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Content contained in this manual is subject to change due to ongoing changes in federal and state laws and regulations. If course providers use this manual as a resource, they are expected to know if any discrepancies exist, and if so, take proper steps to ensure that their students receive the most accurate, up-to-date information that will enable them to properly serve as Indiana Navigators.
# Table of Contents

Table of Contents ............................................................................................................. 2  
Index of Tables .................................................................................................................. 10  
Index of Figures ............................................................................................................... 12  
I. Consumer Assistance Basics ....................................................................................... 13  
   A. Chapter Objectives ..................................................................................................... 13  
   B. Key Terms ................................................................................................................ 13  
   C. Introduction to Consumer Assistance ........................................................................ 17  
   D. Federally-mandated Consumer Assistants .............................................................. 17  
      1. Federal Navigators .................................................................................................. 18  
         a. Definition and Purpose of Federal Navigators ................................................... 18  
         b. Federal Navigator Roles and Responsibilities .................................................... 18  
         c. Becoming a Federal Navigator ............................................................................ 19  
         d. Federal Navigators serving Hoosiers – State Requirements ................................ 20  
      2. Certified Application Counselors .......................................................................... 20  
         a. Definition and Purpose of Certified Application Counselors ............................... 20  
         b. Certified Application Counselors - Roles and Responsibilities ............................ 21  
         c. Becoming a Certified Application Counselor ..................................................... 21  
         d. Certified Application Counselors Serving Hoosiers – State Requirements ............. 22  
      3. Non-Navigator Assistance Personnel .................................................................... 22  
         a. Definition and Purpose of Non-Navigator Assistance Personnel ......................... 22  
         b. Non-Navigator Assistance Personnel Roles and Responsibilities ......................... 23  
         c. Becoming Non-Navigator Assistance Personnel ................................................. 23  
         d. Non-Navigator Assistance Personnel serving Hoosiers – State requirements .......... 24  
   E. State of Indiana – Roles and Responsibilities with Consumer Assistance ............. 24  
      1. State Role in the Certification/Registration and Re-certification/Re-registration processes ...... 25  
         a. State monitoring and oversight ............................................................................ 25  
         b. State enforcement actions .................................................................................... 25  
      2. Indiana Navigators and Application Organizations Requirements for Completing Certification and Registration ........................................................................................................... 26  
         a. Requirements Proscribed by State Legislation ...................................................... 27  
         b. Consequences for Not Meeting Requirements ..................................................... 28  
   F. State-certified Consumer Assistance ...................................................................... 28  
      1. Who needs to be certified as an Indiana Navigator or Application Organization? ............. 28  
      2. Application Organizations ..................................................................................... 30  
         a. Application Organization Roles and Responsibilities ............................................ 30  
         b. Becoming an Application Organization .................................................................. 32
Indiana Navigator Training Resource Manual

Table of Contents

i. Becoming an Application Organization - Registration ........................................ 32
ii. Becoming an Application Organization – Conflict of Interest ................................ 33
iii. Becoming an Application Organization – Privacy and Security .......................... 34

c. Obtaining and Maintaining Application Organization registration - Reporting Requirements. 34
d. Maintaining Application Organization Registration: Renewal ................................ 36

3. Indiana Navigators ........................................................................................................... 37
   a. Indiana Navigator roles and responsibilities .......................................................... 37
   b. Becoming an Indiana Navigator - Application ....................................................... 38
   c. Becoming an Indiana Navigator - Precertification training and Certification Exam .......... 40
   d. Maintaining Indiana Navigator Certification ......................................................... 41
   e. Indiana Navigator Certification Renewal ................................................................. 42
   f. Options and requirements for Indiana Navigator Applicants ................................... 42
   g. State limitations for Indiana Navigators ................................................................. 44
      i. Conflict of Interest Policy ................................................................................... 44
         aa. Financial Conflict of Interest ........................................................................ 44
         bb. Conflict of Loyalty ......................................................................................... 45
         cc. Changes in Potential or Actual Conflicts of Interest .................................... 46
         dd. Conflict of Interest Disclosure Form ............................................................... 46
      ii. Additional requirements for federally-designated entities .................................. 46
      iii. Receiving compensation ................................................................................... 46
      iv. Privacy & Security Agreement and Confidentiality Standards ............................ 47
      v. Advice on Plan Selection .................................................................................... 48

4. Health Insurance Producers, Agents, and Brokers ......................................................... 49

   Source: Healthcare.com (2014), Difference between Health Insurance Agents and Brokers,  
   www.healthcare.com/health-insurance/basics/health-insurance-topics/difference-between-health-insurance-agents-and-brokers/ ......................................................... 50

G. Ethics for Indiana Navigators and Application Organizations ........................................ 50
   1. Ethical Standard: Commitment to clients .............................................................. 51
   2. Ethical Standard: Self-determination .................................................................. 51
   3. Ethical Standard: Informed consent ...................................................................... 52
   4. Ethical Standard: Competence ............................................................................ 52
   5. Ethical Standard: Cultural competence ................................................................... 53
   6. Ethical Standard: Conflicts of interest ................................................................. 53
   7. Ethical Standard: Privacy and confidentiality ........................................................ 53
   8. Ethical Standard: Access to records ..................................................................... 54
   9. Ethical Standard: Professional conduct ............................................................... 54

H. Vulnerable and Underserved populations ...................................................................... 55
   1. Serving different cultures and languages (CLAS Standards) ................................. 55
   2. Serving persons with disabilities .......................................................................... 57
II. Medicaid Basics and Indiana Health Coverage Programs (IHCPs) ........................................... 59
   A. Chapter Objectives ........................................................................................................ 59
   B. Key Terms .................................................................................................................. 59
   C. Introduction ................................................................................................................ 65
   D. Overview of Indiana Health Coverage Programs ....................................................... 65
      1. Hoosier Healthwise .................................................................................................. 65
      2. Healthy Indiana Plan ............................................................................................... 66
         a. Hoosier Healthwise & HIP - Managed Care Entities ..................................... 68
      3. Care Select ............................................................................................................. 70
      4. Traditional Medicaid (Fee-for-Service) ............................................................... 72
      5. M.E.D. Works ....................................................................................................... 73
      6. 590 Program .......................................................................................................... 75
      7. Home & Community Based Services Waivers (HCBS) ..................................... 75
         a. Behavioral and Primary Healthcare Coordination Program ....................... 77
      8. Medicare Savings Program .................................................................................. 78
      9. Family Planning Eligibility Program .................................................................... 79
     10. Spend Down .......................................................................................................... 81
     11. Breast and Cervical Cancer Program .................................................................... 82
     12. Right Choices Program ....................................................................................... 83
   E. Presumptive Eligibility (PE) ...................................................................................... 83
      1. Presumptive Eligibility: Covered Services, Eligibility Overview, and Qualified Providers .... 84
         a. PE for Pregnant Women .................................................................................. 84
         b. Qualified Providers ......................................................................................... 85
      2. Hospital Presumptive Eligibility ........................................................................... 86
         a. Overview .......................................................................................................... 86
         b. Qualified Hospitals .......................................................................................... 87
   F. Indiana Medicaid Benefit Packages .......................................................................... 87
   G. Overview of Services Available under Medicaid & the Children’s Health Insurance Program (CHIP) ................................................................. 89
      1. Overview of Healthy Indiana Plan (HIP) Benefits ................................................. 90
   H. General Medicaid Factors of Eligibility ................................................................. 90
      1. Residency ............................................................................................................. 90
      2. Citizenship/Immigration Status ........................................................................... 92
      3. Requirement to Provide a Social Security Number ........................................... 93
      4. Requirement to file for other benefits ............................................................... 94
   I. Assignment of Medical Rights ................................................................................ 94
   J. Access to Other Insurance ..................................................................................... 95
   K. Eligibility Determination & Enrollment Standard Changes under the ACA ............ 95
Indiana Navigator Training Resource Manual

Table of Contents

1. Medicaid Modified Adjusted Gross Income (MAGI) Methodologies ................................................................. 95
   a. MAGI Conversion .................................................................................................................................................. 100
   b. Non-MAGI Populations ...................................................................................................................................... 101
L. Eligibility Groups ..................................................................................................................................................... 103
M. The Eligibility Hierarchy ......................................................................................................................................... 108
  1. Infants & Children .................................................................................................................................................. 108
     a. CHIP Specific Eligibility Provisions .................................................................................................................. 109
  2. Parents and Other Caretaker Relatives .................................................................................................................... 109
  3. Transitional Medical Assistance ............................................................................................................................ 110
  4. Pregnant Women ...................................................................................................................................................... 111
  5. Former Foster Children ............................................................................................................................................ 111
  6. Long Term Care/Nursing Facility ............................................................................................................................ 111
     a. Miller Trusts and Eligibility for Medicaid Coverage of Long-Term Care and Home and Community-Based Services .............................................................................................................................. 113
N. Income Standards ..................................................................................................................................................... 114
O. Authorized Representatives ......................................................................................................................................... 115
P. Verifying Factors of Eligibility .................................................................................................................................. 116
Q. Eligibility Appeals ..................................................................................................................................................... 121
R. What an Individual Can Expect After Being Determined Eligible for Indiana Medicaid .......................................... 123
  1. Effective Date of Eligibility ........................................................................................................................................ 123
  2. Notices & Insurance Card .......................................................................................................................................... 123
  3. CHIP Premiums ......................................................................................................................................................... 124
  4. HIP Personal Responsibility and Wellness (POWER) Account Contributions .......................................................... 124
  5. M.E.D. Works Premiums .......................................................................................................................................... 125
S. Eligibility Redeterminations ....................................................................................................................................... 126
  1. Eligibility Redeterminations for Members Eligible Based on Blindness or Disability ........................................... 127
  2. Reporting Changes ................................................................................................................................................... 127
  3. Pregnancy & Newborn Coverage .............................................................................................................................. 127
T. Using Coverage ........................................................................................................................................................ 128
U. Prior Authorization ..................................................................................................................................................... 128
V. Cost-Sharing ............................................................................................................................................................ 129
   Table 38: Transportation Copayments ............................................................................................................................ 129
   1. Post-Eligibility Appeals ............................................................................................................................................. 130
     a. Hoosier Healthwise, HIP & Care Select Grievances & Appeals ........................................................................ 131
     b. Appeals to the State ............................................................................................................................................... 131
W. Contacting the State for Assistance & Information .................................................................................................. 132
III. Health Insurance Basics and the Federal Marketplace ............................................................................................ 135
   A. Chapter Objectives ................................................................................................................................................. 135

Version 2.0 (as of June 18, 2014)
B. Key Terms .................................................................................................................. 135
C. Basics of the Affordable Care Act ............................................................................ 146
   1. Individual Impacts .................................................................................................... 147
      a. Requirement to Have Health Insurance .............................................................. 147
      b. Guaranteed Issue and Guaranteed Renewability .............................................. 147
      c. Comprehensive Coverage .................................................................................. 147
      d. New Avenues to Purchase Health Insurance ...................................................... 148
      e. Help Paying for Health Insurance and Cost Sharing ...................................... 148
      f. Enrollment Periods ............................................................................................... 149
   2. Employer Impacts ..................................................................................................... 149
      a. Full-time Equivalent Employees ..................................................................... 149
   3. Small Employers ...................................................................................................... 152
      a. SHOP Marketplace ............................................................................................ 152
      b. Small Employer Tax Credits ............................................................................. 153
      c. Employer Shared-Responsibility Payments ....................................................... 154
      d. Minimum Value of Plans ..................................................................................... 156
      e. Employer Interaction with the Individual Marketplace .................................... 156
   4. Insurer Impacts .......................................................................................................... 157
      a. Rating Requirements .......................................................................................... 157
      b. Market Reforms .................................................................................................. 157
      c. Certification Requirements ................................................................................ 157
      d. Medical Loss Ratio ............................................................................................. 157
D. Health Insurance Basics and Characteristics of Coverage under the Affordable Care Act 158
   1. Basics of Health Insurance Markets ....................................................................... 158
   2. Basics of Health Insurance Coverage ..................................................................... 159
      a. Health Plan Cost .................................................................................................. 160
   3. Types of Health Insurance Coverage ..................................................................... 164
      a. Major Medical Insurance ................................................................................... 164
      b. Metal Tiers (Actuarial Value) ............................................................................. 164
      c. Catastrophic Plans .............................................................................................. 165
      d. Grandfathered Plans .......................................................................................... 165
      e. Grandmothered Health Plans .......................................................................... 166
      f. Qualified Health Plans ....................................................................................... 167
      g. Multi-State Plans ................................................................................................ 169
   4. Other Commercial Coverage Types ........................................................................ 169
      a. Stand-Alone Plans .............................................................................................. 170
      b. Other Excepted Benefit Plans .......................................................................... 171
      c. High Risk Pool Coverage .................................................................................. 171
E. Characteristics of the Health Insurance Market under the Affordable Care Act

1. Minimum Essential Coverage (MEC)
   a. Government-Sponsored Coverage
   b. Minimum Essential Coverage (MEC) Detail: Medicare
   c. Minimum Essential Coverage (MEC) Detail: Medicaid and the Children’s Health Insurance Program (CHIP)
   d. Minimum Essential Coverage (MEC) Detail: Medicaid Family Planning Coverage
   e. Minimum Essential Coverage (MEC) Detail: Medicaid Tuberculosis Related Services
   f. Minimum Essential Coverage (MEC) Detail: Medicaid Pregnancy-Related Services
   g. Minimum Essential Coverage (MEC) Detail: Medicaid Coverage of Emergency Medical Services
   h. Coverage for Veterans and Other Federal Coverage
   i. Employer-Sponsored Coverage
   j. Coverage in the Individual Market
   k. Coverage under a Grandfathered Plan
   l. COBRA & Retiree Coverage
   m. Additional Coverage as Specified
   n. Updates to Coverage Types

2. Individual Shared Responsibility Requirement
   a. Exemptions
   b. Applying for an Exemption
   c. Exemption Appeals
   d. Exemption Wrap-Up

3. Shared-Responsibility Payment

4. Guaranteed Availability and Guaranteed Renewability
   a. Pre-Existing Conditions
   b. Dependent Age 26

5. Elimination of Lifetime and Annual Maximums

6. Rating Factors
   a. Rating for Age
   b. Rating for Tobacco
   c. Rating for Location
   d. State-Specific
      i. Family Plans
      ii. Small Group Plans

7. Medical Loss Ratio (MLR)


9. Small Business Health Insurance Options Program (SHOP)
   a. SHOP Enrollment
IV. General Guide for Indiana Navigators: Helping Consumer Apply for Health Coverage ........................................... 241

A. Chapter Objectives ............................................................................................................................................. 241

B. Key Terms ......................................................................................................................................................... 241

C. Preparing to Help Consumers Apply for Health Coverage .............................................................................. 245

1. Step One: Inform the Consumer of Any Actual or Potential Conflicts of Interest and of the Indiana Navigator’s Roles and Responsibilities ............................................................................. 245

10. Changes to Health Insurance Regulatory Conditions under the Affordable Care Act ......................... 200

a. ACA-Mandated Benefits: Preventive Services ................................................................................................. 200
   i. United State Preventive Task Force (USPTF) Guidelines ........................................................................... 201
   ii. Preventive Guidelines for Women ............................................................................................................... 206
   iii. Preventive Guidelines for Children ........................................................................................................... 207
   iv. Guidelines for Immunizations ..................................................................................................................... 209

b. Essential Health Benefits (EHBs) ..................................................................................................................... 210
c. State-Mandated Benefits ................................................................................................................................. 212
d. Actuarial Value (AV) ........................................................................................................................................ 216

11. Changes in Insurance Affordability Options under the Affordable Care Act .............................................. 217

a. Insurance Affordability Programs .................................................................................................................... 217
b. Federal Poverty Level (FPL) ............................................................................................................................. 217
c. Modified Adjusted Gross Income (MAGI) ....................................................................................................... 218

12. Eligibility for Insurance Affordability Programs ............................................................................................ 218

a. Requirement to File ........................................................................................................................................ 219
b. Requirement to Report Changes ..................................................................................................................... 219

13. Applying for Insurance Affordability Programs ............................................................................................. 220

a. Household Eligibility ....................................................................................................................................... 220
b. Payment of the Premium Tax Credits ............................................................................................................. 220
c. APTC Reconciliation ....................................................................................................................................... 224
d. Cost-Sharing Reductions (CSRs) .................................................................................................................... 225
e. Open Enrollment Periods/Re-enrollment—2015 and Beyond ........................................................................ 227
f. Special Enrollment Periods ............................................................................................................................. 228
g. Open Enrollment Period and the Outside Market ............................................................................................ 232
h. Applying for Individual or Family Marketplace Coverage ............................................................................ 232
   i. Applying for QHP Coverage Only ................................................................................................................. 233
   ii. Applying for QHP Coverage with Insurance Affordability Programs ..................................................... 235
   iii. Enrollment .................................................................................................................................................. 237
   iv. Plan Termination .......................................................................................................................................... 238
   v. Mid-Year Changes ......................................................................................................................................... 238
   vi. Churn .......................................................................................................................................................... 239
   vii. Re-enrollment ........................................................................................................................................... 239
   viii. Appeals ..................................................................................................................................................... 240

IV. General Gu
2. Steps Two and Three: Complete Preliminary Eligibility Screening and Recommend the “Best Door” for the Consumer to take ................................................................. 245

D. How to Help Consumer Apply for Indiana Health Coverage Programs (IHCPs) .................... 251
   1. Medicaid (Hoosier Healthwise or Traditional, Fee-for-Service) ..................................... 251
      a. Using the Online Medicaid Application ........................................................................ 252
      b. Checking Medicaid Application Status ......................................................................... 253
      c. Medicaid Eligibility Based on Blindness or Disability – As of June 1, 2014 ................ 254
   2. The Healthy Indiana Plan (HIP) ...................................................................................... 257
      a. HIP Application - Online ............................................................................................. 257
      b. HIP Application – By Phone ....................................................................................... 257
      c. HIP Application – Where to Submit ............................................................................. 257
   3. Home and Community-Based Services Waiver Programs .............................................. 258
   4. Presumptive Eligibility (PE) .......................................................................................... 258

E. How to Help Consumers Apply for Coverage and Insurance Affordability Programs on the federal Marketplace ........................................................................... 260
   1. Federal Marketplace Applications Basics ........................................................................ 261
      a. Beginning the Federal Marketplace Application .......................................................... 261
      b. Disability Question on the federal Marketplace Application .......................................... 262
      c. Employer Coverage Questions on the federal Marketplace Application ...................... 262
      d. Sources of information needed for the federal Marketplace application ..................... 263
   2. Interaction with the federal Marketplace .......................................................................... 264
      a. After completing an application .................................................................................... 264
      b. To challenge a decision ............................................................................................... 265
      c. Reporting changes ..................................................................................................... 265
      d. Eligibility Redeterminations ....................................................................................... 266

Glossary ............................................................................................................................... 269
Common Acronyms .............................................................................................................. 293
Revision History .................................................................................................................. 295
Index of Tables

Table 1: Possible Types of Federal Navigators ............................................................... 18
Table 2: Primary Duties for Federal Navigators ............................................................. 19
Table 3: Primary duties for Certified Application Counselors ........................................ 21
Table 4: Requirements for Designation as Certified Application Counselor .................... 22
Table 5: Indiana Code 27-19 Required and Prohibited Indiana Navigator and AO Actions .... 27
Table 6: Possible IDOI Enforcement Actions Against Indiana Navigators and Application Organizations 28
Table 7: Determining Whether One Meets Definitions of Indiana Navigator or AO ............ 29
Table 8: Requirements and Responsibilities for Applicant Organizations .......................... 31
Table 9: Steps to Obtain and Renew Indiana Navigator Certification ............................... 38
Table 10: How to Complete the Indiana Navigator Criminal Background Check .............. 39
Table 11: Requirements and Options for Indiana Navigators When Applying for Certification . 43
Table 12: Steps to Protect a Consumer's Personal Information ........................................ 48
Table 13: Similarities and Differences Between Health Insurance Producers, Agents, and Brokers .... 50
Table 14: Standards of Ethical Behavior ......................................................................... 51
Table 15: Percent of Hoosiers with Disabilities, By Type ............................................... 58
Table 16: HIP and Hoosier Healthwise MCEs ................................................................. 68
Table 17: HIP and Hoosier Healthwise Helplines ............................................................ 69
Table 18: CMO Contact Information .............................................................................. 72
Table 19: M.E.D. Works Premiums (based on 2014 FPL) ............................................... 74
Table 20: Home and Community-Based Services Waivers ............................................. 76
Table 21: Behavioral and Primary Healthcare Coordination Program Criteria ................... 78
Table 22: Medicare Savings Program ............................................................................ 79
Table 23: Breast and Cervical Cancer Screening Program Services ............................... 82
Table 24: Hoosier Healthwise Benefit Packages ............................................................ 88
Table 25: Traditional Medicaid Benefit Packages .......................................................... 88
Table 26: Medicaid-Eligible Immigration Status ............................................................. 93
Table 27: How MAGI Differs from Current Methodologies ............................................ 99
Table 28: Indiana’s MAGI Equivalent Thresholds ......................................................... 101
Table 29: 2014 Medicaid Eligibility Groups & Program Enrollment .............................. 104
Table 30: Children’s Program Eligibility by Age and FPL ............................................. 108
Table 31: Monthly Income Limits for Hoosier Healthwise (Based on 2014 FPL) ................. 114
Table 32: Monthly Income Limits for HIP Eligibility (Based on 2014 FPL) ....................... 114
Table 34: Verification Documentation .................................................................... 118
Table 35: CHIP Premium Amounts (Based on 2014 FPL) ............................................. 124
Table 36: HIP MCE Contacts .................................................................................................................. 125
Table 37: M.E.D. Works Premiums (Based on 2014 FPL) .................................................................... 125
Table 38: Transportation Copayments ................................................................................................ 129
Table 39: Pharmacy Copayments ........................................................................................................ 129
Table 40: CHIP Copayments .................................................................................................................. 130
Table 41: Example of Full-time Equivalent Employee Count ............................................................. 151
Table 42: Small Employer Tax Credits in 2014 and 2015 - Percent of employer contribution .......... 153
Table 43: Large Employer Shared Responsibility Payments ............................................................... 154
Table 44: Types of Minimum Essential Coverage ............................................................................. 173
Table 45: Types of Exemptions .............................................................................................................. 181
Table 46: Hardship Exemptions ............................................................................................................ 182
Table 47: Estimated Premium Cost to Qualify for an Affordability Exemption .................................... 184
Table 48: Affordability Exemptions ...................................................................................................... 185
Table 49: Annual Shared Responsibility Payment Amounts ............................................................... 188
Table 50: Minimum Income Levels for Percent Penalties ................................................................. 188
Table 51: Federal Age Rating Curve .................................................................................................. 192
Table 52: Rating for Family Plans ........................................................................................................ 195
Table 53: USPSTF A and B Recommended Preventive Items and Services (April 2014) .................... 201
Table 54: Health Resources and Services Administration's Recommended Preventive Services for
Women (April 2014) ............................................................................................................................ 206
Table 55: Indiana Insurance Mandates ............................................................................................... 214
Table 56: Actuarial Value ...................................................................................................................... 216
Table 57: 2014 Percent of Federal Poverty Level Guidelines Annual Income .................................... 217
Table 58: Required Contribution to Second Lowest-Cost Silver Plan Premium of APTC-Eligible Tax Filers ................................................................................................................................. 222
Table 59: APTC Maximum Reconciliation Amounts .......................................................................... 224
Table 60: Cost Sharing Reductions, Silver Plan Actuarial Value, and 2014 Out-of-Pocket Maximums ... 225
Table 61: AV and Allowable Out-of-Pocket Maximums by Metal Tier for CSR-Eligible Individuals .... 226
Table 62: Enrollment and Effective Dates for APTC and CSR ............................................................ 228
Table 63: Special Enrollment Periods .................................................................................................. 229
Table 64: Limited Circumstance Special Enrollment Periods ............................................................... 230
Table 65: Eligibility for non-pregnant adults ....................................................................................... 248
Table 66: Eligibility for Pregnant Women ............................................................................................ 249
Table 67: Eligibility for Children ......................................................................................................... 250
Table 68: Indiana Health Coverage Program Application Methods .................................................... 251
Table 69: HCBS Waiver Contacts ....................................................................................................... 258
Table 70: Resources for Indiana Health Coverage Programs ............................................................. 260
Table 71: Information Sources for the Federal Marketplace Application .......................................... 264
Index of Figures

- **Figure 1**: Most Common Non-English Languages Spoken in Indiana, Changes Between 2000 and 2010. 56
- **Figure 2**: MAGI Income Calculation ........................................................................................................... 96
- **Figure 3**: Calculating Household Size Using MAGI .................................................................................. 98
- **Figure 4**: How a Miller Trust Works ........................................................................................................... 113
- **Figure 5**: Division of Family Resources Regional Contacts ........................................................................ 133
- **Figure 6**: Example of Healthcare Cost-sharing between Consumer and Issuer ...................................... 162
- **Figure 7**: Minimum Essential Coverage and Medicare Summary ............................................................... 174
- **Figure 8**: Indiana Rating Areas .................................................................................................................. 194
- **Figure 9**: Process to File a Medicaid Eligibility or Termination, Reduction, or Suspension of Benefits Appeal ................................................................................................................................. 254
- **Figure 10**: Medicaid Applications without SSA Disability Determination ................................................. 256
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 history, conflicts of interest, privacy and security standards, reporting requirements, and ethical standards.
3. Understand what additional resources are available for becoming a consumer assistant.

B. Key Terms

1. **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).
2. **Agent** (also referred to as Broker or Producer) 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 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 certified by the federal Marketplace.
3. **Application Organization (AO)** is an organization that has employees and/or volunteers helping Hoosier 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)). 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 Healthcare.gov.
5. **Certified Application Counselor (CAC)** is a federal consumer assistant, established under the ACA and [45 C.F.R. 155.225](http://www.gpo.gov/fdsys/content/getdoc.action?symbol=45CFR155225&media=pdf), 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 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. **Conflict of Interest Policy** is the state policy document published by the Indiana Department of Insurance (IDOI) by which all Indiana Navigators and AOs must comply. The document discusses what may constitute an actual or potential conflict of interest (i.e. financial 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 application processes for Indiana Navigators and AOs, the Indiana Navigator or AO must review this 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.

7. **Consumer Assistant** is a broad term used to describe individuals or entities providing outreach, education, or enrollment assistance with a Marketplace or an Indiana Health Coverage Program. This term includes agents and brokers, Indiana Navigators, AOs, Federal Navigators, CACs, federal non-Navigator Assistance Personnel, or Champions of Coverage.

8. **Department of Health and Human Services (HHS)** is the United States federal government’s principal health agency. HHS developed and manages the federal Marketplace and manages the establishment, training, certification, monitoring, and oversight of Marketplace agents/brokers, carriers, and federal consumer assistants.

9. **Ethics** refers to the set of standards that an Indiana Navigator or Application Organizations (AO) must follow in order to better improve consumer access to accurate, unbiased information regarding the range of health coverage options. These standards include a commitment to consumers; self-determination; informed consent; competence; cultural competence and social diversity; adherence to conflicts of interest and privacy and confidentiality standards; access to records; and professional conduct.

10. **Family and Social Services Administration (FSSA)** is a healthcare and social service funding agency within the 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. FSSA has the authority, along with the Indiana Department of Insurance (IDOI), to implement and enforce the provisions of [Indiana Code 27-19](http://legi.in.gov/laws/code/index.do?year=2011&act=27&section=19), which establishes Indiana Navigator and AO standards in relation to the federal Marketplace and Indiana Health Coverage Programs (IHCPs) operating in Indiana.
11. **Federal Marketplace** (also referred to as **Federally-facilitated Marketplace** or **FFM**) is a federally-developed and federally-operated 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) 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 CACs) that provide Marketplace outreach, education, and enrollment services. This is the Marketplace model used in Indiana.

12. **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, and provided with grant-funding by the federal government to provide Marketplace outreach, education, and enrollment services. Federal Navigators serving in Indiana must complete the Indiana Navigator certification process or AO registration process with the Indiana Department of Insurance.

13. **Healthcare.gov** is a health insurance Marketplace website owned and operated by the federal 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 federal Marketplace and Partnership Marketplace states. The website also fragment those consumers who may be eligible for Medicaid, and has a separate portal for small businesses (the SHOP Marketplace).

14. **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. 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 or registered with the State of Indiana. IC 27-19 refers to these state consumer assistants as Indiana “Navigators” and “Application Organizations” (AOs), and provides certain requirements and guidelines for these consumer assistants. IC 27-19 gives the Indiana Department of Insurance (IDOI) the authority to implement and enforce the provisions established in this code.

15. **Indiana Department of Insurance (IDOI)** is an agency of the Indiana state government whose duty is to monitor and regulate the business of insurance in Indiana and give Hoosier consumers information on their options for obtaining insurance. IDOI has the authority, along with FSSA, to implement and enforce the provisions of **Indiana Code 27-19**, which establishes Indiana Navigator and AO standards in relation to the federal Marketplace and Indiana Health Coverage Programs (IHCPs) operating in Indiana.

16. **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), Care Select, Traditional Medicaid, and home and community
based waiver services (HCBS). Applications for IHCPs can be accessed through the DFR Benefits Portal at www.dfrbenefits.in.gov.

17. **Indiana Navigator** is an individual who assists Hoosier insurance consumers in completing applications for qualified health plans (QHPs) on the federal Marketplace or IHCP applications. An individual that meets the definition of “navigator” under Indiana Code 27-19-2-12 must be certified as an Indiana Navigator with the IDOI and abide by all the standards required of Indiana Navigators. An Indiana Navigator may, but is not required to be associated with an Application Organization.

18. **Marketplace** (also referred to as **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 Affordable Care Act. The term includes a Federally-designated Marketplace (FFM or federal Marketplace), a Partnership Marketplace, or a State-based Marketplace. Indiana operates as a federal Marketplace.

19. **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 or organizations are trained and able to provide help to consumers, small businesses, and their employees looking for health coverage options through the Marketplace.

20. **Partnership Marketplace** (also referred to as **Partnership Exchange**) is a mix between the 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 or consumer assistance and outreach. Indiana does not follow this Marketplace model, but rather operates as a federal Marketplace.

21. **Privacy and Security Agreement** refers to either the **Indiana Navigator Privacy and Security Agreement** or the **Indiana AO Privacy and Security Agreement** (two separate forms) published by the IDOI, by which all Indiana Navigators and AOs must comply. The agreement defines what constitutes a consumer’s “personal information” and discusses the privacy and security standards that all Indiana Navigators and AOs must follow in order to protect a consumer’s personal information. As part of the initial and renewal application processes for Indiana Navigators and AOs, the Indiana Navigator or AO must sign and submit this agreement to the IDOI.

22. **State-based Marketplace** is a 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. Indiana does not follow this Marketplace model, but rather operates as a federal Marketplace.
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 intended to serve as unbiased, knowledgeable resources that help reduce consumer confusion about new options for healthcare coverage through outreach, education, and enrollment assistance. In State-based Marketplace states, these Navigators will be selected, funded, trained, and monitored by the state. For fully Federally-facilitated Marketplaces and Federally-facilitated Partnership Marketplaces, these Navigators will instead be 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, producers, 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 the 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 Federally-facilitated Partnership 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 will play in Indiana’s federal Marketplace will be explained in greater detail below.

D. Federally-mandated Consumer Assistants

There are three primary types of federally-mandated Consumer Assistants offering detailed information and application 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 here. 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 ACA (42 U.S.C. 18031(i)) and 45 CFR 155.210, this type of consumer assistance 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 Navigators in each Marketplace (see Table 1), as well as the primary duties they must fulfill in order to be 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 Navigators, the ACA introduced state authority to establish licensing, certification, or other standards, regardless of the selected Marketplace model.

<table>
<thead>
<tr>
<th>Table 1: Possible Types of Federal Navigators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community and Consumer-focused nonprofit groups;</td>
</tr>
<tr>
<td>• Trade, industry, and professional associations;</td>
</tr>
<tr>
<td>• Commercial fishing industry organizations, ranching and farming organizations;</td>
</tr>
<tr>
<td>• Chambers of commerce; unions;</td>
</tr>
<tr>
<td>• Resource partners of the Small Business Administration;</td>
</tr>
<tr>
<td>• Licensed agents and brokers;</td>
</tr>
<tr>
<td>• Other public or private entities that meet the requirements (i.e. Indian tribes, tribal organizations, urban Indian organizations, and State/local human service agencies)</td>
</tr>
</tbody>
</table>

Sources: Patient Protection and Affordable Care Act (2010), Section 1311(i) Navigators, 42 U.S.C. 18031(i)
Table 2: Primary Duties of Federal Navigators

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

Sources: Patient Protection and Affordable Care Act (2010), Section 1311(i) Navigators, 42 U.S.C. 18031(i)

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 (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 and, for 2014-2015, the application must be submitted by July 10, 2014 to receive consideration. CMS will notify applicants of their selection by September 8, 2014. 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. The grant funding lasts for one year.

Once approved to receive the CMS federal Navigator designation and grant funding, federal Navigators must complete 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 http://marketplace.cms.gov/training/get-training.html.

While other individuals and organizations may perform the same functions as the federal Navigator, they will only be considered federal Navigators in FFM or Partnership states if they receive this funding.\(^1\) Other comparable entities (i.e. non-Navigator Assistance Personnel) may be held to identical role and

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\(^1\) The selection and funding process may differ in states with a State-based Marketplace, as they exercise full oversight of this program. However, while the selection and funding process may differ, the basic minimum duties will remain the same across all states.
responsibility requirements and may also receive compensation for the consumer assistance work they perform, but as they have not received the federal Navigator funding, they are considered inherently different 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 or registration requirements outlined in the Indiana Application Organization section and Indiana Navigator section below. 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 QHP through the Marketplace or in an insurance affordability program in the State of Indiana, 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 become CAC organizations via CMS’s website at [http://marketplace.cms.gov/help-us/cac-apply.html](http://marketplace.cms.gov/help-us/cac-apply.html). Similar to federal Navigators, in fully Federally-facilitated Marketplace (FFM) states like Indiana, designated CAC organizations and their individual CACs receive training and certification materials from the federal government. CAC organizations are monitored by the federal government and are responsible for monitoring the individual CACs they train.

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 federal Marketplace only designates organizations and not individuals.
Unlike federal Navigators, designated 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>
<thead>
<tr>
<th>Table 3: Primary duties of Certified Application Counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible.</td>
</tr>
<tr>
<td>• To assist consumers in applying for coverage in a QHP through the Marketplace and for insurance affordability programs.</td>
</tr>
<tr>
<td>• To help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs.</td>
</tr>
<tr>
<td>• Disclose to consumers any relationships the CAC or sponsoring CAC organization has with QHPs or insurance affordability programs, or other potential conflicts of interest.</td>
</tr>
<tr>
<td>• Comply with privacy and security standards and applicable authentication and data security standards.</td>
</tr>
<tr>
<td>• Act in the best interest of the consumers assisted.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• Abide by any other federal standards and agreements entered into with the Marketplace or designated CAC organization.</td>
</tr>
</tbody>
</table>


Like federal Navigators, designated CAC organizations and 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 http://marketplace.cms.gov/help-us/cac-apply.html. Other organizations and individuals may perform the same functions as 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 CACs. 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 on CMS’s website at http://marketplace.cms.gov/training/get-training.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

<table>
<thead>
<tr>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Marketplace-approved training and pass all Marketplace-approved certification examinations.</td>
</tr>
<tr>
<td>Disclose to the designated CAC organization, or to the Marketplace if directly certified by the Marketplace, 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.</td>
</tr>
<tr>
<td>Comply with privacy and security standards and applicable authentication and data security standards.</td>
</tr>
<tr>
<td>Agree to act in the best interest of the consumers assisted.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Enter into an agreement with the designated CAC organization regarding compliance with federal standards.</td>
</tr>
</tbody>
</table>


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 are also required to fulfill Indiana Navigator certification requirements. Indiana AO registration and Indiana Navigator certification requirements are outlined in the Indiana Application Organization section and Indiana Navigator section below. 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 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 guidance, 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 will serve. 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 its 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.

**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.

**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 for 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, particularly neighboring states of Illinois (Partnership state), Michigan (Partnership state), and perhaps Kentucky (State-based Marketplace state). Because these states share borders with Indiana, it is possible that these out-of-state non-Navigator Assistance Personnel may also serve Indiana residents. If that is the case, 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 can be reviewed in the Indiana Application Organization section and Indiana Navigator section below.

While Indiana does not anticipate that there will be many non-Navigator Assistance Personnel serving Hoosier consumers, those that do will be required to meet Indiana Navigator certification requirements, including an online application, precertification training, a certification examination, disclosure of any actual or potential conflicts of interest, agreement to privacy and security requirements, and other standards outlined in the Indiana Navigator section below.

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 many state-specific policy and operational changes taking place in the Medicaid and private insurance market 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 will 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 enroll in 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 an AO registration processes can be found on IDOI’s website at 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 certification and annual renewal process, 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 Indiana Navigator certification examination in consultation with the Family and Social Services Administration (FSSA). Indiana Navigator precertification education (PE) and continuing education (CE) course providers, criminal background check results, Conflict of Interest Disclosure Forms, and Privacy and Security Agreements are also assessed by the IDOI for potential disqualifying results. One primary focus of the Indiana Navigator certification and AO registration process is consumer protection, so the State will scrutinize any information or situation that may jeopardize Hoosier consumers.

a. State monitoring and oversight

The State will rely largely upon two primary mechanisms to monitor Indiana Navigators and AOs: complaints and internal tracking. Complaints from consumers or their family members, other organizations, or other State agencies will trigger an IDOI investigation of the incident. Complaint forms can be either completed 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 Navigators and Application Organizations 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. Failure to complete these requirements will result in the termination of registration or certification. Indiana Navigators and AOs are given a grace period for the thirty (30) days following their renewal date. During this time they may complete the renewal process and pay a higher renewal fee in order to renew the registration or certification. There is no additional penalty for the failure to renew, but if the individual or organization fails to renew within the grace period, that individual or organization will need to reapply as a new Indiana Navigator or AO and complete all of the initial application steps, which, for individuals, will mean they need to complete the criminal background check process and retake the required training and certification examination.

