Healthy Indiana Plan 2.0

Special Populations

HEALTHY INDIANA PLAN℠

Health Coverage = Peace of Mind

Objectives

- ✓ After reviewing this presentation you will understand:
  - HIP 2.0 features, options, benefits, and cost sharing
  - Different options, enrollment, benefits, and cost sharing available for certain populations, including:
    - Medically frail
    - Low-income Parents and Caretakers, and 19-20 year olds
    - Transitional Medical Assistance
    - Pregnant
    - Native Americans

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 pays 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.

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: 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.

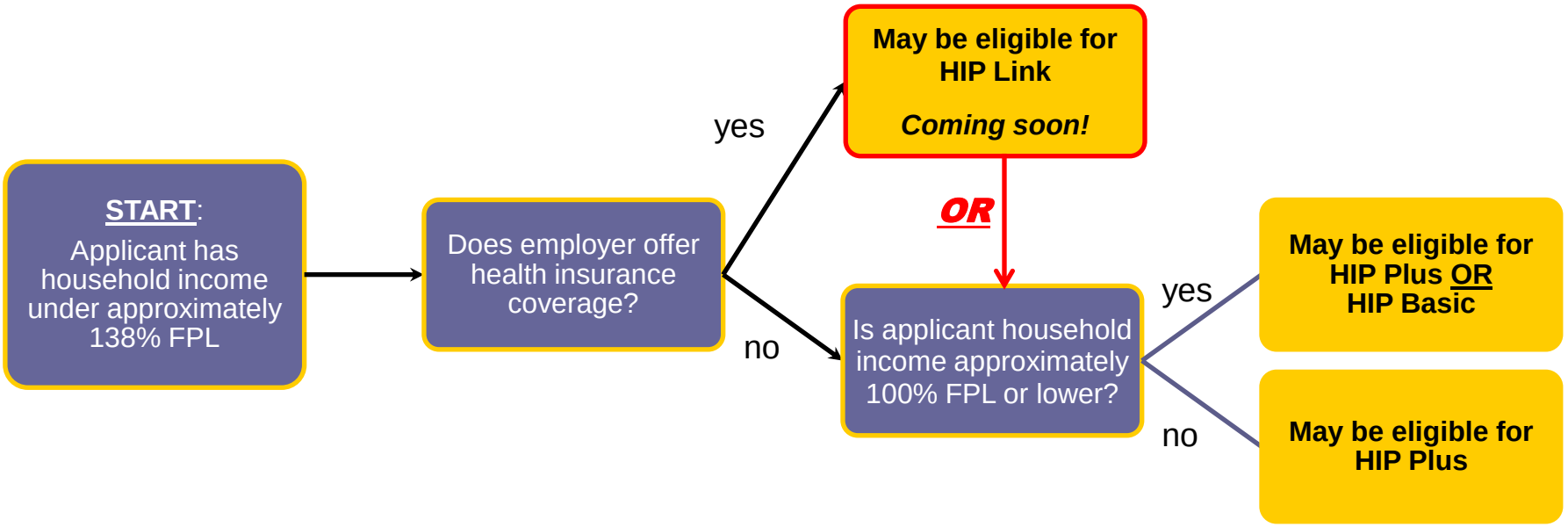
Members with a **qualified and participating** employer are eligible for the employer-sponsored health insurance.

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

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 and/or
  - Receive required preventive services

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.

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 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 – MEDICALLY FRAIL

The Medically Frail

What is medically frail?

- Required federal designation
- Individuals with certain serious physical, mental, and behavioral health conditions are required to have access to the standard Medicaid benefits
  - Called HIP State Plan benefits

What conditions make someone "medically frail?"

