



# Indiana Navigator

## Training Resource Manual

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# I. Consumer Assistance Basics

## A. Chapter Objectives

1. Understand the roles, responsibilities, and requirements of consumer assistants, including Indiana Navigators, Application Organizations (AOs), federal Certified Application Counselors (CACs), federal Navigators, and non-Navigator Assistance Personnel.
2. Understand the Indiana law regarding Indiana Navigators and AOs, including the initial certification and registration processes, the annual renewal processes, prohibited actions and background history, conflicts of interest, privacy and security standards, reporting requirements, and ethical standards.
3. Understand what resources are available for becoming a consumer assistant.

## B. Key Terms

1. **Administrative Action** (also known as **Enforcement Action**) refers to a disciplinary action the Commissioner of the Indiana Department of Insurance (IDOI) may take against a certified Indiana Navigator or registered Application Organization (AO) for violation of Indiana laws or regulations pertaining to Indiana Navigators and Application Organizations. An administrative action may include any of the following, or a combination of the following: (a) reprimand; (b) civil penalty; (c) probation; (d) suspension; (e) revocation; (f) permanent revocation; or (g) a cease and desist order.
2. **Affordable Care Act (ACA)** (also known as **Patient Protection and Affordable Care Act (PPACA)** or **Obamacare**) is a federal statute that was signed into law ([Public Law 111-148](#)) by President Barack Obama on March 23, 2010 and later amended by the federal Health Care and Education Reconciliation Act of 2010 ([Public Law 111-152](#)). The law provides fundamental reforms to the United States healthcare and health insurance systems, including the establishment of health insurance Marketplaces and federal consumer assistance programs (such as federal Navigators, CACs, and non-Navigator Assistance Personnel).
3. **Application Organization (AO)** is an organization that has employees and/or volunteers helping Hoosier health insurance consumers complete applications for health coverage through the federal Marketplace or Indiana Health Coverage Programs (such as Medicaid, the Children's Health Insurance Program (CHIP), or the Healthy Indiana Plan (HIP 2.0)). Organizations meeting the definition of "application organization" under [Indiana Code 27-19-2-3](#) must be registered with the Indiana Department of Insurance (IDOI).
4. **Centers for Medicare & Medicaid Services (CMS)** is a federal agency within the U.S. Department of Health and Human Services (HHS) that administers Medicare, works in partnership with state governments to administer Medicaid and the Children's Health Insurance Program (CHIP), and oversees the federal Marketplace/[healthcare.gov](#).
5. **Certified Application Counselor (CAC)** is a federal consumer assistant, established under the ACA and [45 C.F.R. 155.225](#), who is certified under a federally-designated CAC organization to provide Marketplace education and enrollment assistance. If an organization is designated by the federal government as a CAC organization on the federal Marketplace operating in Indiana, the organization must also be registered as an Application Organization (AO) with the Indiana Department of Insurance (IDOI). If an individual is certified as a federal CAC under a federally-designated CAC organization, the individual must also be certified as an Indiana Navigator with the Indiana Department of Insurance.

6. **Compensation**, for purposes of the Indiana Department of Insurance (IDOI) Conflict of Interest Policy for Indiana Navigators and Application Organizations (AOs), means anything of value, including money or other in-kind benefits of any type, such as grants, credit, loans, as well as any other type of financial influence, including but not limited to gifts, free or discounted travel and prizes, whether paid as commission or otherwise. Compensation does not include tangible goods bearing insurer name or other advertisement having an aggregate value of less than \$100 per year per insurer. Compensation received by an Indiana Navigator or AO from a health insurance issuer for the enrollment of an individual in a health plan is prohibited under Indiana Code 27-19-4 and the IDOI Conflict of Interest Policy.
7. **Complaint** (also referred to as **Consumer Complaint**) means a formal grievance brought by an individual against an insurer, producer, Indiana Navigator, Application Organization (AO), or other individual or business entity regulated by the Indiana Department of Insurance (IDOI). Complaints filed with IDOI will trigger an IDOI investigation of the incident. Complaint forms can be completed either online or printed from IDOI's website at [www.in.gov/idoi/2552.htm](http://www.in.gov/idoi/2552.htm). Complaints against an individual's health plan should first be filed with the company selling the policy. If no resolution can be formed with the insurer, a complaint may be filed with the Indiana Department of Insurance.
8. **Conflict of Interest** (see also **Conflict of Loyalty** and **Financial Interest**) is, for purposes of the Indiana Department of Insurance (IDOI) Conflict of Interest Policy for Indiana Navigators and Application Organizations (AOs), either a: (a) "conflict of loyalty;" or (b) "financial interest;" existing for an Indiana Navigator or Application Organization. Any actual or potential conflict of interest held by an Indiana Navigator or AO must be disclosed to IDOI on the Indiana Navigator or AO Conflict of Interest Disclosure Form.
9. **Conflict of Interest Disclosure Form** refers to either the Indiana Navigator Conflict of Interest Disclosure Form or the Application Organization (AO) Conflict of Interest Disclosure Form developed by the Indiana Department of Insurance (IDOI) to be used by Indiana Navigators or AOs to disclose any actual or potential conflicts of interest, as defined by the IDOI Conflict of Interest Policy, when applying for Indiana Navigator certification or AO registration, when renewing certification or registration, and within 30 days of any change in conflict of interest status. The forms are available on the IDOI website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).
10. **Conflict of Interest Policy** is the state policy document published by the Indiana Department of Insurance (IDOI) by which all Indiana Navigators and Application Organizations (AOs) must comply. The document discusses what may constitute an actual or potential conflict of interest (*i.e.*, financial conflict of interest or conflict of loyalty) and the rules and requirements surrounding such conflicts of interest by which all Indiana Navigators and AOs must comply. As part of the initial and renewal certification application processes for Indiana Navigators and AOs, the Indiana Navigator and AO must review the **Conflict of Interest Policy** and submit to the IDOI either the **Navigator Conflict of Interest Disclosure Form** or **AO Conflict of Interest Disclosure Form**, agreeing to the terms of the policy and disclosing any actual or potential conflicts of interest.
11. **Conflict of Loyalty** (see also **Conflict of Interest**) is, for purposes of the Indiana Department of Insurance (IDOI) Conflict of Interest Policy for Indiana Navigators and Application Organizations (AOs), a non-financial conflict of interest that an individual or business entity has, directly or indirectly, through business or family, an interest or relationship with a third party that prohibits or inhibits, or potentially prohibits or inhibits, the individual or business entity from exercising independent judgment in the best interests of the consumer. Any actual or potential conflict of loyalty must be disclosed to IDOI on the Indiana Navigator or AO Conflict of Interest Disclosure Form.
12. **Consumer Assistant** is a broad term used to describe individuals or entities providing outreach, education, and/or enrollment assistance with a state or federal health insurance marketplace or an

Indiana Health Coverage Program (IHCP), such as Medicaid, Children's Health Insurance Program (CHIP), and Health Indiana Plan (HIP 2.0). The term includes agents and brokers, Indiana Navigators, Application Organizations (AOs), federal Navigators, federal Certified Application Counselors (CACs), federal non-Navigator Assistance Personnel, or Champions of Coverage.

13. **Department of Health and Human Services (HHS)** is the United States federal government's principal health agency. HHS developed and manages the federal Marketplace/[healthcare.gov](https://www.healthcare.gov) and manages the establishment, training, certification, monitoring, and oversight of Marketplace agents, brokers, carriers, and federally-certified consumer assistants.
14. **Ethics** refers to the set of standards that an Indiana Navigator and Application Organizations (AO) must follow in order to provide fair, accurate, unbiased information to consumers regarding health coverage options available to them. These standards may include commitment to consumers, self-determination, informed consent, competence, cultural competence and social diversity, adherence to conflicts of interest and privacy and security standards, access to records, and professional conduct.
15. **Family and Social Services Administration (FSSA)** is the healthcare and social service funding agency within Indiana state government. Most of FSSA's budget is paid to thousands of Hoosier healthcare service providers. The five care divisions within FSSA include the Division of Family Resources (DFR), Office of Medicaid Policy and Planning (OMPP), Division of Disability and Rehabilitative Services (DDRS), Division of Mental Health and Addiction (DMHA), and Division on Aging (DOA). FSSA has the authority, along with the Indiana Department of Insurance (IDOI), to implement and enforce the provisions of [Indiana Code 27-19](#), which establishes the Indiana Navigator and Application Organization (AO) certifications and standards in relation to the federal Marketplace/[healthcare.gov](https://www.healthcare.gov) and Indiana Health Coverage Programs (IHCPs) operating in Indiana.
16. **Federally-facilitated Marketplace (FFM)** (also referred to as **Federal Marketplace** or **HealthCare.gov**) is a federally-developed and federally-operated insurance marketplace that makes qualified health plans (QHPs) available to qualified individuals and/or qualified employers in accordance with the Affordable Care Act. The current federal Marketplace website ([healthcare.gov](https://www.healthcare.gov)) was developed and is operated by the U.S. Department of Health and Human Services (HHS). HHS also oversees the establishment, training, monitoring, and oversight of federal consumer assistance programs (i.e., federal Navigators and Certified Application Counselors (CACs)) that provide Marketplace outreach, education, and enrollment services. This is the Marketplace model operating in Indiana.
17. **Federal Navigator**, established under the ACA ([42 U.S.C. 18031\(i\)](#)) and [45 C.F.R. 155.210](#), is an entity or individual trained, certified, monitored, and provided grant-funding by the federal government to provide health insurance marketplace outreach, education, and enrollment services. Federal Navigators serving in Indiana must also complete the Indiana Navigator certification process or Application Organization (AO) registration process with the Indiana Department of Insurance (IDOI).
18. **Financial Interest** (see also **Conflict of Interest**) is, for purposes of the Indiana Department of Insurance (IDOI) Conflict of Interest Policy for Indiana Navigators and Application Organizations (AOs), when, as a result of the consumer insurance selection at issue, an Indiana Navigator or AO will receive, or may receive, any compensation or other financial arrangement or benefit, either directly or indirectly, from a third party. An individual or business entity, who receives compensation from a health insurance issuer for the enrollment of an individual in a health plan, is prohibited from serving as an Indiana Navigator or Application Organization. Any actual or potential financial interest must be disclosed to IDOI on the Indiana Navigator or AO Conflict of Interest Disclosure Form.
19. **Healthcare.gov** (also referred to as the **Federal Marketplace** or **Federally-facilitated Marketplace**) is a health insurance marketplace website owned and operated by the federal Centers for Medicare & Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS), to

facilitate the sale of qualified health plans (QHPs) and eligibility determinations for premium tax credits (PTCs) and cost-sharing reductions (CSRs) for consumers in Federal Marketplace and Partnership Marketplace states, as well as some State-based Marketplace states. The website also fragments those consumers who may be eligible for Medicaid, and has a separate portal for small businesses (the SHOP Marketplace).

20. [Indiana Administrative Code - Title 760, Article 4](#), titled “Navigators and Application Organizations,” is an Indiana Department of Insurance (IDOI) administrative rule regarding matters relating to an individual acting as an Indiana Navigator and a business entity acting as an Application Organization (AO) in the state of Indiana. It supplements Indiana Code 27-19 and establishes rules regarding Indiana Navigator certification and AO registration with IDOI, duties, conflicts of interest, privacy and security information, reporting requirements, enforcement, and other matters. It also established rules regarding the approval and required procedures of Indiana Navigator precertification education providers and continuing education courses. The rule became effective on July 10, 2016.
21. [Indiana Code 27-19](#), titled “Health Benefit Exchange,” is an Indiana state statute that was signed into law by Governor Mike Pence on May 11, 2013. Indiana Code (IC) 27-19 requires consumer assistants that help Hoosier insurance consumers with applications for qualified health plans (QHPs) on the federal Marketplace or applications for Indiana Health Coverage Programs (IHCPs) to be certified with the State of Indiana. IC 27-19 refers to these state consumer assistants as Indiana “Navigators” and “Application Organizations” (AOs), and establishes certain certification requirements and standards for these consumer assistants. IC 27-19 gives the Commissioner of the Indiana Department of Insurance (IDOI), in consultation with the Secretary of the Indiana Family & Social Services Administration (FSSA), the authority to implement and enforce the provisions established in this code.
22. [Indiana Department of Insurance \(IDOI\)](#) is the agency of Indiana state government whose duty is to monitor and regulate the business of insurance in Indiana and provide Hoosier consumers information on their options for obtaining insurance. IDOI has the authority, in consultation with the Indiana Family & Social Services Administration (FSSA), to implement and enforce the provisions of [Indiana Code 27-19](#), which establishes Indiana Navigator and Application Organization (AO) standards in relation to the Federal Marketplace ([healthcare.gov](http://healthcare.gov)) and Indiana Health Coverage Programs (IHCPs) (see [dfrbenefits.in.gov](http://dfrbenefits.in.gov)) operating in Indiana.
23. [Indiana Health Coverage Program \(IHCP\)](#) (also referred to as **Public Health Insurance Program**) is a term that refers to any of the several programs operating under Indiana Medicaid, which have been developed to address the medical needs of the low income, aged, disabled, blind, pregnant, and other populations meeting the eligibility criteria. Each IHCP has different criteria for eligibility. Types of IHCPs include, but are not limited to, Hoosier Healthwise, Healthy Indiana Plan (HIP 2.0), Children’s Health Insurance Program (CHIP), Hoosier Care Connect, traditional Medicaid, and home and community-based service (HCBS) waivers. Applications for IHCPs can be accessed through the DFR Benefits Portal at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov).
24. [Indiana Navigator](#) is an individual who assists Hoosier insurance consumers in completing applications for qualified health plans (QHPs) on the Federal Marketplace ([healthcare.gov](http://healthcare.gov)) or Indiana Health Coverage Program (IHCP) applications, such as Medicaid, Healthy Indiana Plan (HIP 2.0), or Children’s Health Insurance Program (CHIP) – see [dfrbenefits.in.gov](http://dfrbenefits.in.gov). An individual that meets the definition of “navigator” under [Indiana Code 27-19-2-12](#) must be certified as an Indiana Navigator with the Indiana Department of Insurance (IDOI) and abide by all the standards required of Indiana Navigators (see initial and renewal application processes and other resources at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm)). An Indiana Navigator may, but is not required to, be associated with an Application Organization (AO).

25. **Indiana Navigator Designation Form for Licensed Insurance Producers and Consultants** (also referred to as the **Navigator Designation Form** or **Designation Form**) is a form developed by the Indiana Department of Insurance (IDOI) that may be completed by insurance producers or consultants licensed in the state of Indiana as part of the initial Indiana Navigator certification application process, in place of the online new or renewal application for Indiana Navigators. The form may be accessed online at [www.in.gov/idoi/2929.htm](http://www.in.gov/idoi/2929.htm) (for new applications) or at [www.in.gov/idoi/2930.htm](http://www.in.gov/idoi/2930.htm) (for renewal applications).
26. **Marketplace** (also referred to as **Exchange** or **Health Benefit Exchange**) is a governmental agency or non-profit entity that makes qualified health plans (QHPs) available to qualified individuals or qualified employers in accordance with the Patient Protection and Affordable Care Act (PPACA, or ACA). The term includes a Federally-facilitated Marketplace (FFM, or Federal Marketplace), a Partnership Marketplace, or a State-based Marketplace. Indiana operates as a FFM at [healthcare.gov](http://healthcare.gov).
27. **Navigator Continuing Education (CE)** (also referred to **Continuing Education (CE)**) is education and training programs approved by the Indiana Department of Insurance (IDOI) that may be completed by certified Indiana Navigators to satisfy their yearly Navigator CE requirement. Each year, as part of the annual certification renewal process, an Indiana Navigator must complete at least two (2) hours of Navigator CE from an IDOI-approved Navigator CE provider. A list of approved Navigator CE providers may be accessed through IDOI's website at [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm).
28. **Navigator Examination** (also referred to as **Navigator Certification Examination** or **Navigator Assessment**) is the Indiana Department of Insurance (IDOI) examination given to individuals as part of the initial Indiana Navigator certification application process. The navigator examination is a 90-minute exam consisting of 60 multiple-choice questions outlined in the Navigator Examination Score Report. An individual must score at least a 70% (42 correct out of 60) on the exam to be considered for certification. The exam is registered and scheduled through the Performance Assessment Network (PAN) and administered at Ivy Tech Community Colleges across the state. Additional information on the navigator examination is available online at [www.in.gov/idoi/2836.htm](http://www.in.gov/idoi/2836.htm).
29. **Navigator Examination Score Report** (also referred to as **Score Report**) is a document developed by the Indiana Department of Insurance (IDOI) that outlines each topic covered on the Indiana Navigator examination and how many questions are devoted to each topic. The navigator examination score report may be accessed online at [www.in.gov/idoi/2836.htm](http://www.in.gov/idoi/2836.htm).
30. **Navigator Precertification Education (PE)** (also referred to as **Precertification Education (PE)**) is education and training programs approved by the Indiana Department of Insurance (IDOI) that may be completed by individuals as part of the initial Indiana Navigator certification application process. Approved Navigator PE courses are a minimum of eight (8) hours long and may be either in-person (e.g., classroom, seminar, one-on-one) or self-study (e.g., online) courses. A Navigator PE course must be completed and the course "Certificate of Completion" received from the approved Navigator PE provider in order for an individual to take the navigator examination. A list of approved Navigator PE providers open to the public is available on the IDOI website at [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm).
31. **Navigator Service Request Form** is a form developed by the Indiana Department of Insurance (IDOI) to be used by Indiana Navigators and Application Organizations (AOs) to report certain reporting requirements, including: (1) change of resident address or phone number; (2) change of legal name; (3) correction to social security number (SSN), federal employer identification number (FEIN), or date of birth (DOB); (4) change of business address or phone number; (5) to add, remove or update a location of an AO; (6) to request a cancellation of an Indiana Navigator certification or AO registration; (7) to add or update a federal Navigator or Certified Application Counselor (CAC) number; (8) to add an assumed business name; (9) to add or remove an associated Indiana

Navigator or AO from the AO registration; or (10) to add or update a personal or business email address. The form is available on the IDOI website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

32. **Navigator Subject Matter Content Outline** (also referred to as **Subject Matter Content Outline** or **Content Outline**) is an outline developed by the Indiana Department of Insurance (DOI) that lists the specific topics that should be covered in navigator precertification education (PE) courses in order to be approved by the Indiana Department of Insurance. The outline follows this manual and the Indiana Navigator training resource modules, and covers topics that may be tested on the navigator examination, as outlined in the navigator examination score report. The outline identifies and classifies entry level knowledge that Indiana Navigators need to have in order to properly assist Hoosiers with application for and enrollment in health coverage programs and to abide by the laws and regulations governing Indiana Navigators. The outline is available online at [www.in.gov/idoi/2937.htm](http://www.in.gov/idoi/2937.htm).
33. **Navigator Training Resource Module** (also referred to as **Training Module**) is a document developed by the Indiana Department of Insurance (DOI) in a slideshow presentation format that may be used as a resource for Indiana Navigator precertification education (PE) course providers. There are four training resource modules that cover the four chapters in this training resource manual, including: (a) consumer assistance basics and Indiana Navigator laws and regulations; (b) Indiana Health Coverage Programs (IHCPs); (c) the Federally-facilitated Marketplace (FFM); and (d) guidance on helping consumers complete applications for health coverage. The training resource modules are posted online at [www.in.gov/idoi/2937.htm](http://www.in.gov/idoi/2937.htm).
34. **Non-Navigator Assistance Personnel** (also known as **In-Person Assister** or **In-Person Counselor**) is a type of consumer assister intended to exist in Partnership Marketplace states to complement the federal Navigator program while remaining distinct and apart from the Navigator program. These individuals and organizations are trained to provide assistance to individual consumers, small businesses and their employees searching for health coverage through the marketplace.
35. **Partnership Marketplace** (also referred to as **Partnership Exchange**) is a mix between the Federally-facilitated Marketplace (FFM, or Federal Marketplace) and a State-based Marketplace, which allows a state to assume primary responsibility for certain functions of the Federal Marketplace permanently or as the state works toward operating a State-based Marketplace. These functions may include, for example, plan management and/or consumer assistance and outreach. Indiana does not follow this marketplace model, but rather operates as a Federal Marketplace at [healthcare.gov](http://healthcare.gov).
36. **Performance Assessment Network (PAN)** is the examination registration, scheduling, and reporting provider for all examinations offered by the Indiana Department of Insurance (DOI), which are administered at Ivy Tech Community College locations across the state. Indiana Navigators must register and schedule the Indiana Navigator examination through PAN's online exam registration/scheduling system—<https://secure.vitapowered.com/idoi/login.screen>. Steps to completing the navigator examination registration/scheduling process through PAN are available online at [www.in.gov/idoi/2836.htm#RSE](http://www.in.gov/idoi/2836.htm#RSE).
37. **Personal Information**, for purposes of the Indiana Department of Insurance (DOI) privacy and security agreements for Indiana Navigators and Application Organizations (AOs), means any nonpublic information that is provided to an Indiana Navigator by an individual for purposes of assisting and/or enrolling such individual in a qualified health plan (QHP) through a health insurance marketplace or an Indiana Health Coverage Program (IHCP). Personal information includes, but is not limited to: (a) social security number; (b) name; (c) contact information; (d) driver's license number; (e) financial account numbers; (f) medical or health information; (g) state or federal tax information; or (h) state identification card number. Indiana Navigators and AOs must abide by the

IDOI privacy and security agreements to ensure the confidentiality and protection of consumers' personal information.

38. **Privacy and Security Agreement** refers to either the [Indiana Navigator Privacy and Security Agreement](#) or the [Indiana Application Organization \(AO\) Privacy and Security Agreement](#) (two separate documents) published by the Indiana Department of Insurance (IDOI), by which all Indiana Navigators and AOs must comply. The agreement defines what constitutes a consumer's "personal information" and establishes the privacy and security standards and procedures that all Indiana Navigators and AOs must follow in order to protect a consumer's personal information. As part of the application process for Indiana Navigators and AOs, the Indiana Navigator and AO must sign and submit the agreement to the Indiana Department of Insurance.
39. **Producer** (also referred to as **Agent**, **Broker** or **Agency**) is an individual or business entity licensed by a state to sell, solicit, or negotiate insurance products within the state. A licensed insurance agent/broker/producer that sells health insurance products, or receives compensation from a health insurance carrier for the enrollment of an individual in a health plan, is prohibited from being an Indiana Navigator or Application Organization (AO) in the state of Indiana. A licensed insurance agent/broker/producer that sells health insurance products on the federal Marketplace must be registered with the federal Marketplace.
40. **Reporting Requirement** refers to information that must be reported to the Indiana Department of Insurance (IDOI) by a certified Indiana Navigator or registered Application Organization (AO). This includes, but is not limited to, a change in legal name or address, an administrative or criminal action against the Indiana Navigator or AO, any changed or new conflict of interest, any security breach of a consumer's personal information, or an addition or removal of an Indiana Navigator or AO location from the Application Organization. Indiana Navigator reporting requirements are listed online at [www.in.gov/idoi/2931.htm](http://www.in.gov/idoi/2931.htm) and AO reporting requirements are posted online at [www.in.gov/idoi/2935.htm](http://www.in.gov/idoi/2935.htm).
41. **Security Breach**, for purposes of the Indiana Department of Insurance (IDOI) privacy and security agreements for Indiana Navigators and Application Organizations (AOs), is an unauthorized acquisition or disclosure of personal information that compromises the security, confidentiality, or integrity of such personal information. Indiana Navigators and AOs must abide by the IDOI privacy and security agreements addressing security breaches.
42. **Sircon** (also known as **Vertafore**) is a vendor of the Indiana Department of Insurance (IDOI) that provides online databases and resources for IDOI to manage the licensing, compliance, complaints, administrative procedures, revenue tracking, and other regulatory procedures of individuals and entities regulated by the Indiana Department of Insurance. Indiana Navigators and Application Organizations (AOs) complete new and renewal applications through Sircon's website—[www.sircon.com](http://www.sircon.com)—and Navigator continuing education (CE) providers and precertification education (PE) providers manage their courses through online accounts set up with Sircon.
43. **State-Based Marketplace** is a health insurance marketplace developed and operated by a state to make qualified health plans (QHPs) available to qualified individuals or qualified employers in accordance with the Patient Protection and Affordable Care Act (PPACA, or ACA). Indiana does not follow this marketplace model, but rather operates as a Federally-facilitated Marketplace (FFM, or Federal Marketplace) at [healthcare.gov](http://healthcare.gov).

## C. Introduction to Consumer Assistance

When the [Affordable Care Act](#) (ACA) was signed into law in 2010, it not only introduced many of the changes coming to Medicaid and private insurance marketplaces, but also introduced the concept of navigators. Navigators are individuals or entities who serve as unbiased, knowledgeable resources to

help reduce consumer confusion about options for healthcare coverage through outreach, education, and enrollment.

In State-based Marketplace states, navigators are selected, funded, trained, and monitored by the state. In Federally-facilitated Marketplaces (FFMs) and Partnership Marketplaces, navigators are instead selected, funded, trained, and monitored by the federal government.

In addition to [federal Navigators](#), states may have a variety of other consumer assistants, including [non-Navigator Assistance Personnel](#), [Certified Application Counselors \(CACs\)](#), [Authorized Representatives](#), presumptive eligibility (PE) Qualified Providers, [insurance brokers and agents](#), and others that may be named and defined by the state.

It is possible that not all of these consumer assistants will exist in every state. The requirements for certification of different consumer assistants may vary from state to state based on the marketplace model and specific policy options the state has selected. For example, all marketplaces (regardless of the model) are required to have navigators that meet the federal definition, but each state may choose to implement additional standards for navigators, as long as those additional state-specific requirements do not prevent the implementation of the federal requirements.

Another example of consumer assistant variation between states is that of non-Navigator Assistance Personnel, which are required for states that have chosen a Partnership Marketplace model, and are optional in State-based Marketplace states and Federally-facilitated Marketplaces. The similarities and differences between these consumer assistants and the roles they play in Indiana's Federally-facilitated Marketplace (FFM) will be explained in greater detail in this chapter.

## D. Federally-Mandated Consumer Assistants

There are three primary types of federally-mandated consumer assistants offering outreach, education, and enrollment assistance to consumers: [federal Navigators](#), [Certified Application Counselors \(CACs\)](#), and [non-Navigator Assistance Personnel](#). While these entities have many of the same roles and responsibilities, there are some subtle differences explained on the Centers for Medicare & Medicaid Services (CMS) website at [www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html).

Additional information about the different consumer assistants can also be found in the following sections.

### 1. Federal Navigators

#### *a. Definition and Purpose of Federal Navigators*

Of all of the consumer assistance types, federal Navigators (a term that can refer to both individuals and organizations) have been the most thoroughly-defined. Established under the Section 1311(i) of the Patient Protection and Affordable Care Act (ACA) ([42 U.S.C. 18031\(i\)](#)) and [45 CFR 155.210](#), this type of consumer assistant was designed to provide unbiased and accurate education, outreach, and insurance enrollment assistance on a marketplace. The ACA began by laying out basic roles and requirements for these consumer assistants, and further guidance has continued to define the title.

### ***b. Federal Navigator Roles and Responsibilities***

The original ACA text prescribed a minimum number of types of organizations to be represented as federal Navigators in each marketplace ([see Table 1](#)), as well as the primary duties they must fulfill in order to be federal Navigators ([see Table 2](#)). The ACA also established basic training guidelines, stating that the training was to ensure, among other things, competency to address the needs of underserved and vulnerable populations (including emphasis on accessibility for a variety of cultures, languages, and types of disabilities), eligibility and enrollment procedures, the range of public programs and qualified health plan (QHP) options available, and proper handling of tax data and personal information.

In addition to these federal requirements for federal Navigators, the ACA introduced state authority to establish state licensing, certification, or other standards, regardless of the marketplace model selected.

**Table 1: Possible Types of Federal Navigators**

- Community and consumer-focused nonprofit groups
- Trade, industry, and professional associations
- Commercial fishing industry organizations, ranching and farming organizations
- Chambers of commerce; unions
- Resource partners of the Small Business Administration
- Licensed agents and brokers
- Other public or private entities that meet the requirements (*i.e.*, Indian tribes, tribal organizations, urban Indian organizations, and state/local human service agencies)

Sources: Patient Protection and Affordable Care Act (2010), Section 1311(i) Navigators, [42 U.S.C. 18031\(i\)](#) Code of Federal Regulations, Navigator Program Standards, [45 CFR 155.210](#).

**Table 2: Primary Duties of Federal Navigators**

- Comply with non-discrimination standards
- Demonstrate relationships/potential relationships with qualified health plan (QHP)-eligible populations
- Maintain expertise in eligibility, enrollment, and program specification and conduct public education activities to raise awareness about the Exchange
- Provide information and services in a fair, accurate, and impartial manner
- Facilitate selection of QHP
- Provide referrals for enrollees with a grievance, complaint, or question
- Make consumers aware of the tax implications of their enrollment decisions
- Provide information about costs of coverage
- Inform consumers that assistance can result in eligibility determination for insurance affordability programs
- Assist consumers with applying for premium tax credits (PTC) and cost-sharing reductions (CSR)

Sources: Patient Protection and Affordable Care Act (2010), Section 1311(i) Navigators, [42 U.S.C. 18031\(i\)](#) Code of Federal Regulations, Navigator program standards, [45 CFR 155.210](#).

### ***c. Becoming a Federal Navigator***

In order to be considered a federal Navigator – and thus be held to the standards and requirements listed above – organizations or individuals in Federally-facilitated Marketplace (FFM) or Partnership Marketplace states must apply and be selected to receive cooperative agreement funds from the

Centers for Medicare and Medicaid Services (CMS). The federal Navigator cooperative agreement application is available at [www.grants.gov](http://www.grants.gov)<sup>1</sup> and must be submitted by the deadline stated for the year in order to receive consideration. CMS notified applicants of their selection on September 2, 2015. The amount of the award varies by state and by applicant, as each Federally-facilitated and Partnership state is eligible for a different award total, based on the number of uninsured residents in the state. 2015 Navigator grants were awarded through September 1, 2018—a three year project period.

Once approved to receive the CMS federal Navigator designation and grant funding, federal Navigators must complete the CMS training and certification requirements. The CMS training and presentations for federal Navigators, as well as Certified Application Counselors (CACs), can be found on CMS's website at <https://marketplace.cms.gov/technical-assistance-resources/assister-programs/about-assister-programs.html>.

While other individuals and organizations may perform the same functions as a federal Navigator, they will only be considered federal Navigators in FFM or Partnership states if they receive the funding and certification.<sup>2</sup> Other comparable entities (*i.e.*, non-Navigator Assistance Personnel) may be held to identical role and responsibility requirements and may also receive compensation for the consumer assistance work they perform (except CACs – they cannot collect compensation), but as they have not received the federal Navigator funding, they are considered different types of consumer assistants.

#### *d. Federal Navigators Serving Hoosiers – State Requirements*

In addition to meeting any federal training and certification requirements, federal Navigators serving Hoosier consumers are also required to fulfill the certification and registration requirements of [Indiana Application Organizations \(AOs\)](#) and [Indiana Navigators](#) discussed in more detail later in this chapter. Federal and state training and certification requirements are not interchangeable. In order to operate as a navigator in the state of Indiana, an individual who is a federal Navigator must also become a certified Indiana Navigator and an entity that is a federal Navigator must also become a registered Indiana Application Organization (AO).

While the federal Navigator program is an optional program for entities and individuals to participate in, in order to provide application and enrollment assistance in a qualified health plan (QHP) through the Federal Marketplace ([www.healthcare.gov](http://www.healthcare.gov)) or in an Indiana Health Coverage Program (IHCP), entities must be registered as AOs and individuals must be certified as Indiana Navigators.

## **2. Certified Application Counselors**

### *a. Definition and Purpose of Certified Application Counselors*

Like the federal Navigator program, the ACA requires marketplaces to establish a Certified Application Counselor (CAC) program to assist consumers through unbiased and accurate education and application assistance. CAC organizations apply to and are designated by the marketplace, and those organizations are responsible for training their staff and volunteers as individual CACs. Organizations may apply to

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<sup>1</sup> See also <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html> for more information on Federal Navigator funding opportunities and a lists of past recipients

<sup>2</sup> The selection and funding process may differ in states with a State-based Marketplace, as the states exercise full oversight of the program. However, while the selection and funding process may differ, the basic minimum duties are the same across all states.

become CAC organizations through the federal Centers for Medicare & Medicaid Services (CMS) website at <https://marketplace.cms.gov/technical-assistance-resources/assister-programs/cac.html>.

Similar to federal Navigators, in Federally-facilitated Marketplace (FFM) states like Indiana, CAC organizations and their individual CACs receive training and certification materials from the federal government (CMS). CAC organizations are monitored by the federal government and are responsible for monitoring the individual CACs they train and certify.

Participation in both the federal Navigator and CAC programs are optional. Individuals and organizations are not required by federal law to be certified as federal Navigators or CACs in order to provide consumer health coverage education and application assistance. In Indiana, individuals wishing to participate in either of these programs must do so through a federally-designated organization, as the FFM only designates organizations and not individuals.

Unlike federal Navigators, CAC organizations do not receive federal grant awards to act as CAC organizations and are not required to provide public education and outreach services to the same extent as federal Navigators.

### ***b. Certified Application Counselors - Roles and Responsibilities***

Federal rules have prescribed the primary duties that CACs must fulfill (see [45 CFR 155.225](#)). CAC primary duties include all of the following (see [Table 3](#)):

**Table 3: Primary Duties of Certified Application Counselors**

- To provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible.
- To assist consumers in applying for coverage in a QHP through the Marketplace and for insurance affordability programs.
- To help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs.
- Disclose to consumers any relationships the CAC or sponsoring CAC organization has with QHPs or insurance affordability programs, or other potential conflicts of interest.
- Comply with privacy and security standards and applicable authentication and data security standards.
- Act in the best interest of the consumers assisted.
- Either directly or through an appropriate referral to a Navigator or non-Navigator assistance personnel, or to the Marketplace call center, provide information in a manner that is accessible to individuals with disabilities.
- Abide by any other federal standards and agreements entered into with the Marketplace or designated CAC organization.

Source: Centers for Medicare & Medicaid Services (2013), [45 CFR 155.225](#).

Like federal Navigators, federally-designated CAC organizations and individual CACs may not impose fees on consumers for application or other assistance related to the marketplace.

### *c. Becoming a Certified Application Counselor*

In order to be considered a CAC organization, organizations in a FFM or Partnership Marketplace state must apply and be designated by the Centers for Medicare and Medicaid Services (CMS) as a CAC organization. Organizations may apply via CMS's website at <https://marketplace.cms.gov/technical-assistance-resources/assister-programs/cac.html>. Other organizations and individuals may perform the same functions of a CAC, but they will only be considered a CAC if they receive the designation.

Standards for training and certification are available for individual staff and volunteers working on behalf of designated CAC organizations. Marketplace-approved training for CACs must cover qualified health plan (QHP) options available to eligible consumers, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state.

CMS training and presentations for federal Navigators and CACs may be found through CMS's website at <https://marketplace.cms.gov/technical-assistance-resources/assister-programs/about-assister-programs.html>. To become certified as CACs, CAC applicants must do each of the following (see Table 4):

**Table 4: Requirements for Designation as Certified Application Counselor**

- Complete Federally-facilitated Marketplace (FFM)-approved training and pass all FFM-approved certification examinations.
- Disclose to the designated CAC organization, or to the FFM if directly certified by the FFM, and to potential applicants, any relationships the CAC or sponsoring CAC organization has with QHPs or insurance affordability programs, or other potential conflicts of interest.
- Comply with privacy and security standards and applicable authentication and data security standards.
- Agree to act in the best interest of the consumers assisted.
- Either directly or through an appropriate referral to a federal Navigator or non-Navigator assistance personnel, or to the FFM call center, provide information in a manner that is accessible to individuals with disabilities.
- Enter into an agreement with the designated CAC organization regarding compliance with federal standards.

Source: Cohen, G., *Guidance on Certified Application Counselor Program for the Federally Facilitated Marketplace including State Partnership Marketplaces* (2013), <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CAC-guidance-7-12-2013.pdf>

### *d. Certified Application Counselors Serving Hoosiers – State Requirements*

Federal and state registration, training, and certification requirements are not interchangeable, and designated CAC organizations must also be registered as Application Organizations (AOs) with the State of Indiana and certified individual CACs serving Hoosier consumers must also fulfill Indiana Navigator certification requirements under [Indiana Code 27-19](#) and [760 IAC 4](#) (see guidelines on IDOI website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm)).

Indiana AO registration and Indiana Navigator certification requirements are outlined in the [Application Organization section](#) and [Indiana Navigator section](#) later in this chapter. While the [Federal CAC program](#) is an optional program for entities and individuals, in order to provide application and enrollment

assistance through the [Federal Marketplace](#) or [Indiana Health Coverage Program \(IHCP\) application](#), in the state of Indiana, entities must be registered as AOs and individuals must be certified as Indiana Navigators.

### 3. Non-Navigator Assistance Personnel

#### *a. Definition and Purpose of Non-Navigator Assistance Personnel*

Non-Navigator Assistance Personnel has been called many different things, starting as an “assister” in the ACA, then re-named “in-person assister” in January 2012 CMS guidance<sup>3</sup>, occasionally referred to as “in-person counselor,” and finally designated “non-Navigator Assistance Personnel” in the CMS April 2013 Notice of Proposed Rulemaking (NPRM) and subsequent final rule. In spite of the changing names, there has been a relatively consistent expectation for the role this group serves. Intended to exist in Partnership Marketplace states, this group is to be a consumer assistance program developed by the state to complement the federal Navigator program while remaining “distinct and apart from the Navigator program.”

CMS describes the non-Navigator Assistance Personnel program as a way for states to be creative in their management of state-specific consumer assistance needs while adhering to the same standards and requirements (e.g., meeting conflict of interest standards, cultural and linguistic standards, access standards for persons with disabilities, training topics, etc.) applied to federal Navigators. In spite of the similarity in training topic standards, the January 2012 guidance from CMS states that non-Navigator Assistance Personnel should also coordinate with the federal Navigators to avoid duplication of efforts in consumer assistance. Although non-Navigator Assistance Personnel will share training and a mission of consumer education, outreach, and enrollment assistance with federal Navigators, the true size, scope, selection, and state-specific components of this program will vary by state.

While it was originally discussed solely in the context of Partnership Marketplace states, the non-Navigator Assistance Personnel option is also extended to State-based Marketplace states that have such a program funded through federal Exchange Establishment grant funds. As State-based Marketplace states are restricted from using Exchange Establishment grant funds to pay for their federally-mandated Navigator programs, the development of the non-Navigator Assistance Personnel option allows more states to utilize federal funds for consumer assistance efforts. CMS has issued guidance that non-Navigator Assistance Personnel will not be available in states that have chosen the FFM model, as Indiana has.

#### *b. Non-Navigator Assistance Personnel Roles and Responsibilities*

While the specific roles and responsibilities of non-Navigator Assistance Personnel may vary by state, the general role of all non-Navigator Assistance Personnel is to provide consumer education and support in the insurance affordability program eligibility and enrollment process.

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<sup>3</sup> See “Guidance on the State Partnership Exchange,” Center of Consumer Information and Insurance Oversight (CCIIO) (Jan. 3, 2013), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf>

### *c. Becoming Non-Navigator Assistance Personnel*

The process of becoming non-Navigator Assistance Personnel will vary by state, but their federal training standards and requirements will be the same as those of federal Navigators.

### *d. Non-Navigator Assistance Personnel serving Hoosiers – State Requirements*

Currently, Indiana does not anticipate the development of a non-Navigator Assistance Personnel program, as it is not a Partnership Marketplace state and is not receiving federal funds to establish such a program. As a result, the individuals most likely to be designated for this role will be in other states. If out-of-state non-Navigator Assistance Personnel also serve Indiana residents, Indiana requires that these out-of-state consumer assistants also meet Indiana Navigator certification and Application Organization (AO) registration standards. The specific process for registration of AOs and certification of Indiana Navigators will be reviewed in the [Indiana Application Organization section](#) and [Indiana Navigator section](#) to follow.

## **E. State of Indiana – Roles and Responsibilities with Consumer Assistance**

There are federal training and certification requirements for federally-designated consumer assistants (e.g., federal Navigators and Certified Application Counselors (CACs)), but these requirements do not include the state-specific policy and operational changes taking place in the Medicaid and private and federal insurance markets in Indiana. In order to provide a basic and standard understanding of these state-specific programs and markets, the State of Indiana has developed the Indiana Navigator certification and Application Organization (AO) registration. With an understanding of how these insurance affordability programs work in the state, Indiana Navigators and AOs will be better-prepared to assist Hoosier consumers in understanding their health coverage options.

This certification and registration creates new roles and responsibilities for state agencies, as well as organizations and individuals helping consumers apply for health coverage. These responsibilities surround the development of the certification and registration, its day-to-day operations, and the monitoring and oversight of certified Indiana Navigators and registered Application Organizations.

Further information on the Indiana Navigator certification and AO registration processes can be found on the Indiana Department of Insurance (IDOI) website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

### **1. State Role in the Certification/Registration and Re-certification/Re-registration Processes**

The Indiana Department of Insurance (IDOI) plays a primary role in the initial certification and annual renewal processes, as it receives and reviews all Indiana Navigator and AO initial applications and annual renewal applications, found on IDOI's website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm). The IDOI also developed the initial and annual renewal applications and navigator examination in consultation with the Family and Social Services Administration (FSSA).

Indiana Navigator precertification education (PE) and continuing education (CE) course providers, criminal background checks, Conflict of Interest disclosure forms, and Privacy and Security agreements are also assessed by the IDOI for potential disqualifying events. One primary focus of the Indiana

Navigator certification and AO registration process is consumer protection, therefore the state will scrutinize any information or situation that may jeopardize Hoosier consumers.

### *a. State Monitoring and Oversight*

The state will rely largely on two primary mechanisms for monitoring Indiana Navigators and AOs: complaints and internal tracking. Complaints from consumers or their family members, other individuals or organizations, or other state agencies, will trigger an IDOI investigation of the incident. Complaint forms can be completed either online or printed from IDOI's website at [www.in.gov/idoi/2552.htm](http://www.in.gov/idoi/2552.htm).

Internal tracking of health coverage application submissions will also be a way for the state to monitor the quality of the applications submitted with Indiana Navigator and AO assistance. Approved Indiana Navigators and AOs will be issued unique certification numbers to use on all applications for health coverage with which they assist.

The quality of the health coverage applications will be particularly important for hospitals qualified to perform more robust presumptive eligibility (PE) assessments, as they will be held to state quality standards in order to retain the ability to assess PE for Medicaid. See the [Hospital Presumptive Eligibility section](#) for more information about the Patient Protection and Affordable Care Act (ACA) provisions that allow hospitals to make PE determinations.

### *b. State Enforcement Actions*

As an Indiana Navigator or AO, there are certain things that an individual or organization can and cannot do, as defined by Indiana laws and regulations, the [Conflict of Interest Policy](#), and the Privacy and Security Agreements. If an Indiana Navigator or AO violates an established rule or standard issued by the state, the state has a number of enforcement actions it may take. Those enforcement actions include one or more of the following:

- Reprimand,
- Civil penalty,
- Probation,
- Suspension,
- Temporary revocation,
- Permanent revocation, and/or
- Cease and desist order.

These enforcement actions will vary based on the severity of the incident and are at the discretion of the Commissioner of Insurance in consultation with the Secretary of the Family and Social Services Administration.

## **2. Indiana Navigator and Application Organization Requirements for Completing Certification and Registration**

In order to maintain an active registration or certification, all Application Organizations (AOs) are required to renew their registration each year, and all Indiana Navigators are required to complete continuing education (CE) requirements and renew their certification application each year. The

processes and applications for annual renewal can be accessed via IDOI's website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

Failure to complete these renewal requirements will result in the termination of registration or certification. Indiana Navigators and AOs are given a late period for the thirty (30) days following their license expiration date. During this time they may complete the renewal process and pay a higher renewal fee in order to renew the registration or certification. If the individual or organization fails to renew within the late period, that individual or organization will need to reapply as a new Indiana Navigator or AO and complete all of the initial application steps.

Federally-designated Navigators and Certified Application Counselors (CACs) are required to complete the Indiana Navigator certification and AO registration requirements in addition to federal requirements through the federal Centers for Medicare & Medicaid Services (CMS). These consumer assistants will be responsible for meeting federal requirements, and failure to do so may make the consumer assistants subject to federal enforcement actions. The failure to meet state requirements will not only result in potential enforcement action in the state, but may also have consequences with regard to federal certification.

#### *a. Requirements in State Legislation*

Within [Indiana Code 27-19](#) there are lists of required and prohibited actions to which Indiana Navigators and AOs must adhere. Those items are detailed in the following table ([see Table 5](#)):

**Table 5: Required and Prohibited Actions by Navigators and Application Organizations**

Required Actions	Prohibited History	Prohibited Actions
<ul style="list-style-type: none"> <li>• Complete Continuing Education requirements</li> <li>• Disclose all conflicts of interest to the Commissioner during application and for any conflicts arising after application</li> <li>• Comply with administrative or court order imposing child support obligation</li> <li>• Pay state income tax or comply with administrative or court order directing payment of state income tax</li> <li>• Inform IDOI of change in legal name or address</li> <li>• Verify that each associated Indiana Navigator has been certified and not committed any act that would be grounds for denial, suspension, or revocation</li> </ul>	<ul style="list-style-type: none"> <li>• Holds/held an insurance producer license, Indiana Navigator certification, AO registration, or equivalent license, certification, or registration that has been denied, suspended, or revoked</li> <li>• Conviction of felony or other crime determined by IDOI in consultation with FSSA</li> <li>• Admission or conviction of unfair trade practice or fraud in the business of insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Provides incorrect, misleading, incomplete, or materially untrue information in the application</li> <li>• Obtains or attempts to obtain license, certification, or registration through misrepresentation or fraud</li> <li>• Violates: <ul style="list-style-type: none"> <li>○ Insurance law or regulation,</li> <li>○ Subpoena or order of Commissioner,</li> <li>○ Rule of federal Marketplace,</li> <li>○ Rule adopted under IC 27-19-3-3(d), and/or</li> <li>○ ACA and regulations developed under ACA</li> </ul> </li> <li>• Intentionally misrepresents terms of actual/proposed insurance contract or application</li> <li>• Uses fraudulent, coercive, or dishonest practices, or demonstrates incompetence or untrustworthiness in acting as Indiana Navigator or AO</li> <li>• Cheats on navigator examination</li> <li>• Receives consideration from health insurance issuer in connection with enrollment of individual into a health plan</li> </ul>

Source: Indiana General Assembly (2013), [Indiana Code 27-19](#); see also [760 IAC 4](#)

### ***b. Consequences for Not Meeting Requirements***

For Indiana Navigators and AOs that fail to meet state requirements, by either failing to do what they are required to do or by doing what they are prohibited from doing, there is a range of possible enforcement actions the Indiana Department of Insurance (IDOI) may take. Those actions are detailed in the following table ([see Table 6](#)):

**Table 6: Possible IDOI Enforcement Actions against Navigators and Application Organizations**

Enforcement Action	Implementation
<i>Reprimand</i>	<ul style="list-style-type: none"> <li>• The IDOI may notify the Indiana Navigator and/or AO of a potential issue that requires entity application and behavior modification.</li> <li>• If the Indiana Navigator and/or AO makes appropriate modifications, further enforcement action may not be needed.</li> </ul>
<i>Levy a civil penalty</i>	<ul style="list-style-type: none"> <li>• The IDOI may impose fees for requirement violations.</li> <li>• The fee amounts and conditions under which they are issued may vary based on the severity of the case.</li> </ul>
<i>Suspend certification</i>	<ul style="list-style-type: none"> <li>• The IDOI may determine that a violation is severe enough to merit the temporary or permanent suspension/revocation of certification/registration.</li> </ul>
<i>Revoke certification for a limited time</i>	<ul style="list-style-type: none"> <li>• During the time in which a certification or registration is suspended or revoked, an individual or organization is not to act as an Indiana Navigator/Application Organization.</li> </ul>
<i>Revoke certification permanently</i>	<ul style="list-style-type: none"> <li>• If the violation is believed to be a risk for consumers and the Indiana Navigator and/or AO has shown that it intends to act in spite of the suspension/revocation, the IDOI may also need to issue a cease and desist order. Failure to comply may then have other financial and litigious implications.</li> </ul>
<i>Issue cease and desist order</i>	

Source: Indiana General Assembly (2013), [Indiana Code 27-19](#); see also [760 IAC 4](#)

## F. State-certified Consumer Assistance

Not all organizations and individuals working with Hoosier consumers are subject to the state laws regarding Indiana Navigators and Application Organizations (AOs). The following table (see [Table 7](#)) may help clarify what activities and designations require an individual or organization to receive these state designations.

### 1. Who needs to be certified as an Indiana Navigator or Application Organization?

Based on the activities one performs, an individual or organization may need to be certified as an Indiana Navigator or registered as an Application Organization with the Indiana Department of Insurance (IDOI). To help determine whether an individual or organization needs to obtain the certification or registration, an individual or organization may refer to the following table (see [Table 7](#)). For all “Yes” responses to the listed activities, the information in the right columns state if such an activity requires certification.

**Table 7: Determining If You Meet Definition of Indiana Navigator or Application Organization**

<b>*ANSWER <u>ALL</u> QUESTIONS*</b>		
<b>DO YOU...</b>	<b>ORGANIZATION</b>	<b>INDIVIDUAL</b>
(1) Have designation as a federal Navigator or Certified Application Counselor?	Organization meets definition of Application Organization requiring registration with Indiana Department of Insurance.	The requirement to be certified as an Indiana Navigator will depend on the individual's exact activities.
(2) Help individuals complete the Federal Marketplace (see <a href="http://healthcare.gov">healthcare.gov</a> ) application?	Organization meets definition of Application Organization requiring registration with Indiana Department of Insurance.	Individual meets the definition of Indiana Navigator requiring certification with the Indiana Department of Insurance.
(3) Help individuals complete Indiana Applications for Health Coverage (see <a href="http://dfrbenefits.in.gov">dfrbenefits.in.gov</a> ), such as Medicaid, Children's Health Insurance Program, or Healthy Indiana Plan 2.0?	Organization meets the definition of Application Organization requiring registration with Indiana Department of Insurance.	Individual meets definition of Indiana Navigator requiring certification with Indiana Department of Insurance.
(4) Help <u>ONLY</u> the following individuals complete Indiana Medicaid application? (1) Those eligible for Medicaid nursing home care; or (2) Those eligible for Medicaid home & community-based waiver services	This activity alone does not require organization to register as an Application Organization with the Indiana Department of Insurance.	This activity alone does not require individual to become certified as an Indiana Navigator with the Indiana Department of Insurance.
(5) Complete <u>ONLY</u> the Presumptive Eligibility (PE) application for Medicaid or HIP?	This activity alone does not require organization to register as an Application Organization with the Indiana Department of Insurance.	This activity alone does not require individual to become certified as an Indiana Navigator with the Indiana Department of Insurance.
(6) Refer potential Federal Marketplace or Indiana Health Coverage Program applicants to others for help with their applications?	This activity alone does not require organization to register as an Application Organization with the Indiana Department of Insurance.	This activity alone does not require individual to become certified as an Indiana Navigator with the Indiana Department of Insurance.
(7) Help individuals complete the Medicaid application as the individual's Authorized Representative through the Family & Social Services Administration (FSSA)?	This activity alone does not require organization to register as an Application Organization with the Indiana Department of Insurance. This activity does require organization to be listed on the FSSA Authorized Representative form.	This activity alone does not require individual to be certified as an Indiana Navigator with the Indiana Department of Insurance. This activity does require individual to complete the FSSA Authorized Representative form to submit with the application.
(8) Perform your job function for/as a state agency, division, or subdivision thereof?	This activity does not require organization to register as an Application Organization with the Indiana Department of Insurance.	This activity does not require individual to become certified as an Indiana Navigator with the Indiana Department of Insurance.
(9) Assist a population, complete a type of application, or hold another designation not listed above?	Call the IDOI Navigator Director at (317) 232-2414 or email <a href="mailto:navigator@idoi.in.gov">navigator@idoi.in.gov</a> to determine whether you need to register as an Application Organization.	Call the IDOI Navigator Director at (317) 232-2414 or email <a href="mailto:navigator@idoi.in.gov">navigator@idoi.in.gov</a> to determine whether you need to be certified as an Indiana Navigator.

## 2. Application Organizations

### *a. Application Organization Roles and Responsibilities*

Application Organizations (AOs), established under [Indiana Code 27-19-2-3](#), are organizations that have employees and/or volunteers assisting Hoosier consumers to complete health coverage applications for the Federally-facilitated Marketplace (FFM) or state-based health coverage programs (e.g., Medicaid, Healthy Indiana Plan (HIP 2.0), Children's Health Insurance Plan (CHIP)). They are defined in [Indiana Code 27-19](#) and [760 IAC 4](#), which also establishes the standards and requirements of AOs, including registration and reporting requirements with the Indiana Department of Insurance (IDOI).

Examples of AOs may include: hospitals, health centers, community-based social service agencies, and Medicaid Enrollment Centers. Organizations that have been selected and funded as federal Navigators, or designated as federal Certified Application Counselor (CAC) organizations, are also included in the definition of Application Organizations.

In order for AOs to be in compliance with Indiana state law, AOs must do each of the following:

- (1) Register with the Indiana Department of Insurance (IDOI).
- (2) Be in good standing with the Indiana Secretary of State (SOS).
- (3) Renew registration with the IDOI annually.
- (4) Abide by all state reporting, conflict of interest, privacy and security, and other standards.

Application Organizations have a number of options when it comes to the application, training, and certification process for associated Indiana Navigators. For example, AOs may help their associated Indiana Navigators financially by helping to cover the cost of the application, background check, education, and navigator examination fee, or it may offset costs by performing a criminal background check or by offering pre-licensing education (PE) internally instead of having the Indiana Navigator applicant utilize a third party vendor for training.

Details of requirements and responsibilities for AOs as well as optional activities are detailed in the following table (see [Table 8](#)):

**Table 8: Requirements and Responsibilities of Applicant Organizations**

	Requirement	Option
<b>Application<sup>4</sup></b>	<ul style="list-style-type: none"> <li>Register with the IDOI (complete <a href="#">online application</a> and pay nonrefundable application fees)</li> <li>Be in good standing with the Indiana Secretary of State</li> <li>Complete and submit the <a href="#">AO Conflict of Interest Disclosure Form</a> and <a href="#">AO Privacy and Security Agreement</a></li> <li>Disclose any actual or potential conflict of interest defined by <a href="#">Conflict of Interest Policy</a></li> <li>Submit contact list of each physical location of the AO, if more than one location</li> <li>Have no prohibited conflict of interest</li> <li>Designate a lead Indiana Navigator</li> <li>Report all associated Indiana Navigators working on the AO's behalf</li> </ul>	<ul style="list-style-type: none"> <li>Perform criminal background check on individual Indiana Navigator(s)</li> <li>Pay application fee on behalf of Indiana Navigator(s)</li> </ul>
<b>Pre-certification Education (PE)</b>	<ul style="list-style-type: none"> <li>Attest that all individual Indiana Navigators have completed pre-certification education (PE)</li> </ul>	<ul style="list-style-type: none"> <li>Become an approved Navigator pre-certification education (PE) provider<sup>5</sup> with IDOI and provide PE training to Indiana Navigators</li> </ul>
<b>IDOI Navigator Examination<sup>6</sup></b>	<ul style="list-style-type: none"> <li>Attest that all individual Indiana Navigators have passed the Indiana Navigator certification examination</li> </ul>	<ul style="list-style-type: none"> <li>Pay for the certification examination on behalf of each Indiana Navigator</li> </ul>
<b>Annual Continuing Education (CE) and Renewal<sup>7</sup></b>	<ul style="list-style-type: none"> <li>Complete annual online renewal application and pay non-refundable renewal application fee</li> <li>Complete and submit <a href="#">Conflict of Interest Disclosure Form</a>, if a new conflict of interest has arisen since last application</li> <li>Disclose any new actual or potential conflict of interest (as defined by the <a href="#">Conflict of Interest Policy</a>) not previously disclosed</li> <li>Disclose additional or deletions to associated Indiana Navigators within 30 days of a change</li> <li>Submit updated contact list of each physical location of the AO, if more than one location</li> <li>Abide by all other state reporting, conflict of interest, and privacy and security standards</li> </ul>	<ul style="list-style-type: none"> <li>Become a certified Navigator continuing education (CE) provider<sup>8</sup> with IDOI to provide CE to Indiana Navigators</li> <li>Pay renewal application fees on behalf of Indiana Navigators</li> </ul>

Source: Indiana General Assembly (2013), [Indiana Code 27-19](#). See also [760 IAC 4](#) and [www.in.gov/idoi](#).

<sup>4</sup> The initial Indiana Navigator application process is online at [www.in.gov/idoi/2929.htm](#), and the initial Application Organization (AO) application process is online at [www.in.gov/idoi/2825.htm#IAP](#).

<sup>5</sup> The Navigator pre-certification education (PE) course provider application is online at [www.in.gov/idoi/2936.htm](#).

<sup>6</sup> IDOI navigator examination procedure and guidelines are online at [www.in.gov/idoi/2836.htm](#).

<sup>7</sup> The annual renewal requirements for Indiana Navigators are posted online at [www.in.gov/idoi/2930.htm](#), and the annual renewal requirements for Application Organizations (AOs) is online at [www.in.gov/idoi/2934.htm](#).

<sup>8</sup> The Navigator continuing education (CE) course application is posted online at [www.in.gov/idoi/2938.htm](#).

### ***b. Becoming an Application Organization***

A list of steps and requirements for submitting an initial or renewal Application Organization (AO) application is posted on the Indiana Department of Insurance (IDOI) website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

An organization with one or more physical locations may submit one initial online AO application and annual renewal application, pay one nonrefundable application and annual renewal fee, submit one AO Conflict of Interest Disclosure Form and one AO Privacy and Security Agreement for the organization when initially applying and renewing registration each year. An organization with multiple locations must also submit to the IDOI the name, address, telephone, email and/or website, and contact person for each physical location within the Application Organization. The organization may also include all counties a particular location covers to be included on the Indiana state healthcare reform website at [www.in.gov/healthcarereform/2468.htm](http://www.in.gov/healthcarereform/2468.htm).

There are some organizations that assist consumers with health coverage applications that would not need to become Application Organizations. This may be the case for two primary reasons: (1) if the organization does not meet the definition of an AO under [Indiana Code 27-19](#) and [760 IAC 4](#) or is excluded under the law because it only provides assistance in a limited capacity; or (2) if the organization cannot become an AO because it has a prohibited conflict of interest defined by the [Conflict of Interest Policy for Navigators and Application Organizations](#). An organization might fall into the first category if it only provides general information about health coverage applications and not actual application assistance. For example, social service agencies that provide consumers with information on where to go to assess eligibility and enroll in Medicaid or health plans, may not need to register as Application Organizations.

The law also provides exclusions for certain organizations, such as state agencies, or employees that do only presumptive eligibility (PE) determinations or submit Medicaid applications as an Authorized Representative (AR) through the AR agreement with the Indiana Family & Social Services Administration (FSSA). An organization might fall into the second category if it receives compensation from health insurance issuers for consumer enrollment into health plans. For example, insurance agencies that receive compensation from health issuers when their agents enroll consumers into health plans would not register as Application Organizations.

#### **i. Becoming an Application Organization – Online Application**

If an organization meets the definition of an Application Organization (AO) under [Indiana Code 27-19](#) and [760 IAC 4](#), it will register with the state by filing an online application with the Indiana Department of Insurance (IDOI) at [www.in.gov/idoi/2825.htm](http://www.in.gov/idoi/2825.htm). The application consists of questions about the organization and its activities, its owner(s), and its associated Indiana Navigators. An authorized representative of the organization will: (1) provide contact information and other identifying information for the organization; (2) designate a designated/responsible/lead Indiana Navigator<sup>9</sup> to serve as the primary contact for the organization; (3) provide the names of those individuals who have

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<sup>9</sup> While the number of associated Indiana Navigators may grow and change over time, the organization will only need to designate one lead Indiana Navigator on the application in order to meet application requirements. All other associated Indiana Navigators may be added over time. Since the organization will need to attest to the fact that the designated lead Indiana Navigator has been certified, the organization will need to coordinate with that lead Navigator to ensure he or she is certified before the organization completes its application.

ownership interest in the organization; (4) answer background questions on behalf of those with ownership interest to ensure compliance with Indiana law; and (5) attest to abide by the laws, regulations, and other requirements pertaining to Application Organizations.

The organization will submit the completed application along with the nonrefundable application fee. For resident businesses in Indiana, the application fee is \$50 per year plus an online processing fee. For businesses residing outside of Indiana, the application fee is \$100 per year plus an online processing fee. The fees are subject to change based on the discretion of the Commissioner of Insurance. The most accurate, up-to-date fee information may be found on the IDOI website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

After the online AO application, fee, and other required information are submitted, the application will be reviewed by the IDOI for completion and potential disqualifying information. If there are questions about the application, IDOI may contact the organization with a request for additional information. Once all concerns are addressed, the IDOI will either approve or deny the application. If the application is approved, an automated email notification of the approval will be sent to the AO. If the organization's application is denied, a letter will be mailed to the organization containing information about the reason for denial and the organization's appeal rights.

## ii. Becoming an Application Organization – Conflict of Interest Disclosure Form

As a part of the application process, the authorized representative completing the application on behalf of an organization must review the [Conflict of Interest Policy](#). This policy is identical to that reviewed and agreed to by all Indiana Navigators; but the representative will not only attest to any of his or her personal conflicts of interest, but also the potential or actual conflicts of interest of the organization's other owners, officers, partners, board members, or directors, as well as any conflicts of interest related to the mission and operations of the organization.

Described in greater detail in the [Indiana Navigator section](#), there are two primary types of conflicts of interest that may exist: a "financial interest" or a non-financial "conflicts of loyalty." Regardless of the type of conflict of interest and whether it is an actual or potential conflict of interest, the representative must report an actual or potential conflict of interest to the IDOI by completing the associated [Conflict of Interest Disclosure Form](#). The Commissioner will review these conflicts of interest to ensure that none are prohibited by existing state laws or regulations.

## iii. Becoming an Application Organization – Privacy and Security Agreement

As a part of the application process, the individual completing the application on behalf of the organization must submit a completed [AO Privacy and Security Agreement](#). This agreement will be similar to that reviewed and agreed to by all individual Indiana Navigators. The organization as a whole will agree to abide by the privacy and security standards, including its owners, partners, board members, officers, directors, certified Indiana Navigators, or other employees.

By signing the AO Privacy and Security Agreement, the organization generally agrees to each of the following, stated in more detail in the agreement:

- That personal information the AO receives from consumers for purposes of assisting with application for and enrollment in a Qualified Health Plan (QHP) or public health insurance program is confidential and should be maintained and protected.

- To follow all state and federal laws governing the confidentiality, privacy, and security of personal information.
- To comply with the safeguards outlined in the agreement to maintain and protect the confidentiality of personal information.
- To properly report to the consumer and IDOI and mitigate damages when a security breach or improper disclosure of personal information occurs.
- To make available their internal privacy practices and policies to the IDOI upon request.
- To be subject to enforcement action by the Commissioner of Insurance if in noncompliance with the Agreement.

#### iv. Becoming an Application Organization – List of All Locations (for Multi-Location AOs)

As part of the Application Organization (AO) application process<sup>10</sup>, if an organization has more than one location at which the organization will conduct AO/Navigator services, the AO must submit a list of each location. The list must include the following information for each location:

1. Name of location;
2. Address;
3. Telephone number;
4. Email;
5. Website (if applicable); and
6. Main contact person for the facility.

The list may also include the Indiana counties that a particular location services, if the location services one or more counties outside of the location's address. Lists will be used to publish an AO's locations and contact information by county on the "Find a Navigator" tool on the Indiana Healthcare Reform website at [www.in.gov/healthcarereform/2468.htm](http://www.in.gov/healthcarereform/2468.htm).

#### c. Obtaining and Maintaining Application Organization Registration - Reporting Requirements

Application Organizations (AOs) must follow all reporting requirements with the State of Indiana. On the initial AO online application and annual renewal application, the organization must report the following to the Indiana Department of Insurance (IDOI):

- All owners with 5% interest or voting interest, partners, officers, and directors of the Application Organization.
- The designated/responsible/lead Indiana Navigator(s) associated with the AO.
- All certified Indiana Navigators associated with the AO.
- Whether the AO or any owner, partner, officer or director of the AO has ever been convicted of, or whether the AO or any owner, partner, officer or director is currently charged with, committing a crime or had a judgment withheld or deferred.
- Whether the AO or any owner, partner, officer or director has ever been named or involved as a party in an administrative proceeding or arbitration proceeding regarding any professional or occupational license or registration.

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<sup>10</sup> The initial Application Organization (AO) application process is posted online at [www.in.gov/idoi/2825.htm](http://www.in.gov/idoi/2825.htm), and the annual renewal process for AOs is posted online at [www.in.gov/idoi/2934.htm](http://www.in.gov/idoi/2934.htm).

- Whether the AO or any owner, partner, officer or director has ever been notified by any jurisdiction to which they are applying of any delinquent state income tax obligation that is not subject to a repayment agreement.
- Whether the AO or any owner, partner, officer or director is a party to, or has ever been found liable in, any lawsuit, arbitrations or mediation proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentations or breach of fiduciary duty.
- Whether the AO or any other owner, partner, officer, or director of the AO has ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct.
- Whether the AO will provide criminal background checks for all of its Indiana Navigators.
- Whether the AO or any owner, partner, officer or director receive consideration from a health insurance issuer in connection with the enrollment of an individual in a health plan.
- Whether the AO or any owner, partner, officer or director has any actual or potential conflicts of interest as defined by the [Conflict of Interest Policy](#).
- Whether there is more than one location within the AO, and if so, what is the name, business address, telephone, email and/or website, and contact person for each physical location of the Application Organization.
- Whether the AO is registered as a federal Navigator or federal Certified Application Counselor (CAC) Organization with the federal government through the Centers for Medicare & Medicaid Services (CMS), and if so, what its federal ID number is.
- Whether the AO provides application assistance in any language other than English, and if so, to list all languages offered.

Once registered as an AO with the IDOI, AOs are required to follow all other state reporting requirements established under Indiana laws and regulations. The following reporting requirements must be submitted to the IDOI in a manner prescribed by IDOI and include the following:

- Any additions or deletions of Indiana Navigators associated with the AO must be reported no later than 30 days following the change.
- Any additions or deletions of locations under the AO must be reported within 30 days of the change and must include the following information for each location:
  - Name of Location,
  - Address,
  - Telephone Number,
  - Email
  - Website (if applicable), and
  - Contact Person for Location.
- A change in legal name or address of the AO must be reported no later than 30 days after the change occurs.
- Any of the following actions taken against the AO must be reported no later than 30 days after the final disposition of the matter:
  - An administrative action against a professional license, certification, or registration of the organization within any jurisdiction.
  - A federal or state criminal action within any jurisdiction.
  - An administrative action or court order requiring payment of state income tax.

- An administrative or legal action related to unfair trade practice or fraud in the business of insurance within any jurisdiction.
- Any potential or existing changes in conflict of interest status, in accordance with the [Conflict of Interest Policy](#), must be reported no later than 30 days after the change or new conflict of interest occurs.
- If a security breach or improper disclosure of a consumer's personal information occurs, the AO must notify each of the following, in accordance with the [Privacy and Security Agreement](#):
  - The affected consumer(s), as soon as reasonably practical but no later than 10 days following the discovery of the security breach or improper disclosure; and
  - IDOI, as soon as reasonably practical but no later than five days following discovery of the security breach or improper disclosure.

Additional information on AO reporting requirements can be found on IDOI's website at [www.in.gov/idoi/2935.htm](http://www.in.gov/idoi/2935.htm).

#### ***d. Maintaining Application Organization Registration: Renewal***

An AO's approved registration will remain active for one year, given there are no findings of misconduct, prohibited conflicts of interest, or other disqualifying factors during that time. Approximately 60 days before the one year expiration, the IDOI will email a reminder notice to the business email provided by the AO in the AO application that it is time to renew the registration. At that point up through the expiration date, the AO must complete the renewal application, which is located on IDOI's website at [www.in.gov/idoi/2934.htm](http://www.in.gov/idoi/2934.htm).

While the AO should update any essential contact information<sup>11</sup>, inform IDOI of any associated Indiana Navigator or location changes and of any changes in conflicts of interest<sup>12</sup> throughout the year, the completion of the renewal application is primarily a confirmation that the existing records are complete and accurate.

The AO must also disclose any changed or new Conflicts of Interest not previously disclosed to the IDOI through the [AO Conflict of Interest Disclosure Form](#), and provide an updated contact list of all locations of the AO if the AO has more than one location providing AO/Navigator services. Upon submitting the renewal application, an updated Conflict of Interest Disclosure Form (if applicable), and list of locations (if applicable), the AO's application will be renewed by the IDOI and the AO will receive a notice of approval or denial as appropriate.

The AO will have a 30-day late/extended period following the expiration date in which to complete the renewal application and pay a higher non-refundable renewal fee. If the organization does not complete

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<sup>11</sup> An Application Organization (AO) may make updates to any contact information, or update its locations or associated Indiana Navigators through the Navigator/AO [Service Request Form](#) located at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm) under both the Indiana Navigators and Application Organizations boxes, or at [www.in.gov/idoi/2935.htm](http://www.in.gov/idoi/2935.htm).

<sup>12</sup> An Application Organization (AO) may update any actual or potential Conflicts of Interest through the [AO Conflict of Interest Disclosure Form](#) posted online at <http://www.in.gov/idoi/2935.htm>.

the renewal application within that time, it will lose its registration as an AO and will need to complete each of the initial AO application steps<sup>13</sup> in order to regain its AO registration.

If the AO fails to renew its registration within the 30-day late period, the associated Indiana Navigators will maintain their Indiana Navigator status as long as there is no reason to take enforceable action against the individual (*e.g.*, no credible consumer complaints), and individual renewal requirements are satisfied.

Additional information on the process for annual renewal of AOs can be found on IDOI's website at [www.in.gov/idoi/2934.htm](http://www.in.gov/idoi/2934.htm).

### 3. Indiana Navigators

#### *a. Indiana Navigator Roles and Responsibilities*

Indiana Navigators, established under [Indiana Code 27-19](#) and [760 IAC 4](#), are individuals certified to help Hoosier insurance consumers complete insurance affordability program applications – namely Medicaid, the Children's Health Insurance Program (CHIP), the Healthy Indiana Plan (HIP), and qualified health plans (QHPs) through the Federally-facilitated Marketplace (FFM)/[www.healthcare.gov](http://www.healthcare.gov).

These individuals may be associated with an Application Organization (AO), also established under [IC 27-19](#) and [760 IAC 4](#), but do not have to be in order to be an Indiana Navigator. Individuals who must be certified as Indiana Navigators, include, but are not limited to:

- Federally-funded and certified federal Navigators
- Federally-designated Certified Application Counselors (CACs)
- Medicaid Enrollment Center staff or volunteers
- Staff or volunteers of other organizations helping with insurance affordability program applications

All individuals meeting the definition of an Indiana Navigator will be required to complete certification with the Indiana Department of Insurance (IDOI), but those also designated by the federal government (for example, those receiving federal Navigator cooperative agreement funds and those designated as CACs) may need to meet additional federal requirements, such as training and certification. In these cases, the federal and state training and certification requirements are not interchangeable, and the individuals must complete both trainings in order to be compliant with not federal and state law.

There are some exceptions provided in the Indiana Navigator definition for certain individuals that are not required to obtain the Indiana Navigator certification. Individuals that may, but are not required to, obtain the Indiana Navigator certification, include, but are not limited to:

- Presumptive eligibility (PE) hospital staff assisting with only PE determinations for health coverage and not also assisting with the full applications for health coverage
- An employee or contractor of a state agency, division, or subdivision thereof acting as an Indiana Navigator as part of their job function

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<sup>13</sup> The initial application steps for Application Organizations (AOs) is posted online at [www.in.gov/idoi/2825.htm](http://www.in.gov/idoi/2825.htm).

- An Authorized Representative (AR) through the AR agreement with FSSA assisting individuals with applications for Medicaid as an AR only, and not also assisting consumers with applications for health coverage not as an Authorized Representative;
- Individuals assisting consumers who may, based on preliminary information obtained from the consumer, be eligible for an Indiana Health Coverage Program (IHCP), such as Medicaid, CHIP, or HIP 2.0, for reasons in addition to the consumer's income or assets (for example, consumers who may be eligible for Medicaid home and community based waiver services or Medicaid nursing home care)
- Individuals assisting consumers with the process for obtaining health insurance coverage that do not assist with application completion and enrollment

There are also some exclusions for certain individuals who are prohibited from obtaining the Indiana Navigator certification. For example, individuals who receive consideration from health insurance issuers for the enrollment of individuals in health plans are prohibited from becoming Indiana Navigators. This includes licensed health insurance producers (agents or brokers) that sell, solicit, or negotiate insurance products on behalf of insurance issuers. Such licensed health producers are prohibited from acting as both health producers and Indiana Navigators.

While the federal training and certification requirements may vary based on the type of consumer assistant, all individuals meeting the definition of an Indiana Navigator will need to complete the same series of steps in order to obtain Indiana Navigator certification. These steps are listed in the following table (see [Table 9](#)), as well as online at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm), and are detailed in the following sections.

**Table 9: Steps to Obtain and Renew Indiana Navigator Certification**

- 1) Complete the initial Indiana Navigator [online application](#) and pay the nonrefundable application fee (\$50 for Indiana resident, \$100 for non-resident) and online processing fee
- 2) Review the [Conflict of Interest Policy](#), then complete and submit the Indiana Navigator [Conflict of Interest Disclosure Form](#) to the Indiana Department of Insurance (IDOI)<sup>14</sup>
- 3) Review, sign and submit the Indiana Navigator [Privacy and Security Agreement](#) to IDOI
- 4) Complete Navigator Precertification Education (PE) with an IDOI-approved training provider<sup>15</sup>
- 5) Pass IDOI Navigator Examination<sup>16</sup>
- 6) Once certified, complete annual Navigator Continuing Education (CE) requirement (two hours each year)<sup>17</sup>
- 7) Complete annual [online renewal application](#) and pay the nonrefundable renewal fee (\$50 for Indiana resident, \$100 for non-resident) and processing fee
- 8) Abide by all Indiana Navigator reporting requirements<sup>18</sup> with the IDOI

<sup>14</sup> All application documents may either be attached electronically to the online application, or emailed, faxed, or mailed to the Indiana Department of Insurance (IDOI) at: [navigator@idoi.in.gov](mailto:navigator@idoi.in.gov) (email), 317-234-5882 (fax), or 311 West Washington Street, Indianapolis, Indiana 46204 (mail).

<sup>15</sup> A list of all Navigator Precertification Education (PE) providers open to the public is posted on IDOI's website at [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm).

<sup>16</sup> Information on registering/scheduling the navigator examination, as well as other examination procedure and guidelines, is available on IDOI's website at [www.in.gov/idoi/2836.htm](http://www.in.gov/idoi/2836.htm).

<sup>17</sup> Approved Navigator Continuing Education (CE) providers may be viewed through IDOI's website at [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm).

<sup>18</sup> A list of Indiana Navigator reporting requirements is posted on IDOI's website at [www.in.gov/idoi/2931.htm](http://www.in.gov/idoi/2931.htm).

Sources: Indiana Department of Insurance, "Indiana Navigator Initial Application Process (6 Steps)," [www.in.gov/idoi/2929.htm](http://www.in.gov/idoi/2929.htm); "Indiana Navigator Process for Annual Renewal (3 Steps)," [www.in.gov/idoi/2930.htm](http://www.in.gov/idoi/2930.htm); "Indiana Navigator Reporting Requirements," [www.in.gov/idoi/2931.htm](http://www.in.gov/idoi/2931.htm)

In addition to performing these steps to obtain and renew Indiana Navigator certification, there are duties the Indiana Navigator should understand and may perform as a means of assisting consumers. Those responsibilities include, but are not limited to:

- Consumer outreach and education
- Assessing the level and type of consumer need
- Assisting with eligibility assessment
- Assisting with enrollment
- Checking consumer enrollment status
- Assisting with eligibility appeals
- Assisting with re-enrollment
- Understanding basic concepts related to obtaining, using, and maintaining health coverage

### ***b. Becoming an Indiana Navigator - Application***

If an individual meets the definition of an Indiana Navigator under [Indiana Code 27-19](#) and [760 IAC 4](#), the individual will initiate the certification process with the Indiana Department of Insurance (IDOI) by filing an application through the IDOI website at: [www.in.gov/idoi/2824.htm](http://www.in.gov/idoi/2824.htm). The application consists of questions about the applicant, the applicant's association with any Application Organizations (AOs), and background questions regarding the applicant, such as criminal history and any actual or potential conflicts of interest as defined by the [Conflict of Interest Policy](#). The application will also have the applicant attest to comply with all laws and regulations pertaining to Indiana Navigators.

In addition to the Indiana Navigator application, the applicant will need to pass a criminal background check. If the applicant is associated with an AO that agrees to complete the criminal background check on the applicant's behalf, the applicant will not need to complete an additional criminal background check. If the applicant is not associated with an AO or if the AO does not perform a criminal background check, the applicant will need to have a criminal background check completed and have the results sent to the Indiana Department of Insurance.

Background check records should be dated no more than 30 days prior to the date the applicant submits the online Indiana Navigator application. For example, if an applicant submits the online application on December 1, 2016, the background check results should be dated November 1, 2016 or later.

The options and processes for completing criminal background checks are detailed in the following table (see [Table 10](#)), and can also be found on IDOI's website at [www.in.gov/idoi/2827.htm](http://www.in.gov/idoi/2827.htm).

**Table 10: Options for Completing an Indiana Navigator Criminal Background Check**

Method	Process
<b>Paper</b>	<ul style="list-style-type: none"> <li>Complete paper Indiana State Police (ISP) form               <ol style="list-style-type: none"> <li><a href="http://www.in.gov/ai/appfiles/isp-lch/LCH_4-12_Approved_Form.pdf">www.in.gov/ai/appfiles/isp-lch/LCH_4-12_Approved_Form.pdf</a></li> <li>In "Reason for Search," box write "Indiana Navigator Certification"</li> <li>In "where this response will be sent" box enter mailing address                   <ul style="list-style-type: none"> <li>If AO completing check, enter AO mailing address</li> <li>If individual completing check, enter individual mailing address</li> </ul> </li> <li>Under "Reason for Request," select (2)</li> </ol> </li> <li>Once you receive the criminal background check record from ISP; submit the record to IDOI by either: <b>Email:</b> <a href="mailto:navigator@idoi.in.gov">navigator@idoi.in.gov</a>; <b>OR Fax:</b> 317-234-5882 ("attn: Navigator Director"); <b>OR Mail:</b> Indiana Department of Insurance, c/o Navigator Director, 311 W. Washington Street, Indianapolis, IN 46204</li> </ul>
<b>Electronic</b>	<ul style="list-style-type: none"> <li>Perform criminal background check online               <ol style="list-style-type: none"> <li>Go to: <a href="http://www.in.gov/ai/appfiles/isp-lch">www.in.gov/ai/appfiles/isp-lch</a></li> <li>Enter individual information</li> <li>For "Reason for Request," select Option #2, "Has applied for a license...", and enter Indiana Code cite: "under IC <b>27-19-4</b>"</li> </ol> </li> <li>Save/Print criminal background check record and submit a copy of the record to IDOI by either: <b>Email:</b> <a href="mailto:navigator@idoi.in.gov">navigator@idoi.in.gov</a>; <b>OR Fax:</b> 317-234-5882 ("attn: Navigator Director"); <b>OR Mail:</b> Indiana Department of Insurance, c/o Navigator Director, 311 W. Washington Street, Indianapolis, IN 46204</li> </ul>
<b>Other</b>	<ul style="list-style-type: none"> <li>Application Organizations may complete alternative criminal background checks for their employees, which must be at least as rigorous as the Indiana State Police background check.</li> </ul>

Source: Indiana Department of Insurance, "Options for Indiana Navigator Criminal Background Check," [www.in.gov/idoi/2827.htm](http://www.in.gov/idoi/2827.htm)

In addition to the Indiana Navigator application, the applicant will need to sign and submit<sup>19</sup> a copy of the Indiana Navigator [Conflict of Interest Disclosure Form](#) and [Privacy and Security Agreement](#) to the Indiana Department of Insurance. If the individual has any existing or potential conflicts of interest, the individual will also need to detail those on the Conflict of Interest Disclosure Form. Additional information regarding conflicts of interest and privacy standards is located in the [State Limitations for Indiana Navigators](#) section following.

Upon completion of the online application, the applicant will need to pay the application fee. As of May 1, 2013, the nonrefundable application fee for Indiana Navigators is \$50 for Indiana residents and \$100 for non-residents. All applicants will also be required to pay the online processing fee (\$14.40 as of May 1, 2013). This fee is subject to change at the discretion of the Commissioner of Insurance, and the most accurate and up-to-date fee information may be found on the IDOI website at [www.in.gov/idoi/2929.htm](http://www.in.gov/idoi/2929.htm).

<sup>19</sup> All application documents may either be attached electronically to the online application, or emailed, faxed, or mailed to the Indiana Department of Insurance (IDOI) at: [navigator@idoi.in.gov](mailto:navigator@idoi.in.gov) (email), 317-234-5882 (fax), or 311 West Washington Street, Indianapolis, Indiana 46204 (mail).

After the application and fee are submitted, the application will be reviewed by the IDOI for completion and potential disqualifying information. If there are questions about the application, the applicant may be contacted by the IDOI with a request for additional information. The application will remain “Pending” or “Under State Review” until all information is received for the application and the Navigator precertification education (PE) and navigator examination are completed successfully. If the application is approved, an automated email notification of approval will be sent to the Indiana Navigator. If the individual’s application is denied, a letter will be mailed to the individual containing the reason for denial and the individual’s right to appeal the decision.

### *c. Becoming an Indiana Navigator - Precertification Education and Navigator Examination*

All applicants will need to complete Navigator precertification education (PE) prior to taking the navigator examination. In order to complete the education, individuals will need to locate a training provider that has been approved by the IDOI to provide Navigator PE. A list of approved Navigator PE providers can be found on the IDOI website at [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm).

The cost of Navigator PE may vary, based on the source of the training. The topics of the Navigator PE will include information on consumer assistance, different marketplace models (such as the Federally-facilitated Marketplace (FFM) and Federally-facilitated Marketplace-Partnership (“Partnership”)), and Medicaid; including basic information and state-specific application. Additional information on Navigator PE training criteria and resources can be found on IDOI’s website at [www.in.gov/idoi/2937.htm](http://www.in.gov/idoi/2937.htm).

Following the training, individuals will need to register and schedule the navigator examination with the Performance Assessment Network (PAN),<sup>20</sup> the organization selected by the IDOI to administer the Navigator examination. Individuals may register and schedule the assessment at the following website powered by PAN: <https://secure.vitapowered.com/idoi/login.screen>. PAN will provide a variety of times, dates, and locations from which the individual will be able to select. The cost to register and schedule the Navigator examination is \$84.75 (as of May 1, 2013 – amount subject to change).

The individual must score at least a 70% (42 out of 60) on the assessment in order to be considered for certification. If individual does not receive a passing score, the individual may take the assessment again until the sooner of: the individual receiving a passing score or no later than 90 days after the initial application submission date. Additional information on the Navigator examination can be found on IDOI’s website at [www.in.gov/idoi/2836.htm](http://www.in.gov/idoi/2836.htm).

When the Navigator examination is passed successfully, and all other application materials are received and approved by the IDOI, the Indiana Navigator will receive an email notice of approval. In addition to the email approval notification, the Indiana Navigator will receive a unique certification ID number that the Indiana Navigator must use when helping consumers complete insurance affordability program applications. The Indiana Navigator may obtain a copy of the certificate as proof of state certification.<sup>21</sup> Also, each Indiana Navigator will be listed on the “Find a Navigator” webpage of the Indiana state

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<sup>20</sup> Assistance with registration and scheduling of the navigator examination may be obtained from PAN at either [idoi\\_support@panpowered.com](mailto:idoi_support@panpowered.com) (email) or 877-449-8378 (telephone).

<sup>21</sup> Currently, Indiana Navigator certificates may be obtained by emailing a request to [navigator@idoi.in.gov](mailto:navigator@idoi.in.gov).

healthcare reform website at [www.in.gov/healthcarereform/2468.htm](http://www.in.gov/healthcarereform/2468.htm) under the counties each Indiana Navigator serves.

If the individual does not pass the Navigator examination, the certification process is not complete, and the IDOI will neither approve nor deny the application. Once a year has passed from the initial submission of the Indiana Navigator application, the application will be considered null and void, and the individual will need to complete a new application for consideration to serve as an Indiana Navigator.

#### ***d. Maintaining Indiana Navigator Certification – Continuing Education and Reporting Requirements***

In order for Indiana Navigators to maintain their certification, they must complete the minimum Navigator continuing education (CE) requirement and maintain updated information with the IDOI. In order to maintain current knowledge and understanding of consumer assistance, the federally-facilitated or Partnership Marketplaces, and Medicaid changes and implementation, all Indiana Navigators must annually complete at least two (2) hours<sup>22</sup> of continuing education.

Approved Navigator CE providers may be viewed through [www.sircon.com](http://www.sircon.com),<sup>23</sup> much like the pre-certification education (PE). An individual may use an associated AO or a third party training entity as a source for CE, as long as the entity has had its CE course approved by the IDOI. The training entity will download all completions of CE credits to the Indiana Navigator's transcript, which may be verified at [www.sircon.com](http://www.sircon.com).<sup>24</sup>

In addition to keeping education current, it is also important that an Indiana Navigator maintain up-to-date contact information and abide by all reporting requirements with the IDOI posted online at [www.in.gov/idoi/2931.htm](http://www.in.gov/idoi/2931.htm). Indiana Navigators must inform the IDOI of any changes to legal name, business or personal contact information, criminal or administrative actions, conflicts of interest, breached in privacy/security of a consumer's personal information, and delinquent state tax or child support payments, within thirty (30) days of such change. Failure to abide by reporting requirements could lead to an IDOI enforcement action taken against the individual pursuant to [Indiana Code 27-19-4-3](#) and [760 IAC 4](#).

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<sup>22</sup> The two-hour Navigator continuing education (CE) requirement is subject to change. To verify the requirement, go to the Indiana Department of Insurance website at [www.in.gov/idoi/2930.htm](http://www.in.gov/idoi/2930.htm).