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. Those entities will be responsible for meeting federal requirements, and the failure to do so may make the entities 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. It will be the responsibility of the federal Department of Health and Human Services (HHS) to determine what those enforcement actions are, and when and how they will occur.
a. Requirements Proscribed by 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: Indiana Code 27-19 Required and Prohibited Indiana Navigator and Application Organization Actions

<table>
<thead>
<tr>
<th>Required Actions</th>
<th>Prohibited History</th>
<th>Prohibited Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete Continuing Education requirements</td>
<td>• Holds/held an insurance producer license, Indiana Navigator certification, AO</td>
<td>• Provides incorrect, misleading, incomplete, or materially untrue information in the application</td>
</tr>
<tr>
<td>• Disclose all conflicts of interest to the Commissioner – during application and</td>
<td>registration, or equivalent license, certification, or registration that has been</td>
<td>• Obtains or attempts to obtain license, certification, or registration through</td>
</tr>
<tr>
<td>for any conflicts arising after application</td>
<td>denied, suspended, or revoked</td>
<td>misrepresentation or fraud</td>
</tr>
<tr>
<td>• Comply with administrative or court order imposing child support obligation</td>
<td>• Conviction of felony or other crime determined by IDOI and FSSA</td>
<td>• Violates:</td>
</tr>
<tr>
<td>• Pay state income tax or comply with administrative or court order directing</td>
<td>• Admission or conviction of unfair trade practice or fraud in the business of</td>
<td>o Insurance law or regulation,</td>
</tr>
<tr>
<td>payment of state income tax</td>
<td>insurance</td>
<td>o Subpoena or order of Commissioner,</td>
</tr>
<tr>
<td>• Inform IDOI of change in legal name or address</td>
<td>• Intentionally misrepresents terms of actual/proposed insurance contract or</td>
<td>o Rule of federal Marketplace,</td>
</tr>
<tr>
<td>• Verify that each associated Indiana Navigator has been certified and not</td>
<td>o Rule adopted under IC 27-19-3-3(d), and/or</td>
<td>o ACA and regulations developed under ACA</td>
</tr>
<tr>
<td>committed any act that would be grounds for denial, suspension, or revocation</td>
<td>• Uses fraudulent, coercive, or dishonest practices, or demonstrates incompetence</td>
<td>• Cheats on Indiana Navigator certification exam</td>
</tr>
<tr>
<td></td>
<td>or untrustworthiness in acting as Indiana Navigator or AO</td>
<td>• Receives consideration from health insurance issuer in connection with enrollment of individual into health plan</td>
</tr>
</tbody>
</table>

b. Consequences for Not Meeting Requirements

For Indiana Navigators and AOs that fail to meet the State requirements – either failing to do the things they are supposed to or by doing things they are prohibited from doing – there is a range of possible enforcement actions IDOI may take. Those actions are detailed in the following table (see Table 6):

Table 6: Possible IDOI Enforcement Actions Against Indiana Navigators and Application Organizations

<table>
<thead>
<tr>
<th>Enforcement Action</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reprimand</td>
<td>• The IDOI may notify the Indiana Navigator and/or AO of a potential issue that requires entity application and behavior modification.</td>
</tr>
<tr>
<td></td>
<td>• If the Indiana Navigator and/or AO makes appropriate modifications, further enforcement action may not be needed.</td>
</tr>
<tr>
<td>Levy a civil penalty</td>
<td>• The IDOI may impose fees for requirement violations.</td>
</tr>
<tr>
<td></td>
<td>• The fee amounts and conditions under which they are issued may vary based on the severity of the case.</td>
</tr>
<tr>
<td>Suspend certification</td>
<td>• The IDOI may determine that a violation is severe enough to merit the temporary or permanent suspension/revocation of certification/registration.</td>
</tr>
<tr>
<td>Revoke certification for a limited time</td>
<td>• 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.</td>
</tr>
<tr>
<td>Revoke certification permanently</td>
<td>• 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.</td>
</tr>
<tr>
<td>Issue cease and desist order</td>
<td></td>
</tr>
</tbody>
</table>


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 understand 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. To help determine whether an individual or organization needs to obtain certification or registration, the individual or organization may refer to Table 7 below. For all “yes” responses to the listed activities, the information in the right columns state if such an activity requires certification.
### Table 7: Determining Whether One Meets Definitions of Indiana Navigator or AO

<table>
<thead>
<tr>
<th>Do you...</th>
<th>Organization</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have designation as a federal Navigator or Certified Application Counselor?</td>
<td>Organization meets the definition of an Application Organization and needs to register.</td>
<td>The need to be certified as an Indiana Navigator will depend on the individual’s exact activities.</td>
</tr>
<tr>
<td>Help individuals complete the <strong>federal Marketplace application</strong>?</td>
<td>Organization meets the definition of an Application Organization and needs to register.</td>
<td>Individual meets the definition of an Indiana Navigator and needs to be certified.</td>
</tr>
<tr>
<td>Help individuals complete an <strong>Indiana Health Coverage Application</strong>, such as Medicaid, Children’s Health Insurance Program, and/or Healthy Indiana Plan?</td>
<td>Organization meets the definition of an Application Organization and needs to register.</td>
<td>Individual meets the definition of an Indiana Navigator and need to be certified.</td>
</tr>
<tr>
<td>Help ONLY the following individuals complete the Indiana Medicaid application? (1) Those eligible for Medicaid nursing home care; or (2) Those eligible for Medicaid home &amp; community-based waiver services</td>
<td>This activity does not require the organization to register as an Application Organization.</td>
<td>This activity does not require an individual to register as an Indiana Navigator.</td>
</tr>
<tr>
<td>Help someone fill out a Medicaid application as the individual’s Authorized Representative?</td>
<td>This activity does not require the organization to register as an Application Organization.</td>
<td>This activity does not require an individual to be certified as an Indiana Navigator.</td>
</tr>
<tr>
<td>Complete ONLY the Presumptive Eligibility application for Medicaid?</td>
<td>This activity does not require the organization to register as an Application Organization.</td>
<td>This activity does not require an individual to register as an Indiana Navigator.</td>
</tr>
<tr>
<td>Refer potential federal Marketplace and/or Indiana Health Coverage applicants to others for help with their application?</td>
<td>This activity does not require the organization to register as an Application Organization.</td>
<td>This activity does not require an individual to register as an Indiana Navigator.</td>
</tr>
<tr>
<td>Assist a population or complete a type of application not listed above?</td>
<td>Call Navigator Director at (317) 232-2414 or email <a href="mailto:Navigator@doi.in.gov">Navigator@doi.in.gov</a> to determine whether you need to be registered as an Application Organization.</td>
<td>Call Navigator Director at (317) 232-2414 or email <a href="mailto:Navigator@doi.in.gov">Navigator@doi.in.gov</a> to determine whether you need to be certified as an Indiana Navigator.</td>
</tr>
</tbody>
</table>
2. Application Organizations (AOs)

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 applications for Marketplace-based health plans and insurance affordability programs, and state-based health coverage programs (Medicaid, Healthy Indiana Plan (HIP), and Children’s Health Insurance Plan (CHIP)). They are defined in Indiana Code 27-19, which also introduces the roles and responsibilities of AOs, including registration and reporting requirements.

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

1. Register with the State.
2. Be in good standing with the Indiana Secretary of State.
3. Renew registration with the State annually.
4. Abide by all State reporting, conflict of interest, and privacy standards.

Application Organizations (AOs) 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 and certification examination fee, and may offset other costs by performing a criminal background check and by offering training 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 for Applicant Organizations**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Option</th>
</tr>
</thead>
</table>
| Application | • Register with the State (complete [online application](#) and pay nonrefundable application fees)  
• Be in good standing with the Secretary of State  
• Complete and submit the [AO Conflict of Interest Disclosure Form](#) and [AO Privacy and Security Agreement](#)  
• Disclose any actual or potential conflict of interest (see [Conflict of Interest Policy](#))  
• No prohibited conflict of interest  
• Designate a lead Indiana Navigator  
• Report all other Indiana Navigators working on the AO’s behalf  
• Perform criminal background check on individual Indiana Navigator(s)  
• Pay application fee on behalf of Indiana Navigator(s) |
| Training (Pre-certification) | • Attest that all individual Indiana Navigators have completed training  
• Become a certified training entity with the Indiana Department of Insurance (IDOI) and provide training to individual Indiana Navigator(s) |
| Certification Examination | • Not applicable  
• Pay for certification examination on behalf of individual Indiana Navigator(s) |
| Re-certification (Renewal) | • Complete new online application annually and pay non-refundable application/renewal fee annually  
• Complete and submit the [Conflict of Interest Disclosure Form](#) and [Privacy and Security Agreement](#)  
• Disclose any actual or potential conflict of interest (see [Conflict of Interest Policy](#))  
• Update individual Indiana Navigator(s) report within 30 days of association change (as needed)  
• Abide by all other State reporting, conflict of interest, and privacy and security standards  
• Become a certified training entity with IDOI to provide continuing education (CE) to individual Indiana Navigator(s) |

b. Becoming an Application Organization

An Application Organization ("AO") is an organization that has employees and/or volunteers helping Hoosiers complete applications for health coverage on the federal Marketplace or through the Indiana Health Coverage Application (such as Medicaid, the Children's Health Insurance Program (CHIP), or the Healthy Indiana Plan (HIP)). Organizations meeting the definition of Application Organization under Indiana Code 27-19-2-3 must be registered with the State. Examples of possible AOs 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.

An organization with multiple 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 State the name, address, telephone, email and/or website, and contact person for each physical location within the Application Organization.

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 because it only provides assistance in a limited capacity; or (2) if the organization does not need to become an AO because it has a prohibited conflict of interest. An organization might fall into the first category if it only provides general information about health coverage applications; 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. 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 insurance plans would not register as AOs, either.

i. Becoming an Application Organization - Registration

If an organization meets the definition of an Application Organization (AO) under Indiana Code 27-19-2-3, it will register with the State by filing an online application through the Indiana Department of Insurance (IDOI) website, [http://www.in.gov/idoi/2825.htm](http://www.in.gov/idoi/2825.htm). This application consists of questions about the AO applicant, its owner(s), and it’s associated Indiana Navigators. A representative of the AO applicant will: (1) provide contact information for the organization; (2) designate a responsible Indiana
Navigator\textsuperscript{2} to serve as the primary contact for any issues regarding filed applications; (3) provide information for those individuals who have 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 current and ongoing compliance with various aspects of the Indiana Code 27-19. The AO applicant will submit the completed application along with a fee. As of May 1, 2013, the non-refundable fee for AOs will vary based on the physical location of the organization. For organizations in Indiana, the application fee will be $50 per year plus any online processing fees. For those outside of Indiana, the application fee will be $100 per year plus any online processing fees. This fee is subject to change based on the discretion of the Commissioner of Insurance. The most accurate and up-to-date fee information may be found on the IDOI website, www.in.gov/idoi/2825.htm.

After the online AO application and fee are submitted, it will be reviewed by the IDOI for completion and potential disqualifying responses. If there are questions about any of the responses, IDOI may contact the AO applicant with a request for additional information. Once all of these concerns are addressed, the IDOI will either approve or deny the application. If the application is approved, an 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

As a part of the application process, the individual completing the application on behalf of the AO applicant must review the Conflict of Interest Policy. This policy will be identical to that reviewed and agreed to by all individual Indiana Navigators; but the AO representative will not only attest to any of his or her personal conflicts of interest, but also the potential and actual conflicts of interest for the organization’s other owners, partners, board members, and/or directors as well as any conflicts of interest related to the mission and operations of the organization.

Described in greater detail in the individual Indiana Navigator section, there are two primary types of conflicts of interest that may exist: financial conflicts of interest and 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 AO representative must report it to the IDOI by completing the associated Conflict of Interest

\footnote{While the number of associated Indiana Navigators may grow and change over time, the AO applicant 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. As the potential Application 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 individual to ensure he or she is indeed certified before the organization completes its application.}
Disclosure Form. The Commissioner will review these conflicts of interest to ensure that none are prohibited by the existing state legislation.

iii. Becoming an Application Organization – Privacy and Security

As a part of the application process, the individual completing the application on behalf of the AO applicant 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; but the AO representative will not only agree to abide by the privacy and security standards, but also attest that the organization’s other owners, partners, board members, and/or directors agree to abide by the privacy and security standards.

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

- That the personal information the AO receives from consumers for purposes of assisting with application for and enrollment in a 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.

C. Obtaining and Maintaining Application Organization registration - Reporting Requirements

All AOs must follow reporting requirements with the State. On the initial AO online application and annual renewal application, the organization must report the following to the IDOI:

- All owners with 5% interest or voting interest, partners, officers, and directors of the Application Organization.
- The designated/responsible 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 ever been named or involved as a party in an administrative proceeding or arbitration proceeding regarding any professional or occupational license or registration.

• Whether the AO or any owner, partner, officer or director ever been notified by any jurisdiction to which you are applying of any delinquent state income tax obligation that is not the subject of a repayment agreement.

• Whether the AO or any owner, partner, officer or director a party to, or 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 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 compensation/commission directly 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 have any existing or potential conflicts of interest as defined in 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.

Once registered as an AO with the State, AOs are required to follow all other State reporting requirements established under Indiana laws and regulations. These 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 in a timely manner and must include the following information for each location:
  o Name of Location,
  o Address,
  o Telephone Number,
  o Email Address and/or Website, and
  o Contact Person for Location.
A change in legal name or address 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 the organization’s professional license, certification, or registration 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 both:
- 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; in accordance with the Privacy and Security Agreement.

Additional information on AO reporting requirements can be found on IDOI’s website at www.in.gov/idoi/2825.htm#RR4AO.

d. Maintaining Application Organization Registration: Renewal

An AO’s approved registration is good for one year, given there are no allegations of misconduct or prohibited conflicts of interest during that time. Sixty days before the one year expiration, the IDOI will send a reminder notice to the email provided by the AO in the AO application that it is time to renew the registration. At that point, the AO will complete another application, very similar to the application completed the year before. While the AO should update any essential contact information, inform the State of any associated Indiana Navigator or location changes, and inform the State of any changes in conflict of interest throughout the year, the completion of the new application is primarily a confirmation that the existing records are complete and accurate.

The AO will also update the signed conflict of interest statement and submit disclosures of conflict of interest, as appropriate. Upon paying the renewal fee, the AO’s application will be assessed by IDOI staff and the AO will receive a notice of approval or denial as appropriate.
The AO will have a 30-day grace 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 the renewal application within that time, it will lose its registration as an AO and will need to complete a new application and submit the associated fee in order to regain AO status.

If the AO fails to renew its registration within the 30-day grace period, the associated Indiana Navigators will lose their association with the AO, but may maintain their Indiana Navigator status as long as there is no reason to take enforceable action against the individual (i.e. no credible consumer complaints).

Additional information on the process for annual renewal of AOs can be found on IDOI’s website at www.in.gov/idoi/2825.htm#PARC.

3. Indiana Navigators

a. Indiana Navigator roles and responsibilities

Indiana Navigators, established under Indiana Code 27-19-2-12, are individuals certified to help 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), premium tax credits (PTCs), and cost-sharing reductions (CSRs) through the federal Marketplace. These individuals may be associated with an Application Organization (AO) (discussed above), 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 federal Navigators.
- Federally-designated Certified Application Counselors (CACs).
- Medicaid Enrollment Center staff or volunteers helping with applications for health coverage.
- Staff or volunteers of other organizations helping with applications for health coverage.

All individuals meeting the definition of an Indiana Navigator will be required to complete IDOI certification, 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. Individuals designated by the federal government may be required to complete federal training and certification. In this case, the federal and state training and certification requirements are not interchangeable, and the individual will be required to complete both trainings in order to be in compliance with federal and state law. 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 table below (see Table 9) and are detailed in the following sections.

<table>
<thead>
<tr>
<th>Table 9: Steps to Obtain and Renew Indiana Navigator Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Complete the Indiana Navigator online application and pay the nonrefundable application fee and processing fee</td>
</tr>
<tr>
<td>2) Review the Conflict of Interest Policy, then complete and submit the Indiana Navigator Conflict of Interest Disclosure Form and Privacy and Security Agreement to IDOI</td>
</tr>
<tr>
<td>3) Complete precertification education with an IDOI-approved training provider</td>
</tr>
<tr>
<td>4) Pass certification exam</td>
</tr>
<tr>
<td>5) Complete continuing education (CE) requirements</td>
</tr>
<tr>
<td>6) Complete annual renewal online application and pay the nonrefundable renewal fee and processing fee</td>
</tr>
</tbody>
</table>

Source: Indiana Department of Insurance (2014), Indiana Navigator Certification, [www.in.gov/idoi/2824.htm](http://www.in.gov/idoi/2824.htm)

In addition to performing these steps to obtain and renew Indiana Navigator certification, there are duties the Indiana Navigator must 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

b. Becoming an Indiana Navigator - Application

If an individual meets the definition of an Indiana Navigator under Indiana Code 27-19-2-12, he or she will initiate the certification process with the State by filing an application through the IDOI website at: [www.in.gov/idoi/2824.htm](http://www.in.gov/idoi/2824.htm). This application consists of questions about the Indiana Navigator applicant, his or her association with AOs, and background questions regarding items such as criminal background and conflicts of interest. The application will also have the Indiana Navigator applicant attest to the current and ongoing compliance with Indiana law.

In addition to the application, the Indiana Navigator applicant will need to pass a criminal background check. If the individual is associated with an AO that agrees to complete the criminal background check on his or her behalf, the individual will not need to have an additional criminal background check. If the individual is not associated with an AO or if that AO does not perform a criminal background check, the
Indiana Navigator applicant will need to have a criminal background check completed by the Indiana State Police and have the results sent to the IDOI.

Background check records should be dated within one month of the date an applicant submits the online Indiana Navigator application. For example, if an applicant submits the online application on February 1, 2014, the background check results should be dated January 1, 2014 or later.

For Indiana residents, the criminal background check will cost approximately $7-17 (amount subject to change), depending on how an organization or individual decides to complete the process. The options and processes for accepted 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.

Table 10: How to Complete the Indiana Navigator Criminal Background Check

<table>
<thead>
<tr>
<th>Method</th>
<th>Process</th>
</tr>
</thead>
</table>
| **Paper** | • Complete paper Indiana State Police (ISP) form  
a. www.in.gov/ai/appfiles/isp-lch/LCH_4-12_Approved_Form.pdf  
b. In “Reason for Search,” box write “Indiana Navigator Certification”  
c. In “where this response will be sent” box enter mailing address  
  - If AO completing check, enter AO mailing address  
  - If individual completing check, enter individual mailing address  
d. Under “Reason for Request,” select (2)  
  • Once you receive the criminal background check record from ISP; submit the record to IDOI by either: Email: Navigator@idoi.in.gov; OR Fax: 317-232-5251 (“attn: Navigator Director”); OR Mail: Indiana Department of Insurance, c/o Navigator Director, 311 W. Washington St. Ste. 300, Indianapolis, IN 46204 |
| **Electronic** | • Perform criminal background check online  
a. www.in.gov/ai/appfiles/isp-lch  
b. Enter individual information  
c. For "Reason for Request," select Option #2, "Has applied for a license...," and enter Indiana Code cite: "under IC 27-19-4"  
  • Save/Print criminal background check record and submit record to IDOI by either: Email: Navigator@idoi.in.gov; OR Fax: 371-232-5251 ("attn: Navigator Director"); OR Mail: Indiana Department of Insurance, c/o Navigator Director, 311 W. Washington St. Ste. 300, Indianapolis, IN 46204 |
| **Other** | • Application Organizations may complete an alternative criminal background check for their employees, but that background check must be at least as rigorous as the State Police background check. |

Source: Indiana Department of Insurance (2014), Background Check, www.in.gov/idoi/2827.htm
In addition to the application, the Indiana Navigator applicant will need to sign and submit a copy of the Indiana Navigator Conflict of Interest Disclosure Form and Privacy and Security Agreement to the IDOI. If the individual has any existing or potential conflicts of interest, he or she 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 below.

Once the Indiana Navigator applicant has completed the online application, he or she will need to pay the application fee. As of May 1, 2013, the nonrefundable fee for Indiana Navigators will vary based on the applicant’s home address. Indiana residents will pay a $50 application fee and non-Indiana residents will pay a $100 application fee each year. 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, and the most accurate and up-to-date fee information may be found on the IDOI website, [www.in.gov/idoi/2824.htm](http://www.in.gov/idoi/2824.htm).

After the application and fee are submitted, the application will be reviewed by the IDOI for completion and potential disqualifying responses. If there are questions about any of the responses, the Indiana Navigator applicant may be contacted by the IDOI with a request for additional information. Once all of these concerns are addressed, the IDOI will either approve or deny the application. If the application is approved, an email notification of approval will be sent to the Indiana Navigator, and if the individual’s application was denied, a letter will be mailed to the individual containing information about the reason for denial and the individual’s appeal rights.

c. Becoming an Indiana Navigator - Precertification training and Certification Exam

All Indiana Navigator applicants will need to complete precertification training prior to taking the certification examination. In order to complete the training, individuals will need to locate a training entity that has been approved by the IDOI to provide Indiana Navigator training. A list of these training entities can be found on the IDOI website, [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm), and may include the individual’s associated AO, if such an association exists.

The cost of the precertification training may vary, based on the source of the training. The topics of the precertification training will include information on consumer assistance, different Marketplace models (for example, Federally-Facilitated Marketplace (FFM) and Federally-Facilitated Marketplace-Partnership (“Partnership”)), and Medicaid; including basic information and state-specific application. Additional information on precertification training can be found on IDOI’s website at [www.in.gov/idoi/2826.htm](http://www.in.gov/idoi/2826.htm).

Following this training, individuals will need to sign up to take a certification examination and pay the associated fee to the Performance Assessment Network (PAN), the organization selected by the IDOI to
administer the certification examination. Individuals may sign up for the examination at the following website: [https://secure.vitapowered.com/idoi/login.screen](https://secure.vitapowered.com/idoi/login.screen). PAN will have a variety of times, dates, and locations from which the individual will be able to select the most convenient for his or her schedule.
The Indiana Navigator applicant must score at least a 70% on the exam in order to be considered for certification. If he or she does not receive this passing score, the Indiana Navigator applicant may take the examination again until the sooner of: the individual receiving a passing score or a year from the initial application date elapses. Additional information on how to prepare for and properly register for and schedule a certification exam can be found on IDOI’s website at [www.in.gov/idoi/2836.htm](http://www.in.gov/idoi/2836.htm).

When the certification examination is passed successfully, the individual will be approved as a certified Indiana Navigator and will receive a notice of that approval. In addition to the notification, the new Indiana Navigator will receive a unique ID number that he or she will use when helping consumers complete an insurance affordability program application. The new Indiana Navigator will also be able to print a copy of his or her certificate as proof of State certification. A copy of the Indiana Navigator’s certificate can be obtained by emailing a request to IDOI at navigator@idoi.in.gov. Email requests must come from the email on file for the Indiana Navigator.

If the individual does not pass the 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 filing 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

For Indiana Navigators to maintain their certification, they must complete at least a minimum 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 hours[^3] of continuing education. Much like the pre-certification training, an individual may use his or her associated AO or a third party training entity as a source for CE, as long as the entity has had CE materials approved by the IDOI in advance. The training entity – regardless of whether it is the AO or another third party training group - will then download all applicable CE credits to the Indiana Navigator’s transcript, which will facilitate the individual’s certification renewal.

In addition to keeping education current, it is also important to ensure the IDOI has the most updated contact information and assurance of Indiana Navigator eligibility. For this reason, all Indiana Navigators

[^3]: The two hour continuing education requirement is subject to change. Verify the requirement at the Indiana Department of Insurance website, [www.in.gov/idoi/2824.htm#PAR](http://www.in.gov/idoi/2824.htm#PAR).
must inform the IDOI of any changes to legal name, address, criminal history, conflict of interest, and
delinquent state tax and/or child support payments within thirty (30) days of such a change. Failure to
do so could lead to enforcement action taken against the individual.

e. **Indiana Navigator Certification Renewal**

Every year, an Indiana Navigator will be required to renew his or her certification. While similar to the
application process, the renewal process will be a little shorter because the Indiana Navigator will not
need to repeat the criminal background check process. The individual will receive a reminder
notification from the IDOI approximately 60 days prior to the renewal date, and within that time, he or
she will need to complete another, slightly shorter application, noting any changes that have not already
been reported to the IDOI. The individual will also need to sign and submit a new Conflict of Interest
Disclosure Form disclosing any potential conflicts of interest, a new Privacy and Security
Agreement, and must have completed at least two hours of continuing education with a State-approved
training entity; but individuals will not need to complete another certification examination. Finally, the
individual will need to submit the non-refundable fee – currently $50 for Indiana residents and $100 for
non-Indiana residents.

Following the completion of this 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, he or she will retain
the original unique ID number and will be able to print a new certificate to prove current certification. A
copy of an Indiana Navigator’s certificate can be obtained by emailing a request to
navigator@idoi.in.gov. This correspondence must come from the same email address the Indiana
Navigator has on file with IDOI. If the individual is denied, he or she will receive a letter explaining the
reason for denial and his or her appeal rights.

While the Indiana Navigator should complete his or her renewal prior to the renewal date, an individual
will have a 30-day grace period after the renewal date to complete the renewal process and submit the
higher non-refundable renewal fee. If the renewal has not been completed and submitted by the end of
this grace period, the Indiana Navigator certification will no longer be valid, and the individual will have
to begin the certification process again as a new applicant – including the requirements to undergo a
criminal background check and pass the certification examination.

f. **Options and requirements for Indiana Navigator Applicants**

Not all aspects of the certification process need to be borne solely by the Indiana Navigator applicant. If
the individual is associated with an AO, that organization may choose to be financially or educationally
involved in the process. The options for shared financial and educational responsibility are detailed in the following table (see Table 11):

Table 11: Requirements and Options for Indiana Navigators When Applying for Certification

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>● Complete online application and pay nonrefundable application fee and processing fee</td>
</tr>
<tr>
<td></td>
<td>● Pass Criminal Background Check</td>
</tr>
<tr>
<td></td>
<td>● No prohibited conflict of interest</td>
</tr>
<tr>
<td></td>
<td>● Complete and submit Conflict of Interest Disclosure Form, disclosing any actual or potential conflicts of interest</td>
</tr>
<tr>
<td></td>
<td>● Complete and submit Privacy and Security Agreement</td>
</tr>
<tr>
<td></td>
<td>● Report overseeing Application Organization (AO) as applicable</td>
</tr>
<tr>
<td></td>
<td>● Background check may be performed by overseeing AO or by state-designated background check entity</td>
</tr>
<tr>
<td></td>
<td>● Application fee and processing fee may be paid by overseeing AO</td>
</tr>
<tr>
<td>Training (Pre-certification)</td>
<td>● Complete training with State-approved training entity</td>
</tr>
<tr>
<td></td>
<td>● Training fees may be paid by overseeing AO</td>
</tr>
<tr>
<td></td>
<td>● Training may be provided by overseeing AO (if certified)</td>
</tr>
<tr>
<td>Certification Examination</td>
<td>● Pass certification examination with state certification examination vendor</td>
</tr>
<tr>
<td></td>
<td>● Certification examination fees may be paid by overseeing AO</td>
</tr>
<tr>
<td>Renewal (Re-certification)</td>
<td>● Complete online renewal application annually and pay renewal application fee and processing fee</td>
</tr>
<tr>
<td></td>
<td>● Complete and submit Conflict of Interest Disclosure Form, disclosing any actual or potential conflicts of interest</td>
</tr>
<tr>
<td></td>
<td>● Complete and submit Privacy and Security Agreement</td>
</tr>
<tr>
<td></td>
<td>● Complete Continuing Education (CE) (min. 2 hr. per year)</td>
</tr>
<tr>
<td></td>
<td>● Update overseeing AO(s) as applicable</td>
</tr>
<tr>
<td></td>
<td>● Renewal application fee and processing fee may be paid by overseeing AO</td>
</tr>
</tbody>
</table>

*Source: Indiana Department of Insurance (2014), Indiana Navigator Certification, [www.in.gov/doi/2824.htm](http://www.in.gov/doi/2824.htm)*
g. State limitations for Indiana Navigators

Indiana Navigators and AOs will 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. Those forms include a Conflict of Interest Disclosure Form and a Privacy and Security Agreement with confidentiality expectations. In addition to these forms, there are 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 State 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), 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 State on the Conflict of Interest Disclosure Form and a written disclosure to each Hoosier consumer assisted, while other financial conflicts of interest prohibit individuals and organizations from certification as Indiana Navigators and registration as Application Organizations.

A prohibited conflict of interest occurs when an individual or organization receives direct financial compensation for the enrollment of an individual into a particular health coverage 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 he/she/it 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 agents, brokers, and/or producers who receive direct compensation from health insurance issuers for the enrollment of individuals into specific plans.
While such individuals may not be able to be Indiana Navigators, the health insurance producer will still be able to serve in the same capacity that he or she had prior to the implementation of the Patient Protection and Affordable Care Act (ACA). Should a licensed health insurance producer wish to serve as an Indiana Navigator, he or she must relinquish those commissions received from health insurance issuers 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 would include some indirect financial incentives for Indiana Navigators or Application Organizations. One possible example of this indirect financial conflict of interest would be someone who is a partial owner in an insurance agency. This individual benefits 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, he or she 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 his or her interest to the IDOI and to all consumers the Indiana Navigator assists (prior to providing assistance). If the individual assures the Commissioner that he or she will not allow the financial conflict of interest to bias his or her assistance to consumers, the Commissioner may decide to approve the application; however, if there are consumer complaints about the Indiana Navigator steering consumers to the insurance agency with which he or she is part owner, the Commissioner has the authority to take enforcement action against that individual.

**bb. Conflict of Loyalty**

In order to address non-financial conflicts of interest, the Indiana Conflict of Interest Policy lays out the idea of a conflict of loyalty. By Indiana definition, this conflict of loyalty occurs when an individual or organization has – directly or indirectly, though 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, this conflict of loyalty may occur with Indiana Navigators or AOs that have a business relationship with an insurance carrier unrelated to plan enrollment but perhaps related to reimbursement rates. A specific example of this type of relationship would be a hospital that may have an interest in enrolling consumers in specific plans that provide the hospital with higher reimbursement rates; but the hospital does not receive direct compensation from the insurance carrier as a response to enrolling an individual in the carrier’s plan.

If a conflict of loyalty exists, the Indiana Navigator and/or 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 still be reported to the Indiana Department of Insurance. In addition
to disclosure to the IDOI, Indiana Navigators and AOs must also disclose in writing any conflicts of loyalty
to consumers prior to providing assistance. Although these conflicts of loyalty have been disclosed to
consumers, it is still the responsibility of the Indiana Navigator and/or AO to strive to act in the best
interest of each individual consumer that receives assistance.

cc. Changes in Potential or Actual Conflicts of Interest

It is also possible that conflicts of interest (financial conflicts and/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 and/or AO must report those new conflicts to the IDOI on the Conflict of Interest Disclosure Form within 30 days of the change in the conflict of interest status and must update the
written consumer disclosure to reflect these changes, as well.

dd. Conflict of Interest Disclosure Form

If an Indiana Navigator or AO has a potential or actual conflict of interest (financial interest or conflict of
loyalty) as described above, the Indiana Navigator or AO must disclose the potential or actual conflict to
the IDOI via the Conflict of Interest Disclosure Form. 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 and/or actual conflicts of interest the
Indiana Navigator or AO may have. This form is to be updated on annual certification/registration
renewal; or it may be updated more often if the conflicts of interest change over the course of the year.

ii. Additional requirements for federally-designated entities

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 that CMS has also designated as consumer assistants
(e.g., federal Navigators or CACs). Individuals and organizations that have/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/seek the state certification will not be required to meet federal conflict
of interest standards.

iii. Receiving compensation

One of the primary concerns addressed in the Indiana Conflict of Interest Policy for Indiana Navigators
and AOs is the receipt of compensation from a health insurance issuer in connection with enrolling
consumers into particular 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. Within this statement, compensation is defined as anything of value, including money or other in-kind benefits of any type (for example: paid commission, grants, credit, loans, gifts, free or discounted travel or prizes); but the statement excludes tangible goods or other advertisement with an aggregate value of less than $100 per year per issuer. This allows Indiana Navigators and AOs to 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 CACs from receiving compensation from the consumers they assist with health coverage applications. 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, and/or CACs may not receive compensation from the consumers they assist with health coverage applications.

iv. Privacy & Security Agreement and Confidentiality Standards

In working with consumers, Indiana Navigators and AOs may have access to some very 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 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 or public health insurance 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 and annual renewal application processes, which can be found on IDOI’s website at [www.in.gov/idoi/2823.htm](http://www.in.gov/idoi/2823.htm).

By agreeing to meet the privacy and security requirement, 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; and agrees to follow all state and federal laws governing the privacy and security of the consumer’s personal information. Currently, federal guidance related to the practical protection of personal information by federally-designated entities has not been released, but all 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 information privacy and security, there are
actions that an Indiana Navigator or AO can take, and there are actions that these entities can encourage consumers to take that could reduce the risk that personal information may be inappropriately accessed. Several of these actions are listed in the following table (see Table 12) and reflect the actions addressed in the Privacy and Security Agreement.

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

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

Sources: Federal Trade Commission (2014), 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 General Assembly (2009), Indiana Code 24-4.9-3

v. Advice on Plan Selection

One primary restriction placed on Indiana Navigators 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.

While Indiana Navigators cannot provide the specific level of recommendation licensed health insurance producers can, they are able to provide consumers with some valuable information that might be able 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 individual should consider is valuable. General questions regarding doctor preferences and health care use could direct consumers as they consider their plan selection and avoiding direct plan recommendations will keep the Indiana Navigator from overstepping his or her authorization to provide advice.

4. Health Insurance Producers, Agents, and Brokers

In the course of a consumer’s search for health insurance coverage, he or she may be confronted by a range of different terms referring to individuals selling health insurance: Producers, Agents, and Brokers being 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 Health Insurance Producers, Agents, and Brokers

<table>
<thead>
<tr>
<th>Is also…</th>
<th>Producer</th>
<th>Agent (Captive)</th>
<th>Agent (Independent)</th>
<th>Broker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-</td>
<td>...a Producer</td>
<td>...a Producer</td>
<td>...an Agent...a Producer</td>
</tr>
<tr>
<td>Definition</td>
<td>• General term • Refers to anyone selling insurance products</td>
<td>• Individual selling insurance products for a single carrier; obligated to only represent products from that single insurance carrier</td>
<td>• Individual selling insurance products for one or more carriers</td>
<td>• Individual providing broad knowledge and recommendations on available insurance plans for multiple insurance carriers</td>
</tr>
<tr>
<td>Purpose</td>
<td>-</td>
<td>• Focused on timely and accurate processing of forms, premiums, and paperwork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advantage</td>
<td>-</td>
<td>• Tend to have deeper knowledge of carrier plans</td>
<td>• Tend to have broader knowledge of general marketplace and offerings from multiple carriers • Tend to have higher level of insurance industry experience • Tend to have highest level of education</td>
<td></td>
</tr>
<tr>
<td>Disadvantage</td>
<td></td>
<td>• Will only provide information on plans for single insurance carrier</td>
<td>• May charge administrative fee or higher premiums</td>
<td></td>
</tr>
</tbody>
</table>


### G. Ethics for Indiana Navigators and Application Organizations

The intention of state and federal consumer assistants is to improve consumer access to accurate, unbiased information regarding a range of health coverage options. Although personal bias is an ever-present 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 the next person.
In addition to considering individual needs, it is important that consumer assistants – federal and state – adhere to certain standards as they work with clients. Those standards 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 each standard is explained briefly below in the following table (see Table 14):

Table 14: Standards of Ethical Behavior

<table>
<thead>
<tr>
<th>DO:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Be honest regarding any personal bias or conflict of interest</td>
<td>• Give complete and accurate information</td>
</tr>
<tr>
<td>• Admit when one does not know an answer</td>
<td>• Protect the personal information of the people being assisted</td>
</tr>
<tr>
<td>• Be sensitive to different cultures</td>
<td>• Use professional language</td>
</tr>
<tr>
<td>DO NOT:</td>
<td></td>
</tr>
<tr>
<td>• Make up or guess an answer to a question</td>
<td>• Ask anyone for more information than absolutely necessary</td>
</tr>
<tr>
<td>• Joke about sensitive physical, social, or cultural differences</td>
<td>• Use derogatory or profane language toward or about a consumer</td>
</tr>
<tr>
<td>• Be afraid to refer a consumer to someone else if they have needs outside of the Indiana Navigator scope of training</td>
<td></td>
</tr>
</tbody>
</table>


1. Ethical Standard: Commitment to clients

**Application of standard:** The primary responsibility of all consumer assistants is to promote the needs identified by the consumer. This means listening to the consumer, using best judgment to determine the type of help 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 the consumer needs exceed an Indiana Navigator’s ability to help; and in this case, commitment to the client means a referral to another resource.

2. Ethical Standard: Self-determination

**Application of standard:** Another primary role for the Indiana Navigator is to promote the consumer’s ability to make better, more informed choices about what is best for him or her. This is done by presenting complete and correct information on all of the health coverage options that might be available to the individual consumer and answering basic questions about that coverage. Armed with
more information, the goal is to empower the consumer to make educated choices that reflect his or her needs, priorities, and goals.

3. Ethical Standard: Informed consent

Application of standard: 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 their ability to help, and the extent to which they are entrusting a possible stranger with very sensitive personal information. For this reason, it is vital that Indiana Navigators ensure the consumer is informed of what to expect of the process prior to addressing questions of need. 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 real or potential conflicts of interest. This should help the consumer decide if the Indiana Navigator is someone with whom he or she feels comfortable working, and should help prevent the consumer from getting upset and issuing 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 him or her into an inappropriate plan.

4. Ethical Standard: Competence

Application of standard: Within the first several years of ACA implementation, there may be many changes to federal and state policies and processes. For this reason, it is vital that all Indiana Navigators strive to remain up-to-date on all 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 – the opposite of the desired impact. 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 comprehend the similarities and differences between them. This knowledge could be helpful to the consumer; but understanding the plan characteristics alone does not give the Indiana Navigator license to advise on plan selection.
5. **Ethical Standard: Cultural competence**

**Application of standard:** Indiana Navigators may assist a diverse range of individuals. Regardless of the type of consumer, an Indiana Navigator has made a commitment to help that consumer to understand his or her health coverage options, and should do so in a culturally sensitive way. Questions, languages, and priorities may vary based on a consumer’s culture; and it is the role of the Indiana Navigator to work within the context that individual’s culture to address his or her needs. Some elements that may impact culture are: 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**

**Application of standard:** 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 the training, but in general, a conflict of interest is any condition – potential or actual – that could interfere with an Indiana Navigator’s ability to provide impartial information. As the primary role of the Indiana Navigator is to serve the interests of the consumer, the Indiana Navigator should work to limit the impact of these conflicts on the consumer. As some conflicts of interest may not be completely eliminated, however, it is necessary that the Indiana Navigator disclose in writing those interests first to the IDOI on the [Conflict of Interest Disclosure Form](#) and then to each consumer prior to providing assistance. Some conflicts of interest may seem somewhat obvious, but it is still necessary to report them – particularly for the benefit of consumers unaccustomed to the complex worlds of healthcare and insurance.

7. **Ethical Standard: Privacy and confidentiality**

**Application of standard:** Indiana Navigators must abide by the terms of the Privacy and Security Agreement and respect a consumer’s right to privacy. This means that the Indiana Navigator should not ask the consumer any questions that are not vital to addressing the individual’s needs; and the Indiana Navigator should keep all shared information confidential. Any information is only to be shared at the request of the individual consumer (or his or her authorized representative). This is the case for applications for health insurance coverage and insurance affordability programs as well as for information shared with the family of the consumer - Indiana Navigators should only share information the consumer allows or requests.

It is also important to be aware of where a client shares his or her 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 the application at a public library, discuss strategies for communicating in a way that will allow the greatest privacy and limit public exposure of
8. Ethical Standard: Access to records

Application of standard: Some Indiana Navigators may have access to client 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 listed above, Indiana Navigators must also maintain the privacy and security of consumer records, only sharing information from the records with the consumer or his or her authorized representative, unless the consumer requests otherwise. Other family members 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

Application of standard: As an Indiana Navigator serving the general public, it is important to act in a professional way. This means that Indiana Navigators are to avoid entering into sexual 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 consensual, it is the Indiana Navigator that holds the risk if such a relationship is reported; so 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 partners in a relationship to want to help each other, Indiana Navigators with a past or present relationship history 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.

It is also important to remember that not all contact must be sexual in nature to be considered inappropriate. Non-sexual physical contact is another ethical concern, as it can be seen as a way to exploit or harm consumers, as well. As with sexual relationships, all Indiana Navigators are advised to set clear, appropriate, and culturally-sensitive boundaries with clients at the outset.

