or HIP Basic plan and full State Plan benefits.

HIP 2.0 COST SHARING - REQUIRED CONTRIBUTIONS AND COPAYMENTS

POWER Account

- ✓ Unique feature of the Healthy Indiana Plan (HIP)
- ✓ Health savings-like account
  - Members receive monthly POWER account statements
  - Used to pay for the first $2,500 of service costs
- ✓ HIP Plus:
  - Members make monthly contributions to POWER account
    - Contribution amount is approximately 2% of income
    - Contribution ranges from $1 to $100 per month
  - Members exempt from most other cost sharing
- ✓ If members leave the program early they may still receive invoices for unpaid POWER account contributions from their health plan, depending on the cost of health care services received
- ✓ ***Rollover***: All members may reduce future HIP Plus POWER account contributions
  - Must have remaining contribution in POWER account
  - Depending on plan: requirement or bonus for receiving preventive services

POWER Account

HIP Plus POWER account

Pays for $2,500 deductible
Member contributes
May double rollover

Year-End Account Balance

- Unused member contribution rollover to offset next year's required contribution
- Amount **doubled** if preventive services complete – up to 100% of contribution amount
- **Example**: Member has $100 of member contributions remaining in POWER account. This is credited to next year's required contribution amount. Credit is doubled to $200 if preventive services were completed.

HIP Basic POWER account

Pays for $2,500 deductible
Cannot be used to pay HIP Basic copays
Capped rollover option

Year-End Account Balance

- If preventative services completed, members can offset required contribution for HIP Plus by up to 50% the following year
- Members may not double their rollover as in HIP Plus
- **Example**: Member receives preventive services and has 40% of original account balance remaining at year end. May choose to move to HIP Plus the following year and receive a 40% discount on the required contribution.

HIP Plus: POWER Account Contribution (PAC)

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- ✓ POWER account contributions are approximately 2% of member income
  - Minimum contribution is $1 per month
  - Maximum contribution is $100 per month
- ✓ Employers & not-for-profits may assist with contributions
  - Employers and not-for-profits may pay up to 100% of member PAC
  - Payments made directly to member's selected managed care entity
- ✓ Spouses split the monthly PAC amount

Maximum Monthly HIP 2.0 POWER account contributions (PAC)

FPL	Monthly Income, Single Individual	Maximum Monthly PAC*, Single Individual	Maximum Monthly Income, Household of 2	Maximum Monthly PAC, Spouses**
<22%	Less than $214	$4.28	Less than $289	$2.89 each
23%-50%	$214.01 to $487	$9.74	$289.01 to $656	$6.56 each
51%-75%	$487.01 to $730	$14.60	$656.01 to $984	$9.84 each
76%-100%	$730.01 to $973	$19.46	$984.01 to $1,311	$13.11 each
101%-138%	$973.01 to $1,358.70	$27.17	$1,311.01 to $1,831.20	$18.31 each

*Amounts can be reduced by other Medicaid or CHIP premium costs
**To receive the split contribution for spouses, both spouses must be enrolled in HIP

Non-payment Penalties

- ✓ Members remain enrolled in HIP Plus as long as they make POWER account contributions (PACs) and are otherwise eligible
- ✓ Penalties for members not making the PAC contribution:

≤100% FPL

- Moved from HIP Plus to HIP Basic
- Copays for all services

>100% FPL

- Dis-enrolled from HIP*
- Locked out for six months**

*EXCEPTION: Individuals who are medically frail.
**EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area. If an individual locked out of HIP becomes medically frail, he/she should report the change to his/her former health plan to possibly qualify to return to HIP early.