<sup>23</sup> To search for an approved Navigator CE course: Go to [www.sircon.com](http://www.sircon.com), select "Lookup Education Courses or Transcript" under Quick Start, select "Approved Courses Inquiry," from the dropdown select "Indiana" and click Submit, leave Education Type as "Continuing Education" and under Course Category select "Navigator CE" and click Submit. A list of all approved Navigator CE courses will then generate.

<sup>24</sup> To view a Navigator's CE transcript: Go to [www.sircon.com](http://www.sircon.com), select "Lookup Education Courses or Transcript" under Quick Start, select "Continuing Education Transcript Inquiry," select "Indiana" from the dropdown, enter Navigator license number and last name and click Submit. The Navigator's CE Transcript will generate showing number of CE course hours applied/completed, number of remaining hours that need to be completed, and the CE status (either "Pending" or "Satisfied").

### *e. Indiana Navigator Certification Renewal*

Every year, an Indiana Navigator will be required to renew<sup>25</sup> the Navigator's certification. The Navigator will receive an email reminder notification approximately sixty (60) days prior to the certification expiration date to the business email on file with IDOI for the Navigator, and within that time, the Navigator will need to complete the online renewal application, noting any changes that have not already been reported to the IDOI and submitting the non-refundable renewal fee (\$50 for Indiana residents and \$100 for non-residents). If there have been changes to the Navigator's conflict of interest status under the [Conflict of Interest Policy](#) since the Navigator's last renewal or conflict of interest disclosure, the Navigator will need to sign and submit a new [Navigator Conflict of Interest Disclosure Form](#) disclosing all actual or potential conflicts of interest.

The Navigator must have also completed at least two (2) hours of Navigator continuing education (CE) with an IDOI-approved Navigator CE provider. Navigators do not need to complete Navigator pre-certification education (PE) or another Navigator examination.

Following the completion of the renewal application, IDOI will review the information and will request any supplemental information as needed. After the renewal application is processed, the IDOI will send the Indiana Navigator a notice with approval or denial. If the individual is approved, the individual will retain the original unique certification ID number and will be able to obtain a new certificate<sup>26</sup> to prove current certification. If the individual is denied, the individual will receive a letter explaining the reason for denial and right to appeal the decision.

While the Indiana Navigator should complete the renewal prior to the certification expiration date, the Navigator will have a 30-day late/reinstatement period after the expiration date to complete the renewal process. A higher, non-refundable late/reinstatement fee<sup>27</sup> will be assessed during the 30-day late/reinstatement period in addition to the renewal fee. If the renewal is not completed and submitted by the end of the late/reinstatement period, the Indiana Navigator certification will no longer be valid, and the individual will have to begin the entire initial certification process again as a new applicant.

### *f. Application Organization's Options for Assisting Indiana Navigators in Applying and Renewing Certifications*

Not all aspects of the Indiana Navigator certification process need to be borne solely by the individual applying for certification. If the individual is associated with an Application Organization (AO), that organization may choose to be involved in the process. The AO's options for assisting its Indiana Navigators with the certification process are detailed in the following table (see [Table 11](#)):

<sup>25</sup> The annual Navigator certification renewal steps are posted on IDOI's website at [www.in.gov/idoi/2930.htm](http://www.in.gov/idoi/2930.htm).

<sup>26</sup> Currently, Indiana Navigators and Application Organizations (AOs) may obtain copies of their certificates by emailing the IDOI at [navigator@idoi.in.gov](mailto:navigator@idoi.in.gov). IDOI will respond with an electronic/PDF version of the certificate. IDOI does not issue paper copies of certificates.

<sup>27</sup> The fees for a Navigator renewal application submitted within the 30-day late/reinstatement period include the renewal application fee (\$50 for Indiana residents and \$100 for non-residents) PLUS the reinstatement/late fee of three times the renewal fee (\$150 for Indiana residents and \$300 for non-residents).

**Table 11: Application Organization Options for Assisting Individuals in Applying for and Renewing Indiana Navigator Certifications**

	Navigator Requirement	Application Organization (AO) Option
<b>Application</b>	<ul style="list-style-type: none"> <li>Complete online application and pay nonrefundable application fee and processing fee</li> <li>Pass Criminal Background Check</li> <li>No prohibited conflicts of interest</li> <li>Complete and submit Conflict of Interest Disclosure Form, disclosing any actual or potential conflicts of interest</li> <li>Complete and submit Privacy and Security Agreement</li> <li>Report overseeing Application Organization (AO), if applicable</li> </ul>	<ul style="list-style-type: none"> <li>Background check may be performed by AO or by state-designated background check entity</li> <li>Application fee and processing fee may be paid by AO</li> </ul>
<b>Pre-certification Education (PE)</b>	<ul style="list-style-type: none"> <li>Complete Navigator PE with IDOI-approved PE provider</li> </ul>	<ul style="list-style-type: none"> <li>Navigator PE fees may be paid by overseeing AO</li> <li>Navigator PE may be provided by AO (if approved PE provider)</li> </ul>
<b>Certification Examination</b>	<ul style="list-style-type: none"> <li>Pass Navigator certification examination with state certification examination vendor</li> </ul>	<ul style="list-style-type: none"> <li>Certification examination fees may be paid by AO</li> </ul>
<b>Annual Renewal (Re-certification)</b>	<ul style="list-style-type: none"> <li>Complete online renewal application annually and pay renewal application fee and processing fee</li> <li>Complete and submit Conflict of Interest Disclosure Form, if any changes or new actual or potential conflicts of interest have arisen since last application</li> <li>Complete Navigator continuing education (CE) (min. 2 hr. per year) from approved CE provider</li> <li>Update overseeing AO(s), if applicable</li> </ul>	<ul style="list-style-type: none"> <li>Renewal application fee and processing fee may be paid by AO</li> <li>Navigator CE may be provided by AO (if an approved CE provider)</li> </ul>

Source: Indiana Department of Insurance, [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm)

### ***g. State Limitations for Indiana Navigators***

Indiana Navigators and Application Organizations (AOs) have specific parameters within which they must operate. Several of these parameters relate to the forms Indiana Navigators and AOs complete when they apply to become Indiana Navigators and AOs. The forms include the Conflict of Interest Disclosure Form<sup>28</sup> and Privacy and Security Agreement<sup>29</sup>. In addition to these forms, there are

<sup>28</sup> There are two separate Conflict of Interest Disclosure Forms – one for [Indiana Navigators](#) and one for [Application Organizations](#).

<sup>29</sup> There are two separate Privacy and Security Agreements – one for [Indiana Navigators](#) and one for [Application Organizations](#).

expectations surrounding consumer fraud, waste, and abuse, receipt of compensation, as well as advice given on plan selection.

### i. Conflict of Interest Policy

For Indiana Navigators and AOs, conflicts of interest are defined in the [Conflict of Interest Policy](#) as personal or business interests that may influence the advice and assistance the Indiana Navigator or AO provides to a consumer. These conflicts may be financial or non-financial, direct or indirect. Some conflicts may be addressed by simply reporting them to the Indiana Department of Insurance (IDOI) on the Conflict of Interest Disclosure Form and disclosing them in writing to each consumer assisted, while other conflicts will disqualify an individual or organization from being able to serve as an Indiana Navigator or Application Organization.

#### aa. *Financial Conflict of Interest*

The Indiana Conflict of Interest Policy begins with an acknowledgement of the purpose of the Indiana Navigator certification, which is to provide fair, accurate, and impartial information and assistance regarding health insurance plan and product options, enrollment, as well as eligibility for public health insurance programs (Medicaid, CHIP, HIP 2.0), QHPs, PTCs, and cost-sharing reductions. While the Conflict of Interest Policy recognizes that certified individuals and organizations may have dual interests, they must recognize that it is their responsibility to always act in the best interest of the consumer. For this reason, financial conflicts of interest are of particular concern to the State. Some of these conflicts may be addressed through a disclosure to the IDOI on the Conflict of Interest Disclosure Form and a written disclosure to each consumer assisted, while other financial conflicts of interest may prohibit individuals or organizations from certification as Indiana Navigators or registration as Application Organizations.

A prohibited conflict of interest occurs when an individual or organization receives compensation from an insurer for the enrollment of an individual into a health plan. If an individual or organization is disqualified due to a prohibited financial conflict of interest, it does not necessarily mean that the individual or organization cannot help consumers, but it does mean that they must help those consumers in a different capacity. Perhaps the most direct example of a prohibited conflict of interest is with regard to licensed health insurance producers (agents or brokers) who receive compensation from health insurers for enrollment of individuals into the insurer's plans. Though such individuals may not be eligible to become Indiana Navigators, the health insurance producers will still be able to serve in the same capacity that they had prior to the implementation of the Patient Protection and Affordable Care Act (ACA) and Indiana Navigator law ([Indiana Code 27-19](#)). Should a licensed health insurance producer wish to serve as an Indiana Navigator, the producer must not sell, solicit, or negotiate health insurance products on behalf of particular insurance carriers in order to be in compliance with Indiana state law.

Although this direct financial conflict of interest is prohibited for Indiana Navigators and AOs, there are other possible financial conflicts of interest that may be permissible at the discretion of the Commissioner of Insurance. Permissible financial conflicts of interest may include some indirect financial incentives for Indiana Navigators or Application Organizations. One example may be someone who is a partial owner in an insurance agency. The individual may benefit financially when the insurance agents associated with the agency are selling a large number of health insurance plans, but does not receive direct reimbursement for consumer enrollment into those plans. There is concern that, if that individual should become an Indiana Navigator, the individual may direct consumers to the insurance agency for

final plan selection and enrollment, thus providing biased information to the consumer. For this reason, such an individual would need to disclose the conflict of interest to the IDOI and to all consumers the Indiana Navigator assists. If the individual attests to not allow the financial conflict of interest to bias or influence his or her assistance of consumers and to abide by the [Conflict of Interest Policy](#), the IDOI may approve the application. However, if the IDOI receives consumer complaints about the Indiana Navigator steering consumers to the insurance agency or plans represented by the agency with which he or she is part owner, the IDOI may take enforcement action against that individual pursuant to [Indiana Code 27-19-4-3](#) and [760 IAC 4](#).

*bb. Conflict of Loyalty*

In order to address non-financial conflicts of interest, the [Conflict of Interest Policy](#) lays out the idea of a Conflict of Loyalty. By Indiana definition, a conflict of loyalty occurs when an individual or organization has – directly or indirectly, through business or family – an interest or relationship with a third party that prohibits or inhibits the individual or organization from exercising independent judgment in the best interests of the consumer. For example, a conflict of loyalty may occur with individuals or organizations that have a business relationship with an insurance carrier unrelated to plan enrollment but related to reimbursement rates. An example of this type of relationship may be a hospital that has an interest in enrolling consumers in specific plans that provide the hospital with higher reimbursement rates for treatment of patients. But the hospital does not receive direct compensation from the insurance carrier for enrolling an individual in the carrier’s plan.

If a conflict of loyalty exists, the Indiana Navigator and AO must notify the IDOI of the conflict on the Conflict of Interest Disclosure Form, detailing the nature of the conflict. Even if no personal conflict prevents an Indiana Navigator or AO from providing fair and impartial information, the potential for such a conflict does exist and must be reported to the Indiana Department of Insurance. In addition to disclosure to the IDOI, Indiana Navigators and AOs must disclose in writing any actual or potential conflicts of loyalty to consumers prior to providing assistance. Once these conflicts of loyalty are disclosed, it is the responsibility of the Indiana Navigator and AO to provide fair, impartial, and accurate information in the best interest of each consumer receiving assistance.

*cc. Changes in Actual or Potential Conflicts of Interest*

It is possible that conflicts of interest (financial interests or conflicts of loyalty) will change over time, so if new actual or potential conflicts arise during the term of certification or registration, the Indiana Navigator or Application Organization (AO) must report those new conflicts to the IDOI on the Conflict of Interest Disclosure Form within 30 days of the change, and must update the written consumer disclosure to reflect these changes as well.

*dd. Conflict of Interest Disclosure Form*

If an Indiana Navigator or Application Organization (AO) has an actual or potential conflict of interest (financial interest or conflict of loyalty) as defined in the [Conflict of Interest Policy](#), the Indiana Navigator or AO must disclose the actual or potential conflict to the IDOI on the Conflict of Interest Disclosure Form. The [Indiana Navigator Conflict of Interest Disclosure Form](#) and [AO Conflict of Interest Disclosure Form](#) are posted throughout the IDOI Indiana Navigator/AO website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm). The form is very basic, requiring acknowledgement that the individual or organization has read, understands, and agrees to the Conflict of Interest Policy. The form also requires a detailed description of any

potential or actual conflicts of interest that the Indiana Navigator or AO may have. This form is to be updated within 30 days of a change in conflict of interest status.

## ii. Additional Requirements for Federally-Designated Consumer Assistants

While Indiana requires that all Indiana Navigators confirm and disclose any actual or potential conflicts of interest, the federal Centers for Medicare and Medicaid Services (CMS) may have additional conflict of interest requirements for Indiana Navigators also designated as consumer assistants with CMS (*e.g.*, federal Navigators or Certified Application Counselors (CACs)). Individuals and organizations that have or seek both the state and federal certifications must abide by both the state and federal conflict of interest standards. Individuals and organizations that only have or seek the state certification may not be required to meet federal conflict of interest standards pertaining directly to federally-designated consumer assistants.

## iii. Receiving Compensation

One of the primary concerns addressed in the Indiana [Conflict of Interest Policy](#) for Indiana Navigators and Application Organizations (AOs) is the receipt of compensation from a health insurance issuer in connection with enrolling consumers into health plans. Receiving compensation from a health insurance issuer in connection with the enrollment of consumers into health plans is a prohibited conflict of interest under both state and federal law. Compensation that is not in connection with the enrollment of consumers into health plans is generally not a prohibited conflict of interest. Compensation is defined as anything of value, including money or other in-kind benefits of any type (*e.g.*, paid commission, grants, credit, loans, gifts, free or discounted travel or prizes). However, compensation does not include tangible goods or other advertisement with an aggregate value of less than \$100 per year per issuer. Therefore, Indiana Navigators and AOs may receive limited amounts of promotional material from health insurance issuers without a disqualifying conflict of interest.

Indiana Navigators and AOs are not prohibited by Indiana law from receiving compensation from consumers they assist with health coverage applications. However, federal law prohibits federal Navigators and Certified Application Counselors (CACs) from receiving compensation from the consumers they assist. Therefore, individuals and organizations only certified as Indiana Navigators and AOs may receive compensation from the consumers they assist, while individuals and organizations also certified as federal Navigators, CAC organizations, or CACs may not receive compensation from the consumers they assist with health coverage applications.

## iv. Privacy and Security Agreement and Confidentiality Standards

In working with consumers, Indiana Navigators and Application Organizations (AOs) may have access to personal information including, but not limited to, personal identifying information, income information, and health information. Due to the sensitivity of this information, individuals and organizations must sign and submit to the Indiana Department of Insurance (IDOI) the Indiana Navigator or AO Privacy and Security Agreement, agreeing to maintain the confidentiality of any information provided by the consumer (or Authorized Representative acting on behalf of the consumer) in the process of applying for and enrolling in a qualified health plan (QHP) on the Federally-facilitated Marketplace or Indiana Health Coverage Program. There are two separate Privacy and Security Agreements—one for Indiana Navigators and one for Application Organizations—that must be signed and submitted to the IDOI as part of the initial application. Both the [Indiana Navigator Privacy and Security Agreement](#) and the [AO](#)

[Privacy and Security Agreement](http://www.in.gov/idoi/2823.htm) are posted on the IDOI Indiana Navigator/AO website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

By agreeing to meet the privacy and security requirements, an Indiana Navigator or AO agrees to protect consumers' personal information with operational, administrative, technical, and physical safeguards to prevent unauthorized or inappropriate access, use, or disclosure of that information. The Indiana Navigator and AO also agree to follow all state and federal laws governing the privacy and security of consumers' personal information. Indiana Navigators may refer to Ind. Code §§ [24-4-14](#) and [24-4.9](#) for a greater understanding of existing [albeit not comprehensive] state requirements regarding information protection and reporting in the event consumer information is inappropriately disclosed. Also, for the sake of consumer privacy and security, there are actions that an Indiana Navigator or AO should take, and there are actions they should encourage consumers to take in order to reduce the risk of personal information being inappropriately accessed. Several of these actions are listed in the following table (see [Table 12](#)) and reflect the required actions stated in the Privacy and Security Agreements.

**Table 12: Steps to Protect a Consumer's Personal Information**

Entity Responsible	Recommended or Required?	Action
<i>Consumer</i>	Recommended	Only disclose personal information to individuals or entities authorized to view or receive personal information
		Only disclose the minimum amount of personal information required to accomplish the intended purpose (e.g., to complete an application for health coverage)
<i>Indiana Navigator or Application Organization</i>	Required	When sharing the consumer's personal information with an authorized individual or entity, only provide the minimum amount of personal information needed to accomplish the intended purpose (e.g., to complete an application for health coverage)
		Protect the consumer's personal information against any reasonably anticipated threats or hazards to confidentiality, integrity, and availability (e.g., do not leave unattended a computer screen displaying personal information)
		Protect the consumer's personal information against any reasonably anticipated uses or disclosures that are not permitted or required by law (e.g., do not hand information over to a third party unless required by law or authorized by the consumer)
		Per Ind. Code § <a href="#">24-4.9-3.5</a> , consumer personal information must be securely destroyed or disposed of in a way that will make the information unusable
		Per Ind. Code § <a href="#">24-4.9-3</a> , if the Indiana Navigator or Application Organization becomes aware of a security breach or improper disclosure of personal information, the consumer must be informed

Sources: Federal Trade Commission, *Consumer Information: How to Keep Your Personal Information Secure*, [www.consumer.ftc.gov/articles/0272-how-keep-your-personal-information-secure](http://www.consumer.ftc.gov/articles/0272-how-keep-your-personal-information-secure); [Indiana Code 24-4.9](#); see also

Indiana Department of Insurance [Indiana Navigator Privacy and Security Agreement](#) and [Application Organization Privacy and Security Agreement](#)

#### v. Advice on Plan Selection

One primary restriction placed on Indiana Navigators and Application Organizations (AOs) is the ability to advise consumers on health coverage plan selection. Currently, health insurance producers licensed in the State of Indiana are the only individuals authorized to provide advice on specific plan selection. Without this licensure, Indiana Navigators do not have the training, expertise, or authorization required to offer this very specific type of recommendation.

Though Indiana Navigators cannot provide the same level of advice licensed health insurance producers can, they are able to provide consumers with valuable information to help the consumer make the best personal choice. Selecting a health insurance plan is complex and highly individualized, so identifying some of the key components the consumer should consider is valuable for the consumer. General questions regarding doctor preferences and healthcare use could help direct consumers as they consider their plan selection. Avoiding direct plan recommendations will keep the Indiana Navigator from overstepping their boundaries in providing application assistance.

### 4. Health Insurance Producers (Agents, and Brokers)

In the course of a consumer's search for health insurance coverage, the consumer may be confronted by a range of different terms referring to individuals selling health insurance. Producers, a.k.a. insurance agents or brokers, are the most common terms consumers will encounter. The following table (see [Table 13](#)) explains the differences and similarities between these titles.

**Table 13: Similarities and Differences between Agents and Brokers (Producers)**

	Producer	Agent		Broker
		(Captive)	(Independent)	
Is also known as...	...an Agent ...a Broker	...a Producer	...a Producer	...an Agent ...a Producer
Definition	<ul style="list-style-type: none"> <li>General term</li> <li>Refers to anyone selling insurance products</li> </ul>	<ul style="list-style-type: none"> <li>Individual selling insurance products for a single carrier; obligated to only represent products from that single insurance carrier</li> </ul>	<ul style="list-style-type: none"> <li>Individual selling insurance products for one or more insurance carriers</li> </ul>	<ul style="list-style-type: none"> <li>Individual providing broad knowledge and recommendations on available insurance plans for multiple insurance carriers</li> </ul>
Purpose	-	<ul style="list-style-type: none"> <li>Focused on timely and accurate processing of forms, advising on carrier's products</li> </ul>	<ul style="list-style-type: none"> <li>Focused on timely and accurate processing of forms, finding best quotes</li> </ul>	<ul style="list-style-type: none"> <li>Focused on advising on carrier plan selection, finding best quotes, customer service</li> </ul>
Advantage	-	<ul style="list-style-type: none"> <li>Tend to have deeper knowledge of carrier plans</li> <li>May be able to offer lower premiums or other features/ services</li> </ul>	<ul style="list-style-type: none"> <li>May have access to plans that better fit consumer's individual needs</li> </ul>	<ul style="list-style-type: none"> <li>Tend to have broader knowledge of offerings from multiple carriers</li> <li>Tend to have higher level of education and experience</li> </ul>
Disadvantage		<ul style="list-style-type: none"> <li>Will only provide information on plans for single insurance carrier</li> </ul>	<ul style="list-style-type: none"> <li>Tend to have access to less carrier offerings than a brokerage</li> </ul>	<ul style="list-style-type: none"> <li>May charge administrative fee or higher premiums</li> </ul>

Any person who sells, solicits, or negotiates health insurance products in the state of Indiana is required under [Indiana Code 27-1-15.6](#) to be licensed as a health insurance producer through the Indiana Department of Insurance (IDOI). This includes individuals who sell, solicit, or negotiate health insurance through the Federally-facilitated Marketplace (FFM)/[www.healthcare.gov](http://www.healthcare.gov) or products off of the Marketplace. Information on Indiana insurance producer licensing requirements is available on IDOI's website at [www.in.gov/idoi/2446.htm](http://www.in.gov/idoi/2446.htm).

In addition to being licensed with the state, insurance producers wanting to assist on the FFM/[www.healthcare.gov](http://www.healthcare.gov) must also complete any federal training and registration requirements with the Centers for Medicaid & Medicare Services (CMS). Information on training and registration requirements, and additional resources for producers, is available on CMS's website at [www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/a-b-resources.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/a-b-resources.html).

## G. Ethics for Indiana Navigators and Application Organizations (AOs)

The purpose of state and federal consumer assistants is to improve consumer access to fair, accurate, unbiased information regarding a range of health coverage options. Although personal bias is a challenge, it is important to recognize that each consumer asking for help has a different set of needs and priorities, and what may be best for one person is not what will be best for another person. In addition to considering individual needs, it is important that both state and federal consumer assistants adhere to a certain set of ethical standards as they work with consumers. Those [standards](#) may include commitment to clients, self-determination, informed consent, competence, cultural competence and social diversity, conflicts of interest, privacy and confidentiality, access to records, and professional conduct. The application of these standards is explained briefly in the following table (see [Table 14](#)):

**Table 14: Standards of Ethical Behavior**

### DO:

- Be honest regarding any personal bias or conflict of interest
- Give complete and accurate information
- Admit when one does not know an answer
- Protect the personal information of the people being assisted
- Be sensitive to different cultures
- Use professional language

### DO NOT:

- Do not make up or guess an answer to a question
- Do not ask anyone for more information than absolutely necessary
- Do not joke about sensitive physical, social, or cultural differences
- Do not use derogatory or profane language toward or about a consumer
- Do not be afraid to refer a consumer to someone else if they have needs outside of the Indiana Navigator scope of training

### 1. Ethical Standard: Commitment to Clients

The primary responsibility of all consumer assistants is to identify and address the needs of the consumer. This means listening to the consumer, using best judgment to determine the type of assistance the individual needs, and working within the Indiana Navigator's scope of knowledge and training in order to address those needs. It is possible that consumer needs may exceed an Indiana Navigator's ability to help. In this case, commitment to the client means referring the consumer to another resource that may be better equipped to help the consumer.

### 2. Ethical Standard: Self-Determination

Another primary role of Indiana Navigators is to assist the consumer in making more informed choices in their best interests when shopping for health insurance coverage. This is done by presenting complete and accurate information on all of the health coverage options available to a particular consumer and answering the consumer's questions about the details of those coverages. Armed with more information, the goal is to empower the consumer to make more informed choices that reflect the consumer's needs, priorities, and goals.

### 3. Ethical Standard: Informed Consent

There is a great deal of public confusion surrounding the implementation of the ACA, how it impacts health coverage, and what resources are available to help understand it. Many of the individuals utilizing Indiana Navigator services will not understand the differences between the different types of consumer assistants, the limitations in consumer assistants' ability to help, and the extent to which the consumer is entrusting a possible stranger with very sensitive personal information. For this reason, it is imperative that Indiana Navigators ensure that consumers are informed of what to expect of the process prior to addressing questions of need.

Indiana Navigators may avoid future anger and frustration by briefly explaining what an Indiana Navigator can and cannot do, what types of questions the Indiana Navigator may need to ask as a part of the application process, and any actual or potential conflicts of interest of the Indiana Navigator or the Navigator's Application Organization. This should help the consumer decide if the Indiana Navigator is someone with whom the consumer feels comfortable working, and should help prevent the consumer from getting upset and submitting a complaint later, feeling as though the Indiana Navigator was not helpful (when it was really just a matter of his or her need being outside the Indiana Navigator scope), asked too many personal questions (when such questions were really just necessary to complete the application), or steering the consumer into an inappropriate plan.

### 4. Ethical Standard: Competence

Within the first several years of ACA implementation, there may be several changes to federal and state laws and regulations. For this reason, it is vital that all Indiana Navigators strive to remain up-to-date on any changes as they occur. While not every change is going to impact every consumer, it is particularly important to know which changes will impact a consumer's program eligibility and enrollment, and to share that information. It is also important for Indiana Navigators to realize that, while they may know significantly more about ACA implementation than the average consumer, overloading a consumer with all of the information may just make the consumer more confused.

Competence is not a matter of sharing all of the information, but rather identifying what information would be helpful to share while staying within the boundaries of training and expertise of the consumer assistant. For example, an Indiana Navigator may study the plans available on the [Federal Marketplace](#) and understand the similarities and differences between them. This knowledge may be helpful to the consumer, but understanding the plan characteristics alone does not give the Indiana Navigator authority to advise on which plans to select.

### 5. Ethical Standard: Cultural Competence

Indiana Navigators may assist a diverse range of individuals. Regardless of the type of consumer, an Indiana Navigator has made a commitment to help the consumer understand the consumer's health coverage options, and should do so in a culturally sensitive manner. Questions, languages, and priorities may vary based on the consumer's culture, and it is the role of the Indiana Navigator to work within the context the individual's culture to address the individual's needs. Some elements that may impact culture include: age, gender, religion, race, ethnicity, national origin, immigration status, sexual orientation, gender identity or expression, marital status, political belief, socio-economic status, or mental or physical disability.

## 6. Ethical Standard: Conflicts of Interest

Financial and non-financial conflicts of interest recognized by the state of Indiana are discussed in greater detail in the [Conflict of Interest section](#) of this manual, but in general, a conflict of interest is any actual or potential condition that could interfere with an Indiana Navigator's ability to provide fair and impartial information to the consumer.

The primary role of the Indiana Navigator is to serve the best interests of the consumer. Therefore, the Indiana Navigator should work to limit any actual or potential conflicts of interest on the consumer. Since some conflicts of interest may not be completely eliminated, it is required that the Indiana Navigator disclose in writing those conflicts of interests first to the IDOI on the Conflict of Interest Disclosure Form<sup>30</sup> and then to each consumer prior to providing assistance. Some conflicts of interest may seem obvious, but it is still necessary to report them for the benefit of consumers.

## 7. Ethical Standard: Privacy and Confidentiality

Indiana Navigators and Application Organizations (AOs) must abide by the terms of the Privacy and Security Agreements<sup>31</sup> and respect a consumer's right to privacy and security of personal information. This means that the Indiana Navigator should not ask the consumer any questions that are not necessary to addressing the individual's needs, and the Indiana Navigator should keep all information shared by the consumer confidential. Any information is only to be shared at the authorization of the consumer, or by the consumer's Authorized Representative. This is the case for applications for health insurance coverage as well as for information shared with the family of the consumer.

It is also important to be aware of where a consumer shares personal information and, to what extent possible, help a consumer identify private and secure locations and methods of communication and application. For example, if a consumer plans to complete an application at a public library, discuss strategies for communicating in a way that will allow the greatest privacy and limit public exposure of personal information. Ideally, consumers will retain copies of any documents completed at the end of a meeting. This prevents the Indiana Navigator from having to properly destroy the documents in a way that will protect the consumer's personal information.

## 8. Ethical Standard: Access to Records

Some Indiana Navigators may have access to consumer records and applications, but should only access records at the request or permission of the consumer. To access consumer records for the sake of curiosity is an invasion of consumer privacy and a serious ethical violation that could result in enforcement action taken against the Indiana Navigator.

As with the [Privacy and Confidentiality section](#), Indiana Navigators must also maintain the privacy and security of consumer records, only sharing information from the records with the consumer or the consumer's Authorized Representative, unless the consumer requests otherwise. Other family members

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<sup>30</sup> There are two separate Conflict of Interest Disclosure Forms – one for [Indiana Navigators](#) and one for [Application Organizations](#).

<sup>31</sup> There are two separate Privacy and Security Agreements – one for [Indiana Navigators](#) and one for [Application Organizations](#).

may call to inquire, but it is important to speak directly with the consumer to obtain consent for information to be released to other individuals.

## 9. Ethical Standard: Professional Conduct

As an Indiana Navigator serving the general public, it is important to act in a professional manner. This means that Indiana Navigators are to avoid entering into sexual, harmful, abusive, or other inappropriate physical relationships with consumers or their family members, as this relationship may be seen as a way to exploit or harm the consumer. Even if the relationship is consensual, it is the Indiana Navigator that holds the risk if such a relationship is reported. It is in the best interest of both the Indiana Navigator and the consumer to set clear, appropriate, and culturally-sensitive boundaries at the beginning of the interaction. Although it is natural for individuals in a relationship to want to help each other, Indiana Navigators with a relationship with the consumer may want to consider referring the consumer to another Indiana Navigator as a way to ensure the preservation of appropriate professional boundaries and impartial assistance.

In addition to physical relationships, it is also necessary to act in a professional manner with regards to language. Telling jokes or using derogatory or foul language are to be avoided. Jokes about personal characteristics like race, gender, sexual orientation, age, religion, physical appearance, etc. may be funny to one individual, but it is difficult to know what may be hurtful or offensive to someone else. Consumers are coming to Indiana Navigators for help, and unprofessional language undermines Indiana Navigator credibility.

## H. Vulnerable and Underserved Populations

Vulnerable and medically-underserved populations may be defined by age, race or ethnicity, language, gender, socioeconomic status, geographic location, or other factors that have historically limited or currently restrict the ability to access healthcare. The characteristics of these groups can vary from state to state and county to county.

In order to improve access to care for all populations, and particularly those that have traditionally struggled the most, the ACA has established standards for federal Navigators to target vulnerable and underserved populations in their outreach, education, and enrollment efforts. As a condition of receiving federal Navigator cooperative agreement funds, organizations must first demonstrate that they have existing relationships or the direct potential to develop relationships with underserved and vulnerable populations in their declared service area.

While federal Navigators are required to help anyone requesting assistance, their primary focus is to seek out those that may not have access to healthcare or health coverage assistance and ensure they receive the information and resources they need to make informed decisions about their health coverage options.

Individuals with non-mainstream cultural and language needs and those with physical and mental disabilities. have received particular federal attention for their lack of health coverage access and the sensitivity surrounding their education and enrollment in health coverage programs. These populations have been singled out for particular federal requirements, with “the National Standards for Culturally and Linguistically Appropriate Services Standards in Health and Health Care” ([the National CLAS](#)

[Standards](#)) developed to address cultural and language differences, and comparable guidelines regarding how to work with persons with disabilities.

## 1. Serving Different Cultures and Languages – the National CLAS Standards

One particular area of focus for federally-mandated consumer assistants (federal Navigators, non-Navigator Assistance Personnel, and Certified Application Counselors (CACs)) is that of cultural and linguistic access and sensitivity. While these elements were addressed at a basic level within the ACA legislation, they were addressed in greater detail in the July 2013 [final rule](#) released by the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS), which is codified in [45 CFR 155.215](#).

Drawing from the National CLAS Standards (see [Table 15](#) below), 45 CFR 155.215 states that consumer assistants operating in under the Federally-facilitated Marketplace (FFM) must develop and maintain general knowledge about racial, ethnic, and cultural groups in their service area. They must also be able to provide the following:

- Provide information and assistance in consumer's preferred language (only using consumer; family may translate if consumer prefers this over other methods)
- Provide oral and written notice of availability of language assistance services
- Recruit, support, and promote staff that represents demographic characteristics of service area

**Table 15: National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards)**

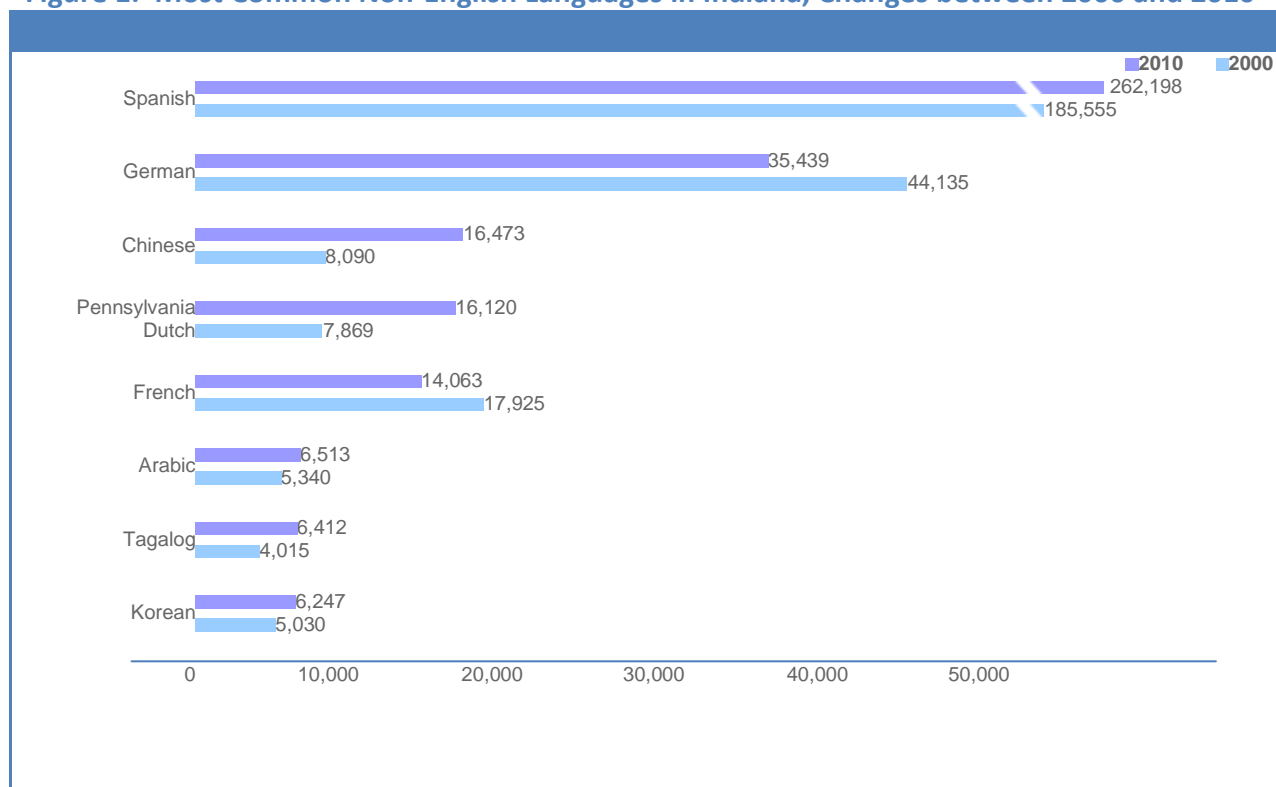
<b>Principle Standard:</b>
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
<b>Governance, Leadership and Workforce:</b>
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
<b>Communication and Language Assistance:</b>
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
<b>Engagement, Continuous Improvement, and Accountability:</b>
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

As HHS develops informational tools for consumers, it acknowledges the importance of developing written and spoken resources in English and Spanish, with the potential for information in other languages available online and through the use of language lines for callers.

In Indiana, English is the most commonly-spoken language, but following English, the language Indiana Navigators can expect to encounter the most often will be Spanish (see [Figure 1](#) below). Indiana

Navigators and Application Organizations (AOs) available to assist Hoosiers in Spanish are marked with an asterisk (\*) on the Indiana Healthcare Reform website at [www.in.gov/healthcarereform/2468.htm](http://www.in.gov/healthcarereform/2468.htm). Of the more than 100 languages spoken in the state, Spanish is the second most common language in most counties, followed by German (in Adams, Blackford, Crawford, Daviess, Martin, Perry, and Rush counties) and Chinese (in Monroe County). These language demographics will likely continue to change as the demographics of the state continue to change. As seen in Figure 1, the number of individual German speakers has declined since 2000 while the number of Chinese-speakers has doubled and the number of Pennsylvania Dutch speakers has more than doubled in the same amount of time.

**Figure 1: Most Common Non-English Languages in Indiana, Changes between 2000 and 2010**



Source: Modern Language Association, (2010), *MLA Language Map Data Center*, [www.mla.org/map\\_data](http://www.mla.org/map_data)

Although Indiana Navigators will obviously not be required to speak all of these languages, it is helpful for them to know what resources are available for translation services. One option is referring consumers to Indiana Navigators and AOs providing assistance in Spanish. Another such resource is the CMS call center, which the federal agency is to offer to consumers 24 hours a day, seven days a week. The call center is to offer immediate consumer assistance in English and Spanish, and will utilize a language line for those speaking other languages. The contact information for the federal call center is 1-800-318-2596 (TTY: 1-855-889-4325).

## 2. Serving Persons with Disabilities

The ACA provides requirements that any consumer assistant would be required to have some basic level of competency in working with persons with disabilities. There are a broad range of possible difficulties and disabilities that an Indiana Navigator may encounter. Some of these potential disabilities include:

- Hearing disability
- Visual disability
- Cognitive disability
- Ambulatory disability
- Self-care disability
- Independent living disability

In order to further address the needs of this diverse group, [45 CFR 155.215](#) provides that consumer assistants established under a Federally-facilitated Marketplace (FFM) are required to:

- Ensure consumer education materials, websites, and other resources are accessible to those with disabilities.
- Provide auxiliary aids and services for individuals with disabilities at no cost (only using consumer family if consumer prefers this over other methods).
- Provide assistance in a location and in a manner physically accessible to individuals with disabilities.
- Ensure authorized representatives are able to assist individual with disability make informed decisions.
- Be able to refer people with disabilities to local, state, and federal support services.
- Be able to work with individuals regardless of age, disability, or culture.

In Indiana, it is most likely that consumer assistants will work with individuals that have either a cognitive disability or physical challenges in the form of ambulatory or independent living disabilities. The following table (see [Table 16](#)) shows the different categories of disability and the percentage of Hoosiers that report experiencing that disability.

**Table 16: Percent of Hoosiers with Disabilities, by Type**

Type of Disability	Prevalence in Indiana in 2013
Hearing Disability	4.1%
Visual Disability	2.6%
Cognitive Disability	5.5%
Ambulatory Disability	7.9%
Self-Care Disability	2.7%
Independent Living Disability	5.8%
<b>Total Disability Prevalence</b>	<b>13.9%</b>

Source: Cornell University (2015), *2013 Disability Status Report: Indiana*, [www.disabilitystatistics.org/StatusReports/2013-PDF/2013-StatusReport\\_IN.pdf](http://www.disabilitystatistics.org/StatusReports/2013-PDF/2013-StatusReport_IN.pdf)

## II. Indiana Health Coverage Programs

### A. Chapter Objectives

1. Understand the Indiana Health Coverage Program (IHCP) (*e.g.*, Medicaid, Healthy Indiana Plan (HIP) 2.0, Children's Health Insurance Program (CHIP)) eligibility factors and be able to assess whether a consumer might be eligible for an Indiana Health Coverage Program.
2. Understand what information a consumer needs to provide as part of the Indiana Application for Health Coverage (IAHC).
3. Understand a consumer's options for applying for IHCPs through the state of Indiana.
4. Understand what a consumer should expect after the IAHC is filed.

### B. Key Terms

1. **1115 (c) Waiver** is a vehicle by which the Centers for Medicare & Medicaid Services (CMS) may waive certain Medicaid and Children's Health Insurance Program (CHIP) regulations, allowing a state to test new or existing ways to deliver and pay for healthcare services under these two programs. In Indiana, the Healthy Indiana Plan (HIP) 2.0 operates under an 1115 (c) waiver.
2. **1634 Status** is a federal designation given to states for determining Medicaid eligibility for the aged, blind, and disabled populations. Under this program, recipients of Supplemental Security Income (SSI) through the federal Social Security Administration (SSA) obtain automatic Medicaid enrollment and need not complete a separate state Medicaid application. Indiana became a 1634 Status state in 2013.
3. **Authorized Representative (AR)** is an individual or organization designated by an applicant or beneficiary to act responsibly on the applicant's behalf to assist with the individual's application and renewal of eligibility and other ongoing communications. Authorized representatives may be authorized to sign an application on the applicant's behalf, complete and submit a renewal form and receive copies of the applicant or beneficiary's notices and other communications from the Medicaid agency. Authorized representatives in Indiana must enter into the AR agreement with the state Division of Family Resources (DFR).
4. **Auto Assignment** is the process by which an individual who does not select a Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP) 2.0 Managed Care Entity (MCE) at the time of the HHW or HIP 2.0 application, or within fourteen (14) days of the submission of the application, is automatically assigned to a Managed Care Entity.
5. **Behavioral and Primary Healthcare Coordination Program (BPHC)** is a program that provides access to Medicaid Rehabilitation Option (MRO) services to individuals with Serious Mental Illness (SMI) whose income would otherwise be too high to qualify for Medicaid coverage. A person deemed eligible for BPHC receives full Medicaid benefits.
6. **Benefits Portal** is a website developed and managed by the state Division of Family Resources (DFR) by which Hoosier insurance consumers may apply for Indiana Health Coverage Programs (IHCPs) as well as check the status of pending applications. The DFR Benefits Portal is located at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov).
7. **Children's Health Insurance Program (CHIP)** is a health coverage program for children authorized in 1997 under Title XXI of the Social Security Act. CHIP provides health coverage to children whose income is too high to qualify for Medicaid. CHIP is administered by states with joint funding from the federal government and the states. States can implement CHIP through a Medicaid expansion,

separate CHIP or combination of the two approaches. Indiana operates CHIP through both a Medicaid expansion and separate CHIP program.

8. **[Division of Family Resources \(DFR\)](#)** is a division of the Indiana Family and Social Services Administration (FSSA), which establishes eligibility for Medicaid, Healthy Indiana Plan (HIP) 2.0, the Supplemental Nutrition Assistance Program (SNAP - food assistance), and the Temporary Assistance for Needy Families (TANF - cash assistance). DFR also manages the DFR Benefits Portal, where consumers may apply for an Indiana Health Coverage Program (IHCP).
9. **[Eligibility Group](#)** (also referred to as **[aid category](#)**) refers to a particular group/category that is eligible for Medicaid. An individual is determined eligible for the appropriate group/category based on factors of eligibility such as age, income, pregnancy, disability or blindness. See [Table 33](#) for the list of Medicaid eligibility groups.
10. **[Eligibility Hierarchy](#)** is the system used to determine a Medicaid applicant's eligibility for the most comprehensive Medicaid benefit package, in the absence of a stated preference.
11. **[Family Planning Eligibility Program](#)** is an Indiana Medicaid program that allows eligible men and women the ability to receive certain family planning services and supplies for the primary purpose of preventing or delaying pregnancy.
12. **[Fast Track](#)** is a payment option that allows Hoosiers eligible for the Healthy Indiana Plan (HIP 2.0) to expedite the start of their coverage in the HIP Plus program. Fast Track allows a member to make a \$10 payment on the application or while the member's application is being processed. The \$10 payment goes toward the first POWER account contribution. If the member makes a Fast Track payment and is eligible for HIP 2.0, the member's HIP Plus coverage will begin the first of the month in which the member made the Fast Track payment.
13. **[Federal Poverty Level \(FPL\)](#)** is a figure released each year by the federal government that estimates the minimum amount an individual or family would need to make to cover basic living expenses. Measure reflects income and household size, and changes annually. See [Table 64](#) for the current FPL guidelines.
14. **[Gateway to Work](#)** is a voluntary feature of Healthy Indiana Plan (HIP 2.0) that helps connect HIP 2.0 members to Indiana's workforce training programs, volunteer work, work search resources, hiring events, and potential employers. HIP 2.0 members who are unemployed or working less than 20 hours per week will be referred to available employment, work search and job training programs that will assist them in securing new or potentially better employment.
15. **[Health Maintenance Organization \(HMO\)](#)** is a designation given to health insurers offering products or services in any market segment (individual, small group, large group, or self-insured) in order to also provide or arrange for the delivery of health care services to enrollees on a prepaid basis. Individuals covered under a HMO will have a prescribed set of providers that may provide covered services. Except for certain services, including emergency services, HMOs are not required to cover services provided by out of network providers.
16. **[Healthy Indiana Plan \(HIP 2.0\)](#)** is Indiana's health coverage program for non-disabled Hoosiers between the ages of 19-64 whose family incomes are less than approximately 138% of the federal poverty level (FPL) and who are not eligible for Medicare or another Medicaid category. HIP 2.0 has four pathways to coverage—HIP Plus, HIP Basic, HIP Employer Link, and HIP State Plan. See [Table 17](#) showing the distinctions between these different pathways to coverage. Covered individuals and the state of Indiana make monthly contributions to a POWER Account. The first \$2,500 of healthcare expenses for the year is covered by the POWER Account, and additional healthcare expenses are fully covered at no additional cost to the HIP 2.0 member.
17. **[HIP Basic](#)** (see also **[Healthy Indiana Plan \(HIP 2.0\)](#)**) is the fallback option for HIP 2.0 members with household income less than or equal to 100 percent of the federal poverty level (FPL) who don't make their POWER account contributions. The benefits are reduced. Essential health benefits (EHBs)

are covered but not vision or dental services. The member is also required to make a copayment each time the member receives a healthcare service, such as going to the doctor, filling a prescription or staying in the hospital. These payments may range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay. HIP Basic can be much more expensive than HIP Plus. See [Table 17](#) showing the distinctions between the four different HIP 2.0 pathways to coverage.

18. [HIP Employer Link](#) (see also [Healthy Indiana Plan \(HIP 2.0\)](#)) is an option for eligible HIP 2.0 members who work and have access to their employer's health plan. HIP Employer Link members will also have a POWER account and contribute to their coverage like other HIP 2.0 members. But with HIP Employer Link, the POWER account can be used to pay the insurance premiums and out-of-pocket medical expenses associated with the member's employer-sponsored plan. The employer must choose to participate in HIP Employer Link and be registered with the state. Employers also must contribute 50 percent of the member's premium. Members can receive counseling on whether their employer plan would be best suited for them. See [Table 17](#) showing the distinctions between the four different HIP 2.0 pathways to coverage.
19. [HIP Plus](#) (see also [Healthy Indiana Plan \(HIP 2.0\)](#)) is the initial plan selection for all members in HIP 2.0 which offers the best value for members. HIP Plus has comprehensive benefits including vision and dental. The member pays an affordable monthly POWER account contribution based on income. There is no copayment required for receiving services with one exception: using the emergency room where there is no true emergency. See [Table 17](#) showing the distinctions between the four different HIP 2.0 pathways to coverage.
20. [HIP State Plan](#) (see also [Healthy Indiana Plan \(HIP 2.0\)](#)) is a pathway to coverage under HIP 2.0 that provides enhanced benefits to individuals determined to be medically frail, low-income parents and caretakers, and transitional medical assistance (TMA) individuals. The HIP State Plan benefits grant individuals comprehensive coverage including vision, dental, non-emergency transportation, chiropractic services and Medicaid Rehabilitation Option services. These HIP State Plan benefits will continue as long as the individual's health condition, disorder or disability status continues to qualify them as medically frail. See [Table 17](#) showing the distinctions between the four different HIP 2.0 pathways to coverage.
21. [Home and Community-Based Services \(HCBS\) Waivers](#), authorized under Section 1915(c) of the Social Security Act, are Indiana Medicaid waivers designed to provide an array of services to enrollees allowing them to live in community settings and to avoid institutionalization. HCBS waivers "waive" the requirement of an admission to an institution in order for Medicaid to pay for the needed home and community-based services. The different types of HCBS waivers that Indiana offers are outlined in [Table 23](#).
22. [Hoosier Care Connect](#) is a healthcare program for individuals aged 65 years and older, blind or disabled, who are not eligible for Medicare. In this program, individuals pick a health plan that works with them and their doctor to ensure that the individual gets consistent and high-quality healthcare based upon the individual's individualized needs. The health plans individuals may choose include Anthem, CareSource Indiana, Managed Health Services (MHS), or MDwise.
23. [Hoosier Healthwise \(HHW\)](#) is an Indiana Medicaid program for pregnant women and children up to age nineteen. The program covers medical care like doctor visits, prescription medicine, mental healthcare, dental care, hospitalizations, surgeries, and family planning, at little or no cost to the member or the member's family.
24. [HPE Adult](#) is a hospital presumptive eligibility (HPE) aid category for individuals determined to be presumptively eligible for the Healthy Indiana Plan (HIP 2.0). HPE Adult members receive *HIP Basic* coverage, are enrolled with a HIP 2.0 managed care entity (MCE), and have cost-sharing obligations.

25. **Indiana Application for Health Coverage (IAHC)** is an application for an Indiana Health Coverage Program (IHCP) which may be submitted to the Division of Family Resources (DFR) either online through the DFR Benefits Portal, by phone, fax, mail, or in-person at a local DFR office. The different methods for submitting an IAHC, as well as contact information, are listed in [Table 76](#).
26. **Indiana Health Coverage Program (IHCP)** is a term that refers to any of the several programs operated under Indiana Medicaid, which have been developed to address the medical needs of the low income, aged, disabled, blind, pregnant, and other populations meeting the eligibility criteria. Each IHCP has different criteria for eligibility. Types of IHCPs include, but are not limited to, Hoosier Healthwise, Healthy Indiana Plan (HIP) 2.0, Hoosier Care Connect, traditional Medicaid, and the home and community-based services (HCBS) waiver. Applications for IHCPs can be accessed through the DFR Benefits Portal at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov).
27. **Managed Care Entity (MCE)** (also referred to as **Managed Care Organization (MCO)**) is a general term used to describe health plans that are designed to control the quality and cost of healthcare delivery. The term includes models such as a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). In Indiana Medicaid, benefits are delivered in Hoosier Healthwise, HIP 2.0, and Hoosier Care Connect, through MCEs for some populations.
28. **Medicaid** is a means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. It provides free or low-cost health insurance coverage to individuals meeting the States' eligibility criteria, which are developed within the parameters established by the federal government. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving eligible individuals.
29. **Medical Review Team (MRT)** (also referred to as the **Medicaid Medical Review Team (MMRT)**) is a group that determines a Medicaid applicant's eligibility for Indiana Medicaid based on a disability. To meet the disability requirement, a person must have a significant impairment that is expected to last a minimum of 12 months. The MRT makes this determination and notifies the Division of Family Resources (DFR) of its decision.
30. **Medically Frail** is a term used to describe an individual who has one or more of the following: (a) disabling mental disorder; (b) chronic substance abuse disorder; (c) serious and complex medical conditions; (d) physical, intellectual or developmental disability that significantly impair the individual's ability to perform one or more activities of daily living; or (e) disability determination based on Social Security Administration (SSA) criteria. Individuals who qualify for the Healthy Indiana Plan (HIP 2.0) can receive enhanced benefits through the HIP State Plan pathway to coverage if they are determined to be medically frail.
31. **Medicare Savings Program** is a Medicaid program that helps Medicare beneficiaries pay for Medicare premiums and cost-sharing. There are four different categories of the Medicare Savings Program described in [Table 25](#).
32. **M.E.D. Works** (short for **Medicaid for Employees with Disabilities**) is Indiana's healthcare program for working people with disabilities. M.E.D. Works members pay premiums based on their income and receive full Medicaid benefits.
33. **Miller Trust** (also referred to as **Qualified Income Trust (QIT)**) is a legal arrangement for holding funds that allows an individual with income that exceeds 300 percent of the federal Supplemental Security Income (SSI) benefit rate (also known as the Special Income Limit) to become eligible for Medicaid coverage of institutional or home and community-based services.
34. **Modified Adjusted Gross Income (MAGI)** is an eligibility methodology for insurance affordability programs. MAGI equals adjusted gross income (AGI) plus tax excluded foreign earned income, tax exempt interest and tax exempt Title II Social Security income. MAGI methodologies are applied to individuals applying for premium tax credits (PTCs) and in the Medicaid program to children, pregnant women, parent and caretaker relatives and adults.

35. **Modified Adjusted Gross Income (MAGI) Conversion** refers to states' requirements to convert current Medicaid income eligibility standards to a MAGI equivalent as part of the transition to MAGI-based methodologies in 2014. The goal of the MAGI conversion process is to establish a MAGI-based income standard that is not less than the effective income eligibility standard as applied on the date of the Affordable Care Act (ACA) enactment for each eligibility group.
36. **Non-Modified Adjusted Gross Income (Non-MAGI) Population** is a population that is exempt from MAGI methodologies for the Medicaid eligibility determination process. Non-MAGI Medicaid eligibility methodologies are maintained for non-MAGI populations. For Medicaid, non-MAGI methodologies are applied to individuals age 65 or older when age is a condition of eligibility, individuals being determined eligible on the basis of blindness or disability, individuals applying for long-term services and supports for which a level of care need is a condition of eligibility, individuals whose eligibility does not require an income determination to be made by the Medicaid agency, individuals applying for Medicare cost-sharing, former foster children under age 26, and deemed newborns.
37. **Office of Medicaid Policy and Planning (OMPP)** is a division of the Indiana Family and Social Services Administration (FSSA) that administers Medicaid programs and performs medical review of Medicaid disability claims.
38. **Pathway to Coverage** is a phrase used to describe the four different plan options under the Healthy Indiana Plan (HIP 2.0). The four HIP 2.0 pathways to coverage include HIP Plus, HIP Basic, HIP Employer Link, and HIP State Plan. See [Table 17](#) showing a comparison of these different HIP 2.0 pathways to coverage.
39. **POWER Account** (also referred to as **Personal Wellness and Responsibility Account**) is an account used to pay medical costs for HIP 2.0 members. Members use their POWER accounts to pay for the first \$2,500 of covered services in any coverage year. Expenses for additional health services over \$2,500 are fully covered at no additional cost to the member (except in the HIP Basic program where the member is responsible for any required copayments). Contributions to the account are made by the state of Indiana and each member. Monthly POWER account contributions by members are determined by income and family size and are approximately two percent of annual family income.
40. **Preferred Provider Organization (PPO)** is a type of health plan that contracts with certain providers (referred to as in "network providers"). Individuals may choose to receive service from among the network providers or may choose to go to an out-of-network provider and in general be subject to greater cost sharing.
41. **Presumptive Eligibility (PE)** (also referred to as **PE for Pregnant Women (PEPW)**, **Hospital PE (HPE)**, or **PE for Inmates**) is a determination by a qualified provider (QP) that an individual is eligible for Medicaid benefits on the basis of preliminary self-declared information that the individual has gross income at or below the applicable Medicaid income eligibility standard. Indiana operates the following PE programs: Presumptive Eligibility (PE), PE for Pregnant Women (PEPW), Hospital PE (HPE), and PE for Inmates. See [Table 27](#) showing the comparisons between these programs.
42. **Primary Medical Provider (PMP)** is a healthcare provider selected or assigned to a beneficiary of a managed care entity (MCE) (*i.e.*, Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP 2.0)). Once a beneficiary is enrolled in a MCE, the beneficiary then selects a PMP or, if one is not selected within 30 days, the MCE will assign a PMP to the enrollee. Enrollees must see their PMP for all medical care; if specialty services are required the PMP will provide a referral. The PMP receives a monthly administration fee for each member actively assigned to the PMP. Other services are reimbursed on a fee-for-service basis.
43. **Prior Authorization (PA)** is a process under which the medical necessity of a requested service is reviewed. This is required for certain covered services to document the medical necessity for those

services. To determine whether a procedure code requires PA for members in the fee-for-service (FFS) delivery system, members should access the Indiana Health Coverage Programs (IHCP) provider [Fee Schedule](#). To determine whether a procedure code requires PA for members enrolled in managed care programs, members should contact the managed care entity (MCE) with which the member is enrolled.

44. **[Provider](#)** (also referred to as **[Healthcare Provider](#)**) is an individual or entity that provides healthcare or medical services to a patient. Common examples include a doctor's office, hospital, or health clinic. A provider can be either "[in-network](#)" (covered) or "[out-of-network](#)" (not covered) with the health insurance coverage offered by a health insurance issuer. *\*Note: a health insurance issuer may sometimes be referred to as a health insurance provider. It is an important distinction to remember that the "health insurance provider" (the provider/issuer/insurer/carrier of the health insurance) is different from the "healthcare provider" (the provider of healthcare or medical services).* To determine whether a provider is in-network or out-of-network with an insurer, a list of in-network providers can be accessed through the health insurer's website or by calling the health insurers consumer help desk.
45. **[Qualified Provider \(QP\)](#)** (also referred to as **[Presumptive Eligibility \(PE\) Qualified Entity](#)**) is an entity that is determined by the Indiana Family and Social Services Administration (FSSA) to be capable of making determinations of presumptive eligibility (PE) and meets all the qualifications established by the state. See [Table 27](#) showing the different types of QPs under each PE program.
46. **[Redetermination](#)** (also referred to as **[Eligibility Redetermination](#)**) is the process by which an enrolled consumer is re-enrolled, terminated, or transferred into an Indiana Health Coverage Program (IHCP) or the Federally-facilitated Marketplace (FFM). Eligibility redeterminations are to ensure that consumers are still eligible and in the right programs. The process is done every 12 months or when the enrollee reports any changes to household income, household size, or residence.
47. **[Re-Enrollment](#)** is the annual process by which consumers are redetermined eligible for Indiana Health Coverage Program (IHCP) or Federally-facilitated Marketplace (FFM) coverage and the steps consumers must take to re-enroll in coverage. All individuals enrolled in an IHCP or the FFM will receive a notice asking them to report any changes in circumstances. Any changes reported will be considered in the annual eligibility redetermination.
48. **[Right Choices Program](#)** is a program designed to provide intense member education, care coordination, and utilization management to eligible Hoosier Healthwise, Hoosier Care Connect, HIP 2.0, and traditional Medicaid members identified as overusing or abusing services.
49. **[Social Security Administration \(SSA\)](#)** is a federal agency through which Indiana Medicaid disability applications go through to determine if an individual is eligible for Medicaid disability. Direct applications to Indiana Medicaid may be made if the applicant is a child, has a recognized religious objection to applying for federal benefits (e.g., Amish), seeks eligibility under the M.E.D. Works medically improved category, or cites other "good cause" for not applying through the Social Security Administration.
50. **[Social Security Disability Insurance \(SSDI\)](#)** is a federal insurance program that provides benefits to qualified individuals who can no longer work. To be eligible, the individual must meet the SSA's definition of disabled. Disabled individuals with SSDI are eligible for Medicaid disability insurance in Indiana and need not undergo the state Medical Review Team (MRT) process. SSDI is also a source used to determine a consumer's disability status through the federal Marketplace application.
51. **[Spend Down Program](#)** was a Medicaid program that, prior to June 1, 2014, was available to individuals whose income or resources are too high to qualify for Medicaid, but they otherwise met the Medicaid eligibility criteria based on age, blindness or disability. As of June 1, 2014, the Medicaid spend down program is no longer in effect. Indiana now automatically enrolls individuals that the

Social Security Administration (SSA) determines eligible for Supplemental Security Income (SSI) into Indiana Medicaid and will accept all SSA determinations of disability. This has eliminated the arduous and duplicative requirement that aged, blind and disabled applicants also complete a second application and go through a second medical review team (MRT) process to be determined eligible for Indiana Medicaid with disability coverage.

52. **Supplemental Nutrition Assistance Program (SNAP)** is a federal aid program administered by the Food and Nutrition Service of the U.S. Department of Agriculture (USDA), which provides food assistance to low and no income people and families living in the United States. Distribution of SNAP benefits occurs at the state level. In Indiana, the Family and Social Services Administration (FSSA) is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. Hoosiers can apply for SNAP online at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov), by phone at 1-800-403-0864, or by visiting a Division of Family Resources (DFR) local office listed at [www.in.gov/fssa/dfr/2999.htm](http://www.in.gov/fssa/dfr/2999.htm).
53. **Supplemental Security Income (SSI)** is a federal program that pays benefits to adults and children determined disabled by the U.S. Social Security Administration (SSA) and who have limited income and resources. Individuals receiving SSI are automatically deemed eligible for Medicaid disability insurance in Indiana. SSI is also a source used to determine a consumer's disability status through the Federally-facilitated Marketplace (FFM)/[www.healthcare.gov](http://www.healthcare.gov) application.
54. **Temporary Assistance for Needy Families (TANF)** is a federal program that provides cash assistance and supportive services to assist families with children under age 18, helping them achieve economic self-sufficiency. Hoosiers can apply for TANF online at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov), by phone at 1-800-403-0864, or by visiting a Division of Family Resources (DFR) local office listed at [www.in.gov/fssa/dfr/2999.htm](http://www.in.gov/fssa/dfr/2999.htm).
55. **Traditional Medicaid** (also referred to as **Fee-for-Service (FFS)**) is a program created to provide healthcare coverage to individuals with low incomes. In traditional Medicaid, beneficiaries are not enrolled in a Managed Care Entity (MCE) or Care Management Organization (CMO) and can see any IHCP-enrolled provider. All provider claims are paid fee-for-service by the State's Fiscal Agent, Hewlett-Packard. Only certain eligibility groups are covered by traditional Medicaid.
56. **Transitional Medical Assistance (TMA)** is a program that provides continued Medicaid coverage to Medicaid-enrolled parents, caretaker relatives or children under 19 who lose Medicaid eligibility due to increased earnings of the parent or caretaker relative. It provides coverage for up to one year for an increase in income (maximum 185% FPL income in second six months), and requires quarterly reporting.
57. **Web Interchange** is a secure website operated by the Indiana Health Coverage Program (IHCP) to allow IHCP-enrolled providers to check member eligibility, receive information on claims payment, update their provider profile and submit presumptive eligibility (PE) applications.

## C. Introduction

Medicaid is a means-tested federal-state entitlement program enacted in 1965 by [Title XIX of the Social Security Act](#). It provides free or low-cost health insurance coverage to individuals meeting the states' eligibility criteria which are developed within the parameters established by the federal government. In general, Medicaid coverage was available to low-income children, pregnant women, families and the aged, blind and disabled. In 2015 Indiana elected to expand HIP 2.0 to cover all non-disabled adults. Eligibility criteria such as income, resource or age limits vary by eligibility category. Income limits for eligibility groups which are based on the federal poverty level (FPL) are adjusted yearly when the federal government publishes revised federal poverty levels.

Indiana Medicaid operates several different programs which have been developed to address the medical needs of the target populations. These programs are collectively referred to as the Indiana Health Coverage Programs (IHCPs). Each program has different criteria for eligibility. Following is a high-level overview of current Indiana Health Coverage Programs.

## D. Overview of Indiana Health Coverage Programs

### 1. Hoosier Healthwise

Hoosier Healthwise (HHW) is Indiana Medicaid's program for pregnant women and children under 19 years old. Enrollees *excluded* from mandatory enrollment in HHW include:

- Individuals in nursing homes and other long-term care institutions
- Undocumented individuals who are eligible only for emergency services (Package E – see [Table 29](#))
- Individuals receiving hospice or home and community-based waiver services
- Individuals enrolled in Medicaid on the basis of age, blindness or disability
- Wards of the court and foster children

Hoosier Healthwise covers children in both Medicaid and the Children's Health Insurance Program. Individuals eligible for and enrolled in HHW select a managed care entity (MCE). Hoosier Healthwise MCEs operate similarly to insurance companies in the commercial market and are responsible for managing enrollee's care within a fixed, per-member per-month capitation rate. More information on MCEs can be found in the [Medicaid Managed Care Entities – Hoosier Healthwise & HIP 2.0 section](#).

Further information on HHW can be found on FSSA's website at <http://provider.indianamedicaid.com/provider-specific-information/managed-care/hoosier-healthwise.aspx>.

### 2. Healthy Indiana Plan (HIP 2.0)

The Healthy Indiana Plan (HIP 2.0) is for Hoosier non-disabled adults 19-64 years of age (including low-income parents and caretakers previously covered under HHW) whose family incomes are less than approximately 138% of the federal poverty level (FPL) and who are not eligible for Medicare or another Medicaid category. HIP 2.0 is authorized through an 1115(c) waiver with CMS<sup>32</sup> under [Section 1115\(c\) of the Social Security Act](#). On January 27, 2015, CMS approved HIP 2.0 as an extension of the original Healthy Indiana Plan (HIP). In addition, HIP 2.0 was signed into law in Indiana on March 21, 2016 under [Public Law 30](#). From 2008-2014, the state of Indiana operated the original Healthy Indiana Plan. HIP 2.0 preserves the core principles of the original HIP, but does make several changes, including the following:

- In the new HIP 2.0 program, the first \$2,500 of medical expenses for covered benefits are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account.

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<sup>32</sup> See Indiana waiver submissions, CMS responses, and other correspondences and presentations for Healthy Indiana Plan (HIP 2.0) approval at [www.in.gov/fssa/hip/2336.htm](http://www.in.gov/fssa/hip/2336.htm).

This is an increase from \$1,100 in the original program. The plan deductible is also increased to \$2,500.

- There is no longer any limit to the number of Hoosiers who can enroll in the Healthy Indiana Plan. Any person between the ages of 19 and 64 who has an income under approximately 138% FPL and who is otherwise eligible can be a member of HIP 2.0.
- The new program also includes additional benefits such as maternity coverage without any cost sharing, and dental and vision coverage for HIP Plus members.
- New features provide options for families to be covered by the same health plan and for members to participate in their employer's health insurance plans.
- There are now multiple program options, with significant incentives for all members to participate in the premium HIP Plus program.
- A new feature of the program is "Gateway to Work," which helps connect HIP members to Indiana's workforce training programs, work search resources and potential employers.

The goals of the original HIP are to:

- Reduce the number of uninsured low-income Hoosiers
- Reduce barriers and improve statewide access to healthcare services for low-income Hoosiers
- Promote value-based decision making and personal health responsibility
- Promote primary prevention and preventive care services
- Prevent chronic disease progression with secondary prevention
- Provide appropriate and quality-based healthcare services
- Assure state fiscal responsibility and efficient management of the program

Through goals of HIP 2.0 are to preserve the core principals of the original HIP while working to:

- Replace traditional Medicaid in Indiana for all non-disabled adults
- Provide new coverage choices for Hoosiers
- Promote employer-sponsored coverage and family coverage options
- Improve the health status of Hoosiers
- Provide health coverage to low-income Hoosiers and ensure an adequate network for both HIP 2.0 and Medicaid enrollees
- Empower participants to make cost-conscious and quality-conscious healthcare decisions
- Create pathways to jobs that promote independence from public assistance
- Ensure that the HIP 2.0 expansion is fiscally sustainable

Individuals can be kept apprised of the status of HIP 2.0 through the IHCPs bulletins, banners and newsletters available at <http://provider.indianamedicaid.com/news,-bulletins,-and-banners.aspx>. Individuals may also consult the HIP 2.0 website at [www.in.gov/fssa/hip](http://www.in.gov/fssa/hip).

### ***a. Eligibility for HIP 2.0***

HIP 2.0 covers Indiana residents between the ages of 19 and 64 whose family incomes are less than approximately 138% FPL and who are not eligible for Medicare or another Medicaid category. A calculator may be accessed at [www.in.gov/fssa/hip/2352.htm](http://www.in.gov/fssa/hip/2352.htm) that can help someone determine if they are eligible for HIP 2.0 and can estimate what their monthly POWER account contribution would be. For individuals just joining HIP 2.0, they want to make sure to choose a health plan (Anthem, CareSource

Indiana, MDwise, or Managed Health Services (MHS)) that includes their doctor. They may call 1-877-GET-HIP-9 or email [HIP2.0@fssa.in.gov](mailto:HIP2.0@fssa.in.gov) to discuss their options.

Once a member's eligibility starts, they may not change their health plan until redetermination of eligibility occurs 12 months after enrollment (EXCEPTION: pregnant women and Native Americans may change plans). Plans may be changed prior to paying a POWER account contribution or before beginning full eligibility as a HIP Basic member.

### ***b. POWER Account Contributions and Preventive Care***

In the HIP 2.0 program, the first \$2,500 of medical expenses for covered benefits are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. If annual healthcare expenses are more than \$2,500, the first \$2,500 is covered by the member's POWER account, and expenses for additional health services over \$2,500 are fully covered at no additional cost to the member (except in the HIP Basic program where the member is responsible for any required copayments). If the member's annual healthcare expenses are less than \$2,500 per year, they may rollover their remaining contributions to reduce their monthly payment for the next year. The state will pay most of this amount, but the member will also be responsible for paying a portion of the member's initial healthcare costs based on their income.

Monthly POWER account contributions are determined by income and family size and are approximately 2% of annual family income with a minimum contribution of one dollar. Income ranges and contribution amounts for all family sizes can be calculated using the tool at [www.in.gov/fssa/hip/2352.htm](http://www.in.gov/fssa/hip/2352.htm).

HIP 2.0 empowers members to make important decisions about the cost and quality of their healthcare. As an incentive, members who remain in the HIP Plus program can reduce their POWER account contribution amounts after a year in the program based on the amount remaining in their accounts. If they receive recommended preventive care services throughout the year, the discount will be doubled. Members in the HIP Basic plan also have a POWER account, but since they are not making contributions the potential amount of their discount for receiving preventive care is lower.

In HIP 2.0, employers and non-profits can contribute any amount up to the full contribution amount. In addition, the health plans may implement a rewards program that allows members to "earn" additional dollars in their POWER account. Total contributions may not exceed the members required contribution to their POWER account.

If a HIP 2.0 member chooses to leave the program early, the member's contributions not spent on healthcare costs may be returned to the member. Since contributions are based on a projected annual amount, leaving the program early may also result in the member being required to pay the contributions for the remaining months of the enrollment period. This may occur if the member had significant healthcare expenses before leaving the program.

As long as members make their required monthly POWER account contributions, they will have no other costs. The only exception to this is a charge of up to \$25 if a member goes to the hospital emergency room for a non-emergency. Each month, the member's health plan will send a monthly statement showing how much is left in their POWER account.

Members who make POWER account contributions on-time each month participate in HIP Plus where they have better benefits and predictable costs. Members with incomes *above* the FPL that choose not to make their POWER account contributions will be removed from the program and not be allowed to re-enroll for six months. This enrollment lockout will not apply if the member is medically frail, residing in a domestic violence shelter or in a state-declared disaster area (not in policy), obtained and subsequently lost private insurance coverage, has a loss of income after disqualification due to increased income, or took up residence in another state and later returned to Indiana.

Members who have incomes *below* the FPL who do not make their contributions will be moved to the HIP Basic plan. HIP Basic does not cover vision and dental coverage and could be more expensive. The Basic plan requires members to make a small payment, called a copayment, each time they go to the doctor or hospital except for preventive care or family planning services. Unlike POWER account contributions, which belong to the member and could be returned if the member leaves the program early, copays cannot be returned to the member.

POWER account contributions are paid directly to the member's health plan (Anthem, CareSource Indiana, MDwise, or Managed Health Services (MHS)). Members will receive information from their health plans about the various ways POWER account contributions can be paid. These include by mail, over the phone, online and via payroll deduction through the member's employer. Each health plan also has designated retail locations around the state where you can make your payment in person. Members may call their health plan for details about these options and locations.

### ***c. Pathways to Coverage – HIP Plus, HIP Basic, HIP Employer Link, HIP State Plan***

HIP 2.0 has four “pathways to coverage”—HIP Plus, HIP Basic, HIP Employer Link, and the HIP State Plan—discussed further in the following sections. The following table (see [Table 17](#)) shows the distinctions between these pathways to coverage:

**Table 17: HIP Plus, HIP Basic, HIP Employer Link, and HIP State Plan – Comparison Chart**

	HIP Plus	HIP Basic	HIP Employer Link	HIP State Plan
<b><i>Who Is Eligible?</i></b>	<ul style="list-style-type: none"> <li>Income up to 138% FPL</li> <li>Consistent POWER account contributions</li> </ul>	<ul style="list-style-type: none"> <li>Fail to make POWER account contribution</li> </ul>	<ul style="list-style-type: none"> <li>Optional for individuals with access to cost-effective employer-sponsored insurance</li> </ul>	<ul style="list-style-type: none"> <li>Income under 138% FPL</li> <li>Individuals with complex medical or behavioral conditions</li> <li>Low income 19/20 year olds</li> <li>TMA eligible individuals</li> </ul>
<b><i>How Does a Member Pay?*</i></b>	<ul style="list-style-type: none"> <li>POWER account contributions paid to MCE</li> <li>No copays except non-emergency ER visits (\$8-25)</li> </ul>	<ul style="list-style-type: none"> <li>Copayments for most services paid to providers</li> <li>More expensive than HIP Plus</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced POWER account can be used for premiums, copayments or deductibles for employer insurance</li> <li>Member receives check to help cover cost of employer insurance</li> </ul>	<ul style="list-style-type: none"> <li>Copayments <u>or</u> POWER account contributions</li> </ul>
<b><i>What Are the Benefits?</i></b>	<ul style="list-style-type: none"> <li>Comprehensive medical benefits including maternity</li> <li>Vision and dental</li> <li>Increased service limits</li> <li>Comprehensive drug benefit</li> </ul>	<ul style="list-style-type: none"> <li>Comprehensive medical benefits including maternity</li> <li>Lower service limits</li> <li>More limited drug benefit</li> </ul>	<ul style="list-style-type: none"> <li>Employer plan benefits</li> </ul>	<ul style="list-style-type: none"> <li>Comprehensive medical benefits including maternity</li> <li>Current Medicaid benefits are required by federal law</li> <li>Enhanced behavioral health services</li> </ul>

\*Note: Pregnant women in all categories are exempt from cost-sharing, including copayments and POWER account contributions.

Source: Family and Social Services Administration, [www.in.gov/fssa/hip/files/DF-CS-110614\\_HIP2.0-Plan-comparison-chart\\_v1r1.pdf](http://www.in.gov/fssa/hip/files/DF-CS-110614_HIP2.0-Plan-comparison-chart_v1r1.pdf)

### i. HIP Plus

The initial plan selection for all HIP 2.0 members is HIP Plus, which offers the best value for members. HIP Plus has comprehensive benefits including vision and dental. The member pays an affordable monthly POWER account contribution based on income. There is no copayment required for receiving services with one exception: using the emergency room where there is no true emergency.

HIP Plus provides more benefits than the HIP Basic program, including vision and dental services. It also allows more visits for physical, speech and occupational therapy, and covers additional services like bariatric surgery and Temporomandibular Joint Disorders (TMJ) treatment. With HIP Plus, members can get 90-day refills on prescriptions and receive medication by mail order. Members also receive medication therapy management services that are designed to work closely with their doctors and pharmacies to provide additional assurances that prescription therapies are safe and effective.

HIP Plus also has the option for member's to participate in "Fast Track." Fast Track is a payment option that allows eligible Hoosiers to expedite the start of their coverage in the HIP Plus program. Fast Track allows a member to make a \$10 payment while the member's application is being processed. The \$10 payment may be made on the application or to the MCE after applying and goes toward the first POWER account contribution. If the member makes a Fast Track payment and is eligible for HIP 2.0, the member's HIP Plus coverage will begin the first of the month in which the member made the Fast Track payment or the first payment of their POWER account contribution. To learn more about Fast Track payments, visit the HIP 2.0 website at [www.in.gov/fssa/hip/2501.htm](http://www.in.gov/fssa/hip/2501.htm).

Members can only get into HIP Plus at initial enrollment, for 60 days after redetermination, or if they become ineligible for HIP Basic due to an increase in income. Once a member pays they cannot change managed care entities. A provider bulletin regarding selecting a HIP 2.0 health plan is available at <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201581.pdf>. There is also a provider bulletin regarding start dates available at <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201607.pdf>.

### ii. HIP Basic

HIP Basic is the fallback option for members with household income less than or equal to 100% of FPL who do not make their POWER account contributions. HIP Basic coverage begins the first day of the month after the 60-day payment period expires for HIP Plus. Individuals with income under 100% FPL who do not make a POWER account contribution will move to HIP Basic coverage after 60 days of non-payment.

The benefits are reduced. Essential health benefits (EHBs) are covered but not vision or dental services, bariatric surgery or Temporomandibular Joint Disorders (TMJ). HIP Basic benefits also allow fewer visits to physical, speech and occupational therapists. Unlike HIP Plus, HIP Basic has more limited options for getting medication. Members are limited to 30-day prescription supply and cannot order medications by mail. HIP Basic also does not provide medication therapy management services.

The HIP Basic member is also required to make a copayment each time the member receives a healthcare service, such as going to the doctor, filling a prescription or staying in the hospital. These

payments may range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay. The following table (see [Table 18](#)) shows the HIP Basic copayment amounts:

**Table 18: HIP Basic Copayment Amounts**

Service	HIP Basic Copayment Amounts
<b>Outpatient services, including office visits</b>	\$4
<b>Inpatient services, including hospital stays</b>	\$75
<b>Preferred drugs</b>	\$4
<b>Non-preferred drugs</b>	\$8
<b>Non-emergency ER visit</b>	\$8 for the first occurrence, \$25 each time thereafter*

\*Also applies to HIP Plus

Source: Family and Social Services Administration, [www.in.gov/fssa/hip/2457.htm](http://www.in.gov/fssa/hip/2457.htm)

HIP Basic can be much more expensive than HIP Plus. Members in the HIP Basic plan will still use the POWER account to cover their \$2,500 annual deductible, but the funds in the account will be contributed entirely by the state. HIP Basic plan members will still receive POWER account statements to assist them in managing the account and to increase their awareness of the cost of the healthcare services they receive.

HIP Basic coverage begins the first day of the month after the 60-day payment period expires for HIP Plus. Individuals with income under 100% FPL who do not make a POWER account contribution will move to HIP Basic coverage after 60 days of non-payment.

### iii. HIP Employer Link

HIP Employer Link is an option for eligible HIP 2.0 members who work and have access to their employer's health plan. HIP Employer Link members have a POWER account and contribute to their coverage like other HIP 2.0 members. But with HIP Employer Link, the POWER account can be used to pay the insurance premiums and out-of-pocket medical expenses associated with the member's employer-sponsored plan.

The employer must choose to participate in HIP Employer Link and be registered with the state. Employers also must contribute 50% of the member's premium. Members can receive counseling on whether their employer plan would be best suited for them.

Individuals with access to employer-sponsored health insurance do not have to use their employer's plan and will be given the option to choose based on which plan is best for their individual healthcare needs. All HIP-eligible adults with access to employer-sponsored insurance will receive options counseling through an enrollment broker regarding whether enrollment in HIP 2.0 or their employer plan would be best suited to their individual needs and situation.

Individuals with employer-sponsored insurance can request HIP Employer Link when they file their application or, if they are already enrolled, can report a change with DFR and request to transfer to HIP

Employer Link. HIP Employer Link coverage may begin as soon as the month of application, but will not overlap with any existing HIP or Medicaid coverage.

Individuals who choose to enroll in employer-sponsored insurance will still have a POWER account and will be required to make monthly contributions. The state will fund the POWER account to the average amount that an individual covered by an employer-sponsored plan may be expected to spend for premium and other out-of-pocket expenses. Individuals in HIP Employer Link receive a premium reimbursement from their POWER account on a monthly basis to help cover the costs of employer-sponsored insurance.

Individuals with employer-sponsored insurance can request HIP Employer Link when they file their application or if they are already enrolled can report a change with the DFR and request to transfer to HIP Employer Link. HIP Employer Link coverage may begin as soon as the month of application but will not overlap with any existing HIP or Medicaid coverage.

More information about HIP Employer Link is available at [www.hipemployerlink.in.gov](http://www.hipemployerlink.in.gov).

#### iv. HIP State Plan

Enhanced HIP 2.0 benefits are available to low-income parents and caretakers, transitional medical assistance (TMA) individuals, and individuals whose health status qualifies them as “medically frail.” As defined by the Centers for Medicare and Medicaid Services (CMS), an individual will be considered medically frail if the individual has one or more of the following:

- Disabling mental disorder;
- A chronic substance abuse disorder;
- Serious and complex medical conditions;
- Physical, intellectual or developmental disability that significantly impair the individual’s ability to perform one or more activities of daily living; or
- A disability determination based on Social Security Administration (SSA) criteria.

A list of conditions that may qualify someone as medically frail is available on the HIP 2.0 website at [www.in.gov/fssa/hip/2465.htm](http://www.in.gov/fssa/hip/2465.htm). The process for determining whether someone qualifies as medically frail is available at <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201619.pdf>.

The HIP State Plan benefits grant the individual comprehensive coverage including vision, dental, non-emergency transportation, chiropractic services and Medicaid Rehabilitation Option services. These HIP State Plan benefits will continue as long as the eligibility status or health condition, disorder or disability status continues to qualify the person as medically frail. For individuals found to be medically frail, the HIP State Plan benefits will begin the first of the month following the frail determination.

The MCE (Anthem, CareSource Indiana, MDwise, or Managed Health Services (MHS)) may contact the member annually to review their health condition. It is important to answer their questions to maintain HIP State Plan benefits. If the member fails to verify the member’s condition at the request of the health plan, the member could still have access to comprehensive coverage including vision and dental, by participating in HIP Plus, but would lose access to the additional HIP State Plan benefits including

coverage for non-emergency transportation and chiropractic services. If the member has questions about or changes in the member's health condition, the member should contact the health plan directly.

#### *d. Becoming Pregnant While on HIP 2.0*

In the original HIP program, members were required to leave HIP and transfer to Medicaid when they became pregnant. Under the new HIP 2.0 program, maternity services are covered. HIP 2.0 members who are pregnant may keep their coverage for the duration of their pregnancy or until their annual redetermination (whichever comes first). Pregnant members who stay in HIP 2.0 will have all cost sharing suspended and will receive additional benefits during their pregnancy including non-emergency transportation.

A pregnant HIP 2.0 member must promptly report her pregnancy. After reporting a pregnancy, pregnant mothers will initially have a choice to stay in their HIP Basic/HIP Plus plan or transfer to HIP Maternity. HIP Maternity coverage is under Hoosier Healthwise and is more like a traditional Medicaid program. The member will not have a POWER account or receive monthly statements to track healthcare costs. Neither choice will result in a noticeable difference in benefits. All pregnant women will receive additional benefits such as vision, dental, non-emergency transportation and access to additional smoking cessation services designed specifically for them. Before deciding which pregnancy coverage option is best for them, pregnant members should talk to their doctors and make sure the doctor is in the health plan's network.

If a pregnant member's annual redetermination occurs during pregnancy, federal guidelines require that she be moved to HIP Maternity. Again, she will not notice any changes in her benefits or cost-sharing.

At the end of pregnancy, the member's additional pregnancy benefits will continue for another 60-day post-partum period. The member will continue to not have any cost sharing responsibilities during this period. However she should promptly report to the state that her pregnancy has ended to prevent any breaks in coverage. At the end of the post-partum period, her cost-sharing will resume. She must begin paying her POWER account contribution at this time to maintain HIP Plus benefits. If she fails to promptly report the end of her pregnancy and/or pay her POWER account contribution, she could face a gap in coverage.

#### *e. Gateway to Work*

Gateway to Work is a new feature of HIP 2.0 that helps connect HIP 2.0 members to Indiana's workforce training programs, volunteer work, work search resources, hiring events, and potential employers. HIP 2.0 members who are unemployed or working less than 20 hours per week will be referred to available employment, work search and job training programs that will assist them in securing new or potentially better employment.

Gateway to Work is a voluntary program. HIP 2.0 members will be notified if they have been referred to the program. Eligibility for HIP 2.0 coverage is not affected if a member chooses to not participate. Those interested in participating in Gateway to Work should call 1-800-403-0864 and select Option 1 for the health coverage menu and then Option 6 for Gateway to Work.

More information about Gateway to Work may be found at [www.in.gov/fssa/hip/2466.htm](http://www.in.gov/fssa/hip/2466.htm).

### *f. How to Apply for HIP 2.0*

HIP 2.0 applications are available online at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov), by mail or by visiting your local Division of Family Resources (DFR) office – listed by county at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov). Applicants can call 1-877-GET-HIP-9 to find more information about the application process or to find their local DFR office.

Once an applicant submits the application with all required information, applications are processed within 45 business days. After your application is processed, the applicant will receive a letter by mail stating whether the applicant qualifies for the program.

Once approved for HIP 2.0, the new member will be assigned to the health plan<sup>33</sup> the member chose on the application. If the member does not choose a health plan, one will be selected for them. Then the health plan will mail the member a welcome packet. An invoice for their POWER account contribution will also be received. Coverage for HIP Plus members begins in the month when their first POWER account contributions or Fast Track payments are received and processed. HIP Basic coverage begins the first of the month after the invoice payment period. All HIP 2.0 members will receive a letter informing them when coverage starts and how to get the most out of their HIP 2.0 benefits.

### *g. Payment of the POWER Account Invoice*

Once the POWER account invoice or \$10 fast track prepayment is made, the individual cannot change managed care entities (MCEs). The individual gets 60 days to pay from the date of the initial \$10 fast track invoice and does not receive additional time to pay after being found eligible for benefits and receiving an invoice for their actual POWER account amount.

Individuals may choose an MCE on the application or call the enrollment broker at **1-877-GET-HIP-9** (1-877-438-4479) to make an MCE change. The enrollment broker will only make a plan change if the individual has not yet paid their POWER account contribution.

Making a fast track payment or a POWER account prepayment is the only way to get into HIP Plus, if an individual want to change plans and has not received an invoice to pay they should call their preferred health plan (see [Table 19](#)) to make a payment as soon as possible to make sure they can enroll in HIP Plus.

The enrollment broker can also help individuals find the plan that works best for them and includes their preferred doctor in their network. Individuals should call the enrollment broker with questions about plans, or to change plans prior to enrolling or at their annual eligibility redetermination. If an individual wants to change plans for the next year they must do so 45 days prior to the end of their benefit year.