In addition to physical relationships, it is also necessary to act in a professional manner with regards to language. Telling jokes and using derogatory or foul language are to be avoided at all costs. 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 to someone else. Consumers
are coming to Indiana Navigators for help, and unprofessional, off-color comments or use of 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 established standards for federal Navigators to target vulnerable and underserved populations in their outreach and education 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 health care or health coverage assistance and ensure they receive the information and resources they need to make informed decisions about their health coverage options. Groups that have received particular federal attention for their lack of health coverage access and the sensitivity surrounding their education and enrollment in health coverage programs are those with non-mainstream cultural and language needs and those with physical and mental disabilities. These populations have been singled out for particular federal requirements, with Culturally and Linguistically Appropriate Services (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 (CLAS Standards)

One particular area of focus for federally-mandated consumer assistants (federal Navigators, non-Navigator Assistance Personnel, and Certified Application Counselors) is that of cultural and linguistic access and sensitivity. While these elements were addressed on a basic level within the ACA legislation, they were addressed in greater detail in the notice of proposed rulemaking (NPRM) released by the Centers for Medicare and Medicaid (CMS) in April 2013 and in the final rule released July 2013.

The July 2013 final rule stated that federal Navigators must develop and maintain general knowledge about racial, ethnic, and cultural groups in the given service area. They must also be able to provide the following:
• Provide information & assistance in consumer’s preferred language (only using consumer family to translate if consumer prefers this over other methods)
• Provide oral and written notice of availability of language assistance services
• Recruit, support, & promote staff that represents demographic characteristics of service area

As the federal Department of Health and Human Services (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). 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 the figure below, 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 Spoken in Indiana, Changes Between 2000 and 2010**

<table>
<thead>
<tr>
<th>Language</th>
<th>2000</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>185,555</td>
<td>262,198</td>
</tr>
<tr>
<td>German</td>
<td>44,135</td>
<td>65,439</td>
</tr>
<tr>
<td>Chinese</td>
<td>8,090</td>
<td>16,473</td>
</tr>
<tr>
<td>Pennsylvania Dutch</td>
<td>7,869</td>
<td>16,120</td>
</tr>
<tr>
<td>Dutch</td>
<td>14,063</td>
<td>17,925</td>
</tr>
<tr>
<td>French</td>
<td>6,513</td>
<td>14,063</td>
</tr>
<tr>
<td>Arabic</td>
<td>5,340</td>
<td>8,512</td>
</tr>
<tr>
<td>Tagalog</td>
<td>4,015</td>
<td>5,412</td>
</tr>
<tr>
<td>Korean</td>
<td>5,030</td>
<td>6,247</td>
</tr>
</tbody>
</table>

*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 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.

2. Serving persons with disabilities

The ACA provides requirements that any federal Navigator would be required to have some basic level of competency in working with persons with disabilities. While the group “people with disabilities” is referred to as though it is one population, 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, the final rule released in July 2013 confirmed that all federal Navigators will be required to:

- Ensure consumer education materials, websites, etc. are accessible to those with disabilities.
- Provide auxiliary aids & services for individuals with disabilities at no cost (only using consumer family if consumer prefers this over other methods).
- Provide assistance in a location & in a manner physically accessible to individuals with disabilities.
- Ensure authorized representatives are able to assist individual with disability make informed decision.
- 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 table below shows the different categories of disability and the percentage of Hoosiers that report experiencing that disability.
### Table 15: Percent of Hoosiers with Disabilities, By Type

<table>
<thead>
<tr>
<th>Type of disability</th>
<th>Prevalence in Indiana in 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing disability</td>
<td>2.2%</td>
</tr>
<tr>
<td>Visual disability</td>
<td>3.7%</td>
</tr>
<tr>
<td>Cognitive disability</td>
<td>5.2%</td>
</tr>
<tr>
<td>Ambulatory disability</td>
<td>7.4%</td>
</tr>
<tr>
<td>Self-care disability</td>
<td>2.5%</td>
</tr>
<tr>
<td>Independent living disability</td>
<td>5.7%</td>
</tr>
<tr>
<td><strong>Total Disability Prevalence</strong></td>
<td><strong>13.1%</strong></td>
</tr>
</tbody>
</table>

II. Medicaid Basics and Indiana Health Coverage Programs (IHCPs)

A. Chapter Objectives

1. Understand the Medicaid eligibility factors and be able to assess whether a consumer might be eligible for Medicaid
2. Understand what information a consumer needs to provide as part of the Medicaid application
3. Understand a consumer’s options for applying for Indiana Health Coverage Programs (IHCPs) through the State of Indiana
4. Understand what a consumer should expect after the Medicaid application 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 health care services under these two programs. In Indiana, the Healthy Indiana Plan (HIP) 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. In addition, 1634 Status states may, but are not required to, operate a Medicaid spend-down program. Indiana became a 1634 Status state in 2013.
3. **Authorized Representative (AR)** is an individual or organization designated by a Medicaid or insurance affordability program applicant or beneficiary to act responsibly on his or her 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.
4. **Auto Assignment** is the process by which an individual who does not select a Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP) Managed Care Entity (MCE) at the time of the HHW or HIP 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 Indiana Department 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.ifcem.com/CitizenPortal/application.do](http://www.ifcem.com/CitizenPortal/application.do).

7. **Care Management Organization (CMO)** is an organization contracted with Indiana Health Coverage Programs (IHCPs) to perform the care management, prior authorization, and utilization management of physical, behavioral, and transportation services for members in Care Select. The CMO manages care for Care Select members through its network of Primary Medical Providers (PMPs), specialists, and other providers. Currently, MDwise and Advantage Health Solutions serve as Indiana’s Care Management Organizations.

8. **Care Select** is an optional health care program for Indiana Medicaid enrollees who have special health needs or would benefit from specialized attention. Care Select includes comprehensive care coordination for members. Individuals eligible for Care Select include those who are eligible for Medicaid on the basis of being aged, blind, disabled, a ward of the court or foster child, or a child receiving adoptive services or adoption assistance and have a specific medical condition.

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

10. **Division of Family Resources (DFR)** is a division of the Indiana Family and Social Services Administration (FSSA), which establishes eligibility for Medicaid, 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).

11. **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 29 for the 2014 list of Medicaid eligibility groups.

12. **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.

13. **Eligibility Redetermination** refers to the annual requirement for Medicaid recipients to have their Medicaid eligibility re-determined. If sufficient information is available in a beneficiary’s electronic account to renew eligibility, an eligibility notice is sent and the individual is required to contact the
Medicaid Agency if any information is inaccurate. If insufficient data is available to renew eligibility, a pre-populated renewal form is sent to the beneficiary detailing the required information.

14. **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.

15. **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. For 2014, the FPL for a single person is $973 per month, and $1,988 per month for a family of four.

16. **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.

17. **Healthy Indiana Plan (HIP)** is Indiana’s health coverage program for Hoosier adults between the ages of 19-64 whose incomes are at or below 100% FPL and who are not covered by Medicare or other Minimum Essential Coverage (MEC). HIP is authorized through an 1115 Waiver with the federal Centers for Medicare & Medicaid Services (CMS). Covered individuals and the State make monthly contributions to a POWER Account.

18. **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 to prevent 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 20.

19. **Hoosier Healthwise (HHW)** is Indiana Medicaid’s program for low income families, pregnant women and children under the age of 19.

20. **Indiana Application for Health Coverage (IAHC)** is an application for an Indiana Health Coverage Program (IHCP) which may be submitted to DFR either online through the 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 68.

21. **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), Care Select, Traditional Medicaid, and home and community based waiver services (HCBS).
22. **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 the Hoosier Healthwise and HIP through MCEs for some populations.

23. **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 health care providers for serving eligible individuals.

24. **Medicaid Review Team (MRT)** 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 DFR of its decision.

25. **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 22.

26. **M.E.D. Works** is Indiana’s health care program for working people with disabilities. M.E.D. Works members pay premiums based on their income and receive full Medicaid benefits.

27. **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 benefit rate (also known as the Special Income Limit—$2,163 monthly in 2014) to become eligible for Medicaid coverage of institutional or home and community-based services.

28. **Modified Adjusted Gross Income (MAGI)** is a methodology implemented for eligibility effective January 1, 2014 for insurance affordability programs. MAGI equals adjusted gross income 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 and in the Medicaid program to children, pregnant women, parent and caretaker relatives and adults.

29. **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.

30. **Non-Modified Adjusted Gross Income (Non-MAGI) Population** is a population that is exempt from MAGI methodologies for the Medicaid eligibility determination process. Current Medicaid eligibility methodologies are maintained for Non-MAGI populations in 2014 and beyond. 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.

31. **Office of Medicaid Policy and Planning (OMPP)** is a department within FSSA that administers Medicaid programs and performs medical review of Medicaid disability claims.

32. **POWER Account** (also referred to as **Personal Wellness and Responsibility Account**) is an account used to pay medical costs for HIP recipients. It is valued at $1,100 per adult. Contributions to the account are made by the State of Indiana and each participant. No participant will pay more than 2% of his/her family income on the plan.

33. **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.

34. **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.

35. **Presumptive Eligibility (PE)** is a determination by a Qualified Provider 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 two PE programs, PE for Pregnant Women and Hospital PE. PE for pregnant women (also referred to as “Managed Care”) provides temporary coverage of prenatal care services (Package P only). Hospital PE is PE determined by qualified hospitals for pregnant women (Package P only), children under 19, low-income parents and caretakers, the Family Planning Eligibility Program, or former foster children up to age 26.

36. **Primary Medical Provider (PMP)** is a healthcare provider selected or assigned to a beneficiary of a MCE (i.e., HHW or HIP). 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.
37. **Prior Authorization (PA)** is a process under which the medical necessity of a requested service is reviewed.

38. **Qualified Provider (QP)** (also referred to as **Presumptive Eligibility (PE) Qualified Entity**) is an entity that is determined by the Indiana State Medicaid Agency to be capable of making determinations of PE and meets all the qualifications established by the state.

39. **Right Choices Program** is a program designed to provide intense member education, care coordination, and utilization management to eligible Hoosier Healthwise, Care Select, HIP, and Traditional Medicaid members identified as overusing or abusing services.

40. **Social Security Administration (SSA)** is a federal agency through which Indiana Medicaid disability applications go through, effective June 1, 2014, 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 to SSA.

41. **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 Medicaid Review Team (MRT) process. SSDI is also a source used to determine a consumer’s disability status through the federal Marketplace application.

42. **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.

43. **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 FSSA is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. Additional information on the program can be found on FSSA’s website at [www.in.gov/fssa/dfr/2691.htm](http://www.in.gov/fssa/dfr/2691.htm).

44. **Supplemental Security Income (SSI)** is a federal program that pays benefits to adults and children determined disabled by the 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 federal Marketplace application.

45. **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 DFR local office listed at [www.in.gov/fssa/dfr/2999.htm](http://www.in.gov/fssa/dfr/2999.htm).

46. **Traditional Medicaid** (also referred to as **Fee-for-Service**) 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.

47. **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.

48. **Web Interchange** is a secure website operated by the IHCP to allow IHCP-enrolled providers to check member eligibility, receive information on claims payment, update their provider profile and submit 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 is available to low-income children, pregnant women, families and the aged, blind and disabled. 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 FPLs.

The Children’s Health Insurance Program (CHIP) is a health coverage program for children and was 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. States can implement CHIP through a Medicaid expansion, separate CHIP or combination of the two approaches. In Indiana, CHIP is operated through a combination of the two approaches. Medicaid and CHIP are both administered by states with joint funding from the federal government and the states.

### D. Overview of Indiana Health Coverage Programs

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.

1. **Hoosier Healthwise**

Hoosier Healthwise is Indiana Medicaid’s program for low income families (parents and caretakers), pregnant women and children under 19 years old. Enrollees excluded from mandatory enrollment in Hoosier Healthwise include:
- Individuals in nursing homes and other long-term care institutions
- Undocumented individuals who are eligible only for emergency services (Package E – see Table 24)
- 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 CHIP. Individuals eligible for and enrolled in Hoosier Healthwise 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 section.

Further information on Hoosier Healthwise can be found on FSSA’s website at http://provider.indianamedicaid.com/provider-specific-information/managed-care/hoosier-healthwise.aspx

2. Healthy Indiana Plan

The Healthy Indiana Plan (HIP) is for Hoosier adults 19-64 years of age. It is authorized through an 1115(c) waiver with CMS. 1115(c) waivers provide a vehicle for the Centers for Medicaid and Medicare Services (CMS) to waive regulations and are intended to allow states to test new or existing ways to deliver and pay for health care services. In September 2013, the State received authorization from CMS to continue the HIP program for one year (through December 31, 2014). To align with the Affordable Care Act (ACA)’s availability of subsidized federal Marketplace coverage for those with income between 100% and 400% of the FPL, CMS’s Special Terms and Conditions, available at www.in.gov/fssa/hip/files/IN_2014_HIP_Extension_STCs_Final.pdf, stipulated that the HIP income eligibility threshold be lowered to 100% of the FPL effective January 1, 2014. HIP enrollees over 100% of the FPL received notification from the State on their options and were directed to the federal Marketplace. Due to problems with the roll out of the federal Marketplace, HIP eligibility was extended those over 100% FPL (including the 5% disregard) through April 2014 to allow for transition to the federal Marketplace.

Individuals can be kept apprised of the status of HIP through the IHCPs bulletins, banners and newsletters available at http://provider.indianamedicaid.com/news-bulletins-and-banners.aspx. Individuals may also consult the HIP Web site at http://www.in.gov/fssa/hip/.
The goals of the HIP are to:

- Reduce the number of uninsured low-income Hoosiers
- Reduce barriers and improve statewide access to health care 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 health care services
- Assure State fiscal responsibility and efficient management of the program

HIP provides:

- A Personal Wellness and Responsibility (POWER) Account valued at $1,100 per adult per year to pay for medical costs up to the amount of the deductible. The POWER accounts provide incentives for participants to utilize services in a cost-efficient manner. Contributions to the account are made by the state and each participant (on a sliding scale based on income). Effective January 1, 2014, no participant contributes more than 2% of his or her gross family income to the POWER account. Employers and non-profits can contribute a portion of the enrollee’s required POWER Account contributions.
- A basic commercial benefits package once annual medical costs exceed $1,100
- $500 in “first dollar” preventive benefits; these benefits are at no cost to HIP members and will not deplete the POWER account. Preventive care includes services such as annual physical exams, health screenings, smoking cessation, and mammograms.

Individuals who fail to make their monthly POWER Account contribution after a 60-day grace period are disenrolled from HIP and excluded from eligibility for 12 months. This 12-month exclusion does not apply to individuals who have not made their first POWER account contribution. Additionally, if individuals fail to complete their annual redetermination, they will be disenrolled from the program.

Individuals have no copayments except for non-emergency use of the emergency room. POWER Account funds cannot be used by the member to pay the copayment. HIP enrollees are subject to a copayment for non-emergency use of the emergency room; the amount ranges from $3 to $25 depending on caretaker status and income. Copayments are waived if the parent is found to have an emergency medical condition or if he or she is admitted to the hospital on the same day as the visit.

If all age and gender appropriate preventive services are completed within the benefit year, all (state and individual) POWER Account funds remaining in the account will roll over to offset the following year’s contribution. If preventive services are not completed, only the individual’s prorated contribution to the account rolls over (not the State portion). When a beneficiary receives a full rollover which helps
to fund the next year’s deductible, this effectively reduces the amount of the member’s monthly contribution in the next year.

Further information on the HIP program can be found on FSSA’s website at [www.in.gov/fssa/hip/](http://www.in.gov/fssa/hip/).

### a. Hoosier Healthwise & HIP - Managed Care Entities

The State contracts with Managed Care Entities (MCEs) to provide a variety of services to Hoosier Healthwise & HIP enrollees. The same MCEs are available for both programs with the goal to integrate the two programs to the greatest extent possible, creating a health plan that results in a seamless coverage experience for families. MCEs 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 health care 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 three MCEs outlined below (see Table 16):

<table>
<thead>
<tr>
<th>MCE</th>
<th>Member Services</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem</td>
<td>1-866-408-6131</td>
<td><a href="http://www.anthem.com">www.anthem.com</a></td>
</tr>
<tr>
<td>MDwise</td>
<td>1-800-356-1204</td>
<td><a href="http://www.mdwise.org">www.mdwise.org</a></td>
</tr>
<tr>
<td>Managed Health Services (MHS)</td>
<td>1-800-647-4848</td>
<td><a href="http://www.mhsindiana.com">www.mhsindiana.com</a></td>
</tr>
</tbody>
</table>
Individuals are given the opportunity to select an MCE on their application. Those that do not select an MCE within fourteen days 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 & 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 17) administered by the State’s Enrollment Broker, Maximus.

<table>
<thead>
<tr>
<th>Program</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoosier Healthwise</td>
<td>1-800-889-9949</td>
</tr>
<tr>
<td>HIP</td>
<td>1-877-GET-HIP-9</td>
</tr>
</tbody>
</table>

Once a beneficiary is enrolled in an MCE, he or she 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 all medical care; 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 when there is “just cause” ([42 CFR §438.56](#))
  - Lack of access to medically necessary services covered under the MCE’s contract with the State.
  - The MCE does not, for moral or religious objections, cover the service the enrollee seeks.
  - The enrollee needs related services performed at the same time and not all related services are available within the MCE’s network. The enrollee’s primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
  - Lack of access to providers experienced in dealing with the enrollee’s health care needs.
  - Poor quality of care. Poor quality of care includes failure to comply with established standards of medical care administration, or significant language or cultural barriers.

HIP 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
- Anytime there is “just cause” (defined above for Hoosier Healthwise)

In order to change MCEs for “just 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, he or she can contact the Enrollment Broker who reviews the request for disenrollment.

### 3. Care Select

Care Select is an optional health care program for Indiana Medicaid enrollees who have special health needs or would benefit from specialized attention. This program will be in effect until January 1, 2015, at which time the State intends to transition enrollees to a new coordinated care program for a portion of Indiana’s disabled population. Updates on development of this new program will be made available on FSSA’s website at [www.in.gov/fssa](http://www.in.gov/fssa) under the Aged, Blind and Disabled Task Force section.
Care Select includes comprehensive care coordination for members. Through the Care Select program, the State addresses the following:

- Promotion of treatment regimens for chronic illnesses to better conform to evidence-based practices
- Assistance to primary care providers to be more aware of and to incorporate knowledge of functional assessments, behavior changes, self-care strategies and methods of addressing emotional or social distress into overall patient care
- Promotion of care that is less fragmented and more holistic which supports more communication across settings and providers
- Promotion of holistic care addressing physical, behavioral, medical and social needs
- Increased involvement of consumers in the management and treatment of chronic diseases through health risk assessments, education and support
- Promotion of preventive care

Individuals eligible for Care Select include those who are eligible for Medicaid on the basis of being aged, blind, disabled, a ward of the court or foster child, or a child receiving adoptive services or adoption assistance. In addition to falling in one of these eligibility categories, an individual must have one of the following medical conditions:

- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Hypertension
- Chronic Kidney Disease without dialysis
- Serious Mental Illness
- Serious Emotional Disturbance (SED)
- Depression
- The co-morbidity of diabetes and hypertension
- The co-morbidities and/or combinations of any of these disease states
- Other serious or chronic medical condition, as approved by the Indiana Office of Medicaid Policy and Planning (OMPP)

Individuals do not specifically apply for Care Select. Medicaid enrollees in an eligible aid category with one of the qualifying conditions, as evidenced by claims history or their medical provider contacting the Enrollment Broker at 1-866-963-7383, have the option to participate. Individuals meeting the eligibility
criteria can opt out and enroll in Traditional Medicaid (described further in the Traditional Medicaid (Fee-for-Service) section).

Care Select enrollees chose or are assigned to both a Care Management Organization (CMO) and Primary Medical Provider (PMP). MDwise and Advantage Health Solutions serve as the State’s CMOs. Member services contact information for the State’s two CMOs is as follows (see Table 18):

<table>
<thead>
<tr>
<th>Care Management Organization</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantage</td>
<td>1-800-784-3981</td>
<td><a href="http://www.advantageplan.com">www.advantageplan.com</a></td>
</tr>
<tr>
<td>MDwise</td>
<td>1-800-356-1204</td>
<td><a href="http://www.mdwise.org/for-members/indiana-care-select">www.mdwise.org/for-members/indiana-care-select</a></td>
</tr>
</tbody>
</table>

Enrollees in Care Select receive services such as disease management and care management based on their assessed level.

Further information on the Care Select program can be found on FSSA’s website at http://provider.indianamedicaid.com/provider-specific-information/managed-care/care-select.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 & 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; or those whose alien status remains unverified receiving Emergency Services only
- Persons receiving home and community-based waiver or hospice services
- Dual eligibles (individuals receiving Medicaid & 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
- IV-E Adoption Assistance Children

Version 2.0 (as of June 18, 2014)
• Former foster children under the age of 26 who were enrolled in Indiana Medicaid as of their 18th 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 is Indiana’s health care 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. As of June 1, 2014, current members will be 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)
• Be working (there is no minimum work effort for the program)

M.E.D. Works members receive full Medicaid benefits. They can 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 his or her 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, 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 19: M.E.D. Works Premiums (based on 2014 FPL)

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


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 & 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 his or her 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 FSSA’s 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.

Further information on the 590 program can be found on FSSA’s website at http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/590-program.aspx.

7. Home & Community Based Services Waivers (HCBS)

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 below (see Table 20):
Table 20: Home and Community-Based Services Waivers

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
</table>
| Aged & Disabled & Traumatic Brain Injury     | • Income: up to 300% of the maximum Supplemental Security Income (SSI) federal benefit rate (1/1/14 limit: $2,163 per month)  
• Parental income & resources are disregarded for children under 18  
• Complex medical condition which requires direct assistance for any of the following:  
  o Decubitus ulcers, comatose condition or management of severe pain  
  o Medical equipment such as ventilator, suctioning, tube feeding central intravenous access  
  o Special routines or prescribed treatments such as tracheotomy, acute rehab conditions, administration of oxygen  
  o Other substantial medical conditions  
  o Diagnosis of traumatic brain injury (for TBI waiver)                                                                                                           |
| Community Integration & Habilitation Waiver & Family Supports Waiver | • Income: up to 300% of the maximum SSI federal benefit rate (1/1/14 limit: $2,163 per month)  
• Parental income & resources are disregarded for children under 18 years old  
• Diagnosis of intellectual disability that is attributable to:  
  o Mental retardation, autism, epilepsy, cerebral palsy or condition (other than mental illness) similar to mental retardation that results in impairment of functioning similar to that of a person who is mentally retarded  
  o Originates before the person is 22 years old  
  o Has continued or is expected to continue indefinitely and  
  o 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 & expressive language, learning, mobility, self-direction and capacity for independent living  
  o Must result in requiring 24-hour supervision & 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  |


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). As of June 1, 2014, current waiver recipients under the disability
category will be 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 waiver or the Traumatic Brain Injury Waiver, individuals can go the 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.

To apply for the Community Integration & Habilitation or Family Supports waiver, 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.

There are currently waiting lists for two of the HCBS waivers, the Family Supports waiver and the Traumatic Brain Injury waiver. Individuals should keep their contact information current and reports any changes while on the waiting list. Individuals on the waiting list for the waivers administered by the Department of Aging may be eligible for other services and supports and can contact the AAA for more information. Families on the waiting list for the BDDS waiver 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 FSSA’s website at http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/hcbs-waivers.aspx.

a. Behavioral and Primary Healthcare Coordination Program

Beginning June 1, 2014, the Behavioral and Primary Healthcare Coordination (BPHC) Program, authorized under Section 1915 (i) of the Social Security Act, will offer 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 table below (see Table 21):
### Table 21: Behavioral and Primary Healthcare Coordination Program Criteria

<table>
<thead>
<tr>
<th>Targeting Criteria</th>
<th>Needs-Based Criteria</th>
<th>Financial Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 19+</td>
<td>Demonstrated need related to management of behavioral and physical health</td>
<td>Income below 300% of the Federal Poverty level</td>
</tr>
<tr>
<td>MRO-eligible primary mental health diagnosis (i.e., schizophrenia, bipolar disorder, major depressive disorder, psychotic disorder)</td>
<td>Demonstrated impairment of self-management of physical and behavioral health services</td>
<td>Single: $2,918/month</td>
</tr>
<tr>
<td></td>
<td>ANSA* Level of Need 3+</td>
<td>Married: $3,933/month</td>
</tr>
<tr>
<td></td>
<td>Demonstrated health need which requires assistance in coordinating behavioral and physical healthcare</td>
<td></td>
</tr>
</tbody>
</table>

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

**Sources:** Indiana Family and Social Services Administration (2014), Behavioral and Primary Healthcare Program Overview Presentation for Providers, see [http://www.in.gov/fssa/ddrs/4862.htm](http://www.in.gov/fssa/ddrs/4862.htm)


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 FSSA’s website at [www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx](http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx). On this Web page, under “Provider,” select “Other” and “Mental Health Provider.” Then, select “Community Mental Health Center (CMHC)” under “Specialty.”

Further information on the BPHC Program can be found 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 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 table below (see **Table 22**):
Table 22: Medicare Savings Program

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Threshold (effective June 1, 2014)</th>
<th>Resource Limit</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| Qualified Medicare Beneficiary (QMB) | 150% FPL:  
Single: $1,459/month  
Married: $1,967/month  
(prior to June 1, 2014, 100% FPL) | Single: $7,160  
Couple: $10,750 | Medicare Part A & B Premiums, Co-pays, Deductibles & Coinsurance |
| Specified Low Income Medicare Beneficiary (SLMB) | 170% FPL:  
Single: $1,654/month  
Married: $2,229/month  
(prior to June 1, 2014, 120% FPL) | Single: $7,160  
Couple: $10,750 | Part B Premiums |
| Qualified Individual (QI) | 185% FPL:  
Single: $1,800/month  
Married: $2,426/month  
(prior to June 1, 2014, 135% FPL) | Single: $7,160  
Couple: $10,750 | Part B Premiums |
| Qualified Disabled Worker (QDW) | 200% FPL:  
Single: $1,946/month  
Married: $2,622/month | Single: $7,160  
Couple: $10,750 | Part A Premiums |

Sources: Indiana Family and Social Services Administration, 1634 Transition Stakeholder Presentation (2014), http://www.in.gov/fssa/files/1634_Stakeholder_Presentation_FINAL.pdf

To be eligible for QDW, an individual must have lost premium free Medicare Part A coverage due to their working status.


9. Family Planning Eligibility Program

The family planning 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 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 ($1,372/month for a single individual; $1,849 for a couple).

The following services are covered by the Family Planning 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
10. Spend Down

Prior to June 1, 2014, the spend-down program was available to individuals whose income or resources were too high to qualify for Medicaid, but otherwise met the Medicaid eligibility criteria based on age, blindness or disability. After this date, the spend-down program will be eliminated in conjunction with Indiana’s transition to 1634 status and other eligibility changes taking place. Spend down operated similarly to a deductible. Under this program an individual qualified for Medicaid coverage after the individual’s spend-down amount had been met each month. The spend down was the amount of money the individual was obligated to incur on qualified medical expenses (including health insurance premiums for individuals with other insurance coverage) on a monthly basis before Medicaid paid for services. When an individual on spend down received a medical service, the medical provider filed a claim with Medicaid for the balance. When Medicaid reviewed the claim, the amount of spend down was deducted. Every month the recipient owed up to the amount of spend down to providers. Medicaid then paid for any covered services over the spend-down amounts that were received during the month.

Some medical expenses, called non-claims, had to be submitted to FSSA to meet spend down. These medical expenses are:

- Allowable expenses paid by a state or local program
- Expenses for services received before the individual became enrolled in Medicaid
- Out-of-pocket expenses of a spouse not on Medicaid if the spouse’s income was used in determining the spend-down amount
- Out-of-pocket expenses of a parent of a child under age 18 if the parent’s income was used to determine the spend-down amount
- Copayments required for expenses covered by VA or other insurance including Medicare Rx copayments
- A spouse’s MED Works premium
- Expenses for services received from a non-Medicaid provider.

The spend-down program will no longer operate for eligibility periods after of June 1, 2014, in conjunction with other Indiana Medicaid eligibility changes and the State’s transition to 1634 status. With this change, individuals previously eligible for spend-down will transition to more comprehensive and affordable health coverage. For example, some of the members who were previously eligible for the spend-down program will be transitioned to full Medicaid coverage or qualify for subsidized coverage via the federal Marketplace. Others will be eligible for the Medicare Savings Program or other Medicare supplemental coverage. Members using the spend-down program prior to June 1, 2014 may continue to submit spend down claims and non-claim expenses incurred before June 1, 2014 using the
normal process. Additional information on how these changes will impact the application process can be found in the Helping Consumers Apply for Coverage section.

11. 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. 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 23):

<table>
<thead>
<tr>
<th>Age</th>
<th>Eligible Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-49</td>
<td>Free office visit &amp; Pap test</td>
</tr>
<tr>
<td>50-64</td>
<td>Free office visit, Pap test, mammogram</td>
</tr>
<tr>
<td>65 and older</td>
<td>Free office visit, Pap test, mammogram only if not enrolled in Medicare</td>
</tr>
</tbody>
</table>


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 http://www.in.gov/isdh/24967.htm.
12. Right Choices Program

The Right Choices Program (RCP) is designed to provide intense member education, care coordination, and utilization management to eligible Hoosier Healthwise, Care Select, Healthy Indiana Plan (HIP), 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 and/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 (i.e., Hoosier Healthwise or HIP Managed Care Entity, Care Select Care Management Organization, etc).


E. Presumptive Eligibility (PE)

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 are 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 Health Coverage Application is filed: Day on which a decision is made on that 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 Indiana Health Coverage Application is processed, the provider still receives reimbursement for the services provided during the PE period.

1. Presumptive Eligibility: Covered Services, Eligibility Overview, and Qualified Providers

a. PE for Pregnant Women

PE for Pregnant Women provides time-limited coverage to pregnant women while her Indiana Health Coverage Application 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 5 years or longer
  - Refugee
Women are only eligible for one PE period per pregnancy.


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 can be found in Chapter 5 of the IHCP Qualified Provider Presumptive Eligibility Manual located on FSSA’s website at http://provider.indianamedicaid.com/IHCP/Manuals/Qualified%20Provider%20Presumptive%20Eligibility%20Manual.pdf. 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 FSSA’s website at www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx & selecting “Show only Presumptive Eligibility Qualified Providers.”

Additional information on PE for pregnant women may be found on FSSA’s 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.

2. Hospital Presumptive Eligibility

a. Overview

Effective January 1, 2014, all states are required to permit hospitals that meet state requirements to make PE determinations. In Indiana, the eligibility groups or populations for which hospitals will be permitted to determine eligibility presumptively 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
Hospitals will not determine PE for any other eligibility groups such as the aged, blind, disabled or the Children’s Health Insurance Program.

b. Qualified Hospitals

To enroll as a Qualified Hospital eligible to make PE 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 PE determinations in accordance with state policies. Qualified Hospitals will receive training on completion of the Hospital PE (HPE) application. Contracted staff may complete the HPE applications and make the PE 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 Health Coverage Application paperwork to the FSSA
- Complete and submit the HPE QP eligibility attestations through the HPE enrollment process of Web Interchange.


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 24):
Table 24: Hoosier Healthwise Benefit Packages

<table>
<thead>
<tr>
<th>Benefit Package</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package A</td>
<td>Standard Plan - Full Medicaid Coverage for children, pregnant women, and families</td>
</tr>
<tr>
<td>Package C</td>
<td>CHIP – Preventive, primary &amp; acute care services for qualified children under 19</td>
</tr>
<tr>
<td>Package P</td>
<td>Presumptive Eligibility for Pregnant Women – Ambulatory prenatal coverage for pregnant women who are determined “presumptively eligible” while their Indiana Application for Health Coverage is being processed</td>
</tr>
</tbody>
</table>


The benefit packages associated with the Traditional Medicaid Program are also described below (refer to Table 25 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, Care Select enrollees are eligible for the Standard Plan, full Medicaid coverage.

Table 25: Traditional Medicaid Benefit Packages

<table>
<thead>
<tr>
<th>Benefit Package</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Plan</td>
<td>Full Medicaid Coverage</td>
</tr>
<tr>
<td>Medicare Savings Program</td>
<td>QMB: Medicare Part A &amp; B Premiums, Deductibles &amp; coinsurance</td>
</tr>
<tr>
<td></td>
<td>SLMB/QI: Medicare Part B Premium</td>
</tr>
<tr>
<td></td>
<td>QDWI: Medicare Part A Premium</td>
</tr>
<tr>
<td>Package E</td>
<td>Emergency Services Only: Coverage for treatment of serious medical emergencies. This package is for certain immigrants who do not qualify for full Medicaid coverage</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Family Planning Services Only</td>
</tr>
</tbody>
</table>

Source: Indiana Family and Social Services Administration (2014), Traditional Medicaid (Fee-For-Service), 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 (CHIP)

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

A detailed description of all Medicaid covered services and limitations is available at 405 IAC 5. 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

1. Overview of Healthy Indiana Plan (HIP) Benefits

Healthy Indiana Plan (HIP) provides a basic commercial benefits package. Covered services include:

• Physician services
• Prescriptions
• Diagnostic exams
• Home health services
• Outpatient & inpatient hospital
• Hospice
• Preventive services
• Family planning
• Case & disease management
• Mental health coverage

Vision, dental and maternity services are not currently covered by the Health Indiana Plan. Full information on HIP-covered benefits is available at 405 IAC 9.

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 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 sections below. 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/HHW can be found in the Program Policy Manual located on FSSA’s website at 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 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 Health Coverage Application 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 Health Coverage Application. 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). 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 & who are assisted under Title IV-B and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV-E
- 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 26):
### Table 26: Medicaid-Eligible Immigration Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
</table>
| Lawful Permanent Resident under the Immigration and Naturalization Act (INA) | • Eligible for full Medicaid if residing in U.S. prior to 8/22/96  
  • If entered U.S. on or after 8/22/96 eligible for Package E only (emergency Medicaid) for five years  
    o 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  
    o Eligible for full Medicaid after five years |
| Refugees under Section 207 of the INA & Iraqi & Afghani Special Immigrants under Section 101(a)(27) of the INA | • Eligible for full Medicaid |
| Conditional entrants under Section 203(a)(7) of the INA in effect prior to April 1, 1980 | • Eligible for full Medicaid |
| Parolees under Section 212(d)(5)                                        | • Individuals granted this status for at least one year & who entered the U.S. prior to 8/22/96 are eligible for full Medicaid  
  • If entered U.S. on or after 8/22/96 eligible for Package E only (emergency Medicaid)  
    o Unless they are honorably discharged veteran or in active military duty |
| Asylees under Section 208 of the INA                                     | • Eligible for full Medicaid |
| Persons whose deportation is withheld under Section 243(h) of the INA   | • Eligible for full Medicaid |
| Amerasians admitted pursuant to Section 584 of P.L. 100-202 and amended by P.L. 100-461 | • Eligible for full Medicaid |
| Cuban and Haitian entrants                                              | • Eligible for full Medicaid |
| Other immigrants, visitor and non-immigrants                            | • Eligible for emergency Medicaid only |

Sources: 42 CFR §435.406  

### 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 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 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 CHIP or HIP.

Individuals are required to provide information on any other insurance they have on their application. 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 DFR via a phone call to 1-800-403-0864, by mail to the FSSA Document Center, online through the FSSA Benefits Portal or at a local office. A full listing of local offices and the FSSA Benefits Portal can be found on FSSA’s website at www.in.gov/fssa/dfr/2999.htm.

K. Eligibility Determination & Enrollment Standard Changes under the ACA

The Affordable Care Act (ACA) implements changes to how Medicaid eligibility is determined beginning in 2014. Current income eligibility determination for children, pregnant women, non-disabled adults under the age of 65, and parents and caretaker relatives will be replaced by a new methodology referred to as Modified Adjusted Gross Income (MAGI). Current financial methodologies will remain in place for individuals who are exempt from MAGI and for current beneficiaries prior to their annual redetermination or any applicable change reporting in 2014. Additional changes include a new application, referred to as the Indiana Application for Health Coverage, methods under which applications will be accepted, verification policies and redetermination standards.

1. Medicaid Modified Adjusted Gross Income (MAGI) Methodologies

MAGI methodologies are implemented for eligibility effective January 1, 2014. For Medicaid beneficiaries enrolled as of December 31, 2013, current methodologies remain in place until the individual’s annual redetermination or a change is reported as described in further detail in the Eligibility Redeterminations section. In accordance with federal regulations, states were required to begin utilizing MAGI methodologies during the federal Marketplace initial open enrollment period which began October 1, 2013. The eligibility of individuals who apply for health coverage during the initial
open enrollment period was determined based on current rules. If they were found ineligible for 2013 enrollment they were evaluated for potential eligibility effective January 1, 2014 based on MAGI rules.

Individuals who are found potentially eligible for Premium Tax Credits (PTC) and Cost Sharing Reductions (CSR) will have their application and electronic account transferred to the federal Marketplace 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 verification, withdrawal of application, etc.). 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. 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 and non-taxable income is not counted under MAGI. MAGI income equals:

**Figure 2: MAGI Income Calculation**

<table>
<thead>
<tr>
<th>Adjusted Gross Income</th>
<th>Tax Excluded Foreign Earned Income</th>
<th>Tax Exempt Interest</th>
<th>Tax Exempt Title II Social Security Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 individuals with whom he or she 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 he or she 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 MAGI**

Source: 42 CFR §435.603

Under MAGI, the budget period for Medicaid remains current monthly income versus projected annual income as used for PTC. That is, Medicaid eligibility is determined based on current monthly income and family size.
Table 27: How MAGI Differs from Current Methodologies

<table>
<thead>
<tr>
<th>Topic</th>
<th>Pre-MAGI</th>
<th>2014- MAGI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td>Asset limits are applied to certain categories of children, pregnant</td>
<td>Asset tests no longer applied – no asset limit for MAGI</td>
</tr>
<tr>
<td></td>
<td>women &amp; families</td>
<td></td>
</tr>
<tr>
<td><strong>Income Counting</strong></td>
<td>Countable income generally includes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Earned income:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Wages, salaries, commissions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o In-kind earnings, e.g. goods or services in lieu of wages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unearned income:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Retirement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Disability payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Unemployment &amp; worker’s compensation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Annuities, pensions &amp; other regular payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Alimony &amp; child support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Dividends, interest &amp; royalties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Life insurance proceeds (when paid in installments)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Winnings, prizes &amp; awards</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Gifts &amp; inheritances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Benefits administered through the Social Security Administration (SSA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Taxable income is generally counted as income &amp; non-taxable income is</td>
<td></td>
</tr>
<tr>
<td></td>
<td>excluded. The following are key changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Child support received is no longer counted as income</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Veterans benefits no longer counted as income</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Worker’s compensation no longer counted as income</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Self-employment &amp; farm income after depreciation &amp; deduction of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>capital losses is counted</td>
<td></td>
</tr>
<tr>
<td><strong>Income Disregards</strong></td>
<td>The state disregards (or does not count) certain types of income.</td>
<td>Income disregards no longer applied (were considered in MAGI conversion).</td>
</tr>
<tr>
<td></td>
<td>Disregards vary somewhat by eligibility category but examples include</td>
<td>General 5% FPL disregard applied when consumer ineligible. Expenses</td>
</tr>
<tr>
<td></td>
<td>a $50 disregard of monthly child support and disregard of expenses for</td>
<td>that are tax deductible are deducted from income.</td>
</tr>
<tr>
<td></td>
<td>dependent’s care.</td>
<td></td>
</tr>
<tr>
<td><strong>Household Composition Rules</strong></td>
<td>Household composition rules vary somewhat by eligibility category but</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the following generally applies:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stepparents &amp; stepsiblings are excluded</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Children’s income counted for parents’/siblings’ household income</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&amp; family size, but if this causes ineligibility of family, a second</td>
<td></td>
</tr>
<tr>
<td></td>
<td>step is performed for individual determinations to ensure eligibility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>is not caused by children/sibling income</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adult children not included in household</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stepparents, stepchildren &amp; stepsiblings are now included in the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>household</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The income of children &amp; siblings who are required to file a tax</td>
<td></td>
</tr>
<tr>
<td></td>
<td>return is counted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adult children claimed as a tax dependent are now included in the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>household of the tax filer</td>
<td></td>
</tr>
</tbody>
</table>

Source: 42 CFR §435.603
a. MAGI Conversion

As part of the transition to MAGI (Modified Adjusted Gross Income)-based methodologies in 2014, states are required to convert current 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 as applied on the date of the Affordable Care Act enactment for each eligibility group. As a result of this process, the income standard for some eligibility groups has 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 table below (see Table 28) 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 28: Indiana’s MAGI Equivalent Thresholds

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


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 will be exempt from MAGI methodologies and current Medicaid eligibility rules will continue to apply in 2014. These exempted populations include:

- Individuals age 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 & supports for which a level-of-care (LOC) need is a condition of eligibility (e.g., Home and Community-Based Services waivers, nursing home LOC, etc.)
• 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 his/her 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 his or her household;
• Household goods such as furniture and appliances
• Personal items such as jewelry or clothes
• Burial plots, irrevocable funeral trusts & term life insurance
Eligibility determination for a non-MAGI category can be triggered through multiple methods. An individual applying through the federal Marketplace or the 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 he or she can stay enrolled in that manner. If applicable, the federal Marketplace transfers the electronic accounts of individuals potentially eligible for Medicaid on the basis of non-MAGI to the DFR for determination. An individual can be enrolled in a MAGI Medicaid category or receive a Premium Tax Credit 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 he or she 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% 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 & Children under Age 19 (42 CFR 435.118)
- Pregnant Women (42 CFR 435.116)
- Parents & 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 table below (see Table 29) outlines Indiana Medicaid’s 2014 eligibility groups, the associated program,
benefit package and the methodology under which eligibility for the category will be determined. Specific information on eligibility criteria for the different populations is described in further detail in subsequent sections.