Exceptions to Non-payment Penalties

- ✓ Exceptions to penalties for select HIP Plus members with household income over 100% FPL who stop paying their POWER account contributions (PACs)
  - Native Americans
    - No required contributions
    - No copayments for using the emergency room for routine care
    - May opt out of managed care and into fee-for-service at any time, effective April 1, 2015
  - Medically frail
    - Must pay copayments until outstanding PAC is paid
  - Individuals qualified for Transitional Medical Assistance
    - Move to HIP State Plan Basic
    - HIP State Plan Basic copayments apply

HIP Basic Plan: Cost Sharing

When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic members are responsible for the following copayments for health and pharmacy services.

Service	HIP Basic Copay Amounts Income ≤100% FPL
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	Up to $25

Copayments may not be more than the cost of services received.

HIP Plus Contributions Are Not Premiums

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- ✓ Unlike premiums, members own their contributions
- ✓ If members leave the program early with an unused balance, the portion of the unused balance they are entitled to is returned to them
  - Members reporting a change in eligibility and leaving the program (e.g. move out of state) will retain 100% of their unused portion
  - Members leaving for non-payment of the POWER account will retain 75% of their unused portion
- ✓ If members leave the program early but incurred expenses, they may receive a bill from their health plan for their remaining portion of the health expenses
- ✓ Members remaining in the program may be eligible to receive a rollover of their remaining contributions
  - Rollover is applied to the required contribution for the following year

5% of income limit

- ✓ Member cost sharing is subject to a 5% of income limit
  - Members are protected from paying more than 5% of their **quarterly** income toward HIP cost sharing requirements, including the total of all:
    - POWER account contributions (PAC)
    - Emergency Room copayments
    - HIP Basic copayments
- ✓ Members meeting their 5% of income limit on a quarterly basis will have cost sharing responsibilities eliminated for the remainder of the quarter
  - Individuals meeting the 5% limit and enrolled in HIP Plus will receive the minimum $1 minimum monthly contribution for the remainder of the quarter

RECOMMENDATION:
Members should keep record of their expenses and if they think they have met their 5% of income limit, they should contact their managed care entity (e.g. Anthem, MDwise, MHS)

HIP Employer Benefit Link
COMING SOON!

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- ✓ **NEW EMPLOYER PLAN OPTION**
  - Families can choose to enroll in employer-sponsored health insurance
  - Employer must sign up and contribute 50% of member's premium
- ✓ **POWER ACCOUNT**
  - Member makes contributions to POWER account
  - *Defined contribution* from State to allow individuals to
    - Pay for employer plan premiums &
    - Defray out-of-pocket expenses

Promote family coverage in private market

Promote HIP member health coverage choices

Leverage POWER account potential

HIP 2.0 - SUMMARY

Summary

- ✓ After reviewing this presentation, you should understand the following aspects of HIP 2.0:
  - Program features, including the POWER account
  - Plan options
    - HIP Basic
    - HIP Plus
    - HIP Link
    - HIP State Plan
  - Cost sharing requirements
  - Benefits

HIP 2.0 - SUPPLEMENTAL MATERIAL

Primary HIP Eligibility Categories

HIP Plus (MARP)

- Household income up to ~138% FPL
- Best value plan
- Pay monthly POWER account contribution
- No copayments for most medical services

HIP Basic (MARB)

- Household income less than or equal to 100% FPL
- No POWER account contribution
- Pay copayments for most medical services

HIP State Plan Plus (MASP)

- Income under 138% FPL and:
  - Medically Frail, OR
  - Low-income Parents/Caretakers, OR
  - Low-income 19 & 20 year olds OR
  - Transitional Medical Assistance (TMA)*
- Make monthly POWER account contribution

HIP State Plan Basic (MASB)

- Income less than or equal to 100% FPL** and:
  - Medically Frail, OR
  - Low-income Parents/Caretakers, OR
  - Low-income 19 & 20 year olds, OR
  - TMA*

*No household income limit for first six months. Income cannot exceed 185% FPL for additional six months of coverage. Individual may have additional coverage options if also medically frail.