### *h. Hoosier Healthwise and HIP 2.0 Managed Care Entities*

The state of Indiana contracts with managed care entities (MCEs) to provide a variety of services to Hoosier Healthwise and HIP 2.0 enrollees. The same MCEs are available for both programs with the goal

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<sup>33</sup> As comparison of the three available HIP 2.0 health plans in 2016 (Anthem, MDwise, and Managed Health Services (MHS)) is available at [www.in.gov/fssa/hip/files/IN-HIP-PlanChartSmmry\\_41MAX\\_031015.pdf](http://www.in.gov/fssa/hip/files/IN-HIP-PlanChartSmmry_41MAX_031015.pdf). Beginning in 2017, CareSource Indiana will also be available as a fourth option.

to integrate the two programs to the greatest extent possible, creating a health plan that results in a seamless coverage experience for families. Managed care entities provide the following services and functions:

- Developing a network of contracted providers from whom enrollees receive covered services
- Case management
- Disease management
- Operating a member services helpline to address all enrollee questions, complaints and concerns
- Screening enrollees for special healthcare needs and coordinating the provision of necessary healthcare services as a result of the screening outcomes
- Operating a 24-hour nurse call line, which is available to provide around-the-clock medical advice from trained medical professionals
- Providing member handbooks to enrollees outlining covered benefits, available services, etc.
- Managing member grievances and appeals
- Utilization management (processing prior authorizations in accordance with medical management criteria and practice guidelines, etc.)
- Operating member incentive programs to encourage appropriate utilization of health services and/or health promoting behaviors
- Provider claims payment
- Quality management

Indiana currently contracts with four MCEs outlined in the following table (see [Table 19](#)):

**Table 19: HIP 2.0 and Hoosier Healthwise Managed Care Entities (MCEs)**

MCE	Member Services	Website
<i>Anthem</i>	1-866-408-6131	<a href="http://www.anthem.com">www.anthem.com</a>
<i>CareSource Indiana</i>	1-877-806-9284	<a href="http://www.caresource.com">www.caresource.com</a>
<i>MDwise</i>	1-800-356-1204	<a href="http://www.mdwise.org">www.mdwise.org</a>
<i>Managed Health Services(MHS)</i>	1-800-647-4848	<a href="http://www.mhsindiana.com">www.mhsindiana.com</a>

Individuals are given the opportunity to select an MCE on their application. Those that do not select an MCE are auto-assigned to one, according to a state designed auto-assignment methodology. The auto-assignment methodology is designed to promote continuity of care for enrollees and considers factors such as previous MCE enrollment and enrollment of family members. All applicants should be encouraged to select an MCE at the time of application to facilitate member choice versus auto-assignment.

Some factors for beneficiaries to consider when selecting an MCE include the following:

- Provider network
  - If an individual has an established relationship with the doctor, is that doctor available in the MCE network?
  - Are the locations of network providers easily accessible for the enrollee? Are the locations convenient to the individual's work, home or school?

- Special programs and enhanced services
  - MCEs offer disease management, wellness programs, educational programs and enhanced benefits. Is there a service or program offered by the MCE that is particularly important or attractive to the enrollee?

Individuals that need assistance in selecting an MCE can contact the following helplines (see [Table 20](#)) administered by the state's enrollment broker, MAXIMUS.

**Table 20: HIP 2.0 and Hoosier Healthwise Helplines**

Program	Phone #
<b>Hoosier Healthwise</b>	1-800-889-9949
<b>HIP 2.0</b>	1-877-GET-HIP-9

Once a beneficiary is enrolled in an MCE, the beneficiary also selects a primary medical provider (PMP). The MCE assists the enrollee in PMP selection; if one is not selected within 30 days the MCE will assign one to the enrollee. Enrollees must see their PMP for most medical care;<sup>34</sup> if specialty services are required the PMP will provide a referral. Provider types eligible to serve as a PMP include IHCP-enrolled providers with the following specialties:

- Family practice
- General practice
- Internal medicine
- Obstetrics (OB)/Gynecology (GYN )
- General pediatrics

To ensure continuity of care, Hoosier Healthwise enrollees are eligible to change MCEs only at the following times:

- Anytime during the first 90 days with a health plan
- Annually during an open enrollment period (the annual open enrollment period date is driven by an individual's eligibility versus an annual timeframe in which all Hoosier Healthwise enrollees are eligible to select an MCE)
- Anytime there is a "for cause" determination (listed on the MCE contract)
  - Receiving poor quality of care;
  - Failure to provide covered services;
  - Failure of the Contractor to comply with established standards of medical care administration;
  - Lack of access to providers experienced in dealing with the member's health care needs;
  - Significant language or cultural barriers;
  - Corrective action levied against the Contractor by FSSA;
  - Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;

<sup>34</sup> There are some self-referral services that are not required to go through the PMP (see the Indiana Administrative Code [405 IAC 5](#) (Hoosier Healthwise) and [405 IAC 10](#) (HIP 2.0)).

- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections, as described in Section 9.3.3;
- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE; or
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

HIP 2.0 enrollees are only eligible to change MCEs at the following times:

- In the first 60 days *or* until they make the first POWER account contribution
- Annually at eligibility redetermination; plan change must be made 45 days prior to the end of the benefit period
- Anytime it is "for cause" (defined above for Hoosier Healthwise)

In order to change MCEs for "for cause" enrollees must first contact their MCE to allow the MCE to attempt to resolve the concern. If the individual is not satisfied with the outcome of contact with the MCE, the individual can contact the enrollment broker who reviews the request for disenrollment.

### 3. Hoosier Care Connect

Hoosier Care Connect is a healthcare program for individuals who are aged 65 years and older, blind, or disabled and who are also not eligible for Medicare. In this program, individuals select a health plan that works with them and their doctor to ensure that the individual gets the most appropriate care based upon their individualized needs. Hoosier Care Connect covers a variety of individuals who are not eligible for Medicare, including:

- Aged individuals;
- Blind individuals;
- Disabled individuals;
- Individuals receiving Supplemental Security Income (SSI); or
- Individuals enrolled through M.E.D. Works.

When individuals enroll with Hoosier Care Connect, they must select their health plan. They may choose Anthem, CareSource Indiana, Managed Health Services (MHS), or MDwise.<sup>35</sup> Once they have selected a health plan, they will be asked a series of questions about their healthcare. These questions will allow the health plan to understand the individual's needs so that the plan may provide the individual with all

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<sup>35</sup> Individuals may visit the Indiana Medicaid website at <http://member.indianamedicaid.com/programs--benefits/important-things-to-know/working-with-your-health-plan.aspx> for guidance on how to pick the best health plan for them.

the services needed. If the individual has extra needs, the health plan will ask some more specific questions so that they may be further involved with the individual's healthcare treatment.

If individuals have questions about their benefits or coverage, they should contact their health plan or the Indiana Medicaid enrollment broker, MAXIMUS, listed at the following numbers (see [Table 21](#)):

**Table 21: Hoosier Care Connect Health Plan Contacts**

Health Plan	Phone Number
<b>Anthem</b>	1-844-284-1797
<b>CareSource Indiana</b>	1-877-806-9284
<b>MDwise</b>	1-800-356-1204
<b>Managed Health Services (MHS)</b>	1-877-647-4848
<i>Indiana Medicaid Enrollment Broker</i>	
<b>MAXIMUS</b>	1-866-963-7383

Hoosier Care Connect includes all covered services that are covered under Hoosier Healthwise (HHW)<sup>36</sup> Package A. Hoosier Care Connect members also receive special services for their individual healthcare needs, such as medication therapy management, healthcare coordination, and access to a 24-hour nurse helpline.

Further information on the Hoosier Care Connect program can be found on the Indiana Medicaid website at <http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-care-connect/faq-hoosier-care-connect.aspx>.

#### 4. Traditional Medicaid (Fee-for-Service)

The following Indiana Medicaid beneficiaries are enrolled in traditional Medicaid:

- Blind persons, who meet income and resource requirements
- Disabled persons, who meet income and resource requirements
- Aged persons, who meet income and resource requirements
- Persons in nursing homes and other long-term care institutions, who meet income and resource requirements
- Undocumented aliens who do not meet a specified qualified status
- Lawful permanent residents who have lived in the United States less than five years
- Those whose alien status remains unverified receiving Emergency Services only (Note: this is not [MEC](#))
- Persons receiving home and community-based waiver or hospice services
- Dual eligibles (individuals receiving Medicaid and Medicare)
- Persons eligible on the basis of having breast or cervical cancer
- Refugees who do not qualify for another aid category
- Former Independent Foster Children up to age 18
- IV-E Foster Care Children

<sup>36</sup> A list of Hoosier Healthwise covered services may be viewed at <http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise/hhw-covered-services-.aspx>.

- IV-E Adoption Assistance Children
- Former foster children under the age of 26 who were enrolled in Indiana Medicaid as of their 18<sup>th</sup> birthday

In traditional Medicaid, beneficiaries are not enrolled in a MCE or CMO and can see any IHCP-enrolled provider. All provider claims are paid fee-for-service by the state's fiscal agent, Hewlett-Packard. More information on the eligibility criteria for groups enrolled in traditional Medicaid can be found in the [Eligibility Groups section](#).

## 5. M.E.D. Works

M.E.D. Works, which stands for **M**edicaid for **E**mployees with **D**isabilities, is Indiana's healthcare program for working people with disabilities. To be eligible for M.E.D. Works, individuals must meet the following criteria:

- Be 16-64 years of age
- Fall below 350% FPL (spousal income excluded)
- If seeking eligibility under the MA W (regular M.E.D. Works) category: Be disabled according to the federal Social Security Administration's (SSA's) definition, or have a pending application for disability benefits with the SSA and a medical review team (MRT) determination of disability. Current members are exempt from this requirement until their next MRT scheduled progress report, at which time they will be required to submit an application to SSA for a disability determination. If no progress report is due, the SSA application requirement is waived, and the individual will continue to meet the disability requirement based on the SSA determination. If this SSA application has not been submitted within 45 days of the MRT progress report due date, the member will be rendered ineligible. If the member has not fully recovered, the member will continue to be eligible. Applicants seeking eligibility under the MADI (M.E.D. Works medically improved) category will not be required to have a pending or approved disability application with SSA but will be assessed only by the MRT team.
- Not exceed the countable asset limit (*Single: \$2,000, Couple: \$3,000*), with the exception of an Independence Self-Sufficiency Account as detailed below
- Be working (there is no minimum work effort for the program)

M.E.D. Works members receive full Medicaid benefits. They may receive health insurance through their employer, and M.E.D. Works premiums will be adjusted by the amount paid for employer coverage and Medicaid will serve as secondary payer. If an individual loses their job, M.E.D. Works coverage can continue for 12 months following involuntary employment termination when the Indiana Division of Family Resources (DFR) is notified within 60 days and other eligibility criteria continues to be met.

M.E.D. Works members pay the following monthly premiums (see [Table 22](#)), based on the income of the applicant/recipient and spouse. These monthly income limits are adjusted annually based on the updated federal poverty levels (FPLs) released by the federal government.

**Table 22 : M.E.D. Works Premiums (based on 2016 FPL)**

	Monthly Income	Premium
<b>Single</b>	\$1,485 – \$1,733	\$48
	\$1,734 – \$1,980	\$69
	\$1,981 – \$2,475	\$107
	\$2,476 – \$2,970	\$134
	\$2,971 – \$3,465	\$161
	\$3,466 and over	\$187
<b>Married</b>	\$2,003 – \$2,336	\$65
	\$2,337 – \$2,670	\$93
	\$2,671 – \$3,338	\$145
	\$3,339 – \$4,005	\$182
	\$4,006 – \$4,671	\$218
	\$4,674 and over	\$254

Source: Family and Social Services Administration, *FAQ: MED WORKS*,

<http://member.indianamedicaid.com/programs--benefits/medicaid-programs/med-works/fag-med-works.aspx>.

See also INDIANA HEALTH COVERAGE PROGRAM POLICY MANUAL, Chapter 3010.20.20,

[https://secure.in.gov/fssa/files/Medicaid\\_Combined\\_PM.pdf](https://secure.in.gov/fssa/files/Medicaid_Combined_PM.pdf)

M.E.D. Works members will receive a premium book with coupon stub that will provide information on where to send payments. Assistance can also be provided through the M.E.D. Works payment line at 1-866-273-5897.

M.E.D. Works participants can put up to \$20,000 in a Savings for Independence and Self-Sufficiency Account. This is an account to allow individuals to put aside money to purchase goods or services that increase their ability to find or retain a job or increase independence without rendering them ineligible for Medicaid due to excess resources. An application must be completed to designate a Savings for Independence and Self-Sufficiency Account; [State Form 50929](#)—“M.E.D. Works Request for Independence and Self-Sufficiency Account”—is utilized. To receive approval for an account, the member must explain what the money will be used for and how it will improve the member’s independence or employability. Each request is reviewed based on the individual’s unique situation, and goods or services to be purchased must meet some of the following criteria:

- Savings will be used to buy something that is necessary for the individual to keep or increase employment
- Must explain what will be purchased with expected purchase date
- Goal must be achievable in reasonable time period
- Account cannot be used for personal recreation

Further information on the M.E.D. Works program can be found on the Indiana Medicaid website at <http://member.indianamedicaid.com/programs--benefits/medicaid-programs/med-works.aspx>.

## 6. 590 Program

The 590 Program provides coverage for healthcare services for residents of state-owned facilities. This includes facilities operated by the Family and Social Services Administration (FSSA), Division of Mental Health and Addiction (DMHA), and Indiana State Department of Health (ISDH). The 590 Program does

*not* cover incarcerated individuals residing in Department of Corrections (DOC) facilities. 590 Program enrollees are eligible for Package A benefits with the exception of transportation which is provided by the facility.

The 590 Program differs from traditional Medicaid and Hoosier Healthwise in the following ways:

- If a member enrolled in the 590 Program receives services that have a total billed amount per claim of less than \$150, the 590 Program facility where the member resides is responsible for payment of the service.
- Prior authorization (PA) is required for all services equal to or greater than \$500 per service per claim provided to members enrolled in the 590 Program.
- The 590 Program covers only services rendered outside the 590 program facility.
- Transportation is not a covered service. Transportation must be provided by the facility where the member resides.
- Identification cards are not issued to members enrolled in the 590 Program. An IHCP member who resides in a state-owned facility may have a Hoosier Health Card, but IHCP eligibility is terminated upon entry into the facility unless the member is younger than 21 years old or older than 65 years old.
- All providers must verify that the member enrolled in the 590 Program resides in a state-owned facility.
- All members enrolled in the 590 Program must be chaperoned to off-site providers.
- Individuals who are on probation or incarcerated are not eligible for the 590 Program.
- The 590 Program does not cover targeted case management (TCM) services.

Further information on the 590 Program can be found on the Indiana Medicaid website at <http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/590-program.aspx>.

## 7. Home and Community-Based Services (HCBS) Waivers

Home and Community-Based Services (HCBS) waivers are authorized under [Section 1915\(c\) of the Social Security Act](#) and are designed to provide an array of services to enrollees to prevent institutionalization. Prior to the development of HCBS, Medicaid only paid for long term care services that were provided in an institution. The waiver program “waives” the requirement of an admission to an institution in order for Medicaid to pay for the needed HCBS. Indiana offers the HCBS waivers as outlined in the following table (see [Table 23](#)):

**Table 23: Home and Community-Based Services (HCBS) Waivers**

Waiver	Eligibility Criteria
<b>*Aged &amp; Disabled (A&amp;D) Waiver or Traumatic Brain Injury (TBI) Waiver</b>	<ul style="list-style-type: none"> <li>Income: up to 300% of the maximum supplemental security income (SSI) federal benefit rate (1/1/16 limit: \$2,199 per month)</li> <li>Parental income and resources are disregarded for children under 18</li> <li>Complex medical condition which requires direct assistance for any of the following: <ul style="list-style-type: none"> <li>Decubitus ulcers, comatose condition or management of severe pain</li> <li>Medical equipment such as ventilator, suctioning, tube feeding central intravenous access</li> <li>Special routines or prescribed treatments such as tracheotomy, acute rehab conditions, administration of oxygen</li> <li>Other substantial medical conditions</li> <li>Diagnosis of traumatic brain injury (for TBI waiver)</li> </ul> </li> </ul>
<b>**Community Integration &amp; Habilitation (CIH) Waiver or Family Supports Waiver (FSW)</b>	<ul style="list-style-type: none"> <li>Income: up to 300% of the maximum SSI federal benefit rate (1/1/16 limit: \$2,199 per month)</li> <li>Parental income and resources are disregarded for children under 18 years old</li> <li>Diagnosis of intellectual disability that is attributable to: <ul style="list-style-type: none"> <li>Mental disability, autism, epilepsy, cerebral palsy or condition (other than mental illness) similar to mental disability that results in impairment of functioning similar to that of a person who is mentally disabled</li> <li>Originates before the person is 22 years old</li> <li>Has continued or is expected to continue indefinitely</li> <li>Constitutes substantial disability to person's ability to function normally in society due to substantial functional limit in three of six major life areas: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living</li> <li>Must result in requiring 24-hour supervision and requiring aggressive program of specialized and generic services planned and coordinated by an interdisciplinary team that's intended to promote greater self-determination and functional independence</li> </ul> </li> </ul>

\*These waivers are administered by the FSSA Division of Aging (DA). Further information on these programs is available on the DA website at [www.in.gov/fssa/da/3476.htm](http://www.in.gov/fssa/da/3476.htm).

\*\*These waivers are administered by the FSSA Division of Disability and Rehabilitative Services (DDRS). Further information on these programs is available on the DDRS website at [www.in.gov/fssa/ddrs/2639.htm](http://www.in.gov/fssa/ddrs/2639.htm).

Source: Family and Social Services Administration, *Indiana Client Eligibility System Program Policy Manual*, Chapter 3300, [www.in.gov/fssa/files/3300.pdf](http://www.in.gov/fssa/files/3300.pdf)

All HCBS waiver recipients must be eligible for Medicaid coverage under an Indiana Medicaid category. To qualify for Indiana Medicaid under the disability category, (MA-D), members must have a Social Security Administration (SSA) disability determination or a pending application for SSA benefits within 45 days of application to Indiana Medicaid (some members, such as children under the age of 18, are exempt from this requirement). Current waiver recipients under the disability category are exempt from this requirement until their next MRT scheduled progress report, at which time they will be required to submit an application to SSA for a disability determination. If this SSA application has not been

submitted within 45 days of the MRT progress report due date, the member will be rendered ineligible for Indiana Medicaid under the disability category.

To apply for the Aged and Disabled (A&D) Waiver or the Traumatic Brain Injury (TBI) Waiver, individuals can go to their local Area Agencies on Aging (AAA) or call 1-800-986-3505 for more information. The nearest AAA can be found at [www.iaaaa.org/icontent.asp?id=27](http://www.iaaaa.org/icontent.asp?id=27) or at [www.in.gov/fssa/da/3478.htm](http://www.in.gov/fssa/da/3478.htm).

To apply for the Community Integration & Habilitation (CIH) Waiver or Family Supports Waiver (FSW), individuals can go the local Bureau of Developmental Disabilities Services (BDDS) office or call 1-800-545-7763 for more information. The nearest BDDS office can be found on FSSA's website at [www.in.gov/fssa/ddrs/4088.htm](http://www.in.gov/fssa/ddrs/4088.htm).

There are currently waiting lists for two of the HCBS waivers—the FSW and the TBI Waiver. Individuals should keep their contact information current and report any changes while on the waiting list.

Individuals on waiting lists for a waiver administered by the Division of Aging (A&D or TBI waivers) may be eligible for other services and supports and can contact the AAA for more information. Families on waiting lists for a waiver administered by the Division of Disability and Rehabilitative Services (DDRS) (CIH Waiver or FSW) are eligible for some care giver support services such as respite. The local BDDS office can provide further information and a listing of service providers. Additionally, if a primary care giver of an individual on a waiting list has a serious illness or incapacity, emergency support services may be available.

Further information on HCBS waivers can be found on the Indiana Medicaid website at <http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/hcbs-waivers.aspx>.

#### ***a. Behavioral and Primary Healthcare Coordination Program***

The Behavioral and Primary Healthcare Coordination (BPHC) Program, authorized under [Section 1915\(i\) of the Social Security Act](#), offers access to Medicaid Rehabilitation Option (MRO) services for individuals with serious mental illness (SMI) whose income would otherwise be too high to qualify for Medicaid coverage. This program was created to fill a service gap for individuals with SMI needing assistance with coordination of primary and behavioral healthcare needs and navigating the healthcare system. An individual deemed eligible for BPHC will receive full Medicaid benefits. BPHC criteria are outlined in the following table (see [Table 24](#)):

**Table 24: Behavioral and Primary Healthcare Coordination Program Criteria**

Targeting Criteria	Needs-Based Criteria	Financial Eligibility
<ul style="list-style-type: none"> <li>• <b>Age 19+</b></li> <li>• <b>MRO-eligible primary mental health diagnosis (i.e., schizophrenia, bipolar disorder, major depressive disorder, psychotic disorder)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrated need related to management of behavioral and physical health</li> <li>• Demonstrated impairment of self-management of physical and behavioral health services</li> <li>• ANSA* Level of Need 3+</li> <li>• Demonstrated health need which requires assistance in coordinating behavioral and physical healthcare</li> </ul>	<ul style="list-style-type: none"> <li>• Income below 300% of the federal poverty level (FPL)</li> <li>• Single: \$2,970/month (2016)</li> <li>• Married: \$4,005/month (2016)</li> </ul>

\*Refers to a score on the Adult Needs and Strengths Assessment (ANSA), a behavioral health screening tool.

Sources: Family and Social Services Administration, [Behavioral and Primary Healthcare Program Overview Presentation for Providers](#), see [www.in.gov/fssa/ddrs/4862.htm](http://www.in.gov/fssa/ddrs/4862.htm); U.S. Department of Health and Human Services, [2016 Poverty Guidelines](#), <https://aspe.hhs.gov/poverty-guidelines>

Individuals may apply for the BPHC program through a Community Mental Health Center (CMHC) approved by the FSSA Division of Mental Health and Addiction (DMHA) as a BPHC provider. A list of CMHCs can be found on the Indiana Medicaid website at <http://provider.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx>. On this webpage, under “Provider,” select “Other” and “Mental Health Provider.” Then, select “Community Mental Health Center (CMHC)” under “Specialty.”

Further information on the BPHC Program is on FSSA’s website at [www.in.gov/fssa/ddrs/4862.htm](http://www.in.gov/fssa/ddrs/4862.htm).

## 8. Medicare Savings Program

The Medicare Savings Program helps low-income beneficiaries pay for Medicare—Part A (hospital insurance) and/or Part B (medical insurance)—costs. To be eligible, individuals must be entitled to Medicare Part A. There are four eligibility categories within the Medicare Savings Program as outlined in the following table (see [Table 25](#)):

**Table 25: Medicare Savings Program**

Program	*Minimum Income Threshold	*Resource Limit	Benefits
<b>Qualified Medicare Beneficiary (QMB)</b>	Single: \$1,505/month Married: \$2,023/month	Single: \$7,280 Married: \$10,930	Medicare Part A and B Premiums, Copayments, Deductibles & Coinsurance
<b>Specified Low Income Medicare Beneficiary (SLMB)</b>	Single: \$1,703/month Married: \$2,290/month	Single: \$7,280 Married: \$10,930	Part B Premiums
<b>Qualified Individual (QI)</b>	Single: \$1,852/month Married: \$2,490/month	Single: \$7,280 Married: \$10,930	Part B Premiums

\*Note: These minimum income and resource limits are guidelines only. Individuals may qualify with incomes or resources exceeding these limits. The only way to know for sure is to apply.

Source: Indiana Department of Insurance, [www.in.gov/idoi/2513.htm#2](http://www.in.gov/idoi/2513.htm#2)

To be eligible for the Qualified Disabled Worker (QDW) program, an individual must have lost premium free Medicare Part A coverage due to their working status.

Further information on the Medicare Savings Program can be found on the Medicare.gov website at <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html> and the Indiana Department of Insurance website at [www.in.gov/idoi/2513.htm](http://www.in.gov/idoi/2513.htm).

## 9. Family Planning Eligibility Program

The Family Planning Eligibility Program allows men and women to receive certain family planning services. Family planning services and supplies are provided to enrollees with the primary purpose of preventing or delaying pregnancy. Individuals have to specifically request to be considered for such coverage on the Indiana Application for Health Coverage (IAHC), if not eligible for full coverage Medicaid. Pregnant women who deliver or whose pregnancy ends are considered automatically eligible for the family planning after the post-partum period, if not eligible under another category.

To qualify for family planning, an enrollee must meet the following requirements:

- Does not qualify for any other category of Medicaid
- Must meet the citizenship or immigration status requirements (described further in the [Citizenship/Immigration Status section](#))
- Cannot be pregnant
- Cannot have had a hysterectomy or sterilization
- Have income at or below 141% FPL (\$1,396/month for an individual; \$1,883 for a couple (2016)).

The following services are covered by the Family Planning Eligibility Program:

- Annual family planning visits
- Pap smears
- Food and Drug Administration (FDA) approved oral contraceptives, devices and supplies, including emergency contraceptives

- Follow-up care for complications associated with contraceptive methods
- Initial diagnosis and treatment for sexually transmitted diseases (STDs) and Sexually Transmitted Infections (STIs), if medically indicated
- FDA approved anti-infective agents for initial treatment of STD/STI
- Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods
- Tubal ligation
- Hysteroscopic sterilization with an implant device
- Vasectomies

The following services are non-covered by the Family Planning Eligibility Program:

- Abortions
- Artificial insemination
- IVF (in vitro fertilization)
- Fertility counseling
- Fertility drugs
- Inpatient hospital stays
- Treatment for any chronic condition, including STDs or STIs beyond initial treatment
- Services unrelated to family planning (Note: this is not [MEC](#))

## 10. Breast and Cervical Cancer Program

Coverage under the Indiana Breast and Cervical Cancer Program (BCCP) provides Medicaid coverage to women diagnosed with breast and cervical cancer through the Indiana State Department of Health (ISDH) BCCP screening program.

Under the BCCP, uninsured or underinsured Indiana residents may qualify for free breast and cervical cancer screenings and diagnostic tests if they fall below 200% of the federal poverty level (FPL). To find a screening provider, women can call the family helpline number at 1-855-435-7178. Women qualify for the following screening services based on age (see [Table 26](#)):

**Table 26: Breast and Cervical Cancer Screening Program Services**

Age	Eligible Services
40-49	Free office visit and Pap test
50-64	Free office visit, Pap test, mammogram
65 and older	Free office visit, Pap test, mammogram only if not enrolled in Medicare

Source: Indiana State Department of Health, *For Patients*, [www.in.gov/isdh/19859.htm](http://www.in.gov/isdh/19859.htm).

When a woman is diagnosed with cancer through this program, she is eligible to receive Medicaid coverage for the duration of her cancer treatment. No additional income test is applied by Medicaid. The screening agency which discovered the cancer or precancerous condition will assist the woman in applying for Medicaid. Coverage remains active throughout the duration of her cancer treatment and terminates upon treatment completion.

Persons who have been diagnosed with breast or cervical cancer but were not screened through the ISDH BCCP can apply for Medicaid coverage under the Option 3 program by calling the family helpline number at 1-855-435-7178. To qualify, individuals must:

- Be over 18 and under 65 years of age
- Not be eligible for Medicaid under any other program
- Have no health insurance that covers their treatment
- Have income less than 200% FPL
- Be in need of treatment for breast or cervical cancer

Further information on the BCCP can be found on ISDH's website at [www.in.gov/isdh/24967.htm](http://www.in.gov/isdh/24967.htm).

## 11. Right Choices Program

The Right Choices Program (RCP) is designed to provide intense member education, care coordination, and utilization management to eligible Hoosier Healthwise, Hoosier Care Connect, Healthy Indiana Plan (HIP 2.0), and traditional Medicaid members identified as overusing or abusing services. Member utilization reviews identify who uses services more extensively than peers. The RCP member remains eligible to receive all medically necessary, covered services allowed by the Indiana Health Coverage Programs (IHCPs). However, services are reimbursed only when rendered by one of the RCP providers or when rendered by a specialist who has received a valid, written referral from the primary RCP physician.

RCP members are placed on the program initially for two years. At the end of the two years a utilization review is conducted to determine if RCP status should be extended. Individuals in the RCP are restricted to the following provider types:

- Hospitals
- Pharmacies
- Physicians

As appropriate for the individual case, a member may be restricted to additional provider types. The RCP is administered by the entity with whom the individual is enrolled (*e.g.*, a Hoosier Healthwise, HIP 2.0, or Hoosier Care Select managed care entity (MCE)).

Further information on the Right Choices Program can be found on the Indiana Medicaid website at [http://provider.indianamedicaid.com/general-provider-services/providing-services/right-choices-program-\(rcp\).aspx](http://provider.indianamedicaid.com/general-provider-services/providing-services/right-choices-program-(rcp).aspx).

## 12. End Stage Renal Disease Program

The End Stage Renal Disease (ESRD) program is a continuation of Medicaid coverage for individuals with ESRD who were at risk of losing access to kidney transplant services as a result of the end of the Medicaid Spend Down provision in 2014. Individuals eligible for continued coverage under this option must also:

- Be eligible for Medicare;
- Have income between 150% FPL and 300% FPL;
- Not be institutionalized;
- Be resource eligible based on standards in effect as of May 31, 2014 (\$1500 for an individual and \$2250 for a married couple); and

- Not be eligible for full benefits under another Medicaid coverage option.

Anyone newly diagnosed with ESRD should consult their transplant or dialysis provider about coverage options, or call the Indiana State Health Insurance Assistance Program (SHIP) at 1-800-452-4800.

Additional information on the ESRD program is available online at [www.in.gov/fssa/4898.htm](http://www.in.gov/fssa/4898.htm).

## E. Presumptive Eligibility

Presumptive eligibility (PE) allows individuals meeting the eligibility requirements described in this section to have services covered and paid for by Medicaid pending the outcome of a full Medicaid determination. Prior to January 1, 2014, Indiana only operated PE for pregnant women. Beginning in 2014, states were required to allow hospitals to make PE determinations for Medicaid, regardless of if the state opts to offer PE for other populations.

The PE application process entails a simplified application in which individuals attest to basic information such as self-declared income and basic demographic information. Verification documents are not required during the PE application process. Individuals must know their gross family income and citizenship status at the time of application for presumptive eligibility. The PE period extends from the date an individual is determined presumptively eligible until:

- When an [Indiana Application for Health Coverage](#) (IAHC) is filed: Day on which a decision is made on that application or the first of the month after the decision is made on the application, for example:
  - Denials – coverage ends the day the decision was made on the application
  - Approvals for non-HIP – the day the decision was made on the application
  - Approvals for HIP – 1<sup>st</sup> of the month after the decision was made on the application
- When an Indiana Health Coverage Application is not filed: Last day of the month following the month in which the PE determination was made

Individuals do not have appeal rights for PE determinations. If a PE individual is subsequently determined Medicaid ineligible after the IAHC is processed, the provider still receives reimbursement for the services provided during the PE period. The following table (see [Table 27](#)) and sections show the different PE programs in the state of Indiana:

**Table 27: Presumptive Eligibility (PE) Processes**

	Standard PE Process	PE for Pregnant Women Process	Hospital PE Process	PE for Inmates Process
<b>Aid Categories</b>	<ul style="list-style-type: none"> <li>• Infants</li> <li>• Children</li> <li>• Pregnant women</li> <li>• Adults 19-64</li> <li>• Parents/caretakers</li> <li>• Former foster care children</li> <li>• Individuals seeking family planning services</li> </ul>	Pregnant women only	<ul style="list-style-type: none"> <li>• Infants</li> <li>• Children</li> <li>• Pregnant women</li> <li>• Adults 19-64</li> <li>• Parents/caretakers</li> <li>• Former foster care children</li> <li>• Those seeking family planning services</li> </ul>	Inmates of a correction facility under MOU with FSSA, not under house arrest, not pregnant or in labor/delivery, admitted to inpatient hospitalization, under age 65
<b>Qualified Providers</b>	<ul style="list-style-type: none"> <li>• Federally Qualified Health Centers (FQHCs)</li> <li>• Rural Health Clinics (RHCs)</li> <li>• Community Mental Health Centers (CMHCs)</li> <li>• Local health departments</li> </ul>	<ul style="list-style-type: none"> <li>• Advanced practice nurse practitioners</li> <li>• Family/general practitioners</li> <li>• Nurse midwives</li> <li>• General internists</li> <li>• Obstetricians or gynecologists</li> <li>• General pediatricians</li> <li>• FQHCs</li> <li>• RHCs</li> <li>• Medical clinics</li> <li>• Family planning clinics</li> <li>• Local health departments</li> <li>• Hospitals*</li> </ul>	<ul style="list-style-type: none"> <li>• Acute care hospitals</li> <li>• Psychiatric hospitals</li> </ul>	Hospital PE qualified providers
<b>Enrollment Broker Requirement</b>	No requirement; however, PE adult (e.g., HIP PE or MAHA) may contact enrollment broker to change plans	The day a pregnant woman is found presumptively eligible, she must contact the enrollment broker, MAXIMUS, to select a primary medical provider (PMP) and managed care entity.	No requirement	No requirement
<b>Delivery System</b>	Fee-for-service (FFS), except PE adult (e.g., HIP PE or MAHA), which is managed care	Managed care	FFS except <a href="#">HPE Adult</a> , which is managed care	FFS

Source: Family and Social Services Administration, *Presumptive Eligibility*, <http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-%28pe%29.aspx>

## 1. Presumptive Eligibility for Pregnant Women – Qualified Providers

### *a. Presumptive Eligibility for Pregnant Women*

Presumptive eligibility (PE) for Pregnant Women provides time-limited coverage to pregnant women while her [Indiana Application for Health Coverage](#) (IAHC) is under review. This is to ensure timely access to critical prenatal care and services to improve birth outcomes. Presumptive Eligibility allows providers to be reimbursed for prenatal services earlier in a woman's pregnancy. Women eligible for PE for Pregnant Women have coverage for ambulatory prenatal services. The following services are *not* covered during the PE period:

- Inpatient care
- Hospice
- Long term care
- Labor and delivery services
- Postpartum services
- Other services unrelated to the pregnancy or birth
- Abortion services

In order to be eligible for PE for Pregnant Women, a woman must:

- Be pregnant
- Not be a current Medicaid member
- Be an Indiana resident
- Be a U.S. citizen or a qualified non-citizen including (see the [Citizenship/Immigration Status section](#) for further detail):
  - Lawful permanent resident immigrant living lawfully in U.S. for five years or longer
  - Refugee
  - Iraqi and Afghani special immigrants
  - Conditional entrant refugee
  - Individual granted asylum
  - Deportation withheld by order from an immigration judge
  - Amerasian from Vietnam
  - Veteran of U.S. Armed Forces with honorable discharge, active military service or spouse or children of individual who died during active military duty
  - Cuban and Haitian entrants
  - Parolees under Section 212(d)(5) who entered U.S. prior to 8/22/96
- Not currently incarcerated
- Have gross family income less than 208% FPL (refer to the [MAGI Conversion section](#) for additional detail on how income is calculated)

Women are only eligible for one PE period per pregnancy.

More information about PE for Pregnant Women is available on the Indiana Medicaid website at <http://member.indianamedicaid.com/programs--benefits/medicaid-programs/presumptive-eligibility.aspx>.

### ***b. Qualified Providers***

Qualified providers (QPs) make PE determinations in accordance with Indiana eligibility policy and procedures. QPs must meet the following criteria:

- Be enrolled as an Indiana Health Coverage Program (IHCP) provider
- Attend a provider training
- Provide outpatient hospital, rural health clinic or clinic services
- Be able to access HP Web interchange, internet, printer & fax machine
- Allow PE applicants to use an office phone to facilitate the PE and Hoosier Healthwise enrollment process

QPs may include the following provider types/specialties:

- Family or general practitioner
- Pediatrician
- Internist
- Obstetrician or gynecologist
- Certified nurse midwife
- Advanced practice nurse practitioner
- Federally-qualified health care center (FQHC)
- Medical clinic
- Rural health clinic
- Hospital
- Local health department
- Family planning clinic

Providers can enroll to become a QP through [Web interChange](#). Full instructions for completing the application to enroll as a QP, and other helpful provider reference materials, can be accessed on the Indiana Medicaid website at <http://provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx>. After completing the QP enrollment, the provider is notified by the State's designee within 10 days to schedule the mandatory provider training. Qualified Provider enrollment is activated following completion of the training.

Indiana Navigators may refer pregnant women who may be eligible for Medicaid to a QP to enroll and begin receiving services. Indiana Navigators and pregnant women can locate a QP by contacting the Hoosier Healthwise helpline at 1-800-889-9949 or via the Indiana Medicaid website at <http://provider.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx> by selecting "Show only Presumptive Eligibility Qualified Providers."

Additional information on PE for Pregnant Women may be found on the Indiana Medicaid website at [http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-\(pe\)/presumptive-eligibility-for-pregnant-women-\(pepw\).aspx](http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-(pe)/presumptive-eligibility-for-pregnant-women-(pepw).aspx).

## 2. Hospital Presumptive Eligibility – Qualified Hospitals

### *a. Hospital Presumptive Eligibility*

Effective January 1, 2014, all states are required to permit hospitals that meet state requirements to make presumptive eligibility (PE) determinations—referred to as Hospital Presumptive Eligibility (HPE). In Indiana, the eligibility groups or populations for which hospitals are permitted to determine HPE are:

- Low-income infants and children
- Low-income parents or caretakers
- Former foster care children up to the age of 26
- Low-income pregnant women
- Individuals seeking family planning services only
- Adults ages 19-64

Hospitals will not determine HPE for any other eligibility groups such as the aged, blind, disabled or the Children's Health Insurance Program (CHIP).

### *b. HPE Adult – Healthy Indiana Plan (HIP 2.0) Presumptive Eligibility*

Effective February 15, 2015, the Indiana Health Coverage Programs (IHCP) added a new HPE aid category for individuals found presumptively eligible for the [Healthy Indiana Plan \(HIP 2.0\)](#). The new aid category—HPE Adult—differs from prior HPE aid categories in the following ways:

- HPE Adult members will have [HIP Basic](#) plan coverage.
- HPE Adult members will have cost-sharing obligations.
- HPE Adult members will be served under the managed care delivery system and must be enrolled with an IHCP-contracted [managed care entity](#) (MCE).

Individuals are allowed one PE determination per rolling 12 months. To be eligible for HPE Adult, an individual must:

- Be a U.S. citizen or a qualified noncitizen;
- Be an Indiana resident;
- Not be currently incarcerated;
- Not be a current IHCP member;
- Not have Medicare coverage;
- Be a nondisabled adult age 19-64; and
- Have a family income of approximately 138% (which includes 5% income disregard) of the federal poverty level (FPL) or less for the applicable household size.

As with all HPE-eligible individuals, QPs must inform HPE Adult members that they must complete the [Indiana Application for Health Coverage](#) before the temporary eligibility period ends, as well as provide them with information about how to do so.

Additional information regarding HPE Adult may be found in the following IHCP bulletins:  
<http://provider.indianamedicaid.com/ihcp/Bulletins/BT201505.pdf>,

<http://provider.indianamedicaid.com/ihcp/Bulletins/BT201513.pdf>, and  
<http://provider.indianamedicaid.com/ihcp/Bulletins/BT201514.pdf>.

### *c. Qualified Hospitals*

To enroll as a qualified hospital eligible to make HPE determinations, the hospital must be an Indiana Health Coverage Program (IHCP) enrolled hospital which has amended their provider agreement to serve as a qualified hospital. Only acute care hospitals are eligible to enroll as qualified hospitals. The hospital must agree to make HPE determinations in accordance with state policies. Qualified hospitals will receive training on completion of the HPE application. Contracted staff may complete the HPE applications and make the HPE eligibility determination for the qualified hospital as long as the hospital is ultimately responsible for the determination. To be eligible, an acute care hospital must:

- Participate as a provider under the Indiana State Plan or under a demonstration program under Section 1115 of the Social Security Act
- Notify the FSSA of the hospital's intention to make HPE determinations
- Agree to make HPE determinations consistent with state policies and procedures
- Guide individuals in the process for completing and submitting the [Indiana Application for Health Coverage](#) (IAHC) paperwork to the FSSA
- Complete and submit the HPE QP eligibility attestations through the HPE enrollment process of Web Interchange.

More information on the HPE process is available on the Indiana Medicaid website at [http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-\(pe\)/hospital-presumptive-eligibility-\(hpe\).aspx](http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-(pe)/hospital-presumptive-eligibility-(hpe).aspx).

## **3. Presumptive Eligibility for Inmates**

Effective July 1, 2015, the Presumptive Eligibility (PE) for Inmates process allows Hospital Presumptive Eligibility (HPE) qualified providers (QPs) to enroll eligible inmates into an Indiana Health Coverage Program (IHCP) for temporary coverage of authorized inpatient hospitalization services. PE for Inmates is available to individuals who meet the following requirements. The individual must:

- Be an inmate from a correctional facility operating under the memorandum of understanding or contract with the Indiana Family and Social Services Administration (FSSA);
- Not be on house arrest;
- Not be pregnant or admitted for labor and delivery;
- Be admitted for inpatient hospitalization;
- Be under the age of 65; and
- Meet all other standard PE requirements.

Inmates who go through the PE process must complete an Indiana Application for Health Coverage (IAHC) to retain inpatient benefits. Individuals who complete applications and are found eligible will be covered for 12 months. During that time, if an inmate returns to the hospital for inpatient services, the hospital will continue to see the "600" PE code as the inmate's member identification number. The hospital can continue to submit claims using the 600 member ID. If the inmate does not complete an IAHC, the inmate's PE for Inmates coverage will end on the last day of the month following the month in which the inmate was found presumptively eligible, and application through the PE process will not be

available for one year. If the inmate remains incarcerated after one year, the inmate may reapply for coverage through the PE for Inmates process.

Services rendered to individuals covered under the PE for Inmates process will be reimbursed through the fee-for-service (FFS) delivery system at 130% of the FFS rates. Providers are reminded to always verify individuals' eligibility before rendering services. Eligibility can be verified by using Web interChange or through one of the following Eligibility Verification System (EVS) options: (a) Automated Voice Response System; or (b) Electronic Data Interchange (EDI) 270/271 - Eligibility Benefit Transaction.

Additional information regarding PE for Inmates is available on the Indiana Medicaid website at <http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-%28pe%29/presumptive-eligibility-for-inmates.aspx>.

## F. Indiana Medicaid Benefit Packages

Indiana Medicaid offers different benefit packages. Individuals are assigned a benefit package based on the Medicaid aid category for which they have been determined eligible. The benefit packages associated with the Hoosier Healthwise program are described in the following table (see [Table 28](#)):

**Table 28: Hoosier Healthwise Benefit Packages**

Benefit Package	Description
<i>Package A</i>	Standard - full Medicaid coverage for children, pregnant women, and families
<i>Package C</i>	Children's Health Insurance Program (CHIP) – preventive, primary and acute care services for qualified children under 19
<i>Package P</i>	Presumptive Eligibility (PE) for Pregnant Women – ambulatory prenatal coverage for pregnant women who are determined “presumptively eligible” while their Indiana Application for Health Coverage (IAHC) is being processed

Source: Family and Social Services Administration, *Hoosier Healthwise*, <http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/hoosier-healthwise.aspx>

The benefit packages associated with the traditional Medicaid Program are also described below (refer to [Table 29](#) and the [Traditional Medicaid section](#)). While individuals eligible for Package E may be enrolled in any category of assistance (aid category), they will be enrolled in the fee-for-service delivery system only. Additionally, Hoosier Care Connect enrollees are eligible for the Standard Plan, full Medicaid coverage.

**Table 29: Traditional Medicaid Benefit Packages**

Benefit Package	Description
<i>Standard Plan</i>	Full Medicaid Coverage
<i>Medicare Savings Program</i>	<p>Qualified Medicare Beneficiary (QMB): Medicare Part A &amp; B premiums, deductibles, copayments and coinsurance</p> <p>Specified Low Income Medicare Beneficiary (SLMB)/Qualified Individual (QI): Medicare Part B premiums</p> <p>Qualified Disabled Worker (QDW): Medicare Part A premiums</p>
<i>Package E</i>	Emergency Services Only: Coverage for treatment of serious medical emergencies. This package is for certain immigrants who do not qualify for full Medicaid coverage.
<i>Family Planning</i>	Family Planning Services Only

Source: Family and Social Services Administration, *Traditional Medicaid*, [http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/traditional-medicaid-\(fee-for-service\).aspx](http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/traditional-medicaid-(fee-for-service).aspx)

## G. Overview of Services Available under Medicaid, the Children's Health Insurance Program, and the Healthy Indiana Plan

### 1. Medicaid Covered Services

A detailed description of all Medicaid covered services and limitations is available in the Indiana Administrative Code at [405 IAC 5](#). Medicaid provides coverage for the following medical care:

- Hospital care
- Physician office visits
- Check-ups
- Well-child visits
- Clinic services
- Prescription drugs
- Over the counter drugs
- Lab & X-Rays
- Mental health care
- Substance abuse services
- Home health care
- Nursing facility services
- Dental
- Vision
- Therapies
- Hospice
- Transportation
- Family planning
- Foot care
- Chiropractors

## 2. Children's Health Insurance Program Covered Services

Children's Health Insurance Program (CHIP) services are described in full at [407 IAC 3](#). The number of allowable units for certain categories of service varies versus Medicaid. In general, CHIP provides coverage for the Medicaid covered services described above with the following exceptions:

- Nursing facility services are non-covered
- Hospice care is non-covered
- Transportation is limited to ambulance
- Routine foot care is not covered
- Private duty nursing is non-covered
- Organ transplants are non-covered
- Case management services for persons with HIV/AIDS and pregnant women is non-covered

## 3. Healthy Indiana Plan Covered Services

A complete list of Healthy Indiana Plan (HIP 2.0) covered services is available at [405 IAC 10](#). Services covered under the HIP Plus, HIP Basic and HIP State Plan plans include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity services
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive care services
- Early and periodic screening, diagnosis, and treatment services for members 19 and 20 years of age

Services that are **not** covered under the HIP Plus, HIP Basic, or HIP State Plan plans include services that are not medically necessary and any other services not approved by the Centers for Medicare and Medicaid Services (CMS). HIP Plus and HIP Basic do not cover non-emergency transportation services. Also, HIP Plus and HIP State Plan cover vision and dental services, while HIP Basic does not.

## H. General Medicaid Factors of Eligibility

Each Medicaid assistance (or aid) category (described in further detail in the [Eligibility Groups section](#)) has specific eligibility requirements such as age, income, pregnancy status and resource limits (resource limits apply to non-modified adjusted gross income (non-MAGI) populations only). In addition to these aid category specific requirements, to be eligible for Medicaid, an individual must meet the following general eligibility requirements described in the following sections.

This section is intended to provide a general overview of the eligibility requirements. Full descriptions for Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program

(SNAP), and Medicaid/Hoosier Healthwise can be found in the Program Policy Manual located on FSSA's website at [www.in.gov/fssa/dfr/3301.htm](http://www.in.gov/fssa/dfr/3301.htm).

## 1. Residency

To be eligible for Medicaid, an applicant must be a resident of the state of Indiana. For non-institutionalized individuals over the age of 21 and emancipated or married individuals under the age of 21, the state of residency is where the individual is living and intends to reside, including without a fixed address or has entered the state with a job commitment or seeking employment, whether or not currently employed. Homeless individuals and residents of shelters located in Indiana meet the residency requirement. For non-institutionalized individuals not capable of stating intent and individuals under 21, the state of residency is where the individual is living.

An individual is considered incapable of stating intent if any of the following applies:

- Has an intelligence quotient (I.Q.) of 49 or less, or a mental age of seven or less
- Is judged legally incompetent; or
- Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of mental retardation

Prior to 2014, federal regulations included in the definition of state residency the individual's intention to remain in the state permanently or for an indefinite time period. This requirement no longer applies effective January 1, 2014.

For institutionalized individuals, the following residency rules apply:

- For individuals under the age of 21
  - Parent's (or guardian's) state of residence at the time of institutional placement
  - Current state of residence of parent, guardian or person who files application for child if the child is institutionalized in that state
- For individuals ages 21 and over
  - The state where the individual is living and intends to reside
  - If the individual became incapable of indicating intent at or after age 21, the state in which the individual is physically present (except when another state makes an Indiana placement)
- For individuals who became incapable of indicating intent before age 21
  - Parent's (or guardian's) state if they live in a separate state
  - Parent's (or guardian's) state at time of institutional placement
  - Current state of residence of parent, guardian or person who files application for individual if the individual is institutionalized in that state

Residency will be determined based upon the address provided on the [Indiana Application for Health Coverage](#) (IAHC) and electronic data sources. When electronic data sources indicate potential residency in another state, paper documentation verifying residency is requested (see [Verifying Factors of Eligibility section](#) for additional information). There is not a required minimum time period for state residency to be Medicaid eligible and individuals are permitted to be temporarily absent from the state without losing eligibility.

## 2. Citizenship/Immigration Status

To be eligible for Medicaid, an individual must be a U.S. citizen or a U.S. non-citizen national or an immigrant who is in a qualified immigration status. The individual attests to citizenship/immigration status on the [Indiana Application for Health Coverage](#). Electronic data sources through the Federal Hub are reviewed and if the individual's status is not verified electronically, paper documentation is required (see the [Verifying Factors of Eligibility section](#) for additional information).

**IMPORTANT NOTE:** Indiana Navigators should always confirm whether or not a consumer is a U.S. citizen in order to answer the U.S.-citizen question correctly on the Indiana Application for Health Coverage and provide any supporting documentation (if applicable). Navigators must never state that a non-citizen is a citizen, or vice-versa. Also, a permanent resident may be considered a citizen if he or she has been in the U.S. for at least five years.

During the time period when the discrepancy is being resolved (except in cases where the individual attested to citizenship/eligible immigration status and the electronic data sources indicate non-citizenship/non-eligible immigration status), if an individual otherwise meets the eligibility requirements, the individual is provided Medicaid benefits in accordance with federal regulations. This is referred to as the "reasonable opportunity period." The reasonable opportunity period begins on the date the individual receives the written notice regarding the agency's inability to verify citizenship or immigration. Date of receipt is considered to be five days after the date on the notice. The reasonable opportunity period ends 90 days from the date of receipt (*i.e.*, 95 days from the date on the notice).

The following individuals are exempt from the citizenship verification process:

- Individuals receiving Social Security Income (SSI) or Social Security Disability Income (SSDI)
- Individuals enrolled in Medicare
- Individuals in foster care and who are assisted under [Title IV-B of the Social Security Act \(SSA\)](#) and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under [Title IV-E of the SSA](#)
- Newborns born to a Medicaid enrolled mother (*i.e.*, deemed newborns)

Individuals who are not citizens of the U.S. may qualify for Medicaid based on their immigration status. The following statuses are eligible (see [Table 30](#)):

**Table 30: Medicaid-Eligible Immigration Statuses**

Status	Description
<i>Lawful Permanent Resident under the Immigration and Naturalization Act (INA)</i>	<ul style="list-style-type: none"> <li>Eligible for full Medicaid if residing in U.S. prior to 8/22/96</li> <li>If entered U.S. on or after 8/22/96 eligible for Package E only (emergency Medicaid) for five years <ul style="list-style-type: none"> <li>Unless they are honorably discharged veteran or in active military duty or are spouses or children of veterans or military personnel who die during active military duty</li> <li>Eligible for full Medicaid after five years</li> </ul> </li> </ul>
<i>Refugees under Section 207 of the INA or Iraqi &amp; Afghani Special Immigrants under Section 101(a)(27) of the INA</i>	<ul style="list-style-type: none"> <li>Eligible for full Medicaid</li> </ul>
<i>Conditional entrants under Section 203(a)(7) of the INA in effect prior to April 1, 1980</i>	<ul style="list-style-type: none"> <li>Eligible for full Medicaid</li> </ul>
<i>Parolees under Section 212(d)(5)</i>	<ul style="list-style-type: none"> <li>Individuals granted this status for at least one year and who entered the U.S. prior to 8/22/96 are eligible for full Medicaid</li> <li>If entered U.S. on or after 8/22/96 eligible for Package E only (emergency Medicaid) <ul style="list-style-type: none"> <li>Unless they are honorably discharged veteran or in active military duty</li> </ul> </li> </ul>
<i>Asylees under Section 208 of the INA</i>	<ul style="list-style-type: none"> <li>Eligible for full Medicaid</li> </ul>
<i>Persons whose deportation is withheld under Section 243(h) of the INA</i>	<ul style="list-style-type: none"> <li>Eligible for full Medicaid</li> </ul>
<i>Amerasians admitted pursuant to Section 584 of P.L. 100-202 and amended by P.L. 100-461</i>	<ul style="list-style-type: none"> <li>Eligible for full Medicaid</li> </ul>
<i>Cuban and Haitian entrants</i>	<ul style="list-style-type: none"> <li>Eligible for full Medicaid</li> </ul>
<i>Other immigrants, visitor and non-immigrants</i>	<ul style="list-style-type: none"> <li>Eligible for emergency Medicaid only</li> </ul>

Sources: [42 CFR §435.406](#); Family and Social Services Administration, *Indiana Client Eligibility System Program Policy Manual*, Chapter 2400, [www.in.gov/fssa/files/2400.pdf](http://www.in.gov/fssa/files/2400.pdf)

### 3. Requirement to Provide a Social Security Number

Each Medicaid applicant must supply a social security number (SSN) on the [Indiana Application for Health Coverage](#) (IAHC) with the following exceptions:

- Individual is not eligible to receive a SSN
- Individual does not have a SSN and may only be issued one for a valid non-work reason
- Individual refuses to obtain one due to well-established religious objections
- Individual is only eligible for emergency services due to immigration status
- Individual is a deemed newborn

- Individual is receiving Refugee Cash Assistance and is eligible for Medicaid
- Individual has already applied for SSN

If necessary, the state Division of Family Resources (DFR) will assist the applicant in obtaining a social security number. The DFR will also request the SSN of other household members whose income is counted in the eligibility determination. However, these individuals are not required to provide.

#### **4. Requirement to File for Other Benefits**

Individuals must apply for all other benefits for which they may be eligible as a condition of eligibility, unless good cause can be shown for not doing so. Benefits that must be applied for include, but are not limited to:

- Pensions from local, state, or federal government
- Retirement benefits
- Disability
- Social Security benefits
- Veterans' benefits
- Unemployment compensation benefits
- Military benefits
- Railroad retirement benefits
- Workmen's Compensation benefits
- Health and accident insurance payments

### **I. Assignment of Medical Rights**

Medicaid applicants must cooperate in identifying and providing information about responsible third parties who may be financially liable for care and services unless good cause is established for not providing such information. This includes cooperating in establishing paternity and obtaining medical support and payments from the absent parent.

Any circumstances in which cooperation would result in serious physical or emotional harm to the individual or is against the best interests of the child for whom medical support is sought or paternity is being established is considered good cause. As of July 1, 2011, in support of [P.L. 153-2011](#), the assignment of medical rights became operational by state law. This means that no separately executed assignment of rights is required for Medicaid eligibility.

### **J. Access to Other Insurance**

Individuals can have other insurance (often referred to as “third liability”) and be enrolled in Medicaid. However, individuals cannot have other insurance and enroll in the Children’s Health Insurance Program (CHIP) or Healthy Indiana Plan (HIP 2.0).

Individuals are required to provide information on their application regarding any other insurance they have. Pursuant to state and federal law, Medicaid is the payer of last resort. Therefore, if a Medicaid enrolled individual has third party liability, the other insurance serves as the primary payer. Medicaid is responsible for the payment of the member’s coinsurance, deductibles, copayments and other cost-

sharing expenses up to Medicaid's allowed amount. Medicaid's total liability must not exceed the state's allowed amount minus the amount paid by the primary payer.

Medicaid recipients are responsible for reporting all changes in insurance to the Division of Family Resources (DFR) via a phone call to 1-800-403-0864, by mail to the FSSA Document Center (P.O. Box 1810, Marion, IN 46952), online through the [FSSA Benefits Portal](http://www.dfrbenefits.in.gov) or at a local office (listed at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)).

## **K. Eligibility Determination and Enrollment Standard Changes under the Affordable Care Act**

Beginning in 2014, the Affordable Care Act (ACA) implemented changes in how Medicaid eligibility is determined. Income eligibility determination for children, pregnant women, non-disabled adults under the age of 65, and parents and caretaker relatives was replaced by a methodology referred to as modified adjusted gross income (MAGI). Former financial methodologies remain in place for individuals who are exempt from MAGI. Additional changes included a new application, referred to as the Indiana Application for Health Coverage (IAHC),<sup>37</sup> methods under which applications will be accepted, verification policies, and redetermination standards.

### **1. Medicaid Modified Adjusted Gross Income Methodologies**

Modified adjusted gross income (MAGI) methodologies were implemented for eligibility effective January 1, 2014. In accordance with federal regulations, states have begun utilizing MAGI methodologies since the initial [Federally-facilitated Marketplace \(FFM\)](#) open enrollment period, which began on October 1, 2013.

Individuals who are found potentially eligible for premium tax credits (PTCs) and cost-sharing reductions (CSRs) will have their IAHC and electronic account transferred to the FFM for final determination of eligibility for those programs, if the Medicaid denial was based on income ineligibility versus procedural reasons (*e.g.*, failure to submit required information or withdrawal of application). MAGI methodologies will be used for determining Medicaid eligibility for parent and caretaker relatives, children and pregnant women. MAGI methodologies also apply to CHIP and HIP 2.0. Indiana's eligibility categories which will be determined based on MAGI are outlined in further detail in the [Eligibility Groups section](#).

MAGI is a methodology based on federal tax rules for income counting and determining household size and composition for the purposes of determining whose income will be counted in an individual's Medicaid or CHIP eligibility determination. While based on tax rules, MAGI is not simply a number found on an individual's tax return. MAGI household income is the sum of the MAGI-based income (defined in the figure below) of every individual included in the individual's household. If an individual is found ineligible, a 5% FPL disregard is then applied to determine if the application of this disregard renders the individual eligible.

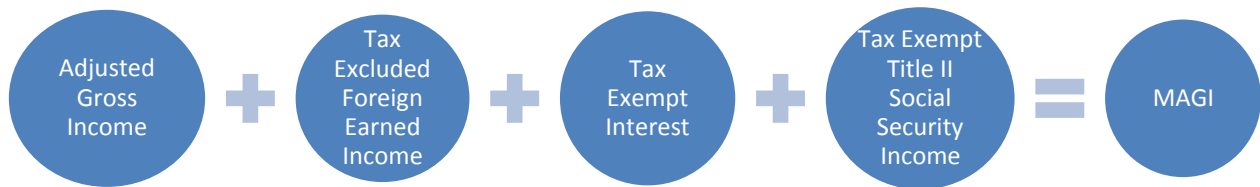
Under MAGI there is no asset test. Income disregards as they are applied today are no longer implemented. Deductions that can be filed on taxes such as alimony paid and student loan interest are deducted from countable income. Generally, taxable income is counted for Medicaid & CHIP eligibility

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<sup>37</sup> The Indiana Application for Health Coverage (IAHC) may be accessed online by going to [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov), selecting "Apply for benefits online," then selecting "Apply for Health Coverage . . ."

and non-taxable income is not counted under MAGI. Modified adjusted gross income is calculated as follows (see [Figure 2](#)):

**Figure 2: Modified Adjusted Gross Income (MAGI) Calculation**



Source: [26 CFR §1.36B-1](#)

While tax return data will not be used in Indiana to calculate MAGI (with the exception of self-employed individuals who will be required to provide a tax return or current business records), adjusted gross income referred to in the figure above is calculated based on the tax rules that generate Adjusted Gross Income on an individual's tax return (Line 37 on U.S. Individual Income Tax Return - Form 1040). MAGI income counting methodologies for Medicaid are generally aligned with Premium Tax Credit (PTC) income counting rules, with the following exceptions:

- Lump sum payments are counted as income only in the month received
- Scholarships, awards or fellowships used for educational purposes and not for living expenses are excluded
- Payments or distributions related to American Indian/Alaska Native designation are excluded

In determining household size and composition under Medicaid MAGI rules, for a tax filer, the individual's household includes the tax filer and all tax dependents. A tax dependent's household is the same as that of the tax filer that claims the dependant. If an individual is not a tax filer or is claimed as a dependent but:

- Is other than a spouse, biological, adopted or step child of the tax filer
- Is under 19 and living with both parents who do not file a joint return
- Is under 19 and claimed as a tax dependent by a non-custodial parent
  - Custodial parent is determined based on a court order or binding separation, divorce or custody agreement establishing physical custody controls. If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

Then the household size consists of the individual and the following other individuals with whom the individual lives:

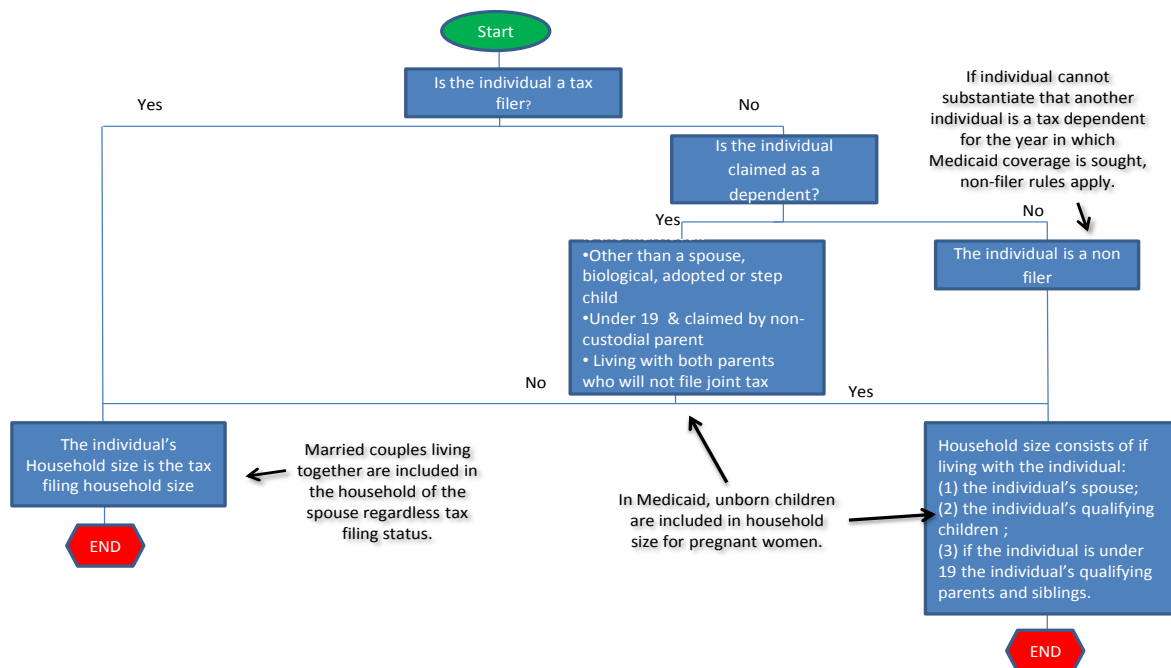
- The individual's spouse
- The individual's biological, adopted or step-children under 19
- If the individual is under 19 - the individual's parents and siblings under 19 (including biological, adopted and step)

Married couples living together are included in the same household regardless of tax filing status (*i.e.*, regardless of if a joint tax return is filed or one spouse is claimed as a dependent).

A child's income is not counted when the child lives with a natural, adopted, or step parent and is not expected to be required to file a tax return. A tax dependent that is not expected to file a tax return for the year in which eligibility is being determined is not included in the household income of the taxpayer whether or not such a tax dependent files a return. For a pregnant woman under MAGI rules, her unborn child(ren) is counted in determining her household size for Medicaid eligibility. In determining the household size for other household members' eligibility, the unborn child(ren) is not counted.

The figure below illustrates the household composition rules under MAGI (see [Figure 3](#)).

**Figure 3: Calculating Household Size Using Modified Adjusted Gross Income (MAGI)**



Source: [42 CFR §435.603](#)

Under MAGI, the budget period for Medicaid remains current monthly income versus projected annual income as used for premium tax credit. That is, Medicaid eligibility is determined based on current monthly income and family size.

**Table 31: How Modified Adjusted Gross Income (MAGI) Differs from Former Methodologies**

Topic	Pre-MAGI (Prior to 2014)	MAGI (2014—)
<b>Assets</b>	Asset limits are applied to certain categories of children, pregnant women and families	Asset tests no longer applied – no asset limit for MAGI
<b>Income Counting</b>	<p>Countable income generally includes:</p> <ul style="list-style-type: none"> <li>• Earned income: <ul style="list-style-type: none"> <li>○ Wages, salaries, commissions</li> <li>○ In-kind earnings, <i>e.g.</i> goods or services in lieu of wages</li> </ul> </li> <li>• Unearned income: <ul style="list-style-type: none"> <li>○ Retirement</li> <li>○ Disability payments</li> <li>○ Unemployment and worker's compensation</li> <li>○ Annuities, pensions and other regular payments</li> <li>○ Alimony and child support</li> <li>○ Dividends, interest and royalties</li> <li>○ Life insurance proceeds (when paid in installments)</li> <li>○ Winnings, prizes and awards</li> <li>○ Gifts and inheritances</li> <li>○ Benefits administered through the Social Security Administration (SSA)</li> </ul> </li> </ul>	<p>Taxable income is generally counted as income and non-taxable income is excluded. The following are key changes:</p> <ul style="list-style-type: none"> <li>• Child support received is no longer counted as income</li> <li>• Veterans benefits no longer counted as income</li> <li>• Worker's compensation no longer counted as income</li> <li>• Self-employment and farm income after depreciation and deduction of capital losses is counted</li> </ul>
<b>Income Disregards</b>	The state disregards (or does not count) certain types of income. Disregards vary somewhat by eligibility category but examples include a \$50 disregard of monthly child support and disregard of expenses for dependent's care.	Income disregards no longer applied (were considered in MAGI conversion). General 5% FPL disregard applied when consumer ineligible. Expenses that are tax deductible are deducted from income.
<b>Household Composition Rules</b>	<p>Household composition rules vary somewhat by eligibility category but the following generally applies:</p> <ul style="list-style-type: none"> <li>• Stepparents and stepsiblings are excluded</li> <li>• Children's income counted for parents'/ siblings' household income and family size, but if this causes ineligibility of family, a second step is performed for individual determinations to ensure eligibility is not caused by children/sibling income</li> <li>• Adult children not included in household</li> </ul>	<ul style="list-style-type: none"> <li>• Stepparents, stepchildren and stepsiblings are now included in the household</li> <li>• The income of children &amp; siblings who are required to file a tax return is counted</li> <li>• Adult children claimed as a tax dependent are now included in the household of the tax filer</li> </ul>

Source: [42 CFR §435.603](#)

### *a. MAGI Conversion Process*

As part of the transition to MAGI-based methodologies in 2014, states were required to convert income eligibility standards to a MAGI equivalent. This is referred to as the MAGI conversion process. The goal of the MAGI conversion process is to establish a MAGI-based income standard that is not less than the effective income eligibility standard for each eligibility group as applied on the date of the Affordable Care Act (ACA) enactment. As a result of this process, the income standard for some eligibility groups have changed effective January 1, 2014.

Under pre-MAGI rules, the state applied various income disregards to a Medicaid applicant's gross income. Income disregards varied somewhat by eligibility group and income type. Examples of income disregards applied by Indiana pre-MAGI include a \$90 earned income disregard, \$50 disregard of monthly child support income received and disregards for expenses for dependent's care. Under pre-MAGI rules these income disregards were deducted from an individual's or family's gross income to determine the net income. If the individual's resulting net income was below the income standard for the applicable eligibility group, the individual was found Medicaid eligible.

As described previously, under MAGI rules, income disregards will no longer be allowed with the exception of a general 5% FPL deduction in certain cases and the application of deductions that can be filed on taxes. Therefore, the MAGI conversion process is intended to determine a MAGI-based income eligibility standard for each MAGI-based eligibility group that is equivalent to the income standard for each eligibility group under pre-MAGI rules.

To calculate the MAGI equivalent for each eligibility group, the federal government implemented a standardized MAGI conversion methodology. Under this standardized methodology, an average disregard amount was calculated for each eligibility group and added to the pre-MAGI income threshold to determine the MAGI equivalent standard. Following is a high level overview of the standardized MAGI conversion process:

1. Calculate the average size of the disregards for individuals whose net income falls within 25% of the FPL below the net income standard
2. Add this average disregard amount to the net income eligibility standard
3. Step 1 + Step 2 = MAGI eligibility standard for the eligibility group

The following table (see [Table 32](#)) outlines the income standards for Indiana's eligibility groups that will utilize the MAGI equivalent income threshold. Because CHIP eligibility prior to 2014 was based on gross income, a MAGI equivalent calculation was not required and the income standard will remain at 250% of the federal poverty level.

**Table 32: Indiana's Modified Adjusted Gross Income (MAGI) Equivalent Thresholds**

Eligibility Group	Pre-2014 Income Standard		MAGI Equivalent Standard	
<b>Parents and Caretaker Relatives*</b> & <b>19-21 Residing in Inpatient Psych Facility Eligible for TANF if Living at Home</b> & <b>Children Aged 19-20 Who Meet Low Income Families Medicaid Income Standard</b>	<b>Family Size</b>	<b>Monthly Income</b>	<b>Family Size</b>	<b>Monthly Income</b>
	<b>1</b>	\$139.50	<b>1</b>	\$152.00
	<b>2</b>	\$229.50	<b>2</b>	\$247.00
	<b>3</b>	\$288.00	<b>3</b>	\$310.00
	<b>4</b>	\$346.50	<b>4</b>	\$373.00
	<b>5</b>	\$405.00	<b>5</b>	\$435.00
	<b>6</b>	\$463.50	<b>6</b>	\$498.00
	<b>7</b>	\$522.00	<b>7</b>	\$561.00
	For each additional family member add \$58.50		For each additional family member add \$63.00	
<b>Pregnant Women</b>	200% FPL		208% FPL	
<b>Children under Age 1: Medicaid Coverage</b>	200% FPL		208% FPL	
<b>Children Ages 1-18: Medicaid Coverage</b>	150% FPL		158% FPL	
<b>Independent Foster Care Adolescents</b>	200% FPL		210% FPL	
<b>Family Planning Services</b>	133% FPL		141% FPL	

\*These are now covered under HIP 2.0.

Source: Family and Social Services Administration, *Modified Adjusted Gross Income (MAGI) Conversion Plan* (2013), <https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-and-the-marketplace/downloads/indiana-magi-conversion-plan-template.pdf>

In sum, due to the MAGI conversion process, the income standard for some groups appears higher than the pre-2014 income standard for Medicaid eligibility. However, because income disregards were previously applied when determining an individual's eligibility, effectively increasing the income standard for eligibility, at the aggregate level these income standards should be comparable.

### **b. Non-MAGI Populations**

Certain populations are exempt from MAGI methodologies and former Medicaid eligibility rules will continue to apply. These exempted populations include:

- Individuals aged 65 or older when age is a condition of eligibility
- Individuals being determined for eligibility on the basis of blindness or disability
- Individuals applying for long-term services and supports for which a level-of-care (LOC) need is a condition of eligibility (e.g., Home and Community-Based Services (HCBS) waivers, nursing home LOC)
- Individuals whose eligibility does not require an income determination to be made by the Medicaid agency (e.g., coverage under the Breast & Cervical Cancer Treatment Program)
- Individuals applying for Medicare cost-sharing (Medicare Savings Program)
- New mandatory former foster children under age 26

- Deemed newborns

The income counting and household compositions rules for determining eligibility for MAGI exempt categories remain the policies in place today. Asset (also referred to as resource) limits and income disregards can be applied to non-MAGI groups. Resources are real or personal property that is owned jointly or by an individual. The owner of a resource is any individual who has the ability to liquidate or dispose of the resource. Resources include, but are not limited to:

- Cash on hand
- Checking accounts
- Savings accounts
- Savings certificates
- Trust funds
- Individual retirement accounts
- Keogh plans
- Credit union accounts
- Burial accounts
- Prepaid funeral agreements
- Stocks
- Bonds
- Nursing home accounts

Some items are not counted as assets, including:

- An individual's home (refers to homestead property as unoccupied or rental properties are counted as an asset)
- A vehicle if it is used for transportation for the individual or a member of their household;
- Household goods such as furniture and appliances
- Personal items such as jewelry or clothes
- Burial plots, irrevocable funeral trusts and term life insurance

Eligibility determination for a non-MAGI category can be triggered through multiple methods. An individual applying through the [Federally-facilitated Marketplace \(FFM\)](#) or the state [Division of Family Resources \(DFR\)](#) may request a determination for a non-MAGI category during the course of the MAGI determination process. Additionally, the Indiana Application for Health Coverage includes screening questions to capture potential eligibility for non-MAGI Medicaid. Answering in the affirmative to any of the disability or long-term care related questions will trigger review for potential eligibility for a non-MAGI group.

An applicant is not obligated to go through the non-MAGI determination process; if the individual is satisfied with MAGI-based coverage the individual may stay enrolled in that manner. If applicable, the FFM transfers the electronic accounts of individuals potentially eligible for Medicaid on the basis of non-MAGI to DFR for determination. An individual can be enrolled in a MAGI Medicaid category or receive a qualified health plan (QHP) while a non-MAGI determination is pending. If the individual has gone through the non-MAGI determination and is determined eligible for a non-MAGI category, eligibility in the MAGI category is ended (if applicable) and the individual is transitioned to the non-MAGI category.

The individual does have the choice regarding which category for which the individual wishes to be considered.

## L. Eligibility Groups

The Affordable Care Act (ACA) and associated regulations implemented changes related to Medicaid eligibility groups. These changes include the following, all effective January 1, 2014:

- The mandatory coverage of individuals under age 26 who were in foster care and receiving Medicaid in the state upon aging out of the foster care system ([42 CFR 435.145](#)). States are required to provide coverage to this group without regard to the individual's income.
- The mandatory coverage of children ages 6-18 in Medicaid up to 133% of the federal poverty level (FPL) versus 100% FPL. This will not impact Indiana as the state already provided coverage to children in this age and income range in the Medicaid versus separate CHIP program.

Additionally, federal regulations consolidated multiple mandatory and optional eligibility groups into the new overarching categories listed below.

- Infants and children under age 19 ([42 CFR 435.118](#))
- Pregnant women ([42 CFR 435.116](#))
- Parents and other caretaker relatives ([42 CFR 435.110](#))

This regulatory consolidation will collapse certain pre-2014 aid categories. This will not result in coverage changes or impact beneficiaries though they may see a change in the name of their aid category. The following table (see [Table 33](#)) outlines Indiana Medicaid's eligibility groups and the associated program. Specific information on eligibility criteria for the different populations is described in further detail in subsequent sections and may also be accessed through the Medicaid Eligibility Policy Manual located online at [www.in.gov/fssa/ompp/4904.htm](http://www.in.gov/fssa/ompp/4904.htm).

**Table 33: Medicaid Eligibility Groups and Program Enrollment (cont. to following pages)**

Eligibility Group	Income Standard and Other Eligibility Requirements	Program Enrollment
<i>Children under 19 – Medicaid</i>	<ul style="list-style-type: none"> <li>• Age 0-1: ≤208% FPL</li> <li>• Age 1-5: 141-158% FPL</li> <li>• Age 6-18: 106-158% FPL</li> </ul>	Hoosier Healthwise
<i>Children under 19 – CHIP</i>	<ul style="list-style-type: none"> <li>• Age: 1-18</li> <li>• 158% &gt;250% FPL</li> </ul>	Hoosier Healthwise
<i>Children under 19 with Adoption Assistance</i>	<ul style="list-style-type: none"> <li>• Automatic eligibility adoption assistance recipients</li> </ul>	Traditional Medicaid (Fee-for-Service)
<i>Foster Children</i>	<ul style="list-style-type: none"> <li>• Automatic coverage for foster children up to age 26 who were enrolled in Indiana Medicaid on their 18<sup>th</sup> birthday</li> </ul>	Traditional Medicaid (Fee-for-Service)
<i>Former Foster Children to Age 26</i>	<ul style="list-style-type: none"> <li>• Former foster children enrolled in Indiana Medicaid as of 18<sup>th</sup> birthday</li> <li>• No income standard</li> <li>• Age: 18-26</li> </ul>	Traditional Medicaid (Fee-for-Service)
<i>Low-Income Parent</i>	<ul style="list-style-type: none"> <li>• MAGI equivalent of pre-2014 income standard</li> </ul>	Healthy Indiana Plan

Eligibility Group	Income Standard and Other Eligibility Requirements	Program Enrollment												
<i>Caretakers</i>	<ul style="list-style-type: none"><li>See <a href="#">Table 38</a> for income threshold by family size</li></ul>	(HIP 2.0)												
<i>Pregnant Women</i>	<ul style="list-style-type: none"><li>Pregnant</li><li>≤208% FPL</li></ul>	Hoosier Healthwise												
<i>Family Planning</i>	<ul style="list-style-type: none"><li>≤141% FPL</li><li>Do not qualify for any other Medicaid category</li></ul>	Traditional Medicaid (Fee-for-Service)												
<i>Aged</i>	<ul style="list-style-type: none"><li>Age: 65 and older</li></ul> <table><tr><th colspan="2">Income Limits</th></tr><tr><td>Unmarried or married and not living with spouse</td><td>\$990</td></tr><tr><td>Married</td><td>\$1,335</td></tr><tr><th colspan="2">Resource Limits</th></tr><tr><td>Unmarried, separated or community spouse</td><td>\$2,000</td></tr><tr><td>Married &amp; living together or separated only for medical reasons</td><td>\$3,000</td></tr></table>	Income Limits		Unmarried or married and not living with spouse	\$990	Married	\$1,335	Resource Limits		Unmarried, separated or community spouse	\$2,000	Married & living together or separated only for medical reasons	\$3,000	Traditional Medicaid (Fee-for-Service)
Income Limits														
Unmarried or married and not living with spouse	\$990													
Married	\$1,335													
Resource Limits														
Unmarried, separated or community spouse	\$2,000													
Married & living together or separated only for medical reasons	\$3,000													
<i>Blind</i>	<ul style="list-style-type: none"><li>Has received a disability determination from the Social Security Administration (SSA) related to blindness, or has received an Indiana Medical Review Team determination of blindness <i>and</i> has filed an application for SSA benefits a maximum of 45 days after applying for Indiana Medicaid</li></ul> <table><tr><th colspan="2">Income Limits</th></tr><tr><td>Unmarried or married and not living with spouse or one parent of child applicant</td><td>\$990</td></tr><tr><td>Married or two parents of child applicant</td><td>\$1,335</td></tr><tr><th colspan="2">Resource Limits</th></tr><tr><td>Unmarried, separated or community spouse, or unmarried or separated parent of child applicant</td><td>\$2,000</td></tr><tr><td>Married and living together or separated only for medical reasons or parents of child applicant living together</td><td>\$3,000</td></tr></table>	Income Limits		Unmarried or married and not living with spouse or one parent of child applicant	\$990	Married or two parents of child applicant	\$1,335	Resource Limits		Unmarried, separated or community spouse, or unmarried or separated parent of child applicant	\$2,000	Married and living together or separated only for medical reasons or parents of child applicant living together	\$3,000	Traditional Medicaid (Fee-for-Service)
Income Limits														
Unmarried or married and not living with spouse or one parent of child applicant	\$990													
Married or two parents of child applicant	\$1,335													
Resource Limits														
Unmarried, separated or community spouse, or unmarried or separated parent of child applicant	\$2,000													
Married and living together or separated only for medical reasons or parents of child applicant living together	\$3,000													
<i>Disabled</i>	<ul style="list-style-type: none"><li>Has received a disability determination from the Social Security Administration (SSA) , or</li><li>Has received an Indiana Medical Review Team determination of blindness <i>and</i> has filed an application for SSA benefits a maximum of 45 days after applying for Indiana Medicaid</li></ul> <table><tr><th colspan="2">Income Limits</th></tr></table>	Income Limits		Traditional Medicaid (Fee-for-Service)										
Income Limits														

Eligibility Group	Income Standard and Other Eligibility Requirements		Program Enrollment
	Unmarried or married and not living with spouse or one parent of child applicant	\$990	
	Married or two parents of child applicant	\$1,335	
	Resource Limits		
	Unmarried, separated or community spouse, or unmarried or separated parent of child applicant	\$2,000	
	Married and living together or separated only for medical reasons or parents of child applicant living together	\$3,000	
M.E.D. Works	<ul style="list-style-type: none"><li>Ages 16-64, disabled, working</li><li>≤350% FPL</li><li>Resource limit: <i>Single: \$2,000; Married: \$3,000</i></li></ul>		Traditional Medicaid (Fee-for-Service)
HIP 2.0 – HIP Plus, HIP State Plan Plus, HIP Employer Link	<ul style="list-style-type: none"><li>Ages 19-64</li><li>133% FPL</li></ul>		HIP Pus, Hip Basic, HIP State Plan, or HIP Employer Link
HIP 2.0 – HIP Basic, Hip State Plan Basic	<ul style="list-style-type: none"><li>Ages 18-64</li><li>100% FPL</li></ul>		

Source: Family and Social Services Administration, *Medicaid Eligibility Policy Manual*, [www.in.gov/fssa/ompp/4904.htm](http://www.in.gov/fssa/ompp/4904.htm)

## M. The Eligibility Hierarchy

In determining an individual's Medicaid eligibility category, in the absence of a stated preference by the applicant, the eligibility determination is system generated based on a hierarchy. The hierarchy is designed so that individuals are first considered for the most comprehensive benefit package with the least restrictive eligibility requirements. For example, children are first considered for enrollment in Medicaid versus the Children's Health Insurance Program (CHIP) and the Family Planning Eligibility Program is the last group on the hierarchy, as it offers the least comprehensive coverage.

More information on Medicaid eligibility can be found on the Indiana Medicaid website at <http://member.indianamedicaid.com/am-i-eligible/eligibility-guide.aspx>.

### 1. Infants and Children

Babies born to Indiana Medicaid enrollees receive coverage for their first year of life without the need for a separate Medicaid application. This is referred to as deemed newborn coverage. There is no income requirement for this group; coverage continues for one year. Newborn coverage continues regardless of whether the infant continues to live with the birth mother or whether the child ever lived with the birth mother in the case of adoption or other custody arrangement. However, if the child is adopted and the names and location of the adoptive parents are unknown, the child can only be covered for the duration of the hospitalization starting with the month of birth.

Children up to age 19 under 250% FPL are eligible for enrollment in the Indiana Health Coverage Program (IHCP). Program enrollment (*i.e.*, in Medicaid or CHIP) depends on the child's age and federal poverty level (FPL) as described in the following table (see [Table 34](#)):

**Table 34: Children's Program Eligibility by Age and Federal Poverty Level (FPL)**

Age	FPL	Program
<b>0-1</b>	≤208% FPL	Medicaid
	>208-250% FPL	CHIP
<b>1-18</b>	≤158% FPL	Medicaid
	>158-250% FPL	CHIP

Source: Family and Social Services Administration, *Indiana Client Eligibility System Program Policy Manual*, Chapter 2400, [www.in.gov/fssa/files/2400.pdf](http://www.in.gov/fssa/files/2400.pdf)

### ***a. Children's Health Insurance Program Specific Eligibility Provisions***

In order to qualify for the Children's Health Insurance Program (CHIP), an individual cannot be covered by other comprehensive health insurance (hospital and medical or major medical). A child whose health insurance coverage was dropped voluntarily may not receive CHIP coverage for 90 days following the month of termination; this is referred to as a waiting period. There is no waiting period imposed in the following situations:

- The child is no longer eligible for Medicaid or another insurance affordability program
- The cost of the discontinued coverage for the child exceeded 5% of household income
- The cost of family coverage that was discontinued, that includes the child, exceeds 9.5% of household income
- The child's parent is determined eligible for a premium tax credit (PTC) to purchase coverage on the Federally-facilitated Marketplace (FFM) because the employer sponsored insurance in which the family was enrolled is determined unaffordable
- The employer no longer offers health plan coverage or stopped offering coverage of dependents
- The loss of eligibility for employer coverage (other than through full payment of the COBRA premium) is due to termination of employment or reduction in work hours
- The loss of coverage is due to death or divorce of the parent, guardian or other family member
- The child has special health care needs

Additionally, children whose parents, caretakers or spouse can cover them under the State of Indiana's health coverage plans offered to state employees are not eligible for the Children's Health Insurance Program.

The Affordable Care Act (ACA) required states to maintain coverage under CHIP for children who lose Medicaid coverage due to the elimination of disregards under modified adjusted gross income (MAGI). This protection applied only to children enrolled in Medicaid as of December 31, 2013 who lost eligibility at their first MAGI based renewal due to the elimination of disregards who were not otherwise CHIP eligible. To comply with these federal requirements, children who transferred to CHIP under this protected status were not denied Medicaid due to having other creditable health insurance coverage. This protected status remained in place until the child's next scheduled renewal (*i.e.*, 12 months). At that time, the regular CHIP eligibility criteria was applied.

As discussed further in the [CHIP Premiums section](#), to be enrolled in CHIP individuals have a monthly premium obligation and are terminated from coverage after 60 days of non-payment.

## 2. Parents and Other Caretaker Relatives

States are required to provide coverage to parent and caretaker relatives under the income standard established by the state within federally defined parameters. In Indiana, the income standard for parents and caretaker relatives is the MAGI equivalent of the coverage level in effect prior to 2014. An explanation of MAGI conversion is provided in the [MAGI Conversion section](#).

A caretaker relative is defined as a relative of a dependent child by blood, adoption, or marriage with whom the child is living who assumes primary responsibility for the child's care. Caretaker relatives include the following:

- Parent
- Stepparent
- Grandparent
- Sibling
- Stepsibling
- Aunt or Uncle
- First Cousin
- Nephew or Niece
- The spouse of any of above, even after marriage is terminated by death or divorce
- Any blood relative within the fifth degree of relationship, including but not limited to, those of half blood, first cousins once removed and individuals of preceding generations as denoted by prefixes of grand, great, great-great, or great-great-great

In Indiana, a dependent child is under the age of 18 and does not need to be deprived of parental support by reason of death, absence from the home, physical or mental incapacity or unemployment.

Parents and caretaker relatives are covered under HIP 2.0 and are eligible for HIP State Plan benefits.

## 3. Pregnant Women

Pregnant women below 208% FPL are eligible for Medicaid in Indiana. For purposes of determining the household size of a pregnant woman in the eligibility determination process, a pregnant woman is counted as two (or more, if the woman is pregnant with more than one child). In determining the eligibility of others in her household (*i.e.*, children or spouse), the unborn child is not counted by the state.

Effective January 1, 2014, verification of the pregnancy from a medical provider is no longer required for application—self attestation of pregnancy is acceptable requirement. In addition to coverage throughout the duration of the woman's pregnancy, coverage continues for a 60 day postpartum period. A pregnant woman enrolled in Medicaid remains eligible throughout the duration of her pregnancy and a 60 day postpartum period, even if a change in income would otherwise render her ineligible.