- Disabling mental disorders (including serious mental illness)
- Chronic substance use disorders
- Serious and complex medical conditions
- A physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living
  - Activities of daily living include bathing, dressing, eating, etc.
- A disability determination from the Social Security Administration

Medically Frail: Benefits and Cost Sharing

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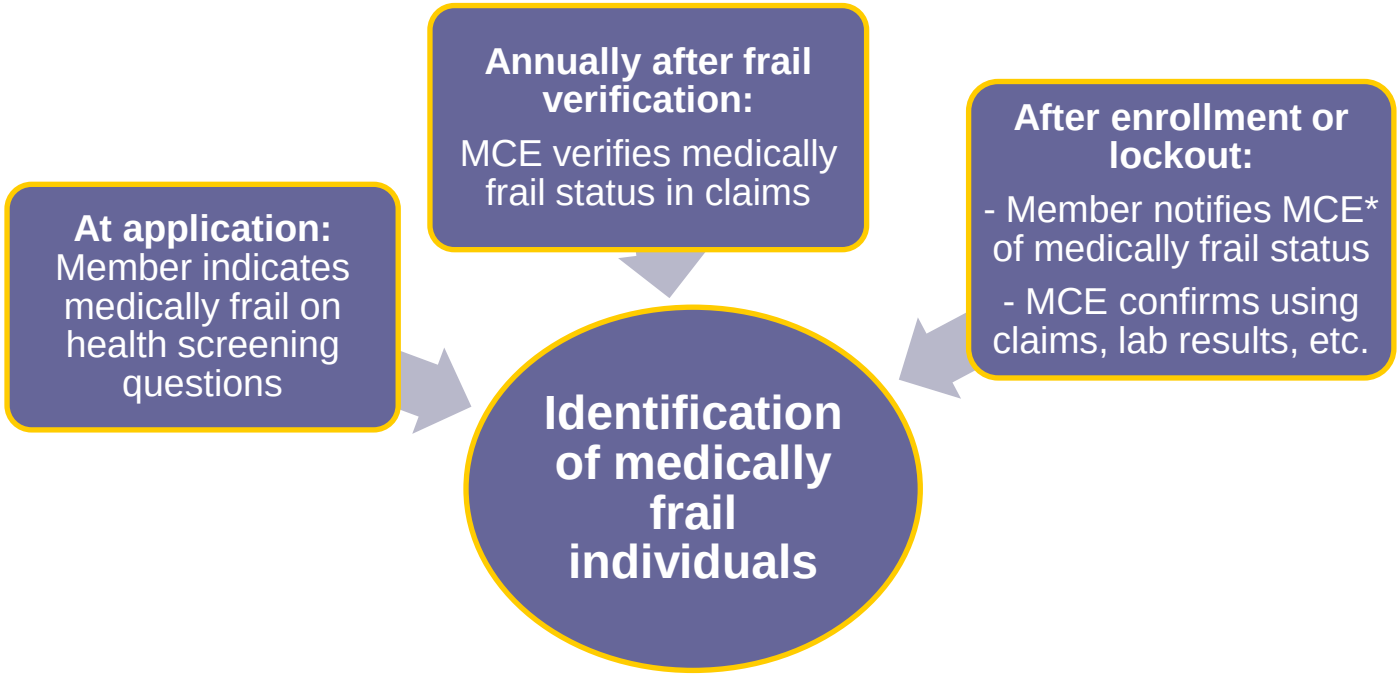
What benefits do medically frail receive?

- HIP State Plan benefits are comprehensive and at least as generous as benefits offered in HIP Basic and HIP Plus and include:
  - Vision
  - Dental
  - Non-emergency transportation
  - Other Medicaid State Plan benefits

What out-of-pocket costs will medically frail individuals have?

- Required to pay HIP cost-sharing of their chosen program:
  - HIP Plus - Monthly POWER account contribution (PAC)
    - Available for individuals with income up to ~138% FPL
    - If fail to pay PAC, must pay copayments for services until outstanding PAC paid
  - HIP Basic - Copayments for services
    - Available for individuals with household income less than or equal to 100% FPL