### Table 29: 2014 Medicaid Eligibility Groups & Program Enrollment (see following pages)

<table>
<thead>
<tr>
<th>2014 Eligibility Group</th>
<th>Income Standard &amp; Other Eligibility Requirements</th>
<th>Program Enrollment</th>
<th>Benefit Package</th>
<th>MAGI Applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deemed Newborn</td>
<td>Born to mother on Medicaid</td>
<td>Hoosier Healthwise</td>
<td>A</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Age: 0-1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No FPL Standard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Automatic enrollment with no application required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children under 19 – Medicaid</td>
<td>Age 0-1: ≤208% FPL</td>
<td>HHW</td>
<td>A</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Age 1-18: ≤158% FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children under 19 – CHIP</td>
<td>Age 0-1: &gt;208% - 250% FPL</td>
<td>HHW</td>
<td>C</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Age 1-18: &gt;158% - 250% FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children under 19 with Adoption Assistance</td>
<td>Automatic eligibility adoption assistance recipients</td>
<td>Fee-for-Service (FSS) Tradition Medicaid</td>
<td>Full Benefits</td>
<td>No</td>
</tr>
<tr>
<td>Foster Children</td>
<td>Automatic coverage for foster children up to age 26 who were enrolled in Indiana Medicaid on their 18th birthday</td>
<td>FFS Traditional Medicaid</td>
<td>Full Benefits</td>
<td>No</td>
</tr>
<tr>
<td>Former Foster Children</td>
<td>Former foster children</td>
<td>FFS Traditional Medicaid</td>
<td>A</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Ages 18-21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Under 210% FPL (Single: $2,043/month)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Former Foster Children to Age 26</td>
<td>Former foster children enrolled in Indiana Medicaid as of 18th birthday</td>
<td>FFS Traditional Medicaid</td>
<td>A</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No income standard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age: 18-26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents &amp; Caretaker Relatives</td>
<td>MAGI equivalent of pre-2014 income standard</td>
<td>HHW</td>
<td>A</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>See Table 32 for income threshold by family size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>Pregnant women</td>
<td>HHW</td>
<td>A</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>≤208% FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>≤141% FPL</td>
<td>FFS Family Planning Only</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not qualify for any other Medicaid category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-21 residing in</td>
<td>MAGI equivalent of pre-2014 income standard</td>
<td>FFS Traditional</td>
<td>Full Benefits</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>See Table 32 for income threshold by family size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014 Eligibility Group</td>
<td>Income Standard &amp; Other Eligibility Requirements</td>
<td>Program Enrollment</td>
<td>Benefit Package</td>
<td>MAGI Applies</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------</td>
<td>--------------------</td>
<td>----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>inpatient psych facility eligible for TANF if living at home</td>
<td>• Age: 19-21 &lt;br&gt; • Inpatient at a Medicaid certified psychiatric facility &lt;br&gt; • A recipient approved for Medicaid prior to his 21st birthday remains eligible until age 22 so long as he remains in the psychiatric facility</td>
<td>Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children aged 19 &amp; 20</td>
<td>• MAGI equivalent of pre-2014 income standard &lt;br&gt; • See Table 32 for income threshold by family size &lt;br&gt; • Age: 19-20</td>
<td>HHW</td>
<td>A</td>
<td>Yes</td>
</tr>
<tr>
<td>Aged</td>
<td>• Age: 65 and older &lt;br&gt; &lt;br&gt; <strong>Income Limits (effective 6/1/14)</strong>&lt;br&gt; Unmarried or married &amp; not living with spouse $973*&lt;br&gt; Married $1,311* &lt;br&gt; <strong>Resource Limits (effective 6/1/14)</strong>&lt;br&gt; Unmarried, separated or community spouse $2,000 &lt;br&gt; Married &amp; living together or separated only for medical reasons $3,000</td>
<td>FFS Traditional Medicaid</td>
<td>Full Benefits</td>
<td>No</td>
</tr>
<tr>
<td>Blind</td>
<td>• 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 and has filed an application for SSA benefits a maximum of 45 days after applying for Indiana Medicaid &lt;br&gt; • <strong>Income Limits (effective 6/1/14)</strong>&lt;br&gt; Unmarried or married &amp; not living with spouse or one parent of child applicant $973*&lt;br&gt; Married or two parents of child applicant $1,311* &lt;br&gt; <strong>Resource Limits (effective 6/1/14)</strong>&lt;br&gt; Unmarried, separated or community spouse, or unmarried or separated parent of child applicant $2,000</td>
<td>FFS Traditional Medicaid</td>
<td>Full Benefits</td>
<td>No</td>
</tr>
<tr>
<td>2014 Eligibility Group</td>
<td>Income Standard &amp; Other Eligibility Requirements</td>
<td>Program Enrollment</td>
<td>Benefit Package</td>
<td>MAGI Applies</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------</td>
<td>----------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>Married &amp; living together or separated only for medical reasons or parents of child applicant living together</td>
<td>$3,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*General income disregard of $20.00 is not included*

| Disabled               | Has received a disability determination from the Social Security Administration (SSA), or Has received an Indiana Medical Review Team determination of blindness and has filed an application for SSA benefits a maximum of 45 days after applying for Indiana Medicaid |                |                |              |

**Income Limits (effective 6/1/14)**

| Unmarried or married & not living with spouse or one parent of child applicant | $973* | FFS Traditional Medicaid | Full Benefits | No |
| Married or two parents of child applicant | $1,311* |

**Resource Limits (effective 6/1/14)**

| Unmarried, separated or community spouse, or unmarried or separated parent of child applicant | $2,000 |
| Married & living together or separated only for medical reasons or parents of child applicant living together | $3,000 |

*General income disregard of $20.00 is not included*

| Breast & Cervical Cancer | Diagnosed with breast & cervical cancer through ISDH screening program—or—Coverage through “Option 3” if diagnosed with breast or cervical cancer but not screened through ISDH BCCP screening
- Over 18 & under 65
- Not eligible for Medicaid under any other program
- Have no health insurance that covers their treatment
- ≤200% FPL | FFS Traditional Medicaid | Full Benefits | No |

| M.E.D. Works | Ages 16-64 | FFS Traditional Medicaid | Full Benefits | No |
| Disabled    |
| Working     |
### 2014 Eligibility Group

<table>
<thead>
<tr>
<th>Income Standard &amp; Other Eligibility Requirements</th>
<th>Program Enrollment</th>
<th>Benefit Package</th>
<th>MAGI Applies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>≤350% FPL</strong>&lt;br&gt;($3,406/month; spousal income not counted)</td>
<td>FFS Traditional Medicaid</td>
<td>Full Benefits</td>
<td>No</td>
</tr>
<tr>
<td><strong>Resource limit:</strong>&lt;br&gt;o <em>Single</em>: $2,000&lt;br&gt;o <em>Married</em>: $3,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### RCAP Related Coverage
- Automatic coverage for Residential Care Assistance Program

#### Medicare Savings Program: QMB
- **150% FPL** (effective June 1, 2014; prior to June 1, 2014, 100% FPL)
- **Resource limit:**<br>o *Single*: $7,160<br>o *Couple*: $10,750

<table>
<thead>
<tr>
<th>Medicare Savings Program: SLMB</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>170% FPL</strong>&lt;br&gt;(Single: $1,654/month, Married: $2,229/month)</td>
<td>N/A</td>
<td>Medicare Part B Premium</td>
<td>No</td>
</tr>
<tr>
<td><strong>Resource limit:</strong>&lt;br&gt;o <em>Single</em>: $7,160&lt;br&gt;o <em>Couple</em>: $10,750</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Medicare Savings Program: Qualified Individual
- **185% FPL** (effective June 1, 2014; prior to June 1, 2014, 135% FPL)<br>(Single: $1,800/month, Married: $2,426/month)
- **Resource limit:**<br>o *Single*: $7,160<br>o *Couple*: $10,750

#### Medicare Savings Program: QDW
- **200% FPL**<br>(Single: $1,945/month, Married: $2,622/month)
- **Resource limit:**<br>o *Single*: $7,160<br>o *Couple*: $10,750
- **Lost premium-free Medicare Part A due to employment status**

<table>
<thead>
<tr>
<th>Refugee</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-converted MAGI Aid to Families with Dependent Children (AFDC) standards</td>
<td>FFS Traditional Medicaid</td>
<td>Full Benefits</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthy Indiana Plan</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>100% FPL</strong></td>
<td>HIP</td>
<td>HIP Benefits</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Sources: Indiana Family and Social Services Administration, Indiana Client Eligibility System Program Policy Manual, http://www.in.gov/fssa/dfr/3301.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 CHIP and the Family Planning Eligibility Program is the last group on the hierarchy, as it offers the least comprehensive coverage. Additionally, individuals who are eligible for a mandatory Medicaid category cannot opt to enroll in an optional category.


1. Infants & 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 & FPL level as described in the following table (see Table 30):

<table>
<thead>
<tr>
<th>Age</th>
<th>FPL</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>≤208% FPL</td>
<td>Medicaid</td>
</tr>
<tr>
<td></td>
<td>&gt;208-250% FPL</td>
<td>CHIP</td>
</tr>
<tr>
<td>1-18</td>
<td>≤158% FPL</td>
<td>Medicaid</td>
</tr>
<tr>
<td></td>
<td>&gt;158-250% FPL</td>
<td>CHIP</td>
</tr>
</tbody>
</table>

a. **CHIP Specific Eligibility Provisions**

In order to qualify for 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 ninety 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 federal Marketplace 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 CHIP.

The Affordable Care Act (ACA) requires states to maintain coverage under CHIP for children who lose Medicaid coverage due to the elimination of disregards under MAGI. This protection applies only to children enrolled in Medicaid as of December 31, 2013 who lose eligibility at their first MAGI based renewal due to the elimination of disregards who are not otherwise CHIP eligible. To comply with these federal requirements, children who transfer to CHIP under this protected status will not be denied Medicaid due to having other creditable health insurance coverage. This protected status remains in place until the child’s next scheduled renewal (i.e., 12 months). At that time, the regular CHIP eligibility criteria will be 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 sixty (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, effective January 1, 2014, the
income standard for parents and caretaker relatives will be 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.

3. Transitional Medical Assistance

Medicaid enrolled parents, caretaker relatives or children under 19 with income under the thresholds in Table 31 and Table 33, who lose eligibility due to increased earnings of the parent or caretaker relative are eligible for continued Medicaid coverage under Transitional Medical Assistance (TMA). Congress has authorized the TMA program through March 31, 2015. To be eligible for TMA, the individual must have received and been eligible for Medicaid in one of these groups, in Indiana in three of the six months immediately preceding the ineligibility. TMA is available for two six-month periods. To be eligible for the first six months of TMA coverage, there must be at least one child under 18 living in the household. An additional six months of coverage is provided when the child continues to live in the household, the caretaker continues to have earnings and the gross earned income less out-of-pocket child care expenses does not exceed 185% of FPL.
4. 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.

5. 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 18th birthday, up to age 26, without regard to income.

6. 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.

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. Under the spousal impoverishment provisions of the Medicare Catastrophic Care Act (MCCA), 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 & Request 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 2014 figures.

The community spouse may maintain all of his or her personal income and half of the income generated by assets owned by both spouses. If this amount is less than $1,939 monthly (effective 7/2013), the community spouse may maintain a portion of the institutionalized spouse’s income to bring his or her monthly income up to this level. If the community spouse’s monthly income is more than the Maximum Maintenance Standard ($2,931 effective 1/2014), he or she cannot keep any of the institutionalized spouse’s income.

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 his or her own income to pay for nursing home care. The following are allowable deductions:

- A $52 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). Effective January 1, 2014, the community spouse asset limit is the greatest of the following amounts:

- The state minimum standard of $23,488;
- The spousal share, up to a maximum of $117,240;
  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 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 IRAs.

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

Effective June 1, 2014, if an applicant has monthly income that exceeds 300% of the maximum Supplemental Security Income (SSI) Federal Benefit Rate ($2,163 monthly in 2014), 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 his or her monthly income that exceeds the SIL in the trust. 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 figure below (see Figure 4) provides a high-level overview of 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: Indiana Family and Social Services Administration, 1634 Transition Stakeholder Presentation (2014), 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 FSSA’s website at 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 FPLs. The tables below (see Table 31, Table 32, and Table 33) reflect the income limits for March 1, 2014 eligibility based upon the 2014 FPLs. Annual updates can be accessed in the Federal Register located at 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 31: Monthly Income Limits for Hoosier Healthwise (Based on 2014 FPL)**

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Parents &amp; Caretaker Relatives</th>
<th>Children</th>
<th>Pregnant Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>n/a</td>
<td>$2,432</td>
<td>n/a</td>
</tr>
<tr>
<td>2</td>
<td>$247</td>
<td>$3,278</td>
<td>$2,727</td>
</tr>
<tr>
<td>3</td>
<td>$310</td>
<td>$4,123</td>
<td>$3,431</td>
</tr>
<tr>
<td>4</td>
<td>$373</td>
<td>$4,969</td>
<td>$4,134</td>
</tr>
<tr>
<td>5</td>
<td>$435</td>
<td>$5,815</td>
<td>$4,838</td>
</tr>
</tbody>
</table>


**Table 32: Monthly Income Limits for HIP Eligibility (Based on 2014 FPL)**

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Monthly Income Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$973</td>
</tr>
<tr>
<td>2</td>
<td>$1,311</td>
</tr>
<tr>
<td>3</td>
<td>$1,649</td>
</tr>
<tr>
<td>4</td>
<td>$1,988</td>
</tr>
<tr>
<td>5</td>
<td>$2,326</td>
</tr>
<tr>
<td>6</td>
<td>$2,665</td>
</tr>
<tr>
<td>7</td>
<td>$3,003</td>
</tr>
<tr>
<td>8</td>
<td>$3,441</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Family Size</th>
<th>Monthly Income Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$152</td>
</tr>
<tr>
<td>2</td>
<td>$247</td>
</tr>
<tr>
<td>3</td>
<td>$310</td>
</tr>
<tr>
<td>4</td>
<td>$373</td>
</tr>
<tr>
<td>5</td>
<td>$435</td>
</tr>
<tr>
<td>6</td>
<td>$498</td>
</tr>
<tr>
<td>7</td>
<td>$561</td>
</tr>
</tbody>
</table>

Add on for each additional family member $63


For the Aged, Blind and Disabled categories and Home and Community-Based Services 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 1st 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.

0. 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 are commonly a trusted family member, but they can also be a third party entity.

The designation of an authorized representative 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. There are different avenues for an individual to designate an authorized representative. One method is through the Indiana Application for Health Coverage which asks questions to facilitate the designation of an authorized representative. Additionally, State Form 55366 – Authorized Representative, available on FSSA’s website at www.in.gov/fssa/dfr/2689.htm can be used to designate an authorized representative. Completed forms are delivered via fax to 1-800-403-0864 or to the applicant’s local county office.

In completing the Authorized Representative 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 authorized representative is valid until the applicant or beneficiary:

- Modifies the authorization
- Notifies the agency that the representative is no longer authorized to act on his or her behalf
- The authorized representative informs the agency that he or she 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.


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 section 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 table below (see Table 34) 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 can submit the requested documentation via fax to 1-800-403-0864, deliver them in person to a local Division of Family Resources (DFR) Office or mail to the FSSA Document Center at the address below:

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 and/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 34: Verification Documentation (see following pages)

<table>
<thead>
<tr>
<th>Eligibility Factor</th>
<th>When Documentation is Required</th>
<th>Examples of Acceptable Paper Documentation*</th>
</tr>
</thead>
</table>
| Income             | 1. If individual attests on the application to income below the Medicaid or CHIP income standard & electronic data on income is unavailable.  
                    2. If an individual attests on the application to income below the Medicaid or CHIP income threshold and the electronic data indicates income above the applicable threshold.  
                    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. | • Wage receipts  
                    • Wage statements  
                    • Pay stubs  
                    • Employment verification form or written statements containing the required information |
| Residency          | Paper documentation verifying residency is sought when available electronic data source indicates residency in another state. | • Driver's license  
                    • School records  
                    • Other forms of I.D  
                    • Employment records  
                    • Church records  
                    • Rent/mortgage receipts and/or utility bills  
                    • Local postal record  
                    • Written statement from a third party |
<table>
<thead>
<tr>
<th>Eligibility Factor</th>
<th>When Documentation is Required</th>
<th>Examples of Acceptable Paper Documentation*</th>
</tr>
</thead>
</table>
| **Age** (Date of Birth) | Paper documentation verifying date of birth is sought when available electronic data sources indicate age difference. | Birth certificate or health department records or other credible sources, including:  
- hospital records  
- physician’s records  
- Bureau of Vital Statistics  
- baptismal, confirmation, or other church records  
- passport  
- naturalization papers  
- immigration papers  
- alien registration card  
- court records, including adoption records, in which the child's age has been noted  
- records of social agencies (including the Local Office)  
- insurance company records  
- school records |
| **Citizenship** | If citizenship is not verified electronically (Note: as discussed in the Citizenship/Immigration Status Section, 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.) |  
- Birth certificate  
- US Citizenship & Immigration Services records  
- Baptismal records  
- Medical records  
- School records  
- Military records  
- Court records |
<table>
<thead>
<tr>
<th>Eligibility Factor</th>
<th>When Documentation is Required</th>
<th>Examples of Acceptable Paper Documentation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigration Status</td>
<td>If immigration status is not verified electronically (Note: as discussed in the Citizenship/Immigration Status Section, 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.)</td>
<td>• US Citizenship &amp; Immigration Services records</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>If social security number is not verified electronically</td>
<td>• Social security card</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Correspondence from Social Security Administration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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)</td>
</tr>
<tr>
<td>Household Composition</td>
<td>If attested information is not consistent with electronic data and impacts eligibility outcome (i.e., difference renders individual not eligible, eligible for different benefit package or eligible for different cost-sharing amount).</td>
<td>• Divorce documents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Death certificate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Birth certificate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adoption paperwork</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>N/A: State is required to accept self-attestation.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*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)
Q. Eligibility Appeals

Medicaid applicants and beneficiaries have the right to appeal decisions of the State regarding their eligibility. 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
- Spend down amount (only if the member is appealing a claim or non-claim expense to meet a spend-down amount prior to June 1, 2014. After this date, the spend-down program is no longer in effect).
- 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 federal Marketplace to conduct Medicaid eligibility determinations may also delegate authority for processing appeals. Indiana has not delegated such authority. Therefore, appeals of Medicaid eligibility determinations will continue to be handled by the State in 2014. At the time of the drafting of this document, the federal government had not yet released final regulations governing the appeals process in 2014 and beyond; therefore, this information is subject to change pending future guidance. However, 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.

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) 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 he or she 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.

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 his behalf. If the decision is favorable to the appellant and involves HIP or CHIP, the individual would be required to pay any contributions or premiums back to the effective date of coverage.

After June 1, 2014, 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, he or she should appeal to SSA. 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), he or she should file the appeal to Indiana Medicaid.

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 can be found on FSSA’s website at http://member.inianamedicaid.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 3 months of retroactive eligibility from the date of application. During periods of retroactive eligibility a Medicaid enrollee is not assigned to a Hoosier Healthwise MCE (Managed Care Entity) or Care Select Care Management Organization (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, he or she 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). For these programs, final enrollment is dependent on premium contribution (CHIP) or POWER account payment (HIP). 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 & 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 enrollees)

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

3. CHIP Premiums

Individuals in CHIP (Children’s Health Insurance Program) are responsible for monthly premiums as outlined below.

<table>
<thead>
<tr>
<th>Family FPL</th>
<th>Monthly Premium for 1 Child</th>
<th>Monthly Premium for 2 or More Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>158% up to 175%</td>
<td>$22</td>
<td>$33</td>
</tr>
<tr>
<td>175% up to 200%</td>
<td>$33</td>
<td>$50</td>
</tr>
<tr>
<td>200% up to 225%</td>
<td>$42</td>
<td>$53</td>
</tr>
<tr>
<td>225% up to 250%</td>
<td>$53</td>
<td>$70</td>
</tr>
</tbody>
</table>

Source: 407 IAC 2-3

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 Health Coverage Application 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 Personal Responsibility and Wellness (POWER) Account Contributions

As detailed further in the [Healthy Indiana Plan (HIP) section](#), HIP enrollees are responsible for monthly contributions to the POWER Account.
After being determined eligible for HIP, the individual will receive an invoice from their Managed Care Entity (MCE) detailing the required contribution and payment instructions. Enrollment in HIP is not finalized until the individual remits the first POWER Account contribution. Members receive monthly invoices for monthly contribution amounts. If a HIP enrollee does not make a required monthly contribution within 60 days of its due date, the enrollee will be terminated from HIP and will not be able to reapply for 12 months. HIP enrollees with questions about their POWER Account contributions should contact the Managed Care Entity with whom they are enrolled as outlined below (see Table 36):

<table>
<thead>
<tr>
<th>MCE</th>
<th>Member Services</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem</td>
<td>1-866-408-6131</td>
<td><a href="http://www.anthem.com">www.anthem.com</a></td>
</tr>
<tr>
<td>MDwise</td>
<td>1-800-356-1204</td>
<td><a href="http://www.mdwise.org">www.mdwise.org</a></td>
</tr>
<tr>
<td>Managed Health Services(MHS)</td>
<td>1-800-647-4848</td>
<td><a href="http://www.mhsindiana.com">www.mhsindiana.com</a></td>
</tr>
</tbody>
</table>

5. M.E.D. Works Premiums

As described further in the M.E.D. Works section, enrollees in the M.E.D. Works program are responsible for monthly premium payments as outlined below. 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>
<thead>
<tr>
<th>Monthly Income</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,459 - $1,702</td>
<td>$48</td>
</tr>
<tr>
<td>$1,703 - $1,945</td>
<td>$69</td>
</tr>
<tr>
<td>$1,946 - $2,432</td>
<td>$107</td>
</tr>
<tr>
<td>$2,433 - $2,918</td>
<td>$134</td>
</tr>
<tr>
<td>$2,919 - $3,404</td>
<td>$161</td>
</tr>
<tr>
<td>$3,405</td>
<td>$187</td>
</tr>
<tr>
<td>$1,967 - $2,294</td>
<td>$65</td>
</tr>
<tr>
<td>$2,295 - $2,622</td>
<td>$93</td>
</tr>
<tr>
<td>$2,623 - $3,278</td>
<td>$145</td>
</tr>
<tr>
<td>$3,279 - $3,933</td>
<td>$182</td>
</tr>
<tr>
<td>$3,934 - $4,588</td>
<td>$218</td>
</tr>
<tr>
<td>$4,589</td>
<td>$254</td>
</tr>
</tbody>
</table>

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 MAGI (Modified Adjusted Gross Income) 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 (Modified Adjusted Gross Income) 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, effective December 2014. 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, beginning in 2015. 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, or to a local Division of Family Resources (DFR) office. 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 (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, his or her 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 Medical Review Team (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, by calling 1-800-403-0864, by mail to the FSSA Document Center or at a local DFR office. The state will review eligibility based on reported changes and provide written notice to enrollees of any resulting eligibility changes.

3. Pregnancy & 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 MCE (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 above. Alternatively, many hospitals will report the birth of the baby through a “babygram” sent via fax to the DFR.
T. Using Coverage

Once an individual is determined eligible and enrolled in the applicable program (i.e., Hoosier Healthwise, HIP, Care Select or Traditional Medicaid), he or she 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 and Care Select 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)
- Eye care services, except surgical services (except HIP)
- Podiatric services (except HIP)
- Psychiatric services
- Family planning services
- Emergency services
- Immunizations
- Mental health providers (for HIP & 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) and Hoosier Healthwise (HHW) programs, the MCEs (Managed Care Entities) 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 Managed Care Entity, 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. Cost-Sharing

Certain Medicaid & CHIP covered services have required copayments. This section does not apply to HIP enrollees.

There are co-pays for transportation services for Medicaid enrollees as outlined in the table below. 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 MCE enrollees

<table>
<thead>
<tr>
<th>Copayment</th>
<th>Transportation Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.50 each one-way trip</td>
<td>Transportation services that pay $10 or less</td>
</tr>
<tr>
<td>$1 each one-way trip</td>
<td>Transportation services that pay $10.01 to $50</td>
</tr>
<tr>
<td>$2 each one-way trip</td>
<td>Transportation services that pay $50.01 or more</td>
</tr>
</tbody>
</table>

Source: 405 IAC 5-30-2

Pharmacy copayments are outlined in the table below (see Table 39). The following services are exempt from copayment requirements:

- Family planning services & 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>
<thead>
<tr>
<th>Copayment</th>
<th>Pharmacy Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3</td>
<td>Brand Name &amp; Generic Legend Drugs</td>
</tr>
<tr>
<td></td>
<td>OTC Drugs covered by OTC Drug Formulary</td>
</tr>
<tr>
<td></td>
<td>Compound drug dispensed (legend or nonlegend)</td>
</tr>
</tbody>
</table>

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
- Care Select 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 below (see Table 40).

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Transportation</td>
<td>$10 for each one-way trip</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td></td>
</tr>
<tr>
<td>Generic Compound &amp; Sole Source</td>
<td>$3</td>
</tr>
<tr>
<td>Brand Name Prescription &amp; Insulin</td>
<td>$10</td>
</tr>
</tbody>
</table>

Source: 407 IAC 3-10-3

1. Post-Eligibility Appeals

After an individual has been determined eligible and is enrolled in Medicaid or CHIP, he or she has appeal rights related to actions taken by the State. At the time of the drafting of this document, the federal government had not yet released final regulations governing the appeals process in 2014 and beyond; therefore, this information is subject to change pending future guidance. 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

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, he or she 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 and Hoosier Healthwise) or a Care Management Organization (CMO) (Care Select) or Traditional Medicaid. Both processes are described below.

a. Hoosier Healthwise, HIP & Care Select Grievances & Appeals

Members enrolled in HIP or Hoosier Healthwise should contact their Managed Care Entity (MCE) to file a grievance or appeal. Care Select enrollees contact their Care Management Organization (CMO) to file a grievance or an 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/CMO in which they are enrolled for specific instructions on submission. Additionally, all notices of action from the MCE/CMO will provide instructions on appeal rights, timelines and procedures. If a HIP or Hoosier Healthwise enrollee is not satisfied with the appeal decision made by the MCE, he or she can 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, he or she can still request a State Fair Hearing if dissatisfied with the outcome of the IRO.

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 he or she 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/CMO Member Services Helpline, or in writing.

b. Appeals to the State

Medicaid beneficiaries who are not enrolled with an MCE or 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 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

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 FFSA 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.

W. Contacting the State for Assistance & 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 FSSA’s website at 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 can also contact 1-800-403-0864. A listing of local county offices can be found at on FSSA’s website www.in.gov/fssa/files/DFR_Map_and_County_List.pdf and contact emails by region are provided below (see Figure 5). For case specific inquiries which require a response, the inquirer must be an authorized representative.
Figure 5: Division of Family Resources Regional Contacts

**Division of Family Resources**
**Indiana Family & Social Services Administration**

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.

General questions or comments to the FSSA can be submitted on FSSA’s website via [www.in.gov/fssa/2404.htm](http://www.in.gov/fssa/2404.htm).
III. Health Insurance Basics and the Federal 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 Marketplace
3. Understand what the federal Marketplace is, who can use it, and where Hoosiers consumers should go for assistance with the federal Marketplace
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 on the federal Marketplace
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 federal Marketplace 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. **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, CACs, and non-Navigator Assistance Personnel).
3. **Agent** (also referred to as **Broker** or **Producer**) 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 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 certified by the federal Marketplace.

4. **Applicable Large Employer** is, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. Such an employer is eligible to enroll in the SHOP Marketplace and would not be subject to the employer shared responsibility payments.

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 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

6. **Catastrophic Plan** is a health plan available on and off the federal Marketplace 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 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 the gaining and losing of health insurance coverage. Individuals that experience a change in circumstances during the year that impacts their eligibility in the Marketplace 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 bill consumers might receive from their health care provider after a visit for a percentage of the cost of care.

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 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. **Copayment** (also referred to as **Copay**) is flat fee consumers may need to pay before they are seen by the healthcare provider. Some plans may charge copayments for some services and coinsurance for others.

14. **Cost-sharing** is a common feature of different health insurance plans, and the specific requirements vary between plans. A health plan’s cost-sharing policy can be found in their Summary of Benefits and Coverage.

15. **Cost-sharing Reduction (CSR)** is a health-plan discount on a Marketplace 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 meets all requirements for a PTC, is enrolled in a Silver Plan on the federal Marketplace, and whose household income is between 100% and 250% Federal Poverty Level (FPL) (or between 100% and 300% FPL for Native Americans).

16. **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.

17. **Department of Health and Human Services (HHS)** is the United States federal government’s principal health agency. HHS developed and manages the federal Marketplace and manages the establishment, training, certification, monitoring, and oversight of Marketplace agents/brokers, carriers, and federal consumer assistants.

18. **Dependant** is a child up to 26 years old under the Affordable Care Act. The Affordable Care Act 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 his or her job). Beginning in 2014, children up to age 26 can stay on their parent’s employer plan even if they have another offer of coverage through an employer.

19. **Employer Mandate** (also referred to as **Employer Shared-responsibility**) is the ACA requirement that, stating January 1, 2015, employers with more than 50 full-time equivalent employees (FTEs) will be subject to tax penalties if at least one FTE receives a Premium Tax Credit (PTC).

20. **Enrollment Period** is the time period in which certain individuals can apply and enroll for health coverage through the federal Marketplace. The term includes an open enrollment period, special enrollment period, and SHOP enrollment period.

21. **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. 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.

22. **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.

23. **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. For 2014, the FPL for a single person is $973 per month, and $1,988 per month for a family of four.

24. **Federal Marketplace** (also referred to as **Federally-facilitated Marketplace** or FFM) is a federally-developed and federally-operated 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) 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 CACs) that provide Marketplace 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.

25. **Flexible Spending Account (FSA)** is a medical savings account that allows an individual and the individual’s employer to contribute pre-tax dollars towards the cost of 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.

26. **Free Look Period** is a period where a new insurance policy owner is able to terminate the contract without penalties such as surrender charges. A Free Look Period allows the contract holder to decide whether or not to keep the insurance policy. If the contract purchaser is not satisfied with the policy, the contract purchaser can receive a full refund for it.

27. **Full-time Equivalent Employee (FTE) Count** is a method under the ACA to count employees to determine if an employer is a small or large employer. 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.

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 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

29. **Grandfathered Health Plan** is a health insurance policy that was in existence prior to the 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 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 federal Marketplace. 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 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 the 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 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 federal 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 federal Marketplace and Partnership Marketplace states. The website also fragment 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 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 federal Marketplace 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 an 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.

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 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 **Issuer** or **Carrier**), 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 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 an employer employing an average of at least 51 full-time employees and full-time equivalent employees (FTEs). Starting in 2015, employers with at least 51 full-time and FTE employees (101 beginning in 2016) will be subject to the employer shared-responsibility provisions of the ACA (the “Employer Mandate”). These employers will be subject to a fine levied by the IRS for each month in which they have one or more
full-time employees receiving a Premium Tax Credit (PTC). These employers are not eligible for the SHOP Marketplace.

44. **Major Medical Insurance** is a health insurance plan that offers individuals comprehensive insurance against potential healthcare costs. Major Medical 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. However, some Major Medical Insurance products are not considered MEC, for example certain types of student health insurance.

45. **Marketplace** (also referred to as **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 Affordable Care Act. The term includes a Federally-designated Marketplace (FFM or federal Marketplace), a Partnership Marketplace, or a State-based Marketplace. Indiana operates as a federal Marketplace.

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 ACA, carriers must maintain a certain Medical Loss Ratio, which varies by market segment (Large Group 85%, Small Group 80%, Individual 80%). If a carrier does not meet the MLR requirement, individuals and small businesses will receive a refund.

47. **Medicare** is a federal insurance program administered by 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 ACA and individuals eligible for Medicare and not eligible for the federal Marketplace.

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 the 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 must have for him/herself and his/her dependent(s) to meet the Individual Mandate under the Affordable Care Act. The list of MEC types 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. 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 will not be eligible for a Premium Tax Credit (PTC).

51. **Modified Adjusted Gross Income (MA GI)** is a methodology implemented for eligibility effective January 1, 2014 for insurance affordability programs. MAGI equals adjusted gross income 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 (MA GI) Conversion** is the process by which states are required to convert pre-2014 Medicaid eligibility standards to a MAGI equivalent. 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 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 meets other standards, such as having essential community providers, maintaining a network that is sufficient in number and types of providers, and making the insurers 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 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 the 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 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 Marketplace. The initial open enrollment period was October 1, 2013 through March 31, 2014. The next open enrollment period is November 15, 2014 through February 15, 2015. The annual open enrollment period is to be determined by the Centers for Medicare & Medicaid Services.

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** is the greatest amount that a consumer pays for healthcare services in any plan year before the insurance carrier pays 100% of healthcare costs. Out-of-pocket maximum is set by the federal Internal Revenue Service (IRS). For 2014, this maximum amount is $6,350 for an individual and $12,700 for a family.

59. **Pediatric** refers to children under the age of nineteen. Under the 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 Plans). Out-of-pocket expenses in 2014 are capped at $6,350 for individual plans and $12,700 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. (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, for coverage issued or renewed beginning January 1, 2014.

62. **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.

63. **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 the federal Marketplace. An individual may apply for a PTC through the federal Marketplace, and the federal Marketplace determines the individual’s PTC eligibility and maximum PTC amount. To be eligible for a PTC on the federal Marketplace operating in Indiana, an individual must: (1) be a U.S. citizens,
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% FPL; and (5) have no other MEC or an available MEC with a premium more than 9.5% of household income or that does not provide MV (at least 60% 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).

64. **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.

65. **Qualified Health Plan (QHP)** is a health insurance plan that has been certified under the ACA to meet the criteria for availability through a Marketplace. All QHPs sold on the federal Marketplace 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 Plans (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.

66. **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 the 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.

67. **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.

68. **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.

69. **SHOP Enrollment Period** is the timeframe in which qualified employers may apply and enroll in the 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.

70. **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 in 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

71. **SHOP (Small Business Health Options Program) Marketplace** is the federal Marketplace available to small employers to purchase health coverage for their employees. Eligible employers for 2014-2015 must have 50 or fewer full-time equivalent employees. In 2016 and after, employers with 100 and fewer FTEs will be eligible for the SHOP Marketplace. 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/).

72. **Small Employer** (also referred to as **Small Group Employer**) is an employer who employs 50 or fewer full-time equivalent employees (FTEs). Starting in 2014, a small employer may purchase health insurance for its employees using the SHOP Marketplace. Employers that have fewer than 25 FTEs may qualify for tax credits on the SHOP Marketplace. Starting in 2016, the amount of FTEs used to define small employer will be raised to 100 full-time equivalent employees.

73. **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 63.

74. **Stand-Alone Dental Plan** refers to the dental-only health insurance plans offered through the Health Insurance 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 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.

75. **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 tax subsidies 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 ACA. 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.

Sidebar: Beginning in 2014, States can elect to establish only a SHOP while HHS operates the individual market Exchange. A state must provide reasonable assurance to CMS that it will be in a position to establish and operate just a SHOP in 2014.

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 the Marketplace because the employer does not offer coverage or offers coverage that is not affordable (the cost of single premiums exceed 9.5% of the employee’s household income) or does not provide minimum value (MV) (covers 60% of healthcare costs).

Version 2.0 (as of June 18, 2014)
For insurers, the ACA makes 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 creates a new category of health insurance plan, the Qualified Health Plan (QHP), as the only type of plan that is offered on the federal Marketplace. 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 has been 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 federal Marketplace.

1. Individual Impacts

a. Requirement to Have Health Insurance

Called the Individual Shared-responsibility or the Individual Mandate, this ACA requirement 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 that insurers will issue coverage. Additionally, insurers will not be 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 metal level tiers. All health plans subject to the ACA in the individual and small group market must offer plans at the Bronze, Silver, Gold 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 level.

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, a “buy-down” of plan premiums by insurer to lower cost-sharing, etc.), 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 as they do today directly from the health insurer, through an insurance agent or broker, or online. However, they will also have access to the new federal Marketplace. To purchase coverage on the federal Marketplace 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 federal Marketplace 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 will 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 federal Marketplace. Individuals can approach the federal Marketplace directly and apply for health coverage, or may work through an insurer that sells plans on the federal Marketplace or a Marketplace broker or web-broker. However, health insurance plans that are not offered on the federal Marketplace 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 will be covered through the PTC program. The amount of the PTC is estimated when the individual applies for insurance affordability programs via the federal Marketplace, 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 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 FPL), who select a qualifying plan, to pay for cost-sharing obligations related to seeking health care. This program has the potential to greatly reduce cost sharing that qualifying
individuals may owe for health care 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 federal Marketplace (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 QHPs sold on the federal Marketplace during open enrollment periods. For 2014, the open enrollment period is from October 1, 2013 to March 31, 2014. In 2015, the open enrollment period will be from November 15, 2014 to February 15, 2015. Outside of these enrollment periods, individuals may only purchase or change a federal Marketplace plan if they have a life event that qualifies them for a special enrollment period. Examples of these life events include individuals losing access to employer-sponsored coverage or experiencing an event like marriage, divorce, or the birth or adoption of a child. Health insurers that sell plans outside of the federal Marketplace may elect to only sell plans during the Marketplace 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 ACA contains provisions impacting small and large employers. Small employers with up to 50 full-time equivalent employees (FTEs) will have access to the SHOP Marketplace to purchase coverage for their employees. Small employers with up to 25 FTEs and average wages less than $50,000 annually may be eligible for tax credits through 2015 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. Starting in 2015, large employers with 51 or more full-time equivalent employees will be subject to a shared responsibility penalty if they do not offer coverage that is affordable and provides minimum value to all full-time employees and an employee receives a Premium Tax Credit in the Marketplace.