#### 4. Former Foster Children

The Affordable Care Act (ACA) created a new mandatory coverage group for former foster children up to age 26. Prior to January 1, 2014, Indiana provided coverage to former foster children up to age 21 with incomes below 200% FPL.

Effective January 1, 2014, in accordance with federal requirements, the state will provide coverage to former foster children who were enrolled in Indiana Medicaid and in foster care under the responsibility of Indiana on their 18<sup>th</sup> birthday, up to age 26, without regard to income.

#### 5. Long-Term Care/Nursing Facility

Any person seeking nursing facility placement in Indiana must complete the pre-admission screening (PAS) process. This process is used to determine the appropriateness of the placement to ensure that nursing facility alternatives have been explored. Failure to participate in the PAS results in the individual being ineligible for Medicaid reimbursement in a nursing facility for up to one year from the date of admission. Application is made through the nursing facility to which the individual is seeking admission, a hospital at which the individual is a patient, or through a local Area Agency on Aging.<sup>38</sup>

In determining a nursing facility resident's financial eligibility for Medicaid, special income and resource provisions apply when the institutionalized individual has a community spouse. A community spouse is an individual who is married to an elderly, blind or disabled institutionalized applicant or recipient of Medicaid. Spouses of nursing home residents have protection from losing income and assets in order to pay for the institutionalized spouse's care.

Community spouses are allowed to retain income and assets that are above the regular income and resource limits for Medicaid eligibility. The state calculates the "spousal share" or the amount of income and assets that may be maintained for the support of the community spouse. To determine the spousal share, the couple completes Form 2060 - Resource Assessment Notice and Request<sup>39</sup> and provides documentation of the resource values as of the date of admission to the nursing facility. These amounts are adjusted annually; the dollar amounts reflected below represent 2016 figures.<sup>40</sup>

The community spouse may maintain all of the community spouse's personal income and half of the income generated by assets owned by both spouses. If this amount is less than \$2,003 monthly, the community spouse may maintain a portion of the institutionalized spouse's income to bring the community spouse's monthly income up to this level. If the community spouse's monthly income is more than the Maximum Maintenance Standard (\$2,981), the community spouse cannot keep any of the institutionalized spouse's income.

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<sup>38</sup> Contact information and locations of the local Area Agencies on Aging are posted on the FSSA website at [www.in.gov/fssa/da/3478.htm](http://www.in.gov/fssa/da/3478.htm).

<sup>39</sup> DFR offices are to provide Form 2060 to interested persons upon request and should provide a supply to facilities in the county. A completed Form 2060 can be mailed to FSSA Document Center or the local DFR office. Local DFR offices are listed online at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov).

<sup>40</sup> Source: *Medicaid Policy Manual*, Chapter 3000, [www.in.gov/fssa/ompp/4904.htm](http://www.in.gov/fssa/ompp/4904.htm)

With the exception of any portion allocated to the community spouse as described above and the allowable deductions listed below, the institutionalized spouse must use all of the institutionalized spouse's own income to pay for nursing home care. The following are allowable deductions:

- A \$52 monthly personal needs allowance
- Court ordered guardianship fees paid to the applicant/recipient's legal guardian, not to exceed \$35 per month
- Once per year, federal, state and local taxes on unearned income which are owed and paid
- A portion of sheltered workshop earnings and earnings which are part of a habilitation plan
- Health insurance premiums

Medical expenses not subject to payment by a third party and are not covered by Medicaid, with the exception of nursing facility expenses incurred during an imposed transfer of property penalty. Any costs for the nursing home care that remain are covered by Medicaid.

In determining the maximum assets a community spouse may own without rendering the institutionalized spouse ineligible, most assets are considered joint regardless of whose name they are in (*i.e.*, the community spouse or institutionalized spouse). As of 2016, the community spouse asset limit is the greatest of the following amounts:

- The state minimum standard of \$23,844;
- The spousal share, up to a maximum of \$119,220;  
Any amount of resources ordered by a court against the institutionalized spouse for the support of the community spouse; or  
The amount established by an administrative law judge (ALJ) as the result of an appeal.

Examples of countable assets include bank accounts, stocks, bonds, mutual funds, revocable trusts, the cash value of life insurance policies and individual retirement accounts (IRAs). More information on what counts as income or assets is available in the Indiana Long Term Care Insurance Program (ILTCIP) website at [www.in.gov/iltcp/2343.htm](http://www.in.gov/iltcp/2343.htm).

### ***a. Miller Trusts and Eligibility for Medicaid Coverage of Long-Term Care and Home and Community-Based Services***

If an applicant has monthly income that exceeds 300% of the maximum Supplemental Security Income (SSI) federal benefit rate,<sup>41</sup> also known as the Special Income Limit (SIL), the applicant must establish a Miller Trust prior to becoming eligible for Medicaid coverage of institutional or home and community-based services.

A Miller Trust, also known as a Qualified Income Trust (QIT), is a legal arrangement for holding funds which allows an individual with income over the 300% of SSI threshold to qualify for coverage. The Medicaid agency disregards income placed in the trust for the purpose of eligibility. At a minimum, an individual must place the portion of the individual's monthly income that exceeds the SIL in the trust.

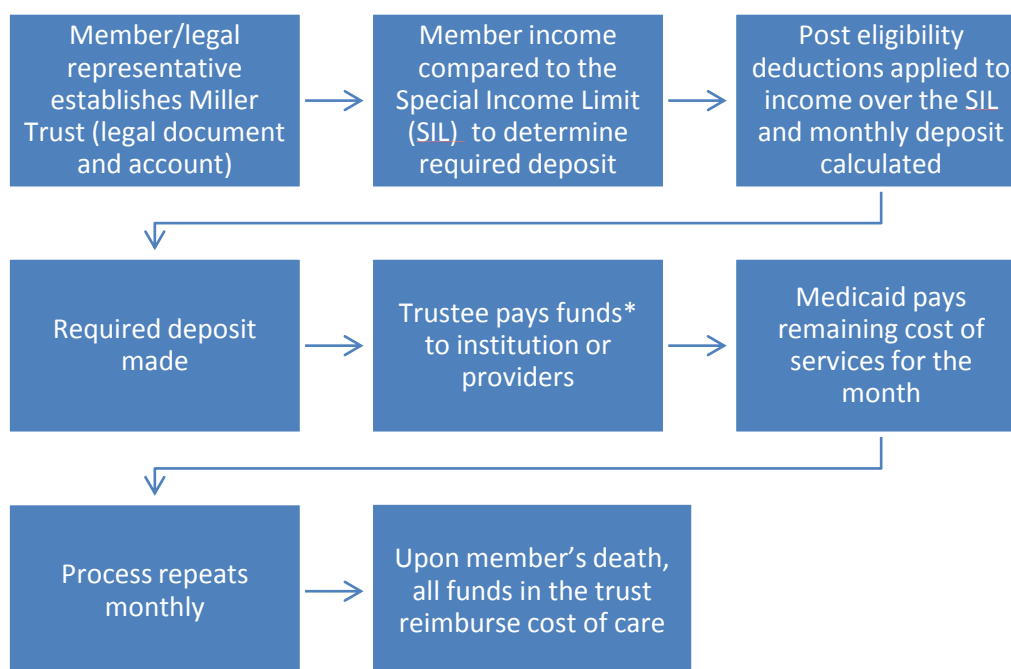
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<sup>41</sup> The monthly maximum federal SSI amounts for 2016 are \$733 for an eligible individual and \$1,100 for an eligible individual with an eligible spouse (see [www.ssa.gov/oact/cola/SSI.html](http://www.ssa.gov/oact/cola/SSI.html)). Multiplied by three these numbers are \$2,199 and \$3,300, respectively.

Individuals may apply certain deductions to these funds, and the remaining amount in the trust is paid to the institution as part or all of the member's liability.

The following figure (see [Figure 4](#)) provides a high-level overview of how a Miller Trust works:

**Figure 4: How a Miller Trust Works**



\*Funds deposited in Miller Trust represent all or part of member's liability to the facility, depending on whether member's entire income is deposited or simply the amount that exceeds SIL. Either approach is acceptable.

Source: Family and Social Services Administration, *1634 Transition Stakeholder Presentation* (2014), [www.in.gov/fssa/files/1634\\_Stakeholder\\_Presentation\\_FINAL.pdf](http://www.in.gov/fssa/files/1634_Stakeholder_Presentation_FINAL.pdf)

Indiana Navigators may refer applicants for institutional care with income over the SIL who need a Miller Trust to become eligible for Medicaid coverage of institutional or long-term care to the agency's Miller Trust resource page on the FSSA website at [www.in.gov/fssa/ddrs/4860.htm](http://www.in.gov/fssa/ddrs/4860.htm).

## N. Income Standards

Income limits for eligibility groups which are based on the federal poverty level (FPL) are adjusted yearly with the annual publishing by the federal government of revised federal poverty levels. The following tables (see [Table 35](#), [Table 36](#), [Table 37](#), [Table 38](#) and [Table 39](#)) reflect the income limits for 2016 eligibility based upon the 2016 federal poverty levels. Annual updates can be accessed in the Federal Register located at [www.federalregister.gov](http://www.federalregister.gov) upon publication. They are typically published in late January and become effective for Indiana Medicaid eligibility determinations in March or April.

**Table 35: Monthly Income Threshold for Medicaid Categories: Pregnant Women**

Family Size	Monthly Income Threshold
1	n/a
2	\$2,776
3	\$3,494
4	\$4,212
5	\$4,929

Source: Family and Social Services Administration, *Indiana Medicaid Eligibility Guide*, <http://member.indianamedicaid.com/am-i-eligible/eligibility-guide.aspx>

**Table 36: Monthly Income Threshold for Medicaid Categories: Elderly/Disabled**

Family Size	Monthly Income Threshold
1	\$1,619
2	\$2,191
3	\$2,763
4	\$3,335
5	\$3,907
6	\$4,479
7	\$5,051
Add on for each additional family member	\$572

Source: Family and Social Services Administration, *Medicaid Policy Manual*, [www.in.gov/fssa/files/3000.pdf](http://www.in.gov/fssa/files/3000.pdf)

**Table 37: Monthly Income Limits for HIP 2.0 Eligibility**

Family Size	Monthly Income Limit for HIP Basic Eligibility	Monthly Income Limit for HIP Plus Eligibility*
1	\$990	\$1,382.54
2	\$1,335	\$1,864.33
3	\$1,680	\$2,346.12
4	\$2,025	\$2,827.91
5	\$2,370	\$3,309.71
6	\$2,715	\$3,791.50
7	\$3,060.83	\$4,274.45
8	\$3,407.50	\$4,758.57
For each additional person add:	\$346.67	\$484.12

Source: Family and Social Services Administration, *HIP 2.0 Federal Poverty Level Income Chart*, [www.in.gov/fssa/hip/2460.htm](http://www.in.gov/fssa/hip/2460.htm)

**Table 38: Monthly Income Threshold for Medicaid Categories: Parents & Caretakers\***

Family Size	Monthly Income Threshold
1	\$152
2	\$247
3	\$310
4	\$373
5	\$435
6	\$498
7	\$561
Add on for each additional family member	\$63

\*Covered in HIP 2.0 and eligible for HIP State Plan benefits

Source: Family and Social Services Administration, *Medicaid Policy Manual*, [www.in.gov/fssa/ompp/4904.htm](http://www.in.gov/fssa/ompp/4904.htm)

**Table 39: Monthly Income Threshold for Medicaid Categories: Children Only**

Family Size	Monthly Income Threshold	
	Package A	Package C
1	\$1,564	\$2,475
2	\$2,109	\$3,337
3	\$2,654	\$4,200
4	\$3,199	\$5,052
5	\$3,744	\$5,925

Source: Family and Social Services Administration, *Indiana Medicaid Eligibility Guide*, <http://member.indianamedicaid.com/am-i-eligible/eligibility-guide.aspx>

For the aged, blind and disabled categories and Home and Community-Based Services (HCBS) waivers, the income standard is tied to the Supplemental Security Income (SSI) payment standards. The SSI payment standards are updated effective January 1 of each year whenever there is a cost of living adjustment (COLA). Therefore, any changes to the income standards for these eligibility groups are effective January 1<sup>st</sup> each year.

For the Medicare Savings Program, income standards are updated based on the annual FPL changes. However, any COLA increase in Social Security benefits received annually in January by Social Security beneficiaries is disregarded until April of the same year. The months of the COLA disregard are referred to as “transition months.” The April date is based on the FPL guidelines being published in February, if FPLs are published at a different time, the transition months are adjusted accordingly.

## O. Authorized Representatives

Medicaid applicants and beneficiaries may designate an individual or organization to act responsibly on their behalf in assisting with the application, redetermination process and ongoing communications with the state. Authorized Representatives (ARs) are commonly a trusted family member, but they can also be a third party entity.

The designation of an AR must be in writing and signed by the applicant or beneficiary and the Authorized Representative. Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, is treated as a written designation by the applicant or beneficiary of Authorized Representation. If an individual is medically incapable of signing the authorization, medical documentation must be provided.

An individual may designate an AR through the [Indiana Application for Health Coverage](#) (IAHC), which includes the AR form with the application. The AR form is bar-coded to match each specific case to allow for expedited processing and better service to the AR and the consumer.

**IMPORTANT NOTE:** It is important that an AR be designated through the AR form attached to the Indiana Application for Health Coverage. Each bar-coded AR form is unique to a specific case, therefore copies should not be made of the form to attach to other cases, nor should the bar code be altered under any circumstances.

In completing the AR form, the individual designates what functions the representative is authorized to complete including:

- Application functions
  - Sign application
  - Provide all required proof of information necessary to determine eligibility for benefits
  - Receive the notice of the application decision
  - Speak on applicant's behalf at a hearing if the application decision is appealed
- Ongoing
  - Report changes
  - Attend periodic redeterminations
  - Receive the appointment notices and any redetermination mail-in forms

Designation as an AR is valid until the applicant or beneficiary:

- Modifies the authorization
- Notifies the agency that the representative is no longer authorized to act on the applicant's or beneficiary's behalf
- The AR informs the agency that the AR no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based.

Additional information on ARs can be found on the Indiana Medicaid website at <http://member.indianamedicaid.com/members-rights--responsibilities/advocaterepresentative-authorization-form.aspx>.

## P. Verifying Factors of Eligibility

After an individual has submitted an application as described in the [Medicaid Application section](#) of the Helping Consumers Apply for Coverage chapter of the manual, the state will verify certain factors of eligibility. Beginning in 2014, states are only permitted to collect paper documentation from Medicaid applicants to verify factors of eligibility when electronic data sources, which have been deemed to be

useful and reliable by the state, are not available or an individual's self-attested information entered on the [Indiana Application for Health Coverage](#) is not "reasonably compatible" with electronic data.

States have some discretion in developing reasonable compatibility policies. This modifies the pre-2014 process under which the state used electronic data sources for some eligibility factors with Medicaid applicants providing paper documentation upfront to support self-attested application information for other factors of eligibility. Indiana utilizes a variety of electronic data sources, including state data sources and federal data sources accessed through the Federal Hub, to verify factors of eligibility. The state will not utilize electronic Federal Tax Information (FTI) from the IRS to verify income as annual tax return data is outdated for purposes of determining current monthly income. Examples of data sources which will be consulted include but are not limited to:

- Social Security Administration (SSA)
- Department of Homeland Security
- TALX Work Number
- State Wage Information Collection Agency (SWICA)
- State Unemployment Compensation
- Vital Statistics

The next table (see [Table 40](#)) outlines when paper documentation will be required, by eligibility factor, and examples of acceptable forms of documentation. Individuals will be notified via the Pending Verification Checklist (DFR Form 2032) when additional documentation is required to complete the eligibility determination process as well as the acceptable forms of documentation, submission instructions and deadline for submission. The case name and case number should be written on each document submitted, and the Cover Sheet contained in the mailing should be sent in with the supporting documentation. Individuals are generally required to provide documentation within 10 calendar days and may submit the requested documentation via fax to 1-800-403-0864, deliver them in person to a local Division of Family Resources (DFR) office (searchable at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)), or mail to the FSSA Document Center at the following address: **FSSA Document Center, P.O. Box 1810, Marion, IN 46952.**

The requirement to provide verification documents is limited to those necessary to ensure an accurate eligibility determination. For example, financial and demographic information is required only for those individuals living in the home who are members of the Assistance Group (AG); therefore information will not be required to verify the circumstances of a non-AG member.

When providing verifications, applicants should provide the most current documentation available. Financial eligibility is based on the best estimate of income and circumstances which will exist in the month for which the assistance is being considered. This estimate is founded upon the most complete information available to the DFR as of the authorization date. This eligibility determination requires knowledge of an individual's or AG's current, past or anticipated future circumstances. A presumption that current or historical trends will continue in the future is not made. Use of historical trends is used if there is reason to believe, with supporting documentation, that the trends will continue.

**Table 40: Verification Documentation for an Indiana Application for Health Coverage (cont. to following pages)**

Eligibility Factor	When Documentation is Required	Examples of Acceptable Paper Documentation*
<i>Income</i>	<ol style="list-style-type: none"> <li>1. If individual attests on the application to income below the Medicaid or CHIP or HIP 2.0 income standard and electronic data on income is unavailable.</li> <li>2. If an individual attests on the application to income below the Medicaid or CHIP or HIP 2.0 income threshold and the electronic data indicates income above the applicable threshold.</li> <li>3. If the difference between what an individual attests on the application and the electronic data results in a different benefit package or cost-sharing amount, documentation will be required from the applicant to resolve.</li> </ol>	<ul style="list-style-type: none"> <li>• Wage receipts</li> <li>• Wage statements</li> <li>• Pay stubs</li> <li>• Employment verification form or written statements containing the required information</li> </ul>
<i>Residency</i>	Paper documentation verifying residency is sought when available electronic data source indicates residency in another state.	<ul style="list-style-type: none"> <li>• Driver's license</li> <li>• School records</li> <li>• Other forms of I.D</li> <li>• Employment records</li> <li>• Church records</li> <li>• Rent/mortgage receipts and/or utility bills</li> <li>• Local postal record</li> <li>• Written statement from a third party</li> </ul>

Eligibility Factor	When Documentation is Required	Examples of Acceptable Paper Documentation*
<i>Age (Date of Birth)</i>	Paper documentation verifying date of birth is sought when available electronic data sources indicate age difference.	<p>Birth certificate or health department records or other credible sources, including:</p> <ul style="list-style-type: none"> <li>• hospital records</li> <li>• physician's records</li> <li>• Bureau of Vital Statistics</li> <li>• baptismal, confirmation, or other church records</li> <li>• passport</li> <li>• naturalization papers</li> <li>• immigration papers</li> <li>• alien registration card</li> <li>• court records, including adoption records, in which the child's age has been noted</li> <li>• records of social agencies (including the Local Office)</li> <li>• insurance company records</li> <li>• school records</li> </ul>
<i>Citizenship</i>	If citizenship is not verified electronically (Note: as discussed in the <a href="#">Citizenship/Immigration Status section</a> , there are certain circumstances under which the applicant has 95 days to resolve the discrepancy while receiving benefits; this is referred to as the reasonable opportunity period. If the electronic data indicates the applicant is not a citizen when the individual attests to being a citizen the individual is not given this reasonable opportunity period.)	<ul style="list-style-type: none"> <li>• Birth certificate</li> <li>• US Citizenship &amp; Immigration Services records</li> <li>• Baptismal records</li> <li>• Medical records</li> <li>• School records</li> <li>• Military records</li> <li>• Court records</li> </ul>

Eligibility Factor	When Documentation is Required	Examples of Acceptable Paper Documentation*
<b>Immigration Status</b>	If immigration status is not verified electronically (Note: as discussed in the <a href="#">Citizenship/Immigration Status section</a> , there are certain circumstances under which the applicant has 95 days to resolve the discrepancy while receiving benefits; this is referred to as the reasonable opportunity period. If the electronic data indicates the applicant is not a citizen when the individual attests to being a citizen the individual is not given this reasonable opportunity period.)	<ul style="list-style-type: none"> <li>US Citizenship &amp; Immigration Services records</li> </ul>
<b>Social Security Number</b>	If social security number (SSN) is not verified electronically	<ul style="list-style-type: none"> <li>Social security card</li> <li>Correspondence from Social Security Administration</li> <li>Medicare card with the suffix A, J, M, T (the presence of another suffix indicates the individual is receiving benefits under another individual's SSN and therefore does not serve as verification of SSN)</li> </ul>
<b>Household Composition</b>	If attested information is not consistent with electronic data and impacts eligibility outcome ( <i>i.e.</i> , difference renders individual not eligible, eligible for different benefit package or eligible for different cost-sharing amount).	<ul style="list-style-type: none"> <li>Divorce documents</li> <li>Death certificate</li> <li>Birth certificate</li> <li>Adoption paperwork</li> </ul>
<b>Pregnancy</b>	N/A: State is required to accept self-attestation.	N/A

\*The documents listed are intended to serve as examples of accepted documentation; applicants and beneficiaries may submit other documents that contain the same information.

Sources: Indiana Family and Social Services Administration, [Indiana Client Eligibility System Program Policy Manual, Chapters 2400 and 2800](#), available at [www.in.gov/fssa/dfr/3301.htm](http://www.in.gov/fssa/dfr/3301.htm); [Modified Adjusted Gross Income \(MAGI\) Conversion Plan \(2013\)](#), [www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-and-the-Marketplace/Downloads/Indiana-MAGI-Conversion-Plan-Template.pdf](http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-and-the-Marketplace/Downloads/Indiana-MAGI-Conversion-Plan-Template.pdf)

## Q. Eligibility Appeals

Medicaid applicants and beneficiaries have the right to appeal decisions of the state regarding their eligibility. Appeals of some decisions must first go to the [managed care entity](#) (MCE) before being directed to the state. Appealable actions include the termination, suspension or reduction of Medicaid eligibility or covered services. Following is a list of some common examples of appealable actions:

- The effective date of Medicaid coverage
- Premium or cost-sharing obligation
- Denial of eligibility
- Computation of the spousal share and the community spouse resource standard

This section describes eligibility related appeals; refer to the [Post-Eligibility Appeals section](#) for additional information on appeals related to authorizations for covered services.

States that delegate authority to the [Federally-facilitated Marketplace \(FFM\)](#) to conduct Medicaid eligibility determinations may also delegate authority for processing appeals. Indiana has not delegated such authority. Therefore, appeals of Medicaid eligibility determinations are handled by the state. Applicants and beneficiaries are entitled to receive written notice of their appeal rights whenever an action is taken on their case. Therefore, they should be encouraged to carefully read all notices for relevant instructions such as deadlines to submit an appeal, where to submit an appeal and requirements for submission.

Individuals must file appeals by the date listed on their notice. Current eligibility will be maintained while the appeal is pending if the individual files an appeal before the date the decision goes into effect. The individual may opt to not have benefits continued pending the appeals decision. Appeals of some decisions must first go to the managed care entity before being directed to the state.

If the last day of the month before the effective date falls on a weekend or holiday, the appeal must be received by the next business day. If the decision of the state is upheld, the appellant is required to pay for the benefits received while awaiting the appeal outcome. Therefore, if an individual does not want to continue benefits during the appeal, this should be clearly indicated on the appeal request. If benefits involve the Healthy Indiana Plan (HIP 2.0) or the Children's Health Insurance Program (CHIP), the individual is required to continue to make the required contributions or premiums during the continued benefit period.

When an appeal request is received, the FSSA schedules a fair hearing. The appellant is notified in writing of the date, time and place of the hearing. This is generally held in the Division of Family Resources (DFR) [county office](#) where the appellant resides, but it may be conducted by phone at the appellant's request. Pre-hearing conferences are held on some cases during which the appellant can describe why the appellant is dissatisfied and the DFR explains the reason for the action which has been taken. If resolution occurs at this pre-hearing conference, the applicant can withdraw the request for appeal. The fair hearing will continue as scheduled if the appeal is not withdrawn.

The hearing will be held in front of an administrative law judge (ALJ). Individuals can represent themselves or seek assistance from another individual such as a lawyer, friend or relative. Individuals

who wish to have legal representation but cannot afford it can contact Indiana Legal Services. Contacts by location are available at [www.indianalegalservices.org/providers](http://www.indianalegalservices.org/providers).

Both the individual and state will present their respective positions and the ALJ will render a decision. For eligibility-related appeals, the state's designee typically presents the state's position via telephone. Notification of the ALJ decision will be sent in writing to the individual. Any necessary adjustments to eligibility as an outcome of the decision will be made in accordance with the hearing outcome. If the decision is not favorable to the appellant, the appellant may be required to repay back benefits paid on the appellant's behalf. If the decision is favorable to the appellant and involves HIP 2.0 or CHIP, the individual would be required to pay any contributions or premiums back to the effective date of coverage.

Individuals who wish to challenge an eligibility decision under the disability category will appeal either to the Social Security Administration (SSA) or to Indiana Medicaid depending on the reason for the initial denial. If the applicant was denied Medicaid eligibility because of an SSA disability denial on file, the applicant should appeal to the Social Security Administration. If the Indiana Medical Review Team (MRT) determined the applicant non-disabled, or the application was denied for reasons other than disability (*i.e.*, excess income or resources), the applicant should file the appeal to Indiana Medicaid. If an individual is dissatisfied with the hearing decision, the individual has the right to request a review by FSSA through an Agency Review. The written notice outlining the hearing decision will include instructions on how to file a request for Agency Review, including the deadline to file.

Individuals that receive continued benefits during an appeal and subsequently lose their appeal may be subject to benefit recovery at the discretion of the state.

Additional information on eligibility appeals can be found on the Indiana Medicaid website at <http://member.indianamedicaid.com/members-rights--responsibilities/appeals-and-grievances.aspx>.

## **R. What an Individual Can Expect After Being Determined Eligible for Indiana Medicaid**

### **1. Effective Date of Eligibility**

Individuals can be determined Medicaid eligible for up to three months of retroactive eligibility from the date of application. During periods of retroactive eligibility a Medicaid enrollee is not assigned to a Hoosier Healthwise or Hoosier Care Connect managed care entity (MCE) (*i.e.*, no retroactive MCE assignments are made). If an enrollee received covered services during the period of retroactive eligibility and paid out-of-pocket for such costs, the enrollee is to receive reimbursement from the provider and the provider can then bill Medicaid.

This three-month retroactive eligibility period does not apply to the Children's Health Insurance Program (CHIP) or the Healthy Indiana Plan (HIP 2.0). For these programs, final enrollment is dependent on premium contribution (CHIP) or POWER account payment (HIP 2.0). For CHIP, members become eligible for benefits on the first day of the month in which they applied and paid the first month's premium. For example, if an application was filed in June, approved on the 15th of June and the applicant's first month's premium was paid in full, eligibility would begin on the first day of June.

For all programs, an individual's eligibility notice will detail the effective date of eligibility.

## 2. Notices and Insurance Card

An individual determined eligible for Medicaid will receive the following initial communication materials:

- An eligibility determination notice from the state within 24 hours of eligibility determination plus mailing time
- A member identification card (see below) referred to as the Hoosier Health Card within five business days plus mailing time (this is not sent to HIP 2.0 enrollees)



- HIP 2.0 enrollees receive a member ID card from their managed care entity (MCE)
- Hoosier Healthwise and HIP 2.0 enrollees receive communication materials from their MCE, including a member handbook
- CHIP & M.E.D. Works eligible individuals receive premium invoices
- HIP 2.0 eligible individuals receive Personal Wellness and Responsibility (POWER) Account contribution notices

## 3. CHIP Premiums

Individuals in the Children's Health Insurance Program (CHIP) are responsible for monthly premiums as outlined in the following table (see [Table 41](#)):

**Table 41: CHIP Premium Amounts (Based on 2016 FPL)**

Family FPL	Monthly Premium for 1 Child	Monthly Premium for 2 or More Children
<b>158% up to 175%</b>	\$22	\$33
<b>175% up to 200%</b>	\$33	\$50
<b>200% up to 225%</b>	\$42	\$53
<b>225% up to 250%</b>	\$53	\$70

Sources: Family and Social Services Administration, [Hoosier Healthwise FAQ](#), <http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise/faq-hoosier-healthwise.aspx>; *Indiana Health Coverage Program Policy Manual*, Section 3010.30.40, [http://www.in.gov/fssa/files/Medicaid\\_PM\\_3000.pdf](http://www.in.gov/fssa/files/Medicaid_PM_3000.pdf)

Eligibility in CHIP is not finalized until an individual pays the first required premium. CHIP eligible families will receive a monthly premium invoice. Monthly payment in full is required. Premium payment checks or money orders should be mailed to: **Hoosier Healthwise, P.O. Box 3127, Indianapolis, IN 46206-3127**.

There is a 60-day grace period for non-payment of CHIP premiums. CHIP coverage will be terminated if payment is not received within this time. To reenroll, a new [Indiana Application for Health Coverage](#) must be submitted and past due premiums must be paid. However, under federal regulations, effective

January 1, 2014, if an individual fails to repay past due premiums and reapplies for CHIP, the state will not prohibit reenrollment if more than 90 days has passed since the date of disenrollment for non-payment. This replaces the old policy under which repayment of a past due premium was a condition of reenrollment. CHIP members who have questions about premium payments can call 1-866-404-7113.

#### 4. HIP 2.0 Personal Responsibility and Wellness (POWER) Account Contributions

As detailed in the [Healthy Indiana Plan \(HIP 2.0\) section](#), HIP 2.0 enrollees are responsible for monthly contributions to the POWER Account.

After being determined eligible for HIP 2.0, the individual will receive an invoice from their managed care entity (MCE) detailing the required contribution and payment instructions. Enrollment in [HIP Plus](#) is determinant on making POWER Account contributions. Members receive monthly invoices for monthly contribution amounts. If a HIP 2.0 enrollee does not make required monthly contributions, the enrollee will “fallback” into the [HIP Basic](#) plan, which is less predictable and more costly than the HIP Plus plan. POWER account contributions are approximately 2% of income and are a minimum of \$1 per month. HIP 2.0 enrollees with questions about their POWER Account contributions should contact the MCE with whom they are enrolled as outlined in the following table (see [Table 42](#)):

**Table 42: HIP 2.0 Managed Care Entity (MCE) Contacts**

MCE	Member Services	Website
<i>Anthem</i>	1-866-408-6131	<a href="http://www.anthem.com">www.anthem.com</a>
<i>CareSource Indiana</i>	1-877-806-9284	<a href="http://www.caresource.com">www.caresource.com</a>
<i>MDwise</i>	1-800-356-1204	<a href="http://www.mdwise.org">www.mdwise.org</a>
<i>Managed Health Services(MHS)</i>	1-800-647-4848	<a href="http://www.mhsindiana.com">www.mhsindiana.com</a>

#### 5. M.E.D. Works Premiums

As detailed in the [M.E.D. Works section](#), enrollees in the M.E.D. Works (**M**edicaid for **E**mployees with **D**isabilities) program are responsible for monthly premium payments as shown in the following table (see [Table 43](#)). Premiums are based on the income of the applicant/recipient and spouse. These monthly income limits are adjusted annually based on the updated FPLs released by the federal government.

**Table 43: M.E.D. Works Premiums (Based on 2016 FPL)**

	Monthly Income	Premium
<b>Single</b>	\$1,459 - \$1,702	\$48
	\$1,703 - \$1,945	\$69
	\$1,946 - \$2,432	\$107
	\$2,433 - \$2,918	\$134
	\$2,919 - \$3,404	\$161
	\$3,405	\$187
<b>Married</b>	\$1,967 - \$2,294	\$65
	\$2,295 - \$2,622	\$93
	\$2,623 - \$3,278	\$145
	\$3,279 - \$3,933	\$182
	\$3,934 - \$4,588	\$218
	\$4,589	\$254

Sources: Family and Social Services Administration, *FAQ: M.E.D. WORKS*, <http://member.indianamedicaid.com/programs--benefits/medicaid-programs/med-works/fag-med-works.aspx>; *Indiana Medicaid Policy Manual*, Chapter 3010.20.20, [https://secure.in.gov/fssa/files/Medicaid\\_Combined\\_PM.pdf](https://secure.in.gov/fssa/files/Medicaid_Combined_PM.pdf)

After being determined eligible for the program, enrollees will receive a monthly invoice. Payments are sent to: **M.E.D. Works, P.O. Box 946, Indianapolis, IN 46206**.

M.E.D. Works enrollees with questions related to premium payments can be directed to the M.E.D. Works Payment Line at 1-866-273-5897.

## S. Eligibility Redeterminations

Medicaid redeterminations are conducted every 12 months for modified adjusted gross income (MAGI) categories. For non-MAGI groups, redeterminations must be completed at least every 12 months, but may occur more frequently to align with other benefits redetermination. For MAGI categories, the state will renew eligibility without requiring additional information from the enrollee if there is sufficient information in the enrollee's electronic account to do so. If sufficient information is available to determine ongoing eligibility, the individual is notified of the eligibility determination and required to notify the state of any inaccuracies. No signature or any additional information is required from the individual if all information contained in the notice is accurate. For non-MAGI categories, this electronic renewal process does not apply as there are no electronic data sources available to determine resource eligibility.

If insufficient information is available to determine ongoing eligibility, a pre-populated renewal form will be sent to the individual requesting the missing information. Instructions, including the due date for returning the redetermination form and documentation, are provided on the mailing. Redetermination materials can be submitted to 1-800-403-0864, by mail to the FSSA Document Center (P.O. Box, 1810, Marion, IN 46952), or to a local Division of Family Resources (DFR) office (listed at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)). Individuals should include their case name and case number on all submitted documents.

Eligibility is terminated for individuals who do not return the materials (redetermination form and/or required verifications) in a timely manner. If eligibility is terminated but the individual returns the

documents within 90 days of the original due date, eligibility is reviewed without the need to submit an [Indiana Application for Health Coverage](#). If the individual fails to return the materials within 90 days of the original due date, the individual must file a new Indiana Application for Health Coverage.

### **1. Eligibility Redeterminations for Members Eligible Based on Blindness or Disability**

Due to Indiana's transition to 1634 status effective June 1, 2014, the state will accept and defer to Social Security Administration (SSA) disability determinations for Medicaid eligibility purposes. The state will require most members eligible under the blindness and disability Medicaid categories (MA B and MA D) to apply to SSA at the time of their redetermination (Medical Review Team (MRT) progress report) for a disability determination and any other benefits for which they may be eligible, if they have not already done so. This requirement will be waived for children under the age of 18 and members of a group that has a recognized religious objection to applying for federal benefits, such as the Amish.

If the member does not fulfill the requirement to file an application with SSA within 45 days of the MRT progress report, the member's eligibility will be denied for failing to comply with the requirements of the process and will have to re-apply. While the SSA application is pending, the Indiana MRT process will run concurrently and MRT will render its own decision. The MRT's disability determination will be effective until the SSA renders its decision.

### **2. Reporting Changes**

Enrollees are required to report changes to the state. Examples of required changes to report include a change in address, income or family composition. Changes can be reported via FSSA's website at [www.in.gov/fssa/dfr/2999.htm](http://www.in.gov/fssa/dfr/2999.htm), by calling 1-800-403-0864, by mail to the FSSA Document Center (P.O. Box, 1810, Marion, IN 46952), or at a local DFR office (listed at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)). The state will review eligibility based on reported changes and provide written notice to enrollees of any resulting eligibility changes.

### **3. Pregnancy and Newborn Coverage**

Babies born to Medicaid enrollees receive coverage for their first year of life without the need for a separate Medicaid application. They will be covered under Hoosier Healthwise and enrolled in their mother's managed care entity. This is referred to as deemed newborn coverage. There is no deemed newborn coverage for CHIP enrollees; these mothers must file an application for coverage for their baby.

All Hoosier Healthwise enrollees must have a primary medical provider (PMP), including newborns. Enrollees should be encouraged to select a provider for their baby prior to birth. The provider for the baby must be in the same network as the mother. This process is referred to as pre-birth selection. Once a pregnant enrollee has selected a PMP for the baby, she should call her MCE to finalize the selection. Upon the birth of the child, the mother must report the birth to the DFR via the methods of reporting changes described in the previous section. Alternatively, many hospitals will report the birth of the baby through a "babygram" sent via fax to the Division of Family Resources.

## T. Using Coverage

Once an individual is determined eligible and enrolled in the applicable program (*e.g.*, Hoosier Healthwise, HIP 2.0, Hoosier Care Connect, or traditional Medicaid), the individual is eligible to begin accessing covered services. Enrollees should present their ID card every time they seek services and may only receive services from Indiana Health Coverage Program (IHCP) enrolled providers, with the exception of emergency services. Hoosier Healthwise, HIP 2.0 and Hoosier Care Connect enrollees are required to seek services from their primary medical provider (PMP), with the exception of emergency services. PMPs will provide referrals to specialists as required. Additionally, individuals may self-refer to the following IHCP enrolled provider types and services:

- Chiropractic services (except HIP 2.0)
- Eye care services, except surgical services
- Podiatric services (except HIP 2.0)
- Psychiatric services
- Family planning services
- Emergency services
- Immunizations
- Mental health providers (for HIP 2.0 and Hoosier Healthwise must be an in-network provider)
- Diabetes self-management services

## U. Prior Authorization

Some services require prior authorization (PA), a process under which the medical necessity of a requested service is reviewed. Under the Healthy Indiana Plan (HIP 2.0) and Hoosier Healthwise (HHW) programs, the managed care entities (MCEs) with whom the state contracts are authorized to establish their own PA policies within the parameters established by federal Medicaid managed care regulations and the terms of the MCE's contract with the state. Enrollees are notified of the services which require PA through their Member Handbooks issued by the MCEs and may also seek additional information through the MCE member services helpline.

An enrollee's provider submits a PA request to the applicable entity (*i.e.*, Hoosier Healthwise or HIP 2.0 MCE, or the state's designee for traditional Medicaid enrollees). If a PA request is denied, an individual has the right to appeal and such appeal rights will be included in the PA determination letter with instructions and parameters for appealing. Further information on the appeals process is available in the [Post Eligibility Appeals section](#). Failure to receive PA prior to receiving services may result in the provider receiving a denial of claims payment.

## V. Copayments

Certain Medicaid and Children's Health Insurance Program (CHIP) covered services have required copayments. This section does not apply to HIP 2.0 enrollees; see [Table 18](#) for a list of copayments required under the HIP Basic plan.

There are copays for transportation services for Medicaid enrollees as outlined in the following table (see [Table 44](#)). The following services are exempt from the transportation copayment requirement:

- Emergency ambulance
- Transportation provided to enrollees under 18
- Transportation provided to pregnant women
- Transportation provided to enrollees who are inpatient in hospital, nursing facility, intermediate care facility for individuals with intellectual disability or other medical institutions
- Transportation provided to Hoosier Healthwise managed care entity (MCE) enrollees

**Table 44: Transportation Copayments for Medicaid Enrollees**

Copayment	Transportation Service
<i>\$0.50 each one-way trip</i>	Transportation services that pay \$10 or less
<i>\$1 each one-way trip</i>	Transportation services that pay \$10.01 to \$50
<i>\$2 each one-way trip</i>	Transportation services that pay \$50.01 or more

Source: [405 IAC 5-30-2](#)

Pharmacy copayments are outlined in the following table (see [Table 45](#)). The following services are exempt from copayment requirements:

- Family planning services and supplies furnished to enrollees of child-bearing age
- Drugs dispensed in an emergency
- Provided to enrollees under 18
- Provided to pregnant women
- Provided to enrollees who are inpatient in hospital, nursing facility, intermediate care facility for individuals with intellectual disability or other medical institutions

**Table 45: Pharmacy Copayments for Medicaid Enrollees**

Copayment	Pharmacy Service
\$3	Brand Name and Generic Legend Drugs
	Over-the-Counter (OTC) Drugs covered by OTC Drug Formulary
	Compound drug dispensed (legend or nonlegend)

Source: [405 IAC 5-24-7](#)

Enrollees are charged a \$3 copayment for non-emergency services rendered in the emergency department, with the exception of the following:

- Hoosier Healthwise enrollees
- Hoosier Care Connect enrollees
- Family planning services
- Provided to enrollees who are inpatient in hospital, nursing facility, intermediate care facility for individuals with intellectual disability or other medical institutions

CHIP enrollees are responsible for the copayments outlined in the following table (see [Table 46](#)).

**Table 46: CHIP Copayments**

Service	Copayment
Ambulance Transportation	<b>\$10 for each one-way trip</b>
<u>Pharmacy Services</u>	
Generic Compound and Sole Source	<b>\$3</b>
Brand Name Prescription and Insulin	<b>\$10</b>

Source: [407 IAC 3-10-3](#)

## 1. Post-Eligibility Appeals

After an individual has been determined eligible and is enrolled in Medicaid or CHIP, the individual has appeal rights related to actions taken by the state. Appealable actions include:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, as defined by the state
- Failure of a contractor to act within the required timeframes
- Lack of satisfaction with a [medically frail](#) determination (HIP 2.0)

For example, an individual can appeal prior authorization decisions, a delay in receipt of covered medical services, change in nursing home or waiver level of care, termination of eligibility or other actions which affect receipt of Medicaid or medical services.

Individuals must file appeals by the date listed on their notice of action. Current benefits may be continued while the appeal is pending if the individual files an appeal within the timeframe specified on their notice. If an individual receives services while the appeal is underway, if the denial of services is upheld upon appeal, the individual may be financially responsible for the services received during the appeal.

The appeal process differs based on whether or not an individual is enrolled in a managed care entity (MCE) (HIP 2.0, Hoosier Healthwise, or Hoosier Care Connect) or traditional Medicaid. Both processes are described in the following sections.

Additional information on eligibility appeals may be found on the Indiana Medicaid website at <http://member.indianamedicaid.com/members-rights--responsibilities/appeals-and-grievances.aspx>.

### *a. HIP 2.0, Hoosier Healthwise, and Hoosier Care Connect Grievances and Appeals*

Members enrolled in HIP 2.0, Hoosier Healthwise, or Hoosier Care Connect should contact their managed care entity (MCE) to file a grievance or appeal. Enrollees in these programs are required to exhaust the MCE grievance and appeal process prior to filing an appeal with the state. Enrollees should be directed to the MCE in which they are enrolled for specific instructions on submission. Additionally, all notices of action from the MCE will provide instructions on appeal rights, timelines and procedures.

If a HIP 2.0, Hoosier Healthwise, or Hoosier Care Connect enrollee is not satisfied with the appeal decision made by the MCE, the enrollee may request an external review. This can be conducted either by an independent review organization (IRO) or the enrollee can go directly to the State Fair Hearing

process. If an individual opts to go through the IRO, the individual can still request a State Fair Hearing if dissatisfied with the outcome of the internal review organization.

In addition to the appeals process, enrollees may file a grievance. A grievance is an expression of dissatisfaction about any matter other than an action. An example of an issue for which an individual would file a grievance is if the individual is dissatisfied with the quality of care provided or the conduct of a provider or employee. Individuals must file a grievance within 60 days from the day or event in question. Grievances can be filed orally by contacting the appropriate MCE member services helpline, or in writing.

Additional information on eligibility appeals may be found on the Indiana Medicaid website at <http://member.indianamedicaid.com/members-rights--responsibilities/appeals-and-grievances.aspx>.

### ***b. Appeals to the State***

Medicaid beneficiaries who are not enrolled with an MCE or care management organization (CMO) submit their appeals directly to the state. Beneficiaries will always receive written notice of their appeal rights whenever an action is taken on their case. Therefore, they should be encouraged to carefully read all notices for relevant instructions such as deadlines to submit an appeal, where to submit an appeal, and requirements for submission.

After an appeal is filed, individuals will be notified in writing of any applicable hearings. The notice will include the date, time and place of the hearing. The hearing will be held in front of an administrative law judge (ALJ). Both the individual and state will present their position and the ALJ will render a decision. Notification of the ALJ decision will be sent in writing to the individual. Individuals may represent themselves or seek assistance from another individual such as a lawyer, friend or relative. Individuals who wish to have legal representation but cannot afford it can contact Indiana Legal Services. Contacts by location are available at: [www.indianalegalservices.org/providers](http://www.indianalegalservices.org/providers).

Both the individual and state will present their position and the ALJ will render a decision. Notification of the ALJ decision will be sent in writing to the individual. Any necessary adjustments to eligibility as an outcome of the decision will be made in accordance with the hearing outcome. If an individual is dissatisfied with the hearing decision he or she has the right to request a review by the FSSA through an Agency Review. The written notice outlining the hearing decision will include instructions on how to file a request for Agency Review, including the deadline to file.

Additional information on eligibility appeals may be found on the Indiana Medicaid website at <http://member.indianamedicaid.com/members-rights--responsibilities/appeals-and-grievances.aspx>.

## **W. Contacting the State for Assistance and Information**

Assistance is available for applicants and beneficiaries in person, online and via phone. Individuals can use the benefits portal and screening tool, located on the Division of Family Resources (DFR) website at [www.in.gov/fssa/dfr/2999.htm](http://www.in.gov/fssa/dfr/2999.htm), to:

- Utilize the screening tool to see if they qualify for benefits
- Apply for benefits
- Check the status of an application

- Report a change

Individuals may also contact 1-800-403-0864. A listing of local DFR county offices can be found at on FSSA's website at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov) and contact emails by region are provided in the following map (see [Figure 5](#)). For case specific inquiries which require a response, the inquirer must be an [Authorized Representative](#).

Questions or comments to FSSA can be submitted on FSSA's website at [www.in.gov/fssa/2404.htm](http://www.in.gov/fssa/2404.htm).

Figure 5: Division of Family Resources Regional Contacts

## Division of Family Resources

### Indiana Family & Social Services Administration

- Region 1 (Lake): DFR.region1@fssa.IN.gov  
 Region 2 (St. Joseph): DFR.region2@fssa.IN.gov  
 Region 3 (Allen): DFR.region3@fssa.IN.gov  
 Region 4 (Grant): DFR.region4@fssa.IN.gov  
 Region 5 (Marion): DFR.region5@fssa.IN.gov  
 Region 6 (Vigo): DFR.region6@fssa.IN.gov  
 Region 7 (Vanderburgh): DFR.region7@fssa.IN.gov  
 Region 8 (Clark): DFR.region8@fssa.IN.gov  
 Region 9 (Tippecanoe): DFR.region9@fssa.IN.gov  
 Region 10 (Wayne): DFR.region10@fssa.IN.gov



**Inquiries sent to a DFR Region e-mail address will receive a response within 3-5 business days.**

Find a complete list of offices and contact information beginning on the next page.



## III. Health Insurance Basics and the Federally-facilitated Marketplace

### A. Chapter Objectives

1. Understand basic insurance concepts, how the health insurance market works, and the key costs and benefits on a health insurance plan description
2. Understand the key concepts of the Affordable Care Act (ACA) and what are the requirements for consumers and for health insurance plans sold on the Federally-facilitated Marketplace (FFM)
3. Understand what the FFM is, who can use it, and where Hoosiers consumers should go for assistance with the FFM
4. Understand how to help a consumer identify whether or not the consumer may be eligible for coverage and cost assistance programs, and how to enroll into Indiana Health Coverage Programs (IHCPs) or the FFM
5. Understand the new insurance affordability programs including qualified health plans (QHPs), premium tax credits (PTCs), and cost-sharing reductions (CSRs), how these programs work, and who is eligible for these programs

### B. Key Terms

1. **Actuarial Value (AV)** is the average percentage of allowed medical cost expected to be paid by a health plan over all covered enrollees. All health plans offered on and off of the Federally-facilitated Marketplace (FFM) in the individual and small group markets are required to meet certain AV standards that are to be displayed to consumers. In general, plans with higher AVs will have higher premiums and lower cost sharing.
2. **Adverse Selection** is when individuals wait until they become sick or need healthcare services to enroll in a plan. Off-marketplace plans can restrict purchase of plans to the Federally-facilitated Marketplace (FFM) open enrollment periods, which gives the plans the ability to limit adverse selection. The Affordable Care Act (ACA) eliminated health plan's ability to screen for health status and exclude preexisting conditions prior to enrollment.
3. **Affordable Care Act (ACA)** (also referred to as **Patient Protection and Affordable Care Act (PPACA)** or **Obamacare**) is a federal statute that was signed into law ([Public Law 111-148](#)) by President Barack Obama on March 23, 2010 and later amended by the federal Health Care and Education Reconciliation Act of 2010 ([Public Law 111-152](#)). The law provides fundamental reforms to the United States healthcare and health insurance systems, including the establishment of health insurance marketplaces and federal consumer assistance programs (such as federal Navigators, Certified Application Counselors (CACs), and non-Navigator Assistance Personnel).
4. **Benchmark Plan** (also referred to as **Essential Health Benefit (EHB) Benchmark Plan**) is the health plan in a state that identifies the benefits and services classified as essential health benefits (EHBs) in the state. The Anthem preferred provider organization (PPO) plan is the benchmark plan in Indiana, supplemented by FEDVIP dental and vision benefits. Summaries of each state's benchmark plan can be found on the Centers for Medicare and Medicaid Services (CMS) website at [www.cms.gov/ccio/resources/data-resources/ehb.html](http://www.cms.gov/ccio/resources/data-resources/ehb.html).
5. **Bronze Plan** is a type of qualified health plan (QHP) offered to consumers on a marketplace. It is designed so that an insurance carrier will pay 60% of covered healthcare expenses with the remaining 40% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the lowest of the three

QHPs/Metal Plans offered in Indiana). Out-of-pocket expenses in 2017 are capped at \$7,150 for individual plans and \$14,300 for family plans.

6. **Catastrophic Plan** is a health plan available on and off the Federally-facilitated Marketplace (FFM) for individuals who are under the age of 30 or who received an exemption from the Individual Mandate to maintain minimum essential coverage (MEC). It is exempt from actuarial value (AV) requirements. The individual is responsible for most healthcare costs until deductible/out-of-pocket maximum is met. It qualifies as MEC for the Individual Mandate, and the individual is not eligible for premium tax credits (PTCs) or cost-sharing reductions (CSRs).
7. **Certificate of Coverage** is a list of benefits, services, cost sharing, exclusions, and limits applied by a particular health insurance policy.
8. **Child-only Policy** (or **Child-only Plan**) is an individual market policy that is sold to a child under the age of nineteen. Child-only policies do not include policies that are sold to adults with children as dependents.
9. **Churn** is transferring from one health insurance coverage to another. Individuals that experience a change in circumstances during the year that impacts their eligibility in the Federally-facilitated Marketplace (FFM) or a state insurance affordability program may experience churn to another health coverage program for themselves or their dependents.
10. **COBRA Insurance** (also known as **Consolidated Omnibus Budget Reconciliation Act**) is a type of temporary health insurance coverage authorized under federal law (COBRA) that may allow an individual to elect to keep the individual's insurance coverage if the individual's employment ends, the individual loses coverage as a dependent of the covered employee, or another qualifying event occurs. If an individual elects COBRA coverage, the individual pays 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.
11. **Coinsurance** is a consumer's share/percentage of the cost of a healthcare service, paid in addition to the deductible amount. For example, after the consumer has met the deductible amount the consumer's coinsurance may be 20% (i.e., "80/20" – health plan pays 80% and consumer pays 20%) of healthcare costs up until the consumer reached the out-of-pocket maximum.
12. **Common-Law Employee** (or **Employee**) is an individual who the Internal Revenue Service (IRS) would consider an employee based on the degree of control an employer has over the individual and the overall relationship between the employer and the individual. This common-law standard is used under the Affordable Care Act (ACA) to define an employee. Non-employee directors, sole proprietors, partners, 2% or more shareholders in an S corporation, and a leased employee are not treated as employees.
13. **Consumer Directed Health Plan (CDHP)** (also known as a **High Deductible Health Plan (HDHP)**) is a health plan that has a high deductible cost but often lower premiums. An individual with a CDHP is eligible for a health savings account (HSA) to which the individual can contribute pre-tax dollars for qualified healthcare expenses. Employers can also contribute to health savings accounts.
14. **Copayment** (also referred to as **Copay**) is a flat fee consumers may need to pay when they are seen by the healthcare provider. Some plans may charge copayments for some services and coinsurance for others.
15. **Cost-Sharing** is the share of costs covered by an individual's insurance that the individual pays out of his or her own pocket. This generally includes deductibles, coinsurance, and copayments, but not premiums (unless it is premiums paid for Medicaid and the Children's Health Insurance Program (CHIP)). A health plan's cost-sharing policy can be found in its Summary of Benefits and Coverage.
16. **Cost-Sharing Reduction (CSR)** is a qualified health plan (QHP) discount on the Federally-facilitated Marketplace (FFM) that lowers the amount a consumer has to pay out-of-pocket for deductibles, coinsurance, and copayments. A CSR is offered in addition to premium tax credits (PTCs). Qualifying individuals do not have to apply for a CSR separately if the individual: (1) meets all requirements for

- a PTC; (2) is enrolled in a silver plan on the FFM; and (3) has household income between 100% and 250% federal poverty level (FPL) (or between 100% and 300% FPL for Native Americans).
17. **Deductible** is a set amount that the individual will spend toward healthcare before the insurance carrier begins to make payments. Once the deductible is met, the carrier may require only copayments, may split costs of care with the individual (coinsurance), or may pay for the entire cost of care.
  18. **Department of Health and Human Services (HHS)** is the United States federal government's principal health agency. HHS developed and manages the Federally-facilitated Marketplace (FFM) and manages the establishment, training, certification, monitoring, and oversight of FFM agents, brokers, carriers, and federal consumer assistants (e.g., federal Navigators, Certified Application Counselors (CACs), and non-Navigator Assistance Personnel).
  19. **Dependent** is a child up to 26 years old under the Affordable Care Act (ACA). The ACA requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches 26 years old. Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-based coverage (such as through the adult child's job). Children up to age 26 may stay on their parent's employer plan even if they have another offer of coverage through an employer.
  20. **Employer Mandate** (also referred to as **Employer Shared-Responsibility**) is the Affordable Care Act (ACA) requirement that employers with more than 50 full-time employees and full-time equivalent employees (FTEs) offer health insurance coverage to its full-time employees and FTEs (and their dependents) that meet the minimum standards established by the ACA, or pay tax penalties referred to as "employer shared-responsibility payments."
  21. **Enrollment Period** (see also **Open Enrollment Period**, **Special Enrollment Period (SEP)**, and **SHOP Enrollment Period**) is the time period in which certain individuals can apply for and enroll in health coverage through the Federally-facilitated Marketplace (FFM). The term includes an open enrollment period or special enrollment period (SEP) on the individual FFM, and the SHOP enrollment period on the FFM for small employers.
  22. **Essential Health Benefit (EHB)** is a type of benefit that insurance carriers in the individual and small group markets are required to cover. Starting in 2014, the ACA requires health plans to cover certain benefits in each of the 10 EHB categories, listed in [Table 61](#). Within each of the EHB categories exact benefits may vary by state, the state selects a "benchmark" plan, and the selected plan sets a baseline of benefits that must be covered by other plans.
  23. **Explanation of Benefits (EOB)** is a document that describes what an insurer paid for a health service accessed by a consumer enrolled in one of the insurer's health insurance policies, what the consumer paid and/or owes for the service, and a summary of the consumer's remaining deductible and out-of-pocket maximum amounts. Each time a health service is accessed by a consumer, the consumer will receive an EOB from their insurer.
  24. **Federal Poverty Level (FPL)** is a figure released each year by the federal government that estimates the minimum amount an individual or family would need to make to cover basic living expenses. Measure reflects income and household size, and changes annually. It is also used as a factor in determining eligibility in cost reduction programs on the Marketplace (e.g., premium tax credits and cost-sharing reductions) and Indiana Health Coverage Programs (IHCPs). The FPLs for 2016 can be found in [Table 64](#).
  25. **Federally-facilitated Marketplace (FFM)** (also referred to as the **Exchange**, **Marketplace**, **Federal Marketplace**, or **HealthCare.gov**) is a federally-developed and federally-operated health insurance marketplace that makes qualified health plans (QHPs) available to qualified individuals and/or qualified employers in accordance with the Affordable Care Act (ACA). The current FFM website—

[HealthCare.gov](http://HealthCare.gov)—was developed and is operated by the U.S. Department of Health and Human Services (HHS). HHS also oversees the establishment, training, monitoring, and oversight of federal consumer assistance programs (e.g., federal Navigators and Certified Application Counselors (CACs)) that provide FFM outreach, education, and enrollment services. This is the marketplace model used in Indiana. The state is to observe federal guidelines and maintain oversight of state-regulated health insurance products and may implement other consumer protection guidelines (e.g., additional training and certification requirements for consumer assistants serving in the state) that do not prevent the application of the Affordable Care Act.

26. **[Flexible Spending Account \(FSA\)](#)** is a medical savings account that allows an individual and the individual's employer to contribute pre-tax dollars towards future medical costs. Unlike a health savings account (HSA) or health reimbursement account (HRA), funds in the FSA expire at the end of the year.
27. **[Full-time Equivalent Employee \(FTE\) Count](#)** is a method under the Affordable Care Act (ACA) to count employees to determine whether an employer is subject to the Employer Mandate payment or whether an employer is eligible for the SHOP Marketplace. The count includes the sum of both full-time employees and full-time equivalent employees. Full-time employees are the number of employees working an average of 30 hours or more a week. Full-time equivalent employees are the sum of all hours worked by part-time employees (employees working under 30 hours per week) in each week divided by 30. An employee is any individual employed by an employer but not an individual owner or partner. Eligibility for the small group and large group insurance markets is based on full-time employee counts.
28. **[Gold Plan](#)** is a type of qualified health plan (QHP) offered to consumers on a marketplace. It is designed so that the insurance carrier will pay 80% of covered healthcare expenses with the remaining 20% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium. Out-of-pocket expenses in 2017 are capped at \$7,150 for individual plans and \$14,300 for family plans.
29. **[Grandfathered Health Plan](#)** is a health insurance policy that was in existence prior to the Affordable Care Act (ACA) was signed into law on March 23, 2010, and has not had substantial changes. Such a plan does not have to comply with many of the ACA requirements and qualifies as minimum essential coverage (MEC) for the Individual Mandate.
30. **[Grandmothered Health Plan](#)** (also referred to as **[Transitional Health Plan](#)**) is a health insurance policy that was effective after the Affordable Care Act (ACA) was signed on March 23, 2010. Grandmothered health plans include some, but not all, of the ACA features, and they cannot be sold on the Federally-facilitated Marketplace (FFM). In Indiana, these policies can be renewed through October 1, 2016 as long as they are non-discriminatory (e.g., they do not exclude consumers based on pre-existing conditions). Plans that are renewed must not undergo any material changes and are not required to contain the 10 essential health benefits (EHBs) or to adopt the rating structure of fully ACA-compliant plans.
31. **[Group Market](#)** is the market for health insurance coverage offered in connection with a group health plan.
32. **[Health Contingent Wellness Program](#)** is a program for group health plans that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward).
33. **[Health Insurance](#)** (also referred to as **[Insurance](#)**, **[Benefits](#)**, or **[Coverage](#)**) is a type of insurance coverage that provides for the payments of an individual's healthcare/medical costs, including losses from accident, medical expense, disability, or accidental death and dismemberment. Health insurance includes Qualified Health Plans (QHPs) purchased through a Marketplace as well as health

plans purchased off a marketplace, including commercial health insurance products, Indiana Health Coverage Programs (IHCPs), and Medicare.

34. **Health Reimbursement Account (HRA)** is an employer-funded medical savings account that reimburses an employee for out-of-pocket medical expenses and health insurance premiums. An HRA is available to consumers enrolled in a high deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses, and unlike a Flexible Spending Account (FSA), funds roll over year to year if the consumer does not spend them.
35. **Health Savings Account (HSA)** is a medical savings account that allows the individual and the individual's employer to contribute pre-tax dollars towards the cost of future health costs. Dollars in a HSA do not expire (unlike a flexible spending account (FSA)) and belong solely to the individual (including the employer contribution), but individuals must pay a penalty if they use the funds for anything other than qualified health care expenses.
36. **Healthcare.gov** is a health insurance marketplace website owned and operated by the U.S. Department of Health and Human Services (HHS) to facilitate the sale of qualified health plans (QHPs) and eligibility determinations for premium tax credits (PTCs) and cost-sharing reductions (CSRs) for consumers in Federally-facilitated Marketplace (FFM) and Partnership Marketplace states, as well as some State-based Marketplace states. The website also fragments those consumers who may be eligible for Medicaid, and has a separate portal for small businesses (the SHOP Marketplace).
37. **High Risk Pool** (also referred to as **Indiana's High Risk Pool** or **ICHIA (Indiana Comprehensive Health Insurance Association)**) refers to individuals with high risk health conditions that have been historically denied commercial insurance due to their health status. Indiana's High Risk Pool—ICHIA—once provided coverage for these individuals; however, with the Affordable Care Act (ACA) market reforms, major medical insurers may no longer deny individuals coverage based on health status. Thus, the ICHIA program is no longer needed, and individuals that once sought coverage through ICHIA can now apply for coverage through the Federally-facilitated Marketplace (FFM) or directly through an insurer, because they can no longer be denied coverage based on health status.
38. **In-Network Provider** is a healthcare provider (such as a hospital, doctor, or health clinic) in a contract with an insurer, agreeing to provide healthcare/medical services at a discounted rate in return for access to a large group of insured individuals. A list of in-network providers can be accessed through an insurer's website or by calling an insurer's consumer help desk.
39. **Individual Mandate** (also referred to as **Individual Shared-Responsibility**) is a U.S. Internal Revenue Service (IRS) tax penalty imposed on an individual that does not maintain minimum essential coverage (MEC) for themselves and their dependents nor qualify for any of the [exemptions](#) from the MEC requirement. Exemptions from the Individual Mandate are listed in [Table 45](#).
40. **Individual Market** is the market for health insurance coverage offered to individuals other than in connection with a group health plan.
41. **Insurance Affordability Program** refers to either of two programs—premium tax credit (PTC) or cost-sharing reduction (CSR)—that was established by the Affordable Care Act (ACA) to make insurance premiums and cost-sharing more affordable through a marketplace. Eligible consumers may only take advantage of these programs if they apply for coverage through a marketplace.
42. **Insurer** (also known as an insurance **Issuer**, **Carrier**, or **Company**), for health insurance purposes, is an insurance company, insurance service, or insurance organization, which has a certificate of authority to engage in the business and sale of health insurance policies in a state and which is subject to state law which regulates insurance. This term may include a [health maintenance organization](#) (HMO). [Indiana Code 27-19-4-3\(a\)\(16\)](#) prohibits Indiana Navigators and application

organizations (AOs) from receiving consideration from a health insurance issuer in connection with the enrollment of a consumer into a health plan.

43. **Large Employer** (also referred to as **Large Group Employer**) is, in Indiana, an employer who employed an average of more than 50 employees on business days during the preceding year. Employers with more than 50 full-time employees are eligible for the large group insurance market in Indiana. Employers with more than 50 full-time employees plus full-time equivalent employees (FTEs) are subject to the employer shared-responsibility provisions of the Affordable Care Act (ACA) (the “Employer Mandate”) and are not eligible for the SHOP Marketplace. An employee is defined as any individual employed by an employer but not an individual owner or partner.
44. **Major Medical Insurance** is a health insurance plan that offers individuals comprehensive insurance against potential healthcare costs. Major medical policies offer coverage for a wide array of health benefits, providers, products, and services. Plans that only cover a specific health condition or service are not major medical products. In general, being covered by a major medical policy will qualify as minimum essential coverage (MEC) under the Affordable Care Act (ACA). However, some major medical plans are not considered MEC, for example certain types of student health insurance.
45. **Marketplace** (also referred to as **Exchange**) is a shopping and enrollment service for health insurance that makes qualified health plans (QHPs) available to qualified individuals or qualified employers in accordance with the Patient Protection and Affordable Care Act (PPACA, or ACA) of 2010. The term includes a Federally-facilitated Marketplace (FFM, or Federal Marketplace), a Partnership Marketplace, or a State-based Marketplace. Indiana operates as a FFM at [healthcare.gov](http://healthcare.gov).
46. **Medical Loss Ratio (MLR)** is the percent of premiums collected by a health insurance carrier and spent on medical services and quality improvement. Under the Affordable Care Act (ACA), carriers must maintain a certain MLR, which varies by market segment (large group 85%, small group 80%, individual 80%). If a carrier does not meet the MLR requirement, the covered individuals and small businesses will receive a refund.
47. **Medicare** is a federal insurance program administered by the Centers for Medicare and Medicaid Services (CMS) that guarantees access to health insurance for: (1) individuals aged 65 and older who have worked and paid into the program; (2) individuals under 65 with qualifying disabilities; (3) individuals with End Stage Renal Disease; and (4) individuals with Amyotrophic Lateral Sclerosis. Medicare qualifies as minimum essential coverage (MEC) under the Affordable Care Act (ACA) and individuals eligible for Medicare are not eligible for the Federally-facilitated Marketplace (FFM).
48. **Metal Tier** (also referred to as **Health Plan Category**, **Metal Level**, or **Metal Plan**) refers to any of the four categories of health plans offered in a marketplace (*i.e.*, Bronze, Silver, Gold, or Platinum). The plans are categorized based on the percentage the plans pay of the average overall cost of providing essential health benefits (EHBs) to consumers. The plan a consumer chooses affects the total amount the consumer will likely spend for EHBs during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum).
49. **Minimum Essential Coverage (MEC)** is a type of health insurance coverage that an individual and the individual’s dependents must have to meet the Individual Mandate under the Affordable Care Act (ACA). The list of MEC types (see [Table 50](#)) is determined by the federal government and is subject to change. Types of coverage not currently considered MEC may apply for recognition as minimum essential coverage. Individuals may receive an exemption from the requirement to maintain minimum essential coverage.
50. **Minimum Value (MV)** is the lowest threshold for the value of a health plan under the Affordable Care Act (ACA). A plan with MV should cover, on average, at least 60% of the medical costs of a standard population. Individuals offered employer-sponsored coverage that provides MV and that’s affordable are not eligible for a premium tax credit (PTC).

51. **Modified Adjusted Gross Income (MAGI)** is an eligibility methodology for insurance affordability programs. MAGI equals adjusted gross income (AGI) plus tax excluded foreign earned income, tax exempt interest and tax exempt Title II social security income. MAGI methodologies are applied to individuals applying for premium tax credits (PTCs) and in the Medicaid program to children, pregnant women, parent and caretaker relatives and adults.
52. **Modified Adjusted Gross Income (MAGI) Conversion** is the process by which states were required to convert pre-2014 Medicaid eligibility standards to a MAGI equivalent. The goal of the MAGI conversion process was to establish a MAGI-based income standard that is not less than the effective income eligibility standard as applied on the date of Affordable Care Act (ACA) enactment for each eligibility group.
53. **Network Adequacy Standards** is provision in the Affordable Care Act (ACA) requiring marketplace insurers to ensure that the provider networks of each of their qualified health plans (QHPs) are available to all enrollees and meet other standards, such as having essential community providers, maintaining a network that is sufficient in number and types of providers, and making the insurer's provider directory for a QHP available to the marketplace for publication online.
54. **Non-Grandfathered Health Plan** is a health insurance policy that does not have "Grandfathered" status (*i.e.*, was not in existence prior to when the Affordable Care Act (ACA) was signed into law on March 23, 2010). The term may include a qualified health plan (QHP), grandmothered (or "transitional") plan, or any other health plan on or off a marketplace that was effective after the ACA became effective.
55. **Non-Modified Adjusted Gross Income (Non-MAGI) Populations** is a Medicaid eligibility determination process for populations exempt from modified adjusted gross income (MAGI) methodologies. Non-MAGI methodologies are applied to individuals ages 65 or older when age is a condition of eligibility, individuals being determined eligible on the basis of blindness or disability, individuals applying for long-term services and supports for which a level of care need is a condition of eligibility, individuals whose eligibility does not require an income determination to be made by the Medicaid agency, individuals applying for Medicare cost-sharing, former foster children under age 26, and deemed newborns.
56. **Open Enrollment Period** is the timeframe in which individuals can apply and enroll in health coverage through the individual Federally-facilitated Marketplace (FFM). The annual open enrollment period is determined by the Centers for Medicare and Medicaid Services (CMS) and may be viewed on the FFM website at [www.healthcare.gov](http://www.healthcare.gov). For 2017 FFM coverage, the open enrollment period is November 1, 2016 – January 31, 2017. People may qualify for **special enrollment periods (SEPs)**, allowing them to enroll on the FFM outside of open enrollment. Individuals may apply for Indiana Health Coverage Programs (IHCPs) at any time of the year.
57. **Out-of-Network Provider** is a healthcare provider that is not contracted with a particular insurer to provide healthcare/medical services at a discounted rate for consumers covered by the insurer. Some out-of-network providers may not accept an individual's health insurance, and payment may be requested up front. For providers that do not accept an individual's health insurance, an individual may submit a form directly to their insurer showing what they paid for the service. If this form is submitted, the amount the enrollee spent for covered services will count toward the plan deductible and out-of-pocket maximum, and if the enrollee has met the deductible the insurer may issue compensation. To determine whether a provider is in-network or out-of-network with an insurer, a list of in-network providers can be accessed through the health insurer's website or by calling the health insurers consumer help desk.
58. **Out-of-Pocket Maximum** (also known as **Out-of-Pocket Limit**) is the greatest amount that a consumer pays for healthcare services in any plan year before the insurance carrier pays 100% of healthcare costs. This limit never includes premiums paid or healthcare services not covered by the

policy. Out-of-pocket maximum is set by the federal Internal Revenue Service (IRS). For 2017, this maximum amount is \$7,150 for an individual and \$14,300 for a family.

59. **Pediatric** refers to children under the age of nineteen. Under the Affordable Care Act (ACA), pediatric healthcare services, including oral and vision care, are considered essential health benefits (EHBs) that an insurance carrier in the individual and small group markets are required to cover.
60. **Platinum Plan** is a type of qualified health plan (QHP) offered to consumers on a marketplace. It is designed so that the insurance carrier will pay 90% of covered healthcare expenses with the remaining 10% to be paid by consumers. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the highest of the four QHPs/metal tiers). Out-of-pocket expenses in 2017 are capped at \$7,150 for individual plans and \$14,300 for family plans.
61. **Policy Year** is either: (1) the 12-month period that is designated as the policy year in the policy documents of a grandfathered health plan offered in the individual health insurance market. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year. Or (2) A calendar year for a non-grandfathered health plan offered in the individual health insurance market, or in a market in which the state has merged the individual and small group risk pools.
62. **Pre-Existing Condition** is a health issue (such as cancer, diabetes, asthma, etc.) that an individual has prior to obtaining health insurance. Under the Affordable Care Act (ACA), as of January 1, 2014 health insurance issuers can no longer deny someone coverage, offer less coverage, or charge more for coverage based on a pre-existing condition. The pre-existing conditions rule does not apply to "grandfathered" health plans.
63. **Premium** is the amount that a consumer must periodically pay to the insurance carrier for a health insurance plan. Individuals pay the premium regardless of whether or not they use the health insurance. It is meant to compensate the insurer for bearing the risk of a payout should the insurance agreement's coverage be required. Premiums are usually paid on a monthly basis, but may be quarterly or yearly.
64. **Premium Tax Credit (PTC)** (also referred to as **Subsidy**) is a tax credit that lowers premium costs for certain eligible individuals to help them afford health coverage purchased through a marketplace. An individual may apply for a PTC through the Federally-facilitated Marketplace (FFM), and the FFM determines the individual's PTC eligibility and maximum PTC amount. To be eligible for a PTC on the FFM operating in Indiana, an individual must: (1) be a U.S. citizen, national or legal resident of the U.S.; (2) be an Indiana resident; (3) be non-incarcerated; (4) have a household income between 100% and 400% of the federal poverty level (FPL); and (5) have no other minimum essential coverage (MEC) or an available MEC with a premium more than 9.66% of household income or that does not provide minimum value (MV) (at least 60% actuarial value (AV)). A PTC can be either claimed retroactively when the consumer's taxes are filed or may be paid in advance directly to the health insurer to reduce premiums (this advanced PTC is referred to as an **Advanced Premium Tax Credit** or **APTC**).
65. **Producer** (also referred to as **Agent**, **Broker** or **Agency**) is an individual or business entity licensed by a state to sell, solicit, or negotiate insurance products within the state. A licensed health insurance agent/broker/producer that sells health insurance products and receives compensation from a health insurance carrier for doing so is prohibited from being an Indiana Navigator or Application Organization (AO) in the state of Indiana. A licensed insurance agent/broker/producer that sells health insurance products on the Federally-facilitated Marketplace (FFM) must be certified by the Federally-facilitated Marketplace.

66. **Provider** (also referred to as **Healthcare Provider**) is an individual or entity that provides healthcare or medical services to a patient. Common examples include a doctor's office, hospital, or health clinic. A healthcare provider can be either "**in-network**" (covered) or "**out-of-network**" (not covered) with the health insurance coverage offered by a health insurance issuer. *\*Note: a health insurance issuer may sometimes be referred to as a health insurance provider. It is an important distinction to remember that the "health insurance provider" (the provider/issuer/insurer/carrier of the health insurance) is different from the "healthcare provider" (the provider of healthcare or medical services).* To determine whether a provider is in-network or out-of-network with an insurer, a list of in-network providers can be accessed through the health insurer's website or by calling the health insurers consumer help desk.
67. **Qualified Health Plan (QHP)** is a health insurance plan that has been certified under the Affordable Care Act (ACA) to meet the criteria for availability through a marketplace. All QHPs sold on the Federally-facilitated Marketplace (FFM) are certified by federal and state agencies to be sure they provide minimum essential coverage (MEC), cover essential health benefits (EHBs), meet actuarial value (AV) standards, appear as metal tiers (Bronze, Silver, Gold, or Platinum), and meet provider network standards. Like all other non-grandfathered plans, QHPs cannot consider the consumer's health status for the purposes of plan eligibility or plan cost.
68. **Rate Review** is the process by which a state insurance department may review and approve, deny, or negotiate health insurance premiums offered by insurers on or off a marketplace. Under its authority granted by the Indiana Code and federal Effective Rate Review Status, the Indiana Department of Insurance (IDOI) reviews and approves/denies/negotiates premiums for all health insurance policies sold to Hoosiers.
69. **Rating Factors** (also referred to as **Premium Rating Factors**) are the information insurance companies use to decide what premium to charge any particular individual. Prior to the Affordable Care Act (ACA), the premium cost for major medical plans could vary based on health status, gender, age, weight, tobacco or alcohol use, location, or other factors. Beginning in 2014, the ACA limits the allowable rating factors to age, location, and tobacco use. These plans may no longer charge different rates based on gender or health status.
70. **Redetermination** (also referred to as **Eligibility Redetermination**) is the process by which an enrolled consumer is re-enrolled, terminated, or transferred into an Indiana Health Coverage Program (IHCP) or the Federally-facilitated Marketplace (FFM). Eligibility redeterminations are to ensure that consumers are still eligible and in the right programs. The process is done every 12 months or when the enrollee reports any changes to household income, household size, or residence.
71. **Re-Enrollment** is the annual process by which consumers are redetermined eligible for Indiana Health Coverage Program (IHCP) or Federally-facilitated Marketplace (FFM) coverage and the steps consumers must take to re-enroll in coverage. All individuals enrolled in an IHCP or the FFM will receive a notice asking them to report any changes in circumstances. Any changes reported will be considered in the annual eligibility redetermination.
72. **Reward** refers to either a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive (and avoiding a penalty) such as the absence of a premium surcharge or other financial or nonfinancial disincentive.
73. **Seasonal Worker** is a worker who performs labor or services on a seasonal basis as defined by the U.S. Secretary of Labor, and retail workers employed exclusively during holiday seasons.
74. **SHOP Enrollment Period** is the timeframe in which qualified employers may apply and enroll in the Small Business Health Options Program (SHOP) Marketplace. The SHOP enrollment period is a "rolling enrollment period" meaning that, in most circumstances, SHOP coverage may be obtained at any time of the year and is not subject to an open enrollment period. For employers that do not

meet minimum participation or minimum contribution requirements, there will be a once annual open enrollment period; all other employers may enroll in the SHOP at any time.

75. **Silver Plan** is a type of qualified health plan (QHP) offered to consumers on a marketplace. It is designed so that an insurance carrier will pay 70% of covered healthcare expenses with the remaining 30% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the second lowest in Indiana behind the bronze plan). Out-of-pocket expenses for 2017 are capped at \$7,150 for individual plans and \$14,300 for family plans.
76. **Small Business Health Options Program (SHOP)** (also referred to as the **SHOP Marketplace**) is the Federally-facilitated Marketplace (FFM) available to small employers to purchase health coverage for their employees. Eligible employers in Indiana must have 50 or fewer full-time equivalent employees (FTEs). Employers using SHOP can use brokers or can use SHOP independently. SHOP is located online at [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses).  
**Small Employer** (also referred to as **Small Group Employer**) is, in Indiana, an employer who employed an average of at least one but not more than 50 employees during the preceding year. Employers with one to 50 full-time employees are eligible for the small group insurance market in Indiana. Employers with one to 50 full-time employees plus full-time equivalent employees (FTEs) are not subject to the employer shared-responsibility provisions of the Affordable Care Act (ACA) (the "Employer Mandate") and are eligible for the SHOP Marketplace. Employers that have fewer than 25 full-time employees plus FTEs may qualify for employer healthcare tax credits on the SHOP Marketplace. An employee is defined as any individual employed by an employer but not an individual owner or partner.
77. **Special Enrollment Period (SEP)** is a timeframe outside of the open enrollment period in which a consumer may enroll in health coverage through the Federally-facilitated Marketplace (FFM) due to certain qualifying life events, such as losing other health coverage, marriage, divorce, or a birth or adoption of a child. A list of life events that qualify for a SEP is outlined in [Table 70](#). An individual will qualify for a SEP 60 days following qualifying life events.
78. **Stand-Alone Dental Plan** refers to the dental-only health insurance plans offered through a marketplace. Individuals can get dental coverage in two ways: as part of a health plan, or by itself through a separate, stand-alone dental plan. Under the Affordable Care Act (ACA), dental coverage is considered an essential health benefit (EHB) for children under age 18, but is not considered an EHB for adults ages 18 and over. Therefore, insurers are not required to offer adult dental coverage, and adults will not be penalized for not having dental coverage.
79. **State Health Insurance Assistance Program (SHIP)** is a free and unbiased counseling program provided by the Indiana Department of Insurance (IDOI) for Medicare beneficiaries in Indiana. SHIP is part of a federal network of SHIPs located in every state.
80. **Summary of Benefits and Coverage** is a document given to consumers by a health insurer when shopping for health coverage, enrolling in coverage, at the beginning of each new plan year, or within seven business days of requesting a copy from the insurer. The Summary of Benefits and Coverage summarizes the key features of a health plan, such as covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
81. **Wellness Program** is a program of health promotion or disease prevention. Participation in such a program may result in lower premiums or other cost-sharing.

## C. Basics of the Affordable Care Act

The Affordable Care Act (ACA), passed in March 2010, created new health insurance requirements for individuals, employers, and insurers. The ACA also required a new marketplace (sometimes termed an “exchange”) to be created in each state that will offer individuals and small businesses a new avenue to purchase health insurance coverage. The states are able to choose between three models of marketplaces: federally-facilitated (federal), operated in partnership with the federal government, or operated by the state. Indiana has chosen to allow the federal government to facilitate its marketplace. This new avenue to purchase coverage is intended to facilitate consumer choice in selecting a health plan that best meets individual needs.

For individuals, the ACA created new requirements to maintain coverage, provisions for [premium tax credits](#) (PTCs) and [cost-sharing reductions](#) (CSRs) to help individuals and families up to 400% of the [federal poverty level](#) (FPL) afford coverage, tax penalties associated with not having health insurance, and put annual restrictions on when coverage will be available for purchase. The coverage options offered to individuals will also be substantially different than individual coverage prior to the implementation of the Affordable Care Act. Among the major changes, the ACA eliminated the ability for insurers to deny coverage or charge higher premiums to individuals based on health status, and changed requirements around cost-sharing and the comprehensiveness of offered benefits. Low-income individuals in some states may also have access to expanded Medicaid programs.

Small businesses have the option to obtain coverage for their employees in the [Small Business Health Options Program](#) (SHOP). The ACA also imposes new requirements on small businesses regarding how to count employees, new restrictions on deductible amounts in the insurance plans offered to employees, general changes to the structure and benefits offered in small employer plans, and a transition of the tax credits for offering health insurance to availability only for those who purchase coverage in the SHOP.

For large employers, the ACA changes the way employees are counted and implements new employer-shared responsibility provisions. Starting in 2015, these provisions require employers to pay fines if their employees receive premium tax credits (PTCs) for coverage in a marketplace because the employer does not offer coverage or offers coverage that is not affordable (the cost of single premiums exceed 9.66% of the employee’s household income) or does not provide [minimum value](#) (MV) (covers 60% of healthcare costs).

For insurers, the ACA made changes to how insurers issue plans, how insurers develop premium rates, how the cost-sharing and benefits are structured, and who and what benefits their plans have to cover. The ACA also created a new category of health insurance plan, the [qualified health plan](#) (QHP), as the only type of plan that is offered on the [Federally-facilitated Marketplace](#) (FFM). Insurers are also required to meet new [medical loss ratio](#) (MLR) and [actuarial value](#) (AV) requirements.

**Sidebar:** In the original passage of the ACA, the terminology used was exchange. For exchanges run by the federal government, the name was changed to marketplace. State-run exchanges or marketplaces may use exchange, marketplace, or their own terminology. In Indiana, the exchange is run by the federal government and is termed the Federally-facilitated Marketplace (FFM), Marketplace, or Federal Marketplace.

## 1. Individual Impacts

### *a. Requirement to Have Health Insurance*

Called the Individual Shared-responsibility provision or the Individual Mandate, the ACA requirement that individuals have health insurance subjects individuals to a tax penalty if they do not maintain [minimum essential coverage](#) (MEC) for themselves and their dependents or receive an [exemption](#) from the requirement. Minimum Essential Coverage is defined by types of health coverage; and individuals with health coverage through employers, government programs, or the individual market are likely to meet this requirement.

### *b. Guaranteed Issue and Guaranteed Renewability*

Individuals who previously would have been denied for health insurance because of their health status are now guaranteed under the ACA that insurers will issue coverage. Additionally, insurers are not able to charge higher premiums to individuals because of pre-existing conditions.

### *c. Comprehensive Coverage*

All non-grandfathered major medical plans are required to cover certain preventive health benefits designated by the Affordable Care Act. In addition, health plans sold on the individual and small group markets will be required to cover the [essential health benefits](#) (EHBs) and to offer plans in the metal tiers. All health plans subject to the ACA in the individual and small group market must offer plans at the [bronze, silver, gold and/or platinum](#) level. The benefits offered in each level may not vary; however, the amount of cost-sharing an individual would pay for services will vary by metal tier.

Existing individual and small group health insurance policies that do not meet all of the requirements of the ACA (*i.e.*, “grandmothered” or “transitional” plans) may be renewed in Indiana at the discretion of the issuers through October 1, 2016. These plans must not undergo any material changes to the plan (*e.g.*, a change in plan benefits, or a “buy-down” of plan premiums by insurer to lower cost-sharing), are required to cover certain preventive health benefits designated by the ACA, and are not required to contain the 10 EHBs or to adopt the rating structure of fully ACA-compliant plans.

### *d. New Avenues to Purchase Health Insurance*

Individuals may shop for and purchase health insurance directly from the health insurer, through an insurance agent or broker, or online. However, they also have access to the [Federally-facilitated Marketplace](#) (FFM). To purchase coverage on the FFM in Indiana, individuals must be a United States citizen, national, or legal resident, reside or intend to reside in the state of application (Indiana), and not be incarcerated. Individuals will have a choice among all FFM plans that offer coverage for their location and family composition and will be able to select a plan based on quality, covered benefits, covered providers, and expected cost-sharing level.

### *e. Help Paying for Health Insurance and Cost-Sharing*

There are two provisions that help qualified individuals afford health insurance premiums and cost-sharing for health services received. Both of these programs are only available for individuals who are screened and found eligible by the Federally-facilitated Marketplace. Individuals can approach the FFM directly and apply for health coverage, or may work through an insurer that sells plans on the FFM or a

FFM agent, broker, or web-broker. However, health insurance plans that are not offered on the FFM will not be eligible for these affordability programs that reduce premium cost and cost sharing for eligible individuals.

The first program, the [premium tax credit](#) (PTC), helps individuals at qualifying income levels to afford health insurance premiums. This program requires individuals to pay a certain amount towards the premiums to cover themselves and their families. The percentage of income that individuals and families must pay toward a premium varies based on income level. Premium costs in excess of the amount the individual or family must pay is covered through the PTC program. The amount of the PTC is estimated when the individual applies for insurance affordability programs via the FFM, and can be in advance directly paid to the health insurer to reduce premiums or claimed retroactively when taxes are filed (see the [APTC Reconciliation section](#) for more information on this process). Individuals who smoke will not receive a tax credit for any premium portion related to tobacco use.

The second program, [cost-sharing reductions](#) (CSRs), helps eligible individuals with qualifying income levels (under 250% of the [federal poverty level](#) (FPL)), who select a qualifying plan, to pay for cost-sharing obligations related to obtaining healthcare. This program has the potential to greatly reduce cost sharing that qualifying individuals may owe for healthcare expenses. Individuals who qualify for CSRs must select a [silver](#) level plan to receive the benefit. There is no separate application for this program; however, individuals may have to pay slightly more in monthly premiums for a silver plan than for other available plans on the FFM ([bronze](#) plans). The slightly higher monthly premium payment translates into reduced cost-sharing responsibility when the individual seeks care.

#### ***f. Enrollment Periods***

Individuals can only purchase [qualified health plans](#) (QHPs) sold on the FFM during open enrollment periods. For 2017 coverage, the open enrollment period is November 1, 2016 – January 31, 2017. Outside of open enrollment, individuals may only purchase or change a FFM plan if they have life event that qualifies them for a [special enrollment period](#) (SEP). Examples of these life events include individuals losing access to other health coverage or experiencing an event like marriage, divorce, or the birth or adoption of a child.

Health insurers that sell plans outside of the FFM may elect to only sell plans during the FFM open enrollment periods. Regardless of whether an individual is purchasing a plan inside or outside of the Marketplace, individuals that do not purchase a plan during the open enrollment period will not be able to purchase health insurance at other times of the year.