**EXCEPTION: TMA does not have to have income under 100% to be eligible for HIP State Plan Basic

HIP & HIP 2.0 Comparison

	Original HIP	HIP 2.0
Effective Date	January 1, 2008	January 1, 2015
Eligibility	**In 2014**, income less than or equal to 100% FPL **2008-2013**, income equal to or less than 200% FPL	Income under ~138% FPL
Other Coverage	Individuals cannot be covered under Medicare or have other minimum essential health coverage	Individuals cannot be covered under Medicare or other Medicaid categories
POWER Account	$1,100	$2,500
Benefit Limits	Annual limit: $300,000 Lifetime limit: $1 million	No annual or lifetime coverage limit
Plan Options	None – all members in the same program	3 program options: HIP Basic, HIP Plus, and HIP Link

2014 Monthly Income by Federal Poverty Level

Household Size	22%	50%	75%	100%	133%	~138% FPL*	200%
1	$214	$487	$730	$973	$1,294	$1,358.10	$1,945
2	$289	$656	$984	$1,311	$1,744	$1,830.58	$2,622
3	$363	$825	$1,237	$1,650	$2,194	$2,303.06	$3,299
4	$438	$994	$1,491	$1,988	$2,644	$2,775.54	$3,975
5	$512	$1,163	$1,745	$2,326	$3,094	$3,248.03	$4,652
6	$587	$1,333	$1,999	$2,665	$3,544	$3,720.51	$5,329
7	$661	$1,502	$2,252	$3,003	$3,994	$4,192.99	$6,005
8	$735	$1,671	$2,506	$3,341	$4,444	$4,665.47	$6,682
For each additional person, add:	$75	$170	$254	$339	$450	$472.48	$677

*133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.

Minimum Essential Coverage

- ✓ Individual Mandate
  - Affordable Care Act (ACA) requirement
  - All individuals must maintain Minimum Essential Coverage (MEC) for themselves and their dependents
    - Adults may not be eligible for HIP if they do not have MEC for their children
- ✓ Understanding MEC
  - List of coverage types determined by the federal government
  - Coverage types may change
    - Some coverage types only classified as MEC in 2014
  - Types of coverage not currently considered MEC may apply for recognition as MEC
- ✓ Exemptions from MEC
  - Individuals may receive an exemption from the requirement to maintain MEC

Federal List of Minimum Essential Coverage Types

In order to meet Individual Mandate requirements, all Americans must have at least one of the following:

Government sponsored health coverage

- Medicare Program
- Most Medicaid Programs
- Children's Health Insurance Program
- Veterans Administration programs: including TriCare and CHAMP VA
- Coverage for Peace Corps Volunteers
- Refugee medical assistance
- Medicare advantage plans

Employer-sponsored health insurance coverage

Individual market health coverage

Grandfathered health plan

Additional coverage as specified

- Any health coverage not recognized may apply to be Minimum Essential Coverage. The federal government will maintain a list of recognized types of minimum essential coverage.
- HIP 2.0, pending approval from the federal government

…<u>or they will need to receive an exemption or pay the tax penalty.</u>

NOT Minimum Essential Coverage (MEC)

Individuals may have health insurance coverage that is not considered MEC, such as:

- Certain Medicaid Programs
  - Examples:
    - Optional family planning services
    - Emergency medical services
- Limited-scope coverage, or offered on a separate policy from primary health coverage

  - **Examples:**

Accidental death and dismemberment coverage	Benefits provided under certain health flexible spending arrangements	Coverage for employer-provided on-site medical clinics
Automobile liability insurance	Workers' compensation	Long-term care benefits
Disability insurance	Credit-only insurance	Vision benefits
General liability insurance	Fixed indemnity insurance	Medicare supplemental policies
TRICARE supplemental policies	Similar supplemental coverage for a group health plan	Separate policies for coverage of only a specified disease (example: cancer only policies)

They will need to either:

☑ Obtain coverage that **IS** MEC ☑ Obtain an exemption ☑ Pay the tax penalty