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. This is called the full-time equivalent employee (FTE) count. Previously, to determine if an employer was a small or large employer, a count would be taken of all of their full-time employees. Full-

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4 In 2014 through 2015 the SHOP will offer coverage to employers with up to 50 employees, beginning in 2016 the SHOP will offer coverage to employers with up to 100 employees.
time employees are defined as employees working an average of 30 hours⁵ or more a week. The full-time equivalent employee 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 30.⁶ 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 applicable⁷ 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/ and www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf 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 below table (see Table 41) 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.

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⁵ As of February 12, 2014, 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.

⁶ As a proxy, employers may divide the hours worked by all part-time employees in a month and divide by four.

⁷ Employers will use information about the number of employees they employ and their hours of service during 2014 to determine whether they employ enough employees to be an applicable large employer for 2015.
Table 41: Example of Full-time Equivalent Employee (FTE) Count

<table>
<thead>
<tr>
<th>Month</th>
<th>Full-time Employees</th>
<th>Full-time equivalent employees</th>
<th>Total Employee Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>35</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>February</td>
<td>36</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>March</td>
<td>36</td>
<td>11</td>
<td>47</td>
</tr>
<tr>
<td>April</td>
<td>36</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>May</td>
<td>35</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>June</td>
<td>37</td>
<td>16</td>
<td>53</td>
</tr>
<tr>
<td>July</td>
<td>37</td>
<td>16</td>
<td>53</td>
</tr>
<tr>
<td>August</td>
<td>37</td>
<td>20</td>
<td>57</td>
</tr>
<tr>
<td>September</td>
<td>35</td>
<td>16</td>
<td>51</td>
</tr>
<tr>
<td>October</td>
<td>37</td>
<td>11</td>
<td>48</td>
</tr>
<tr>
<td>November</td>
<td>35</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>December</td>
<td>35</td>
<td>10</td>
<td>45</td>
</tr>
</tbody>
</table>

Annual Average Employees 35.9 13.3 49.2


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 federal Marketplace and ineligible for large group coverage by virtue of having less 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 would not be eligible for initial 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.irs.gov/pub/irs-drop/n-12-58.pdf](http://www.irs.gov/pub/irs-drop/n-12-58.pdf). Employers with questions about their FTE count and if they are a large or small employer should contact an agent or broker or the Marketplace at [www.healthcare.gov](http://www.healthcare.gov) or 1-800-706-7893.

3. Small Employers
   
   a. **SHOP Marketplace**

   The Small Business Health Options Program (SHOP) is a Marketplace for small employers with 50 or under full-time equivalent employees. Small employers may use this Marketplace 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.

   Employers interested in SHOP coverage should contact their agent or broker or the Marketplace directly at [www.healthcare.gov](http://www.healthcare.gov) or 1-800-706-7893. Employers may set up an online account for the Marketplace at any time and will be able to receive an eligibility determination for Marketplace coverage and begin the plan selection process starting October 1, 2013. Employers may view a sample employer application on CMS’s 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 are available online at [www.healthcare.gov](http://www.healthcare.gov). More information on the SHOP Marketplace is available in the **SHOP section**.

   **Sidebar:** To apply for SHOP coverage: (1) Create an account at [www.healthcare.gov](http://www.healthcare.gov), (2) complete the online application, (3) for the start of the open enrollment period in 2013 employers will have to print and mail in the applications as the electronic SHOP application will not be available.
b. Small Employer Tax Credits

Small employers with fewer than 25 full-time equivalent employees (FTEs), excluding the owner and family members, with less than an average per employee wage of $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 has been available since 2010 and can be claimed by eligible small employers when they file their taxes. From 2010 to 2013, the amount of the small employer tax credit was up to 35% of the amount the employer paid towards coverage for employees. In 2014 and 2015, this tax credit will be up to 50% of the amount the employer pays towards coverage for employees 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 table below (see Table 42) 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 in 2014 and 2015. 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>
<thead>
<tr>
<th>Full-time equivalent employees</th>
<th>Average Annual Wages</th>
<th>&lt;$25k</th>
<th>$30k</th>
<th>$35k</th>
<th>$40k</th>
<th>$45k</th>
<th>$50k</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>47%</td>
<td>37%</td>
<td>27%</td>
<td>17%</td>
<td>7%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>43%</td>
<td>33%</td>
<td>23%</td>
<td>13%</td>
<td>3%</td>
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<td></td>
</tr>
<tr>
<td>13</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
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<td>0%</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>37%</td>
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<td>0%</td>
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<tr>
<td>15</td>
<td>33%</td>
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<tr>
<td>16</td>
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<td>17</td>
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<td>7%</td>
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<tr>
<td>18</td>
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<td>3%</td>
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<tr>
<td>20</td>
<td>17%</td>
<td>7%</td>
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<td>0%</td>
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<tr>
<td>21</td>
<td>13%</td>
<td>3%</td>
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<td>22</td>
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</tr>
<tr>
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<td>7%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>25+</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Congressional Research Service (2010). Summary of Small Business Health Insurance Tax Credit
Employers interested in applying for the tax credit can find more information on the federal Internal Revenue Service (IRS) website at 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 or 1-800-706-7893 for further detail on the application process and requirements.

c. Employer Shared-Responsibility Payments

Starting in 2015, employers with over 50 full-time equivalent employees (FTEs) or a combination of full-time and part-time equivalent employees will be subject to the employer shared responsibility provisions or employer mandate. These employers will be subject to a fine levied by the IRS for each month in which they have one or more full-time employees receiving a Premium Tax Credit (PTC). 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% of their full-time employees. Additional guidance is provided at www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf for other methods used to assess the employer shared responsibility payment.

Table 43: Large Employer Shared Responsibility Payments

<table>
<thead>
<tr>
<th>Employers offering coverage to at least 95% of full-time employees</th>
<th>Employers not offering coverage to at least 95% of full-time employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penalty is the lesser of:</td>
<td>• $167 per month or $2,000 per year for every employee full-time and full-time equivalent employee, excluding the first 30 employees</td>
</tr>
<tr>
<td>• $250 per month or $3,000 per year for each full-time employee receiving a Premium Tax Credit, or</td>
<td></td>
</tr>
<tr>
<td>• $167 per month or $2,000 per year for every employee full-time and full-time equivalent employee, excluding the first 30 employees</td>
<td></td>
</tr>
</tbody>
</table>

Source: Internal Revenue Service (2014), Shared Responsibility for Employers.

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.

8 Large employers with between 50 and 100 employees may have up to five full-time employees that are not offered coverage.

9 The percent for full-time employees or full-time equivalent used to access the shared responsibility payment may change to 70%, as applicable, for 2015 and back to 95% for 2016.
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\(^\text{10}\). 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 9.5% 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.

Large employers may be subject to this penalty when employees receive a PTC. 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 9.5% 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 9.5% 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 following 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 2015 will be paid in 2016. Employers may appeal the assessment of the employer shared-responsibility provisions. This appeal should be directed to the IRS (Internal Revenue Service), the agency that administers the penalties.

\(^{10}\) $2,000 x (75-30) = $90,000
Sidebar: Individuals eligible to enroll in a non-calendar year employer-sponsored plan with a plan year beginning in 2013 and ending in 2014 may not be liable for the shared-responsibility payment for certain months in 2014. The transition relief begins in January 2014 and continues through the month in which the 2013-2014 plan year ends.

d. Minimum Value of Plans

Nothing requires employer plans to provide minimum value (MV) plans. 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, to calculate their health plan’s minimum value. Employers needing assistance with the MV calculator should contact the federal Marketplace at www.healthcare.gov 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 federal Marketplace. To apply for coverage on the federal Marketplace, 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 Premium Tax Credits (PTC) for themselves or their dependents. This form will ask for information such as the 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 minimum value (MV) of their employer-sponsored coverage option. The form that employers may be asked to complete by employees applying for coverage on the federal Marketplace for themselves or their dependents can be viewed at www.healthcare.gov/downloads/MarketplaceApp_Checklist_Generic.pdf.

Employers will also receive a notice from the federal Marketplace every time one of their employees receives a premium tax credit. Employers are required to notify employees of the coverage available on the federal Marketplace, even if affordable coverage that provides minimum value (MV) is offered to all full-time employees.

4. Insurer Impacts

a. Rating Requirements

Insurers may now only charge individuals premiums based on age, location, and smoking status.

b. Market Reforms

Market reforms require insurers to cover dependents up to age 26, 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 federal Marketplace 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 paying for enrollee’s 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 percent. Insurers that do not meet the threshold for enrollees’ health care cost will owe refunds to enrollees or the federal government for the difference between the MLR requirement and the amount spend 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 and 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: The ACA definition of the Small Group varies from the Indiana definition in the way it counts employees. The ACA count mechanism is for full-time equivalent employees (FTEs) that considers hours worked and will include part-time workers; this varies from the way Indiana counts employees for the purposes of determining if they are eligible for a Small Group market insurance plan. As the federal government is running the Marketplace in Indiana, the ACA FTE definition will be used to determine if employers are eligible in the SHOP (Small Business Health Option Program) and if they are subject to the employer responsibility requirements. It is possible that employers that are considered small employers in Indiana and may be eligible for a Small Group policy on the outside market, but will not be eligible for the SHOP, and will be subject to the employer-responsibility requirements. Further discussion on this topic is included in the Employer Shared-Responsibility Payments section.

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 health care 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 Plans (CDHP), also known as a High Deductible Health Plans (HDHP). PPOs are health plans that have a contract with certain providers, these providers are 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. EPO’s 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 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 HSAs.

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 health care services.
Enrollees may expect that 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 health care 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 health care services. Health plan members who do not pay their premiums will have their health insurance coverage canceled.

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 base amount that the member pays for services prior to their 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 below). Deductibles must be met on 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 his or her 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 below). 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 his or her 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.

* Excluding some doctor visits, which may be covered by $15 copayment
** Issuer pays 80%, and consumer pays 20%

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). For 2014, this maximum amount is $6,350 for an individual and $12,700 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 $6,350 individual and $12,700 family amounts. The maximum out-of-pocket limits for 2015 are up to $6,600 for individual and $13,200 for family.

Stand-alone pediatric dental benefits may also have a separate out-of-pocket maximum of $700 for a single enrollee and $1,400 for more than one enrollee. For 2015, stand-alone dental plans will have a separate out-of-pocket maximum of $350 for a single enrollee and $700 for more than one enrollee. The stand-alone pediatric dental out-of-pocket maximums only apply to benefits for those under 19; there is no mandated limit for adults. In 2015, plans will be 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 will remain.

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.

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 insurers 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). HSAs are only available for individuals that select Consumer Directed Health Plans (CHDP) or High Deductible Health Plans (HDHP). Both HSAs and FSAs allow the individual and the individual’s employer to contribute pretax 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. 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 Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Health Maintenance Organizations (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 Grandmothered/Transitional plan) in the Individual and Small Group markets on and off the Marketplace are required to offer coverage that is indexed to certain Actuarial Value (AV) and referred to as “Metal Tier(s).” 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 enrollees 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 (MEC). Catastrophic Plans may provide family coverage and may enroll children, but they are not available in the Small Group. Catastrophic Plans offered inside the federal Marketplace will be subject to the open and special enrollment periods. Outside of the federal Marketplace, 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 federal Marketplace to offer these products. These plans are not eligible for the Premium Tax Credit (PTC) or Cost-Sharing Reductions (CSRs).

d. Grandfathered Plans

The Affordable Care Act (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 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 their 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 (MEC). 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 minimum value (MV), these individuals will not be eligible for Premium Tax Credits (PTCs).

**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 federal Marketplace.

On March 5, 2014, 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 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 Grandmothered Plans or switch to a different insurer to replace a Grandmothered Plan.

The Grandmothered Plans renewed under this option must not undergo any material changes to the plan (e.g., a change in plan benefits, a “buy-down” of plan premiums by insurer to lower cost-sharing, etc.); otherwise, an ACA-compliant product would be required. The Grandmothered Plans renewed under this option are not required to contain the 10 Essential Health Benefits (EHB), or to adopt the rating structure of fully ACA-compliant plans. However, Grandmothered Plans must comply with the following ACA provisions upon renewal:
Elimination of annual dollar limits on EHB to the extent the Grandmothered Plans cover Essential Health Benefits

- 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 Grandmothered Plan option—are required to provide notice to any individuals and small businesses that have received a discontinuation letter. Voluntary termination of a policy by an individual does not constitute a special enrollment period.

**f. Qualified Health Plans (QHPs)**

Plans sold on the Individual or SHOP Marketplace must be certified as Qualified Health Plans (QHPs). For individuals, the QHPs offered through the Marketplace are the only plans that an individual can purchase that are eligible for the Premium Tax Credits (PTCs) or Cost-Sharing Reductions (CSRs). 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 Essential Health Benefit (EHB) requirements and offer metal level plans that are indexed to Actuarial Value (AV) including Bronze, Silver, Gold, or Platinum plans.

In addition to these market-wide requirements, QHPs offered on the federal Marketplace 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. QHPs 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 have been no health insurer options...
for child-only coverage. Coverage through child-only plans will become an option on and off the federal Marketplace with start dates of January 1, 2014. Child-only plans offered on the federal Marketplace are QHPs and are eligible for the Premium Tax Credit (PTC) and Cost-Sharing Reductions (CSRs).

QHPs 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 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, QHP’s 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. In 2014, QHPs must include at least 20% 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 are expected to change in coming years. In 2015, QHPs will be required to include at least 30% of essential community providers as network providers.

QHPs 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 that 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 framework for a Quality Rating System (QRS) is being developed to rate Qualified Health Plans (QHPs) offered through a Marketplace on specific quality measures. QHP issuers will be required to collect and report data for the QRS.

QHPs may be offered both on and off of the Marketplace. QHPs offered off of the Marketplace must have the same pricing as those offered on the Marketplace. Only QHPs offered through the Marketplace are eligible for Insurance Affordability Programs including Premium Tax Credit (PTC) and Cost-sharing Reductions (CSRs). QHPs will be identified through their marketing materials. QHPs offered off of the federal Marketplace will identify that they have QHP certification, but that not eligible for Insurance Affordability Programs.

To enroll in a QHP on the federal Marketplace, individuals must be a U.S. citizen, national, or legal resident, not be incarcerated, and reside or intend to reside in the state in which the QHP offers. For individuals that do not meet the citizen, national or legal resident requirement, the plan must be made available to the individual outside the federal Marketplace if it is a plan 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.

g. Multi-State Plans

Multi-State Plans are plans that will be offered initially in some states, but in all states by 2016. These plans are offered through the federal Marketplace and are plans that the Federal Office of Personnel and Management contracts with issuers to offer in the Marketplaces. Multi-State Plans are Qualified Health Plans (QHPs) and are eligible for individuals interested in receiving Premium Tax Credits (PTCs) and Cost-Sharing Reductions (CSRs). They will not be offered on the outside market.

In Indiana, Multi-State Plans will be required to offer the same set of Essential Health Benefits (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 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 federal Marketplace. Pediatric dental is an Essential Health Benefit (EHB) requirement under the ACA, and health plans that offer dental only benefits are available on the federal Marketplace. If there are a sufficient number of stand-alone dental plans on the Marketplace, 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 federal Marketplace, 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. These plans will be subject to a $700 maximum out-of-pocket amount for a single individual and $1,400 for a family in 2014. 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 federal Marketplace 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 then 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 federal Marketplace 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 federal Marketplace will be required to assure the carrier that they have stand-alone dental coverage for the pediatric dental Essential Health Benefit (EHB) through a Marketplace certified stand-alone dental plan. It is currently
unclear what the consequences are of purchasing coverage without pediatric dental off of the federal Marketplace and not purchasing pediatric dental coverage.

Stand-alone dental plans off of the federal Marketplace 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 the 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, Indiana Comprehensive Health Insurance Association (ICHIA), provides 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 may no longer deny individuals coverage based on health status; thus, the ICHIA program is no longer needed. Individuals seeking coverage through ICHIA should apply for coverage through the federal Marketplace 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), is also phasing out in 2014. Individuals interested in PCIP coverage should apply through the Marketplace 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 (MEC)

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 which 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 2014, certain types of coverage considered to be MEC and types not considered to be MEC are outlined in the table below (see Table 44). Individuals with questions on whether their coverage type is recognized as MEC should contact their coverage provider or the federal Marketplace at www.healthcare.gov or 1-800-318-2596.
### Table 44: Types of Minimum Essential Coverage (MEC)

<table>
<thead>
<tr>
<th>Types of Minimum Essential Coverage (MEC)</th>
<th>Not Minimum Essential Coverage (MEC)¹¹</th>
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<tbody>
<tr>
<td>○ Coverage under a government sponsored program</td>
<td>o Medicaid Programs not considered MEC include coverage for the following:</td>
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<tr>
<td>• The Medicare Program</td>
<td>• Optional family planning services</td>
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<tr>
<td>• The Medicaid Program</td>
<td>• Optional tuberculosis related services</td>
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<tr>
<td>• The Children’s Health Insurance Program</td>
<td>• Pregnancy related services</td>
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<tr>
<td>• Veterans Administration programs: including most TriCare and CHAMP VA</td>
<td>• Emergency medical services</td>
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<tr>
<td>• Department of Defense non-appropriated fund benefits</td>
<td>• 1115 demonstration waiver</td>
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<td>• Coverage for Peace Corps Volunteers</td>
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<tr>
<td>○ Coverage under an employer-sponsored health plan</td>
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<tr>
<td>o COBRA</td>
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<td>o Retiree Coverage</td>
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<tr>
<td>○ Coverage under a health plan offered in the individual market within a State</td>
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<tr>
<td>○ Coverage under a grandfathered health plan</td>
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<td>○ Additional Coverage as specified</td>
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<tr>
<td>• Self-funded student health coverage</td>
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<tr>
<td>• Recognized as MEC only in 2014</td>
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<tr>
<td>• Refugee medical assistance</td>
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<td>• Medicare advantage plans</td>
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<td>• State high risk pool coverage</td>
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<tr>
<td>• Recognized as MEC only in 2014</td>
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</tr>
<tr>
<td>○ Other Coverage not considered MEC:</td>
<td></td>
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<tr>
<td>o Foreign Health Care Coverage</td>
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<tr>
<td>o Short Term Coverage</td>
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<tr>
<td>o Coverage in territories sold outside the Marketplace</td>
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<tr>
<td>o 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.</td>
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<tr>
<td>o Excepted benefits including, limited-scope vision benefits, long-term care benefits, and benefits provided under certain health flexible spending arrangements.</td>
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<tr>
<td>o 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</td>
<td></td>
</tr>
</tbody>
</table>

Source: *26 CFR §1.5000A-2 & 45 CFR §156.602.*

¹¹ Coverage that is not considered MEC is subject to change based on release of final guidance from the Department of Treasury.
**a. Government-Sponsored Coverage**

Government-sponsored coverage, including Medicaid, the Children Health Insurance Program (CHIP), 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.

**b. Minimum Essential Coverage (MEC) 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, this types of Medicare is 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*

<table>
<thead>
<tr>
<th>MEC</th>
<th>Not MEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A (Hospital)</td>
<td>Medicare Part B (Medical)</td>
</tr>
<tr>
<td>Medicare Part C (Private Market)</td>
<td>Medicare Part D (Prescription)</td>
</tr>
</tbody>
</table>
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).

c. **Minimum Essential Coverage (MEC) Detail: Medicaid and the Children's Health Insurance Program (CHIP)**

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.

d. **Minimum Essential Coverage (MEC) 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](#).
e. Minimum Essential Coverage (MEC) 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.


f. Minimum Essential Coverage (MEC) 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 considered to be covered by Minimum Essential Coverage. The IRS has indicated that no penalties will be imposed on individuals that have pregnancy related coverage in 2014, however women with pregnancy related coverage will be subject to the penalty after 2014 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.

g. Minimum Essential Coverage (MEC) 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.
**h. 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. \(^{12}\) Comprehensive benefits available under TRICARE and CHAMPVA will be considered to be 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.

**i. 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)\(^{13}\), 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 they meet the requirement to maintain MEC for every month in which they are enrolled.

**j. 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\(^ {14}\). For every month the individual is enrolled in a plan on the individual market they will meet the requirement to maintain Minimum Essential Coverage.

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\(^{12}\) Per the minimum essential coverage 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 MEC.

\(^{13}\) The essential health benefits 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.

\(^{14}\) Individuals may only enroll in the catastrophic plan if they are under age 30 or have received an affordability or hardship exemption.
k. 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 requirements. Enrollees of grandfathered plans will meet the requirement to maintain MEC of every month they are enrolled.

l. COBRA & Retiree Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act) 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 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.

m. Additional Coverage as Specified

Federal guidance specifies certain additional types of coverage as Minimum Essential Coverage. These coverage types include self-funded student health coverage, refugee medical assistance, and state High Risk Pool coverage. Self-funded student health coverage and state High Risk Pool coverage are only automatically recognized as MEC for 2014. 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. Only self-funded student health coverage qualifies as Minimum Essential Coverage. In 2014, determining what student health insurance is considered MEC, and which is not may be difficult. 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 self-funded
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 federal Marketplace. After 2014, self-funded student health plans may apply to be recognized as MEC, but they are not automatically recognized. A list detailing recognized types of MEC will be made available by the federal Department of Health and Human Services (HHS) for years after 2014. Individuals with questions about whether their student health insurance options qualifies as MEC in 2015 and after should consult the HHS list of Minimum Essential 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.

Indiana’s state High Risk Pool, the Indiana Comprehensive Health Insurance Association (ICHIA) will phase out in 2014. Individuals currently covered through this program will be able to seek insurance in Marketplaces or other programs. The state High Risk Pool will not be an option for individuals seeking coverage in 2014 and beyond. Additionally, the federal High Risk Pool or Pre-existing Condition Insurance Program (PCIP) will also phase out in 2014. Individuals accustomed to seeking coverage in High Risk Pools should transition to Marketplaces. Health plans will no longer be able to deny coverage or refuse to cover individuals for pre-existing conditions.

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.

**n. Updates to Coverage Types**

Sponsors of other coverage types that are not current listed as MEC may apply to HHS to have the coverage they sponsor recognized as Minimum Essential Coverage. The CMS specifically invites sponsors of foreign health coverage and AmeriCorps coverage to apply to have their health plans recognized as Minimum Essential Coverage. In general, individuals with access to MEC other than coverage in the Individual Market are not eligible for tax subsidies on the federal Marketplace. However, for coverage recognized as additional MEC by the Secretary of HHS and the Secretary of the Treasury, additional guidance will be issued around if access to this coverage excludes individuals from Premium Tax Credit (PTC) eligibility. HHS will maintain a public list of the types of coverage recognized as Minimum Essential 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 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 (see Table 45) from the MEC requirement. Those who do not have MEC or an exemption will be required to pay a shared-responsibility payment to the IRS upon filing of taxes.

a. Exemptions

The ACA allows for individuals to apply for exemptions (see Table 45) from the requirement to maintain Minimum Essential Coverage. Depending on the type, an exemption may be requested through either prospectively or retrospectively through the IRS or the Marketplace.

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 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 be able to be granted only by the federal Marketplace or the Internal Revenue Service (IRS); 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 federal Marketplace 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.

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15 Patient Protection and Affordable Care Act Title 1Subtitle F Part 1 Section 1501
### Table 45: Types of Exemptions

<table>
<thead>
<tr>
<th>Exemption</th>
<th>Exemption Qualifications</th>
<th>Through Agency</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious Conscious</td>
<td>Practicing member of recognized religious sect or division (established pre-1950) with recognized ethical or moral objections to health insurance. Must also waive social security benefits.</td>
<td>Marketplace</td>
<td>- Exemption may be granted for more than one year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Granted prospectively or retrospectively</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Child turning 21 must resubmit application</td>
</tr>
<tr>
<td>Hardship</td>
<td>Individual determined to have suffered hardship with respect to the capability of obtaining a QHP</td>
<td>Marketplace or IRS depending on Hardship type</td>
<td>- Details of types of Hardship Exemptions discussed below</td>
</tr>
<tr>
<td>Indian Tribe</td>
<td>Be a member of a federally recognized tribe</td>
<td>Marketplace or IRS through tax filing process</td>
<td>- Marketplace must grant on continuing basis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Granted until Marketplace notified no longer in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Granted prospectively or retrospectively</td>
</tr>
<tr>
<td>Health Care Sharing Ministry</td>
<td>Member of Health Care Sharing Ministry 503(c) registered organization.</td>
<td>Marketplace or IRS through tax filing process</td>
<td>- Reapply every year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Only eligible if a member of ministry at time application submitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Granted retrospectively</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Marketplace will only grant in year it applies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- For previous year exemption through tax filing process</td>
</tr>
<tr>
<td>Incarceration</td>
<td>Incarcerated at least one day in a month after the disposition of charges</td>
<td>Marketplace or IRS through Tax filing process</td>
<td>- Marketplace only grants if requested in applicable year; IRS can grant retrospectively</td>
</tr>
<tr>
<td>Household – income below filing limit</td>
<td>Individuals below the filing limit</td>
<td>IRS through tax filing process</td>
<td>- Requires assessment of household income to be completed after year end through tax filing</td>
</tr>
<tr>
<td>Inability to afford coverage</td>
<td>Lowest cost Minimum Essential Coverage option costs more than 8% of income</td>
<td>IRS through tax filing process</td>
<td>- Requires assessment of household income &amp; cost of coverage through tax filing at year end</td>
</tr>
<tr>
<td>Not-lawfully present</td>
<td>Individuals not lawfully present not required to be covered</td>
<td>IRS through tax filing process</td>
<td>- Implemented exclusively through tax filing</td>
</tr>
<tr>
<td>Short coverage gaps</td>
<td>One gap of less than 3 months permitted without penalty</td>
<td>IRS through tax filing process</td>
<td>- May not be granted until year concludes</td>
</tr>
</tbody>
</table>

Source: [26 CFR §1.5000A-3](#).
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 46). These exemptions may be granted by the federal Marketplace or the IRS, depending on exemption type and can be processed retrospectively or prospectively.

Table 46: Hardship Exemptions (see following page)

<table>
<thead>
<tr>
<th>#</th>
<th>Hardship Exemption</th>
<th>Description</th>
<th>Granted by</th>
<th>Other</th>
</tr>
</thead>
</table>
| 1   | Inability to purchase              | • Significant unexpected increase in essential expenses due to financial or domestic circumstances including unexpected natural or human caused events.  
• Expense of purchasing health insurance would have caused individual to experience serious deprivation of food, shelter, clothing or other necessities.  
• Individual has experienced other factors similar to these and this prevented obtaining of minimum essential coverage. | Marketplace | • Exemption will be provided at minimum for the month it is applied for; Marketplaces have discretion to provide for additional months after the hardship. |
| 2   | Lack of affordable coverage based on projected income | • Cost of the lowest cost minimum essential coverage option is greater than 8% of income for individual or dependent.  
• Exemption is only available from the Marketplace as a hardship exemption through the end of the open or | Marketplace | • Same as IRS affordability exemption but may be awarded prospectively.  
• Individuals awarded this exemption may enroll in catastrophic plan.  
• Eligibility for an employer-sponsored plan only considered if the |
<table>
<thead>
<tr>
<th>#</th>
<th>Hardship Exemption</th>
<th>Description</th>
<th>Granted by</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>special enrollment period.</td>
<td>• Exemption is granted for entire year regardless of changes in circumstances.</td>
<td></td>
<td>plan meets minimum value requirements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Calculation for affordable coverage will account for increased premiums due to not completing wellness programs related to tobacco use in an employer-sponsored plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Retrospective affordability exemptions granted by IRS through tax filing process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Below filing threshold</td>
<td>Individual exempt if not required to file because gross income below filing threshold, but they file and dependent income bumps above filing threshold.</td>
<td>IRS</td>
<td>Exemption can be granted during tax filing or outside of tax filing</td>
</tr>
<tr>
<td>4</td>
<td>Medicaid Expansion population</td>
<td>Individual exempt if determined ineligible for Medicaid solely because state did not expand Medicaid.</td>
<td>Marketplace</td>
<td>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 PTC.</td>
</tr>
<tr>
<td>5</td>
<td>Employer-sponsored coverage exception: Combined coverage cost</td>
<td>Individuals exempt if multiple members determined eligible for affordable self-only employer-sponsored coverage but combined the cost of coverage exceeds 8% of income.</td>
<td>IRS</td>
<td>Exemption may be granted through tax filing process or other process.</td>
</tr>
<tr>
<td>6</td>
<td>Eligible for services through and Indian health care provider</td>
<td>Individuals that are not members of federally recognized tribes, but that are eligible for services through an Indian health care provider may receive an Exemption.</td>
<td>Marketplace</td>
<td>Exemption granted on continuing basis until reported that applicant no longer meets requirements</td>
</tr>
</tbody>
</table>
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 Marketplace or retrospectively through the IRS must demonstrate that the lowest cost MEC exceeded 8% of their household income.

Table 47: Estimated Premium Cost to Qualify for an Affordability Exemption

<table>
<thead>
<tr>
<th>Income and Premium Amounts for Affordability Exemptions</th>
<th>Annual Income</th>
<th>$10,000</th>
<th>$20,000</th>
<th>$30,000</th>
<th>$40,000</th>
<th>$50,000</th>
<th>$60,000</th>
<th>$70,000</th>
<th>$80,000</th>
<th>$90,000</th>
<th>$100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Income</td>
<td>$833</td>
<td>$1,667</td>
<td>$2,500</td>
<td>$3,333</td>
<td>$4,167</td>
<td>$5,000</td>
<td>$5,833</td>
<td>$6,667</td>
<td>$7,500</td>
<td>$8,333</td>
<td></td>
</tr>
<tr>
<td>Insurance must cost more than:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Premium</td>
<td>$800</td>
<td>$1,600</td>
<td>$2,400</td>
<td>$3,200</td>
<td>$4,000</td>
<td>$4,800</td>
<td>$5,600</td>
<td>$6,400</td>
<td>$7,200</td>
<td>$8,000</td>
<td></td>
</tr>
<tr>
<td>Monthly Premium</td>
<td>$67</td>
<td>$133</td>
<td>$200</td>
<td>$267</td>
<td>$333</td>
<td>$400</td>
<td>$467</td>
<td>$533</td>
<td>$600</td>
<td>$667</td>
<td></td>
</tr>
</tbody>
</table>

Source: 76 CFR §1.5000A-3

Unlike determinations for Insurance Affordability Programs, determinations for exemptions based on affordability income 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 48) 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 federal Marketplace 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 48: Affordability Exemptions

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Affordability for employer-sponsored coverage – employee</strong></td>
<td>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% of income is unaffordable and the individual may receive exemption.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Affordability for employer-sponsored coverage-related individual</strong></td>
<td>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% of income then the related individuals are exempt.</td>
<td>If cost of coverage for the self-only coverage is less than 8% of income then the employee is not exempt even if cost of coverage for family coverage is greater than 8% of income. Individuals who receive this exemption will not be subject to a shared responsibility payment but will also not be eligible for Premium Tax Credits or Cost Sharing Reductions.</td>
</tr>
<tr>
<td><strong>Affordability for coverage in individual market</strong></td>
<td>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 (i.e. an aunt and two nieces could base affordability on lowest cost Adult +2 plan). Any advanced payments of the Premium Tax Credit that the individual(s) would be eligible for are taken into account and if with this consideration contribution for the lowest cost bronze plan is greater than 8% of income for applicable individuals then individuals are exempt.</td>
<td>Guidance is still unclear if premium rate increases for tobacco use will be included or not in the calculation of individual market affordability.</td>
</tr>
</tbody>
</table>

Source: 26 CFR §1.5000A-3
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% of income, but is less than 9.5% of income will be eligible for an exemption, but not 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 9.5% of income, none of the employees’ dependents eligible for employer-sponsored coverage could receive PTC in the Marketplace regardless of the cost of family coverage. Additionally, PTCs for individuals between 250% and 400% FPL only come into effect after the individual or family has spent 8.05% to 9.5% 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 Internal Revenue Service (IRS) or the federal Marketplace, depending on the type. For exemptions obtained through the federal Marketplace the individual may use either the Single Streamlined Application or a separate exemption application. If an individual has already completed a single streamlined application to apply for health coverage, they 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 their Single Streamlined Application can be used to assess federal Marketplace 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 federal Marketplace exemption application. Exemptions granted by the IRS are obtained through the tax-filing process or other processes yet to be determined.

c. Exemption Appeals

Individuals have the right to appeal exemptions denials. Appeals for exemption denials would be directed to the agency that issued the initial denial. Exemption appeals denied by the federal Marketplace would be directed back to the federal Marketplace and exemption appeals denied by the IRS would be directed to the IRS.

16 $28,725 for an individual and $58,875 for a family of 4 based on 2013 federal poverty level
d. Exemption Wrap-Up

Individuals who are granted an exemption are exempt from the requirement to enroll in Minimum Essential Coverage (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.

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 MEC for themselves and their dependents. Any month in which the individual or their 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 their 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 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 the dollar amount penalty for every non-covered individual or dependent in the household or 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 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 2014, 2015, and 2016 (see Table 49):
Table 49: Annual Shared-Responsibility Payment Amounts

<table>
<thead>
<tr>
<th>Year</th>
<th>Penalty is the greater of:</th>
<th>Maximum Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dollar Penalty, assessed for every household member without MEC</td>
<td>Percent Penalty</td>
</tr>
<tr>
<td>2014</td>
<td>Adult: $95</td>
<td>1% of annual household income</td>
</tr>
<tr>
<td></td>
<td>Under age 18: $48</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum: $285</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>Adult: $325</td>
<td>2% of annual household income</td>
</tr>
<tr>
<td></td>
<td>Under age 18: $163</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum: $975</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>Adult: $695</td>
<td>3% of annual household income</td>
</tr>
<tr>
<td></td>
<td>Under age 18: $348</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum: $2,085</td>
<td></td>
</tr>
</tbody>
</table>

Source: 26 CFR §1.5000A-4

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 below penalties will be subject to the percent penalty displayed in the table above (see Table 49).

Table 50: Minimum Income Levels for Percent Penalties

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income level where percent penalty applies—Individual</td>
<td>&gt;$9,500 taxable income</td>
<td>&gt;$16,500 taxable income</td>
<td>&gt;$27,800 taxable income</td>
</tr>
<tr>
<td>Income level where percent penalty applies—Family</td>
<td>&gt;$28,500 taxable income</td>
<td>&gt;$48,750</td>
<td>&gt;$83,400</td>
</tr>
</tbody>
</table>

Source: 26 CFR §1.5000A-4

For example, an individual with $30,000 in taxable income would be subject to the percent penalty in all years. In 2014, the individual would be responsible for paying 1% of his or her income or $300 as a Shared-Responsibility Payment. In 2015, an individual with the same income would be responsible for paying 2% of his or her taxable income or $600 as a Shared-Responsibility Payment. In 2016, they would be responsible for paying 3% of their taxable income or $900 as a Shared-Responsibility Payment.

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17 Penalty is the greater of the amounts show in the table, but may not be greater than the average national QHP bronze plan premium.
18 Family is 3 to 6 individuals dependent on ages of applicable family members.
Based on current guidance, it appears that unlike calculation of the affordability determination, maximum penalty amounts for the shared responsibility payment are not decreased by amounts that an individual would have been eligible for under a Premium Tax Credit (PTC). The maximum amount an individual or family could pay is the national average cost bronze plans for the applicable individuals, and it is possible that this would be greater than the amount they would pay for the lowest-cost Bronze Plan with the PTC applied. As further guidance is released, this provision may change.

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.


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 health conditions. Beginning in 2014, consumers will be 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, beginning in 2014, a health plan must guarantee an offer of coverage to all individuals that apply. 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:** Beginning 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. However, the employer would be able to enroll in a new plan during the once annual period for Shop guaranteed availability (November 15th to December 15th).

Under the Guaranteed Availability requirement, plans qualified to be offered both on and off the federal Marketplace will be required to allow individuals who do not qualify to purchase federal Marketplace coverage to purchase the plan directly from the carrier. With this requirement, individuals that do not qualify for federal Marketplace coverage will have guaranteed availability to federal Marketplace 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 will be 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 under coverage purchased in 2014 and beyond.

The requirement to not allow 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.

b. **Dependent Age 26**

The ACA requires that all health plans that offer coverage for dependents to 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 if 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 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 around dependent age 26 in Indiana can be found on IDOI’s at [www.in.gov/idoi/files/Bulletin_189.pdf](http://www.in.gov/idoi/files/Bulletin_189.pdf).

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 (EHB) for all non-grandfathered health plans. Health plans can still place dollar limits on benefits that are not considered to be part of the EHBs.\(^{19}\) 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 to their EHB coverage in cases of high-cost events.

6. **Rating Factors**

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 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. 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.