## **2. Employer Impacts**

The Affordable Care Act (ACA) contains provisions impacting small and large employers. In Indiana, small employers with up to 50 full-time equivalent employees (FTEs) have access to the [SHOP Marketplace](#) to purchase coverage for their employees.<sup>42</sup> Small employers with up to 25 FTEs may be eligible for tax credits to help pay for the cost of coverage for their employees. To receive these tax credits, the small employers must enroll in coverage through the SHOP Marketplace. Large employers with 51 or more

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<sup>42</sup> Under the ACA, the definition of small employer was set to change effective January 1, 2016, increasing a small employer from one to 50 employees to one to 100 employees. However, the federal PACE Act ([H.R. 1624—2015](#)) prevents this change from happening, unless a state chooses to define a small employer as having up to 100 employees. As of 2016, Indiana has chosen to keep the definition at one to 50 employees.

FTEs will be subject to the [Employer Mandate](#)/shared-responsibility payment if they do not offer coverage that is affordable and provides [minimum value](#) (MV) to all FTEs and a FTE receives a [premium tax credit](#) (PTC) from the Federally-facilitated Marketplace (FFM).

#### *a. Full-Time Equivalent Employees*

The ACA institutes a new way to count employees to determine if an employer is a small or large employer for the purpose of determining if an employer is subject to the Employer Mandate payment or if an employer is eligible for the SHOP Marketplace. This is called the full-time equivalent employee (FTE) count. Previously, a count would be taken of all of their full-time employees. Full-time employees are defined as employees working an average of 30 hours<sup>43</sup> or more a week. The FTE count includes these full-time employees and adds a full-time equivalent estimate for part-time employees that work on average less than 30 hours per week. For example, an employer with 20 employees that work over 30 hours a week on average would have 20 full-time employees.

To determine FTEs, the employer would sum all hours worked by part-time employees in each week and divide this sum by 30.<sup>44</sup> Full-time equivalent employees are calculated based on an annual average of hours worked. Employers that have staffing variability during the year and sometimes have over 50 FTEs and sometimes under 50 FTEs will need to calculate their annual average employees to determine if they are a small or an applicable<sup>45</sup> large employer for the purposes of SHOP enrollment and the large employer shared-responsibility provisions.

Additional guidance is provided by the federal government at [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses), [www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf](http://www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf), and [www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions](http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions) to assist employers on how to account for various employee types and circumstances, such as a salaried employees who do not clock in their hours, when determining if an organization is considered a small or large group employer. Furthermore, this guidance describes the transitional relief available to employers for the shared-responsibility requirements beginning in 2015.

The following table (see [Table 47](#)) provides an illustration of how an employer might determine full-time equivalent employees. This illustration is an example only and is not intended to provide instructions for employers on how to calculate their full-time equivalent employees.

<sup>43</sup> 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week, provided that the employer applies this equivalency rule on a reasonable and consistent basis. This monthly standard takes into account that the average month consists of more than four weeks.

<sup>44</sup> As a proxy, employers may divide the hours worked by all part-time employees in a month and divide by four.

<sup>45</sup> Employers will use information about the number of employees they employ and their hours of service during 2016 to determine whether they employ enough employees to be an applicable large employer for 2017.

**Table 47: Example of Full-time Equivalent Employee (FTE) Count**

Month	Full-time Employees	Full-time equivalent employees	Total Employee Count
<i>January</i>	35	10	45
<i>February</i>	36	12	48
<i>March</i>	36	11	47
<i>April</i>	36	12	48
<i>May</i>	35	15	50
<i>June</i>	37	16	53
<i>July</i>	37	16	53
<i>August</i>	37	20	57
<i>September</i>	35	16	51
<i>October</i>	37	11	48
<i>November</i>	35	10	45
<i>December</i>	35	10	45
<b>Annual Average Employees</b>	<b>35.9</b>	<b>13.3</b>	<b>49.2</b>

In the example, even though the employer has over 50 full-time employees and FTEs for some months, on average over the year there are fewer than 50 full-time and full-time equivalent employees. Thus, the employer would be eligible to enroll in the [SHOP](#) and would not be subject to the [employer shared-responsibility payments](#).

**Sidebar:** Eligibility for the small group market in the state is based on full-time employees while eligibility for the SHOP is based on full-time equivalent employees. Employers that have over 50 employees when FTEs are included, but under 50 full-time employees, will not be eligible for initial enrollment in the SHOP and will be subject to employer shared-responsibility provisions. However, they will also be eligible for small group coverage off of the FFM and ineligible for large group coverage by virtue of having fewer than 50 full-time employees.

If the employer's annual average FTE count, displayed in the highlighted box of the chart above, is greater than 50 employees, the employer is not be eligible for enrollment in the SHOP and would be subject to the employer shared-responsibility requirements. However, employers of seasonal workers that have an average annual FTE count over 50 may not be subject to the employer shared-responsibility requirement if their employee count exceeds 50 employees for no more than four months out of the year *and* the employees in excess of 50 are considered seasonal workers. In addition, employees that enroll in coverage through the SHOP when they have under 50 FTEs may continue to reenroll in SHOP coverage even if they grow to over 50 full-time equivalent employees. The FTE count is based on the parent business. Businesses with multiple divisions or subsidiaries that are owned by the same organization will sum their FTE counts.

**Sidebar:** Though the FTE count will determine if a business is a small or large business and eligible to purchase on SHOP or subject to the large employer mandate, the employees that will be offered coverage under a plan are only those employees that are full-time employees, meaning those that work over 30 hours a week. Under the ACA, employers are not required to offer coverage to employees that work under 30 hours a week for employers that exceed 50 employees.

More information on FTE count can be found at [www.healthcare.com/small-businesses](http://www.healthcare.com/small-businesses) and [www.irs.gov/pub/irs-drop/n-12-58.pdf](http://www.irs.gov/pub/irs-drop/n-12-58.pdf). Employers may calculate their FTE count at [www.healthcare.gov/shop-calculators-fte/](http://www.healthcare.gov/shop-calculators-fte/). Employers with questions about their FTE count and if they are a large or small employer should contact an agent or broker<sup>46</sup> or the SHOP at [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses) or 1-800-706-7893.

### 3. Small Employers

#### *a. SHOP Marketplace*

The Small Business Health Options Program (SHOP) is a marketplace for small employers in Indiana with 50 or fewer full-time equivalent employees (FTEs). Small employers may use the SHOP to purchase coverage for their employees. In most circumstances SHOP, coverage may be obtained at any time of the year and is not subject to an open enrollment period. For employers that do not meet minimum participation or minimum contribution requirements, there will be a once annual “open enrollment period;” all other employers may enroll in the SHOP at any time.

Small employers interested in SHOP coverage should contact their agent or broker or the SHOP directly at [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses) or 1-800-706-7893. Employers may set up an online account for the SHOP at any time and will be able to receive an eligibility determination for SHOP coverage and begin the plan selection process. Employers may view a sample employer application on the Centers for Medicare and Medicaid Services (CMS) website at [www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/shop-employer-application-5-31-2013.pdf](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/shop-employer-application-5-31-2013.pdf) and a sample employee application at [www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/shop-employee-application-5-31-2013.pdf](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/shop-employee-application-5-31-2013.pdf). These applications may be completed online at [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses). Also, detailed, step-by-step guides on how to complete the application and enrollment process are posted online at [www.healthcare.gov/small-businesses/choose-and-enroll/enroll-in-shop](http://www.healthcare.gov/small-businesses/choose-and-enroll/enroll-in-shop). More information on the SHOP is available in the [SHOP section](#).

#### *b. Small Employer Tax Credits*

Small employers with fewer than 25 FTEs, excluding the owner and family members, with an average per employee wage lower than \$50,000 annually, may be eligible for a tax credit if they purchase coverage on the SHOP Marketplace for their full-time employees. This tax credit can be claimed by eligible small employers when they file their taxes. The amount of the small employer tax credit is up to 50% of the amount the employer pays towards premiums for employees (up to 35% for tax-exempt

<sup>46</sup> A list of agents and brokers who have completed the FFM registration is posted on the CMS website at <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html#Agent%20and%20Broker%20Federally-Facilitated%20Marketplace%20%28FFM%29%20Registration%20Completion%20List>.

employers) and can only be claimed if the employer purchases insurance for their employees through the SHOP Marketplace.

The amount of the tax credit varies by the number of employees and the employee's average wages. Employers with fewer workers and a lower average wage will receive a greater relative tax credit. The following table (see [Table 48](#)) displays the percent of their contribution that qualifying employers may expect to be returned at tax filing if they have offered coverage through the SHOP Marketplace. This table is for illustrative purposes only, and does not represent the actual tax credit any small employer may or may not be eligible for.

**Table 48: Small Employer Tax Credits - Percent of Employer Contribution**

Full-time equivalent employees	Average Annual Wages					
	<\$25k	\$30k	\$35k	\$40k	\$45k	\$50k
< 10	50%	40%	30%	20%	10%	0%
11	47%	37%	27%	17%	7%	0%
12	43%	33%	23%	13%	3%	0%
13	40%	30%	20%	10%	0%	0%
14	37%	27%	17%	7%	0%	0%
15	33%	23%	13%	3%	0%	0%
16	30%	20%	10%	0%	0%	0%
17	27%	17%	7%	0%	0%	0%
18	23%	13%	3%	0%	0%	0%
19	20%	10%	0%	0%	0%	0%
20	17%	7%	0%	0%	0%	0%
21	13%	3%	0%	0%	0%	0%
22	10%	0%	0%	0%	0%	0%
23	7%	0%	0%	0%	0%	0%
24	3%	0%	0%	0%	0%	0%
25+	0%	0%	0%	0%	0%	0%

Source: Congressional Research Service (2010), *Summary of Small Business Health Insurance Tax Credit*, [www.ncsl.org/documents/health/SBtaxCredits.pdf](http://www.ncsl.org/documents/health/SBtaxCredits.pdf)

Employers may also utilize the tax credit estimator available at [www.healthcare.gov/shop-calculators-taxcredit](http://www.healthcare.gov/shop-calculators-taxcredit).

Employers interested in applying for the tax credit can find more information on the Internal Revenue Service (IRS) website at [www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers](http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers). Employers that are interested in applying for the tax credit should contact their agent or broker, a tax professional, or the SHOP Marketplace at [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses) or 1-800-706-7893 for further detail on the application process and requirements.

### ***c. Employer Shared-Responsibility Payments***

Starting in 2015, employers in Indiana with over 50 full-time employees, including full-time equivalent employees (FTEs), have been subject to the employer shared-responsibility provisions (the "Employer Mandate"). These employers are subject to a tax penalty levied by the IRS for each month in which they have one or more full-time employees receiving a [premium tax credit](#) (PTC) through the [Federally-](#)

[facilitated Marketplace](#) (FFM). Employers will not be subject to the shared-responsibility payment if employees that work on average less than 30 hours a week receive a premium tax credit. The shared-responsibility payment assessed when full-time employees receive a PTC will vary depending on whether or not the employer offers coverage to at least 95%<sup>47</sup> percent of their full-time employees.

Additional guidance is provided at [www.healthcare.gov/small-businesses/health-care-law-and-business/employer-shared-responsibility-payment](http://www.healthcare.gov/small-businesses/health-care-law-and-business/employer-shared-responsibility-payment) for other methods used to assess the employer shared-responsibility payment.

**Table 49: Large Employer Shared-Responsibility Payments**

Employers Offering Coverage to At Least 95% of Full-Time Employees	Employers <u>Not</u> Offering Coverage to At Least 95% of Full-Time Employees
Penalty is the lesser of: <ul style="list-style-type: none"> <li>• \$3,000 per year (\$250 per month) for each full-time employee receiving a premium tax credit (PTC), or</li> <li>• \$2,000 per year (\$167 per month) for every full-time employee and full-time equivalent employee (FTE), excluding the first 30 employees</li> </ul>	<ul style="list-style-type: none"> <li>• \$2,000 per year (\$167 per month)* for every full-time employee and FTE, excluding the first 30 employees</li> </ul>

\* For an employer that offers coverage for some months but not others during the calendar year, the payment is computed separately for each month for which coverage was not offered.

Source: Internal Revenue Service, *Calculation of Employer Shared Responsibility Payment*, [www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act#Calculation](http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act#Calculation)

An employer with 75 FTEs that offers coverage to at least 95% of their full-time employees and has one full-time employee who receives a PTC for the entire year would be subject to a penalty of \$3,000, if the full-time employee only received a PTC for a month, this employer would be subject to a \$250 penalty. An employer with 75 FTEs that does not offer coverage to at least 95% of full-time employees and has one or more full-time employee(s) receive a PTC for an entire year will be subject to a penalty of \$90,000.<sup>48</sup> If one or more full-time employees receive a PTC for a single month then the employer with 75 FTEs will be subject to a penalty of \$7,500.

Employers that offer coverage to at least 95% of their full-time employees but have a substantial number of full-time employees that receive a PTC due to the employer coverage either being unaffordable (premium contribution exceeds 9.66% of household income for single coverage) or not offering [minimum value](#) (MV) will pay: the lesser of \$3,000 for each employee receiving a PTC for the entire year or \$2,000 for each full-time employee and FTE, excluding the first 30 employees. For example, if an employer with 75 FTEs that offers coverage to at least 95% of their employees has 35 full-time employees that receive PTCs for the entire year, they would not be subject to the \$3,000 penalty for every individual receiving a PTC, as this would be \$105,000, which is greater than the \$90,000 an employer of the same size that did not offer coverage to at least 95% of FTEs would pay. This employer would pay the maximum penalty amount of \$90,000. The amounts of the employer penalty will be updated on an annual basis.

<sup>47</sup> Large employers with between 50 and 100 employees may have up to five full-time employees that are not offered coverage.

<sup>48</sup> \$2,000 x (75-30) = \$90,000

Large employers may be subject to this penalty when employees receive a premium tax credit. Individuals that have access through an employer to affordable coverage that provides MV are not eligible for a premium tax credit. Large employers will only be subject to this penalty if:

- The employer-sponsored plan is not affordable for the employee. For employer-sponsored insurance, affordable coverage costs less than 9.66% of the employee's household income for a single (not family) premium. Because employers do not know what employees' household income is, they may claim a safe harbor exemption if the cost of their lowest cost coverage option, including discounts for non-smoking, is less than 9.66% of the employee's annual wage as reported on the employees W2.
- The employer-sponsored plan does not provide minimum value. Minimum value is discussed in the [next section](#).
- The employer does not provide an employer-sponsored plan option to full-time employees. Employers may still implement a waiting period for enrollment in the employer-sponsored coverage of up to 90 days for new employees. Employers will not be liable for any employer shared-responsibility payments for the employees in the waiting period.

Employer shared-responsibility payments for 2016 will be paid in 2017, 2017 will be paid in 2018, and so on. Employers may appeal the assessment of the employer shared-responsibility provisions. This appeal should be directed to the IRS, the federal agency that administers the penalties.

#### *d. Minimum Value of Plans*

Nothing requires employer plans to provide minimum value (MV). Employees may be eligible for [premium tax credits](#) (PTCs) if their employer-sponsored plan does not provide MV and employers with over 50 full-time equivalent employees may be subject to the [employer shared-responsibility payments](#) if any of their full-time employees receive premium tax credits. To provide MV, an employer-sponsored plan must have an [actuarial value](#) (AV) of at least 60 percent. In other words, the employer-sponsored plan must cover at least 60% of the cost of the benefits offered on the plan over the entire population. Employer contributions to health savings accounts (HSAs) and health reimbursement accounts (HRAs) for cost-sharing will count towards MV, as will any incentives employees earn for tobacco cessation activities.

Minimum value does not require that certain benefits be offered. Plans purchased on the large group market or employer self-insurance plans are not required to meet the [essential health benefit](#) (EHB) requirements and individuals covered by large employer plans that provide MV may not have coverage for all 10 categories of the essential health benefits. Minimum value only refers the percent of the cost of benefits covered in aggregate by the employer.

Employers may use the MV calculator, which can be downloaded through CMS's website at [www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm), to calculate their health plan's minimum value. Employers needing assistance with the MV calculator should contact the SHOP at [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses) or 1-800-706-7893 or their agent or broker. Employers with questions pertaining to if their health plan meets the MV requirements should contact their carrier or an agent or broker.

### *e. Employer Interaction with the Individual Marketplace*

Both small and large employers may expect to have some interaction with the Federally-facilitated Marketplace. To apply for coverage on the FFM, individuals may need help from their employer to complete the application. Employers can expect to be asked to complete a form for employees that are applying for PTCs for themselves or their dependents. This form will ask for information such as the federal employer identification number (EIN), a contact for employer health coverage options, if the employee or their dependents are eligible for health coverage, and what the cost of the coverage is for the employee and any eligible dependents. Employers may also expect to be asked to provide the MV of their employer-sponsored coverage option. The form that employers may be asked to complete by employees applying for coverage on the FFM for themselves or their dependents can be viewed at [www.healthcare.gov/downloads/employer-coverage-tool.pdf](http://www.healthcare.gov/downloads/employer-coverage-tool.pdf).

Employers will also receive a notice from the FFM every time one of their employees receives a premium tax credit. Employers are required to notify employees of the coverage available on the FFM, even if affordable coverage that provides MV is offered to all full-time employees.

## **4. Insurer Impacts**

### *a. Rating Requirements*

Insurers may only charge individuals' premiums based on age, location, and tobacco-use status, and not based on pre-existing conditions.

### *b. Market Reforms*

Market reforms require insurers to cover dependents up to age 26 if they offer dependent coverage, eliminate the ability of insurers to deny coverage or charge higher premiums on the basis health status, and require issuers offering coverage in the individual and small group markets to meet [essential health benefit](#) (EHB) and [actuarial value](#) (AV) requirements.

### *c. Certification Requirements*

All health insurance plans sold in the [Federally-facilitated Marketplace](#) (FFM) must be certified as [qualified health plans](#) (QHPs). Among many other requirements, QHPs must meet standards related to the adequacy of their provider networks, quality, and non-discrimination.

### *d. Medical Loss Ratio*

All insurers must meet [medical loss ratio](#) (MLR) requirements. The MLR refers to the percent of funds collected through premiums, after accounting for taxes and fees, which an insurer spends on enrollee health care costs. Insurers must meet an 80% threshold for coverage offered in the individual and small group markets. For the large group market, the requirement is 85%. Insurers that do not meet the threshold for expenditures on enrollees' healthcare costs will owe refunds to enrollees or the plan sponsor for the difference between the MLR requirement and the amount spent on enrollee medical costs.

## D. Health Insurance Basics and Characteristics of Coverage under the Affordable Care Act

### 1. Basics of Health Insurance Markets

The market for health insurance is divided into individual, small group, large group, and self-insured segments. These market divisions are based on the types of policies issued and the number of people covered by each policy.

In the individual market, health insurance policies cover only an individual and eligible family members and dependents. The insurance policy issued will cover a single individual or family.

In the small group market, health insurance policies are issued to employers to cover the employees and at the employer's discretion, their families and dependents. In Indiana, small group policies can be issued to employers with 50 or fewer eligible employees. "Eligible employees" are defined as those "common-law employees" (recognized by IRS as the employer's employee; does not include owner or owner's spouse) who work 30 or more hours per week and have met any employer waiting period requirements. Part-time employees, temporary employees and seasonal employees do not count when determining if an employer is eligible in the small group or not.

**Sidebar:** Under the Affordable Care Act (ACA), the definition of small employer was set to change effective January 1, 2016, and increase a small employer from one who employs one to 50 employees to one who employs one to 100 employees. However, the PACE Act (H.R. 1624 – 114<sup>th</sup> Congress), prevents this from happening. Unless a state chooses to define small employer as having up to 100 employees, the definition of small employer will remain at one to 50 employees, as is the case in Indiana. See IDOI Bulletin 221.

Similar to the small group market, large group market health insurance policies are issued to employers to cover their employees and, at the employer's discretion, their family and dependents. However, large group policies are designed for employers with over 50 eligible employees.

Another option for employers is to self-insure. Under a self-insured scenario, the employer—not an insurance company—is responsible for paying health costs of enrolled employees up to a capped amount. The capped amount is called "stop-loss insurance" and covers self-insured employers who have employees with high cost medical events. For self-insured policies, insurance companies act as administrators of health benefits for the employer. In general, large employers are most likely to self-insure, though not all large group policies are self-insured.

Insurers offering products or services in any market segment (individual, small group, large group, or self-insured) may be designated as a health maintenance organization (HMO). In general, HMOs have more exclusive provider contracts than other health insurers; that is, individuals covered under an HMO will have a prescribed set of providers that may provide covered services. Due to the way HMOs contract with providers, their provider networks may be smaller than non-HMO networks; however, these tighter networks may provide a more coordinated healthcare experience. Except for certain services, including emergency services, HMOs are not required to cover services provided by out of network providers.

Other than the HMO designation, insurance policies may be designated as preferred provider organizations (PPO), point of service (POS), exclusive provider organization (EPO), or consumer directed health plan (CDHP), also known as a high deductible health plan (HDHP). PPOs are health plans that have a contract with certain providers, referred to as in-network providers. Individuals may choose to receive service from among the preferred providers or may choose to go to an out-of-network provider and in general be subject to greater cost-sharing. POS plans require individuals to select a primary care physician (PCP) who can then refer individuals to other providers that may have a contract with the insurance company 'in network' or be out of the insurance company's network. EPOs are similar to PPOs; however, under an EPO the individual will receive no insurance coverage for non-emergency services rendered at providers that are not in the plan's network. CDHP plans are plans that have higher deductible costs but often have lower premiums. Individuals with CDHP plans are eligible for a health savings account (HSA), to which they can contribute pre-tax dollars for qualified health expenses. Employers can also contribute to health savings accounts.

The Indiana Department of Insurance (IDOI) is responsible for regulating individual, small group, large group and HMO insurers. The IDOI verifies that insurers are financially solvent, have actuarially sound rates, and meet state regulatory requirements. Self-insured plans are regulated by the federal government.

## 2. Basics of Health Insurance Coverage

Regardless of the market from which the individual receives coverage, when a member has purchased and is enrolled in health insurance coverage, the member will receive a card that contains member information and basic cost-sharing details. The exact information included on the insurance card is not standard and will vary from plan to plan. This card must be presented to providers when individuals seek healthcare services.

Enrollees may expect health insurance coverage to provide coverage as described in the health insurance policy's "Certificate of Coverage." The Certificate of Coverage will list the benefits and services that are covered by the plan, the cost-sharing that will be applied, and any associated limits. Benefits and services that are excluded from coverage will also be listed. To understand the scope and cost-sharing coverage provisions, members should consult their Certificate of Coverage, look online at the carrier's website, or call their health insurance plan with specific questions. Health insurance plans may not cover all services offered by medical providers, or may apply different member cost-sharing requirements dependent on the service and selected healthcare provider.

Consumers may also receive a "Summary of Benefits and Coverage" from an insurer, which summarizes the key features of a health plan, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. The Summary of Benefits and Coverage helps consumers better understand the coverage they have and compare different coverage options. Consumers may receive the Summary of Benefits and Coverage from an insurer when shopping for health insurance coverage, when enrolling in coverage, at the beginning of each new plan year, or within seven business days of requesting a copy from their issuer or group health plan.

### *a. Health Plan Cost*

Outside of the benefits covered, one of the main features of health insurance plans is how the cost of the health plan to the beneficiary is distributed between the premium and other cost-sharing, including deductibles, coinsurance, and copayments.

Members enrolled in commercial health insurance will pay a monthly fee, termed a premium, to maintain their enrollment in coverage. The member pays this monthly fee regardless of whether or not the member accesses healthcare services. Health plan members who do not pay their premiums will have their health insurance coverage cancelled.

When members access healthcare services, cost-sharing will likely apply. Depending on the plan, members may have deductibles, copayments, and coinsurance. The cost-sharing required by the policy will be described in the Certificate of Coverage, and a summary will be provided on the health insurance card.

A deductible is the base amount the member pays for services prior to the health insurance paying for coverage. For example a health plan with a \$1,000 deductible will require that members pay \$1,000 for health services prior to the health plan paying for a portion of care received (see [Figure 6](#)). Deductibles are set on an annual basis, and every plan year the enrollee's deductible will be reset. Health insurers may have separate deductibles for separate services, for example, pharmacy and medical services. Certain services, such as preventive services, may be paid by the health plan in full even if a member has not met the member's deductible. In general, members with deductibles will receive a bill from their healthcare provider after their visit showing the amount the member owes for the service. This amount will be the amount the insurer would have paid to the healthcare provider for the service. Members with deductibles are responsible for paying the provider for these expenses until they have met their deductible. In addition to a deductible, members may be required to pay either coinsurance or copayments to their healthcare provider.

Coinsurance refers to a percent of the cost of the service the healthcare provider will expect to have paid at the time of the visit. For example, 20% coinsurance means that 20% of the total cost of the service will be charged to the individual when the individual accesses healthcare services, up to the coinsurance limit (e.g., \$5,000). For example, if the cost of the service is \$100, the individual will be expected to pay \$20 if the coinsurance limit has not been met. Once the coinsurance limit is met, the issuer pays the full cost of the service (see [Figure 6](#)). Depending on the health plan and healthcare provider, individuals may be expected to pay coinsurance at the time of the visit, or they may receive a bill from the provider showing the amount of coinsurance owed after the visit.

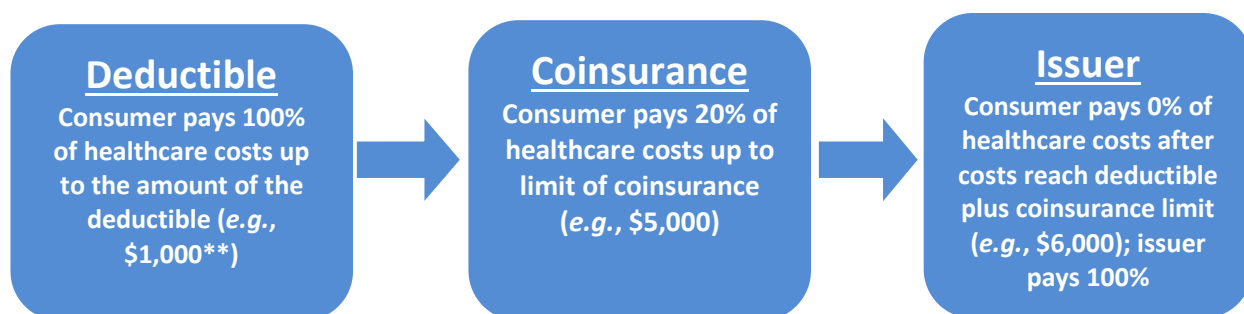
Copayments (or "copays") refer to a specific dollar amount that an individual will pay for a particular service, regardless of the total cost of the service accessed. For example, an individual may have a \$15 copayment for a doctor's office visit. Copayments are generally required to be paid at the time of the service. Coinsurance and copayments can differ based on the type of service accessed; and there may be different amounts applied to primary care physician visits, specialist visits, and prescription drugs. In addition, prescription drug coverage may have cost-sharing tiers, and depending on the prescription selected, the individual may pay different copayments or coinsurance amounts. Copayments and coinsurance count towards the enrollee's deductible. Until the enrollee has met the enrollee's deductible, the provider may bill the enrollee directly, even if copayment or coinsurance was paid at the

time of the health service. The amount of the bill will be for the difference between the copayment or the coinsurance paid at the time of the visit and the amount the insurer would have paid for the service. After the deductible is met for covered services, the enrollee will only be responsible for paying the copayment or coinsurance up to the policy's out-of-pocket maximum cost.

The following figure provides an illustration of how deductibles, coinsurance, and copayments work (see [Figure 6](#)):

**Figure 6: Example of Healthcare Cost-Sharing between a Consumer and Issuer**

Example plan features: \$1,000 deductible, 20% (80/20\*) coinsurance rate (up to \$5,000), \$1,000 out-of-pocket limit (deductible excluded), and \$15 copayment. Example shows the cost-sharing from the consumer's point of view.



\*Issuer pays 80%, and consumer pays 20% of healthcare costs

\*\*Excluding some doctor visits, which may be covered by \$15 copayment

The health plan's out-of-pocket maximum is the greatest amount that an enrollee can expect to pay for services in any plan year. Out-of-pocket maximum will likely be different for individual and family plans. Beginning in 2014, out-of-pocket maximums for the majority of health plans in the market will be limited to a maximum amount set by the Internal Revenue Service (IRS).<sup>49</sup>

Stand-alone dental plans or pediatric dental benefits may also have a separate out-of-pocket maximum. The stand-alone pediatric dental out-of-pocket maximums only apply to benefits for those under 19; there is no mandated limit for adults. Beginning in 2015, plans are required to coordinate out-of-pocket maximums across benefits and individuals will not be subject to separate out-of-pocket maximums for services covered on a single plan with the exception of stand-alone pediatric dental benefits. The separate out-of-pocket maximum for stand-alone pediatric dental benefits remains.

Out-of-pocket maximums will be lower for individuals eligible for [cost-sharing reductions](#) (CSRs) based on their income. Out-of-pocket maximums apply only to in-network providers and the [essential health benefits](#) (EHBs). Benefits in excess of the EHBs and non-emergency services provided out of network are not subject to this out-of-pocket maximum. Out-of-pocket maximums are determined on an annual basis and reset each policy year.

<sup>49</sup> For 2017, this maximum amount is \$7,150 for an individual and \$14,300 for a family. These limits apply to medical benefits only and if, for example, pharmacy benefits are separately administered, they may have separate out-of-pocket maximums up to the \$7,150 individual and \$14,300 family amounts.

Many health insurance plans will have different cost-sharing requirements for in-network and out-of-network providers. In-network providers have engaged in a contract with the insurer and agreed to provide services at a discounted rate in return for access to a large group of insured individuals. A list of in-network providers can be accessed through the health insurer's website or by calling the health insurer's consumer help desk. Enrollees in need of emergency services who seek care through an out-of-network provider will not be subject to increased out-of-network cost-sharing. Additionally, if an insurance plan does not contract with a provider that can provide an ACA-mandated preventive service in-network, the plan must cover the service provided by an out-of-network provider and apply in-network cost-sharing.

Cost-sharing for out-of-network providers will likely be higher than in-network providers. Some out-of-network providers may not accept an individual's health insurance, and payment may be requested up front. For providers that do not accept an individual's health insurance, an individual may submit a form directly to their insurer showing what they paid for the service. If this form is submitted, the amount the enrollee spent for covered services will count toward the plan deductible and out-of-pocket maximum, and if the enrollee has met his or her deductible the insurer may issue compensation.

To help pay for cost-sharing, including coinsurance, copayments, and deductibles, individuals can take advantage of health savings accounts (HSAs) or flexible spending accounts (FSAs). Health savings accounts are only available for individuals that select consumer directed health plans (CDHPs) or high deductible health plans (HDHPs). Both HSAs and FSAs allow the individual and the individual's employer to contribute pre-tax dollars towards the cost of future health costs. Dollars in HSAs do not expire and belong solely to the individual (including the employer contribution), but individuals must pay a penalty if they use the funds for anything other than qualified health care expenses. FSAs also allow individuals and employers to contribute to potential cost sharing; however, funds in flexible spending accounts expire at the end of the year. Some individuals may also have access to a health reimbursement account (HRA) through their employer. These accounts allow the individual to pay for cost-sharing; however, in general, unlike HSAs, the employer owns the funds (as opposed to the individual).

Each time a health service is accessed, members will receive an "Explanation of Benefits" (EOB) from their insurer. This document will describe what the insurer paid for the service, what the member paid and/or owes for the service, and a summary of the member's remaining deductible and out-of-pocket maximum amounts. These forms provide information to the member on their use of services and are not bills.

### 3. Types of Health Insurance Coverage

#### *a. Major Medical Insurance*

Health insurance plans termed major medical insurance offer individuals comprehensive insurance against potential healthcare costs. Major medical insurance plans offer coverage for a wide array of health benefits, providers, products, and services. Plans that only cover a specific health condition or service are not major medical products. In general, being covered by a major medical insurance product will qualify as [minimum essential coverage](#) (MEC) under the Affordable Care Act (ACA). However, some major medical insurance products are not considered MEC, for example certain types of student health insurance. For more detail on if a certain major medical insurance product will meet the requirement to maintain MEC, see the [Minimum Essential Coverage section](#).

Major medical insurance products are offered in the individual, small group, large group, and self-insured markets and can be structured as a preferred provider organization (PPO), exclusive provider organization (EPO), health maintenance organization (HMO), or point of service (POS) plans. Many of the ACA provisions apply to major medical insurance plans. For individuals enrolling in plans through a large employer offering large group or self-insured coverage to their employees, the process of enrolling in major medical insurance coverage will not change substantially. The coverage offered by these plans will be required to meet the ACA preventive benefit plan requirements and other market reforms and will be subject to [minimum value](#) (MV) requirements. However, for individuals enrolled in these coverage types, the options and enrollment process will not vary substantially.

For consumers or business looking for coverage in the small group or individual markets, the coverage options and benefits will vary from the previous process.

### *b. Metal Tiers (Actuarial Value)*

All non-grandfathered health coverage (excluding grandmothers/transitional plans) in the individual and small group markets on and off the Marketplace are required to offer coverage that is indexed to a certain [actuarial value](#) (AV) and are referred to as “[metal tiers](#).” The plans offered will be designated bronze, silver, gold, or platinum. The higher level plans (e.g., gold and platinum) will, in general, have higher premiums, but require less member cost-sharing. Regardless of metal level, all coverage in the individual and small group markets will also be required to cover the [essential health benefits](#) (EHB). Overall, the benefits covered will not vary by metal level, however, the enrollee’s cost-sharing responsibility will vary by metal level.

### *c. Catastrophic Plans*

Consumers looking for coverage in the individual market may also have the option of selecting a catastrophic plan. These plans offer coverage that does not meet the bronze metal tier requirements. Those insured by catastrophic plans can expect, in aggregate, to pay over 40% of their total medical cost. In general, these plans will have a deductible equal to the out-of-pocket maximum levels and will only provide coverage for required preventive care and a few primary care physician visits prior to the enrollee meeting the deductible. Other than these services, enrollees will be required to cover the costs for all healthcare until the out-of-pocket maximum is met in or for any plan year.

With catastrophic-plan coverage, enrollees may expect that they will pay less for the policy, but will bear a greater share of the expenses if they have a health event. Catastrophic plans are not available to all individuals and may only be purchased by those who are under 30 or who have received an exemption from the [individual shared-responsibility requirement](#) to maintain minimum essential coverage. Catastrophic plans may provide family coverage and may enroll children, but they are not available in the small group. Catastrophic plans offered inside the [Federally-facilitated Marketplace](#) (FFM) will be subject to the [open enrollment periods](#) and [special enrollment periods](#) (SEPs). Outside of the FFM, as with all outside market plans, enrollment in catastrophic plans may be restricted to the open enrollment periods at the health insurance issuer’s discretion. Catastrophic plans may be available; however, there is no requirement for health insurance issuers on or off the FFM to offer these products. These plans are not eligible for the [premium tax credit](#) (PTC) or [cost-sharing reduction](#) (CSR).

#### *d. Grandfathered Plans*

The ACA allows health plans that were in existence as of the passage of the law to obtain “Grandfathered” status and to be exempt from compliance with many ACA provisions related to benefits, cost-sharing, pre-existing condition exclusions, and annual maximums. Plans may only maintain grandfathered coverage status if they do not make substantial changes to their policies. If a plan eliminates a benefit, increases enrollee cost-sharing, or increases or adds annual maximums, it will cease to be a grandfathered plan. The grandfathered plan provision is intended to allow employer-sponsored and individual coverage a more gradual transition to the ACA requirements.

Because plans lose grandfathered status if they make changes, it is expected that each year, fewer and fewer individuals will be covered by grandfathered plans and more individuals will receive coverage under plans that must fully comply with all ACA requirements. Individuals who are newly enrolling in coverage will not be enrolled into grandfathered coverage, with the exception of individuals who are added as a spouse or dependent on a grandfathered individual policy. Those enrolling into group coverage may receive grandfathered coverage if the large or small group plan they are enrolling in has maintained its grandfathered status since the passage of the Affordable Care Act.

It is difficult to tell if any particular employer-sponsored health plan is grandfathered. If an individual finds that his or her plan is not covering the ACA-mandated preventive services without cost-sharing, or is imposing an annual maximum limit, the individual should contact the employer or plan administrator to determine if the coverage is grandfathered coverage.

Grandfathered coverage meets the requirement to maintain minimum essential coverage. Individuals offered grandfathered coverage through an employer may choose to not accept the coverage and purchase coverage that meets the ACA requirements in the individual market. However, unless the grandfathered coverage option was unaffordable or did not provide MV, these individuals will not be eligible for premium tax credits.

#### *e. Grandmothered Health Plans*

Grandmothered health plans, often referred to as “transitional” health plans, are health plans that were effective after the ACA was signed into law on March 23, 2010, and issued prior to December 31, 2013. Grandmothered plans include some, but not all, of the ACA features, and they cannot be sold on the Federally-facilitated Marketplace.

On March 5, 2014, the Centers for Medicare and Medicaid Services (CMS) released a [bulletin](#) stating that it will allow insurers to renew existing individual and small group health insurance policies even though they do not meet all of the requirements of the Affordable Care Act. The extension will be for two years, meaning policies can be renewed through October 1, 2016 if a state’s insurance regulators permit such renewals. An insurer may choose to renew all individual policies and non-renew small group policies, or vice-versa.

On March 31, 2014, the Indiana Department of Insurance (IDOI) released a [bulletin](#) stating that it will allow insurers to determine whether to renew grandmothered plans so long as the renewals are made on a non-discriminatory basis. Therefore insurers must renew or non-renew all individual or small group policies. Plans that are cancelled cannot be reinstated. The IDOI is not requiring insurers to renew

policies. In addition, consumers may not purchase new grandfathered plans or switch to a different insurer to replace a grandfathered plan.

The grandfathered plans renewed under this option must not undergo any material changes to the plan (e.g., a change in plan benefits or a “buy-down” of plan premiums by insurer to lower cost-sharing); otherwise, an ACA-compliant product would be required. The grandfathered plans renewed under this option are not required to contain the 10 EHBs, or to adopt the rating structure of fully ACA-compliant plans. However, grandfathered plans must comply with the following ACA provisions upon renewal:

- Elimination of annual dollar limits on EHB to the extent the grandfathered plans cover EHBs
- No pre-existing condition exclusion (small groups)
- Waiting periods not to exceed 90 days (small groups)
- Mental health parity rules (individual plans upon renewal July 1, 2014 or later; not applicable to small group plans)
- Cover certain preventive health benefits designated by the ACA (individual and small group)
- Spending no less than 80% of premiums on medical costs (individual and small group)

Carriers who elect to offer 2014 renewals of these existing plans—the grandfathered plan option—were required to provide notice to any individuals and small businesses that received a discontinuation letter. Voluntary termination of a policy by an individual does not constitute a special enrollment period.

#### *f. Qualified Health Plans*

Plans sold on the individual or [SHOP](#) marketplaces must be certified as [qualified health plans](#) (QHPs). For individuals, the QHPs offered through a marketplace are the only plans that an individual can purchase that are eligible for PTCs or cost-sharing reductions. For small businesses, the QHPs on the SHOP are the only plans that an employer can receive a tax credit for beginning in 2014.

Like all individual and small group plans, all QHPs must meet the EHB requirements and offer metal tier plans that are indexed to AV, including bronze, silver, gold, or platinum plans.

In addition to these market-wide requirements, QHPs offered on the FFM are subject to additional requirements and must receive a certification. Each QHP must offer an option, at minimum, for the silver and gold metal tier and must offer comparable child-only plans. Child-only plans are options that enroll only a child without offering coverage for the child’s parent, caregiver, or legal guardian. In cases where employer-sponsored coverage does not offer coverage for dependents, the child caregiver relationship does not allow the dependent to be added to the adult’s plan, or to the parents or legal guardians covered by Medicare. These policies offer an opportunity to purchase coverage only for a child without having an adult covered as well through a family policy. Qualified health plans must offer child-only policies in at least the silver and gold levels.

In Indiana, since the passage of the ACA and the subsequent elimination of health insurers’ ability to deny coverage for children based on preexisting conditions, there were no health insurer options for child-only coverage. Coverage through child-only plans is an option on and off the FFM as of January 1, 2014. Child-only plans offered on the FFM are QHPs and are eligible for PTCs and cost-sharing reductions.

Qualified health plans must also be accredited, or be in the process of gaining accreditation, through a recognized accrediting entity. The National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) are recognized as accrediting entities for qualified health plans. Accreditation is an independent evaluation of the health plan that identifies area of improvement and allows for health plan quality reporting. Terminology displayed next to a QHP such as “Accredited by NCQA” or “Accredited by URAC” means that the plan has received an independent evaluation by the accrediting entity and is considered to be accredited. If the plan is in the process of receiving accreditation, the QHP will be indicated as “Not yet accredited.”

In addition to accreditation, QHPs must meet network adequacy and standards related to providing coverage through a sufficient number of essential community providers. In absence of state-specific standards, health plans that are accredited are assumed to meet the network adequacy standards as network adequacy is a component of the accreditation process. Plans that are in the process of receiving accreditation must submit documentation of network adequacy. QHPs must also meet the requirement to have a sufficient number of essential community providers in their network. Essential community providers are health providers and clinics that are in health provider shortage areas and/or serve predominantly low-income clients. As of 2016, QHPs are required to include at least 30% of the essential community providers in their service area as network providers, or they must submit a justification as to why they do not meet this standard. Both the network adequacy and essential community provider policies are transitional and may change in future years.

Qualified health plans must also meet non-discrimination standards and they may not design or offer health benefits in a manner that discriminates against individuals on any basis, including race, gender, and health status. These plans may not change their premium amount during the year; provided nothing changes in the enrollee’s circumstance, those who enroll are assured that until the close of the plan year, their premium or cost-sharing will remain constant. Premiums may change if enrollees add or remove dependents from their policy, move to a different rating area, or change their tobacco use status.

Finally, QHPs must meet transparency requirements. They must keep their provider lists, including the list of providers that are accepting new patients, up to date and make them readily available to members. They must also provide cost-sharing information to members for specific services upon member inquiry.

**Sidebar:** The ACA requires the U.S. Department of Health & Human Services (HHS) to develop quality data collection and reporting tools such as a Quality Rating System (QRS), a Quality Improvement Strategy (QIS), and an enrollee satisfaction survey system. The framework for a QRS has been continually developed to rate QHPs offered through a marketplace on specific quality measures. Issuers of QHPs are required to collect and report data for the Quality Rating System.

Qualified health plans may be offered both on and off of a marketplace. Qualified health plans offered off of a marketplace must have the same pricing as those offered on a marketplace. Only QHPs offered through a marketplace are eligible for [insurance affordability programs](#), including PTCs and cost-sharing reductions. QHPs will be identified through their marketing materials. Qualified health plans offered off of the FFM will identify that they have QHP certification, but that they are not eligible for insurance affordability programs.

To enroll in a QHP on the FFM, individuals must be U.S. citizens, nationals, or legal residents, not be incarcerated, and reside or intend to reside in the state in which the QHP is offered. For individuals that do not meet the citizen, national or legal resident requirement, the plan must be made available to the individual outside the FFM if it is eligible to be sold on the outside market.

**Sidebar:** While QHP requirements do not limit individuals that have Medicare from purchasing a QHP, existing requirements prohibit insurers from selling a major medical policy to cover an individual that has Medicare. Individuals covered by Medicare looking for additional coverage should contact the State Health Insurance Assistance Program (SHIP) at 1-800-452-4800. More information about SHIP can be found at [www.in.gov/idoi/2507.htm](http://www.in.gov/idoi/2507.htm).

### *g. Multi-State Plans*

Multi-state plans are plans that were offered initially in some states, but in all states by 2016. These plans are offered through the FFM and are plans that the Federal Office of Personnel and Management contracts with issuers to offer in the marketplaces. Multi-state plans are QHPs and are eligible for individuals interested in receiving PTCs and cost-sharing reductions. They will not be offered on the outside market.

In Indiana, multi-state plans will be required to offer the same set of EHBs and meet the same requirements as other plans on the market.

## **4. Other Commercial Coverage Types**

In addition to the types of [major medical insurance](#) discussed, excepted benefits will continue to be offered in the market. Excepted benefit plans are plans that cover a specific service or condition and do not provide comprehensive health coverage. These plans are not subject to many of the [Affordable Care Act](#) (ACA) market reforms and may still use lifetime and annual maximums and factors other than age, location, and tobacco use to develop their premiums. These plans may also deny, or charge additional premium based on pre-existing health conditions.

### *a. Stand-Alone Plans*

Stand-alone dental plans will be the only excepted benefit plan that are offered on the [Federally-facilitated Marketplace](#) (FFM). Pediatric dental is an [essential health benefit](#) (EHB) requirement under the ACA, and health plans that offer dental-only benefits are available on the Federally-facilitated Marketplace. If there are a sufficient number of stand-alone dental plans on the FFM, major medical QHPs will not have to offer the pediatric dental benefit. Marketplace stand-alone dental plans are prohibited from applying lifetime or annual maximums to the pediatric dental portion of the stand-alone dental benefit.

To be offered on the FFM, stand-alone dental plans must go through a certification process similar to [qualified health plans](#) (QHPs) and must meet certain requirements including network adequacy, essential community providers, and non-discrimination. Stand-alone dental plans will not be offered in the [metal tier](#) levels of QHPs, but instead the pediatric stand-alone dental benefit will be offered at a high and low level of 70% and 85% [actuarial value](#) (AV), respectively. The out-of-pocket limit for stand-alone dental plans will not be coordinated with the enrollee's major medical insurance plan. Note, these

requirements only apply to pediatric dental benefits, or benefits for those under 18 years old. There are no ACA requirements related to actuarial value or out-of-pocket limits for adult dental benefits.

Stand-alone dental plans on the FFM may be purchased with the use of the [premium tax credit](#) (PTC). If, after the purchase of a major medical plan, an individual has remaining PTC funds, these funds may be applied to the purchase of a stand-alone dental plan. The individual will pay any remaining premium not covered by the remaining PTC funds. Stand-alone dental plans are not eligible for [cost-sharing reductions](#) (CSRs). Individuals that qualify for CSR for their major medical plan will not receive them for their stand-alone plan.

Individuals purchasing coverage on the FFM will not be required to purchase a pediatric dental stand-alone plan if the QHP they select does not offer pediatric dental. However, individuals purchasing coverage that does not offer pediatric dental coverage off of the FFM will be required to assure the carrier that they have stand-alone dental coverage for the pediatric dental EHB through a marketplace certified stand-alone dental plan.

Stand-alone dental plans off of the FFM are offered both as marketplace-certified, for individuals who need to make an assurance that they have coverage through a marketplace-certified stand-alone dental plan, and as plans without this designation. Stand-alone dental plans on a marketplace may also offer adult dental, however pediatric dental is a requirement.

#### ***b. Other Excepted Benefit Plans***

Of the other excepted benefit plans available, the most common is stand-alone vision. Other excepted benefit plans include: (1) those sold for disease-specific coverage such as “cancer-only policies;” (2) those sold for benefit-specific coverage such as inpatient hospital coverage; or (3) “fixed indemnity insurance” offered on a separate policy from primary health coverage. These excepted benefit plans are not subject to ACA market reform requirements, are not offered through marketplaces, and are not eligible to be purchased through [insurance affordability programs](#). Individuals interested in purchasing these plans should seek information through an insurance agent or broker.

#### ***c. High Risk Pool Coverage***

Indiana’s high risk pool—the Indiana Comprehensive Health Insurance Association (ICHIA)—provided coverage for individuals with high risk conditions who have been denied commercial insurance due to their health status. With the ACA market reforms, major medical insurers could no longer deny individuals coverage based on health status; thus, the ICHIA program was no longer needed. Individuals seeking coverage through ICHIA should apply for coverage through the FFM or directly through an insurer. They may no longer be denied based on health status.

Similarly, the temporary federal program for individuals with high-risk conditions, the Pre-Existing Condition Insurance Plan (PCIP), phased out in 2014. Individuals interested in PCIP coverage should apply through the FFM or directly with an insurer. Beginning in 2014, these individuals may no longer be denied coverage due to health status.

## E. Characteristics of the Health Insurance Market under the Affordable Care Act

### 1. Minimum Essential Coverage

The Affordable Care Act (ACA) contains a provision requiring non-exempt individuals to maintain minimum essential coverage (MEC) for each month in the year. Coverage for one day in the month is considered to be coverage for the entire month. The requirement to maintain MEC is referred to as the shared-responsibility provision or the [Individual Mandate](#). Non-exempt individuals who do not maintain MEC will be subject to a tax penalty from the Internal Revenue Service (IRS).

Minimum essential coverage is coverage that is considered comprehensive health insurance by the Affordable Care Act. Minimum essential coverage is not defined by the benefits covered, but by types of coverage. In determining if an individual has maintained MEC, neither the cost the individual has paid for the coverage or what the coverage offers is taken into account. The only concern is if the individual's type of coverage is considered to be MEC by the federal government.

Under the ACA, certain government-sponsored health coverage programs and private market coverage types are designated as MEC; and the Secretary of the U.S. Department of Health and Human Services (HHS) in coordination with the Secretary of the Treasury are provided with the ability to designate other coverage as minimum essential coverage. In addition, there are coverage types that are not considered to be MEC that are defined by federal guidance.

The types of coverage designated as MEC and those not recognized as MEC will be continually updated by the federal government. As of 2016, certain types of coverage considered to be MEC and types not considered to be MEC are outlined in the following table (see [Table 50](#)).

Individuals with questions on whether their coverage type is recognized as MEC should contact their coverage provider or the [Federally-facilitated Marketplace](#) (FFM) at [www.healthcare.gov](http://www.healthcare.gov) or 1-800-318-2596 (TTY: 1-855-889-4325). A list of health plans that qualify as MEC is posted on the FFM website at [www.healthcare.gov/fees/plans-that-count-as-coverage](http://www.healthcare.gov/fees/plans-that-count-as-coverage).

**Table 50: Types of Minimum Essential Coverage**

Types of Minimum Essential Coverage (MEC)	NOT Minimum Essential Coverage (MEC)*
<ul style="list-style-type: none"> <li>○ Coverage under a government sponsored program               <ul style="list-style-type: none"> <li>• The Medicare Program</li> <li>• The Medicaid Program</li> <li>• The Children’s Health Insurance Program (CHIP)</li> <li>• The Healthy Indiana Plan (HIP 2.0)</li> <li>• Veterans Administration programs: including most TriCare and CHAMP VA</li> <li>• Department of Defense non-appropriated fund benefits</li> <li>• Coverage for Peace Corps Volunteers</li> </ul> </li> <li>○ Coverage under an employer-sponsored health plan               <ul style="list-style-type: none"> <li>• COBRA</li> <li>• Retiree Coverage</li> </ul> </li> <li>○ Coverage under a health plan offered in the individual market within a state</li> <li>○ Coverage under a grandfathered health plan</li> <li>○ Additional coverage as specified               <ul style="list-style-type: none"> <li>• Most student health coverage</li> <li>• Refugee medical assistance</li> <li>• Medicare advantage plans</li> <li>• State high risk pool coverage</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>○ Medicaid Programs not considered MEC include coverage for the following:               <ul style="list-style-type: none"> <li>• Optional family planning services</li> <li>• Optional tuberculosis related services</li> <li>• Pregnancy related services</li> <li>• Emergency medical services</li> <li>• 1115 demonstration waiver</li> </ul> </li> <li>• Veteran’s Administration programs not considered MEC               <ul style="list-style-type: none"> <li>a. Tricare- Line of Duty Care</li> <li>b. Tricare- Space Available</li> </ul> </li> </ul> <p>Other coverage not considered MEC:</p> <ul style="list-style-type: none"> <li>○ Foreign Health Care Coverage</li> <li>○ Short Term Coverage</li> <li>○ Coverage in territories sold outside a marketplace</li> <li>○ Accidental death and dismemberment coverage, disability insurance, general liability insurance, automobile liability insurance, workers’ compensation, credit-only insurance, and coverage for employer-provided on-site medical clinics.</li> <li>○ Excepted benefits including, limited-scope vision benefits, long-term care benefits, and benefits provided under certain health flexible spending arrangements.</li> <li>○ Separate policies for coverage of only a specified disease (example: cancer only policies), or fixed indemnity insurance offered on a separate policy from primary health coverage: Medicare supplemental policies, TRICARE supplemental policies, and similar supplemental coverage for a group health plan</li> </ul>

\* Coverage that is not considered MEC is subject to change based on release of final guidance from the Department of Treasury.

Sources: [26 CFR §1.5000A-2](#) & [45 CFR §156.602](#); [HealthCare.gov](#), [www.healthcare.gov/fees/plans-that-count-as-coverage](http://www.healthcare.gov/fees/plans-that-count-as-coverage)

### *a. Government-Sponsored Coverage*

Government-sponsored coverage, including Medicaid, the Children Health Insurance Program (CHIP), the Healthy Indiana Plan (HIP 2.0), Medicare programs and coverage for Veterans and Peace Corps volunteers, is, with a few exceptions, considered to be minimum essential coverage. Individuals enrolled in these coverage types will meet the requirement to maintain MEC for every month in which they are enrolled.

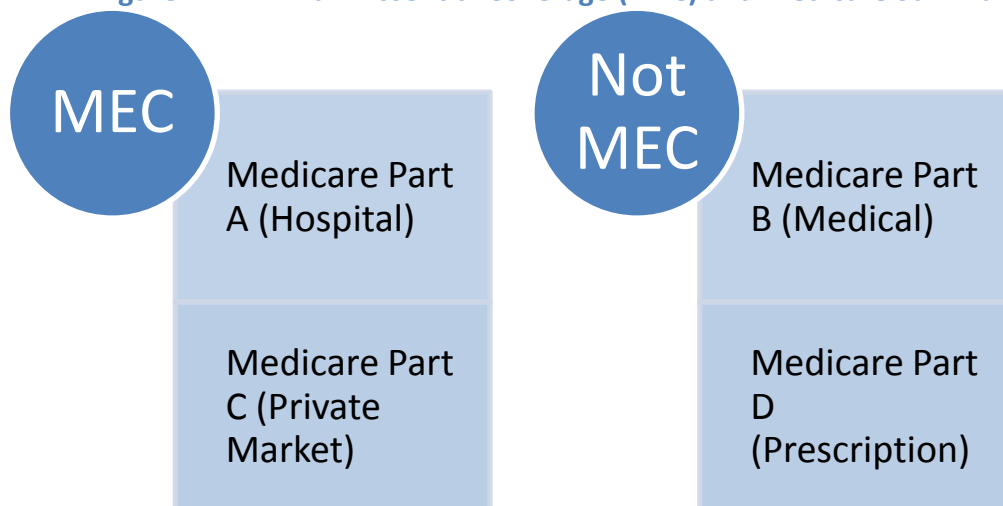
#### *i. Minimum Essential Coverage Detail: Medicare*

The Medicare program is a taxpayer-funded program administered by the federal government. It provides health coverage to those age 65 and older and qualifying disabled individuals. Many qualified individuals are automatically enrolled in Medicare.

Medicare has multiple components. Part A covers hospital and home health services; and the vast majority of beneficiaries do not pay a premium for it. Part B covers doctor visits and other non-hospital related medical items and services, and in general requires payment of a premium. Part C combines Medicare Part A and Part B and is referred to as Medicare Advantage; it offers both hospital and outpatient medical coverage through private market health insurers. Part D covers pharmacy benefits.

To qualify as having MEC, individuals only have to be enrolled in Part A. Medicare Part C also counts as minimum essential coverage. For the minority of individuals who do not qualify for Part A and have bought into Part B and D coverage, these types of Medicare are not considered to be minimum essential coverage. In addition, for a minority of individuals that must pay premiums for Medicare Part A, they are only considered to have access to MEC if they enroll in this coverage and would not be ineligible for [premium tax credits](#) (PTCs) based on access to Medicaid Part A if they choose not to enroll.

**Figure 7: Minimum Essential Coverage (MEC) and Medicare Summary**



In addition, some individuals purchase Medicare supplemental policies, termed Medigap policies. Medigap policies by themselves are not considered to be MEC; however, purchase of a Medigap policy requires enrollment in Part A and Part B, so individuals with a Medigap policy should meet the MEC requirements due their enrollment in Part A.

More information on Medicare can be accessed at [www.medicare.gov](http://www.medicare.gov) and individuals with Medicare-specific questions or concerns can access the above mentioned website or contact 1-800-Medicare (1-800-633-4227) or the local State Health Insurance Assistance Program (SHIP) at 1-800-452-4800 or find more SHIP info at [www.in.gov/idoi/2507.htm](http://www.in.gov/idoi/2507.htm).

## ii. Minimum Essential Coverage Detail: Medicaid and the Children's Health Insurance Program

Medicaid and the Children's Health Insurance Program (CHIP) are programs that are administered by states and jointly funded through the federal government and the state. Each state has different program options and eligibility criteria. In general, Medicaid and CHIP offer coverage to low-income individuals that meet the program eligibility criteria; depending on the program, the eligibility criteria for Medicaid may be related to income, age, disability, or health status.

For more information on details and eligibility criteria for Medicaid and CHIP in Indiana, please see the details in the [Medicaid section](#) and [CHIP section](#).

With the exception of the following programs, all Medicaid and CHIP programs are considered to be MEC and enrollment in these programs will satisfy the requirement to maintain minimum essential coverage.

## iii. Minimum Essential Coverage Detail: Healthy Indiana Plan

The Healthy Indiana Plan (HIP 2.0) is the state of Indiana's plan to improve and expand the successful Healthy Indiana Plan (HIP) and concurrently replace traditional Medicaid in Indiana for all non-disabled Hoosiers ages 19-64. HIP 2.0 builds on the successes of the original HIP design. It adds new pathways for coverage—HIP Plus, HIP Basic, HIP State Plan, and HIP Employer Link—that promote employer-sponsored coverage and continue HIP's private market consumer-directed model with incentives for members to take personal responsibility for their health.

Full details on HIP 2.0 are available on the HIP 2.0 website at [www.in.gov/fssa/hip](http://www.in.gov/fssa/hip) and in the [Healthy Indiana Plan \(HIP 2.0\) section](#) of this resource manual.

## iv. Minimum Essential Coverage Detail: Medicaid Family Planning Coverage

The federal Centers for Medicare & Medicaid Services (CMS) offers states the option to implement a Medicaid program that provides family planning services. This coverage is not considered to be MEC and those enrolled in the family planning coverage option through Medicaid must seek other sources of MEC to meet the requirement to maintain minimum essential coverage.

For more information on the Medicaid [family planning coverage option](#) please see the [Medicaid section](#).

## v. Minimum Essential Coverage Detail: Medicaid Tuberculosis Related Services

The Centers for Medicare & Medicaid Services offers states the option to implement a Medicaid program that covers individuals who are diagnosed with tuberculosis for tuberculosis-related services. This coverage is not considered to be MEC and those enrolled in coverage for tuberculosis-related services must seek other sources of MEC to meet the requirement to maintain minimum essential

coverage. Indiana has not implemented this optional coverage category, so there will be no Indiana residents with this coverage type.

More information on tuberculosis related services can be found on CMS's website at <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/Info-Bulletin-TB.pdf>

#### vi. Minimum Essential Coverage Detail: Medicaid Pregnancy-Related Services

States have the option, with federal approval, to provide pregnancy-related coverage to certain Medicaid-eligible pregnant women versus full Medicaid coverage. Women covered by a Medicaid program offering benefits based on the covered individual being pregnant are not also considered to be covered by minimum essential coverage. Women with pregnancy-related Medicaid coverage should verify if their state's program is considered MEC. If it is not considered MEC, those women are subject to the individual shared-responsibility penalty if they do not receive other minimum essential coverage.

In Indiana, Medicaid provides full benefits to pregnant women and therefore they will qualify as being covered by minimum essential coverage.

More information on pregnancy-related services in Indiana can be found in the [Medicaid section](#).

#### vii. Minimum Essential Coverage Detail: Medicaid Coverage of Emergency Medical Services

Medicaid provides limited emergency services to non-citizens who are not eligible for Medicaid due to their immigration status but who would otherwise meet the Medicaid eligibility criteria. For individuals receiving these emergency services, only medical benefits are not considered to have minimum essential coverage. Individuals not-lawfully present are not required to have MEC; however, those lawfully present non-citizens who receive Medicaid coverage limited to emergency medical services (EMS) will need to seek other coverage to meet the requirement to maintain minimum essential coverage.

#### viii. Minimum Essential Coverage Detail: Coverage for Veterans and Other Federal Coverage

Those with access to medical benefits through the Veterans Administration will most likely meet the requirement to maintain minimum essential coverage.<sup>50</sup> Comprehensive benefits available under TRICARE and CHAMPVA will be considered MEC and individuals enrolled in these programs will meet the requirement to maintain MEC for each month in which they are enrolled. However, programs that do not offer comprehensive health coverage or only cover a specific benefit will likely not be considered to be minimum essential coverage. This includes supplemental TRICARE policies.

Federally-sponsored coverage for Peace Corps volunteers counts as minimum essential coverage. Individuals with these coverage types will meet the MEC requirement for every month in which they are enrolled in the coverage.

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<sup>50</sup> Per the minimum essential coverage (MEC) guidance, health coverage programs for veterans and their dependents under Title 10 USC chapter 55 and Title 38 USC chapter 17 or 18 will qualify as minimum essential coverage.

### ***b. Employer-Sponsored Coverage***

Health insurance coverage obtained through an employer as small group, large group, or self-insured coverage is considered to be minimum essential coverage. Employer-sponsored coverage includes coverage offered by federal, state, and local government to their employees. Those enrolled in employer-sponsored coverage will meet the requirement to maintain minimum essential coverage. This is the case even if the employer-sponsored coverage did not offer coverage of the [essential health benefits](#) (EHBs),<sup>51</sup> would not be considered to be affordable for the individual, or did not provide [minimum value](#) (MV). If the individual is enrolled in the employer-sponsored insurance, then he or she meets the requirement to maintain MEC for every month in which they are enrolled.

#### ***i. COBRA & Retiree Coverage***

Consolidated Omnibus Budget Reconciliation Act (COBRA) and retiree coverage that are sponsored by an employer count as MEC for the enrolled individuals. However, individuals that are eligible for COBRA or retiree coverage, but do not enroll, will not be excluded from eligibility for the [premium tax credit](#) (PTC) based on having access to other minimum essential coverage. Individuals that enroll in COBRA or retiree coverage will not be eligible for the PTC and will be considered to have access to other minimum essential coverage. Failure to pay COBRA premiums resulting in loss of coverage will not trigger a [special enrollment period](#) (SEP) for the individual.

If an employer has over 25 employees, the employee may be eligible for COBRA benefits on termination of employment. The employee has 60 days to choose COBRA or an ACA plan. If the employee chooses COBRA, the employee is eligible for an ACA plan only during open enrollment or upon termination of the COBRA benefits. If an employer has fewer than 25 employees, under Indiana small group law a conversion policy must be offered.

### ***c. Coverage in the Individual Market***

Health insurance coverage obtained through the individual market is considered to be minimum essential coverage. Those enrolled in individual market coverage will meet the requirement to maintain minimum essential coverage. This is the case even if the individual is enrolled in a [catastrophic plan](#).<sup>52</sup> For every month the individual is enrolled in a plan on the individual market, the individual will meet the requirement to maintain minimum essential coverage.

### ***d. Coverage under a Grandfathered Plan***

Certain health plans that have maintained a “grandfathered” status may not meet all of the ACA requirements related to benefits, lifetime and annual, maximums, dependent age, or other provisions. However, these plans may still be offered if they have maintained their status since the implementation of the ACA as a grandfathered plan and have not made changes to their benefits or rates. Coverage offered by grandfathered plans is considered to be MEC, even though it may not meet some of the ACA

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<sup>51</sup> The essential health benefits (EHBs) are not required to be covered in the large group or self-insured markets, only non-grandfathered individual and small group market plans are required to cover the essential health benefits.

<sup>52</sup> Individuals may only enroll in the catastrophic plan if they are under age 30 or have received an affordability or hardship exemption.

requirements. Enrollees of grandfathered plans will meet the requirement to maintain MEC of every month they are enrolled.

#### *e. Additional Coverage as Specified*

Federal guidance specifies certain additional types of coverage as minimum essential coverage. These coverage types include most student health plans, refugee medical assistance, and state high risk pool coverage. Enrollees of these types of coverage would be considered covered by MEC for each month in which they were enrolled.

Not all types of student health insurance will be considered to be minimum essential coverage. Individuals with questions about if their student health insurance coverage meets the MEC requirements should contact the educational institution and the health plan in question. Individuals that have access to qualifying student health coverage are only considered eligible for MEC if they enroll in the coverage. Those that do not enroll may be eligible for [premium tax credits](#) (PTCs) or [cost-sharing reductions](#) (CSRs) in the Federally-facilitated Marketplace. A list detailing recognized types of MEC is made available by the U.S. Department of Health and Human Services (HHS). Individuals with questions about whether their student health insurance options qualify as MEC should consult the HHS list of minimum essential coverage available at [www.healthcare.gov/fees/plans-that-count-as-coverage](http://www.healthcare.gov/fees/plans-that-count-as-coverage).

**Sidebar:** Student health plans are a type of coverage offered to students and their dependents under a written agreement between an institution of higher education and an issuer. Effective May 12, 2014, student health insurance coverage is not required to be offered as a calendar year plan, since coverage is offered normally on an academic year basis. As a result, student health coverage is exempt from the requirement to establish open enrollment periods and coverage effective dates based on a calendar policy year.

Any coverage that only covers a certain limited condition, or provides additional coverage to reduce enrollee cost sharing will not be considered MEC; these coverage types include cancer only policies, hospital only policies, or long-term care coverage.

#### *f. Updates to Coverage Types*

Sponsors of other coverage types that are not currently listed as MEC may apply to HHS to have the coverage they sponsor recognized as minimum essential coverage. HHS maintains a public list of the types of coverage recognized as MEC at [www.healthcare.gov/fees/plans-that-count-as-coverage](http://www.healthcare.gov/fees/plans-that-count-as-coverage). Organizations that become recognized as MEC will be required to notify their enrollees.

## **2. Individual Shared-Responsibility Requirement**

The shared-responsibility provision of the [Affordable Care Act](#) (ACA), commonly referred to as the “individual mandate,” requires that all individuals maintain [minimum essential coverage](#) (MEC) for themselves and their dependents. Individuals who do not maintain MEC for themselves or their dependents may apply for exemptions<sup>53</sup> (see [Table 51](#)) from the MEC requirement. Those who do not

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<sup>53</sup> A list of possible exemptions from the requirement to have health insurance is available online at [www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee](http://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee).

have MEC or an exemption will be required to pay a shared-responsibility payment to the IRS upon tax filing.

#### *a. Exemptions*

The ACA allows for individuals to apply for exemptions (see [Table 51](#)) from the requirement to maintain minimum essential coverage. Depending on the type, an exemption may be requested either prospectively or retrospectively through the [Internal Revenue Service](#) (IRS) or the [Federally-facilitated Marketplace](#) (FFM).

Individuals granted exemptions will not face a shared responsibility tax penalty for not maintaining minimum essential coverage. For employers, employees who have been granted an exemption will not count towards their required participation rate of 70 percent. Eligibility for exemptions can be categorical, based on income, or related to other circumstances. Examples of categorical exemptions include if an individual is a member of an American Indian tribe, a member of a religious sect with a documented ethical or moral opposition to health insurance, or is currently incarcerated. Exemptions based on income include the affordability exemption and the exemption for individuals with income below the tax filing threshold. The only way for an individual to be certain if the individual is eligible for an exemption, is to apply.

Individuals seeking an exemption from the shared-responsibility requirement may apply for one or more of the nine exemption types. Depending on the exemption type, it may only be able to be granted by the IRS or FFM; some exemptions may be granted by both entities. The time period the exemption is valid for also varies; exemptions may be granted on a monthly, annual, or multi-year basis. Individuals may be eligible for multiple exemptions at the same time. The IRS and FFM will process all exemption requests received for an individual. To be eligible for an exemption in any month the individual must meet the criteria for the exemption for at least one day in that month.

**Table 51: Types of Exemptions from the Individual Mandate**

Exemption	Exemption Qualifications	Through Agency	Other
<i>Religious Conscious</i>	Practicing member of recognized religious sect or division (established pre-1950) with recognized ethical or moral objections to health insurance	Marketplace	<ul style="list-style-type: none"> <li>Exemption may be granted for more than one year</li> <li>Granted prospectively or retrospectively</li> <li>Child turning 21 must resubmit application</li> </ul>
<i>Hardship</i>	Individual determined to have suffered hardship with respect to the capability of obtaining a qualified health plan (QHP)	Marketplace or IRS depending on Hardship type	<ul style="list-style-type: none"> <li>Details of types of hardship exemptions discussed in <a href="#">Table 52</a></li> </ul>
<i>Indian Tribe</i>	Be a member of a federally recognized tribe	Marketplace or IRS through tax filing process	<ul style="list-style-type: none"> <li>Marketplace must grant on continuing basis</li> <li>Granted until Marketplace notified no longer in effect</li> <li>Granted prospectively or retrospectively</li> </ul>
<i>Health Care Sharing Ministry</i>	Member of Health Care Sharing Ministry 503(c) registered organization	Marketplace or IRS through tax filing process	<ul style="list-style-type: none"> <li>Reapply every year</li> <li>Only eligible if a member of ministry at time application submitted</li> <li>Granted retrospectively in year it applies</li> <li>For previous year exemption through tax filing process</li> </ul>
<i>Incarceration</i>	Incarcerated at least one day in a month after the disposition of charges	Marketplace or IRS through tax filing process	<ul style="list-style-type: none"> <li>Marketplace only grants if requested in applicable year; IRS can grant retrospectively</li> </ul>
<i>Household – income below filing limit</i>	Individuals below the filing limit	IRS through tax filing process	<ul style="list-style-type: none"> <li>Requires assessment of household income to be completed after year end through tax filing</li> </ul>
<i>Inability to afford coverage</i>	Lowest cost minimum essential coverage (MEC) option costs more than 8.13% of income	IRS through tax filing process	<ul style="list-style-type: none"> <li>Requires assessment of household income and cost of coverage through tax filing at year end</li> </ul>
<i>Not-lawfully present</i>	Individuals not lawfully present not required to be covered	IRS through tax filing process	<ul style="list-style-type: none"> <li>Implemented exclusively through tax filing</li> </ul>
<i>Short coverage gaps</i>	One gap of less than three months permitted without penalty	IRS through tax filing process	<ul style="list-style-type: none"> <li>May not be granted until year concludes</li> </ul>

Source: [26 CFR §1.5000A-3](#). See also [www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee](http://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee) and [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions).

If individuals apply for an exemption based on membership to healthcare sharing ministry or a religious organization with an objection to health insurance that is not recognized by HHS, they will be informed of how their health sharing ministry or religious organization can obtain recognition for the purposes of shared-responsibility payment exemptions. These individuals associated with non-recognized groups will not be provided with an exemption but will be notified how to get their organization recognition to qualify for the exemption.

For the hardship exemptions, there are six different types of exemptions that may fall into this category (see [Table 52](#)). These exemptions may be granted by the IRS or the FFM, depending on exemption type and can be processed retrospectively or prospectively.

**Table 52: Hardship Exemptions from the Individual Mandate (cont. to next page)**

Hardship Exemption	Description	Granted by	Other
<i>Inability to purchase</i>	<ul style="list-style-type: none"> <li>Significant unexpected increase in essential expenses due to financial or domestic circumstances including unexpected natural or human caused events.</li> <li>Expense of purchasing health insurance would have caused individual to experience serious deprivation of food, shelter, clothing or other necessities.</li> <li>Individual has experienced other factors similar to these and this prevented obtaining of minimum essential coverage (MEC).</li> </ul>	<ul style="list-style-type: none"> <li>Marketplace</li> </ul>	<ul style="list-style-type: none"> <li>Exemption will be provided at minimum for the month it is applied for; marketplaces have discretion to provide for additional months after the hardship.</li> </ul>
<i>Lack of affordable coverage based on projected income</i>	<ul style="list-style-type: none"> <li>Cost of the lowest cost MEC option is greater than 8.13% of income for individual or dependent.</li> <li>Exemption is only available from the Marketplace as a hardship exemption through the end of the open or special enrollment period (SEP).</li> <li>Exemption is granted for entire year regardless of changes in circumstances.</li> <li>Calculation for affordable coverage will account for increased premiums due to</li> </ul>	<ul style="list-style-type: none"> <li>Marketplace</li> </ul>	<ul style="list-style-type: none"> <li>Same as IRS affordability exemption but may be awarded prospectively.</li> <li>Individuals awarded this exemption may enroll in catastrophic plan.</li> <li>Eligibility for an employer-sponsored plan only considered if the plan meets minimum value requirements.</li> </ul>

Hardship Exemption	Description	Granted by	Other
	not completing wellness programs related to tobacco use in an employer-sponsored plan. <ul style="list-style-type: none"> <li>Retrospective affordability exemptions granted by IRS through tax filing process.</li> </ul>		
<i>Below filing threshold</i>	Individual exempt if not required to file because gross income below filing threshold, but they file and dependent income bumps above filing threshold.	<ul style="list-style-type: none"> <li>IRS</li> </ul>	<ul style="list-style-type: none"> <li>Exemption can be granted during tax filing or outside of tax filing.</li> </ul>
<i>Medicaid expansion population</i>	Individual exempt if determined ineligible for Medicaid solely because state did not expand Medicaid.	<ul style="list-style-type: none"> <li>Marketplace</li> </ul>	<ul style="list-style-type: none"> <li>Final rule will grant exemption to all individuals that would have been eligible for a Medicaid expansion even if those individuals are also eligible for a premium tax credit (PTC).</li> </ul>
<i>Employer-sponsored coverage exception: Combined coverage cost</i>	Individuals exempt if multiple members determined eligible for affordable self-only employer-sponsored coverage but combined the cost of coverage exceeds 8.13% of income.	<ul style="list-style-type: none"> <li>IRS</li> </ul>	<ul style="list-style-type: none"> <li>Exemption may be granted through tax filing process or other process.</li> </ul>
<i>Eligible for services through and Indian healthcare provider</i>	Individuals that are not members of federally recognized tribes, but that are eligible for services through an Indian healthcare provider may receive an Exemption.	<ul style="list-style-type: none"> <li>Marketplace</li> </ul>	<ul style="list-style-type: none"> <li>Exemption granted on continuing basis until reported that applicant no longer meets requirements</li> </ul>

Source: [45 CFR 155.605](#). See also [www.healthcare.gov/health-coverage-exemptions/hardship-exemptions](http://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions) and [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions).

In addition to the different types of hardship exemptions, affordability exemptions vary depending on the relationship of the individual to the insured. Individuals receiving an affordability exemption either prospectively through the FFM or retrospectively through the IRS must demonstrate that the lowest cost MEC exceeded 8.13%<sup>54</sup> of their household income. The following table (see [Table 53](#)) shows the approximate annual and monthly premiums individuals at certain income levels would have to pay for the lowest cost MEC in order to qualify for an affordability exemption.

<sup>54</sup> Sources: [www.treasury.gov/press-center/press-releases/Documents/3-17-16%20ACA%20Exemptions%20One%20Pager%20-%20Unaffordable%20Coverage.pdf](http://www.treasury.gov/press-center/press-releases/Documents/3-17-16%20ACA%20Exemptions%20One%20Pager%20-%20Unaffordable%20Coverage.pdf); [www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply/](http://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply/)

**Table 53: Estimated Premium Costs to Qualify for an Affordability Exemption**

Income and Premium Amounts for Affordability Exemptions										
<i>Annual Income</i>	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<i>Monthly Income</i>	\$833	\$1,667	\$2,500	\$3,333	\$4,167	\$5,000	\$5,833	\$6,667	\$7,500	\$8,333
Insurance must cost more than:										
<i>*Annual Premium</i>	\$813	\$1,626	\$2,439	\$3,252	\$4,065	\$4,878	\$5,691	\$6,504	\$7,317	\$8,130
<i>*Monthly Premium</i>	\$68	\$136	\$203	\$271	\$339	\$407	\$474	\$542	\$610	\$677

\*These are estimated, minimum amounts reflecting 8.13% of income. To know for sure if an individual qualifies for an affordability exemption, the individual should apply for the exemption.

Sources: [26 CFR §1.5000A-3](#). See also [www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply](http://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply) and [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions).

Unlike determinations for [insurance affordability programs](#), determinations for exemptions based on affordability do not include non-taxable social security benefits as income, but are increased by any amount of employer salary reduction agreement. Affordability exemptions (see [Table 54](#)) can be granted retrospectively by the IRS and based on taxable income for the most recent year tax data was available; or they can be conducted prospectively by the FFM and based on projected annual income. Affordability exemptions are calculated differently dependent upon what type of coverage is being examined for affordability and whether the individual is a dependent.

**Table 54: Affordability Exemptions from the Individual Mandate**

Type	Description	Other
<i>Affordability for employer-sponsored coverage – employee</i>	For self-only coverage, affordability for the purpose of an exemption is determined based on the cost of the lowest cost self-only coverage. Coverage that exceeds 8.13% of income is unaffordable and the individual may receive exemption.	When calculating the affordability of employer-sponsored insurance all premium discounts related to wellness programs, including programs for tobacco use, are considered to be unearned.
<i>Affordability for employer-sponsored coverage- related individual</i>	Affordability of employer-sponsored insurance for related individuals is determined based on cost of coverage for the lowest cost employer-sponsored plan that covers both the employee and the related individuals. If the cost of coverage for the family is greater than 8.13% of income then the related individuals are exempt.	<p>If cost of coverage for the self-only coverage is less than 8.13% of income then the employee is not exempt, even if cost of coverage for family coverage is greater than 8.13% of income.</p> <p>Individuals who receive this exemption will not be subject to a shared-responsibility payment but will also not be eligible for premium tax credits (PTCs) or cost-sharing reductions (CSRs).</p>
<i>Affordability for coverage in individual market</i>	For individuals only eligible in the individual market affordability is based on the cost of the lowest cost bronze plan that covers the applicable individuals, or the taxpayer may elect to base the affordability on the lowest cost bronze plan that would cover a similar group (e.g., an aunt and two nieces could base affordability on lowest cost Adult +2 plan). Any advanced payments of the PTC that the individual(s) would be eligible for are taken into account; and if, with this consideration, the contribution for the lowest cost bronze plan is greater than 8.13% of income for applicable individuals, then individuals are exempt.	Guidance is still unclear if premium rate increases for tobacco use will be included or not in the calculation of individual market affordability.

Source: [26 CFR §1.5000A-3](#). See also [www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply](http://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply) and [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions).

**SIDEBAR:** There is a discrepancy between the affordability provisions and the premium tax credit (PTC) provisions. Individuals and families who have access to minimum essential coverage (MEC) where the cost exceeds 8.13% of income, but is less than 9.66%<sup>55</sup> of income, are eligible for an exemption, but not

<sup>55</sup> Source: [www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit](http://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit)

eligible for a premium tax credit. For related individuals in an employer-sponsored plan, eligibility for a PTC is based on the contribution for self-only coverage. Therefore, if the employee's contribution for self-only coverage costs less than 9.66% of income, none of the employees' dependents eligible for employer-sponsored coverage can receive PTC in the Federally-facilitated Marketplace (FFM) regardless of the cost of family coverage. Additionally, PTCs for individuals between 250% and 400% of the federal poverty level (FPL)<sup>56</sup> only come into effect after the individual or family has spent 8.13% to 9.66% of their income towards the purchase of insurance. Individuals in this income range could potentially be eligible both for a PTC and an affordability exemption. The exemption is not guaranteed in these circumstances because the amount of the PTC is based on the cost of the second lowest-cost silver plan and qualification for the exemption is based on the lowest-cost bronze plan.

### *b. Applying for an Exemption*

As displayed above, individuals may apply for the exemption either through the IRS or the FFM, depending on the type of exemption. For exemptions obtained through the FFM, the individual may use either the "single streamlined application" or a separate exemption application.<sup>57</sup> If an individual has already completed a single streamlined application to apply for health coverage, he or she may not need to complete an additional application to apply for an exemption (this depends on the type of exemption). Any information previously entered on the single streamlined application can be used to assess FFM exemptions. Individuals only interested in applying for an exemption and not interested in eligibility for qualified health plans (QHPs) or insurance affordability programs may use the FFM exemption application. Most exemptions granted by the IRS are obtained through the tax-filing. Information on claiming and reporting exemptions from the Individual Mandate is available on the IRS website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions).

### *c. Exemption Appeals*

Individuals have the right to appeal exemption denials. Appeals for exemption denials would be directed to the agency that issued the initial denial. Exemption appeals denied by the FFM would be directed back to the FFM and exemption appeals denied by the IRS would be directed to the IRS.

Information on appealing an FFM decision is available online [www.healthcare.gov/marketplace-appeals](http://www.healthcare.gov/marketplace-appeals). and information on appealing an IRS decision is available online at [www.irs.gov/Individuals/Appeals-Resolving-Tax-Disputes](http://www.irs.gov/Individuals/Appeals-Resolving-Tax-Disputes).

### *d. Exemption Wrap-Up*

Individuals who are granted an exemption are exempt from the requirement to enroll in MEC; however, they are not excluded from enrolling in minimum essential coverage. An individual may have an exemption from the shared-responsibility payment and may still enroll in minimum essential coverage.

<sup>56</sup> \$29,700 for an individual and \$60,750 for a family of four based on 2016 federal poverty level

<sup>57</sup> The single streamlined application refers to the individual FFM health coverage application through [www.healthcare.gov](http://www.healthcare.gov). The separate exemption applications are available at [www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply](http://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply).

Individuals who are not enrolled in MEC and who do not receive one of the above exemptions from the requirement to maintain MEC will owe a shared-responsibility payment to the IRS when filing their taxes.

### 3. Shared-Responsibility Payment

Individuals are required to maintain [minimum essential coverage](#) (MEC) for themselves and their dependents. Any month in which the individual or his or her dependents are covered by MEC or eligible for an exemption for at least one day counts as a covered month. For months where the non-exempt individual or non-exempt dependents did not have at least one day of MEC, a shared-responsibility payment is owed for every applicable individual without MEC or an exemption.

Shared-responsibility penalty payments are calculated on a monthly basis for every non-exempt individual in the household without minimum essential coverage. Penalties may not be greater than the national average premium for a [qualified health plan](#) (QHP) bronze plan that would cover the applicable individual(s).

Maximum penalties will vary by family composition, age, and potentially smoking status. Subject to the maximum amount, the assessed penalty is the greater of: (1) the dollar amount penalty for every non-covered individual or dependent in the household; or (2) the percentage of taxable income amount penalty. Dollar amount penalties are charged on every individual without coverage in the household and the maximum dollar amount penalty for a household is 300% of the individual dollar amount penalty. However, if the percent of income penalty is greater than the maximum dollar amount penalty then the percent of income penalty will apply. The following table shows the annual shared-responsibility payment amounts for 2016 (see [Table 55](#)):

**Table 55: Annual Shared-Responsibility Payment Amounts\***

Year	Penalty is the greater of:		Maximum Penalty
	Dollar Penalty, assessed for every household member without minimum essential coverage (MEC)	Percent Penalty	
2016	Adult: \$695	2.5% of annual household income	National average premium for a qualified health plan (QHP) bronze plan that would cover the applicable individual(s)
	Under age 18: \$347.50		
	Maximum: \$2,085		

\*Penalty is the greater of the amounts shown in the table but may not be greater than the average national QHP bronze plan premium.

Source: [26 CFR §1.5000A-4](#). See also [www.healthcare.gov/fees/fee-for-not-being-covered](http://www.healthcare.gov/fees/fee-for-not-being-covered) and [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment#Calculating%20the%20Payment](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment#Calculating%20the%20Payment).

Monthly penalty amounts would be one-twelfth (1/12) of the annual penalty amounts, for each month in which an individual or dependent was not covered.

In general, individuals at lower incomes will pay the dollar amount penalty, while individuals at higher incomes will pay the percent penalty. Individuals and family with income above the following incomes (see [Table 56](#)) will be subject to the percent penalty displayed in the table above (see [Table 55](#)).

**Table 56: Minimum Income Levels for Percent Penalties**

	2016
<i>Income level where percent penalty applies—Individual</i>	>\$27,800 taxable income
<i>Income level where percent penalty applies—Family*</i>	>\$83,400 taxable income

\*Family of three to six individuals dependent on ages of applicable family members.

Source: [26 CFR §1.5000A-4](#)

For example, an individual with \$30,000 in taxable income would be subject to the percent penalty in 2016. The individual would be responsible for paying 2.5% of his or her taxable income, or \$750, as a shared-responsibility payment.

Shared-responsibility payments are assessed when individuals file taxes. The IRS may not file notice of lien or levy on the taxpayer's property for failure to pay an assessed shared-responsibility payment, and the taxpayer may not be subject to criminal prosecution or penalty for failing to pay the assessed payment in a timely manner. However, the IRS may collect shared-responsibility payments through deducting the owed amount from individuals' overpayment returns.

Federal guidance on MEC, shared-responsibility payments, and exemptions can be accessed online at [www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02141.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02141.pdf), [www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02139.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02139.pdf), and <https://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27998.pdf>.<sup>58</sup>

#### 4. Guaranteed Availability and Guaranteed Renewability

The [Affordable Care Act](#) (ACA) eliminates the ability for health plans offering major medical products to refuse to issue coverage based on health status, family health history, age, gender, or other factors. Prior to the ACA, depending on local state laws, health plans could deny individuals coverage based on pre-existing health conditions.

Beginning in 2014, consumers have been able to purchase major medical products without regard to health status. In limited circumstances, issuers may deny enrollment to individuals if the individual is not a resident of the health plan's service area or if the health plan has reached capacity for their provider network and is not accepting new enrollees. In all other circumstances, a health plan must guarantee an offer of coverage to all individuals that apply.

<sup>58</sup> Other helpful information regarding MEC, the individual mandate, and exemptions can be viewed on the FFM/Healthcare.gov website at [www.healthcare.gov/fees/plans-that-count-as-coverage](http://www.healthcare.gov/fees/plans-that-count-as-coverage), [www.healthcare.gov/fees/fee-for-not-being-covered](http://www.healthcare.gov/fees/fee-for-not-being-covered), and [www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee](http://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee), respectively., and at the IRS website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage), [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision), and [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions), respectively.

Individuals are not required to enroll in the offered coverage. Enrollees are also assured that their health insurance will be able to be renewed (including [grandmothered plans](#) up through October 1, 2016, subject to discretion of issuers), provided that they pay their premiums and still live within the issuer's service area.

**Sidebar:** As of January 1, 2015, a health insurance issuer is prohibited from denying coverage options to same-sex spouses under the same terms and conditions as coverage offered to opposite-sex spouses. An issuer cannot deny insurance coverage to same-sex spouses if the marriage was validity entered into in a jurisdiction where the laws authorize the marriage of two individuals of the same sex, regardless of the jurisdiction in which the insurance policy is offered, sold, issued, renewed, in effect, or operated, or where the policyholder resides. In addition, same-sex spouses will receive [premium tax credits](#) (PTCs) and [cost-sharing reductions](#) (CSRs), as applicable.