Medically Frail Identification



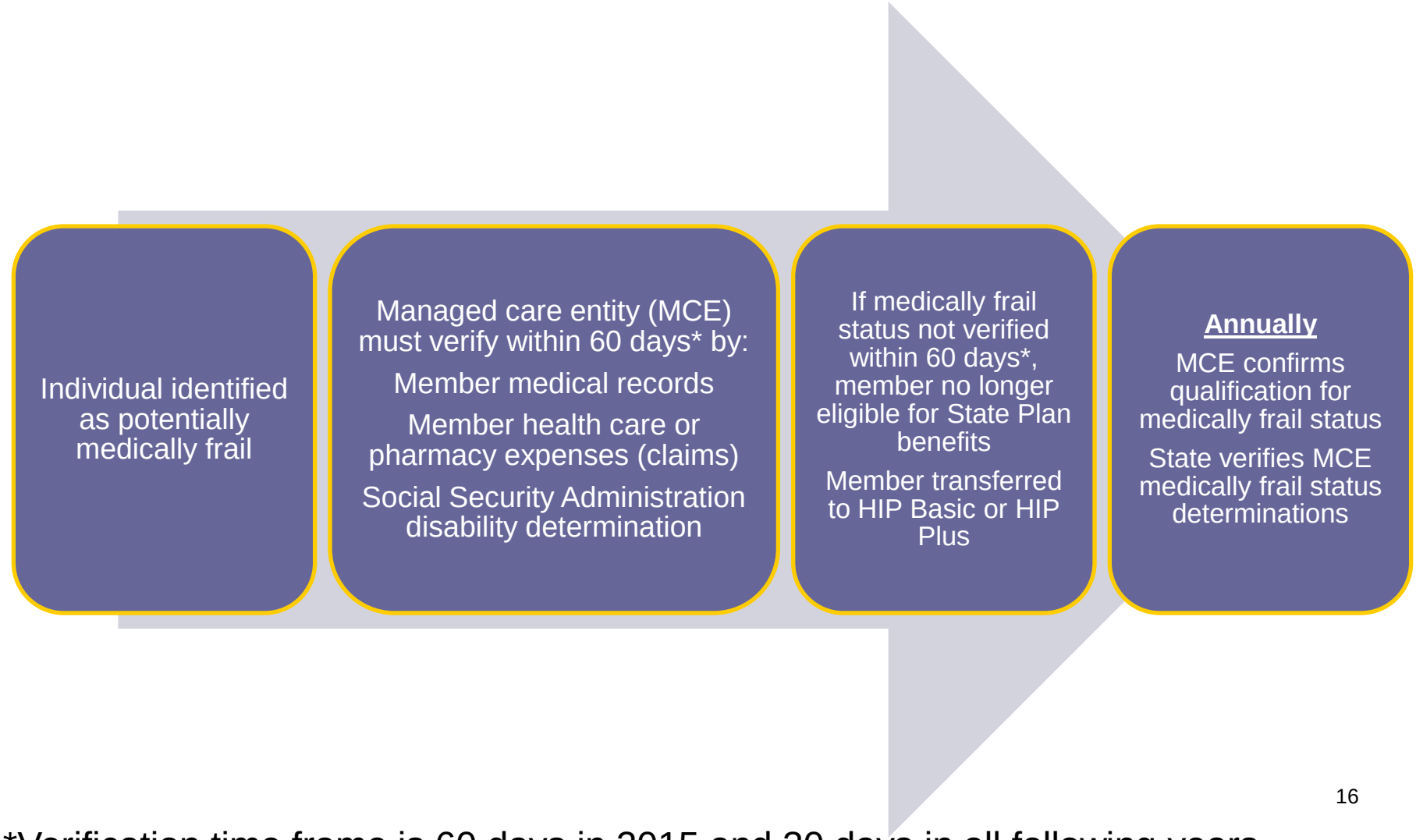
If MCE cannot confirm on-going medically frail status, it will remove the designation

If member reports medically frail to managed care entity (MCE) and findings show individual does not meet definition of medically frail, individual will receive notification of finding and appeal rights

If member disagrees with medically frail appeal decision, may appeal to the State

*Only MCE can review medically frail status; so member will not notify Division of Family Resources of medically frail status

Medically Frail Verification



*Verification time frame is 60 days in 2015 and 30 days in all following years

HIP 2.0 – LOW-INCOME PARENTS, CARETAKERS, AND 19-20 YEAR OLDS

Transition to HIP 2.0: MAGF and MA T

- ✓ Some individuals currently enrolled in Medicaid will be covered by HIP 2.0
  - Low-income Parents and Caretakers (MAGF)
  - Low-income 19 & 20 year olds (MA T)
- ✓ Eligible for:
  - HIP State Plan Plus OR HIP State Plan Basic
- ✓ Benefits:
  - Comprehensive benefits, equivalent to current Medicaid benefits
- ✓ Cost-sharing:
  - HIP State Plan Plus: Monthly POWER account contribution
  - HIP State Plan Basic: Copayments at point of service

HIP 2.0 - TRANSITIONAL MEDICAL ASSISTANCE

Transitional Medical Assistance

What is Transitional Medical Assistance (TMA)?