\(^{19}\) Essential Health Benefits vary by state, please see the essential health benefit section for more detail.
a. Rating for Age

The ACA limits how much a major medical plan can increase the cost of their plan for older individuals to a 3 to 1 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 51) 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>
<thead>
<tr>
<th>AGE</th>
<th>PREMIUM RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20</td>
<td>0.635</td>
</tr>
<tr>
<td>21</td>
<td>1.000</td>
</tr>
<tr>
<td>22</td>
<td>1.000</td>
</tr>
<tr>
<td>23</td>
<td>1.000</td>
</tr>
<tr>
<td>24</td>
<td>1.000</td>
</tr>
<tr>
<td>25</td>
<td>1.004</td>
</tr>
<tr>
<td>26</td>
<td>1.024</td>
</tr>
<tr>
<td>27</td>
<td>1.048</td>
</tr>
<tr>
<td>28</td>
<td>1.087</td>
</tr>
<tr>
<td>29</td>
<td>1.119</td>
</tr>
<tr>
<td>30</td>
<td>1.135</td>
</tr>
<tr>
<td>31</td>
<td>1.159</td>
</tr>
<tr>
<td>32</td>
<td>1.183</td>
</tr>
<tr>
<td>33</td>
<td>1.198</td>
</tr>
<tr>
<td>34</td>
<td>1.214</td>
</tr>
</tbody>
</table>

Table 51: Federal Age Rating Curve

<table>
<thead>
<tr>
<th>AGE</th>
<th>PREMIUM RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>1.222</td>
</tr>
<tr>
<td>36</td>
<td>1.230</td>
</tr>
<tr>
<td>37</td>
<td>1.238</td>
</tr>
<tr>
<td>38</td>
<td>1.246</td>
</tr>
<tr>
<td>39</td>
<td>1.262</td>
</tr>
<tr>
<td>40</td>
<td>1.278</td>
</tr>
<tr>
<td>41</td>
<td>1.302</td>
</tr>
<tr>
<td>42</td>
<td>1.325</td>
</tr>
<tr>
<td>43</td>
<td>1.357</td>
</tr>
<tr>
<td>44</td>
<td>1.397</td>
</tr>
<tr>
<td>45</td>
<td>1.444</td>
</tr>
<tr>
<td>46</td>
<td>1.500</td>
</tr>
<tr>
<td>47</td>
<td>1.563</td>
</tr>
<tr>
<td>48</td>
<td>1.635</td>
</tr>
<tr>
<td>49</td>
<td>1.706</td>
</tr>
<tr>
<td>50</td>
<td>1.786</td>
</tr>
<tr>
<td>51</td>
<td>1.865</td>
</tr>
<tr>
<td>52</td>
<td>1.952</td>
</tr>
<tr>
<td>53</td>
<td>2.040</td>
</tr>
<tr>
<td>54</td>
<td>2.135</td>
</tr>
<tr>
<td>55</td>
<td>2.230</td>
</tr>
<tr>
<td>56</td>
<td>2.333</td>
</tr>
<tr>
<td>57</td>
<td>2.437</td>
</tr>
<tr>
<td>58</td>
<td>2.548</td>
</tr>
<tr>
<td>59</td>
<td>2.603</td>
</tr>
<tr>
<td>60</td>
<td>2.714</td>
</tr>
<tr>
<td>61</td>
<td>2.810</td>
</tr>
<tr>
<td>62</td>
<td>2.873</td>
</tr>
<tr>
<td>63</td>
<td>2.952</td>
</tr>
<tr>
<td>64 and older</td>
<td>3.000</td>
</tr>
</tbody>
</table>


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-1 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 3-to-1 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 the 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 health care 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 and www.census.gov/population/metro/data/metrodef.html

d. State-Specific

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

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lake, LaPorte, Kosciusko</td>
</tr>
<tr>
<td>2</td>
<td>St. Joseph, Starke, Elkhart, Kosciusko, Marshall, St. Joseph, Starke</td>
</tr>
<tr>
<td>3</td>
<td>Adams, DeKalb, Huntington, Latviaunge, Noble, Steuben, Warren, Wells, Whitley</td>
</tr>
<tr>
<td>4</td>
<td>Allen</td>
</tr>
<tr>
<td>5</td>
<td>Benton, Jasper, Newton, Warren, White</td>
</tr>
<tr>
<td>6</td>
<td>Cass, Fulton, Howard, Miami, Pulaski</td>
</tr>
<tr>
<td>7</td>
<td>Carroll, Clark, Fountain, Montgomery, Polk, Tippecanoe, Tipton</td>
</tr>
<tr>
<td>8</td>
<td>Blackford, Delaware, Grant, Jay, Randolph</td>
</tr>
<tr>
<td>9</td>
<td>Clay, Posey, Sullivan, Vermillion, Vigo</td>
</tr>
<tr>
<td>10</td>
<td>Boone, Hamilton, Marion, Morgan, Shelby, Hendricks</td>
</tr>
<tr>
<td>11</td>
<td>Fayette, Hancock, Henry, Madison, Union, Wayne</td>
</tr>
<tr>
<td>12</td>
<td>Bartholomew, Decatur, Jackson, Jennings, Rush</td>
</tr>
<tr>
<td>13</td>
<td>Brown, Johnson, Lawrence, Monroe, Owen</td>
</tr>
<tr>
<td>14</td>
<td>Delaware, Franklin, Clinton, Ohio, Ripley, Switzerland</td>
</tr>
<tr>
<td>15</td>
<td>Daviess, Dubois, Greene, Knox, Martin, Orange, Perry, Pike, Spencer</td>
</tr>
<tr>
<td>16</td>
<td>Clark, Crawford, Floyd, Harrison, Jefferson, Scott, Washington</td>
</tr>
<tr>
<td>17</td>
<td>Gibson, Posey, Warrick, Vanderburgh</td>
</tr>
</tbody>
</table>

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 federal 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 52: Rating for Family Plans

<table>
<thead>
<tr>
<th></th>
<th>Family Members 21 and older</th>
<th>Family Members 20 and under</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate for Age</td>
<td>Assign an age rating to each family member</td>
<td>Rate for the oldest 3 family members 20 and under</td>
</tr>
<tr>
<td>Rate for Tobacco Use</td>
<td>Assign a tobacco rating to each family member</td>
<td>Rate for the oldest 3 family members over 18 and 20 or under</td>
</tr>
<tr>
<td>Rate for Location</td>
<td>Assign a location rating to each family member</td>
<td>Rate for the oldest 3 family members 20 and under</td>
</tr>
<tr>
<td>Calculate Premiums</td>
<td>Determine premium for each individual</td>
<td>Determine premium for the oldest 3 members 20 and under</td>
</tr>
<tr>
<td>Family Premium</td>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

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

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20 In Indiana, tobacco use is prohibited for those under 18. The tobacco rating factor can only be applied to members who may legally use tobacco in the state in which they reside.
tobacco waived. The final premium an enrollee of a small group plan pays will depend on the employer’s contribution to the health plan.

**Sidebar:** For plans effective January 1, 2014, a health-contingent wellness program offered in connection with a group health plan may offer a reward of 30% of the cost for coverage. The amount may increase to 50% for wellness programs designed to prevent or reduce tobacco. Health-contingent wellness programs are designed to offer alternatives in order to avoid prohibited discrimination among members.

7. **Medical Loss Ratio (MLR)**

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%. 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 2014 to December 2014 plan year, health plans must report their MLR by July 31, 2015. 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 2014 plan year can expect to receive their rebate payment by September 1, 2015. 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 consumers rebate will depend on their health plans 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.


**Sidebar:** It is currently unclear if, for enrollees who receive Premium Tax Credits (PTCs), Medical Loss Ratio (MLR) rebates will be paid to the enrollee or to the federal government. Enrollees who receive PTCs pay up to a certain percentage of their income for their premium and any remaining premium is covered through a federal subsidy. As the MLR rebates are for excess premium collected, it is possible that the rebate may go to the payer of the last dollar of premium, which for individuals receiving PTC would be the federal government. If the MLR rebates are paid to the federal government for individuals who receive PTCs, then enrollees with PTCs should not expect to receive any MLR rebates. This section will be updated when this policy is clarified.

### 8. Marketplace vs. Non-Marketplace Coverage

Marketplaces do not eliminate the avenues through which individuals and small businesses purchase coverage today. Individuals and small businesses will still be able to purchase coverage through current methods that may include direct purchase from carriers, through agents or brokers, and through carrier websites. However, coverage available through the federal and [SHOP Marketplaces](http://shop.gov) will allow access to programs not available on the outside market. In addition, while all plans sold in 2014 have to meet the new market requirements including the [Rating Factors](http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), [Dependent Age 26](http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), [Essential Health Benefits (EHBs)](http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), [Actuarial Value (AV)](http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), and [Elimination of Lifetime and Annual Limits](http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), health plans sold through Marketplaces are subject to additional requirements placed on [Qualified Health Plans (QHPs)](http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf).

In general, a [Major Medical plan](http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf) sold either on or off of the federal Marketplace will offer comprehensive health coverage and will meet the requirement for individuals to maintain [Minimum Essential Coverage (MEC)](http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf). However, individuals who purchase a Major Medical plan off of the federal Marketplace in the individual market may be required to attest that they also have coverage for pediatric dental essential health benefits if these benefits are not included in their medical plan.

Not all plans offered outside of the federal Marketplace will be offered on the federal Marketplace, so there may be a greater selection of plan offerings outside of the federal Marketplace. Plans on the
federal Marketplace are not required to offer their coverage options outside of the Marketplace, so there may be a different selection of plans on the federal Marketplace than is available off of the Marketplace. Due to guaranteed availability and guaranteed renewability clauses, individuals who do not qualify to purchase a QHP will have an avenue to access the QHP through an off-Marketplace coverage option. If a health insurance offers the same health plan both on and off the Marketplace that health plan must have the same premiums regardless if it is sold on or off the Marketplace.

For individuals, only plans sold on the federal Marketplace are eligible for the Premium Tax Credit (PTC) or Cost-sharing Reductions (CSR). 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 Marketplace open enrollment periods. Consumers that seek coverage outside of the open enrollment period without receiving a special enrollment period may not be able to purchase a health plan.

**SIDEBAR:** Off-Marketplace plans ability to restrict purchase of plans to federal Marketplace open enrollment periods gives the plans the ability to limit adverse selection. Adverse selection is when individuals wait until they become sick or need health care services to enroll in a plan. The Affordable Care Act (ACA) eliminated health plan’s ability to screen for health status and exclude preexisting conditions prior to enrollment. Restricting enrollment to the federal Marketplace 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 federal Marketplace will take advantage of this option. Therefore, individuals who do not enroll on or off of the Marketplace during an open enrollment period and do not experience an event that may trigger a special enrollment period, may not have the opportunity to enroll throughout the year.

9. **Small Business Health Insurance Options Program (SHOP)**

The SHOP Marketplace is a forum for small businesses to purchase group coverage for their employees. In 2014 and 2015, businesses that qualify for Small Group Market coverage in the state based on their number of employees may use the SHOP to find, select, and enroll employees in coverage. Beginning in 2016, the SHOP will be available to all businesses that have up to 100 full-time equivalent employees.

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21 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.
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 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, it is planned that employees will be able to select from amongst SHOP plans in a metal level 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 15th to December 15th.

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 15th to December 15th. 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 of low-wage individuals under 25 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 deductible of $2,000 for an individual plan and $4,000 for a family plan. Deductible limits for the Small Group limit have been removed for 2015 (www.govtrack.us/congress/bills/113/hr4302/text). SHOP functionality in states with a federal Marketplace will likely change between 2014 and 2015 as some features have been...
delayed for full implementation. Employers that enroll in the SHOP in 2014 can expect that the 2015 enrollment experience and requirements will vary from the initial enrollment experience.

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/. 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 must set a contribution level and select a plan for their employees. For 2015 and after, the employer will select a metal coverage level (Bronze, Silver, Gold, or Platinum), as well as a reference plan within that coverage level. The employer will set 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 will pay their portion and their employee’s portion of premiums for their group coverage directly to the insurer that issues the coverage. For years beginning in 2015, the employer and employees portions of the premium will go directly to the SHOP Marketplace. The SHOP will then distribute 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 individuals 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 below lists for preventive care (see Table 53) 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. For example, for a new preventive screening recommended November 13, 2013 that issuers must include this service in their health plans for plan and policy years beginning on or after November 13, 2014.

i. United State Preventive Task Force (USPTF) Guidelines

Current United States Preventive Task Force A&B recommendations can be found online at www.uspreventiveservicestaskforce.org/uspsabrecs.htm.

As of April 2014, the preventive items and services recommended by the United States Preventive Task Force included:

**Table 53: USPSTF A and B Recommended Preventive Items and Services (April 2014) (see following pages)**

<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
<th>Description</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abdominal aortic aneurysm screening: men</td>
<td>The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.</td>
<td>B</td>
</tr>
<tr>
<td>2</td>
<td>Alcohol misuse screening and counseling</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>3</td>
<td>Anemia screening: pregnant women</td>
<td>The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.</td>
<td>B</td>
</tr>
<tr>
<td>4</td>
<td>Aspirin to prevent cardiovascular disease: men</td>
<td>The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.</td>
<td>A</td>
</tr>
<tr>
<td>5</td>
<td>Aspirin to prevent cardiovascular disease</td>
<td>The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic</td>
<td>A</td>
</tr>
<tr>
<td>#</td>
<td>Topic</td>
<td>Description</td>
<td>Grade</td>
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<td>-------</td>
</tr>
<tr>
<td>6</td>
<td>Bacteriuria screening: pregnant women</td>
<td>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.</td>
<td>A</td>
</tr>
<tr>
<td>7</td>
<td>Blood pressure screening in adults</td>
<td>The USPSTF recommends screening for high blood pressure in adults age 18 years and older.</td>
<td>A</td>
</tr>
<tr>
<td>8</td>
<td>BRCA risk assessment and genetic counseling/testing</td>
<td>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 (<em>BRCA1</em> or <em>BRCA2</em>). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.</td>
<td>B</td>
</tr>
<tr>
<td>9</td>
<td>Breast cancer preventive medication</td>
<td>The USPSTF recommends that clinicians engage in shared, informed decisionmaking 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.</td>
<td>B</td>
</tr>
<tr>
<td>10</td>
<td>Breast cancer screening</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>11</td>
<td>Breastfeeding counseling</td>
<td>The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.</td>
<td>B</td>
</tr>
<tr>
<td>12</td>
<td>Cervical cancer screening</td>
<td>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.</td>
<td>A</td>
</tr>
<tr>
<td>13</td>
<td>Chlamydial infection screening: nonpregnant women</td>
<td>The USPSTF recommends screening for chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older nonpregnant women who are at increased risk.</td>
<td>A</td>
</tr>
<tr>
<td>14</td>
<td>Chlamydial infection screening: pregnant women</td>
<td>The USPSTF recommends screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.</td>
<td>B</td>
</tr>
<tr>
<td>15</td>
<td>Cholesterol abnormalities screening: men 35 and older</td>
<td>The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.</td>
<td>A</td>
</tr>
<tr>
<td>#</td>
<td>Topic</td>
<td>Description</td>
<td>Grade</td>
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</tr>
<tr>
<td>16</td>
<td>Cholesterol abnormalities screening: men younger than 35</td>
<td>The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>B</td>
</tr>
<tr>
<td>17</td>
<td>Cholesterol abnormalities screening: women 45 and older</td>
<td>The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>A</td>
</tr>
<tr>
<td>18</td>
<td>Cholesterol abnormalities screening: women younger than 45</td>
<td>The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>B</td>
</tr>
<tr>
<td>19</td>
<td>Colorectal cancer screening</td>
<td>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.</td>
<td>A</td>
</tr>
<tr>
<td>20</td>
<td>Dental caries prevention: preschool children</td>
<td>The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than age 6 months whose primary water source is deficient in fluoride.</td>
<td>B</td>
</tr>
<tr>
<td>21</td>
<td>Depression screening: adolescents</td>
<td>The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.</td>
<td>B</td>
</tr>
<tr>
<td>22</td>
<td>Depression screening: adults</td>
<td>The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</td>
<td>B</td>
</tr>
<tr>
<td>23</td>
<td>Diabetes screening</td>
<td>The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.</td>
<td>B</td>
</tr>
<tr>
<td>24</td>
<td>Falls prevention in older adults: exercise or physical therapy</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>25</td>
<td>Falls prevention in older adults: vitamin D</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>26</td>
<td>Folic acid supplementation</td>
<td>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.</td>
<td>A</td>
</tr>
<tr>
<td>27</td>
<td>Gestational Diabetes Screening</td>
<td>The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.</td>
<td>B</td>
</tr>
<tr>
<td>#</td>
<td>Topic</td>
<td>Description</td>
<td>Grade</td>
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</tr>
<tr>
<td>28</td>
<td>Gonorrhea prophylactic medication: newborns</td>
<td>The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.</td>
<td>A</td>
</tr>
<tr>
<td>29</td>
<td>Gonorrhea screening: women</td>
<td>The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).</td>
<td>B</td>
</tr>
<tr>
<td>30</td>
<td>Healthy diet counseling</td>
<td>The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.</td>
<td>B</td>
</tr>
<tr>
<td>31</td>
<td>Hearing loss screening: newborns</td>
<td>The USPSTF recommends screening for hearing loss in all newborn infants.</td>
<td>B</td>
</tr>
<tr>
<td>32</td>
<td>Hemoglobinopathies screening: newborns</td>
<td>The USPSTF recommends screening for sickle cell disease in newborns.</td>
<td>A</td>
</tr>
<tr>
<td>33</td>
<td>Hepatitis B screening: pregnant women</td>
<td>The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.</td>
<td>A</td>
</tr>
<tr>
<td>34</td>
<td>Hepatitis C virus infection screening: adults</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>35</td>
<td>HIV screening: nonpregnant adolescents and adults</td>
<td>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.</td>
<td>A</td>
</tr>
<tr>
<td>36</td>
<td>HIV screening: pregnant women</td>
<td>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.</td>
<td>A</td>
</tr>
<tr>
<td>37</td>
<td>Hypothyroidism screening: newborns</td>
<td>The USPSTF recommends screening for congenital hypothyroidism in newborns.</td>
<td>A</td>
</tr>
<tr>
<td>38</td>
<td>Intimate partner violence screening: women of childbearing age</td>
<td>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 who do not have signs or symptoms of abuse.</td>
<td>B</td>
</tr>
<tr>
<td>39</td>
<td>Iron supplementation in children</td>
<td>The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.</td>
<td>B</td>
</tr>
<tr>
<td>40</td>
<td>Lung cancer screening</td>
<td>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 smoked previously.</td>
<td>B</td>
</tr>
<tr>
<td>#</td>
<td>Topic</td>
<td>Description</td>
<td>Grade</td>
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</tr>
<tr>
<td>41</td>
<td>Obesity screening and counseling: adults</td>
<td>The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.</td>
<td>B</td>
</tr>
<tr>
<td>42</td>
<td>Obesity screening and counseling: children</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>43</td>
<td>Osteoporosis screening: women</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>44</td>
<td>Phenylketonuria screening: newborns</td>
<td>The USPSTF recommends screening for phenylketonuria in newborns.</td>
<td>A</td>
</tr>
<tr>
<td>45</td>
<td>Rh incompatibility screening: first pregnancy visit</td>
<td>The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
<td>A</td>
</tr>
<tr>
<td>46</td>
<td>Rh incompatibility screening: 24–28 weeks' gestation</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>47</td>
<td>Sexually transmitted infections counseling</td>
<td>The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.</td>
<td>B</td>
</tr>
<tr>
<td>48</td>
<td>Skin cancer behavioral counseling</td>
<td>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.</td>
<td>B</td>
</tr>
<tr>
<td>49</td>
<td>Tobacco use counseling and interventions: nonpregnant adults</td>
<td>The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</td>
<td>A</td>
</tr>
<tr>
<td>50</td>
<td>Tobacco use counseling: pregnant women</td>
<td>The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.</td>
<td>A</td>
</tr>
<tr>
<td>51</td>
<td>Tobacco use interventions: children and adolescents</td>
<td>The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.</td>
<td>B</td>
</tr>
<tr>
<td>52</td>
<td>Syphilis screening: nonpregnant persons</td>
<td>The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.</td>
<td>A</td>
</tr>
</tbody>
</table>
The Federal Marketplace

ii. Preventive Guidelines for Women

The HRSA’s recommendations for women’s preventive care can be accessed online at www.hrsa.gov/womensguidelines/. The table below (see Table 54) shows the recommendations as of April 2014.

Table 54: Health Resources and Services Administration’s Recommended Preventive Services for Women (April 2014)

<table>
<thead>
<tr>
<th>#</th>
<th>Preventive Service</th>
<th>HHS Guideline</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Well-woman visits</td>
<td>Preventive care visit for adult women to obtain recommended preventive services that are age and developmentally appropriate</td>
<td>Annual, unless more visits needed due to woman’s health needs</td>
</tr>
<tr>
<td>2</td>
<td>Screening for gestational diabetes</td>
<td>Screening for gestational diabetes</td>
<td>Between 24-28 weeks of gestation for pregnant women and at first prenatal visit for women at high risk for diabetes</td>
</tr>
<tr>
<td>3</td>
<td>Human papillomavirus testing</td>
<td>High-risk human papillomavirus DNA testing in women with normal cytology results</td>
<td>Should begin at 30 years of age and occur at least every 3 years</td>
</tr>
<tr>
<td>4</td>
<td>Counseling for sexually transmitted infections</td>
<td>Counseling on sexually transmitted infections for sexually active women</td>
<td>Annual</td>
</tr>
<tr>
<td>5</td>
<td>Counseling/screening for human immune-deficiency virus</td>
<td>Counseling and screening for human immune-deficiency virus infection for sexually active women</td>
<td>Annual</td>
</tr>
<tr>
<td>6</td>
<td>Contraceptive methods and counseling.</td>
<td>FDA-approved contraceptive methods, sterilization procedures, and education and counseling for women with reproductive capacity</td>
<td>As prescribed</td>
</tr>
<tr>
<td>7</td>
<td>Breastfeeding support, supplies, counseling</td>
<td>Comprehensive lactation support and counseling during pregnancy and/or postpartum; costs for renting breastfeeding equipment</td>
<td>In conjunction with each birth.</td>
</tr>
<tr>
<td>8</td>
<td>Screening/counseling for interpersonal and domestic violence</td>
<td>Screening and counseling for interpersonal and domestic violence</td>
<td></td>
</tr>
</tbody>
</table>

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

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.
### Recommendations for Preventive Pediatric Health Care

**Bright Futures/Indiana Academy of Pediatrics**

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed to guide the care of children who are receiving competent primary care, with no evidence of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

#### III. The Federal Marketplace

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, setting aside an individual child's circumstances, may be appropriate.

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### Table: Preventive Health Care Guidelines

<table>
<thead>
<tr>
<th>AGE</th>
<th>INFANCY</th>
<th>EARLY CHILDHOOD</th>
<th>MIDDLE CHILDHOOD</th>
<th>ADOLESCENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2 mo</td>
<td>Prenatal</td>
<td>Birth</td>
<td>1 mo</td>
<td>2 mo</td>
</tr>
</tbody>
</table>

---

**Key:**
- ⦿ to be performed
- ⦿ risk assessment to be performed, with appropriate action to follow, if positive
- ⦿ range during which a service may be provided, with this symbol indicating the preferred age
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 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
- Recommendations for pregnant women: www.vaccines.gov/who_and_when/pregnant/index.html

### b. Essential Health Benefits (EHBs)

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 will be 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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Ambulatory Patient Services</td>
</tr>
<tr>
<td>2.</td>
<td>Hospitalization</td>
</tr>
<tr>
<td>3.</td>
<td>Mental health and substance use disorder health treatment</td>
</tr>
<tr>
<td>4.</td>
<td>Laboratory services</td>
</tr>
<tr>
<td>5.</td>
<td>Pediatric services including oral and vision care</td>
</tr>
<tr>
<td>6.</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>7.</td>
<td>Maternity and newborn care</td>
</tr>
<tr>
<td>8.</td>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>9.</td>
<td>Rehabilitative and habilitative services and devices</td>
</tr>
<tr>
<td>10.</td>
<td>Preventive and wellness services and chronic disease management</td>
</tr>
</tbody>
</table>

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 for 2014 and 2015. HHS (U.S. Department of Health and Human Services) and CCIIO (the Center for Consumer Information and Insurance Oversight) will revisit the EHB, and the benefits and process for determining EHB may change for 2016 and beyond.

For 2014 and 2015, 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. Summaries of each state’s EHB benchmark plan can be found on CMS’s website at cciio.cms.gov/resources/data/ehb.html.

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.

The services that should comprise the habilitative services category are not well defined by the ACA or any subsequent federal guidance. Federal guidance gave states the option of developing a definition for habilitative services if these services were not covered by the benchmark plan. Alternatively states could allow health insurers to define habilitative services. However, if the benchmark plan covered habilitative services then the services that the carrier considered to be habilitative become the definition of habilitative services for the state.

In Indiana, the EHB benchmark is the Anthem PPO (Preferred Provider Organization) 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. However, EHB are based on the actual benefits in the plan and not on the summary. The Certificate of Coverage for Indiana’s Benchmark Plan can be accessed on IDOI’s website at www.in.gov/idoi/files/Policy_17575IN054_Cert_5BlueAccessPPO.pdf.

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, hearing aids, or smoking cessation. 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 Essential EHB 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 may be viewed on IDOI’s website at [www.in.gov/idoi/files/FEPBlueVi.pdf](http://www.in.gov/idoi/files/FEPBlueVi.pdf) and the Certificate of Coverage for the pediatric dental services may be viewed on IDOI’s website at [www.in.gov/idoi/files/MetLife_Dental_Fedvip.pdf](http://www.in.gov/idoi/files/MetLife_Dental_Fedvip.pdf). All pediatric dental and vision services covered by these benchmark plans are considered to be EHB’s in Indiana.

Frequently asked questions about EHB in Indiana can be viewed at on IDOI’s website at [www.in.gov/idoi/files/IN_EHB_FAQ.pdf](http://www.in.gov/idoi/files/IN_EHB_FAQ.pdf).

**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 federal Marketplace, the Individual or Small Group Market plan may elect not to offer the pediatric dental coverage if there is a stand-alone dental plan offered on the Marketplace. In this instance, the plan on the Marketplace 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 Marketplace, the plan may elect not to offer pediatric dental coverage, but must require individuals purchasing the plan to attest that they have coverage for Marketplace 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 55) 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 that 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 Benefits (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 for 2014 and 2015 provides 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 55):
## Table 55: Indiana Insurance Mandates (2 pages)

<table>
<thead>
<tr>
<th>Benefit (&amp; Citation)</th>
<th>Large Group</th>
<th>Small Group</th>
<th>Individual</th>
<th>Employer Based (group)</th>
<th>HMO Not-Employer Based (non-group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of adopted children (27-8-5-21, 27-8-5-16.5)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Coverage of Chiropractor Provider for provision of covered services. Does not mandate coverage of chiropractic services. (27-8-6-4, 27-13-36-2.5)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Clinical Trial (27-8-25, 27-13-7-20.2)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Dependent Coverage- non-newborn (27-8-15-33)</td>
<td>N/A</td>
<td>Mandate</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetes treatment, supplies, and equipment (27-8-14.5, 27-8-5-16.5)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Maternity Benefits – if provided minimum benefits mandated (27-8-24, 16-41-17)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Substance Abuse/ Chemical Dependency Treatment – if provided no limits on services unless policy holder chooses policy with limits (27-8-5-15.6, 27-13-7-14.8)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Non Formulary Drugs and Devices (27-13-38)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Point of service product- dental services (27-13-37-4)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Must Offer</td>
<td>Must Offer</td>
</tr>
<tr>
<td>New born testing (16-41-17, 27-8-24)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Mental Health Parity (27-8-5-15.6 &amp; 16.5, 27-13-7-14.8)</td>
<td>Mandate</td>
<td>N/A</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Dependent continuation for Mental Retardation &amp; Physical Disability (27-8-5-2(a)(8), 27-8-5-19(c)(17), 27-8-5-16.5)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Mental Illness and Substance Abuse 27-8-5-15.6(e)</td>
<td>Must Offer</td>
<td>Must Offer</td>
<td>Must Offer</td>
<td>Must Offer</td>
<td>Must Offer</td>
</tr>
<tr>
<td>Postpartum Hospital Stay if Maternity Benefits provided (27-8-24)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td>Autism Spectrum Disorders (27-8-14.2, 27-13-7-14.7)</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Must Offer</td>
<td>Mandate</td>
<td>Must Offer</td>
</tr>
</tbody>
</table>

---

22 Autism spectrum disorder coverage is required in all non-grandfathered individual plans due to the benefits in Indiana’s EHB benchmark. The requirement to offer the coverage applies to grandfathered plans.
<table>
<thead>
<tr>
<th>Benefit (&amp; Citation)</th>
<th>Large Group</th>
<th>Small Group</th>
<th>Individual</th>
<th>Employer Based (group)</th>
<th>HMO Not-Employer Based (non-group)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newborns (27-8-5.6, 27-8-5-16.5)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td><strong>Dependent Age 26 (27-8-5-2, 27-8-5-28)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td><strong>Medical Food (27-8-24.1, 27-13-7-18)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Off label drugs (27-8-20)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td><strong>Orthotic and Prosthetic Devices (27-8-24.2, 27-13-7-19)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td><strong>Post-Mastectomy Reconstructive Surgery (27-8-5-26, 27-13-7-14, 27-8-5-16.5)</strong></td>
<td>Mandate (if contract covers Mastectomy)</td>
<td>Mandate (if contract covers Mastectomy)</td>
<td>Mandate (if contract covers Mastectomy)</td>
<td>Mandate (if contract covers Mastectomy)</td>
<td>Mandate (if contract covers Mastectomy)</td>
</tr>
<tr>
<td><strong>Continuation of Coverage Statement (27-13-7-13)</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td><strong>Morbid Obesity (27-8-14.1, 27-13-7-14.5, 27-8-5-16.5)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>N/A</td>
<td>Must Offer</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Dental Care for Mental or Physically Disabled (27-8-5-27, 27-13-7-15)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>N/A</td>
<td>Must Offer</td>
<td>Mandate</td>
</tr>
<tr>
<td><strong>Mammography (27-8-14-6, 27-13-7-15.3, 27-8-5-16.5)</strong></td>
<td>Must Offer</td>
<td>Mandate</td>
<td>N/A</td>
<td>Mandate</td>
<td>Must Offer</td>
</tr>
<tr>
<td><strong>Prostate Antigen Test (27-8-14.7, 27-13-7-17, 27-8-5-16.5)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Must Offer</td>
<td>Mandate</td>
<td>Must Offer</td>
</tr>
<tr>
<td><strong>Colorectal Cancer Testing (27-8-14.8, 27-13-7-17, 27-8-5-16.5)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Must Offer</td>
<td>Mandate</td>
<td>Must Offer</td>
</tr>
<tr>
<td><strong>Chemotherapy Parity (Oral and intravenous) (27-8-32, 27-13-7-20.2)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td><strong>Medical Child Support (27-8-23, 27-8-5-16.5)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
<tr>
<td><strong>Coverage for Athletic Trainer Services (if rehabilitative services covered) (27-8-6-6)</strong></td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
<td>Mandate</td>
</tr>
</tbody>
</table>


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23 Insurers may impose cost-sharing on this preventive benefit as it is not an ACA mandated preventive service.
d. **Actuarial Value (AV)**

All health plans offered on and off of the federal Marketplace 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 Essential Health Benefits (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 health care expenses may pay a greater percentage of their total health care costs.

Non-grandfathered Major Medical products must meet certain AV bands to be able to offer coverage either on the federal Marketplace or in the outside market. Every plan offered on or off the federal Marketplace in the Individual or Small Group Market must fall into one of the below AV bands. With the exception of Catastrophic Plans, plans with AV outside of these bands cannot be offered.

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>AV target</th>
<th>AV Band</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>58-62%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>68-72%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>78-82%</td>
</tr>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>88-92%</td>
</tr>
</tbody>
</table>

*Source: 45 CFR §156.140*

An enrollee may expect that, in general, plans with higher AV’s will have higher premiums but reduced cost-sharing. Conversely, plans with lower AV’s 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. AV will be calculated and displayed for every non-grandfathered health plan offered on and off of the federal Marketplace in the Individual and Small Group markets.

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 federal Marketplace.

b. Federal Poverty Level (FPL)

The amount of the Premium Tax Credit (PTC) and the level of Cost sharing Reduction (CSR) are based on the applicant’s income. For these programs income is expressed as a percentage of the federal poverty level (FPL). FPLs are published by the Department of Health and Human Services (HHS) and updated each year. FPLs are based around a poverty threshold amount which is referred to as 100% FPL. Households with incomes at or below this amount are designated 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 57) displays the FPL levels for 2014. Eligibility for PTC and CSR in 2014 will be based on the 2013 FPL levels. The updated FPL guidelines for 2015 will be published in January 2015; it is currently unclear when the federal Marketplace will begin to use the 2015 guidelines for determining PTC and CSR eligibility.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>100%</th>
<th>133%</th>
<th>150%</th>
<th>200%</th>
<th>250%</th>
<th>300%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,670</td>
<td>$15,521</td>
<td>$17,505</td>
<td>$23,340</td>
<td>$29,175</td>
<td>$35,010</td>
<td>$46,680</td>
</tr>
<tr>
<td>2</td>
<td>$15,730</td>
<td>$20,921</td>
<td>$23,595</td>
<td>$31,460</td>
<td>$39,325</td>
<td>$47,190</td>
<td>$62,920</td>
</tr>
<tr>
<td>3</td>
<td>$19,790</td>
<td>$26,321</td>
<td>$29,685</td>
<td>$39,580</td>
<td>$49,475</td>
<td>$59,370</td>
<td>$79,160</td>
</tr>
<tr>
<td>4</td>
<td>$23,850</td>
<td>$31,721</td>
<td>$35,775</td>
<td>$47,700</td>
<td>$59,625</td>
<td>$71,550</td>
<td>$95,400</td>
</tr>
<tr>
<td>5</td>
<td>$27,910</td>
<td>$37,120</td>
<td>$41,865</td>
<td>$55,820</td>
<td>$69,775</td>
<td>$83,730</td>
<td>$111,640</td>
</tr>
<tr>
<td>6</td>
<td>$31,970</td>
<td>$42,520</td>
<td>$47,955</td>
<td>$63,940</td>
<td>$79,925</td>
<td>$95,910</td>
<td>$127,880</td>
</tr>
<tr>
<td>7</td>
<td>$36,030</td>
<td>$47,920</td>
<td>$54,045</td>
<td>$72,060</td>
<td>$90,075</td>
<td>$108,090</td>
<td>$144,120</td>
</tr>
<tr>
<td>8</td>
<td>$40,090</td>
<td>$53,320</td>
<td>$60,135</td>
<td>$80,180</td>
<td>$100,225</td>
<td>$120,270</td>
<td>$160,360</td>
</tr>
</tbody>
</table>

For each additional person, add:

<table>
<thead>
<tr>
<th>100%</th>
<th>133%</th>
<th>150%</th>
<th>200%</th>
<th>250%</th>
<th>300%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,060</td>
<td>$5,400</td>
<td>$6,090</td>
<td>$8,120</td>
<td>$10,150</td>
<td>$12,180</td>
<td>$16,240</td>
</tr>
</tbody>
</table>

c. Modified Adjusted Gross Income (MAGI)

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 (HAS) contributions, and other deductions. More information on Adjusted Gross Income can be found on the IRS’s website at 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 adjusted gross income 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 57, 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).

12. Eligibility for Insurance Affordability Programs

In addition to having MAGI between 100% and 400% FPL, to be eligible for Insurance Affordability Programs an individual must meet all of the below requirements:

- Be a citizen, national, or lawful resident of the United States
- Not be incarcerated
- Reside or intend to reside in the state the individual is applying for coverage in
- 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 federal Marketplace. Catastrophic Plans, and plans sold off of the federal Marketplace 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, they may apply on behalf of their 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 federal Marketplace 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 2014, 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 they will file an income tax return in 2014. 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 for 2014 and the amount of APTC received.

Individuals may apply for APTC beginning in October 2013, in which the estimated APTC amounts will be based on an individual’s 2012 tax return. Individuals that have not filed a 2012 return will be permitted to provide other documentation of their income amount. However, individuals that do not file their 2014 return or file for a timely extension may experience a disruption of APTC payments in 2015. To be eligible for APTC, married couples must file a joint return.24 Married couples that received APTC and file separately for 2014 will owe the amount of APTC received back to the IRS when they file their 2014 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 CSR reduction. These changes include: increases or decreases in income, changes in household composition, changes in location, and changes in citizenship or incarceration status. If the amount of APTC an individual is eligible for decreases during the year and he or she 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 federal Marketplace

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24 A victim of domestic abuse who is married and unable to file a joint tax return may claim a Premium Tax Credit as referenced in http://www.irs.gov/pub/irs-drop/n-14-23.pdf.
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 PTC and CSR may only be accessed through the federal Marketplace (www.healthcare.gov). Individuals interested in obtaining APTC or CSR for themselves or their dependents must apply for these programs through the federal Marketplace during an open or special enrollment period. Those who seek health insurance outside of the Marketplace will not be eligible for Insurance Affordability Programs.

In Indiana, APTC are obtained through the Federal Marketplace. More information on APTC and application information can be obtained at www.healthcare.gov or by calling 1-800-318-2596.

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’ federal Marketplace, or through the Marketplace where the individual resides. Household members that are not dependents must apply separately for APTC. For example, in a household that consists of three sisters and their dependent children, each sister must apply separately for themselves and their dependent children, unless one of the sisters is legally the dependent of another.

b. Payment of the Premium Tax Credits

Payments of the PTC are for qualifying individuals that have incomes between 100% and 400% FPL based on MAGI and that enroll in a Qualified Health Plan (QHP) sold on the federal 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 the 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 is shown below (see Table 58). Note that the annual income and monthly income amounts are determined through MAGI methodology and not the income that an individual receives on his or her paycheck.
### Table 58: Required Contribution to Second Lowest-Cost Silver Plan Premium of APTC-Eligible Tax Filers

<table>
<thead>
<tr>
<th>Percent of income contribution</th>
<th>Individual Estimated Total Annual and Monthly Contributions Required Before APTC</th>
<th>Family of 4 Estimated Total Annual and Monthly Contributions Required Before PTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td>$11,670 to $15,521 Annual Income</td>
<td>$23,850 to $31,722 Annual Income</td>
</tr>
<tr>
<td>3% to 4%</td>
<td>$15,522 to $17,506 Annual Income</td>
<td>$31,722 to $35,776 Annual Income</td>
</tr>
<tr>
<td>6.3% to 8.05%</td>
<td>$23,341 to $29,176 Annual Income</td>
<td>$35,776 to $47,700 Annual Income</td>
</tr>
<tr>
<td>8.05% to 9.5%</td>
<td>$29,176 to $35,011 Annual Income</td>
<td>$47,701 to $59,626 Annual Income</td>
</tr>
<tr>
<td>&gt;9.5%</td>
<td>&gt;$35,011 Annual Income</td>
<td>&gt;$59,626 Annual Income</td>
</tr>
<tr>
<td>N/A Not Eligible</td>
<td></td>
<td>N/A Not Eligible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of income contribution</th>
<th>Individual Estimated Total Annual and Monthly Contributions Required Before APTC</th>
<th>Family of 4 Estimated Total Annual and Monthly Contributions Required Before PTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td>$233 to $310 Annual Income</td>
<td>$477 to $634 Annual Income</td>
</tr>
<tr>
<td>3% to 4%</td>
<td>$466 to $700 Annual Income</td>
<td>$952 to $1,431 Annual Income</td>
</tr>
<tr>
<td>6.3% to 8.05%</td>
<td>$700 to $1,470 Annual Income</td>
<td>$1,431 to $3,005 Annual Income</td>
</tr>
<tr>
<td>8.05% to 9.5%</td>
<td>$1,470 to $2,349 Annual Income</td>
<td>$3,005 to $4,800 Annual Income</td>
</tr>
<tr>
<td>&gt;9.5%</td>
<td>&gt;$2,349 Annual Income</td>
<td>&gt;$4,800 Annual Income</td>
</tr>
<tr>
<td>N/A Not Eligible</td>
<td></td>
<td>N/A Not Eligible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of income contribution</th>
<th>Individual Estimated Total Annual and Monthly Contributions Required Before APTC</th>
<th>Family of 4 Estimated Total Annual and Monthly Contributions Required Before PTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td>$973 to $1,293 Monthly Income</td>
<td>$1,988 to $2,643 Monthly Income</td>
</tr>
<tr>
<td>3% to 4%</td>
<td>$1,294 to $1,459 Monthly Income</td>
<td>$2,643 to $3,975 Monthly Income</td>
</tr>
<tr>
<td>6.3% to 8.05%</td>
<td>$1,459 to $1,945 Monthly Income</td>
<td>$3,975 to $5,963 Monthly Income</td>
</tr>
<tr>
<td>8.05% to 9.5%</td>
<td>$1,945 to $2,431 Monthly Income</td>
<td>$5,963 to $7,950 Monthly Income</td>
</tr>
<tr>
<td>&gt;9.5%</td>
<td>&gt;$2,431 Monthly Income</td>
<td>&gt;$7,950 Monthly Income</td>
</tr>
<tr>
<td>N/A Not Eligible</td>
<td></td>
<td>N/A Not Eligible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of income contribution</th>
<th>Individual Estimated Total Annual and Monthly Contributions Required Before APTC</th>
<th>Family of 4 Estimated Total Annual and Monthly Contributions Required Before PTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td>$19 to $26 Monthly Income</td>
<td>$40 to $53 Monthly Income</td>
</tr>
<tr>
<td>3% to 4%</td>
<td>$39 to $58 Monthly Income</td>
<td>$79 to $119 Monthly Income</td>
</tr>
<tr>
<td>6.3% to 8.05%</td>
<td>$58 to $123 Monthly Income</td>
<td>$119 to $250 Monthly Income</td>
</tr>
<tr>
<td>8.05% to 9.5%</td>
<td>$123 to $277 Monthly Income</td>
<td>$250 to $566 Monthly Income</td>
</tr>
<tr>
<td>&gt;9.5%</td>
<td>&gt;$277 Monthly Income</td>
<td>&gt;$566 Monthly Income</td>
</tr>
<tr>
<td>N/A Not Eligible</td>
<td></td>
<td>N/A Not Eligible</td>
</tr>
</tbody>
</table>


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 (EHB); additional benefits will not be covered by a PTC calculation. Because of the amount of the PTC is

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25 Amounts based on 2014 FPL. 2015 FPL will be released in January 2015 and will impact income and contribution estimates. FPL for APTC is based on MAGI.
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 the table above (see Table 58).