Guaranteed availability and guaranteed renewability apply to group market plans as well. Small group market plans are required to meet minimum participation requirements on the [SHOP](#) and may be required by the carriers to meet minimum contribution requirements. However, even if these requirements are not met, there will be one annual period where small group market plans may enroll in SHOP coverage, which will meet the guaranteed availability requirements for the small group market. On the small group market, issuers may decline to renew plans if they do not meet the minimum participation or minimum contribution requirements.

Under the guaranteed availability requirement, plans qualified to be offered both on and off the [Federally-facilitated Marketplace](#) (FFM) are required to allow individuals who do not qualify to purchase FFM coverage to purchase the plan directly from the carrier. With this requirement, individuals that do not qualify for FFM coverage have guaranteed availability to FFM plans. These requirements apply to [major medical insurance](#) plans. Health plans that are covering limited or excepted benefits (*e.g.*, dental, vision, hospital only, etc.) do not have to comply with guaranteed availability or guaranteed renewability and, at their discretion, may deny individuals an offer of coverage based on health status or other factors.

#### *a. Pre-Existing Conditions*

Individuals who have pre-existing health conditions may no longer be excluded from an offer of coverage beginning in 2014. For children, the requirement to offer coverage regardless of any pre-existing conditions went into effect in 2010. Those with pre-existing conditions who may have been excluded from health insurance coverage prior to the ACA will now have access to coverage.

In addition to the requirement that coverage be offered without regard to pre-existing conditions, there may be no exclusions to the offered coverage based on pre-existing conditions at the time of enrollment. Prior to the ACA requirements, many health insurers excluded pre-existing conditions from the offer of coverage. For example, prior to 2014, the individual in need of knee surgery may have received an offer of health insurance, but the insurance would not cover the knee surgery. Beginning in 2014 for adults (and already in effect for children), an individual in need of knee surgery is able to enroll and receive coverage for services related to the knee surgery right away. This is a change in practice for many health insurers. Individuals with pre-existing conditions will be assured those conditions will be covered by coverage purchased in 2014 and beyond.

The requirement to not allow an individual's health status to impact an offer of coverage applies only to major medical insurance plans. Health plans that are covering limited or excepted benefits (e.g., dental, vision, hospital only, etc.) do not have to comply with this requirement, and at their discretion, may exclude pre-existing conditions from an offer of coverage.

Additional information on pre-existing conditions may be viewed online at [www.healthcare.gov/coverage/pre-existing-conditions](http://www.healthcare.gov/coverage/pre-existing-conditions).

### ***b. Dependent Aged 26***

The ACA requires that all health plans that offer coverage for dependents cover eligible dependents up to 26 years of age. Eligible dependents include the natural and adopted children, step children, and children subject to legal guardianship of the individual holding the policy. The requirement applies regardless of whether the dependent has access to other coverage, is not a financial dependent, is married, lives in another location, is not a dependent on the adult's tax return or is not a current student.

For married dependents under age 26, their spouses and children would not be required to be covered under the dependent age 26 requirements. Dependents can be on their parents' coverage even if they have another offer of coverage from an employer.

Details on requirements for dependents aged 26 in Indiana can be found in the Indiana Department of Insurance (IDOI) bulletin at [www.in.gov/idoi/files/Bulletin\\_189.pdf](http://www.in.gov/idoi/files/Bulletin_189.pdf) and the FFM website at [www.healthcare.gov/young-adults/children-under-26](http://www.healthcare.gov/young-adults/children-under-26).

## **5. Elimination of Lifetime and Annual Maximums**

The Affordable Care Act (ACA) eliminates any lifetime or annual maximums applied to coverage that would be considered to be part of the [essential health benefits](#) (EHBs) for all non-grandfathered health plans. Health plans can still place dollar limits on benefits that are not considered to be part of the essential health benefits.<sup>59</sup> Lifetime limits were eliminated in 2010, and annual limits are prohibited beginning in 2014. Individuals enrolled in non-grandfathered health plans will not be at risk of reaching any caps on their EHB coverage in cases of high-cost events.

## **6. Rating Factors**

Rating factors (or "premium rating factors") refer to the information insurance companies use to decide what premium to charge any particular individual. Prior to the [Affordable Care Act](#) (ACA), the premium cost for major medical plans could vary based on health status, gender, age, weight, tobacco or alcohol use, location, or other factors.

Beginning in 2014, the ACA limited the allowable rating factors to age, location, and tobacco use. These plans may no longer charge different rates based on gender or health status. Plans that are not considered [major medical insurance](#) plans and offer excepted benefits including dental only, vision only, or other specific benefit coverage are not subject to these rating requirements and may rate on factors other than age, location, and tobacco use.

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<sup>59</sup> Essential health benefits (EHBs) vary by state. Please see the [Essential Health Benefits section](#) for more detail.

### *a. Rating for Age*

The ACA limits how much a major medical plan can increase the cost of the plan for older individuals to a three-to-one ratio. Older adults may be charged no more than three-times the premium as younger adults. The Center for Consumer Information and Insurance Oversight (CCIIO) developed an age rating curve (see [Table 57](#)) to determine how premiums can change based on the individual's age. Per this age curve, individuals under 20 years will have a premium that costs 63.5% of the premium for individuals between 21 and 24, and at age 64, an individual may expect his or her premium to be three-times as much as an individual at 21 years of age.

**Table 57: Federal Premium Rating Curve Based on Age**

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and older	3.000

Source: CMS, *Overview: Final Rule for Health Insurance Market Reforms (2013)*, [www.cms.gov/CCIIO/Resources/Files/Downloads/market-rules-technical-summary-2-27-2013.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/market-rules-technical-summary-2-27-2013.pdf). See also [www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html).

### *b. Rating for Tobacco*

The ACA allows health insurance issuers to charge up to 1.5 times the premium for individuals that use tobacco. Under ACA regulation, tobacco use is defined as use of any tobacco product on average four or more times per week over the past six months. Any religious or ceremonial uses of tobacco would be excluded from this definition. Rate increases for tobacco may only be applied to individuals who may legally use tobacco under state laws. If an individual incorrectly reports tobacco use, issuers may not cancel the policy, but they may charge back premiums for the months the tobacco use was incorrectly reported.

Health insurance issuers may vary their tobacco use rating factor based up to a 1.5-to-one ratio, and they may have different ratios for different ages, however, at no point may a rate increase for tobacco based on age contradict the three-to-one age rating limit. For example, the rates for a smoker at age 64

may be no more than three times the rate for a smoker at age 21, though the rate for a smoker at age 64 may be 4.5 times higher than the rate for a non-smoker at 21 years of age.

The method used to develop the premium rating for tobacco use, whether to vary the premium for tobacco use based on age, and how much to vary it, is currently up to issuer discretion. Different health plans offered on a marketplace may have different policies on rating for tobacco use and the premium may vary for tobacco users, depending on their age and the health plan they select.

### *c. Rating for Location*

As the cost of healthcare may vary by location, the ACA allows insurers to adjust their premiums depending on an enrollee's location. States may establish their own rating areas with the approval of the Center for Consumer Information and Insurance Oversight (CCIIO). If states do not establish rating areas, the default rating areas are the state's Metropolitan Statistical Areas (MSA), plus one additional area to encompass rural areas not included by the MSAs.

More information on MSA's can be found online at [www.census.gov/population/metro/files/metro\\_micro\\_Feb2013.pdf](http://www.census.gov/population/metro/files/metro_micro_Feb2013.pdf) and [www.census.gov/population/metro/data/metrodef.html](http://www.census.gov/population/metro/data/metrodef.html)

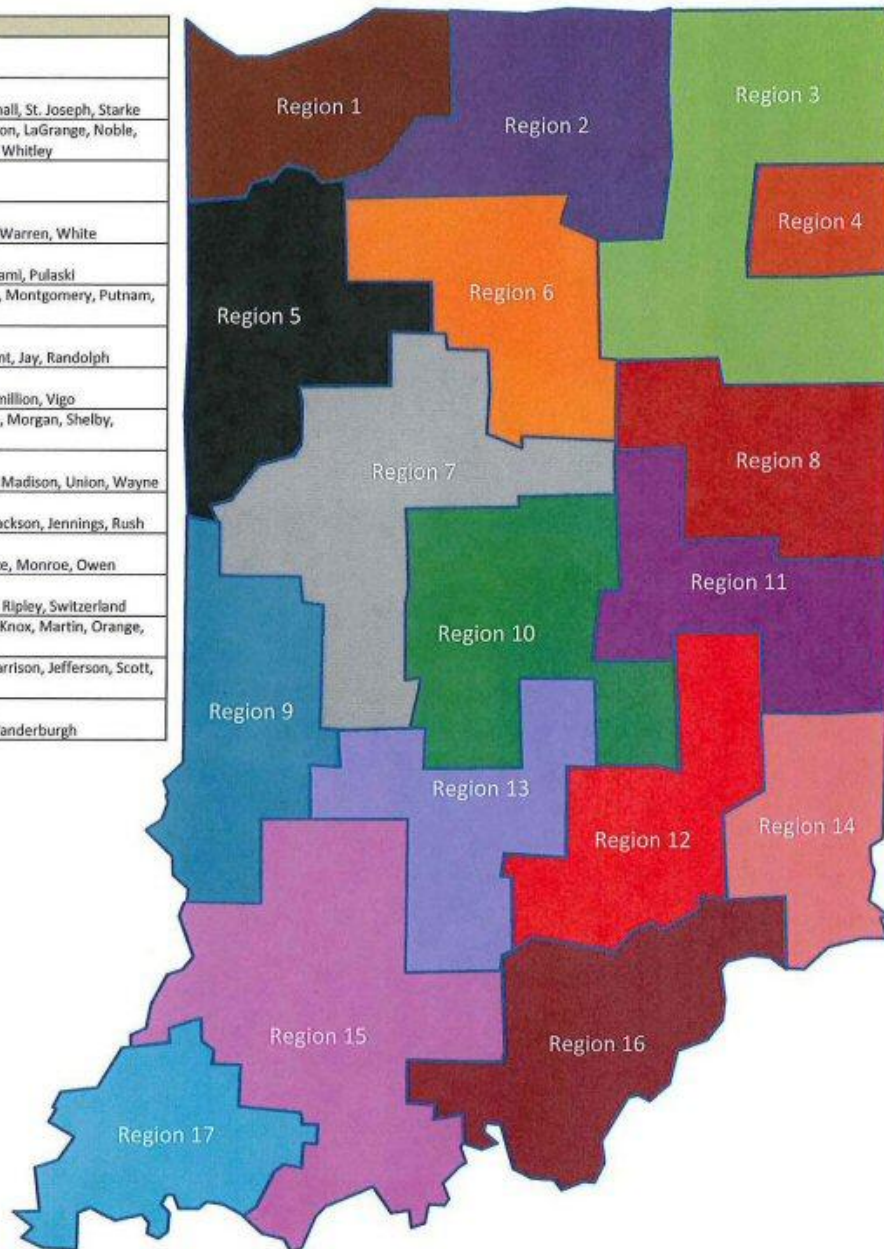
### *d. State-Specific Rating Areas*

Indiana has accepted the default number of rating areas proposed by CCIIO and has a rating area for each MSA plus one additional rating area for a total of 17 rating areas in Indiana. However, the State modified the boundaries of the proposed rating areas to make them more contiguous; and thus Indiana's rating areas do not precisely follow the boundaries of the Census Bureau's MSAs but are instead based on county boundaries. Carriers may assign different premium rating factors to each area. The following map (see [Figure 8](#)), delineates Indiana's rating areas.

Figure 8: Indiana Rating Areas

Geographic Rating Areas in Indiana

Region	Counties
1	Lake, LaPorte, Porter
2	Elkhart, Kosciusko, Marshall, St. Joseph, Starke
3	Adams, DeKalb, Huntington, LaGrange, Noble, Steuben, Wabash, Wells, Whitley
4	Allen
5	Benton, Jasper, Newton, Warren, White
6	Cass, Fulton, Howard, Miami, Pulaski
7	Carroll, Clinton, Fountain, Montgomery, Putnam, Tippecanoe, Tipton
8	Blackford, Delaware, Grant, Jay, Randolph
9	Clay, Parke, Sullivan, Vermillion, Vigo
10	Boone, Hamilton, Marion, Morgan, Shelby, Hendricks
11	Fayette, Hancock, Henry, Madison, Union, Wayne
12	Bartholomew, Decatur, Jackson, Jennings, Rush
13	Brown, Johnson, Lawrence, Monroe, Owen
14	Dearborn, Franklin, Ohio, Ripley, Switzerland
15	Daviess, Dubois, Greene, Knox, Martin, Orange, Perry, Pike, Spencer
16	Clark, Crawford, Floyd, Harrison, Jefferson, Scott, Washington
17	Gibson, Posey, Warrick, Vanderburgh



Source: Indiana Department of Insurance, *Bulletin 197: Geographical Rating Areas* (2013), [www.in.gov/legislative/iac/20130403-IR-760130130NRA.xml.html](http://www.in.gov/legislative/iac/20130403-IR-760130130NRA.xml.html)

In the [SHOP](#), location rating may be based either on the location of the business or the location of the employees. For small businesses with employees in multiple states, the employees may be covered through the marketplace in their home state or through the marketplace in the business's home state.

### i. Family Plans

In Indiana, when calculating the premium for family plans, the premium attributable to each member of the family is added together to get the premium for the family plan. Each rating factor will be attributed to each member separately and a combined premium for the family will be calculated. All family members age 21 and over will be included in the calculation of the family premium, but only the oldest three family members age 20 and under will be included. This means that for a couple with four children 20 and under, only the oldest three dependents under 21 will be considered when calculating the family premium.

**Table 58: Rating for Family Plans**

	<b>Family Members 21 and older</b>	<b>Family Members 20 and under</b>
<i>Rate for Age</i>	Assign an age rating to each family member	Rate for the oldest three family members 20 and under
<i>Rate for Tobacco Use</i>	Assign a tobacco rating to each family member	Rate for the oldest three family members over 18 and 20 or under*
<i>Rate for Location</i>	Assign a location rating to each family member	Rate for the oldest three family members 20 and under
<i>Calculate Premiums</i>	Determine premium for each individual	Determine premium for the oldest three members 20 and under
<i>Family Premium</i>	<b>Sum premiums for members 21 and older and the oldest three family members 20 and under to reach the total amount of premium for the family</b>	

\* In Indiana, tobacco use is prohibited for those under eighteen. The tobacco rating factor can only be applied to members who may legally use tobacco in the state in which they reside.

Source: [45 CFR §147.102](#)

### ii. Small Group Plans

Similar to developing a premium for a family, plans in the small group calculate premiums by determining each plan members individual rating factor based on age, tobacco use, and location, and then adding all of the individual premiums to reach a group rate. For group plans, individuals that use tobacco but enroll in a wellness plan or smoking cessation program will have the increased rate for tobacco waived. The final premium an enrollee of a small group plan pays will depend on the employer's contribution to the health plan.

## 7. Medical Loss Ratio

The [Affordable Care Act](#) (ACA) requires that all issuers of major medical products spend a certain percentage of their annual revenue on medical costs. The percentage a health insurance plan spends on medical costs for enrollees is referred to as the plan's medical loss ratio (MLR). Medical costs include both the costs of claims paid and any activities the health plan undertakes to improve the quality of healthcare provided.

The ACA requires that large group plans have a MLR of 85% and that individual plans and small group plans have a MLR of 80 percent. These amounts are adjusted for fees and taxes required on the

insurance companies. Plans that do not meet these MLR requirements must pay rebates to enrollees to compensate them for the excess premium collected. Health plans were required to start reporting on MLR and issuing rebates to consumers in 2012 for the 2011 plan year. However, beginning in 2014, there are some additional changes to the insurance market that make the calculation of MLR and the associated consumer rebates more complicated.

Starting in 2014, each insurance plan's final MLR is calculated annually after the application of programs that may impact the final MLR, including risk adjustment, reinsurance, risk corridors, and any other fees and taxes. The annual calculations commence after the close of the plan year; and risk adjustment, reinsurance, and risk corridors are applied to each health plan. After these programs are applied, the health plan must calculate its medical loss ratio.

For 2014 and years after, health plans will have to report their MLR to the federal government and enrollees by July 31 of the year following the plan year. For example, for the January 2016 to December 2016 plan year, health plans must report their MLR by July 31, 2017. With this notification, enrollees in the health plan will know if they can expect a rebate from their health plan. Health plans that owe consumers rebates are required to pay these rebates by September 1 of the year following the plan year. Consumers that are owed a rebate for the 2016 plan year can expect to receive their rebate payment by September 1, 2017. Rebates for small and large group plans will be paid to the employer and it will be at the discretion of the employer on how and when they should be distributed to enrollees. There is no expected amount of rebate, and each consumer's rebate will depend on the health plan's final MLR and how many members were enrolled.

Enrollees who believe they should have received a rebate, but have not, should contact their health insurance plan.

More detailed information on MLR and rebate calculations can be found online at [www.healthcare.gov/health-care-law-protections/rate-review](http://www.healthcare.gov/health-care-law-protections/rate-review) and [www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html).

## 8. Marketplace vs. Non-Marketplace Coverage

Marketplaces did not eliminate the avenues through which individuals and small businesses purchased coverage prior to the implementation of the [Affordable Care Act](#) (ACA). Individuals and small businesses are still able to purchase coverage through methods that may include direct purchase from carriers, through agents or brokers, or through carrier websites. However, coverage available through the [individual](#) and [SHOP](#) marketplaces allow access to programs not available on the outside market. In addition, while all plans sold have to meet market requirements including the [rating factors](#), [dependent age 26](#), [essential health benefits](#) (EHBs), [actuarial value](#) (AV) requirements, and [elimination of lifetime and annual limits](#), health plans sold through marketplaces are subject to additional requirements placed on [qualified health plans](#) (QHPs).

In general, a [major medical plan](#) sold either on or off of the [Federally-facilitated Marketplace](#) (FFM) will offer comprehensive health coverage and will meet the requirement for individuals to maintain [minimum essential coverage](#) (MEC). However, individuals who purchase a major medical plan off of the FFM in the individual market may be required to attest that they also have coverage for pediatric dental [essential health benefits](#) (EHBs) if these benefits are not included in their medical plan.

Not all plans offered outside of the FFM will be offered on the FFM, so there may be a greater selection of plan offerings outside of the Federally-facilitated Marketplace. Plans on the FFM are not required to offer their coverage options outside of the FFM, so there may be a different selection of plans on the FFM than is available off of the Federally-facilitated Marketplace. Due to [guaranteed availability and guaranteed renewability clauses](#), individuals who do not qualify to purchase a QHP have an avenue to access the QHP through an off-marketplace coverage option. If a health insurance carrier offers the same health plan both on and off the FFM, that health plan must have the same premiums regardless if it is sold on or off the Federally-facilitated Marketplace.

For individuals, only plans sold on the FFM are eligible for [premium tax credits](#) (PTCs) or [cost-sharing reductions](#) (CSRs). These programs have the potential to decrease the premium cost and the level of cost sharing paid by qualifying individuals. For small businesses, the small business tax credits are only available through the SHOP Marketplace. Small businesses that would like to take advantage of these tax credits must seek coverage for their employees through the SHOP Marketplace.

At their discretion, off-marketplace individual plans may restrict enrollment to the FFM open enrollment periods. Consumers that seek coverage outside of the open enrollment period without receiving a [special enrollment period](#) (SEP) may not be able to purchase a health plan.

**Sidebar:** Off-marketplace plans' ability to restrict purchase of plans to the FFM open enrollment periods gives the plans the ability to limit adverse selection. Adverse selection is when individuals wait until they become sick or need healthcare services to enroll in a plan. The Affordable Care Act (ACA) eliminated health plans' ability to screen for health status and exclude preexisting conditions prior to enrollment. Restricting enrollment to the FFM open enrollment periods is one of the few avenues left for health plans to combat adverse selection; and many health plans may choose to limit enrollment to these periods. In Indiana, it is expected that health plans offering plans outside of the FFM will take advantage of this option. Therefore, individuals who do not enroll on or off of the FFM during an open enrollment period and do not experience an event that may trigger a SEP, may not have the opportunity to enroll throughout the year.

## 9. Small Business Health Insurance Options Program

The Small Business Health Insurance Options Program (SHOP) Marketplace is a forum for small businesses to purchase group coverage for their employees. Starting in 2014, businesses that qualified for small group market coverage in the state based on their number of employees<sup>60</sup> could use the SHOP to find, select, and enroll employees in coverage. Employers that enroll in SHOP coverage and then grow past the small group limit for employees may continue with their SHOP coverage, and renew their SHOP coverage, should they desire to do so.

In general, there is no open enrollment period for SHOP coverage and qualifying employers may enroll their group at any time. Employees enrolled in SHOP coverage will meet the requirement to maintain [minimum essential coverage](#) (MEC). Employers apply to the SHOP for their employees and employees must be eligible for a [qualified health plan](#) (QHP) to be able to receive SHOP coverage. For federally-

<sup>60</sup> In Indiana, between 2 and 50 full-time employees and full-time equivalent employees (FTEs); self-employed and sole-proprietorships excluded. Employees are defined as those "common-law employees," which are recognized by the IRS as the employer's employee and not as an independent contractor.

facilitated SHOP Marketplaces, the SHOP will initially allow employers to select a plan for their employees and then will facilitate employee enrollment into the selected health plan. For years after 2014, employees are able to select from amongst SHOP plans in a [metal tier](#) selected by the employer.

The SHOP requires that at least 70% of employees, who are not enrolled in other MEC and who do not have an exemption, take up the offer of coverage for the employer to be eligible for SHOP coverage. For employers who do not meet the minimum participation requirement, the [guaranteed availability and guaranteed renewability provisions](#) still apply; and there will be one annual SHOP open enrollment period where employers with less than a 70% participation rate may enroll in the SHOP. This period is from November 15<sup>th</sup> to December 15<sup>th</sup>.

As is the practice today, health insurance plans in the SHOP may require that employers contribute a minimum percentage of the premium for the group plan for their employees. Employers that do not meet the health plans contribution rate requirements may be denied coverage for all periods during the year, except during the once annual SHOP open enrollment period from November 15<sup>th</sup> to December 15<sup>th</sup>. By allowing enrollment of these employers during this enrollment period, the guaranteed availability and guaranteed renewability provisions are met for SHOP.

Starting in 2014, employers that wish to receive the small employer tax credit for offering coverage must obtain coverage through the SHOP to receive the tax credit. This tax credit is available for qualifying employers with fewer than 25 low-wage employees, and will credit back to them a portion of the premium spent on health coverage for their employees.

SHOP plans will be required to meet the [essential health benefit](#) (EHB) requirements, and be certified as qualified health plans. However, all plans in the small group market are required to have reduced deductibles when compared to plans in the individual market. SHOP plans are limited to a certain deductible. There are no deductible limits for small group plans.

#### *a. SHOP Enrollment*

Employers that wish to use the SHOP Marketplace to attain coverage for employees may enroll in the SHOP with the help of an agent or broker or may enroll directly via [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses). The SHOP Marketplace will have unique applications for employers to complete that will provide basic information about their employees. Employees will provide more detailed personal information and information on their dependents when enrolling in the health plan. Employers will be able to manually enter in information on the employees or upload employee information to the SHOP directly.

In 2014, the employer was required to set a contribution level and select a plan for their employees. In 2015 and after, the employer must select [a metal coverage level](#) (bronze, silver, gold, or platinum), as well as a reference plan within that coverage level. The employer sets their contribution level as a percentage of the premium based on that reference plan and then employees are free to select any available SHOP plan from amongst the eligible plans in the selected coverage level.

In 2014, employers paid their portion and their employee's portion of premiums for their group coverage directly to the insurer that issued the coverage. For years beginning in 2015, the employer and employees portions of the premium go directly to the SHOP Marketplace. The SHOP then distributes these payments to the health plans chosen by the enrollees.

## 10. Changes to Health Insurance Regulatory Conditions under the Affordable Care Act

### a. ACA-Mandated Benefits: Preventive Services

The Affordable Care Act (ACA) mandates the inclusion of certain categories of preventive services in all non-grandfathered health plans. These services must be provided without the application of any cost sharing, including deductible, copayment, or coinsurance requirements. The preventive services required by the ACA are described in reference to lists of recommended services developed by various governmental agencies.

Under the ACA requirements to cover preventive health services, all health plans must cover: (1) all preventive items or services that have a rating of 'A' or 'B' by the United States Preventive Task Force (USPSTF); (2) Immunizations recommended for the individual's age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); (3) for infants, children and adolescents, preventive care and screenings included in the Health Resources and Services Administration's (HRSA) comprehensive guidelines; and (4) preventive screenings for women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Health plans may not require cost-sharing for any of the items or services listed by any of these sources. Health plans may cover additional preventive services that are not included in these lists at their discretion, but they are required to cover at least those preventive services included on the above lists.

The following lists for preventive care (see [Table 59](#)) will be maintained and updated by the USPSTF, HRSA, and the CDC's Advisory Committee on Immunization Practices. As recommended items, services, and immunizations change, issuers will have to update their benefit packages to align with the recommendations. In general, a health insurance issuer has one year following the issuance of a new preventive health guideline to implement coverage of the preventive health service in their health plans. The one year period is based on the next plan or policy year commencing one year after the recommendation was made.

#### i. United States Preventive Services Task Force Guidelines

Current United States Preventive Services Task Force (USPSTF) A and B recommendations can be found online at [www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations](http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations). As of July 2016, the preventive items and services recommended by USPSTF include the following (see [Table 59](#)):

**Table 59: USPSTF Recommended Preventive Items and Services (cont. to following pages)**

#	Topic	Description	Grade
1	<i>Abdominal aortic aneurysm screening: men</i>	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B
2	<i>Alcohol misuse screening and counseling</i>	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B

#	Topic	Description	Grade
3	<i>Aspirin preventive medication: adults aged 50 to 59 years with a <math>\geq 10\%</math> 10-year cardiovascular risk</i>	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B
4	<i>Bacteriuria screening: pregnant women</i>	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A
5	<i>Blood pressure screening in adults</i>	The USPSTF recommends screening for high blood pressure in adults age 18 years and older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A
6	<i>BRCA risk assessment and genetic counseling/testing</i>	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes ( <i>BRCA1</i> or <i>BRCA2</i> ). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B
7	<i>Breast cancer preventive medication</i>	The USPSTF recommends that clinicians engage in shared, informed decision-making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B
8	<i>Breast cancer screening</i>	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B
9	<i>Breastfeeding counseling</i>	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B
10	<i>Cervical cancer screening</i>	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A
11	<i>Chlamydial infection screening: women</i>	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B
12	<i>Cholesterol abnormalities screening: men 35 and older</i>	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A
13	<i>Cholesterol abnormalities</i>	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart	B

#	Topic	Description	Grade
	<i>screening: men younger than 35</i>	disease.	
14	<i>Cholesterol abnormalities screening: women 45 and older</i>	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A
15	<i>Cholesterol abnormalities screening: women younger than 45</i>	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B
16	<i>Colorectal cancer screening</i>	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A
17	<i>Dental caries prevention: infants and children up to age 5 years</i>	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B
18	<i>Depression screening: adolescents</i>	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B
19	<i>Depression screening: adults</i>	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B
20	<i>Diabetes screening</i>	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B
21	<i>Falls prevention in older adults: exercise or physical therapy</i>	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B
22	<i>Falls prevention in older adults: vitamin D</i>	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B
23	<i>Folic acid supplementation</i>	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A
24	<i>Gestational diabetes mellitus screening</i>	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of	B

#	Topic	Description	Grade
		gestation.	
25	<i>Gonorrhea prophylactic medication: newborns</i>	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A
26	<i>Gonorrhea screening: women</i>	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B
27	<i>Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors</i>	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B
28	<i>Hearing loss screening: newborns</i>	The USPSTF recommends screening for hearing loss in all newborn infants.	B
29	<i>Hemoglobinopathies screening: newborns</i>	The USPSTF recommends screening for sickle cell disease in newborns.	A
30	<i>Hepatitis B screening: nonpregnant adolescents and adults</i>	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B
31	<i>Hepatitis B screening: pregnant women</i>	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A
32	<i>Hepatitis C virus infection screening: adults</i>	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B
33	<i>High blood pressure in adults: screening</i>	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A
34	<i>HIV screening: nonpregnant adolescents and adults</i>	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A
35	<i>HIV screening: pregnant women</i>	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A
36	<i>Hypothyroidism screening: newborns</i>	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A
37	<i>Intimate partner violence screening: women of childbearing age</i>	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women	B

#	Topic	Description	Grade
		who do not have signs or symptoms of abuse.	
38	<i>Lung cancer screening</i>	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B
39	<i>Obesity screening and counseling: adults</i>	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m <sup>2</sup> or higher to intensive, multicomponent behavioral interventions.	B
40	<i>Obesity screening and counseling: children</i>	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B
41	<i>Osteoporosis screening: women</i>	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B
42	<i>Phenylketonuria screening: newborns</i>	The USPSTF recommends screening for phenylketonuria in newborns.	A
43	<i>Preeclampsia prevention: aspirin</i>	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B
44	<i>Rh incompatibility screening: first pregnancy visit</i>	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A
45	<i>Rh incompatibility screening: 24–28 weeks' gestation</i>	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B
46	<i>Sexually transmitted infections counseling</i>	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B
47	<i>Skin cancer behavioral counseling</i>	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B
48	<i>Tobacco use counseling and interventions: nonpregnant adults</i>	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.	A
49	<i>Tobacco use counseling: pregnant women</i>	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A

#	Topic	Description	Grade
50	<i>Tobacco use interventions: children and adolescents</i>	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B
51	<i>Syphilis screening: nonpregnant persons</i>	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A
52	<i>Syphilis screening: pregnant women</i>	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A
53	<i>Visual acuity screening in children</i>	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B

Source: United States Preventive Services Task Force (2016), *USPSTF A and B Recommendations*, [www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations](http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations)

## ii. Preventive Services Guidelines for Women

The Health Resources and Services Administration (HRSA) provides recommendations for preventive care for women, which can be accessed online at [www.hrsa.gov/womensguidelines](http://www.hrsa.gov/womensguidelines). The following table (see [Table 60](#)) shows the recommendations as of July 2016.

**Table 60: HRSA Recommended Preventive Services for Women**

#	Preventive Service	HHS Guideline	Frequency
1	<i>Well-woman visits</i>	Preventive care visit for adult women to obtain recommended preventive services that are age and developmentally appropriate	Annual, unless more visits needed due to woman's health needs
2	<i>Screening for gestational diabetes</i>	Screening for gestational diabetes	Between 24-28 weeks of gestation for pregnant women and at first prenatal visit for women at high risk for diabetes
3	<i>Human papillomavirus testing</i>	High-risk human papillomavirus DNA testing in women with normal cytology results	Should begin at 30 years of age and occur at least every three years
4	<i>Counseling for sexually transmitted infections.</i>	Counseling on sexually transmitted infections for sexually active women	Annual
5	<i>Counseling/screening for human immune-deficiency virus</i>	Counseling and screening for human immune-deficiency virus infection for sexually active women	Annual
6	<i>Contraceptive methods and counseling.</i>	FDA-approved contraceptive methods, sterilization procedures, and education and counseling for women with reproductive capacity	As prescribed
7	<i>Breastfeeding support, supplies, counseling</i>	Comprehensive lactation support and counseling during pregnancy and/or postpartum; costs for renting breastfeeding equipment	In conjunction with each birth.
8	<i>Screening/counseling for interpersonal and domestic violence</i>	Screening and counseling for interpersonal and domestic violence	

Source: Health Resources Services Administration, *Women's Preventive Services Guidelines* (2014), [www.hrsa.gov/womensguidelines/](http://www.hrsa.gov/womensguidelines/)

**Sidebar:** Religious employers may be exempt from the requirement to cover women's contraceptives if they maintain religious objections to this requirement. To qualify as an exempt religious employer the organization must be covered by the IRS definition at 26 USC § 6033 (a)(3)(A)(i) or (iii) and be a church or other house of worship or an affiliated organization or association. Not-for-profit religious organizations with objections to the offering of contraceptive coverage but that do not qualify for the exemption will not be required to contract or pay for contraceptive coverage for their employees; however, their employees will be required to be offered the coverage for contraceptives. In these cases, the insurer of the group health plan for the not-for-profit, or the third-party administrator for a self-insured health plan, will be required to offer the employees of the objecting not for profit contraceptive coverage at no cost to the employee or the not-for profit. To employees of these organizations, contraceptive coverage will be provided and neither the organizations nor the employees will be responsible for paying for the coverage for contraceptives. More details on the guidelines around religious exemptions for contraceptive coverage can be found on CMS's website at [www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html)

### iii. Preventive Guidelines for Children

For infant, child, and adolescent preventive services, the HRSA worked with the American Academy of Pediatrics to develop a list of recommendations for services at each age group. These recommendations are called the "bright futures recommendations." Recommendations are excerpted below and more detailed information on the bright futures recommendations can be found online at <http://brightfutures.aap.org/about.html>.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

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[illegible]

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished as suggested, age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a consultation. The prenatal visit should include anticipatory guidance, perinatal medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (<http://www.aapublications.org/content/134/14/1405.pdf>).
3. If a child is born to a mother who is not breastfeeding, anticipatory guidance and instruction and support should be offered.
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (<http://www.aapublications.org/content/136/3/367.pdf>). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Guidelines for Healthy Term Newborns" (<http://www.aapublications.org/content/125/2/405.pdf>).
5. Screen, per the 2007 AAP statement "Early Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" ([http://www.aapublications.org/content/130/Supplement\\_4/14.pdf](http://www.aapublications.org/content/130/Supplement_4/14.pdf)).
6. Screen for specific risk conditions, such as obesity, per the 2009 AAP statement "Guidelines for the Management of Overweight and Obesity in the General Pediatric Population" (<http://www.aapublications.org/content/134/14/1405.pdf>).
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visit at 3 through 5 years of age. See 2014 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (<http://www.aapublications.org/content/137/1/11.pdf>) and "Procedures for Evaluation of the Visual System by Pediatricians" (<http://www.aapublications.org/content/137/1/11.pdf>).
8. Available resources should be consulted, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (<http://www.aapublications.org/content/120/4/898.pdf>).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (<http://www.aapublications.org/content/131/1/405.pdf>).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" ([http://www.aapublications.org/content/130/Supplement\\_4/14.pdf](http://www.aapublications.org/content/130/Supplement_4/14.pdf)).
11. A recommended screening tool is available at <http://www.aapublications.org/CD/577/index.html>.
12. Recommended screening using the Patient Health Questionnaire (PHQ-2) or other tools available in the QIAD-PC toolkit and at [http://www.aap.org/en-us/advocacy-and-policy/health-initiatives/Mental-Health/Documents/MH\\_ScreeningChart.pdf](http://www.aap.org/en-us/advocacy-and-policy/health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf).
13. At each visit, age-appropriate physical examination is essential, with infant toilet training and older children undressed and suitably draped. See 2014 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (<http://www.aapublications.org/content/135/6/613.pdf>).
14. These may be modified, depending on entry point into physical and individual need.
15. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/opa/communication/medinfo/consent/healthcareprovidersrecommendednewbornscreeningpanel.pdf>), as determined by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening regulations (<http://www.hhs.gov/ohrt/secretary-advisory-committee-on-heritable-disorders-in-newborns-and-children/>).
16. Follow-up must be provided, as appropriate, by the pediatrician.
17. Screening for congenital congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (<http://www.aapublications.org/content/133/1/11.pdf>).
18. Schedules, per the AAP Committee on Infectious Diseases, are available at <http://www.aapublications.org/site/pressroom/schedules.shtml>.
19. Every child should be an opportunity to update and complete a child's immunizations.
20. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (<http://www.aapublications.org/content/128/2/266.pdf>).
21. Available resources should be consulted, per the AAP statement "Year 2007 Position Statement: Committee on Childhood Lead Poisoning Prevention Statement: Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" ([http://www.cdc.gov/ehp/lead/ACCLP/PFinal\\_Comment\\_030712.pdf](http://www.cdc.gov/ehp/lead/ACCLP/PFinal_Comment_030712.pdf)).
22. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
23. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.
24. See AAP-endorsed 2011 guidelines from the National Heart, Lung and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" ([http://www.nhlbi.nih.gov/healthdiv/divcardio/integrated\\_guidelines.pdf](http://www.nhlbi.nih.gov/healthdiv/divcardio/integrated_guidelines.pdf)).
25. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Sexually active adolescents should have HIV screening by the age of 13, per the AAP statement (<http://www.aapublications.org/content/128/5/1023.pdf>) once between the ages of 13 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
26. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/09ac/ac090101.html>). Indications for pelvic examinations prior to age 21 are noted in the 2014 AAP statement "Guidelines for the Examination for Adolescents in the Pediatric Office Setting" (<http://www.aapublications.org/content/136/3/367.pdf>).
27. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (<http://www.aapublications.org/content/134/14/1405.pdf>) and refer to a dental home. If primary water source is deficient in fluoride, consider use of fluoride supplements, reduction of sugary drinks with fluoride toothpaste, the proper dosage for age. See 2004 AAP statement "Oral Health Risk Assessment: Timing and Establishment of the Dental Home" (<http://www.aapublications.org/content/115/1/124.pdf>).
28. See 2014 AAP statement "Fluoride Use in Caries Prevention in the Primary Care Setting" (<http://www.aapublications.org/content/134/3/336.pdf>) and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children" (<http://www.aapublications.org/content/134/1/124.pdf>).
29. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/09ac/ac090101.html>). Once teeth are present, fluoride varnish should be applied to the teeth every 3-6 months in the primary care setting. See 2014 AAP statement "Fluoride Use in Caries Prevention in the Primary Care Setting" (<http://www.aapublications.org/content/134/3/336.pdf>).

#### iv. Guidelines for Immunizations

The Center for Disease Control's (CDC's) Advisory Committee on Immunization Practices recommends immunizations based on age, health status, and immunization history. Many of these recommendations are contingent on age and health status; however, in general children and adults that meet qualifying conditions can expect to have the following immunizations covered without cost sharing under the ACA's mandate for preventive health services.

- Hemophilus influenza Type B
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Tetanus, Diphtheria, Pertussis
- Varicella

Vaccines that are not considered preventive and are administered for purposes such as travel would not be covered by the ACA mandate to cover preventive vaccines without applying cost-sharing requirements.

More detail on Advisory Committee on Immunization Practices recommendations can be found online at [www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm?s\\_cid=rr6002a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm?s_cid=rr6002a1_e).

Other resources on vaccination qualifications and requirements can be found through the resources below:

- Recommendations for birth through 18 years:  
[www.vaccines.gov/who\\_and\\_when/infants\\_to\\_teens/index.html](http://www.vaccines.gov/who_and_when/infants_to_teens/index.html)
- Recommendations for children catching up on vaccines:  
[www.vaccines.gov/who\\_and\\_when/child/index.html](http://www.vaccines.gov/who_and_when/child/index.html)
- Recommendations for adults: [www.vaccines.gov/who\\_and\\_when/adults/index.html](http://www.vaccines.gov/who_and_when/adults/index.html)
- Recommendations for adults with medical conditions:  
[www.vaccines.gov/who\\_and\\_when/health\\_conditions/index.html](http://www.vaccines.gov/who_and_when/health_conditions/index.html)
- Recommendations for college students: [www.vaccines.gov/who\\_and\\_when/college/index.html](http://www.vaccines.gov/who_and_when/college/index.html)
- Recommendations for seniors: [www.vaccines.gov/who\\_and\\_when/seniors/index.html](http://www.vaccines.gov/who_and_when/seniors/index.html)
- Recommendations for pregnant women:  
[www.vaccines.gov/who\\_and\\_when/pregnant/index.html](http://www.vaccines.gov/who_and_when/pregnant/index.html)

#### *b. Essential Health Benefits*

While the ACA mandated preventive services apply to all non-grandfathered health plans in all market segments, the essential health benefits (EHB) requirements only apply to the individual and small group markets and to Medicaid benchmark plans. Starting in 2014, all non-grandfathered major medical plans

in the individual and small group market are required to cover the EHB, at a minimum. Health plans subject to the EHB requirements must cover these benefits or they will not be able to offer coverage in the state. Benefits considered to be EHB cannot be subject to annual spending limitations in accordance with the elimination of lifetime and annual maximum amounts; however, visit limits may still apply to these benefits. As defined by the ACA, the EHB must include at minimum benefits in the following 10 categories (see [Table 61](#)):

**Table 61: Essential Health Benefit (EHB) Categories**

1. Ambulatory Patient Services	6. Emergency Services
2. Hospitalization	7. Maternity and Newborn Care
3. Mental Health and Substance Use Disorder Services, including behavioral health treatment	8. Prescription Drugs
4. Laboratory Services	9. Rehabilitative and Habilitative Services and Devices
5. Pediatric Services, including oral and vision care	10. Preventive and Wellness Services and Chronic Disease Management

Source: *HealthCare.gov (2016), Essential Health Benefits*,  
[www.healthcare.gov/glossary/essential-health-benefits](http://www.healthcare.gov/glossary/essential-health-benefits)

The ACA lists these broad categories as essential health benefits. To define the exact services comprise the EHB in each category, each state has an EHB “benchmark plan” that identifies the benefits and services classified as EHB in the state. Summaries of each state’s EHB benchmark plan can be found on CMS’s website at [www.cms.gov/ccio/resources/data-resources/ehb.html](http://www.cms.gov/ccio/resources/data-resources/ehb.html).

The EHB benchmark plan is comprised of the benefits offered in one of the following health insurance plans: the three largest health plans by enrollment in the small group market, one of the three largest state employee plans, one of the largest federal employee plans, or the largest commercially offered HMO by enrollment offered in the state. States may select from among these benchmark plans; however, if a state did not make a benchmark plan selection, the default benchmark plan is the largest small group plan by enrollment in the state. This plan will reflect benefits and services commonly offered in current small group health plans, and all health plans in the individual and small group markets will be required to offer services that are at least substantially equal to the benchmark plan. If the benchmark plan did not include benefits in one of the EHB categories noted above, the benefits were supplemented from another plan.

Pharmacy EHB requirements differ from medical benefit requirements. For pharmacy benefits, the drugs covered by the selected benchmark are divided into classes and categories of drugs. Health plans do not have to cover the exact drugs covered by the EHB benchmark plan, but must offer the same number of drugs in each class and category as the benchmark health plan, or at least one drug in a class or category if there are none covered by the benchmark health plan. A list of prescription drugs covered by health plans should be available by request.

In Indiana, the EHB benchmark plan is the Anthem preferred provider organization (PPO) plan. This plan offers comprehensive coverage in all categories except pediatric dental and vision. The pediatric dental and vision benefits are supplemented from the federal employees’ vision and dental plan. Habilitative services are covered in this plan at parity with rehabilitative services. The Indiana Department of

Insurance (IDOI) has elected to not allow plans to substitute benefits, so all plans offered in the individual and small group markets in Indiana will be required to cover at minimum the exact benefits present in the Anthem PPO plan. A summary of the Indiana EHB benchmark benefits can be accessed on CMS's website at [cciio.cms.gov/resources/data/ehb.html#indiana.html](https://cciio.cms.gov/resources/data/ehb.html#indiana.html). However, EHB are based on the actual benefits in the plan and not on the summary. The certificate of coverage and a summary of Indiana's benchmark plan can be accessed on IDOI's website at [www.in.gov/idoi/2812.htm](http://www.in.gov/idoi/2812.htm).

The Indiana EHB plan covers a broad and comprehensive range of medical services meeting all EHB requirements, except the requirement to offer pediatric dental and vision services. However, it does *not* cover: acupuncture, bariatric surgery, infertility treatment and diagnoses, or hearing aids. The plan covers chiropractic services limited to 12 visits a year, and physical, occupational, and speech therapy services limited to 20 visits per therapy, per year. The benefits offered in the benchmark plan are the EHB for Indiana and are the minimum benefits that must be offered by all non-grandfathered individual and small group plans in the market.

The cost of providing these benefits will determine the amount of [premium tax credits](#) (PTC). Plans may offer benefits in excess of the EHBs and may cover services not covered by the EHB benchmark plan or offer limits on services greater than that offered by the EHB benchmark plan. However, these services will not be considered to be EHB, they may be subject to lifetime and annual maximums, and PTCs will not cover the cost for the additional services.

Indiana's EHB benchmark does not cover the pediatric dental or vision benefits. These benefits have separate plan benchmarks that define what benefits and services must be offered under this plan. The certificate of coverage for the pediatric vision services and for the pediatric dental services may be viewed on IDOI's website at [www.in.gov/idoi/2812.htm](http://www.in.gov/idoi/2812.htm). All pediatric dental and vision services covered by these benchmark plans are considered to be EHBs in Indiana.

Frequently asked questions (FAQs) about EHBs in Indiana may be viewed on IDOI's website at [www.in.gov/idoi/2812.htm](http://www.in.gov/idoi/2812.htm).

**Sidebar:** Pediatric dental is listed as a required EHB in the Affordable Care Act. HHS defines pediatric dental as recommended dental services for those age 18 and under. For those over 18, with no dependents under 18 covered on their plan, the requirement for the plan to cover pediatric dental services remains in place. In the Federally-facilitated Marketplace (FFM), the individual or small group market plan may elect not to offer the pediatric dental coverage if there is a stand-alone plan offered on the FFM. In this instance, the plan on the FFM does not have to verify that the individual has purchased pediatric dental coverage. However, for individual and small group market health plans sold outside of the FFM, the plan may elect not to offer pediatric dental coverage, but must require individuals purchasing the plan to attest that they have coverage for FFM certified pediatric dental services. It is unclear what the consequences to the health plan or the individual would be if the individual did not actually obtain coverage for pediatric dental services.

### *c. State-Mandated Benefits*

There are certain benefits that, due to state law, health insurers must cover or must offer as an option to all enrollees. Benefits mandated by state law (see [Table 62](#)) may apply only to certain market

segments and issuer types (*i.e.*, the individual, small group, or large group markets, or to health maintenance organizations (HMOs)). Additionally, state-mandated benefits may be mandated to be covered or be a mandate for the issuer to offer the enrollees the option of selecting coverage for the benefit (*e.g.*, must offer).

Many of the mandates that must be offered by law in Indiana are also requirements of the Affordable Care Act. For example, mandates related to preventive screenings for cancer, mental health parity, and coverage of substance abuse disorders are all also required by the ACA's preventive services and EHB requirements.

Indiana's mandates also restrict issuers' ability to exclude certain providers from their networks. For example, there are mandates that prohibit issuers from excluding chiropractors and personal trainers as provider types. However, these mandates do not require coverage of chiropractic or personal trainer services. They only require that if a chiropractor or personal trainer can, within the scope of his or her practice, provide a covered benefit to an enrollee, he or she cannot be excluded by the issuer solely due to provider type.

The interaction of the ACA preventive health mandates, the state mandates, and the [essential health benefit](#) (EHB) requirements for the non-grandfathered individual and small group plans increase the benefits that enrollees can expect to be offered on plans. In instances where mandates from among these groups do not align, the most comprehensive mandate takes precedence. For example, an Indiana state mandate requires that chiropractors be covered providers, but does not require coverage for chiropractic services. However, the EHB requirements provide for a minimum of 12 chiropractic visits for plans in the individual and small group markets. These plans must comply with both mandates and offer at minimum 12 visits and cover chiropractors for other services that can be provided within the scope of their license.

The EHB benchmark plan is a small group plan and all the benefits covered in this plan become required EHB for non-grandfathered plans in both the individual and the small group markets. Since the benchmark plan covered all of Indiana's required small group mandates, these now also become required in the individual market even if the state mandate does not have this requirement. For example, coverage of autism spectrum disorders is required by Indiana law in the small group market. However, in the individual market, by Indiana mandate, the health plan has to offer the option to purchase this coverage, but the health plan is not required to assure these services are covered in every issued policy. However, since autism spectrum disorders were covered in Indiana's EHB benchmark plan, coverage for these services is required to be in all non-grandfathered individual policies.

In addition, some state mandates around preventive requirements may go beyond what is required by federal law. For example, in Indiana, prostate antigen testing is a mandated service. However, this service is not required under the ACA preventive requirements. Insurers may not impose cost-sharing on plan enrollees for ACA-required covered preventive services; however, insurers may require enrollee cost-sharing for preventive services mandated by the state only. For instance, though prostate antigen screening is a preventive service in Indiana, health plans are not required to provide it without imposing cost-sharing. The following table outlines Indiana state insurance mandates (see [Table 62](#)):

**Table 62: Indiana Insurance Benefit Mandates (cont. to next page))**

Required Benefit (with Indiana Code Citation)	Large Group	Small Group	Individual	HMO	
				Employer Based (group)	Not-Employer Based (non-group)
<i>Minimum postpartum hospital stay if maternity benefits are provided (IC 27-8-24)</i>	Mandate	Mandate	Mandate	Mandate	Mandate
<i>Maternity benefits: minimum benefits if maternity coverage provided (IC 27-8-24; 16-41-17)</i>	Mandate	Mandate	Mandate	Mandate	Mandate
<i>Non-formulary drugs and devices (IC 27-13-38)</i>	N/A	N/A	N/A	Mandate	Mandate
<i>Autism and other pervasive developmental disorders (IC 27-8-14.2; 27-13-7-14.7)</i>	Mandate	Mandate	N/A	Mandate	N/A
<i>Coverage for prosthetic and orthotic devices (IC 27-8-24.2; 27-13-7-19)</i>	Mandate	Mandate	Mandate	Mandate	Mandate
<i>Colorectal cancer screening (IC 27-8-14.8; 27-13-7-17; 27-8-5-16.5)</i>	Mandate	Mandate	N/A	Mandate	N/A
<i>Mammography (IC 27-8-14-6; 27-13-7-15.3; 27-8-5-16.5)</i>	N/A	Mandate	N/A	Mandate	N/A
<i>Newborn testing (IC 16-41-17; 27-8-24)</i>	Mandate	Mandate	Mandate	Mandate	Mandate
<i>Prostate cancer screening (IC 27-8-14.7; 27-13-7-17; 27-8-5-16.5)</i>	Mandate	Mandate	N/A	Mandate	N/A
<i>Breast reconstructive surgery (if mastectomy is covered) (IC 27-8-5-25; 27-13-7-14; 27-8-5-16.5)</i>	Mandate	Mandate	Mandate	Mandate	Mandate
<i>Clinical trials (IC 27-8-25; 27-13-7-20.2)</i>	Mandate	Mandate	Mandate	Mandate	Mandate
<i>Chemotherapy parity (oral and intravenous) (IC 27-13-7-20.2)</i>	Mandate	Mandate	Mandate	Mandate	Mandate
<i>Dental anesthesia and hospital charges (IC 27-8-5-27; 27-13-7-15)</i>	Mandate	Mandate	N/A	Mandate	Mandate
<i>Diabetes treatment,</i>	Mandate	Mandate	Mandate	Mandate	Mandate

Required Benefit (with Indiana Code Citation)	Large Group	Small Group	Individual	HMO	
				Employer Based (group)	Not-Employer Based (non-group)
<i>supplies, equipment (IC 27-8-14.5; 27-8-5-16.5)</i>					
<i>Inherited Metabolic Disorder – PKU (IC 27-8-24.1; 27-13-7-18)</i>	Mandate	Mandate	Mandate	Mandate	N/A
<i>Mental health parity (27-8-5-15.6; 27-13-7-14.8; 27-8-5-16.5)</i>	Mandate	N/A	Mandate	Mandate	Mandate
<i>Substance abuse/chemical dependency treatment (IC 27-8-5-15.6; 27-13-7-14.8)</i>	Mandate	Mandate	Mandate	Mandate	Mandate
<i>Off-label use of certain drugs if Rx coverage provided (IC 27-8-20)</i>	Mandate	Mandate	Mandate	Mandate	Mandate

Source: Centers for Medicare & Medicaid Services, *Indiana – State Required Benefits*, [www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/in-state-required-benefits.pdf](http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/in-state-required-benefits.pdf)

#### d. Actuarial Value

All health plans offered on and off of the FFM in the individual and small group markets are required to meet certain actuarial value (AV). Actuarial value refers to the percent of expected costs for EHBs that the health plan will cover on average for all enrollees. For example, an insurance plan that had 68% AV would expect to cover on average 68% of the medical costs of its members for EHB in aggregate and the remaining 32% of costs would be borne by the members. The AV statistic is compiled to be an average for all enrollees in the plan. For enrollees with higher medical costs who quickly reach their out-of-pocket maximum limits, the insurance plan may cover more than 68% of their costs, while enrollees with fewer healthcare expenses may pay a greater percentage of their total healthcare costs.

Non-grandfathered [major medical](#) products must meet certain AV bands to be able to offer coverage either on the FFM or in the outside market. Every plan offered on or off the FFM in the individual or small group markets must fall into one of the below AV bands. With the exception of [catastrophic plans](#), plans with AV outside of the following AV bands cannot be offered (see [Table 63](#)).

**Table 63: Actuarial Value (AV)**

Metal Level	AV target	AV Band
<i>Bronze</i>	60%	58-62%
<i>Silver</i>	70%	68-72%
<i>Gold</i>	80%	78-82%
<i>Platinum</i>	90%	88-92%

Source: [45 CFR § 156.140](#)

An enrollee may expect that, in general, plans with higher AVs will have higher premiums but reduced cost-sharing. Conversely, plans with lower AVs will have lower premiums, but will subject the enrollee to higher cost-sharing. This is true for all enrollees with the exception of those who qualify for [cost-sharing reductions](#) (CSRs), who may experience reduced cost-sharing, but are required to select a silver plan to receive the benefit. Actuarial value will be calculated and displayed for every non-grandfathered health plan offered on and off of the FFM in the individual and small group markets.

More information on AV can be found online at [www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf) and [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

## 11. Changes in Insurance Affordability Options under the Affordable Care Act

### a. Insurance Affordability Programs

The [Affordable Care Act](#) (ACA) includes two programs designed to make insurance premiums and cost-sharing more affordable. These programs are referred to as the [premium tax credit](#) (PTC) and the [cost-sharing reduction](#) (CSR). Consumers may only take advantage of these programs if they apply for coverage through the [Federally-facilitated Marketplace](#) (FFM).

### b. Federal Poverty Level (FPL)

The amount of the PTC and the level of CSR are based on the applicant's income. For these programs income is expressed as a percentage of the federal poverty level (FPL). Federal poverty levels are published by the U.S. Department of Health and Human Services (HHS) and updated each year. Federal poverty levels are based around a poverty threshold amount which is referred to as 100% FPL. Households with incomes at or below this amount are designating as living in poverty. The poverty threshold increases for each individual living in the household. Other income levels are referenced to 100% FPL. For example, 150% FPL is 1.5 multiplied by the 100% of FPL income level. The following table (see [Table 64](#)) displays the FPL levels for 2016. Eligibility for PTC and CSR in 2017 will be based on the 2016 FPL levels.

**Table 64: 2016 Percent of Federal Poverty Level (FPL) Guidelines Annual Income**

Household Size	100%	133%	150%	200%	250%	300%	400%
1	\$11,880	\$15,800	\$17,820	\$23,760	\$29,700	\$35,640	\$47,520
2	\$16,020	\$21,306	\$24,030	\$32,040	\$40,050	\$48,060	\$64,080
3	\$20,160	\$26,812	\$30,240	\$40,320	\$50,400	\$60,480	\$80,640
4	\$24,300	\$32,319	\$36,450	\$48,600	\$60,750	\$72,900	\$97,200
5	\$28,440	\$37,825	\$42,660	\$56,880	\$71,100	\$85,320	\$113,760
6	\$32,580	\$43,331	\$48,870	\$65,160	\$81,450	\$97,740	\$130,320
7	\$36,730	\$48,850	\$55,095	\$73,460	\$91,825	\$110,190	\$146,920
8	\$40,890	\$54,383	\$61,335	\$81,780	\$102,225	\$122,670	\$163,560
For each additional person, add:	\$4,160	\$5,532	\$6,240	\$8,320	\$10,400	\$12,480	\$16,640

Source: Department of Health and Human Services (2016), [HHS Poverty Guidelines for 2016](https://aspe.hhs.gov/poverty-guidelines), <https://aspe.hhs.gov/poverty-guidelines>

### *c. Modified Adjusted Gross Income*

Income used to determine eligibility for insurance affordability programs is *not* an individual's or household's take-home pay. It is taxable income less applicable deductions, increased by:

- Foreign earned income
- Tax exempt interest
- Social security benefits

This income calculation is called modified adjusted gross income (MAGI). MAGI is adjusted gross income (AGI) as reported on an individual's tax return, increased by the above amounts. AGI is income reduced by eligible deductions including trade or business activities, individual retirement account (IRA) contributions, health savings account (HSA) contributions, and other deductions. More information on AGI can be found on the Internal Revenue Service (IRS) website at [www.irs.gov/uac/Definition-of-Adjusted-Gross-Income](http://www.irs.gov/uac/Definition-of-Adjusted-Gross-Income). MAGI and AGI are income in reference to the income reported on an individual's tax return.

Individuals who would like to know if they may be eligible for insurance affordability programs should refer to their prior year tax returns for their AGI amount and increase this amount by the items specified above. This will be the best estimate of MAGI. If the MAGI is between 100% and 400% of FPL as displayed on [Table 64](#), the individual/household may meet the income qualifications for [insurance affordability programs](#).

The only way for an individual or a household to know for certain if they qualify for Insurance Affordability Programs is to apply through the federal Marketplace ([www.healthcare.gov](http://www.healthcare.gov)).

## **12. Eligibility for Insurance Affordability Programs**

In addition to having [modified adjusted gross income](#) (MAGI) between 100% and 400% of the [federal poverty level](#) (FPL), to be eligible for [insurance affordability programs](#) an individual must meet all of the following requirements:

- Be a citizen, national, or lawful resident of the United States
- Not be incarcerated
- Reside or intend to reside in the state in which the individual is applying for coverage
- Not be claimed as a dependent on another individual's tax return
- Not be eligible for other [minimum essential coverage](#) (MEC) or only be eligible for employer-sponsored coverage that does not meet [minimum value](#) (MV) or affordability requirements
- Enroll in a bronze, silver, gold, or platinum level [qualified health plan](#) (QHP) on the [Federally-facilitated Marketplace](#) (FFM). [Catastrophic plans](#) and plans sold off of the FFM are not eligible for insurance affordability programs.

An individual that does not meet these requirements may apply on behalf of a dependent that does meet the requirements. The individual will not be eligible for insurance affordability programs; however, the individual may apply on behalf of his or her dependents.

### *a. Requirement to File*

The main insurance affordability program is the [premium tax credit](#) (PTC). To be eligible to receive the tax credit to subsidize a FFM health insurance purchase, an individual must certify that the individual will file a tax return for the applicable benefit year. For example, if an individual is applying for a PTC in 2017, the individual can be eligible to receive the tax credit prior to tax filing; however, to receive an advanced payment, the individual must attest that he or she will file an income tax return in 2017. [Advanced payments of the premium tax credit](#) (APTC) will be reconciled with the Internal Revenue Service (IRS) at tax filing and individuals may receive additional credit, or owe additional tax based on final MAGI and the amount of APTC received. Individuals that do not file their return or file for a timely extension may experience a disruption of APTC payments for the next year.

To be eligible for APTC, married couples must file a joint return.<sup>61</sup> Married couples that received APTC and file separately will owe the amount of APTC received back to the IRS when they file their taxes.

### *b. Requirement to Report Changes*

Individuals are required to report changes that may impact their eligibility for or the amount of their APTC or [cost-sharing reduction](#) (CSR). These changes include: increases or decreases in income, changes in household composition, changes in location, and changes in citizenship or incarceration status.<sup>62</sup> If the amount of APTC an individual is eligible for decreases during the year and the individual does not report the change, additional taxes may be owed at filing when the APTC payments are reconciled. Conversely, if the amount for which an individual is eligible increases during the year, the individual may be paying greater contributions than required and may be able to benefit from additional APTC. The FFM will periodically check available data sources for changes that will impact eligibility, but it is the consumer's primary responsibility to report significant changes.

## **13. Applying for Insurance Affordability Programs**

Both insurance affordability programs—[premium tax credits](#) (PTCs) and [cost-sharing reductions](#) (CSRs)—may only be accessed through the Federally-facilitated Marketplace (FFM) ([www.healthcare.gov](http://www.healthcare.gov)). Individuals interested in obtaining APTC or CSR for themselves or their dependents must apply for these programs through the FFM during an open or [special enrollment period](#) (SEP). Those who seek health insurance outside of the FFM will not be eligible for insurance affordability programs.

In Indiana, PTCs are obtained through the Federally-facilitated Marketplace. More information on PTCs and application information can be obtained at [www.healthcare.gov](http://www.healthcare.gov) or by calling the FFM at 1-800-318-2596 (TTY: 1-855-889-4325).

### *a. Household Eligibility*

Individuals may apply for insurance affordability programs for themselves and their dependents. Individuals may apply for dependents that live in separate locations. This application may be completed either through the applicants' FFM, or through the marketplace where the individual resides. Household

<sup>61</sup> A victim of domestic abuse who is married and unable to file a joint tax return may claim a premium tax credit (PTC) as referenced in [www.irs.gov/pub/irs-drop/n-14-23.pdf](http://www.irs.gov/pub/irs-drop/n-14-23.pdf).

<sup>62</sup> A list of what life changes an individual should report to the Federally-facilitated Marketplace (FFM) is posted on the FFM website at [www.healthcare.gov/reporting-changes/which-changes-to-report](http://www.healthcare.gov/reporting-changes/which-changes-to-report).

members that are not dependents must apply separately for a premium tax credit. For example, in a household that consists of three sisters and their dependent children, each sister must apply separately for herself and her dependent children, unless one of the sisters is legally the dependent of another.

### *b. Payment of the Premium Tax Credits*

Payments of the PTCs are for qualifying individuals that have incomes between 100% and 400% of the [federal poverty level](#) (FPL) based on [modified adjusted gross income](#) (MAGI) and that enroll in a [qualified health plan](#) (QHP) sold on the Federally-facilitated Marketplace. These tax credits are refundable so that individuals may receive them even if they do not have a tax liability. In addition, to help pay for health insurance during the tax year, eligible individuals can elect to have the credits paid directly to their insurer to help cover premium cost. This option is called the “advanced payment of the premium tax credit” (APTC).

Individuals eligible for the PTC may elect not to receive it during the year and cover their own premium cost. As long as these individuals were enrolled in a PTC eligible plan, they will receive the PTC that could have helped pay for their coverage as a refund on their taxes. The amount of PTC is calculated based on a required contribution that varies by household FPL based on MAGI and the premium of an index plan.

**Sidebar:** The ‘index plan’ for APTC calculation is the second lowest cost silver plan that will cover the applicable individuals. Silver plans are [metal tier](#) plans that will offer coverage at approximately 70% [actuarial value](#) (AV). Every health insurance issuer that offers a QHP on a marketplace will be required to offer a silver and gold plan level. The PTC amount will be calculated based on the cost of the second lowest cost silver plan option that covers the members of the household. If the members of the household cannot be covered on the same plan then the plan premiums to cover all the individuals in the household may be summed, or an index plan that covers a similar family composition may be selected.

The PTC only applies if an individual or household has made a contribution towards the plan. This contribution will be a percent of income, based on MAGI, and will vary by federal poverty level. To receive APTC, an individual must be enrolled in an insurance plan and must pay a required percentage contribution towards the premium, based on income. If the advanced payment option is selected, the APTC is paid directly to the individual’s or household’s qualified health plan(s). Individuals may choose not to accept any APTC and enroll in a health plan at full cost. In this case, the APTC amount will be received as a credit or refund during tax filing.

The percent of income and estimated income dollar amount that an individual would pay for the index plan prior to the application of APTC shown in the following table (see [Table 65](#)). Note that the annual income and monthly income amounts are determined through MAGI methodology and not the income that an individual receives on the individual’s paycheck.

**Table 65: Required Contribution to Silver Plan Prior to Application of APTC\***

		100-133% FPL	133-150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL	>400% FPL
<i>Individual</i> <i>Estimated Total Annual and Monthly Contributions Required Before APTC</i>	<i>Percent of income contribution</i>	2%	3% to 4%	4% to 6.3%	6.3% to 8.05%	8.05% to 9.5%	9.5%	N/A Not Eligible
	<i>Annual Income</i>	\$11,880 to \$15,799	\$15,800 to \$17,819	\$17,820 to \$23,759	\$23,760 to \$29,699	\$29,700 to \$35,639	\$35,640 to \$47,519	>\$47,519
	<i>Annual Contribution</i>	\$237 to \$315	\$474 to \$712	\$712 to \$1,496	\$1,496 to \$2,390	\$2,390 to \$3,385	\$3,385 to \$4,514	N/A Not Eligible
	<i>Monthly Income</i>	\$990 to \$1,316	\$1,316 to \$1,484	\$1,485 to \$1,979	\$1,980 to \$2,474	\$2,475 to \$2,969	\$2,970 to \$3,959	>\$3,959
	<i>Monthly Contribution</i>	\$19 to \$26	\$39 to \$59	\$59 to \$124	\$124 to \$199	\$199 to \$282	\$282 to \$376	N/A Not Eligible
<i>Family of 4</i> <i>Estimated Total Annual and Monthly Contributions Required Before PTC</i>	<i>Percent of income contribution</i>	2%	3% to 4%	4% to 6.3%	6.3% to 8.05%	8.05% to 9.5%	9.5%	N/A Not Eligible
	<i>Annual Income</i>	\$24,300 to \$33,318	\$32,319 to \$36,449	\$36,450 to \$48,599	\$48,600 to \$60,749	\$60,750 to \$72,899	\$72,900 to \$97,199	>\$97,199
	<i>Annual Contribution</i>	\$486 to \$666	\$969 to \$1,457	\$1,458 to \$3,061	\$3,061 to \$4,890	\$4,890 to \$6,925	\$6,925 to \$9,233	N/A Not Eligible
	<i>Monthly Income</i>	\$2,025 to \$2,776	\$2,693 to \$3,037	\$3,037 to \$4,049	\$4,050 to \$5,062	\$5,062 to \$6,074	\$6,075 to \$8,099	>\$8,099
	<i>Monthly Contribution</i>	\$40 to \$55	\$80 to \$121	\$121 to \$255	\$255 to \$407	\$407 to \$577	\$577 to \$769	N/A Not Eligible

\*Amounts are based on 2016 federal poverty level (FPL). 2017 FPL will be released in January 2017 and will impact income and contribution estimates. Federal poverty level for advanced payment of premium tax credit (APTC) is based on modified adjusted gross income (MAGI).

Source: [26 CFR § 1.36B-3](#)

The maximum amount of PTC is the difference between the required contribution and the premium for the index plan(s) that cover the applicable individuals. The PTC only covers the [essential health benefits](#) (EHBs); additional benefits will not be covered by a PTC calculation. Because the amount of the PTC is also indexed to the silver level of coverage, if an individual selects a more expensive plan (gold or platinum) the individual may expect to pay more than the income percentage referenced in [Table 65](#).

Once an individual or family has made its required monthly contribution towards the premium cost, then the PTC covers the remaining cost of the second lowest-cost silver plan. For example, if the annual

premium for the second lowest-cost silver plan to cover a non-tobacco user with income at 200% FPL (\$23,760 per year) was estimated at \$3,550 or \$295 a month, the individual would be responsible for paying approximately \$1,496 per year or \$124 per month, and the PTC amount would be \$2,054 per year or \$171 monthly, as calculated from the difference between the premium cost of the second lowest-cost silver plan.<sup>63</sup>

The amount of PTC that an individual or family is eligible for will vary depending on the age of those applying to be covered, and their location. This is due to the fact that insurance premium rates vary depending on an individual's age, location, and tobacco use.

Individuals that face increased premium cost because of tobacco use will not be eligible for PTCs to cover the additional premium related to smoking. Though it is not a requirement, insurers may charge up to 50% more in premiums for those who smoke. From the above example, if the individual at 200% FPL (\$23,760 per year) was a tobacco user, the individual's premium may be as much as 1.5 times \$3,550, or \$5,325. However, the amount of the individual's PTC would not change. The individual would still be eligible for a total PTC of \$2,054 per year or \$171 monthly, and would be responsible for paying the remaining premium of \$3,271 per year or \$272 per month. In this case, due to tobacco use, the individual is paying more than the amount of income contributions stipulated by the PTC calculation process.<sup>64</sup>

**Sidebar:** Tobacco use is defined by the Affordable Care Act (ACA) as use of any tobacco product on average four or more times per week over the past six months. Only those that may legally use tobacco in the state where they are applying for coverage are subject to the increased premium for tobacco use. Questions about tobacco use will be asked on the application for insurance affordability programs and for coverage. If, after enrollment, a health insurer discovers that an individual is or has become a tobacco user then they may charge additional premiums back to the date of tobacco use initiation. Insurers may not terminate an individual's health plan if an individual has misrepresented his or her tobacco use; however, an insurer may terminate an individual's plan for non-payment of increased premiums related to tobacco use.

Once the PTC amount is calculated, then it will not change based on the plan selected. Individuals may reduce what they pay for health insurance by selecting a lower cost plan or may increase what they pay by selecting a higher cost plan or additional benefits beyond the essential health benefits.

Individuals may also choose to accept less than the maximum amount for advanced payments of the PTC, and can reconcile the amounts with the IRS when filing their taxes the following year. Individuals that received too much APTC will owe the IRS money and those that received too little will receive a tax credit. If an individual expects that their income will increase during the year or if they prefer to receive a larger refund on tax filing, then they may want to accept less than the maximum amount of APTC to avoid potential tax penalties. At any time an individual may contact the FFM to reduce their APTC amount or to request a new assessment for maximum APTC amount. The FFM may be reached at [www.healthcare.gov](http://www.healthcare.gov) or by calling 1-800-318-2596 (TTY: 1-855-889-4325).

<sup>63</sup> Note, the rates cited in this paragraph are examples only and are not based on any actual premium rates.

<sup>64</sup> Note, the rates cited in this paragraph are examples only and are not based on any actual premium rates.

**Sidebar:** As of December 30, 2013, if a marketplace discovers that it did not reduce an individual's premium by the correct amount of the APTC, then the marketplace must notify the individual within 45 calendar days of the discovery and refund the individual any excess premium paid by or for the individual.

### *c. APTC Reconciliation*

Beginning with the 2014 tax filing, individual's that are eligible for APTC will reconcile these amounts when they file their taxes. Those that have received payments in excess of what they were eligible for will pay back this amount to the IRS; while individuals that received less APTC will receive these payments as refunds on their tax return.

The amount that an individual may owe the IRS due to an over payment of the APTC is capped and individuals between 100% and 400% FPL may owe no more than the following amounts (see [Table 66](#)) due to excess APTC payments.

**Table 66: APTC Maximum Reconciliation Amounts**

Household income	Single Individual	Family
< 200% FPL	\$300	\$600
200% to 300% FPL	\$750	\$1,500
300% to 400%	\$1,250	\$2,500

Source: [26 CFR § 1.36B-4](#)

For example, if a single individual is assessed to have 275% FPL based on MAGI, and when they file their taxes it shows that they received a \$900 overpayment of APTC, then their tax liability is limited to \$750 dollars.

### *d. Cost-Sharing Reductions*

In addition to PTCs, individuals and/or households may be eligible for cost-sharing reductions (CSRs). To be eligible for CSR the individual or household must also be eligible for the PTC and have income below 250% FPL.

Cost-sharing reductions increase the AV of the individual's health plan and reduce the expected cost-sharing an individual may pay throughout the year. This insurance affordability program only applies if the individual selects a silver plan. A silver plan without a CSR is a 70% AV plan. This means that on aggregate for all individuals enrolled in the health plan, the insurance company will pay 70% of the total healthcare cost and the members will pay 30 percent. Individual members may pay more or less than 30% of their health cost, as AV is calculated over all of the members enrolled in the plan. Cost-sharing reductions increase the proportion of costs that are paid by the health plan, at no additional cost to the member. From a base 70% AV, CSRs increase the AV of the plan up to 94% for some individuals. This results in a decrease in overall cost-sharing, including a decrease in the total allowable out-of-pocket maximum.

**Table 67: Cost-Sharing Reductions, Silver Plan Actuarial Value, and Out-of-Pocket Maximums**

	Actuarial Value	Individual Annual Out-of-Pocket Maximum 2017	Family Annual Out-of-Pocket Maximum 2017
<b>100-150% FPL</b>	94%	\$2,350	\$4,700
<b>150-200% FPL</b>	87%	\$2,350	\$4,700
<b>200-250% FPL</b>	73%	\$5,700	\$11,400
<b>&gt;250% FPL</b>	70%	\$7,150	\$14,300

Sources: Department of Health and Human Services, *Final HHS Notice of Benefit and Payment Parameters for 2017*, [www.cms.gov/ccio/resources/regulations-and-guidance/](http://www.cms.gov/ccio/resources/regulations-and-guidance/)

Not all plans will have exactly the out-of-pocket maximums displayed in [Table 67](#); however, they may have out-of-pocket maximums no greater than these amounts. Depending on the plan selected, distribution of the out-of-pocket maximums between deductibles, copayments and coinsurance will vary; however, individuals and families that are eligible for CSR and enroll in silver plans will experience lower overall cost-sharing than those that are eligible for a CSR and do not enroll in a silver plan. For example, for 2017 the allowable out-of-pocket maximum is \$7,150 for an individual and \$14,300 for a family regardless of income. If individuals with household incomes under 250% FPL choose a bronze plan, they will not be eligible for cost-sharing reductions.

The monthly premium payment for the bronze plan will be less than the premiums for the silver plan; however, individuals that are CSR eligible and enroll in a bronze plan vs. a silver plan can face maximum allowable out-of-pocket costs almost three times greater than CSR-eligible individuals that enroll in a silver plan. CSR-eligible individuals that select a gold or platinum plan will pay more in premiums, however, they are not guaranteed to receive the reduced cost-sharing that is available under the silver plan.

**Table 68: Actuarial Value (AV) and Allowable Out-of-Pocket Maximums by Metal Tier for CSR-Eligible Individuals**

Metal Tier	AV and Out-of-Pocket Maximums	100 - 150% FPL	150 - 200% FPL	200% - 250% FPL	>250% FPL
<b>Bronze</b>	<i>Actuarial Value</i>	60%	60%	60%	60%
	<i>Premium Cost</i>	Low	Low	Low	Low
	<i>Allowable Out-of-pocket maximum individual</i>	\$7,150	\$7,150	\$7,150	\$7,150
	<i>Allowable Out-of-pocket maximum family</i>	\$14,300	\$14,300	\$14,300	\$14,300
<b>Silver</b>	<i>Actuarial Value</i>	94%	87%	73%	70%
	<i>Premium Cost</i>	Medium	Medium	Medium	Medium
	<i>Allowable Out-of-pocket maximum individual</i>	\$2,350	\$2,350	\$5,700	\$7,150
	<i>Allowable Out-of-pocket maximum family</i>	\$4,700	\$4,700	\$11,400	\$14,300
<b>Gold</b>	<i>Actuarial Value</i>	80%	80%	80%	80%
	<i>Premium Cost</i>	High	High	High	High
	<i>Allowable Out-of-pocket maximum individual</i>	\$7,150	\$7,150	\$7,150	\$7,150
	<i>Allowable Out-of-pocket maximum family</i>	\$14,300	\$14,300	\$14,300	\$14,300
<b>Platinum</b>	<i>Actuarial Value</i>	90%	90%	90%	90%
	<i>Premium Cost</i>	Highest	Highest	Highest	Highest
	<i>Allowable Out-of-pocket maximum individual</i>	\$7,150	\$7,150	\$7,150	\$7,150
	<i>Allowable Out-of-pocket maximum family</i>	\$14,300	\$14,300	\$14,300	\$14,300

Sources: [45 CFR § 156.410](#) and [45 CFR § 156.140](#)

To obtain a CSR, an eligible individual needs to apply for a QHP and insurance affordability programs through the FFM, and then enroll in a silver plan. There is no additional paperwork required to receive the reduced cost-sharing.

Individuals that experience income changes during the year must report these changes. Changes in income or household composition may affect the amount of CSR an individual receives. Changes should be reported directly to the FFM at [www.healthcare.gov](http://www.healthcare.gov) or 1-800-318-2596 (TTY: 1-855-889-4325).

**Sidebar:** There are two additional CSRs for qualifying members of federally recognized tribes. Members of federally recognized tribes with incomes at or under 300% FPL may enroll in a silver plan that has 100% AV and no cost-sharing (and therefore, no out-of-pocket maximum). Members of federally recognized tribes with income over 300% FPL may enroll in a silver plan that offers no cost-sharing for any services provided by an Indiana health provider. Only members of federally recognized tribes are eligible for these CSR options. A list of federally recognized tribes can be accessed through [www.healthcare.gov/glossary/federally-recognized-tribe](http://www.healthcare.gov/glossary/federally-recognized-tribe).

When some family members belong to a federally-recognized tribe and some do not, the family faces a difficult decision regarding plan enrollment. Family members that are not tribal members may not enroll in the CSR that are specifically for tribal members. These families may either purchase multiple plans, one to cover the tribal members and to take advantage of the CSR that are only available to the members of federally recognized tribes, and a separate plan to cover the remaining family members. Alternatively, the family members that are members of federally recognized tribes may decline to enroll in the plans available only to tribal members and the entire family may enroll in a plan that is not restricted to members of federally recognized tribes.

**Sidebar:** As of December 30, 2013, if a QHP issuer does not ensure that an eligible individual received the correct CSRs required, then the QHP issuer must notify the individual of the improper reduction within 45 calendar days and refund any excess cost sharing paid by or for the individual. In addition, if a QHP issuer provides greater CSRs to an individual than required, then the QHP issuer will not be eligible for reimbursement for the reductions provided and may not seek reimbursement from the individual or provider as applicable.

### *e. Open Enrollment Periods/Re-enrollment*

Individuals that are enrolling or re-enrolling in QHPs through the FFM/[www.healthcare.gov](http://www.healthcare.gov) may only enroll or re-enroll in and switch QHP's during an open or [special enrollment period](#) (SEP). An uninsured individual that approaches the FFM for coverage outside of an open enrollment period and who is not eligible for a SEP, will not be allowed to enroll or re-enroll through the FFM or take advantage of PTCs or cost-sharing reductions.

The dates for the open enrollment period for enrollment or re-enrollment in a QHP through the FFM and application for insurance affordability programs may be viewed at [www.healthcare.gov/glossary/open-enrollment-period](http://www.healthcare.gov/glossary/open-enrollment-period). For 2017 coverage through the FFM, the open enrollment period is November 1, 2016 – January 31, 2017. Individuals must enroll or re-enroll by a certain date in order to be eligible for health coverage and insurance affordability programs as of January 1<sup>st</sup> of the coverage year. Coverage will not begin until the next month for individuals that enroll or re-enroll after that designated date and who are eligible to receive insurance affordability programs. The date an individual applies may not be the date of enrollment. The following table (see [Table 69](#)) shows enrollment and effective dates for insurance affordability programs in the 2017 open enrollment period.

**Table 69: 2017 Open Enrollment and Effective Dates for Coverage**

Enrollment Date	November 1, 2016 to December 15, 2016	December 16, 2016 to January 15, 2017	January 16, 2017 to January 31, 2017
Coverage Initiation Date	January 1, 2015	February 1, 2015	March 1, 2015

Source: [45 CFR § 155.410](#) and [45 CFR § 155.420](#)

These effective dates are based on the individual's health plan selection. Individuals that are determined eligible for insurance affordability programs prior to the 15<sup>th</sup> of the month, but who do not select a QHP until after the 15<sup>th</sup> of the month, will have to wait until the following month for the programs to become effective. Health insurance plans may offer coverage in advance of the effective dates if the individual pays the full amount of the premium, without APTC payments; however, individuals waiting for their APTC payments will have to abide by the above effective dates. For all individuals, coverage will not commence until the first premium payment is made in full, so individuals eligible for APTC must pay their portion of the premium prior to coverage initiation.

After the open enrollment period in 2017, HHS will provide additional information regarding the dates and guidelines for subsequent enrollment periods online at [www.healthcare.gov](http://www.healthcare.gov). It is also important to remember that enrollees must re-enroll on a yearly basis.

#### ***f. Special Enrollment Periods***

Other than the open enrollment periods, individuals may only enroll in or change QHPs during a special enrollment period (SEP). Special enrollment periods apply to the individual and his or her dependents, and an entire family may be subject to a SEP if one member gains access to such a period. Certain events trigger SEPs, and in general, individuals have 60 days from an event that triggers a SEP to enroll in or change, if applicable, a qualified health plan. An exception to the 60-day rule is that individuals losing coverage from an employer have 30 days after the event. Depending on the triggering event, the SEP will have different effective dates.

There are six events (described in [Table 70](#) as well as online at [www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period](http://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period)) that may trigger a SEP where an individual may change QHPs or complete initial enrollment into a qualified health plan.

**Table 70: Special Enrollment Periods**

Event	Description
1. <i>Loss of Qualifying Health Coverage</i>	<ul style="list-style-type: none"> <li>• Loses minimum essential coverage (MEC)*</li> <li>• Becomes newly eligible for advanced payments of the premium tax credit (APTC) due to changes to employer-sponsored coverage</li> </ul>
2. <i>Change in Household Size</i>	<ul style="list-style-type: none"> <li>• Gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a court order</li> </ul>
3. <i>Change in Primary Place of Living</i>	<ul style="list-style-type: none"> <li>• Gains access to new qualified health plans (QHPs) as a result of a permanent move**</li> </ul>
4. <i>Change in Eligibility for Marketplace Coverage or Help Paying for Coverage</i>	<ul style="list-style-type: none"> <li>• Becomes newly eligible for enrollment in a QHP due to gaining status as a citizen, national, or lawfully present individual*** or being released from incarceration</li> <li>• Is determined newly eligible or newly ineligible for APTC or has a change in eligibility for cost-sharing reductions (CSRs)</li> <li>• Previously in the “coverage gap” (household income below 100% FPL and lived in non-Medicaid expansion state) and newly eligible for APTC</li> <li>• Gains or maintains status as a member of a federally-recognized tribe or a shareholder in the Alaska Native Corporation</li> </ul>
5. <i>Enrollment or Plan Error</i>	<ul style="list-style-type: none"> <li>• Enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Marketplace or HHS, its instrumentalities, or a non-Marketplace entity providing enrollment assistance or conducting enrollment activities</li> <li>• Enrollment or non-enrollment in a QHP or inaccurate eligibility determination is a result of a technical error, such as a Marketplace-related enrollment delay</li> <li>• Enrollment in a QHP is impacted by a plan or benefit display error</li> <li>• Non-enrollment in a QHP is the result of being determined ineligible for Medicaid or CHIP by the state Medicaid or CHIP agency</li> </ul>
6. <i>Other Qualifying Factors</i>	<ul style="list-style-type: none"> <li>• Enrollment or non-enrollment in a QHP is the result of an exceptional circumstance, as determined by the Secretary of HHS, including being incapacitated or experiencing a natural disaster</li> <li>• Enrollment or non-enrollment in a QHP is the result of an unforeseen event or a first-time requirement for Marketplace enrollees</li> <li>• Enrollment or non-enrollment in a QHP is the result of a significant life event resulting in lack of access to the application or account, and a change in situation or status now requires that the person obtain minimum essential coverage. This includes victims of domestic abuse or spousal abandonment. This also applies to servicemen and women who are starting or ending their service.</li> </ul>

\* Loss of MEC due to nonpayment of premiums does not qualify for a special enrollment period.

\*\* Moving solely for medical treatment or vacation does not qualify for a special enrollment period.

\*\*\*Change from one legally present status to another does not qualify for a special enrollment period.

Sources: [45 CFR § 155.420](#); Centers for Medicare & Medicaid Services, [Special Enrollment Periods Available through the Federally-facilitated Marketplace \(May 6, 2016\)](#),

[www.regtap.info/uploads/library/ENR\\_SEPStreamliningIssuerVersion\\_050616\\_5CR\\_050616.pdf](http://www.regtap.info/uploads/library/ENR_SEPStreamliningIssuerVersion_050616_5CR_050616.pdf); Centers for Medicare & Medicaid Services, [Special Enrollment Periods for the Health Insurance Marketplace](#), <https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-for-marketplace.pdf>.

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included the following events (see [Table 71](#)) as limited circumstance that allow eligible consumers to select a plan after open enrollment ends.

In addition, CMS has

**Table 71: Limited Circumstance Special Enrollment Periods (cont. to next page)**

Event	Coverage Effective Date
1. <i>An individual faces exceptional circumstances as determined by the Centers for Medicare and Medicaid Services (CMS), such as natural disaster, medical emergency, and planned system outages that occur on or around plan selection deadlines.</i>	At the discretion of the Federally-facilitated Marketplace (FFM), coverage effective date will be either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month, on the first day of the following second month).
2. <i>Misinformation, misrepresentation or inaction in which misconduct by individuals or entities providing enrollment assistance (like an insurance company, navigator, Certified Application Counselor (CAC), FFM call center representative, agent or broker) resulted in one of the following: (1) Failure to enroll individual in a plan; (2) Individuals being enrolled in wrong plan against their wish; or (3) individual did not receive advanced premium tax credits or cost-sharing reductions for which they were eligible.</i>	At FFM discretion, coverage effective date will be either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month, on the first day of the following second month).
3. <i>Enrollment error in which individual enrolled through the FFM, but the insurance company did not get their information</i>	At FFM discretion, coverage effective date will be either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month, on the first day of the following second month).
4. <i>System errors related to immigration status</i>	At FFM discretion, coverage effective date will be either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month, on the first day of the following second month).
5. <i>Plan display errors on FFM website</i>	At FFM discretion, coverage effective date will be either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month on the first day of the following second month).
6. <i>Individuals who were found ineligible for</i>	At FFM discretion, coverage effective date will be

Event	Coverage Effective Date
<i>Medicaid or the Children's Health Insurance Program (CHIP) and their applications were not transferred to the state from the FFM in time to enroll in a plan during open enrollment</i>	either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month on the first day of the following second month).
<b>7. Individual is not able to complete enrollment due to error messages</b>	At FFM discretion, coverage effective date will be either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month on the 1 <sup>st</sup> day of the following second month).
<b>8. Individual is working with a caseworker on an enrollment issue that is not resolved prior to March 31</b>	At FFM discretion, coverage effective date will be either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month on the 1 <sup>st</sup> day of the following second month).
<b>9. Individual is a survivor of domestic abuse/violence or spousal abandonment</b>	At FFM discretion, coverage effective date will be either the date of the event or the regular coverage effective dates ( <i>i.e.</i> , for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month on the first day of the following second month).
<b>10. Other system errors, as determined by CMS, which hindered enrollment completion</b>	At FFM discretion, coverage effective date will be either the date of the event or the regular coverage effective dates (for QHP selection through the 15 <sup>th</sup> of the month, on the first day of the next month; for QHP selection after the 15 <sup>th</sup> of the month on the first day of the following second month).