- Individual gets a job or a pay increase that disqualifies him/her from coverage under the Low-income Parents and Caretaker category
- No upper income limit

How long are individuals eligible for TMA?

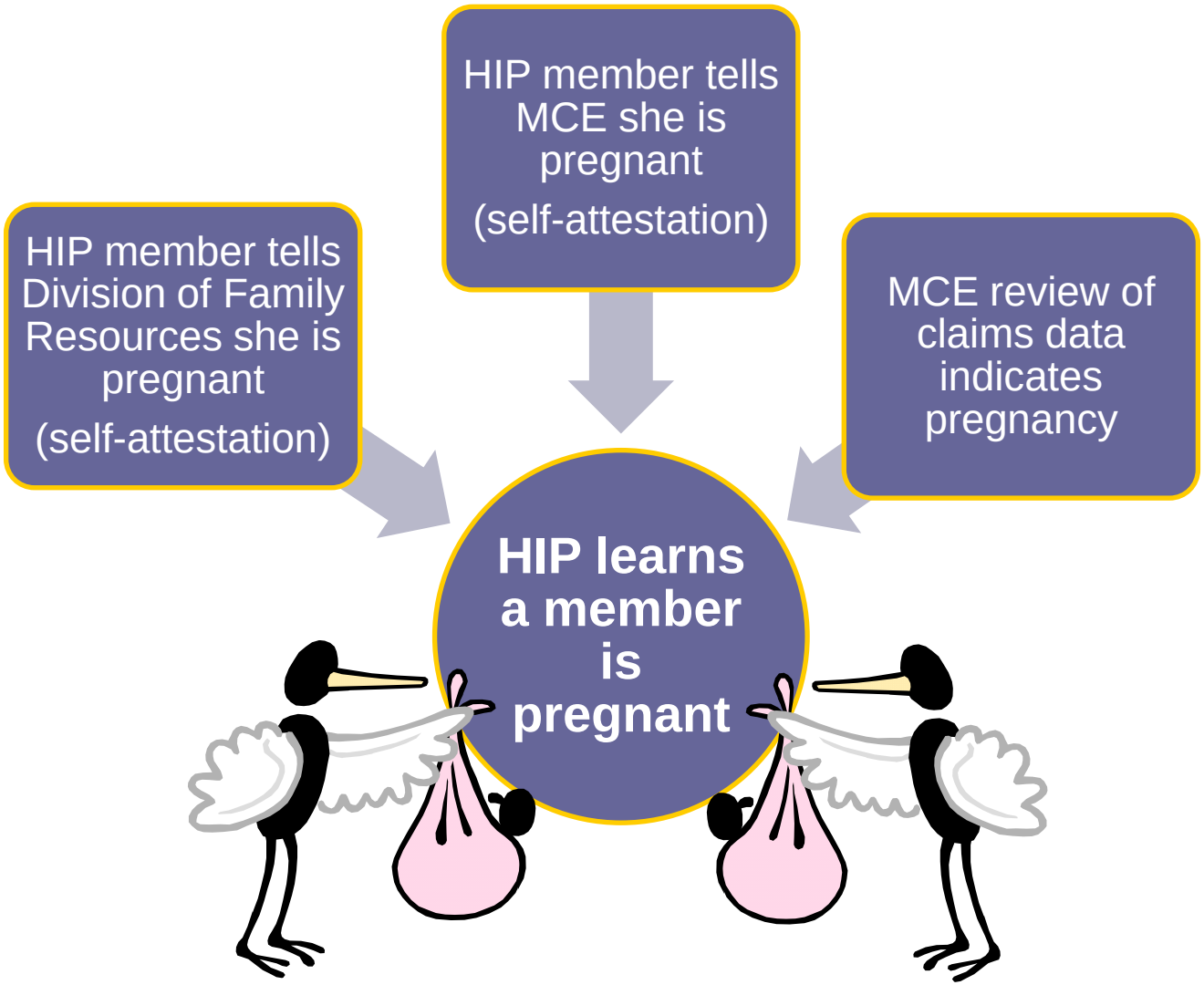
- 6-12 months
- Quarterly reporting required to maintain TMA