Once an individual or family has made their required monthly contribution towards their 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 ($23,341 per year) was estimated at $3,500 or $292 a month, the individual would be responsible for paying $1,470 per year or $123 a month, and the PTC amount would be $2,030 per year or $169 monthly as calculated from the difference between the premium cost of the second lowest cost Silver Plan.

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 ($23,341 per year) was a tobacco user, his or her premium may be as much as 1.5 times $3,500 or $5,250. However, the amount of the individual’s PTC would not change. The individual would still be eligible for a total PTC of $2,030 per year or $169 monthly, and would be responsible for paying the remaining premium of $3,220 per year or $268 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.

**Sidebar:** Tobacco use is defined by the 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 their tobacco use; however, an insurer may terminate an individual’s plan for non-payment of increased premiums related to tobacco use.

---

26 Note, the rates cited in this paragraph are examples only and are not based on any actual premium rates in Indiana or any other state. Premium rates on the federal Marketplace will be available October 1, 2013.

27 Note, the rates cited in this paragraph are examples only and are not based on any actual premium rates in Indiana or any other state. Premium rates on the federal Marketplace will be available October 1, 2013.
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 federal Marketplace to reduce their APTC amount or to request a new assessment for maximum APTC amount. The federal Marketplace may be reached at www.healthcare.gov or by calling 1-800-318-2596.

Sidebar: As of December 30, 2013, if the Marketplace discovers that it did not reduce an individual’s premium by the correct amount of the advance payment of the PTC, then the Marketplace must notify the individual within 45 calendar days of 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 2014 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 below amounts (see Table 59) due to excess APTC payments.

<table>
<thead>
<tr>
<th>Household income</th>
<th>Single Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200% FPL</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>200% to 300% FPL</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>300% to 400%</td>
<td>$1,250</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

For example, if a single individual is assessed to have 275% FPL based on MAGI, and when they file their 2014 taxes it shows that they received a $900 overpayment of APTC, then their tax liability is limited to $750 dollars.
d. Cost-Sharing Reductions (CSRs)

In addition to APTC 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.

CSRs increase the Actuarial Value (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. CSRs 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>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150% FPL</td>
<td>94% $2,250</td>
<td>$4,500</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>87% $2,250</td>
<td>$4,500</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>73% $5,200</td>
<td>$10,400</td>
</tr>
<tr>
<td>&gt;250% FPL</td>
<td>70% $6,350</td>
<td>$12,700</td>
</tr>
</tbody>
</table>

Source: 45 CFR §156.410

Not all plans will have exactly the out-of-pocket maximums displayed in Table 60; 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 overall lesser cost-sharing than those that are eligible for a CSR and do not enroll in a Silver Plan.

For example, the allowable out-of-pocket maximum for a bronze plan is $6,350 for an individual and $12,700 for a family regardless of the individuals income, and if they would be eligible for CSR if they enrolled in a Silver Plan. 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 will 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 61: AV and Allowable Out-of-Pocket Maximums by Metal Tier for CSR-Eligible Individuals

<table>
<thead>
<tr>
<th>Tier</th>
<th>Actuarial Value</th>
<th>100 - 150% FPL</th>
<th>150 - 200% FPL</th>
<th>200% - 250% FPL</th>
<th>&gt;250% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actuarial Value</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Premium Cost</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Allowable Out-of-pocket maximum individual</td>
<td>$6,350</td>
<td>$6,350</td>
<td>$6,350</td>
<td>$6,350</td>
</tr>
<tr>
<td></td>
<td>Allowable Out-of-pocket maximum family</td>
<td>$12,700</td>
<td>$12,700</td>
<td>$12,700</td>
<td>$12,700</td>
</tr>
<tr>
<td>Silver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actuarial Value</td>
<td>94%</td>
<td>87%</td>
<td>73%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Premium Cost</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td></td>
<td>Allowable Out-of-pocket maximum individual</td>
<td>$2,250</td>
<td>$2,250</td>
<td>$5,200</td>
<td>$6,350</td>
</tr>
<tr>
<td></td>
<td>Allowable Out-of-pocket maximum family</td>
<td>$4,500</td>
<td>$4,500</td>
<td>$10,400</td>
<td>$12,700</td>
</tr>
<tr>
<td>Gold</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actuarial Value</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Premium Cost</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Allowable Out-of-pocket maximum individual</td>
<td>$6,350</td>
<td>$6,350</td>
<td>$6,350</td>
<td>$6,350</td>
</tr>
<tr>
<td></td>
<td>Allowable Out-of-pocket maximum family</td>
<td>$12,700</td>
<td>$12,700</td>
<td>$12,700</td>
<td>$12,700</td>
</tr>
<tr>
<td>Platinum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actuarial Value</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Premium Cost</td>
<td>Highest</td>
<td>Highest</td>
<td>Highest</td>
<td>Highest</td>
</tr>
<tr>
<td></td>
<td>Allowable Out-of-pocket maximum individual</td>
<td>$6,350</td>
<td>$6,350</td>
<td>$6,350</td>
<td>$6,350</td>
</tr>
<tr>
<td></td>
<td>Allowable Out-of-pocket maximum family</td>
<td>$12,700</td>
<td>$12,700</td>
<td>$12,700</td>
<td>$12,700</td>
</tr>
</tbody>
</table>

Source: [45 CFR §156.410 & 45 CFR §156.140](#)
To obtain a CSR, an eligible individual only needs to apply for a Qualified Health Plan (QHP) and Insurance Affordability Programs through the Marketplace, 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 federal Marketplace at [www.healthcare.gov](http://www.healthcare.gov) or 1-800-318-2596.

| Sidebar: | There are two additional Cost-Sharing Reductions 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 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 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). |

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– 2015 and Beyond

Individuals that are enrolling or re-enrolling in [Qualified Health Plans](http://www.healthcare.gov) (QHPs) through the Marketplace or apply for [Insurance Affordability Programs](http://www.healthcare.gov) may only enroll or re-enroll in and switch QHP’s during an open or special enrollment period. An uninsured individual that approaches the federal Marketplace for coverage outside of an open enrollment period and who is not subject to a special enrollment period, will not be allowed to enroll or re-enroll through the federal Marketplace or take advantage of the Premium Tax Credit (PTC) or Cost sharing Reductions (CSR).
The open enrollment period for 2015 enrollment or re-enrollment in a QHP through the federal Marketplace and application for Insurance Affordability Programs is **November 15, 2014 through February 15, 2015**. Individuals that enroll or re-enroll between November 15 and December 15, 2014 will be eligible for health coverage and Insurance Affordability Programs as of January 1, 2015. However, coverage will not begin until the next month for individuals that enroll or re-enroll after December 15, 2014 and who are eligible to receive Insurance Affordability Provisions. The date an individual applies may not be the date of enrollment. The table below (see Table 62) shows enrollment and effective dates for Insurance Affordability Programs in the 2015 open enrollment period.

<table>
<thead>
<tr>
<th>Enrollment Date</th>
<th>APTC Initiation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 15, 2014 to December 15, 2014</td>
<td>January 1, 2015</td>
</tr>
<tr>
<td>December 16, 2014 to January 15, 2015</td>
<td>February 1, 2015</td>
</tr>
<tr>
<td>January 16, 2015 to February 15, 2015</td>
<td>March 1, 2015</td>
</tr>
</tbody>
</table>

*Source: 45 CFR §155.410 & §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 15th of the month, but who do not select a QHP until after the 15th 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 2015, HHS will provide additional information regarding the dates and guidelines for subsequent enrollment periods. **NOTE: 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. Special enrollment periods apply to the individual and their dependents, and an entire family may be subject to a special enrollment period if one member gains access to such a period. Certain events trigger special enrollment periods, and in general, individuals have 60 days from an event that triggers a special enrollment period to enroll in or change, if applicable, a QHP. 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 special enrollment period will have different effective dates. There are eight events (described in Table 63 below) that may trigger a special enrollment period where an individual may change QHPs or complete initial enrollment into a Qualified Health Plan.
### Table 63: Special Enrollment Periods

<table>
<thead>
<tr>
<th>Event</th>
<th>Coverage Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loss of Minimum Essential Coverage (MEC)</td>
<td>Coverage effective first day of following month. Individuals that lose coverage because of failure to pay a premium are not eligible for a special enrollment period due to loss of MEC.</td>
</tr>
<tr>
<td>2. Individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption or placement for foster care</td>
<td>For birth, adoption, placement for adoption or placement for foster care coverage, effective dates is date of event. For marriage, coverage effective date is first day of the following month.</td>
</tr>
<tr>
<td>3. Individual or his dependent that did not previously have citizen, national or lawful present status gains such status</td>
<td>Regular effective dates apply. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>4. QHP that the individual or dependent is enrolled in substantially violated a material provision of its contract in relation to the enrollee</td>
<td>At Marketplace discretion, coverage effective date will be either date of event or the regular coverage effective dates. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th, on 1st day of the following second month.</td>
</tr>
<tr>
<td>5. Enrolled individual found newly eligible or ineligible for APTC, or change in eligibility for Cost Sharing Reductions. This includes individuals who will lose employer-sponsored coverage within 60 days, or the coverage will become unaffordable or not provide minimum coverage. These individuals may access an advanced special enrollment period to ensure there is no coverage gap</td>
<td>Regular effective dates apply. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month. Enrollees may only access this enrollment period if they are already enrolled in a QHP through the Marketplace.</td>
</tr>
<tr>
<td>6. Qualified individual or enrollee gains access to new QHPs as a result of a permanent move</td>
<td>Regular effective dates apply. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>7. Individuals with Indian status may enroll in QHP or change from one QHP to another once per month. Indian status means the individual can be verified as a member of one of the 566 federally recognized tribes referenced at: <a href="http://www.gpo.gov/fdsys/pkg/FR-2012-08-10/pdf/2012-19588.pdf">www.gpo.gov/fdsys/pkg/FR-2012-08-10/pdf/2012-19588.pdf</a></td>
<td>Regular effective dates apply. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>8. SHOP specific special enrollment for individuals newly eligible or ineligible for Medicaid premium assistance for Employer-Sponsored Insurance</td>
<td>Applicable effective dates not specified, SHOP special enrollment periods are for 30 days.</td>
</tr>
</tbody>
</table>

Source: [45 CFR §155.420](http://www.gpo.gov/fdsys/pkg/FR-2012-08-10/pdf/2012-19588.pdf)
In addition, CMS has included the following events (see Table 64) as limited circumstance in which special enrollment periods apply to eligible consumers to select a plan after open enrollment ends.

<table>
<thead>
<tr>
<th>Event</th>
<th>Coverage Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An individual faces exceptional circumstances as determined by CMS, such as natural disaster, medical emergency, and planned system outages that occur on or around plan selection deadlines.</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>2. Misinformation, misrepresentation or inaction in which misconduct by individuals or entities providing enrollment assistance (like an insurance company, Navigator, CAC, 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.</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>3. Enrollment error in which individual enrolled through the Marketplace, but the insurance company did not get their information</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>4. System errors related to immigration status</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>5. Display errors on Marketplace website</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>Event</td>
<td>Coverage Effective Date</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6. Individuals who were found ineligible for Medicaid or CHIP and their applications were not transferred to the State Medicaid or CHIP agency from the Marketplace in time to enroll in a plan during open enrollment</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>7. Individual is not able to complete enrollment due to error messages</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>8. Individual is working with a caseworker on an enrollment issue that is not resolved prior to March 31</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>9. Individual is married, and is a victim of domestic abuse as referenced in <a href="http://www.irs.gov/pub/irs-drop/n-14-23.pdf">http://www.irs.gov/pub/irs-drop/n-14-23.pdf</a>. Individuals in this category can apply and select a plan through May 31, 2014</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
<tr>
<td>10. Other system errors, as determined by CMS, which hindered enrollment completion</td>
<td>At Marketplace discretion, coverage effective date will be either the date of the event or the regular coverage effective dates. I.e. For QHP selection through the 15th of the month, on the first day of the next month, and for QHP selection after the 15th of the month on the 1st day of the following second month.</td>
</tr>
</tbody>
</table>


Due to exceptional circumstances, qualified individuals may be eligible for advance payments of the premium tax credit (APTC) and advance payments of cost-sharing reductions (CSRs) on a retroactive...
basis from the issuer. The subsidies may be in effect based on the retroactive date, established by the Marketplace, 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 federal Marketplace. Open enrollment periods only apply to the individual market; businesses seeking group coverage are not subject to these periods.

\( g. \) \textit{Open Enrollment Period and the Outside Market}

Health plans offering individual coverage outside of the federal Marketplace may elect to restrict enrollment into their products to the federal Marketplace open and special enrollment periods. It is expected that the health plans will follow the federal Marketplace open and special enrollment periods. Individuals that do not enroll in health insurance during the open enrollment period and who do not experience a special enrollment event will not have the option to enroll in coverage off of the federal Marketplace.

\( h. \) \textit{Applying for Individual or Family Marketplace Coverage}

Though individuals may only enroll in coverage through the federal Marketplace during the open enrollment period, individuals may apply for an eligibility determination for federal Marketplace coverage at any time during the year. For 2013, until the open enrollment period begins on October 1, individuals may create an account at www.healthcare.gov and enter in basic information that will assist with their Marketplace enrollment for 2014. Beginning October 1, 2013, individuals that have created an account will be able to complete applications for eligibility and enrollment in Qualified Health Plans (QHP) and Insurance Affordability Programs. Starting October 1, 2013, qualified individuals that have submitted an application will be able to select plans for coverage beginning January 1, 2014. For years after 2014, individuals that complete an application for coverage prior to or during the open enrollment period may be able to select coverage starting October 15\textsuperscript{th} with an effective coverage date of January 1, 2014.

Individuals that apply for coverage through the Marketplace 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 premium tax credit funds.

Individuals that are interested in applying for federal Marketplace coverage with or without application for PTCs or CSRs may complete one of the three Health Insurance Marketplace Applications for Health Coverage. The three applications are: an application for individuals only interested in QHP coverage, an application for individuals interested in QHP coverage with PTCs for themselves, and an application for
individuals and their families interested in QHP coverage with Premium Tax Credits. These applications can be completed online at www.healthcare.gov, or submitted on paper, over the phone, or in person. For information on submitting paper applications, phone applications, or applications in person individuals can contact the federal Marketplace at www.healthcare.gov or call 1-800-318-2596. Individuals applying online or by phone will not have to select their application, but will be asked to answer the appropriate questions based on their circumstances.

All applications will allow the individual to designate an Authorized Representative to handle their account. If the authorize representative form is completed, the person designated will receive coverage notices for the individual and may make coverage option decisions for the individual. The Authorized Representative designation will be valid until the individual revokes it.

i. Applying for QHP Coverage Only

When submitting an application only for coverage through a QHP where the individuals is not interested in help paying for the costs of the coverage through Insurance Affordability Programs, the individual will indicate on the online application that they are not interested in help paying for coverage or will select the paper application that is solely designated as an Application for Health Coverage.

Individuals who apply only for QHP coverage will complete a condensed application. To be eligible to purchase a QHP on the federal Marketplace, individuals must only meet all of the following criteria:

- Be a citizen, national or legal resident of the United States,
- Be a resident or intend to be a resident of the state they are applying for coverage in, and
- Not be incarcerated.

These are the only eligibility requirements to use the federal Marketplace in Indiana. Those eligible to enroll in a QHP through the federal Marketplace may do so even if they have access to other Minimum Essential Coverage (MEC). For individuals paying in full for their QHP coverage through the Marketplace, there are no eligibility restrictions other than legal residency, state residency, and non-incarceration.

Individuals that are incarcerated may apply for coverage for their dependents through the federal Marketplace; however, individuals that are incarcerated may not purchase and be covered by a QHP on the federal 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 federal Marketplace 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 federal Marketplace to apply for coverage on behalf of their dependents that are citizens, nationals, or legal residents of the United States. The federal Marketplace 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 federal Marketplace plans without going through a federal Marketplace determination by contacting the carrier directly.28

The application for coverage through the federal Marketplace coverage alone (without the accompanying application for Insurance Affordability Provisions) will ask for the individual’s name, address, Social Security Number or immigration document identification, and information about how they would like to receive information from the federal Marketplace or health plan. Individuals should provide their full legal names when applying for federal Marketplace coverage to ensure that information can be appropriately verified. Individuals that are applying for coverage on behalf of their dependents do not have to provide proof of their own citizenship or legal residency; however, they will have to provide this information for the dependents for whom they are seeking coverage. They will also provide basic information on all dependents, including name, date of birth, Social Security Number, relationship to the applying individual, and residency. The full legal name of the dependent should be used on the application to assure that the information can be verified by the federal Marketplace.

Individuals will be asked on the application for coverage through a QHP for information on any membership in federally recognized tribes.29

Finally, individuals will sign and date the application and attest that all information provided is accurate.

When the application is complete, the federal Marketplace will verify the information with available electronic data sources. If there are any inconsistencies between the provided information and the electronic data sources, individuals may have to provide documentation for their citizen, national or legal resident status, their state residency status, or their incarceration status. 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.

28 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.
29 A list of federally recognized tribes can be found at: www.gpo.gov/fdsys/pkg/FR-2012-08-10/pdf/2012-19588.pdf.
Individuals that enroll in a QHP through the Marketplace without electing to receive an Advanced Payment of the Premium Tax Credit (APTC) may still receive an APTC Reconciliation at tax filing. Eligible individuals enrolled in qualifying coverage through the Individual Market for themselves and their dependents, may choose to receive an amount of APTC or elect to forego help paying for their QHP through the Marketplace initially and receive their PTC payments retrospectively upon tax filing.

A sample application for QHP coverage on the Marketplace can be accessed on CMS’s website at www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/. Since October 1, 2013, the live application has been accessible at www.healthcare.gov or by calling 1-800-318-2596.

ii. Applying for QHP Coverage with Insurance Affordability Programs

Individuals seeking QHP coverage and Insurance Affordability Programs must complete a longer application. In addition to the eligibility requirements for receiving coverage through a QHP on the Marketplace, Individuals that seek PTCs for help paying for the premium cost of coverage must:

- 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 federal Marketplace

Individuals seeking coverage for themselves or their families through QHPs on the federal Marketplace and simultaneously applying for Insurance Affordability Programs will be asked to provide the basic information requested for those individuals interested just in QHP enrollment and also information about their, and their family income, and any other offers of Minimum Essential Coverage. Having access to other MEC may not disqualify the individual from receiving Premium Tax Credits, 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.

In addition to these questions, 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 9.5% of household income) and provides minimum value (MV). Individuals can access a check list for what they need to apply for federal Marketplace coverage and Insurance Affordability Provisions simultaneously, and the form to provide to their employer online at www.healthcare.gov/downloads/MarketplaceApp_Checklist_Generic.pdf.
Individuals will also be asked to provide permission for the federal Marketplace 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 PTC. However, individuals are not required to provide this authorization for any longer time period. Individuals will be asked to provide authorization for the federal Marketplace 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 federal Marketplace authorization to access their tax information in subsequent years. In addition, individuals that provide the federal Marketplace 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.

The federal Marketplace will verify the information provided by the individual with available electronic data sources, including the IRS tax data. If there are any inconsistencies between the provided information and the electronic data sources individuals may have to provide documentation related to the discrepancies. 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 work to submit the required documentation to assure that they are able to enroll in coverage with minimal delay.

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 IRS to the QHP and the individual will experience the benefit in the form of a reduced monthly premium. The individual will reconcile any overpayments or underpayments of APTC with the IRS at tax filing. The federal Marketplace APTC eligibility determination will allow for individuals their maximum estimated amount of APTC. If, after filing taxes for the year, it is discovered that the individual has accepted too little APTC, it will be refunded to them at tax filing, and if the individual has accepted too much APTC they will be liable to return these funds at tax filing up to reconciliation limits. 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 APTC 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 APTC and request an APTC redetermination from the federal Marketplace upon the income decrease or household size increase. Individuals with questions about how much or how little APTC they should accept should contact a tax professional or the federal Marketplace at www.healthcare.gov or by calling 1-800-318-2596.

Individuals that apply for APTC will also be assessed for Cost-sharing Reductions (CSRs). Individuals do not apply for CSR separately. Households with incomes below 250% Federal Poverty Level (FPL) that meet the APTC 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 federal Marketplace. In Indiana, the federal Marketplace 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 federal 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.

A sample application for an individual to apply for QHP coverage with Insurance Affordability Programs for only themselves can be accessed on CMS’s website at www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources. A sample application for individuals applying for themselves and their families for help paying for QHP coverage with Insurance Affordability Programs can be accessed on CMS’s website at www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources. Individuals that apply online through the federal Marketplace may not see all the questions present on these sample application forms, or may see additional questions dependent on their circumstances.

iii. Enrollment

While individuals may apply and receive their eligibility determination at any time after October 1, 2013, individuals may only enroll in QHPs through the Marketplace during open enrollment and special enrollment periods. The initial open enrollment period is from October 1, 2013 to March 31, 2014. After this initial open enrollment period, the 2015 annual open enrollment period is from October 15, 2014 to February 15, 2015. Subsequent enrollment periods will be determined by HHS.

When enrolling in a plan, individuals will have to choose a Bronze, Silver, Gold, or Platinum plan based on Actuarial Value (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 federal Marketplace 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 federal Marketplace at www.healthcare.gov or by calling 1-800-318-2596 and ask for a listing of federal Marketplace-certified insurance agents and brokers.
iv. 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. QHPs 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 plan directly.

v. 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 federal Marketplace 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 Marketplace 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 federal Marketplace and for Insurance Affordability Programs. Individuals that have had a change in circumstance may receive a notification form the Marketplace 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 Marketplace QHPs. Individuals should respond to all Marketplace queries regarding eligibility and may contact the Marketplace directly with questions at www.healthcare.gov or 1-800-318-2596.
vi. 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 an APTC through the Marketplace that experiences an income decrease or a household size increase may find that their children are newly eligible for CHIP. Similarly, a woman covered by a QHP with APTC that becomes pregnant may become eligible for Medicaid during her pregnancy.

For individuals enrolled in QHPs or APTC through the Marketplace, all changes relating to income, location, household size, and health or disability status should be reported at www.healthcare.gov or 1-800-318-2596. Individuals may also transition from Medicaid programs to the federal Marketplace. Medicaid and the federal Marketplace will coordinate this transition and individuals may contact either Indiana Medicaid at www.in.gov/fssa or 1-800-403-0864, or the federal Marketplace with questions or concerns around these transitions.

vii. Re-enrollment

Qualified Health Plan enrollment lasts for a calendar year. Even individuals who experienced a plan change during a special enrollment period will complete the re-enrollment process during the next enrollment period. All individuals enrolled in through the federal Marketplace 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 federal Marketplace in the annual eligibility redetermination. Individuals that do not report changes will have their eligibility re-determined based on the information available to the federal Marketplace 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 must select a new QHP. 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 Marketplace QHPs without APTC. If these individuals have not provided authorization for the federal Marketplace 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 a PTC without providing authorization for the federal Marketplace to access their tax information and may
not receive an advanced payment of the 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 federal Marketplace to access their tax information, then they will not receive a redetermination until they provide this authorization. Individuals may request a redetermination solely for 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.

Sidebar: Individuals enrolled in APTC need to be aware that their APTC amount may change upon reenrollment. It is unclear what the Marketplace policy is at reenrollment when individuals are eligible for less or additional APTC than they were eligible for in the previous year. Individuals will experience out-of-pocket premium changes at enrollment as QHP premiums may change annually and individual APTC may also change. How the federal Marketplace will apply APTC for individuals that do not respond to redetermination notices remains unclear; the federal Marketplace may apply the same amount as the previous year, or the maximum amount the individual is determined eligible for. Individuals that may experience changes in circumstances that will impact the amount of APTC for which they are eligible, including a change in household size or a change in income, should respond to the annual redetermination notice. This will help to ensure they are accepting the appropriate APTC and will not be subject to penalties at reconciliation.

viii. 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 federal Marketplace to file an appeal. The federal Marketplace can be contacted through www.healthcare.gov or 1-800-318-2596. 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. QHPs 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 317-232-2385 for more information.
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 tools, knowledge, and additional resources to use in promoting informed 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. In addition, 1634 Status states may, but are not required to, operate a Medicaid spend-down program. 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 federal Marketplace eligibility or benefits can be made via an Appeal Request Form located at [www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf](http://www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf). Appealable decisions are specified on the form.

3. **Benefits Portal** is a website developed and managed by the Indiana Department 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.ifcem.com/CitizenPortal/application.do](http://www.ifcem.com/CitizenPortal/application.do).

4. **Best Door** refers to a consumer’s decision to either complete the Indiana Application for Health Coverage (IAHC) or the federal Marketplace application for health coverage based on certain eligibility criteria (e.g., Table 65, Table 66, and Table 67) 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 29 for the 2014 list of Medicaid eligibility groups.

6. **Eligibility Redetermination** is the process by which an enrolled consumer is re-enrolled, terminated, or transferred into State Medicaid or the federal Marketplace. The eligibility redetermination is 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.

7. **Federal Marketplace** (also referred to as Federally-facilitated Marketplace or FFM) is a federally-developed and federally-operated 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) 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 CACs) that provide Marketplace outreach, education, and enrollment services. This is the Marketplace model used in Indiana.

8. **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. For 2014, the FPL for a single person is $973 per month, and $1,988 per month for a family of four.

9. **Healthcare.gov** is a health insurance Marketplace website owned and operated by the federal 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 federal Marketplace and Partnership Marketplace states. The website also fragment those consumers who may be eligible for Medicaid, and has a separate portal for small businesses (the SHOP Marketplace).

10. **Healthy Indiana Plan (HIP)** is Indiana’s health coverage program for Hoosier adults between the ages of 19-64 whose incomes are at or below 100% FPL and who are not covered by Medicare or other Minimum Essential Coverage (MEC). HIP is authorized through an 1115 Waiver with the federal Centers for Medicare & Medicaid Services (CMS). Covered individuals and the State make monthly contributions to a POWER Account.

11. **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 to prevent 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 20.
12. **Indiana Application for Health Coverage (IAHC)** is an application for an Indiana Health Coverage Program (IHCP) which may be submitted to DFR either online through the 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 68.

13. **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), Care Select, Traditional Medicaid, and home and community based waiver services (HCBS). Applications for IHCPs can be accessed through the DFR Benefits Portal at www.dfrbenefits.in.gov.

14. **Insurance Affordability Program** refers to either of two programs—Premium Tax Credit (PTC) or Cost-sharing Reduction (CSR)—that was established by the 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.

15. **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 health care providers for serving eligible individuals.

16. **Medicaid Review Team (MRT)** 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 DFR of its decision.

17. **Open Enrollment Period** is the timeframe in which individuals can apply and enroll in health coverage through the individual Marketplace. The initial open enrollment period was October 1, 2013 through March 31, 2014. The next open enrollment period is November 15, 2014 through February 15, 2015. The annual open enrollment period is to be determined by the Centers for Medicare & Medicaid Services.

18. **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 federal Marketplace 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 65, Table 66, and Table 67), in order to better direct the consumer to the type of coverage for which the consumer is most likely eligible.
19. **Presumptive Eligibility (PE)** is a determination by a Qualified Provider 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 two PE programs, PE for Pregnant Women and Hospital PE. PE for pregnant women (also referred to as “Managed Care”) provides temporary coverage of prenatal care services (Package P only). Hospital PE is PE determined by qualified hospitals for pregnant women (Package P only), children under 19, low-income parents and caretakers, the Family Planning Eligibility Program, or former foster children up to age 26.

20. **Re-enrollment** is the yearly process by which consumers enrolled in a Qualified Health Plan (QHP) through the Marketplace take steps to re-enroll in coverage. Enrollment in a QHP lasts for one calendar year, at which time the enrollee must re-enroll in order to be covered through the Marketplace. All individuals enrolled in the federal Marketplace 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 federal Marketplace in the annual eligibility re-determination.

21. **Social Security Administration (SSA)** is a federal agency through which Indiana Medicaid disability applications go through, effective June 1, 2014, 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 to SSA.

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 Medicaid 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 63.

24. **Supplemental Security Income (SSI)** is a federal program that pays benefits to adults and children determined disabled by the 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 federal Marketplace 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/or 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; and 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 via the Indiana Department of Insurance (IDOI) website at www.in.gov/idoi/2823.htm.

Before helping a consumer complete an application through Indiana’s Health Coverage Program portal (www.dfrbenefits.in.gov) or through the federal Marketplace (www.healthcare.gov), an Indiana Navigator should complete each of the following three steps: (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 federal Marketplace; 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. The Indiana Navigator should also clearly describe the Indiana Navigator’s role in the health coverage application process and highlight limitations, including the inability to advise on plan selection. 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) OR apply to purchase a plan offered through the federal Marketplace. However, by asking some basic questions about United States citizenship/legal resident status, household income, and household composition, the Indiana Navigator may be better-able to 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 most efficient, or if the federal Marketplace 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 okay to do so. The Indiana Navigator should also explain that both the IAHC and the federal Marketplace 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 federal Marketplace. The federal Marketplace will then contact the consumer regarding eligibility to purchase coverage, as well as eligibility for Premium Tax Credits (PTC) and/or Cost-Sharing Reductions (CSR). Conversely, if the applicant completes the federal Marketplace application and that application reveals that the consumer may be eligible for an Indiana Health Coverage Program (IHCP), it will be routed to the Department of Family Resources (DFR) for processing.

The tables on the following three pages (see Table 65, Table 66, and Table 67) 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 federal Marketplace.

Adults with household income 105% of the Federal Poverty Level (FPL) or less should apply for Medicaid. Adults with household income over 105% up to and including 400% FPL may be eligible for subsidized coverage (Premium Tax Credits and Cost-Sharing Reductions) through the federal Marketplace and should apply through the federal Marketplace. Adults with household incomes over 400% FPL may apply for coverage through the federal Marketplace or through the outside market.

Pregnant women with household income 213% FPL or less should apply for Medicaid. Pregnant women with household income over 213% FPL up to and including 400% FPL may be eligible for subsidized coverage through the federal Marketplace and should apply at the federal Marketplace. Pregnant women with household incomes over 400% FPL may apply for coverage on the federal Marketplace or seek coverage on the outside market. Note, for Medicaid 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 Medicaid. Children under age 19 with household income over 255% FPL up to and including 400% FPL may be eligible for
subsidized coverage through the federal Marketplace and should apply at the federal Marketplace. Children under 19 with household incomes over 400% FPL may apply for coverage on the federal Marketplace or seek coverage on the outside market.

United States Citizenship, national, or legal residency status is also an eligibility requirement for both IHCP and federal Marketplace 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 these tables 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 through which “door” (IHCP or federal Marketplace) 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 to the other “door” 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 a longer if the “wrong” door was initially chosen; however, it saves the applicant the time of completing two separate applications.

Table 65: Eligibility Screening Chart for Non-pregnant Adults

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<th>100%</th>
<th>105%</th>
<th>125%</th>
<th>150%</th>
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**Best Door** Recommendation

- Apply for Medicaid [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)
- Apply for federal Marketplace [www.healthcare.gov](http://www.healthcare.gov)
- Apply on or off federal Marketplace

Household income at or below 105% FPL
Household income above 105% to 400% FPL
Household income above 400% FPL

*Medicaid uses the 2014 federal poverty level to determine eligibility; but the federal Marketplace will use the 2013 federal poverty level through the end of 2014

**For Medicaid applicants over 100% FPL, add “disregard” 5% of FPL and re-calculate eligibility for select types of Medicaid

Source: State of Indiana, Adult Income Chart (2014), [www.in.gov/healthcarereform/2381.htm](http://www.in.gov/healthcarereform/2381.htm)
### Table 66: Eligibility Screening Chart for Pregnant Women

**Income as a % of Federal Poverty Level (FPL) – 2014**

<table>
<thead>
<tr>
<th>Household size</th>
<th>15%</th>
<th>30%</th>
<th>50%</th>
<th>75%</th>
<th>100%</th>
<th>105%</th>
<th>125%</th>
<th>150%</th>
<th>213%</th>
<th>214%</th>
<th>255%</th>
<th>300%</th>
<th>400%</th>
<th>401%</th>
<th>425%</th>
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<tbody>
<tr>
<td>1</td>
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<td>$5,835</td>
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<td>$14,588</td>
<td>$17,505</td>
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<td>$24,974</td>
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<td>$4,719</td>
<td>$7,865</td>
<td>$11,798</td>
<td>$15,730</td>
<td>$16,517</td>
<td>$19,663</td>
<td>$23,595</td>
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<td>$33,191</td>
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<td>$29,685</td>
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<td>$41,794</td>
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<td>$78,120</td>
<td>$78,315</td>
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<td>$23,850</td>
<td>$25,043</td>
<td>$29,813</td>
<td>$35,775</td>
<td>$50,801</td>
<td>$50,801</td>
<td>$60,053</td>
<td>$71,550</td>
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</tr>
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<td>$34,888</td>
<td>$41,865</td>
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<td>$59,000</td>
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<td>$83,730</td>
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<td>$33,569</td>
<td>$39,963</td>
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<td>$54,045</td>
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<td>$42,095</td>
<td>$50,113</td>
<td>$60,135</td>
<td>$85,392</td>
<td>$84,808</td>
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<td>$120,270</td>
<td>$158,520</td>
<td>$158,916</td>
<td>$168,428</td>
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<tr>
<td>8+ for each additional add</td>
<td>$609</td>
<td>$1,218</td>
<td>$2,030</td>
<td>$3,045</td>
<td>$4,060</td>
<td>$4,263</td>
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<td>$16,120</td>
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</table>

**“Best Door” Recommendation**
- **Apply for Medicaid** [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)
- **Apply for federal Marketplace** [www.healthcare.gov](http://www.healthcare.gov)
- **Apply on or off federal Marketplace**

Household income at or below 213% FPL**
Household income above 213% to 400% FPL
Household income above 400% FPL

*Medicaid uses the 2014 federal poverty level to determine eligibility; but the federal Marketplace will use the 2013 federal poverty level through the end of 2014

**For Medicaid applicants over 100% FPL, add “disregard” 5% of FPL and re-calculate eligibility for select types of Medicaid

*Source: State of Indiana, Pregnant Women Income Chart (2014), [www.in.gov/healthcarereform/2383.htm](http://www.in.gov/healthcarereform/2383.htm)
### Table 67: Eligibility Screening Chart for Children

<table>
<thead>
<tr>
<th>Household size</th>
<th>15%</th>
<th>30%</th>
<th>50%</th>
<th>75%</th>
<th>100%</th>
<th>105%</th>
<th>125%</th>
<th>150%</th>
<th>213%</th>
<th>255%</th>
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<th>400%</th>
<th>401%</th>
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</tr>
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<tbody>
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<td>1</td>
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<td>$5,835</td>
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<td>$11,670</td>
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<td>$7,865</td>
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<td>$5,937</td>
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<td>$19,790</td>
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<td>$94,200</td>
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<tr>
<td>5</td>
<td>$4,187</td>
<td>$8,373</td>
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<td>$34,888</td>
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<td>$9,591</td>
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<tr>
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<td>$10,809</td>
<td>$18,015</td>
<td>$27,023</td>
<td>$36,030</td>
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<td>$20,045</td>
<td>$30,068</td>
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<td>$101,453</td>
<td>$118,890</td>
<td>$158,520</td>
<td>$158,916</td>
<td>$168,428</td>
</tr>
</tbody>
</table>

| 8+ for each additional add | $609 | $1,218 | $2,030 | $3,045 | $4,060 | $4,263 | $5,075 | $6,090 | $8,648 | $10,353 | $10,291 | $12,060 | $16,080 | $16,120 | $17,085 |

**Best Door** Recommendation

Apply for Medicaid [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)
Apply for federal Marketplace [www.healthcare.gov](http://www.healthcare.gov)
Apply on or off federal Marketplace

*Medicaid uses the 2014 federal poverty level to determine eligibility; but the federal Marketplace will use the 2013 federal poverty level through the end of 2014

**For Medicaid applicants over 100% FPL, add “disregard” 5% of FPL and re-calculate eligibility for select types of Medicaid

Source: State of Indiana, Child Income Chart (2014), [www.in.gov/healthcarereform/2382.htm](http://www.in.gov/healthcarereform/2382.htm)
D. How to Help Consumer Apply for Indiana Health Coverage Programs (IHCPs)

1. Medicaid (Hoosier Healthwise or Traditional, Fee-for-Service)

If the eligibility screening indicates that the applicant falls into the yellow section of the charts above (see Table 65, Table 66, and Table 67), an Indiana Health Coverage Application 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 IHCP. Applications will be accepted online, by mail or fax, by telephone, or in person at a local Division of Family Resources (DFR) office. Online application is recommended, both for consumers applying on their own behalf and for Indiana Navigators assisting consumers. The table below (see Table 68) gives more details on the different methods available for application.

<table>
<thead>
<tr>
<th>Application Method</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| Online (recommended)     | 1. Go to the DFR Web site, [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)  
                           | 2. Complete and submit application                                          |
| By Mail or Fax           | 1. Go to the DFR Web site, [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)  
                           | 2. Print paper application                                                   |
                           | 3. Complete and return application                                           |
                           |   • By mail: P.O. Box 1810, Marion, IN 46952                                |
                           |   • By fax: 1-800-403-0864                                                  |
| By Phone                 | Call the DFR at 1-800-403-0864                                              |
| In person at DFR offices | Find the local DFR office at [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov) |

To help the consumer complete an application for the consumer and for any dependents, the Indiana Navigator will need the following information. The consumer should come prepared with as much of this information as possible.

**Demographic Information**
- Full name
- Date of birth
- Social Security Number, if applicable
- Gender
- Marital status
- Home address, phone number
E-mail address
Language
Race and Ethnicity
Citizenship/Immigration information

Information about any existing health coverage

Income and household information
- Tax filing information
- Current employment and wages/salaries
- Any other form of income (Social Security, child support, alimony)
- Deductions
- Assets and resources

Whether the following statuses apply
- Pregnancy
- Blindness or Disability
- In a nursing or residential care facility
- In jail
- In foster care

The Indiana Navigator or Authorized Representative assisting the consumer in completing the Indiana Health Coverage Application should provide their address, phone number, and relationship to applicant. Additionally, Indiana Navigators should include their certification number on the application, as well as the name and certification number of the Application Organization (AO) with which they are associated, if applicable.

a. Using the Online Medicaid Application

As previously discussed, the Indiana Application for Health Coverage is accepted via multiple avenues; however, the online version is the preferred method and can be accessed at 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 can 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, clicking on the “Manage Current Benefits” link, and entering the following information.