Sources: [45 CFR § 155.420](#); Centers for Medicare & Medicaid Services, *Guidance on Special Enrollment Periods for Complex Cases* (March 26, 2014), [www.cms.gov/ccio/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf](http://www.cms.gov/ccio/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf). See also [www.healthcare.gov/sep-list](http://www.healthcare.gov/sep-list).

Due to exceptional circumstances, qualified individuals may be eligible for APTC and CSRs on a retroactive basis from the issuer. The subsidies may be in effect based on the retroactive date, established by the FFM, on which coverage would have been effective absent the exceptional circumstance.

Individuals that do not enroll in coverage during the open enrollment period and who do not have a special enrollment period will not be able to enroll in QHPs or insurance affordability programs through the Federally-facilitated Marketplace. Open enrollment periods only apply to the individual market; businesses seeking group coverage are not subject to these periods.

Individuals may see if they qualify for a SEP through an interactive SEP screener available on the FFM website at [www.healthcare.gov/screener](http://www.healthcare.gov/screener).

### *g. Open Enrollment Period and the Outside Market*

Health plans offering individual coverage outside of the FFM may elect to restrict enrollment into their products to the FFM open and special enrollment periods. It is expected that the health plans will follow the FFM open and special enrollment periods. Individuals that do not enroll in health insurance during the open enrollment period and who do not experience a SEP event will not have the option to enroll in coverage off of the Federally-facilitated Marketplace.

### *h. Applying for Individual or Family Coverage through the Federally-facilitated Marketplace*

Though individuals may only enroll in coverage through the FFM during the open enrollment period, individuals may apply for an eligibility determination for FFM coverage at any time during the year. Until the open enrollment period begins, individuals may create an account at [www.healthcare.gov](http://www.healthcare.gov) and enter in basic information that will assist with their FFM enrollment. Beginning on open enrollment, individuals that have created an account will be able to complete applications for eligibility and enrollment in QHPs and insurance affordability programs. Qualified individuals that have submitted an application will be able to select plans for coverage in the benefit year.

Individuals that apply for coverage through the FFM may apply for coverage for themselves and their family for either QHP coverage paid in full by the applicant or QHP coverage paid for through a combination of applicant and PTC funds.

### *i. Applying for Qualified Health Plan Coverage*

Individuals that are interested in applying for FFM coverage may do so either online, by phone, with in-person help, or by mail. These four methods for submitting a FFM application are outlined in the following table (see [Table 72](#)). Information that individuals may need to apply for coverage may include social security numbers, employer and income information for everyone in their family (such as pay stubs, W-2 forms, or wage and tax statements), policy numbers for any current health insurance, and information about any job-related health insurance available to their family.<sup>65</sup>

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<sup>65</sup> Additional tips on how to get ready to apply for health coverage through the FFM are available on the FFM website at [www.healthcare.gov/apply-and-enroll/get-ready-to-apply](http://www.healthcare.gov/apply-and-enroll/get-ready-to-apply), including a [checklist](#) stating what information an individual may need to apply for and renew coverage.

**Table 72: Methods to Apply for FFM Coverage**

Method	Details
<i>Online</i>	Individuals may complete the FFM application at <a href="http://www.healthcare.gov">www.healthcare.gov</a> during the FFM open enrollment period. They may also see if they qualify for a special enrollment period (SEP) on the FFM, or for Medicaid or the Children's Health Insurance Program (CHIP), through the FFM screener at <a href="http://www.healthcare.gov/screener">www.healthcare.gov/screener</a> .
<i>By Phone</i>	By calling the FFM call center at <b>1-800-318-2596 (TTY: 1-855-889-4325)</b> , the individual will be assisted by a customer service representative in filling out the application, reviewing plan options, and enrolling in coverage. The call center is available 24 hours a day, 7 days a week, and is closed on Memorial Day, July 4 <sup>th</sup> , Labor Day, Thanksgiving Day, and Christmas Day.
<i>With In-Person Help</i>	Individuals may contact trained and licensed/certified people in their community. Certified federal Navigators or Certified Application Counselors (CACs) may be viewed through the FFM website at <a href="https://localhelp.healthcare.gov/#intro">https://localhelp.healthcare.gov/#intro</a> . Certified Indiana Navigators may be viewed through the Indiana Healthcare Reform website at <a href="http://www.in.gov/healthcarereform/2468.htm">www.in.gov/healthcarereform/2468.htm</a> . Licensed agents or brokers or web brokers registered with the FFM may be viewed on the CMS website at <a href="https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/a-b-resources.html">https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/a-b-resources.html</a> .
<i>By Mail</i>	Individuals may fill out and mail in the paper FFM application available at <a href="https://marketplace.cms.gov/applications-and-forms/marketplace-application-for-family.pdf">https://marketplace.cms.gov/applications-and-forms/marketplace-application-for-family.pdf</a> . They will receive eligibility results in the mail within two weeks of application receipt. If eligible, they must then create an online account through <a href="http://www.healthcare.gov">www.healthcare.gov</a> or use the FFM call center to enroll into coverage.

Source: HealthCare.gov, [www.healthcare.gov/apply-and-enroll/how-to-apply](http://www.healthcare.gov/apply-and-enroll/how-to-apply)

An individual can designate a FFM authorized representative<sup>66</sup> to handle his or her account. If the authorized representative designation is completed, the authorized representative will receive coverage notices for the individual and may make coverage option decisions for the individual. The authorized representative designation is valid until the individual revokes it.

For individuals paying in full for their QHP coverage through the FFM, there are no eligibility restrictions other than legal U.S. residency, state residency, and non-incarceration. Individuals seeking QHP coverage and insurance affordability programs must, in addition to the [eligibility requirements](#) for receiving coverage through a QHP on the FFM, meet each of the following:

- Have income between 100% and 400% of [federal poverty level](#) (FPL)
- Not have access to other [minimum essential coverage](#) (MEC)
- Not be claimed as a dependent on someone else's tax return
- Enroll in a [metal-tier](#) QHP through the FFM

Individuals that are incarcerated may apply for coverage for their dependents through the FFM; however, individuals that are incarcerated may not purchase and be covered by a QHP on the Federally-facilitated Marketplace. To be considered incarcerated, individuals must be held in an institution after the disposition of charges. Individuals in custody awaiting trial are not considered incarcerated. Individuals that are not state residents may apply for coverage on the FFM for dependents that are state residents or intend to become state residents. Families living in multiple states may be covered on multiple marketplaces.

Similarly, individuals that are not citizens, nationals, or legal residents of the United States may use the FFM to apply for coverage on behalf of their dependents that are citizens, nationals, or legal U.S. residents. The FFM may not require an individual applying for coverage solely on behalf of the individual's dependents to provide documentation of the individual's own legal resident status. Through ["guaranteed issue" and "guaranteed availability,"](#) individuals that are not citizens, nationals, or legal residents of the United States may purchase qualifying FFM plans without going through a FFM determination by contacting the carrier directly.<sup>67</sup>

The application for coverage through the FFM will first ask for basic information from the individual, including name, address, social security number or immigration document identification, and information about how he or she would like to receive information from the FFM or health plan. Individuals will also provide basic information on all dependents, including name, date of birth, social security number, relationship to the applying individual, and residency. Full legal names of the applicant and any dependents should be used on the application to assure that the information can be verified by the Federally-facilitated Marketplace. Individuals will be asked on the application for information on any

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<sup>66</sup> Note: Federally-facilitated Marketplace (FFM) authorized representatives are different than authorized representatives assisting with Indiana Applications for Health Coverage (IAHCs). Additional information on FFM authorized representatives is available on the FFM website at [www.healthcare.gov/glossary/authorized-representative](http://www.healthcare.gov/glossary/authorized-representative).

<sup>67</sup> Incarcerated individuals may also have the same option to purchase a QHP plan directly. However, individuals that are not state residents and do not intend to reside in Indiana are not eligible for Indiana insurance products based on state insurance law. These individuals should seek an insurance product through their home state.

membership in federally-recognized tribes.<sup>68</sup> Finally, individuals will sign and date the application attesting that all information provided is accurate.

In addition, individuals applying for the PTC will be asked if they are pregnant, have a health condition that impacts their activities of daily living, information about employment, and student loan interest payments. Individuals that are applying for themselves and their dependents will be asked to provide this information for every individual who is applying for the premium tax credit. If an individual has access to employer-sponsored coverage, a page of the application will need to be completed by every employer that offers coverage. Individuals cannot be eligible for the PTC if they have access to employer-sponsored insurance that is affordable (e.g., costs less than 9.66% of household income) and provides [minimum value](#) (MV).

Individuals will also be asked to provide permission for the FFM to access their tax information on file with the Internal Revenue Service (IRS). To receive an eligibility determination for PTC, individuals must provide this authorization in the year they are requesting the premium tax credit. However, individuals are not required to provide this authorization for any longer time period. Individuals will be asked to provide authorization for the FFM to access their tax information in subsequent years. Individuals may approve this request for up to a five-year period, may limit the period to shorter than five years, or may not provide the FFM authorization to access their tax information in subsequent years. In addition, individuals that provide the FFM with authorization to access their tax information in subsequent years may revoke this authorization at any time. Tax information is accessed to verify income and household size for the purposes of PTC eligibility.

Having access to other MEC may not disqualify the individual from receiving PTCs, however, individuals will be asked to report where they have access to coverage. In addition, individuals will have to indicate that they and/or their dependents are not claimed on any other tax returns.

When the application is complete, the FFM will verify the information with available electronic data sources, including IRS tax data. If there are any inconsistencies between the provided information and the electronic data sources, individuals may have to provide additional documentation. Data inconsistencies will occur for some applying individuals, even if they have provided correct and valid data, due to administrative errors and lag in compiling administrative data. Individuals who submit applications where data cannot be verified through electronic means should submit the requested verification documentation as quickly as possible to minimize the delay of enrolling in coverage.

Additional information on additional documents that may be required and how to submit documents is available on the FFM website at [www.healthcare.gov/verify-information/send-more-info](http://www.healthcare.gov/verify-information/send-more-info).

Eligible individuals that accept PTC to help pay their health plans will not receive the funds directly; rather, these funds will be paid from the CMS to the QHP issuer and the individual will experience the benefit in the form of a reduced monthly premium. The individual will [reconcile](#) any overpayments or underpayments of PTC with the IRS at tax filing. The FFM PTC-eligibility determination will allow individuals to apply their maximum estimated amount of premium tax credit to their monthly premium. If, after filing taxes for the year, it is discovered that the individual has accepted too little PTC, it will be refunded to him or her at tax filing, and if the individual has accepted too much PTC he or she will be liable to return these funds at tax filing up to [reconciliation limits](#).

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<sup>68</sup> A list of federally-recognized tribes can be found at [www.gpo.gov/fdsys/pkg/FR-2012-08-10/pdf/2012-19588.pdf](http://www.gpo.gov/fdsys/pkg/FR-2012-08-10/pdf/2012-19588.pdf) and [www.healthcare.gov/glossary/federally-recognized-tribe](http://www.healthcare.gov/glossary/federally-recognized-tribe).

Individuals that expect that their income will increase or their household size will decrease throughout the year may consider accepting a lesser initial amount of PTC to avoid owing money to the IRS at tax filing. Individuals that expect an income decrease or a household size increase may want to accept the maximum PTC and request a PTC redetermination from the FFM upon the income decrease or household size increase. Individuals with questions about how much or how little PTC they should accept should contact a tax professional or the FFM at [www.healthcare.gov](http://www.healthcare.gov) or 1-800-318-2596 (TTY: 1-855-889-4325) .

Individuals that apply for PTC will also be assessed for cost-sharing reductions. Individuals do not apply for CSR separately. Households with incomes below 250% FPL that meet the PTC eligibility requirements will receive CSR if they enroll in a silver-level plan. No additional action is required on the part of the individual.

If an individual does not know what other types of coverage the individual may be eligible for, the individual is still free to submit an application to the Federally-facilitated Marketplace. In Indiana, the FFM will complete an assessment of Medicaid eligibility, and if the applicant or any of the applicant's dependents are deemed to be eligible for Medicaid, the information will be forwarded to the appropriate program. Individuals that apply for Medicaid and are not eligible but may be eligible for insurance affordability programs will have their application forwarded to the Federally-facilitated Marketplace. While certain additional information may be asked of these individuals, they will not be required to complete an entire additional application for coverage, as the information they provide on their original application will be transferred to the appropriate program.

## ii. Enrollment

While individuals may apply and receive their eligibility determination at any time after open enrollment or their SEP, individuals may only enroll in QHPs through the FFM during open enrollment and special enrollment periods. Information on when the most recent open enrollment period is, as well as a link to SEP information, is available on the FFM website at [www.healthcare.gov/glossary/open-enrollment-period](http://www.healthcare.gov/glossary/open-enrollment-period).

When enrolling in a plan, individuals will have to choose a [bronze, silver, gold, or platinum plan](#) based on AV and will need to analyze what plan options offer unique features that are of interest to the individual including: benefits, cost-sharing, and healthcare provider options. Individuals that are eligible for CSRs must enroll in a silver plan to receive the cost-sharing reduction. Individuals that are not eligible for or do not want CSR may enroll in a bronze, silver, gold, or platinum plan and still receive the premium tax credit. The FFM will have a built-in plan compare function that will assist individuals to evaluate the features available in different plans. Individuals that need additional assistance in selecting a plan may contact the FFM at [www.healthcare.gov](http://www.healthcare.gov) or by calling 1-800-318-2596 (TTY: 1-855-889-4325) and ask for a listing of FFM-certified insurance agents and brokers.

## iii. Plan Termination

Individuals may terminate their enrollment in a QHP at any time, for any reason. To terminate enrollment in a QHP the individual should contact their QHP issuer directly.

QHPs may terminate enrollees for non-payment of premiums, enrollment in another QHP, or fraud. Coverage under the QHP does not initiate until the first premium payment is received. After the first payment, individuals enrolled in a QHP that do not receive APTC will have a 30-day grace period for subsequent premium payments. After their initial premium payment, individuals that receive APTC will have a 90-day grace period to pay their premiums. Individuals who do not pay outstanding premiums in full by the end of this grace period may be liable for the full cost of any health services received in days 31 to 90.

In general, premium payments are due on a monthly basis, though individuals may be able to work out weekly or multi-month payment arrangements by contacting their QHP issuer. Qualified health plans are required to accept a variety of payment methods for the payment of premiums. Individuals concerned about the method with which to pay their QHP premiums should contact their QHP issuer directly.

#### iv. Mid-Year Changes

Individuals may report changes that impact their eligibility throughout the year. If income changes, individuals may be newly eligible for insurance affordability programs or have access to more or less APTC, which will decrease or increase their monthly premium payments. Individuals may also add or remove a dependent on their policy, change location, or experience another significant event that qualifies them for a special enrollment period. Some changes may allow individuals to change their QHP selection or modify their APTC or CSR amount, while reporting other changes ensures that the FFM has up-to-date information for completing annual redeterminations and will limit the amount of additional information the individual will have to provide during the annual redetermination.

In addition to changes reported by individuals, the FFM will also conduct periodic data queries to see if enrollee's circumstances have changed, and if they are still eligible for QHP enrollment through the FFM and for insurance affordability programs. Individuals that have had a change in circumstance may receive a notification from the FFM asking them to verify this change. Depending on the change, this may impact their amount or eligibility for APTC, CSR, or their eligibility for enrollment in FFM qualified health plans. Individuals should respond to all FFM queries regarding eligibility and may contact the FFM directly with questions at [www.healthcare.gov](http://www.healthcare.gov) or 1-800-318-2596 (TTY: 1-855-889-4325).

#### v. Churn

Individuals that experience a change in circumstances during the year that impacts their eligibility may experience "churn" to another health coverage program for themselves or their dependents. For example, a family that receives a PTC through the FFM that experiences an income decrease or a household size increase may find that their children are newly eligible for the [Children's Health Insurance Program](#) (CHIP). Similarly, a woman covered by a QHP with PTC that becomes pregnant may become eligible for [Medicaid during her pregnancy](#).

For individuals enrolled in QHPs or PTC through the FFM, all changes relating to income, location, household size, and health or disability status should be reported to the FFM at [www.healthcare.gov](http://www.healthcare.gov) or 1-800-318-2596 (TTY: 1-855-889-4325). Individuals may also transition from Medicaid programs to the Federally-facilitated Marketplace. Medicaid and the FFM will coordinate this transition and individuals may contact either Indiana Medicaid at [www.in.gov/fssa](http://www.in.gov/fssa) or 1-800-403-0864, or the FFM with questions or concerns around these transitions.

## vi. Re-enrollment

Qualified health plan enrollment lasts for a calendar year. Even individuals who experienced a plan change during a SEP will complete the re-enrollment process during the next enrollment period. All individuals enrolled in through the FFM will receive a notice prior to the next open enrollment period asking them to report any changes in circumstances. Any changes reported will be considered by the FFM in the annual eligibility redetermination. Individuals that do not report changes will have their eligibility re-determined based on the information available to the FFM through electronic data sources.

Once their eligibility is re-determined, individuals will receive a re-determination notice. Individuals that did not report changes will have another chance to report changes in circumstance at this point. Individuals that do not report changes and are re-determined eligible will remain enrolled in their previously selected QHP option, if this remains available. If the individual's QHP is no longer available, the individual may be auto-reenrolled into a new plan or may select a new qualified health plan. Even if their current plan is still available the next year, individuals may always change their QHP coverage during an open enrollment period.

Individuals accepting APTC will have their eligibility re-determined similarly to individuals that are enrolled in FFM QHPs without advanced payment of the premium tax credit. If these individuals have not provided authorization for the FFM to access their tax information in subsequent years, they will be asked to authorize this access for the year the eligibility determination is being conducted. Individuals may not receive APTC without providing authorization for the FFM to access their tax information and may not receive APTC after their initial year, if they did not file taxes for the year of receipt. If an individual who receives APTC does not provide authorization in a subsequent year for the FFM to access their tax information, then they will not receive a redetermination until they provide this authorization. Individuals may request a redetermination to enroll in a QHP without APTC without providing the authorization to provide tax data.

Individuals re-determined eligible for APTC will receive a notice of their eligibility determination and their APTC amount. As discussed, these individuals may choose to accept less APTC than the full amount, and may change QHPs during the open enrollment period. Individuals eligible for APTC that do not respond to their eligibility redetermination notice will be reenrolled in their same QHP, if it is still available. Both APTC and premium amounts may change at reenrollment, so individuals should watch for reenrollment notices and take appropriate action.

**IMPORTANT NOTE:** Individuals enrolled in a QHP with or without APTC need to be aware that their QHP premium and/or APTC amounts may change upon reenrollment. Individuals will experience out-of-pocket premium changes at enrollment as QHP premiums and/or APTC change. Therefore, individuals should be very cautious before re-enrolling or auto-reenrolling in their qualified health plan and should be encouraged to evaluate<sup>69</sup> what new options may be available to them. New QHPs may be available with lower plan premiums and greater premium tax credits.

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<sup>69</sup> One tool available to consumers when evaluating whether to keep or change FFM coverage is the short quiz available on the FFM website at [www.healthcare.gov/downloads/comparing-plans-to-re-enroll.pdf](http://www.healthcare.gov/downloads/comparing-plans-to-re-enroll.pdf).

The Centers for Medicare and Medicaid Services (CMS) released additional guidance on annual FFM eligibility redeterminations and re-enrollments for plan year 2017 at [www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ARR-2017-Guidance-051016-508.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ARR-2017-Guidance-051016-508.pdf).

#### vii. Appeals

Individuals that believe their eligibility determination for a QHP, or eligibility for or amount of an APTC or CSR is incorrect, should contact the FFM to file an appeal. The FFM can be contacted through [www.healthcare.gov](http://www.healthcare.gov) or 1-800-318-2596 (TTY: 1-855-889-4325). Individuals may file appeals relating to eligibility for or amount of an APTC for up to three years after they experienced the triggering event.

Individuals that believe they have been denied a provider or service they should have had access to through their QHP, should contact the plan administrator. Qualified health plans have grievance procedures in place to address individual complaints. Individuals should contact their QHP issuer as soon as they become aware of the problem. Individuals who do not feel their situation is resolved through the QHP grievance procedure may request an appeal from the QHP issuer, as applicable. An external grievance or review may follow if the appeal is not resolved. Individuals can contact the Indiana Department of Insurance (IDOI) at 317-232-2395 or [www.in.gov/idoi/2547.htm#6](http://www.in.gov/idoi/2547.htm#6) for more information on filing a consumer complaint against an insurance company.

## IV. General Guide for Indiana Navigators: Helping Consumer Apply for Health Coverage

### A. Chapter Objectives

1. Ability to screen consumers for the “best door” to health insurance coverage.
2. Ability to help consumers apply for state and federal health coverage programs.
3. Ability to address consumer questions and concerns before and after consumer health coverage applications are submitted.
4. Gain helpful knowledge, tools, and additional resources for assisting health insurance consumers.
5. Understand how and when it is appropriate to refer consumers to other resources.

### B. Key Terms

1. **1634 Status** is a federal designation given to states for determining Medicaid eligibility for the aged, blind, and disabled populations. Under this program, recipients of Supplemental Security Income (SSI) through the federal Social Security Administration (SSA) obtain automatic Medicaid enrollment and need not complete a separate state Medicaid application. Indiana became a 1634 Status state in 2013.
2. **Appeal** is a consumer’s right to request an evaluation and re-determination of the consumer’s health plan eligibility or features. An **appeal of Indiana Medicaid** eligibility or benefits can be made to the Indiana Division of Family Resources (DFR) in a manner specified in the DFR denial/change notice. An **appeal of Federally-facilitated Marketplace** (FFM) eligibility or benefits can be made via a letter or the appeal request form available at [www.healthcare.gov/marketplace-appeals/ways-to-appeal](http://www.healthcare.gov/marketplace-appeals/ways-to-appeal). Appealable decisions are specified on the form.
3. **Benefits Portal** is a website developed and managed by the state Division of Family Resources (DFR) by which Hoosier insurance consumers may apply for Indiana Health Coverage Programs (IHCPs) as well as check the status of pending applications. The DFR Benefits Portal is located at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov).
4. **Best Door** refers to a consumer’s decision to either complete the Indiana Application for Health Coverage (IAHC) or the Federally-facilitated Marketplace (FFM) application for health coverage based on certain eligibility criteria (e.g., [Table 73](#), [Table 74](#), and [Table 75](#)) determined by the consumer and/or the application assister (e.g., Indiana Navigator) assisting the consumer.
5. **Eligibility Group** (also referred to as **aid category**) refers to a particular group/category that is eligible for Medicaid. An individual is determined eligible for the appropriate group/category based on factors of eligibility such as age, income, pregnancy, disability or blindness. See [Table 33](#) for the list of Medicaid eligibility groups.
6. **Federal Poverty Level (FPL)** is a figure released each year by the federal government that estimates the minimum amount an individual or family would need to make to cover basic living expenses. Measure reflects income and household size, and changes annually. See [Table 64](#) for the current FPL guidelines.
7. **Federally-facilitated Marketplace (FFM)** (also referred to as the **Exchange**, **Marketplace**, **Federal Marketplace**, or **HealthCare.gov**) is a federally-developed and federally-operated health insurance marketplace that makes qualified health plans (QHPs) available to qualified individuals and/or qualified employers in accordance with the Affordable Care Act (ACA). The current FFM website—

[HealthCare.gov](https://www.healthcare.gov)—was developed and is operated by the U.S. Department of Health and Human Services (HHS). HHS also oversees the establishment, training, monitoring, and oversight of federal consumer assistance programs (e.g., federal Navigators and Certified Application Counselors (CACs)) that provide FFM outreach, education, and enrollment services. This is the marketplace model used in Indiana. The state is to observe federal guidelines and maintain oversight of state-regulated health insurance products and may implement other consumer protection guidelines (e.g., additional training and certification requirements for consumer assistants serving in the state) that do not prevent the application of the Affordable Care Act.

8. [Healthcare.gov](https://www.healthcare.gov) is a health insurance marketplace website owned and operated by the U.S. Department of Health and Human Services (HHS) to facilitate the sale of qualified health plans (QHPs) and eligibility for premium tax credits (PTCs) and cost-sharing reductions (CSRs) for consumers in Federally-facilitated Marketplace (FFM) and Partnership Marketplace states. The website also fragments those consumers who may be eligible for Medicaid, and has a separate portal for small businesses (the SHOP Marketplace).
9. [Healthy Indiana Plan \(HIP 2.0\)](#) is Indiana's health coverage program for non-disabled Hoosiers between the ages of 19-64 whose family incomes are less than approximately 138% of the federal poverty level (FPL) and who are not eligible for Medicare or another Medicaid category. HIP 2.0 has four pathways to coverage—HIP Plus, HIP Basic, HIP Employer Link, and HIP State Plan. See [Table 17](#) showing the distinctions between these different pathways to coverage. Covered individuals and the state of Indiana make monthly contributions to a POWER Account. The first \$2,500 of healthcare expenses for the year is covered by the POWER Account, and additional healthcare expenses are fully covered at no additional cost to the HIP 2.0 member.
10. [Home and Community-Based Services \(HCBS\) Waiver](#), authorized under Section 1915(c) of the Social Security Act, is an Indiana Medicaid waiver designed to provide an array of services to enrollees allowing them to live in community settings and to avoid institutionalization. The HCBS waiver “waives” the requirement of an admission to an institution in order for Medicaid to pay for the needed home and community-based services. The different types of HCBS waivers that Indiana offers are outlined in [Table 23](#).
11. [Indiana Application for Health Coverage \(IAHC\)](#) is an application for an Indiana Health Coverage Program (IHCP) which may be submitted to the Division of Family Resources (DFR) either online through the DFR Benefits Portal, by phone, fax, mail, or in-person at a local DFR office. The different methods for submitting an IAHC, as well as contact information, are listed in [Table 76](#).
12. [Indiana Health Coverage Program \(IHCP\)](#) is a term that refers to any of the several programs operated under Indiana Medicaid, which have been developed to address the medical needs of the low income, aged, disabled, blind, pregnant, and other populations meeting the eligibility criteria. Each IHCP has different criteria for eligibility. Types of IHCPs include, but are not limited to, Hoosier Healthwise, Healthy Indiana Plan (HIP) 2.0, Hoosier Care Connect, traditional Medicaid, and the home and community-based services (HCBS) waiver.
13. [Insurance Affordability Program](#) refers to either of two programs—premium tax credit (PTC) or cost-sharing reduction (CSR)—that was established by the Affordable Care Act (ACA) to make insurance premiums and cost-sharing more affordable through a marketplace. Eligible consumers may only take advantage of these programs if they apply for coverage through a marketplace.
14. [Medicaid](#) is a means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. It provides free or low-cost health insurance coverage to individuals meeting the States' eligibility criteria, which are developed within the parameters established by the federal government. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving eligible individuals.

15. **Medical Review Team (MRT)** (also referred to as the **Medicaid Medical Review Team (MMRT)**) is a group that determines a Medicaid applicant's eligibility for Indiana Medicaid based on a disability. To meet the disability requirement, a person must have a significant impairment that is expected to last a minimum of 12 months. The MRT makes this determination and notifies the Division of Family Resources (DFR) of its decision.
16. **Open Enrollment Period** is the timeframe in which individuals can apply and enroll in health coverage through the individual Federally-facilitated Marketplace (FFM). The annual open enrollment period is determined by the Centers for Medicare and Medicaid Services (CMS) and may be viewed on the FFM website at [www.healthcare.gov](http://www.healthcare.gov). For 2017 FFM coverage, the open enrollment period is November 1, 2016 – January 31, 2017. People may qualify for **special enrollment periods (SEPs)** allowing them to enroll on the FFM outside of open enrollment. Individuals may apply for Indiana Health Coverage Programs (IHCPs) at any time of the year.
17. **Preliminary Eligibility Screening** is a technique that Indiana Navigators may use to evaluate whether a consumer would be better suited to apply for an Indiana Health Coverage Program (IHCP) or for health coverage through the Federally-facilitated Marketplace (FFM) before assisting with a health coverage application. The Indiana Navigator may ask basic questions about United States citizenship/legal resident status, household income, household composition, and refer to the eligibility screening charts (see [Table 73](#), [Table 74](#), and [Table 75](#)), in order to better direct the consumer to the type of coverage for which the consumer is most likely eligible.
18. **Presumptive Eligibility (PE)** (also referred to as **PE for Pregnant Women (PEPW)**, **Hospital PE (HPE)**, or **PE for Inmates**) is a determination by a qualified provider (QP) that an individual is eligible for Medicaid benefits on the basis of preliminary self-declared information that the individual has gross income at or below the applicable Medicaid income eligibility standard. Indiana operates the following PE programs: Presumptive Eligibility (PE), PE for Pregnant Women (PEPW), Hospital PE (HPE), and PE for Inmates. See [Table 27](#) showing the comparisons between these programs.
19. **Redetermination** (also referred to as **Eligibility Redetermination**) is the process by which an enrolled consumer is re-enrolled, terminated, or transferred into an Indiana Health Coverage Program (IHCP) or the Federally-facilitated Marketplace (FFM). Eligibility redeterminations are to ensure that consumers are still eligible and in the right programs. The process is done every 12 months or when the enrollee reports any changes to household income, household size, or residence.
20. **Re-Enrollment** is the annual process by which consumers are redetermined eligible for Indiana Health Coverage Program (IHCP) or Federally-facilitated Marketplace (FFM) coverage and the steps consumers must take to re-enroll in coverage. All individuals enrolled in an IHCP or the FFM will receive a notice asking them to report any changes in circumstances. Any changes reported will be considered in the annual eligibility redetermination.
21. **Social Security Administration (SSA)** is a federal agency through which Indiana Medicaid disability applications go through to determine if an individual is eligible for Medicaid disability. Direct applications to Indiana Medicaid may be made if the applicant is a child, has a recognized religious objection to applying for federal benefits (e.g., Amish), seeks eligibility under the M.E.D. Works medically improved category, or cites other "good cause" for not applying through the Social Security Administration.
22. **Social Security Disability Insurance (SSDI)** is a federal insurance program that provides benefits to qualified individuals who can no longer work. To be eligible, the individual must meet the SSA's definition of disabled. Disabled individuals with SSDI are eligible for Medicaid disability insurance in Indiana and need not undergo the state Medical Review Team (MRT) process. SSDI is also a source used to determine a consumer's disability status through the federal Marketplace application.

23. **Special Enrollment Period** is a timeframe outside of the open enrollment period in which a consumer may enroll in health coverage through the Marketplace due to certain qualifying life events, such as losing access to employer-sponsored coverage, marriage, divorce, a birth or adoption of a child, etc. A list of life events that qualify for a special enrollment period is outlined in [Table 70](#).
24. **Supplemental Security Income (SSI)** is a federal program that pays benefits to adults and children determined disabled by the U.S. Social Security Administration (SSA) and who have limited income and resources. Individuals receiving SSI are automatically deemed eligible for Medicaid disability insurance in Indiana. SSI is also a source used to determine a consumer's disability status through the Federally-facilitated Marketplace (FFM)/[www.healthcare.gov](http://www.healthcare.gov) application.

## C. Preparing to Help Consumers Apply for Health Coverage

Indiana Navigators and Application Organizations (AOs) may assist consumers seeking health coverage in several different ways. They may conduct outreach efforts to educate the public about available health coverage options and the availability of Indiana Navigators—individuals trained and certified to help consumers complete applications for health coverage. Outreach efforts could include, but are not limited to, the following activities:

- Media and public relations efforts
- Mailings
- Integration of Indiana Navigator services with other services the organization provides
- A presence at community events, such as health fairs, back-to-school events, and others

Additionally, consumers may locate an Indiana Navigator or an AO by county via the Indiana Healthcare Reform website at [www.in.gov/healthcarereform/2468.htm](http://www.in.gov/healthcarereform/2468.htm).

Before helping a consumer complete an application through the Indiana Health Coverage Program (IHCP) portal ([www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)) or through the Federally-facilitated Marketplace (FFM) ([www.healthcare.gov](http://www.healthcare.gov)), an Indiana Navigator should complete each of the following three steps (discussed in more detail in the following sections): (1) inform the consumer of any actual or potential conflicts of interest and the Indiana Navigator's roles and responsibilities; (2) complete a preliminary eligibility screening to determine whether the consumer should apply through the state health coverage portal or the FFM; and (3) recommend which health coverage application the consumer should complete.

### 1. Step One: Inform the Consumer of Any Actual or Potential Conflicts of Interest and of the Indiana Navigator's Roles and Responsibilities

Before assisting a consumer with an application for health coverage, an Indiana Navigator should first disclose in writing any actual or potential conflicts of interest pursuant to the [Conflict of Interest Policy](#).<sup>70</sup> The Indiana Navigator should also clearly describe the Indiana Navigator's role in the health

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<sup>70</sup> An Indiana Navigator and Application Organization (AO) is also required to disclose any actual or potential conflict of interest to the Indiana Department of Insurance (IDOI) as part of the initial application for certification or registration as well as within 30 days of a new actual or potential conflict of interest that arises. Navigators may make disclosure on the Navigator Conflict of Interest Disclosure Form posted online at [www.in.gov/idoi/files/Navigator\\_Conflict\\_of\\_Interest\\_Disclosure\\_Form.pdf](http://www.in.gov/idoi/files/Navigator_Conflict_of_Interest_Disclosure_Form.pdf), and AOs may make disclosure on the

coverage application process and highlight limitations, including the inability to advise on plan selection and to present all health-plan options available to the consumer in a fair, accurate, and impartial manner in the consumer's best interests. All explanations should be stated in clear, concise language, and should help the consumer understand the nature of assistance the Indiana Navigator can and cannot provide.

## **2. Steps Two and Three: Complete Preliminary Eligibility Screening and Recommend the “Best Door” for the Consumer to take**

Consumers may choose to complete an Indiana Application for Health Coverage (IAHC) at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov) OR apply to purchase a plan offered through the FFM at [www.healthcare.gov](http://www.healthcare.gov). However, by asking some basic questions about United States citizenship/legal resident status, household income, and household composition, the Indiana Navigator may be able to better direct the consumer to the form of coverage for which the consumer is most likely eligible. When completing the basic eligibility screening, the Indiana Navigator should inform the consumer that there are limitations to the assessment questions asked, and that the result of the preliminary screening does not definitively determine actual eligibility for either form of health coverage.

The Indiana Navigator should specifically state that the purpose of this basic eligibility screening process is simply to determine the program(s) for which the consumer is most likely to be eligible. The consumer can then decide if completing an IAHC is the right choice, or if the FFM is the “best door” to begin the application process. The screening is intended to be a guide and the results are not binding. If the results reveal that a consumer is likely eligible for one form of coverage and the consumer would rather apply for the other form of coverage, it is acceptable to do so.

The Indiana Navigator should also explain that both the IAHC and the FFM application are considered “single streamlined applications,” meaning that if a consumer completes an IAHC and is found ineligible, the application will be automatically routed to the Federally-facilitated Marketplace. The FFM will then contact the consumer regarding eligibility to purchase coverage, as well as eligibility for [premium tax credits](#) (PTCs) and/or [cost-sharing reductions](#) (CSRs). Conversely, if the applicant completes the FFM application and that application reveals that the consumer may be eligible for an IHCP, it will be routed to the state Department of Family Resources (DFR) for processing.

The tables on the following three pages (see [Table 73](#), [Table 74](#), and [Table 75](#)) outline the income ranges and household sizes at which consumers and their families are likely to be eligible for an IHCP and for subsidized and non-subsidized coverage on and off the Federally-facilitated Marketplace.

Adults with household income at approximately 138% of the [federal poverty level](#) (FPL) or less should apply for an IHCP at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov). Adults with household income over approximately 138% and up to or including 400% FPL may be eligible for subsidized coverage (PTCs and/or CSRs) through the FFM and should apply through the FFM at [www.healthcare.gov](http://www.healthcare.gov). Adults with household incomes over 400% FPL may apply for coverage through the FFM or through the outside commercial insurance market.

Pregnant women with household income 213% FPL or less should apply for IHCP coverage at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov). Pregnant women with household income over 213% FPL up to and including 400% FPL may be eligible for subsidized coverage through the FFM and should apply through the FFM at [www.healthcare.gov](http://www.healthcare.gov). Pregnant women with household incomes over 400% FPL may apply for coverage on the FFM or seek coverage on the outside market. Note: for IHCP coverage a pregnant woman's household size is always at least two as the woman's unborn child is included in the household size calculation.




Children under age 19 with household income up to 255% FPL should apply for IHCP coverage through [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov). Children under age 19 with household income over 255% FPL and up to or including 400% FPL may be eligible for subsidized coverage through the FFM and should apply at the FFM at [www.healthcare.gov](http://www.healthcare.gov). Children under 19 with household incomes over 400% FPL may apply for coverage on the FFM or seek coverage through the outside market.

United States citizenship, national, or legal residency status is also an eligibility requirement for both IHCP and FFM coverage. However, if a consumer is not a citizen, national, or legal resident of the United States, the consumer may still apply for coverage on behalf of dependents if they are citizens, nationals, or legal residents.

Indiana Navigators may refer to the following tables (see [Table 73](#), [Table 74](#), and [Table 75](#)) after asking preliminary questions about consumers' household income and size and then provide information regarding potential eligibility for different coverage options. With this information, the consumer can then choose the "best door" (IHCP, FFM, or outside market) through which the consumer would like to enter the application process. The advantage to choosing the "best door" based on the preliminary screening is that even if the consumer is found ineligible for the program for which the consumer applies, the application will be automatically sent through the other "door"/program with no additional action required. The only disadvantage of using the "best door" based on preliminary eligibility screening instead of completing two separate applications is that processing may take longer if the "best door" was not initially chosen; however, it saves the applicant the time of completing two separate applications.




More detailed screening tools to determine preliminary eligibility for IHCPs and the FFM are available on the Family and Social Services Administration (FSSA) website at [www.ifcem.com/CitizenPortal/application.do](http://www.ifcem.com/CitizenPortal/application.do) and on the FFM website at [www.healthcare.gov/screener](http://www.healthcare.gov/screener).

**Table 73: 2016 Eligibility Screening Chart for Non-Pregnant Adults**

Household Size	Gross Household Income as a Percentage (%) of Federal Poverty Level (FPL) – 2016		
	At or Below 138% FPL	Between 138% FPL and 400% FPL	Above 400% FPL
1	\$16,590.42 or less	\$16,560.43 — \$47,520.00	\$47,520.01 or more
2	\$22,371.93 or less	\$22,371.94 — \$64,080.00	\$64,080.01 or more
3	\$28,153.44 or less	\$28,153.45 — \$80,640.00	\$80,640.01 or more
4	\$33,934.95 or less	\$33,934.96 — \$97,200.00	\$97,200.01 or more
5	\$39,716.46 or less	\$39,716.47 — \$113,760.00	\$113,760.01 or more
6	\$45,497.97 or less	\$45,497.98 — \$130,320.00	\$130,320.01 or more
7	\$51,293.45 or less	\$51,293.46 — \$146,920.00	\$146,920.01 or more
8	\$57,102.89 or less	\$57,102.90 — \$163,560.00	\$163,560.01 or more
<b><u>“Best Door” Recommendation</u></b>			
 Apply for Indiana Health Coverage Program (IHCP) at <a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a>			
 Apply on Federally-facilitated Marketplace (FFM) at <a href="http://www.healthcare.gov">www.healthcare.gov</a>			
 Apply on FFM at <a href="http://www.healthcare.gov">www.healthcare.gov</a> or Commercial Market			




Source: State of Indiana, *Adult Income Chart* (2016), [www.in.gov/healthcarereform/2381.htm](http://www.in.gov/healthcarereform/2381.htm)

**Table 74: Eligibility Screening Chart for Pregnant Women**

Household Size	Gross Household Income as a Percentage (%) of Federal Poverty Level (FPL) – 2016		
	At or Below 213% FPL	Between 213% FPL and 400% FPL	Above 400% FPL
1	\$26,569.62 or less	\$26,569.63 — \$47,520.00	\$47,520.01 or more
2	\$35,828.73 or less	\$35,828.74 — \$64,080.00	\$64,080.01 or more
3	\$45,087.84 or less	\$45,087.85 — \$80,640.00	\$80,640.01 or more
4	\$54,346.95 or less	\$54,346.95 — \$97,200.00	\$97,200.01 or more
5	\$63,606.06 or less	\$63,606.07 — \$113,760.00	\$113,760.01 or more
6	\$72,865.17 or less	\$72,865.17 — \$130,320.00	\$130,320.01 or more
7	\$82,146.65 or less	\$82,146.65 — \$146,920.00	\$146,920.01 or more
8	\$91,450.69 or less	\$91,450.69 — \$163,560.00	\$163,560.01 or more
<b><u>“Best Door” Recommendation</u></b>			
 Apply for Indiana Health Coverage Program (IHCP) at <a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a>			
 Apply on Federally-facilitated Marketplace (FFM) at <a href="http://www.healthcare.gov">www.healthcare.gov</a>			
 Apply on FFM at <a href="http://www.healthcare.com">www.healthcare.com</a> or Commercial Market			

Source: State of Indiana, *Pregnant Women Income Chart* (2016), [www.in.gov/healthcarereform/2383.htm](http://www.in.gov/healthcarereform/2383.htm)

Table 75: Eligibility Screening Chart for Children

Household Size	Gross Household Income as a Percentage (%) of Federal Poverty Level (FPL) – 2016		
	At or Below 255% FPL	Between 255% FPL and 400% FPL	Above 400% FPL
1	\$31,808.70 or less	\$31,808.71 - \$47,520.00	\$47,520.01 or more
2	\$42,893.55 or less	\$42,893.55 - \$64,080.00	\$64,080.01 or more
3	\$53,978.40 or less	\$53,978.40 - \$80,640.00	\$80,640.01 or more
4	\$65,063.25 or less	\$65,063.26 - \$97,200.00	\$97,200.01 or more
5	\$76,148.10 or less	\$76,148.11 - \$113,760.00	\$113,760.01 or more
6	\$87,232.95 or less	\$87,232.96 - \$130,320.00	\$130,320.01 or more
7	\$98,344.58 or less	\$98,344.59 - \$146,920.00	\$146,920.01 or more
8	\$109,482.98 or less	\$109,482.99 - \$163,560.00	\$163,560.01 or more
<b><u>“Best Door” Recommendation</u></b>  Apply for Indiana Health Coverage Program (IHCP) at <a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a>  Apply on Federally-facilitated Marketplace (FFM) at <a href="http://www.healthcare.gov">www.healthcare.gov</a>  Apply on FFM at <a href="http://www.healthcare.gov">www.healthcare.gov</a> or Commercial Market			

Source: State of Indiana, *Child Income Chart* (2016), [www.in.gov/healthcarereform/2382.htm](http://www.in.gov/healthcarereform/2382.htm)

## D. How to Help Consumer Apply for Indiana Health Coverage Programs

### 1. Medicaid (Hoosier Healthwise or Traditional, Fee-for-Service)

If the eligibility screening indicates that the applicant falls into the yellow section of the eligibility screening charts (see [Table 73](#), [Table 74](#), and [Table 75](#)), an [Indiana Application for Health Coverage](#) (IAHC)—located at online [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)—is likely the best application to use. In addition to household income requirements, a consumer must also meet the United States citizen, national, or legal resident requirements and be an Indiana resident to be eligible for an [Indiana Health Coverage Program](#) (IHCP).

Applications are accepted online, by mail or fax, by telephone, or in person at local Division of Family Resources (DFR) offices. The online application is recommended, both for consumers applying on their own behalf and for Indiana Navigators assisting consumers. The following table (see [Table 76](#)) gives more details on the different methods available for application.

**Table 76: Methods to Complete the Indiana Application for Health Coverage**

Application Method	Instructions
<i>Online (recommended)</i>	<ol style="list-style-type: none"> <li>1. Go to DFR website—<a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a></li> <li>2. Complete and submit application</li> </ol>
<i>By Mail or Fax</i>	<ol style="list-style-type: none"> <li>1. Go to DFR website—<a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a></li> <li>2. Print paper application</li> <li>3. Complete and return application by either:               <ol style="list-style-type: none"> <li>a) Mail: P.O. Box 1810, Marion, IN 46952; or</li> <li>b) Fax: 1-800-403-0864</li> </ol> </li> </ol>
<i>By Phone</i>	Call DFR for Medicaid/CHIP assistance at 1-800-403-0864, and for HIP 2.0 assistance at 1-877-438-4479
<i>In Person at DFR Office</i>	Find local DFR office at <a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a>

To help the consumer complete an application for the consumer and for any dependents, the Indiana Navigator will need the following information (see [Table 77](#)). The consumer should come prepared with as much of this information as possible.

**Table 77: Consumer Information Needed to Complete Indiana Application for Health Coverage**

Information Category	Specific Information
<i>Demographic information</i>	<ul style="list-style-type: none"> <li>✓ Full name</li> <li>✓ Date of birth</li> <li>✓ Social Security Number, <a href="#"><i>if applicable</i></a></li> <li>✓ Gender</li> <li>✓ Marital status</li> <li>✓ Home address, phone number</li> <li>✓ E-mail address</li> <li>✓ Language</li> <li>✓ Race and Ethnicity</li> <li>✓ Citizenship/Immigration information</li> </ul>
<i>Information about any existing health coverage</i>	<ul style="list-style-type: none"> <li>✓ Type of coverage (e.g., employer insurance, COBRA, Medicare, TRICARE, VA health care program, Peace Corps, etc.)</li> <li>✓ Name of health insurance company</li> <li>✓ Policy/ID number</li> </ul>
<i>Income and household information</i>	<ul style="list-style-type: none"> <li>✓ Tax filing information</li> <li>✓ Current employment and wages/salaries</li> <li>✓ Any other form of income (social security, child support, alimony)</li> <li>✓ Deductions</li> <li>✓ Assets and resources</li> </ul>
<i>Whether the following statuses apply</i>	<ul style="list-style-type: none"> <li>✓ Pregnancy</li> <li>✓ Blindness or disability</li> <li>✓ In a nursing or residential care facility</li> <li>✓ In jail</li> <li>✓ In foster care</li> </ul>

**IMPORTANT NOTE:** An Indiana Navigator assisting the consumer in completing the IAHC must include on the application the navigator's name and state certification number as they appear on the navigator's state certification issued by the Indiana Department of Insurance (IDOI). An individual's state certification through IDOI is different than the individual's federal certification through the Centers for Medicare and Medicaid Services (CMS) (e.g., the Certified Application Counselor (CAC) or federal Navigator certifications) to conduct Federally-facilitated Marketplace (FFM) services. In addition to entering the navigator's name and state certification number on the IAHC, the navigator must also enter the name and state registration number of the navigator's associated Application Organization (AO), if applicable, as they appear on the AO's registration certificate issued by the Indiana Department of Insurance.

#### *a. Using the Online Medicaid Application*

As discussed, the IAHC is accepted via multiple avenues; however, the online version is the preferred method and may be accessed at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov). The online application is dynamic in nature.

That is, the questions that are asked of the applicant are determined based on responses to previous questions. To expedite processing time by preventing the need for additional information due to application incompleteness, applicants should provide as complete of information as possible.

Paper documentation is not required to be submitted up front with the application; however, individuals may attach and send with the application. As discussed further in the [Verifying Factors of Eligibility section](#), DFR will access federal and state data sources to verify and validate application information. The applicant will be notified when additional information or documentation is needed and provided with instructions on how to submit.

### ***b. Checking Medicaid Application Status***

Upon completion of the online application, a summary of the submitted application data will be provided. Applicants may check the status of their application by accessing [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov), clicking on the “Manage Current Benefits” link, and entering the following information.

- Case number
- Case name
- Date of birth
- Last four digits of social security number

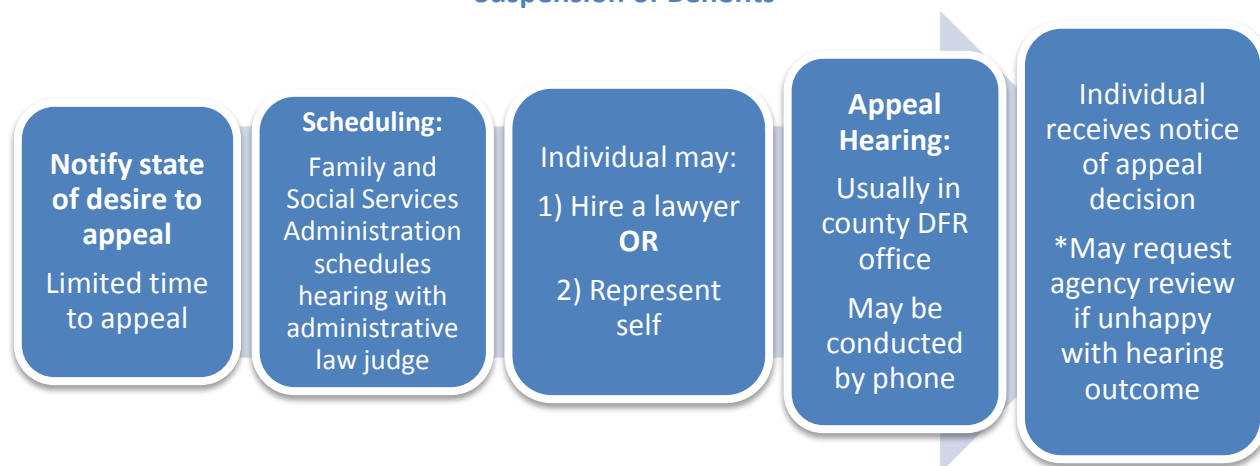
With authorization, an Indiana Navigator may check the status of an application on behalf of the consumer. Consumers can expect to hear from the DFR regarding their eligibility decision within 45 days (90 days if the Medicaid application is based on blindness or disability). This notice, sent via U.S. mail, will inform the consumer that the application either: (a) has been approved; (b) has been denied (and may be routed to the FFM for assessment for QHP coverage and/or insurance affordability programs); or (c) needs more information to make a decision. Indiana Navigators should remind consumers to look for this notice and respond promptly and fully to all instructions and requests for information.

If a consumer receives a denial notice, the consumer may appeal DFR’s decision. The following figure (see [Figure 9](#)) depicts the process of filing an eligibility appeal.<sup>71</sup> Consumers who are already covered under Medicaid-Hoosier Healthwise may also appeal termination, reductions, and suspension of benefits, in which case benefits are still in effect during the appeals process. Indiana Navigators may advise a consumer on how to file appeals.

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<sup>71</sup> Additional information on filing an IHCP eligibility appeal with FSSA is online at <http://member.indianamedicaid.com/members-rights--responsibilities/appeals-and-grievances.aspx> and [www.in.gov/fssa/dfr/3094.htm](http://www.in.gov/fssa/dfr/3094.htm).

**Figure 9: Process to File an Appeal of Medicaid Eligibility or Termination, Reduction, or Suspension of Benefits**



\*Request for agency review must be filed within 15 days of the notice of appeal decision or before the date the decision goes into effect (listed on the notice), whichever is sooner.

Source: Family and Social Services Administration, <http://member.indianamedicaid.com/members-rights-responsibilities/appeals-and-grievances.aspx>

### **c. Medicaid Eligibility Based on Blindness or Disability**

The process for eligibility determination under the blindness and disability category underwent significant changes effective June 1, 2014 due to Indiana's transition to a state with [1634 status](#). Individuals may apply for coverage under the Medicaid blindness and disability categories through three different avenues, depending on their personal situation.

1. **Receiving Supplemental Security Income (SSI):** The consumer will be automatically enrolled in Medicaid without any additional steps. This individual should not need to complete a separate Medicaid application for consideration for coverage.
2. **Determined disabled by the Social Security Administration (SSA) but not eligible for SSI:** Although a person may be declared disabled by the SSA, excess income may prevent the individual from getting SSI. The individual may still be eligible for Medicaid. To find out if the individual is eligible for Medicaid coverage, the individual will need to complete a separate Medicaid application. After the consumer submits the Medicaid application, the state will verify disability status with the SSA and will consider other factors of eligibility.
3. **Not receiving SSI and not determined disabled by the SSA:** This consumer may apply directly to Medicaid; and Medicaid will require the individual to file an application for disability with the SSA within 45 days of submitting the application to Medicaid. The application will be processed through the Indiana Medical Review Team (MRT), and if the individual is considered disabled AND meets the other eligibility criteria, the individual will be enrolled in Medicaid. If the individual does not submit an application to the

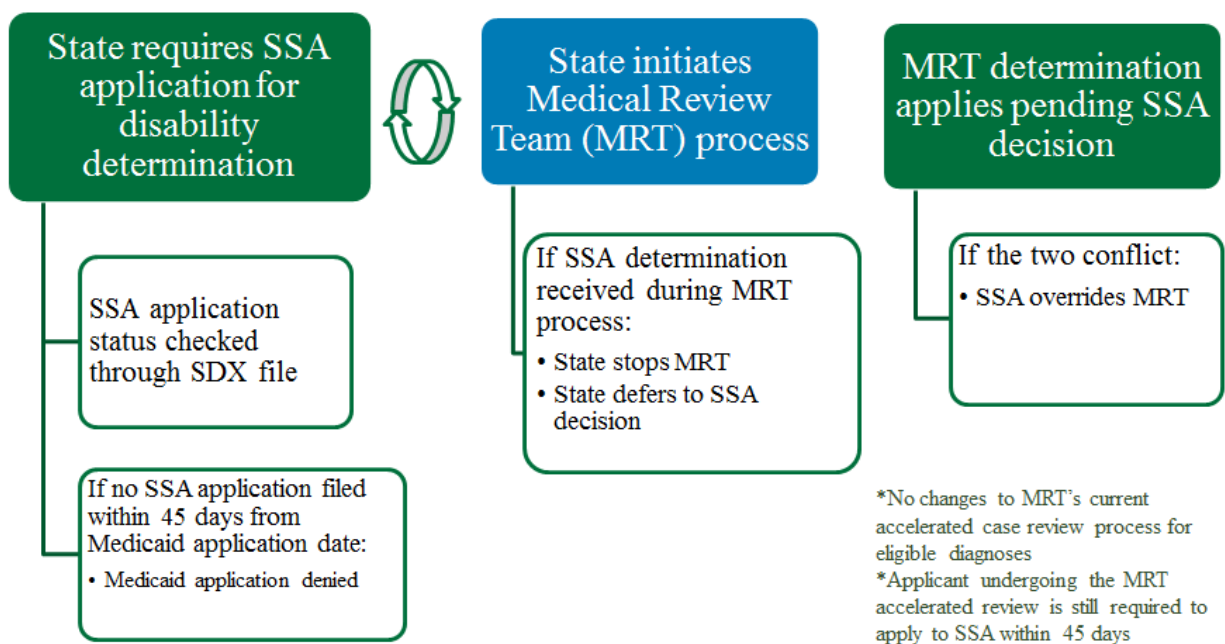
**Sidebar:** There are two exceptions to the SSA application requirement: 1) children under age of 18 applying for Medicaid under the disability category; 2) groups with a recognized religious objection to receiving federal benefits, such as the Amish; 3) M.E.D. Works participants, if medically improved; or 4) another good cause.

SSA for benefits within 45 days of submitting the Indiana Medicaid application, the individual will be denied for failure to comply with the requirements of the process. While the SSA application is pending, the MRT process will run concurrently and MRT will render its own decision. The MRT's disability determination will be effective until the SSA renders its decision.

Effective June 1, 2014, the state will defer to the SSA's disability determination for Medicaid eligibility purposes. That is, if the SSA's disability determination differs from that of the state MRT, the SSA decision is considered final. As a 1634 state, Indiana is required to defer to all SSA disability determinations. For example, if the MRT determined an individual to be non-disabled but SSA later determined that same individual to be disabled, the individual would be considered disabled for Medicaid eligibility purposes.

The following figure (see [Figure 10](#)) summarizes the scenario in which an individual without an SSA disability determination applies directly to Indiana Medicaid for coverage under the blindness or disability categories, effective June 1, 2014.

**Figure 10: Medicaid Applications without SSA Disability Determination**



Source: Indiana Family and Social Services Administration, *2014 Disability Eligibility Changes (1634 Transition)*, [www.in.gov/fssa/files/1634\\_Stakeholder\\_Presentation\\_FINAL.pdf](http://www.in.gov/fssa/files/1634_Stakeholder_Presentation_FINAL.pdf)

Effective June 1, 2014, individuals with a disability denial from SSA will not typically qualify for Medicaid under the blindness and disability categories. However, there will be two cases in which the MRT will process a Medicaid disability application in spite of a SSA disability denial on file:

1. If an applicant alleges a new disabling condition or a change or worsening of the applicant's prior condition since the unfavorable SSA determination and more than 12 months have passed, Indiana Medicaid will accept and process an Indiana Medicaid application. In this case, the state may require the individual to re-apply to SSA as one of the requirements of the Medicaid application process.

2. If the applicant alleges a change of condition within the last 12 months and SSA has refused to consider new evidence, the state will accept and process an Indiana Medicaid application. Individuals that meet these criteria will go through the separate MRT disability determination process. If the state finds the individual disabled and the individual meets all other criteria the individual will be enrolled in Medicaid.

**NOTE:** According to CMS, an individual with a Medicaid disability waiver can purchase Marketplace coverage but is not eligible for a premium tax credit (PTC). Furthermore, a family that is eligible for a PTC can still get the PTC even if a family member has a Medicaid disability waiver. That family member would be excluded as a member of the household for purposes of calculating the PTC amount.

## 2. Healthy Indiana Plan (HIP 2.0)

Adults between the ages of 19 and 64 who fall at or below 138% of the federal poverty level (FPL)<sup>72</sup> and are not eligible for Medicare or Medicaid may be eligible for the Healthy Indiana Plan (HIP 2.0). If an Indiana Navigator is working with someone who falls into this category, the “best door” for coverage is likely the HIP 2.0/Indiana Application for Health Coverage. If the consumer’s income is too high to be eligible for HIP 2.0, the application will be re-routed to the Federally-facilitated Marketplace. Additional information on HIP 2.0 eligibility and the different HIP 2.0 “pathways to coverage” is available in the [Healthy Indiana Plan \(HIP 2.0\) section](#) of Chapter Three.

The IAHC application methods (see [Table 76](#)) and types of information needed to complete the IAHC are also used for the HIP 2.0 application. Applications are available online at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov), by phone, mail, or by visiting a local DFR office. Hoosiers may call 1-877-GET-HIP-9 to find more information about the application process or to find their local DFR office. Indiana Navigators should work with consumers to ensure they have the required application information prior to starting the process.

Applications are processed within 45 business days once all required information is received. After an application is processed, the individual will receive a letter by mail telling them if they qualify for HIP 2.0.

Once an individual is approved for HIP 2.0, they will be assigned to the health plan they chose on their application. If they did not choose a health plan, one will be selected for them. Their health plan will mail them a welcome packet, and they will receive an invoice for their [POWER account](#) contribution. HIP POWER account contributions must be paid by the due date stated on the invoice to become enrolled in [HIP Plus](#). If they selected a health plan on their application, they will also receive an invoice for a [“Fast Track” payment](#) while their application is being processed, which can expedite their enrollment in HIP Plus.

Lower income members who choose not to make POWER account contributions will be enrolled in [HIP Basic](#). Those with incomes above the [federal poverty level](#) (FPL) who do not make their POWER account contributions by the due date will not be enrolled and would have to reapply.

Coverage for HIP Plus members begins in the month when their first POWER account contributions or Fast Track payments are received and processed. HIP Basic coverage begins the first of the month after

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<sup>72</sup> See the HIP 2.0 income eligibility chart at [www.in.gov/fssa/hip/2460.htm](http://www.in.gov/fssa/hip/2460.htm).

the invoice payment period. All HIP 2.0 members will receive a letter informing them when coverage starts and how to get the most out of their HIP 2.0 benefits.

**Note:** Under HEA 1269-2015, county jails and sheriffs, as Authorized Representatives and/or Indiana Navigators, must make best efforts to apply for healthcare coverage on behalf of prisoners whose incarceration is greater than 30 days. An online video tutorial on the application process is available through the HIP 2.0 website at [www.in.gov/fssa/hip/2507.htm](http://www.in.gov/fssa/hip/2507.htm).

### 3. Home and Community-Based Services Waiver Programs

Consumers who are at risk of being institutionalized (in a nursing home or residential care facility) due to age, blindness, or mental or physical disability may be eligible for Indiana Medicaid home and community-based services (HCBS) waiver programs. These individuals have special needs, and there are specific resources dedicated to assisting them. See the [Home and Community-Based Services Waivers section](#) in the Medicaid portion of the manual for more details on eligibility for these waivers. If an Indiana Navigator encounters someone in this situation, it is best to seek guidance for assisting the individual at the following resources (see [Table 78](#)):

**Table 78: Home and Community-Based Services Waiver Contacts**

	Aged, Disabled, and Traumatic Brain Injury Waiver	Community Integration and Habilitation Waiver; Family Supports Waiver
<i>Where to Go</i>	Area Agency on Aging	Bureau of Developmental Disabilities Services
<i>Phone number</i>	1-800-986-3505	1-800-545-7763
<i>Web site to locate an office:</i>	<a href="http://www.iaaaa.org/iconent.asp?id=27">www.iaaaa.org/iconent.asp?id=27</a>	

### 4. Presumptive Eligibility

Indiana Navigators may encounter some individuals whose services will be able to be covered by Medicaid “presumptively,” that is, without receiving an official eligibility notice or determination from the state. In the period when the consumer has “presumptive eligibility” (PE), Medicaid will cover all healthcare services received regardless of whether the consumer is definitively determined eligible after the consumer’s application has gone through the entire application process. Consumers with income in the yellow (preliminary assumed Medicaid-eligible) sections in the “best door” eligibility screening charts (see [Table 73](#), [Table 74](#), and [Table 75](#)) may be presumptively eligible for certain Indiana Health Coverage Programs (IHCPs). See the [Presumptive Eligibility section](#) in the Medicaid chapter of the manual for more details on presumptive eligibility.

Before January 1, 2014, PE applied only to pregnant women, intending to encourage timely prenatal care. Beginning on January 1, 2014, qualified providers (QPs) started assessing PE for Medicaid for the following additional populations:

- Children under 19
- Low-income parents/caretakers
- Family Planning Eligibility Program

- Former foster care children up to 26 years

Only QPs may make PE determinations for those groups. To be determined presumptively eligible, the QP will collect basic demographic, household income, and citizenship/legal resident status information. If it appears that the consumer will be eligible for Medicaid based on this information, the consumer will be deemed presumptively eligible and will be able to receive benefits for a limited time while the applicant completes and submits a full IAHC and that application is processed for ongoing Medicaid eligibility. Even if the full application is subsequently denied, services performed during the PE period are covered.

If the consumer is deemed not presumptively eligible for Medicaid based on the information provided to the QP, the consumer cannot appeal this decision. However, the consumer still has the option to complete a full Indiana Application for Health Coverage.

The following table (see [Table 79](#)) provides a list of resources for applying for and reporting changes for Indiana Health Coverage Programs.

**Table 79: Resources for Indiana Health Coverage Programs**

Question about...	Information Source	Contact Information
<b>Application</b>	FSSA Division of Family Resources (DFR)	<ul style="list-style-type: none"> <li>• Access online or paper Indiana Application for Health Coverage (IAHC) through the FSSA Benefits Portal at <a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a></li> <li>• Call Medicaid/ CHIP at 1-800-403-0864, or HIP 2.0 at 1-877-GET-HIP-9</li> <li>• Visit a local DFR office – listed at <a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a></li> </ul>
	Presumptive Eligibility	<a href="http://member.indianamedicaid.com/am-i-eligible/presumptive-eligibility.aspx">member.indianamedicaid.com/am-i-eligible/presumptive-eligibility.aspx</a>
<b>Reporting Changes</b>	FSSA	<ul style="list-style-type: none"> <li>• Online at <a href="https://fssabenefits.in.gov/CitizenPortal/application.do#">https://fssabenefits.in.gov/CitizenPortal/application.do#</a></li> <li>• Call Medicaid/ CHIP at 1-800-403-0864, or HIP 2.0 at 1-877-GET-HIP-9</li> <li>• Visit a local DFR office – listed at <a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a></li> </ul>

## E. How to Help Consumers Apply for Coverage and Insurance Affordability Programs on the Federally-facilitated Marketplace

If, when conducting a preliminary eligibility screening, an Indiana Navigator determines that a consumer falls into the blue or red section of the eligibility screening charts (see [Table 73](#), [Table 74](#), and [Table 75](#)), an application to the Federally-facilitated Marketplace (FFM) is likely the “best door” for the application process. If a consumer falls into the blue section, the consumer may also be eligible for [premium tax credits](#) (PTCs) or [cost-sharing reductions](#) (CSRs) to lower the costs of coverage. Regardless of whether a consumer falls into this range, the consumer may wish to complete an application for PTCs/CSRs to verify possible eligibility. The FFM makes all determinations about whether a consumer is eligible for PTCs and cost-sharing reductions.

It is important to note that, while many IHCPs accept new applicants year-round, the FFM has set [enrollment periods](#); so individuals will need to be eligible for one of those enrollment periods if they wish to purchase coverage on the Federally-facilitated Marketplace.

## 1. Federally-facilitated Marketplace Applications Basics

### *a. Beginning the FFM Application*

When completing the FFM application, the type of application a consumer completes will depend on the number of people on whose behalf the consumer is applying and whether the consumer wants to apply for [insurance affordability programs](#) (PTCs and CSRs). If the application is completed online, the dynamic format will direct consumers and Indiana Navigators to the appropriate application based on answers to questions designed to gather this information.

Indiana Navigators may want to advise consumers to have the following documents for each member of the household on hand to provide the most accurate information during the application process:

- Social security cards or immigration documents
- W2 forms or pay stubs
- Any existing health coverage policy information
- Information on additional documentation that may be required for FFM applications is available online at [www.healthcare.gov/verify-information/documents-and-deadlines](http://www.healthcare.gov/verify-information/documents-and-deadlines)

To complete an application to the FFM, consumers must create an account on the FFM website at [www.healthcare.gov](http://www.healthcare.gov).<sup>73</sup> To create an account, a consumer must provide contact information and complete questions to verify the consumer's identity.

Additional information required for the application may include:

- Income (if the consumer wants to apply for insurance affordability programs)
  - Regular and one-time payments received
  - Income that the consumer pays out (deductions)
    - Alimony
    - Student loan interest
    - Educator expenses
    - Moving expenses
    - Contributions to an individual retirement account (if consumer has no retirement through a job)
    - Tuition costs, if paid out-of-pocket and deducted on tax return (line 34)
  - Any expected income changes during the year
  - Additional information on what is included or excluded as income and helpful tools for estimating income are available on the FFM website at [www.healthcare.gov/income-and-household-information/income](http://www.healthcare.gov/income-and-household-information/income).
- The number of other people in the household

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<sup>73</sup> The direct link to log in or create an FFM account is [www.healthcare.gov/marketplace/global/en\\_US/registration](http://www.healthcare.gov/marketplace/global/en_US/registration).

- Applying for coverage
- Not applying for coverage
  - Already have coverage
  - Applying separately
- Relationship to other household members
  - Dependents
- Whether or not the consumer plans to file a tax return
- Any recent changes in health insurance coverage.

Some types of income and deductions are not considered for eligibility for PTCs and/or CSRs, so it is important to follow application instructions on the type of income and deductions to report and which to exclude. Applicants should report all income unless the application or federal call center employee states otherwise.

### ***b. Disability Question on the FFM Application***

When completing the application, the Indiana Navigator and consumer may come across questions screening for disabilities of the primary applicant or other family members. These questions are intended to help determine if the consumer or the consumer's household members may be eligible for an Indiana Health Coverage Program (IHCP) based on disability. The consumer should answer "yes" to the FFM disability question if the consumer and/or a household member:

- Is blind, deaf, or hard of hearing
- Receives Social Security Disability Insurance (SSDI) or Supplemental Security Insurance (SSI)
- Has physical, intellectual, or mental health condition causing:
  - Serious difficulty completing activities of daily living
  - Difficulty doing errands
  - Serious difficulty concentrating, remembering, or making decisions
  - Difficulty walking or climbing stairs.
- Additional information on what constitutes disabilities on the FFM application is available online at [www.healthcare.gov/people-with-disabilities/marketplace-application](http://www.healthcare.gov/people-with-disabilities/marketplace-application)

#### **Common Activities of Daily Living:**

- Eating
- Bathing
- Dressing
- Toileting
- Transferring

### ***c. Employer Coverage Questions on the FFM Application***

The FFM application may require consumers who are currently employed to provide the following information on the application:

- Employer name
- Federal Employer Identification Number (EIN)
- Employer contact information (address, phone number, e-mail address)

The FFM application may require additional information from individuals with access to employer-sponsored coverage, including:

- Who (with employer) to contact about employee health coverage (usually someone in the human resources department)
- Amount employee pays for premium cost
- Any known changes in future employer coverage
- Whether employer-sponsored coverage meets [minimum value](#) (MV) (whether the policy covers at least 60% of healthcare costs for the covered pool, on average, after premiums)

A consumer may also need to provide information about future individual and dependent eligibility for employer-sponsored coverage.

#### *d. Sources of Information Needed for the FFM Application*

Indiana Navigators may direct consumers to and consult the resources listed in the following table (see [Table 80](#)) for information needed to complete the FFM application for coverage and insurance affordability programs.

**Table 80: Information Sources for the Federally-facilitated Marketplace (FFM) Application**

Question about...	Information Source	Contact Information
<i>Application</i>	FFM website	<a href="http://www.healthcare.gov">www.healthcare.gov</a>
<i>Income</i>	FFM call center	1-800-318-2596 (TTY: 1-855-889-4325)
	Pay stub	Varies (from employer)
	W-2 form	Varies (from employer)
	Self-employed: Internal Revenue Service	<a href="http://www.irs.gov">www.irs.gov</a> "Instructions for Schedule C"
<i>Citizenship/Immigration</i>	FFM call center	1-800-318-2596 (TTY: 1-855-889-4325)
	Social Security Administration (SSA)	1-800-772-1213; <a href="http://www.socialsecurity.gov">www.socialsecurity.gov</a>
	U.S. Citizenship and Immigration Services	1-800-375-5283 <a href="http://www.uscis.gov/glossary">www.uscis.gov/glossary</a>
<i>Work History</i>	SSA	1-800-772-1213; <a href="http://www.socialsecurity.gov">www.socialsecurity.gov</a>
<i>Employer Coverage</i>	Employer	Varies (usually HR department)
<i>Reporting Changes in Income or Family Size</i>	FFM call center	1-800-318-2596 (TTY: 1-855-889-4325)

## 2. Interaction with the Federally-facilitated Marketplace

### *a. After Completing an Application*

Indiana Navigators should inform consumers that, after completing an application, the FFM will contact the consumer about eligibility or may need additional information to determine eligibility. The FFM will notify the consumer of the consumer's eligibility or need for more information through notices. These notices may be paper and/or electronic, based on the consumer's indicated preference, and consumers may sign up to receive alerts that they have a notice by opting in to text message, e-mail, and U.S. mail notifications. If consumers choose to receive electronic notices, they can typically view the notifications by logging into the account they used to complete the application at [www.healthcare.gov](http://www.healthcare.gov).

Additional information regarding FFM eligibility notices is available online at [www.healthcare.gov/marketplace-appeals/your-eligibility-notice](http://www.healthcare.gov/marketplace-appeals/your-eligibility-notice).

### *b. To Challenge a Decision*

A consumer may challenge a FFM decision in the following circumstances:

- The consumer disagrees with a FFM eligibility decision regarding enrollment in a qualified health plan (QHP), premium tax credit, (PTC) or cost-sharing reduction (CSR).
- The consumer disagrees with the amount of PTC or CSR determined by the Federally-facilitated Marketplace.

Information on how to appeal a FFM decision will be included on most notices, and consumers wishing to appeal such decisions should follow the instructions on the notice or may call the FFM call center for additional information. It is important to note that appeals usually have a time limit, so consumers wishing to appeal a FFM decision will need to be aware of those time limits and comply with them in order to receive consideration for their appeal.

Concerns related to a QHP decision not to cover a particular provider or service are outside the jurisdiction of the Federally-facilitated Marketplace. If a consumer wants to file an appeal regarding a QHP decision to not cover a service or provider, the consumer should follow the appeal process outlined in the QHP's Certificate of Coverage. If the consumer is unable to resolve the grievance within the QHP's appeal process, the consumer may contact the Indiana Department of Insurance (IDOI) at [www.in.gov/idoi/2547.htm](http://www.in.gov/idoi/2547.htm) to arbitrate the dispute.

Additional information on filing an appeal with the FFM is available online at [www.healthcare.gov/marketplace-appeals/ways-to-appeal](http://www.healthcare.gov/marketplace-appeals/ways-to-appeal).

### *c. Reporting Changes*

Consumers' life circumstances affect their continued eligibility for enrollment in QHPs, PTCs, and cost-sharing reductions. Indiana Navigators should encourage consumers with whom they work to report changes to the FFM in a timely manner to ensure continued QHP coverage and the proper level of affordability subsidy. Applicants should report the following changes to the FFM, or to their Indiana Health Coverage Program (IHCP), as soon as possible to avoid owing subsidies back at tax filing (FFM) or

committing fraud (IHCP). Changes in income, household size, and citizenship circumstances could also increase the amount of subsidy available for FFM plans or render a child or family eligible to enroll in a QHP or an Indiana Health Coverage Program. The following table (see [Table 81](#)) shows the possible reasons for changes in household size, income, location, citizenship or immigration status, or health coverage:

**Table 81: Changes to Report to the Federally-Facilitated Marketplace**

Changes to Report	Examples
<i>Household Size</i>	<ul style="list-style-type: none"> <li>• Birth or adoption</li> <li>• Someone becomes pregnant</li> <li>• Someone moves out of the house</li> <li>• Someone passes away</li> <li>• Marriage or divorce</li> <li>• Child on plan turns 26</li> </ul>
<i>Household Income</i>	<ul style="list-style-type: none"> <li>• Someone gets a new job</li> <li>• Someone loses a job</li> <li>• Someone gets raise</li> </ul>
<i>Household Location</i>	<ul style="list-style-type: none"> <li>• Household moves into a new home—this is particularly important to report when moving out-of-state or to a different part of the state, as many QHPs offer local or regional coverage that may have a broad provider network, but is available to residents of a limited service area. If a consumer moves, the consumer may need to select a new QHP; and if the consumer moves out-of-state, the consumer may need to re-apply for coverage on that state's <a href="#">Marketplace</a>.</li> </ul>
<i>Citizenship or Immigration Status</i>	<ul style="list-style-type: none"> <li>• Someone becomes a United States citizen, national or legal resident</li> </ul>
<i>Health Coverage</i>	<ul style="list-style-type: none"> <li>• Someone in your household getting an offer of job-based coverage, even if they do not enroll in it</li> <li>• Someone in your household getting coverage from a public program like Medicaid, CHIP, Medicare, or HIP 2.0</li> <li>• Someone in your household losing coverage, like job-based coverage or Medicaid</li> </ul>

Source: HealthCare.gov, Which changes to report, [www.healthcare.gov/reporting-changes/which-changes-to-report](http://www.healthcare.gov/reporting-changes/which-changes-to-report)

Periodically, the FFM and the state of Indiana will run eligibility checks using databases to determine if consumer circumstances have changed and if they are still eligible for QHPs, PTCs, CSRs, and/or Indiana Health Coverage Programs. However, Indiana Navigators should encourage consumers to notify the FFM

and/or state Division of Family Resources (DFR) as soon as circumstances change. Timely communication of changes helps to avoid future problems with coverage.

More information on reporting changes to the FFM is available online at [www.healthcare.gov/reporting-changes/which-changes-to-report](http://www.healthcare.gov/reporting-changes/which-changes-to-report).

#### *d. Eligibility Redeterminations*

Both the state and the FFM will check at least once a year to ensure consumers are still enrolled in the appropriate program for their income level, household size, residence, and citizenship. A consumer with coverage on the FFM may authorize the FFM to access the consumer's tax information to automatically assess eligibility for PTC and cost-sharing reductions. Allowing access to this information reduces the chances the FFM will need additional information from the consumer to make an eligibility redetermination.

If the state or the FFM can find enough data electronically to assess continued eligibility for enrollment in an IHCP, QHP, or insurance affordability programs, they will renew coverage with minimal response required from the consumer. In some cases, it may be that the consumer only needs to respond to an eligibility determination if the consumer wishes to challenge a decision or make a change. As was the case with other appeals, the consumer will need to be aware of any deadlines and act in accordance with the instructions on the notice to make any needed changes. If the state or the FFM is unable to find enough information electronically to make a continued eligibility reassessment, the consumer will be contacted to provide the needed data.



## Glossary

**1115 (c) Waiver** is a vehicle by which the Centers for Medicare & Medicaid Services (CMS) may waive certain Medicaid and Children's Health Insurance Program (CHIP) regulations, allowing a state to test new or existing ways to deliver and pay for healthcare services under these two programs. In Indiana, the Healthy Indiana Plan (HIP) 2.0 operates under an 1115 (c) waiver.

**1634 Status** is a federal designation given to states for determining Medicaid eligibility for the aged, blind, and disabled populations. Under this program, recipients of Supplemental Security Income (SSI) through the federal Social Security Administration (SSA) obtain automatic Medicaid enrollment and need not complete a separate state Medicaid application. Indiana became a 1634 Status state in 2013.

**Actuarial Value (AV)** is the average percentage of allowed medical cost expected to be paid by a health plan over all covered enrollees. All health plans offered on and off of the Federally-facilitated Marketplace (FFM) in the individual and small group markets are required to meet certain AV standards that are to be displayed to consumers. In general, plans with higher AVs will have higher premiums and lower cost sharing.

**Adverse Selection** is when individuals wait until they become sick or need healthcare services to enroll in a plan. Off-marketplace plans can restrict purchase of plans to the Federally-facilitated Marketplace (FFM) open enrollment periods, which gives the plans the ability to limit adverse selection. The Affordable Care Act (ACA) eliminated health plan's ability to screen for health status and exclude preexisting conditions prior to enrollment.

**Affordable Care Act (ACA)** (also known as **Patient Protection and Affordable Care Act (PPACA)** or **Obamacare**) is a federal statute that was signed into law (**Public Law 111-148**) by President Barack Obama on March 23, 2010 and later amended by the federal Health Care and Education Reconciliation Act of 2010 (**Public Law 111-152**). The law provides fundamental reforms to the United States healthcare and health insurance systems, including the establishment of health insurance Marketplaces and federal consumer assistance programs (such as federal Navigators, CACs, and non-Navigator Assistance Personnel).

**Agency** (see **Producer**)

**Agent** (see **Producer**)

**Aid Category** (see **Eligibility Group**)

**Administrative Action** (also known as **Enforcement Action**) refers to a disciplinary action the Commissioner of the Indiana Department of Insurance (IDOI) may take against a certified Indiana Navigator or registered Application Organization (AO) for violation of Indiana laws or regulations pertaining to Indiana Navigators and Application Organizations. An administrative action may include any of the following, or a combination of the following: (a) reprimand; (b) civil penalty; (c) probation; (d) suspension; (e) revocation; (f) permanent revocation; or (g) a cease and desist order.

**Appeal** is a consumer's right to request an evaluation and re-determination of the consumer's health plan eligibility or features. An [appeal of Indiana Medicaid](#) eligibility or benefits can be made to the Indiana Division of Family Resources (DFR) in a manner specified in the DFR denial/change notice. An [appeal of Federally-facilitated Marketplace](#) (FFM) eligibility or benefits can be made via a letter or the appeal request form available at [www.healthcare.gov/marketplace-appeals/ways-to-appeal](http://www.healthcare.gov/marketplace-appeals/ways-to-appeal). Appealable decisions are specified on the form.

**Application Organization (AO)** is an organization that has employees and/or volunteers helping Hoosier health insurance consumers complete applications for health coverage through the federal Marketplace or Indiana Health Coverage Programs (such as Medicaid, the Children's Health Insurance Program (CHIP), or the Healthy Indiana Plan (HIP 2.0)). Organizations meeting the definition of "application organization" under [Indiana Code 27-19-2-3](#) must be registered with the Indiana Department of Insurance (IDOI).

**Authorized Representative (AR)** is an individual or organization designated by an applicant or beneficiary to act responsibly on the applicant's behalf to assist with the individual's application and renewal of eligibility and other ongoing communications. Authorized representatives may be authorized to sign an application on the applicant's behalf, complete and submit a renewal form and receive copies of the applicant or beneficiary's notices and other communications from the Medicaid agency. Authorized representatives in Indiana must enter into the AR agreement with the state Division of Family Resources (DFR).

**Auto Assignment** is the process by which an individual who does not select a Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP) 2.0 Managed Care Entity (MCE) at the time of the HHW or HIP 2.0 application, or within fourteen (14) days of the submission of the application, is automatically assigned to a Managed Care Entity.

**Behavioral and Primary Healthcare Coordination Program (BPHC)** is a program that provides access to Medicaid Rehabilitation Option (MRO) services to individuals with Serious Mental Illness (SMI) whose income would otherwise be too high to qualify for Medicaid coverage. A person deemed eligible for BPHC receives full Medicaid benefits.

**Benchmark Plan** (also referred to as **Essential Health Benefit (EHB) Benchmark Plan**) is the health plan in a state that identifies the benefits and services classified as essential health benefits (EHBs) in the state. The Anthem preferred provider organization (PPO) plan is the benchmark plan in Indiana. Summaries of each state's benchmark plan can be found on the Centers for Medicare and Medicaid Services (CMS) website at [www.cms.gov/ccio/resources/data-resources/ehb.html](http://www.cms.gov/ccio/resources/data-resources/ehb.html).

**Benefits** (see [Health Insurance](#))

**Benefits Portal** is a website developed and managed by the state Division of Family Resources (DFR) by which Hoosier insurance consumers may apply for Indiana Health Coverage Programs (IHCPs) as well as check the status of pending applications. The DFR Benefits Portal is located at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov).

**Best Door** refers to a consumer's decision to either complete the Indiana Application for Health Coverage (IAHC) or the Federally-facilitated Marketplace (FFM) application for health coverage based on

certain eligibility criteria (e.g., [Table 73](#), [Table 74](#), and [Table 75](#)) determined by the consumer and/or the application assister (e.g., Indiana Navigator) assisting the consumer.

**Broker** (see [Producer](#))

**Bronze Plan** is a type of qualified health plan (QHP) offered to consumers on a marketplace. It is designed so that an insurance carrier will pay 60% of covered healthcare expenses with the remaining 40% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the lowest of the three QHPs/Metal Plans offered in Indiana). Out-of-pocket expenses in 2017 are capped at \$7,150 for individual plans and \$14,300 for family plans.

**Carrier** (see [Insurer](#))

**Catastrophic Plan** is a health plan available on and off the Federally-facilitated Marketplace (FFM) for individuals who are under the age of 30 or who received an exemption from the Individual Mandate to maintain minimum essential coverage (MEC). It is exempt from actuarial value (AV) requirements. The individual is responsible for most healthcare costs until deductible/out-of-pocket maximum is met. It qualifies as MEC for the Individual Mandate, and the individual is not eligible for premium tax credits (PTCs) or cost-sharing reductions (CSRs).

**Centers for Medicare & Medicaid Services (CMS)** is a federal agency within the U.S. Department of Health and Human Services (HHS) that administers Medicare, works in partnership with state governments to administer Medicaid and the Children's Health Insurance Program (CHIP), and oversees the federal Marketplace/[healthcare.gov](http://healthcare.gov).

**Certificate of Coverage** is a list of benefits, services, cost sharing, exclusions, and limits applied by a particular health insurance policy.

**Certified Application Counselor (CAC)** is a federal consumer assistant, established under the ACA and [45 C.F.R. 155.225](#), who is certified under a federally-designated CAC organization to provide Marketplace education and enrollment assistance. If an organization is designated by the federal government as a CAC organization on the federal Marketplace operating in Indiana, the organization must also be registered as an Application Organization (AO) with the Indiana Department of Insurance (IDOI). If an individual is certified as a federal CAC under a federally-designated CAC organization, the individual must also be certified as an Indiana Navigator with the Indiana Department of Insurance.

**Child-Only Policy** (or **Child-Only Plan**) is an individual market policy that is sold to a child under the age of nineteen. Child-only policies do not include policies that are sold to adults with children as dependents.

**Children's Health Insurance Program (CHIP)** is a health coverage program for children authorized in 1997 under Title XXI of the Social Security Act. CHIP provides health coverage to children whose income is too high to qualify for Medicaid. CHIP is administered by states with joint funding from the federal government and the states. States can implement CHIP through a Medicaid expansion, separate CHIP or combination of the two approaches. Indiana operates CHIP through both a Medicaid expansion and separate CHIP program.

**Churn** is transferring from one health insurance coverage to another. Individuals that experience a change in circumstances during the year that impacts their eligibility in the Federally-facilitated Marketplace (FFM) or a state insurance affordability program may experience churn to another health coverage program for themselves or their dependents.

**COBRA Insurance** (also known as **Consolidated Omnibus Budget Reconciliation Act**) is a type of temporary health insurance coverage authorized under federal law (COBRA) that may allow an individual to elect to keep the individual's insurance coverage if the individual's employment ends, the individual loses coverage as a dependent of the covered employee, or another qualifying event occurs. If an individual elects COBRA coverage, the individual pays 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

**Coinsurance** is a consumer's share/percentage of the cost of a healthcare service, paid in addition to the deductible amount. For example, after the consumer has met the deductible amount the consumer's coinsurance may be 20% (*i.e.*, "80/20" – health plan pays 80% and consumer pays 20%) of healthcare costs up until the consumer reached the out-of-pocket maximum.

**Common-Law Employee** (or **Employee**) is an individual who the Internal Revenue Service (IRS) would consider an employee based on the degree of control an employer has over the individual and the overall relationship between the employer and the individual. This common-law standard is used under the Affordable Care Act (ACA) to define an employee. Non-employee directors, sole proprietors, partners, 2% or more shareholders in an S corporation, and a leased employee are not treated as employees.

**Company** (see **Insurer**)

**Complaint** (also referred to as **Consumer Complaint**) means a formal grievance brought by an individual against an insurer, producer, Indiana Navigator, Application Organization (AO), or other individual or business entity regulated by the Indiana Department of Insurance (IDOI). Complaints filed with IDOI will trigger an IDOI investigation of the incident. Complaint forms can be completed either online or printed from IDOI's website at [www.in.gov/idoi/2552.htm](http://www.in.gov/idoi/2552.htm). Complaints against an individual's health plan should first be filed with the company selling the policy. If no resolution can be formed with the insurer, a complaint may be filed with the Indiana Department of Insurance.