Transitional Medical Assistance

- ✓ Individuals with TMA coverage before February 2015 will not transition to HIP 2.0
- ✓ Individuals newly eligible for TMA will receive HIP State Plan Plus or HIP State Plan Basic benefits
- ✓ Regardless of income, individuals receiving Transitional Medical Assistance (TMA) may not be dis-enrolled from the program for at least 6 months
  - May receive TMA up to 12 months if individual complies with required quarterly reporting
- ✓ For TMA members with income over ~138% FPL:
  - May not be dis-enrolled in the first 6 months
  - May be eligible for a second 6 month benefit period if:
    - Comply with required reporting
    - Income under 185% FPL

HIP 2.0 - PREGNANCY

Pregnancy Determination



HIP Coverage for Pregnant Women

Woman becomes pregnant while enrolled in HIP

- HIP member becomes pregnant
- Additional pregnancy-only benefits begin
  - No cost sharing during pregnancy/post-partum period
  - OPTION: May request to move to HIP Maternity (MAGP)

Woman is pregnant at application or redetermination

- Woman eligible for HIP 2.0 and is pregnant at the time of application or at her annual redetermination timeframe will receive HIP Maternity (MAGP)
  - No cost sharing during pregnancy/post-partum period
  - May have coverage gap when reentering HIP after pregnancy if end of pregnancy not reported on time

RECOMMEND:
Report end of pregnancy promptly to guarantee continued HIP coverage without a gap

HIP Maternity (MAGP) Coverage

- Receive HIP Maternity ID card to use when accessing services
- Coverage does not have a POWER account
- Prevent a coverage gap: Pregnant women should promptly notify the State of pregnancy end date
- To maintain coverage in HIP after pregnancy, pay POWER account contribution as soon as possible after pregnancy ends

Pregnancy Benefits

- ✓ Pregnant women receive benefits only available to pregnant women, regardless of selected HIP plan
  - Exempt from cost sharing
  - Additional benefits continue for a 2 month post-partum period

Additional Benefits Include:
Vision
Dental
Non-emergency transportation
Chiropractic

End of Pregnancy

Post-partum period begins

Pregnancy ends

Report to health plan or Division of Family Resources

Members with HIP Maternity coverage (MAGP) receive notice that HIP Maternity coverage ending, with opportunity to re-enroll in HIP

60 day post-partum period

Member receives post-partum coverage without cost sharing

Member with MAGP should pay POWER account contribution to regain HIP Plus and **avoid a possible gap in coverage**

Member who did not transfer to MAGP will continue her HIP Plan after her 60 day post-partum period, with additional pregnancy-only benefits ending after post-partum period

Post-partum period ends

Member must report end of pregnancy before end of post-partum period or must re-apply for HIP

POWER account contributions or cost sharing reinstated

HIP 2.0 – NATIVE AMERICANS

Native Americans

- ✓ By federal rule, Native Americans are exempt from cost sharing
  - Receive HIP Plus
  - Do not have POWER account contributions or emergency room copayments
  - May opt out of HIP Plus and into fee-for-service coverage as of April 1, 2015
- ✓ May be eligible for HIP State Plan benefit option if also:
  - Medically frail,
  - Low-income Parent/Caretaker,
  - Low-income 19-20 year olds

Native American status subject to verification with DFR.

Acceptable forms of verification include: tribal card, tribal letter, previous use of Indian Health Services, etc.

HIP 2.0 - SUMMARY

Summary

- ✓ After reviewing this presentation, you should now have an understanding of:
  - HIP 2.0 features, options, benefits, and cost sharing
  - Different options, enrollment, benefits, and cost sharing available for certain populations, including:
    - Medically frail
    - Low-income Parents and Caretakers, and 19-20 year olds
    - Transitional Medical Assistance
    - Pregnant
    - Native Americans

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 to100% 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