- Case number
- Case name
- Date of birth
- Last four digits of SSN

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 federal Marketplace for assessment for coverage and Insurance Affordability Programs application); or (c) needs more information to make a decision. Indiana Navigators should remind consumers to look for this notice and respond promptly to all instructions and requests for information.

If a consumer receives a denial notice, the consumer may appeal the DFR’s decision. The figure below (see Figure 9) depicts the process of filing an eligibility appeal. 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.
*Appeals must be filed within 15 days of the notice OR before the date the decision goes into effect (listed on the notice); whichever is sooner.

*Source: Family and Social Services Administration (2013)*

c. Medicaid Eligibility Based on Blindness or Disability –As of June 1, 2014

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 SSA for benefits within 45 days of submitting the Indiana Medicaid application, it will be denied for a 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 figure below (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.
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 his or her 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.
Beneficiaries enrolled under the blindness or disability categories as of June 1, 2014 will retain their eligibility without regard to their disability status with the Social Security Administration. However, during all members’ next regular MRT progress report, disability status with SSA will be taken into account. To maintain eligibility, most members will need an SSA disability determination or a pending application at the time of their MRT progress report. Many current members already receive disability benefits from the Social Security Administration. Current members without SSA disability status may start the SSA application process prior to their next scheduled MRT progress report.

2. The Healthy Indiana Plan (HIP)

Non-disabled, non-pregnant adults between the ages of 19 and 64 who fall at or below 100% FPL (effective January 1, 2014) may be eligible for the Healthy Indiana Plan (HIP). If an Indiana Navigator is working with someone who falls into this category, the “best door” for coverage is likely the HIP application. If the consumer’s income is too high to be eligible for HIP, the application will be routed to the federal Marketplace. If the consumer is determined ineligible for HIP due to the program’s enrollment caps, the consumer may receive a recommendation to apply directly to the State Medicaid Agency.

The same type of information needed to complete the DFR Medicaid application is also needed to complete the HIP application. Indiana Navigators should work with consumers to ensure they have the required application information prior to starting the process. To access a HIP application, a consumer or Indiana Navigator may go online to find an application, visit a DFR office in person, or complete the application by phone.

a. HIP Application - Online

1. Go to State website
   - [www.in.gov/fssa/hip/2332.htm](http://www.in.gov/fssa/hip/2332.htm)
2. Click “HIP Application,” Selecting English or Spanish, depending on the preferred language
3. Print application

b. HIP Application – By Phone

- Call 1-877-GET-HIP9 (1-877-438-4479)
- Request that application be mailed

c. HIP Application – Where to Submit

Complete the application and deliver to local DFR office or send to:
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 Waiver Programs. These individuals have special needs; and there are specific resources dedicated to assisting them. See the Home and Community-Based Waivers section in the Medicaid portion of this training resource 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 resources below (see Table 69).

<table>
<thead>
<tr>
<th>Where to Go</th>
<th>Aged, Disabled, and Traumatic Brain Injury Waiver</th>
<th>Community Integration and Habilitation Waiver; Family Supports Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area Agency on Aging</td>
<td>1-800-986-3505</td>
<td>Bureau of Developmental Disabilities Services</td>
</tr>
<tr>
<td>1-800-545-7763</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 69: HCBS Waiver Contacts

4. Presumptive Eligibility (PE)

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 eligible” (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 tools (see Table 65, Table 66, and Table 67) may be presumptively eligible for certain Indiana Health Coverage Programs (IHCPs).
Before January 1, 2014, PE applied only to pregnant women, intending to encourage timely prenatal care. Beginning on January 1, 2014, Qualified Hospitals (QHs) 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 QHs may make PE determinations for those groups. To be determined presumptively eligible, the Qualified Provider (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 Indiana Health Coverage Application 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 Health Coverage Application.
E. How to Help Consumers Apply for Coverage and Insurance Affordability Programs on the federal Marketplace

If, when conducting a preliminary eligibility screening, an Indiana Navigator determines that a consumer falls into the blue or purple section of the charts above (see Table 65, Table 66, and Table 67), an application to the federal Marketplace is likely the best “door” for the application process. If a consumer falls into the blue section, the consumer may also be eligible for a Premium Tax Credit (PTC) 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 federal Marketplace makes all determinations about whether a consumer is eligible for PTCs and CSRs.

It is important to note that, while many Indiana Health Coverage Programs accept new applicants year-round, the federal Marketplace 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 federal Marketplace.
1. Federal Marketplace Applications Basics

a. Beginning the Federal Marketplace Application

There are three types of applications a consumer can complete to apply for coverage on the federal Marketplace. 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

To complete an application to the federal Marketplace, consumers must create an account on the federal Marketplace Web site, www.healthcare.gov. 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
- The number of other people in the household
  - Applying for coverage
  - Not applying for coverage
    - Already have coverage
    - Applying separately
Common Activities of Daily Living:

- Eating
- Bathing
- Dressing
- Toileting
- Transferring

b. Disability Question on the federal Marketplace 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 federal Marketplace disability question if the consumer and/or other household members:

- 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.

c. Employer Coverage Questions on the federal Marketplace Application

The federal Marketplace application may require consumers who are currently employed to provide the following information on the application:

- Employer name
- Employer Identification Number (EIN)
- Employer contact information (address, phone number, e-mail address)

The federal Marketplace 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 (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 federal Marketplace application

Indiana Navigators may direct consumers to the resources listed in the table below (see Table 71) for information needed to complete the federal Marketplace application for coverage and Insurance Affordability Programs.
### Table 71: Information Sources for the Federal Marketplace Application

<table>
<thead>
<tr>
<th>Question about…</th>
<th>Information Source</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Application</strong></td>
<td>Federal Marketplace website</td>
<td><a href="http://www.healthcare.gov">www.healthcare.gov</a></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td>Federal Marketplace Call Center</td>
<td>1-800-318-2596</td>
</tr>
<tr>
<td></td>
<td>Pay stub</td>
<td>Varies (from employer)</td>
</tr>
<tr>
<td></td>
<td>W-2 form</td>
<td>Varies (from employer)</td>
</tr>
<tr>
<td></td>
<td>Self-employed: Internal Revenue Service</td>
<td><a href="http://www.irs.gov">www.irs.gov</a> “Instructions for Schedule C”</td>
</tr>
<tr>
<td><strong>Citizenship/Immigration</strong></td>
<td>Federal Marketplace Call Center</td>
<td>1-800-318-2596</td>
</tr>
<tr>
<td></td>
<td>Social Security</td>
<td>1-800-772-1213; <a href="http://www.socialsecurity.gov">www.socialsecurity.gov</a></td>
</tr>
<tr>
<td></td>
<td>U.S. Citizenship and Immigration Services</td>
<td><a href="http://www.uscis.gov/glossary">www.uscis.gov/glossary</a></td>
</tr>
<tr>
<td><strong>Work history</strong></td>
<td>Social Security</td>
<td>1-800-772-1213; <a href="http://www.socialsecurity.gov">www.socialsecurity.gov</a></td>
</tr>
<tr>
<td><strong>Employer Coverage</strong></td>
<td>Employer</td>
<td>Varies (usually HR department)</td>
</tr>
<tr>
<td><strong>Reporting changes in income or family size</strong></td>
<td>Federal Marketplace Call Center</td>
<td>1-800-318-2596</td>
</tr>
</tbody>
</table>

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2. **Interaction with the federal Marketplace**

   **a. After completing an application**

   Indiana Navigators should inform consumers that, after completing an application, the federal Marketplace will contact them about eligibility or may need additional information to determine eligibility. The federal Marketplace 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 can 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.

b. To challenge a decision

A consumer may challenge a federal Marketplace decision in the following circumstances:

- The consumer disagrees with a federal Marketplace eligibility decision regarding enrollment in a Qualified Health Plan (QHP), Premium Tax Credit, (PTC) or Cost-Sharing Reductions (CSR).
- The consumer disagrees with the amount of PTC or CSR determined by the federal Marketplace.

Information on how to appeal a federal Marketplace 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 federal Marketplace call center for additional information. It is important to note that appeals usually have a time limit; so consumers wishing to appeal a federal Marketplace 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 federal 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 to arbitrate the dispute.

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 federal Marketplace in a timely manner to ensure continued QHP coverage and the proper level of affordability subsidy. Applicants should report the following changes to the federal Marketplace, or to their Indiana Health Coverage Program (IHCP), as soon as possible to avoid owing subsidies back at tax filing (federal Marketplace) or committing fraud (Medicaid). Changes in income, household size, and citizenship circumstances could also increase the amount of subsidy available for federal Marketplace plans or render a child or family eligible to enroll in a QHP or an Indiana Health Coverage Program.
Household Size—for example:

- Someone becomes pregnant
- Someone moves out of the house
- Someone passes away

Household Income—for example:

- Someone gets a new job
- Someone loses a job
- Someone gets raise

Household location—for example:

- 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 Marketplace.

Citizenship status—for example:

- Someone becomes a United States citizen or legal resident

Periodically, the federal Marketplace 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 IHCPs, QHPs, and Insurance Affordability Programs (PTCs and/or CSRs). However, Indiana Navigators should encourage consumers to notify the Division of Family Resources (DFR; Medicaid) or the federal Marketplace as soon as circumstances change. Timely communication of changes helps to avoid future problems with coverage.

d. Eligibility Re determinations

Both the State and the federal Marketplace 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 circumstances. A consumer with coverage on the federal Marketplace may authorize the federal Marketplace 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 federal Marketplace will need additional information from the consumer to make an eligibility redetermination.
If the State or the federal Marketplace can find enough data electronically to assess continued eligibility for enrollment in an IHCP, a QHP, and 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 he or she 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 federal Marketplace 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 health care services under these two programs. In Indiana, the Healthy Indiana Plan (HIP) 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. In addition, 1634 Status states may, but are not required to, operate a Medicaid spend-down program. 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 federal Marketplace 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.

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).

Agent (also known as Broker or Producer) 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 who sells health insurance products or receives compensation from a health insurance carrier 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 certified by the federal Marketplace.

Aid Category (see Eligibility Group)

Advanced Premium Tax Credit (APTC) (see Premium Tax Credit (PTC))
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 federal Marketplace eligibility or benefits can be made via an Appeal Request Form located at [www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf](http://www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf). Appealable decisions are specified on the form.

Applicable Large Employer is, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. Such an employer is eligible to enroll in the SHOP Marketplace and would not be subject to the employer shared responsibility payments.

Application Organization (AO) is an organization that has employees and/or volunteers helping Hoosier 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)). 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 is an individual or organization designated by a Medicaid or insurance affordability program applicant or beneficiary to act responsibly on his or her 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.

Auto Assignment is the process by which an individual who does not select a Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP) Managed Care Entity (MCE) at the time of the HHW or HIP 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.

Benefits (see Health Insurance)
Benefits Portal is a website developed and managed by the Indiana Department 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.ifcem.com/CitizenPortal/application.do.

Best Door refers to a consumer’s decision to either complete the Indiana Application for Health Coverage (IAHC) or the federal Marketplace application for health coverage based on certain eligibility criteria (e.g., Table 65, Table 66, and Table 67) determined by the consumer and/or the application assister (e.g., Indiana Navigator) assisting the consumer.

Broker (see Agent)

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 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

Care Management Organization (CMO) is an organization contracted with Indiana Health Coverage Programs (IHCPs) to perform the care management, prior authorization, and utilization management of physical, behavioral, and transportation services for members in Care Select. The CMO manages care for Care Select members through its network of Primary Medical Providers (PMPs), specialists, and other providers. Currently, MDwise and Advantage Health Solutions serve as Indiana’s Care Management Organizations.

Care Select is an optional health care program for Indiana Medicaid enrollees who have special health needs or would benefit from specialized attention. Care Select includes comprehensive care coordination for members. Individuals eligible for Care Select include those who are eligible for Medicaid on the basis of being aged, blind, disabled, a ward of the court or foster child, or a child receiving adoptive services or adoption assistance and have a specific medical condition.

Catastrophic Plan is a health plan available on and off the federal Marketplace for individuals who are under the age or 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 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 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 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 (also known as Transition Risk) is the gaining and losing of health insurance coverage. Individuals that experience a change in circumstances during the year that impacts their eligibility in the Marketplace or a state insurance affordability program may experience churn to another health coverage program for themselves or their dependents.

Coinsurance is a bill consumers might receive from their health care provider after a visit for a percentage of the cost of care.

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.
**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 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.

**Conflict of Interest Policy** is the state policy document published by the Indiana Department of Insurance (IDOI) by which all Indiana Navigators and AOs must comply. The document discusses what may constitute an actual or potential conflict of interest (i.e. financial 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 application processes for Indiana Navigators and AOs, the Indiana Navigator or AO must review this 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.

**Consolidated Omnibus Budget Reconciliation Act** (see **COBRA Insurance**)

**Consumer Assistant** is a broad term used to describe individuals or entities providing outreach, education, or enrollment assistance with a Marketplace or an Indiana Health Coverage Program. This term includes agents and brokers, Indiana Navigators, AOs, Federal Navigators, CACs, federal non-Navigator Assistance Personnel, or Champions of Coverage.

**Copay** (see **Copayment**)

**Copayment** (also referred to as **Copay**) is flat fee consumers may need to pay before they are seen by the healthcare provider. Some plans may charge copayments for some services and coinsurance for others.

**Cost-sharing** is a common feature of different health insurance plans, and the specific requirements vary between plans. A health plan’s cost-sharing policy can be found in their Summary of Benefits and Coverage.

**Cost-sharing reduction** is a health-plan discount on a Marketplace 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 meets all requirements for a PTC, is enrolled in a Silver Plan on the federal Marketplace, and whose household income is between 100% and 250% Federal Poverty Level (FPL) (or between 100% and 300% FPL for Native Americans).

**Coverage** (see **Health Insurance**)

Version 2.0 (as of June 18, 2014)
**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 federal Marketplace and manages the establishment, training, certification, monitoring, and oversight of Marketplace agents/brokers, carriers, and federal consumer assistants.

**Dependant** is a child up to 26 years old under the Affordable Care Act. The Affordable Care Act 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 his or her job). Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

**Division of Family Resources (DFR)** is a division of the Indiana Family and Social Services Administration (FSSA), which establishes eligibility for Medicaid, 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 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 29** for the 2014 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.

**Eligibility Redetermination** is the process by which an enrolled consumer is re-enrolled, terminated, or transferred into State Medicaid or the federal Marketplace. The eligibility redetermination is 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.

**Employee** (see **Common-Law Employee**)
**Employer Mandate** (also referred to as **Employer Shared-Responsibility**) is the ACA requirement that, stating January 1, 2015, employers with more than 50 full-time equivalent employees (FTEs) will be subject to tax penalties if at least one FTE receives a Premium Tax Credit (PTC).

**Employer Shared-Responsibility** (see **Employer Mandate**)

**Enrollment Period** is the time period in which certain individuals can apply and enroll for health coverage through the federal Marketplace. The term includes an open enrollment period, special enrollment period, and SHOP enrollment period.

**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. 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.

**Ethics** refers to the set of standards that an Indiana Navigator or Application Organizations (AO) must follow in order to better improve consumer access to accurate, unbiased information regarding the range of health coverage options. These standards include a commitment to consumers; self-determination; informed consent; competence; cultural competence and social diversity; adherence to conflicts of interest and privacy and confidentiality 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 a healthcare and social service funding agency within the 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. 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 Indiana Navigator and AO standards in relation to the federal Marketplace 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.

**Federal Marketplace** (also referred to as **Federally-facilitated Marketplace (FFM)**) is a federally-developed and federally-operated 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 CACs) that provide Marketplace outreach, education, and enrollment services. This is the Marketplace model used in Indiana.

**Federal Navigator**, established under the ACA ([42 U.S.C. 18031(i)](https://www.law.cornell.edu/uscode/text/42/part-II/chapter-III/title-42)) and [45 C.F.R. 155.210](https://www.gpo.gov/fdsys/pkg/FR-2013-09-11/pdf/2013-22125.pdf), is an entity or individual trained, certified, and provided with grant-funding by the federal government to provide Marketplace outreach, education, and enrollment services. Federal Navigators serving in Indiana must complete the Indiana Navigator certification process or AO registration process with the Indiana Department of Insurance.

**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. For 2014, the FPL for a single person is $973 per month, and $1,988 per month for a family of four.

**Federally-facilitated Marketplace (FFM)** (see **Federal Marketplace**)

**Fee-for-Service** (see **Traditional Medicaid**)

**Flexible Spending Account (FSA)** is a medical savings account that allows an individual and the individual’s employer to contribute pre-tax dollars towards the cost of 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.

**Free Look Period** is a period where a new insurance policy owner is able to terminate the contract without penalties such as surrender charges. A Free Look Period allows the contract holder to decide whether or not to keep the insurance policy. If the contract purchaser is not satisfied with the policy, the contract purchaser can receive a full refund for it.
**Full-time Equivalent Employee (FTE) Count** is a method under the ACA to count employees to determine if an employer is a small or large employer. 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.

**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 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

**Grandfathered Health Plan** is a health insurance policy that was in existence prior to the 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 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 federal Marketplace. 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 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 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 the Marketplace, including commercial health insurance products, Indiana Health Coverage Programs (IHCPs), and Medicare.
Health Insurance Benefits (see Health Insurance)

Health Insurance Carrier (see Insurer)

Health Insurance Coverage (see Health Insurance)

Health Insurance Insurer (see Insurer)

Health Insurance Issuer (see Insurer)

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 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 Provider (see Provider)

Healthcare.gov is a health insurance Marketplace website owned and operated by the federal 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 federal Marketplace and Partnership Marketplace states. The website also fragment those consumers who may be eligible for Medicaid, and has a separate portal for small businesses (the SHOP Marketplace).
Healthy Indiana Plan (HIP) is Indiana’s health coverage program for Hoosier adults between the ages of 19-64 whose incomes are at or below 100% FPL and who are not covered by Medicare or other Minimum Essential Coverage (MEC). HIP is authorized through an 1115 Waiver with the federal Centers for Medicare & Medicaid Services (CMS). Covered individuals and the State make monthly contributions to a POWER Account.

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 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 federal Marketplace or directly through an insurer, because they can no longer be denied coverage based on health status.

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 to prevent 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 20.

Hoosier Healthwise (HHW) is Indiana Medicaid’s program for low income families, pregnant women and children under the age of 19.

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 Application for Health Coverage (IAHC) is an application for an Indiana Health Coverage Program (IHCP) which may be submitted to DFR either online through the 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 68.
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. 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 or registered with the State of Indiana. IC 27-19 refers to these state consumer assistants as Indiana “Navigators” and “Application Organizations” (AOs), and provides certain requirements and guidelines for these consumer assistants. IC 27-19 gives the Indiana Department of Insurance (IDOI) the authority to implement and enforce the provisions established in this code.

Indiana Department of Insurance (IDOI) is an agency of the Indiana state government whose duty is to monitor and regulate the business of insurance in Indiana and give Hoosier consumers information on their options for obtaining insurance. IDOI has the authority, along with FSSA, to implement and enforce the provisions of Indiana Code 27-19, which establishes Indiana Navigator and AO standards in relation to the federal Marketplace and Indiana Health Coverage Programs (IHCPs) operating in Indiana.

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), Care Select, Traditional Medicaid, and home and community based waiver services (HCBS). Applications for IHCPs can be accessed through the DFR Benefits Portal at 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 or IHCP applications. An individual that meets the definition of “navigator” under Indiana Code 27-19-2-12 must be certified as an Indiana Navigator with the IDOI and abide by all the standards required of Indiana Navigators. An Indiana Navigator may, but is not required to be associated with an Application Organization.

Individual Mandate (also referred to as Individual Shared-Responsibility) is an 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.

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 Affordability Program refers to either of two programs—Premium Tax Credit (PTC) or Cost-sharing Reduction (CSR)—that was established by the 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 referred to as Issuer or Carrier), 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 AOs from receiving consideration from a health insurance issuer in connection with the enrollment of a consumer into a health plan.

Large Employer (also referred to as Large Group Employer) is an employer employing an average of at least 51 full-time employees and full-time equivalent employees (FTEs). Starting in 2015, employers with at least 51 full-time and FTE employees (101 beginning in 2016) will be subject to the employer shared-responsibility provisions of the ACA (the “Employer Mandate”). These employers will be subject to a fine levied by the IRS for each month in which they have one or more full-time employees receiving a Premium Tax Credit (PTC). These employers are not eligible for the SHOP Marketplace.

Large Group Employer (see Large Employer)

Major Medical Insurance is a health insurance plan that offers individuals comprehensive insurance against potential healthcare costs. Major Medical 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. However, some Major Medical Insurance products 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 the Hoosier Healthwise and HIP through MCEs for some populations.

Managed Care Organization (MCO) (see Managed Care Entity (MCE))
**Marketplace** (also referred to as **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 Affordable Care Act. The term includes a Federally-designated Marketplace (FFM or federal Marketplace), a Partnership Marketplace, or a State-based Marketplace. Indiana operates as a federal Marketplace.

**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 health care providers for serving eligible individuals.

**Medicaid Review Team (MRT)** 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 DFR of its decision.

**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 ACA, carriers must maintain a certain Medical Loss Ratio, which varies by market segment (Large Group 85%, Small Group 80%, Individual 80%). If a carrier does not meet the MLR requirement, individuals and small businesses will receive a refund.

**Medicare** is a federal insurance program administered by 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 ACA and individuals eligible for Medicare and not eligible for the federal Marketplace.

**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 22**.

**M.E.D. Works** is Indiana’s health care 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**)

Version 2.0 (as of June 18, 2014)
**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 the 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 benefit rate (also known as the Special Income Limit—$2,163 monthly in 2014) 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 must have for him/herself and his/her dependent(s) to meet the Individual Mandate under the Affordable Care Act. The list of MEC types 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. 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 will not be eligible for a Premium Tax Credit (PTC).

**Modified Adjusted Gross Income (MAGI)** is a methodology implemented for eligibility effective January 1, 2014 for insurance affordability programs. MAGI equals adjusted gross income 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 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.
**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 meets other standards, such as having essential community providers, maintaining a network that is sufficient in number and types of providers, and making the insurers 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 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 the 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. Current Medicaid eligibility methodologies are maintained for Non-MAGI populations in 2014 and beyond. 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 or organizations are trained and able to provide help to consumers, small businesses, and their employees looking for health coverage options through the Marketplace.

**Obamacare** (see Affordable Care Act (ACA))

**Office of Medicaid Policy and Planning (OMPP)** is a department within 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 Marketplace. The initial open enrollment period was October 1, 2013 through March 31, 2014. The next open enrollment period is November 15, 2014 through February 15, 2015. The annual open enrollment period is to be determined by the Centers for Medicare & Medicaid Services.
**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 Maximum** is the greatest amount that a consumer pays for healthcare services in any plan year before the insurance carrier pays 100% of healthcare costs. Out-of-pocket maximum is set by the federal Internal Revenue Service (IRS). For 2014, this maximum amount is $6,350 for an individual and $12,700 for a family.

**Partnership Exchange** (see *Partnership Marketplace*)

**Partnership Marketplace** (also referred to as *Partnership Exchange*) is a mix between the 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 or consumer assistance and outreach. Indiana does not follow this Marketplace model, but rather operates as a federal Marketplace.

**Patient Protection and Affordable Care Act (PPACA)** (see *Affordable Care Act (ACA]*)

**Pediatric** refers to children under the age of nineteen. Under the 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.

**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 Plans). Out-of-pocket expenses in 2014 are capped at $6,350 for individual plans and $12,700 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. (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, for coverage issued or renewed beginning January 1, 2014.

**POWER Account** (also referred to as Personal Wellness and Responsibility Account) is an account used to pay medical costs for HIP recipients. It is valued at $1,100 per adult. Contributions to the account are made by the State of Indiana and each participant. No participant will pay more than 2% of his/her family income on the plan.

**Pre-Authorization** (see Prior Authorization (PA))

**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 federal Marketplace 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 65, Table 66, and Table 67), 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 Tax Credit (PTC)** (also referred as **Subsidy**)

is a tax credit that lowers premium costs for certain eligible individuals to help them afford health coverage purchased through the federal Marketplace. An individual may apply for a PTC through the federal Marketplace, and the federal Marketplace determines the individual's PTC eligibility and maximum PTC amount. To be eligible for a PTC on the federal Marketplace operating in Indiana, an individual must: (1) be a U.S. citizens, 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% FPL; and (5) have no other MEC or an available MEC with a premium more than 9.5% of household income or that does not provide MV (at least 60% 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 (APTC)**).

**Presumptive Eligibility (PE)** is a determination by a Qualified Provider 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 two PE programs, PE for Pregnant Women and Hospital PE. PE for pregnant women (also referred to as “Managed Care”) provides temporary coverage of prenatal care services (Package P only). Hospital PE is PE determined by qualified hospitals for pregnant women (Package P only), children under 19, low-income parents and caretakers, the Family Planning Eligibility Program, or former foster children up to age 26.

**Presumptive Eligibility (PE) Qualified Entity** (see **Qualified Provider**)

**Primary Medical Provider (PMP)** is a healthcare provider selected or assigned to a beneficiary of a MCE (i.e., HHW or HIP). 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)** (also referred to as **Pre-Authorization**) is a process under which the medical necessity of a requested service is reviewed.
**Privacy and Security Agreement** refers to either the Indiana Navigator Privacy and Security Agreement or the Indiana AO Privacy and Security Agreement (two separate forms) published by the IDOI, by which all Indiana Navigators and AOs must comply. The agreement defines what constitutes a consumer’s “personal information” and discusses the privacy and security standards that all Indiana Navigators and AOs must follow in order to protect a consumer’s personal information. As part of the initial and renewal application processes for Indiana Navigators and AOs, the Indiana Navigator or AO must sign and submit this agreement to the IDOI.

**Producer** (see **Agent**)

**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.

**Qualified Health Plan (QHP)** is a health insurance plan that has been certified under the ACA to meet the criteria for availability through a Marketplace. All QHPs sold on the federal Marketplace 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 Plans (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 State Medicaid Agency to be capable of making determinations of PE and meets all the qualifications established by the state.
Re-enrollment is the yearly process by which consumers enrolled in a Qualified Health Plan (QHP) through the Marketplace take steps to re-enroll in coverage. Enrollment in a QHP lasts for one calendar year, at which time the enrollee must re-enroll in order to be covered through the Marketplace. All individuals enrolled in the federal Marketplace 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 federal Marketplace in the annual eligibility re-determination.

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 the 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.

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, Care Select, HIP, and Traditional Medicaid members identified as overusing or abusing services.

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.

SHOP Enrollment Period is the timeframe in which qualified employers may apply and enroll in the 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 (Small Business Health Options Program) Marketplace is the federal Marketplace available to small employers to purchase health coverage for their employees. Eligible employers for 2014-2015 must have 50 or fewer full-time equivalent employees. In 2016 and after, employers with 100 and fewer FTEs will be eligible for the SHOP Marketplace. Employers using SHOP can use brokers or can use SHOP independently. SHOP is located online at www.healthcare.gov/small-businesses/.
**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 in 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

**Small Employer** (also referred to as **Small Group Employer**) is an employer who employs 50 or fewer full-time equivalent employees (FTEs). Starting in 2014, a small employer may purchase health insurance for its employees using the SHOP Marketplace. Employers that have fewer than 25 FTEs may qualify for tax credits on the SHOP Marketplace. Starting in 2016, the amount of FTEs used to define small employer will be raised to 100 full-time equivalent employees.

**Small Group Employer** (see **Small Employer**)

**Social Security Administration (SSA)** is a federal agency through which Indiana Medicaid disability applications go through, effective June 1, 2014, 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 to SSA.

**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 Medicaid Review Team (MRT) process. SSDI is also a source used to determine a consumer’s disability status through the federal Marketplace application.

**Stand-Alone Dental Plan** refers to the dental-only health insurance plans offered through the Health Insurance 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 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.

**Subsidy** (see **Premium Tax Credit (PTC)**)
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 FSSA is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. Additional information on the program can be found on FSSA’s website at www.in.gov/fssa/dfr/2691.htm.

Supplemental Security Income (SSI) is a federal program that pays benefits to adults and children determined disabled by the 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 federal Marketplace application.

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 63.

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.

State-based Marketplace is a 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. Indiana does not follow this Marketplace model, but rather operates as a federal Marketplace.

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, by phone at 1-800-403-0864, or by visiting a DFR local office listed at www.in.gov/fssa/dfr/2999.htm.

Traditional Medicaid (also referred to as Fee-for-Service) 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.

Transition Risk (see Churn)
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.

Web Interchange is a secure website operated by the IHCP to allow IHCP-enrolled providers to check member eligibility, receive information on claims payment, update their provider profile and submit 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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>AGI</td>
<td>Adjusted Gross Income</td>
</tr>
<tr>
<td>AO</td>
<td>Application Organization</td>
</tr>
<tr>
<td>APTC</td>
<td>Advance Premium Tax Credit (a type of Premium Tax Credit (PTC))</td>
</tr>
<tr>
<td>AV</td>
<td>Actuarial Value</td>
</tr>
<tr>
<td>BPHC</td>
<td>Behavioral and Primary Healthcare Coordination Program</td>
</tr>
<tr>
<td>CAC</td>
<td>Certified Application Counselor</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>CMO</td>
<td>Care Management Organization</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid</td>
</tr>
<tr>
<td>CSR</td>
<td>Cost-sharing Reduction</td>
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<td>Federally-Facilitated Exchange (also known as Federally-Facilitated Marketplace (FFM))</td>
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<td>FMAP</td>
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<td>Hoosier Healthwise</td>
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<td>Health Savings Account</td>
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<td>Indiana Application for Health Coverage</td>
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<td>Indiana Department of Insurance</td>
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<td>IHCP</td>
<td>Indiana Health Coverage Program</td>
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<td>Modified Adjusted Gross Income</td>
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<td>MCE</td>
<td>Managed Care Entity (also known as Managed Care Organization (MCO))</td>
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<td>MV</td>
<td>Minimum Value</td>
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<td>Medical Loss Ratio</td>
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<td>Medicaid Review Team</td>
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<td>Acronym</td>
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<td>Personal Wellness and Responsibility Account</td>
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<td>Patient Protection and Affordable Care Act</td>
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<td>Preferred Provider Organization</td>
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<td>PTC</td>
<td>Premium Tax Credit (one type is called Advanced Premium Tax Credit (APTC))</td>
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<td>QHP</td>
<td>Qualified Health Plan</td>
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<td>Qualified Income Trust (also referred to as Miller Trust)</td>
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<td>Qualified Provider</td>
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<td>Small Business Health Insurance Options Program</td>
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<td>SNAP</td>
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<td>Supplemental Security Income</td>
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<td>TANF</td>
<td>Temporary Assistance for Needy Families</td>
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<td>TMA</td>
<td>Transitional Medical Assistance</td>
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## Revision History

### I. Consumer Assistance Basics

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Summary of Changes</th>
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<tr>
<td>7/30/2013</td>
<td>1.0</td>
<td>Initial Baseline</td>
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</tbody>
</table>
| 6/20/2014 | 2.0    | **NEW**: Chapter Objectives section  
  |         | **NEW**: Key Terms section  
  |         | **NEW**: Introduction to federally-mandated consumer assistants  
  |         | **UPDATE**: Federal Navigator grant opportunity language reflects implemented grant application and selection process  
  |         | **UPDATE**: Source information for tables and figures, including:  
  |         |   - **NEW**: Federal Navigator requirements  
  |         |   - **NEW**: Certified Application Counselor primary duties  
  |         |   - **NEW**: Requirements to receive designation as a Certified Application Counselor  
  |         |   - **NEW**: Requirements and possible enforcement actions permitted for the Indiana Department of Insurance  
  |         |   - **NEW**: Options and Requirements for Indiana Navigators  
  |         |   - **NEW**: Steps to protect consumer personal information  
  |         |   - **NEW**: Similarities and Differences Between Health Insurance Producers, Agents, and Brokers  
  |         |   - **NEW**: Standards of Ethical Behavior  
  |         |   - **NEW**: Most Common Non-English Languages Spoken in Indiana  
  |         |   - **NEW**: Percent of Hoosiers with Disabilities  
  |         | **UPDATE**: Clarify requirements for federal Navigators to participate in Indiana Navigator program  
  |         | **UPDATE**: Update the application deadline (7/10/14) and decision date (9/8/14) for Federal Navigator grants  
  |         | **NEW**: Certified Application Counselor (CAC) section  
  |         | **MOVE**: State roles and responsibilities moved toward the beginning of the Consumer Assistance section  
  |         | **NEW**: Tool to determine if an individual or organization must be certified as an Indiana Navigator or Application Organization by the State  
  |         | **UPDATE**: The role of the Indiana Department of Insurance and Family and Social Services Administration  
  |         | **UPDATE**: State mechanisms for monitoring and oversight for Indiana Navigators and Application Organizations  
  |         | **NEW**: Application requirements for organizations that have multiple physical locations  
  |         | **NEW**: Becoming an Application Organization – Privacy and Security section  
  |         | **NEW**: Obtaining and Maintaining Application Organization registration -
Reporting Requirements section

- **NEW**: Timing requirements for completing the criminal background check to become an Indiana Navigator
- **UPDATE**: Consolidate criminal background check options for individuals and organizations from two tables to one table
- **NEW**: Instructions to obtain a copy of the Indiana Navigator certification
- **NEW**: Instructions to obtain a copy of the Indiana Navigator certification
- **MOVE**: Relocate Conflict of Interest Disclosure Form section
- **UPDATE**: Clarify requirements for federal- vs. state-certified consumer assistants
- **UPDATE**: Clarify consumer assistant ability to receive compensation for services
- **UPDATE**: Clarify different Privacy and Security forms for Indiana Navigators and Application Organizations
- **NEW SECTION**: Helping a Consumer Apply for Coverage

### II. Medicaid Basics and Indiana Health Coverage Programs (IHCPs)

<table>
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<tr>
<th>Date</th>
<th>Version</th>
<th>Summary of Major Changes</th>
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<tr>
<td>6/20/2014</td>
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<td>• <strong>NEW</strong>: Chapter Objectives section</td>
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<td></td>
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<td>• <strong>NEW</strong>: Key Terms section</td>
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<td></td>
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<td>• <strong>UPDATE</strong>: Care Select vendors and program phase-out planned for January 2015</td>
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<td>• Social Security Administration disability application requirements for the following groups:</td>
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<tr>
<td></td>
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<td>  - <strong>NEW</strong>: M.E.D. Works (MA W only)</td>
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<td>  - <strong>NEW</strong>: Home and Community-Based Waivers</td>
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<td>  - <strong>NEW</strong>: Blind (MA B)</td>
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<tr>
<td></td>
<td></td>
<td>  - <strong>NEW</strong>: Disabled (MA D)</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>REMOVE/UPDATE</strong>: Reflect changes to the spend down program</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>UPDATE</strong>: M.E.D. Works monthly income limits</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>NEW</strong>: Added a section on the 1915 (i) Behavioral and Primary Healthcare Coordination program (purpose, eligibility and targeting criteria, and brief application instructions)</td>
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<td></td>
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<td>• <strong>UPDATE</strong>: Updated all references to the SIL/300% of the maximum federal benefit rate for institutional and HCBS</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>UPDATE</strong>: 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</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>UPDATE</strong>: Updated income eligibility limits for all MAGI categories based on 2014 FPL</td>
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<td>- HIP</td>
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<td>- HHW children</td>
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<td>- CHIP children</td>
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<td></td>
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<td>- Pregnant women</td>
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</table>
- **UPDATE:** Updated Family Planning Eligibility Program income eligibility levels for 2014
- **REMOVE:** 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.
- **NEW:** Specified the date through which Congress has authorized Transitional Medical Assistance (March 15, 2015)
- **UPDATE:** Updated spousal impoverishment standards (income and resources minimums and maximums) for 2014
- **NEW:** 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.
- **MOVE:** 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:
  - Description of the different ways in which blind and disabled members can apply for Medicaid coverage post-1634 transition (through SSA & IN Medicaid)
  - New requirement for applicants under the blindness and disability categories to obtain an SSA determination, and exceptions to this requirement
  - Description of when MRT will make a disability decision if the SSA has a disability denial on file
  - Description of the obligation of current members to obtain a disability determination from SSA at the time of the progress report
  - Specified that the previous description of the Medicaid application process applies until June 1, 2014
- **REMOVE:** Removed Eligibility Notices section.
- **NEW:** 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/.
- **NEW:** Added a short section on specific eligibility redetermination requirements for members eligible based on blindness or disability.
- **REMOVE:** Deleted 1/1/14-3/31/14 Eligibility Redeterminations Section

### III. Health Insurance Basics and the Federal Marketplace

<table>
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<td>1.0</td>
<td>• Baseline</td>
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<tr>
<td>6/20/14</td>
<td>2.0</td>
<td>• <strong>NEW:</strong> Chapter Objectives section</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>NEW:</strong> Key Terms section</td>
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<td>• <strong>NEW:</strong> Subsection describing Grandmothered, or Transitional, health plans.</td>
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<td>• <strong>NEW:</strong> States can elect to establish only a SHOP while HHS operates the individual market Exchange.</td>
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<td>• <strong>UPDATE:</strong> The open enrollment period for 2015.</td>
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<td></td>
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<td>• <strong>NEW:</strong> Calculating worker hours.</td>
</tr>
</tbody>
</table>
- **NEW:** Additional guidance to assist employers on how to account for various employee types and circumstances.
- **NEW:** Calculating whether employers employ enough employees to be an applicable large employer for 2015.
- **NEW:** Individual and SHOP applications.
- **NEW:** Defining a combination of full-time and part-time equivalent employees.
- **UPDATE:** The percent of full-time employees or full-time equivalent used to access the shared responsibility payment.
- **UPDATE:** Transition relief from the shared responsibility payment.
- **UPDATE:** The maximum out-of-pocket limits for 2015.
- **UPDATE:** Out-of-pocket maximum for stand-alone dental plans.
- **NEW:** The framework for a Quality Rating System (QRS) is being developed.
- **UPDATE:** Requirements surrounding Student Health Plans.
- **NEW:** Beginning in January 1, 2015, there will be new provisions surrounding same-sex spouses.
- **UPDATE:** Requirements surrounding wellness programs.
- **REMOVE:** Maximum deductibles for the small group market in 2015 removed as of April 1, 2014.
- **NEW:** New guidance surrounding victims of domestic abuse who wish to claim a Premium Tax Credit.
- **NEW:** Handling incorrect calculations of Premium Tax Credit.
- **NEW:** Handling incorrect calculations of Cost-sharing Reductions.
- **NEW:** Limited circumstances in which special enrollment periods for consumers.
- **NEW:** Exceptional circumstances considered for retroactive Premium Tax Credit and/or Cost-sharing Reductions.
- **REMOVE:** Two limited circumstances (#4, 9) were removed to avoid duplication.
- **UPDATE:** QHP grievance procedures to address individual complaints.
- **UPDATE:** Minimum Essential Coverage Table.
- **UPDATE:** United States Preventive Task Force Recommended Preventive Services Table.
- **UPDATE:** Health Resources Services Administration Recommended Women’s Preventive Services.

### IV. General Guide for Indiana Navigators: Helping Consumer Apply for Health Coverage

<table>
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<tr>
<th>Date</th>
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