**Conflict of Interest** (see also **Conflict of Loyalty** and **Financial Interest**) is, for purposes of the Indiana Department of Insurance (IDOI) Conflict of Interest Policy for Indiana Navigators and Application Organizations (AOs), either a: (a) "conflict of loyalty;" or (b) "financial interest;" existing for an Indiana Navigator or Application Organization. Any actual or potential conflict of interest held by an Indiana Navigator or AO must be disclosed to IDOI on the Indiana Navigator or AO Conflict of Interest Disclosure Form.

**Conflict of Interest Disclosure Form** refers to either the Indiana Navigator Conflict of Interest Disclosure Form or the Application Organization (AO) Conflict of Interest Disclosure Form developed by the Indiana Department of Insurance (IDOI) to be used by Indiana Navigators or AOs to disclose any actual or potential conflicts of interest, as defined by the IDOI Conflict of Interest Policy, when applying for

Indiana Navigator certification or AO registration, when renewing certification or registration, and within 30 days of any change in conflict of interest status. The forms are available on the IDOI website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

**Conflict of Interest Policy** is the state policy document published by the Indiana Department of Insurance (DOI) by which all Indiana Navigators and Application Organizations (AOs) must comply. The document discusses what may constitute an actual or potential conflict of interest (*i.e.*, financial conflict of interest or conflict of loyalty) and the rules and requirements surrounding such conflicts of interest by which all Indiana Navigators and AOs must comply. As part of the initial and renewal certification application processes for Indiana Navigators and AOs, the Indiana Navigator and AO must review the **Conflict of Interest Policy** and submit to the DOI either the **Navigator Conflict of Interest Disclosure Form** or **AO Conflict of Interest Disclosure Form**, agreeing to the terms of the policy and disclosing any actual or potential conflicts of interest.

**Conflict of Loyalty** (see also **Conflict of Interest**) is, for purposes of the Indiana Department of Insurance (DOI) Conflict of Interest Policy for Indiana Navigators and Application Organizations (AOs), a non-financial conflict of interest that an individual or business entity has, directly or indirectly, through business or family, an interest or relationship with a third party that prohibits or inhibits, or potentially prohibits or inhibits, the individual or business entity from exercising independent judgment in the best interests of the consumer. Any actual or potential conflict of loyalty must be disclosed to DOI on the Indiana Navigator or AO Conflict of Interest Disclosure Form.

**Consolidated Omnibus Budget Reconciliation Act** (see **COBRA Insurance**)

**Consumer Assistant** is a broad term used to describe individuals or entities providing outreach, education, and/or enrollment assistance with a state or federal health insurance marketplace or an Indiana Health Coverage Program (IHCP), such as Medicaid, Children's Health Insurance Program (CHIP), and Health Indiana Plan (HIP 2.0). The term includes agents and brokers, Indiana Navigators, Application Organizations (AOs), federal Navigators, federal Certified Application Counselors (CACs), federal non-Navigator Assistance Personnel, or Champions of Coverage.

**Consumer Complaint** (see **Complaint**)

**Consumer Directed Health Plan (CDHP)** (also known as a **High Deductible Health Plan (HDHP)**) is a health plan that has a high deductible cost but often lower premiums. An individual with a CDHP is eligible for a health savings account (HSA) to which the individual can contribute pre-tax dollars for qualified healthcare expenses. Employers can also contribute to health savings accounts.

**Content Outline** (see **Navigator Subject Matter Content Outline**)

**Continuing Education (CE)** (see **Navigator Continuing Education (CE)**)

**Copay** (see **Copayment**)

**Copayment** (also referred to as **Copay**) is a flat fee consumers may need to pay when they are seen by the healthcare provider. Some plans may charge copayments for some services and coinsurance for others.

**Cost-Sharing** is the share of costs covered by an individual's insurance that the individual pays out of his or her own pocket. This generally includes deductibles, coinsurance, and copayments, but not premiums (unless it is premiums paid for Medicaid and the Children's Health Insurance Program (CHIP)). A health plan's cost-sharing policy can be found in its Summary of Benefits and Coverage.

**Cost-Sharing Reduction (CSR)** is a qualified health plan (QHP) discount on the Federally-facilitated Marketplace (FFM) that lowers the amount a consumer has to pay out-of-pocket for deductibles, coinsurance, and copayments. A CSR is offered in addition to premium tax credits (PTCs). Qualifying individuals do not have to apply for a CSR separately if the individual: (1) meets all requirements for a PTC; (2) is enrolled in a silver plan on the FFM; and (3) has household income between 100% and 250% federal poverty level (FPL) (or between 100% and 300% FPL for Native Americans).

**Coverage** (see [Health Insurance](#))

**Deductible** is a set amount that the individual will spend toward healthcare before the insurance carrier begins to make payments. Once the deductible is met, the carrier may require only copayments, may split costs of care with the individual (coinsurance), or may pay for the entire cost of care.

**Department of Health and Human Services (HHS)** is the United States federal government's principal health agency. HHS developed and manages the Federally-facilitated Marketplace (FFM) and manages the establishment, training, certification, monitoring, and oversight of FFM agents, brokers, carriers, and federal consumer assistants (e.g., federal Navigators, Certified Application Counselors (CACs), and non-Navigator Assistance Personnel).

**Dependent** is a child up to 26 years old under the Affordable Care Act (ACA). The ACA requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches 26 years old. Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-based coverage (such as through the adult child's job). Children up to age 26 may stay on their parent's employer plan even if they have another offer of coverage through an employer.

**Designation Form** (see [Indiana Navigator Designation Form for Licensed Insurance Producers and Consultants](#))

**Division of Family Resources (DFR)** is a division of the Indiana Family and Social Services Administration (FSSA), which establishes eligibility for Medicaid, Healthy Indiana Plan (HIP) 2.0, the Supplemental Nutrition Assistance Program (SNAP - food assistance), and the Temporary Assistance for Needy Families (TANF - cash assistance). DFR also manages the DFR Benefits Portal, where consumers may apply for an Indiana Health Coverage Program (IHCP).

**Eligibility Redetermination** (see [Redetermination](#))

**Eligibility Group** (also referred to as **Aid Category**) refers to a particular group/category that is eligible for Medicaid. An individual is determined eligible for the appropriate group/category based on factors of

eligibility such as age, income, pregnancy, disability or blindness. See [Table 33](#) for the list of Medicaid eligibility groups.

**[Eligibility Hierarchy](#)** is the system used to determine a Medicaid applicant's eligibility for the most comprehensive Medicaid benefit package, in the absence of a stated preference.

**[Employee](#)** (see [Common-Law Employee](#))

**[Employer Mandate](#)** (also referred to as **[Employer Shared-Responsibility](#)**) is the Affordable Care Act (ACA) requirement that employers with more than 50 full-time employees and full-time equivalent employees (FTEs) offer health insurance coverage to its full-time employees and FTEs (and their dependents) that meet the minimum standards established by the ACA, or pay tax penalties referred to as "employer shared-responsibility payments."

**[Employer Shared-Responsibility](#)** (see [Employer Mandate](#))

**[Enforcement Action](#)** (see [Administrative Action](#))

**[Enrollment Period](#)** (see also **[Open Enrollment Period](#)**, **[Special Enrollment Period \(SEP\)](#)**, and **[SHOP Enrollment Period](#)**) is the time period in which certain individuals can apply for and enroll in health coverage through the Federally-facilitated Marketplace (FFM). The term includes an open enrollment period or special enrollment period (SEP) on the individual FFM, and the SHOP enrollment period on the FFM for small employers.

**[Essential Health Benefit \(EHB\)](#)** is a type of benefit that insurance carriers in the individual and small group markets are required to cover. Starting in 2014, the ACA requires health plans to cover certain benefits in each of the 10 EHB categories, listed in [Table 61](#). Within each of the EHB categories exact benefits may vary by state, the state selects a "benchmark" plan, and the selected plan sets a baseline of benefits that must be covered by other plans.

**[Essential Health Benefit \(EHB\) Benchmark Plan](#)** (see [Benchmark Plan](#))

**[Ethics](#)** refers to the set of standards that an Indiana Navigator and Application Organizations (AO) must follow in order to provide fair, accurate, unbiased information to consumers regarding health coverage options available to them. These standards may include commitment to consumers, self-determination, informed consent, competence, cultural competence and social diversity, adherence to conflicts of interest and privacy and security standards, access to records, and professional conduct.

**[Exchange](#)** (see [Marketplace](#))

**[Explanation of Benefits \(EOB\)](#)** is a document that describes what an insurer paid for a health service accessed by a consumer enrolled in one of the insurer's health insurance policies, what the consumer paid and/or owes for the service, and a summary of the consumer's remaining deductible and out-of-pocket maximum amounts. Each time a health service is accessed by a consumer, the consumer will receive an EOB from their insurer.

**[Family and Social Services Administration \(FSSA\)](#)** is the healthcare and social service funding agency within Indiana state government. Most of FSSA's budget is paid to thousands of Hoosier healthcare

service providers. The five care divisions within FSSA include the Division of Family Resources (DFR), Office of Medicaid Policy and Planning (OMPP), Division of Disability and Rehabilitative Services (DDRS), Division of Mental Health and Addiction (DMHA), and Division on Aging (DOA). FSSA has the authority, along with the Indiana Department of Insurance (IDOI), to implement and enforce the provisions of [Indiana Code 27-19](#), which establishes the Indiana Navigator and Application Organization (AO) certifications and standards in relation to the federal Marketplace/[healthcare.gov](http://healthcare.gov) and Indiana Health Coverage Programs (IHCPs) operating in Indiana.

**[Family Planning Eligibility Program](#)** is an Indiana Medicaid program that allows eligible men and women the ability to receive certain family planning services and supplies for the primary purpose of preventing or delaying pregnancy.

**[Fast Track](#)** is a payment option that allows Hoosiers eligible for the Healthy Indiana Plan (HIP 2.0) to expedite the start of their coverage in the HIP Plus program. Fast Track allows a member to make a \$10 payment on the application or while the member's application is being processed. The \$10 payment goes toward the first POWER account contribution. If the member makes a Fast Track payment and is eligible for HIP 2.0, the member's HIP Plus coverage will begin the first of the month in which the member made the Fast Track payment.

**[Federal Navigator](#)**, established under the ACA ([42 U.S.C. 18031\(i\)](#)) and [45 C.F.R. 155.210](#), is an entity or individual trained, certified, monitored, and provided grant-funding by the federal government to provide health insurance marketplace outreach, education, and enrollment services. Federal Navigators serving in Indiana must also complete the Indiana Navigator certification process or Application Organization (AO) registration process with the Indiana Department of Insurance (IDOI).

**[Federal Poverty Level \(FPL\)](#)** is a figure released each year by the federal government that estimates the minimum amount an individual or family would need to make to cover basic living expenses. Measure reflects income and household size, and changes annually. It is also used as a factor in determining eligibility in cost reduction programs on the Marketplace (e.g., premium tax credits and cost-sharing reductions) and Indiana Health Coverage Programs (IHCPs). The FPLs for 2016 can be found in [Table 64](#).

**[Federal Marketplace](#)** (see **[Federally-facilitated Marketplace \(FFM\)](#)** and **[HealthCare.gov](#)**)

**[Federally-facilitated Marketplace \(FFM\)](#)** (also referred to as the **[Exchange](#)**, **[Marketplace](#)**, **[Federal Marketplace](#)**, or **[HealthCare.gov](#)**) is a federally-developed and federally-operated health insurance marketplace that makes qualified health plans (QHPs) available to qualified individuals and/or qualified employers in accordance with the Affordable Care Act (ACA). The current FFM website—[HealthCare.gov](http://HealthCare.gov)—was developed and is operated by the U.S. Department of Health and Human Services (HHS). HHS also oversees the establishment, training, monitoring, and oversight of federal consumer assistance programs (e.g., federal Navigators and Certified Application Counselors (CACs)) that provide FFM outreach, education, and enrollment services. This is the marketplace model used in Indiana. The state is to observe federal guidelines and maintain oversight of state-regulated health insurance products and may implement other consumer protection guidelines (e.g., additional training and certification requirements for consumer assistants serving in the state) that do not prevent the application of the Affordable Care Act.

**[Fee-for-Service \(FFS\)](#)** (see **[Traditional Medicaid](#)**)

**Financial Interest** (see also **Conflict of Interest**) is, for purposes of the Indiana Department of Insurance (IDOI) Conflict of Interest Policy for Indiana Navigators and Application Organizations (AOs), when, as a result of the consumer insurance selection at issue, an Indiana Navigator or AO will receive, or may receive, any compensation or other financial arrangement or benefit, either directly or indirectly, from a third party. An individual or business entity, who receives compensation from a health insurance issuer for the enrollment of an individual in a health plan, is prohibited from serving as an Indiana Navigator or Application Organization. Any actual or potential financial interest must be disclosed to IDOI on the Indiana Navigator or AO Conflict of Interest Disclosure Form.

**Flexible Spending Account (FSA)** is a medical savings account that allows an individual and the individual's employer to contribute pre-tax dollars towards future medical costs. Unlike a health savings account (HSA) or health reimbursement account (HRA), funds in the FSA expire at the end of the year.

**Full-time Equivalent Employee (FTE) Count** is a method under the Affordable Care Act (ACA) to count employees to determine whether an employer is subject to the Employer Mandate payment or whether an employer is eligible for the SHOP Marketplace. The count includes the sum of both full-time employees and full-time equivalent employees. Full-time employees are the number of employees working an average of 30 hours or more a week. Full-time equivalent employees are the sum of all hours worked by part-time employees (employees working under 30 hours per week) in each week divided by 30. An employee is any individual employed by an employer but not an individual owner or partner. Eligibility for the small group and large group insurance markets is based on full-time employee counts.

**Gateway to Work** is a voluntary feature of Healthy Indiana Plan (HIP 2.0) that helps connect HIP 2.0 members to Indiana's workforce training programs, volunteer work, work search resources, hiring events, and potential employers. HIP 2.0 members who are unemployed or working less than 20 hours per week will be referred to available employment, work search and job training programs that will assist them in securing new or potentially better employment.

**Gold Plan** is a type of qualified health plan (QHP) offered to consumers on a marketplace. It is designed so that the insurance carrier will pay 80% of covered healthcare expenses with the remaining 20% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium. Out-of-pocket expenses in 2017 are capped at \$7,150 for individual plans and \$14,300 for family plans.

**Grandfathered Health Plan** is a health insurance policy that was in existence prior to the Affordable Care Act (ACA) was signed into law on March 23, 2010, and has not had substantial changes. Such a plan does not have to comply with many of the ACA requirements and qualifies as minimum essential coverage (MEC) for the Individual Mandate.

**Grandmothered Health Plan** (also referred to as **Transitional Health Plan**) is a health insurance policy that was effective after the Affordable Care Act (ACA) was signed on March 23, 2010. Grandmothered health plans include some, but not all, of the ACA features, and they cannot be sold on the Federally-facilitated Marketplace (FFM). In Indiana, these policies can be renewed through October 1, 2016 as long as they are non-discriminatory (e.g., they do not exclude consumers based on pre-existing conditions). Plans that are renewed must not undergo any material changes and are not required to

contain the 10 essential health benefits (EHBs) or to adopt the rating structure of fully ACA-compliant plans.

**Group Market** is the market for health insurance coverage offered in connection with a group health plan.

**Health Benefit Exchange** (see **Marketplace**)

**Health Contingent Wellness Program** is a program for group health plans that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward).

**Health Insurance** (also referred to as **Insurance**, **Benefits**, or **Coverage**) is a type of insurance coverage that provides for the payments of an individual's healthcare/medical costs, including losses from accident, medical expense, disability, or accidental death and dismemberment. Health insurance includes Qualified Health Plans (QHPs) purchased through a Marketplace as well as health plans purchased off a marketplace, including commercial health insurance products, Indiana Health Coverage Programs (IHCPs), and Medicare.

**Health Maintenance Organization (HMO)** is a designation given to health insurers offering products or services in any market segment (individual, small group, large group, or self-insured) in order to also provide or arrange for the delivery of health care services to enrollees on a prepaid basis. Individuals covered under a HMO will have a prescribed set of providers that may provide covered services. Except for certain services, including emergency services, HMOs are not required to cover services provided by out of network providers.

**Health Plan Category** (see **Metal Tier**)

**Health Reimbursement Account (HRA)** is an employer-funded medical savings account that reimburses an employee for out-of-pocket medical expenses and health insurance premiums. An HRA is available to consumers enrolled in a high deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses, and unlike a Flexible Spending Account (FSA), funds roll over year to year if the consumer does not spend them.

**Health Savings Account (HSA)** is a medical savings account that allows the individual and the individual's employer to contribute pre-tax dollars towards the cost of future health costs. Dollars in a HSA do not expire (unlike a flexible spending account (FSA)) and belong solely to the individual (including the employer contribution), but individuals must pay a penalty if they use the funds for anything other than qualified health care expenses.

**Healthcare.gov** (also referred to as the **Federal Marketplace** or **Federally-facilitated Marketplace (FFM)**) is a health insurance marketplace website owned and operated by the federal Centers for Medicare & Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS), to facilitate the sale of qualified health plans (QHPs) and eligibility determinations for premium tax credits (PTCs) and cost-sharing reductions (CSRs) for consumers in Federal Marketplace and Partnership Marketplace states, as well as some State-based Marketplace states. The website also fragments those

consumers who may be eligible for Medicaid, and has a separate portal for small businesses (the SHOP Marketplace).

**Healthcare Provider** (see [Provider](#))

**Healthy Indiana Plan (HIP 2.0)** is Indiana's health coverage program for non-disabled Hoosiers between the ages of 19-64 whose family incomes are less than approximately 138% of the federal poverty level (FPL) and who are not eligible for Medicare or another Medicaid category. HIP 2.0 has four pathways to coverage—HIP Plus, HIP Basic, HIP Employer Link, and HIP State Plan. See [Table 17](#) showing the distinctions between these different pathways to coverage. Covered individuals and the state of Indiana make monthly contributions to a POWER Account. The first \$2,500 of healthcare expenses for the year is covered by the POWER Account, and additional healthcare expenses are fully covered at no additional cost to the HIP 2.0 member.

**High Deductible Health Plan (HDHP)** (see [Consumer Directed Health Plan \(CDHP\)](#))

**High Risk Pool** (also referred to as **Indiana's High Risk Pool** or **ICHIA (Indiana Comprehensive Health Insurance Association)**) refers to individuals with high risk health conditions that have been historically denied commercial insurance due to their health status. Indiana's High Risk Pool—ICHIA—once provided coverage for these individuals; however, with the Affordable Care Act (ACA) market reforms, major medical insurers may no longer deny individuals coverage based on health status. Thus, the ICHIA program is no longer needed, and individuals that once sought coverage through ICHIA can now apply for coverage through the Federally-facilitated Marketplace (FFM) or directly through an insurer, because they can no longer be denied coverage based on health status.

**HIP Basic** (see also **Healthy Indiana Plan (HIP 2.0)**) is the fallback option for HIP 2.0 members with household income less than or equal to 100 percent of the federal poverty level (FPL) who don't make their POWER account contributions. The benefits are reduced. Essential health benefits (EHBs) are covered but not vision or dental services. The member is also required to make a copayment each time the member receives a healthcare service, such as going to the doctor, filling a prescription or staying in the hospital. These payments may range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay. HIP Basic can be much more expensive than HIP Plus. See [Table 17](#) showing the distinctions between the four different HIP 2.0 pathways to coverage.

**HIP Employer Link** (see also **Healthy Indiana Plan (HIP 2.0)**) is an option for eligible HIP 2.0 members who work and have access to their employer's health plan. HIP Employer Link members will also have a POWER account and contribute to their coverage like other HIP 2.0 members. But with HIP Employer Link, the POWER account can be used to pay the insurance premiums and out-of-pocket medical expenses associated with the member's employer-sponsored plan. The employer must choose to participate in HIP Employer Link and be registered with the state. Employers also must contribute 50 percent of the member's premium. Members can receive counseling on whether their employer plan would be best suited for them. See [Table 17](#) showing the distinctions between the four different HIP 2.0 pathways to coverage.

**HIP Plus** (see also **Healthy Indiana Plan (HIP 2.0)**) is the initial plan selection for all members is HIP 2.0 which offers the best value for members. HIP Plus has comprehensive benefits including vision and dental. The member pays an affordable monthly POWER account contribution based on income. There

is no copayment required for receiving services with one exception: using the emergency room where there is no true emergency. See [Table 17](#) showing the distinctions between the four different HIP 2.0 pathways to coverage.

**[HIP State Plan](#)** (see also **[Healthy Indiana Plan \(HIP 2.0\)](#)**) is a pathway to coverage under HIP 2.0 that provides enhanced benefits to individuals determined to be medically frail, low-income parents and caretakers, and transitional medical assistance (TMA) individuals. The HIP State Plan benefits grant individuals comprehensive coverage including vision, dental, non-emergency transportation, chiropractic services and Medicaid Rehabilitation Option services. These HIP State Plan benefits will continue as long as the individual's health condition, disorder or disability status continues to qualify them as medically frail. See [Table 17](#) showing the distinctions between the four different HIP 2.0 pathways to coverage.

**[Home and Community-Based Services \(HCBS\) Waivers](#)**, authorized under Section 1915(c) of the Social Security Act, are Indiana Medicaid waivers designed to provide an array of services to enrollees allowing them to live in community settings and to avoid institutionalization. HCBS waivers “waive” the requirement of an admission to an institution in order for Medicaid to pay for the needed home and community-based services. The different types of HCBS waivers that Indiana offers are outlined in [Table 23](#).

**[Hoosier Care Connect](#)** is a healthcare program for individuals aged 65 years and older, blind or disabled, who are not eligible for Medicare. In this program, individuals pick a health plan that works with them and their doctor to ensure that the individual gets consistent and high-quality healthcare based upon the individual's individualized needs. The health plans individuals may choose include Anthem, CareSource Indiana, Managed Health Services (MHS), or MDwise.

**[Hoosier Healthwise \(HHW\)](#)** is an Indiana Medicaid program for pregnant women and children up to age nineteen. The program covers medical care like doctor visits, prescription medicine, mental healthcare, dental care, hospitalizations, surgeries, and family planning, at little or no cost to the member or the member's family.

**[Hospital PE \(HPE\)](#)** (see **[Presumptive Eligibility \(PE\)](#)**)

**[HPE Adult](#)** is a hospital presumptive eligibility (HPE) aid category for individuals determined to be presumptively eligible for the Healthy Indiana Plan (HIP 2.0). HPE Adult members receive *HIP Basic* coverage, are enrolled with a HIP 2.0 managed care entity (MCE), and have cost-sharing obligations.

**[ICHIA \(Indiana Comprehensive Health Insurance Association\)](#)** (see **[High Risk Pool](#)**)

**[In-Network Provider](#)** is a healthcare provider (such as a hospital, doctor, or health clinic) in a contract with an insurer, agreeing to provide healthcare/medical services at a discounted rate in return for access to a large group of insured individuals. A list of in-network providers can be accessed through an insurer's website or by calling an insurer's consumer help desk.

**[In-Person Assister](#)** (see **[Non-Navigator Assistance Personnel](#)**)

**[In-Person Counselor](#)** (see **[Non-Navigator Assistance Personnel](#)**)

**[Indiana Administrative Code - Title 760, Article 4](#)**, titled “Navigators and Application Organizations,” is an Indiana Department of Insurance (IDOI) administrative rule regarding matters relating to an individual acting as an Indiana Navigator and a business entity acting as an Application Organization (AO) in the state of Indiana. It supplements Indiana Code 27-19 and establishes rules regarding Indiana Navigator certification and AO registration with IDOI, duties, conflicts of interest, privacy and security information, reporting requirements, enforcement, and other matters. It also established rules regarding the approval and required procedures of Indiana Navigator precertification education providers and continuing education courses. The rule became effective on July 10, 2016.

**[Indiana Application for Health Coverage \(IAHC\)](#)** is an application for an Indiana Health Coverage Program (IHCP) which may be submitted to the Division of Family Resources (DFR) either online through the DFR Benefits Portal, by phone, fax, mail, or in-person at a local DFR office. The different methods for submitting an IAHC, as well as contact information, are listed in [Table 76](#).

**[Indiana Code 27-19](#)**, titled “Health Benefit Exchange,” is an Indiana state statute that was signed into law by Governor Mike Pence on May 11, 2013. Indiana Code (IC) 27-19 requires consumer assistants that help Hoosier insurance consumers with applications for qualified health plans (QHPs) on the federal Marketplace or applications for Indiana Health Coverage Programs (IHCPs) to be certified with the State of Indiana. IC 27-19 refers to these state consumer assistants as Indiana “Navigators” and “Application Organizations” (AOs), and establishes certain certification requirements and standards for these consumer assistants. IC 27-19 gives the Commissioner of the Indiana Department of Insurance (IDOI), in consultation with the Secretary of the Indiana Family & Social Services Administration (FSSA), the authority to implement and enforce the provisions established in this code.

**[Indiana Department of Insurance \(IDOI\)](#)** is the agency of Indiana state government whose duty is to monitor and regulate the business of insurance in Indiana and provide Hoosier consumers information on their options for obtaining insurance. IDOI has the authority, in consultation with the Indiana Family & Social Services Administration (FSSA), to implement and enforce the provisions of [Indiana Code 27-19](#), which establishes Indiana Navigator and Application Organization (AO) standards in relation to the Federal Marketplace ([healthcare.gov](http://healthcare.gov)) and Indiana Health Coverage Programs (IHCPs) (see [dfrbenefits.in.gov](http://dfrbenefits.in.gov)) operating in Indiana.

**[Indiana Health Coverage Program \(IHCP\)](#)** (also referred to as **Public Health Insurance Program**) is a term that refers to any of the several programs operating under Indiana Medicaid, which have been developed to address the medical needs of the low income, aged, disabled, blind, pregnant, and other populations meeting the eligibility criteria. Each IHCP has different criteria for eligibility. Types of IHCPs include, but are not limited to, Hoosier Healthwise, Healthy Indiana Plan (HIP 2.0), Children’s Health Insurance Program (CHIP), Hoosier Care Connect, traditional Medicaid, and home and community-based service (HCBS) waivers. Applications for IHCPs can be accessed through the DFR Benefits Portal at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov).

**[Indiana Navigator](#)** is an individual who assists Hoosier insurance consumers in completing applications for qualified health plans (QHPs) on the Federal Marketplace ([healthcare.gov](http://healthcare.gov)) or Indiana Health Coverage Program (IHCP) applications, such as Medicaid, Healthy Indiana Plan (HIP 2.0), or Children’s Health Insurance Program (CHIP) – see [dfrbenefits.in.gov](http://dfrbenefits.in.gov). An individual that meets the definition of “navigator” under [Indiana Code 27-19-2-12](#) must be certified as an Indiana Navigator with the Indiana

Department of Insurance (IDOI) and abide by all the standards required of Indiana Navigators (see initial and renewal application processes and other resources at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm)). An Indiana Navigator may, but is not required to, be associated with an Application Organization (AO).

**Indiana Navigator Designation Form for Licensed Insurance Producers and Consultants** (also referred to as the **Navigator Designation Form** or **Designation Form**) is a form developed by the Indiana Department of Insurance (IDOI) that may be completed by insurance producers or consultants licensed in the state of Indiana as part of the initial Indiana Navigator certification application process, in place of the online new or renewal application for Indiana Navigators. The form may be accessed online at [www.in.gov/idoi/2929.htm](http://www.in.gov/idoi/2929.htm) (for new applications) or at [www.in.gov/idoi/2930.htm](http://www.in.gov/idoi/2930.htm) (for renewal applications).

**Individual Mandate** (also referred to as **Individual Shared-Responsibility**) is a U.S. Internal Revenue Service (IRS) tax penalty imposed on an individual that does not maintain minimum essential coverage (MEC) for themselves and their dependents nor qualify for any of the [exemptions](#) from the MEC requirement. Exemptions from the Individual Mandate are listed in [Table 51](#).

**Individual Market** is the market for health insurance coverage offered to individuals other than in connection with a group health plan.

**Individual Shared-Responsibility** (see [Individual Mandate](#))

**Insurance** (see [Health Insurance](#))

**Insurance Affordability Program** refers to either of two programs—premium tax credit (PTC) or cost-sharing reduction (CSR)—that was established by the Affordable Care Act (ACA) to make insurance premiums and cost-sharing more affordable through a marketplace. Eligible consumers may only take advantage of these programs if they apply for coverage through a marketplace.

**Insurer** (also known as an insurance **Issuer**, **Carrier**, or **Company**), for health insurance purposes, is an insurance company, insurance service, or insurance organization, which has a certificate of authority to engage in the business and sale of health insurance policies in a state and which is subject to state law which regulates insurance. This term may include a [health maintenance organization](#) (HMO). [Indiana Code 27-19-4-3\(a\)\(16\)](#) prohibits Indiana Navigators and application organizations (AOs) from receiving consideration from a health insurance issuer in connection with the enrollment of a consumer into a health plan.

**Issuer** (see [Insurer](#))

**Large Employer** (also referred to as **Large Group Employer**) is, in Indiana, an employer who employed an average of more than 50 employees on business days during the preceding year. Employers with more than 50 full-time employees are eligible for the large group insurance market in Indiana. Employers with more than 50 full-time employees plus full-time equivalent employees (FTEs) are subject to the employer shared-responsibility provisions of the Affordable Care Act (ACA) (the “Employer Mandate”) and are not eligible for the SHOP Marketplace. An employee is defined as any individual employed by an employer but not an individual owner or partner.

**Major Medical Insurance** is a health insurance plan that offers individuals comprehensive insurance against potential healthcare costs. Major medical policies offer coverage for a wide array of health benefits, providers, products, and services. Plans that only cover a specific health condition or service are not major medical products. In general, being covered by a major medical policy will qualify as minimum essential coverage (MEC) under the Affordable Care Act (ACA). However, some major medical plans are not considered MEC, for example certain types of student health insurance.

**Managed Care Entity (MCE)** (also referred to as **Managed Care Organization (MCO)**) is a general term used to describe health plans that are designed to control the quality and cost of healthcare delivery. The term includes models such as a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). In Indiana Medicaid, benefits are delivered in Hoosier Healthwise, HIP 2.0, and Hoosier Care Connect, through MCEs for some populations.

**Managed Care Organization (MCO)** (see **Managed Care Entity (MCE)**)

**Marketplace** (also referred to as **Exchange** or **Health Benefit Exchange**) is a shopping and enrollment service for health insurance that makes qualified health plans (QHPs) available to qualified individuals or qualified employers in accordance with the Patient Protection and Affordable Care Act (PPACA, or ACA) of 2010. The term includes a Federally-facilitated Marketplace (FFM, or Federal Marketplace), a Partnership Marketplace, or a State-based Marketplace. Indiana operates as a FFM at [healthcare.gov](http://healthcare.gov).

**Medicaid** is a means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. It provides free or low-cost health insurance coverage to individuals meeting the States' eligibility criteria, which are developed within the parameters established by the federal government. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving eligible individuals.

**Medicaid for Employees with Disabilities** (see **M.E.D. Works**)

**Medicaid Medical Review Team (MMRT)** (see **Medical Review Team (MRT)**)

**Medical Loss Ratio (MLR)** is the percent of premiums collected by a health insurance carrier and spent on medical services and quality improvement. Under the Affordable Care Act (ACA), carriers must maintain a certain MLR, which varies by market segment (large group 85%, small group 80%, individual 80%). If a carrier does not meet the MLR requirement, the covered individuals and small businesses will receive a refund.

**Medical Review Team (MRT)** (also referred to as the **Medicaid Medical Review Team (MMRT)**) is a group that determines a Medicaid applicant's eligibility for Indiana Medicaid based on a disability. To meet the disability requirement, a person must have a significant impairment that is expected to last a minimum of 12 months. The MRT makes this determination and notifies the Division of Family Resources (DFR) of its decision.

**Medically Frail** is a term used to describe an individual who has one or more of the following: (a) disabling mental disorder; (b) chronic substance abuse disorder; (c) serious and complex medical conditions; (d) physical, intellectual or developmental disability that significantly impair the individual's ability to perform one or more activities of daily living; or (e) disability determination based on Social

Security Administration (SSA) criteria. Individuals who qualify for the Healthy Indiana Plan (HIP 2.0) can receive enhanced benefits through the HIP State Plan pathway to coverage if they are determined to be medically frail.

**Medicare** is a federal insurance program administered by the Centers for Medicare and Medicaid Services (CMS) that guarantees access to health insurance for: (1) individuals aged 65 and older who have worked and paid into the program; (2) individuals under 65 with qualifying disabilities; (3) individuals with End Stage Renal Disease; and (4) individuals with Amyotrophic Lateral Sclerosis. Medicare qualifies as minimum essential coverage (MEC) under the Affordable Care Act (ACA) and individuals eligible for Medicare are not eligible for the Federally-facilitated Marketplace (FFM).

**Medicare Savings Program** is a Medicaid program that helps Medicare beneficiaries pay for Medicare premiums and cost-sharing. There are four different categories of the Medicare Savings Program described in [Table 25](#).

**M.E.D. Works** (short for **Medicaid for Employees with Disabilities**) is Indiana's healthcare program for working people with disabilities. M.E.D. Works members pay premiums based on their income and receive full Medicaid benefits.

**Metal Level** (see [Metal Tier](#))

**Metal Plan** (see [Metal Tier](#))

**Metal Tier** (also referred to as **Health Plan Category**, **Metal Level**, or **Metal Plan**) refers to any of the four categories of health plans offered in a marketplace (*i.e.*, Bronze, Silver, Gold, or Platinum). The plans are categorized based on the percentage the plans pay of the average overall cost of providing essential health benefits (EHBs) to consumers. The plan a consumer chooses affects the total amount the consumer will likely spend for EHBs during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum).

**Miller Trust** (also referred to as **Qualified Income Trust (QIT)**) is a legal arrangement for holding funds that allows an individual with income that exceeds 300 percent of the federal Supplemental Security Income (SSI) benefit rate (also known as the Special Income Limit) to become eligible for Medicaid coverage of institutional or home and community-based services.

**Minimum Essential Coverage (MEC)** is a type of health insurance coverage that an individual and the individual's dependents must have to meet the Individual Mandate under the Affordable Care Act (ACA). The list of MEC types (see [Table 50](#)) is determined by the federal government and is subject to change. Types of coverage not currently considered MEC may apply for recognition as minimum essential coverage. Individuals may receive an exemption from the requirement to maintain minimum essential coverage.

**Minimum Value (MV)** is the lowest threshold for the value of a health plan under the Affordable Care Act (ACA). A plan with MV should cover, on average, at least 60% of the medical costs of a standard population. Individuals offered employer-sponsored coverage that provides MV and that's affordable are not eligible for a premium tax credit (PTC).

**Modified Adjusted Gross Income (MAGI)** is an eligibility methodology for insurance affordability programs. MAGI equals adjusted gross income (AGI) plus tax excluded foreign earned income, tax exempt interest and tax exempt Title II Social Security income. MAGI methodologies are applied to individuals applying for premium tax credits (PTCs) and in the Medicaid program to children, pregnant women, parent and caretaker relatives and adults.

**Modified Adjusted Gross Income (MAGI) Conversion** refers to states' requirements to convert current Medicaid income eligibility standards to a MAGI equivalent as part of the transition to MAGI-based methodologies in 2014. The goal of the MAGI conversion process is to establish a MAGI-based income standard that is not less than the effective income eligibility standard as applied on the date of the Affordable Care Act (ACA) enactment for each eligibility group.

**Navigator Assessment** (see **Navigator Examination**)

**Navigator Continuing Education (CE)** (also referred to **Continuing Education (CE)**) is education and training programs approved by the Indiana Department of Insurance (IDOI) that may be completed by certified Indiana Navigators to satisfy their yearly Navigator CE requirement. Each year, as part of the annual certification renewal process, an Indiana Navigator must complete at least two (2) hours of Navigator CE from an IDOI-approved Navigator CE provider. A list of approved Navigator CE providers may be accessed through IDOI's website at [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm).

**Navigator Designation Form** (see **Indiana Navigator Designation Form for Licensed Insurance Producers and Consultants**)

**Navigator Examination** (also referred to as **Navigator Certification Examination** or **Navigator Assessment**) is the Indiana Department of Insurance (IDOI) examination given to individuals as part of the initial Indiana Navigator certification application process. The navigator examination is a 90-minute exam consisting of 60 multiple-choice questions outlined in the Navigator Examination Score Report. An individual must score at least a 70% (42 correct out of 60) on the exam to be considered for certification. The exam is registered and scheduled through the Performance Assessment Network (PAN) and administered at Ivy Tech Community Colleges across the state. Additional information on the navigator examination is available online at [www.in.gov/idoi/2836.htm](http://www.in.gov/idoi/2836.htm).

**Navigator Examination Score Report** (also referred to as **Score Report**) is a document developed by the Indiana Department of Insurance (IDOI) that outlines each topic covered on the Indiana Navigator examination and how many questions are devoted to each topic. The navigator examination score report may be accessed online at [www.in.gov/idoi/2836.htm](http://www.in.gov/idoi/2836.htm).

**Navigator Precertification Education (PE)** (also referred to as **Precertification Education (PE)**) is education and training programs approved by the Indiana Department of Insurance (IDOI) that may be completed by individuals as part of the initial Indiana Navigator certification application process. Approved Navigator PE courses are a minimum of eight (8) hours long and may be either in-person (*e.g.*, classroom, seminar, one-on-one) or self-study (*e.g.*, online) courses. A Navigator PE course must be completed and the course "Certificate of Completion" received from the approved Navigator PE provider in order for an individual to take the navigator examination. A list of approved Navigator PE providers open to the public is available on the IDOI website at [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm).

**Navigator Service Request Form** is a form developed by the Indiana Department of Insurance (IDOI) to be used by Indiana Navigators and Application Organizations (AOs) to report certain reporting requirements, including: (1) change of resident address or phone number; (2) change of legal name; (3) correction to social security number (SSN), federal employer identification number (FEIN), or date of birth (DOB); (4) change of business address or phone number; (5) to add, remove or update a location of an AO; (6) to request a cancellation of an Indiana Navigator certification or AO registration; (7) to add or update a federal Navigator or Certified Application Counselor (CAC) number; (8) to add an assumed business name; (9) to add or remove an associated Indiana Navigator or AO from the AO registration; or (10) to add or update a personal or business email address. The form is available on the IDOI website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

**Navigator Subject Matter Content Outline** (also referred to as **Subject Matter Content Outline** or **Content Outline**) is an outline developed by the Indiana Department of Insurance (IDOI) that lists the specific topics that should be covered in navigator precertification education (PE) courses in order to be approved by the Indiana Department of Insurance. The outline follows this manual and the Indiana Navigator training resource modules, and covers topics that may be tested on the navigator examination, as outlined in the navigator examination score report. The outline identifies and classifies entry level knowledge that Indiana Navigators need to have in order to properly assist Hoosiers with application for and enrollment in health coverage programs and to abide by the laws and regulations governing Indiana Navigators. The outline is available online at [www.in.gov/idoi/2937.htm](http://www.in.gov/idoi/2937.htm).

**Navigator Training Resource Module** (also referred to as **Training Module**) is a document developed by the Indiana Department of Insurance (IDOI) in a slideshow presentation format that may be used as a resource for Indiana Navigator precertification education (PE) course providers. There are four training resource modules that cover the four chapters in this training resource manual, including: (a) consumer assistance basics and Indiana Navigator laws and regulations; (b) Indiana Health Coverage Programs (IHCPs); (c) the Federally-facilitated Marketplace (FFM); and (d) guidance on helping consumers complete applications for health coverage. The training resource modules are posted online at [www.in.gov/idoi/2937.htm](http://www.in.gov/idoi/2937.htm).

**Network Adequacy Standards** is provision in the Affordable Care Act (ACA) requiring marketplace insurers to ensure that the provider networks of each of their qualified health plans (QHPs) are available to all enrollees and meet other standards, such as having essential community providers, maintaining a network that is sufficient in number and types of providers, and making the insurer's provider directory for a QHP available to the marketplace for publication online.

**Non-Grandfathered Health Plan** is a health insurance policy that does not have "Grandfathered" status (*i.e.*, was not in existence prior to when the Affordable Care Act (ACA) was signed into law on March 23, 2010). The term may include a qualified health plan (QHP), grandmothers (or "transitional") plan, or any other health plan on or off a marketplace that was effective after the ACA became effective.

**Non-Modified Adjusted Gross Income (Non-MAGI) Population** is a population that is exempt from MAGI methodologies for the Medicaid eligibility determination process. Non-MAGI Medicaid eligibility methodologies are maintained for non-MAGI populations. For Medicaid, non-MAGI methodologies are applied to individuals age 65 or older when age is a condition of eligibility, individuals being determined eligible on the basis of blindness or disability, individuals applying for long-term services and supports for which a level of care need is a condition of eligibility, individuals whose eligibility does not require an

income determination to be made by the Medicaid agency, individuals applying for Medicare cost-sharing, former foster children under age 26, and deemed newborns.

**Non-Navigator Assistance Personnel** (also known as **In-Person Assister** or **In-Person Counselor**) is a type of consumer assister intended to exist in Partnership Marketplace states to complement the federal Navigator program while remaining distinct and apart from the Navigator program. These individuals and organizations are trained to provide assistance to individual consumers, small businesses and their employees searching for health coverage through the marketplace.

**Obamacare** (see **Affordable Care Act (ACA)**)

**Office of Medicaid Policy and Planning (OMPP)** is a division of the Indiana Family and Social Services Administration (FSSA) that administers Medicaid programs and performs medical review of Medicaid disability claims.

**Open Enrollment Period** is the timeframe in which individuals can apply and enroll in health coverage through the individual Federally-facilitated Marketplace (FFM). The annual open enrollment period is determined by the Centers for Medicare and Medicaid Services (CMS) and may be viewed on the FFM website at [www.healthcare.gov](http://www.healthcare.gov). For 2017 FFM coverage, the open enrollment period is November 1, 2016 – January 31, 2017. People may qualify for **special enrollment periods (SEPs)**, allowing them to enroll on the FFM outside of open enrollment. Individuals may apply for Indiana Health Coverage Programs (IHCPs) at any time of the year.

**Out-of-Network Provider** is a healthcare provider that is not contracted with a particular insurer to provide healthcare/medical services at a discounted rate for consumers covered by the insurer. Some out-of-network providers may not accept an individual's health insurance, and payment may be requested up front. For providers that do not accept an individual's health insurance, an individual may submit a form directly to their insurer showing what they paid for the service. If this form is submitted, the amount the enrollee spent for covered services will count toward the plan deductible and out-of-pocket maximum, and if the enrollee has met the deductible the insurer may issue compensation. To determine whether a provider is in-network or out-of-network with an insurer, a list of in-network providers can be accessed through the health insurer's website or by calling the health insurers consumer help desk.

**Out-of-Pocket Limit** (see **Out-of-Pocket Maximum**)

**Out-of-Pocket Maximum** (also known as **Out-of-Pocket Limit**) is the greatest amount that a consumer pays for healthcare services in any plan year before the insurance carrier pays 100% of healthcare costs. This limit never includes premiums paid or healthcare services not covered by the policy. Out-of-pocket maximum is set by the federal Internal Revenue Service (IRS). For 2017, this maximum amount is \$7,150 for an individual and \$14,300 for a family.

**Partnership Exchange** (see **Partnership Marketplace**)

**Partnership Marketplace** (also referred to as **Partnership Exchange**) is a mix between the Federally-facilitated Marketplace (FFM, or Federal Marketplace) and a State-based Marketplace, which allows a state to assume primary responsibility for certain functions of the Federal Marketplace permanently or

as the state works toward operating a State-based Marketplace. These functions may include, for example, plan management and/or consumer assistance and outreach. Indiana does not follow this marketplace model, but rather operates as a Federal Marketplace at [healthcare.gov](http://healthcare.gov).

**Pathway to Coverage** is a phrase used to describe the four different plan options under the Healthy Indiana Plan (HIP 2.0). The four HIP 2.0 pathways to coverage include HIP Plus, HIP Basic, HIP Employer Link, and HIP State Plan. See [Table 17](#) showing a comparison of these different HIP 2.0 pathways to coverage.

**Patient Protection and Affordable Care Act (PPACA)** (see [Affordable Care Act \(ACA\)](#))

**PE for Inmates** (see [Presumptive Eligibility \(PE\)](#))

**PE for Pregnant Women (PEPW)** (see [Presumptive Eligibility \(PE\)](#))

**Pediatric** refers to children under the age of nineteen. Under the Affordable Care Act (ACA), pediatric healthcare services, including oral and vision care, are considered essential health benefits (EHBs) that an insurance carrier in the individual and small group markets are required to cover.

**Performance Assessment Network (PAN)** is the examination registration, scheduling, and reporting provider for all examinations offered by the Indiana Department of Insurance (IDOI), which are administered at Ivy Tech Community College locations across the state. Indiana Navigators must register and schedule the Indiana Navigator examination through PAN's online exam registration/scheduling system—<https://secure.vitapowered.com/idoi/login.screen>. Steps to completing the navigator examination registration/scheduling process through PAN are available online at [www.in.gov/idoi/2836.htm#RSE](http://www.in.gov/idoi/2836.htm#RSE).

**Personal Information**, for purposes of the Indiana Department of Insurance (IDOI) privacy and security agreements for Indiana Navigators and Application Organizations (AOs), means any nonpublic information that is provided to an Indiana Navigator by an individual for purposes of assisting and/or enrolling such individual in a qualified health plan (QHP) through a health insurance marketplace or an Indiana Health Coverage Program (IHCP). Personal information includes, but is not limited to: (a) social security number; (b) name; (c) contact information; (d) driver's license number; (e) financial account numbers; (f) medical or health information; (g) state or federal tax information; or (h) state identification card number. Indiana Navigators and AOs must abide by the IDOI privacy and security agreements to ensure the confidentiality and protection of consumers' personal information.

**Personal Wellness and Responsibility Account** (see [POWER Account](#))

**Platinum Plan** is a type of qualified health plan (QHP) offered to consumers on a marketplace. It is designed so that the insurance carrier will pay 90% of covered healthcare expenses with the remaining 10% to be paid by consumers. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the highest of the four QHPs/metal tiers). Out-of-pocket expenses in 2017 are capped at \$7,150 for individual plans and \$14,300 for family plans.

**Policy Year** is either: (1) the 12-month period that is designated as the policy year in the policy documents of a grandfathered health plan offered in the individual health insurance market. If there is

no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year. Or (2) A calendar year for a non-grandfathered health plan offered in the individual health insurance market, or in a market in which the state has merged the individual and small group risk pools.

**POWER Account** (also referred to as **Personal Wellness and Responsibility Account**) is an account used to pay medical costs for HIP 2.0 members. Members use their POWER accounts to pay for the first \$2,500 of covered services in any coverage year. Expenses for additional health services over \$2,500 are fully covered at no additional cost to the member (except in the HIP Basic program where the member is responsible for any required copayments). Contributions to the account are made by the state of Indiana and each member. Monthly POWER account contributions by members are determined by income and family size and are approximately two percent of annual family income.

**Pre-Existing Condition** is a health issue (such as cancer, diabetes, asthma, etc.) that an individual has prior to obtaining health insurance. Under the Affordable Care Act (ACA), as of January 1, 2014 health insurance issuers can no longer deny someone coverage, offer less coverage, or charge more for coverage based on a pre-existing condition. The pre-existing conditions rule does not apply to “grandfathered” health plans.

**Precertification Education (PE)** (see [Navigator Precertification Education \(PE\)](#))

**Preferred Provider Organization (PPO)** is a type of health plan that contracts with certain providers (referred to as in “network providers”). Individuals may choose to receive service from among the network providers or may choose to go to an out-of-network provider and in general be subject to greater cost sharing.

**Preliminary Eligibility Screening** is a technique that Indiana Navigators may use to evaluate whether a consumer would be better suited to apply for an Indiana Health Coverage Program (IHCP) or for health coverage through the Federally-facilitated Marketplace (FFM) before assisting with a health coverage application. The Indiana Navigator may ask basic questions about United States citizenship/legal resident status, household income, household composition, and refer to the eligibility screening charts (see [Table 73](#), [Table 74](#), and [Table 75](#)), in order to better direct the consumer to the type of coverage for which the consumer is most likely eligible.

**Premium** is the amount that a consumer must periodically pay to the insurance carrier for a health insurance plan. Individuals pay the premium regardless of whether or not they use the health insurance. It is meant to compensate the insurer for bearing the risk of a payout should the insurance agreement's coverage be required. Premiums are usually paid on a monthly basis, but may be quarterly or yearly.

**Premium Rating Factors** (see [Rating Factors](#))

**Premium Tax Credit (PTC)** (also referred to as **Subsidy**) is a tax credit that lowers premium costs for certain eligible individuals to help them afford health coverage purchased through a marketplace. An individual may apply for a PTC through the Federally-facilitated Marketplace (FFM), and the FFM determines the individual's PTC eligibility and maximum PTC amount. To be eligible for a PTC on the FFM operating in Indiana, an individual must: (1) be a U.S. citizen, national or legal resident of the U.S.; (2) be

an Indiana resident; (3) be non-incarcerated; (4) have a household income between 100% and 400% of the federal poverty level (FPL); and (5) have no other minimum essential coverage (MEC) or an available MEC with a premium more than 9.66% of household income or that does not provide minimum value (MV) (at least 60% actuarial value (AV)). A PTC can be either claimed retroactively when the consumer's taxes are filed or may be paid in advance directly to the health insurer to reduce premiums (this advanced PTC is referred to as an **Advanced Premium Tax Credit** or **APTC**).

**Presumptive Eligibility (PE)** (also referred to as **PE for Pregnant Women (PEPW)**, **Hospital PE (HPE)**, or **PE for Inmates**) is a determination by a qualified provider (QP) that an individual is eligible for Medicaid benefits on the basis of preliminary self-declared information that the individual has gross income at or below the applicable Medicaid income eligibility standard. Indiana operates the following PE programs: Presumptive Eligibility (PE), PE for Pregnant Women (PEPW), Hospital PE (HPE), and PE for Inmates. See [Table 27](#) showing the comparisons between these programs.

**Presumptive Eligibility (PE) Qualified Entity** (see [Qualified Provider \(QP\)](#))

**Primary Medical Provider (PMP)** is a healthcare provider selected or assigned to a beneficiary of a managed care entity (MCE) (*i.e.*, Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP 2.0)). Once a beneficiary is enrolled in a MCE, the beneficiary then selects a PMP or, if one is not selected within 30 days, the MCE will assign a PMP to the enrollee. Enrollees must see their PMP for all medical care; if specialty services are required the PMP will provide a referral. The PMP receives a monthly administration fee for each member actively assigned to the PMP. Other services are reimbursed on a fee-for-service basis.

**Prior Authorization (PA)** is a process under which the medical necessity of a requested service is reviewed. This is required for certain covered services to document the medical necessity for those services. To determine whether a procedure code requires PA for members in the fee-for-service (FFS) delivery system, members should access the Indiana Health Coverage Programs (IHCP) provider [Fee Schedule](#). To determine whether a procedure code requires PA for members enrolled in managed care programs, members should contact the managed care entity (MCE) with which the member is enrolled.

**Privacy and Security Agreement** refers to either the [Indiana Navigator Privacy and Security Agreement](#) or the [Indiana Application Organization \(AO\) Privacy and Security Agreement](#) (two separate documents) published by the Indiana Department of Insurance (IDOI), by which all Indiana Navigators and AOs must comply. The agreement defines what constitutes a consumer's "personal information" and establishes the privacy and security standards and procedures that all Indiana Navigators and AOs must follow in order to protect a consumer's personal information. As part of the application process for Indiana Navigators and AOs, the Indiana Navigator and AO must sign and submit the agreement to the Indiana Department of Insurance.

**Producer** (also referred to as **Agent**, **Broker** or **Agency**) is an individual or business entity licensed by a state to sell, solicit, or negotiate insurance products within the state. A licensed insurance agent/broker/producer that sells health insurance products, or receives compensation from a health insurance carrier for the enrollment of an individual in a health plan, is prohibited from being an Indiana Navigator or Application Organization (AO) in the state of Indiana. A licensed insurance agent/broker/producer that sells health insurance products on the Federally-facilitated Marketplace (FFM) must be registered with the Federally-facilitated Marketplace.

**Provider** (also referred to as **Healthcare Provider**) is an individual or entity that provides healthcare or medical services to a patient. Common examples include a doctor's office, hospital, or health clinic. A healthcare provider can be either "[in-network](#)" (covered) or "[out-of-network](#)" (not covered) with the health insurance coverage offered by a health insurance issuer. *\*Note: a health insurance issuer may sometimes be referred to as a health insurance provider. It is an important distinction to remember that the "health insurance provider" (the provider/issuer/insurer/carrier of the health insurance) is different from the "healthcare provider" (the provider of healthcare or medical services).* To determine whether a provider is in-network or out-of-network with an insurer, a list of in-network providers can be accessed through the health insurer's website or by calling the health insurers consumer help desk.

**Public Health Insurance Program** (see [Indiana Health Coverage Program \(IHCP\)](#))

**Qualified Health Plan (QHP)** is a health insurance plan that has been certified under the Affordable Care Act (ACA) to meet the criteria for availability through a marketplace. All QHPs sold on the Federally-facilitated Marketplace (FFM) are certified by federal and state agencies to be sure they provide minimum essential coverage (MEC), cover essential health benefits (EHBs), meet actuarial value (AV) standards, appear as metal tiers (Bronze, Silver, Gold, or Platinum), and meet provider network standards. Like all other non-grandfathered plans, QHPs cannot consider the consumer's health status for the purposes of plan eligibility or plan cost.

**Qualified Income Trust (QIT)** (see [Miller Trust](#))

**Qualified Provider (QP)** (also referred to as **Presumptive Eligibility (PE) Qualified Entity**) is an entity that is determined by the Indiana Family and Social Services Administration (FSSA) to be capable of making determinations of presumptive eligibility (PE) and meets all the qualifications established by the state. See [Table 27](#) showing the different types of QPs under each PE program.

**Rate Review** is the process by which a state insurance department may review and approve, deny, or negotiate health insurance premiums offered by insurers on or off a marketplace. Under its authority granted by the Indiana Code and federal Effective Rate Review Status, the Indiana Department of Insurance (IDOI) reviews and approves/denies/negotiates premiums for all health insurance policies sold to Hoosiers.

**Rating Factors** (also referred to as **Premium Rating Factors**) are the information insurance companies use to decide what premium to charge any particular individual. Prior to the Affordable Care Act (ACA), the premium cost for major medical plans could vary based on health status, gender, age, weight, tobacco or alcohol use, location, or other factors. Beginning in 2014, the ACA limits the allowable rating factors to age, location, and tobacco use. These plans may no longer charge different rates based on gender or health status.

**Re-Enrollment** is the annual process by which consumers are redetermined eligible for Indiana Health Coverage Program (IHCP) or Federally-facilitated Marketplace (FFM) coverage and the steps consumers must take to re-enroll in coverage. All individuals enrolled in an IHCP or the FFM will receive a notice asking them to report any changes in circumstances. Any changes reported will be considered in the annual eligibility redetermination.

**Redetermination** (also referred to as **Eligibility Redetermination**) is the process by which an enrolled consumer is re-enrolled, terminated, or transferred into an Indiana Health Coverage Program (IHCP) or the Federally-facilitated Marketplace (FFM). Eligibility redeterminations are to ensure that consumers are still eligible and in the right programs. The process is done every 12 months or when the enrollee reports any changes to household income, household size, or residence.

**Reporting Requirement** refers to information that must be reported to the Indiana Department of Insurance (IDOI) by a certified Indiana Navigator or registered Application Organization (AO). This includes, but is not limited to, a change in legal name or address, an administrative or criminal action against the Indiana Navigator or AO, any changed or new conflict of interest, any security breach of a consumer's personal information, or an addition or removal of an Indiana Navigator or AO location from the Application Organization. Indiana Navigator reporting requirements are listed online at [www.in.gov/idoi/2931.htm](http://www.in.gov/idoi/2931.htm) and AO reporting requirements are posted online at [www.in.gov/idoi/2935.htm](http://www.in.gov/idoi/2935.htm).

**Reward** refers to either a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive (and avoiding a penalty) such as the absence of a premium surcharge or other financial or nonfinancial disincentive.

**Right Choices Program** is a program designed to provide intense member education, care coordination, and utilization management to eligible Hoosier Healthwise, Hoosier Care Connect, HIP 2.0, and traditional Medicaid members identified as overusing or abusing services.

**Score Report** (see [Navigator Examination Score Report](#))

**Seasonal Worker** is a worker who performs labor or services on a seasonal basis as defined by the U.S. Secretary of Labor, and retail workers employed exclusively during holiday seasons.

**Security Breach**, for purposes of the Indiana Department of Insurance (IDOI) privacy and security agreements for Indiana Navigators and Application Organizations (AOs), is an unauthorized acquisition or disclosure of personal information that compromises the security, confidentiality, or integrity of such personal information. Indiana Navigators and AOs must abide by the IDOI privacy and security agreements addressing security breaches.

**SHOP Enrollment Period** is the timeframe in which qualified employers may apply and enroll in the Small Business Health Options Program (SHOP) Marketplace. The SHOP enrollment period is a "rolling enrollment period" meaning that, in most circumstances, SHOP coverage may be obtained at any time of the year and is not subject to an open enrollment period. For employers that do not meet minimum participation or minimum contribution requirements, there will be a once annual open enrollment period; all other employers may enroll in the SHOP at any time.

**SHOP Marketplace** (see [Small Business Health Options Program \(SHOP\)](#))

**Silver Plan** is a type of qualified health plan (QHP) offered to consumers on a marketplace. It is designed so that an insurance carrier will pay 70% of covered healthcare expenses with the remaining 30% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the second lowest in Indiana behind the bronze

plan). Out-of-pocket expenses for 2017 are capped at \$7,150 for individual plans and \$14,300 for family plans.

**Sircon** (also known as **Vertafore**) is a vendor of the Indiana Department of Insurance (IDOI) that provides online databases and resources for IDOI to manage the licensing, compliance, complaints, administrative procedures, revenue tracking, and other regulatory procedures of individuals and entities regulated by the Indiana Department of Insurance. Indiana Navigators and Application Organizations (AOs) complete new and renewal applications through Sircon's website—[www.sircon.com](http://www.sircon.com)—and Navigator continuing education (CE) providers and precertification education (PE) providers manage their courses through online accounts set up with Sircon.

**Small Business Health Options Program (SHOP)** (also referred to as the **SHOP Marketplace**) is the Federally-facilitated Marketplace (FFM) available to small employers to purchase health coverage for their employees. Eligible employers in Indiana must have 50 or fewer full-time equivalent employees (FTEs). Employers using SHOP can use brokers or can use SHOP independently. SHOP is located online at [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses).

**Small Employer** (also referred to as **Small Group Employer**) is, in Indiana, an employer who employed an average of at least one but not more than 50 employees during the preceding year. Employers with one to 50 full-time employees are eligible for the small group insurance market in Indiana. Employers with one to 50 full-time employees plus full-time equivalent employees (FTEs) are not subject to the employer shared-responsibility provisions of the Affordable Care Act (ACA) (the "Employer Mandate") and are eligible for the SHOP Marketplace. Employers that have fewer than 25 full-time employees plus FTEs may qualify for employer healthcare tax credits on the SHOP Marketplace. An employee is defined as any individual employed by an employer but not an individual owner or partner.

**Small Group Employer** (see **Small Employer**)

**Social Security Administration (SSA)** is a federal agency through which Indiana Medicaid disability applications go through to determine if an individual is eligible for Medicaid disability. Direct applications to Indiana Medicaid may be made if the applicant is a child, has a recognized religious objection to applying for federal benefits (e.g., Amish), seeks eligibility under the M.E.D. Works medically improved category, or cites other "good cause" for not applying through the Social Security Administration.

**Social Security Disability Insurance (SSDI)** is a federal insurance program that provides benefits to qualified individuals who can no longer work. To be eligible, the individual must meet the SSA's definition of disabled. Disabled individuals with SSDI are eligible for Medicaid disability insurance in Indiana and need not undergo the state Medical Review Team (MRT) process. SSDI is also a source used to determine a consumer's disability status through the federal Marketplace application.

**Special Enrollment Period (SEP)** is a timeframe outside of the open enrollment period in which a consumer may enroll in health coverage through the Federally-facilitated Marketplace (FFM) due to certain qualifying life events, such as losing other health coverage, marriage, divorce, or a birth or adoption of a child. A list of life events that qualify for a SEP is outlined in [Table 70](#). An individual will qualify for a SEP 60 days following qualifying life events.

**Spend Down Program** was a Medicaid program that, prior to June 1, 2014, was available to individuals whose income or resources are too high to qualify for Medicaid, but they otherwise met the Medicaid eligibility criteria based on age, blindness or disability. As of June 1, 2014, the Medicaid spend down program is no longer in effect. Indiana now automatically enrolls individuals that the Social Security Administration (SSA) determines eligible for Supplemental Security Income (SSI) into Indiana Medicaid and will accept all SSA determinations of disability. This has eliminated the arduous and duplicative requirement that aged, blind and disabled applicants also complete a second application and go through a second medical review team (MRT) process to be determined eligible for Indiana Medicaid with disability coverage.

**Stand-Alone Dental Plan** refers to the dental-only health insurance plans offered through a marketplace. Individuals can get dental coverage in two ways: as part of a health plan, or by itself through a separate, stand-alone dental plan. Under the Affordable Care Act (ACA), dental coverage is considered an essential health benefit (EHB) for children under age 18, but is not considered an EHB for adults ages 18 and over. Therefore, insurers are not required to offer adult dental coverage, and adults will not be penalized for not having dental coverage.

**State Health Insurance Assistance Program (SHIP)** is a free and unbiased counseling program provided by the Indiana Department of Insurance (IDOI) for Medicare beneficiaries in Indiana. SHIP is part of a federal network of SHIPs located in every state.

**State-based Marketplace** is a health insurance marketplace developed and operated by a state to make qualified health plans (QHPs) available to qualified individuals or qualified employers in accordance with the Patient Protection and Affordable Care Act (PPACA, or ACA). Indiana does not follow this marketplace model, but rather operates as a Federally-facilitated Marketplace (FFM, or Federal Marketplace) at [healthcare.gov](http://healthcare.gov).

**Subject Matter Content Outline** (see [Navigator Subject Matter Content Outline](#))

**Subsidy** (see [Premium Tax Credit \(PTC\)](#))

**Summary of Benefits and Coverage** is a document given to consumers by a health insurer when shopping for health coverage, enrolling in coverage, at the beginning of each new plan year, or within seven business days of requesting a copy from the insurer. The Summary of Benefits and Coverage summarizes the key features of a health plan, such as covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

**Supplemental Nutrition Assistance Program (SNAP)** is a federal aid program administered by the Food and Nutrition Service of the U.S. Department of Agriculture (USDA), which provides food assistance to low and no income people and families living in the United States. Distribution of SNAP benefits occurs at the state level. In Indiana, the Family and Social Services Administration (FSSA) is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. Hoosiers can apply for SNAP online at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov), by phone at 1-800-403-0864, or by visiting a Division of Family Resources (DFR) local office listed at [www.in.gov/fssa/dfr/2999.htm](http://www.in.gov/fssa/dfr/2999.htm).

**Supplemental Security Income (SSI)** is a federal program that pays benefits to adults and children determined disabled by the U.S. Social Security Administration (SSA) and who have limited income and

resources. Individuals receiving SSI are automatically deemed eligible for Medicaid disability insurance in Indiana. SSI is also a source used to determine a consumer's disability status through the Federally-facilitated Marketplace (FFM)/[www.healthcare.gov](http://www.healthcare.gov) application.

**Temporary Assistance for Needy Families (TANF)** is a federal program that provides cash assistance and supportive services to assist families with children under age 18, helping them achieve economic self-sufficiency. Hoosiers can apply for TANF online at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov), by phone at 1-800-403-0864, or by visiting a Division of Family Resources (DFR) local office listed at [www.in.gov/fssa/dfr/2999.htm](http://www.in.gov/fssa/dfr/2999.htm).

**Traditional Medicaid** (also referred to as **Fee-for-Service (FFS)**) is a program created to provide healthcare coverage to individuals with low incomes. In traditional Medicaid, beneficiaries are not enrolled in a Managed Care Entity (MCE) or Care Management Organization (CMO) and can see any IHCP-enrolled provider. All provider claims are paid fee-for-service by the State's Fiscal Agent, Hewlett-Packard. Only certain eligibility groups are covered by traditional Medicaid.

**Training Module** (see [Navigator Training Resource Module](#))

**Transitional Health Plan** (see [Grandmothered Health Plan](#))

**Transitional Medical Assistance (TMA)** is a program that provides continued Medicaid coverage to Medicaid-enrolled parents, caretaker relatives or children under 19 who lose Medicaid eligibility due to increased earnings of the parent or caretaker relative.

**Vertafore** (see [Sircon](#))

**Web Interchange** is a secure website operated by the Indiana Health Coverage Program (IHCP) to allow IHCP-enrolled providers to check member eligibility, receive information on claims payment, update their provider profile and submit presumptive eligibility (PE) applications.

**Wellness Program** is a program of health promotion or disease prevention. Participation in such a program may result in lower premiums or other cost-sharing.



## Common Acronyms

ACA	Affordable Care Act (also known as Patient Protection and Affordable Care Act (PPACA))
AGI	Adjusted Gross Income
AO	Application Organization
APTC	Advance Premium Tax Credit (a type of Premium Tax Credit (PTC))
AV	Actuarial Value
BPHC	Behavioral and Primary Healthcare Coordination Program
CAC	Certified Application Counselor
CDHP	Consumer Driven Health Plan
CHIP	Children's Health Insurance Program
CMO	Care Management Organization
CMS	Centers for Medicare and Medicaid
CSR	Cost-sharing Reduction
DFR	Division of Family Resources
EHB	Essential Health Benefits
EOB	Explanation of Benefits
FFE	Federally-Facilitated Exchange (also known as Federally-facilitated Marketplace (FFM))
FFM	Federally-facilitated Marketplace (also known as Federally-Facilitated Exchange (FFE))
FFS	Fee for Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FSSA	Family and Social Services Administration
FTE	Full-time Equivalent Employee
HCBS	Home and Community-Based Services Waiver
HHS	Department of Health and Human Services
HHW	Hoosier Healthwise
HIP	Healthy Indiana Plan
HMO	Health Maintenance Organization
HRA	Health Reimbursement Account
HSA	Health Savings Account
IAHC	Indiana Application for Health Coverage
IDOI	Indiana Department of Insurance
IHCP	Indiana Health Coverage Program
MAGI	Modified Adjusted Gross Income
MCE	Managed Care Entity (also known as Managed Care Organization (MCO))
MCO	Managed Care Organization (also known as Managed Care Entity (MCE))
MEC	Minimum Essential Coverage
MV	Minimum Value
MLR	Medical Loss Ratio
MRT	Medical Review Team
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PE	Presumptive Eligibility

PMP	Primary Medical Provider
POWER	Personal Wellness and Responsibility Account
PPACA	Patient Protection and Affordable Care Act (also known as Affordable Care Act (ACA))
PPO	Preferred Provider Organization
PTC	Premium Tax Credit (one type is called Advanced Premium Tax Credit (APTC))
QHP	Qualified Health Plan
QIT	Qualified Income Trust (also referred to as Miller Trust)
QP	Qualified Provider
SHOP	Small Business Health Insurance Options Program
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TMA	Transitional Medical Assistance

## Revision History

I. Consumer Assistance Basics		
Date	Version	Summary of Changes
7/30/2013	1.0	<ul style="list-style-type: none"> <li>Initial Baseline</li> </ul>
6/20/2014	2.0	<ul style="list-style-type: none"> <li><a href="#">NEW</a>: Chapter Objectives section</li> <li><a href="#">NEW</a>: Key Terms section</li> <li><a href="#">NEW</a>: Introduction to federally-mandated consumer assistants</li> <li><a href="#">UPDATE</a>: Federal Navigator grant opportunity language reflects implemented grant application and selection process</li> <li><a href="#">UPDATE</a>: Source information for tables and figures, including:               <ul style="list-style-type: none"> <li><a href="#">NEW</a>: Federal Navigator requirements</li> <li><a href="#">NEW</a>: Certified Application Counselor primary duties</li> <li><a href="#">NEW</a>: Requirements to receive designation as a Certified Application Counselor</li> <li><a href="#">NEW</a>: Requirements and possible enforcement actions permitted for the Indiana Department of Insurance</li> <li><a href="#">NEW</a>: Options and Requirements for Indiana Navigators</li> <li><a href="#">NEW</a>: Steps to protect consumer personal information</li> <li><a href="#">NEW</a>: Similarities and Differences Between Health Insurance Producers, Agents, and Brokers</li> <li><a href="#">NEW</a>: Standards of Ethical Behavior</li> <li><a href="#">NEW</a>: Most Common Non-English Languages Spoken in Indiana</li> <li><a href="#">NEW</a>: Percent of Hoosiers with Disabilities</li> </ul> </li> <li><a href="#">UPDATE</a>: Clarify requirements for federal Navigators to participate in Indiana Navigator program</li> <li><a href="#">UPDATE</a>: Update the application deadline (7/10/14) and decision date (9/8/14) for federal Navigator grants</li> <li><a href="#">NEW</a>: Certified Application Counselor (CAC) section</li> <li><a href="#">MOVE</a>: State roles and responsibilities moved toward the beginning of the Consumer Assistance section</li> <li><a href="#">NEW</a>: Tool to determine if an individual or organization must be certified as an Indiana Navigator or Application Organization by the State</li> <li><a href="#">UPDATE</a>: The role of the Indiana Department of Insurance and Family and Social Services Administration</li> <li><a href="#">UPDATE</a>: State mechanisms for monitoring and oversight for Indiana Navigators and Application Organizations</li> <li><a href="#">NEW</a>: Application requirements for organizations that have multiple physical locations</li> <li><a href="#">NEW</a>: Becoming an Application Organization – Privacy and Security section</li> <li><a href="#">NEW</a>: Obtaining and Maintaining Application Organization registration - Reporting Requirements section</li> <li><a href="#">NEW</a>: Timing requirements for completing the criminal background check to become an Indiana Navigator</li> <li><a href="#">UPDATE</a>: Consolidate criminal background check options for individuals and organizations from two tables to one table</li> </ul>

		<ul style="list-style-type: none"> <li>• <a href="#">NEW</a>: Instructions to obtain a copy of the Indiana Navigator certification</li> <li>• <a href="#">NEW</a>: Instructions to obtain a copy of the Indiana Navigator certification</li> <li>• <a href="#">MOVE</a>: Relocate Conflict of Interest Disclosure Form section</li> <li>• <a href="#">UPDATE</a>: Clarify requirements for federal- vs. state-certified consumer assistants</li> <li>• <a href="#">UPDATE</a>: Clarify consumer assistant ability to receive compensation for services</li> <li>• <a href="#">UPDATE</a>: Clarify different Privacy and Security forms for Indiana Navigators and Application Organizations</li> <li>• <a href="#">NEW SECTION</a>: Helping a Consumer Apply for Coverage</li> </ul>
1/3/2017	3.0	<ul style="list-style-type: none"> <li>• <a href="#">NEW</a>: Added the following Key Terms: <ul style="list-style-type: none"> <li>○ Administrative Action</li> <li>○ Complaint</li> <li>○ Conflict of Interest</li> <li>○ Conflict of Interest Disclosure Form</li> <li>○ Conflict of Loyalty</li> <li>○ Financial Interest</li> <li>○ Indiana Administrative Code – Title 760, Article 4</li> <li>○ Indiana Navigator Designation Form for Licensed Producers and Consultants</li> <li>○ Navigator Continuing Education (CE)</li> <li>○ Navigator Examination</li> <li>○ Navigator Examination Score Report</li> <li>○ Navigator Precertification Education (PE)</li> <li>○ Navigator Service Request Form</li> <li>○ Navigator Subject Matter Content Outline</li> <li>○ Navigator Training Resource Module</li> <li>○ Performance Assessment Network (PAN)</li> <li>○ Personal Information</li> <li>○ Reporting Requirement</li> <li>○ Security Breach</li> <li>○ Sircon</li> </ul> </li> <li>• <a href="#">UPDATE</a>: Various grammatical updates and clarifications to existing Key Terms</li> <li>• <a href="#">UPDATE</a>: Various updates, additions, deletions, and clarifications to text, website links, tables, figures, and other data within this chapter to reflect more current and accurate information</li> <li>• <a href="#">NEW</a>: Added 28 footnotes clarifying information and providing additional resources</li> <li>• <a href="#">NEW</a>: Added references to 760 IAC 4 throughout chapter</li> <li>• <a href="#">NEW</a>: Added subsection “Becoming an Application Organization – List of All Locations (For Multi-Location AOs)”</li> <li>• <a href="#">NEW</a>: Added paragraph regarding certain individuals excluded from the definition of navigator</li> <li>• <a href="#">NEW</a>: Added paragraph regarding agent/broker registration requirements and resources on the Federally-facilitated Marketplace (FFM)</li> <li>• <a href="#">NEW</a>: Added CLAS Standards table</li> </ul>

**II. Medicaid Basics and Indiana Health Coverage Programs**

Date	Version	Summary of Major Changes
7/30/2013	1.0	Initial Baseline
6/20/2014	2.0	<ul style="list-style-type: none"> <li>• <a href="#">NEW</a>: Chapter Objectives section</li> <li>• <a href="#">NEW</a>: Key Terms section</li> <li>• <a href="#">UPDATE</a>: Care Select vendors and program phase-out planned for January 2015</li> <li>• Social Security Administration disability application requirements for the following groups: <ul style="list-style-type: none"> <li>○ <a href="#">NEW</a>: M.E.D. Works (MA W only)</li> <li>○ <a href="#">NEW</a>: Home and Community-Based Waivers</li> <li>○ <a href="#">NEW</a>: Blind (MA B)</li> <li>○ <a href="#">NEW</a>: Disabled (MA D)</li> </ul> </li> <li>• <a href="#">REMOVE/UPDATE</a>: Reflect changes to the spend down program</li> <li>• <a href="#">UPDATE</a>: M.E.D. Works monthly income limits</li> <li>• <a href="#">NEW</a>: Added a section on the 1915 (i) Behavioral and Primary Healthcare Coordination program (purpose, eligibility and targeting criteria, and brief application instructions)</li> <li>• <a href="#">UPDATE</a>: Updated all references to the SIL/300% of the maximum federal benefit rate for institutional and HCBS</li> <li>• <a href="#">UPDATE</a>: Updated income and resource eligibility thresholds for full aged, blind, and disabled Medicaid and the Medicare Savings Program to align with 1634 changes—left prior eligibility thresholds in as well</li> <li>• <a href="#">UPDATE</a>: Updated income eligibility limits for all MAGI categories based on 2014 FPL <ul style="list-style-type: none"> <li>-HIP</li> <li>-HHW children</li> <li>-CHIP children</li> <li>-Pregnant women</li> </ul> </li> <li>• <a href="#">UPDATE</a>: Updated Family Planning Eligibility Program income eligibility levels for 2014</li> <li>• <a href="#">REMOVE</a>: For the presumptive eligibility section, removed the description of the QP application process for pregnancy and hospital providers. Providers have their own manual for the application process.</li> <li>• <a href="#">NEW</a>: Specified the date through which Congress has authorized Transitional Medical Assistance (March 15, 2015)</li> <li>• <a href="#">UPDATE</a>: Updated spousal impoverishment standards (income and resources minimums and maximums) for 2014</li> <li>• <a href="#">NEW</a>: Addressed the Miller trust issue: added a section on the purpose of a Miller trust, how a Miller trust works, and the basic process for establishing one.</li> <li>• <a href="#">MOVE</a>: Removed Medicaid Application section for inclusion in another Consumer Assistance Manual chapter, Helping Consumers Apply for Coverage. Major changes to this section have been made in the new chapter and are as follows: <ul style="list-style-type: none"> <li>-Description of the different ways in which blind and disabled members can</li> </ul> </li> </ul>

		<p>apply for Medicaid coverage post-1634 transition (through SSA &amp; IN Medicaid)</p> <ul style="list-style-type: none"> <li>-New requirement for applicants under the blindness and disability categories to obtain an SSA determination, and exceptions to this requirement</li> <li>-Description of when MRT will make a disability decision if the SSA has a disability denial on file</li> <li>-Description of the obligation of current members to obtain a disability determination from SSA at the time of the progress report</li> <li>-Specified that the previous description of the Medicaid application process applies until June 1, 2014</li> <li>• REMOVE: Removed Eligibility Notices section.</li> <li>• <a href="#">NEW</a>: Added a brief description of how individuals with an unfavorable eligibility decision under the disability category should appeal based on the reason for denial after 6/1/14/.</li> <li>• <a href="#">NEW</a>: Added a short section on specific eligibility redetermination requirements for members eligible based on blindness or disability.</li> <li>• REMOVE: Deleted 1/1/14-3/31/14 Eligibility Redeterminations Section</li> </ul>
1/3/2017	3.0	<ul style="list-style-type: none"> <li>• <a href="#">NEW</a>: Added the following Key Terms: <ul style="list-style-type: none"> <li>○ Appeal</li> <li>○ Fast Track</li> <li>○ Gateway to Work</li> <li>○ Healthy Indiana Plan (HIP 2.0)</li> <li>○ HIP Basic</li> <li>○ HIP Employer Link</li> <li>○ HIP Plus</li> <li>○ HIP State Plan</li> <li>○ Hoosier Care Connect</li> <li>○ HPE Adult</li> <li>○ Medically Frail</li> <li>○ Pathway to Coverage</li> </ul> </li> <li>• <a href="#">UPDATE</a>: Deleted the following Key Terms: <ul style="list-style-type: none"> <li>○ Care Management Organization (CMO) (see Managed Care Entity (MCE))</li> <li>○ Care Select</li> <li>○ Healthy Indiana Plan (HIP)</li> </ul> </li> <li>• <a href="#">UPDATE</a>: Various grammatical updates and clarifications to existing Key Terms</li> <li>• <a href="#">UPDATE</a>: Various updates, additions, deletions, and clarifications to text, website links, tables, figures, and other data in this chapter to reflect more current and accurate information</li> <li>• <a href="#">NEW</a>: Added 10 footnotes clarifying information and providing additional resources</li> <li>• <a href="#">NEW</a>: Added important note that Authorized Representatives should be designated through the Indiana Application for Health Coverage</li> <li>• <a href="#">NEW</a>: Added Important Note regarding U.S. Citizen question on the Indiana Application for Health Coverage</li> </ul>

		<ul style="list-style-type: none"> <li>• <a href="#">NEW</a>: Added HIP 2.0 paragraph</li> <li>• <a href="#">NEW</a>: Deleted prior Healthy Indiana Plan section and added new HIP 2.0 section</li> <li>• <a href="#">NEW</a>: Added table showing comparisons between HIP Plus, HIP Basic, HIP Employer Link, and HIP State Plan</li> <li>• <a href="#">NEW</a>: Added table showing HIP Basic copayment amounts</li> <li>• <a href="#">NEW</a>: Added “for cause” reasons that a Hoosier Healthwise enrollee may change MCEs</li> <li>• <a href="#">NEW</a>: Deleted prior Care Select section and added new Hoosier Care Connect section</li> <li>• <a href="#">UPDATE</a>: Deleted Spend Down section</li> <li>• <a href="#">NEW</a>: Added End Stage Renal Disease Program section</li> <li>• <a href="#">NEW</a>: Added table showing comparisons between different presumptive eligibility (PE) programs</li> <li>• <a href="#">NEW</a>: Added section regarding HPE Adult</li> <li>• <a href="#">NEW</a>: Added new section regarding PE for Inmates</li> <li>• <a href="#">NEW</a>: Added section regarding HIP 2.0 covered services</li> <li>• <a href="#">UPDATE</a>: Deleted Transitional Medical Assistance section</li> <li>• <a href="#">NEW</a>: Added table for elderly/disabled income limits under Medicaid</li> <li>• <a href="#">NEW</a>: Added table for children income limits under Medicaid</li> </ul>
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### III. Health Insurance Basics and the Federally-Facilitated Marketplace

Date	Version	Description
7/30/2013	1.0	<ul style="list-style-type: none"> <li>• Baseline</li> </ul>
6/20/2014	2.0	<ul style="list-style-type: none"> <li>• <a href="#">NEW</a>: Chapter Objectives section</li> <li>• <a href="#">NEW</a>: Key Terms section</li> <li>• <a href="#">NEW</a>: Subsection describing Grandmothered, or Transitional, health plans.</li> <li>• <a href="#">NEW</a>: States can elect to establish only a SHOP while HHS operates the individual market Exchange.</li> <li>• <a href="#">UPDATE</a>: The open enrollment period for 2015.</li> <li>• <a href="#">NEW</a>: Calculating worker hours.</li> <li>• <a href="#">NEW</a>: Additional <a href="#">guidance</a> to assist employers on how to account for various employee types and circumstances.</li> <li>• <a href="#">NEW</a>: Calculating whether employers employ enough employees to be an applicable large employer for 2015.</li> <li>• <a href="#">NEW</a>: Individual and SHOP applications.</li> <li>• <a href="#">NEW</a>: Defining a combination of full-time and part-time equivalent employees.</li> <li>• <a href="#">UPDATE</a>: The percent of full-time employees or full-time equivalent used to access the shared responsibility payment.</li> <li>• <a href="#">UPDATE</a>: Transition relief from the shared responsibility payment.</li> <li>• <a href="#">UPDATE</a>: The maximum out-of-pocket limits for 2015.</li> <li>• <a href="#">UPDATE</a>: Out-of-pocket maximum for stand-alone dental plans.</li> <li>• <a href="#">NEW</a>: The framework for a Quality Rating System (QRS) is being developed.</li> <li>• <a href="#">UPDATE</a>: Requirements surrounding Student Health Plans.</li> <li>• <a href="#">NEW</a>: Beginning in January 1, 2015, there will be new provisions surrounding</li> </ul>

		<p>same-sex spouses.</p> <ul style="list-style-type: none"> <li>• <a href="#">UPDATE</a>: Requirements surrounding wellness programs.</li> <li>• <a href="#">REMOVE</a>: Maximum deductibles for the small group market in 2015 removed as of <a href="#">April 1, 2014</a>.</li> <li>• <a href="#">NEW</a>: New <a href="#">guidance</a> surrounding victims of domestic abuse who wish to claim a Premium Tax Credit.</li> <li>• <a href="#">NEW</a>: Handling incorrect calculations of Premium Tax Credit.</li> <li>• <a href="#">NEW</a>: Handling incorrect calculations of Cost-sharing Reductions.</li> <li>• <a href="#">NEW</a>: Limited circumstances in which special enrollment periods for consumers.</li> <li>• <a href="#">NEW</a>: Exceptional circumstances considered for retroactive Premium Tax Credit and/or Cost-sharing Reductions.</li> <li>• <a href="#">REMOVE</a>: Two limited circumstances (#4, 9) were removed to avoid duplication.</li> <li>• <a href="#">UPDATE</a>: QHP grievance procedures to address individual complaints.</li> <li>• <a href="#">UPDATE</a>: Minimum Essential Coverage Table.</li> <li>• <a href="#">UPDATE</a>: United States Preventive Task Force Recommended Preventive Services Table.</li> <li>• <a href="#">UPDATE</a>: Health Resources Services Administration Recommended Women's Preventive Services.</li> <li>• <a href="#">Update</a>: 2014 Federal Poverty Levels (throughout document).</li> </ul>
1/3/2017	3.0	<ul style="list-style-type: none"> <li>• <a href="#">NEW</a>: Added the following Key Terms: <ul style="list-style-type: none"> <li>○ Adverse Selection</li> <li>○ Benchmark Plan</li> <li>○ Consumer Directed Health Plan (CDHP)</li> <li>○ Explanation of Benefits (EOB)</li> <li>○ Pre-Existing Condition</li> <li>○ Rating Factor</li> <li>○ State Health Insurance Assistance Program (SHIP)</li> <li>○ Summary of Benefits and Coverage</li> </ul> </li> <li>• <a href="#">UPDATE</a>: Deleted the following Key Terms: <ul style="list-style-type: none"> <li>○ Applicable Large Employer</li> </ul> </li> <li>• <a href="#">UPDATE</a>: Various grammatical updates and clarifications to existing Key Terms</li> <li>• <a href="#">UPDATE</a>: Various updates, additions, deletions, and clarifications to text, website links, tables, figures, and other data within this chapter to reflect more current and accurate information</li> <li>• <a href="#">NEW</a>: Added five footnotes clarifying information and providing additional resources</li> <li>• <a href="#">NEW</a>: Added HIP 2.0 subsection regarding HIP 2.0 as MEC</li> <li>• <a href="#">NEW</a>: Added table showing the 10 essential health benefit (EHB) categories</li> <li>• <a href="#">NEW</a>: Added table on FFM application methods</li> </ul>
<b>IV. General Guide for Indiana Navigators: Helping Consumer Apply for Health Coverage</b>		
Date	Version	Description

<b>6/20/2014</b>	2.0	<ul style="list-style-type: none"> <li>• Baseline</li> </ul>
<b>1/3/2017</b>	3.0	<ul style="list-style-type: none"> <li>• <a href="#">NEW</a>: Added the following Key Terms:               <ul style="list-style-type: none"> <li>○ Redetermination</li> </ul> </li> <li>• <a href="#">UPDATE</a>: Various grammatical updates and clarifications to existing Key Terms</li> <li>• <a href="#">UPDATE</a>: Various updates, additions, deletions, and clarifications to text, website links, tables, figures, and other data within this chapter to reflect more current and accurate information</li> <li>• <a href="#">NEW</a>: Added four footnotes clarifying information and providing additional resources</li> <li>• <a href="#">NEW</a>: Added table outlining information that may be needed from a consumer when completing the Indiana Application for Health Coverage</li> <li>• <a href="#">NEW</a>: Added important note clarifying how Indiana Navigators must enter their names and certification numbers on Indiana Applications for Health Coverage</li> <li>• <a href="#">NEW</a>: Added note discussing an individual's eligibility for a PTC on the Marketplace if the individual is eligible for a Medicaid disability waiver</li> <li>• <a href="#">NEW</a>: Added HIP 2.0 application section</li> <li>• <a href="#">NEW</a>: Added important note regarding HEA 1269-2015 dealing with inmate health coverage enrollment assistance</li> <li>• <a href="#">NEW</a>: Added table showing life changes to report to FFM</li> </ul>